Report to the Massachusetts Special Commission on State Institutions

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Introduction

This report was prepared by the Center for Developmental Disabilities Evaluation and Research (CDDER), a center within the Eunice Kennedy Shriver Center at UMass Chan Medical School, for the Special Commission on State Institutions. This Commission, established by section 144 of the Fiscal Year 2023 Budget, was formed "…to study and report on the history of state institutions for people with intellectual or developmental disabilities or mental health conditions in the Commonwealth…" (Special Commission on State Institutions, 2022). The Commission is directed to:

(i) review existing records in the possession of the Commonwealth related to the network of current and former state institutions for people with intellectual or developmental disabilities or mental health conditions;
(ii) examine the current availability of and barriers to accessing records by former residents of such institutions, their descendants and relatives, and the general public;
(iii) assess and compile records of burial locations for the residents who died while in the care of such institutions;
(iv) determine the likelihood and possible locations of unmarked graves at sites of former state institutions for people with intellectual or developmental disabilities or mental health conditions; and
(v) design a framework for public recognition of the Commonwealth's guardianship of residents with disabilities throughout history, which may include, but shall not be limited to, recommendations for memorialization and public education on the history and current state of the independent living movement, deinstitutionalization and the inclusion of people with disabilities.

In 2023, the Commission selected CDDER as the entity to support its work. Since that time, CDDER has been gathering information through key informant interviews, review of articles and books about these institutions and Massachusetts history, review of Massachusetts state law, review of indices and catalogs of materials, review of laws and practices of other states, and review of hundreds of documents. CDDER has prepared this report of its findings for the Commission's review to help establish a foundation of information to inform its formulation of recommendations.

This report begins with a timeline of events relevant to how the Commonwealth addressed people with mental health conditions and people with intellectual or developmental disabilities who needed public assistance. This timeline is relevant to trace when state institutions were established, and when and how the institutions started serving specific groups of people through many of their closures. The arc of this timeline follows a changing social context both within Massachusetts and nationally of how people with mental health conditions and people with intellectual or developmental disabilities were considered by society. This timeline aids in

providing a framework for public education on the history and current state of deinstitutionalization and inclusion, in alignment with part of the charge of the Commission.

This report includes references and terms that were used at various times in history to describe people with mental health conditions and people with intellectual or developmental disabilities that are offensive today. These terms are presented as they were historically used, including in the names of institutions, to highlight changes in social history, particularly in how people with mental health conditions and people with intellectual or developmental disabilities were regarded and valued as citizens. How people were thought of at any point in this history, whether they were considered “paupers”, “inmates”, “patients”, “students”, or “consumers”—and often an incoherent mix of these and other designations—shaped the approaches to how they were treated, the rights they had, and how they were classified. These approaches influenced how people were treated in life, in death, and during burial, as well as the laws governing their treatment in institutions and the records related to their time there.

This report then reviews the information gathered to date about records containing information on people who lived at institutions in the Commonwealth, including those that are still in the Commonwealth’s possession and those that are not. It also reviews the laws governing retention and access to these records, including peoples’ accounts of their experiences when trying to obtain records of their institutionalized, deceased family members. The report then covers what is known about where the people who died while living in institutions are buried, whether their graves can be identified, and how the bodies of people who died at institutions were handled over time. Finally, the report presents models from other states that have created frameworks for remembrance for people who lived in institutions. Throughout these sections, multiple opportunities are presented to the Commission for their consideration as they formulate their report of findings and recommendations for next steps.

Executive Summary

Historical Timeline

In order to examine the history of institutions in Massachusetts for people with mental health conditions and people with intellectual or developmental disabilities, it is important to review how the state originally took care of different groups of people who needed public assistance and how the systemic approaches changed over time.

Public Welfare Laws and Programs

This timeline begins with how public assistance was provided to people in Massachusetts beginning with the Massachusetts Bay Colony, formed by English Settlers in the 1600s. Initially people who needed assistance in these colonial times were all supported in the same models (Almshouses), with labels such as “paupers” or the “poor”. A series of laws were created and changed over time, governing public assistance for people who needed it beginning in this era. These laws changed in response to many forces, the first of which were related to financial pressures about how to pay for public assistance. Early on towns funded services. However, as financial pressures mounted, towns tried to limit the number of people they needed to support by passing costs onto shipmasters and train operators that brought people from other states or countries needing support, or pressuring out people labeled as “outsiders”, or trying to get financial resources from the person’s family members.

As these approaches evolved, colonial laws gradually restricted the rights of individuals requiring public assistance. For instance, beginning in 1693, legal measures were established to allow for the seizure of property from those unable to support themselves in order to cover the costs of their care. In a related shift, the status of individuals who needed assistance and were considered incapable of working was changed from “pauper” to “inmate”.

Early in the 1700s, individuals with support needs who were deemed “weak, sick, and unable to work” became increasingly overrepresented in correctional systems. Oversight groups established to monitor Almshouses and other forms of pauper support observed the dire conditions and poor outcomes for those within these institutions. In response, recommendations emerged to provide separate care for individuals with mental health conditions and people with intellectual or developmental disabilities (under different labels at the time), recognizing the negative consequences of existing models where all individuals were treated together. Since there were minimal quality standards in place around public services, people with mental health conditions or people with intellectual or developmental disabilities who needed and depended on these supports were frequently found to be living in suboptimal, inhumane conditions. Subsequently, lawmakers created separate service models for these specific populations to try to ensure their support and safety.

At the same time, different public institutions emerged to separate out those who were considered able to work; these people were expected to work in structured environments designed to use their labor to financially support their assistance.

As Massachusetts was formed into a state in 1788, towns were organized into counties, and the cost of providing assistance to people shifted from towns to counties. Eventually, costs shifted to state systems, paving the way for more congregate, institutional care. Privatization of care was attempted with unfavorable results due to low funding and few requirements or oversight. Guardianship[1] had been introduced by the court system in colonial Massachusetts and expanded to the children of people under guardianship just before Massachusetts became a state. Through this evolution, people with mental health conditions and people with intellectual or developmental disabilities increasingly lost their rights and property, eventually being committed to these institutions, unable to leave on their own free will.

A Shift to State-based Care and Introduction of Medical Models

The state-based institutions for care that emerged increasingly moved to a more medical model with the introduction of state hospitals. These hospitals were formed in attempts to keep people with mental health conditions and people with intellectual or developmental disabilities out of the correctional systems, and as the medical field advanced, to offer treatment to these populations. Laws emerged requiring humane treatment of these populations of people needing assistance in the early 1800s. While conditions may have improved compared to their prior treatment, these laws were not sufficient to ensure human treatment of people with disabilities in institutions, and many experienced horrid conditions, abuse and neglect.

Reform Movement of the Mid-1800s

Reform movements in the Commonwealth were underway in the mid-1800s based on models observed in Europe reforms which were focused on rehabilitation. Further differentiation emerged in the treatment of people with mental health conditions to try to distinguish between those that were considered to be “curable” and not, with those considered more curable to be referred for “treatment” to specialized mental health hospitals which were emerging. State hospitals were built for people with mental health conditions which had infirmary-like settings, as well as residential quarters with correctional-cell-like features to keep people under lock and key. Commitment and discharge processes to these institutions became more formalized in the 1800s. Rules and regulations were created about discipline, inspections, etc. Despite this shift to a more hospital-based model, these state hospitals considered the patients at state hospitals to be inmates.

During this period, populations of people with mental health conditions or intellectual or developmental disabilities were further split, with separate institutional models being created for people considered to have an intellectual disability. Additionally, separate models of care

[1] Guardianship is a legal process where an individual is appointed by the court to make decisions on behalf of someone else who is deemed unable to make their own decisions.

were formed for children. Children who were paupers began being bound out to families to work, while the Commonwealth separately explored whether children with disabilities could be educated. Specialized schools, like the Perkins Institution and the Asylum for the Blind and the Experimental School for Teaching and Training Idiotic Children were formed to experiment in teaching these children, who were not previously educated in traditional school systems.

In the early and mid-1800s, the U.S. Industrial Revolution was gaining momentum and residential Reform schools were introduced to teach job skills to children who were considered to be “paupers”, “disobedient”, or involved with minor crimes through education, religion, moral instruction and training in the trades. These schools were an alternative to adult prisons. While children with disabilities were frequently sent to Reform schools, the schools struggled to support children with disabilities. Around this same time, as more people moved to cities during the onset of the Industrial Age, public safety fears regarding people with mental health conditions grew. These forces led governmental leaders to establish a system of hospitals and asylums to confine psychiatric patients. By the latter half of the 19th century, many states had opened public psychiatric asylums. Between 1870 and 1930, the state rapidly expanded institutional settings, building 10 new institutions for people considered to be “mentally ill” and “training schools” for people with intellectual or developmental disabilities across the state. This period of expansion ended with the opening of the Metropolitan State Hospital, a mental health institution, in 1930.

The segregation of people with disabilities from society intersected with a growing eugenics movement, promoting the idea that healthy and "superior" people should reproduce, while those deemed inferior, such as those with disabilities or who didn't fit societal norms, should not. Eugenicists believed society would benefit by removing people they considered unfit through segregation, social exclusion and sterilization. Monson State Hospital for Epileptics, in particular, became involved in eugenics in the early 1900s with the Superintendent of the hospital, an advocate and tester of eugenic sterilization. Staff at Monson conducted studies on the pedigree of some inmates, hosted a eugenics conference on the hospital grounds, and carried out sterilizations of residents despite these procedures being illegal in the state. (Danielson & Davenport, 1912; Paul, Julius, 1965).

Growing Civil Rights and a Call for More Community-Based Care

In the 1920s, there were calls for institutions to be radically downsized in favor of “decentralized” community care and education of people with intellectual disabilities. Institutions had become both severely overcrowded and severely underfunded by the state. During this time, there were key advancements in social policies, including the Social Security Act (1935) to provide federal financial support to people with disabilities. There was also building momentum of the organization of advocates, separately, on behalf of people with mental health conditions, and on behalf of people with intellectual or developmental disabilities, particularly parents of children with intellectual or developmental disabilities. Around the same time, a series of documentaries exposing horrific treatment and grave abuses

at the institutions were released. Together with the advocacy groups that had formed, these efforts created public support for change. Eventually in the 1960s, after then-President Kennedy's calls for change, deinstitutionalization and community services started to emerge, along with major social advances, including the Civil Rights Act establishing protections against discrimination toward people with disabilities and the establishment of Medicare and Medicaid programs which offered crucial support for people with disabilities.

Legal Framework Emerges for Deinstitutionalization

In the 1970s, class action lawsuits were filed in Massachusetts on behalf of people with intellectual disabilities regarding the conditions at the state institutions as a violation of the residents' statutory and constitutional rights. As a result, the first community-based residential programs were created in the Commonwealth for people with intellectual or developmental disabilities. In 1976, the Center for Public Representation filed a class-action lawsuit (Brewster vs. Dukakis) on behalf of patients at Northampton State Hospital. The case was settled in 1978 with a consent decree, which mandated the creation and funding of community-based mental health services.

During the 1970s, the Independent Living Center model emerged to assist citizens with disabilities to live independently in their community of choice. Federally, Section 504 of the Rehabilitation Act of 1973, and federal court rulings separately regarding people with "mental illness" established that people can't be institutionalized in a psychiatric hospital against their will unless determined to be a threat, and that people with intellectual disabilities must be served in the least restrictive setting leading to a pathway of more community-based care options. Leaders in Massachusetts began closing institutions, both for people with mental health conditions and for people with intellectual or developmental disabilities. The last state mental health hospital, Metropolitan State Hospital, closed in 1992.

The Americans with Disabilities Act (ADA), passed in 1990, is a civil rights law that prohibits discrimination against individuals with disabilities in areas like employment, public services, and public accommodations. In 1999, the U.S. Supreme Court's Olmstead v. L.C. decision interpreted the ADA to mean that unjustified segregation of people with disabilities is discriminatory. The Court ruled that individuals have the right to receive services in the most integrated setting appropriate, which often means community-based care rather than institutionalization. Together, the ADA and the Olmstead decision support the rights of people with disabilities to live and participate fully in their communities.

Current Day

Currently, two institutions remain open for people with intellectual and developmental disabilities, Wrentham and Hogan Developmental Centers, overseen by the Department of Developmental Services.

For people with Serious Mental Illness, the Department of Mental Health oversees a network of state hospitals, psychiatric units, and community mental health centers that provide inpatient and residential services.

The Office of Inpatient Management of the DMH currently operates Taunton State Hospital, the Worcester Recovery Center and Hospital, and the Dr. Solomon Carter Fuller Mental Health Center. In addition, DMH Office of Inpatient Management operates inpatient psychiatric units at two Department of Public Health hospitals, the Hathorne Units at Tewksbury State Hospital and the Metro Boston Mental Health Units at Shattuck Hospital. DMH services in these hospitals / units include continued care and treatment for individuals with longer term needs for mental health treatment and acute forensic mental health evaluation and treatment for individuals with mental health and criminal justice involvement. Worcester Recovery Center and Hospital also offers adolescent inpatient services. The Recovery From Addictions Program at Taunton State Hospital provides substance abuse services to individuals with substance use concerns.

In addition, the Department of Mental Health operates two community mental health centers with inpatient beds: Cape Cod and Islands (Pocasset) Mental Health Center in Bourne, Corrigan Mental Health Center in Fall River. These inpatient units admit individuals referred for acute mental health evaluation and treatment. Additionally, DMH funds secure Intensive Residential Treatment Programs (IRTPs) for adolescents and a Clinically Intensive Residential Treatment Program (CIRT) for children, which offer structured care designed to reduce reliance on long-term hospital stays and support transitions back to community settings.

There is one mental health correctional center, Bridgewater State Hospital, that houses males with civil commitments without criminal sentences, and pre-trial detainees sent for competency and criminal responsibility evaluations by the court run by the Department of Corrections.

Records and Records Access

As people with intellectual or developmental disabilities and people with mental health conditions were supported by public support systems, various types of records were generated.

The documentation of patient information in Massachusetts state asylums, hospitals, and schools for people with intellectual or developmental disabilities has evolved significantly over time, with an increasing focus on detail. The information in these records was largely driven by the purpose of the record and the prevailing requirements at the time, frequently coming from laws, regulations and policies. What was collected in records changed across history as the groups that supported people changed, and the requirements of documents changed with the evolving inclusion of the medical, educational, and regulatory oversight systems.

The patient admission records from Massachusetts state institutions were created to track patient support, admissions, and discharges, beginning with the 1863 establishment of the Board of State Charities. These records, sent to the Board and its successors, documented patients in various institutions for the “mentally ill” and the “feeble-minded,” with records spanning from the mid-19th to the early 20th century.

Early records were organized by the form of support (state or private), but later registers were arranged numerically by registration number. These records were used for institutional oversight and patient management, with some registers including patients admitted before their respective registers were created. Early institutions collected data to show they were worth the state funding they received. Superintendents were legally required to submit annual statistical reports to the state legislature (Bank & Schore, 1981).

Institutional records typically include detailed information about each patient, such as name, age, sex, marital status, birthplace, and how they were committed (e.g., by court, family, or transfer). They also note the patient's source of support (state, town, private), admission and discharge dates, and sometimes remarks about the patient’s condition, cause of death, or transfer. These early institutional records, however, provided little detail about the care or treatment provided. Additionally, the quality of these records was often problematic. Medical notes, which were sometimes lengthy and time-consuming to write, were often rendered ineffective due to poor legibility, leading them to be considered useless in the long run (Bank & Schore, 1981).

Early case files at the State Schools for the disabled included demographic information and information about the patient’s physical and mental health condition, their parentage, birthplace, and family history, and the results of psychological and intelligence tests. The record often included correspondence with state boards, parents, guardians, and other caretakers. Some records included discharge papers and death certificates.

Annual reports from Massachusetts State Schools, prepared by the superintendent, included statistical data and summaries of school activities over the past year, and served as the trustees' annual report. Major departments submitted reports to the superintendent, including the research unit and the traveling school clinic, as well as departments responsible for social services, education, medical and dental services, and industrial training. The reports included information about operations and expenditures, aggregate information about admissions, transfers, and releases, as well as the general health of the population.

Over time, the documentation in individual records increased to include a photograph of the resident, results of psychological assessments, analysis of physical examinations and routine reports by doctors of the resident’s condition and progress. The most detailed records included information such as a cover sheet with personal, commitment, and discharge information, records of physical, neurological, and mental health examinations, dental records, photographs,

weight, diet, and menstruation charts, patient history, attendant and nursing notes. As genetic testing became available, certain records may also have this information.

The main types of records that were kept across time include:

- Applications for services, commitments, transfers and discharge records, including probate court commitment orders, medical certificates, as well as waiting lists.
- Census listings about who was living at publicly funded institutions in a given year.
- Individual files, inclusive of:
    - medical and treatment records, psychometric test results, physical examination records, mental age, IQ, medical history and medical needs, medications and diagnoses,
    - educational records, academic grades and testing,
    - disciplinary records,
    - court records, and
    - family history, and social relations, such as family supports and personal interests.
- Incident-related records such as data on hospitalizations, restraints, behaviorally related incidents, and investigations of allegations of abuse or neglect.
- Annual and sometimes quarterly reports included information about institutional finances, operations, programming, and other statistical information.
- Burial and death records, and autopsy and pathology reports
- Regulatory oversight and auditing records.

Some of the records from institutions are available online, some are held by the Massachusetts agencies governing the services of these populations or the Massachusetts State Archives, some are in university libraries, some are in private collections. Additionally, some have been destroyed in fires or lost. There is a documented history of some mishandling of records at former institutions where the records were left unsecured on closed campuses. There have also been accounts of records from institutions being sold publicly on auction websites.

The maintenance and retention of institutional records, the laws dictating which records must be retained and archived, and the practices governing access to these records have changed over time. Under existing retention laws, if individual records are transferred to the State Archives, routine records older than 20 years would not be preserved.

Currently, incomplete archives of individual records remain from the state institutions. The existing records are stored in different locations. The details of what records remain vary depending on the entity which maintains the records, and the level of detail of their accounting of the records. The state of preservation and quality of the environment in which the records are held also varies. The access procedures for these records also vary depending on the entity that holds the records.

The Harvard Law School Cyberlaw Clinic provided an analysis of the laws that govern third-party access to government-held healthcare records. They found that *"few laws and regulations are directly applicable to the records"* and *"For most of these laws, there are only a few cases discussing their requirements as understood by the courts."* Their analysis examined "*underlying trends and…theories across the existing court decisions and regulations."* They recommended that the Commission "*advocate for legislative and regulatory reform based on prior State Commissions' work"* which is described in their memo to the Commission (The Harvard Law School Cyberlaw Clinic, personal communication, 2024a).

Personal experiences of people who have tried to access records indicate a cumbersome and lengthy process that is not straightforward. Frequently, people have reported they need to procure the services of a lawyer to go to probate court to prove that they have a legal right to access the records of their family member, involving court and legal fees.

In their pursuit of records, people have reported citations of laws that prevent them from learning if an agency has any information about their family member until they follow all legal pursuits, which can be costly and time-consuming. They also report inconsistent responses about their permission to access the records, and little to no context provided for redactions in records received, and receipt of incomplete records.

Opportunities for the Commission to consider:

- Asking for a more detailed accounting of records currently held by the Department of Developmental Services and the Department of Mental Health, including date ranges.
- Making recommendations to state agencies, particularly the Departments of Mental Health, Developmental Services and Corrections, developing procedures and guidance about what must be done to protect and account for records when an institution or state service office closes. These recommendations from the Commission could include specific content recommended to be a part of these procedures.
- Formally ask for documentation about what sets of records the state agencies that ran institutions requested permission to be destroyed from the Records Conservation Board. In preparation for this report, CDDER has initiated this request with the Massachusetts State Archives.
- Making an appeal to the Supervisor of Records, regarding the interpretation that other states have made that the Health Insurance Portability and Accountability Act (HIPAA) does not prohibit disclosure of state public records, because it contains an exception for records made public by state law. Relatedly, there are legal arguments that recent changes to records access laws meant that medical records are no longer absolutely exempt from mandatory disclosure and that the state must balance the public interest in disclosure against privacy interests when considering these records requests.

- Making recommendations to the Statewide Records Retention Schedule to ensure that individual records from state institutions would be maintained at the Massachusetts State Archives when the managing agencies no longer need to retain them. Currently, the schedule for retention of medical records is set to a 20-year period.
- Making recommendations for changes in laws that govern access to records of people who lived at institutions by family members, such as making the records access process more consistent and transparent for family members, including clarification on whether state agencies can confirm record availability prior to family members needing to go to court and/or pay fees.
- Recommend a policy that establishes the period of time that must pass before individual records from state institutions can be accessed from the Massachusetts State Archives. Unlike many other states, there is currently no period set in Massachusetts General Law.
- Making recommendations about record access regarding records held by various libraries and other private collections that do not appear to be governed by state retention laws.
- Recommend the creation of an amnesty program to incentivize people to return records that were obtained illegally to the appropriate state agencies without facing any legal ramifications.

Burials and Burial Locations

The burial practices for deceased inmates in Massachusetts state institutions were shaped by a combination of legal, financial, and social factors. When an inmate died, if they had no family or means for a proper burial, state institutions took responsibility for handling the body, typically burying it on the institution's grounds.

Institutional Burial Practices

The practices surrounding institutional burials varied by facility, but common themes of simplicity, anonymity, and lack of ceremony were common. Graves were marked only by numbers or minimal symbols. Some cemeteries used concrete slabs or markers. For example, MetFern, the cemetery associated with the Walter E Fernald School and Metropolitan State Hospital, marked graves with numbers or a letter “C” or “P” indicating whether the deceased was Catholic or Protestant, followed by a number indicating the order of burial. This method of marking graves reflected a lack of personalization and recognition of individual identity, likely due to the negative stigma surrounding institutionalized individuals. Some scholars speculate that this lack of identifying markers was intended to protect families from the shame associated with having a relative die in an institution.

Annual reports from several institutions document that the inmates built simple pine box caskets in woodshops, while burial clothing, such as shrouds, robes, sheets, shirts, nightdresses,

and chemises, were produced by patients in the sewing room. Fellow inmates were sometimes permitted to participate in these burials, providing prayers, songs, and other forms of respect for the deceased. At Belchertown State School, for example, the inmates would dig graves, and little ceremony was involved in the burials. Residents were often told only that the deceased had "left". The involvement of patients in both the construction of coffins and the digging of graves reflects the broader exploitation and lack of dignity afforded to these individuals.

Over time, institutional burial practices evolved in response to both the changing legal landscape and the financial burdens of the Great Depression, leading to the development of additional burial grounds. Epidemics also led to the establishment of on-site cemeteries at a number of institutions.

Death and Burial Records

The laws and processes around death registration, burial permits, and death certificates in Massachusetts have been shaped by efforts to create a standardized and reliable system for public health and historical recordkeeping.

In 1842, Massachusetts required towns to maintain registries of birth, marriage, and death records, with these records submitted to the state annually. The law initially lacked standardization, leading to incomplete and inconsistent data collection, especially regarding deaths in institutions like almshouses, hospitals, and prisons. In 1842, a report by the Secretary of the Commonwealth highlighted these issues and recommended reforms, such as the standardization of registration return[2] forms, mandatory reporting by informants, and the introduction of burial permits and death certificates.

By 1860, these recommendations became law, requiring undertakers to obtain burial permits from town clerks and ensuring that death records included detailed information about the deceased and cause of death. This system continued to evolve, with changes in the early 1900s requiring undertakers to ensure death certificates were filed with local Boards of Health before burial permits could be issued. However, hospitals and institutions remained exempt from filing full death certificates, leading to discrepancies in vital statistics

In 1935, Massachusetts shifted the responsibility for death records to the deceased's place of residence, even if the death occurred in an institution, a move aimed at addressing gaps in recordkeeping. The system of registration and reporting continued to be refined, with significant changes occurring by 1964, when responsibilities for vital statistics were transferred to the Commissioner of Public Health.

[2] In the context provided, a "return" refers to a blank report or record that towns were required to complete and submit to the State Secretary every year. Returns contained detailed information about population size, including births, marriages, and deaths, enabling the government to make useful statistical comparisons for social welfare purposes. By the 1834, returns were made both Overseers of the Poor and by Goals and Houses of Correction throughout the state (Abstract Of The Return Of Paupers [1833], 1834).

Unmarked Graves

Unmarked burials, particularly in historical cemeteries associated with state institutions, present significant challenges in identifying and preserving graves. As institutions like hospitals and schools for the disabled aged, many graves were marked with temporary, fragile markers or not marked at all. Over time, these markers may have disappeared or been displaced, especially in cemeteries near developing areas, posing a risk of unrecognized graves. In these cases, thorough historical research and tools like Ground Penetrating Radar (GPR) are essential to locate and protect these burial sites.

Several Massachusetts laws and regulations are designed to protect burial grounds and address the issue of unmarked graves. Key laws include the Preservation of Ancient Burial Places (Chapter 114, Section 17), which protects burial grounds over 100 years old, and the Discovery of Skeletal Remains (Chapter 38, Section 6), which mandates immediate notification to the Office of Chief Medical Examiner if human remains are found. Additionally, the Care of Neglected Burial Places (Chapter 114, Section 18) allows towns to take responsibility for abandoned burial sites, ensuring their protection.

Case studies from Massachusetts institutions highlight the complexities surrounding unmarked graves. For instance, the former State Reform School for Boys in Westborough, which later became the Westborough Insane Hospital, may contain unmarked graves of former inmates buried on the grounds. If these graves are discovered, they must be managed in accordance with legal guidelines, especially since the site is designated as protected conservation land. Similarly, the Northampton State Hospital burial ground, which was used from 1858 to 1921, contains 181 confirmed burials, but many records were lost, and the site is no longer recognizable as a burial ground.

During construction at Bridgewater State Hospital in 1981, human skeletal remains were discovered, but no official records confirmed the existence of a cemetery in the area, creating uncertainty about the scope of the burial site. Similarly, in 2010, a local historian uncovered a cluster of stones on the grounds of Foxborough State Hospital, raising questions about unmarked graves, though there is limited documentation to identify those buried there.

Anatomical Science

In 1921, Massachusetts passed Chapter 113 of the General Law, which required state institutions to provide unclaimed bodies of deceased patients to medical schools for anatomical dissection. This law mandated that the body of any deceased individual in a state-run institution be delivered to a medical school within three days of death, unless claimed by family or friends. The law also required the bodies to be preserved for 14 days, allowing time for identification and ensuring a decent burial if no one came forward.

This practice continued for much of the 20th century, but by 2024, requests for bodies from medical schools had become rare, as modern methods of acquiring cadavers had replaced the

need for this practice. The law is now largely a historical record, reflecting past practices that were once integral to medical education.

The push for anatomical studies extended beyond just cadaver dissection. In the early 20th century, some institutions, like the Danvers Insane Hospital, advocated for changing the law to allow for postmortem examinations without family consent. Pathologists argued that this would streamline autopsies and advance medical knowledge. These efforts were often supported by institutional officials, such as George Kline, the Commissioner of the Department of Mental Diseases, who encouraged state hospitals to supply more bodies to medical schools, emphasizing the benefits of such cooperation.

While these practices contributed to medical advancements, they also raised significant ethical concerns, especially regarding the lack of consent and the dignity of deceased individuals, particularly those from marginalized groups.

The burial practices for deceased inmates in Massachusetts institutions reflect a complex interplay of legal, financial, and social factors, where institutional priorities often overshadowed individual dignity. From the simplicity and anonymity of grave markings to the involvement of patients in funeral preparations, these practices reveal a stark reality of exploitation and neglect. The evolution of death and burial recordkeeping, while addressing some discrepancies and improving accountability, still left many graves unmarked and individual identities lost to time. The legacy of these practices continues to raise important questions about the treatment of vulnerable individuals and the ethical implications of state-sanctioned policies.

Opportunities for the Commission to consider:

- Making a recommendation to Repeal Chapter 113 of the General Law, which requires state institutions to give unclaimed bodies of deceased patients to medical schools for anatomical dissection.
- Create educational materials for local town and city historical and conservation commissions on how to handle possible unmarked graves.
- Make recommendations to further study and/or support cemetery restoration efforts to preserve and protect these sites.
- Make public lists of those buried in cemeteries where only numbers and/or letters were used, so their identities can be recognized.
- Make recommendations to install better signage at burial locations to explain the history and significance of the site.
- Make recommendations to address the conditions at “The Pines” cemetery in Tewksbury to ensure its preservation and proper care.
- Make recommendations to close the pathway to potential grave relocation at Glavin Center to protect burial sites.
- Recommend and request funding to conduct research on areas where unmarked graves may exist to better understand and protect these locations.

Framework for Remembering Massachusetts' State-Run Institutions

The Special Commission on State Institutions has been tasked with developing a framework to publicly acknowledge the Commonwealth's historical responsibility for residents of state-run institutions for people with intellectual or developmental disabilities, as well as those with mental health conditions. This includes formulating recommendations for memorialization and public education. The framework's objective is to address the complex history of state-run institutions by recognizing both the painful legacy of institutionalization and the resilience of those affected. It also seeks to promote awareness of the independent living movement, deinstitutionalization, and the ongoing efforts to ensure the inclusion of people with disabilities in society. The memorial will serve as a tribute to those who lived in these institutions and as a catalyst for reflection and action toward more inclusive care models and evolving policies.

In collaboration with the CDDER the Framework for Remembrance workgroup has gathered insights from five organizations involved in creating memorials to honor former residents of state-run institutions. These memorial projects play a crucial role in preserving the past while advancing social justice, inclusivity, and education. Although each memorial is unique, they all share the common goal of honoring the dignity of those who lived and died in state institutions.

The Belchertown State School Friends Association is working to create a memorial and museum at the former Belchertown State School, educating visitors about the history of special education, institutional care, and disability rights. This group emphasizes both the positive and negative aspects of the institution's legacy while collaborating with local entities on various improvements.

The MetFern Cemetery Project, which began in 2018, aims to memorialize individuals buried at MetFern Cemetery in Waltham, documenting their lives through a project involving local high school students. This initiative focuses on restoring the cemetery, honoring the deceased, and advocating for legislative changes for better access to historical records.

The Danvers State Memorial Committee worked to restore cemeteries at Danvers State Hospital, replacing simple markers with headstones bearing the names of patients who died there. It also ensured that the sale of the property included provisions for housing people with mental health needs and perpetual care of the cemetery.

The California Memorial Project (CMP), created through Senate Bill 1448 in 2002, focuses on restoring cemeteries and hosting annual remembrance events on the third Monday of September and advocating for transparency in the history of state institutions.

Lastly, the Willowbrook Mile Memorial Walking Trail, located at the former Willowbrook State School in Staten Island, NY, tells the story of the school through twelve interpretive stops. This accessible trail integrates the history of Willowbrook with current efforts for social justice, offering lessons in collaboration, inclusivity, and accessibility.

Each of these initiatives highlights the importance of collaboration, inclusivity, and accessibility in memorializing the past. Ensuring accessibility was a central focus for the Willowbrook Mile Memorial Walking Trail, where efforts were made to remove barriers and create a welcoming environment for all visitors, including those with communication and mobility challenges. Key accommodations include wheelchair-friendly pathways, large print and braille options on information panels, guided tours with audio descriptions, sign language interpreters, captions for video presentations, and materials in plain language. These efforts ensure that the memorials are accessible to people of all abilities.

Key lessons and recommendations from each of these groups emphasize early and continuous engagement with diverse stakeholders, including former patients, families, local agencies, and public officials, to ensure the memorial reflects the community's needs and history. By including ex-patients and a broad range of allies, such as families, and public officials, the memorial can create a more powerful and inclusive impact.

A unified purpose and shared goals are key to maintaining focus and motivation, helping to align the group's efforts toward a common objective. Ongoing mobilization and engagement, including activities such as rallies and public hearings, keep the cause visible and build momentum, which can influence policymakers and the broader public.

Effective communication plays a vital role in any project’s success. A compelling message that resonates with both the community and decision-makers is essential to achieving goals. Safeguarding the vision of the project amidst external pressures is important to maintain its focus and credibility, ensuring it remains true to its purpose.

Planning and risk management are also critical components of success. Critical planning elements include effective governance, sound financial planning, and legal considerations, while maintaining flexibility to adapt to challenges. Securing diverse funding sources, such as government grants, private foundations, and corporate sponsors, is vital for the long-term sustainability of large-scale projects.

Most importantly, the memorial must account for the complex emotions tied to institutionalization, ensuring it serves as a space for healing and respectful reflection while honoring the dignity of all involved.

The Framework for Remembrance presents an opportunity to honor the dignity of individuals affected by institutionalization, reflecting on past injustices and advocating for a more inclusive, compassionate future. By preserving history, fostering social justice, and engaging the community, the Framework for Remembrance can become a powerful symbol of progress and an educational resource for future generations. It aims to ensure that such injustices are never repeated and to create a society that embraces all individuals with dignity and respect.

Historical Timeline

In order to examine the history of institutions in Massachusetts for people with mental health conditions and people with intellectual or developmental disabilities[3], it is important to review how the state originally took care of different groups of people experiencing poverty and how the systemic approaches changed over time. This includes tracking when and where these populations were served and how this changed over time due to the enactment of new protection laws, along with the evolution of institutional development and expansion.

Public Welfare Laws and Programs

Public welfare laws for poor[4] populations began in early colonial times. Existing laws made "Overseers of the Poor" and town selectmen legally obligated to support people who were poor and unable to support themselves. The overseers or selectmen would also be subject to fines upon cases of refusal, neglect, or inability to provide adequate supports to these populations. These initial laws laid the groundwork for the development of pauper law[5] and the establishment and integration of various labor systems within public institutions, including houses of correction, workhouses, poorhouses, the house of industry, town and state almshouses, reformatory schools, and the state farm. These laws greatly impacted people with mental health conditions and people with intellectual or developmental disabilities that were supported in these public institutions (An Act In Addition To The Several Laws Of This Province Relating To The Support Of Poor And Indigent Persons, 1742).

Methods of Public Assistance for the Able-Bodied and Sick Poor - Town Almshouses, Workhouses, and Poor Farms (1600s and 1700s)

Early American public relief for the poor was heavily influenced by English traditions, particularly the Elizabethan Poor Laws.[6] These laws categorized the poor into vagrants[7], involuntary unemployed, and helpless individuals, distinguishing between the "worthy" (orphans, widows, the disabled) and "unworthy" (drunkards, lazy) poor. Local parishes were tasked with administering aid, raising taxes for almshouses, and ensuring able-bodied individuals worked. The Law of Settlement and Removal of 1662 allowed local authorities to

[3] These populations were often referred to as the "unfortunate class." People with intellectual disabilities were often called "idiots", "brutes", "feeble-minded", and "mentally defective", while people with mental health conditions were often called "insane", "lunatics", "maniacs", and "deranged."
[4] Also referred to as paupers or pauper populations.
[5] Laws that governed how poor populations were supported by society.
[6] The Elizabethan Poor Laws were a series of laws passed in England in the 16th century to help the poor.
[7] A vagrant is essentially a person who wanders around without a fixed home or job, often without visible means of support.

eject those who could not prove residency or contributions to the parish (1662 Poor Relief Act [The Settlement Act], n.d.)

Colonial and later state governments adopted similar laws, requiring proof of legal residency for public assistance. Common methods of public aid included the contract system, auctioning the poor, indoor relief[8], such as commitment to workhouses, almshouses (also known as poorhouses), and outdoor relief[9].

The contract system involved placing individuals with caretakers for a fixed sum (The Gilder Lehrman Institute of American History, n.d.), while auctioning involved selecting the lowest bidder to care for the needy (Klebaner, 1955). These practices, especially in rural areas, often led to neglect and abuse due to the focus on cost-cutting in care (Hansan, 2011).

Early on, Overseers of the Poor aimed to deter able-bodied people from seeking public aid by requiring daily work. They also promoted virtuous living among those in need who were considered non-able-bodied and often included people who were sick, disabled, elderly, and homeless children. The coexistence of these different categories of poor people led to the eventual establishment of separate public charity facilities, with able-bodied individuals placed in town workhouses or poor farms and non-able-bodied people commonly placed in town almshouses and even jails.

Almshouses, established by towns under order of provincial law, were created to serve all people in poverty (widows, orphans, or people with physical disabilities, and mental health conditions) who were legal residents of that town. Legal residency[10] was a requirement to be able to live at an almshouse. Since the burden of caring for people in poverty fell on the local town, townspeople “warned out” new arrivals who they suspected of needing community support. Warning out of town was a common method for established New England communities to pressure or coerce "outsiders" to settle elsewhere. It consisted of a notice ordered by the Board of Selectmen of a town and served by the constable upon any newcomer who might become a town charge.

The length of stay at an almshouse was dependent on the person’s needs. Stays could be short, or longer term, and sometimes even last for the remainder of a person’s life.

Laws for the Relief of Idiots and Distracted Persons: Pre-Guardianship Laws (1693 - 1730)

Laws to provide and ensure the relief, support, and safety of people labeled as “idiots, non-compos[11], or distracted” within the Commonwealth were enacted as early as 1693. Town

[8] "Indoor relief" meant providing aid to the poor within institutions like workhouses or almshouses.
[9] “Outdoor relief” meant aiding people in their own homes, often in the form of money, food, or clothing.
[10] Legal residence is a person's primary or true home, where they intend to stay and return to, even if they are currently living elsewhere. Legal residence is important for legal purposes determining eligibility for certain benefits or for paying taxes and to vote.
[11] Non compos mentis refers to someone who is insane or not mentally competent to conduct one's affairs.

selectmen and Overseers of the Poor were legally obligated through Chapter 18 of the Acts of 1693-1694 to care for people within their jurisdiction[12] who were not cognitively able to support themselves nor had families willing to do so and were therefore considered to be at risk of becoming a public charge[13] or a pauper. Like the poor, those who were considered "idle", "disorderly", or "vagrant" and were unable to support themselves, town selectmen and Overseers of the Poor were authorized by the court to take control of or sell the estates of those labeled as "idiots" or "distracted persons". The income generated from these transactions was required to be used for their care and support. This would be done for the remainder of their lives or until the person was "restored to be of sound mind" (An Act In Addition To The Act For The Relief Of Ideots And Distracted Persons, 1708, p. 152). Chapter 5 of the Acts of 1708 further established that any remaining income would also be used to pay debts that the "idiot" or "distracted person" may have incurred prior to the onset of their mental health condition (An Act In Addition To The Act For The Relief Of Ideots And Distracted Persons, 1708).

Essentially, this model, which granted local authorities' greater control over the property of these populations, paved the way for the introduction of guardianship protection laws.

Poor and Vagrancy Laws for the Able-Bodied and Sick – House of Corrections (1700s)

Besides being sent to town workhouses and poor farms, able-bodied, poor populations, including people labeled as "rogues"[14], "vagabonds"[15], "common beggars", "lewd"[16], "idle" or "disorderly"[17] would be sent to work at a county house of correction for up to six months in exchange for food and shelter. While these correctional institutions were created "…for the keeping, correcting and setting to work…" of such people (An Act In Further Addition To An Act Entitled "An Act For The Relief Of Id[i][e]Ots And Distracted Persons," 1726, p. 378), they also provided for the relief of the weak, sick, and unable to work, including people with mental health conditions or physical disabilities. Although these public establishments, through judge-appointed masters, gained custody of these populations and were accountable for their welfare, they were also authorized to enforce disciplinary action as deemed necessary in the form of corporal punishment, mechanical restraint, and food deprivation (An Act In Further

[12] Jurisdiction refers to the legal authority a court or governmental body has to make decisions and apply laws within a specific area or over certain people.
[13] A public charge is an individual who is financially dependent on government assistance.
[14] A "rogue" can be defined as a dishonest or unprincipled person.
[15] Vagabonds, also referred to as a vagrants, were defined as "idle persons, who have no visible means of support, live without lawful employment, wander abroad and beg, are not able to give a good account of themselves, lodge in out-houses, barns, sheds, or the open air, and go about from door to door to beg or receive alms" (Massachusetts State Board of Charity, 1878, p. 15).
[16] "Lewd" meant behavior that was considered indecent, obscene, or lascivious, particularly involving sexual acts or language.
[17] Disorderly persons included drunkards, debtors, fortunetellers, nightwalkers, stubborn children or servants, etc.

Addition To An Act Entitled “An Act For The Relief Of Id[i][e]Ots And Distracted Persons,” 1726, p. 378).

Laws for the Relief of Idiots and Distracted Persons, Including Lunaticks: Guardianship Laws (1726 - 1779[18])

Further iterations of these laws on idiots and distracted persons were found in Chapter 12 of 1726 and Chapter 14 of 1731, which added “lunaticks" to the group for the very first time, as well as established the role of the guardian, which essentially took over the role of the Overseer of the Poor and town selectmen with respect to the managing or selling of a person’s estate (An Act In Further Addition To An Act Entitled “An Act For The Relief Of Id[i][e]Ots And Distracted Persons,” 1726; An Act In Further Addition To An Act Entitled “An Act For The Relief Of Id[i][e]Ots And Distracted Persons,” 1731).

The guardianship process, managed through the probate court[19], along with the support of town selectmen[20], consisted of identifying and examining individuals that were suspected of belonging to these groups within their respective county. When a case was confirmed, the judge would appoint the person a guardian responsible for providing them both personal and financial support and protection until they were “restored to their right mind.”

To initiate the guardianship process, assigned guardians would have to pay the court a bond[21] ensuring that they would accurately account for the person’s estate with the court registry[22], and properly settle any financial debts and manage any income generated from the estate to pay for the person’s “comfortable maintenance and support.” In the event of insufficient funds, the court would authorize and license the guardian to transfer or sell a portion of the person’s estate to pay towards expenses.

This process changed as a result of Chapter 140 of the Acts of 1830, which required the additional written consent of the Overseer of the Poor and notice of potential sale of property to relatives, or anyone interested in purchasing land prior to licensing the guardian to sell an estate. Any remainder of the estate would be returned to the person upon reaching full recovery. From this transaction, the guardian was also compensated for their services. If at any time during this process, anyone was suspected of mismanaging a person’s estate (e.g.,

[18] The conditions of this law mentioned in this section of the report were extended all the way through 1779 with the multiple reenactments of the Act For The Rel[e]i[e]f Of Idiots And Distracted Persons and the Act for Continuing Sundry Laws of this Province, Expired or Near Expiring (An Act For Reviving And Continuing Sundry Laws That Are Expired, And Near Expiring, 1775; An Act In Further Addition To An Act, Entitled, “An Act For The Rel[e]i[e]f Of Idiots And Distracted Persons.,” 1737).

[19] Probate court is a judicial system branch that handles the execution of wills and the distribution of estates.

[20] A town selectman is an elected official responsible for the administrative and executive functions of a town.

[21] A bond was a written promise to do something or pay money. If the promise wasn't kept, the person had to pay a penalty. Bonds were used for loans, property sales, or agreeing to perform specific actions. They ensured people fulfilled their commitments, with financial consequences if they didn't.

[22] A registry is a place where official records and documents are kept.

embezzlement), they would be brought to court. And, if the person in question refused to cooperate, they would be sent to jail (An Act In Addition To The Several Acts Concerning The Sale Of Real Estate By Executors, Administrators And Guardians, 1830).

In 1783, under Chapter 38 of the Acts of 1783, guardianship laws were extended to the children of "idiots", "distracted persons", and "lunatics" and would apply to them as if their mother or father were deceased (An Act Im Powering The Judges Of Probate To Appoint Guardians To Minors And Others, 1783). Later, per Chapter 46 of the Acts of 1789, probate court judges were fully authorized to dismiss any guardian on the grounds of need or urgency for people labeled as "idiots" or "lunatics" or their children. A fourteen-day written notification was required notifying the guardian of their upcoming court hearing where they would be given the opportunity to defend themselves (An Act Authorizing Judges Of Probate To Dismiss Guardians From Their Guardianship In Certain Cases, 1789).

Use of Town Pauper Auctions to Privatize Support of Paupers Unable to Care for Themselves (late 1700s - 1830s)

Laws regulating town pauper auctions, also known as public vendues, were enacted by the 1770s. Section 2 of Chapter 44 of the Acts of 1772-1773 further referenced the type of sales to include "any servant or minor" (An Act To Regulate The Sale Of Goods At Public Vendue, And To Limit The Number Of Auctioneers, 1772, p. 249). By the early 1830s, there was evidence noted by the Special Commission responsible for establishing the State Lunatic Hospital at Worcester that town pauper "lunatics" were also auctioned locally (Report Of The Commissioners Appointed To Superintend The Erection Of A Lunatic Hospital At Worcester, 1832). Despite the terms "auctions" or "vendues" implying that poor people were sold, town auctions were used as another mechanism to offset pauper expenses incurred by towns by shifting them over to the lowest bidders, which were private homes who accepted the lowest public rates for the keeping of paupers. However, this came at the risk of the safety and welfare of lunatic paupers whose supports were described "…with various degrees of attention or of cruelty" (*Historical Background on the Poor and Poor Relief in Early 19th-Century New England*, 2003, p. 12).

House of Corrections Commitment and Discharge Laws Void of Legal Protections for "Idiots" and "Lunatics" (1797 - 1835)

Chapter 62 of the Acts of 1797 established the role of the Overseer of the House of Corrections for each county. They were charged with inspecting the conditions of the facilities, inmates, and finances, and overseeing early-release, employment programs (i.e. probation or parole in this era). Section 3d of this Act authorized for the confinement of individuals found to be a "lunatic" and "furiously mad"[23]. The person, their family, or town of residence were responsible for financially supporting the person while in jail. Additionally, this population was required to

[23] Per Section 3d of Chapter 62 of the Acts of 1797, a lunatic or a person furiously mad was legally defined as someone who would pose a threat to the peace and safety of the community if let free.

work, if able (An Act In Addition To An Act Intitled An Act For Suppressing Rogues, Vagabonds, Common Beggars, & Other Idle Disorderly & Lewd Persons, 1797).

Commitment laws changed over time and per Chapter 28 of the Acts of 1816, the Supreme Judicial Court could now acquit someone from a crime or offense and prohibit their indictment "by reason of insanity or mental derangement". Regardless of acquittal, if they deemed that person "… dangerous to the safety of the citizens, or to the peace of the Commonwealth," then the court was "authorized and empowered" to imprison the person at their, their families, or their town of residence's expense until, "…he or she be restored to his or her right mind, or otherwise delivered by due course of law". If deemed stable and no longer a threat to society by a Justice of the Supreme Judicial Court or by two Justices of the Peace, then the person could be released from prison. The court was also "authorized and empowered" to grant custody to the person's friend or family so long as the friends or family paid a bond to the county Probate Court for the "…safe keeping of such lunatic person, and for the payment of all damages which any person shall or may sustain by reason of the act and doings of such lunatic"(An Act Extending The Powers Of The Justices Of The Supreme Judicial Court In Certain Cases, 1816, pp. 224–226).

The right to solicit the discharge of a "lunatic" by family or friends was further formalized in the laws regarding the suppression and punishment of people considered to be "rogues", "vagabonds", or "common beggars". Specifically, Section 2 of House Bill No. 81 of 1827 established a legal pathway for friends and families with financial means to request for the custody and release of a known "lunatic" confined in any house of corrections. Like the discharge laws of 1816, family and friends were still required to pay a bond to the court as collateral for the protection and support of the discharged person (An Act In Further Addition To The Several Acts For The Suppressing And Punishing Of Rogues, Vagabonds, Common Beggars, And Other Idle, Disorderly And Lewd Persons, 1827).

Introduction of Age-related Classifications for the Poor – State Pauper Idiots and Lunatics (1800s)

Throughout the first half of the 1800s, the Commonwealth established age-related criteria for the classification of poor people who were dependent on state supports. These people were commonly referred to as state paupers. According to Chapter 81 of the Acts of 1822, healthy males between the ages of 17 and 59 who were able to work were no longer classified as state paupers (An Act Relating To State Paupers, 1822). Chapter 21 of the Acts of 1823 expanded this exclusion criteria from 13 to 59 years of age (An Act Relating To State Paupers, 1823), while a legislative bill in 1824 proposed it be extended to females (A Bill Relating To Paupers, 1824). In 1839, Senate Bill No. 41 once again proposed to expand the exclusion age range from 10 to 59. However, unlike previous bills and acts, this bill explicitly demanded for the exclusion of people labeled as "idiots" and "lunatics". This meant that any person deemed to be a "lunatic" or

"idiot" lacking a legal settlement[24], family, or friends to support them, would always be considered a state pauper regardless of their age and ability to work (Report And Bill Concerning State Paupers, 1839).

Financial Support of the Poor, Including Reimbursements for Pauper Idiots and Lunatics (1800s)

The financial framework for the support of idiot and lunatic paupers largely depended on existing laws that defined the parties responsible for contributing financial resources towards their care. This included the person themself if they had an estate, their family or friends with financial means, their town or city of legal settlement, and lastly, the Commonwealth. In the late 1700s, according to Chapter 59 of the Acts of 1793, the court sought some proportion of financial support from a pauper's first- and second-degree relatives who were also state residents. If such relatives were not an option, then the Overseers of the Poor from the person's town of legal settlement or wherever they were visiting, would be responsible for employing them, if able, and raising money to pay towards their supports. Towns that provided emergency assistance to paupers with legal settlements in other towns had the right to seek reimbursement accordingly. If the pauper had no family nor legal settlement, then the state would assume full financial responsibility and they would be considered a state pauper (An Act Providing For The Relief And Support, Employment And Removal Of The Poor, And For Repealing All Former Laws Made For Those Purposes, 1793).

The laws around the financial support of paupers evolved with the establishment of state public institutions, including almshouses and lunatic hospitals. Specifically, per Chapter 77 of the Acts 1841, state hospitals were granted the right to seek reimbursement from a lunatic pauper's town or city of legal settlement, and if none, then from the state treasury (An Act Concerning Lunatics, 1841). Chapter 114 of the Resolves of 1845 established the rate structure of state pauper lunatics for any town, city or county seeking reimbursement from the state. Rates were based on how long a state lunatic pauper received supports. Weekly and yearly rates would not exceed $2.50 or $100, respectively, and reimbursements could never exceed the actual amount paid upfront by the town, city, or county (Resolve Concerning the Support of the State Lunatic Paupers, 1845). Although the Act Concerning State Paupers and Alien Passengers of 1846 declared that towns and cities could no longer seek state reimbursement for paupers, it explicitly excluded pauper "lunatics". Therefore, the Act reinforced the towns' and cities' ability to seek state reimbursement for the support of "lunatic" populations in their town, city, or county (An Act Concerning State Paupers And Alien Passengers, 1846).

Senate Bill No. 107 of 1847 proposed that governor-appointed Commissioners of Lunacy be established for every county. Two of the three commissioners had to be physicians in good standing. Their main roles were to investigate and certify cases of "insanity" among state

[24] A legal settlement is the town or city where you have your permanent home or principal establishment and to where, whenever you are absent, you intend to return.

paupers, and to maintain a register and make returns to the Secretary of the Commonwealth of all state “lunatic” paupers, including names and residences. In addition, any town, city, or county seeking reimbursement for state lunatic paupers was required to provide a certificate of insanity issued by the county Commissioners of Lunacy along with the claim (An Act Concerning State Lunatic Paupers, 1848).

In addition to a certificate of insanity, Senate Bill No. 66 of 1848 demanded county Commissioners of Lunacy, Overseers of the Poor, or lunatic hospital superintendents to certify under oath all cases of state “lunatic” paupers (An Act Concerning State Lunatic Paupers, 1848). According to Chapter 207 of the Acts of 1849, town, cities, and counties also had to furnish satisfactory evidence that the state “lunatic” pauper was being “supported in a suitable and comfortable manner”(An Act Relative To State Lunatic Paupers, 1849, p. 3). Senate Bill No. 114 of 1848 was an amendment to the previous bill and extended and applied the state reimbursement requirements described above to state “lunatic” paupers to people deemed “furiously mad” who were committed to a house of correction (Amendment Moved By Mr. Simmons To The Bill Concerning State Lunatic Paupers, 1848).

These requirements formalized and made the process of deeming people as “lunatic” paupers more consistent through the integration of expert opinion and certification. These requirements were also put in place to try to ensure the safekeeping of people labeled as “lunatics” in public institutions by ensuring people could not falsely assert themselves as “lunatics”.

A Shift to State Care Models - Reports and Subsequent Laws Supporting the Treatment of “Idiots” and “Lunatics” in Hospitals (1820s)

In 1827, a special committee was appointed to investigate the conditions of correctional facilities across the state. In its report, inmates were categorized into groups, including, debtors, criminals serving sentences, and “lunatics” and persons “furiously mad”, most of which were poor and had never committed crimes. Most importantly, the committee uncovered a far larger number of “lunatics” and “madmen” in prisons and houses of correction than expected. While many prisoners were treated humanely, the treatment of people with mental health conditions was deeply troubling. These individuals were neglected, with some having been confined for over 20 years in deplorable conditions. The committee recognized the urgent need for reform and emphasized that immediate action was required to improve the lives of these vulnerable individuals. They argued that prisons were entirely unsuitable for confining people with mental health conditions, as they were detrimental to both the patients and the other prisoners. Even when jailers were humane, their lack of understanding about how to properly care for people with mental health conditions exacerbated the individuals' suffering. Many had been left to endure unnecessary hardships due to mismanagement. The committee recommended that those with mental health conditions be kept clean, provided with proper warmth and food, and given the necessary care to aid in their recovery. They also suggested

that these individuals be transferred to the General Hospital or a facility near the Insane Hospital for more appropriate care (Report Of The House Committee Appointed To Examine The State Of The Goals In The Commonwealth, As Well As The Penitentiary At Worcester, 1827).

This form of discrimination and inequitable treatment in the early 1800s, led to the legal and systemic safeguarding of the "mentally ill" in the Act to Provide for the Safe-Keeping of Lunatics of 1828. Instead of correctional facilities, the law required the commitment of people who were imprisoned or newly identified "lunatics" and "furiously mad"[25] to asylums or hospitals. To accommodate the placement of this population, the Massachusetts Governor and other state officials were responsible for contracting with the only existing lunatic asylum at the time, Massachusetts General Hospital, and building new asylums and hospitals as needed. The law required the Governor to assign a superintendent and physician for each hospital and establish a visiting committee charged with inspecting these facilities twice a year. The law also required the humane and careful treatment of this population detained in correctional facilities, while hospitals and asylums were in the process of being built (An Act To Provide For The Safe-Keeping Of Lunatics, And Persons Furiously Mad, 1828).

Section 6 of the Act to Provide for the Safe-Keeping of Lunatics outlined the court processes for requesting the commitment of this population into the hospital system, as well as the payment model. The commitment process consisted of a written complaint to two justices of the peace, which was followed by a formal hearing and examination of the case. If the judge determined the person to be a "lunatic" or "furiously mad", then a warrant would be issued for their commitment to a hospital or asylum until they reached full recovery. Recovery would be determined by the hospital physician with final approval of the visiting committee, which was documented in a formal discharge certificate. The order of parties responsible for service-related expenses was the person or their family if they could afford it. If not, then the person's town of residency. And, if none of the above applied, then the state would be the payor of last resort. (An Act To Provide For The Safe-Keeping Of Lunatics, And Persons Furiously Mad, 1828).

Mid-19th Century Reform Movement

Opening of the State Lunatic Hospital at Worcester (1830s)

House Bill No. 39 of 1830 created a committee that surveyed all towns across Massachusetts with the aim of determining the current size and placement of insane populations. Approximately 300 lunatics and persons furiously mad were identified and confined in poorhouses, houses of industry, house of corrections, jails, insane hospitals, among others (Report Of The Committee Regarding The Accommodation Of Lunatics And Persons Furiously Mad, Including Text To A Resolve, 1830). Based on these results, the committee pushed for the

[25] Per Section 6 of the Acts of 1828, a lunatic or a person furiously mad was defined as someone who would pose a threat to the peace and safety of the community if let free.

enactment of a law to purchase land and construct a Lunatic Hospital. House Bill No. 13 of 1830 authorized the construction of a state lunatic hospital at Worcester in the amount of thirty thousand dollars to serve up to one hundred and twenty people (Resolve Regarding The Construction Of A Lunatic Hospital, 1830).

Senate Bill No. 02 of 1832 created a special commission responsible for planning, designing, and monitoring the construction of the State Lunatic Hospital at Worcester. In its official report, the commission stressed the need to provide this population with safe and secure living environments and humane and compassionate treatment.

At this point in time, levels of insanity were chiefly based on the degree of violence a person exhibited and how dangerous they were perceived to be to society. The insane were characterized with great uncontrollable strength in comparison to the average person. For these reasons, the hospital was built with physical barriers to prevent patients from escaping and causing harm to themselves or others. The hospital included an infirmary, which was essential to the medical care of this population. Solitary confinement cells were included in the constructions plan for those patients characterized as, "…both dangerous and incurable, and whom bolts and bars alone can restrain" (Report Of The Commissioners Appointed To Superintend The Erection Of A Lunatic Hospital At Worcester, 1832, p. 9).

Three classes of lunatics were established: 1) those detained in correctional facilities based on the Acts of 1797 Chapter 62 and 1816 Chapter 28; 2) town pauper lunatics, including those residing in almshouses, or whose town contracted with local jails for their detainment, or who were put up for bid at town auction; and, 3) insane persons who were not so "furiously mad" and had the financial means and supports to be independent from state charities.

These commissioners made recommendations around the rules and regulations for the discipline and governing of the hospital and the different classes of lunatics it was to serve. This included, but was not limited to commitment and discharge processes, the governing structure, led by an on-site superintendent who was also a physician, along with a Board of Trustees, and the creation of a five-member Board of Visitors charged with monitoring and conducting inspections, setting by-laws for all hospital departments, and selecting a principal or superintendent.

The Emergence of Institutional Care for "Mentally Ill" Convicts in Massachusetts (1840s–1880s)

In the early 19th century, Massachusetts law permitted the confinement of individuals labeled as "idiots," "lunatics," and the "insane not furiously mad" in county jails and houses of correction. This practice had persisted for decades, with reports from 1832 and 1833 revealing that people with mental health conditions were accumulating in prisons, almshouses, and even private dungeons. In response to these alarming conditions, reformers began advocating for more humane treatment.

One of the earliest legislative steps toward reform was Senate Bill No. 02 of 1832, which created a special commission to plan, design, and oversee the construction of the State Lunatic Hospital at Worcester. In its official report, the commission emphasized the importance of providing safe, secure environments and humane, compassionate treatment for people with mental health conditions. A five-member Board of Visitors recommended prioritizing the transfer of people with mental health conditions from jails to the new hospital as beds became available. They also proposed fines for jails or houses of correction that accepted private contracts to detain the insane without proper authorization.

The commissioners strongly advocated for treating people with mental health conditions in hospitals rather than penal institutions. They cited drastically different recovery outcomes, noting that while jails and houses of correction saw virtually no recoveries, well-run hospitals reported recovery rates as high as 90 percent

> *"...they have never heard of more than three or four instances of restoration, among all those who have been subjected to the rigors of confinement, in Jails and Houses of Correction while well-regulated Institutions for the reception and appropriate treatment of the insane, have returned fifty, sixty and in some instances ninety per cent, of recoveries."* (Report Of The Commissioners Appointed To Superintend The Erection Of A Lunatic Hospital At Worcester, 1832, p. 13)

They also highlighted the profound injustice inflicted on people with mental health conditions:

> *"From the absence of suitable Institutions amongst us, the insane have been visited with heavier doom than that inflicted upon the voluntary contemners of the law... Though the insane have been made fellow-prisoners with the criminal, they have suffered the absolute privation of every comfort for the body and every solace for the mind."* (Report Of The Commissioners Appointed To Superintend The Erection Of A Lunatic Hospital At Worcester, 1832, p. 14)

Yet, challenges arose with patients deemed "incurably insane." These individuals, often from impoverished backgrounds, occupied hospital beds and limited access for those labeled "curable". Social class heavily influenced treatment eligibility: the poor were often considered beyond help and relegated to almshouses, while the wealthy could access private hospitals like McLean Hospital, founded in 1811 as the "Asylum for the Insane". This dynamic led to overcrowding in public institutions.

In the 1840s, mounting concerns over people with mental health conditions held in prisons prompted further legislative reforms. Reformers like Dorothea Dix, a nurse and advocate for the indigent people with mental health conditions, continued this momentum. Dix launched a national crusade to establish mental asylums and separate people with mental health conditions from criminals. Her *Memorial to the Legislature of Massachusetts* in 1843 exposed widespread abuse and poor living conditions for those with mental illness. Influenced by European developments in mental healthcare (Norwood, 2017), Dix's efforts led to the

founding and expansion of state asylums, including the Worcester State Hospital, followed by additional institutions in Northampton and Taunton. These hospitals prioritized rehabilitation and shorter-term care to help patients return to their homes.

In 1842, the Inspectors of the State Prison issued a report describing the psychological harm caused by incarceration and seclusion, stating:

> *"In this prison the insane are forgotten by the public and sequestered from the humanity of their friends and kindred, and doomed to spend years in hopeless misery."* (Documents Relating To The State Prison, 1843, p. 4)

This led to the introduction of Senate Bill No. 34 and the passage of An Act Concerning Lunatic Convicts (1842). The law required prison medical staff to report suspected cases of people with mental health conditions to the warden, who then referred them for court evaluation. If confirmed, the person was transferred to the State Lunatic Hospital, with the possibility of returning to prison upon recovery.

Governor George N. Briggs supported these reforms in an 1844 message to the legislature, recommending the formation of a medical commission to assess convicts with mental health conditions. This resulted in Senate Bill No. 46, creating a commission of leading physicians from prisons and public and private hospitals to determine if individuals should be transferred to mental health institutions.

These efforts culminated in the 1849 passage of Chapter 68, An Act Concerning Insane Persons Charged with Criminal Offences, which allowed courts to commit defendants found to be insane to the State Lunatic Hospital at Worcester instead of jail—even retroactively applying to individuals already confined.

In 1855, the Commission on Lunacy issued a report which was backed by the explicit support and approval of the Committee on Public Charitable Institutions. The report asserted that houses of correction and State Almshouses were inadequate for the care of individuals with mental health conditions noting:

> *"In these institutions the curable are healed, the violent are subdued, the excitable are controlled, and those who are elsewhere troublesome are there easily calmed and managed."* (Report On Insanity And Idiocy In Massachusetts, By The Commission On Lunacy, 1855)

Recognizing the limitations of existing facilities and the growing demand for mental health care, the Commission urged the state to increase its annual budget and invest in the construction of new hospitals. They especially emphasized the need for facilities in underserved regions, such as the western part of the state, to accommodate the expanding population in need of both temporary treatment and long-term institutional support.

Under General Statutes Chapter 180, Section 1, a special commission was established in the 1880s to evaluate individuals in the State Prison who were suspected of having a mental health condition. This commission included the State Prison's physician and the superintendents of all state mental hospitals. Their task was to investigate and determine whether inmates already incarcerated or awaiting imprisonment were suffering from a mental health condition, referred to at the time as "lunacy" (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

If a diagnosis of lunacy was confirmed, the commission would notify the court, which would then issue a warrant for the inmate's transfer to a state mental hospital for treatment. Upon recovery, the individual was returned to prison to serve the remainder of their original sentence. Importantly, the time spent in the hospital was counted toward the fulfillment of their prison term (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

The Evolution of Massachusetts' Almshouse System (1850s)

In the mid-19th century, Massachusetts faced a growing crisis in public welfare. The influx of impoverished and ill Irish immigrants during the 1840s placed immense pressure on local cities and towns, whose almshouses—historically responsible for the care of their own poor—were quickly overwhelmed. This demographic shift, combined with emerging reformist ideals, reshaped the Commonwealth's approach to poverty and institutional care. Progressive thinkers of the time believed that environmental factors could influence human behavior and well-being, spurring innovations in the design and purpose of hospitals, penitentiaries, and mental health asylums across the United States.

In response to the escalating humanitarian need, the Massachusetts General Court chartered three state-funded almshouses in 1852, located in Tewksbury, Bridgewater, and Monson. These facilities opened in May 1854 and were intended to house "state paupers", individuals without legal residence in any town. By the end of their first year, the demand far exceeded expectations, prompting the state to take full responsibility for their care. This marked a significant paradigm shift in public welfare, transferring the burden of care from municipalities to the state (An Act Concerning The State Pauper Establishments Within This Commonwealth, 1853; An Act In Relation To Paupers Having No Settlement In This Commonwealth, 1852).

While these new institutions were designed to replace the older town-based relief system and eliminate outdoor relief (the practice of providing aid to the poor in their homes), poverty persisted and even increased. The almshouses evolved into multifaceted facilities, serving as orphanages, hospitals, mental health institutions, and homes for the elderly. Inmates included orphans, the "insane," the elderly, the sick, and the intellectually or developmentally disabled. Children, in particular, suffered high mortality rates. Conditions varied, but categorization was meticulous, residents were labeled as "sick", "drunk", "insane", "healthy", "lame", "feeble", "aged", or "blind". Admission to almshouses was sometimes voluntary but often coerced through legal mechanisms wielded by magistrates and the Overseers of the Poor.

Despite their broad mandate, the almshouses lacked coherent rehabilitation or vocational training programs. Inmates performed farm work and seasonal labor primarily to offset the cost of their own care rather than to promote long-term self-sufficiency. The system, though technically "voluntary" after the Civil War due to the 14th Amendment's prohibition against involuntary servitude, retained a coercive character. Individuals convicted of minor infractions such as drunkenness or loitering could still be forced into institutions—though by the late 19th century, such placements were more often in workhouses or correctional facilities.

Another issue was the commingling of vastly different populations under one roof. Almshouses served as overflow facilities for state mental health hospitals, leading to controversy over mixing the "pauper" population with those labeled "lunatics" or "idiots". Laws in the 1850s and 1860s mandated individuals with mental health conditions who were not considered dangerously insane be placed in almshouses rather than jails. Although this was seen as a more humane alternative, it exposed the lack of specialized care and further highlighted institutional inadequacies (Report Of The Committee On Public Charitable Institutions, 1854).

By 1858, criticism of the almshouse system prompted the Massachusetts Legislature to form a Special Joint Commission to investigate and reform the state's charitable institutions. Their 1859 report acknowledged the failure of the almshouse model, citing poor conditions and inefficiencies. While recommending incremental reforms rather than immediate abolition, the Commission did advocate for separating populations by need—especially relocating those with mental health conditions to dedicated buildings. This report laid the foundation for the creation of a centralized oversight body to supervise state-funded and partially funded institutions (Report Of The Special Joint Committee Appointed To Investigate The Whole System Of The Public Charitable Institutions Of The Commonwealth Of Massachusetts, 1859).

However, these recommendations were met with skepticism. The Massachusetts Board of State Charities, in its 1864 report, criticized the Commission's hesitancy to dismantle the failing system. As stated in 1865:

> *"The conclusion to which (the special joint commission) came was, that the evils of the Almshouse System, on the whole, outweighed its advantages, and that eventually it must be given up. But they were unwilling to recommend its immediate abandonment…"* (Massachusetts Board of State Charities, 1865, p. 247)

Although the almshouse model continued for some time, the groundwork had been laid for a new approach to public welfare, one centered on specialized care, professional oversight, and institutional differentiation.

The Role of Massachusetts Almshouses in the Care of the Disabled

In 1865, in response to concerns from superintendents about the high mortality rates among the sick poor admitted to almshouses, Massachusetts passed a law creating the position of the Special Agent for the Sick Poor. This law required local authorities to care for the sick at home,

with the state reimbursing them, and only individuals without a known legal residence could be sent to a state almshouse. Despite this, the number of sick individuals at almshouses remained high, leading to the development of medical services within these institutions, including male and female hospital wards, resident medical staff, and medical training programs for physicians, nurses, and pharmacists. The State Almshouse at Bridgewater, in particular, evolved into a medical center offering maternity and pediatric care. However, the death rate remained high, as many inmates arrived in poor health due to previous illness, poor living conditions, or exposure to disease. Additionally, many individuals deemed incurable were sent to the almshouse to die, including those with conditions like consumption, paralysis, and cancer (O'Connell, 1984).

Besides male and female hospital wards, there were separate rooms and yards for the large number of people labeled as "insane" who were admitted to the almshouse to set them apart from other inmates (O'Connell, 1984). As a result, over time, people with disabilities made up a significant portion of the populations living in almshouse.

When experiencing overcrowding, almshouses periodically transferred the disabled to other almshouses, asylums or local prisons, where life was very hard for the children and the adults who were elderly, sick or disabled. The Superintendent of the State Almshouse at Bridgewater, Levi Goodspeed, observed that during 1855 nearly 100 "insane poor" were admitted, most of them "…taken from the different lunatic asylums-- cases that were considered incurable" (Massachusetts Correctional Institution Bridgewater, 1856, pp. 12, 29). The "insane poor" needed the custodial care provided at the Almshouse. The practice of sending sick people to the almshouse, when all hope of recovery was abandoned, continued. Levi Goodspeed reported in 1865 that "many of these cases of consumption, paralysis, cancer and hernia, had been previously treated at other hospitals or by physicians and surgeons in private practice, pronounced incurable and sent here to die" (Massachusetts Correctional Institution Bridgewater, 1866, p. 21).

In 1890, there was an amendment to Chapter 87 of the Public Statutes, which required the State Board of Lunacy and Charity to identify "insane" persons found in almshouses or other settings that were not receiving proper treatment. There was another amendment to Chapter 319 of the Acts of 1886, which prohibited Overseers of the Poor from committing any insane person whose onset of their condition was less than a year to an institution where treatment was not provided (An Act To Insure Hospital Care And Treatment For Certain Insane Persons, 1890).

A number of institutions and practices evolved from the services provided at the State Almshouses, for example, specialized hospitals, medical training, orphanages, welfare and poor relief, prisons, and schools for the people with intellectual or developmental disabilities. Over time, the services provided by almshouses were assumed by specialized institutions that were developed across Massachusetts and served more specific groups of people determined to have similar conditions or similar needs.

Placement of Idiots and Lunatics not Furiously Mad in Town and State Almshouses (1850s – 1860s)

In 1856, per Senate Bill No. 77, the Committee on Public Charitable Institutions demanded correctional facility placements of "idiots" and "lunatics" who were not "furiously mad" cease and be replaced with direct placements of these populations within the precincts of any of the three State Almshouses at Monson, Bridgewater, or Tewksbury (Report Of The Committee On Public Charitable Institutions, 1856). The almshouse setting, although not ideal either, was thought and found to be more beneficial to both the person in custody and to the institution rather than them being detained in a jail. The State Almshouses also served as an alternative location for overcrowded hospitals to transfer their patients, though this practice was controversial, as some of those sent to the almshouses were known to disturb the other inmates. The Superintendent of the State Almshouse at Bridgewater provided an account highlighting the positive impact of integrating these populations into the state almshouse system:

> *"During the past year there have been admitted nearly one hundred insane and idiotic poor, most of whom were taken from the different lunatic asylums, — cases that were considered incurable. Many of this class, particularly of the male portion, have made themselves very useful, doing good service upon the farm…. With quite a number of this unfortunate class, there has been a marked degree of improvement, mentally as well as physically."* (Report Of The Committee On Public Charitable Institutions, 1856, p. 3)

Similar to other commitment laws, the written application for the placement of these populations at any of the three State Almshouses had to be approved and authorized by two justices of the peace or the police court. If able-bodied, those committed would be required to do some type of indoor or outdoor labor, which would go towards the support of all paupers, except for "alien paupers". Inspectors of the almshouses were authorized to discharge a person to live independently or to be supported by relatives, friends, masters, guardians, or any town of legal settlement, so long as they believed that the discharge would be beneficial to the person.

The above bill was further defined for "idiot" populations in Chapter 71 of the General Statutes of 1856. Per Section 38 of this law, "idiots" having no known legal settlement that were brought to the attention of the court or of at least two justices of the peace by a person other than an Overseer of the Poor, would be sent to the nearest State Almshouse (Massachusetts State Board of Health, Lunacy, and Charity, 1880). This was also reflected in Chapter 108 of the Acts of 1856, which also prohibited "lunatic" and "insane" persons from being confined in jails and required these populations to be committed to a state lunatic hospital or a State Almshouse (An Act Relating To Lunatics And Idiots, 1856).

By 1862, per a report from the Commission on Public Charitable Institutions, the number of "insane", "idiotic", and "demented" state paupers exceeded that of the general population at

the State Almshouse at Bridgewater. The Commission once again expressed its concerns regarding the unsuitable conditions at this Almshouse and suggested that, at the very least, the state should fund for the construction of additional facilities to accommodate existing and future populations of “harmless” and “incurable” pauper inmates (Report Of Public Charitable Institutions, 1862). Finally, in 1886, the construction of a new building at the State Workhouse at Bridgewater[26] was approved to accommodate up to 125 “chronic insane” pauper men (An Act To Provide A Building For The Chronic Insane At The State Workhouse At Bridgewater, 1886).

Insane pauper populations, including insane pauper criminals, was also prevalent at the State Almshouse at Tewksbury, and per Chapter 80 of the Resolves of 1864, the state funded for the construction of two separate buildings within the grounds of the State Almshouse to accommodate the “incurable insane” and the “insane criminals” (Resolve Providing For Insane Persons At Tewksbury, 1864).

Education of Children

Commitments of Children to State Institutions: Primary and Reform Schools (1850s – 1860s)

Reform schools in the mid-1800s aimed to rehabilitate children who committed minor offenses by providing education in the trades to prepare them for jobs. However, these schools, such as the State Reform School for Boys in Westborough that opened in 1848 and the Lancaster Industrial School for Girls that opened in 1854, faced significant challenges with children who had disabilities as documented in annual reports and other materials. These children often struggled or were unable to work and often needed extra support, leading to them being viewed as occupying space needed for other children. To address this, some reform schools built separate housing on their campuses specifically for children with disabilities. This segregation highlighted the difficulties these institutions faced in integrating children with disabilities into standard reform school programming (Brenzel, 1983).

Also, around this time, the state aimed to improve conditions for poor children in state almshouses, including those labeled as "feeble" or "physically disabled”, by keeping them apart from adult populations and providing them with education and training (Massachusetts State Almshouse at Monson, 1855). By 1864, the State Almshouse at Monson closed and the State Primary School at Monson officially opened where children from the State Almshouses at Bridgewater and Tewksbury were sent.

[26] Per St 1887, c 264, the State Workhouse at Bridgewater, including the almshouse, was renamed to the State Farm at Bridgewater, given the new commitments of chronic insane paupers. At this time, the State Farm was under the supervision of the State Board of Lunacy and Charity, until it was transferred to the State Board of Charity as a result of the splitting of the State Board of Lunacy and Charity, per St 1898, c 433 (Massachusetts State Archives, 2020).

In the mid-1800s, Massachusetts saw a growing concern for the welfare of its poor and orphaned children, especially those residing in state almshouses. These children were often left to fend for themselves, with little to no education or structured care. At the time, the number of children in almshouses was lower than that of individuals labeled “insane”, and in many cases, children were either neglected or labeled as “feeble-minded” (Sanborn, 1884). The state recognized the need for reform and began to take steps to create institutions for the education and care of these children.

In 1855, the Legislature passed a law that established the State Pauper School, a first step toward improving the conditions of these children. The school was designed to provide education and care to children who had no one else to care for them, with the goal of eventually reintegrating them into society or placing them in homes. The school officially began operations in 1856 (An Act Providing For The Classification Of State Paupers, 1855). However, the law was repealed in 1856 due to resistance from the superintendents of the State Almshouses, who argued that it would be too costly to house all pauper children in one location and suggested other solutions, such as building separate facilities within existing almshouses (Massachusetts Board of State Charities, 1865).

Despite the repeal, the idea of a state-run school for pauper children persisted, and by 1866, the State Primary School at Monson was officially established by General Statutes (General Statute 1866, Chapter 209). This institution was built specifically to separate children from the adult paupers in the almshouses and provide them with proper education and care. By that time, many children had already been transferred to Monson from the State Almshouses at Bridgewater and Tewksbury. The 14th Annual Report for the State Almshouse at Monson noted that over 300 of the 615 residents were children under the age of 15, many of whom were in poor health when they arrived (Massachusetts State Almshouse at Monson, 1855, p. 5). These children received education and training, while the older ones were “bound out” to local families.

Although the State Primary School was legally established in 1866, its roots can be traced back to the Act of 1855, which aimed to provide these children with a better life, away from the adult pauper population. The law in 1855 also outlined the school’s primary objective to care for children who had no one else, as well as to keep them separate from adult paupers (Massachusetts Board of State Charities, 1865, p. 273). Despite the law being short-lived, the school continued to grow, and by 1870, a new law allowed judges to place children in the State Primary School if it was deemed in their best interest (An Act Relating To The State Visiting Agency And Juvenile Offenders, 1870).

In 1872, the State Almshouse at Monson was officially abolished, and the facility fully transitioned into the State Primary School. This shift allowed the school to continue to house children in need, while also serving as a temporary shelter for mothers and children. By the time the State Primary School closed its doors in 1895, it had become an integral part of the state’s efforts to care for its most vulnerable children (An Act To Abolish The State Almshouses

At Bridgewater And Monson, 1872). Throughout its operation, the school continued to evolve, with the Superintendent of the Almshouse overseeing its regulations and the care of its students, which included children sent from other institutions such as the State Reform School for Boys at Westborough (Massachusetts Board of Education, 1874, p. 132).

Reform and Industrial Schools

Children who committed minor offenses, such as skipping school or being disobedient, could be sent to industrial training schools or reform schools. The decision for commitment could be made by the court, the child's family, or local officials. The goal was for these stays to be temporary and short-term. Once a child had learned job skills and how to avoid trouble, they would either return home or be placed with a local family.

In the early 1800s, as the country entered the Industrial Revolution and the demand for factory workers, particularly in the Northeast, was increasing, these specialized schools began offering vocational education to prepare children for jobs in the growing industrial economy. Reform schools in the mid-1800s aimed to rehabilitate children by providing education in the trades, as seen in institutions such as the State Reform School for Boys in Westborough (opened in 1848) and the Lancaster Industrial School for Girls (opened in 1854). However, these schools faced significant challenges with children who had disabilities, as documented in annual reports and other materials. These children often struggled or were unable to work and needed additional support, leading to perceptions that they were occupying space needed for others. To address this, some schools built separate housing on their campuses specifically for children with disabilities, highlighting the difficulties in integrating them into standard reform school programming (Brenzel, 1983).

1803, the Boston Female Asylum was opened as an orphanage in Boston, MA to care for girls under the age of 10 who were in poverty.

1814, the Boston Asylum for Indigent Boys was established by the Massachusetts Legislature in Boston, MA to "afford shelter and support to the children of the virtuous poor" (*An Account of the Boston Asylum for Indigent Boys*, 1823, p. 3).

1833, the Boston Farm School was established on Thompson Island in Boston Harbor as a private school. It was created by a group of Boston philanthropists to create a home and school for at-risk boys (principally orphans or boys with single parents). The school's aim was to instruct young men in "agriculture, gardening, or such useful occupations as will contribute to their present maintenance, and tend to form in them habits of industry and order, and to prepare them to earn their own livelihood" (An Act To Incorporate The Proprietors Of The Boston Farm School, 1833, pp. 704–705).

1835, the Boston Asylum for Indigent Boys merged with the Boston Farm School and was renamed the Boston Asylum and Farm School for Indigent Boys. The school, located on Thompson Island, served approximately 70 boys between the ages of five to eleven who

divided their time between farm work, studying, playing, and performing chores (An Act To Incorporate The Boston Asylum And Farm School For Indigent Boys, 1835).

1846, the Massachusetts State Reform School for Boys opened in Westborough, MA and was designed to house 400 boys. This was followed by the opening of the Lyman School for Boys in the 1860s, which was also in Westborough. The philosophy behind these institutions was that juveniles had greater potential for rehabilitation compared to adults, and therefore, should not be treated within adult correctional facilities. The boys that were sent there ranged from those who were "feeble minded," as well as boys with mental health conditions, runaways, orphans, abandoned children, and those who had committed serious crimes.

From 1900 through the 1930s, successive administrations portrayed the Lyman School's classification process as equivalent to the diagnostic procedures of the state's best mental hygiene clinics. During these decades they used testing either to transfer boys to mental health institutions or to justify the segregation of the "feebleminded", "physically handicapped" or "emotionally disturbed" within their own programs and facilities that were most convenient for the staff (Leaf, 1988, p. 68).

Training and Education of the Disabled Child

In 1829, Dr. John Dix Fisher and several Boston leaders founded the New England Asylum for the Blind, inspired by Fisher's visit to the world's first school for blind children in Paris. Upon his return to America, Fisher obtained a charter from the Massachusetts legislature to establish a similar institution. In 1830, the state provided limited funding, which was supplemented by donations from the trustees. The following year, reformer Samuel Gridley Howe was appointed director. After studying European teaching methods, Howe opened the school in 1832 with six students. He promoted the school through public exhibitions, raising private funds, though he initially struggled to reach the intended enrollment of thirty students. In 1833, the school moved to a larger facility, and by 1839, enrollment had grown to sixty-five. One of the trustees, Thomas Perkins, sold his home and used the proceeds to help convert a hotel in South Boston into a new school site—eventually known as the Perkins School for the Blind (*Perkins School for the Blind*, n.d.).

In the mid-1840s, the Commonwealth of Massachusetts began investigating whether children with intellectual or developmental disabilities could benefit from education or training. Under the Resolves of 1846, Chapter 117, the Governor appointed three individuals as Commissioners on Idiocy to assess the needs of this underserved group and recommend ways to support them (Resolve for the Appointment of Commissioners on Idiocy, 1846). The commission's report, authored by Howe, led to the 1848 creation of the Experimental School for Teaching and Training Idiotic Children (Massachusetts Archives, n.d.-a).

For the school to be established, a state-funded public charity had to commit to hosting the program and managing its $2,500 annual budget. In its 1849 Eighteenth Annual Report, the

Trustees and Secretary of the Perkins Institution agreed to host the experimental school in a separate wing, provided it did not interfere with their primary mission of educating blind students (Perkins Institution and Massachusetts Asylum for the Blind, 1850). Despite being located at Perkins, the experimental school was formally connected to the same school district as the State Normal School at West Newton and was subject to visits from the district's Board of Education Visiting Committee (Massachusetts Board of Education, 1850).

Following the three-year experimental period, the Massachusetts School for Idiotic and Feeble-Minded Youth was officially incorporated in April 1850 (Statute 1850, Chapter 150) and opened at a new location in South Boston in 1852. Most students from the experimental school transferred to this new facility. According to the Resolves of 1851, Chapter 44, governance of the new institution included both state-appointed and corporate trustees. A separate Board of Visitors, comprising only state officials, including the governor, was tasked with reviewing bylaws and regulations and could visit the school at any time (Experimental School for Teaching and Training Idiotic Children, 1852).

Under the school's Terms of Admission, children aged six to twelve underwent a one-month trial period to assess their suitability for the program. A final decision on admission was then shared with parents. This practice stemmed from the frequent unreliability of application information (Experimental School for Teaching and Training Idiotic Children, 1852).

The school was required to provide free education to at least thirty students from impoverished families. Applications for these state-supported beneficiaries had to include a formal request addressed to the Governor, a certificate from local officials confirming financial need, and a physician's certificate verifying mental deficiency and ruling out insanity (Experimental School for Teaching and Training Idiotic Children, 1852).

In 1851, the program evolved into a permanent institution: the Massachusetts School for Idiotic and Feeble-Minded Youth. This transition reflected its official status and came with new state requirements, including educating at least thirty students annually and receiving a yearly stipend. The governor appointed four board members and was also part of a Board of Visitors that included the state's top political leaders. Howe maintained that this was a public school, not a medical institution, and referred to the students as "pupils".

By 1860, although not purely educational, the Massachusetts School for Idiotic and Feeble-Minded Youth was recognized as one of several special institutions connected to the Board of Education, alongside the State Reform School for Boys and the Industrial School for Girls. These were described as "…aids and encouragements to universal education" (Massachusetts Board of Education, 1861, p. 138), and thus regularly featured in the Board's annual reports.

In the 1886 annual report of the State Board of Lunacy and Charity, the School for the Feeble-Minded at South Boston was listed as a state charitable institution. At this point in time, besides being a school, it was also considered a residential asylum because it now had a custodial department (Massachusetts State Board of Lunacy and Charity, 1887).

However, in 1898, Section 26 of the General Statutes, Chapter 433, established that the School for the Feeble-Minded at Waltham would no longer report to the Board of Education but instead to the Board of Insanity (Massachusetts Board of Education, 1900). Despite this shift, the Board of Education's 1899 annual report acknowledged that the school remained connected to the state's general educational policy. The report emphasized that the school's work was still significant enough to warrant continued recognition by the Board, as it had in previous years: *"...the school is still related to the general educational policy of the Commonwealth as to justify recognition of its important work by the Board, as in former years"* (Massachusetts Board of Education, 1900, p. 621).

The importance of this institution to the Board was further demonstrated in a detailed description of its mission:

> *"From her own treasury, she provides for the instruction and education of indigent children of feeble intellect who are capable of benefiting from school instruction, and, in her compassion for the unfortunate, she also pays for their maintenance. Thus, the school is a part of the public education system. It was founded for the benefit of improvable cases. Our late president, in a footnote added by himself to the annual report of 1896, while it was in press, remarked: [The school department of this institution, originally the only department, remains and will always remain the chief department, worthy, above all other departments, of being amply sustained]."* (Massachusetts Board of Education, 1900, p. 624)

Eventually, the institution became the Walter E. Fernald State School and expanded to include an asylum department for individuals who were beyond school age or unable to benefit from its educational programs (Massachusetts School for Idiotic and Feeble-Minded Youth, 1851).

Expansion of Institutional Care

Between 1870 and 1930, Massachusetts experienced a dramatic expansion of state-run institutions for individuals labeled as "insane" and "idiots". This institutional growth was driven by evolving beliefs about mental illness and social responsibility, as well as by structural changes in the state's approach to public welfare.

One key factor in this expansion was the closure of state almshouses, which had historically housed the poorest and "least capable" individuals. As the State Almshouses at Monson and Bridgewater closed in 1872 and 1877 respectively, and the Tewksbury State Almshouse evolved into a facility for the "ill" or "infirm" who could not be discharged or transferred to the State Workhouse, a shift occurred. Many individuals previously housed in almshouses were now placed in newly created institutions that promised more specialized care (Appleman, 2018).

The 1875 report by the Massachusetts Commissioners provided a detailed statistical account of individuals labeled "insane" and "idiots" who were dependent on either family or state support. Data were collected through returns submitted by Overseers of the Poor, physicians,

clergymen, municipal officers, and hospital superintendents. Individuals were classified under various categories, including “furious” vs. “harmless”, “curable” vs. “incurable”, and “native” vs. “foreign”. The report found that 2,632 (70.8%) “insane” individuals and 1,087 (29.2%) “idiots” were fully dependent. Among the “insane”, 43.4% were hospitalized, 7.9% were in houses of correction or almshouses, and 48.8% were cared for at home or in local institutions; 76.7% were deemed “incurable”. Based on these figures, the Commission recommended institutionalizing 1,774 additional individuals, including 1,713 “insane” persons and 61 “violent idiots”. The report emphasized that early intervention significantly improved recovery outcomes, whereas delays increased the risk of chronic mental illness. As of 1874, there were approximately 4,000 “insane” individuals in Massachusetts, with 37.5% housed in state hospitals and the remainder in other public and private facilities. The report also identified subpopulations requiring specialized care, including “inebriates”, “epileptics”, and the “criminal insane” (Report Of The Commissioners Of Lunacy, To The Commonwealth Of Massachusetts, 1875).

At the same time, a growing belief in the therapeutic value of institutionalization for mental illness helped justify the construction of more facilities. According to Klein and Wittes (2011), there was increasing confidence that mental illness could be cured through confinement in purpose-built asylums (Klein & Wittes, 2011). This sentiment was echoed in an 1855 report by the Joint Standing Committee on Charitable Institutions, which stated that recovery from mental illness required removal from familiar environments to hospitals designed to meet patients’ specific needs (Report Of The Joint Standing Committee On Charitable Institutions, 1855).

This shift in philosophy was reflected in the establishment and expansion of institutions across the state. The State Lunatic Hospital at Danvers opened in 1873, setting a precedent for purpose-built psychiatric facilities. In 1884, the Westborough Insane Asylum was established on the former site of the State Reform School for Boys, which was relocated and renamed the Lyman School for Boys.

The Massachusetts School for Idiotic and Feebleminded Youth moved to Waltham in 1888 and became the Walter E. Fernald State School, which later expanded to include the Templeton Colony in 1899. Additional facilities followed, including the Massachusetts Hospital for Dipsomaniacs and Inebriates in Foxborough (1889), the Medfield Insane Asylum (1892), and the conversion of the Bridgewater State Almshouse into a facility for the criminally insane in 1895.

In the early 20th century, institutional development continued. The Worcester Farm Colony (later Grafton State Hospital) was established in 1902, followed by the Wrentham State School in 1906 and the Belchertown State School in 1922. Addiction treatment was also reorganized, with services moved from Foxborough to the newly opened Pondville State Hospital in 1914. The institutional boom culminated in 1930 with the opening of the Metropolitan State Hospital in Waltham, later home to the Gaebler Children’s Center.

During this expansion the population under the care of Massachusetts state institutions grew. The number of individuals classified as “insane” increased from approximately 12,574 to 15,421, although their percentage of the total population slightly declined from 83.4% to 80%. The “feeble-minded” population grew significantly in both number and proportion, rising from 1,846 (12.2%) to 3,066 (15.9%). The number of “epileptics” also increased from 517 (3.4%) to 686 (3.6%). A new category, “voluntary” (sane) individuals, appeared in 1918, accounting for 22 people (0.11%). Overall, the data reflect a growth in institutional populations and evolving classifications within the state’s mental health system (Massachusetts Commission on Mental Diseases, 1919; State Board of Insanity, 1911).

During this time, eugenics was becoming more popular. Eugenics promoted the idea that healthy and "superior" people should reproduce, while those deemed inferior, such as those with disabilities or who did not fit societal norms, should not reproduce. Eugenicists believed society would benefit by removing people they considered unfit through segregation and social exclusion. Massachusetts played a central role in shaping the American eugenics movement. Dr. Everett Flood, the superintendent of the Massachusetts State Hospital for Epileptics, was alleged to have castrated 26 patients at his institution during the early 20th century and reported good results. Although the operation was not legal, it gained approval from the Board of Control of Institutions, highlighting how local figures were actively engaged in practices that supported the eugenic goals of controlling the reproduction of institutionalized individuals (Lombardo, 2008).

In May 1911, Monson State Hospital for Epileptics hosted a pivotal meeting of prominent eugenicists, including Harry Laughlin of the Eugenics Record Office and Charles Davenport, one of the movement’s leading theorists. Alongside figures such as Bleecker Van Wagenen, they outlined an aggressive platform to use Massachusetts as a model for eliminating so-called “anti-social classes” through sterilization and social control. Their proposals, later presented at the First International Eugenics Congress in London in 1912, placed the state at the ideological forefront of global efforts to manipulate human heredity in the name of public welfare and national strength (Kevles, 1985).

These ambitions had devastating real-world consequences. At institutions like the Fernald School, sterilizations were sometimes conducted under the mistaken belief that they could "cure" mental illness, sexual behavior, or other perceived deviance. Dr. Walter Fernald participated in surgical castrations early in his career at the request of desperate or misinformed families. Although he later expressed remorse for the trauma inflicted, the harm was irreversible. One especially tragic case involved an intellectually disabled woman sterilized under the false promise of protection; instead, her inability to conceive made her a target for sexual exploitation, resulting in sexually transmitted disease and further victimization. Such outcomes starkly reveal how sterilization policies often increased vulnerability rather than offering safety (Green, 2025a, 2025b).

In the 1930s social policies and legislation was influenced by prevailing eugenic ideology. A bill known as *An Act Providing for Sexual Sterilization of Inmates of State and County Institutions in Certain Cases* was introduced to the Massachusetts legislature. This bill sought to authorize the sterilization of institutionalized individuals deemed "unfit" to reproduce, yet it failed to pass in both houses of the state legislature (An Act Providing For Sexual Sterilization Of Inmates Of State And County Institutions In Certain Cases, 1934). Despite the bill's failure, it underscored the state's ongoing commitment to eugenic policies that aimed to control reproduction among marginalized populations.

Despite this, Massachusetts did not pursue sterilization as aggressively as states like California or Virginia. This was partly due to figures like Dr. Fernald, whose evolving views on the psychological harms of sterilization may have tempered its implementation in the state, even as national momentum for such policies increased (Green, 2025a).

Establishment of the Department for Defective Delinquents

The creation of defective delinquent departments in Massachusetts was deeply intertwined with the eugenics movement's broader goals to identify, segregate, and prevent the reproduction of individuals considered socially or biologically "unfit". "Defective Delinquents" were individuals considered both intellectually limited and behaviorally problematic, often charged with minor offenses but deemed unfit for standard correctional or mental health institutions. The 1911 passage of Chapter 595 formalized their segregation through specialized departments at existing facilities, reflecting a broader effort to separate those seen as socially or morally deviant from the general inmate population and to tailor their confinement and care to perceived needs.

Specialized departments for so-called "defective delinquents" were established at the Reformatory for Women, the Massachusetts Reformatory, and the State Farm at Bridgewater (An Act To Provide For The Maintenance At The Reformatory For Women, The Massachusetts Reformatory And The State Farm Of Departments For Defective Delinquents, 1911). Superintendents of schools, asylums, and prisons held the authority to transfer inmates they considered unfit for their institutions. These inmates were often cited for violating institutional rules through behavior deemed "immoral" or "indecent"(*Bulletin of the Massachusetts Commission on Mental Diseases. v.7-17, 1923-33*, 1923).

Commitment as a "defective delinquent" required a formal diagnosis of mental deficiency by two certified physicians, followed by a court order. Placement was determined by age and sex: males under 21 were sent to the Massachusetts Reformatory; males 21 and older to the State Farm; and all females, regardless of age, to the Reformatory for Women. Those committed to reformatory-based departments were placed under the custody of the Board of Prison Commissioners, while those at the State Farm fell under its board of trustees. Release from these institutions could be petitioned through the courts. If the individual was deemed safe for reintegration, they were paroled for one year. After this period, permanent discharge could be

granted if no further issues arose. If parole was violated, recommitment was allowed without the need for a new medical certificate. State law required that detailed records of all diagnoses and proceedings be carefully maintained.

In 1914, the Massachusetts Board of Insanity conducted a comprehensive survey to assess the mental health status of prisoners, including all those classified as “defective delinquents”. The survey covered institutions such as Bridgewater State Hospital and the School for the Feeble-Minded. Its objective was to refine how the state identified and managed individuals with borderline intellectual disabilities and to explore alternatives to incarceration (State Board of Insanity, 1916).

Judges expressed growing frustration at the lack of appropriate treatment facilities, noting that many individuals were incarcerated simply because no suitable care options existed. They emphasized that these people needed long-term support and training, not punishment, and that commitment, not sentencing, was the proper course of action. Legal and institutional constraints, however, forced them to send mentally deficient individuals to prisons.

As the State Board of Insanity observed in its 1916 report:

> *“Now that classification on the basis of mentality opens another avenue of advancement, certain features of our present procedure seem very crude and illogical. For example, it is illogical to impose a definite sentence upon anyone incompetent to support himself honestly. What such a one needs is treatment, not punishment. And it is illogical to limit his incarceration when he needs a long course of specially adapted training similar to that of the feebleminded, the limit of which can be determined only by the slow progress he makes. He should be committed, not sentenced. … The justices of our courts deplore the necessity of sending these deficients to a penal institution; but since there is no other place, inadequately equipped offenders must be sent there or soon be turned loose again on the community.”* (State Board of Insanity, 1916, pp. 259–260)

In 1919, Massachusetts formed a Special Commission to improve its handling of defective delinquents, the feeble-minded, and other vulnerable or criminally involved populations. The commission included representatives from correctional, mental health, and educational institutions. Its recommendations focused on building a unified system for managing both adult and juvenile offenders, with decisions based on age, mental health condition, and rehabilitative potential (Resolve Providing For A Special Commission To Investigate And Consider The Methods Of Treating Defective Delinquents And Criminals, 1918).

Key proposals included:

- Mandating mental health screenings in courts and correctional facilities.
- Prioritizing treatment over punishment for mentally abnormal or deficient offenders.

- Initiating early intervention programs for children showing signs of mental deficiency, starting as young as age three.
- Differentiating among the feeble-minded, recognizing that some required institutional care while others could live in the community under supervision.
- Expanding Wrentham State School and constructing a new institution in Belchertown to meet growing demand.

The creation of specialized systems for “defective delinquents” reflected both evolving medical understandings and persistent societal discomfort with individuals who fell between categories of “criminal” and “mentally defective”. While well-intentioned in aiming to provide appropriate treatment rather than punishment, these systems were also marked by broad discretionary powers, limited legal protections, and a lasting impact on those institutionalized. The 1919 Special Commission’s work signaled a growing recognition of the need for more nuanced, humane, and preventive approaches, though many of its recommendations would take decades to realize fully (Report Of The Special Commission Relative To The Control, Custody And Treatment Of Defectives, Criminals And Misdemeanants, 1919).

The Development and Impact of Early 20th Century Community based Services in Massachusetts

During the early 20th century, significant developments occurred in the field of mental health care in Massachusetts, especially concerning the treatment and care of individuals categorized as "insane" or "feeble-minded". This period marked a shift toward more humane, preventive, and community-centered approaches to mental health, with particular attention given to outpatient care, boarding out programs, and the development of specialized clinics for the “mentally handicapped”. Key legislative and institutional developments between 1909 and 1921 laid the groundwork for modern community-based services in Massachusetts, focusing on boarding out programs, the establishment of outpatient departments, and the creation of traveling clinics for the “feeble-minded”.

Boarding Out and the "Insane" (1909)

One of the earliest pieces of legislation addressing the care of individuals with mental health issues in Massachusetts was the 1909 provision for boarding out patients considered to be non-dangerous and quiet from public or private institutions. Sections 71 through 74 of Chapter 504 of the Acts of 1909 provided that such individuals could be placed in suitable homes or other environments within Massachusetts but excluded those committed for reasons of dipsomania, inebriation, or narcotic abuse (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909). This legislation built upon earlier boarding-out practices initiated in the late 1880s, which had originally been developed for orphans and neglected children and later extended to include the “chronically insane”. Under Chapters 385 and 319 of the Acts of 1885 and 1886, temporary residential placements in private family homes—often with rural farmers

or mechanics—were legally sanctioned, with financial support provided by the state or by relatives of the individual. This model was seen as a more humane and socially inclusive alternative to institutionalization, offering comfort, a chance at self-sufficiency, and alleviating overcrowding in hospitals (Massachusetts State Board of Lunacy and Charity, 1887). Recommendations for boarding out were made by hospital superintendents and required thorough evaluations, while placements were monitored by state representatives to ensure appropriate care.

The Act of 1909 formalized and expanded this practice, emphasizing more humane alternatives to institutionalization by allowing patients to live in the community while still maintaining their status as inmates of the institution from which they had been released. The families who boarded out these individuals received a monthly payment of up to $3.25 from the state treasury. To ensure the well-being of these boarded individuals, the State Board of Insanity, along with hospital trustees, were mandated to conduct quarterly visits to monitor the conditions in which these individuals were living. The law also stipulated that patients could be removed from their boarding arrangements if they were subject to abuse, neglect, or mistreatment. This program represented a significant shift in the treatment of patients with mental health conditions, emphasizing integration into society rather than confinement within institutional walls (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909).

Outpatient Departments and Preventive Mental Health Care (1915)

In the early 1900s, the concept of outpatient care began to take shape as a means of preventing unnecessary institutionalization and promoting early intervention for those experiencing mental health challenges. The first outpatient department connected to a state hospital was established at Foxborough State Hospital in 1909 (State Board of Insanity, 1906, 1911). By 1915, outpatient departments had been established at numerous other state institutions, including Bridgewater, Boston, Danvers, Worcester, and Northampton, among others (State Board of Insanity, 1916).

The purpose of these outpatient departments was to provide preventive care and support to individuals in the early stages of mental illness, aiming to reduce the need for long-term custodial care in hospitals. This initiative also facilitated better communication between social workers and individuals who were boarded out or on temporary leave from institutions. Additionally, the outpatient departments played a critical role in after-care services, offering temporary support to patients following their discharge to prevent readmissions (State Board of Insanity, 1916). Educational clinics were also organized to raise awareness among community physicians about mental health hygiene, demonstrating the state's commitment to integrating mental health care into broader public health efforts.

The Traveling School Clinics for the "Feeble-Minded" (1914–1921)

Perhaps one of the most innovative and impactful developments in early 20th-century mental health care in Massachusetts was the creation of traveling clinics for children identified as "feeble-minded". In 1914, the Massachusetts School for the Feeble-Minded launched the first traveling clinic, a service designed to provide expert evaluations of children suspected of having mental health conditions (Massachusetts Archives, n.d.-c). These clinics, which were staffed by psychologists, psychiatrists, and social workers, were hosted both at the school and in various school districts across the state.

The primary goal of the traveling clinics was to provide comprehensive evaluations, including psychometric, psychiatric, and sociopsychiatric assessments, for children who had been identified by schools or parents as potentially having “mental defects” for three or more years. The clinics also aimed to provide guidance to parents on in-home care, advise public schools on special education programs, and engage in community outreach to promote early intervention. As the demand for diagnostic services grew, the Department of Mental Diseases, established in 1920, expanded the traveling clinic model to all 14 state institutions under its jurisdiction (*Traveling Clinic Case Files, 1921-1955 Walter E. Fernald State School*, n.d.).

By the 1920s, the traveling clinic service had become the primary means of diagnosing and tracking individuals with mental health conditions in Massachusetts. The clinic records included detailed information about each child, such as family history, educational progress, and social relations, which were used to make recommendations about placement and training (*Traveling Clinic Case Files, 1921-1955 Walter E. Fernald State School*, n.d.). These records became the foundation of a central registry for the "feeble-minded" and represented a critical step in understanding and addressing the needs of this population.

However, by the 1940s, the traveling clinic model began to fade, particularly due to the disruptions of World War II. It was eventually replaced by the mental health center model in the 1950s (*Traveling Clinic Case Files, 1921-1955 Walter E. Fernald State School*, n.d.).

The Special Commission to Investigate Training Facilities for Retarded Children was established under Chapter 77 of the Resolves of 1952 to examine the educational resources available for children with intellectual disabilities in Massachusetts. In its 1953 report, the Commission categorized these children into three groups: "educable retarded", "trainable retarded", and "custodial retarded". It identified a severe lack of appropriate educational programs and recommended several reforms, including the creation of a division for the education of “handicapped children” within the Department of Education, financial reimbursement to local communities for special education costs, expanded training in special education across state universities and colleges, and follow-up services for children until age twenty (Report Of The Special Commission Established To Make An Investigation And Study Relative To Training Facilities Available For Retarded Children, 1954).

20th Century Deinstitutionalization and Independent Living Movement

Community Supervision of the "Feeble-Minded"

During this time Massachusetts faced a workforce crisis due to a combination of factors, including a growing demand for industrial labor due to World War I, economic slowdowns, and the Great Depression. In 1920, the Joint Special Committee on Public Institutions underscored in its report the chronic workforce crisis of support staff and how it negatively impacted the treatment and care of inmates across all charitable public institutions. It also stressed that large institutions did not promote economy or efficiency and that medium-sized institutions with a capacity of no more than 2,000 patients were most suitable for these populations as they provided greater individualized supports. The Committee also raised the need to establish a state program to support and supervise the "feeble-minded" both in and outside of institutional settings, including an institution for "defective delinquents". It also pushed for the advancement of research in the field of "mental disease" and "mental defect". Here is an excerpt reflective of the Commission's view regarding the provision of supports for and controlling of the "feeble-minded" population, including a view that they should be kept from having children of their own:

> *"A more reasonable attitude is now developing in the care of the feeble-minded. Views of irresponsible theorists relative to the possibility of their cure have now been completely abandoned, as it has been positively demonstrated that this condition is due to a defect in the brain, and that this defect is incurable, because it is a permanent lack and not a disease. Consequently, all that can be done for cases of this nature is to provide proper care, and to prevent, as far as possible, their propagation of offspring to inherit like deficiencies."* (Report Of The Joint Special Committee On Public Institutions, 1920, p. 12)

Due to the large volume of "feeble-minded" children being screened by traveling clinic outpatient services, the Department of Mental Diseases recognized that a large portion of this population could be supported and cared for at home and in the community instead of costly institutions. This need was emphasized by the Department in its 1922 annual report:

> *"There is great need for extension of this principle of community supervision as far as possible instead of expensive institutional support and the large expenditures for the construction of buildings (new construction costs approximately $1,500 per bed; annual maintenance, at least $300 per patient). The importance of the feebleminded problem now warrants the recommendation that there be created with the Department of Mental Diseases a Division for the Feeble-minded."* (Department of Mental Diseases, 1923, p. 8)

Consequently, in 1923, a state program called the Division for the Feeble-minded (later renamed to the Division of Mental Deficiency in 1926) was officially created under the

Department of Mental Disease, along with its Division on Mental Hygiene (Department of Mental Diseases, 1924). In its 1924 annual report, the Department explained that the Division was established to:

> *"… deal with the problems of the feeble-minded as well as for various phases of the work carried on in the field of mental defect, both within the institutions and in the community," and "…provides for identification, registration, education, supervision, segregation."* (Department of Mental Diseases, 1925, p. 6)

Federal Policy Shifts Toward Deinstitutionalization and Community Based Supports

Over the past century, a series of landmark federal laws have fundamentally reshaped the treatment and support systems for individuals with disabilities and mental health conditions in the United States. Beginning with the Social Security Act of 1935 and continuing through to the Affordable Care Act of 2010, federal legislation has progressively expanded civil rights protections, restructured healthcare and education access, and supported the transition from institutionalization to community-based care. These laws not only acknowledged the rights and dignity of people with disabilities and mental health conditions but also allocated critical resources to create inclusive systems of support in housing, employment, education, and healthcare. Together, this evolving legal framework laid the groundwork for deinstitutionalization and the development of more integrated, person-centered services across the country.

1935, the Social Security Act was passed. This established federally funded benefits and funds to states for assistance to the elderly, people who are blind, and people with disabilities. The Act extended existing vocational rehabilitation programs.

1938, the U.S. Fair Labor Standards Act was enacted, which established minimum wage, overtime pay, recordkeeping, and child labor standards. This includes Section 14(c) which allows employers to obtain certificates from the U.S. Department of Labor authorizing them to pay people disabilities less than the federal minimum wage. This Act is still in existence in 2024.

1946, the National Mental Health Act was signed by President Truman, which shifted U.S. mental health policy from institutional care for the "mentally ill" to community-based, outpatient services, reducing dependence on mental health hospitals. This legislation also called for establishing a National Institute of Mental Health (National Institute of Mental Health, n.d.-a).

The three primary objectives of the legislation were (1) to provide federal funding for research into psychiatric disorders, including causes, diagnosis, and treatment, (2) to train mental health professionals through fellowships and grants, and (3) to offer federal grants to states for establishing mental health clinics, treatment centers, and funding demonstration projects on prevention, diagnosis, and treatment (Institute of Medicine, 1991).

The National Institute of Mental Health was placed within the National Institutes of Health, which connected it with other research agencies like the National Cancer Institute, aligning mental health research with broader biomedical science (Grob, 1994).

1955, the Mental Health Study Act was enacted which established the Joint Commission on Mental Illness and Health to review, investigate, and accredit mental health agencies and providers to ensure that the "mentally ill" are receiving adequate care and treatment (National Institute of Mental Health, n.d.-b).

1955, Chapter 637 of the Acts redefined key mental health terminology in Massachusetts law, replacing outdated terms such as "insane" and "feeble-minded" with "mentally ill" and "mentally deficient". The updated definition of "mentally ill" established specific criteria for involuntary commitment, identifying individuals with conditions like psychosis or character disorders that impair judgment or emotional control and pose a danger to themselves, others, or public order. Importantly, the law clarified that such a diagnosis did not automatically imply criminal irresponsibility or civil incompetence. "Mentally deficient" was defined as significantly impaired intellectual functioning, evidenced by psychological signs (An Act Further Regulating The Procedures For The Hospitalization And Commitment Of The Mentally Ill, 1955).

1963, President Kennedy signed the Community Mental Health Act of 1963 (CMHA). With the CMHA, Kennedy and Congress sought to decrease the number of institutionalized individuals through federal grants to help states build and staff community mental health centers. These centers were designed to offer five essential services: consultation and education for communities and professionals, inpatient facilities, outpatient clinics, emergency response, and partial hospitalization (Institute of Medicine, 1991).

1964, the Civil Rights Act, signed by President Johnson, prohibited discrimination on the basis of race, religion, ethnicity, national origin, creed, and later gender. This Act outlawed discrimination on the basis of race in public accommodations and employment, as well as in federally assisted programs.

1965, the Community Mental Health Centers Act Amendments of 1965 (Public Law 89-105) was signed into law. The Act authorized federal assistance for staffing mental health centers and expanded teacher training and research and demonstration projects for "handicapped children".

1965, Medicare and Medicaid were established through the passage of the Social Security Amendments of 1965, providing federally subsidized health care to disabled and elderly Americans covered by the Social Security program. These amendments changed the definition of disability under the Social Security Disability Insurance program, specifically around the duration of a disability, which changed from "long continued and indefinite duration" (Cojen & Ball, 1965, p. 6) to "expected to last for not less than 12 months" (Cojen & Ball, 1965, p. 7).

Included in the amendments was the Institutions for Mental Diseases (IMD) Rule, also known as Section 1905(a)(30)(B) of the Social Security Act, which prevents the use of federal Medicaid funds to pay for care in most mental health residential treatment facilities that are larger than 16 beds (Congressional Research Service, 2023). The IMD Rule initially denied Medicaid reimbursement for inpatient services for people between the ages of 21 and 65. This created a financial disincentive for states to maintain large psychiatric institutions, encouraging the development of community-based mental health services as a more cost-effective alternative. While the IMD Rule was amended in 2018 to allow for short-term inpatient stays under certain conditions, the impact of this rule on deinstitutionalization was substantial.

1961, the President's Panel on Mental Retardation was established in 1961 by President John F. Kennedy and originated as a blue-ribbon panel[27]. It aimed to improve the lives of individuals with intellectual disabilities. The committee was largely shaped by Eunice Kennedy Shriver, who led the Joseph P. Kennedy Jr. Foundation (JPKF)[28] and played a key role in its establishment in 1946.

1966, the President's Committee on Mental Retardation advisory committee was established by President Johnson and formed by Executive Order 11280 to research issues related to people with intellectual or developmental disabilities. Its mission is to provide advice to the President and the Secretary of the U.S. Department of Health and Human Services on issues related to intellectual disabilities, focusing on improving the quality of life for individuals with I/DD. The PCPID aims to ensure the right of a "decent, dignified place in society" for people with intellectual disabilities and promotes policies and initiatives that support independence and lifelong inclusion of people with intellectual disabilities in their respective communities (Administration for Community Living, n.d.-b).

The committee's duties include advising the president and secretary of the U.S. Department of Health and Human Services concerning the following for people with intellectual or developmental disabilities (Administration for Community Living, n.d.-a):

- Expansion of educational opportunities.
- Promotion of homeownership.
- Assurance of workplace integration.
- Improvement of transportation options.
- Expansion of full access to community living.
- Increasing access to assistive and universally designed technologies.

[27] A blue-ribbon panel is a group of experts and nonpartisan individuals appointed to study, investigate, or analyze a topic.

[28] The JPKF was established in 1946 by Joseph P. Kennedy Sr. and Rose Fitzgerald Kennedy to honor their eldest son Joseph P. Kennedy Jr. and was inspired by their daughter Rosemary Kennedy, who was diagnosed with an intellectual disability. The Board is comprised of members of the Kennedy family, for whom advocacy around intellectual and developmental disabilities is an enduring commitment.

Originally called the President's Committee on Mental Retardation, it was renamed in 2003 by President George W. Bush due to the negative connotations associated with the term "mental retardation" (President's Committee on Mental Retardation, Health and Human Services Department, 2003).

The President's Committee for People with Intellectual Disabilities (PCPID) consists of 34 members including 19 citizen members, including parents, professionals, and advocates, who are appointed by the President to serve two-year terms and 13 ex officio members from key federal agencies, such as Health and Human Services, Education, Labor, Housing, and others.

PCPID is supported by federal employees and meets at least twice a year, often convening informally as well. It submits an annual report to the President to offer recommendations on policies and initiatives related to intellectual disabilities. The Committee is overseen by the Administration on Intellectual and Developmental Disabilities but does not administer federal funds, grants, or direct assistance. It operates solely as an advisory body to guide federal action.

1970, the Developmental Disabilities Services and Facilities Construction Amendments were passed and contained the first legal definition of developmental disabilities. They authorized grants for services and facilities for the rehabilitation of people with developmental disabilities and state Developmental Disabilities Councils. It also gave states the responsibility for planning services for people with severe disabilities.

1970, Public Law 88-164 created a program to construct facilities for people with intellectual or developmental disabilities throughout the nation. As a result, twenty "University Affiliated Facilities" (UAF) and twelve "Centers for Research on Mental Retardation and Related Aspects of Human Development" were created. These facilities provided training in intellectual or developmental disabilities for interdisciplinary professionals. In Massachusetts, the Eunice Kennedy Shriver Center, a UAF affiliated with Massachusetts General Hospital at the time, was established in October 1970 and was located adjacent to the Walter E. Fernald School. At the time of its opening, the Shriver Center offered services, professional training, research, services aimed at improving the health, safety, and quality of life for individuals with intellectual or developmental disabilities (Gunnar and Rosemary Dybwad Papers, 1970).

1971, Medicaid created the optional Intermediate Care Facility (ICF) model under the state plan Medicaid services. These facilities were created in the community as an alternative to institutions for people with intellectual or developmental disabilities. The model provided matching funds to states for running the facilities as long as they met standards covering management, health care service provisions, protection of people served, and other criteria. This was the first long-term service benefit from Medicaid, specifically for people with intellectual or developmental disabilities.

1972, Chapter 766 was passed which served as the model for the first federal special education law. Chapter 766 helped bring thousands of young people into more inclusive educational settings and required team evaluations, annual reviews, and Individual Educational Programs

(IEPs). It also required that local school systems educate every student in their community and fund appropriate educational costs (Commonwealth of Massachusetts, 2025d).

1973, "Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability" (U.S. Department of Health and Human Services, Office for Civil Rights, n.d.). Section 504 states that,

> *"…no qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination under any program or activity that either receives Federal financial assistance or is conducted by any Executive agency or the United States Postal Service"* (U.S. Department of Justice Civil Rights Division, 2024).

Then President Nixon had vetoed a previous version of the bill in 1972, stating it "…mask[s] bad legislation beneath alluring labels…", stating it would cause a "spending spree" and "fiscal irresponsibility"(*Veto of the Vocational Rehabilitation Bill. | The American Presidency Project*, 1973).

1973, the creation of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) represented a significant step in supporting states to manage substance abuse and mental health services by enacting several grant programs to support state initiatives to expand community-based psychiatric services, and the improvement of state hospitals (Duff, 2020).

1975, the Community Support Program (CSP) was created by the National Institute of Mental Health to address the broader needs of individuals transitioning from state institutions to community living. CSP emphasized the importance of providing a full range of supports beyond clinical treatment, such as housing, income support, medical care, employment, and transportation. Although CSP funding was modest, it had a significant impact on reshaping state mental health policies and services (Erickson, 2021).

1975, the Education for all Handicapped Children Act of 1975 is passed, which requires public schools to provide free public education to all eligible children with disabilities in the least restrictive environment appropriate to their individual needs. This act was later renamed the Individuals with Disabilities Education Act (IDEA).

1977, the President's Commission on Mental Health was established by Executive Order 11973 to recommend programs and services to meet the nation's mental health needs. The Commission was chaired by Rosalynn Carter in an honorary capacity, with physician and lawyer Dr. Thomas E. Bryant serving as Chairman and Executive Director. This led to the passage of the Mental Health Systems Act, which redefined federal priorities and expanded the scope of services provided to people with mental health conditions, moving beyond clinical care to include supports for social integration and well-being. In 1981, the Act was repealed, which was part of a broader political shift that favored reducing the size and role of federal government.

Instead of a federally managed, comprehensive mental health system, funding for community mental health services would be provided to states via block grants (Erickson, 2021).

1978, Title VII was added by an amendment to the federal Rehabilitation Act of 1973 and provided federal funding for the development of a national network of Independent Living Services and Centers for Independent Living programs.

1980, the Civil Rights of Institutionalized Persons Act (CRIPA),*"…is a United States federal law intended to protect the rights of people in state or local correctional facilities, nursing homes, mental health facilities, group homes and institutions for people with intellectual and developmental disabilities…it authorizes the U.S. Attorney General to investigate conditions of confinement at State and local government institutions such as prisons, jails, pretrial detention centers, juvenile correctional facilities, publicly operated nursing homes, and institutions for people with psychiatric or developmental disabilities. Its purpose is to allow the Attorney General to uncover and correct widespread deficiencies that seriously jeopardize the health and safety of residents of institutions. The Attorney General does not have authority under CRIPA to investigate isolated incidents or to represent individual institutionalized persons."* (U.S. Department of Justice Civil Rights Division, 2024)

1981, Section 2176 of the Omnibus Budget Reconciliation Act of 1981 established Home and Community-Based Services waivers to fund community-based residential options for people who met eligibility criteria for institutional care, including people with intellectual or developmental disabilities. This model was incorporated into the Social Security Act at Section 1915(c). In this model, states can choose to provide an array of services as an alternative to institutional care that would not be covered under Medicaid otherwise. The creation of this model supported the recognition that people with intellectual or developmental disabilities could be served in homes and communities instead of institutions. It was an important pathway to greater independence and community access (Duckett & Guy, 2002).

1983, Section 1915(c) was added by Congress to the Social Security Act. This change provided states the option to receive a waiver of Medicaid rules governing institutional care, allowing for Medicaid funding to be used to provide Home and Community Based Services (HCBS).

1986, a major reorganization of mental health services in Massachusetts took place with the passage of Chapter 599 of the Acts of 1986. This legislation redefined the role of the Department of Mental Health (DMH), clarifying its structure and mission. Led by a commissioner appointed by the Secretary of Human Services with the Governor's approval, DMH became solely responsible for mental health services across the state. The Department's focus shifted to supporting individuals with serious and long-term mental health conditions through early intervention, ongoing treatment, and research.

This legislation also created a separate Department of Mental Retardation (now the Department of Developmental Services) through Chapter 19B. Responsibility for supporting individuals with intellectual or developmental disabilities was formally transferred from the

Department of Mental Health to this newly established agency. It oversaw both public and private facilities, managed services such as diagnosis, treatment, education, and residential care for children and adults, and worked to expand access to these supports. The Department also had the authority to license and regulate service providers. Its work was guided by a 15-member advisory council and boards of trustees for each state-run school. Facilities under its care included the Walter E. Fernald, Wrentham, Belchertown, and Paul A. Dever State Schools.

1990, the Americans with Disabilities Act (ADA) was signed into law. This is the first comprehensive civil rights law in the world for people with disabilities that,

> *"…prohibits discrimination against people with disabilities in everyday activities. The ADA prohibits discrimination on the basis of disability just as other civil rights laws prohibit discrimination on the basis of race, color, sex, national origin, age, and religion. The ADA guarantees that people with disabilities have the same opportunities as everyone else to enjoy employment opportunities, purchase goods and services, and participate in state and local government programs.* (U.S. Department of Health and Human Services, Office for Civil Rights, n.d.)

1992, SAMHSA (Substance Abuse and Mental Health Services) was established by Congress as part of reorganization efforts stemming from the abolition of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). SAMHSA's mission is to reduce the impact of substance abuse and mental health conditions on America's communities (Duff, 2020). There are four SAMHSA offices, called Centers, that administer block grant programs and data collection activities.

The Center for Mental Health Services (CMHS) focuses on prevention and treatment of mental health disorders. CMHS leads federal efforts to promote the prevention and treatment of mental health disorders. CMHS is the driving force behind the Children's Mental Health Initiative, which is focused on creating and sustaining systems of care. This initiative provides grants to improve and expand systems of care to meet the needs of children and adolescents with serious emotional, behavioral, or mental health disorders.

- The Center for Substance Abuse Prevention (CSAP) seeks to reduce the abuse of illegal drugs, alcohol, and tobacco.
- The Center for Substance Abuse Treatment (CSAT) supports effective substance abuse treatment and recovery services.
- The Center for Behavioral Health Statistics and Quality (CBHSQ) collects, analyzes, and publishes behavior health data.

1992, the Rehabilitation Act Amendments of 1992 made significant changes to the Federal/State Rehabilitation Program. These amendments introduced substantial modifications to the principles, goals, processes, and outcomes of the program, aiming to help individuals with disabilities, regardless of the severity of their condition, achieve and maintain employment outcomes that align with their interests and abilities. Guided by the presumption of ability, the

amendments emphasize that with the right services and supports, individuals with disabilities can succeed in employment and rehabilitation goals.

The primary responsibilities of the vocational rehabilitation system under the amendments included:

1. Helping individuals with disabilities make informed choices about employment outcomes that promote integration and inclusion in the community.
2. Developing personalized rehabilitation programs with the full participation of the individual.
3. Matching the needs and interests in these programs with appropriate services, such as rehabilitation technology and supported employment.
4. Encouraging collaboration with other agencies, including local education authorities, to create a unified service system.
5. Focusing on the quality of services and holding service representatives accountable for respecting the dignity, participation, and growth of individuals with disabilities as their employment goals evolve.

The Rehabilitation Act Amendments of 1992 also support the service systems that help employers identify and implement reasonable job accommodations required by the ADA. They also facilitate transition planning and implementation activities outlined in the IDEA. The amendments prioritize the abilities and choices of individuals with disabilities, encouraging the services system and broader community to support their efforts to work, live, and engage in society (*PL 102-569: The Rehabilitation Act Amendments of 1992*, n.d.).

1996, the Mental Health Parity Act (MHPA) passed by Congress made it illegal for health insurance plans to put stricter limits on mental health benefits compared to other health benefits, like surgeries or doctor visits. The law didn't require insurance to cover mental health services, but if it did, the coverage would have to be equivalent to other medical benefits.

1998, the Workforce Investment Act of 1998 included amendments to the Rehabilitation Act of 1973. The amendments improved access to local and state workforce development programs for individuals with disabilities (Heldrich, 2000).

1999, the Surgeon General's Report on Mental Health highlighted the efficacy of mental health treatments, affirming that there was a range of effective treatment options available to individuals (U.S. Department of Health and Human Services, 1999).

2000, the Developmental Disabilities Assistance and Bill of Rights Act of 2000, U.S.C. §15041 et seq., is a federal law that funds programs to support individuals with developmental disabilities and their families. The law established a national network of University Centers for Excellence in Developmental Disabilities Education, Research, and Service (UCEDDs), which conduct research, provide education, and offer services. It also created State Councils on Developmental Disabilities and Protection and Advocacy agencies to advocate for people with developmental

disabilities and investigate cases of abuse. Additionally, the law helps shape policies that affect individuals with developmental disabilities, ensuring equal rights to access and community inclusion. It also includes a Bill of Rights that guarantees services for people with developmental disabilities that must be free from abuse, neglect, and exploitation.

2001, the President's New Freedom Commission on Mental Health was established to improve access to education, employment, assistive technologies, and community life for people with disabilities, including those with psychiatric disabilities. Three key obstacles to quality care for Americans with mental health conditions were identified - stigma, unfair limitations on mental health benefits in insurance, and a fragmented mental health service system. The New Freedom Commission on Mental Health, established as part of the initiative, was tasked with addressing these challenges and improving the mental health care system (President's New Freedom Commission on Mental Health, n.d.).

2008, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was created. This law builds off the Mental Health Parity Act of 1996 and prevents group health plans and insurers from imposing stricter limitations on mental health and substance use disorder (MH/SUD) benefits compared to medical and surgical benefits (U.S. Centers for Medicare & Medicaid, 2024). It requires that copays and visit limits for MH/SUD benefits be no more restrictive than those for medical benefits. It also prohibits separate limitations specifically for MH/SUD benefits. MHPAEA does not require health plans to cover MH/SUD benefits. The Affordable Care Act, however, mandates the coverage of MH/SUD services as under Essential Health Benefits (EHBs) in individual and small group plans (U.S. Centers for Medicare & Medicaid, 2024).

In 2010, the federal government made rules to make sure insurance companies were following the law. These rules helped check if insurance companies were treating MH/SUD services fairly.

In 2021, another update to the MHPAEA added a requirement for insurance companies to keep track of their coverage rules and show the government (or state authorities) that they were following the law. This made it easier to check if insurance companies were treating MH/SUD services fairly (Massachusetts Association for Mental Health, n.d.).

2009, the Workforce Investment Act of 2009 establishes that state vocational rehabilitation agencies must set aside 15% of their funding to provide transition services to young people with disabilities. Section 188 of the Act prohibits covered entities from discriminating against people with disabilities and requires them to take positive actions to assist qualified individuals with disabilities.

2010, the Patient Protection and Affordable Care Act 2010 (PPACA) amended Section 510 of the Rehabilitation Act, addressing access to medical diagnostic equipment for people with disabilities. This amendment specifically targets equipment such as examination tables and chairs, weight scales, x-ray machines, radiological equipment, and mammography equipment. Under this provision, the U.S. Access Board is authorized to develop accessibility standards for

these medical diagnostic tools in consultation with the Food and Drug Administration (FDA). The standards aim to ensure that people with disabilities have independent access to and can use medical diagnostic equipment to the maximum extent possible. The Board is also tasked with periodically reviewing and updating these standards to ensure ongoing accessibility (*Understanding the Affordable Care Act*, n.d.).

2010, the "Rosa's Law" was signed by President Obama. This law changed "mental retardation" to "intellectual disability" in U.S. federal law. This law was part of the advocacy efforts for the use of inclusive, people first language for people with intellectual disabilities.

2010, the Affordable Care Act (ACA) was passed. The ACA requires most health plans to cover mental health services under Essential Health Benefits (EHBs). These services had to follow the rules in the MHPAEA, making them more available to people. Mental health parity laws require that health insurance plans treat mental health conditions and substance use disorders (SUDs) equally with physical health conditions. This includes pre-existing conditions. (U.S. Centers for Medicare & Medicaid, 2024).

2024, Massachusetts Bill H.4396, 'An Act relative to individuals with intellectual or developmental disabilities' passes, which directed the removal of out-of-date and offensive language, including the term "mentally retarded", from the Massachusetts General Laws when referencing people with disabilities.

Legal Catalysts of Deinstitutionalization

The deinstitutionalization movement in Massachusetts was shaped by a series of groundbreaking federal and state lawsuits spanning over four decades, each challenging the legal, ethical, and practical foundations of institutional care for individuals with mental health conditions and people with intellectual or developmental disabilities. Beginning with the landmark case in 1972, *PARC v. Pennsylvania* (*Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania*, n.d.) which affirmed the right to education for children with disabilities, Massachusetts soon became a focal point of legal action aimed at transforming its own state institutions. Lawsuits such as *Ricci v. Okin* and *Brewster v. Dukakis* exposed the inhumane conditions and lack of adequate care in state-run facilities, leading to sweeping reforms and the creation of consent decrees mandating community-based treatment alternatives. These efforts were further strengthened by pivotal court decisions like *Rogers v. Commissioner* and *Olmstead v. L.C.*, which underscored individuals' rights to autonomy, due process, and treatment in the least restrictive environment. Collectively, these cases catalyzed a shift away from institutionalization and laid the groundwork for a more inclusive and rights-based mental health system in Massachusetts.

In Massachusetts, the legal actions of the 1970s did not emerge in a vacuum. They were preceded and, in many ways, catalyzed by growing public awareness of the inhumane conditions within state institutions. One of the most influential early exposures came in 1966

with *Christmas in Purgatory*, a powerful photo-essay by Burton Blatt and Fred Kaplan. The book documented, in unflinching detail, the systemic neglect, overcrowding, and dehumanization faced by individuals with intellectual disabilities in state-run facilities. Its stark imagery and urgent narrative helped galvanize both public opinion and professional discourse, laying essential groundwork for the legal and policy challenges that followed, such as the 1972 class action lawsuit on behalf of residents at Belchertown State School. Similarly, *Titicut Follies*, the 1967 documentary by Frederick Wiseman, revealed the brutal conditions inside Bridgewater State Hospital, highlighting the mistreatment of men labeled criminally insane. Though it was banned from public viewing for decades, it had a profound impact within legal and professional circles. Together, these works exposed the systemic failures of institutional care in Massachusetts and helped lay the foundation for the broader deinstitutionalization movement and a shift toward more humane, rights-based systems of care.

1972, a class action lawsuit was filed which challenged the conditions at the Belchertown State School. The plaintiffs, invoking the Social Security Act, argued that the deplorable conditions violated their constitutional and statutory rights, including the right to receive adequate care and treatment. This lawsuit was not an isolated case; similar actions were filed against other Massachusetts state institutions, including Wrentham, The Dever School, and the Walter E. Fernald State School. These cases were later consolidated, and after court-ordered inspections revealed the severe inadequacies of care, the parties involved negotiated consent decrees, which were approved in 1978. These decrees are now regarded as pivotal in significantly improving the conditions and quality of life for residents across these institutions.

This case led to numerous reforms of the system of care in Massachusetts for people with intellectual or developmental disabilities, including the establishment of an Office of Quality Assurance.

> *"On May 25, 1993, Judge Tauro issued a memorandum order that closed the five consolidated cases, because of his finding that court oversight and monitoring of the facilities was no longer necessary because 'Massachusetts now [had] a system of care and habilitation [for people with mental disabilities] ... probably second to none anywhere in the world,' and in light of the establishment of a new Governor's Commission on Mental Retardation. He vacated the consent decrees, replacing them with an order containing substantive and procedural provisions for future compliance with Constitutional and statutory standards of care. Ricci v. Okin, 823 F.Supp. 984 (D.Mass. 1993)."* (*Ricci v. Okin*, n.d.)

1975, the U.S. Supreme Court, in O'Connor v. Donaldson, ruled that people cannot be institutionalized in a psychiatric hospital against their will unless they are determined to be a threat to themselves or to others.

1976, the federal court ruled in Lessard v. Schmidt that Wisconsin's civil commitment procedures were unconstitutional because they lacked adequate procedural safeguards. In this

case, a schoolteacher was involuntarily committed to a County Mental Health Complex first for mental observation and subsequently had her commitment extended multiple times without due process. The teacher filed a class action lawsuit on behalf of herself and others who were similarly committed. The court ruled that the commitment procedures failed to provide timely notice and a hearing, the right to counsel, and proper standard of proof. The case established a "dangerousness" standard for commitment of people with mental health conditions with implications nationwide.

1978, the Massachusetts Supreme Judicial Court decision made it far more difficult to involuntarily commit someone to a psychiatric hospital. After the case of Laura Hagberg, an elderly woman seeking release from Worcester State Hospital, anyone seeking to confine a person with "mental illness" would have to prove "beyond a reasonable doubt" that the person was a danger to themselves or others.

That same year, U.S. District Judge Frank Freedman approved a consent agreement compelling the state to establish alternative treatment options for those confined unnecessarily to Northampton State Hospital. In 1975, a group of patients from the Northampton State Hospital, with the support of the Arc of Massachusetts and the Massachusetts Association for Mental Health, filed a class action lawsuit against the Commonwealth of Massachusetts. The parties were represented by the Center for Public Representation. This lawsuit, Brewster v. Dukakis, represented the first such case in the nation where the plaintiffs asserted that patients of state hospitals had a constitutional right to receive mental health services in the least restrictive environment possible. They argued that treatment should be provided in community-based settings rather than large, restrictive psychiatric institutions.

The lawsuit was settled in 1978, resulting in the Northampton Consent Decree. The Consent Decree had a profound and lasting impact on Massachusetts' mental health system by dramatically reducing the population in state psychiatric hospitals and promoting the shift toward community-based care. This significant change not only transformed the state's approach to mental health treatment, but also played a crucial role in the broader nationwide deinstitutionalization movement (*Northampton Consent Decree*, n.d.).

1978, Governor Michael Dukakis accepts a federal Consent Decree establishing extensive community treatment options in western Massachusetts as alternatives to Northampton State Hospital.

1987, the Department of Mental Health (DMH) entered into a Consent Decree regarding the transfer of individuals already committed to mental health facilities to Bridgewater State Hospital, a state-run facility that historically served individuals with criminal charges. According to the terms of the Consent Decree, the DMH agreed not to petition for transfers of committed patients to Bridgewater unless they had criminal charges pending or were serving a criminal sentence. The only exceptions were for individuals found not guilty by reason of "mental illness" or "mental defect" (*Shawn P. O'Sullivan v. Michael S. Dukakis*, 1987).

The principle established by the Consent Decree is that non-criminal patients should not be transferred to Bridgewater State Hospital without justification related to criminal charges or sentences.

1993, the Governor's Commission on Intellectual Disability was established in 1993 as part of a final court order issued by Judge Joseph Tauro who was overseeing the *Ricci v. Okin* case.

> *"The Commission is an independent citizen oversight body consisting of 13 members appointed by the Governor for a term of three years. The Commission was provided with a comprehensive scope and purpose including the ability to a review of public policy in the area of intellectual disability as well as analyzing and identifying systemic areas of concern affecting the human service delivery system within Massachusetts."* (Department of Developmental Services, n.d.)

1999, a decision was issued in the *Olmstead v. L.C.* case concerning the institutionalization of two women with developmental disabilities and mental health conditions. The case had significant implications, reinforcing the rights of individuals with disabilities to be treated in the least restrictive environments. Below is a description of the findings in the *Olmstead* case:

> *"…the United States Supreme Court held in Olmstead v. L.C. that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity."* (U.S. Department of Justice, Civil Rights Division, n.d.)

1999, the *Rolland v. Cellucci* class action case was settled. This case was brought by the Center for Public Representation on behalf of almost 2,000 people with intellectual or developmental disabilities living in nursing facilities in Massachusetts. The case argued that the people included in the class were,

> *"…unnecessarily admitted to and is [were] inappropriately confined in a nursing facility in contravention of his or her [their] preference and the professional judgment of the Massachusetts Department of Mental Retardation's clinical review team. In addition, each named Plaintiff asserts that he or she has not been provided with minimally adequate training, habilitation and support services."* (Rodgers et al., 2017, p. 1)

The case referenced the ADA, among other federal laws, arguing they were not being provided with "medically necessary services in the most integrated setting consistent with their individual needs" (Rodgers et al., 2017, p. 1). As part of the settlement agreement, the state needed to develop programs to move people with intellectual or developmental disabilities out of nursing homes and into the most integrated community settings possible.

2001, the Rosie D. Complaint challenged the state of Massachusetts' failure to provide essential behavioral health treatment to children, forcing many into psychiatric hospitals or residential facilities instead of receiving services at home, which violated the federal Medicaid Act's requirements. In 2006, the court ruled that the state violated the law, causing children to suffer unnecessary institutionalization. The court ordered the development of in-home services. The Rosie D. Remedial Plan, finalized in 2007, outlined a reform of the mental health system to provide coordinated, home-based services by 2009. A Court Monitor was appointed to ensure compliance with the plan (Center for Public Representation, 2007). The MassHealth Children's Behavioral Health Initiative (CBHI) began as an interagency initiative to carry out the remedy from the Rosie D class action lawsuit. CBHI is now part of the MassHealth Office of Behavioral Health (Commonwealth of Massachusetts, 2025e).

2009, the Civil Rights Division of the U.S. Department of Justice launched an aggressive effort to enforce the Supreme Court's decision in a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs (U.S. Department of Justice, Civil Rights Division, n.d.). President Obama issued a proclamation launching the "Year of Community Living," and directed the Administration to redouble enforcement efforts. The Division has responded by working with state and local governments officials, disability rights groups and attorneys around the country, and with representatives of the U.S. Department of Health and Human Services, to fashion an effective, nationwide program to enforce the integration mandate of the Department's regulation implementing Title II of the ADA (U.S. Department of Justice, Civil Rights Division, n.d.).

2014, the Disability Law Center (DLC) and the Department of Correction (DOC) entered into an agreement to address concerns raised about Bridgewater State Hospital (BSH) treatment practices and physical conditions (Disability Law Center, 2024). Over the years, DLC has issued numerous reports highlighting ongoing issues at BSH, including inadequate medical and mental health care, the overuse of seclusion and restraint, and poor physical conditions, among others. Conditions have worsened due to high staff turnover and increasing reliance on controversial practices like Emergency Treatment Orders (ETOs), which DLC argued were used improperly for punishment. The reports also raised alarms over the lack of person-centered treatment, insufficient programming, and unsafe conditions, such as mold and poor sanitation.

DLC has repeatedly called for the transfer of oversight from the DOC to the Department of Mental Health (DMH), citing systemic issues in the DOC's ability to oversee mental health care effectively. Advocates have voiced concerns about the contractor's[29] profit-driven model and its impact on care, urging for services to be brought back under state control with oversight from local professionals. Despite some efforts to address these issues, many of the core problems remain unresolved, and DLC continues to advocate for comprehensive reform at BSH.

[29] Wellpath Recovery Solutions was the healthcare provider for Bridgewater State Hospital (BSH) in Massachusetts until June 30, 2024. VitalCore Health Strategies replaced Wellpath as the healthcare provider for BSH.

The Evolution of Civil Commitment in Massachusetts

In Massachusetts, as in much of the United States, the early history of civil commitment up until the mid-20th century was characterized by a custodial and paternalistic approach. Before the 1960s, individuals could be institutionalized with minimal due process, often based on vague and broadly defined criteria like "insanity" or perceived danger to themselves or others. These loose standards allowed for the involuntary commitment of individuals with little legal oversight or protection. Institutionalization during this period was primarily focused on containment rather than treatment. Those committed to mental health facilities were often placed in large state hospitals for indefinite periods, facing long-term confinement with limited autonomy and few opportunities for rehabilitation. Patients had little control over their treatment or conditions, and the lack of stringent legal safeguards meant that many were institutionalized without clear or consistent evidence. This era reflected a time when mental healthcare was largely custodial, with the goal of separating individuals from society rather than addressing their psychological needs in a holistic way.

The scope of civil commitment during this period also extended to children. Chapter 589 of the Acts of 1956 provided specific statutory mechanisms for the commitment of minors to state mental health institutions. Section 7 of the Act allowed for “delinquent” and “wayward” children between the ages of seven and seventeen facing indictment to be committed to a state hospital or to Bridgewater State Hospital. Meanwhile, Section 6 addressed non-criminal cases, permitting the commitment of children under the age of sixteen who were “suffering from psychosis, neurosis, psychoneurosis, behavior disorder, or other mental disability”, provided they were not classified as “feeble-minded”, in which case they could be placed in a state school instead (An Act Relative To The Commitment And Care Of The Mentally Ill, Epileptics, Alcoholics And Drug Addicts, 1956). These provisions reflected the era's broader institutional mindset and underscored the limited differentiation between juvenile justice and mental healthcare, particularly in how children were processed through state systems.

The 1960s and 1970s marked a significant shift in Massachusetts' approach to civil commitment, fueled by national reforms and the deinstitutionalization movement. As psychiatric medications became more effective and public awareness of civil rights grew, there was a push to move away from institutional care and towards community-based treatment. Advocates argued that many individuals could receive more humane and less restrictive care outside overcrowded state hospitals. This shift was also driven by mounting criticisms of hospital conditions, which were often inhumane and insufficient for proper psychiatric care. At the same time, legal reforms played a key role in reshaping the civil commitment process. U.S. Supreme Court rulings, like *Addington v. Texas*, 1979, prompted states to adopt stricter due process protections for individuals facing involuntary commitment. In Massachusetts, this led to the creation of more rigorous standards, requiring clear and convincing evidence of both mental illness and dangerousness before an individual could be institutionalized. These changes marked a broader societal movement toward greater legal safeguards and a rights-based

approach to mental health care, laying the foundation for the modern mental health system in the state.

In the 1980s and 1990s, Massachusetts, like much of the U.S., faced the challenge of balancing effective treatment with the protection of individual liberties. During this time, there was a strong emphasis on expanding community-based mental health services. Outpatient care and alternative treatment forms, such as day programs and residential facilities, became central to the mental health system. This shift aimed at providing patients with more autonomy while still offering necessary support and treatment outside institutional settings. Meanwhile, the state worked to ensure that individuals' rights were upheld within the civil commitment process. Laws were updated to mandate periodic reviews of civil commitments, ensuring that individuals were not held in institutions longer than necessary. Patients were granted rights like legal representation and the opportunity for periodic hearings to reassess their commitment status.

A major legal milestone during this period was the landmark case *Rogers v. Commissioner* of Mental Health (1983), initiated by Ruby Rogers and six others who had been forced to take psychiatric medication during hospitalization. At the time, individuals in psychiatric hospitals did not have the legal right to refuse treatment. Ms. Rogers, a voluntary patient, became the lead plaintiff after being medicated without consent. The Massachusetts Supreme Judicial Court ruled that hospitalization alone was not enough to override a person's right to refuse treatment. Competent individuals retained the right to say "no" to psychiatric medication unless an emergency existed (Commonwealth of Massachusetts, 2025g; Davidow, 2024).

Following this decision, the state established a formal legal process to protect patients' treatment rights. If a doctor determined that a patient could not make informed decisions, they were required to petition the court, which would then decide whether treatment was appropriate using the "substituted judgment" standard, meaning the court must consider what the person would choose if competent. This ruling led to the creation of Rogers Orders, court-approved treatment plans that ensure patients' rights are preserved even when they are deemed incapacitated. Individuals subject to these orders are entitled to legal representation, and if they cannot afford a lawyer, one is appointed (Davidow, 2024).

Two types of Rogers Orders were established: District Court orders (also known as "8B orders"), which apply to individuals committed to hospitals and last only as long as hospitalization continues, and Probate Court orders, which apply to individuals living in the community. Probate Rogers Orders require regular court reviews, are typically limited to 12 months, and include oversight from a "Rogers Monitor," who tracks treatment side effects and changes in decision-making capacity (Davidow, 2024).

Additional cases further shaped this legal framework. In Guardianship of Roe (1981), the court ruled that guardians of individuals living in the community could not authorize the use of antipsychotic medications without court approval. The decision reinforced the role of the judiciary, rather than medical professionals or guardians, in determining whether such

treatments should be administered. The court emphasized that decisions must be made under the substituted judgment standard and not solely based on medical opinion (Commonwealth of Massachusetts, 2025g).

From the 2000s onward, Massachusetts saw significant developments in specialized commitments, particularly related to substance use disorders, sexual offenses, and the intersection between mental health and the criminal justice system. One key legal change was the strengthening of "Section 35" commitments, which allow for the involuntary commitment of individuals with substance use disorders. These commitments, often initiated by family members, law enforcement, or medical professionals, focus on providing treatment while ensuring public safety. Additionally, Massachusetts introduced the Sexually Dangerous Persons Law, establishing a separate legal framework for the post-incarceration civil commitment of individuals deemed sexually dangerous. This law permits the indefinite commitment of such individuals until they are no longer considered a threat, reflecting growing concerns about public safety and the need for specialized treatment for this population. The 2000s also saw increasing attention to the overlap between mental health and the criminal justice system. Recognizing the intersection of mental illness and criminal behavior, Massachusetts implemented diversion programs and court-ordered treatment options, aiming to provide individuals with mental health needs appropriate care instead of lengthy prison sentences. These policy shifts reflect a growing awareness of the need for more nuanced approaches to civil commitment that balance treatment, public safety, and individuals' legal rights.

Significant reforms to the civil commitment process were enacted through Chapter 249 of the Acts of 2000, which took effect in November of that year. These changes fundamentally revised procedures for emergency psychiatric hospitalizations under M.G.L. Chapter 123. Among the most impactful revisions was a reduction in the duration of emergency hospitalization: individuals could now only be held for up to four business days, down from the previous limit of ten calendar days (Commonwealth of Massachusetts Department of Mental Health, 2022). Additionally, the time frame for holding a judicial commitment hearing was reduced from fourteen calendar days to four business days, ensuring more timely legal oversight.

Further revisions were enacted in 2004, refining and clarifying these procedures. The commitment hearing window was slightly extended to five business days from the filing of the petition (An Act Relative To The Civil Commitment Process For Persons With Mental Illness, 2004). The 2004 amendments also decreased the maximum duration of emergency hospitalization from four business days to three business days, further emphasizing the need for rapid legal and clinical review in involuntary commitment cases.

These reforms also improved individual protections. Facilities were now required to inform newly admitted individuals of their right to request legal representation. If requested, the Committee for Public Counsel Services (CPCS) would appoint a lawyer. Moreover, individuals were given the right to request a court hearing by the next business day if they believed their

hospitalization was unjustified, ensuring that patients retained access to due process and timely judicial review.

The Evolution of Community Based Services in Massachusetts

The history of community-based services for individuals with disabilities in Massachusetts is marked by significant milestones in policy, community-based care, and advocacy. Beginning in 1967, with the establishment of the Developmental Evaluation Clinic at Boston Children's Hospital, Massachusetts took early steps toward serving children with intellectual or developmental disabilities. As the state shifted away from institutional care and embraced the deinstitutionalization movement in the 1970s, programs like the Boston Center for Independent Living and the creation of community-based residential options played pivotal roles. Over the decades, state policies evolved, with landmark initiatives such as the Massachusetts Home and Community-Based Services Waivers, the Employment First Policy, and the 2014 Autism Omnibus Law, all contributing to a more inclusive and integrated approach to care and support for people with disabilities. This journey reflects a growing commitment to providing services that promote independence, choice, and participation in the broader community.

1967, the Developmental Evaluation Clinic (DEC) at Boston Children's Hospital was opened. Its mission was to serve children with intellectual and developmental disabilities and their families. Later in 1990, the clinic moved to the University of Massachusetts Boston, and in 1992 was renamed the Institute for Community Inclusion (ICI), one of Massachusetts' two University Centers for Excellence in Developmental Disabilities Education, Research, and Service (UCEDDs).

Early 1970s, the deinstitutionalization movement was taking shape shifting care from state-run institutions to state partnerships with external organizations that operated the first community-based residential programs to meet the needs of people with intellectual or developmental disabilities who were leaving state institutions. Some of the community options were specialized for people with multiple support needs, such as community residences for people with intellectual or developmental disabilities who were also blind (*MAB Adult Disability Services - Residential*, n.d.).

1974, the Boston Center for Independent Living was founded and was the second Independent Living Center in the country. It was created by people with disabilities seeking full integration into society, including Fred Fay, Nancy Magee, Charlie Carr, Elmer Bartels, Bob McHugh, and others. The group worked to advocate for and help establish the Personal Care Assistant program in Massachusetts with what was then the Massachusetts Rehabilitation Commission.

1981, the Massachusetts Home and Community-Based Services (HCBS) Waivers were created to allow individuals with an Intellectual or Developmental Disability to receive services at home rather than in institutions. These waivers are a partnership between the federal government

and the state of Massachusetts, managed through MassHealth, Massachusetts' Medicaid program (Commonwealth of Massachusetts, 2025b).

The Adult Supports Waiver, part of Massachusetts' HCBS Waivers, offers services to individuals who need minimal support and do not require 24-hour care. These individuals typically live in family homes, adult foster care, or independently, and the services focus on meeting their health and welfare needs in these settings. Services are tailored to the individual's situation, providing only what is necessary for safety and independence. The Waiver also allows for participant direction, enabling individuals to manage their services with budget and employer authority if desired.

The Community Living Waiver provides services for individuals needing more support than those in the Adult Supports Waiver but less than those in the Intensive Supports Waiver. These individuals, who also do not require 24-hour care, may live in various settings, such as family homes or adult foster care. Services are designed to meet health and welfare needs at home or in the community, and like the Adult Supports Waiver, it offers participant direction for those who choose it.

The Intensive Supports Waiver serves individuals requiring 24-hour supervision due to significant behavioral, medical, or physical needs. This Waiver provides more comprehensive care and tailors services to the individual's living situation.

To be eligible for the DDS Waivers, individuals must meet the following federal requirements (Commonwealth of Massachusetts, 2025b):

1. Intellectual Disability: The individual must have an intellectual disability, as determined by DDS.
2. MassHealth Enrollment: The individual must be eligible for and enrolled in MassHealth Standard.
3. Age: The individual must be at least 22 years old.
4. ICF/ID Eligibility: The individual must be eligible for admission to an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID).
5. Community Services Agreement: The individual must agree to receive services in the community instead of an institution.
6. Waiver Service Need: The individual must be assessed by DDS as needing one or more waiver services.

Mid 1980s, the Mental Health Action Project was created under the Dukakis Administration to expand community-based services and enhance mental-health funding. However, this initiative was curtailed by fiscal difficulties in the late 1980s and early 1990s and the privatization strategy under Governor William Weld, which aimed to reduce the state's direct role in providing mental health services.

1992, Massachusetts became the first state to implement a statewide federal waiver program to deliver mental health and substance abuse services to its state Medicaid program (MassHealth) enrollees. This program, known as the Medicaid Carve-out, involved outsourcing mental healthcare services to a for-profit specialty provider.

2000, Massachusetts created its own law to expand on the Mental Health Parity Act. Massachusetts law required insurance to cover certain types of mental health conditions, like schizophrenia, major depression, bipolar disorder, and anxiety disorders. The law was meant to provide better mental health coverage than the federal law by focusing on specific mental health conditions (Sudders & Ruthardt, 2000).

2009, the Massachusetts Department of Mental Retardation officially changed its name to the Department of Developmental Services. This change was enacted through legislation in 2008. The name change was a result of advocacy efforts, particularly from self-advocates with intellectual or developmental disabilities, who believed it would promote dignity and respect for people with disabilities. The new name also better reflects the range of services and supports offered by the agency (No. 521: Renaming the Governor's Commission on Mental Retardation to Be the Governor's Commission on Intellectual Disability, 2010).

2010, Massachusetts passed the Employment First Policy at the MA Department of Developmental Services (DDS). The policy establishes integrated, individual employment as the preferred service option for working age adults served by DDS.

2011, the Money Follows the Person (MFP) was a five-year demonstration grant from the Centers for Medicare and Medicaid Services (CMS) awarded to the Massachusetts Office of Medicaid (MassHealth). Through the MFP Demonstration, Massachusetts successfully moved over 2,151 people into community living between 2011 and 2018. The demonstration began in July 2011 and ran through 2016 (Commonwealth of Massachusetts, 2025f; Liao & Peebles, n.d.). Based on the success of the demonstration project, Massachusetts created Moving Forward Plan Waivers. The Moving Forward Plan (MFP) Waivers are home and community-based services (HCBS) programs designed to assist MassHealth-eligible individuals in transitioning from nursing facilities or institutional settings back to their communities, while empowering caregivers and providing comprehensive support.

The MA MFP Community Living (MFP-CL) Waiver provides a variety of services to people ages 65 and older, people with physical disabilities (18-64 years old), and people with mental health conditions (18+ years old) who meet hospital or nursing facility care levels. Services include home health aides, personal care assistance, supported employment, community-based day supports, behavioral health support, home adaptations, physical and occupational therapy and transportation.

The MA MFP Residential Supports (MFP-RS) Waiver offers similar services but focuses on residential support for people aged 65+ and those with physical disabilities or serious mental health conditions (18-64 years old). Services include residential habilitation, assisted living,

shared living/24-hour supports, home adaptations, therapy, and transportation, designed for those meeting hospital or nursing facility care levels.

2012, DDS amended its eligibility requirements (through 115 CMR 2.01) in response to the case *Tartarini v. Department of Mental Retardation* to eliminate the cutoff of an IQ score of 70 in its eligibility determinations. In the case, the court found that DDS' eligibility criteria were not consistent with the state statute authorizing the creation of DDS and were not consistent with current clinical diagnostics, which included people with IQs between 70 and 75 who have significant functional impairments to be diagnosed with "mental retardation". DDS amended its eligibility definitions by adding the word "approximately" to the IQ score requirement and adjusting its requirements for needs in adaptive functioning (*Tartarini vs. Department of Mental Retardation*, 2012).

2014, the 2014 Autism Omnibus Law expands eligibility for DDS services to include adults with autism spectrum disorder (ASD). As a result, Chapter 226 of the Acts of 2014 added "developmental disability" to the service eligibility requirements for DDS, including expansion of eligibility for people with Autism, Prader-Willi syndrome or Smith-Magenis syndrome with substantial support needs.

2016, Massachusetts closed the last of its sheltered workshops which had paid subminimum wage to people with intellectual or developmental disabilities for work they performed while at the workshops. This was done to further integrate people with intellectual or developmental disabilities into integrated work settings. Prior to this, the U.S. Department of Justice had made a statement that people with intellectual or developmental disabilities should work in integrated settings, and the Centers for Medicare and Medicaid Services (CMS) issued guidance restricting Medicaid funding for sheltered workshops.

Record and Records Access

The next section of the report provides a detailed historical account of the evolution of record-keeping and access requirements related to the care and management of individuals labeled as "insane" and "feeble-minded" in Massachusetts from the late 18th century to the early 21st century. It outlines various legislative acts and institutional practices aimed at regulating the admission, treatment, and discharge of these populations, including the establishment of state hospitals, lunatic asylums, schools for the feeble-minded, and receptacles for the criminal insane.

This section also highlights the roles of different governing bodies, such as the Board of State Charities, the State Board of Health, Lunacy, and Charity, and the State Board of Insanity, in overseeing these institutions and departments and ensuring proper documentation and reporting of patient records. Additionally, it discusses the implementation of various laws to improve the accuracy and uniformity of records, the establishment of central registries for insane paupers, insane criminals, and mental defectives, and the introduction of community-based care models like boarding out. It underscores the ongoing challenges and reforms in the mental health and public welfare systems, emphasizing the importance of accurate record-keeping for policymaking and improving patient care for people with mental health conditions and people with intellectual or developmental disabilities.

Relationship to the Evolution of Governing Bodies of State Institutions for People Labeled as “Insane” and “Feeble-minded”

To understand the institutional records related to these populations and the legal barriers to accessing them, it is crucial to explore the key factors that influenced the evolution of record composition, accessibility, and quality. Factors include, but are not limited to, changes to both federal and state legislation, the establishment and reorganization of agencies that oversaw public institutions, state interagency agreements and collaborations, the shifting demographics and needs of service populations, the expansion and reclassification of services, and the development of new service delivery models. Additionally, broader social and economic movements, such as the human rights movement, and technological advancements have also played significant roles in shaping these records.

The first laws that involved registry and record keeping practices were enacted during colonial Massachusetts. These practices established a method for the state to screen for and keep track of people needing state-funded supports. Foundational public institutions that provided services for poor populations, including immigrants, non-immigrants, state residents, non-state residents, and people with disabilities, ranged anywhere from local almshouses, workhouses, and houses of correction. Registries, in the form of passenger lists and institutional registry lists, were required to be vetted and maintained by Overseers of the Poor and masters of workhouses and of houses of corrections. These registries contained basic demographics,

including personal and family information, along with information about a person's socioeconomic status and medical and criminal history.

Registry and Record Requirements

In this section, laws about the creation and maintenance of registries and various records will be summarized sequentially.

Immigration Control and Passenger Lists – Identification of "Paupers", Convicts", "Lunatics" and "Idiots" - (1788 – 1800s)

Portions of An Act Providing for the Support of the Poor attempted to prohibit the settlement of immigrants who were "poor, vicious, and infirm" and who would likely become a public charge (An Act Providing For The Support Of The Poor, 1788). Consequently, masters of ships or other non-American vessels were legally required to report and provide the Overseers of the Poor with passenger lists, including the name, age, nation of origin, and character and condition of each passenger on board. Failure to do so or the submission of falsified passenger lists would result in a £50-pound penalty. The same £50-pound fine applied for each passenger with a known criminal record and a £20-pound fine for each passenger who was poor (An Act Providing For The Relief And Support, Employment And Removal Of The Poor, And For Repealing All Former Laws Made For Those Purposes, 1793).

As years passed, the liability laws for ship masters and alien passengers increased. The Act To Prevent The Introduction Of Paupers, From Foreign Ports Or Places required ship masters to report and pay $500 bonds within five days of arrival for every passenger that the Overseer of the Poor or town selectman determined to become a likely public charge within a three-year period (An Act To Prevent The Introduction Of Paupers, From Foreign Ports Or Places, 1819). In 1830, another Act passed imposing an additional fine on ship masters for landing in other destinations that were not reported (An Act In Addition To An Act, Entitled " An Act To Prevent The Introduction Of Paupers From Foreign Ports Or Places," 1830).

In An Act Relating to Alien Passengers (Chapter 238 of the Acts of 1837), boarding officers (referred to as superintendents of alien passengers later in 1846), appointed by town selectmen, mayors, or aldermen, were authorized to inspect the conditions of every alien passenger on board a vessel stationed at any port within their jurisdiction (An Act Relating To Alien Passengers, 1837; Report Of The Joint Special Committee, Including Text To "An Act Concerning Alien Passengers And Paupers," 1847). Section 2 of the Act stated that any "…lunatic, idiot, maimed, aged or infirm persons, incompetent in the opinion of the officer so examining, to maintain themselves, or who have been paupers in any other country…" (An Act Relating To Alien Passengers, 1837, p. 270) identified by these officers could not disembark, unless the ship master or their employer paid the state a $1,000 bond ensuring these passengers would not become a public charge within the next 10 years of their arrival. A $2 fee

was charged and collected for all other passengers, which would be earmarked in the town's budget for the support of foreign paupers.

Despite these requirements, in a report from 1847 by a Joint Special Committee it was noted that the Superintendent of Alien Passengers of Boston would often waive these bonds for those extremely ill or crippled and would quickly commit them to the nearest almshouse or hospital (Report Of The Joint Special Committee, Including Text To "An Act Concerning Alien Passengers And Paupers," 1847). By 1888, 60% of all people receiving some form of public charity in the Commonwealth were foreign-born. This disproportionate statistic urged the Governor to push Congress to reassess existing federal immigration law to prevent the entry of undesirable individuals, including "convicts, lunatics, idiots and other persons liable to become a public charge" (Resolution Relative To The Immigration And Importation Into The United States Of Convicts, Lunatics, Idiots And Other Persons Liable To Become A Public Charge, 1888, p. 1).

Pauper System and Houses of Correction Registries (1797)

In 1797, the Act in Addition to An Act Intitled an Act for Suppressing Rogues, Vagabonds, Common Beggars, & Other Idle Disorderly & Lewd Persons required both Overseers of the Poor and masters of houses of corrections to maintain registers and accounts of inmates and people under their support, which the state would periodically examine (An Act In Addition To An Act Intitled An Act For Suppressing Rogues, Vagabonds, Common Beggars, & Other Idle Disorderly & Lewd Persons, 1797).

Records Related to Reimbursement Claims for State Paupers (1830)

The Act Relating to the Support of State Paupers (Chapter 120 of the Acts of 1830) required cities, towns, districts, and institutions making state reimbursement claims for state-pauper-related expenses to maintain and provide the following information: name, age (excluding able-bodied people over the age of 12), nationality, arrival into the Commonwealth, when they became a public charge, time of discharge, death, or length of sentence, number of chargeable days, and certifications of no legal settlement nor relatives legally and financially obligated to provide supports to the person (An Act Relating To The Support Of State Paupers, 1830, p. 672).

Abstracts of Pauper Returns (1833-1835)

Pauper annual returns were not required until 1833. Thereafter, and for the very first time, Overseers of the Poor and the Director of the House of Industry in Boston were expected to complete and submit annual returns to the Secretary of the Commonwealth regarding the paupers they supported. Returns would include statistics around gender, race, literacy, marital status, dependents, temperance, source of support (e.g., almshouse, abroad, by contract), weekly and annual expenses for almshouse and non-almshouse supports, birthplace, legal settlement or habitancy within the Commonwealth, available or occupied beds at almshouses, and the number of workshops (Abstract Of The Return Of Paupers [1833], 1834). It was not until 1835, that counts of "insane" and "idiot" paupers, along with city and county population sizes were added to these annual returns (Abstract Of The Returns Of The Poor [1835], 1836).

Workhouse Registry Records (1835)

The Act Concerning Paupers (House Bill No. 32) required workhouse masters to maintain a registry of people committed, including their "name, sex, age, color, trade, birth place, place of settlement within this Commonwealth, (if any) time when received, time of discharge, estimated value of support, estimated value of work done by each pauper admitted in said house" (An Act Concerning Paupers, 1835, p. 8). This information would be reviewed and approved by the Overseers of the Poor and prior to the submission of tabulated data to the Secretary of the Commonwealth.

Abstracts of Pauper Returns (1837)

In 1837, a Joint Committee, composed of three state representatives, was assigned to evaluate the quality of the pauper return system. Major findings included that there was only two-thirds participation of all towns. This finding led them to strongly believe that the blank registry forms (also known as returns) were "…defective and inoperative" (An Act Providing For A Return By Overseers Of The Poor, 1837, p. 4). To address these gaps and deficiencies, the Joint Committee recommended the enactment of Chapter 194 of the Acts of 1837, which made it a legal obligation for every Overseer of the Poor and the Director of the House of Industry to make the annual pauper returns according to the set deadlines. It also defined the role and responsibilities of the Secretary of the Commonwealth, which included providing each town with an improved blank return form and consolidating individual town returns into an aggregate table of statistics, or an abstract of returns, by county. Failure to submit a completed return form would result in a $100 penalty (An Act Providing For A Return By Overseers Of The Poor, 1837).

State Lunatic Pauper Registers (1838 – 1847)

Senate Bill No. 47 of 1848 was a report by the Joint Special Committee that included the expenses and registers (including names) of state lunatic paupers by county for a 10-year period (1838 – 1847). It also included state lunatic paupers committed to the State Lunatic Hospital at Worcester from 1845 through 1847 (Report Of The Joint Special Committee Regarding Lunatic Hospitals And Lunatic Paupers, 1848).

Commitment and Discharge Records of Penal Populations, Including "Idiots" and "Lunatics" (1846)

Section 2 of the Act in Relation to the House of Correction and Asylum for Insane Persons in the County of Essex of 1846, required the master of the house of correction, receptacle, or asylum at Ipswich to keep a record of all commitments and discharges of idiots and insane persons not furiously mad committed for which these penal institutions took custody of (An Act In Relation To The House Of Correction And Asylum For Insane Persons In The County Of Essex, 1846)

Pauper Children Registry & Return System (1848)

House Bill No. 99 of 1848, An Act Concerning Indigent Children, which was proposed by the Committee on Public Charitable Institutions, required Overseers of the Poor and almshouse directors to make an annual return to the Secretary of the State-of supported children 13 years old and younger. Returns included the names, gender, and age of each child. Blank forms were distributed across the state by the Secretary (An Act Concerning Indigent Children, 1848).

Committee on Public Charitable Institutions (1830s)

The Committee on Public Charitable Institutions, along with several other Joint Standing Committees (e.g., Committee on Prisons), was established by the House of Representatives bills and orders of 1836. Each Committee, except for the Committee of the Library, was composed of two members from the Senate and three from the House of Representatives. The Committee on Public Charitable Institutions was charged with visiting and ensuring the health, safety, and well-being of persons committed to the State Lunatic Hospital at Worcester, the New England Institution for the Education of the Blind, and the Massachusetts Charitable Eye and Ear Infirmary (Rules And Orders, To Be Observed In The House Of Representatives Of The Commonwealth Of Massachusetts, 1836). As time passed, the Committees' scope of work increased with the establishment of new public institutions, including, but not limited to the three state almshouses, Boston Lunatic Hospital, and the State Lunatic Hospital at Taunton. In the Committee's report of 1839, it highlighted the organizational principles that the State Lunatic Hospital at Worcester adopted due to its experiences since its opening in 1833:

> *"…whatever may have been the original design of the institution, experience shows, that its character as a hospital to restore the maniac to society, and to usefulness, is quite as important as its character as a receptacle for the safe and comfortable confinement of incurables."* (Report Concerning Public Charitable Institutions, 1839, pp. 12–13)

Commitment Records – State Lunatic Hospital at Worcester (1832)

Senate Bill No. 02 of 1832 required the following information to be supplied to the new State Lunatic Hospital at Worcester to inform treatment for "lunatics" that were coming from jails and being committed to the hospital.

> *"And as all information respecting the disease of any lunatic to be removed to the Hospital as above suggested, the cause of such disease, the period of its duration, the character, whether of ferocity, of melancholy or of any other type, which it may have assumed, will be not only necessary as guide in the classification and treatment of each lunatic, but may also be valuable item in forming statistical tables of insanity, such information ought, as far as practicable, to be communicated by the County authorities respectively, at the time when the lunatics are removed from their several places of confinement."* (Report Of The Commissioners Appointed To Superintend The Erection Of A Lunatic Hospital At Worcester, 1832, p. 23)

Abstracts of Penal Populations, Including "Idiots" and "Lunatics" (1830s)

The Commissioners appointed to examine and report out on the conditions of jails and houses of correction within the Commonwealth, included "idiots", "lunatics", and the "insane" as part of jail and prison populations (House Bill No. 36 of 1834). It also discussed the commitments of such populations to the Insane Hospital at Charlestown, the State Lunatic Hospital at Worcester, including the Worcester Asylum (Report On Gaols And Houses Of Correction In The Commonwealth Of Massachusetts, 1834). In the State Library of Massachusetts Digital Collections, abstracts of returns from jails and houses of corrections can be found beginning in 1837. However, it was not until 1839 where these abstracts began including "idiot" and "insane" as reasons for confinement (Abstract Of Returns Of Inspectors And Keepers Of Jails And Houses Of Correction, 1839).

Committee on Public Charitable Institutions (1840s)[30]

The numerous site visits and record reviews conducted by the Committee over the years informed and resulted in the advocacy and passage of multiple legislation in favor of public charitable institutions and the vulnerable populations they served. For example, countless funding requests made by the trustees of these various charitable institutions to the Governor were approved through law. These requests would often fund infrastructural improvement and expansion projects and attribute to the increases in rates for supporting private and public inmates.

A specific example of hallmark legislation proposed by the Committee, included An Act Concerning the State Lunatic Hospital (Chapter 96 of the Acts of 1842). With its passage, it set a precedent by legally recognizing the Board of Trustees of the State Lunatic Hospital at Worcester as a corporation to facilitate the legal receipt of private and public donations, endowments, bequeaths[31], and grants in the form of money and land (An Act Concerning The State Lunatic Hospital, 1842). The 1846 and 1847 Resolve Concerning the State Lunatic Hospital, which were both introduced by this Committee, requested funding to build on the hospital grounds a separate building with ample space to accommodate "…the imbecile, the raving, and the incurable" (Report And Resolve Concerning The State Lunatic Hospital, 1846, p. 1). These spaces would resemble the apartments and cottages built for the "furiously mad" at the Boston Lunatic Hospital. These property additions helped improve the grouping of inmates and yielded the availability of more hospital beds. Despite these improvements, staffing and financial issues remained a chronic challenge as the hospital census inevitably increased along with the increases in the general population (Report And Resolve Concerning The State Lunatic Hospital, 1846; Report Of The Committee On Public Charitable Institutions, 1847).

[30] Prior to the establishment of the Board of Commissioners of Alien Passengers & State Paupers (1851-1863) and the Board of State Charities (1864-1878).

[31] Bequeath means to give or leave something to someone through a will after you die. It's often used to describe the passing of personal property or money to someone or some entity after a person dies.

The Committee on Public Charitable Institutions was also known for proposing bills for other "charitable-like" systems and institutions that were partially under its purview, such as the Act Concerning Indigent Children of 1848 (House Bill No. 99 of 1848), which pertained to the state pauper children return and registry system (An Act Concerning Indigent Children, 1848), and Senate Bill No. 106 of the Resolves of 1848 and House Bill No. 84 of the Resolves of 1849 that respectively secured the necessary funding to establish the Experimental School for Teaching and Training Idiotic Children and provided continued monetary aid for the State Reform School at Westborough (Report Of The Committee On Public Charitable Institutions, 1849b; Report Of The Joint Committee On Public Charitable Institutions, 1848).

The Committee also played an instrumental role in the expansion of the state "lunatic" hospital and reform school systems, weighed in the multiple petitions for the opening of new hospitals in areas of the state where access to such social services for the insane was limited or non-existent, and advocated, especially after the success of the Experimental School, for continuous state funding of institutional, alternative education to the multitude of "idiot" children that were not receiving any type of services within the Commonwealth, which was estimated at 1,200 children in 1850 (Report Of The Committee On Public Charitable Institutions, 1849a; Report Of The Committee On Public Charitable Institutions, 1850).

Lastly, the Committee also shed light on the perceived positive experiences and successes of these charitable public institutions. For example, in the Committee on Public Charitable Institutions' report of 1842, not only were the agricultural and mechanical departments of the State Lunatic Hospital at Worcester considered to be most effective from a therapeutic, rehabilitative standpoint, but the products rendered from the labor of "lunatic" inmates greatly attributed towards hospital production and cost-efficiency efforts.

> "*…there is no branch of the establishment which performs and promises more aid in the management of the insane, and in liquidating the annual expenses, than the farming and mechanical operations. Consequently, additions have occasionally been made to its landed estate, and increasing attention paid to agriculture*." (Report Of The Committee On Public Charitable Institutions On Visits Made To Several Institutions, 1842, p. 3)

<u>Returns – State Hospital and Penal Systems (1854)</u>

Although statistical returns of "insane" populations were in much need of improvement, the Committee on Public Charitable Institutions reported in 1854 that out of all the "insane" found in some type of public institution (1,198), excluding the state Almshouses, roughly 14.4% (173) were confined in the house of corrections and 85.6% were hospitalized (Report Of The Committee On Public Charitable Institutions, 1854, p. 3).

Education Related Records

Massachusetts Board of Education (1837-1918) and School for Idiotic and Feeble-Minded Youth (1852-1882) – Application Documents and Student Records

The application process for state-supported admission to the Massachusetts School for Idiotic and Feeble-Minded Youth was both rigorous and revealing of contemporary social priorities. Prospective students' families, or representatives applying on their behalf, were required to submit a "Form of Application for Beneficiaries in Massachusetts" directly to the Governor. This form was accompanied by two critical documents: a certificate from the selectmen or Overseers of the Poor of the applicant's town attesting that the child and their family were financially unable to afford the school's services, and a medical certificate from a physician. This latter document had to confirm the absence of "insanity" and the presence of what was then termed "mental deficiency" (Experimental School for Teaching and Training Idiotic Children, 1852). These documents illustrate how the state constructed and enforced categories of disability, drawing sharp lines between mental illness, intellectual disability, and poverty in its effort to allocate limited resources.

In addition to application documents, in the School's Constitution and By-laws, it stated that its Superintendent,

> *"…shall make a record of the name, age, and condition, parentage, and probable causes of idiocy, or deficiency of each pupil, and of all the circumstances that may illustrate his or her condition, or character; and also keep a record, from, time to time, of the progress of each one."* (Massachusetts School for Idiotic and Feeble-Minded Youth, 1851, pp. 11–12)

Registers – State Primary School and State Reform Schools

In 1859, the Board of Control of State Charities (later the Board of State Charities by 1864) was required to provide institutions that received full (e.g., almshouses) or partial aid (e.g., reform schools and schools for the feeble-minded) from the state with blank return forms to record and periodically submit statistical information about their service population (An Act Establishing A Board Of Control Of State Charities, 1859).

In 1864, the Board of State Charities adopted the responsibilities of the former Board, including the maintenance of the Primary School register, which any friend or relative could request access to at the Board's local office in Boston (Massachusetts Board of State Charities, 1870). Initially, to help build its register, the Primary School adopted the Board of Education's register system, including statistical return forms (Massachusetts Board of State Charities, 1865).

Shortly after, the laws around pauper returns for "paupers fully supported" and "persons relieved and partially support" applied to the State Primary School and the two State Reform Schools, respectively. As a result, registries for both types of schools collected the following data for each pupil: registration number; color; age; gender; birthplace; citizen or foreigner;

state residency status; intemperate[32]; insane or idiotic; start and end date of receiving full or partial aid; and cost of support. The difference was that registers for paupers fully supported recorded names and work abilities, while registers for those receiving partial relief collected information about household size. In addition to this, both the Primary and State Reform Schools had to periodically report to the Board regarding the school's number of admissions, discharges, and transfers (Massachusetts Board of State Charities, 1865).

Massachusetts Board of Commissioners of Alien Passengers and State Paupers (1851-1863)

The Massachusetts Board of Commissioners of Alien Passengers and State Paupers was enacted under General Statutes of 1851, Chapter 342. The Board was responsible for ensuring that the laws around foreign immigrants and state paupers were being followed properly wherever they were being provided services, such as the State Almshouses. The Board also provided guidance around the registry and returns of paupers and had access to all the information related to the services they received (An Act To Appoint A Board Of Commissioners In Relation To Alien Passengers And State Paupers, 1851; Massachusetts Archives, n.d.-b).

Commission on Lunacy's Report on Insanity and Idiocy in Massachusetts (1854)

In 1854, the Committee on Public Charitable Institutions expressed the great need for the Commonwealth, through a Governor-appointed Commission on Lunacy, to regularly investigate the conditions of "idiots" and the "insane" across the state by maintaining and analyzing accurate registry returns of these populations (Report Of The Joint Standing Committee On Public Charitable Institutions, 1854). The goals of these efforts were to ensure existing care was appropriate and to identify the need for further developing and enhancing the existing hospital system. The Commission on Lunacy, established by the Resolve of the Legislature in 1854, conducted such an analysis and issued a comprehensive report of their findings, which were summarized by the Committee on Public Charitable Institutions in 1855 (Report Of The Joint Standing Committee On Charitable Institutions, 1855; Report On Insanity And Idiocy In Massachusetts, By The Commission On Lunacy, 1855).

Massachusetts Board of Control of State Charities (1859)

<u>Records - Removal of Certain State Paupers from State Almshouses and Hospitals (1860s)</u>

Based on a statute enacted in 1860, the Board of Alien Commissioners could remove anyone from a State Almshouse or hospital upon the person's request only if they had a legal settlement or someone willing to support them, and the Board felt that they would be unlikely to receive state services again within a year. Documentation of these removals (discharges to the Board of Alien Commissioners) were required to be included in institutional registries and in the person's record (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

[32] In this context, intemperate likely means either an alcoholic or one who could not control their behavior.

Massachusetts Commission on Insanity (1863)

The Commission on Insanity was established by Chapter 91 of the Resolves of 1863. Similar to the charges of the Commission on Lunacy, this Commission was responsible for evaluating existing "insanity" laws and the overall conditions of the "insane" within the Commonwealth through unannounced site visits and visits to surrounding states for comparison purposes. Major topics discussed in one of its first reports included: wrongfully detained persons in insane asylums; uniformity of commitment processes; neglect and prioritization of the "native insane" (as opposed to the "foreign insane"); and separation of "criminal lunatics" (Communication From Executive Department, 1864).

Major findings and recommendations included the urgent need to address the overcrowding found at state hospitals through the establishment of a hospital for the "incurables" at one of the State Almshouses or elsewhere, the discharge of custody of elderly "imbecile" persons to their friends, providing a separate location for "insane criminals" and those acquitted by reason of "insanity", and establishing an asylum for "insane drunkards". The Commission also voiced the need to appoint a standing Commission in Lunacy that would take custody of these populations, resolve appeals of questionable cases of "insanity", and oversee admissions and discharges. The Commission also proposed that, when possible, to consult with the "insane" person in the selection of a court-appointed guardian[33]. Here are other recommendations presented by the Committee: immediate placements in "curative asylums" for newly discovered cases of "insanity", removal of the "insane" from confinement where it is deemed most beneficial for them to be free, requiring certificates of "insanity" by medical professionals and abolishing commitments by judges, making private asylums subject to state regulations regarding licensing and visitation, and requiring state hospitals trustees to appoint and consult with a board of physicians (Communication From Executive Department, 1864).

Massachusetts Board of State Charities (1864-1878) and New Registry Laws

The Board of State Charities was established by the Acts of 1863, Chapter 240. Section 6 of this law abolished the Board of Commissioners in relation to alien passengers and State paupers, as well as the Office of the Superintendent of Alien Passengers of Boston. It also transferred the duties from the abolished board, including the supervision, investigation, and provision of recommendations of the entire system of correctional and public charitable institutions, to the new Board of State Charities. The Board also had the power to transfer, discharge, and admit pauper inmates throughout the entire public charity system (Massachusetts Board of State Charities, 1865).

[33] These guardians, preferably female, would be different from those in charge of overseeing a person's estate (Communication From Executive Department, 1864, p. 19).

The New Registry Laws – Pauper Returns (1864)

In its first report (1864), the Secretary of the Board of State Charities reported that the Board's chief clerk had begun developing a state register for prisons and a similar record for town paupers because of the new registry laws of Chapter 307 of the Acts of 1864 (Massachusetts Board of State Charities, 1865).

To help manage, build, and improve the accuracy of record returns and pauper registries, especially given the high volume of foreign paupers that arrived in Massachusetts between 1846 and 1858, paupers were categorized into three classes: 1) paupers fully supported in hospitals, almshouses or elsewhere; 2) persons relieved and partially supported, such as reform school pupils; and, 3) "vagrants", or traveling paupers. Specifically, Section 6 of the new registry laws required the Overseers of the Poor to submit record returns two times a year to the Secretary of the Board of State Charities for which a copy of them were either stored in the Pauper Register or bound in yearly volumes (Massachusetts Board of State Charities, 1865). General Statutes of 1875, Chapter 216, Section 1 reduced the submission of returns to the Secretary to once a year (Massachusetts State Board of Health, Lunacy, and Charity, 1880). Per Section 6 of Chapter 307 of the Acts of 1864, returns were required to contain the following information for each category (Massachusetts Board of State Charities, 1865, p. 329):

- *Paupers Fully Supported*. - Registered number; name; color; age; sex; birthplace; naturalized or not; settlement in the town; able to perform labor; "intemperate"; "insane or idiotic"; when registered as pauper; where supported; ceased to be supported; average weekly cost.
- *Persons Relieved and Partially Supported*. - Registered number; number in family; color; age; sex; birthplace; came into the State; naturalized or not; settlement in the town; "intemperate"; "insane or idiotic"; when aided; ceased to be aided; residence when aided; whole amount paid.
- *Travelers Lodged and Persons Sent to the State Almshouse*. - Name; date; color; age; sex; height; complexion, when sent to State Almshouse.

Related to this topic, the new Board also voted to require:

> "…*weekly returns of town and private patients from the State Lunatic Hospitals, and monthly returns of admissions, discharges, etc., from all the institutions which do not now make weekly returns*" (Massachusetts Board of State Charities, 1865, p. vii).

The Secretary of the Board of State Charities, F. B. Sanborn, showed his commitment to the new law by stating,

> *"To be perfect, such a registry must be kept in two places: that where the charity is given, and that to which all the gifts are reported, that is, in each town, and at the seat of government for the towns, and it must include the names of the persons relieved, so that*

they can be identified, and their description also, for such as might seek to elude discovery." (Massachusetts Board of State Charities, 1865, p. 328).

Even though these laws existed, as noted in the Board's annual report of 1869, the deficiencies of the registration system persisted because the quality of returns furnished by the Overseers of the Poor was inconsistent. To address this issue, the Secretary of the Commonwealth wanted the Board of State Charities to adopt the same permanency principles around records like the School Boards and many other bureaus did (Massachusetts Board of State Charities, 1870).

The New Registry Laws – Prison Returns (1864)

The initial prison returns system was developed a few years after the pauper return system around 1840. Like many initial registries, there were significant issues with data accuracy resulting from duplication and other categorical limitations. In an attempt to rectify these issues and to create a more standardized registry system, the General Court passed Chapter 307 of the Acts of 1864.

Section 1 of this Act required the Board of State Charities to supply keepers of state and county prisons, workhouses, and houses of industry, reformation, and corrections with blank return schedules[34] to collect and report not only aggregate (e.g., census), but also individual-level data (see dataset examples below) regarding admissions, discharges, and transfers. The latter was claimed to be one of the most important improvements to the registry system since it was believed that any changes in law would have no impact on how the data was analyzed and it provided a way to correct erroneous data entries from the past. Section 1 of this Act also mandated keepers to submit registry returns on a set schedule based on average weekly commitments. For example, prisons that averaged more than 10 commitments per week were required to make weekly returns, while those that averaged 2 to 10 per week made monthly returns (Massachusetts Board of State Charities, 1865, pp. 386–387).

- *Admissions* – Registered number; name; color; age; sex; birthplace; parents both American; parents both temperate; parents both or either convicts; ever married; intemperate; what education; what property; ever in army or navy; ever in reform school; when committed; why committed; number of former commitments; when discharged; how discharged; length of sentence; number of days sick; number of times punished in prison.
- *Discharges* – Registered number; name; when committed; why committed; when discharged; how discharged; time in prison; number of days sick; number of times punished in prison.

Besides furnishing the Board with demographic data, penal institutions were also required to submit annual returns regarding finances and services, including, but not limited to officer

[34] In this context, schedules refer to a set of questions that public institutions were required to respond to by using blank return forms issued by the Secretary of the Board of State Charities.

names and salaries, food, clothing, and medical expenses, revenue from labor of prisoners and paid fines, and the number of vaccinated prisoners (Massachusetts Board of State Charities, 1865, p. 388). Collecting and comparing these different types of datasets allowed the Board to identify concerning trends, such as increases in salary expenses and reductions in prison populations. This was exemplified in the Board's list of special recommendations in its first annual report for the year ending, 1864:

> *"The expenses of these institutions have rapidly increased within a few years, especially in the item of salaries. The aggregate expenditure for this purpose in the State in 1854, was twenty-five thousand three hundred dollars and twelve cents, as reported, while in 1864 it amounted to seventy-one thousand six hundred and eighty-five dollars and fifty-five cents. While the sum paid for salaries has thus nearly trebled, the number of prisoners has diminished nearly one-half. The difference in the sums paid for salaries and for the instruction of prisoners is worthy of notice*." (Massachusetts Board of State Charities, 1865, p. xlii)

In-Person Applications and Records Access in Boston, MA (1869)

The Sixth Annual Report of the Massachusetts Board of State Charities (1869) refers to the Board having a local office in Boston where people wanting to apply for charitable assistance were sent to. Here, applicant histories would be recorded as part of the application process (Massachusetts Board of State Charities, 1870). The office also kept registers of the State Almshouses, Primary School, workhouse, and the asylum for the "insane", which:

> *"Persons having friends or relatives in either of the abovenamed Institutions can thus be supplied with information without the necessity of writing to the Superintendent or visiting their friends."* (Massachusetts Board of State Charities, 1870, p. 221)

Massachusetts Board of State Charities Visiting Agency Records (1869)

Under the direction of the Secretary of the Board of State Charities, a Visiting Agency was formed as a separate department in 1866 for residents of almshouses and reform schools. Records from this agency exist in the Health and Human Services Record Group at the Massachusetts Archives, including lists of people living at these locations, and reports on their condition (Massachusetts State Archives, 2020). A description of the files from 1852-1870, for example, states:

> *"Information varies over time, but generally includes case no., institution no., name, age, birthplace, immigration history, marital status, family location and history, settlement status (taxes, voting, military service), work history, previous residences and institutionalization, health, criminal history, physical appearance and work capability. Frequently notes are added later describing subsequent resident discharge, death, or transfer to other institutions or to place of settlement."* (Massachusetts Board of Alien Commissioners, n.d.)

Reports of status on people include additional periods of 1858 – 1863 and select records from 1864 – 1878.

Massachusetts Board of State Charities (1864-1878) and School for Idiotic and Feeble-Minded Youth (1852-1882)

Despite its initial relationship with the Massachusetts Board of Education (as described previously), the Massachusetts School for Idiotic and Feeble-Minded Youth (referenced as School for Idiots) was listed in the Board of State Charities' First Annual Report (1864) as a state institution that, unlike the state "lunatic" hospitals and almshouses, was partially controlled by the state. In this report, based on visits and research, it was recommended that besides the State, the student's legal settlement, if any, should also make weekly payments towards their schooling just like what was required from reform and industrial school students. The report also provides an overview of the various types of alternative instruction the school offered its students, such as basic functional academics, visual instruction, trade and maintenance work, among others (Massachusetts Board of State Charities, 1865). Of note, the school was not reflected in the Massachusetts Board of Education's annual report for the same year (1864).

Board of Health and Vital Statistics or The State Board of Health (1869 - 1879)

Laws Concerning the Registration of Births, Marriages, and Deaths – Public Institutions, Excluding State Almshouses

General Statutes Chapter 21 Section 2, required persons in charge (keepers or superintendents) of a workhouse, house of correction, hospital, city or town almshouse, and transportation captains, to report every birth and death within six months. Failure to do so would result in a fine up to $5 per offense (Massachusetts Office of the Secretary of State Division of Statistics, 1864).

Laws Concerning the Registration of Births, Marriages, and Deaths - State Almshouses

These new registry laws applied differently to the three State Almshouses. Per General Statutes Chapter 21 Section 8, Superintendents were required to obtain, record, and make a yearly return to the Secretary of the State of all births and deaths that occurred at the Almshouses with the following information (Massachusetts Office of the Secretary of State Division of Statistics, 1864, p. clvi):

- *Birth records*: "the date of the birth, the place of birth, the name of the child, (if any,) the sex and color of the child, the names and the places of birth of the parents, the occupation of the father, the residence of the parents, and the date of the record."
- *Death records*: "the date of the death, the name of the deceased, the sex, the color, the condition, (whether single, widowed, or married,) the age, the residence, the occupation, the place of death, the place of birth, the names and places of birth of the parents, the disease or cause of death, the place of burial, and the date of the record."

Section 9 of this law required the Secretary of the Commonwealth to supply State Almshouses with blank books for records and indexes, as well as blank forms for returns. It is unclear whether a copy of these records had to be sent annually to the Secretary of State, like what town clerks were required to do (Massachusetts Office of the Secretary of State Division of Statistics, 1864).

Public Records Law – Chapter 29

Section 10 of this law stated that records and files may be inspected and copied, while Section 11 stated that changing, damaging, or wrongfully keeping records would result in a $50 fine per offence (Massachusetts Office of the Secretary of State Division of Statistics, 1864).

Public Health and Welfare Statistics (1869 – 1879)

Senate Bill No. 82 of 1862 proposed the creation of a Board of Health and Vital Statistics to address and improve the fragmentation of statistics related to sanitary conditions, public health (e.g. causes of disease and mortality) and welfare of persons receiving supports in any medical public charitable institution, including, but not limited to state lunatic hospitals, hospital departments at the State Almshouses, and the state school for idiots (An Act To Establish A Board Of Health And Vital Statistics In Massachusetts, 1862). This bill was finally enacted by Chapter 420 of the Acts of 1869, which officially established the State Board of Health (also referred to as the Board of Health and Vital Statistics) (Massachusetts State Board of Health, 1870). In its second report, the Board expressed the notable improvement and fundamental importance of the Massachusetts registration system around its work on mortality:

> *"We do not wish to overstate the value of registration returns of the causes of death. They are certainly liable to error, but after much examination we believe them to be made with great care by trustworthy and intelligent men. The system of registration has now been in use in Massachusetts for thirty years, and has been constantly improving."*(Massachusetts State Board of Health, 1871, p. 11)

Commissioners of Lunacy (1874)

Population Data and Evaluation of Registration System (1874)

Section 3 of Chapter 363 of the Acts of 1874 authorized the Governor to appoint two Commissioners of Lunacy in charge of examining the current lunacy laws and conditions of "lunatic inmates" in asylums and hospitals. This included a review of any formal complaints made by inmates to the Superintendent (An Act Relating To The Correspondence Of Insane Persons, And To The Establishment Of A Commission Of Lunacy, 1874).

The report noted the deficiencies and subsequent need for a standardized registry system of the insane. Due to stigma associated with "insanity", many families and friends who supported the "insane" privately were notorious for underreporting. Also, the lack of uniformity in recordkeeping across state charitable institutions was a major contributor to statistical

inaccuracies and incompleteness. For these reasons, the Commission recommended that there be a permanent commission established to oversee the care of the “insane”, which would be tasked with reporting and maintaining accurate records and registries on the state of lunatic hospitals and the “insane” population, to inform policy and improve care (Report Of The Commissioners Of Lunacy, To The Commonwealth Of Massachusetts, 1875).

Committee on Public Charitable Institutions – Commitment and Discharge Records (1876)

In 1876, the Committee on Public Charitable Institutions proposed House Bill No. 267, which touched upon state lunatic hospital commitment and recordkeeping procedures. Commitment procedures consisted of the application requirement of proof of “insanity” by two credentialed physicians, the mandatory examination by a judge prior to any commitment, and the right for the “insane” to a jury trial. Section 5 of the Bill outlined the recordkeeping responsibilities of any superintendent of a state lunatic hospital and private or public asylum. It required that a patient record be developed within three days of commitment for periodic documentation of a person’s mental health state, bodily condition, medical treatment, and any restraints used. These records were also used to document the circumstances of discharge or death (An Act In Regard To Committals Of Insane Persons, 1876).

Consolidation under the State Board of Health, Lunacy, and Charity (1879-1885)

The Organic Act (General Statutes of 1879, Chapter 291) eliminated several independent state boards, including, but not limited to the State Board of Health and Vital Statistics, the Board of State Charities, and the Boards of Inspectors of the State Primary School and the State Almshouse, and merged them all under one governing board called the State Board of Health, Lunacy, and Charity. This newly formed Board took over all the duties of the previous independent boards, which still included the supervision of all public charitable and reformatory institutions (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

Section 5 of the Organic Act stated that the Board should also act as Commissioners of “lunacy” and investigate questionable cases of “insanity”, as well as the environments of private and public “lunatic” hospitals and asylums (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

Lunacy Laws and Commitment Records (1865 - 1879)

In order for anyone to be committed to any public or private hospital, asylum, or receptacle for the “insane”, Sections 2 and 3 of the lunacy commitment laws (General Statutes of 1879, Chapter 195) required a court order and two certificates of “insanity” to be issued by two qualified doctors having no ties to the public charitable system (Massachusetts State Board of Health, Lunacy, and Charity, 1880). In addition to this, Sections 4 and 5 of the same law, required anyone applying for the admission or commitment of a “lunatic” into a state “lunatic” hospital to formally notify the mayor or selectmen of where the lunatic resided and to furnish a statement within 10 days of commitment or admission with the following information:

> *"…age, birthplace, civil condition, and occupation; the supposed cause and the duration and character of his disease, whether mild, violent, dangerous, homicidal, suicidal, paralytic, or epileptic; the previous or present existence of insanity in the person or his family; his habits in regard to temperance; whether he has been in any lunatic hospital, and if so, what one, when, and how long; and, if the patient is a woman, whether she has borne children, and, if so, what time has elapsed since the birth of the youngest; the name and address of some one or more of his nearest relatives or friends, together with any facts showing, whether he has or has not a settlement, and if he has a settlement, in what place…"* (Massachusetts State Board of Health, Lunacy, and Charity, 1880, p. 78)

All documents mentioned above had to be filed in court and a copy made and delivered to the Superintendent of the state lunatic hospital so it could be filed with the person's institutional record (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

Statute 1865, Chapter 268, Section 2, required applicants to provide the Superintendent with contact information of up to 10 adult relatives of the person to be admitted or committed, along with two friends, if desired. This information would also be filed in the person's admission record and the Superintendent would notify each contact within two days of admission (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

Lunatics in the State Prison Referred to State Lunatic Hospitals (1880s)

General Statutes Chapter 180, Section 1, established a special commission, consisting of the State Prison's physician and all state "lunatic" hospital superintendents, to investigate and identify "lunatics" already imprisoned or awaiting imprisonment. If "lunacy" was confirmed, the commission would notify the court who would issue a warrant authorizing the removal of that inmate to a state "lunatic" hospital until recovery. Once recovered, the person would be sent back to prison and stay there until their release. Time spent at the hospital counted towards the time outlined in their original sentence (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

Standard and Critical Incident Records (late 1800s)

General Statutes of 1877, Chapter 233, Section 1 stated that corporal punishment was only to be administered to the boys at the Massachusetts State Reform School for Boys at Westborough. Section 2 of the law required that a record of these incidents be recorded, and that the method and duration be included in these records (Massachusetts State Board of Health, Lunacy, and Charity, 1880).

Another example of this type of critical incident reporting was found in a summary about the Tewksbury Asylum in the *Eighth Annual Report of the State Board of Lunacy and Charity of Massachusetts*. It stated,

> *"The number of attendants is considerable; the insane are better fed and clothed than formerly, and do much more work; a record is kept of their restraint, seclusion, etc., and their whole treatment is more systematic."* (Massachusetts State Board of Lunacy and Charity, 1887, p. cxxix)

Committee on Public Charitable Institutions - Commitment Records (1881)

In 1881, the Committee on Public Charitable Institutions discussed amendments to existing commitment laws to insane hospitals. Per these changes, commitments now had to specify whether the person was violent and dangerous. This would be documented and stored along with the application and statement about the person's violent and dangerous insanity issued by the mayor or town selectman. It also required superintendents to notify the Boad of Health, Lunacy, and Charity of all commitments for investigative and recordkeeping purposes. This notification included the documentation mentioned above, as well as the person's legal settlement (Communication From Senate Committee On Public Charitable Institutions, 1881).

Committee on Public Charitable Institutions - Temporary Leaves (1883)

In 1883, the Committee on Public Charitable Institutions proposed a bill (House Bill No. 146 of 1883) authorizing Superintendents of any state lunatic hospital or the Massachusetts General Hospital, with the approval of the Board, to discharge inmates. They could also permit temporary leaves of "insane inmates" under the care of a guardian, family, or friends, for up to 60 days. Readmittance of these inmates would not require a new commitment order to be issued (An Act To Provide For The Discharge Or Temporary Release Of Inmates Of Institutions For The Insane, 1883).

State Board of Lunacy and Charity (1886-1898)

The Acts of 1886, Chapter 101, established and assigned all health functions to the Massachusetts Board of Health, which lead to the creation of the State Board of Lunacy and Charity (Massachusetts State Board of Lunacy and Charity, 1887).

State Board of Health Agreement Regarding the Custody of Public Health Records

During this transition, it was voted that the Massachusetts Board of Heath form a committee responsible for coordinating the transfer of custody and care and delivery of records, books, and other property related to public health from the former State Board of Health, Lunacy, and Charity's Department of Health to the new Board of Health (Massachusetts State Board of Lunacy and Charity, 1887).

Training Schools of Medical Professionals to Address Inaccuracies of Insanity Certificates

Some state hospitals became major training centers for medical professionals who wanted to specialize in mental health. This resulted in physicians issuing more accurate certificates of "insanity" as required by the court upon a person's commitment to a state hospital. On this subject, the following observation across state hospitals was also noted:

> *"The medical records at the State hospitals have so much improved of late years that they now supply many more facts, more accurately noted and classified, than they formerly contained; thus, remedying some serious defects in the original certificate."* (Massachusetts State Board of Lunacy and Charity, 1887, p. civ–cv)

Massachusetts Board of Education (1837-1918) and School for the Feeble-Minded at South Boston (1883-1890)

Although partially funded by the State, Section 9 of the Acts of 1886, Chapter 298 required the School for the Feeble-Minded at South Boston to report to the Board of Education annually and quarterly. Annual reports would contain information about finances, operations, programming, and other statistical information, while quarterly reports consisted of lists of new admissions and discharges, which outlined who was funded privately or by the state (a state beneficiary) (Massachusetts State Board of Lunacy and Charity, 1887). Consequently, the School was listed as one of the defective classes in the Board of Education's annual report for 1885-1886 (Massachusetts Board of Education, 1887).

Major Split of the State Board of Lunacy and Charity

1899 was a pivotal year when there was a major split of the State Board of Lunacy and Charity, which resulted in two separate boards, the State Board of Charity and the State Board of Insanity (State Board of Insanity, 1900).

State Board of Charity (1899-1919)

The State Board of Charity continued to supervise the "sane" paupers living at the State Almshouse at Tewksbury, as well as those living in the State Farm at Bridgewater (formerly the State Almshouse at Bridgewater). The state reform schools were also assigned to the State Board of Charity (Massachusetts State Board of Charity, 1900).

Court Records Related to the Insane (1904)

Section 2 of the Act Relative to Commitments of Insane Persons and to the Fees Received Therefor (Chapter 459 of the Acts of 1904) was an amendment to a previous law (Section 47 of Chapter 87 of the Revised Laws) that required the transmission of all court dockets and documentation regarding commitments of "insane" persons to new judges upon the death, resignation, or removal of a former judge (An Act Relative To Commitments Of Insane Persons And To The Fees Received Therefor, 1904). This ensured the continuity and proper maintenance of these records within the court system.

State Board of Insanity (1899-1915)

As for the State Board of Insanity, it took full responsibility of paupers labeled as "insane" and the general supervision of all state hospitals for the "insane" (total of five at this time), the

asylums for the “insane” (total of four), and other fully and partially state-funded institutions, including the Massachusetts Hospital for Dipsomaniacs and Inebriates, Massachusetts Hospital for Epileptics, Massachusetts School for the Feeble-minded. Some other major changes that are worth noting, include but are not limited, to the Board requiring a portion of its members to be experts in “insanity” and the replacement of the term “lunatic” with “insane” (State Board of Insanity, 1900).

Registry and Record Requirements (1898)

Section 6 of the General Statutes of 1898, Chapter 433, stated that the Board of Insanity was in charge of providing institutions within its scope blank returns needed for annual reporting on institutional statistics. The Board also had to send mayors and Overseers of the Poor the form of certificates required to be completed prior to a person’s admission into an institution. The form collected “…the age, parentage, birthplace and former residence of, and other facts relating to, the said poor person, as the board may deem” (State Board of Insanity, 1900, pp. 14–15).

Sections 8 and 11 required the Board to maintain a registry of all commitment records and required every institution under its supervision to maintain and add any transfer or discharge records to a person’s overall record file. Section 22 recommended that the Board, if possible, essentially create a records access system for probation officers as part of the commitment decision-making process (State Board of Insanity, 1900).

Transfer of Care Responsibility of “Insane Persons”, Including “Feeble-Minded”, “Epileptic”, and “Addicts” to the State, and Related Records (1909)

Section 1 of Chapter 504 of the Acts of 1909 declared the state’s full responsibility for the board, care, and treatment of any inmate that was “insane”, “feeble-minded”, “epileptic”, or an “addict”. With this change, cities, towns, and counties were no longer liable for supporting these populations. Section 60 of this Act also stated that the Board of Insanity had the same authority to supervise both state schools at the time (the Massachusetts School for the Feeble-Minded and the Wrentham State School) like it did for all other state hospitals for the insane. Sections 68 and 69 of this Act also authorized the Governor and the State Board of Insanity to transfer any inmate as deemed necessary (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909).

Sections 6, 11, and 33 required the State Board of Insanity to prescribe the forms for applications and commitments, including required statements, medical certificates, commitment orders, and annual statistical returns. They also had to keep records of all institutional commitments and admissions (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909).

Section 41 required the following:

> *"Each judge shall keep a docket or record of the causes relative to insane persons coming before him, numbered or otherwise properly designated, and the disposition thereof. He shall also receive and keep on file the original application, statement of applicant and certificate of physicians, and the copy of the order of commitment, attested by, and with the return thereon of, the officer or other person serving the same. Said docket or record and other documents required to be kept as above shall be transmitted, on the death, resignation or removal of the judge to his successor in office."* (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909, p. 692)

Section 77 also required discharge cases to be filed within the individual's court record.

Sections 32, 69, 77, 81, and 103 also required Superintendents of institutions to keep the following records within an inmate's case file: commitment and admission records, including medical certificates, certificates of insanity, and commitment orders[35]; transfer records, including the abstracts of previous hospital records; and discharge and temporary release records, including institutional- and court-related discharge documents, such as medical examination reports and findings, and court evidence and decisions about whether or not the inmate continued to be violent and or a danger to the public. It also required Superintendents to send copies of certificates of insanity, application and commitment statements, and order of commitments to the State Board of Insanity (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909).

Registry and Record Requirements – Schools for the Feeble-Minded (1909)

Sections 59 through 65 of Chapter 504 of the Acts of 1909 outlined the governance and management for the two existing state schools for feeble-minded populations. Part of these regulations touched upon record and reporting requirements. Besides submitting standard annual reports to the State Board of Insanity, which included, but was not limited to financial- and census-related data, state schools had to maintain court-related commitment records, such as commitment orders and medical certificates from qualified physicians. They also had to keep volunteer admission records for applications made by parents and guardians, which also required a physician's certificate confirming mental deficiency and justification for placement, along with a written application (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909).

Registry and Record Requirements – Guardianship (1909)

Section 99 of Chapter 504 of the Acts of 1909 required the court to send copies of guardian appointments, including temporary guardians, to the State Board of Insanity. Section 101 of this Act required a formal petition, and a week's notice to the State Board of Insanity for the discharging of a guardian. Per Section 102, the former requirement related to documentation

[35] Per Chapter 273 of the Acts of 1911, commitment orders needed to be executed within 30 days of issuance or else they would become void (An Act Relative To The Order Of Commitment Of An Insane Person, 1911).

also applied to the licensing of guardians to sell the estate of "insane" persons (An Act To Revise And Codify The Laws Relating To Insane Persons, 1909).

Registry and Record Requirements – Restraints (1911)

In An Act to Regulate the Restraint of Patients in Public or Private Hospitals or Sanatoriums for the Insane (Chapter 589 of the Acts of 1911), various mechanical restraints (e.g., waist straps, wristlets, anklets, head straps, protection sheets, among others) were prohibited from being used across all public and private institutions that supported the "insane", unless a superintendent or physician were present or if the person had a written order in their record for the use of such restraints. The Act also defined the circumstances in which restraints could be executed, including, extreme violence, active homicidal or suicidal conditions, physical exhaustion, infectious disease, or after an operation or injury that caused significant bodily injury. Sections 2 and 5 of this Act respectively defined the reporting requirements related to these types of restraints and violation penalties (An Act To Regulate The Restraint Of Patients In Public Or Private Hospitals Or Sanatoriums For The Insane, 1911).

> *"The superintendent or head physician shall cause records of all restraint to be kept in a book which shall be provided for that purpose by the superintendent or head physician. The book shall be open for inspection at all times by the trustees or other persons having control of the hospital, sanatorium or institution, the state board of insanity, the governor and council, and members of the general court, and shall contain a complete record relative to the restraint, including the cause for restraint, the form used, the name of the patient, the time when the patient was placed under restraint and the time when he was released. Restraint, within the meaning of this act, shall also include therapeutic and chemical restraint and confinement in a strong room, or seclusion in solitary confinement, except when the patients are placed in their rooms for the night."* (An Act To Regulate The Restraint Of Patients In Public Or Private Hospitals Or Sanatoriums For The Insane, 1911, p. 610)

Commission on Economy and Efficiency (1912-1915) and Reorganization of State Board of Insanity (1914)

Chapter 719 of the Acts of 1912 established an independent Commission on Economy and Efficiency to investigate and readjust the finances of the Commonwealth of Massachusetts. It had the tasks of evaluating all state boards, departments, and institutions and identifying opportunities for reorganization and or consolidation that would lead to greater administrative and financial efficiency, and the creation of a system of standardized services directed under a general policy (Massachusetts Commission on Economy and Efficiency, 1913).

The Commission was later reorganized under Chapter 698 of the Acts of 1914 (An Act Relative To The Membership Of A Commission On Economy And Efficiency, 1914). The Commission's impact quickly showed in 1914 within the structure of the State Board of Insanity. Per Chapter 762 of the Acts of 1914, a three-member board that was monetarily compensated not only had

supervisory powers, but also had greater control of state institutions that provided services for the "insane", "feeble-minded", "epileptic", and those suffering from substance abuse (State Board of Insanity, 1916).

Regarding the State Board of Insanity and the state institutions under its supervision, in its 1914 report, the Commission recommended that there be a consolidation and centralization of control vested in a board of five commissioners and a governor-approved chief executive official. This would make the institutions interrelated and reduce the control of the Trustees of these institutions. It would also lead to the separation of policy-making duties and executive work (Massachusetts Commission on Economy and Efficiency, 1915).

Superintendent Duties Related to Records and Committee on Record Improvements (1915)

In its final report in 1915, the State Board of Insanity outlined the duties of the superintendents as it related to the following (State Board of Insanity, 1916):

- *Correspondence*: All patient and hospital related communications made or authorized by the superintendent was to be kept on file.
- *Business Records*: A daily record of business operations was to be maintained.
- *Clinical Records*: A complete clinical record for each patient was to be kept.
- *Family Notifications*: The superintendent was to immediately notify a patient's family in the event of death or injury of any cause.

In the same report, it was noted that a special committee was appointed to examine records across the different institutions and to recommend to the Board of Insanity a blank form or template, "which would make the records and histories uniform in all of the institutions" (State Board of Insanity, 1916, p. 15). The form was officially adopted by the Board.

Massachusetts Commission on Mental Diseases (1916-1919)

Chapter 285 of the Acts of 1916 created the Massachusetts Commission on Mental Diseases and eliminated the Board of Insanity. Section 1 of the Act required all records, books, and property to be transferred to the new Commission (Massachusetts Commission on Mental Diseases, 1917).

Evolution of Records Collected at the School for the Feeble-Minded at Waltham (1891-1924)

In the Commission's first annual report in 1916, it reported the gathering of additional data about residents of the school, stating:

> *"Scientific investigation in the psychological direction has become of increasing importance. The themes of inquiry are physical condition, family history, personal and developmental history, record of school progress, examination in schoolwork, practical knowledge and general information, social reactions, economic efficiency, moral*

reactions and intelligence tests." (Massachusetts Commission on Mental Diseases, 1917, p. 45)

Registry and Record Improvements (1918 - 1920)

In its third annual report, the Commission on Mental Diseases appointed a small committee of superintendents with the task of developing a unform system of records and recordkeeping. At this time, institutions had already adopted uniform records cards for admissions, discharges, etc. (Massachusetts Commission on Mental Diseases, 1919).

Below are some examples from the Commission on Mental Diseases' fourth annual report showing progress towards the improvement and uniformity of institutional records.

- The Massachusetts State Psychiatric Institute described the process of certain research studies that reference the following being used, "…elaborate clinical histories and records which have been collected in a readily available way" (Massachusetts Commission on Mental Diseases, 1920, p. 13).
- Worcester State Hospital described the types of records that were reviewed and discussed during clinical meetings:

  "A clinical meeting consists of reading an abstract by the physician, which embraces a summary of the anamnesis[36]; the condition of the patient when admitted; the physical and neurological findings, including the laboratory reports, the mental status, the social service report in many cases, and the psychological in a few; a stenographic report of the direct examination of the patient, which is included under date as a regular part of the case record." (Massachusetts Commission on Mental Diseases, 1920, p. 50)

- Grafton State Hospital's Pathology Report referred to records being typewritten and organized in volumes starting from when these services were provided (Massachusetts Commission on Mental Diseases, 1920, p. 61).
- Per the report, conferences for hospital social workers were held every three weeks at the State House where policies, case and record work were discussed. The following describes the contents of social records:

  "Special attention has been given to the development of social records, as this appeared to be one of the obvious needs. Conference discussions, comparison of records and office interviews have aided in developing the social record work, although much yet remains to be accomplished in record writing. A filing system was also suggested and is now in general use in most hospitals. Guides or outlines for social case work, social histories and investigations have been prepared and used experimentally. These guides will doubtless aid in developing records and placing

[36] In this context, anamnesis refers to the medical history of a patient.

> *them on a uniform basis."* (Massachusetts Commission on Mental Diseases, 1920, p. 73)

These improvements in social work recordkeeping was further evident in the Director of Social Work's, Hannah Curtis, report contained in the Commission's 1920 annual report. Categorized under "Special Features," the Director described the system as follows:

> *"Until recently there has been no uniform system of social record keeping by which it was possible to analyze social work statistically. This was a real need and one which was more or less difficult to consider because of the varying conceptions of social work in our institutions. To cover the work being done by social workers and after-care workers, and to analyze it according to the generally accepted standards of social work, was not an easy task. However, an outline for monthly statistical social service reports has been arranged and is now in use in the majority of our institutions. For a year or more this system will be considered experimentally but will doubtless ultimately lead to definite and satisfactory statistical statements of the social service departments of our institutions. Following is a list of the sections contained in the outline of the monthly statistical report. There are various related subdivisions which are not here included. I. Total number of cases considered by social service. II. Sources of new cases. III. Purposes for which cases were considered. IV. Medical diagnoses of new cases. V. Social problems in all cases. VI. Nature of social service rendered in all cases. VII. Visits. (Ward, home, agencies, etc.). VIII. Out-patient clinic work. IX. Boarding patients. X. Disposition of social cases. XI. Expense account. Conferences, lectures, miscellaneous.* (Department of Mental Diseases, 1921, p. 40)

<u>Special Requests from State Institutions Regarding Record Storage Needs Given Public Records Laws (early 1900s)</u>

Excerpts from annual reports at the state institutions show an evolving need for record storage at the facilities. In Grafton State Hospital's annual report in 1916, under "Hospital Needs", the hospital's Superintendent, Dr. James May, made the funding request below:

> *"Fireproof record room, Worcester Department, $900. This amount of money is asked for to render fireproof the room in which the records of the Worcester Department are now kept in the building on Summer Street. A fireproof record room is required by the Commissioner of Public Records and is necessary if the laws of the State are to be complied with."* (Grafton State Hospital, 1917, p. 31)

As the census grew at the state institutions and the requirements for recordkeeping expanded, the institutions were challenged to have adequate space to store the records. In the first annual report from Belchertown State School, the Superintendent made the request below:

> *"An administration building should be provided for this coming year, in the interest of efficiency in conducting the affairs of the institution, and as a matter of safety, as*

> *required by law, this building should include a vault for the storage of valuable records."* (Belchertown State School, 1924, p. 3)

Hospital Cottages for Children at Baldwinville Moves Under Commission on Mental Diseases (1918)

Formed in 1882, the Hospital Cottages for Children was opened in Baldwinville, a village in the town of Templeton, Massachusetts. The Hospital tended to support four categories of children, including "epileptics", children with nervous disorders who were not "feeble-minded", children with substantial musculoskeletal conditions, and children who needed short-term care for operations or the fitting of devices (*Directory of the Charitable and Beneficent Organizations of Boston*, 1886). Admission records for 1882-1899, 1900-1918 are available online. In 1918, Chapter 121 moved general supervision of the Cottages to the Commission on Mental Diseases, including placement of children at the Commonwealth's expense, referring to the Hospital as an institution.

Establishment of Registry and Record Privacy for the "Feeble-minded" (1919)

Per Section 2 of Chapter 318 of the General Acts, the Commission was required to create and maintain an official registry of the "feeble-minded" population for statistical reporting purposes. Privacy of people included in this registry was to be protected, with a couple of exceptions:

> *"…but the name of any person so registered shall not be made public except to public officials or other persons having authority over the person so registered, and the records constituting the registry shall not be open to public inspection."* (Massachusetts Commission on Mental Diseases, 1920, p. 171)

Selling and Disposal of State Records, Including Departments and Institutions (1920)

Sections 1 and 2 of Chapter 174 of the Acts of 1920 authorized a group of state officials, including the supervisor of administration, the superintendent of buildings, and the assistant attorney-general, in consultation with leaders of state boards, commissions, departments, and institutions, to sell duplicate state records stored at the state library or in another department, and to periodically destroy what was deemed "…obsolete or worthless records, books and documents" (An Act Relative To The Disposal By The Commonwealth Of Duplicate And Worthless Books And Documents, 1920, p. 123).

The law also required the boards to give a 30-day notice by publishing an announcement in the Boston newspaper about what was going to be sold or destroyed. It also required the boards to notify parties of interest, e.g., historical societies, and to provide public hearings for parties of 25 or more Massachusetts residents with expressed interest. Public hearings also had to be announced in the same newspaper with a 10-day notice (An Act Relative To The Disposal By The Commonwealth Of Duplicate And Worthless Books And Documents, 1920).

Department of Mental Diseases (1920-1938)

Chapter 350 of the General Acts of 1919 replaced the Massachusetts Commission on Mental Diseases with the Department of Mental Diseases. At this point in time, significant changes to the Constitution took place, including one that required the reorganization and consolidation of over 100 State departments into no more than 20 divisions. The changes did not have an impact on the status of the Department of Mental Diseases. However, the Act did declare that Norfolk State Hospital, which was leased to the United States government and formerly under the State Board of Charity's supervision, became part of the Department of Mental Diseases' scope (Massachusetts Commission on Mental Diseases, 1920).

Uniform Institutional Records - Feeble-Minded in the Community (1923)

In its 1923 annual report, the Department of Mental Diseases highlighted the creation of the Committee on Uniform Institutional Records, including Doctor Walter E. Fernald, among others, charged with standardizing the existing records system used across all institutions within the Division for the Feeble-minded, including but not limited to the Belchertown State School and the Massachusetts School for the Feeble-Minded (Department of Mental Diseases, 1924).

Registry and Record Requirements - Brigg's Law (1921)

The Briggs Law, (Section 100A of Chapter 123 of the General Laws), which was enacted in 1921 and thereafter amended several times, mandated the Department of Mental Diseases to conduct impartial psychiatric and mental health status examinations for individuals in the judicial system facing indictment with significant criminal histories, including those who have committed capital offenses (e.g., life sentencing or death penalty). The purpose of these evaluations was to determine whether these individuals had a "mental disease" or a "mental defect", which could possibly impact their criminal responsibility to stand trial. The law was also designed to address the deficiencies of expert testimony in criminal cases and to ensure equitable treatment of defendants with mental disease or defects (Overholser, 1935).

The enactment of this law required court systems to maintain a paper record of every psychiatric evaluation requested from and conducted by the Department of Mental Diseases. Psychiatric evaluation reports would be filed with the court, which could be accessed by the judge, probation officer, district attorney, and defense attorney, as well as referenced during any court hearings as needed. The law also required court clerks to certify that the necessary notice requesting these psychiatric evaluations had been given to the Department of Mental Diseases (Overholser, 1935). This systematic approach of record recordkeeping of these mental health evaluations helped ensure fair trials and sentencing.

Hospital Records Under the Department of Mental Diseases (1926)

House Bill No. 132 of 1926, which amended Section 70 of Chapter 111 of the General Laws, as previously amended in 1923, made records from hospitals under the Department of Mental Diseases exempt from public inspection unless there was a judicial order or an order from the

head of the state department supervising the hospital. Copies of these records were available for a reasonable fee (An Act Relative To The Inspection Of Records Kept By Certain Hospitals Under The Supervision Of The Department Of Mental Diseases, 1926).

Records-Related Initiatives Under the Commissioner of Mental Diseases (1927)

In the 1927 annual report of the Commissioner of Mental Diseases there were many new initiatives regarding records and tabulating data that were noted.

- Division of Mental Hygiene - Recording and Tabulating Clinical Data:
  - *"One of the most interesting and promising developments of this past year was the inaugurating of a new system for recording and tabulating clinical data based on the Powers Coding Card arrangement. This includes the registering of not only the usual demographic facts but also much important and salient clinical material usable for future research projects. It is an invaluable means of facilitating research and promises to give a most interesting cross-section and longitudinal view of the work accomplished to date."* (Department of Mental Diseases, 1928, p. 21)
- Worcester State Hospital – Medical and Surgical Records:
  - *"The hospital has inaugurated a separate record system for the medical and surgical service. These records are following the forms advocated by the American College of Surgeons and give a complete record of every patient and employee who is treated in the medical and surgical service."* (Department of Mental Diseases, 1928, p. 41)
- Westborough State Hospital – Photograph in Patient Record:
  - *"It was believed that the records would be more complete and valuable if a photograph of each patient could be included in his case history at the time of arrival, and with others added later if desirable; and these were obtained in practically every case from the first admission."* (Department of Mental Diseases, 1928, p. 54)

Amendment to Law Around Central Registry for Mental Defectives (1936)

The Central Registry for the Feebleminded was originally established by an amendment to Chapter 123 of the General Laws. Even though this law was amended in 1936, it still contained the clause around privacy as shown in the following statement:

> *"Chapter one hundred and twenty-three of the general Laws is hereby amended by striking out section thirteen, as appearing in the Tercentenary Edition and inserting in place thereof the following: —Section 13. "The department shall establish and maintain a registry of mental defectives, and may report therefrom such statistical information as it deems proper; but the name of any person so registered shall not be made public except upon written request therefore, to public officials or other persons having authority over the person so registered, or to charitable corporations incorporated in this*

> *commonwealth and subject to section twelve of chapter one hundred and eighty, and the records constituting the registry shall not be open to public inspection. (Approved May 22, 1936).”* (Department of Mental Diseases, 1937, p. 110)

Department of Mental Health (1939-Present Day)

Chapter 486 of the Acts of 1938 reorganized the Department of Mental Diseases and created the Department of Mental Health. The new Department continued to be led by a commissioner and an assistant commissioner and still maintained a Division of Mental Hygiene and a Division on Mental Deficiency (Department of Mental Health, 1939).

Central Registry for Mental Defectives (1939)

By 1939, the Central Registry for Mental Defectives not only collected information about this population from mental health hospitals and state schools, but also from several other clinics and community resources, including:

> *“Chapter one hundred and twenty-three of the general Laws is hereby amended: (1) traveling school clinics; (2) admissions to state hospitals; (3) admissions to state schools; (4) cases placed on the waiting lists of state schools; (5) defective delinquents examined by hospital and Department psychiatrists; (6) out-patient examinations of state hospitals; (7) outpatient examinations of state schools; (8) mental hygiene clinics; (9) habit clinics; (10) child guidance clinics; (11) adjustment clinics; (12) defective delinquents admitted to Bridgewater; (13) mentally defective prisoners examined under the Briggs Law; (14) cases referred to the Division of Mental Deficiency; (15) cases examined by the Division of Mental Hygiene; (16) children examined by the psychological clinic of the Springfield schools; (17) cases referred to the Massachusetts Society for the Prevention of Cruelty to Children; and (18) the New England Home for Little Wanderers.”* (Massachusetts Department of Mental Health, 1940, p. 116)

The Central Registry data would be analyzed and tabulated to show percentage distributions across variables, such as age, gender, and I.Q.

Registry, Record Requirements, and Records Access (early 1900s - 1940s)

Section 5 of Chapter 194 of the Acts of 1941 further defined which hospitals were required to maintain patient records, including treatment and medical histories, of people who were determined to be “insane”, “mentally defective”, “feeble-minded”, “epileptic”, and “substance abuse users”. This included hospitals that were fully or partially funded by the state or town, private hospitals that provided free care, and non-profits. The law required that these records be kept in custody of the person in charge of the hospital. Again, patient records were not subject to public inspection, unless officially solicited by the court or the head of the Department of Mental Health. Copies of records were also available through these two outlets and for a fee (An Act Making Further Corrections In The Statutes Of The Commonwealth

Necessitated By The Change Of Name Of The State Department, Formerly Known As The Department Of Mental Diseases, To The Department Of Mental Health, 1941).

Per Chapter 291 of the Acts of 1945, the types of hospitals listed above could keep records in the following forms: handwritten, print, typed, or by photographic or microphotographic processes. The person in charge of a hospital was also allowed to destroy original records once properly photographed, indexed, and filed by the hospital. This process required a written notification to the Supervisor of Public Records (referred to in Chapter 66). The law also reinforced the validity of photographed and micro-photographed records. Most importantly, this act allowed patients or their attorneys, with written authorization from the patient, to request copies and inspect any personal medical records that were in the custody of the hospital director. This did not apply to any records in custody of the Department of Mental Health. Record copies would be distributed for a reasonable fee (An Act Permitting The Inspection Of Hospital Records By A Patient Or His Attorney And The Obtaining Of Copies Of Such Records, 1945).

Senate Bill No. 375 of 1948 was issued along with the petition of Estella E. Marshall, who requested that all records of state institutions be open for inspection by current and former patients and to other people of interest. The bill stated that "…all records of state institutions for the insane shall be open to inspection by the inmates or former inmates to whom they relate and also to all other interested persons" (An Act Providing That All Records Of State Institutions For The Insane Shall Be Open To Inspection By The Inmates To Whom Such Records Relate And Other Interested Persons, 1948, p. 1).

This further definition of what must be kept for records at state hospitals followed national trends. Across the country, individual patient records were kept in a haphazard manner until the early 20th century. In 1902, the American Hospital Association, followed by the American Medical Association in 1905, began efforts to improve medical records, which were often incomplete and inconsistent. These organizations sought to standardize and classify diseases and organize records more systematically. In 1928, the American Medical Record Association was established to set professional standards for recordkeeping. By the 1950s, the Joint Commission on Accreditation of Hospitals introduced regulations for maintaining records. Later, in 1971, the Commission developed specific guidelines for psychiatric hospitals, including the establishment of committees to review and analyze medical records (Bank & Schore, 1981).

<u>Registry, Record Requirements, and Records Access – Exclusion Criteria for Restraints (1946)</u>

The laws from 1911 around chemical and mechanical restraints remained relatively the same, except for the following exclusion criteria noted in House Bill No. 58 of 1946 for what was considered a restraint including "prolonged baths, hot or cold packs, or medication when used as a remedial measure and not as a form of restraint"[37] (An Act Relative To Records Of Restraint

[37] Medication used as a remedial measure simply means using prescribed drugs or therapies to correct, relieve, or improve a medical condition or problem.

In Institutions Under The Supervision Of The Department Of Mental Health, 1946, p. 2). Additionally, it was also not required to record a restraint when chemical or mechanical restraints were used while administering anesthesia or shock therapy, managing a contagious disease, following an operation or accident with serious bodily injury, or other medically-related therapies like insulin treatment (An Act Relative To Records Of Restraint In Institutions Under The Supervision Of The Department Of Mental Health, 1946).

Registry, Record Requirements, and Records Access – Unlawful Statements and Disclosures (1949)

The Act Relative to False Statements in the Records of Inmates in Hospitals Under the Jurisdiction of The Department of Mental Health prohibited and imposed penalties to anyone making false or unsound diagnostic claims in a person's hospital record. It also added a person's physician to the list of exceptions to the record-disclosure laws that restricted the sharing of information or records about any inmate or ex-inmate. Violators were subject to penalties consisting of $500 to $1,000 fines and imprisonment lasting anywhere from six months to three years. In addition to this and most importantly, the law granted current and former patients the right to sue violators for civil damages (An Act Relative To False Statements In The Records Of Inmates In Hospitals Under The Jurisdiction Of The Department Of Mental Health, 1949).

Registry, Record Requirements, and Records Access (1950s)

Advocacy for access to state institutional records continued in the 1950s. House Bill No. 1699 of 1957 was issued along with a petition by Jessie M. MacDonald and others, presented by Mr. Mahan of Leominster, regarding the public examination of records in the Department of Mental Health. The proposed Act mandated that all records, commitment papers, and other data from state hospitals, state schools, or institutions within the mental health department be accessible to the public. If this bill had passed, it would have provided transparency by allowing relatives, friends, inmates, ex-inmates, or any interested individuals to review these records without any restrictions from superintendents or other officials (An Act Relating To Records In State Hospitals, State Schools Or Institutions In The Department Of Mental Health, 1957).

Selling and Disposal of State Records, Including Departments and Institutions (1951)

Chapter 397 of the Acts of 1951 amended Chapter 30, Section 42 of the General Laws, by adding the state librarian or designee office and the Supervisor of Public Records as part of a group authorized to occasionally sell or destroy certain records, books, documents, and vouchers. Like Chapter 174 of the Acts of 1920, a 30-day notice in the Boston daily newspaper and a public hearing, if enough people requested one, were still required with this new iteration of the law (An Act Providing That The Supervisor Of Public Records Shall Be A Member Of The Board Authorized To Sell Or Destroy Certain Books And Records Of The Commonwealth, 1951; An Act Relative To The Disposal By The Commonwealth Of Duplicate And Worthless Books And Documents, 1920). This group was the predecessor to the Records Conservation Board, which was established in the 1960s.

Transfers, Including Records (1955)

Chapter 637 of the Acts of 1955 also established that transfers of people between institutions, including their records, could only apply to involuntary commitments. Standard transfers required a two-day written notice of intent in advance to a patient's family or guardian, while emergency transfers, authorized by the institution's Superintendent, required a post-transfer 24-hour notification. Recordings of transfers had to be documented in both institutional registries, and a patient's commitment and hospital records were to accompany them wherever they were sent (An Act Further Regulating The Procedures For The Hospitalization And Commitment Of The Mentally Ill, 1955).

Record Requirements – Interstate Compact on Mental Health (1956)

Per Chapter 441 of the Acts of 1956, the Commonwealth, under the Commissioner of Mental Health who was designated as the compact administrator, entered into an interstate agreement with participating states (unspecified) for the beneficial transferring and institutionalization of non-criminal patients with "mental illness" or "mental deficiency". Article IV of this Act required sending states to furnish receiving states with complete patient records, while Article X mandated receiving states to send copies of all reports, correspondence, and any other pertinent documents to the compact administrators of sending states. Therefore, these patient records should be comprehensive and include documentation from every state the patient received services from (An Act Making The Commonwealth A Party To The Interstate Compact On Mental Health, 1956).

Record Requirements – Commitment Laws (1956)

Chapter 589 of the Acts of 1956 required the court to send a written notification to a person when an application was submitted to the court for their commitment. The notice included information about their right to a court hearing. A copy of this notice was sent to the person's nearest relative or guardian and would become a part of the person's commitment record and overall institutional patient record. A copy of the certificate of "mental illness" issued by a credentialled physician would also be included in the person's file along with the physician's statement and commitment order issued by the court. The Superintendent of the state hospital was required to send copies of these documents to the Department of Mental Health (An Act Relative To The Commitment And Care Of The Mentally Ill, Epileptics, Alcoholics And Drug Addicts, 1956).

New Definitions and Requirements – Public Records (1958)

The Act Relative to Public Records and Proceedings redefined "public records" as the following:

> *"'Public records'" shall mean any written or printed book or paper, any map or plan of the commonwealth, or of any county, district, city or town which is the property thereof, and in or on which any entry has been made or is required to be made by law, or which any officer or employee of the commonwealth, or of a county, district, city or town has*

> *received or is required to receive for filing, and any book, paper, record or copy mentioned in section eleven A of chapter thirty A, where applicable, section nine F of chapter thirty-four, section twenty-three A of chapter thirty-nine, or sections five to eight, inclusive, and sixteen of chapter sixty-six, including public records made by photographic process as provided in section three of said chapter."* (An Act Relative To Public Records And Proceedings, 1958, p. 1)

Except for the executive council, the law required all government entities, including county commissions and boards, to maintain accurate records of meeting agendas, action items, and votes, which were accessible to the public upon approval. It also required that these meetings be open to the public, including the press (An Act Relative To Public Records And Proceedings, 1958).

Selling and Disposal of State Records – Records Conservation Board (early 1960s)

Chapter 427 of the Acts of 1962 established the Records Conservation Board, which included the following state officials: the state librarian, attorney general, state auditor (also referred to as the state comptroller), chairman of the commission on administration and finance (in 1964, the chairman was replaced by the commissioner), supervisor of public records, and the chief of the archives division in the department of the state secretary (referred to as the archivist). The Board was responsible for verifying what series of public records were held by each state department, managing and preserving public records, setting standards, establishing schedules for the destruction or transfer of records no longer needed for current business, and publishing notices and holding public hearings before destroying any records (An Act Establishing The Records Conservation Board, Defining Its Powers And Duties, And Further Defining Obsolete Records, 1962). Per Chapter 131 of the Acts of 1964, holding hearings was no longer a mandatory part of this process (An Act Changing The Membership Of The Records Conservation Board And Eliminating The Requirement Of Advertising Before Selling Or Destroying Certain Records, 1964).

After-Care Program Records - Special Commission to Make an Investigation and Study of the Administration of the Department of Mental Health (early 1960s)

Chapter 89 of the Resolves of 1961 established an unpaid Special Commission to investigate and study the administration of the Department of Mental Health and the laws of the Commonwealth relative to the admission, treatment, and release of patients in institutions under the control of the Department.

In 1962, the Commission's report emphasized the need for comprehensive clinical records for patients transitioning from in-patient hospitalization to after-care programs, including outsourced community-based mental health programs. The Commission strongly believed that this would significantly improve the continuity of care and overall treatment of an individual post-discharge by better informing prospective clinicians and support professionals who have never interacted with the person. The Commission specifically asked that these types of records

include information on the patient's treatment history, recommended drug dosage levels, among other relevant details. Despite these recommendations, the Commission did recognize that this endeavor would be significantly time-consuming and require consistent effort from professional staff, which the hospital system chronically lacked (Report Of The Special Commission To Investigate And Study The Administration Of The Department Of Mental Health, 1963).

Special Commission to Investigate Training Facilities for Retarded Children (1964)

In 1964, the Special Commission noted that state schools for “retarded” children, including Belchertown, Devers, Fernald, and Wrentham, had a new or existing permanent position for a medical record librarian, which contributed to local and systemic recordkeeping enhancements. It was also recommended, based on the National Association for Retarded Children, the President’s Panel on Mental Retardation, and the American Association of Mental Deficiency, that each state school should have a director of education and training where a certified vocational counselor would maintain individual student records documenting pre-vocational and vocational training experiences (Report Of The Special Commission Established To Make An Investigation And Study Relative To Training Facilities Available For Retarded Children, 1964).

Records and Records Access – Unlawful Commitments or Confinements at Bridgewater State Hospital or any Department of Mental Health Hospital (1967)

Chapter 620 of the Acts of 1967 gave patients questioning the legality of their commitment or someone on their behalf the right to request a hearing with the superior court. As part of this process, superintendents had to grant expert witnesses access to the patient’s complete record. The law also permitted all or a part of a patient’s record to be used as evidence during said hearing (An Act Establishing Special Procedures For Persons Allegedly Committed Or Confined Unlawfully At Bridgewater State Hospital And State Hospitals Under The Jurisdiction Of The Department Of Mental Health, 1967).

Clarification of Non-Public Records vs. Public Records (1968)

Senate Bill No. 1043 of 1968 aimed to clarify the definition of "public records" and specify which records were considered confidential and exempt from public inspection. This applied to any independent authority established by the General Court to serve the public sector.

The following items were not considered public records (An Act Clarifying The Meaning Of “Public Records” In So Far As It Relates To Certain Departments And Public Authorities, 1968):

- Records exempted by state or federal statute.
- Records kept by the General Court and Commissioner of Veterans Services.
- Documents restricted by statute, order, or court decree.
- Records related to investigations by federal or state authorities.
- Test questions, scoring keys, or examination data before testing.
- Specific details of research projects conducted by state institutions.

- Real estate appraisals for public use until the purchase is made.
- Medical, physical, or scholastic achievement records.
- Personnel files, except for salaries, applications, performance ratings, and other elements deemed confidential by an agency.
- Letters of reference.
- Trade secrets or privileged information.
- Library and museum materials that were explicitly restricted by the donor.
- Inter-agency or intra-agency memoranda containing contents that could implicate personal privacy.
- Medical records, such as reports from physicians, psychologists, or psychiatrists that indicate the physical or mental health condition of a patient in a public hospital, public institution, or medical institution. Exceptions included reports about negligence, injury, poisoning, among others.
- Tax returns or records maintained by the Income Tax Bureau.
- Records indicating the name of welfare applicants or their financial situation.
- Confidential financial investigation records.
- Inspection records of certain banks by the department of banks and banking.
- Bidding, bonding, or pre-qualification information on state projects before bid opening.

The following items were considered public records (An Act Clarifying The Meaning Of "Public Records" In So Far As It Relates To Certain Departments And Public Authorities, 1968):

- Proposals and bids for contracts or agreements.
- Executed contracts, agreements, and their amendments.
- Documents showing compliance with competitive bidding requirements after contract award.
- Books, papers, documents, correspondences, and records related to meeting minutes.
- Audits performed by independent certified public accountants.
- Records related to financial transactions.

Development of an Electronic Records System (late 1960s)

Evidence of electronic health record systems can be found as early as the 1960s and 1970s. In 1968, Massachusetts General Hospital, in collaboration with Harvard, developed the Computer Stored Ambulatory Record which improved hospital efficiency by separating parts like accounting from clinical information and recognizing multiple terms for the same disease across different institutions. Later in the 1970s, the federal government implemented an electronic health record system called VistA, originally known as Decentralized Hospital Computer Program, with the Department of Veteran Affairs. The system was praised for reducing medical errors and improving health-record integration (Atherton, 2011).

This local and federal trend of electronic medical records eventually was adopted by the Department of Mental Health. In annual reports from 1967 and 1968, John T. Maltsberger,

M.D., Director of Inpatient Services at Massachusetts Mental Health Center (formerly Boston State Hospital/Psychopathic Department), reported the following:

> *"A significant new development in planning has been the preparation for recording the patient charts on an electronic computer. Dr. Lester Grinspoon has been working with the nursing department and various residents in this connection. Mental status examinations and the daily nurses notes will be the first items to be recorded electronically, and this new program should be put to work sometime next year."* (Massachusetts Mental Health Center, 1968, p. 6)

Restructuring of the Department of Mental Health and Overhaul of the Laws Related to "Mentally Ill" and "Mentally Retarded" Persons (1970)

Chapter 888 of the Acts of 1970 replaced the language contained in Chapter 123 of Massachusetts General Laws. The new provisions introduced by the Act revised and updated the laws relative to the admission, treatment, and discharge of "mentally ill" and "mentally retarded" persons. Some of the new provisions included: mandatory periodic clinical reviews to inform adjustments in treatment and support; patient rights, choice, and protection (e.g., refusal of certain treatments like shock therapy or being photographed); voluntary admission and discharge; emergency restraint and hospitalizations by community physicians and police; community clinical nursery schools for cities or towns with a count of six or more "mentally retarded" children; a licensing system for private, county, and municipal facilities providing treatment for both populations, and; the handling of estates and personal property upon the discharge or death of a patient (An Act Revising The Laws Relative To The Admission, Treatment And Discharge Of Mentally Ill And Mentally Retarded Persons, 1970).

As part of the Department of Mental Health's major reorganization efforts, the law introduced newly established divisions in the following areas: drug rehabilitation, special education, curriculum and instruction, occupational education, and administration and personnel. Each of these divisions was to be headed by an associate commissioner, while other divisions within the department were to be headed by assistant commissioners. The restructuring aimed to streamline and enhance the Department's ability to address various specialized areas within mental health, "mental retardation", and education (An Act Revising The Laws Relative To The Admission, Treatment And Discharge Of Mentally Ill And Mentally Retarded Persons, 1970).

<u>Recordkeeping, Confidentiality, and Conditional Releases of Hospital Records (1970s)</u>

Per Section 36 of the revised Chapter 123 of Massachusetts General Law, the Department of Mental Health was required to keep detailed records of the admission, treatment, and periodic reviews of all persons admitted to facilities under its supervision. Such records were confidential and exempt from public inspection, unless like in the past, a court order was issued or the patient requested that they or their attorney review their personal records (An Act Revising The Laws Relative To The Admission, Treatment And Discharge Of Mentally Ill And

Mentally Retarded Persons, 1970). An additional exception was established by Chapter 614 of the Acts of 1970, which amended Section 70 of Chapter 111 of the General Laws. This amendment authorized the Commissioner of the Department of Mental Health to release hospital records of patients in institutions (hospitals or clinics) under the Department's control, if the Commissioner determined that reviewing such records would be beneficial to the patient. Rules and regulations around these determinations were established by the Commissioner. Copies of records would be furnished for a fee (An Act Relative To The Release Of Hospital Records Of Patients In Institutions Under The Control Of The Department Of Mental Health, 1970).

Per Section 23 of the new version of Chapter 123 of Massachusetts General Law, superintendents were required to make written statements of their refusals of patient rights (legal and civil), including, but not limited to: visits, personal phone calls, and access to personal property and money. Such refusal statements were to be included in a person's treatment record. Section 21 reiterated a superintendent's and hospital physician's duty to review restraints every eight hours and to make a written record of the reasons for the continuation or ending of such restraints. Section 4 required initial and periodic reviews, regardless of whether they were conducted internally or externally via area and regional community mental health and "mental retardation" programs, to be incorporated into a patient's official record. Section 17 also required clinical opinions about a patient's incompetence to serve trial to be added to their record (An Act Revising The Laws Relative To The Admission, Treatment And Discharge Of Mentally Ill And Mentally Retarded Persons, 1970).

Chapter 893 of the Acts of 1973, which amended Section 34D of Chapter 221 of Massachusetts General Law, established the role of a mental health legal advisor committee. This created a pathway for impoverished patients to access free legal counsel through this group of lawyers. A Mental Health Legal Committee was formed by the state Supreme Court to maintain lists of available lawyers in each region of the state under the Department of Mental Health. Consequently, the Act granted these lawyers the right to examine all records pertaining to such patients or residents. This included records from the Department of Mental Health, the Department of Correction, any other government agency, or any institution operated by the Commonwealth or its political subdivisions (An Act Providing For Legal Assistance To The Indigent Mentally Ill, 1973).

In 1978, the Department of Mental Health released an updated policy around restraint and seclusion, which inevitably impacted related documentation and recordkeeping. Facilities had to use a department-approved form (Form A-32-77) to document the behavioral symptoms that led to the use of seclusion or restraint, including any less restrictive alternatives tried beforehand. This form was also used to record the type of restraint used, and the client's condition during relief periods and safety checks. Monthly reports, including active patients on restraint-and-seclusion lists and monthly totals of seclusion-and-mechanical-restraint-related incidents, needed to be submitted to the Department's Office of Quality Assurance. These measures aimed to improve the quality of care, ensure compliance with policies, and provide a

comprehensive information system for better decision-making around restraints and seclusions (Departmental Policy Regarding Seclusion/Restraint, 1978).

Public Records – Evaluations by the Accreditation Council on Facilities for the Mentally Retarded of the Joint Commission on Accreditation of Hospitals (1973)

Chapter 1068 of the Acts of 1973 amended Chapter 19 of the Massachusetts General Law and required every residential facility for the "mentally retarded" to be evaluated every five years by the Accreditation Council on Facilities for the Mentally Retarded of the Joint Commission on Accreditation of Hospitals starting in 1975. Evaluation findings would be shared with the commissioner and facility administrator in a report. Thereafter, the facility administrator had 60 days to prepare an action plan explaining how anything raised in the evaluation report would be addressed both financially and operationally. All documents produced from these processes were declared public records (An Act Requiring Evaluations Of State Residential Facilities For The Mentally Retarded, 1973).

Destruction of Hospital Records (1980s)

Chapter 495 of the Acts of 1981 replaced Section 70 of Chapter 111 of Massachusetts General Law. Besides reiterating the confidentiality and few exceptions regarding the release of medical records of patients receiving Department of Mental Health services, it also stated that any medical record may be destroyed 30 years after the discharge or final treatment of the patient to whom it relates, including records under the control of the Department of Mental Health and the Department of Public Health (An Act Further Regulating The Keeping Of Certain Medical Records, 1981).

There was some degree of resistance to the destruction of patient records, which was proposed in House Bill No. 4556 in 1981 and introduced by Mr. Flood of Canton, MA. The bill proposed that prior to the destruction of any medical records, hospitals and doctor offices had to notify the patient and give them an opportunity to obtain a copy of their medical record prior to destruction (An Act Permitting Patients To Obtain A Copy Of Their Medical Records Before They Are Destroyed By A Hospital, 1981). It is unclear if this ever passed.

Major Split within the Department of Mental Health (1986)

Chapter 599 of the Acts of 1986, which amended Chapter 19 of the Massachusetts General Law, reorganized the management of mental health and developmental disability services in the state by transferring the responsibility of the latter from the Department of Mental Health to the newly established and separate Department of Mental Retardation, which was created by Chapter 19B of the Massachusetts General Law (An Act To Reorganize The Management Of Mental Health And Mental Retardation Services In The Commonwealth, 1986; Massachusetts State Archives, 2020).

Department of Mental Health (1986-Present Day)

Chapter 19 of the Acts of 1986 re-established the Department of Mental Health, detailing its structure, responsibilities, and operational guidelines. The Department, led by a commissioner appointed by the Secretary of Human Services with the Governor's approval, oversaw all matters related to the mental health conditions of the state's citizens. (An Act To Reorganize The Management Of Mental Health And Mental Retardation Services In The Commonwealth, 1986).

Same Provisions on Institutional Records (1986)

Section 36 of Chapter 19 of the Acts of 1986 reiterated the roles and responsibilities of the Department of Mental Health with respect to the recordkeeping of admissions, treatment, and periodic reviews of all persons admitted to facilities under its supervision (An Act To Reorganize The Management Of Mental Health And Mental Retardation Services In The Commonwealth, 1986). These provisions were essentially the same as the previous version of the law (Section 36 of Chapter 888 of the Acts of 1970).

Hospital Records - Bridgewater State Hospital (1986 - 1989)

In 1986, the Department of Correction, in its annual report, declared its responsibility for the security and operations of Massachusetts Correctional Institution (MCI) Bridgewater. Unlike the other state correctional institutions, MCI Bridgewater consisted of the State Hospital, the only maximum-security mental health hospital in the Commonwealth, a Treatment Center for the "sexually dangerous", and an Addiction Center. The report highlighted that treatment and evaluative services at the first two facilities were provided by the Department of Mental Health, while security was provided through the Department of Corrections (Massachusetts Department of Correction, 1987).

Given this interagency relationship, the Department of Correction pushed (House Bill No. 80 of 1989) to include Bridgewater State Hospital in the most recently updated regulations concerning the handling of medical records from the Department of Mental Health (Section 70 of Chapter 111 and Section 36 of Chapter 123 of Massachusetts General Laws). Specifically, the bill called for the Department of Correction to keep all records of state hospital admissions, treatment, and clinical reviews, as well as authorize the medical director or superintendent to make determinations around the disclosure of a patient's records (An Act Pertaining To Bridgewater State Hospital Records, 1989). It is unclear if this ever passed.

Data Systems, Record, Security and Confidentiality (2001)

In 2001, the Department of Mental Health released its 2002-2004 State Mental Health Plan, which included a three-phase implementation plan for a new Mental Health Information System (Department of Mental Health, 2001). The plan consisted of integrating new and existing management information systems, such as the Client Registry and Client Tracking System. The first phase focused on billing and business systems, while the second and third

phases respectively focused on community-care management and inpatient electronic medical records. This new system, scheduled to be completed by 2003, aimed to improve client care by answering key questions about overall services, service recipients, costs, and outcomes. The purpose was also to enhance the quality of data collection, streamline related recordkeeping processes, and maintain and comply with strict client confidentiality standards outlined in the Department's 1998 "Security and Confidentiality Policy for DMH Computerized Information Systems Containing Client Records or Data". To promote the new system across the state agency, DMH even adopted the following slogan, "Improved Information Enhanced Care" (Department of Mental Health, 2001, p. 127).

Medical Record Retention Requirements (2005 and 2007)

Senate Bill No. 1292 of 2005 and Senate Bill No. 2179 of 2007 aimed to amend Section 70 of Chapter 111 of Massachusetts General Law. Both bills suggested adding electronic digital media as one of the various formats medical records could be created and stored. Additionally, these bills wanted to significantly reduce the retention period that hospitals or clinics within the jurisdiction of the Department of Mental Health had to keep medical records prior to destroying them. The first bill proposed a reduction by half from 30 to 15 years, while the second reduced it further to 10 years. Regardless, both bills required such hospitals and clinics to notify the Department and inform patients about the scheduled destruction prior to doing so (An Act Regarding Medical Record Retention Requirements, 2005; An Act Relative To Hospital And Clinic Medical Record Retention, 2007).

Residential Treatment Units - Department of Mental Health and Department of Corrections (2007)

House Bill No. 1313 of 2007 proposed to make additions and amendments to Chapter 127 of Massachusetts General Law. Specifically, it emphasized the collaboration between the Department of Mental Health and the Department of Corrections, which resulted in the establishment of mental health treatment programs within correctional facilities (referred to as Residential Treatment Units). These treatment and rehabilitative housing units were operated and supervised by the Department of Mental Health and were intended to provide prisoners diagnosed with "mental illness", "mental retardation", traumatic brain injury, among other medical conditions with a therapeutic alternative to confinement in a segregated unit (An Act Relative To Confinement Conditions And Treatment Of Prisoners With Mental Illness, 2007).

Department of Mental Retardation (1986)

Per Chapter 19B of the Massachusetts General Law, the Department of Mental Retardation became the official state agency that oversaw the welfare of "mentally retarded" citizens, including the management of state schools and facilities, supervision of private facilities, and development of additional services. (An Act To Reorganize The Management Of Mental Health And Mental Retardation Services In The Commonwealth, 1986).

Same Provisions on Records and Transfer of Records (1986)

Section 17 of Chapter 19B of the Acts of 1986 mirrored the provisions outlined under Section 36 of Chapter 19 of the Acts of 1986 for the Department of Mental Health. However, Section 58 of Chapter 123B of the Acts of 1986 addressed the transferring of property, including all books, papers, records, documents, equipment, land, interests in land, buildings, facilities, and other property related to services for "mentally retarded" persons from the Department of Mental Health to the Department of Mental Retardation. This transfer was to be carried out according to the schedule contained in the transition plan required by Section 54 of the Act. The Commissioner of the Department of Mental Health had to develop and submit the transition plan to a special commission by March of 1987. The goal of this plan was to ensure a smooth transition and continuity of services for "mentally retarded" persons (An Act To Reorganize The Management Of Mental Health And Mental Retardation Services In The Commonwealth, 1986).

Electronic Client Database (1990s)

In its 1990 Transition Briefing Book, the Department of Mental Retardation highlighted that it was in the process of implementing an integrated client database, which would track basic demographic, program, and billing information about all service recipients (roughly 21,000 at this time). The implementation required capital investments in technology and equipment, the standardization of data related to intake and programs, and a workforce training plan. The database would greatly help the Department track services and billing for each service recipient and generate and conduct system-, regional-, and individual-level statistical analyses (Department of Mental Retardation, 1990). Evidence of a consumer registry electronic database, or a management information system, as part of a Total Quality Management initiative was found in the Department's annual reports for fiscal years 1992 and 1993 (Department of Mental Retardation, 1993, 1994). This enabled offices across the state to communicate, share information, compare data, and quickly access information about the Department of Mental Retardation's service population.

Poor Record-Sharing Practices (1992)

In an investigative report made by the Disabled Persons Protection Commission in 1992, it was written that the Department of Mental Retardation had a reputation of withholding information in the form of records or editing original record, used in investigations carried out by the Commission. Consequently, the Commission recommended that all documents related to any investigation conducted under Chapter 19C of Massachusetts General Law should be sent directly to the Commission by qualified investigators, as well as to the Department of Mental Retardation's Central Office for recordkeeping purposes. This would help prevent the potential loss, interception, and or manipulation of original information used in such investigations (Disabled Persons Protection Commission, 1992).

Exemptions to Public Records Law (1992)

In "A Review of the Provisions of the Massachusetts Public Records Law" by the Office of the Massachusetts Secretary of State, Michael Joseph Connolly, Secretary, and James W. Higgins, Supervisor of Public Records, declared that medical and mental health facility records (G.L.c.111, § 70E) and intermediate care facility[38] inspection records for “mentally retarded” citizens (G.L.c.111, § 72) were listed as exempt from disclosure under the public records law to protect the confidentiality of patients' medical and mental health information. These exemptions safeguarded the privacy of personal and sensitive information about the care and treatment that people with “mental illness” or “mental retardation” received at any of these types of facilities (Office of the Massachusetts Secretary of State, 1992).

Records Conservation Board (RCB) – New Statewide Disposal Schedule for Records (1993)

In 1993, the Records Conservation Board outlined the new management practices that state agencies had to start following (Disposal Schedule DS92/92). Board approval was required for agency-specific disposal schedules[39] and overall disposal requests. These rules applied to electronic records, which were treated like public records, and included printing or sharing of computer files. Records involved in pending litigation or public records requests were exempt from disposal until resolved (Office of the Secretary of State et al., 1993).

Patient’s Bill of Rights - Departments of Mental Health and Mental Retardation (1998)

In 1998, a special report by the Attorney General of Massachusetts, Scott Harshbarger, stressed the importance of the "Patient's Bill of Rights" (G.Lc. 111, §70E), which was enacted in 1977. It specifically highlighted how the bill continued to play a critical role in doctor-patient and medical record confidentiality and how it needed to be taken into consideration given the advancements in medical information technologies, including electronic medical records (Attorney General, Commonwealth of Massachusetts, 1998).

Through this bill, patients served in facilities licensed or subject to licensing by the Department of Mental Health and the Department of Mental Retardation were generally allowed to inspect and obtain copies of their own records for a reasonable fee[40]. The bill also ensured confidentiality of patient medical records and protection from unauthorized disclosure and allowed patients to refuse to participate as research subjects or examinations intended solely for educational purposes. The combination of these rights afforded these patients greater autonomy, personal choice, transparency, and legal remedies in the event of a violation.

[38] The Intermediate Care Facility model was introduced in 1971 federally as an optional Medicaid service under state plan Medicaid services. This model authorized federal matching funds for institutional services and introduced long-term services and supports specifically for people with intellectual and developmental disabilities.
[39] These schedules were essentially management plans for recorded information kept by state agencies.
[40] Pursuant to G.L c. 111, § 70., fees were waived if being requested to apply for income-based public benefits (Report Of The Joint Special Committee Regarding Lunatic Hospitals And Lunatic Paupers, 1848).

Nonetheless, the following were some exceptions to the confidentiality of medical information, which mainly related to the state's mandatory reporting requirements (Attorney General, Commonwealth of Massachusetts, 1998):

- Direct disclosure of medical records between mental health practitioners was legally allowed if disclosure to the patient was not perceived to be in the patient's best interest.
- Similarly, the Commissioner of the Department of Mental Health was authorized to permit inspection and/or disclosure of medical records of any of its facilities if they determined it to be in the best interest of the patient or resident (G.L. c. 123 § 36A, 104 C.M.R. 2.07).
- Certain scenarios applicable to mental health and mental retardation where medical care providers were required to disclose specific types of medical information to public health authorities and sometimes law enforcement included suspected abuse of a disabled person (G.L.c. 19A § 30, § 31.); deaths (G.L.c. 46 § 9; G.Lc. 111 § 24B.), cerebral palsy (G.L.c. 111 § 111A.); and abuse or neglect of nursing home residents (G.L c. 111 § 111C).

Lastly, the Attorney General made some recommendations on protecting electronic medical records, which included, but was not limited to implementing strong and clear training and disciplinary policies, identifying and maintaining secure computer locations, using and activating automatic log-off features, ensuring the issuance of unique identifier passwords for authorized users, conducting regular audits, installing layered access programs, maintaining highly sensitive information at restricted access levels, and adopting secure fax and phone use policies (Attorney General, Commonwealth of Massachusetts, 1998).

Investigation Records and Incident Reporting (1998)

In 1998, the Investigations Advisory Panel Report of the Department of Mental Retardation outlined the state regulations on investigations and reporting responsibilities (115 CMR 9.00), which were to be followed by the Department's Investigations Unit (Department of Mental Retardation, 1998). Per *Conduct of Investigation*, Section 9.08 of the regulations, investigators had the right to access and inspect a variety of documents and records related to any complaint or allegation under review. This included, but was not limited to medical, clinical, personnel, and provider records, as well as restraint forms and incident reports.

Records, Forms and Notices, Section 9.13 of the regulations, also required a case file to be created for every complaint received by the Department. The contents of these case files were to contain the written complaint and log number, a disposition letter, a memorandum appointing the investigator, a list of interviewee names along with interview summaries, summaries of documentation reviews, the official investigation report, a decision letter, an action plan (corrective or protective), among others.

Section 9.13 also discussed access to and confidentiality of certain investigative materials, which were governed by the Fair Information Practices Act, M.G.L. c. 66A, § 2(i). In general, any person explicitly mentioned in an investigative case file had the right to access and obtain a copy of that specific section of the record. However, if the Commissioner of the Department believed that releasing information would jeopardize the investigation or someone's privacy, then they could decide to keep certain documents completely private. Justifications for this type of course of action by the Commissioner had to be added to investigative case files.

Lastly, Section 9.13 required non-identifiable complaint and medicolegal death logs to be maintained by Department regional senior investigators. These logs were classified as public records and were therefore available for public inspection and copying in accordance with M.G.L. c. 66, § 1. Under Section 9.16, *Incident Reporting*, after reviewing an incident report, service coordinators were responsible for preparing written recommendations ranging anywhere from the implementation of program-level preventive measures to modifications of individual service plans and behavioral management plans. A copy of such incident-related recommendations would become a part of a service recipient's formal record (Department of Mental Retardation, 1998).

Medical Records and Forms (2004)

The 2004 version of the *Health Promotion and Coordination Initiative: Training and Resource Manual* by the Department of Mental Retardation contained guidelines and standards to ensure quality health care services and support for service recipients (Department of Mental Retardation, 2003). A significant portion of the manual focused on different types of health records and incorporating health care issues into a person's individual service plan (ISP).

The Health Record (HC-5) was designed to provide health care providers and program staff with a comprehensive, yet concise snapshot of an individual's medical history into a single document. The three-page Health Record consisted of a "Portable Record" that contained essential information for routine, episodic, specialty, or emergency medical visits, and a "Complete Record"[41] that provided a more detailed health history. Established protocol required the Health Record to be reviewed and updated annually or whenever an individual experienced any significant changes in their health status, and it was to be incorporated in the annual ISP process. As of 2025, this Health Record exists in the Department's Home and Community Services Information System (HCSIS), where the information may be populated by service provider agency staff or a DDS Service Coordinator. It is only required for use for a subset of service recipients (e.g. those receiving residential services).

Other forms that were part of an overall medical record and used to facilitate communication between health care providers and provider staff or to document important health care

[41] The "Complete Record" replaced the Department's formerly approved Personal Health Fact Sheet.

information and follow-up treatment included the following (Department of Mental Retardation, 2003):

- Preventive Health Screening Checklist (HC-1): A summary checklist that provider staff must have completed prior to the annual physical to ensure consistent and appropriate preventive health care screenings are conducted. (required)
- Health Review Checklist (HC-2): A form used by direct support professionals to record changes in an individual's health status required for annual physical exams and episodic visits to primary health care providers. (required)
- Health Care Practitioner Encounter Form (HC-3): A form to facilitate communication during medical appointments, including information about the reason for the visit and treatment recommendations. (recommended for all types of medical visits)
- Medication Administration Record: A list containing a person's current medications, including the medical prescriber. (recommended attachment to the Encounter Form)
- Annual Physical Examination Form (HC-4): Recommended for use by the health care practitioner during the annual physical examination. (recommended for all types of medical visits)
- Chronological Medical Event Record: A list highlighting all major health events that a person has experienced. (recommended attachment to the Health Record)

Department of Developmental Services (2008 – Present Day)

House Bill 4610 of 2008 proposed to amend Section 1 of Chapter 19B of Massachusetts General Law by changing the title of the Department of Mental Retardation to the Department of Developmental Disability Services. This change was scheduled to go into effect by June 30, 2009 (An Act To Change The Title Of The Department Of Mental Retardation, 2008).

Types of Records Created by Different State Institutions in Massachusetts

In Massachusetts, records related to institutions are managed by the Secretary of State through the Massachusetts State Archives.

The Public Document Series

The Public Document Series is a collection of both historic and contemporary government publications, which can be accessed for free from the State Library of Massachusetts Digital Collections. Specifically, this library contains an extensive number of annual reports, administrative bulletins, legislation and bills, among other publications from both state institutions and governing bodies dating back to colonial times.

One law that heavily influenced the Public Document Series was Chapter 40 of the Acts of 1857. This Act not only mandated public institutions, public officers, and governing boards to submit

annual reports to the Secretary of State, but it also required the Secretary to print and distribute copies of said reports to the General Court, State Library, and other governmental entities (An Act In Relation To Public Reports And Documents, 1857).

Regulations regarding submission timelines, penalties for non-compliance, and printing and distribution processes were outlined in various statutes over the years, as listed below:

- Chapter 4 of the General Statutes of the Commonwealth (1860)
- Public Statutes of the Commonwealth (1882), and later Chapter 9 in the Revised Laws of the Commonwealth (1901)
- Chapter 5 of the General Laws of the Commonwealth (1920)
- Tercentenary Edition of the General Laws of the Commonwealth (1932)

The Act of 1857 also required the Secretary of State to compile and publish a bound volume of annual public reports, distributing them to every city and town in Massachusetts, often for local library use. This broad distribution likely enhanced the legitimacy of agencies included in the Public Document Series. In 1870, George Derby, Secretary of the State Board of Health, suggested that the legislature require State Board reports to be submitted to the Governor and printed for the January legislative session, proposing that they be included in the Public Document Series to increase their visibility and impact.

The Public Document Series is a valuable historical resource, including significant reports from Vital Statistics (No.1) and Health, Lunacy and Charity/Public Welfare (No. 17), as well as annual reports from former state hospitals and asylums, such as Danvers, Taunton, Medfield and Fernald. These documents offer insights into the administration and history of these institutions. Although these documents should not include patient lists, there was one document we came across during our research that did contain the names of both state paupers and state lunatic paupers (Report Of The Joint Special Committee Regarding Lunatic Hospitals And Lunatic Paupers, 1848).

Records at the State Almshouses at Tewksbury, Bridgewater, and Monson

In 1854, Massachusetts created three state almshouses in Tewksbury, Bridgewater, and Monson to help the poor, sick, and disabled, shifting care responsibility from towns and cities to the State. In the first 10 years after opening, each Almshouse began to focus on different groups. Bridgewater became the State Workhouse for criminal offenders, Monson started to take in poor children, and Tewksbury served as a hospital and almshouse for the general poor, also accepting more people with chronic, nonviolent “mental illnesses.”

The three State Almshouses maintained the following information:

- *Admission and discharge registers*: These records include the name, age, place of birth, date of admission, and date of discharge of each person who entered the Almshouse.
- *Lists of inmates*: These records include lists of the inmates in the Almshouse.

- *Lists of deaths*: These records include lists of deaths that occurred in the Almshouse.
- *Accounts*: These records include accounts of money received by the Almshouse.
- *Indentures*[42]: These records include indentures related to the Almshouse.
- *Miscellaneous papers*: These records include miscellaneous papers related to the administration of the Almshouse.

The Board of Charities annual report from 1876 stated that the hospital at the Tewksbury Almshouse was required to, in addition to the above, document in the hospital's records the previous treatment of a patient, and in the case of death, the cause and circumstances of death (Massachusetts Board of State Charities, 1877).

Records at the Massachusetts State Hospitals, including State "Insane" Asylums and State "Lunatic" Hospitals

Massachusetts state hospitals kept records that included patient demographic information, such as marital status, birthplace, diagnosis, the number of previous commitments, and how the patient was committed. Patients were also assigned a registration number. These records were organized in various ways, most often by patient registration number.

Annual reports from Massachusetts state hospitals included information on a variety of topics, including:

- Operations and expenditures;
- Patient admissions, transfers, and releases;
- Religious /chaplain services; and
- Mental health care conditions[43].

Records at the State Schools for the Intellectually and Developmentally Disabled

Early state school case files included demographic information and information about the pupil's physical and mental health condition, their parentage or birthplace with their family history and the results of psychological and intelligence tests. The record often included correspondence with parents, guardians, and other caretakers. Some records included discharge papers and death certificates.

The Forty-Eighth Annual Report of The Trustees of The Massachusetts School for the Feeble-Minded (1895) provides the following example of the Superintendent's duty to document information about the pupils who resided at the school:

[42] "Indentures" meaning legal agreements, contracts, or documents.

[43] For example, the annual reports from Northampton State Hospital often included commentary from Superintendent Dr. Pliny Earle on the conditions of mental health care provision in the state (State Lunatic Hospital Northampton, 1872)

> *"He shall make a record of the name, age and condition, parentage and probable cause of deficiency of each pupil, and of all the circumstances that may illustrate his or her condition or character; and also keep a record, from time to time, of the progress of each one."* (Massachusetts School for the Feeble-Minded at Waltham, 1896, p. 41)

Over time, the documentation increased to include a photograph of the resident, results of psychological assessments, analysis of physical examinations and routine reports by doctors of the resident's condition and progress.

In 1941, a Work Projects Administration (WPA) project[44] was initiated at Fernald State School. The project entailed extensive sorting and weeding of the school's extensive accumulation of correspondence. Correspondence pertaining to individual students was removed and placed in their files (Walter E. Fernald State School, 1941).

Annual reports from Massachusetts state schools included information on a variety of topics, including:

- Operations and expenditures
- Admissions, transfers, and releases
- General health of the population, and
- Reports for the school and the workshops.

It was not until the establishment of Title XIX of the Social Security Act in 1975 that people with disabilities were to receive individualized, needs-based care plans that consider their unique abilities and limitations (Social Security Act, Title XIX, 1975). The Rehabilitation Act of 1973 further expanded support for individuals with disabilities by requiring access to vocational rehabilitation services, including individualized plans to address their specific needs and employment goals (Vocational Rehabilitation and Other Rehabilitation Services, 1982). In 1975, the Education for All Handicapped Children Act (now known as the Individuals with Disabilities Education Act [IDEA]) guaranteed that all children with disabilities receive a Free Appropriate Public Education (FAPE) through an Individualized Education Program (IEP), which is tailored to their specific needs (Individuals with Disabilities Education Act, 1990).

Key aspects of care planning under these laws include:

- *Individualized assessment*: A comprehensive evaluation of the individual's needs, abilities, and limitations to develop a personalized care plan.
- *Collaboration among professionals*: Coordination between healthcare providers, educators, and social workers to ensure a comprehensive approach to care.
- *Least restrictive environment*: Providing services in the most integrated setting suitable for the individual's needs.

[44] The Works Progress Administration was an employment and infrastructure program created by President Franklin Roosevelt in 1935, during the Great Depression. Over its eight years of existence, the WPA put roughly 8.5 million Americans to work building schools, hospitals, roads and other public works.

- *Informed consent*: Obtaining approval from the individual or their legal representative regarding decisions in the care plan.
- *Ongoing reassessment*: Regular reviews of the individual's needs and necessary adjustments to the care plan.

Examples of the Type of Information Found in Institutional Patient Records

Boston State Hospital

The Boston State Hospital annual report of 1920 provides a summary from the Head of the Social Services Department, which outlines the functions of the Social Services Department and describes the components of inpatient records (Boston State Hospital, 1920).

Cases were assigned to Social Workers on a rotating basis to ensure equal distribution of workload. Social Workers were responsible for collecting and compiling background information about the patient, which included contacting the referral source. Social Workers collected the patient's history through an interview with the patient, as well as interviews with agencies, relatives, friends, neighbors, and employers. The Social Worker was also responsible for registering the patient with the Confidential Exchange of Information and Social Service[45]. The Social Worker would also consult with doctors as needed for case-specific issues. Once the background information on the patient was compiled, the Social Worker would present the summary of the case at the weekly standing morning meeting. Further discussions occurred after three months to evaluate progress and plan future actions. A summary of outside history was provided to doctors within 24 hours of admission (Boston State Hospital, 1920).

Social Worker was responsible for assigning each case a folder, and that the record was secured. Patient records were maintained chronologically, including all patient history and actions taken (Boston State Hospital, 1920). Social Workers compiled monthly statistics for each patient, contributing to departmental totals.

Wrentham Developmental Center

In the 1934 annual report from the Wrentham State School, the Social Work Department described the key role the Social Workers had in analyzing new admission histories, identifying gaps or contradictions in the data, and collecting further information from community informants. This comprehensive approach would benefit medical staff, assist in training and placement, and support research efforts (Wrentham State School, 1934).

[45] The Confidential Exchange of Information and Social Services or "The Exchange" was a centralized bureau in Boston where people seeking any type of social service would be registered in order to secure an exchange of information across social service and charitable agencies.

Taunton State Hospital

In the book, *A Brief History of the Taunton Lunatic Hospital 1854-2016*, the author, Joseph Langlois, talks about how medical records at this hospital changed from the 1870s to the 2000s. The author was a previous employee at Taunton State Hospital for over 40 years. In his book, the author provides an analysis of how the records were set up, their quality, and what information was included over time. The author chose small samples of patient records from each decade to show how the records and patient care changed. It is important to remember that this information is not a complete picture and doesn't represent all records from that time. However, it gives useful details about events and assessment methods that are hard to find elsewhere (Langlois, 2020).

Key points from chapter six of this book include (Langlois, 2020):

- *Destruction of Early Records*: The oldest records are lost (approximately 1854-1869), but over 22,000 records from the 1870s to 1960s were maintained on site at Taunton State Hospital.
- *1870s - 1890s*: Records were brief and lacked detail. For example, a schoolteacher with "hysterical insanity" had only two pages of notes over 14 years, offering little insight into her condition or treatment.
- *1900s - 1910s*: Documentation began to include personal and medical histories, but ongoing assessments remained sparse. Seclusion[46] was noted, but its rationale for use was often missing.
- *1920s - 1971*: Documentation quality improved, especially in psychiatric evaluations, yet many records still lacked detail on treatment effectiveness. Notable advancements included better-recorded psychiatric histories.
- *1950s*: Introduction of Thorazine[47], electroconvulsive therapy (ECT)[48], and psychosocial occupational therapy[49] did not lead to significant improvements in record quality. Progress notes were often brief and unsigned, lacking details on treatment efficacy.
- *1960s*: A wide variety of new therapeutic medication, such as anti-psychotic medications[50] were introduced, but records failed to document patient responses or

[46] Seclusion is the practice of confining a patient to a room or area alone, away from other patients, and preventing them from leaving. It's used as a response when a patient's behavior is likely to cause harm to others.
[47] Thorazine is used chiefly as a tranquilizer to control the symptoms of psychotic disorders such as schizophrenia. It can be prescribed in a daily dose but may also be used "as needed" to tranquilize people via an injection.
[48] Electroconvulsive Therapy (ECT) was widely used in the United States in the 1940s and 1950s. It was the main biological treatment for psychiatric disorders during that time.
[49] Psychosocial occupational therapy is a type of therapy that helps people with mental health conditions or psychosocial stressors to develop coping skills and strategies and maintain or resume important roles in their lives.
[50] Antipsychotic drugs, also known as neuroleptics or major tranquilizers, are a class of medications used to treat a range of psychiatric disorders.

treatment plans adequately. Improved documentation emerged with the addition of sheltered workshops[51] staffed by trained counselors (McLean Hospital, n.d.).

- *1970s - 2000s*: The Hospital faced accreditation issues due to poor recordkeeping. Over time, records became more comprehensive, with departments responsible for their documentation. By the late 1990s, the introduction of electronic records significantly improved data accessibility and organization, though the quality remained dependent on staff training and skills.

Overall, the book illustrates a gradual improvement in the thoroughness and quality of medical records, reflecting broader changes in psychiatric treatment and care.

In addition to the findings from this book and through key informant interviews, CDDER learned that DMH inpatient admission cards from decades prior to the electronic system are maintained in alphabetical order by patient name and year of admission. These records include information about when the person died if that occurred and what was known to the agency. Currently, there is no precise details available about the periods of admission cards and records retained by DMH from these historic periods. At least some of the records from both Taunton and Foxborough State Hospitals are held securely at Taunton State Hospital, while some Foxborough records are in the Massachusetts State Archives (Taunton State Hospital Records Department Staff, personal communication, 2024).

Belchertown State School

As part of the system of traveling clinics developed in the 1920s by the Department of Mental Diseases, staff at the 14 institutions under its supervision had outpatient clinics in community locations to identify “mentally retarded” children, making recommendations for their care, and gathering statistical data for a central registry of the feeble-minded, as mandated by St 1919, c 318. Clinic staff examined children who were at least two years behind in their schoolwork. Massachusetts was one of the few states to actively reach out to schools to identify “mentally retarded” children. Both the Department of Education and the Department of Mental Diseases shared responsibility for this task. The State employed special traveling clinics to examine children who were at least two years behind in their schoolwork.

Admission to schools for the feeble-minded could be either voluntary or court ordered. Voluntary admissions were based on a physician’s certificate, with cases ranging from indefinite residence to temporary observation. Court-ordered admissions required both an application and a physician’s certificate.

As an example of an individual record, CDDER was provided with a copy of a record of a young girl who had been committed to Belchertown State School at the age of 10, from 1951 to 1953.

[51] Sheltered workshops are organizations that employ people with disabilities, often in low-wage jobs that repeat the same task.

Her primary school had requested an evaluation by the traveling clinic, as she was behind in her studies.

The record included assessments conducted by the Department of Mental Diseases' School Clinic, which were completed prior to her admission. A Social Worker gathered information from her family and her community school. These assessments included details about her family, developmental history, and behavioral background, categorized respectively as "Social History and Reaction" and "Moral Reactions". Along with test results and school performance, these assessments were summarized in an "abstract"[52]. The girl's mother submitted an application form, which included a certificate from the primary school physician.

Once admitted to Belchertown State School, the record contained the following:

- Basic demographic information, emergency contacts, an inventory of personal possessions at admission, her Patient Ward Card, fingerprint card, and a photograph.
- Medical records, including monthly weight measurements, lab results, annual physical exams, acute medical examinations, consultative notes, dental exams, chest x-rays, and labs.
- Documentation of significant events, accidents, or safety concerns within the program, including escape reports, incident investigations, and physician evaluations.
- School progress reports and test results.
- Running notes, periodically updated from admission to discharge, documenting treatment for illnesses, significant incidents—including one escape attempt, and punishments for misconduct (including seclusion and the removal of privileges).

The record also included correspondence between the girl's mother and the school administration regarding requests for weekend and vacation furloughs. These requests were denied by the Superintendent, following a home investigation conducted by a Belchertown State School Social Worker. The investigation found that the home environment was unsuitable for the girl to visit. This led to heated correspondence between the family and the school administration, including the girl's eldest brother and father contacting the Governor's office to advocate for her furlough. The father and mother ultimately met with the Board of Trustees of Belchertown State School, who firmly upheld their decision to deny the girl's visits home. Correspondence between the administration and the assistant commissioner reflected the family's concerns, but the Trustees maintained their stance that the home was not an appropriate environment for the girl.

While at Belchertown State School, the girl contracted polio, resulting in paralysis of her left leg. She was sent to Mercy Hospital in Springfield, MA for treatment and rehabilitation. Upon her

[52] An abstract is a brief summary of a paper's contents that gives the reader a concise understanding of the research and findings.

discharge from Mercy Hospital, she was sent home to her parents, who never returned her to Belchertown State School.

Current Requirements for Components of Records – DMH and DDS Regulations

DMH and DDS regulations outline the requirements for patient records at both state-run facilities and community based provider agencies [See: (DDS 115 CMR 4.00, 2009) Records (last updated 2009) and (DMH 104 CMR 27.00, 2021)]. These regulations aim to ensure comprehensive, accessible, and accountable recordkeeping for individuals receiving services from these two agencies.

According to these regulations, a patient record must contain identification details, admission information, including diagnosis, medical and psychiatric histories, evaluation results, laboratory reports, service and treatment plans, clinical notes, progress notes, incident reports, and a discharge summary. Entries into the records must be in clear English, legible, dated, accurate, complete, and timely.

Records must also log disclosures of private health information as mandated by HIPAA and include consent forms, guardianship details, and prior records from other facilities. Records can be handwritten, printed, typed, or electronic, with regulations allowing for the destruction of handwritten records after electronic conversion. Electronic records must be securely backed up.

Public Records

Massachusetts Public Records Law

Massachusetts has had laws requiring the disclosure of public records since 1851. The Federal Freedom of Information Act was signed in 1966 by President Lyndon B. Johnson and was amended in 1974 to increase public access to government records. The Massachusetts Public Records Law is similar to the federal law but has some differences. The Massachusetts Public Records Law gives everyone the right to access public information. This includes the ability to inspect, copy, or receive copies of records for a reasonable fee. Public records are defined broadly and include all types of materials, such as books, papers, maps, photographs, recorded tapes, financial statements, statistical data, and other documents created or received by government officials.

In Massachusetts, all government records are presumed public unless there is a specific exemption that allows them to be withheld. Examples of exempt records include (Galvin, 2022):

- Materials pertaining to on-going investigations or prosecutions (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(f), n.d.)
- Personal identifying information (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(c), n.d.)

- Grand jury minutes and related materials (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(a), n.d.; Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(f), n.d.) ; (Massachusetts Rules of Criminal Procedure, Rule 5 (d), 2022)
- Autopsy reports (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(a), n.d.; Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(c), n.d.); (Mass. Gen. Laws, Part I, Title VI, Ch. 38, § 2, n.d.))
- Attorney work product and materials protected by the attorney client privilege (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(d), n.d.)
- Materials pertaining to juvenile delinquency cases (Mass. Gen. Laws, Part I, Title XVII, Ch. 119, § 60A, n.d.)
- Criminal Offender Record Information ("CORI") (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(a), n.d.); (Mass. Gen. Laws, Part I, Title II, Ch. 6, § 167A, n.d.; Mass. Gen. Laws, Part I, Title II, Ch. 6, § 172, n.d.)
- Reports of rape, sexual assault, or domestic violence (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(a), n.d.); (Mass. Gen. Laws, Part I, Title VII, Ch. 41, § 97D, n.d.) and personnel files (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(c), n.d.)

The Massachusetts Public Records law exemption related to institutional records (Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(c), n.d.) exempts personnel and medical files, as well as other materials relating to a specific individual, if their disclosure would be an unwarranted invasion of privacy.

Supervisor of Records

The Supervisor of Records is responsible for determining whether a government record is considered public under the Public Record Law. The Supervisor of Records is appointed by the Secretary of the Commonwealth and is authorized to issue regulations regarding public records access, including fees, appeals, and other matters.

The Massachusetts Supervisor of Records has several key responsibilities:

- *Preserving Records*: Ensures legal compliance in the custody and condition of public records.
- *Determining Public Status*: Evaluates the public status of government records.
- *Inspecting Records*: Has the authority to inspect records privately.
- *Ordering Relief*: Can issue orders for relief if violations are found.
- *Notifying the Attorney General*: Informs the Attorney General if an agency fails to comply with orders.
- *Issuing Written Decisions*: Must respond to petitions from records access officers within five business days.
- *Appeals*: Handles appeals for denied public records requests.

The Supervisor does not oversee records from the Legislature, federal agencies, or the state courts. The Supervisor of Records oversees the Records Management Unit (RMU) at the State

Archives to ensure that government records are properly stored and preserved. The Supervisor of Records and the Public Records Division staff provide training to public entities and associations of public employees on Public Records Law. The Supervisor of Records periodically releases bulletins with new regulatory or process guidance.

Record Access Officers

The Act to Improve Public Records, Chapter 121 of the Acts of 2016, made significant changes to the Public Records Law that took effect on January 1, 2017, which requires a state agency to establish guidelines to assist requestors in seeking public records.

This act created a position called the Records Access Officer (RAO). Each state agency identifies a RAO who is responsible for responding to requests for public records. The RAO's responsibilities include coordinating responses to records requests, helping individuals identify the records they need, assisting in the preservation of public records, and providing requested records as efficiently as possible.

A government agency or other entity can have multiple RAOs assigned to different divisions. When a request is made to one RAO that pertains to records from another division, the RAO must use their expertise to forward the request to the correct party. If the requested records are not held by the RAO's agency, they should identify the appropriate agency that may possess the records.

Both DDS and DMH identify their RAO and provide information about the process to request public records and medical records on their respective web pages at mass.gov.

- DDS: https://www.mass.gov/how-to/department-of-developmental-services-public-records
- DMH: https://www.mass.gov/forms/submit-a-department-of-mental-health-public-records-request

Process for Requesting Records from Massachusetts State Agencies

There are no strict rules for requesting public information. A requester can do it in person or in writing (by mail, fax, or email). The requester needs to describe the information they are looking for but does not have to explain why they want it nor do they have to provide any identification.

If the RAO can provide the records within 10 business days, they must provide a copy of the original record, as long as the request is clear, and the records are available to the agency.

If the agency cannot provide the records within 10 business days because of the request's size or difficulty, or if they are overwhelmed by multiple requests, they must send a written response within 10 business days. The response from the RAO can be given in person or by mail and must include:

- Confirmation that they received the request.
- Details about any records they don't have.
- Information about other agencies that might have the records.
- Reasons for any records they will not share, including the laws that allow them to withhold these records.
- Information about records they will share, including why it might take longer to fulfill the request.
- A timeframe for when they will provide the records up to 15 business days for agencies and 25 for municipalities—unless the requestor agrees to wait longer.
- Suggestions on how to change the request for easier processing.
- An estimate of any fees for obtaining the records.
- Information about the right to appeal the decision to the Supervisor of Records and to take legal action if necessary.

If the request is denied, the agency must explain why and cite the specific laws they are using to withhold the information. They must also inform the requestor about their right to appeal and seek court remedies.

The Public Records Law only requires agencies to disclose information they have at the time of the request. They do not have to create new records or respond to future requests, although they can choose to do so. Sharing parts of an existing record or data is not considered creating a new record since it already exists.

Recommendations for Resolving the Ambiguity Surrounding DMH and DDS Burial Records

The Harvard Law School Cyberlaw Clinic provided an analysis of the laws that govern access to burial records. The following are excerpts from a memo that the Clinic drafted, which contain a brief summary of their analysis and recommendations for the State Commission on Special Institutions (SCSI) to consider (The Harvard Law School Cyberlaw Clinic, personal communication, 2024a).

<u>Brief Summary:</u>

- *"The status of DMH and DPH burial records is uncertain under Massachusetts law. Even comparable records, such as death records, have not clearly been established as public records. Fortunately, there are a number of steps SCSI could take to resolve this ambiguity."* (The Harvard Law School Cyberlaw Clinic, personal communication, 2024a)

<u>Public Records Request for Burial Records:</u>

- *"SCSI or its partners could initiate formal public records requests for the burial records of the Department of Mental Health (DMH) and Department of Developmental Services (DDS). While these requests are likely to be denied, this would require state agencies to*

provide their reasoning in writing. Following a denial, SCSI could pursue two avenues for review:

1. *Review by the Supervisor of Records: A relatively low-cost process where SCSI can request the Supervisor of Records to review the denial. This process typically takes 10-20 business days.*
2. *Judicial Review: SCSI can challenge the denial in court, specifically in Suffolk Superior Court. If successful, this could establish a state-wide precedent for accessing burial records, but litigation is costly and time-consuming."* (The Harvard Law School Cyberlaw Clinic, personal communication, 2024a)

Advisory Opinions:

- *"SCSI could seek advisory opinions to expedite the resolution of the issue without going through the public records request process. Two potential options include:*

    1. *Supreme Judicial Court Opinion: This option could provide a quicker resolution but requires assistance from the Governor or legislature, as only they can request an advisory opinion from the court.*
    2. *Attorney General's Opinion: Although not binding, this is a more feasible option and may offer valuable guidance. However, it also requires the involvement of a legislator or the Governor's office to formally request it."* (The Harvard Law School Cyberlaw Clinic, personal communication, 2024a)

Legislative Reform:

- *"Advocating for Legal Changes: SCSI could recommend legislative changes to clarify the status of burial records under public records laws. This could include:*

    - *Legislation to Mandate Disclosure: SCSI could advocate for laws requiring the government to release the names and burial locations of individuals who died in state institutions, similar to efforts in other states like Oregon and Ohio* (Juvenile Code, Human Services, 2023; *Walsh v. Ohio Dept. Of Health*, 2022).
    - *Amending Public Records and Privacy Laws: A revision to Massachusetts' public records laws (Chapter 4, Section 7) to explicitly clarify that death or burial records are not classified as medical files could remove the current ambiguity. Similarly, clarifying the definition of "patient records" in Chapter 123, Section 36 could help define which records are public."* (The Harvard Law School Cyberlaw Clinic, personal communication, 2024a)

Institutional Records Collections

The Massachusetts State Archives

The Massachusetts State Archives in Boston preserves and makes accessible the essential non-current records of state government and provides records management assistance. The State Archives collects materials produced by state agencies, which include patient records from state hospitals and sanatoriums, almshouses, and reform schools. The State Archives also currently holds records of births, marriages, and deaths for all Massachusetts cities and towns for the years 1841-1950. Massachusetts State Archives policy allows access to individual records after a period of time, generally 75 years, but this period is not set in Massachusetts General Law as it is in many other states.

Records Conservation Board

The Records Conservation Board (RCB) is a Board within the Massachusetts State Archives that is tasked with managing public records. The RCB consists of the State Librarian, the Attorney General, the State Comptroller, the Commissioner of Administration and Finance, the Supervisor of Records, the Secretary of Technology Services and Security, and the State Archivist, or their designee. The State Archivist fills the role of secretary of the Records Conservation Board.

The RCB sets standards for record management. State agencies can retain records they deem necessary, or the records may be archived at the Massachusetts State Archives with access restrictions approved by the Board if not otherwise governed by Massachusetts state law. State agencies have to apply to the RCB to send records to the State Archives. Medical records cannot be destroyed or transferred to the State Archives without permission from the RCB. The process for obtaining permission and required forms is listed on the Secretary of the Commonwealth's Agency Records Department website.

The Board also establishes and maintains the Statewide Records Retention Schedule (SRRS). The SRRS establishes guidelines for how long state government records should be kept, and for what purpose. DDS and DMH records require the approval of the RCB to be transferred or destroyed following consultation with relevant agency Commissioners. Before any sale or destruction of records, the RCB must publish notice that the record set is scheduled to be destroyed and may hold a public hearing.

According to key informant interviews with representatives from the RCB, the retention laws for records have changed over time. Requirements for how long the records are maintained and when they can be destroyed have been updated in the SRRS (J. D. Warner Jr., personal communication, 2024). CDDER is currently researching these changes.

The current statute governing retention of medical records sets a 20-year retention period. If the Departments of Mental Health or Developmental Disabilities were to successfully apply to

transfer records to the State Archive, it is possible that not all individual medical records will be retained if they are older than 20 years. In this case, per a key informant interview, a selection of records may be kept that are unique in nature, or that would serve as examples of the structure and contents of records from this time.

The RCB also issues bulletins periodically that records custodians[53] can reference for updates on retention regulations and processes. Bulletins are either issued by the Supervisor of Public Records (SPR), or jointly by the SPR and the Records Conservation Board (RCB). Some examples of topics covered in the periodic bulletins issued by the RCB and the SPR include:

- Security and custody of records;
- Digitizing records;
- Designation of Records Custodian; and
- Maintenance of Records Storage Areas.

These bulletins can be found online on the Secretary of State's website:

- https://www.sec.state.ma.us/divisions/archives/records-management/spr-bulletins.htm

CDDER is working with the Records Conservation Board and DMH and DDS to create an inventory of the records that have been approved for destruction over time. As of the time of this report, that work is still in progress.

Records Management Unit

The Records Management Unit (RMU) is part of the Massachusetts State Archives, established by the Supervisor of Records to ensure proper storage and preservation of government records. The RMU assists state agencies in managing and securing their records to support business operations and protect privacy of citizens. It also provides guidance on various recordkeeping issues, including storage, electronic data legality, recovery of water-damaged materials, and contingency planning.

Review of Massachusetts Law on Third-Party Access to Government-Held Healthcare Records

The Harvard Law School Cyberlaw Clinic provided another analysis of state law that govern third- party access to government-held healthcare records. The following are excerpts from a memo that the Clinic drafted, which contain a brief summary of their analysis and recommendations for the State Commission on Special Institutions (SCSI) to consider (The Harvard Law School Cyberlaw Clinic, personal communication, 2024b).

[53] A records custodian is simply someone or an organization responsible for managing and caring for records, whether in physical or electronic form. They ensure records are stored securely, organized, and accessible to authorized personnel, and they also handle record requests.

Brief Summary:

- *"Briefly, few laws and regulations are directly applicable to the records in question. For most of these laws, there are only a few cases discussing their requirements as understood by the courts. As such, the analysis in this memorandum examines underlying trends and animating theories across the existing court decisions and regulations. Ultimately, we recommend that SCSI advocate for legislative and regulatory reform based on prior state commissions' work"* (The Harvard Law School Cyberlaw Clinic, personal communication, 2024b).

Advocacy Efforts for Consideration:

- *"There aren't many laws or court cases that directly control how third parties can access patient data from the Department of Mental Health (DMH) and the Department of Developmental Services (DDS). However, some existing laws and regulations can make a strong case for researchers to access this information, though patients' family members are unlikely to get access unless through a court process. Advocacy efforts should focus on convincing the DMH and DDS Commissioners that sharing this data could be in the patients' best interests, with researchers pushing for clearer access through current rules. If needed, lawmakers could also amend laws to better define these access rights in the future."* (The Harvard Law School Cyberlaw Clinic, personal communication, 2024b).

Best Interest Determinations:

- *"For researchers like SCSI, seeking access to patient health data can be a simpler process because state law allows exceptions for disclosing patient records when it's in the "best interest" of the patient. The Commissioners of DMH and DDS have the authority to make these decisions, based on the Commissioner's judgment.*

  One benefit for SCSI is that the process of getting approval may be relatively straightforward, relying on the Commissioner's discretion. However, there are uncertainties about whether each institution needs individual approval or if a blanket approval for SCSI's research can be granted. Thus, SCSI and similar researchers should seek a "best interest determination" from the Commissioner as a first step and also seek guidance on whether they can request data in bulk.

  For family members seeking access to records of deceased patients, the process is more complex. Family members will need to show that their request aligns with the "best interest" of the deceased, which is difficult to demonstrate. They might try to argue that accessing records would honor the dignity and respect of the deceased, but this is not a clear-cut argument.

  Additionally, family members may struggle with DDS and DMH's procedural requirements. It's not clear how they should submit a request for a "best interest determination," or what level of confidentiality they need to maintain to match the

standards set for researchers. Since many records may only be identified by numbers, not names, it could be difficult for DMH or DDS to grant requests for specific patient records, especially if the records are not fully identifiable.

Because of these challenges, family members should still pursue a "best interest determination" from DDS and DMH, framing their requests around the dignity of the deceased patient. They should also seek guidance from the state agencies on the procedural requirements and inquire about efforts to improve access to relevant records in the future." (The Harvard Law School Cyberlaw Clinic, personal communication, 2024b)

Improving Access Through Regulations:

- *"In Massachusetts, regulations have previously allowed certain entities to access patient records if it's determined to be in the "best interest" of the patient. For example, investigators and researchers have been granted access under specific regulations, provided DMH and DDS approves access.*

  The SCSI could push for a regulation that explicitly adds the SCSI and its research partners to the list of those allowed access to patient records without requiring individual approval from the Commissioner for each request. If successful, this would streamline the process for SCSI and remove the need for case-by-case evaluations, making access presumptively in the "best interest" of patients. This approach would build on past precedents where investigative bodies were allowed similar access.

  However, there are existing regulations governing access for investigators and researchers. Access for investigators is regulated by 104 Mass. Code Regs. 32, and research access is governed by 104 Mass. Code Regs. 31. If a new provision is created for SCSI, it would likely require a new chapter of regulations similar to these existing ones. This new regulation could integrate SCSI's existing confidentiality agreements, as seen in the Determination for the Foxborough State Hospital.

  On the other hand, family members of patients face more challenges. Unlike SCSI, there is no existing regulation specifically allowing family members access to patient records. Without a similar regulatory framework, family members would likely have a harder time securing access to these records through regulations." (The Harvard Law School Cyberlaw Clinic, personal communication, 2024b)

Improving Access Through Legislative Reform:

"If there's a conflict between SCSI's access to data and existing laws like Section 36, the Massachusetts State Legislature could step in to create a new statute that explicitly grants SCSI access to the necessary DMH and DDS patient records. This statute could be modeled after existing laws, such as the one in 104 Mass. Code Regs. 27, which grants the Disabled Persons Protection Commission (DPPC) access to certain records under

Mass. Gen. Laws ch. 19C, § 10. This statute helps clarify the DPPC's obligations while resolving conflicts between their access and confidentiality protections.

A legislative reform could also be part of a broader initiative to enhance the powers and procedures for SCSI, especially if the Commission's responsibilities are expanded in the future. However, advocating for new statutes can be a complex and time-consuming process. Given this, researchers and family members might find alternative methods of access—like seeking "best interest" determinations or advocating for new regulations—more practical and accessible in the short term." (The Harvard Law School Cyberlaw Clinic, personal communication, 2024b)

<u>Improving Access Through Litigation:</u>

- *"Another option for SCSI to access patient data is through litigation, where the interpretation of Section 36 and the Massachusetts public records laws could be challenged in court. SCSI might build on cases like O'Brien* (*Commonwealth vs. Paul J. O'Brien*, 1989)*, which balanced the general prohibition on disclosure with the benefits of disclosing information. Additionally, SCSI could argue that, after the 2020 amendments to public records laws, "medical files" are no longer completely exempt from disclosure* (Office of Privacy and Civil Liberties & U.S. Department of Justice, 2022)*. If SCSI faces a denial of a public records request, the case can be reviewed by the Massachusetts Superior Court, but any significant legal change could require an appellate court or even the Massachusetts Supreme Judicial Court.*

  However, pursuing litigation comes with significant challenges. The interaction between Section 36, public records laws, and privacy concerns is complex and would likely require a fact-intensive inquiry, including discovery. Both legal theories for access would involve balancing tests where judges must assess the deceased's privacy interests against the potential public benefits of disclosure. This process would probably require expert testimony and depositions from family members and government officials, leading to substantial financial and time costs.

  Public records litigation, in particular, presents difficulties. While Section 36 offers a balance between privacy and disclosure, the public records laws focus on whether the records should be available to the public, and they weigh the privacy cost more heavily. If DMH and DDS records are considered public, the costs of disclosure may be higher. In terms of balancing these costs, litigation under Section 36 seems more promising, especially for family members seeking access. Section 36 requests are more likely to be persuasive because they focus on privacy concerns specific to the individuals involved, while public records requests vary depending on who is requesting the information.

  While litigation remains a viable option, it may not be the most practical path for SCSI's current needs due to the substantial financial and time commitments it would require. Litigation could become more attractive if the Commission receives additional resources,

> *but for now, other avenues such as seeking "best interest" determinations or advocating for regulatory changes may be more effective."* (The Harvard Law School Cyberlaw Clinic, personal communication, 2024b)

Institution-related Records at the Massachusetts State Archives

The Massachusetts State Archives maintains a collection guide or a "finding aid", which is a detailed document that describes the contents of a specific collection of records. The collection guide provides information like the creator, date range and subject matter, to help navigate and locate specific items within that collection. The collection guide is considered the equivalent of a library catalog for archival materials. Institutional records are listed in the *Health and Human Services Collection Guide* and include records from many state agencies and public institutions, some dating from the mid-19th century (Massachusetts State Archives, 2020). These include public welfare, public health, mental health, developmental disability services, youth services, corrections, and the office for children and families.

There are several types of institutional records held in the Health and Human Services Collection at the Massachusetts State Archives, but the collections are not comprehensive and do not cover every year. Some examples of the types of institutional records held at the Massachusetts State Archives include:

- *Medical Records*: Access to these records is limited by HIPAA laws and Massachusetts Public Record Laws. Medical records of former patients of state institutions are permanently restricted.
- *Registration Information*: This includes details collected at admission, like name, age, and next of kin. These records may also have updates on discharges or deaths.
- *Business Records*: Institutions kept business records, especially more complete ones in recent years. Older annual reports often include facility photos, admission and discharge statistics, descriptions, and treatment lists. Annual reports from state boards that oversaw these institutions are also available.
- *Death Records*: Large institutions often had onsite cemeteries, and deaths were recorded in local vital records, which are open to the public (MGLA c 46 s1). Not all institutional deaths may appear in these town records and information about these deaths and burials may be held in the institution's collection of records. For example, the Fernald State School cemetery registers from 1947-1979 are currently held by the Massachusetts State Archives and access to these records is restricted by statutory provision MGLA c 123B, s 17 which covers the records of patients admitted to facilities under the supervision of the Department. The section states that the department must keep records of all patients' admissions, treatments, and periodic reviews and these records are private and not open to public inspection.

Currently, the Massachusetts State Archives houses the following sets of institutional records restricted for access by statutory provision MGLA c 123B, s 17, which states the following:

"Such records shall be private and not open to public inspection except (1) upon proper judicial order whether or not in connection with pending judicial proceedings, (2) that the commissioner shall allow the attorney of a patient or resident to inspect records of said patient if requested to do so by the patient, resident or attorney, and (3) that the commissioner may permit inspection or disclosure when in the best interest of the patient or resident as provided in the rules and regulations of the department." (Mass. Gen. Laws, Part I, Title XVII, Ch. 123B, § 17, n.d.)

- Boston State Hospital - Inpatient case files, 1856-1985
- Metropolitan State Hospital - Inpatient case files, 1930-1992
- Grafton State hospital - Inpatient case files, 1877-1955
- Boston Psychopathic Hospital - Inpatient case files, 1951-1963
- Medfield State Hospital - Inpatient case files, 1896-1948
- Bridgewater State Hospital - Mental health patient case files, 1887-1967
- Fernald State School - Inpatient case files, 1852-1969
- Westborough State Hospital - Inpatient case files, 1886-1960, 1970-1977
- Danvers State Hospital - Inpatient case files, 1878-1980
- Northampton State Hospital - Inpatient case files, 1858-1993
- Tewksbury State Hospital - Inmate case histories, 1860-1896

Also listed in the Health and Human Services Collection Guide, are records in the Massachusetts State Archives from various Divisions and Boards that were charged with supporting people labeled as "paupers, lunatics, insane, idiotic, deaf and dumb, blind, deformed, and maimed" and other similar labels prior to the establishment of specialized institutions (See the **Historical Timeline** section of this report for detailed listings and names of these governmental bodies and their charges). These files include multiple series of records, such as case histories, case notes, admission and discharge lists, financial documents, and annual reports. However, similar to the records for the institutions listed above, the series of files do not always represent complete series and may span a portion of years that the governmental body or Almshouse, etc. existed.

In addition, the Massachusetts State Archives has records from the Massachusetts Division of Immigration, which was responsible for handling immigration matters before they started being managed federally (per Acts of 1891, c 551). These records include registers of passengers arriving at Massachusetts' ports from 1848 through 1891, including information about the ships on which they arrived and passenger-related fees. This is relevant to institutional records because this Division was responsible for removing certain applicants seeking admission to state almshouses or state lunatic hospitals back to their place of origin (St 1860, c 83), as well as charging shipmasters the related fees if someone who arrived to the U.S. was considered to be "insane, idiotic, deaf and dumb, blind, deformed, maimed" and fell under state care within five years of arrival.

Records Held by the Department of Mental Health and the Department of Developmental Services

Many records from closed DDS and DMH institutions are not held by the Massachusetts State Archives. Some of the records that still exist are currently held in state facilities, which are still in operation, as well as in Area and Central offices of both state agencies. In other cases, records are stored in buildings that are located on institutional campuses that have been closed to other uses. While DDS and DMH regulations do provide expectations that each facility implements reasonable physical, technical, and administrative safeguards to protect the confidentiality, integrity, and availability of patient records, there are no specific regulations related to the environmental conditions of designated storage areas of records, such as temperature and humidity levels, sprinkler, heating or ventilation of the storage areas. Through key informant interviews, we have confirmed that the records are not kept in ideal condition, as some of the buildings are very old and do not have adequate climate control. Additionally, some of the records are reported to be in a very fragile condition. While portions of these records have been stored in alternative formats, such as microfiche, historically, the majority of the records only exist in paper form.

The following information has been gathered mostly through key informant interviews.

- *Wrentham Developmental Center*: Wrentham currently houses records its own records, as well as records from Dever State School from when it closed in 2002. The building at Wrentham where the Dever State School records are maintained is a locked, closed/boarded-up building. In a video recording of the storage area, it is possible to see that records are stored horizontally on shelves. It is also possible to see that the building itself appears to have structural integrity issues with visible water damage to the ceiling and some boarded-up windows.
- *Taunton State Hospital*: This Hospital contains patient records going back to the 1870s. Taunton also has a small number of Foxboro State Hospital records that have not been processed and are reported to be in a very fragile condition.
- *Medfield State Hospital*: Secretary Walsh stated that the Executive Office of Health and Human Services (EOHHS) has been working with DMH to survey the property of Medfield State Hospital.

> *"DMH's survey was limited due to safety concerns, but it will be working with the Division of Capital Asset Management and Maintenance (DCAMM) to determine whether DMH can access apparently unsafe areas."* (K. E. Walsh, personal communication, July 10, 2024)

Letter of Inquiry on Institutional Records to Massachusetts Governor Healey and Secretary of Health and Human Services Walsh from the Special Commission of State Institutions

In a public letter of inquiry[54] to Massachusetts Governor Healey and Secretary of Health and Human Services Walsh, the Special Commission of State Institutions (SCSI) requested a detailed accounting of where the State is holding records from state institutions. In her response, the Secretary of Health and Human Services declined to provide this detail, by instead stating:

> *"DMH and DDS have conducted inventories of closed state institutions formerly operated by each agency to determine whether and were records were stored on premises. In all cases, DMH and DDS confirmed that records of those who resided at the facilities were relocated to secure DMH and DDS facilities prior to the facilities' closure and transfer of ownership."* (K. E. Walsh, personal communication, July 10, 2024, p. 1)

However, recent newspaper reports do not support the Secretary's statement that records of those who resided at the facilities were relocated prior to the facilities' closure and transfer of ownership (Egger, 2024). The Fernald State School was closed in 2014 by DDS, and its ownership was first transferred to DCAMM, then to the City of Waltham. DCAMM acknowledged that it removed records from the Fernald campus after the property's transfer to the City of Waltham. Additionally, after newspaper reporting in 2024, DDS went back to that campus, then in possession of the City of Waltham, to retrieve records found on the campus, including records about people who lived there. A large volume of records was removed by DDS from buildings they could safely access (per a report to the SCSI in an open meeting in 2024), however, not all buildings were able to be safely accessed. At the time of report to the SCSI DDS was in the process of contracting with an external company to address these buildings. The unsecured records left behind after Fernald closed are reported to have included medical and sensitive information about people who lived there, such as diagnoses, medications, symptoms, names, birthdates, and Social Security cards (Egger, 2024). These records were found in buildings that were not secured and included records about people who could still be alive and living in the community today (e.g. records on a child from 1995).

The Wrentham Developmental Center has had recent challenges with trespassers in the section of the campus with closed/boarded up buildings, including one that contains files about people who lived at a state institution. The Center has recently added extra security to these buildings, including those storing records, to prevent unauthorized access (Wrentham Developmental Center staff, personal communication, 2024).

In 2024, a building containing records from the Dever State School was allegedly accessed by a person who was not authorized to enter the building. The campus has been advised to add video surveillance, but as of August 2024, it does not appear from our research that this measure has been put in place.

[54] A letter of inquiry is a short letter that requests information or expresses interest in an opportunity.

Records Not Held Under Basic Preservation Status

Through key informant interviews, we learned that some records from state agencies were destroyed. We believe this occurred during a time when the law permitted the destruction of such records based on a Statewide Records Retention Schedule. We have requested the applications of these agencies to the Records Conservation Board to catalog what is known to have been destroyed. This information request is still pending.

It has also been reported to CDDER that many of the records of closed institutions were not transferred because the state agencies were told that the Massachusetts State Archives were full and didn't have any more storage capacity (Multiple Massachusetts state agency staff, personal communication, 2024). We have confirmed with the Massachusetts State Archives that they do have space to receive records that would be considered permanent records under their current rules (Massachusetts State Archives staff, personal communication, 2024). There was an expansion of capacity in recent history, and it may have been that the agencies needed to hold records until this additional space was opened.

Records Known to be Missing or Destroyed

In January 2014, FOX Undercover uncovered the discovery of private medical records belonging to disabled patients and students, which contradicted earlier claims made by the Executive Office of Health and Human Services (EOHHS). The EOHHS had previously stated that all records had been properly removed during patient relocations and the closures of institutions (Boston 25 News, 2014). This revelation came to light when a teenage urban explorer found records dating back to the 1960s at the former Paul A. Dever State School, exposing significant lapses in oversight by state officials.

Similar discoveries by urban explorers in other abandoned state facilities have raised growing concerns about the security of sensitive information left behind in these closed institutions. Despite claims of effective record management, images of records from defunct hospitals such as Metropolitan, Danvers, and Westborough State Hospitals have been shared with FOX Undercover and can be easily found online. These instances suggest a troubling pattern of insufficient safeguards for private data.

In 2000, a Department of Mental Health spokesman asserted that any existing patient records from Foxborough State Hospital were stored at the Massachusetts State Archives in Boston. However, a Massachusetts State Archives Reference Librarian later confirmed that, while some ledger books from other facilities had been located, records from Foxborough State Hospital were unaccounted for. The Archives hold limited documentation related to Foxborough, such as annual reports, but lack specific case files (Pennington, 2000).

A more recent incident occurred on January 11, 2024, when the Department of Developmental Services (DDS) discovered personal documents at the former Walter E. Fernald Developmental

Center in Waltham, MA. This facility, sold to the City of Waltham in 2014, had housed sensitive patient and staff information that had not been securely stored (Egger, 2024). Following extensive media coverage, it was revealed that the discovered documents contained names, birthdates, diagnoses, and treatment details—highlighting significant lapses in the proper handling of protected health and personal information (Department of Developmental Services, 2024).

During the deinstitutionalization movement in the latter half of the 20th century, as state-run institutions were shut down, state agencies were responsible for ensuring that patient records were either properly archived or securely destroyed. However, documented cases show that some records were abandoned in unsecured buildings, accessible to trespassers or collectors. In certain cases, these records were found in disorganized piles or neglected containers, and some were even removed and listed for sale online.

In January 2014, FOX Undercover revealed the discovery of private medical records belonging to disabled patients and students, prompting a reversal of earlier claims by the Executive Office of Health and Human Services (EOHHS) that all records had been properly removed during patient relocations and the closures of institutions (Boston 25 News, 2014). The investigation was triggered when a teenage urban explorer found records dating back to the 1960s at the former Paul A. Dever State School, leading to an admission of inadequate oversight by state officials.

Urban explorers have similarly uncovered records in various abandoned state facilities, raising concerns about the security of sensitive information that could be left behind in these closed buildings. Although officials claimed to have effective record management practices, pictures of records from closed hospitals, including Metropolitan, Danvers and Westborough State Hospitals, were provided to FOX Undercover and are readily available online.

In 2000, a Department of Mental Health spokesman noted that any existing patient records for Foxborough State Hospital would be at the Massachusetts State Archives in Boston, MA. However, a Massachusetts State Archives Reference Librarian was able to confirm that while some ledger books for other facilities have been located, he couldn't confirm the whereabouts of those for Foxborough State Hospital. The Massachusetts State Archives holds limited documentation on Foxborough State Hospital, including annual reports, but lacks specific, individual case files (Pennington, 2000).

In a related incident on January 11th, 2024, the Department of Developmental Services found personal documents at the former Walter E. Fernald Developmental Center in Waltham, MA, which had been sold to the City of Waltham in 2014 (Egger, 2024). These documents, discovered after wide media coverage, included sensitive information related to both patients and DDS staff, but were not stored correctly (Department of Developmental Services, 2024). While the full extent of unsecured protected health and personal information is unclear, it is

known that some documents contained names, birthdates, diagnoses, and treatment information.

Numerous artifacts have been stolen from Massachusetts state-run mental health hospitals as the facilities were closed, abandoned, or left poorly secured. These artifacts include patient records, photographs and personal belongings. Urban explorers, collectors, and sometimes former employees took these items, often viewing them as historical curiosities or valuable memorabilia. The discovery and sale of private medical records from these closed institutions on platforms such as eBay have sparked serious concerns about privacy, ethical standards, and institutional accountability (*EBay Security Center*, n.d.). These records, often containing highly sensitive personal data and descriptions of patients' conditions or treatments, suggest that the issue extends beyond individual opportunism and points to systemic failures in record management and oversight. Whether the state of Massachusetts actively monitors platforms like eBay for such stolen materials remains uncertain. Direct monitoring is challenging due to the massive scale of online marketplaces, the anonymity of sellers, and the evolving tactics used to obscure illicit listings. While the state may investigate specific reports or complaints, consistent surveillance would require significant resources and interagency coordination.

This pattern points to gaps in record management and long-term planning by state agencies, including the Department of Mental Health, the Department of Developmental Services, and the Executive Office of Health and Human Services. These agencies are responsible for maintaining the security of personal records and limiting unauthorized access to sensitive information. In addition to potential breaches of privacy laws like the Health Insurance Portability and Accountability Act (HIPAA), the use of these records for public or commercial purposes raises broader concerns. When shared in sensational or entertainment contexts, such documents may contribute to misunderstandings or reinforce stigma related to mental health conditions and disabilities overall. Protecting these records helps support both legal standards and broader principles of privacy and dignity.

DMH and DDS Regulations Governing Records and Record Privacy

DDS regulations 115 CMR 4.00 and DMH regulations 104 CMR 27.00 govern access to patient records and require that these be kept private and not subject to public inspection. These regulations apply to all service providers, including state operated facilities. However, there are some exceptions, including:

- When a court order is in place - under state law, family members may obtain medical records of DMH and DDS clients when the family member is the client's legally authorized representative, such as a custodial parent, court-appointed guardian and court-appointed personal representative of a deceased client's estate,
- When the patient or their attorney requests it,

- When the Commissioner deems it to be in the patient's best interest and is permitted by the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR (Code of Federal Regulations) Parts 160 and 164, or
- When required by law.

Both DDS and DMH require written authorization from a patient or their legal representative for any use or disclosures of their health information that are not for treatment, payment, or health care operations. Each facility must provide patients with a notice of privacy practices that include information on state agency record retention procedures.

Inpatient facilities operated by the Department of Mental Health (DMH), contracted by DMH, or licensed by DMH are also subject to Massachusetts General Law, including Ch. 123, § 36 on Mental Health Records entitled "Patient records; inspection; maintenance and retention" with similar records retention and disclosure requirements as the agency regulations.

Process to Request Records Held by DDS and DMH

Current procedures for former and current service recipients to request their own records, as well as for their immediate family members or estate to make such requests on their behalf, appear on both the DMH and DDS Mass.gov webpages.

DMH:

- DMH medical record request: www.mass.gov/dmh-medical-record-request.
- A records request form for clients and Legally Authorized Representatives (LARs) is available through the link immediately above and at www.mass.gov/doc/dmh-request-to-inspect-form-hipaa-f-9/download. The webpage also instructs people to send the completed form to the DMH Area Office where the person received services.

DDS:

- DDS client files can be requested by emailing "DDS.filerequests@mass.gov" directly.
- Additionally, DDS service recipients can contact their DDS Service Coordinator or local Area Office to request a copy of their records.

To obtain medical records from DMH or DDS for a deceased family member, requesters need a court order specifying the release of those records, or a court-appointed Personal Representative may provide authorization.

DMH has posted on their webpage the following language regarding medical records:

> *"Until such time as a court order is granted or a valid Personal Representative authorization is received, DMH cannot: (1) release any medical records; (2) confirm that any person was ever served by DMH; or (3) confirm that records of any DMH service are still in DMH custody or control.*

> *Please note that although many older DMH medical records are maintained – some of which may be in the custody of the State Archives – the DMH record retention policy only requires that medical records be maintained for twenty (20) years. As such, we cannot assure in advance that obtaining a court order or Personal Representative authorization will result in receipt of the records."* (Massachusetts Department of Mental Health, n.d.)

Public Records Requests

DMH and DDS maintain various categories of public records as guided by Public Records laws discussed above. These records include annual reports, proposed regulations, grant awards and bids for public contracts. Other public records include legislative reports and minutes from open meetings. Often, these records are digitized and available online.

The records held by DMH and DDS are considered public records, with some exceptions as defined by the Federal Freedom of Information Act and the Massachusetts Public Records Law. When these records are requested as part of a public records request, parts of the records that are shared may be redacted due to legal restrictions related to privacy.

Requests for public records not available online can be submitted through the EOHHS public records request portal that can be found on the DMH and the DDS mass.gov web pages:

- DDS: https://www.mass.gov/forms/submit-a-department-of-developmental-services-public-records-request
- DMH: https://www.mass.gov/department-of-mental-health-public-records-open-meetings

However, requests for medical records cannot be submitted through the online portal. Requests for public records are reviewed by the Records Access Officer (RAO) at each agency. Under the public record law, the RAO must respond to the public record request, either authorizing the release of records, or denying the release of records. If the RAO denies a request, a requestor may appeal the matter to the Supervisor of Records within 90 days.

Private Collections of Institutional Records

There are many collections of historical institutional records that are held privately outside of the Massachusetts State Archives. Access to these records is restricted according to the best understanding of the librarians and archivists or by the rules set by the institution and can vary depending on the institution holding the records. Access restrictions may be in place for reasons, such as national security, privacy, preservation, or donor agreements. Donors of special collections can outline when and who can access the collection of records. Some archives are not able to be accessed by anyone currently, such as the Clemens E. Benda

papers[55], which are owned by the Boston Medical Library and are restricted. Other collections are not available because the collection of documents have not been processed[56] by the Library.

City of Boston Archives- Boston Lunatic Hospital at South Boston Records

This collection contains only one volume of records from the Boston Lunatic Hospital. This volume is a list of patients who entered the Boston Lunatic Hospital between December 1839 and February 1854. The collection is held at the City of Boston Archival Center.

The Countway Library at Harvard Medical School

The Countway Library is an academic health research library and holds 29 special collections related to the state institutions and the research conducted within them. Records in these collections span from the 1880s to the 1970s, and provide insights into the administration, research, and care within state run institutions over many years. The Countway Library, open to the public, houses collections owned by the Boston Medical Library, including the Clemens Benda Collection, which has restricted contents requiring approval from Harvard's Institutional Review Board (IRB) for access. The Boston Medical Library's collections are primarily stored offsite, making access difficult.

An archival collection is a collection of records that are preserved because of their enduring value. They are usually made up of a variety of materials, such as documents, photographs, maps, and media. Archival collections are organized and described in a way that makes them accessible to researchers. Many of the collections held by Countway Library contain records of prominent physicians and researchers, including their writings, correspondence and frequently included individual patient records. These are kept together for archival relevance. Some record collections have been donated to or deposited with the library. Some donation and deposit agreements require permission from the owner of the records before the record can be released.

Types of records held in these collections include:

- *Patient Information*: Includes consent for experiments, test results, autopsy reports, and case studies. Some records have patient names attached, while others use initials or numbers for identification.

[55] The Clemens Benda Collection contains early records of the Massachusetts School for the Feeble-Minded, patient records from Benda's private psychiatric practice in Arlington and Boston, Massachusetts, correspondence and records from his time as Director of Research at the Fernald School, papers documenting his early studies and clinical work in Berlin before immigrating to the U.S., as well as records produced by research, lecturing, consulting, and other professional activities.

[56] Processing a collection of documents involves arranging them in a logical way and describing the arrangement, contents, and research potential so that users can find the material they need. This is often considered an art, and the processor acts as an intermediary between the creators and users of the documents.

- *Research Findings*: Records from various hospitals show studies conducted, with some detailing specific patients and their conditions.
- *Institutional Oversight*: There are inspection reports and correspondence regarding hospital operations, safety, and patient care.
- *Trustee Reports*: Records include minutes from meetings, reports on patient care, and documentation of abuses.
- *Surplus Records*: Some records were deemed surplus by the state and later released to Countway Library for preservation.

In its policy document, Countway Library has several policies regarding access and preservation of its documents, such as some of the following (Countway Library, Harvard University, n.d.-a):

- Commonly restricted records at the Countway Library include records containing health information about individuals, such as patient records and doctor-patient correspondence. Other types of records that would be restricted include records that contain personally identifying information less than 80 years old that could facilitate fraud or identity theft, such as Social Security numbers and other financial information.
- Requirements for donors to provide a warranty that they have the legal right to give the materials to the Library.
- Preservation guidelines that outline required steps to take to protect fragile materials during handling, packing, transport, storage, and reshelving. The guidelines include key risk factors, such as fire, water, mold, and pests that are carefully monitored.

Record collections enter the Library over time under different agreements, often intermixing patient records with other documents. Access to these records is regulated by the IRB, especially for sensitive patient files. The Library also collaborates with the Massachusetts State Archives, which is aware of the records at Countway. Harvard must adhere to the same access rules as the State Archives, particularly for closed records. While Harvard is not subject to HIPAA regulations, it uses the IRB to oversee access to restricted documents.

Harvard holds records from several institutions. Some records are owned by Harvard, and some are owned by other institutions and are on deposit with Countway Library. The different collections and their related access policies are described below (Countway Library staff, personal communication, 2024):

- Clemens E. Benda Papers 1925-1966: This collection is owned by Boston Medical Library. Benda directed the Wallace Research Lab for the Study of Mental Deficiency at Wrentham State School. Benda was also the director of the Children's Unit of Metropolitan State Hospital and the director of research and clinical psychiatry at Fernald State School. The collection includes correspondence with guardians regarding permission for participation in experiments at Fernald; list of names of participants; results of tests with names attached. All "calcium isotopes" folders in the box appear to be state records. The collection includes detailed autopsy reports of people who died at

Fernald, photographs of brains that seem to belong to Fernald patients. Almost all have full names attached. There is no access allowed to this collection.

- Myrtelle Canavan Papers 1898-1945: This collection is open to research and includes documents from Taunton State Hospital, Fernald School, Boston State Hospital, Foxborough State Hospital, Medfield State Hospital, and Bridgewater State Hospital. Canavan was a state employee at Danver State Hospital, Boston State Hospital and the pathologist for the Massachusetts Department of Mental Diseases. The collection is the product of Canavan's work as a bacteriologist, pathologist, researcher, and curator of the Warren Anatomical Museum at Harvard Medical School. Her professional research is derived from patients of state institutions, but the patient information has been decontextualized.
- Carl Walter Papers 1933-1992, 1996 (inclusive): Walter inspected hospitals for infection control. The collection is open for research and includes reports and correspondence regarding the Boston Psychopathic Hospital and Boston State Hospital.
- Elliot Carr Culter Papers 1911-1948: Cutler was the superintendent of Tewksbury Hospital. This collection was created as a product of Cutler's administrative, teaching, research, and professional activities. Patient records are closed for 80 years from the date of creation, unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have Personally Identifiable Information (PII) or Protected Health Information (PHI) are closed for 80 years from the date of creation, unless access is approved by the Longwood Campus IRB.
- George Gay Papers 1906-1920: This collection includes Wrentham State School inspection reports to the State Board of Insanity. The collection includes evaluations of patients with names attached. Access to patient records is closed for 80 years from the date of creation, unless access is approved by the IRB.
- Joseph E. Murray Papers 1919-2011 (inclusive): Papers are the product of Murray's activities as a plastic surgeon, transplant surgeon, laboratory director, author, and Harvard Medical School alumnus. The collection includes information from Medfield State Hospital. Access to patient records is closed for 80 years from the date of creation, unless access is approved by the IRB.
- Grete Bibring Papers 1929-1977: Dr. Grete Bibring was a psychiatrist who lectured at and did consulting work for state institutions. This collection includes case studies from Metropolitan State Hospital and includes copies of case studies of named, underage patients issued as conference discussion material. Access to patient records is closed for 80 years from the date of creation, unless access is approved by the IRB.
- L. Vernon Briggs Papers 1774-1940 (inclusive), 1911-1938 (bulk): This collection includes documents from Boston State Hospital, Bridgewater State Hospital, Danvers State Hospital, Westborough State Hospital, and Worcester State Hospital. Briggs served on the Massachusetts State Board of Insanity. Key contents include correspondence regarding the investigation of the Bridgewater State Farm superintendent and staffing recommendations for Boston State Hospital, along with discussions on state funding for

a new hospital. A narrative case related to Bridgewater State Farm, employee affidavits from Boston State Hospital, and patient cases from Westborough State Hospital. It also includes statistics, trustee correspondence, Boston State Hospital blueprints, reports of patient abuse, abstracts of patient records, memos on patient care, and trustees' meeting minutes. Access to patient records is closed for 80 years from the date of creation, unless access is approved by the IRB.

- Albert Warren Stearns Papers 1912-1959 (inclusive): This collection contains documents related to Stearns, who served as Commissioner of the Massachusetts Department of Corrections and worked at Danvers State Hospital. The collection includes information on named patient cases for parole consideration, minutes from a meeting of the Department of Mental Diseases Commissioners with patient names. There are multiple folders containing inmate records identified by number only, including details on age, family background, and criminal history, along with correspondence of a mixed professional and non-professional nature addressed to his office. The collection includes case files with named patients from consultations for Tewksbury State Hospital and redacted patient records related to his private practice.
- E. E. Southard Papers 1892-1940 (inclusive): Southard was director of Boston Psychopathic Department. at Boston State Hospital and the pathologist at Danvers State Hospital. The collection includes anatomical monographs (70+ folders) and contains some case reports of patients at Boston State Hospital, Foxborough State Hospital, and Danvers State Hospital. Some records contain patient names, some by number only. Patient records are closed for 80 years from the date of creation, unless access is approved by the Longwood Campus IRB.
- Roy Graham Hoskins Papers 1907-1965: Hoskins directed the Memorial Foundation for Neuro-Endocrine Research, which conducted research at Worcester State Hospital. The collection includes reports focused on a named patient who was the husband of a Foundation donor. It also includes tables listing patients studied at Worcester State Hospital identified only by initials and annual reports detailing research conducted at the Hospital, devoid of identifying information.
- Boston State Hospital: Includes demographic and census information, as well as records of patient treatments and logs of restraint and seclusion. The collection also includes the Patient Register of Deaths, 1885-1929. The record owner is the Massachusetts State Archives and requires the permission of the State Archives to release the records.
- Danvers State Hospital: This collection includes Reports of the Laboratory Work from 1888-1910, and other papers about the Hospital. that are owned by Harvard University. This collection is open to researchers.
- Grafton State Hospital: This collection of records includes patient records, autopsy protocols, commitment papers, superintendent reports to trustees, and annual reports. Declared as "surplus records" by the State in 1973 and "released" to Countway Library at Harvard. The record owner is the Massachusetts State Archives and requires the permission of the State Archives to release the records. The library also holds a number

of collections that are unprocessed and are closed to research. These records include patient records from the Department of Mental Health and Massachusetts Mental Health Centers (MMHCs).

The Warren Anatomical Museum and Collection at Harvard

The Warren Anatomical Museum is one of the last surviving anatomical and pathology collections associated with a U.S. medical school, now functioning as a research and teaching resource within the Center for the History of Medicine at Harvard. The collection was created by John Collins Warren who was a prominent surgeon and medical educator who founded Massachusetts General Hospital. He used the collection for teaching and research at Harvard Medical School starting in 1816. He donated the collection to Harvard Medical School in 1847 to be used for teaching anatomy to incoming students. At the time, human remains were valuable for study due to the lack of formal body donation programs in the 1800s. Warren lobbied for a groundbreaking Massachusetts law in 1831, "An act to protect the sepulchers of the dead, and to legalize the study of anatomy in certain cases" that legalized anatomical dissection.

The Warren Anatomical Museum became a leading medical museum in the U.S., contributing significantly to the field of medical education. It became part of the Countway Library's Center for the History of Medicine in 1999 (*Highlights From the Warren Anatomical Museum*, 2010).

In 1907, Dr. Myrtelle Canavan was appointed assistant bacteriologist[57] at Danvers State Hospital, where she met Elmer Ernest Southard, Bullard Professor of Neuropathology at Harvard Medical School, who encouraged her interest in neuropathology. In 1910, she became resident pathologist at Boston State Hospital, and, in 1914, she was appointed pathologist to the Massachusetts Department of Mental Diseases.

After Southard's death in 1920, Canavan became acting director of the laboratories of the Boston Psychopathic Hospital, which would later become the Massachusetts Mental Health Center. From 1920 until her retirement in 1945, she was an Associate Professor of neuropathology at Boston University and curator of the Warren Anatomical Museum at Harvard Medical School, where she added more than 1,500 specimens.

She had a particular interest in the neuropathology of "mental illness". With Southard and others, she contributed to a monograph series[58] called, *Waverley Researches in the Pathology of the Feeble-Minded,* named for the section of Waltham where the Fernald School, which funded the work, was located (Fernald et al., 1918). The series focused on the anatomical and physiological aspects of feeble-mindedness, a field that had been largely neglected despite substantial interest in related areas, such as education, social service, heredity, eugenics, and

[57] A bacteriologist is a scientist who studies bacteria, especially those that cause disease.
[58] A monograph series are scholarly and scientific books released in successive volumes, each of which is structured like a separate book.

applied psychology. While there had been significant research on mental testing, Fernald, Southard, and Canavan examined brain anatomy to gain a deeper understanding of feeble-mindedness. This extensive study examined the brains of 50 feeble-minded cases (Fernald et al., 1918).

The Yakovlev-Haleem Collection

Dr. Yakovlev began his career as a research fellow in neurology at Harvard Medical School. From 1926 to 1936, he worked as a liaison between Harvard and the Monson State Hospital for Epileptics, where he studied epileptic patients and performed autopsies to understand the nature of seizures.

He later became director of laboratories at the Metropolitan State Hospital (1936–1938), where he contributed to the study of brain anatomy. From 1938 to 1947, he served as Clinical Director at the Walter E. Fernald State School, which he considered his most productive years. There, he used a custom-built microtome to collect brain samples for research and teaching.

From 1955 to 1961, Dr. Yakovlev served as the curator of the Warren Anatomic Museum at Harvard Medical School. The expansion of his brain collection was significant during this time, with up to 20 technicians working on it at its peak.

In 1969, his collection was moved to the Walter E. Fernald State School and later, in 1974, to the Armed Forces Institute of Pathology (AFIP) in Washington, D.C. By then, his collection included over 900 brains and more than 250,000 slides, becoming a key resource for neurological research (Kemper, 1984).

The collection was then managed by curator Mohamad Haleem until it was transferred to the National Museum of Health and Medicine, which is a department of the AFIP. In 1994, the collection was renamed the Yakovlev-Haleem Collection and transferred to the Neuroanatomical Collections of the National Museum of Health and Medicine. Parts of the collection were also held by the Eunice Kennedy Shriver Center for many years and this subcollection was also transferred to the Neuroanatomical Collections of the National Museum of Health and Medicine. “The collections contain normal, pathological, and comparative specimens. Developmental specimens are also available. Each specimen contained in the collections is serially sectioned in one of the three major anatomical planes”(*Neuroanatomical Collections*, n.d.). The specimens span across a variety of ages, starting in the developmental stages, through childhood and into adulthood, with over 30,000 anatomical slides.

> *“The museum's collections are available for research, exhibition, and other educational purposes. The collections are open for research Monday through Friday by appointment only, except federal holidays. The historic and scientific value of the museum's collections requires that NMHM carefully balance the needs of continued scientific and historic investigations with our responsibility to preserve museum assets for future generations. Therefore, NMHM requires that researchers discuss their research projects with*

collections staff and certain requests may require a detailed proposal." (*Neuroanatomical Collections*, n.d.)

UMass Lowell - Tewksbury Almshouse Intake Records (1854-1884)

This collection is comprised of digitized patient intake records from the Tewksbury State Almshouse, primarily covering the years 1860 to 1884. These records feature handwritten interviews conducted at the time of patient admission.

The project received funding through a grant from the Institute of Museum and Library Services, awarded to the University of Massachusetts Lowell Libraries in collaboration with the Public Health Museum of Tewksbury. Original ledgers owned by the Public Health Museum were scanned, covering 1873 to the 1940s, though digitization will only extend to the 1890s due to privacy concerns. A second set of records was microfilmed by the Massachusetts State Archives before being destroyed due to poor condition. These microfilmed records span 1860 to 1873, with very few original records surviving from before 1860.

The collection features 24,000 records from the original ledgers and 18,000 from microfilm. Records are searchable by various criteria, including name, age, gender, birthplace, race, and year of admission. Additionally, over 1,000 alias names and nearly 800 birth records have been cross-referenced.

University of Massachusetts Amherst - Belchertown State School Friends Association Records

The bulk of the Belchertown State School collection consists of records of court appearances, briefs, the consent decree, and related materials, along with reports and correspondence relating to Massachusetts v. Russell W. Daniels, Ricci v. Greenblatt (later Ricci v. Okin), and other cases. Accompanying the legal files are clippings and photocopied newspaper articles; speeches; newsletters; draft of agreements; and scrapbooks.

University of Massachusetts Chan Medical School Lamar Soutter Library - Samuel Bayard Woodward Collection

Samuel Bayard Woodward, M.D. (1787-1850) was a prominent physician and educator known as the first superintendent of the Worcester State Lunatic Hospital (1832-1846) and co-founder of the Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association).

The collection includes digitized essays, addresses, obituaries, letters, and verses authored by Woodward from 1806 to 1848, covering a range of topics, including medical, social, financial, educational, and personal matters.

The original papers of Dr. Woodward are housed in two bound volumes at the Worcester Recovery Center and Hospital. There are no restrictions on accessing the digital collection.

Brandeis University's Robert D. Farber University Archives - Samuel Gridley Howe Library

The Brandeis University Special Collections Department houses a wide array of material from the Walter E. Fernald Developmental Center's Samuel Gridley Howe[59] Library. This collection includes several hundred books from scholars and experts in the fields of science, medicine and disabilities; the papers of Irving Kenneth Zola[60] and of Rosemary and Gunnar Dybwad[61]; and thousands of pamphlets, case studies and journals on topics ranging from what were then called feeblemindedness and cretinism to eugenics and crime. The material, which dates from the 1810s to the 1950s and is related primarily to North America and the United Kingdom, was compiled by the Howe Library from the school superintendent's library, as well as international libraries.

The Howe Library collection at Brandeis also includes material on the President's Committee on Mental Retardation, subject files on all number of relevant topics amassed by both Dybwad and Irving Kenneth Zola, material on self-advocacy, awards and photographs, hundreds of pamphlets on disability studies from the 1870s to the 1950s, and a collection of historical books on similar subjects.

In 2010, the Friends of the Howe Library[62] insisted that the historical documents were saved when the library on the Fernald campus was closed. After consideration of various academic locations, Brandeis University was selected to receive the collection. The collection has not been processed and is in storage. There are no finding aides currently. Some of the records from the Walter E. Fernald School may contain patient names or information. The policy is not to release restricted materials until it is processed. If the records contained restricted information the records would not be released.

According to the Associate University Librarian for Archives and Special Collections, Brandeis has not had a family or next-of-kin request for a patient record but would be very careful about providing access to anything that would be considered personal records.

[59] Samuel Gridley Howe (1801 - 1876) was an American physician, educator, and abolitionist who founded the Perkins School for the Blind and the Massachusetts School for the Feeble-Minded, which later became the Fernald Development Center.

[60] Irving K Zola was a prominent sociologist and writer known for his work in medical sociology and disability studies. He served as the Mortimer Gryzmish Professor of Human Relations at Brandeis University from 1963 until his death in 1994. As a founding member of the Society for Disability Studies and the first editor of Disability Studies Quarterly, he was a passionate advocate for individuals with disabilities.

[61] Doctors Rosemary and Gunnar Dybwad were leading figures in the disability rights movement. They were proponents of normalization, deinstitutionalization, inclusive schooling, and self-determination. Gunnar Dybwad is considered by many to be the "grandfather of the self-advocacy movement." In the 1950s, Dybwad, representing the Association of Retarded Citizens (The Arc), played a key role in organizing family members and friends to advocate for the discharge of individuals from custodial institutions and the development of community-based services for people with intellectual and developmental disabilities.

[62] Friends of the Howe Library is a volunteer organization that supports the libraries that are separate from the library and governance structure (e.g. Board).

Collections of the Massachusetts Historical Society Related to Disabilities

The Massachusetts Historical Society holds numerous personal accounts documenting disability, primarily through letters, diaries, and personal papers. These include first-hand accounts from individuals with physical or mental health conditions, as well as second-hand accounts from family and friends often found in correspondence, diaries, and autobiographies.

The Massachusetts Historical Society also holds autobiographical works, such as *Anecdotes of the Blind* (1835) by Abram V. Courtney and *A Blind Man's Offering* (1892) by Benjamin B. Bowen. Second-hand accounts from family papers often describe the disabilities of relatives, such as letters from Samuel S. Wilde about his son's mental health condition, or Abigail Adams' letter about her daughter's depression.

Other collections include materials related to the medical treatment and institutionalization of people with disabilities, particularly in the context of private institutions and charitable organizations. McLean Asylum for the Insane, and other mental health facilities, are well-represented in the collections, which include letters, diaries, and administrative papers detailing patient care. Documents also cover institutions for individuals with physical disabilities, like the Boston Orthopedic Institution, and papers from the Worcester Insane Hospital. The Channing Family's papers reflect their involvement in mental health care, including founding hospitals like the Channing Asylum in Wellesley (McDonagh, 2023).

Records Openly Available Online

Patient Admission Records and Registers

Access to patient admission records and registers stored at the Massachusetts State Archives are restricted by statutory provision MGLA c 66A. However, patient admission registers are available online at FamilySearch.org, which is a nonprofit organization and website offering genealogical records, education, and software. Although it requires user account registration, it offers free access to its resources. Patient registers available on Family Search include:

State Board of Insanity	1885-1904
Westboro State Hospital	1886-1918
Boston Insane Hospital	1855-1907
Danvers State Hospital	1863-1919
Hospital for Epileptics at Monson	1863-1918
Worcester Insane Hospital	1849-1918
Tewksbury Asylum for Chronically Insane	1863-1918
Mass School for the Feeble Minded	1863-1918
Northampton State Hospital	1858-1907
Taunton Insane Hospital	1854-1907
State Colony for the Insane-Gardner	1902-1905
Foxboro Insane Hospital	1893-1918

Medfield Insane Asylum	1896-1906
State Primary School Monson	1854-1863

Admission records for the Hospital Cottages for Children at Baldwinsville are also available online.

U.S. Census

The U.S. Census in 1830 collected information about the population in the U.S. and collected the name of the head of each household, the age and sex of household members, information on race and information on foreigners who were not naturalized. The Census also collected information about people who had physical disabilities, deafness, and blindness.

The first attempt to measure “mental illness” and “mental retardation” in the U.S. occurred in the 1840 Census, which introduced the categories "insane and idiotic." Individuals identified as "insane and idiotic" were categorized based on whether they were under "private care" (at home) or a "public charge" (in hospitals or almshouses). While these early counts were unreliable, the 1840 Census marked the beginning of mental health statistics in the U.S. (Bank & Schore, 1981).

In each Census for the years 1850, 1860, and 1870 Census, people with “mental disabilities” were consistently treated as a separate category. However, by 1880, professionals in the mental health field recognized that the census methodology had failed to produce accurate data. To address this, the 1880 Census introduced a more precise definition of "insanity," developing a classification system with seven distinct forms, including “mania”, “melancholia”, “monomania”, “paresis”, “dementia”, “dipsomania”, and “epilepsy”.

The 1890 Census continued similar procedures to those of 1880, conducting a special census of the "insane, feeble-minded, deaf and dumb, and blind." However, by the 1900 Census, no special enumeration of these groups was conducted.

In 1902, Congress established the U.S. Bureau of the Census and passed a law prohibiting further general censuses of special populations, restricting future surveys to patients in institutions. The 1904 special census focused solely on the "insane" and "feebleminded" in public and private hospitals and institutions, eliminating diagnostic categories. However, it did collect demographic data on patients, including age, sex, race, and nationality, as well as information on patient movement between institutions and maintenance expenditures for these facilities.

The 1910 special census was modeled after the 1904 census, continuing the focus on institutionalized individuals. Unlike the 1904 census, which did not collect diagnostic data, the 1910 census made an attempt to categorize patients by conditions like alcoholism, psychoses, and general paralysis. A similar census was conducted in 1923, following the structure and data collection methods of the 1910 census.

Annual censuses of patients in mental health institutions began in 1926, conducted by the U.S. Bureau of the Census from 1926 to 1946. These censuses collected data similar to that of the 1910 Census, including demographic information and patient movement, but with an important addition, diagnoses. In the 1923 Census, as well as in those conducted in 1933, 1939, and 1946, diagnostic data were collected to describe the conditions of patients in mental health institutions. This was the result of a collaboration in 1917 between the National Committee for Mental Hygiene and the American Psychiatric Association, which worked to standardize the classification of mental diseases across most state mental health hospitals (Horwitz & Grob, 2011). The new classification was later adopted by the Surgeon General of the Army, the Public Health Service, the U.S. Bureau of the Census, and nearly all public and private mental health hospitals. The U.S. Census continued to collect this information until 1948, when this function was transferred to the National Institute of Mental Health (Bank & Schore, 1981).

From 1926 to 1930, the annual census covered only patients in state mental health hospitals. Starting in 1931, the census expanded to include county, city, Veterans Administration (VA), and private mental health hospitals. Psychiatric wards in general hospitals were also included in the 1933 Census and again in 1939, and they were subsequently included in the annual census from that point onward (Manderscheid et al., 1986).

The National Archives and Records Administration (NARA) makes census records publicly available after 72 years (*The 72-Year Rule*, 2024). Records from the 1790 to 1950 censuses are currently available for research. The names of patients residing in a state institution can be found in census data online through a variety of resources, including:

- *Ancestry.com*: Provides access to digitized census records through a subscription or for free from National Archives computers.
- *Familysearch.org*: Provides access to U.S. federal census records for free with account creation.
- *National Archives*: Provides access to digitized census records online, and you can also visit a National Archives building or regional facility for free access to Ancestry.com and Fold3.com
- *Libraries*: Many libraries offer institutional subscriptions as services that provide access to digitized census records.
- *Census Tools*: Allows you to find a census listing by entering bounding streets on a map.
- *U.S. Census Bureau*: Provides access to ‘Name Lookup Tables’.

<u>Vital Records</u>

Vital records are collected by the National Vital Statistics System and are maintained by state and local governments. Vital records include births, deaths, marriages, divorces, and fetal deaths. They also record information about the cause of death, or details of the birth. Massachusetts State Law Chapter 46 mandates death records are public records (Mass. Gen.

Laws, Part I, Title II, Ch. 46, § 1-34, n.d.). Records are available for review, inspection, transcribing, or for purchasing certified copies.

Massachusetts vital records are maintained at different levels depending on the time period:

- Pre-1841: Vital records were registered locally beginning in 1639, nearly two decades after the Pilgrims' arrival. These records are held by the respective city and town clerks, with only one set of records existing at the municipal level.
- 1841-1910: Starting in 1841, a statewide system was implemented requiring every city and town clerk to submit annual copies of vital records to a central office in Boston. As a result, two sets of records, one at the local level and one at the state level, exist for most births, marriages, and deaths during this period.
- In 1860, Massachusetts General Laws Chapter 21, Sections 1-11 established the legal framework for recording births, marriages, and deaths within the state. “masters of ships, keepers of Workhouses, Houses of Correction, Prisons, Hospitals, and Almshouses, —except the three State Almshouses, —to give like notice (to the town clerk) of every Birth and Death happening among the persons under their respective charges” (Massachusetts Office of the Secretary of State. Division of Statistics, 1860, p. clxii).
- The Massachusetts State Archives holds the registration books for these records, covering all cities and towns from 1841 to 1910. Records from later years are transferred to the Massachusetts State Archives in five-year intervals.
- After 1910: Vital records from 1910 onwards are primarily kept at municipal clerk offices or the Massachusetts Department of Public Health, specifically in the Registry of Vital Records and Statistics.

The Massachusetts State Archives currently hold death records for all Massachusetts cities and towns for the years 1841 through 1925. Massachusetts death records from 1926 to the present are held at the Department of Public Health, Registry of Vital Records and Statistics.

The online FamilySearch database provides access to indexes and images of Massachusetts vital records from 1841 to 1930. These records can be searched to find the names of patients from state hospitals, asylums, and schools for the disabled who died while residing in these institutions. The digitized record sets include:

- Town Clerk, Vital and Town Records, 1626-2001
- Massachusetts Deaths, 1841-1915, 1921-1924
- Massachusetts State Vital Records, 1915-1925
- Massachusetts Deaths and Burials, 1795-1910

Experiences of Individuals Who Have Attempted to Access Institutional Records

In the Spring of 2024 CDDER conducted multiple interviews with decedents and family members of former residents of state institutions. CDDER interviewed four family members of

former residents of the Fernald State School to learn about their personal experience in seeking records held by DDS and/or the State Archives. Two local authors published their own accounts of their experience in researching and locating records of their family members who were hospitalized at Westborough State Hospital, Metropolitan State Hospital and Northampton State Hospital. Their accounts are summarized below.

Summary of David Scott's Search for His Brother's Records[63]

Mr. Scott has been seeking information about his older brother, John, who was born with spina bifida and placed at the Fernald State School at birth. He died at the Fernald School in 1973 at age 17 and is buried in a grave at MetFern Cemetery marked "C-154" (*John Scott C-154*, n.d.) . Mr. Scott's search reflects a deep desire to connect with his brother's past and understand the circumstances of his life at Fernald. His siblings were unaware of the whereabouts of John's grave for half a century.

Mr. Scott has faced significant challenges in obtaining records from the Commonwealth about John over the past 5-6 years. His initial request to DDS was denied, and previous contacts with DDS staff and his state representatives were unproductive until recent media attention (Moore, 2024).

Mr. Scott wants to access John's records from Fernald to understand his brother's personality, interests, care, and circumstances surrounding his death. He is particularly curious about why John was taken from the family and has wondered if it was due to their financial struggles. Those struggles impacted the family's ability to be present for John when he was alive. Mr. Scott noted that his family could not visit John due to transportation issues, which may have contributed to the staff at Fernald being unaware of his family connections.

Mr. Scott learned about John's burial location in 2022, which was distressing for him. He believes his mother would have preferred to bury John in the family plot near Brockton.

In Spring 2024, during a segment on WGBH, Mr. Scott asked Governor Healey for assistance in accessing John's records, and he was connected with the DDS Attorney-Records Access Officer, Gabriella Reisner. He also obtained the pro-bono services of an attorney to act as his legal representative.

As a result of these actions, Mr. Scott was granted access to some records about his late brother John (Devall, 2024). Mr. Scott received over 50 pages of documents detailing John's experiences, revealing outdated and derogatory terms used to describe him and the institution's low expectations for his future. Despite the insights gained, Mr. Scott was told that it is unclear whether other documents exist and will be found, or any process underway to locate them. He feels he still lacks a complete understanding of his brother's care and treatment. Mr. Scott's challenges reflect broader issues families face in accessing records,

[63] (D. Scott, personal communication, 2024)

underscoring ongoing concerns about the treatment of individuals with disabilities in former institutions and the need for greater transparency and accountability.

Summary of Laura Zigman's Search for her Sister's Records[64]

Laura's sister, Cheryl, was born in 1958 with osteopetrosis[65] and was admitted to Fernald State School in the early 1960s. Cheryl, who faced severe health challenges, including blindness, passed away around age 7 after multiple surgeries. In an interview, Laura expressed that this loss deeply affected Laura and her family, casting a long shadow over their lives. Laura's journey reflects a broader struggle for families to access their loved ones' histories and to seek acknowledgment and respect for the lives impacted by institutions like Fernald.

In 2020, while working on a novel, Laura sought to access Cheryl's records but faced repeated obstacles. She found it disheartening to consider the financially costly probate process[66], fearing it might yield no records.

Laura has sought basic details about Cheryl's time at Fernald, including when she was admitted, her abilities (such as her ability to communicate verbally), observations from caregivers, and the progression of her disease. She found a report regarding Cheryl's death, but it lacked specifics about a major surgery she underwent and the hospital where she died. Laura believes that her parents learned of Cheryl's death by phone from the hospital, not from staff at the Fernald School. She has not located a death certificate because she does not know what hospital her sister was admitted to at the time of her death.

During a visit arranged by Steve Brown from WBUR to the Massachusetts State Archives, Laura was shown very few records, which were heavily redacted, even to the point of blacking out photos to protect the identities of staff.

In the summer of 2024, Laura received records from DDS. Six out of the eight pages were entirely redacted, with only one line mentioning Laura's sibling. There was no explanation provided that these pages were simply lists of patient names unrelated to her sibling, so Laura assumed the state was intentionally withholding information. It wasn't until after sending an email demanding clarification about the redactions that they finally explained what had occurred.

Laura advocates for changes to improve access to records for families, criticizing the current rules as prioritizing staff privacy over that of former residents. She suggests creating a fund to

[64] (L. Zigman, personal communication, 2024)
[65] Osteopetrosis, literally 'stone bone', also known as marble bone disease or Albers-Schönberg disease, is an extremely rare inherited disorder where the bones harden.
[66] Probate is the legal process of transferring ownership of a deceased person's property and assets to their beneficiaries. Probate requires going through probate courts and involves paying court fees and may include legal fees. Establishing probate would permit a family member with legal access to a person's estate to request their records from the state.

assist families with the probate process and holding forums to gather insights from those who have navigated similar challenges.

Laura believes that the history of Fernald, both positive and negative, should be publicly recognized. She calls for accountability regarding the mishandling of records at the former institutions and an apology from the state of Massachusetts for how the records at Fernald have been handled. She envisions that any future developments on the Fernald grounds should honor the individuals who lived there, providing education and preserving history for future generations.

Summary of Kim's Turner's Search for Family Records at Fernald[67]

Kim is investigating her family's history related to Fernald State School, where both her grandfather and great-grandmother were admitted around 1900. Kim's quest highlights the emotional and bureaucratic challenges faced by families seeking to understand their histories within institutional settings like Fernald.

Kim's great-grandmother died at the Fernald School during the Spanish flu epidemic, and her grandfather left the school to fight in France during World War I.

Her grandfather was born out of wedlock, and due to financial difficulties, Kim's great-great-grandfather was unable to support her great-grandmother and her son, leading to her great-grandmother's admission to Fernald shortly after her child was removed from her custody at age two. Kim noted that her grandfather was secretive about his experiences at Fernald, mentioning an incident of punishment for eating an apple while at the Templeton Farm Coloney.

Kim wants to understand the circumstances surrounding her family's admissions to Fernald, what their lives were like, and is particularly interested in obtaining a photograph of her great-grandmother.

Kim sought guidance from a historian and found birth and death certificates through census records. The staff at the Massachusetts State Archives provided helpful guidance on navigating the records access process.

Despite initial support from the State Archives, Kim faced significant obstacles when trying to access records. Kim described an attorney she consulted at the Cambridge courthouse as unhelpful, and the fees to file necessary paperwork were prohibitively expensive. She questions why the state requires fees and paperwork before confirming record availability. She finds it illogical, especially given the age of the records and her direct descent from the people about whom she is seeking records. Kim reported that she found a lack of usable resources or aids for

[67] (K. Turner, personal communication, 2024)

descendants seeking to access records about their family members, which she feels has compounded her difficulties.

Summary of Anonymous Search for Records About His Cousin D.[68]

Anonymous is investigating the history of his cousin D, who was institutionalized at Fernald State School for 30 years. D's existence was a family secret until Anonymous found this information as an adult, and even D's siblings were unaware that he existed. Anonymous's search highlights the emotional and bureaucratic difficulties families face when seeking information about their relatives who were institutionalized, as well as the need for improved access to historical records.

Anonymous's cousin D was born with Down Syndrome and was placed at the Fernald School as an infant. After discharge from Fernald, he lived in a group home operated by Work, Community, Independence Inc, a Waltham based human service provider. His birth and institutionalization were kept secret, leading to a lack of awareness among family members, including his siblings.

Over the past few years, Anonymous has been researching D's life and was able to find his obituary, which identified Anonymous's aunt and uncle as his parents. He discovered D was buried at Mt. Feake Cemetery in Waltham, where the city provides plots for indigent individuals. Anonymous and D's siblings plan to install a headstone.

Anonymous described the process for accessing D's records as daunting. Anonymous is not considered the next of kin, and his cousins are unwilling to grant him permission to obtain the records. This unwillingness of his extended family along with the time and expense associated with seeking a court order has deterred Anonymous from pursuing this pathway.

Anonymous did learn that D's grandfather became the primary contact for Fernald, and medical professionals largely dictated decisions regarding D's care. Anonymous found correspondence from the 1950s indicating that D was enrolled in a thyroid study at Fernald, which his grandfather approved.

Anonymous is particularly interested in understanding D's treatment at Fernald, including his behavior, discipline, and medical care, as D may have died from pulmonary fibrosis.

Anonymous perceives the state's records access process as unhelpful, in part because it lacks guarantees regarding the availability or condition of records. Anonymous has spoken with DDS but was directed to Middlesex Probate Court, which he chose not to pursue due to cost and uncertainty.

[68] (Anonymous, personal communication, 2024)

He advocates for more transparency and accountability in the records process, questioning the application of HIPAA in this context and the implications of sharing information about deceased individuals with their families.

Summary of Account from A Door to Their Hearts A Ferro Family Memoir by Jeannine Michli Martin[69]

The author of this book explores her connection to her late grandfather, Giuseppe, who struggled with his mental health. Although he passed away before the author was born, learning about his life has deepened her appreciation for him. Giuseppe was described as gentle but faced significant challenges due to his mental health, a topic rarely discussed by his family.

In February 2016, the author began the search for Giuseppe's medical records from Metropolitan State Hospital, where he had spent nine years. She contacted the Massachusetts State Archives and learned that his records might have been transferred to Worcester State Hospital when Metropolitan State closed. Despite the risk of destruction due to the age of the records, which were over sixty years old, the Medical Records facilitator confirmed they existed on microfilm. She also learned that her grandfather was also a patient at Westborough State Hospital for a short period when he first became “mentally ill”.

In her book, the author details the process of obtaining her grandfather Giuseppe's medical records. She submitted necessary information, including his birth and death dates and prior address to the Medical Records Facilitator, who indicated that the search could take four to six weeks. After a follow-up, the Medical Records facilitator confirmed that Giuseppe's records were found on microfilm, preserved before hard copies were destroyed.

The Medical Records facilitator provided instructions for requesting additional records from Westborough State Hospital and advised the author to obtain the legal authority to access the files. The author downloaded the required form from the Department of Mental Health's website, submitted it along with Giuseppe’s death certificate and a $115 fee to the probate court, and received approval quickly. She then sent the permit back to the Medical Records facilitator, who informed her that the Westborough records were also on microfilm, safely archived in a vault at the DMH Central Office.

After completing necessary paperwork and obtaining legal permissions, the author successfully requested and received copies of records from both Metropolitan and Westborough State Hospitals in May of 2016. This process not only revealed details of Giuseppe’s life and struggles but also allowed the author to connect with a grandfather she never knew.

[69] (Martin, 2018)

Summary of Account from Finding Emma; My Search for the Family My Grandfather Never Knew by Amy Whorf McGuiggan[70]

The author reflects on her quest to uncover her grandfather's family history, particularly why he never spoke about his family. According to family lore, her grandfather, John Osborn, was an orphan. Through extensive research into her family history and collecting vital records she discovered her grandfather had siblings. Using tools like Ancestery.com she was able to connect with a long-lost cousin, her grandfather's niece, the daughter of his brother Earnest.

When the author shared with the long-lost cousin that her father and the author's grandfather were brothers, she was puzzled, believing her father had only a sister. Her cousin recalled her father mentioning his sister and nuns at an orphanage, prompting the author to research orphanages in the Boston area. She discovered the Home for Destitute Catholic Children, which closed in 1954, and learned that records could be obtained from the Labouré Center. However, the website indicated the information available was limited, and descendants might find more through Massachusetts state agencies.

Next, the author contacted the Massachusetts Society for the Prevention of Cruelty to Children and spoke with the director of Adoption Services, who informed her that client records from 1878 to 1939 were archived at the Joseph P. Healey Library at the University of Massachusetts, Boston. The author learned that her grandfather John and his brothers Earnest and George had been placed in an orphanage due to neglect. She obtained records from the Home for Destitute Catholic Children, revealing their entry into the home in 1907 and the circumstances leading to their removal from their parents. Further inquiry led to accessing detailed records from the Massachusetts Society for the Prevention of Cruelty to Children. The director sent her a file containing detailed information, including monthly reports about the family from January 1907 to March 1911, when the case was transferred to the State Board of Charity.

After the release of the 1940 Federal census in April 2012, the author searched the census records and discovered her father's older brother, George, listed as a patient at Northampton State Hospital. This finding sparked her desire to learn more about his life, what led to his hospitalization, how he was cared for, and whether his treatment was inhumane, as depicted in Frederick Wiseman's documentary *Titicut Follies*, which exposed the harsh conditions at Bridgewater State Hospital for the criminally insane (Wiseman, 1967).

The author contacted a reference librarian at the Massachusetts State Archives and discovered that case files for Northampton State Hospital are accessible only with a court order due to HIPAA regulations. Before starting a potentially lengthy probate case, she consulted the Compliance Officer at the Department of Mental Health, who confirmed that a file for her grandfather's older brother George existed. Although the Compliance Officer couldn't disclose

[70] (Whorf McGuiggan, 2019)

details about the file or his length of stay, the author felt compelled to pursue the probate case, even if it only contained minimal information.

In January 2013, the author met with a lawyer and initiated a formal probate case in Hampden County to be appointed as the personal representative of her great uncle, who had died intestate (without a will). This appointment was necessary for the author to legally obtain his medical records. As part of the process, she needed to contact all his heirs at law (an heir by right of blood) and secure their written consent for her appointment.

His estate consisted solely of his medical records. The heirs included his two living daughters, a cousin representing his deceased mother (the author's great-great-grandmother), multiple cousins, and her own mother. Most of the heirs, including the daughters who had never met the author, quickly returned their consent. However, the author's mother was not ready to explore her father's history. While she was upset about the investigation, she did not file a written objection, which was required by law.[71] This might have necessitated her personal appearance in Hampden County, a two-hour drive from her home.

Ultimately, in August of 2013, the author was appointed as the personal representative of her great uncle's estate, and her request for his file was sent to the compliance officer at the Western Massachusetts office of the Department of Mental Health. In October 2013, the author received a one-inch-thick file by certified mail, revealing that her great uncle had been admitted to Northampton State Hospital in 1938 and had lived there for 35 years.

[71] Uniform Probate Code requires a court hearing to give interested parties a chance to object to a party being appointed as the personal representative of a decedent.

Burials

Introduction

Burial of the Poor

As discussed at length in the **Historical Timeline** at the start of this report, the most prevalent means of caring for the poor with public funds in early America were almshouses. Towns in colonial Massachusetts built almshouses to provide care for the sick, the disabled, frail elderly and homeless children who were unable to work and had no one to care for them.

The number of people who needed support increased in the 1840s and was magnified by the rural population displacement caused by the growth of industrialization in New England and the large wave of immigration to the U.S. due to the Great Famine in Ireland. The rising number of impoverished and sick immigrants soon overwhelmed local city and town almshouse.

To address this growing need, the Massachusetts legislature chartered new state-sponsored almshouses in Tewksbury, Bridgewater, and Monson which were all opened by 1854 and took over the care of "state paupers", people without legal residence, for whom the state took responsibility. At that time nearly all people who had a substantial mental health condition or an intellectual or developmental disability who required care outside of their families were not served in separate institutions. By the 1860s, these groups of poor people—the disabled poor—made up a large part of the almshouse population.

When people who were poor died and lacked financial resources, family and social connections, they were buried modestly, often without ceremony. The almshouse decedents were often buried in cemeteries known as "potter's fields". A potter's field, pauper's grave or common grave is a place for the burial of unknown, unclaimed or indigent[72] people.

The burial sites often did not include the traditional markings of a typical cemetery. Pauper graves were often marked in ways that symbolized the exclusion of the poor from society, such as without gravestones or with numbers on metal markers (Strange, 2003).

Before the 1700s, coffins were only used by the wealthier members of the community. Poor people were buried with their bodies wrapped in a shroud (a cloth or sheet) and placed directly in the ground. After the 1700s the poor were often buried in pine boxes (Bell, 1990).

The Institutional Cemetery

As part of their responsibility for the care and custody of individuals labeled as insane or feeble-minded, the state was also tasked with providing end-of-life services. This included religious

[72]Indigents are people experiencing extreme poverty.

ceremonies, burial practices, and securing a final resting place for those without family or friends to claim their bodies. These services were carried out in various ways, such as purchasing burial plots from local cemeteries or establishing institutional cemeteries on the grounds of the facility.

Residents of institutions were often buried in institutional cemeteries for several reasons. Some had no surviving relatives, while others could not afford a proper burial. At some state institutions, like the combined almshouse, infirmary, and hospital in Tewksbury, over 8,500 individuals were buried in wooded areas and overgrown fields. Simple pine box caskets were crafted in the woodshop, while burial clothing—such as shrouds, robes, sheets, shirts, nightdresses, and chemises—was sewn by patients in the sewing room (Medfield Insane Asylum, 1902; Taunton Lunatic Hospital, 1899).

Often, graves were dug by patients of the institution. This practice is illustrated in the book *The Girls and Boys of Belchertown: A Social History of the Belchertown State School for the Feeble Minded*:

> *"The first person to be buried there was interred in 1926, one of seventeen residents who died at the school that year. The farm boys*[73] *dug the grave; residents were told only that So and So had left."* (Hornick, 2012, p. 142)

A former groundskeeper of Foxborough State Hospital described a similar practice. Patients who died at Foxborough State Hospital were buried in cemeteries about one-eighth of a mile from the hospital. The deceased were placed in wooden coffins made by other patients in the hospital's woodshop. The patients would dig the graves and bury the deceased with little to no ceremony.

> *"Sometimes you'd see a priest or some family, but usually nobody would be there but the other patients doing the burying. Over the years, we'd have to fill in the graves with more dirt because the wood rotted, and they sunk in."* (Pennington, 2000)

There is variability in how graves were marked in institutional cemeteries. In some cemeteries, grave makers were concrete slabs that did not include any identifying information about the person. In some institutional cemetery graves, such as MetFern, were marked only with a patient number or with a "C" or "P" for Catholic and Protestant and a number that denotes the order in which the patient was buried. Some contemporary scholars believe that institutional leaders did not place identifying information on their cemetery gravestones to spare the families any social repercussions stemming from the negative stigma of having had a loved one die in an institution (Palomba, 2021).

Father Henry Marquardt, the Catholic chaplain at the Fernald State School, was a staunch advocate for better end-of-life care and dignified burial services. In 1973, he founded the Death and Dying Committee at Fernald to support families in providing more respectful burial options

[73] Farm boys were male residents of the Belchertown State School who worked on the institution's farm.

for their loved ones. The committee helped arrange for proper burials at MetFern or facilitated arrangements for a plot at nearby town cemeteries, such as Mount Feake, located just a short drive from the Fernald State School. In the early 1970s, Fernald State School groundskeeper Wayne Brasco collaborated closely with Father Marquardt to address the poor burial practices at Fernald where residents were reportedly buried in shallow, sometimes flooded graves. Together, they worked to provide a more humane and respectful process for patients' funerals. Brasco played a key role in finding alternative burial sites, aiming to reduce the use of MetFern Cemetery, which had been the primary location for interments.

When the patients at Fernald were officially reclassified as residents of Waltham, Brasco and Marquardt approached Mayor Arthur Clark and successfully advocated for the right to have them buried at Mount Feake Cemetery with both Brasco and Marquardt even personally contributing to the cost of the interments (W. Brasco, personal communication, 2024).

Deceased Inmates

Anatomical Sciences

In the early 1800s, medical professionals began to stress the importance of furthering knowledge of human anatomy. Medical education tended to include cadavers[74], but medical schools were not provided with them because there was not a legal way to obtain the bodies needed to instruct medical students. The safest way for anatomists to acquire cadavers was to steal the dead in ways that would not raise outrage among the community by taking the bodies of deceased from groups who offered little resistance (Waite, 1945). People buried in pauper cemeteries from mental health institutions and almshouses provided easy targets (Humphrey, 1973). Officially and unofficially, bodies were taken from the graves or from the institution's morgue and sold to medical students.

The Massachusetts Medical Society played a key role in advocating for the use of cadavers in medical education, championing the passage of the groundbreaking 1831 Massachusetts Anatomy Act, also known as the "bone bills" (An Act More Effectually To Protect The Sepulchres Of The Dead, And To Legalize The Study Of Anatomy In Certain Cases, 1830) This law responded to the increasing demand for cadavers by legally allowing the bodies of unclaimed poor individuals in Massachusetts to be used for dissection in medical schools and hospitals (An Act More Effectually To Protect The Sepulchres Of The Dead, And To Legalize The Study Of Anatomy In Certain Cases, 1830; Countway Library, Harvard University, n.d.-b). However, the Anatomy Act did not mandate that institutions donate the bodies of deceased inmates who lacked the means or family to claim their remains for burial. Instead, it established a legal framework that enabled medical schools to acquire cadavers for educational purposes.

[74] A cadaver is a dead body, especially one that is used for dissection.

In the 1880s, charges of theft and abuse of the inmates at the Tewksbury State Almshouse were leveled against the administrators of the almshouse, including charges regarding the sale of bodies of the deceased to Harvard and other medical schools for anatomical dissection (Report Of The Committee On Public Charitable Institutions, 1883).

In 1921, the state legislature required officials at state institutions to supply anatomists with all unclaimed bodies which required burial at public expense. Chapter 113 of General Law required citizens who died in state hospitals, asylums or prisons to be sent as cadavers to medical schools (Mass. Gen. Laws, Vol. 1, Ch. 1-127, n.d.). The law required that the body of a person who died at a public institution to be taken by one of the medical schools within three days of death unless the person had family or friends who would claim their body.

The law also required that the medical school preserve the body, intact, for a period of 14 days in order for any friends or family of the decedent to identify the person and claim their body for burial. The medical school which received the body had to provide a bond to the Superintendent or Board of Trustees of the institution certifying the body would be used only for the promotion of anatomical science and the remains would be decently buried.

As of 2024, Chapter 113 Section 1 of the Massachusetts General Law permits officers of medical schools in Massachusetts to request bodies for anatomical science of people who died in any public institution within Massachusetts who are required to be buried at the public expense. In defining these institutions, the law includes Tewksbury hospital or other public institutions supported in whole or part at the public expense, except the state-operated veterans' homes (Mass. Gen. Laws, Part I, Title XVI, Ch. 113, § 1, n.d.). Section 2 of the law specifies that this permission will not be given to veterans or people who requested their body to be buried or to be delivered to their family or a friend (Mass. Gen. Laws, Part I, Title XVI, Ch. 113, § 2, n.d.). In key informant interviews with anatomical departments of Medical Schools in Massachusetts, Medical Schools report no longer requesting cadavers through this process as other practices have replaced the need (Medical school anatomical department staff, personal communication, 2024).

Postmortem Examinations

At the turn of the 20th century, pathology departments at state institutions, which were responsible for conducting post-mortem examinations (autopsies), were pushing for the family consent clause of the 1831 Massachusetts Anatomy Act to be removed. Below is the case for this change that was presented in 1900 in the *Twenty-Third Annual Report of The Trustees of The Danvers* Hospital, included in the *Report of the Pathologist*, Dr. W. L. Worcester, addressed to the Trustees of the Danvers Insane Hospital.

> *"As you are doubtless aware, under the existing law the explicit consent of the relatives is necessary before examinations can be made. While fully appreciating the liberality and good sense shown by the relatives and friends of a large proportion of those dying in*

> *the hospital, the fact remains that it has been impossible to secure the required consent in many very interesting and important cases, and in others there has been very undesirable delay before it could be obtained. Would it not be well to make an effort to secure a modification of the law in this regard? When patients have been supported at the public expense, it seems no more than justice that they should contribute to the public welfare, so far as it can be done without injury to anyone. The examination of the bodies of the dead is an essential condition of the progress of medical knowledge. It can be done without the slightest disfigurement noticeable when the body is prepared for burial, and in most cases would probably be entirely unknown to the friends if their attention were not called to it by request. I am satisfied that if it were permissible to make such examinations on patients dying in public institutions whenever it seemed desirable, there would be less distress on this account than at present."* (Danvers Insane Hospital, 1901, pp. 18–19)

Institutional leaders also saw evident self-interest and benefit to providing bodies to medical colleges as noted by George Kline, Commissioner of the Department of Mental Diseases in 1920, when he urged institutional superintendents to provide more bodies to medical colleges during a shortage.

> *"The Department has in the past advocated as much pathological investigation as is possible to obtain material for and will continue to keep this policy in the future, but in the present crisis it would seem that a hearty cooperation in this matter with the various Medical Schools would ultimately react to our own benefit."* (George Kline, 1920).

Inmates Claimed by Families for Burial vs. Institutional Burials of Unclaimed Inmates

What happened to an inmate's body after death, and who was financially responsible for their burial, depended on several factors, including whether the inmate was a legal resident of a Massachusetts city or town and if they had family or friends able to afford the cost of burial. This is evident in the Superintendent's Report from the Third Annual Report of the Trustees of the State Lunatic Hospital at Taunton (1857), which states, "Most of those deceased have been removed by their friends for burial; a few who were without friends, or were destitute of means, have been interred on the hospital grounds" (Taunton Lunatic Hospital, 1857, p. 22). Similarly, in the First Annual Report of the Trustees of the State Hospital at Danvers, the Superintendent reported that "five inmates (being without friends able to pay for their removal) had been buried in a plot of land set aside from the farm for cemetery purposes" (Danvers Lunatic Hospital, 1879, p. 9). It is also important to note that fellow inmates were often permitted to attend and participate in on-site burials, offering prayers and songs in honor of the deceased.

On-Site Morgues/Deadhouses

Frequently, state institutions, including state insane hospitals, had a morgue-like designated space or "deadhouse," which would consist of one room for storing bodies for post-mortem examinations and another for holding bodies while awaiting burial or removal. In the Westborough Insane Hospital's second annual report (1886), the Superintendent, under a "Needs" category, requested $2,000 to construct such a building to serve this purpose and in 1889 the state allotted the hospital $1,000 to have it built (Westborough Insane Hospital, 1887, 1891). Hospital morgues were occasionally reported as assets in annual state institution treasurer reports (Westborough Insane Hospital, 1896, p. 24). While some institutions explicitly requested such assets, others, like The State Almshouse at Bridgewater in 1872, dedicated a portion of leftover space from a facility expansion project towards the preparation of bodies for burials (O'Connell, 1984).

Funding of Institutional Burials

Immigration and Transportation Companies

During the height of immigration, under Massachusetts General Statutes, Chapter 71, Section 15, the Board of Commissioners of Alien Passengers and State Paupers, which was established in 1851, mandated masters of any vessel (shipmaster or ship captain) to report and pay a bond (fee) for any passengers who were severely ill or disabled. If the shipmaster failed to do so and the passenger died in a state institution within ten years of arrival, the state had the right to financially penalize ($500) and seek reimbursement for all expenses covered by the state, including burial expenses, from the shipmaster for each instance (Massachusetts State Board of Health, Lunacy, and Charity, 1880, pp. 129–131). The same reporting requirements, under Massachusetts General Statutes, Chapter 71, Section 4, applied to other transportation companies, like railroads, that brought foreigners to the state. Per Massachusetts General Statutes, Chapter 71, Section 25, if a person ended up dying at a state institution within a year of their arrival, the state had the right to recover the burial cost from the transportation company (Massachusetts State Board of Health, Lunacy, and Charity, 1880, pp. 127–131).

Non-State Paupers vs. State Paupers

According to Lunatic Hospital Finances Massachusetts General Statutes 1862, Chapter 223, Section 16, burial expenses of town and city paupers who died while receiving services in a state lunatic hospital would be reimbursed to the institution by their place of legal settlement. On the other hand, burial expenses for state paupers from Monson, Bridgewater, or Tewksbury, while receiving services in a state hospital would be paid back by the Commonwealth (Massachusetts State Board of Health, Lunacy, and Charity, 1880, pp. 127–131). Under the Laws Relating to the Massachusetts Hospital for Dipsomaniacs and Inebriates from Revised Laws, Chapter 87, Section 101, in cases where the state made upfront payments for burial

expenses of non-state paupers in state hospitals, the person's legal settlement would have to pay back the state; this remained in effect until January 1904 (Massachusetts Hospital for Dipsomaniacs and Inebriates, 1902, p. xiii).

State Paupers - Family or the State Treasury

In the First Annual Report of the State Board of Health, Lunacy, and Charity of Massachusetts (1879), it was noted that the Department of Charities was divided into two departments, one that oversaw the indoor poor[75] residing in state institutions and the other that oversaw the outdoor poor[76] that were ill, receiving temporary relief from the state, among others. In the same report, under the Indoor Poor Settlement Laws section, it references The Burial of State Paupers and Persons Found Dead, Massachusetts General Statutes, Ch. 70, Section 15, which states that burial expenses for state paupers with no legal settlement would be paid back by any family member legally responsible for the individual. If a state pauper did not have family or they were not able to pay, then the state would pay back the state almshouse $5 for state paupers over the age of 12 years and $2.50 under that age. Massachusetts General Statutes 1867, Chapter 97 changed the previous law by increasing the payback amounts to $10 for state paupers over the age of 12 years and $5 for state paupers that were younger (Massachusetts State Board of Health, Lunacy, and Charity, 1880, pp. 157–159).

State Institutional Burial Reimbursements

Since state institutions paid upfront for most burials, it was common to find "Funeral expenses" and "Burial expenses" listed as miscellaneous line items in the treasurer's report for which they expected the state to pay back. The Northampton Lunatic Hospital's Thirteenth Annual Report (1885) discusses payments for these deaths as an operational revenue source in the face of substantial underfunding:

> *"Although a State institution, this hospital has received no gratuitous assistance from the State since the spring of 1867. Since that time, it has relied for its income solely upon the products of its farm, the board bills of its patients[77], and the small sum of ten dollars each for the funeral expenses of State patients who die in the hospital, and whose remains are not removed for burial. The receipts from the last-mentioned source during the past year were only fifty dollars."* (State Lunatic Hospital at Northampton, 1869, p. 36)

[76] Outdoor relief was a form of social welfare assistance given to people in their communities, rather than in institutions like almshouses (Hansan, 2011).

[77] "For the entire support of State patients, including clothing and all loss from breakage and other kinds of destruction, the hospital received $3.50 each per week, from the treasury of the Commonwealth, from April 1, 1870, to April1, 1879." (State Lunatic Hospital at Northampton, 1869, p. 36)

Claims by Families with Economic Means

According to a report in 1939 of the Special Commission on the Burial of Inmates of Institutions, in order for families to claim the body of a deceased relative that was an inmate of a state institution, they were required by law to prove they could afford to pay for the burial. This presented a barrier for many families who did not have the economic means to arrange, oversee, and provide a proper burial for their loved one (Report Of The Special Commission On The Burial Of Inmates Of Institutions, 1939, p. 8). Families who could afford a burial for their family member still needed to obtain removal and/or burial permits.

Investigation by The Special Commission on The Burial of Inmates of Institutions

A Special Commission on The Burial of Inmates of Institutions was created by Chapter 49 of the Resolves of 1938. The charge of the Commission was to investigate burial practices and overall payments made by the state to various public institutions, including state prisons, hospitals, and schools, for funeral and burial expenses of deceased inmates who were poor. The Commission sampled burial payment practices by various institutions and prisons across the state. Institutions that were included in the 1939 investigation included the State Hospitals at Medfield, Taunton, and Worcester, and the State School at Belchertown and Wrentham. Below is a summary of findings made by the Commission, which were shared with the General Court, in 1939:

> "*The Commission found that there was great variation in regard to the burial of the inmates of the different institutions. Chapter 113, which was set up for the promotion of anatomical science, takes care of a certain percentage of the bodies. All of the others had the proper religious services, but there was no uniformity so far as an allowance for the burial is concerned, because at the present time there is no law to take care of the situation. It is all handled by the superintendent of each institution and by rules and regulations. This being so, the Commission has outlined an amendment to the General Laws which they feel will clarify all phases of the situation."* (Report Of The Special Commission On The Burial Of Inmates Of Institutions, 1939, p. 7)

The purpose of the investigation was to fill this gap in public policy and to develop a uniform and transparent process regarding the burials of deceased inmates. The Commission sought to remedy the issue that families who lacked the financial means to pay for a burial could not be able to claim their family member's body under the current law. They sought to provide these families the "privilege of taking care of their relatives" by permitting the state to pay for the burials (Report Of The Special Commission On The Burial Of Inmates Of Institutions, 1939, p. 8). As a result, the Commission recommended legislation to address the variability in practices and the potential of future administrations either severely limiting or substantially expanding benefits. They did so by proposing an Act (House – No. 1968.); it is unclear if it ever passed.

proposed act stated that the state would pay up to $100 in burial services for deceased inmates whose immediate family claimed the body but lacked the financial resources. Under this law, families would be allowed to make burial arrangements, including the selection of the funeral director and cemetery. Conditions of this law required that the family member making the claim must be a US citizen and resident of the state, while the selection of the cemetery was restricted to the state of Massachusetts, but within an authorized distance. As a means of financial control, the Board of Registration in Embalming would be primarily responsible for reviewing all burial invoices for accuracy prior to the state issuing payment (Report Of The Special Commission On The Burial Of Inmates Of Institutions, 1939, pp. 11–13).

The Special Commission stated the following as a conclusion to the report:

> "*The Commission also feels that because in so many cases the Commonwealth has had to take full responsibility of the maintenance, clothing and medical care of these patients, at great expense to the Commonwealth, the Legislature, in approving this bill, would only be doing what is right and just in providing for decent burial at very nominal cost*." (Report Of The Special Commission On The Burial Of Inmates Of Institutions, 1939, p. 10)

Religious Services

End-of-life and Burial Services Across Different Religious Denominations (1830s – 1950s)

The State Lunatic Hospital at Worcester first requested that religious services be furnished and funded by the Commonwealth in 1836. Not only were these services thought to be helpful in the treatment and recovery process of inmates, but they also provided a degree of comfort during an inmate's end of life, especially for those who had no family or settlement (State Lunatic Hospital at Worcester, 1836).

In the mid-1920s, Dr. William A. Bryan, the Superintendent of Worcester State Hospital, hired Rev. Anton T. Boisen, a former mental health patient, as the first hospital chaplain. Boisen, who had been hospitalized for psychotic breaks in the early 1920s, believed that "mental illness", particularly schizophrenia, could be understood as attempts to address soul-level problems. He sought to bridge the gap between religion and medicine, creating a new form of theological education that included practical clinical training in mental health settings laid the groundwork for what would later become Clinical Pastoral Education.

Boisen's first experiment with this approach took place in 1925 when he invited theological students to Worcester State Hospital to work as ward attendants while engaging in seminars and discussions with hospital staff. This initiative expanded over the years as more theological students enrolled (Kindred, 2020).

Several of the hospitals and schools had a chapel on the campus of the institution. Weekly religious services were officiated by a local clergyman from the surrounding areas. Clergy

would also attend and officiate funerals of deceased inmates, as well as visit the sick and dying upon an inmate's request, which sometimes included the administration of a Catholic inmate's last rites. There is evidence from Boston State Hospital's 1956 annual report that these practices continued for both Catholic and Jewish denominations (Boston State Hospital, 1956, pp. 185–195).

End-of-life and Burial Services Across Different Religious Denominations (1990s – 2020s)

End-of-life planning for people with disabilities has undergone a significant transformation, evolving from a time when professionals made decisions without consulting the individuals themselves, to a period of prioritizing the wishes and preferences of the person. This shift was greatly influenced by the disability rights movement and the powerful slogan "nothing about us without us", which called for greater inclusion and self-determination. Efforts to ensure individuals with disabilities have the opportunity to make informed decisions about end-of-life matters, such as funeral planning, illness planning, and living arrangements, have continued to grow.

In 1990, the federal government enacted the Patient Self-Determination Act (PSDA). This act ensures that patients can make informed decisions about their medical care. Its purpose is to empower patients to direct their own health care choices and promote the use of advanced directives, like living wills and durable powers of attorney for health care (Teoli & Ghassemzadeh, 2023).

Under the PSDA, Health care providers receiving Medicaid and Medicare funding must:

- Inform patients of their right to make health care decisions.
- Provide information about advanced directives.
- Document whether patients have an advanced directive.
- Comply with state laws on advanced directives.
- Prevent discrimination based on advance directive use.
- Educate staff and the community about advanced directives.

The PSDA has played a significant role in raising awareness and encouraging the use of advanced directives. The PSDA is particularly important for people with disabilities, as it affirms their right to make their own healthcare decisions and to have their wishes respected, regardless of their ability to communicate or make decisions independently. It encourages advance care planning, which is crucial for people with disabilities who may have complex healthcare needs and may not be able to communicate their preferences clearly at the time of a medical crisis. The PSDA helps to prevent healthcare providers from making decisions for people with disabilities based on assumptions or stereotypes and ensures that their wishes are respected.

In addition, several national disability organizations and advocacy groups, such as American Association on Intellectual and Developmental Disabilities (AAIDD) and The Arc of the United

States, have developed major policy statements regarding health care decision-making and the quality of end-of-life care for people with intellectual or developmental disabilities.

In 2012, AAIDD adopted a position statement emphasizing four core principles for end-of-life care: Dignity, Autonomy, Life, and Equality.

1. Dignity: All individuals, regardless of disability, deserve respect and recognition of their inherent value throughout their lives, including at the end of life.
2. Autonomy: The wishes of individuals with intellectual or developmental disabilities regarding end-of-life care should be respected, even if their decision-making capacity varies. Self-determination and advocacy are key.
3. Life: Caregivers should promote and protect the life of individuals with intellectual or developmental disabilities. Decisions about life-sustaining treatment should consider the individual's best interest, especially when treatment is ineffective or painful, and should also take religious or spiritual beliefs into account.
4. Equality: People with intellectual or developmental disabilities should have access to appropriate, non-discriminatory end-of-life care, including hospice, pain relief, and spiritual care.

The AAIDD's policy asserts that individuals with intellectual or developmental disabilities should have access to the same end-of-life care as others, with their expressed preferences guiding treatment decisions. Life-sustaining treatment should be continued unless there are specific circumstances, such as ineffective treatment or excessive suffering. In cases where individuals are in a minimally conscious state, life-sustaining treatment should only be withheld if the individual has clearly expressed a competent preference. Legal guardians or next of kin can make decisions when the individual is unable to do so, with judicial review for disputed situations.

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In February of 2013 AAIDD and The Arc issued a joint position statement which emphasizes the right of people with intellectual or developmental disabilities to have timely access to high-quality, affordable, and comprehensive healthcare including access to life sustaining care like cancer therapy and mental health services. Additionally, individuals with intellectual or developmental disabilities should have the opportunity to express their preferences for life-sustaining treatments, either through written or oral advance directives, based on their understanding. These directives should be respected and followed by healthcare providers (American Association on Intellectual and Developmental Disabilities, 2025b).

The Department of Developmental Services

In Massachusetts, the planning for end-of-life (EOL) care centers on the individual receiving care, ensuring they are as involved as possible in decisions. In 2024, DDS issued the policy *The Goal of Care for Life Limiting Illness* which emphasizes informed decision-making that respects the individual's dignity, comfort, and quality of life, in line with their wishes (Goals of Care for Life-Limiting Illness, 2025).

The policy emphasizes that individuals with disabilities have the right to express their preferences regarding medical treatment and end-of-life care, with medical decisions based on informed choice, the avoidance of harm, and the goal of benefiting the individual.

Under the policy, individuals with serious conditions may change their code status, such as full code or DNR, according to their preferences. However, code status does not limit other treatments like antibiotics or pain relief. It also allows for palliative care, which focuses on pain relief and improving quality of life, to be provided alongside curative treatments, while hospice care is introduced when curative treatments are no longer recommended.

The policy provides a pathway to resolve cases of disagreement on treatment decisions, which include consultation with an ethicist or ethics committee and seeking court approval when the individual is unable to provide informed consent. Legally competent individuals can consent to changes in their code status, provided certain conditions, such as a life-threatening illness or chronic disease, are met. Additionally, code status orders for individuals under DDS care are reviewed annually to ensure adherence to the policy.

DDS recommends using the Five Wishes® advance directive to guide discussions and document preferences for EOL care, treatment, comfort, funeral arrangements, and legacy. This

document, while not a medical order, is an important part of the person's record and should ideally be prepared with family or friends before a serious illness. For individuals unable to make decisions, guardianship may be necessary. Additionally, a Health Care Proxy can be arranged by consulting with a Service Coordinator. Medical discussions with primary care physicians may involve considering a MOLST (Medical Orders for Life-Sustaining Treatment) and notifying the Area Office if it's being considered. Case managers, medical providers, and Area Office Nurses can also help explore options for hospice and palliative care, which are covered by MassHealth.

In the 1990s and 2000s, Massachusetts embraced person-centered care, tailoring services to the unique needs, values, and preferences of individuals with intellectual or developmental disabilities, including support for end-of-life planning. DDS adopted the Charting the LifeCourse framework, which promotes person- and family-centered planning throughout life, including webinars on aging and end-of-life topics for caregivers, families, and care professionals (Commonwealth of Massachusetts, 2025a).

Recently, there has been a stronger emphasis on promoting autonomy, dignity, and supported decision-making for individuals with intellectual or developmental disabilities, especially in end-of-life care. Massachusetts has made significant strides in ensuring that individuals with intellectual or developmental disabilities are included in decisions about their care, including:

- Supported Decision-Making: Models have been adopted to assist individuals with intellectual or developmental disabilities in making healthcare decisions, with support from family members, advocates, or professionals (Center for Public Representation, 2025).
- Increased Awareness and Training: Healthcare providers, caregivers, and family members receive training on the unique needs of individuals with intellectual or developmental disabilities, prioritizing their dignity and choices at the end of life (*Aging with Intellectual and Developmental Disability Trainings*, 2025a).
- Hospice Care: Access to hospice care has been expanded, ensuring that these services are tailored to the needs of individuals with intellectual or developmental disabilities, particularly for those living outside institutional settings (Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid, 2013).
- Advance Directives and Healthcare Proxies: There has been growing recognition that individuals with intellectual or developmental disabilities should have the right to create advance directives and healthcare proxies to ensure that their wishes regarding end-of-life care were respected. These legal documents allowed individuals to outline their preferences for treatment, including life-sustaining measures and end-of-life care, if they became incapacitated (Massachusetts Health Decisions, 2025).

DDS Mortality Review

The Department of Developmental Services (DDS) has a formal process to review and report mortality among individuals it supports. This process helps identify causes and circumstances of deaths, which informs quality improvement efforts. The University of Massachusetts Chan Medical School's E.K. Shriver Center has produced annual mortality reports since 2000. DDS also conducts clinical mortality reviews for individuals meeting specific criteria, such as those receiving DDS residential support or dying while in DDS programs (*Mortality Review*, 2025).

The review process involves several steps, including a clinical mortality review by DDS nurses and follow-up by regional and central committees. If a case raises further questions, it may be referred to the Central Mortality Review Committee, which is composed of various DDS officials and experts (Lauer, 2019). Additionally, death reports are investigated for possible abuse, neglect, or other issues by the DDS Investigations Division, the Disabled Persons Protection Commission (DPPC), and the Department of Public Health (DPH), depending on the circumstances.

DDS also offers a series of webinars aimed at supporting aging individuals with intellectual or developmental disabilities. These webinars are designed for caregivers, families, direct care workers, residential managers, and case managers. Topics covered include person-centered planning, health, adapting to age-related changes in the home, day programs, and other community settings, as well as dementia and I/DD. Additionally, the webinars emphasize honoring cultural practices and respecting individual preferences (*Aging with Intellectual and Developmental Disability Trainings*, 2025b).

The Department of Mental Health "Do It Your Way" Project

The "Do It Your Way" project, launched in Massachusetts in 1998, aimed to improve access to advance care planning and end-of-life care for individuals with serious mental illness (SMI). Funded by the Robert Wood Johnson Foundation, this three-year demonstration project sought to explore and promote advance care planning for people with SMI, regardless of their guardianship status. The project focused on studying their capacity to select a healthcare agent and understanding their ability to make and communicate healthcare preferences.

Central to the project was advocating for the right of individuals with SMI to engage in advance care planning and receive high-quality end-of-life care. One of the project's major achievements was fostering collaboration among professionals across different fields. This collaboration created a team of cross-trained individuals who addressed service gaps in EOL care for people with SMI, leading to integrated service delivery opportunities and improved access to care for this underserved population.

The project also developed valuable research tools that identified unique EOL care challenges faced by individuals with SMI. The findings have informed policy development at DMH.

Through its outreach efforts, the project raised awareness among both patients and healthcare providers, enhancing understanding and access to EOL care for individuals with serious mental illness. In the Metro Suburban area, DMH established the End-of-Life Care for Persons with Serious Mental Illness initiative. This project helped mental health care staff in suburban towns near Boston learn about and promote advanced care planning for individuals with SMI. It also trained hospice staff to better address the needs of individuals with SMI who were nearing the end of life. Toward the project's conclusion, staff developed the "Do It Your Way" communications campaign, a subset of its work, to further spread awareness and encourage engagement in advance care planning.

As part of this effort, tools were developed to help providers assess the capacity of individuals with mental health conditions to communicate their healthcare preferences, make medical decisions, and complete advance care directives. Additionally, staff facilitated cross-training, helping hospice workers understand mental illness and teaching mental health care workers about hospice care, thus bridging the gap between the two fields.

The project led to changes in practices. For example, in the Metro Suburban area, an end-of-life committee was formed to ensure that terminally ill patients with SMI could remain in familiar environments for as long as possible.

The project's activities also led to the creation of a statewide DMH Advance Directive Policy Committee in 2000. This committee was tasked with addressing various aspects of patient care, including do-not-resuscitate (DNR) orders, Comfort Care Laws, healthcare proxies, guardianships, and patient preferences. Composed of a policy analyst, three consumers, a DMH attorney, a human rights officer, a case manager, and two residential mental health providers, the committee reviewed relevant policies and regulations. Their efforts culminated in the development of a value statement, which was approved by MA-DMH leadership. The statement emphasized the importance of client participation in all aspects of healthcare, stating:

> *"The MA Department of Mental Health supports clients' participation in all aspects of their healthcare. Therefore, DMH encourages clients to express their wishes regarding medical, psychiatric, and end-of-life care through active participation in treatment planning and the use of advance directives."* (Foti, 2003)

Burial-related Legal Requirements

Death Registry Laws

By the mid-1800's, each town in Massachusetts was legally required (Massachusetts General Statutes 1842, Chapter 15) to have a town clerk or registrar maintain a registry of birth, marriage, and death records for which they had to submit certified copies of to the State Secretary every year. Per the University of Massachusetts Amherst Library, "…two sets of records, at the local and at the state level, exist for almost every birth, marriage, and death

since 1841" (UMass Amherst Libraries, n.d.). Regarding births and deaths (Revised Statutes 1842, Chapter 15, Sections 46 & 47) as it relates to institutions, the law mandated "the keepers of almshouses, workhouses, houses of correction, prisons and hospitals, and the masters of ships to give like notice of births occurring under their charge…within six months after the birth occurs"[78] (Massachusetts Office of the Secretary of State. Division of Statistics, 1842, p. 4). Failure to do so would result in a $5 fine per incident. At this time, there was no standard form of record or return for consistent data collection across the state (Massachusetts Office of the Secretary of State. Division of Statistics, 1842, pp. 4–5).

Despite enacting this law to address statewide statistical public health needs, it was criticized for its "loose construction of the terms of the law" and by the fact that "the laws of Massachusetts prescribe no simple and uniform mode of registration in the several towns" (Massachusetts Office of the Secretary of State. Division of Statistics, 1842, p. 4). In 1842, his first report to the Commonwealth, the Secretary of State, John A. Bolles stated, "So loose and inexact are the rules of law concerning the registration of marriages, births and deaths in this Commonwealth" (Massachusetts Office of the Secretary of State. Division of Statistics, 1842, pp. 4–5).

To help resolve the issues of inconsistent and incomplete recordkeeping practices, Bolles made recommendations to revise the Massachusetts law, and adapt and adopt certain components from European legislation, including, but not limited to, requiring the state to provide town clerks standard registration and return forms; having informants promptly report such events, along with specific information; requiring town clerks to record, index, and issue a certified copy of all records delivered to the state; having these records become a part of public archives; requiring undertakers to obtain written authorization from town clerks (burial permits) for legitimate burials to take place; and requiring an inspection of corpse or certificate of disease by a medical attendant. Most of these recommendations, in full or in part, were enacted into law by 1860 under the Laws Concerning the Registration of Births, Marriages, And Deaths Massachusetts General Statutes Chapter 21, Sections 1-11, and applied to all state institutions, except for the three state almshouses. Per Section 8 of Massachusetts General Statutes Chapter 21, the recording and reporting to the state of the births and deaths occurring in these state almshouses (specified as Tewksbury, Bridgewater and Monson) was the duty of the superintendent and not of the town clerk (Massachusetts Office of the Secretary of State Division of Statistics, 1862, p. clxi–clxii).

Death records usually consisted of basic demographic and death-related data, including disease or cause of death, time and date of death, and place of death and burial (Massachusetts Office

[78] *"Deaths. The same sections apply to deaths as well as to births, and in like manner; with the additional provision that [the eldest person next of kin] shall give notice of the death of his kindred. This is the whole body of law on the subject. Nothing is required to be communicated by any informant to the town clerk, respecting the sex, age, occupation, cause of death, or any other matter which, by the act of '42, the returns are required to contain and set forth; and there is no legal right on his part to make the needful inquiry."* (Massachusetts Office of the Secretary of State. Division of Statistics, 1842, p. 5)

of the Secretary of State Division of Statistics, 1862, p. clxi). Deaths due to "insanity" were grouped in a larger category of brain diseases that also included softening of the brain, paralysis, etc. Intellectual and developmental disabilities of children and adults, which included a subcategory of other malformations, such as "idiocy", were both established as primary categories of causes of death. Deaths of people with intellectual or developmental disabilities could be split among other categories as well including epilepsy, convulsions, spina bifida, "other malformations of children" as established categories in addition to any of the other categories (e.g., infectious disease deaths, systems-based medical conditions, sudden deaths, etc.). Eventually, this data was integrated into the Commonwealth's widening systematization and recordation of overall population-level mortality statistics, which began sometime shortly after the turn of the 20th century (Massachusetts Office of the Secretary of State Division of Statistics, 1882).

Death Certificates and Burial-Related Permits

In 1860, per the Laws Concerning the Registration of Births, Marriages, and Deaths Massachusetts General Statutes, Chapter 21, Section 4, prior to any burial, any person charged with overseeing a burial-ground (also referred to as a sexton or undertaker) was required to report deaths to the town clerk in which the deceased resided or where the death occurred. The person who reported the death paid a ten-cent fee for the clerk to a Certificate of Registry of Death (like a burial permit). A penalty of $20 would be charged to anyone who conducted burials without this permit. Section 1 of this law defined what needed to be in a person's death records, including personal and death-related facts, e.g., name, sex, place of birth, death and burial, disease or cause of death. Undertakers were expected to report these facts to the town clerk. Section 3 of this law required physicians to issue a Certificate of Cause of Death only upon request. Finally, unlike Section 4, Section 8 of this law required superintendents of the three state almshouses to report births and deaths directly to the State Secretary (Massachusetts Office of the Secretary of State Division of Statistics, 1862, p. clxi–clxiii).

By the early 1900s, this process changed and required undertakers to ensure satisfactory death certificates were issued and filed with the local Board of Health prior to them obtaining removal (transporting the body outside the town where the death occurred) or burial permits. Under the new process, once filed, the Board of Health transmitted death certificates to the town clerk who then registered deaths locally and reported them to the Commonwealth shortly after (Massachusetts Office of the Secretary of State. Division of Statistics, 1935).

However, hospitals and institutions were exempt from the death certificate clause and only had to provide the data required to complete the death record. Per the Massachusetts Vital Statistics report of 1917, this led to discrepancies. The report noted that "several important items required by the standard certificate of death are not obtained in the case of deaths in hospitals and institutions" (Massachusetts Office of the Secretary of State. Division of Statistics, 1917, p. 108). Nevertheless, institutions and hospitals continued to be exempt from filing a

standard death certificate 47 years later when certain duties related to vital statistics were transferred from the Secretary of State to the Commissioner of Public Health in 1964 (Massachusetts Registry of Vital Records and Statistics, 1964).

It is important to note that in 1935 the law changed and for the first time in Massachusetts deaths were being charged to the place of residence of the deceased. It was believed that this change would address the registration deficiencies of municipalities that were considered large hospital centers. In the case of institutional deaths, the charges for these deaths were allocated to the deceased inmates' last known place of residence prior to their commitment to any state institution as they were considered temporary residents of these institutions (Massachusetts Office of the Secretary of State. Division of Statistics, 1935). Deaths and births that took place in these institutions continued to be allocated to an inmate's place of previous residence, as reflected in the 1964 Massachusetts Registry of Vital Records annual report (Massachusetts Registry of Vital Records and Statistics, 1964).

Cemeteries

Epidemics

Initially, most state institutions relied on their local town cemeteries to bury deceased inmates. However, epidemics, such as Typhoid fever in the late 1800's (1890), diphtheria and the Spanish flu (1918) in the early 1900's, attributed to a great increase in institutional deaths. This increase caused the need to use mass graves or the development of on-site burial grounds. For example, in 1918 the Commission on Mental Diseases reported a total of 417 institutional deaths related to the epidemic at the time, of which 92% represented patient deaths (State Department of Health, 1919).

Here are some examples as to how the epidemic impacted burial practices at a few state institutions. In the Trustee's Report of the Worcester State Hospital's 1918 annual report, it stated, "The number of deaths from terminal cases and the epidemic of Spanish influenza made burial in the lot at Hope Cemetery no longer possible. A retired, attractive spot at Hillside farm has been prepared for the interment of patients without friends or family ties" (Worcester State Hospital, 1919, pp. 7–8). The same situation occurred at Medfield State Hospital where the town requested the state establish their own cemetery as it could no longer accommodate patient burials as a result of the epidemic at the town's Vine Lake Cemetery (Thompson, n.d.).

In 1919, The Templeton Colony, which was affiliated and overseen by the School for the Feeble-Minded at Waltham, reported in the Trustee's Report the following impact from the epidemic, "The past year has been a trying one, beginning with a recurrence of the dread epidemic of influenza, when in February at the colony we had 245 cases with 15 deaths. For the first time since we moved our big boys to Templeton, we had occasion for a burial lot and so purchased one in the local cemetery" (Massachusetts School for the Feeble-Minded at Waltham, 1920, p.

7). At the time, there were 1,858 inmates served between Waverley (later Fernald State School) and Templeton.

The Great Depression

Between 1906 and 1915, the Commonwealth of Massachusetts purchased six multi-grave lots on this hillside of Rock Hill Cemetery in Foxborough with the intent of providing a final resting place for the patients from Foxborough State Hospital. In 1933, as needs increased during the Great Depression, some families were unable to pay the cost of a burial and just decided to leave their loved ones where they were. The Foxborough State Hospital Cemetery on Cross Street was developed for the internment of deceased patients (Pardo Pellicer, 2024).

U.S. Veterans

Throughout the 1800s, people with disabilities were generally excluded from military service—not always through direct legislation, but often through medical standards that automatically disqualified individuals with physical disabilities or mental health conditions. Conditions such as missing limbs, blindness, deafness, or mental illness were considered incompatible with military duties. These exclusionary standards mirrored broader societal attitudes that viewed people with disabilities as unfit for both military service and civic participation.

One early recognition of the need for mental health care for service members came with Chapter 142 of the Acts of 1918, which authorized any state institution under the general oversight of the Massachusetts Commission on Mental Diseases and McLean Hospital to provide temporary care and treatment for military and naval personnel suffering from “mental illness” who were unable to receive appropriate care through the Armed Forces. Inpatient services were approved for up to 60 days, unless the Commission warranted an extended stay. The law also allowed the Commission to enter federal contracts to serve these populations (An Act To Provide For The Temporary Care Of Persons Suffering From Mental Diseases Who Are In The Military And Naval Service Of The United States, 1918). This legal provision acknowledged that existing military systems were not equipped to adequately handle mental health crises among service members, reflecting early efforts to bridge civilian and military health care in addressing psychiatric needs.

In the 20th century, particularly after World Wars I and II, public attitudes and military policies regarding disability began to evolve—albeit slowly. While strict medical standards continued to bar many individuals with disabilities from enlistment, the return of thousands of injured veterans spurred important developments. Programs like the Veterans Administration (now the Department of Veterans Affairs) and vocational rehabilitation initiatives emerged, acknowledging the contributions and capabilities of disabled service members and marking the beginning of a shift toward greater inclusion (*Veterans Burial Allowance and Transportation Benefits*, 2024).

Service members who entered the military often faced not only physical injury but psychological trauma that was, at the time, poorly understood. During World War I, many soldiers who experienced extreme stress in combat were diagnosed with "shell shock," a term used to describe a range of psychological reactions to the horrors of war. By World War II, the diagnosis had evolved into "combat stress reaction" (CSR), reflecting a growing, though still limited, understanding of mental health in military contexts. According to the Western Front Association, while the concept of wartime psychological trauma was not new, the belief that these illnesses could be treated and potentially cured was a significant shift (The Western Front Association, n.d.). The National WWII Museum notes that more than half a million American service members suffered some form of psychiatric collapse during World War II, with 40% of all medical discharges related to psychiatric conditions. As a result, many veterans found themselves in mental health hospitals following their service, highlighting another dimension of how war shaped the nation's approach to disability (*Invisible Wounds of War: Mental Health in WWII*, n.d.).

Evidence of this evolving recognition can also be seen in institutional records from the post-World War I era. In the 1924 annual report from the Department of Mental Diseases, under the Social Service Report summary for the Massachusetts School for the Feeble-Minded, a section titled Army and Navy Report documented a notable effort to acknowledge the military service of former patients. The report stated:

> *"During the year a special survey was made of former patients who were in service during the world war. The records of 74 patients who were reported to have been in the war, and of 96 others who were thought to be eligible for service, were investigated. Of these 170, 90 boys were verified as showing war service. Dr. Fernald had it in mind to have a boulder placed on the front lawn with a bronze tablet bearing the names of these 90 boys."* (Department of Mental Diseases, 1925, p. 74)

There are a number of cemeteries with residents of institutions that have the graves of veterans identified including:

- Grafton State Hospital Cemetery has marked the graves of 14 veterans who died while in the hospital.
- Gardner State Hospital has marked the graves of seven veterans who died while in the hospital.
- At least two Metropolitan State Hospital patients buried at MetFern served in the armed forces.
- Donald Vitkus, former resident at Belchertown State School, served in the Vietnam war and is buried at Warner Pine Cemetery.

According to the 1918 Annual Report of the Massachusetts School for the Feebleminded forty-seven former Fernald residents were discharged from the school to serve in World War I (Massachusetts School for the Feeble-Minded at Waltham, 1919).

All Massachusetts veterans with honorable discharge are eligible for several burial benefits from the Department of Veterans Affairs (VA), including (*Veterans Burial Allowance and Transportation Benefits*, 2024):

- Headstone, Marker, or Medallion: The VA will provide a government-furnished headstone, marker, or medallion at no cost. While the VA will ship the headstone or marker at government expense, it does not cover the cost of placing it on the grave.
- Burial Flag: The VA will provide a burial flag at no cost to the veteran's family.
- Presidential Memorial Certificate: The VA will also provide a Presidential Memorial Certificate at no cost to the family as a tribute to the deceased veteran.

Cemetery Sites

See **Appendix 2** for individual profiles of known cemeteries on institutional grounds or known to be substantially used by institutions for burial of people who lived at the institutions. These profiles also include a cemetery shared by multiple medical schools for the purposes of burial of bodies donated to science (the Pine Hill Cemetery in Tewksbury, MA).

Unmarked Burials

As cemeteries and burial grounds get older, temporary or fragile grave markers can change or disappear. In some cases, like hospital cemeteries or potter's fields which were used for burial of patients from the state institutions, graves of people buried at or near institutions were frequently not marked or were marked with wooden or other short-lasting signs. It can be hard to see where the graves are, especially as fences, walls, or plants around the cemetery break down over time. As nearby buildings and roads get closer to the cemetery, unmarked graves may be at risk. Researching the history of the land, including maps and documents, can help find these graves. Once found, tools like Ground Penetrating Radar (GPR) can help locate graves and define the edges of old burial sites. More research may be needed if the area is being planned for new buildings or other changes (U.S. Department of the Interior, 2022).

There are several Massachusetts laws and regulations that protect burial grounds, particularly historic cemeteries, and address the preservation of burial sites, especially in cases of unmarked graves or skeletal remains.

1. Preservation of Ancient Burial Places (Chapter 114, Section 17): Protects burial grounds older than 100 years, prohibiting their appropriation for other uses without special legislative approval. This includes unmarked burial grounds.
2. Discovery of Skeletal Remains (Chapter 38, Section 6): Requires immediate notification to authorities if human skeletal remains are discovered. A state archaeologist will assess whether the remains are Native American and determine if the site requires further evaluation.

3. Project Notification and Review (Chapter 9, Section 27C): Mandates that any construction or agricultural activity that might disturb unmarked human remains cease until the site is evaluated by a state archaeologist and the remains are properly handled.
4. Care of Neglected Burial Places (Chapter 114, Section 18): Allows towns to take responsibility for abandoned or neglected burial grounds and maintain them, ensuring no property rights are violated and bodies are not disinterred.
5. Disinterring Bodies (Chapter 272, Section 71): Criminalizes the unlawful removal or disturbance of human remains, imposing fines or imprisonment.
6. Injury to Memorials or Burial Structures (Chapter 272, Section 73): Criminalizes the destruction or damage of tombs, gravestones, veteran markers, or any memorial structures, with severe penalties for violations.
7. Removal of Gravestones for Repair (Chapter 272, Section 73A): Permits the removal of gravestones for repair or reproduction, provided the work is done by authorized educational and professional teams under state guidelines.
8. Code of Massachusetts Regulations: Establishes procedures for obtaining permits for gravestone restoration or reproduction, requiring approval from the Secretary of the Commonwealth. Only non-profit organizations may reproduce gravestones for historical purposes, and a detailed restoration plan must be submitted for review.

When human remains are accidentally uncovered, such as during construction or land disturbance, it is important to follow specific steps. Remains could belong to prehistoric or historic Native Americans or other individuals whose graves were unmarked. If bones are found, they should not be disturbed, and local authorities and a medical examiner must be notified. The medical examiner will assess the remains' age and, if over 100 years old, a State Archaeologist will investigate further (Secretary of the Commonwealth of Massachusetts, n.d.-b).

The State Reform School for Boys in Westborough

The former State Reform School for Boys in Westborough presents a potentially challenging situation regarding unmarked graves. The State Reform School for Boys was displaced from its original location next to Lake Chauncy in Westboro by the Westborough Insane Hospital (later known as the Westborough State Hospital) in 1884. Young boys between the age of 7 and 20, including those with mental health conditions or intellectual or developmental disabilities, were sent to the reform school for minor crimes (Leaf, 1988).

The Worcester Telegram & Gazette reported that there is anecdotal evidence of a burial site on the grounds of the former institutions (Schwan, 2024).

In the event that this site is investigated for the presence of unmarked graves, the investigation must comply with legal guidelines, as the land is conservation land with use restrictions. Collaboration with the Massachusetts State Archivist and relevant authorities is essential to

ensure proper procedures are followed. A detailed archaeological survey, informed by archival research, will be necessary before any other measures can be taken to help confirm and locate burial sites with minimal disturbance. In addition to working with the State Archivist, all necessary permissions must be obtained from town bodies governing the land, such as the Conservation Committee given its location on conservation land adjacent to the lake.

Northampton State Hospital Burial Ground[79]

The Northampton State Hospital burial ground was in use from the institution's founding in 1858 until 1921. The hospital's mortuary slip books contain several direct references to the "hospital cemetery" (12/25/1914), "hospital burial ground" (7/23/1915), and "hillside cemetery" (6/11/1916) in the section for body disposition.

The 4-acre field, once part of a 530-acre site, contains no grave markers, and all burial records have been lost. The site is not recognizable as a burial ground, and the exact location and extent of the burials have not been confirmed.

Research conducted by the Department of Mental Health (DMH) in June 1997 confirmed 181 burials on the hospital grounds. Death records in the hospital casebooks were cross referenced with mortuary slips, death registers from the City of Northampton, and local cemetery records. An additional 413 burials were identified with unclear or unspecified dispositions, such as simply noting "Northampton", which may also refer to those buried on the hospital grounds. In the late 19th century, between one-third and one-half of patients who died at the hospital were buried there.

After 1921, when patients not claimed by family or friends passed away, their burials were documented under "Chapter 113 of General Law" and "Chapter 77 of Regular Law", which allowed unclaimed bodies to be sent to medical schools for dissection and it is likely that their remains are interred at Pine Hill Cemetery in Tewksbury. These laws remain in effect today.

Northampton State Hospital closed in 1993, and the field known as "Cemetery Hill" was abandoned. The City of Northampton acquired a 99-year lease from the Department of Food and Agriculture and subleased the field to Smith Vocational Agricultural School for agricultural training. Protected by a permanent agricultural use restriction, the field is currently used for haying, which helps maintain the area.

Bridgewater State Hospital[80]

In 1981, while digging a 7-foot-deep trench for construction purposes at the Bridgewater State Hospital for the criminally insane, workers uncovered at least 13 neatly laid-out skulls and skeletons. The remains were discovered in a location near an old mausoleum that dates back to

[79] (Massachusetts Department of Conservation and Recreation, 2009)
[80] (Mooney, 1981)

1898, which had historically been used for storing bodies during the winter months when the ground was frozen. This was typically done until the ground thawed enough for proper burial in the spring.

The Hospital Superintendent at the time, Charles Gaughan explained that the bodies were likely connected to the mausoleum and may have been part of a cemetery at the location. However, no official records exist of a cemetery in that area, leading to confusion among hospital staff and authorities. The hospital already has two other cemeteries at nearby locations, one of which dates back to the early 1900s.

The bones were found at 3-foot intervals along one side of the trench, suggesting that more remains may be buried in the area. Workers initially discovered only the tops of the skulls, with the backhoe narrowly missing several of them. Gaughan expressed uncertainty about the full extent of the burial site, including when the bodies were buried and how many might be there.

Foxborough State Hospital

In 2010 Jack Authelet, local Foxboro author and longtime member and president of both the Foxboro Historical Commission and Foxboro Historical Society, came across a cluster of stones between an old building and the original Mansfield and Framingham Railroad tracks near the Foxborough State Hospital campus. Accompanied by his wife they searched the undergrowth and found the remains were disinterred from a far and forgotten corner of the asylum grounds, that had been overlooked in the woods for a century.

This may be a possible explanation for a story employees passed down of a patient who had been buried alone, because they had some type of "communicable disease." No one knew the identity of this patient, where they were buried, or if it was true at all (Pardo Pellicer, 2024).

Authulet had to petition the state to allow for an exhumation without any proof of who was buried there. The identity of the man or woman most probably will remain unknown. In 2000 it was found that *"About the only documentation the Massachusetts Archives has of the former state-run psychiatric hospital is a series of annual reports and some general summaries of the facility, such as when it was opened and when it closed* (Pennington, 2000)*".*

The supervisor at the Massachusetts State Archives said,

> *"Everything that's taken in is cataloged. There are no case files for Foxboro. If a relative of a patient who was believed to be buried on the grounds of the former Foxboro State Hospital were to try to identify which numbered stone belonged to a family member, it would likely be an unattainable task."* (Massachusetts State Archives Supervisor, personal communication, 2024)

Pine Hill Cemetery

Pine Hill Cemetery in Tewksbury was originally used for the burial of unclaimed bodies under Chapter 113 of the General Laws required that the bodies of citizens who died in state hospitals, asylums, or prisons be sent to medical schools for dissection (Massachusetts General Laws, Vol. 1, Chapters 1-127). According to this law, the body of any person who died at a public institution had to be transferred to a medical school within three days unless the deceased had family or friends who would claim the body.

The law also mandated that medical schools preserve the body intact for 14 days to allow any potential family or friends to identify and claim it for burial. Additionally, the medical school receiving the body was required to provide a bond to the Superintendent or Board of Trustees of the institution, certifying that the body would only be used for anatomical study and that the remains would be decently buried afterward.

Although the law is still technically in effect, it has not been implemented for over 75 years, dating back to the 1940s.

The Cemetery is maintained by the medical schools of Boston University, Harvard University, Tufts University, and the University of Massachusetts Medical School. A Burial Agent oversees the cemetery's operations.

In the fall of 2024, the CDDER identified the names of approximately eighty-five former state hospital patients from Bridgewater State Hospital. These individuals were listed in the Bond Book of Bridgewater State Hospital, housed at the Massachusetts State Archives. Their names and dates of death suggest they may have been buried at Pine Hill Cemetery between the late 1930s and mid-1940s.

Traditionally, Pine Hill allowed families to provide flat markers for the graves, but if no marker was supplied, no marker would be placed. Veterans, however, could apply for a VA-issued marker.

Records of burials are currently maintained both in paper form, though older records are not very detailed, and in a digital database. The Burial Agent serves as the keeper of these records. The cemetery is fenced, and an electronic gate was installed after concerns were raised by nearby residents about teens using the area for parties (Pine Hill Cemetery Burial Agent, personal communication, 2024)

Cemetery Preservation and Restoration

The National Association of State Mental Health Program Directors (NASMHPD) issued a statement in 2001 that outlined their position on hospital cemeteries and their preservation and restoration (National Association of State Mental Health Program Directors, 2001).

The position statement outlined what states should do, including:

- Checking the history and condition of cemeteries at psychiatric hospitals.
- Collaborating with groups that support mental health to start cemetery restoration projects.
- Using guides like the one from the Georgia Consumer Council[81] and the National Empowerment Project.

It also stated that states should:

- Try to find the graves and share the information with families.
- Fix and maintain the cemeteries.
- Take care of them forever.
- Build a memorial if not all graves can be found.

The National Historic Preservation Act (NHPA), passed in 1966, established a national framework for preserving historic sites. It created permanent institutions, like state historic preservation offices, and mandated documentation of sites impacted by federal projects. The Act also led to the establishment of the President's Advisory Council on Historic Preservation and the National Register of Historic Places (U.S. Department of the Interior, n.d.-a).

The National Register of Historic Places (NRHP), a significant tool for preserving historical sites, including state hospital cemeteries. The NRHP is managed by the National Park Service and provides various benefits to properties listed, including federal tax incentives and opening up opportunities for funding options, such as grants, to support preservation projects (U.S. Department of the Interior, n.d.-c).

A listing on the NRHP indicates that the property is recognized as a culturally important landmark. Cemeteries on the NRHP help to increase public awareness of the property and may attract historical enthusiasts lending support to ongoing preservation of the site. The NRHP provides some limited protection from adverse effects of state or federal projects and safeguarding them from inappropriate changes or neglect. However, it doesn't prevent property owners from managing their sites unless state or federal involvement is present. In contrast, Local Historic Districts provide stronger protections against unsuitable alterations (Rocchi, 2016).

Several state hospitals and school cemeteries are listed on the NRHP, including those associated with Metropolitan State Hospital/Fernald State School, Wrentham Developmental Center, Belchertown State School, Monson Developmental Center, Grafton State Hospital and Foxborough State Hospital, Tewksbury and Medfield State Hospital (Secretary of the Commonwealth of Massachusetts, n.d.-c).

[81] The Georgia Consumer Council adopted the Central State Hospital Cemetery Memorial Project as a tribute to those who faced behavioral health in a less enlightened time as an effort to reduce stigma and increase community understanding about mental illness.

Massachusetts supports preservation through programs like the Massachusetts Preservation Projects Fund (MPPF), which offers matching grants for properties listed in the State Register of Historic Places (U.S. Department of the Interior, n.d.-b). To qualify, properties need to be listed on the NRHP or State Register, and municipalities or nonprofit organizations can apply for funding. The MPPF addresses issues such as deferred maintenance and ensures long-term site preservation.

Additionally, Preservation Restrictions safeguard historic properties from unauthorized alterations, potentially offering indefinite protection and sometimes qualifying for federal tax deductions (Secretary of the Commonwealth of Massachusetts, n.d.-a).

Lastly, the Community Preservation Act (CPA) provides funding opportunities for preservation projects, including cemetery restoration, though it requires local approval (Levitt, 2010).

Institutional Cemeteries Restoration Status

The cemeteries on institutional grounds are in various states. Some have been restored or well maintained, while others are in various states of disrepair. Below is a list of cemeteries known to be restored, and those where there is evidence that restoration is needed as gathered to date by CDDER.

Restored Cemeteries:

- Belchertown State School - Warner Pine Grove Cemetery
- Danvers State Hospital - Main Cemetery
- Danvers State Hospital - Middleton Colony Cemetery
- Glavin Developmental Center - Hillside West Cemetery
- Medfield State Hospital - Medfield State Hospital Cemetery
- Medfield State Hospital - Vine Lake Cemetery
- Monson Developmental Center- New Hope Cemetery
- Westborough State Hospital - Pine Grove Cemetery[82]
- Wrentham Developmental Center - Louise Johnson Memorial Cemetery

Cemeteries that Require Restoration:

- Boston State Hospital - Mt Hope Cemetery
- Bridgewater State Hospital - The Prison Cemetery
- Bridgewater State Hospital - The Morgue Cemetery
- Foxborough State Hospital - State Hospital Cemetery
- Foxborough State Hospital - Rock Hill Cemetery
- Metropolitan State Hospital and Fernald State School - MetFern Cemetery
- Northampton State Hospital - Hospital Cemetery; also called Hillside Cemetery

[82] Currently being restored (https://westboroughcemeteryproject.org/index.html).

- Tewksbury Hospital - The Pines
- Tewksbury Hospital - Livington Street Cemetery
- Worcester State Hospital - Hillside East Cemetery

Cemeteries to be Evaluated:

- Gardner State Hospital- East Gardner Colony – State Hospital Cemetery
- Grafton State Hospital Cemetery - Hillcrest Cemetery
- Metropolitan State Hospital and Fernald State School - Mt Feake Cemetery
- Metropolitan State Hospital and Fernald State School - Belmont Cemetery
- Taunton State Hospital - Mayflower Hill Cemetery
- Templeton Developmental Center - Pine Grove Cemetery
- Various Institutions - Pine Hill Cemetery, Tewksbury
- Worcester State Hospital - Hope Cemetery

Cemetery Restoration Profiles

Metfern Cemetery Restoration Efforts

The Metfern Cemetery in Waltham contains the remains of approximately 300 people who resided at the Former Fernald State School and the former Metropolitan State Hospital. The MetFern Cemetery had burials between 1947 and 1979. The cemetery spans 2/3 of an acre and contains 28 rows of graves, with a total of 367 known burials. Of these, five graves are marked with proper headstones displaying the names of the deceased. The remaining 362 graves of these interred are identified on monuments only with a letter ("C" or "P") followed by a number. "C" indicated Catholic, and "P" indicated Protestant.

The Massachusetts State Archives holds the cemetery registers for the Fernald Developmental Center for the period covering 1947-1979, which identifies the names of the people buried at each numbered location. People who died at Fernald and Metropolitan State Hospital outside of this time may have been buried at the Mt. Feake Cemetery in Waltham.

The MetFern Cemetery, located at the base of a hillside near a marsh. The cemetery is accessible by walking approximately 0.62 miles from the abandoned hospital building off Trapelo Road, but it is not accessible to individuals using wheelchairs. The cemetery's poor conditions—such as graves filling with water, the use of rocks to sink coffins, and ground instability—led to calls for its closure in the 1970s. Father Henry Marquardt, the Fernald Chaplain, and funeral director Wayne Brasco advocated for the closure, arguing that the deceased should be buried in the city's cemetery. Their efforts, bolstered by legal changes reclassifying institutional inmates as residents, ultimately resulted in the cemetery's closure in 1979.

Though the cemetery was largely forgotten due to the unmarked graves and lack of publicly available records, community members and disability advocates have continued to honor those buried there through remembrance ceremonies. In 2018, teacher Alex Green, along with students from a local private high school, began efforts to memorialize the individuals interred at MetFern. They worked to design historical markers for the cemetery, create a memorial book, and launch a website to share the stories of those buried there (https://www.metfern.org/).

The cemetery is currently in poor condition. There is work needed to locate, reset and repair the cemetery monuments, remove debris and conduct this inventory of burials.

Efforts to preserve and restore the cemetery have garnered support from local government and organizations. In June 2019, Councilor Darcy representing Ward 3 in Waltham where MetFern is located submitted a proposal to use CPA funds "to reset all of the stones, repair and reconstruct those that are damaged or missing, and level the ground" (*Community Preservation Committee (CPC) Meeting Minutes*, 2019, p. 2). According to meeting minutes, the proposal passed unanimously by Waltham's Community Preservation Committee at the September 2019 meeting, and earmarked ($79,750) from the Waltham Community Preservation Act funds for restoration of this cemetery. The approved work included locating, resetting, and repairing the 300 cemetery monuments, repointing the adjacent stone walls, conducting an inventory of the interred individuals, removing debris (such as light pole bases), and erecting historically accurate signage at the cemetery.

In 2020, the goal was to transfer these funds to the Department of Conservation and Recreation (DCR) through a matching grant program, which, if approved, would have provided an additional $80,000 for the DCR to use to restore the cemetery with community input. "The DCR [had planned to keep] the gravestones as they are instead of installing new ones with names, as was done at other institutional cemeteries across the state" (Palomba, 2021).

After the funding was approved, the Community Preservation Committee did not hear back from Councilor Darcy, who sponsored the request, after multiple contact attempts (Waltham Community Preservation Committee staff, personal communication, 2024). The Community Preservation Committee requires quarterly updates on the funded projects [83]. As a result of a lack of an update for multiple quarters, the Community Preservation Committee returned the funds to the CPA account (*Community Preservation Committee (CPC) Meeting Minutes*, 2019, p. 2). Councilor Darcy is no longer on the City Council representing Ward 3.

In November 2024, CDDER made a public records request to the Massachusetts State Archives and subsequently the Department of Developmental Services Records Access Officer to view a copy of the Fernald State School Cemetery registers. On January 2, 2025, CDDER received a

[83] (*Community Preservation Committees*, n.d.)

redacted copy of the requested records along with a letter which describe the legal basis for redaction of the names of individuals who have not been deceased for fifty or more years.

> *"DDS is a covered entity under the Heath Insurance Portability and Accountability Act ("HIPAA"). A covered entity may not use or disclose protected health information ("PHI"), except as permitted or required under the law. 45 CFR 164.502(a). A covered entity must comply with the requirements of HIPAA with respect to the PHI of a deceased individual for a period of 50 years following the death of the individual. 45 CFR 164.502(f).*
>
> *In accordance with G.L. c. 123B, §17 and 115 CMR 4.06(2)(f), DDS finds that it is in the best interest of the deceased individuals to disclose the cemetery registers to SCSI. DDS has redacted the information of individuals who have not been deceased for fifty or more years.*
>
> *DDS reserves the right to retrieve any exempt, privileged, or otherwise protected materials inadvertently included in this production. Any such production is not, and shall not be considered or deemed, a waiver of any applicable privileges or protections from disclosure."*(G. Eisner, personal communication, January 2, 2025)

Names of those interred at MetFern Cemetery from the Fernald Developmental Center and Metropolitan State Hospital can be found online at Find A Grave.

- https://www.findagrave.com/cemetery/749853/metfern-cemetery

Department of Developmental Services Cemeteries

Belchertown State School - Warner Pine Grove Cemetery

The Warner Pine Grove Memorial Cemetery is named in honor of Albert Warner, a former resident of the Belchertown State School. Warner, who became a ward of the state at the age of three due to his mother's "mental illness," was labeled "feeble-minded" throughout his life.

After the school's opening in 1922, eleven residents passed away, prompting the establishment of a small burial ground a mile from the campus in 1925. In 1938, the cemetery was landscaped and marked with numbered cement blocks, in line with the practices at other state institutions in Massachusetts. The final recorded burial took place in 1977. However, after the school's closure, the cemetery fell into neglect, with some describing it as a "mud-hole."

Albert Warner, distressed by the dilapidated state of the cemetery where his friends and mother were buried, spearheaded a restoration project. In 1987, a monument was erected listing the names of those buried there, as part of Warner's effort to ensure respectful recognition of the individual gravesites.

In 1994, the state agreed to further refurbish the cemetery, replacing the numbered blocks with granite stones bearing the names, birth dates, and death dates of each person. The

cemetery was renamed Warner Pine Grove Memorial Cemetery in recognition of Warner's dedication.

Albert Warner passed away in 2006. Both he and his wife, Agnes—also a former resident—were granted the honor of being buried next to his mother's grave.

The last resident of the Belchertown State School to be interred at Warner Pine Grove Memorial Cemetery was Donald Vitkus. A resident in the 1950s, Vitkus was released from the school at 17, went on to serve in the Vietnam War, and later pursued education in human services. He spent his life advocating for people with intellectual or developmental disabilities. After his death from a brain tumor in 2018 at the age of 74, Vitkus's ashes were interred at Warner Pine Grove Memorial Cemetery, fulfilling his wish to be laid to rest among his "brothers and sisters" from Belchertown. During his memorial service, family and advocates celebrated his profound impact, resilience, and advocacy work, including his posthumous receipt of the Benjamin Ricci Commemorative Award.

Each May the Department of Developmental Services holds annual remembrance ceremonies at Warner Pine Grove Memorial Cemetery to honor the lives of those who lived at Belchertown State School and are now interred there. These ceremonies include special moments of remembrance for those former residents who have passed away in the previous year.

Names of those interred in Warner Pine Grove Cemetery can be found online at Find A Grave:

- https://www.findagrave.com/cemetery/2250784/warner-pine-grove-memorial-cemetery

The Irving A. Glavin Regional Center - Hillside West

Located off Lake Street in Shrewsbury, Hillside Cemetery was once part of the farm operated by Worcester State Hospital. The cemetery is divided into two sections: Hillside West and Hillside East. Residents from the Glavin Center were buried in Hillside West.

In 1999, the Department of Developmental Services funded the replacement of the original concrete grave markers with granite stones, each inscribed with the names and dates of the deceased. Hillside West was rededicated in honor of this restoration.

The Department of Developmental Services holds annual remembrance ceremonies at the cemetery to honor all the individuals who lived at the Glavin Center and are now interred there. These ceremonies include special moments of remembrance for those former residents who have recently passed away. Names of the residents interred at Hillside West Cemetery can be found online at Find A Grave:

- https://www.findagrave.com/cemetery/2586796/new-hope-cemetery

An unverified listing of names of residents can also be found here:

- https://www.nekg-vt.com/Shrewsbury/Hillside/hillsidelist.htm

The Irving A. Glavin Regional Center was designated as a Priority Development Area (PDA 271-16) in the 2011 495 Metrowest Development Compact Plan. The town of Shrewsbury selected the Glavin Regional Center property, which is managed by the Commonwealth's Division of Capital Assets and Management and Maintenance (DCAMM), as a focus for potential redevelopment.

As part of its efforts, Shrewsbury requested assistance from the Central Massachusetts Regional Planning Commission (CMRPC) to explore zoning and development opportunities in the area.

In the report issued in May 2014, CMRPC identified potential opportunities to develop the site and included the following statement in relation to the Hillside West Cemetery:

> *"The existing cemeteries associated with the Glavin Center use are presumed to be designated for protection in perpetuity. However, the relocation of these burial grounds may be an option which would allow for additional residential development opportunity or recreational fields."* (Central Massachusetts Regional Planning Commission, 2014, p. 25)

This potential for relocation of burial grounds presents multiple risks and concerns. As described by the International Right of Way Association:

> *"Acquiring and relocating a cemetery provokes intensive concerns that require a high degree of sensitivity and understanding. Typically immersed in controversy, this kind of relocation necessitates an experienced team committed to ensuring that the needs of the client, the family and the deceased are all taken into consideration."* (Carvajal & Grzybowski, 2013, p. 17)

Wrentham Developmental Center - Louise Johnson Memorial Cemetery

The Louise Johnson Memorial Cemetery was rededicated in 1997 to honor Louise Johnson, a dedicated advocate for the residents of the Wrentham Developmental Center (WDC) and the longtime president of the Wrentham Parents Association. Louise Johnson was a passionate champion for the rights and well-being of those who lived at the Center.

Unlike many institutions that marked graves with only a patient ID number, Wrentham Developmental Center ensured that each grave was marked with the individual's name, along with their birth and death dates. The headstones in this cemetery are uniform in size, shape, and color. Each one is a small, flat rectangle, with a number in the left-hand corner, a letter in the right-hand corner, the person's name in all capital letters centered in the middle, and the birth date to the bottom left and the death date to the bottom right.

The oldest grave marker dates back to October 5, 1931, while the most recent marker is for a resident who passed away on May 9, 2013.

The Department of Developmental Services holds annual remembrance ceremonies at the cemetery during the week of Memorial Day to honor all individuals who lived at the Wrentham

Developmental Center and are now interred there. The ceremony features performances by the Massachusetts State Police Pipe and Drums and a brass band playing the National Anthem and Taps. Flowers and wreaths are placed on the graves, and special moments of remembrance are held to honor military service members as well as former residents and staff who have recently passed away.

Additionally, the Wrentham Developmental Center is home to the Wrentham State School Memorial Walk, a memorial trail dedicated on October 22, 1994. This peaceful area features four walls inscribed with the names of deceased individuals from the Center. Located at the front of the facility, the memorial is a place of reflection and remembrance for visitors, many of whom pause to reflect under the surrounding trees. A water fountain adds to the tranquility of the space, making it a calming spot for those who visit.

Names of the residents interred at Louise Johnson Memorial Cemetery can be found online at Find A Grave:

- https://www.findagrave.com/cemetery/2361124/louise-johnson-memorial-cemetery

Monson Developmental Center-New Hope Cemetery

The New Hope Cemetery is on the grounds of the former Monson State Hospital and contains the graves of a number of former patients of the facility. The hospital eventually became known as the Monson Developmental Center until its closure in 2013. The cemetery is maintained by the Commonwealth of Massachusetts, Department of Capital and Asset Management.

The Department of Developmental Services holds annual remembrance ceremonies to remember all the individuals who lived at the Monson Developmental Center and are now interred at the cemetery. There are moments of remembrance given to those former residents who have recently passed away.

Names of the residents interred at New Hope Cemetery can be found online at Find A Grave:

- https://www.findagrave.com/cemetery/2586796/new-hope-cemetery

Department of Mental Health Cemeteries

Danvers State Hospital Cemeteries

The Danvers State Hospital cemetery restoration project involved the significant effort to reclaim and properly memorialize the neglected burial grounds of former patients at the Danvers State Hospital, where hundreds of graves were found in overgrown and forgotten conditions, with many marked only by numbers instead of names; advocates worked to identify individuals, place proper headstones, and create a respectful space to honor the lives of those buried there, highlighting the importance of recognizing the humanity of individuals who had been institutionalized.

The restoration was primarily driven by former patients of state hospitals who sought to reclaim the dignity of their deceased peers by properly marking their graves and creating a space for remembrance. A key part of the project was researching and identifying the individuals buried in the cemeteries, allowing for the placement of headstones with proper names instead of numbers.

The Danvers State Memorial Committee (DSMC) advocated for the proper identification of graves at Danvers State Hospital, arguing that individuals should be buried with their proper names rather than numbers. They believed that the practice of using numbers stemmed from a desire to shield families from the "shame of mental illness" but that it was time to move beyond that stigma and show respect. In discussions with DMH Commissioner Marylou Sudders, DSMC framed the issue not as a matter of confidentiality but of respect for the deceased. They pointed out that patients had not consented to having their names removed and referenced the practice of burying individuals with proper names in state schools for people with intellectual or developmental disabilities. The Commissioner supported the DSMC's stance, agreeing that proper names should be used on grave markers in state hospital cemeteries.

In the spring of 2001, the Danvers State Memorial Committee (DSMC) was able to secure funding for grave markers at the Danvers State Hospital cemeteries. By July 2001, DCAM allocated enough funds for DMH to invite monument companies to bid to mark graves for the 768 individuals buried in the two cemeteries. For those whose graves could not be matched, four large granite stones with bronze plaques were created. Names of those interred in either of the Danvers State Hospital Cemeteries can be found online at:

- https://historyofmassachusetts.org/danvers-state-hospital-cemetery/
- https://www.danversstatehospital.org/cemeteries
- https://www.findagrave.com/cemetery/2186316/danvers-state-hospital-cemetery
- https://www.findagrave.com/cemetery/2676745/middleton-colony-cemetery

Westborough State Hospital - Pine Grove Cemetery

The Westborough Cemetery Memorial Project was created to honor approximately 700 unnamed graves at Pine Grove Cemetery, most of which belong to individuals who died while committed to the Westborough State Hospital between the early 1900s and 1987. These individuals were buried in unmarked "potter's" graves, often without family and with minimal burial arrangements funded by the state. The cemetery also contains graves of the poor, transient, and babies in unmarked plots.

The committee's goal is to raise funds for a memorial at the cemetery that will include the names of all those buried there. The committee's lead researcher has identified nearly 700 names. The project is now a non-profit organization that holds fundraising events and Days of Remembrance. So far, they have raised enough money to complete the masonry for the Memorial's entrance and viewing area. Their next goal is to fund seven headstones, each listing

100 names, to be placed around the Memorial. Once completed, the project will hold a memorial service for the community.

The design of the Memorial at Pine Grove Cemetery aims to convey the vast number of people buried there, with seven large granite pillars symbolizing the many lost lives. The project received a significant boost in August 2023 with a $27,700 donation from the Department of Mental Health which enabled the purchase and installation of granite pillars and the enhancement of the central millstone feature. The final phase of the project involves raising an additional $45,000 to fund seven bronze plates, each engraved with 125 names of individuals buried in the cemetery. The names of the former patients buried at Pine Grove Cemetery have now been posted on the Committee's website on: https://westboroughcemeteryproject.org/index.html.

Medfield State Hospital-Medfield State Hospital Cemetery and Vine Lake Cemetery

The Medfield State Hospital Cemetery, located behind a thicket of brush and fencing off Route 27, was long neglected, with only small, numbered stones marking the graves of 841 individuals who died while living at the hospital. These residents often had no families to claim them and were buried without names. Initially, hospital burials took place in Vine Lake Cemetery until 1918, when the influenza epidemic led to mass burials and the establishment of the hospital cemetery in its current location.

Over the years, the identities of those buried there were forgotten, with only numbered stones marking their graves. In 2005, the Medfield State Hospital Cemetery Restoration Committee was formed to raise awareness of the cemetery's condition. Volunteer efforts, including Boy Scout Eagle projects, cleared debris, and with state funding, granite markers were installed with the names, birth, and death dates of the deceased. A contest led by Medfield High School students produced the quote "Remember us for we too have lived, loved and laughed," now inscribed on a stone at the cemetery's entrance. The town of Medfield also erected a memorial for the patients buried at Vine Lake Cemetery, listing their names and dates of birth and death on bronze plaques at the base of the hill where hospital patients were buried in unmarked graves.

The cemetery has a dignified entrance and rows of granite markers, giving each individual a proper identity.

There is an online listing of patient names buried at Vine Lake Cemetery on the Medfield Historical Society Website.

- https://vinelakecemetery.medfieldhistoricalsociety.org/research/burial-records/

Names of patients buried at the Medfield State Hospital Cemetery can be found online at Find-a-Grave .

- https://www.findagrave.com/cemetery/91221/medfield-state-hospital-cemetery

Grafton State Hospital Cemetery

The Grafton State Hospital Cemetery, spanning several acres, is now accessible to visitors via a sign and walkway from Centech Boulevard. Previously hidden by dense woodland, the area was cleared to improve visibility. In 2008, the cemetery was restored by students and staff from the Home Builders Institute program at the Grafton Job Corps Career Academy. Approximately 50 students cleaned up debris and uncovered around 1,000 graves. The cemetery also is known for a large stone water tower.

The cemetery holds the remains of 1,041 former Grafton State Hospital patients, including 14 veterans, all of whom were unclaimed by their families. A white obelisk at the center, along with a bronze marker listing the veterans' names and grave numbers, commemorates these individuals. Veterans' graves are marked with a United States flag marker. Graves are identified with 6x12 inch granite markers, but only a few of the individuals buried there have actual names and dates inscribed. Local volunteers maintain graves and conduct annual remembrance ceremonies for the veterans each year around Memorial Day.

- https://www.findagrave.com/cemetery/91085/grafton-state-hospital-memorial-cemetery

Tewksbury Hospital and "The Pines" Cemetery

Over 8,500 individuals who lived and died at the Tewksbury Hospital were buried in "The Pines" Cemetery between 1890 and 1933. The Pines is roughly 3 ½ acres in size and abuts the state hospital property.

In 2004 Governor Mitt Romney signed an Act known as ‘Designating Certain Lands in The Town of Tewksbury for Conservation, Agriculture, and Passive Public Recreational Purposes' which designated certain parcels of land for conservation and recreation. This included 410 acres across nine parcels, ensuring the land's use for environmental education, forestry, agriculture, and passive public recreation (An Act Designating Certain Lands in the Town of Tewksbury for Conservation, Agriculture and Passive Public Recreational Purposes, 2004).

In 2007 the Bay Circuit Trail Alliance met with officials from the Tewksbury State Hospital to gain permission to construct the missing segment of the Bay Circuit Trail on the hospital's newly conserved land. This meeting resulted in the formation of a *Memorandum of Understanding* (MOU) between the Bay Circuit Trail Alliance and Tewksbury State Hospital. The agreement outlined the specific terms for establishing and maintaining the trail on the hospital grounds, ensuring the project's alignment with conservation and public use goals (Massachusetts Department of Public Health & Bay Circuit Alliance, 2007a).

Since 2016, volunteers for the community have worked together to restore the cemetery. This area, which was once meticulously maintained as part of the hospital’s "therapeutic environment," is now a critical piece of Tewksbury’s natural and historical landscape. The

preservation of "The Pines" ensures that this part of Tewksbury's history is protected and that it remains a space for both environmental education and passive recreation.

In 2017 Tewksbury Town staff and the Tewksbury Open Space Committee met with the Tewksbury State Hospital to revise the existing Memorandum of Understanding (MOU). The revision allowed for the inclusion of some improvements to the Bay Circuit Trail system, such as kiosks, trail markers, directional arrows, and designated parking areas (Massachusetts Department of Public Health & Bay Circuit Alliance, 2007b).

Department of Corrections - MCI Bridgewater Death Procedures

The Department of Corrections policy outlines procedures for handling an inmate's death in custody, ensuring proper medical care, notification, documentation, and investigation (Commonwealth of Massachusetts, 2025c). These procedures apply to MCI Bridgewater.

Upon an inmate's death, the scene must be preserved until the Medical Examiner assumes jurisdiction. Special investigations may be initiated if necessary. A Medical Investigation Team may be activated to examine the circumstances surrounding the death. Thorough documentation must be completed, including incident reports, medical records, and death certificates. These documents support investigations and ensure compliance with regulatory requirements.

After authorization, the body is removed, and funeral arrangements are made with the family or a local mortuary. If the body is not claimed, burial or cremation will be arranged at the Department's expense. Procedures for burial or cremation are outlined, including obtaining consent for cremation and ensuring proper documentation for both processes. A clergy member should be present during the burial, and cemetery records must be maintained.

Framework for Remembrance

Examples of Remembrance Projects

Over the past several months, CDDER staff and members of the Framework for Remembrance working group have met with and interviewed key informants from five organizations to learn about their experiences in creating memorials to honor the former patients that lived and died in state operated institutions. The groups interviewed provide examples of five distinct types of memorials. The memorials are summarized below by group.

Belchertown State School Friends Association

Belchertown State School Friends Association is an example of a planned memorial and museum to be located on the grounds of the former state school, with a focus on sharing the history of special education, institutionalization, and support for individuals with disabilities. The Belchertown State School Friends Association is a nonprofit organization that aims to preserve the state school administration building while offering community space and educational opportunities. They collaborate with the Belchertown Historic Commission and the Belchertown Cultural Alliance on projects like a museum, memorial, interpretive trails, and revitalization efforts. The website for the association is available here: https://www.bssfriends.org/.

The MetFern Cemetery

The MetFern Cemetery in Waltham is the final resting place of 296 individuals who were buried between 1947 and 1979, after living in two institutions: the Fernald School and the Metropolitan State Hospital.

The cemetery was designed with segregated burial sections for Catholics and Protestants, but it holds people of various faiths, including Muslims and Jews. The graves are marked only with a "C" for Catholic or "P" for Protestant, followed by a number.

Inadequate conditions at the cemetery, such as flooding graves and unsuitable burial sites, prompted activists like Father Henry Marquardt and funeral director Wayne Brasco to advocate for its closure in the 1970s. Their efforts, combined with legal changes and support from disability rights activists, led to the cessation of burials in 1979, while the institutions themselves closed in subsequent years.

Advocates have worked over the years to keep the memory of those buried in the MetFern Cemetery alive, holding ceremonies and placing flowers at the graves. In 2018 Alex Green obtained a list of names from the cemetery register, which had previously been withheld due to

patient privacy concerns. This marked the beginning of a two-year effort to research and memorialize the lives of the individuals buried there.

The project, led by Green, Yoni Kadden, Kevin Levin, and students at Gann Academy, involved extensive research, including the creation of a website, design of historical markers to honor the lives of those buried in the MetFern Cemetery, a memorial book, and lobbying for legal changes to make historical records accessible. The work emphasized the importance of acknowledging the histories of those who lived and died in institutions like Fernald and Metropolitan State, many of whom experienced forced labor, institutional abuse, and neglect.

These efforts have been supported by the Ruderman Family Foundation, Ancestry.com, and local advocacy groups, including the Arc of Massachusetts, and have gained significant support from government officials. The work continues with the restoration of the cemetery and ongoing public education. The Project's website is available here: https://www.metfern.org/.

The Danvers State Memorial Committee

The Danvers State Memorial Committee provides an example of a memorial dedicated to one institution. The Danvers State Memorial Committee was dedicated to the restoration and proper memorialization of the neglected cemeteries at Danvers. The efforts of this group, which was run by former patients of the Danvers State Hospital, aimed to replace the anonymous markers in the two hospital cemeteries with headstones that bore the names of former patients, a story poignantly depicted in the film *From Numbers to Names* (Deegan, 2010). This initiative not only honored the memory of those buried there but also asserted the dignity of their lives. The Committee's website is available here: https://dsmc.info/.

The California Memorial Project

The California Memorial Project provides an example of a framework for remembrance designed to establish annual days of remembrance and cemetery restoration projects at state hospitals and developmental centers for people with intellectual or developmental disabilities throughout the state of California. The California Memorial Project was established in 2002 through Senate Bill 1448. The project was led by peer advocates who sought to remember those who passed away in institutions but also acknowledges current residents in state hospitals, giving voice to their experiences. The Project's website is available here: https://www.disabilityrightsca.org/what-we-do/programs/california-memorial-project-cmp.

The Willowbrook Mile Memorial Walking Trail

The Willowbrook Mile Memorial Walking Trail provides an example of a framework for remembrance for a single institution, which includes an accessible outdoor walking trail with twelve stations that describe the history of the Willowbrook School. The Willowbrook Mile

Committee was committed to creating a memorial that is inclusive, progressive, and universally accessible for individuals of diverse abilities. The project aimed to preserve the site's history while establishing a visionary space that honors the ongoing struggle for social justice for all people. The focus was on ensuring the memorial is creatively designed, collaborative, and sustainably developed, reflecting the values of inclusivity and accessibility. The Project's website is available here: https://www.csi.cuny.edu/about-csi/president-leadership/administration/office-vp-economic-development-and-community-partnerships/reporting-units-and-initiatives/willowbrook-mile.

See **Appendix 3** for a report from the Willowbrook Mile Collaboration, which came together to form the project.

Experiences of Remembrance Projects

Each group had a different experience in creating the memorials. Information about each group, their experiences and the lessons they learned that they shared with the SCSI Framework for Remembrance Working Group are summarized below.

Belchertown State School Friends Association

The Belchertown State School, established in 1922, was the third institution of its kind in the state, created to provide long-term care and support for children with intellectual or developmental disabilities. While initially intended to help integrate these children into society, the school became notorious for poor treatment and inhumane conditions. This led to several lawsuits, including one filed by Benjamin Ricci, a father of a patient. The school closed in 1992 after operating for 70 years.

In 2006, plans emerged to redevelop the former Belchertown State School campus into an upscale resort and spa, with assurances that many original buildings would be preserved. However, the project was eventually abandoned, and the property reverted to the town of Belchertown. Despite initial hopes for redevelopment, the campus remained vacant until demolition began in 2015, when the town collaborated with MassDevelopment to clear land for a new senior living complex.

Determined to preserve the state school's legacy the Belchertown State School Friends Association was revived in 2019. With a newly appointed board, their goal is to save and repurpose the administration building while ensuring that the history of all Massachusetts state schools is documented and accessible to the public. This commitment aims to educate future generations about the past, fostering a deeper understanding of institutional history.

The administration building, constructed between 1926 and 1927 originally housed eight rooms for administrative functions on the first floor, with additional offices and a medical library on the ground floor. More space was added in 1967 for more offices and examination rooms. The

Friends Association maintains a collection of artifacts from Belchertown State School and other institutions for people with disabilities in Massachusetts. This collection includes the Don LaBrecque collection of historic images, which includes historic images of Belchertown along with images of many other state institutions in New England. These collections are all owned by the BSS Friends and the Stone House Museum, which is the home of the Belchertown Historical Association in Belchertown, MA. The administration building is the planned home for these collections.

The Belchertown State School Friends Association is sustained through membership and donations. The association conducts fundraising events and capital campaigns.

Lessons learned from the experiences of the Belchertown State School Friends Association include:

1. Community Partnerships: Community partnerships were crucial to enhance reputation and credibility, helping them reach a broader audience and build community trust. Through collaboration with other organizations lead to additional resources, including funding, volunteers, and in-kind donations[84]. These partnerships provide long-term support, ensuring the organization's sustainability and ongoing impact.
2. Storage: When planning for the storage of collections and artifacts, several key considerations must be taken into account, including location considerations such as avoiding ground storage, avoiding light exposure and distance from water sources like water pipes. Climate control should also be considered as temperature and humidity which can degrade an artifact.
3. Funding: When planning a large-scale project like the Friends of Belchertown State School Association did, it is necessary to identify sources of funding. Government grants are a significant source of funding for nonprofits, and can come from federal, state, and local governments. Private foundations are another option, and can be individual, family-run, or community foundations. Corporations are also another source of funding as they often donate money or goods to support causes they believe in.

Donald Vitkus - The Last Belchertown State School Resident Buried at Warner Pine Grove Memorial Cemetery

The book *You'll Like it Here* by Donald Vitkus and Ed Orzechowski uncovers the irony surrounding Belchertown State School and similar institutions in Massachusetts.

Vitkus spent his childhood at Belchertown in the 1950s, where he faced inhumane conditions, including abuse and overcrowding, after being labeled "a moron" due to a low IQ score. Despite

[84] An in-kind donation is a non-cash gift made to a nonprofit organization. These contributions can be made in the form of time, services, expertise, and goods, often coming from large businesses but also can come from individuals.

these challenges, he found moments of solace through supportive teachers and occasional comforts, like a television funded by the Friends Association, which broadened his perspective.

After his release at 17, Vitkus struggled with the stigma of his past but eventually served in Vietnam and later pursued education in human services, dedicating his life to advocating for people with intellectual or developmental disabilities.

Following his death from a brain tumor at 74, Vitkus's ashes were interred at Warner Pine Grove Memorial Cemetery, honoring his wish to be buried among his “brothers and sisters” from Belchertown. During the memorial service at Warner Pine Grove Memorial Cemetery, family members and advocates celebrated his profound impact, resilience, and advocacy work, including his posthumous receipt of the Benjamin Ricci Commemorative Award.

Danvers State Memorial Committee (DSMC)

In early winter 1997, a significant discovery transformed the narrative surrounding Danvers State Hospital. A former patient, while walking her dog, stumbled upon a small, numbered marker hidden beneath overgrown foliage, leading her to an abandoned patient cemetery. This poignant find sparked a deeper exploration into the site’s forgotten history, prompting her to document the findings and share them through a powerful slideshow presentation with fellow ex-patients. Inspired by this revelation, the Danvers State Memorial Committee (DSMC) was born.

As the Danvers State Hospital property was slated for sale, the DSMC was already engaged in advocacy work to restore the cemeteries. They strategically chose to identify as “ex-patients” rather than “consumer/survivors,” emphasizing their personal connection to the hospital. This terminology reinforced their authority and authenticity in discussions about the future of the site.

Determined to play an active role in the redevelopment process, the DSMC aimed to ensure that the legacy of the hospital and its former patients was respected. Their advocacy extended beyond memorialization; they sought to influence redevelopment plans to ensure that the funding from the sale of the land supported adequate housing solutions for people with mental health needs. Through their efforts, the DSMC demonstrated a commitment not only to honoring the past but also to shaping a more inclusive future for their community.

The successful efforts of the Danvers State Memorial Committee (DSMC) offer several important lessons for advocacy and community organizing, especially in the realm of securing housing through the sale of state hospitals. Here are some key takeaways:

1. Organizing a Diverse Group: The DSMC was comprised entirely of ex-patients, which provided authentic representation in discussions about their needs. Their lived experiences gave them unique authority in negotiations, making their voices powerful in advocating for change. The inclusion of allies, such as DMH administrators and

community members, expanded the committee's influence. Building a coalition that includes various stakeholders can enhance advocacy efforts.

2. Structured Membership - Steering Committee vs. General Membership: The DSMC had a dual structure of both a Steering Committee and General Membership, which allowed for efficient decision-making and advocacy while also demonstrating broad community support. The steering committee handled detailed work, while the general membership could mobilize for larger events, ensuring a strong presence at rallies, hearings, and meetings.
3. Funding and Sustainability: The DSMC funded its activities through diverse funding sources such as small grants, community donations, and support from the DMH Office of Consumer Affairs (Department of Mental Health Office of Consumer/Expatient Relations, 2001). This diversified funding base helped sustain the group's operations over the years and is a crucial element for any advocacy organization.
4. Unified Purpose and Shared Goals: A clear, shared goal—securing housing through the sale of state hospitals—unified the group. This focus on a common objective can motivate members and strengthen advocacy efforts.
5. Emphasizing Ex-Patient Voices: While allies are important, maintaining ex-patient leadership in the spotlight is critical. Their first-hand experiences not only lend credibility but also resonate emotionally with decision-makers and the public.
6. Ongoing Engagement to Sustain Efforts: The DSMC's ongoing work underscores the importance of continuous engagement and advocacy. Building momentum over time can lead to more significant impacts and sustained attention to issues that matter.
7. Community Mobilization through Rallies and Public Engagement: Organizing events that rally community support can amplify advocacy messages and demonstrate the importance of the cause. A visible and passionate community can influence policymakers and stakeholders.
8. Effective Communication: The DSMC's ability to clearly articulate their needs and goals helped frame the narrative around their advocacy. Crafting a compelling message that resonates with both the community and decision-makers is essential.

By applying these lessons, other groups aiming to advocate for marginalized communities can enhance their effectiveness and ensure that their voices are heard in important negotiations and decision-making processes.

California Memorial Project (CMP) Overview

The California Memorial Project (CMP) is dedicated to honoring individuals with mental health conditions and individuals with intellectual or developmental disabilities who lived and died in California state institutions. The program aims to restore dignity to these individuals, recognizing their lives and experiences while fighting stigma and discrimination. From the 1880s to the 1960s, over 45,000 individuals lived in California state institutions, many buried in unmarked graves without recognition.

The CMP holds annual remembrance ceremonies on the third Monday of September. The ceremonies are held across California, including at state institutions and cemeteries, to honor those who have died. The 20th Annual Remembrance Day was held virtually due to COVID-19, allowing wider participation. It included speeches, personal stories from former residents, and artistic contributions, concluding with a moment of silence. The 20th Annual Remembrance Day video can be seen here: https://www.disabilityrightsca.org/what-we-do/programs/california-memorial-project-cmp.

The CMP has also collected 21 oral histories from individuals who lived in state institutions, preserving their stories and advocating for their rights.

The CMP seeks to promote transparency and acknowledgment of the history of people in state institutions while advocating for the rights and dignity of those currently receiving care. The movement aims to create a world free from stigma and discrimination, ensuring that the memories and experiences of all people are honored and remembered.

The CMP was organized and run by peer advocates who worked together for laws to bring back dignity to their peers. In 2002, Senate Bill 1448 addressed the terrible conditions of the state institution gravesites. This law provided valuable support for the disability community.

The successful efforts of the California Memorial Project offer several important lessons for advocacy and community organizing. Here are some key takeaways:

1. Encourage Member Voices: When recruiting, let former patients and peer advocates share their experiences. Ask open-ended questions about their time in the hospital and their thoughts on how to memorialize. This builds trust and empowers members.
2. Choose Accessible Meeting Locations: Hold meetings in convenient, accessible locations served by public transportation. Schedule them at times that work for the majority of members to maximize attendance.
3. Provide Nourishing Food: Always offer healthy food and beverages at meetings. Many members may face financial challenges, and providing nourishment helps create a welcoming atmosphere.
4. Allow for Breaks: Recognize the needs of your members by allowing for regular breaks and informal conversations. This can help maintain a relaxed environment.
5. Prepare Agendas: Have a written agenda for each meeting. Prepare the chairperson in advance and remind members of meeting details the day before, confirming their transportation arrangements.
6. Foster a Respectful Atmosphere: Encourage an environment of tolerance and respect for differing opinions. Use active listening techniques, such as summarizing key points on a flip chart, to validate participants' contributions.
7. Level the Playing Field: Leave professional titles at the door. Create a space where everyone feels equal, fostering open communication.

8. Recognize Diverse Leadership Styles: Acknowledge that leadership can take many forms. Whether someone is a great listener, organizer, speaker, or motivator, all contributions are valuable and should be celebrated.
9. Cultivate Leadership Skills: Provide opportunities for members to practice public speaking. Assist them in scripting their speeches if they prefer, making the process collaborative.
10. Engage the General Membership: Keep the broader membership actively involved by holding regular gatherings, public rallies, and open mic events. Encourage sharing of memories about the hospital and discuss how ex-patients can benefit from its sale.
11. Invite Participation in Public Forums: Encourage members to attend public hearings, developer presentations, and other relevant events. This fosters community engagement and keeps their voices heard in important discussions.

By implementing these strategies, the group can create a supportive environment that empowers former patients, amplifies their voices, and drives effective advocacy.

The Willowbrook Mile

Historical Overview of Willowbrook State School

The Willowbrook Mile, established by the Willowbrook Property Planning Committee in 2005, honors the struggles for social justice and advocacy for people with disabilities. Located partially on the College of Staten Island campus and partially on property controlled by the New York State Office for People with Developmental Disabilities (OPWDD), the memorial officially opened on September 17, 2022, marking the 35th anniversary of Willowbrook's closure. Developed in partnership with local organizations, the project received funding from sources including the New York State Assembly, the College of Staten Island, and community donors, ensuring that the legacy of Willowbrook and its lessons continue to resonate

At its founding, Willowbrook State School on Staten Island New York was initially marketed as an ideal environment for children with intellectual or developmental disabilities, promising quality care and engagement. However, the reality was starkly different, with understaffed facilities and minimal attention to residents, leading to neglectful practices.

Families faced agonizing decisions about institutionalization, often feeling it was their only option due to a lack of community therapies and educational opportunities. Over time, funding cuts and increasing resident numbers turned Willowbrook into a "snake pit," as described by Senator Robert F. Kennedy during his 1965 visit (*Moments in Disability History 9: Willowbrook Leads to New Protections of Rights*, 2013). During an unannounced visit, Senator Kennedy found a group of people numbered in the thousands “living in filth and dirt, their clothing in rags, in rooms less comfortable and cheerful than the cages in which we put animals in a zoo.” (*Moments in Disability History 9: Willowbrook Leads to New Protections of Rights*, 2013)

Awareness of the facility's dire conditions grew in the early 1970s, fueled by investigative journalism. Jane Kurtin's articles in the Staten Island Advance[85], along with powerful images from photographer Eric Aerts (*IC-05: Eric C. L. Aerts Photographs*, n.d.), drew attention to the situation. Geraldo Rivera's televised exposé, Willowbrook: The Last Great Disgrace, shocked the nation and galvanized public support for change (Rivera, 1972).

These combined efforts led to a class-action lawsuit in 1972, affirming the residents' constitutional rights to humane treatment and paving the way for systemic reforms (*New York State Association for Retarded Children v. Carey)*. The challenges at Willowbrook were emblematic of broader systemic issues, as it functioned as a "total institution" where neglect and abuse flourished amid overwhelming resident-to-staff ratios. "The lawsuit sought immediate injunctive relief to improve conditions at Willowbrook, including hiring more staff, providing adequate medical care, prohibiting the use of seclusion and improper physical and chemical restraints, and providing adequate and appropriate clothing and physical conditions for residents. The plaintiffs alleged that the existing conditions violated the residents' constitutional right to treatment under the Due Process Clause of the Fourteenth Amendment, and that their denial of a public education violated the Equal Protection Clause of the Fourteenth Amendment." (*The Closing of Willowbrook*, n.d.).

New York State's indifference further exacerbated the situation, as employee concerns were often ignored, and advocates faced bureaucratic resistance. It took public outcry, media scrutiny, and legal action to compel state officials to enact meaningful changes.

The advocacy surrounding Willowbrook ignited a larger disability rights movement, with families and former residents sharing their stories to affirm the humanity of people with disabilities and advocate for community care systems. The 1975 Consent Judgment from the lawsuit mandated humane treatment and adequate services, leading to a significant reduction in residents and ultimately the facility's closure in 1987.

The closure of Willowbrook marked a pivotal moment in the disability rights movement in New York. In subsequent years, initiatives emerged to preserve the facility's history and prevent similar injustices.

The Willowbrook Mile Memorial Walking Trail

The Willowbrook Mile features 12 stations that commemorate the site's complex history.

1. Willowbrook Archives: The College of Staten Island's Archives and Special Collections, founded in 2000, preserves the history of the Willowbrook site, focusing on the experiences of residents and advocacy efforts. These archives provide vital narratives about the social justice movement for disability rights, including the legal impacts of the Willowbrook Consent Judgment. Access is available by appointment, with some materials viewable online.

[85] Archives available here: https://archivesspace.library.csi.cuny.edu/agents/people/480?&page=1

2. Building 19: In the mid-1990s, a plaque was installed on Building 19 to honor those who resided at Willowbrook. This building, originally intended for fewer than 100 residents, became overcrowded, leading to a loss of dignity and deteriorating conditions.
3. Halloran Hospital: Established in 1938, the site initially served as a school for individuals labeled as "mental defectives" but was repurposed during World War II as Halloran General Hospital. After the war, it returned to its original purpose as Willowbrook, later notorious for its overcrowded conditions.
4. Consent Decree: The 1975 Consent Judgment mandated adequate services for residents, leading to a significant reduction in the population and the eventual closure of Willowbrook in 1987. This ruling played a crucial role in the broader disability rights movement.
5. Isolation to Inclusion: After relocating to the site of the Willowbrook school in 1993, the College of Staten Island/CUNY transformed the legacy of institutionalization into one of societal integration. Programs like the Melissa Riggio Higher Education program provide college experiences for students with disabilities.
6. Exposing the Conditions at Willowbrook: Investigative efforts, including Geraldo Rivera's exposé in 1972, revealed the appalling conditions at Willowbrook, contributing to the legal actions that affirmed residents' rights and spurred reforms.
7. The Baby Unit: Established in the 1960s, the Baby Unit exemplified the failures of institutional care. The 1975 class-action litigation led to community service availability, allowing families to care for their children at home.
8. The Connelly Center: Named after Elizabeth Connelly, the first woman from Staten Island elected to public office, this center continues her advocacy for the rights of individuals with intellectual or developmental disabilities.
9. Building 29: In the era that followed the 1975 Consent Judgement, Building 29 became the home for residents whose families were from Staten Island.
10. Institute for Basic Research: Opened in 1968, this institute focuses on researching intellectual and developmental disabilities, contributing significantly to areas like autism spectrum disorders and providing educational opportunities for graduate students.
11. The Hepatitis Study: From 1956 to 1971, this unethical study involved intentionally infecting children with hepatitis, raising serious ethical concerns and highlighting the need for better protections for vulnerable populations.
12. Gouverneur State School: In 1962, children were transferred from Willowbrook to the condemned Gouverneur Hospital, showcasing the systemic issues of inadequate care and the advocacy that ultimately led to Willowbrook's closure.

Ensuring accessibility for all visitors to the Willowbrook Mile was the central focus of the initiative. The Committee made conscious efforts to remove access barriers and provide a welcoming environment for everyone, including those facing communication and mobility challenges. Here are the specific accommodations that were put in place:

- Mobility Challenges: Pathways along the Mile are designed to be wheelchair-friendly, with smooth surfaces and ramps. Benches and rest areas are available throughout for those needing to rest.
- Blind or Low Vision: Information panels feature large print and braille options. Guided tours with audio descriptions are also offered to enhance the experience.
- Deaf or Hard of Hearing: Sign language interpreters are available upon request for guided tours and events. All video presentations include captions.
- Easy-to-Read Texts: We provide materials in plain language, ensuring that information is accessible to individuals with cognitive disabilities.
- Multilingual Support: Information is available in multiple languages to accommodate non-English speakers, with translations provided for key materials along the Mile.

Some key takeaways from the project:

1. Know your stakeholders: The stakeholders in the Willowbrook project included former residents, families, advocates, numerous local and governmental agencies, community activists, and public officials. The Willowbrook project included important input that was collected from former residents and their families as well as input from people with disabilities and their families in Staten Island.
2. Create a shared vision: Through collaborative efforts with stakeholders, they created a vision for the former Willowbrook State School property. The vision for the project was to create a pathway that allows everyone to engage with the history of the Willowbrook School in an inclusive, productive, and creative way. This initiative emphasized community partnership, aiming to ensure that the project reflected inclusive values and fostered collaboration among diverse stakeholders.
3. Take Time to Plan: This includes laying out timelines, establishing the budget, planning communication with stakeholders and setting milestones for the project. Importantly the committee had to consider what could go wrong in a project and create contingency plans. For example, the Willowbrook Mile project involved managing significant real estate transactions, only to find that the land that they had identified for the walking trail wasn't buildable. The project committee had to come up with an alternative plan. The project committee had to advocate for ongoing funding from the legislature, establishing donors and fundraising mechanisms, working with architects and designers to create the memorial and researching and documenting the history of the school.
4. Safeguard your message: Large projects such as the Willowbrook Mile require the support of donors. It is important to understand that some people will try to impact the project in a way that benefits themselves, such as gaining personal publicity. It is important to continue to stay true to the vision of the project and ensure that the project stays true to the history of the institution.
5. Be ready for a long ride: The Willowbrook project took over seventeen years to complete. It is important to manage expectations - your own and the expectations of stakeholders. There will be setbacks along the way that will impact the project.Setbacks

could impact the timelines for finishing the project, for example, or the overall scope or design of the memorial.

References

1662 Poor Relief Act [The Settlement Act]. Retrieved October 28, 2024, from https://www.workhouses.org.uk/poorlaws/1662act.shtml

A Bill Relating To Paupers, 1824 Legislative Bill (1824). https://archives.lib.state.ma.us/items/0b52e033-6102-40c3-8c58-be8d72e38f8e

Abstract Of Returns Of Inspectors And Keepers Of Jails And Houses Of Correction, House Bill 0041 (1839). https://archives.lib.state.ma.us/items/51835834-5d4e-4b3b-8225-a5164dbb2830

Abstract Of The Return Of Paupers [1833], House Bill 0043 1/2 (1834). https://archives.lib.state.ma.us/items/dc0904a1-2cb6-48dc-8d16-126d13b66189

Abstract Of The Returns Of The Poor [1835], House Bill 0026 (1836). https://archives.lib.state.ma.us/items/b9f945e3-f0a1-4bae-a90e-7e7a0aa73c56

Addington v. Texas (441 U.S. 418 1979). https://supreme.justia.com/cases/federal/us/441/418/

Administration for Community Living. (n.d.-a). Fact Sheet: President's Committee for People with Intellectual Disabilities. U.S. Department of Health and Human Services. https://acl.gov/sites/default/files/news%202017-03/PCPIDfactsheet.pdf

Administration for Community Living. (n.d.-b). The President's Committee for People with Intellectual Disabilities (PCPID). https://acl.gov/programs/empowering-advocacy/presidents-committee-people

Aging with Intellectual and Developmental Disability Trainings. (2025a). Eunice Kennedy Shriver Center. https://shriver.umassmed.edu/programs/cdder/aging_idd_education/

Aging with Intellectual and Developmental Disability Trainings. (2025b). Eunice Kennedy Shriver Center. https://shriver.umassmed.edu/programs/cdder/aging_idd_education/

Almshouse Reports. (n.d.). Massachusetts Genealogy Trails. https://genealogytrails.com/mass/almshouse.html

Amendment Moved By Mr. Simmons To The Bill Concerning State Lunatic Paupers, Senate Bill 0114 (1848). https://archives.lib.state.ma.us/items/cb5ffc9e-a22c-4be5-9f70-d33d421bc289

American Association on Intellectual and Developmental Disabilities. (2025a). Caring at the End of Life. American Association on Intellectual and Developmental Disabilities. https://www.aaidd.org/news-policy/policy/position-statements/caring-at-the-end-of-life

American Association on Intellectual and Developmental Disabilities. (2025b). Health, Mental Health, Vision, and Dental Care. American Association on Intellectual and Developmental Disabilities. https://www.aaidd.org/news-policy/policy/position-statements/health-mental-health-vision-and-dental-care

An Account of the Boston Asylum for Indigent Boys. (1823). John B. Russell. https://primaryresearch.org/pr/dmdocuments/ootp_asyindigentboys.pdf

An Act Authorizing Judges Of Probate To Dismiss Guardians From Their Guardianship In Certain Cases, Mass. Gen. Laws ch. 0046 (1789). https://archives.lib.state.ma.us/items/4d81bf1b-eb61-4bfc-8b8b-5e1ddbce9402

An Act Changing The Membership Of The Records Conservation Board And Eliminating The Requirement Of Advertising Before Selling Or Destroying Certain Records, Mass. Gen. Laws ch. 0131 (1964). https://archives.lib.state.ma.us/items/be92f460-7b3b-401c-8f19-3b1a119b463a

An Act Clarifying The Meaning Of "Public Records" In So Far As It Relates To Certain Departments And Public Authorities, Senate Bill 1043 (1968). https://archives.lib.state.ma.us/items/5eff0a3c-8b53-424d-ba46-df8feca177f7

An Act Concerning Indigent Children, House Bill 0199 (1848). https://archives.lib.state.ma.us/items/7e2fdce3-57ec-4dd5-a4ba-127641fc074d

An Act Concerning Lunatics, Mass. Gen. Laws ch. 0077 (1841). https://archives.lib.state.ma.us/items/c7d1d8e2-b606-4fe2-b083-8f94bb07c0fe

An Act Concerning Paupers, House Bill 0032 (1835). https://archives.lib.state.ma.us/items/c7a5c829-e487-49b4-aabb-2428a7566c0a

An Act Concerning State Lunatic Paupers, Senate Bill 0066 (1848). https://archives.lib.state.ma.us/items/6eb6e4b4-1aa9-4585-97c5-3921f54d47af

An Act Concerning State Paupers And Alien Passengers, Senate Bill 0074 (1846). https://archives.lib.state.ma.us/items/e6cd3ca3-2996-45ae-9dbf-7c3184be4f5d

An Act Concerning The State Lunatic Hospital, Mass. Gen. Laws ch. 0096 (1842). https://archives.lib.state.ma.us/items/99b870a3-2dcf-4ff8-a9bf-ff30a681eec0

An Act Concerning The State Pauper Establishments Within This Commonwealth, Mass. Gen. Laws ch. 0352 (1853). https://archives.lib.state.ma.us/items/8ddc49be-6cf2-4dda-a513-376638d6bd67

An Act Designating Certain Lands in the Town of Tewksbury for Conservation, Agriculture and Passive Public Recreational Purposes, Mass. Gen. Laws ch. 0206 (2004). https://www.tewksbury-ma.gov/DocumentCenter/View/1552/Act-of-2004-PDF

An Act Establishing A Board Of Control Of State Charities, And Concerning The Superintendence Of State Paupers, Senate Bill 0077 (1859). https://archives.lib.state.ma.us/items/ef7cc879-5ac1-46a2-a371-6daeee58f244

An Act Establishing Special Procedures For Persons Allegedly Committed Or Confined Unlawfully At Bridgewater State Hospital And State Hospitals Under The Jurisdiction Of The Department Of Mental Health, Mass. Gen. Laws ch. 0620 (1967). https://archives.lib.state.ma.us/items/9af24564-01e3-4350-84a1-e6176e2761d8

An Act Establishing The Records Conservation Board, Defining Its Powers And Duties, And Further Defining Obsolete Records, Mass. Gen. Laws ch. 0427 (1962). https://archives.lib.state.ma.us/items/49e708ee-93ab-4636-b11b-fc1e0c822468

An Act Extending The Powers Of The Justices Of The Supreme Judicial Court In Certain Cases, Mass. Gen. Laws ch. 0028 §§ 1-4 (1816). https://archives.lib.state.ma.us/items/840bb860-a8e3-4554-a9f9-2ece0cbc96e6

An Act For Reviving And Continuing Sundry Laws That Are Expired, And Near Expiring, Mass. Gen. Laws ch. 0014 (1775). https://archives.lib.state.ma.us/items/864c73f9-b9f2-46c5-923a-05673a842cc9

An Act Further Regulating The Keeping Of Certain Medical Records, Mass. Gen. Laws ch. 0495 (1981). https://archives.lib.state.ma.us/items/68328ecc-8810-46ba-85df-4060aff72b2b

An Act Further Regulating The Procedures For The Hospitalization And Commitment Of The Mentally Ill, And Relating To The Care Of Such Persons, Mass. Gen. Laws ch. 0637 (1955). https://archives.lib.state.ma.us/items/06a52551-6606-460a-ad0c-702d1d021885

An Act Im Powering The Judges Of Probate To Appoint Guardians To Minors And Others, Mass. Gen. Laws ch. 0038 (1783). https://archives.lib.state.ma.us/items/f748d99b-e186-4020-9b44-1c4d291893dc

An Act In Addition To An Act, Entitled " An Act To Prevent The Introduction Of Paupers From Foreign Ports Or Places," Mass. Gen. Laws ch. 0150 (1830). https://archives.lib.state.ma.us/items/31433918-1fa4-437d-8644-059ea994fec4

An Act In Addition To An Act Intitled An Act For Suppressing Rogues, Vagabonds, Common Beggars, & Other Idle Disorderly & Lewd Persons, Mass. Gen. Laws ch. 0062 §§ 1-4 (1797). https://archives.lib.state.ma.us/items/10d1095b-54d4-40a7-8f33-deb370c4a231

An Act In Addition To The Act For The Relief Of Ideots And Distracted Persons, Mass. Gen. Laws ch. 0005 (1708). https://archives.lib.state.ma.us/items/02c190a6-67ab-4f7d-bfe4-2b4c7d592610

An Act In Addition To The Several Acts Concerning The Sale Of Real Estate By Executors, Administrators And Guardians, Mass. Gen. Laws ch. 0140 §§ 1-2 (1830). https://archives.lib.state.ma.us/items/690513ae-ec4b-44e3-b9dc-b055ec2ce1ce

An Act In Addition To The Several Laws Of This Province Relating To The Support Of Poor And Indigent Persons, Mass. Gen. Laws ch. 0018 §§ 1-5 (1742). https://archives.lib.state.ma.us/items/80220524-582a-4c68-b32f-a3daa81a37d0

An Act In Further Addition To An Act, Entitled, "An Act For The Rel[e]i[e]f Of Idiots And Distracted Persons.," Mass. Gen. Laws ch. 0009 (1737). https://archives.lib.state.ma.us/items/ef6d2f3d-b1c6-423a-9050-5349ae4203db

An Act In Further Addition To An Act Entitled "An Act For The Relief Of Id[i][e]Ots And Distracted Persons," Mass. Gen. Laws ch. 0012 §§ 1-9 (1726). https://archives.lib.state.ma.us/items/6be51399-7d65-47f0-af90-71e2cf6e2ca5

An Act In Further Addition To An Act Entitled "An Act For The Relief Of Id[i][e]Ots And Distracted Persons," Mass. Gen. Laws ch. 0014 §§ 1-9 (1731). https://archives.lib.state.ma.us/items/74c5249d-1312-418d-a001-bd3198df739d

An Act In Further Addition To The Several Acts For The Suppressing And Punishing Of Rogues, Vagabonds, Common Beggars, And Other Idle, Disorderly And Lewd Persons, House Bill 0081 (1827). https://archives.lib.state.ma.us/items/88c5f147-9716-4651-8c7c-118c8e3bd6f4

An Act In Regard To Committals Of Insane Persons, House Bill 0267 (1876). https://archives.lib.state.ma.us/items/7124ea17-d4df-462e-866c-7a82590b760f

An Act In Relation To Paupers Having No Settlement In This Commonwealth, Mass. Gen. Laws ch. 0275 (1852). https://archives.lib.state.ma.us/items/48be8d48-f747-4329-aace-9ae4fdb077d6

An Act In Relation To Public Reports And Documents, Mass. Gen. Laws ch. 0040 (1857). https://archives.lib.state.ma.us/items/b3e1857d-65fc-41fc-9a7d-774c9b9adb06

An Act In Relation To The House Of Correction And Asylum For Insane Persons In The County Of Essex, Mass. Gen. Laws ch. 0154 (1846). https://archives.lib.state.ma.us/items/9a6f1f6d-e4a9-4507-89de-d0311a5c1543

An Act Making Further Corrections In The Statutes Of The Commonwealth Necessitated By The Change Of Name Of The State Department, Formerly Known As The Department Of Mental Diseases, To The Department Of Mental Health, Mass. Gen. Laws ch. 0194 (1941). https://archives.lib.state.ma.us/items/3cb72e1a-bae9-4b01-80ca-d8e2122ff3a6

An Act Making The Commonwealth A Party To The Interstate Compact On Mental Health, Mass. Gen. Laws ch. 0441 (1956). https://archives.lib.state.ma.us/items/7873eea3-98b0-4703-962b-8df819fd1455

An Act More Effectually To Protect The Sepulchres Of The Dead, And To Legalize The Study Of Anatomy In Certain Cases, Mass. Gen. Laws ch. 0057 (1830). https://archives.lib.state.ma.us/items/37099206-37f9-47d5-88b1-f7d237298691

An Act Permitting Patients To Obtain A Copy Of Their Medical Records Before They Are Destroyed By A Hospital, House Bill 4556 (1981). https://archives.lib.state.ma.us/items/47233278-c536-4558-aed6-f50d2a89c861

An Act Permitting The Inspection Of Hospital Records By A Patient Or His Attorney And The Obtaining Of Copies Of Such Records, Mass. Gen. Laws ch. 0291 (1945). https://archives.lib.state.ma.us/items/b6b3ff53-f3c3-4d86-a22d-fa10e964b1eb

An Act Pertaining To Bridgewater State Hospital Records, House Bill 0080 (1989). https://archives.lib.state.ma.us/items/c086d5f5-40d9-432d-92b3-5fa87f42b5b7

An Act Providing For A Return By Overseers Of The Poor, Mass. Gen. Laws ch. 0194 (1837). https://archives.lib.state.ma.us/items/bccb555f-71af-403c-956b-225f71cc2cad

An Act Providing For Legal Assistance To The Indigent Mentally Ill, Mass. Gen. Laws ch. 0893 (1973). https://archives.lib.state.ma.us/items/b4eda701-cd2e-4937-af48-5aed00c72d38

An Act Providing For Sexual Sterilization Of Inmates Of State And County Institutions In Certain Cases, House Bill 0160 (1934). https://archives.lib.state.ma.us/items/46c05496-008b-4ca6-be68-db4223dfdb4e

An Act Providing For The Classification Of State Paupers, Mass. Gen. Laws ch. 0412 (1855). https://archives.lib.state.ma.us/items/beb3e8d8-3ffd-455d-9003-742134699687

An Act Providing For The Relief And Support, Employment And Removal Of The Poor, And For Repealing All Former Laws Made For Those Purposes, Mass. Gen. Laws ch. 0059 (1793). https://archives.lib.state.ma.us/items/e2afad73-c994-4032-ac5a-fcc7c3b3b381

An Act Providing For The Support Of The Poor, Mass. Gen. Laws ch. 0061 (1788). https://archives.lib.state.ma.us/items/2f215c78-262a-4e2f-9d5e-f2e5c9851ac3

An Act Providing That All Records Of State Institutions For The Insane Shall Be Open To Inspection By The Inmates To Whom Such Records Relate And Other Interested Persons, Senate Bill 0375 (1948). https://archives.lib.state.ma.us/items/a1ef9d27-bdaf-4275-923d-11696ee3ae52

An Act Providing That The Supervisor Of Public Records Shall Be A Member Of The Board Authorized To Sell Or Destroy Certain Books And Records Of The Commonwealth, Mass. Gen. Laws ch. 0397 (1951). https://archives.lib.state.ma.us/items/3260bc3c-ed85-4b54-a844-0db22bbc3605

An Act Regarding Medical Record Retention Requirements, Senate Bill 1292 (2005). https://archives.lib.state.ma.us/items/0d8a0203-b5b1-4a34-893b-5c40e8a642b1

An Act Relating To Alien Passengers, Mass. Gen. Laws ch. 0238 (1837). https://archives.lib.state.ma.us/items/a2c7be02-7370-4b18-a715-08631fea182c

An Act Relating To Lunatics And Idiots, Mass. Gen. Laws ch. 0108 (1856). https://archives.lib.state.ma.us/items/ad4cdef5-cb44-4f32-b7c4-c7a86e6bd3fc

An Act Relating To Records In State Hospitals, State Schools Or Institutions In The Department Of Mental Health, House Bill 1699 (1957). https://archives.lib.state.ma.us/items/f97a71e6-2d9f-4668-9a3c-4449cda31162

An Act Relating To State Paupers, Mass. Gen. Laws ch. 0081 §§ 1-2 (1822). https://archives.lib.state.ma.us/items/c1271f67-c064-4874-b88a-b09fcae3846e

An Act Relating To State Paupers, Mass. Gen. Laws ch. 0021 §§ 1-3 (1823). https://archives.lib.state.ma.us/items/1d429c32-9323-415b-8994-af90d9c91bd2

An Act Relating To The Correspondence Of Insane Persons, And To The Establishment Of A Commission Of Lunacy, Mass. Gen. Laws ch. 0363 (1874). https://archives.lib.state.ma.us/items/fa7b762b-971d-4580-a4cd-f1ff8e424309

An Act Relating To The State Visiting Agency And Juvenile Offenders, Mass. Gen. Laws ch. 0359 (1870). https://archives.lib.state.ma.us/items/fdf48526-898a-44d8-ab92-cc1274c77354

An Act Relating To The Support Of State Paupers, Mass. Gen. Laws ch. 0120 (1830). https://archives.lib.state.ma.us/items/a9a3a29a-23b3-45d9-88e5-ae833539ffce

An Act Relative To Commitments Of Insane Persons And To The Fees Received Therefor, Mass. Gen. Laws ch. 0459 (1904). https://archives.lib.state.ma.us/items/bb8b2db8-e91c-49ab-9e3e-4666d98a1ddd

An Act Relative To Confinement Conditions And Treatment Of Prisoners With Mental Illness, House Bill 1313 (2007). https://archives.lib.state.ma.us/items/cf53bdae-7769-4bf0-99e1-959f35555151

An Act Relative To False Statements In The Records Of Inmates In Hospitals Under The Jurisdiction Of The Department Of Mental Health, Senate Bill 0025 (1949). https://archives.lib.state.ma.us/items/0a3b63b8-7c6a-42c1-8218-6d9c1a921f9d

An Act Relative To Hospital And Clinic Medical Record Retention, House Bill 2179 (2007). https://archives.lib.state.ma.us/items/1af7721c-c163-4f59-ae89-eecbc226cd94

An Act Relative To Public Records And Proceedings, Senate Bill 0066 (1958). https://archives.lib.state.ma.us/items/ffe1d28d-d604-4f93-9a08-facaf236216b

An Act Relative To Records Of Restraint In Institutions Under The Supervision Of The Department Of Mental Health, House Bill 0058 (1946). https://archives.lib.state.ma.us/items/b18696a0-85f0-45fd-a9dc-79fb4ebaa746

An Act Relative To State Lunatic Paupers, Mass. Gen. Laws ch. 0207 (1849). https://archives.lib.state.ma.us/items/ebadb9cd-179c-4f15-ab87-21c6f12ae1b8

An Act Relative To The Civil Commitment Process For Persons With Mental Illness, Mass. Gen. Laws ch. 0410 §§ 1-2 (2004). https://malegislature.gov/Laws/SessionLaws/Acts/2004/Chapter410

An Act Relative To The Commitment And Care Of The Mentally Ill, Epileptics, Alcoholics And Drug Addicts, Mass. Gen. Laws ch. 0589 (1956). https://archives.lib.state.ma.us/items/ec524d83-b227-4731-97c0-f04e6d1e7613

An Act Relative To The Disposal By The Commonwealth Of Duplicate And Worthless Books And Documents, Mass. Gen. Laws ch. 0174 (1920). https://archives.lib.state.ma.us/items/119ba5d0-6aad-4565-87d8-e94082320961

An Act Relative To The Inspection Of Records Kept By Certain Hospitals Under The Supervision Of The Department Of Mental Diseases, House Bill 0132 (1926). https://archives.lib.state.ma.us/items/9950fed6-2c65-44aa-b43d-013b275cc896

An Act Relative To The Membership Of A Commission On Economy And Efficiency, Mass. Gen. Laws ch. 0698 (1914). https://archives.lib.state.ma.us/items/baee4938-cc54-432f-ae60-c10fb676d2d2

An Act Relative To The Order Of Commitment Of An Insane Person, Mass. Gen. Laws ch. 0273 (1911). https://archives.lib.state.ma.us/items/da3ad78c-5e13-46c6-9910-34bfa15cf986

An Act Relative To The Release Of Hospital Records Of Patients In Institutions Under The Control Of The Department Of Mental Health, Mass. Gen. Laws ch. 0614 (1970). https://archives.lib.state.ma.us/items/0c74cbae-2948-4760-9aa3-43b22ac7d577

An Act Requiring Evaluations Of State Residential Facilities For The Mentally Retarded And Providing For Federal Reimbursement For Services To The Retarded In Intermediate Care Facilities, Mass. Gen. Laws ch. 1068 (1973). https://archives.lib.state.ma.us/items/75577e99-bce8-4e83-91b2-ea9efe236c54

An Act Revising The Laws Relative To The Admission, Treatment And Discharge Of Mentally Ill And Mentally Retarded Persons, Mass. Gen. Laws ch. 0888 (1970). https://archives.lib.state.ma.us/items/771b4d43-01dd-4902-8489-819f118e6f55

An Act To Abolish The State Almshouses At Bridgewater And Monson, Mass. Gen. Laws ch. 0045 (1872). https://archives.lib.state.ma.us/items/4a433f61-d883-477a-8316-e63fd933a53f

An Act To Appoint A Board Of Commissioners In Relation To Alien Passengers And State Paupers, Mass. Gen. Laws ch. 0342 §§ 1-9 (1851). https://archives.lib.state.ma.us/items/5d70e70a-cbe9-4b20-90a5-97cafce2bde4

An Act To Change The Title Of The Department Of Mental Retardation, House Bill 4610 (2008). https://archives.lib.state.ma.us/items/070d44d0-111f-4d82-a18d-1b5ca59f840d

An Act To Establish A Board Of Health And Vital Statistics In Massachusetts, Senate Bill 0082 (1862). https://archives.lib.state.ma.us/items/edaf0c3d-9202-4ada-a3cb-c802bafcebc5

An Act To Incorporate The Boston Asylum And Farm School For Indigent Boys, Mass. Gen. Laws ch. 0028 (1835). https://archives.lib.state.ma.us/items/1798e10b-4f42-46a0-ac4b-1824ecc7475c

An Act To Incorporate The Proprietors Of The Boston Farm School, Mass. Gen. Laws ch. 0135 (1833). https://archives.lib.state.ma.us/items/01c63bba-b318-444b-8eee-f88e29c85d4a

An Act To Insure Hospital Care And Treatment For Certain Insane Persons, Senate Bill 0244 (1890). https://archives.lib.state.ma.us/items/22a7d1d4-30fa-4929-a394-a8f850a1d0b9

An Act To Prevent The Introduction Of Paupers, From Foreign Ports Or Places, Mass. Gen. Laws ch. 0165 (1819). https://archives.lib.state.ma.us/items/87615387-7126-40fa-b430-b2de0abda97e

An Act To Provide A Building For The Chronic Insane At The State Workhouse At Bridgewater, House Bill 0298 (1886). https://archives.lib.state.ma.us/items/d3c5bd3a-176d-4f0b-8b29-38da5f795757

An Act To Provide For The Discharge Or Temporary Release Of Inmates Of Institutions For The Insane, House Bill 0146 (1883). https://archives.lib.state.ma.us/items/6801e36a-6019-4cf4-a34f-95c83225c005

An Act To Provide For The Maintenance At The Reformatory For Women, The Massachusetts Reformatory And The State Farm Of Departments For Defective Delinquents, Mass. Gen. Laws ch. 0595 (1911). https://archives.lib.state.ma.us/items/3788605a-1dc1-4056-9803-c976c92b1299

An Act To Provide For The Safe-Keeping Of Lunatics, And Persons Furiously Mad, House Bill 0028 (1828). https://archives.lib.state.ma.us/items/5dadbe18-78df-4cf3-998b-6de283bec8ac

An Act To Provide For The Temporary Care Of Persons Suffering From Mental Diseases Who Are In The Military And Naval Service Of The United States, Mass. Gen. Laws ch. 0142 (1918). https://archives.lib.state.ma.us/items/15437289-30a8-4bd2-8626-9192222fc332

An Act To Regulate The Restraint Of Patients In Public Or Private Hospitals Or Sanatoriums For The Insane, Mass. Gen. Laws ch. 0589 (1911). https://archives.lib.state.ma.us/items/fdd4052e-4114-466a-949e-e2343d40241f

An Act To Regulate The Sale Of Goods At Public Vendue, And To Limit The Number Of Auctioneers, Mass. Gen. Laws ch. 0044 §§ 1-7 (1772). https://archives.lib.state.ma.us/items/19768558-2f83-42bd-96e2-cbc1c47259ab

An Act To Reorganize The Management Of Mental Health And Mental Retardation Services In The Commonwealth, Mass. Gen. Laws ch. 0599 (1986). https://archives.lib.state.ma.us/items/9b04ffd8-b6fe-42d8-bdc2-da36a9d5f717

An Act To Revise And Codify The Laws Relating To Insane Persons, Mass. Gen. Laws ch. 0504 (1909). https://archives.lib.state.ma.us/items/133e3306-e000-49d1-b34d-20f39e842ae0

Anonymous. (2024). Summary of Anonymous Search for Records About His Cousin D. [Personal communication].

Appleman, L. I. (2018). DEVIANCY, DEPENDENCY, AND DISABILITY: THE FORGOTTEN HISTORY OF EUGENICS AND MASS INCARCERATION. Duke Law Journal, 68(3), 418–478.

Atherton, J. (2011). Development of the Electronic Health Record. AMA Journal of Ethics Virtual Mentor, 13(3), 186–189. https://doi.org/10.1001/virtualmentor.2011.13.3.mhst1-1103.

Attorney General, Commonwealth of Massachusetts. (1998). The Attorney General's special report on medical record confidentiality. https://archives.lib.state.ma.us/items/fcf838f3-29b7-4f3f-aa4f-52a9302e01eb

Bank, R., & Schore, R. (1981). Medical Information Systems: A Historical Overview. International Journal of Mental Health, 10(4), 6–16.

Belchertown State School. (1924). Annual Report of the Trustees of the Belchertown State School for the Year Ending November 30, 1923. Department of Mental Diseases. https://archives.lib.state.ma.us/items/93b73c6a-08f6-4ebd-9025-e1fc520fda7a

Bell, E. L. (1990). The Historical Archaeology of Mortuary Behavior: Coffin Hardware from Uxbridge, Massachusetts. Historical Archaeology, 24(3), 54–78.

Boston 25 News. (2014, January 31). FOX Undercover: State sweeping shuttered buildings for medical records after questions from FOX Undercover. https://www.boston25news.com/news/fox-25-investigates/state-sweeping-shuttered-buildings-for-medical-records-after-questions-from-fox-undercover-1/141558950/

Boston State Hospital. (1920). Annual Report of the Trustees of the Boston State Hospital For the Year Ending November 30, 1920. Wright & Potter. https://archives.lib.state.ma.us/items/0c2aa871-2e2f-4e24-bb11-d20e1dee83e0

Boston State Hospital. (1956). Annual Report of the Trustees of the Boston State Hospital For the Year Ending June 30, 1956. Wright & Potter Printing Company. http://archives.lib.state.ma.us/handle/2452/799432

Brasco, W. (2024). [Personal communication].

Brenzel, B. M. (1983). Daughters of the state: A social portrait of the first reform school for girls in North America, 1856-1905. MIT Press.

Bulletin of the Massachusetts Commission on Mental Diseases. V.7-17, 1923-33. (1923). Wright and Potter. https://www.google.com/books/edition/Bulletin_of_the_Massachusetts_Commission/-eeoBAd2VxkC?hl=en&gbpv=0

Carvajal, M., & Grzybowski, S. (2013, August). With Reverance and Respect: RELOCATING A CEMETERY. Right of Way.

Center for Public Representation. (2007, 2008). About Rosie D. Reforming the Mental Health System in Massachusetts. https://www.rosied.org/page-67061

Center for Public Representation. (2025). Massachusetts SDM Legislation. CPR Supported Decision-Making. https://supporteddecisions.org/massachusetts-sdm-legislation/

Central Massachusetts Regional Planning Commission. (2014, May). Shrewsbury Glavin Center PDA Analysis. https://cmrpc.org/wp-content/uploads/2023/08/Glavin-Center-Report-Final-1.pdf

Cojen, W. J., & Ball, R. M. (1965, September). Social Security Amendments of 1965: Summary and Legislative History. https://www.ssa.gov/policy/docs/ssb/v28n9/v28n9p3.pdf

Commonwealth of Massachusetts. (2025a). Charting the LifeCourse in Massachusetts. Mass.Gov. https://www.mass.gov/news/charting-the-lifecourse-in-massachusetts

Commonwealth of Massachusetts. (2025b). DDS Home and Community Based Services Waivers. https://www.mass.gov/dds-home-and-community-based-services-waivers#:~:text=The%20DDS%20HCBS%20Waivers%20are,home%20instead%20of%20an%20institution

Commonwealth of Massachusetts. (2025c). Department of Correction Public Policies. https://www.mass.gov/lists/department-of-correction-public-policies

Commonwealth of Massachusetts. (2025d). Massachusetts Office on Disability: Disability Rights in Education. https://www.mass.gov/info-details/disability-rights-in-education

Commonwealth of Massachusetts. (2025e). MassHealth Children's Behavioral Health Initiative (CBHI). https://www.mass.gov/info-details/learn-about-cbhi

Commonwealth of Massachusetts. (2025f). Moving Forward Plan (MFP) Waivers. https://www.mass.gov/info-details/moving-forward-plan-mfp-waivers#about-the-program

Commonwealth of Massachusetts. (2025g). Rogers Guardianships. https://www.mass.gov/rogers-guardianships

Commonwealth of Massachusetts Department of Mental Health. (2022). Final Report on the Impact of Chapter 249 of the Acts of 2000: An Act to Reform the Civil Commitment Process for Persons with Mental Illness 2022 Annual Report. https://www.mass.gov/doc/2022-dmh-civil-commitment-annual-report/download

Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. (2013, August). MassHealth Hospice Bulletin 10. https://www.mass.gov/doc/hospice-bulletin-10-

changes-to-masshealth-coverage-types-0/download#:~:text=MassHealth%20pays%20the%20hospice%20provider,a%20continuous%20basis%20at%20home

Commonwealth vs. Paul J. O'Brien (27 Appeals Court of Massachusetts, Middlesex 184 1989). https://law.justia.com/cases/massachusetts/court-of-appeals/1989/27-mass-app-ct-184-0.html

Communication From Executive Department Transmitting A Report Received From The Honorable Josiah Quincy, Jr., Honorable Alfred Hitchcock, M.D., and Horatio R. Storer, M.D., Commissioners Appointed To Make Certain Investigations Of The Subject Of Insanity, And The Disposition Of Persons Alleged To Be Insane, Senate Bill 0072 (1864). https://archives.lib.state.ma.us/items/3682cf14-00d9-43be-a4db-f5317160aaa0

Communication From Senate Committee On Public Charitable Institutions Reporting Amendments To House Bill No. 302, An Act In Addition To An Act Regulating The Commitments Of Persons To Insane Hospitals, Senate Bill 0245 (1881). https://archives.lib.state.ma.us/items/7dcb974b-88cf-4765-bb86-b1ae9fc8d9e5

Community Preservation Committee (CPC) Meeting Minutes. (2019, September 10). https://www.city.waltham.ma.us/sites/g/files/vyhlif12301/f/minutes/2019-09-10_meeting_minutes_final.pdf

Community Preservation Committees. (n.d.). Community Preservation Coalition. https://www.communitypreservation.org/CPCs#:~:text=Keep%20Records%20and%20Report%20on,annually%20to%20the%20legislative%20body

Congressional Research Service. (2023, October). Medicaid's Institution for Mental Diseases (IMD) Exclusion. https://crsreports.congress.gov/product/pdf/IF/IF10222#:~:text=Taking%20into%20consideration%20all%20the,than%20payments%20for%20services%20rendered.

Countway Library, Harvard University. (n.d.-a). Policies. Center for the History of Medicine. Retrieved October 29, 2024, from https://countway.harvard.edu/center-history-medicine/policies

Countway Library, Harvard University. (n.d.-b). The Anatomy Act. Center for the History of Medicine. Retrieved October 28, 2024, from https://collections.countway.harvard.edu/onview/exhibits/show/nature-of-every-member/the-anatomy-act

Countway Library staff. (2024). [Personal communication].

Danielson, F. H., & Davenport, C. B. (1912). The Hill Folk; Report On a Rural Community of Hereditary Defectives. https://hdl.handle.net/1805/1093

Danvers Insane Hospital. (1901). Twenty-Third Annual Report of the Trustees of the Danvers Insane Hospital, for the Year Ending September 30, 1900. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/4e98bc2c-d00f-4f8b-84a7-85ea3d7d1662

Danvers Lunatic Hospital. (1879). First Annual Report of the Trustees of the State Lunatic Hospital at Danvers for the Year Ending September 30, 1878. Rand, Avery & Co. https://archives.lib.state.ma.us/items/23d52bef-1d93-4c2e-895c-9a06ee38d4bf

Davidow, S. (2024). The Truth About Roger's Orders: No, It's Not About Force. Wildflower Alliance. https://wildfloweralliance.org/the-truth-about-rogers-orders-no-its-not-about-force/

Deegan, P. (Director). (2010). From Numbers to Names: State Hospital Cemetery Restoration [Video recording]. https://www.youtube.com/watch?v=A1bgJX93_II

Department of Developmental Services. (n.d.). Governor's Commission on Intellectual Disability (GCID). Commonwealth of Massachusetts. Retrieved October 28, 2024, from https://www.mass.gov/lists/governors-commission-on-intellectual-disability-gcid

Department of Developmental Services. (2024, March 11). HIPAA Breach Notification: The Former Fernald Developmental Center. Commonwealth of Massachusetts. https://www.mass.gov/news/hipaa-breach-notification-the-former-fernald-developmental-center

Department of Mental Diseases. (1921). Annual Report of the Commissioner of Mental Diseases for the Year Ending November 30, 1920. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/3333e0ab-8cd2-47aa-9147-17163086a7b8

Department of Mental Diseases. (1923). Annual Report of the Commissioner of Mental Diseases for the Year Ending November 30, 1922. https://archives.lib.state.ma.us/items/6bbaf821-c9c1-40f1-be5e-14e9cb4fdecf

Department of Mental Diseases. (1924). Annual Report of the Commissioner of Mental Diseases for the Year Ending November 30, 1923. https://archives.lib.state.ma.us/items/9a84343c-e758-48aa-8a54-9a0c82b1fb4e

Department of Mental Diseases. (1925). Annual Report of the Commissioner of Mental Diseases for the Year Ending November 30, 1924. https://archives.lib.state.ma.us/items/28b005dd-2232-470d-ada8-35f8f48c6a19

Department of Mental Diseases. (1928). Annual Report of the Commissioner of Mental Diseases for the Year Ending November 30, 1927. https://archives.lib.state.ma.us/items/789fc2e6-4285-4be4-9f84-00c868018d0a

Department of Mental Diseases. (1937). Annual Report of the Commissioner of Mental Diseases for the Year Ending November 30, 1936. https://archives.lib.state.ma.us/items/ff55f215-4889-4b52-9469-e5c741e1252c

Department of Mental Health. (1939). Annual Report of the Commissioner of Mental Health for the Year Ending November 30, 1938. https://archives.lib.state.ma.us/items/bd28ce64-2cc2-4add-bf80-b9092e2e33b4

Department of Mental Health. (2001, December). Fiscal Years 2002—2004 State Mental Health Plan and Fiscal Year 2001 Adult & Child/Adolescent Implementation Report. https://archives.lib.state.ma.us/items/30010cb5-6e24-436f-a4c7-ba0abdf17e41

Department of Mental Health Office of Consumer/Expatient Relations. (2001). State Hospital Cemetery Restoration in Massachusetts: It's About Time.

Department of Mental Retardation. (1990). DMR transition briefing book. https://archives.lib.state.ma.us/items/b7ea7f97-163e-423e-b95b-a44dbcd139bd

Department of Mental Retardation. (1993). Annual Report July 1, 1992—June 30, 1993. https://archives.lib.state.ma.us/items/7f078258-9b3c-42d1-9c6c-38eb5c290ffc

Department of Mental Retardation. (1994). Annual Report July 1, 1993—June 30, 1994. https://archives.lib.state.ma.us/items/908711d2-64eb-4866-b8ee-b5303f246a45

Department of Mental Retardation. (1998, April 24). Investigations Advisory Panel report for the Department of Mental Retardation. https://archives.lib.state.ma.us/items/92a9c41b-4cea-4610-9adb-44f2fd2bfd2a

Department of Mental Retardation. (2003, December). Health Promotion and Coordination Initiative: Training and Resource Manual. https://archives.lib.state.ma.us/items/39d883bb-ca7b-4c13-9171-1ab62be57c85

Departmental Policy Regarding Seclusion/Restraint (1978). https://archives.lib.state.ma.us/items/1b23d2af-877a-4356-86e7-ad2ce28cd72e

Devall, A. (2024, April 11). One man finally gets answers about his brother's life at the Fernald School. WGBH. https://www.wgbh.org/news/local/2024-04-11/one-man-finally-gets-answers-about-his-brothers-life-at-the-fernald-school

Directory of the Charitable and Beneficent Organizations of Boston Together with "legal Suggestions," Etc.: Prepared for the Associated Charities. (1886). Cupples, Upham and Company.

Disability Law Center. (2024, February). Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served. https://www.dlc-ma.org/wp-content/uploads/2024/03/DLC-BSH-Public-Report-3.13.2024.pdf

Disabled Persons Protection Commission. (1992, July 28). Commissioners' investigation regarding editing of C. 19C investigation reports. https://archives.lib.state.ma.us/items/3c1ec8df-d0cc-42bf-8f8c-793973e071da

Documents Relating To The State Prison, Senate Bill 0017 (1843). https://archives.lib.state.ma.us/items/f2633dc4-b901-431f-961f-d628aaa6839c

Duckett, M. J., & Guy, M. R. (2002). Home and Community-Based Services Waivers. Health Care Financing Review, 22(1), 123–125.

Duff, J. H. (2020, June 23). Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs. Congressional Research Service.

EBay Security Center. (n.d.). EBay. https://pages.ebay.com/securitycenter/law_enforcement_customers.html#:~:text=If%20you've%20been%20defrauded,obtain%20a%20crime%20reference%20number

Egger, O. (2024, January 10). The shameful afterlife of the Fernald School in Waltham. The Boston Globe. https://www.bostonglobe.com/2024/01/10/opinion/shameful-afterlife-fernald-school-waltham/

Eisner, G. (2025, January 2). DDS Assistant General Counsel Letter [Personal communication].

Erickson, B. (2021). Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963. American Journal of Psychiatry Residents' Journal, 16(4), 6–7.

Experimental School for Teaching and Training Idiotic Children. (1852). Third and Final Report on the Experimental School for Teaching and Training Idiotic Children; Also, the First Report of the Trustees of Massachusetts School for Idiotic and Feeble-Minded Youth. Metcalf & Co. https://archives.lib.state.ma.us/items/717b5831-2b96-454d-affa-e512f55ad380

Fernald, W. E., Southard, E. E., & Taft, A. E. (1918). WAVERLEY RESEARCHES IN THE PATHOLOGY OF THE FEEBLEMINDED. Memoirs of the American Academy of Arts and Sciences, 14(2), 19–21.

Foti, M. E. (2003). “Do It Your Way”: A Demonstration Project on End-of-Life Care for Persons with Serious Mental Illness. JOURNAL OF PALLIATIVE MEDICINE, Volume 6, Number 4. https://pubmed.ncbi.nlm.nih.gov/14516513/

Galvin, W. F. (2022, December). A Guide to the Massachusetts Public Records Law. William Francis Galvin, Secretary of the Commonwealth. https://www.mass.gov/doc/a-guide-to-the-massachusetts-public-records-law/download

George Kline. (1920, November 10). (Box 9 Folder 7). Fernald Administrative Correspondence, Mass Archives.

Goals of Care for Life-Limiting Illness, Pub. L. No. 2024- 01 (replaces former policy #2017- 1) (2025). https://www.mass.gov/doc/dds-policy-2024-01-goals-of-care-for-life-limiting-illness/download

Grafton State Hospital. (1917). Thirty-ninth Annual Report of the Grafton State Hospital at North Grafton and Worcester, for the Year Ending November 30, 1916. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/d7d73afb-b227-4747-95ff-9107ba3ddc0c

Green, A. (2025a, April). Walter E. Fernald: Brief life of a complex pioneer of care for the intellectually disabled: 1859-1924. Harvard Magazine. https://www.harvardmagazine.com/2025/03/harvard-walter-fernald-care-intellectually-disabled

Green, A. (2025b, April 1). How one man kept Mass. From sterilizing the disabled. WBUR. https://www.wbur.org/cognoscenti/2025/04/01/walter-e-fernald-disabilites-waltham-eugenics-alex-green

Grob, G. N. (1994). Government and Mental Health Policy: A Structural Analysis. The Milbank Quarterly, 72(3), 471–500.

Gunnar and Rosemary Dybwad Papers. (1970, October 14). Open house at the Eunice Kennedy Shriver Center and the Walter E. Fernald State School. Brandeis University Archives.

Hansan, J. E. (2011, January 19). Poor Relief in the Early America. VCU Libraries Social Welfare History Project. https://socialwelfare.library.vcu.edu/programs/poor-relief-early-amer/

Heldrich, J. J. (2000, January). The Workforce Investment Act of 1998: A Primer for People with Disabilities. Center for Workforce Development Rutgers, the State University of New Jersey. https://www.issuelab.org/resources/2627/2627.pdf

Highlights From the Warren Anatomical Museum. (2010, January 1). Smithsonian Magazine. https://www.smithsonianmag.com/history/highlights-from-the-warren-anatomical-museum-2711632/

Historical Background on the Poor and Poor Relief in Early 19th-Century New England. (2003). Old Sturbridge Inc. https://www.osv.org/content/uploads/2018/02/Historical-Background-on-the-Poor-and-Poor-Relief-in-Early-19th-Century-New-England.pdf

Hornick, R. (2012). The Girls and Boys of Belchertown A Social History of the Belchertown State School for the Feeble-Minded. University of Massachusetts Press.

Horwitz, A. V., & Grob, G. N. (2011). The Checkered History of American Psychiatric Epidemiology. The Milbank Quarterly, 89(4), 628–657.

Humphrey, D. C. (1973). Dissection and discrimination: The social origins of cadavers in America, 1760-1915. Bulletin of the New York Academy of Medicine, 49(9), 819.

IC-05: Eric C. L. Aerts Photographs. (n.d.). Archives and Special Collections, Department of the Library, College of Staten Island, CUNY, Staten Island, New York. Retrieved October 27, 2024, from https://archivesspace.library.csi.cuny.edu/repositories/2/resources/99

Individuals with Disabilities Education Act, 20 U.S.C. § 1400 (1990).

Institute of Medicine. (1991). A Brief History of ADAMHA and Previous Studies of Its Organization: Vol. Research and Service Programs in the PHS: Challenges in Organization. The National Academies Press. https://nap.nationalacademies.org/read/1871/chapter/5

Invisible wounds of war: Mental health in WWII. (n.d.). The National WWII Museum. https://www.nationalww2museum.org/

John Scott C-154. (n.d.). The MetFern Cemetery Website. https://www.metfern.org/bio/C-154

Juvenile Code, Human Services, Vol. 11, Ch. 409, § 409.742 (2023). https://law.justia.com/codes/oregon/volume-11/

Kemper, T. (1984). Paul Ivan Yakovlev 1894-1983. Archives of Neurology, 41(5), 536–540. https://doi.org/doi:10.1001/archneur.1984.04050170082023

Kevles, D. J. (1985). In the name of eugenics: Genetics and the uses of human heredity. Harvard University Press. http://pinguet.free.fr/kevles1985.pdf

Kindred, T. (2020, September 25). The Biography of Anton Theophilus Boisen. Association for Clinical Pastoral Education. https://acpe.edu/docs/default-source/acpe-history/the-biography-of-anton-theophilus-boisen.pdf?sfvrsn=f542507_2

Klebaner, B. J. (1955). Pauper auctions: The 'New England method' of public poor relief. Essex Institute Historical Collections, 91(3). https://www.primaryresearch.org/pr/dmdocuments/ootp_klebaner.pdf

Klein, A., & Wittes, B. (2011). Preventive Detention in American Theory and Practice. Nat'l Sec. J., 85. https://scholarship.law.columbia.edu/cgi/viewcontent.cgi?article=1005&context=national_security_law

Langlois, J. (2020). A Brief History of the Taunton Lunatic Hospital 1854 to 2016. Otherwords Press.

Lauer, E. (2019). 2019 Preliminary Mortality Report. Center for Developmental Disabilities Evaluation and Research UMass Chan Medical School Eunice Kennedy Shriver Center. https://shriver.umassmed.edu/siteassets/uploads/2023/03/2019-dds-preliminary-mortality-report-final_tagged.pdf

Leaf, J. G. (1988). A History of the Internal Organization of the State Reform School for Boys at Westborough, Massachusetts (1846-1974) [Harvard Graduate School of Education]. https://www.proquest.com/openview/d88f4b9154cb72aa8b328a2341cc1a75/1?pq-origsite=gscholar&cbl=18750&diss=y

Levitt, J. N. (2010). Conservation Capital in the Americas. Lincoln Institute of Land Policy. https://www.communitypreservation.org/sites/g/files/vyhlif4646/f/uploads/cca_ch3.pdf

Liao, K., & Peebles, V. (n.d.). Money Follows the Person: State Transitions as of December 31, 2019. Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2019-transitions-brief.pdf

Lombardo, P. A. (2008). Three generations, no imbeciles: Eugenics, the Supreme Court, and Buck v. Bell. University Press. http://digamoo.free.fr/lombardo2008.pdf

MAB Adult Disability Services—Residential. (n.d.). MAB Community Services. Retrieved October 28, 2024, from https://www.mabcommunity.org/adult-disability-services/residential/

Manderscheid, R. W., Witkin, M. J., Rosenstein, M. J., & Bass, R. D. (1986). The National Reporting Program for Mental Health Statistics: History and findings. Public Health Reports (Washington, D.C. : 1974), 101(5), 532–539.

Martin, J. M. (2018). A DOOR TO THEIR HEARTS: A Ferro Family Memoir. Outskirts Press.

Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(a). https://malegislature.gov/Laws/GeneralLaws/PartI/TitleI/Chapter4/Section7

Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(c). https://malegislature.gov/Laws/GeneralLaws/PartI/TitleI/Chapter4/Section7

Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(d). https://malegislature.gov/Laws/GeneralLaws/PartI/TitleI/Chapter4/Section7

Mass. Gen. Laws, Part I, Title I, Ch. 4, § 7(26)(f). https://malegislature.gov/Laws/GeneralLaws/PartI/TitleI/Chapter4/Section7

Mass. Gen. Laws, Part I, Title II, Ch. 6, § 167A. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6/Section167A

Mass. Gen. Laws, Part I, Title II, Ch. 6, § 172. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6/Section172

Mass. Gen. Laws, Part I, Title II, Ch. 46, § 1-34. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleVII/Chapter46

Mass. Gen. Laws, Part I, Title VI, Ch. 38, § 2. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleVI/Chapter38/Section2

Mass. Gen. Laws, Part I, Title VII, Ch. 41, § 97D. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleVII/Chapter41/Section97D

Mass. Gen. Laws, Part I, Title XVI, Ch. 113, § 1. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter113/Section1

Mass. Gen. Laws, Part I, Title XVI, Ch. 113, § 2. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter113/Section2

Mass. Gen. Laws, Part I, Title XVII, Ch. 119, § 60A. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter119/Section60A

Mass. Gen. Laws, Part I, Title XVII, Ch. 123B, § 17. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123B/Section17

Mass. Gen. Laws, Vol. 1, Ch. 1-127.

Massachusetts Archives. (n.d.-a). Journal of Henry Tuck, M.D., 1876-1877 [Massachusetts School for Idiotic and Feeble-Minded Youth]. Retrieved October 28, 2024, from http://chc.library.umass.edu/state-archives/2017/04/18/journal-of-henry-tuck-m-d-massachusetts-school-for-idiotic-and-feeble-minded-youth/

Massachusetts Archives. (n.d.-b). Massachusetts Board of Alien Commissioners Annual Reports [1858-1863]. Retrieved October 25, 2024, from http://chc.library.umass.edu/state-archives/2017/04/11/annual-reports-massachusetts-board-of-alien-commissioners/

Massachusetts Archives. (n.d.-c). Traveling clinic case files, 1921-1955 [Walter E. Fernald State School]. Retrieved October 28, 2024, from http://chc.library.umass.edu/state-archives/2017/04/18/traveling-clinic-case-files-walter-e-fernald-state-school/

Massachusetts Association for Mental Health. (n.d.). Brief History on Parity Legislation. https://www.mamh.org/advocacy/improve-access/parity/brief-history-on-parity-legislation#:~:text=Massachusetts%20went%20much%20further%20in,issued%20or%20renewed%20in%20Massachusetts

Massachusetts Board of Alien Commissioners. (n.d.). Histories of alien residents of almshouses and other institutions, 1852-1870. WorldCat. https://search.worldcat.org/title/298343910

Massachusetts Board of Education. (1850). Thirteenth Annual Report of the Board of Education, together with the Thirteenth Annual Report of the Secretary of the Board (1849). Commonwealth of Massachusetts, Board of Education. http://hdl.handle.net/2452/204732

Massachusetts Board of Education. (1861). Twenty-fourth Annual Report of the Board of Education, together with the Twenty-fourth Annual Report of the Secretary of the Board (1860). Commonwealth of Massachusetts, Board of Education. https://archives.lib.state.ma.us/items/2e32d3fd-8f05-490c-8052-f6b7822a2e4e

Massachusetts Board of Education. (1874). Thirty-seventh Annual Report of the Board of Education, together with the Thirty-seventh Annual Report of the Secretary of the Board, 1872-73. Commonwealth of Massachusetts, Board of Education. https://archives.lib.state.ma.us/items/eb3a6a73-52f2-41f5-b08f-8a74a38f385a

Massachusetts Board of Education. (1887). Fiftieth Annual Report of the Board of Education: Together with the Fiftieth Annual Report of the Secretary of the Board, 1885-86. Commonwealth of Massachusetts, Board of Education. https://archives.lib.state.ma.us/items/d89854fa-2118-42b7-994a-ff62ee55bf7c

Massachusetts Board of Education. (1900). Sixty-third Annual Report of the Board of Education: Together with the Sixty-third Annual Report of the Secretary of the Board, 1898-1899. Commonwealth of Massachusetts, Board of Education. https://archives.lib.state.ma.us/items/56549df0-97eb-4e41-b402-a12143dd6f2b

Massachusetts Board of State Charities. (1865). First Annual Report of the Board of State Charities: To Which are Added the Reports of the Secretary and the General Agent of the Board (1864). Wright & Potter Printing Company. http://archives.lib.state.ma.us/handle/2452/757115

Massachusetts Board of State Charities. (1870). Sixth Annual Report of the Board of State Charities of Massachusetts, to Which are Added the Reports of the Secretary and the General Agent of the Board For the Year Ending September 30, 1869. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/49ec0bea-335b-4bd5-9cdd-880a06179dba

Massachusetts Board of State Charities. (1877). Thirteenth Annual Report of the Board of State Charities of Massachusetts, to Which are Added Reports from its Departments, With an Appendix (1876). Wright & Potter. https://archives.lib.state.ma.us/items/5f2f892a-2c49-4910-bd16-cc552fbb639f

Massachusetts Commission on Economy and Efficiency. (1913). Report of the Commission on Economy and Efficiency: December 31, 1912. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/1c91b7b3-db64-44c2-9c5d-6cc90cc27b28

Massachusetts Commission on Economy and Efficiency. (1915). Annual Report of the Commission on Economy and Efficiency, 1914. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/428cb167-ba17-419b-aa93-8f4850133427

Massachusetts Commission on Mental Diseases. (1917). First Annual Report of the Massachusetts Commission on Mental Diseases of the Commonwealth of Massachusetts for the Year Ending November 30, 1916. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/a8b9ff07-0916-446b-a830-a598fcbf7a45

Massachusetts Commission on Mental Diseases. (1919). Third Annual Report of the Massachusetts Commission on Mental Diseases of the Commonwealth of Massachusetts for the Year Ending November 30, 1918. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/55d82b69-0a65-403e-96ba-ea6ef6201ce6

Massachusetts Commission on Mental Diseases. (1920). Fourth Annual Report of the Massachusetts Commission on Mental Diseases of the Commonwealth of Massachusetts for the Year Ending November 30, 1919. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/a248a3dc-0c82-466b-b2a9-955a6f2bafde

Massachusetts Correctional Institution Bridgewater. (1856). Second Annual Report of the Inspectors of the State Almshouse, at Bridgewater, December, 1855. William White. https://archives.lib.state.ma.us/items/5e6daaa5-3e68-4554-8de5-4916d69b3977

Massachusetts Correctional Institution Bridgewater. (1866). Twelfth Annual Report of the Inspectors of the State Almshouse, at Bridgewater, October 1865. Wright & Potter, State Printers. https://archives.lib.state.ma.us/items/37268d74-e163-46e1-b871-761d4bdce0db

Massachusetts Department of Conservation and Recreation. (2009). Preservation guidelines for municipally owned historic burial grounds and cemeteries (Third Edition). https://archives.lib.state.ma.us/items/76fc4a51-9ae1-477c-ac8f-9d8dd60870b7

Massachusetts Department of Correction. (1987). 1986 Annual Report. https://archives.lib.state.ma.us/items/372be958-4874-4e1b-ac68-fa39784195f2

Massachusetts Department of Mental Health. (n.d.). I Am Seeking DMH Medical Records of a Deceased Family Member. Commonwealth of Massachusetts. Retrieved October 28, 2024, from https://www.mass.gov/info-details/i-am-seeking-dmh-medical-records-of-a-deceased-family-member

Massachusetts Department of Mental Health. (1940). Annual Report of the Commissioner of Mental Health for the Year Ending November 30, 1939. https://archives.lib.state.ma.us/items/217703cc-d489-4c66-91e6-23fdbd477604

Massachusetts Department of Public Health & Bay Circuit Alliance. (2007a, July 7). Memorandum of Understanding. https://www.tewksbury-ma.gov/DocumentCenter/View/1551/Memorandum-of-Understanding-PDF

Massachusetts Department of Public Health & Bay Circuit Alliance. (2007b, July 7). Memorandum of Understanding [Addendum]. https://www.tewksbury-ma.gov/DocumentCenter/View/1549/Addendum-to-Memorandum-of-Understanding-PDF

Massachusetts Health Decisions. (2025). FAQs for Health Care Professionals. Massachusetts Health Decisions. https://masshealthdecisions.org/faqs-health-care-pros/#:~:text=Actions%20of%20the%20guardian%20are,decisions%20make%20by%20a%20guardian

Massachusetts Hospital for Dipsomaniacs and Inebriates. (1902). Tenth Annual Report of the Trustees of the Massachusetts Hospital for Dipsomaniacs and Inebriates (at Foxborough): For the year ending Sept. 30, 1901. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/ff089d01-428e-4b08-8d10-a875d43ce96e

Massachusetts Mental Health Center. (1968). Massachusetts Mental Health Center Annual Report, 1967-1968. https://archives.lib.state.ma.us/items/ec62a801-9e0f-4a00-9563-4ee230f7e816

Massachusetts Office of the Secretary of State. Division of Statistics. (1842). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (1841-42). Dutton and Wentworth. https://archives.lib.state.ma.us/items/e7819c03-4897-4156-b0f3-1a1eff54bf56

Massachusetts Office of the Secretary of State. Division of Statistics. (1860). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (Year ending December 31, 1860). William White. https://archives.lib.state.ma.us/items/3a2ed218-7c44-498b-9e3c-371866b95f35

Massachusetts Office of the Secretary of State Division of Statistics. (1862). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (Year ending December 31, 1862). https://archives.lib.state.ma.us/items/e08a7f75-6371-44c2-a29f-8f42ccb55763

Massachusetts Office of the Secretary of State Division of Statistics. (1864). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (Year ending December 31, 1864). https://archives.lib.state.ma.us/items/20dca866-a022-47a1-8526-ad7ed5ffe22b

Massachusetts Office of the Secretary of State Division of Statistics. (1882). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (Year ending December 31, 1882). https://archives.lib.state.ma.us/items/5efa1612-6cbd-48c9-962e-c6585c3dd536

Massachusetts Office of the Secretary of State. Division of Statistics. (1917). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (Year ending December 31, 1917). Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/a9213ba8-5bce-4270-b334-0417852a3b46

Massachusetts Office of the Secretary of State. Division of Statistics. (1935). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (Year ending December 31, 1935). https://archives.lib.state.ma.us/items/f3c294e3-c3b0-4bdf-b0d7-784cc8014c23

Massachusetts Registry of Vital Records and Statistics. (1964). Annual report on the vital statistics of Massachusetts: Births, marriages, divorces and deaths... (Year ending December 31, 1964). https://archives.lib.state.ma.us/items/5c4ac3b5-195d-46ad-9c25-27aab642e607

Massachusetts Rules of Criminal Procedure, Rule 5 (d) (2022). https://www.mass.gov/rules-of-criminal-procedure/criminal-procedure-rule-5-the-grand-jury

Massachusetts School for Idiotic and Feeble-Minded Youth. (1851). Constitution and by-laws of the Massachusetts School for Idiotic and Feeble-Minded Youth. Cross & Freeman. https://archives.lib.state.ma.us/items/e03518ca-4ba6-4d1e-876a-8bbc14a73c06

Massachusetts School for the Feeble-Minded at Waltham. (1896). Forty-Eighth Annual Report of the Trustees of the Massachusetts School for the Feeble-Minded at Waltham, For the Year Ending September 30, 1895. Wright & Potter Printing Co. https://archives.lib.state.ma.us/items/5ed73658-7c7e-49a8-bd3b-75ba063c53e3

Massachusetts School for the Feeble-Minded at Waltham. (1919). Seventy-first Annual Report of the Trustees of the Massachusetts School for the Feeble-minded at Waltham for the Year Ending November 30, 1918. Wright & Potter, State Printers. https://archives.lib.state.ma.us/items/eadb7798-2de5-46af-8fb8-7424fc993687

Massachusetts School for the Feeble-Minded at Waltham. (1920). Seventy-second Annual Report of the Trustees of the Massachusetts School for the Feeble-minded at Waltham for the Year Ending November 30, 1919. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/4f646ddc-8975-4933-92ec-cea2a6a08c36

Massachusetts State Almshouse at Monson. (1855). Report of the Inspectors of the State Almshouse, at Monson, for the Year Ending December, 31, 1854. William White. https://archives.lib.state.ma.us/items/8099bfe1-d007-4175-8d91-e53ff6647641

Massachusetts State Archives. (2020, August 19). Health and Human Services Collection Guide. https://www.sec.state.ma.us/divisions/archives/collections/FA_HS.pdf

Massachusetts State Archives staff. (2024). [Personal communication].

Massachusetts State Archives Supervisor. (2024). [Personal communication].

Massachusetts State Board of Charity. (1878). Fifteenth Annual Report of the Board of State Charities of Massachusetts. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/e4416716-e787-4191-b74e-8626a7e4f5cf

Massachusetts State Board of Charity. (1900). Twenty-First Annual Report of the State Board of Charity of Massachusetts (1899). Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/33c11029-152b-4bd1-a6c2-312a8f6525d2

Massachusetts State Board of Health. (1870). First Annual Report of the State Board of Health of Massachusetts (1869). https://archives.lib.state.ma.us/items/77899832-c0c4-4886-8563-6d17beadbf9c

Massachusetts State Board of Health. (1871). Second Annual Report of the State Board of Health of Massachusetts (1870). https://archives.lib.state.ma.us/items/62c8c842-febd-462b-be02-d0bfc6ac58c6

Massachusetts State Board of Health, Lunacy, and Charity. (1880). First Annual Report of the State Board of Health, Lunacy, and Charity of Massachusetts, 1879. Supplement containing the Report and Papers on Public Health. Rand, Avery and Company. http://archives.lib.state.ma.us/handle/2452/757131

Massachusetts State Board of Lunacy and Charity. (1887). Eighth Annual Report of the State Board of Lunacy and Charity of Massachusetts, to Which is Added a Supplement, A Statistical Appendix, Documents of the Board, etc. (1886). Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/1c0f5b0a-031e-453e-bc13-e654a88734c0

Massachusetts State Board of Lunacy and Charity. (1899). Twentieth Annual Report of the State Board of Lunacy and Charity of Massachusetts (1898). Wright & Potter. https://archives.lib.state.ma.us/items/bf9980ce-f179-49d2-97ca-4bd2916c7184

McDonagh, E. (2023, April). Collections of the Massachusetts Historical Society related to disability. Massachusetts Historical Society. https://www.masshist.org/collection-guides/view/fas0559#:~:text=The%20MHS%20also%20holds%20printed,Bowen

McLean Hospital. (n.d.). ECT Treatment: A History of Helping Patients. https://www.mcleanhospital.org/essential/ect-treatment-history-helping-patients#:~:text=In%20the%201950s%20and%201960s,reduced%20the%20risk%20of%20injuries

Medfield Insane Asylum. (1902). Sixth Annual Report of the Medfield State Asylum at Medfield, Massachusetts (Post Office, Harding), for the Year Ending September 30, 1901. Wright & Potter. https://archives.lib.state.ma.us/items/9384a9dd-e1ab-4b75-b895-0d3e5b4639dc

Medical school anatomical department staff. (2024). [Personal communication].

Moments in Disability History 9: Willowbrook Leads to New Protections of Rights. (2013, September 1). The Minnesota Governor's Council on Developmental Disabilities. https://mn.gov/mnddc/ada-legacy/ada-legacy-moment09.html

Mooney, C. (1981, March 25). At least 13 neatly laid out human skulls and... United Press International. https://www.upi.com/Archives/1981/03/25/At-least-13-neatly-laid-out-human-skulls-and/2783354344400/

Moore, J. (2024, February 27). Their disabled loved ones languished in state institutions. Now, they want the records. WGBH. https://www.wgbh.org/news/local/2024-02-27/their-disabled-loved-ones-languished-in-state-institutions-now-they-want-the-records

Mortality Review. (2025). Eunice Kennedy Shriver Center. https://shriver.umassmed.edu/programs/cdder/mortality-review/

Multiple Massachusetts state agency staff. (2024). [Personal communication].

National Association of State Mental Health Program Directors. (2001, July 31). NASMHPD POSITION STATEMENT ON STATE PSYCHIATRIC HOSPITAL PATIENT CEMETERIES. https://nasmhpd.org/sites/default/files/cemetaries.pdf

National Institute of Mental Health. (n.d.-a). Celebrating 75 Years: Transforming the Understanding and Treatment of Mental Illnesses. U.S. Department of Health and Human Services, National Institutes of Health. National Institute of Mental Health. (2020). I'm So Stressed Out! Infographic (NIMH Identifier No. OM 20-4319). U.S. Department of Health and Human Services, National Institutes of Health. Retrieved January 11, 2023, from https://www.nimh.nih.gov/sites/default/files/documents/health/publications/so-stressed-out-infographic/so-stressed-out-infographic.pdf

National Institute of Mental Health. (n.d.-b). The NIH Almanac: National Institute of Mental Health (NIMH). https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh

Neuroanatomical Collections. (n.d.). National Museum of Health and Medicine. Retrieved October 28, 2024, from https://medicalmuseum.health.mil/index.cfm?p=collections.neuroanatomical.index

No. 521: Renaming the Governor's Commission on Mental Retardation to Be the Governor's Commission on Intellectual Disability, No. 1154 (2010). https://www.mass.gov/executive-orders/no-521-renaming-the-governors-commission-on-mental-retardation-to-be-the-governors-commission-on-intellectual-disability#:~:text=Whereas%2C%20on%20July%201%2C%202009,the%20Department%20of%20Developmental%20Services

Northampton Consent Decree. (n.d.). Massachusetts Association for Mental Health. https://www.mamh.org/advocacy/legal-advocacy/olmstead/rights-to-community-

living#:~:text=MAMH%20has%20been%20a%20pioneer,eventually%2C%20the%20State%20Hospital%20closed

Norwood, A. (2017). Biography: Dorothea Dix. National Women's History Museum. https://www.womenshistory.org/education-resources/biographies/dorothea-dix

O'Connell, L. (1984). Caring for the Sick Poor: The State Almshouse at Bridgewater, 1854-1887. Bridgewater Review, 3(1), 8-12. https://vc.bridgew.edu/cgi/viewcontent.cgi?article=1753&context=br_rev

Office of Privacy and Civil Liberties & U.S. Department of Justice. (2022, December 15). Overview of the Privacy Act: 2020 Edition. https://www.justice.gov/opcl/overview-privacy-act-1974-2020-edition/disclosures-third-parties

Office of the Massachusetts Secretary of State. (1992). A Review of the provisions of the Massachusetts public records law. https://archives.lib.state.ma.us/items/544334bf-c23e-4f3e-b277-e3e6d798607e

Office of the Secretary of State, Records Conservation Board, & Massachusetts Archives. (1993, March 16). Disposal schedule 92/92: Records-in-common. https://archives.lib.state.ma.us/items/db7e8311-8c1c-42a5-abed-5a1cff6e7af7

Overholser, W. (1935). Briggs Law of Massachusetts: A Review and an Appraisal. Journal of Criminal Law & Criminology, 25(6). https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?article=2524&context=jclc

Palomba, A. L. (2021, July 1). The Quest to Honor Disabled Patients Buried in Anonymous Graves. Atlas Obscura. http://www.atlasobscura.com/articles/metfern-cemetery

Pardo Pellicer, M. (2024, February 24). Foxborough Hospital's Secret Grave. https://marlenepardopellicer.substack.com/p/foxborough-hospitals-secret-grave

Paul, Julius. (1965). Three Generations of Imbeciles Are Enough': State Eugenic Sterilization Laws in American Thought and Practice [Unpublished Manuscript]. Walter Reed Army Institute of Research. https://archives.lib.virginia.edu/repositories/uva-hs/resources/manuscript_by_julius_paul_-_three_generations_of_i

Pennington, J. (2000, November 13). Grave records lost. The Sun Chronicle. https://www.thesunchronicle.com/grave-records-lost/article_46cf2c8c-7a51-5bba-b2f6-7f92a9557259.html

Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania. (n.d.). The Public Interest Law Center. https://pubintlaw.org/cases-and-projects/pennsylvania-association-for-retarded-citizens-parc-v-commonwealth-of-pennsylvania/

Perkins Institution and Massachusetts Asylum for the Blind. (1850). Eighteenth Annual Report of the Trustees of the Perkins Institution and Massachusetts Asylum for the Blind, to the Corporation (1849). John H. Eastburn, Printer. https://archives.lib.state.ma.us/items/478f1620-6ec6-4de8-86c1-c403cb0edfdc

Perkins School for the Blind. (n.d.). VCU Libraries Social Welfare History Project. https://socialwelfare.library.vcu.edu/issues/perkins-school-blind/#:~:text=The%20Massachusetts%20state%20legislature%20granted,to%20six%20students%20in%201832

Pine Hill Cemetery Burial Agent. (2024). [Personal communication].

PL 102-569: The Rehabilitation Act Amendments of 1992. (n.d.). The Rehabilitation Research and Training Center on Supported Employment, Virginia Commonwealth University's Supported Employment Technical Assistance Center, and The United Cerebral Palsy Association, Inc. https://mn.gov/mnddc/parallels2/pdf/90s/93/93-TRA-VCU.pdf

President's Committee on Mental Retardation, Health and Human Services Department. (2003). A Charge We Have To Keep: A Road Map to Personal and Economic Freedom for People with Intellectual Disabilities in the 21st Century President's Committee for People with Intellectual Disabilities. Health and Human Services Department. https://www.govinfo.gov/content/pkg/GOVPUB-HE23_100-PURL-LPS65361/pdf/GOVPUB-HE23_100-PURL-LPS65361.pdf

President's New Freedom Commission on Mental Health. (n.d.). Achieving the Promise: Transforming Mental Health Care in America. https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport-1.htm

Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq. (1973).

Report And Bill Concerning State Paupers, Senate Bill 0047 (1839). https://archives.lib.state.ma.us/items/5a1bb4bc-e6f5-40f2-bd42-26d0cadc7e53

Report And Resolve Concerning The State Lunatic Hospital, House Bill 0087 (1846). https://archives.lib.state.ma.us/items/6e2dc0d5-524f-411a-aab7-c88a2cfaa0be

Report Concerning Public Charitable Institutions, Senate Bill 0066 (1839). https://archives.lib.state.ma.us/items/87ba6b8b-00e5-4403-829c-c91f6f9ed3bf

Report Of Public Charitable Institutions, Senate Bill 0148 (1862). https://archives.lib.state.ma.us/items/f5a3f09a-457e-42aa-afcb-574d8aac9451

Report Of The Commissioners Appointed Under A Resolve Of The Legislature Of Massachusetts, To Superintend The Erection Of A Lunatic Hospital At Worcester, And To Report A System Of Discipline And Government For The Same, Senate Bill 0002 (1832). https://archives.lib.state.ma.us/items/b660881c-0571-4b05-9b5b-5b633633d0d3

Report Of The Commissioners Of Lunacy, To The Commonwealth Of Massachusetts, House Bill 0060 (1875). https://archives.lib.state.ma.us/items/b7e4a561-cf44-4f6e-84b9-1c0cd26ce116

Report Of The Committee On Public Charitable Institutions, Senate Bill 0083 (1854). https://archives.lib.state.ma.us/items/d394c068-3c3d-4512-aba8-513c5cff3a5a

Report Of The Committee On Public Charitable Institutions, Senate Bill 0077 (1856). https://archives.lib.state.ma.us/items/2d31ded1-18e4-4054-8738-c44c652398c8

Report Of The Committee On Public Charitable Institutions, Including "Resolve Concerning The Perkins Institution For The Blind;" And "Resolves Concerning The State Lunatic Hospital.," House Bill 0108 (1847). https://archives.lib.state.ma.us/items/70b533f9-2302-47d0-85d1-45a206a87457

Report Of The Committee On Public Charitable Institutions On Visits Made To Several Institutions, Senate Bill 0066 (1842). https://archives.lib.state.ma.us/items/41f17420-6ca0-4641-a1cf-69ad5a6b2d31

Report Of The Committee On Public Charitable Institutions Regarding A Second Hospital For The Insane, Senate Bill 0075 (1849). https://archives.lib.state.ma.us/items/935d3679-8bfd-4b97-9035-10ec717c425c

Report Of The Committee On Public Charitable Institutions Regarding The State Reform School And Other Charitable Institutions, House Bill 0105 (1849). https://archives.lib.state.ma.us/items/2ad8365b-eaf1-451f-9f9f-3135fc4c1b87

Report Of The Committee On Public Charitable Institutions Regarding Visits To Several Public Charitable Institutions, Senate Bill 0079 (1850). https://archives.lib.state.ma.us/items/a04393d9-217b-4bd8-b131-7ef46b0df5b4

Report Of The Committee On Public Charitable Institutions, Submitting A Statement Of Facts Concerning The Production Of Certain Books By Thomas J. Marsh, Jr., Before The Committee On Public Charitable Institutions, In The Matter Of The Investigation Of The State Almshouse At Tewksbury, House Bill 0417 (1883). https://archives.lib.state.ma.us/items/34d28797-f2ce-4ba5-a433-6c1fe506f1b0

Report Of The Committee Regarding The Accommodation Of Lunatics And Persons Furiously Mad, Including Text To A Resolve, House Bill 0039 (1830). https://archives.lib.state.ma.us/items/272dd06e-21be-4b26-bba7-417955b6d287

Report Of The House Committee Appointed To Examine The State Of The Goals In The Commonwealth, As Well As The Penitentiary At Worcester, House Bill 0050 (1827). https://archives.lib.state.ma.us/items/6f7decf7-33af-4eac-8a70-2cc668143bc0

Report Of The Joint Committee On Public Charitable Institutions, Including Text To “Resolves Concerning Training And Teaching Idiots,” Senate Bill 0106 (1848). https://archives.lib.state.ma.us/items/9dc06ba4-cd8a-497d-a0a3-442fa312b93e

Report Of The Joint Special Committee, Including Text To “An Act Concerning Alien Passengers And Paupers,” Senate Bill 0109 (1847). https://archives.lib.state.ma.us/items/9c819319-557f-4f61-a036-a51048092042

Report Of The Joint Special Committee On Public Institutions To Investigate Conditions Prevailing At The Various State Institutions, March 1920, Senate Bill 0450 (1920). https://archives.lib.state.ma.us/items/2c3853a6-6baa-4efd-9571-c8eaaad4e010

Report Of The Joint Special Committee Regarding Lunatic Hospitals And Lunatic Paupers, Senate Bill 0047 (1848). https://archives.lib.state.ma.us/items/6e6d9ff4-a825-429a-a002-2b5936e3fd24

Report Of The Joint Standing Committee On Charitable Institutions, Including “An Act To Establish A Hospital For Insane In Western Massachusetts,” House Bill 0282 (1855). https://archives.lib.state.ma.us/items/37b60f78-70d3-4700-8192-15d45e7ff113

Report Of The Joint Standing Committee On Public Charitable Institutions Regarding A Visit To Several Charitable Institutions Supported Or Aided By The State, House Bill 0167 (1854). https://archives.lib.state.ma.us/items/9b8ceb39-eaae-473f-9884-7b6e7562b568

Report Of The Special Commission Established To Make An Investigation And Study Relative To Training Facilities Available For Retarded Children, December, 1953, House Bill 2270 (1954). https://archives.lib.state.ma.us/items/bdc4dd13-eaa5-4534-8a6d-1767cb908c21

Report Of The Special Commission Established To Make An Investigation And Study Relative To Training Facilities Available For Retarded Children, May, 1964, House Bill 3601 (1964). https://archives.lib.state.ma.us/items/003b712c-0acf-421f-ae8b-3b92c1cc6e6d

Report Of The Special Commission On The Burial Of Inmates Of Institutions, January 1939, House Bill 1968 (1939). https://archives.lib.state.ma.us/items/649aa040-1a75-42ca-b44b-5c5d5feb786c

Report Of The Special Commission Relative To The Control, Custody And Treatment Of Defectives, Criminals And Misdemeanants, February, 1919., House Bill 1403 (1919). https://archives.lib.state.ma.us/items/57c3328e-3888-446c-956c-70872a678e50

Report Of The Special Commission To Investigate And Study The Administration Of The Department Of Mental Health And Certain Laws Relative Thereto, December 26, 1962, Senate Bill 0645 (1963). https://archives.lib.state.ma.us/items/b4b3a587-02b6-46f7-9dce-41b31b4242f7

Report Of The Special Joint Committee Appointed To Investigate The Whole System Of The Public Charitable Institutions Of The Commonwealth Of Massachusetts, During The Recess Of The Legislature In 1858, Senate Bill 0002 (1859). https://archives.lib.state.ma.us/items/200dad0f-058c-4675-960c-d9b432e7f4d8

Report On Goals And Houses Of Correction In The Commonwealth Of Massachusetts, House Bill 0036 (1834). https://archives.lib.state.ma.us/items/33971b91-b45f-4f89-bb6d-5ad93cf676cc

Report On Insanity And Idiocy In Massachusetts, By The Commission On Lunacy, Under Resolve Of The Legislature Of 1854, House Bill 0144 (1855). https://archives.lib.state.ma.us/items/e3893d2b-58f8-476c-ba57-ab538e6aa2f5

Resolution Relative To The Immigration And Importation Into The United States Of Convicts, Lunatics, Idiots And Other Persons Liable To Become A Public Charge, Senate Bill 0215 (1888). https://archives.lib.state.ma.us/items/62d96670-02a1-48e8-8e46-4ac9887fb839

Resolve Concerning the Support of the State Lunatic Paupers, Resolve ch. 0018 (1845). https://archives.lib.state.ma.us/items/f16c750a-4d85-4ba6-b432-46dbe28f6bdb

Resolve for the Appointment of Commissioners on Idiocy, Resolve Chap. 0117 (1846). https://archives.lib.state.ma.us/items/e44800ce-1271-439f-9bb0-b46c0c0d383d

Resolve Providing For A Special Commission To Investigate And Consider The Methods Of Treating Defective Delinquents And Criminals, Resolve ch. 0064 (1918). https://archives.lib.state.ma.us/items/4bf86d46-d4b2-41df-ba5b-c9b2923ad11a

Resolve Providing For Insane Persons At Tewksbury, Resolve ch. 0080 (1864). https://archives.lib.state.ma.us/items/b4fbefaf-fa36-4a73-bc30-be4261326a7e

Resolve Regarding The Construction Of A Lunatic Hospital, House Bill 0013 (1830). https://archives.lib.state.ma.us/items/d3c934f9-d2c6-4de7-8bb8-9b9c27b3a78b

Ricci v. Okin. (n.d.). Civil Rights Litigation Clearinghouse. https://clearinghouse.net/case/454/

Rivera, G. (Director). (1972). Willowbrook: The Last Great Disgrace [Video recording]. https://www.youtube.com/watch?v=5F7CrMAwCw4

Rocchi, J. (2016, February 9). 10 Steps to Establish a Local Historic District. National Trust for Historic Preservation. https://savingplaces.org/stories/10-steps-to-establish-a-local-historic-district

Rodgers, A. G., Manning, D. S., Rae, J. P., & Breslauer, J. E. (2017). Rolland v. Cellucci: Memorandum and Order with Regard to Plaintiffs' Motion for Class Certification (Docket No. 05). Thomson Reuters.

Rules And Orders, To Be Observed In The House Of Representatives Of The Commonwealth Of Massachusetts, House Bill (1836). https://archives.lib.state.ma.us/items/0426ff34-8b2e-4ead-82b1-ae5298ac2b17

Sanborn, F. B. (1884). The Management Of Almshouses In New England. Proceedings of the National Conference of Charities and Correction. https://www.disabilitymuseum.org/dhm/lib/catcard.html?id=2530

Schwan, H. (2024, May 23). Forgotten children's cemetery? Westborough, history buff at odds over possible burial site. Worcester Telegram & Gazette.

Scott, D. (2024). David Scott's Search for His Brother John's Records [Personal communication].

Secretary of the Commonwealth of Massachusetts. (n.d.-a). Preservation Restrictions. Secretary of the Commonwealth of Massachusetts. https://www.sec.state.ma.us/divisions/mhc/preservation/preservation-restrictions.htm

Secretary of the Commonwealth of Massachusetts. (n.d.-b). What to Do When Human Remains are Accidentally Uncovered. William Francis Galvin, Secretary of the Commonwealth. https://www.sec.state.ma.us/divisions/mhc/knowhow/knowhow4-remains.htm#:~:text=Who%20is%20involved?,is%20protected%20from%20further%20damage

Secretary of the Commonwealth of Massachusetts. (n.d.-c). What to Know about Listing in the National Register of Historic Places. Secretary of the Commonwealth of Massachusetts. https://www.sec.state.ma.us/divisions/mhc/knowhow/knowhow3-national-register.htm

Shawn P. O'Sullivan v. Michael S. Dukakis, C.A. No. 87-3881 (Suffolk Supr. Ct. 1987).

Social Security Act, Title XIX, 42 U.S.C. §§ 1396—1396v (1975).

Special Commission on State Institutions, Mass. Gen. Laws ch. 0126 §144 (2022). https://www.mass.gov/info-details/special-commission-on-state-institutions-statute

State Board of Insanity. (1900). First Annual Report of the State Board of Insanity of the Commonwealth of Massachusetts for the Year Ending September 30, 1899. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/5d9ff398-7197-4ac4-aa42-c5fef927a9e0

State Board of Insanity. (1906). Seventh Annual Report of the State Board of Insanity of the Commonwealth of Massachusetts, for the Year Ending September 30, 1905. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/ec8ab085-6598-4dbb-9c44-5dc3814b97d6

State Board of Insanity. (1911). Twelfth Annual Report of the State Board of Insanity of the Commonwealth of Massachusetts for the Year Ending November 30, 1910. https://archives.lib.state.ma.us/items/ad6725bf-c249-4e01-8637-fc8232d38163

State Board of Insanity. (1916). Seventeenth Annual Report of the State Board of Insanity of the Commonwealth of Massachusetts for the Year Ending November 30, 1915. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/f043c37b-47b2-4a85-9e5c-5b231ba97de0

State Department of Health. (1919). Fourth Annual Report of the State Department of Health of Massachusetts (1918). https://archives.lib.state.ma.us/items/d75ce144-195d-4386-9525-ad6d145bdaa7

State Lunatic Hospital at Northampton. (1869). Thirteenth Annual Report of the Trustees of the State Lunatic Hospital at Northampton, October, 1868. William White. https://archives.lib.state.ma.us/items/3a324716-6baa-489e-90ad-6e0a26459199

State Lunatic Hospital at Worcester. (1836). Third Annual Report of the Trustees of the State Lunatic Hospital at Worcester, December, 1835. Dutton and Wentworth. https://archives.lib.state.ma.us/items/58796e47-5b7e-435d-b51b-ed8b35db3554

State Lunatic Hospital Northampton. (1872). Sixteenth Annual Report of the Trustees of the State Lunatic Hospital at Northampton, October, 1871. William White. https://archives.lib.state.ma.us/items/f6eef87c-ce3d-42eb-8179-f19cb0c5b38d

Strange, J.-M. (2003). Only a Pauper Whom Nobody Owns: Reassessing the Pauper Grave c. 1880-1914. Past & Present, 178, 148–175.

Sudders, M., & Ruthardt, L. (2000, June). Mental Health Parity Bulletin. https://www.mass.gov/doc/2000-06-mental-health-parity/download

Tartarini vs. Department of Mental Retardation, No. 11-P-1009 (Superior Court July 23, 2012). http://law.justia.com/cases/massachusetts/court-of-appeals/2012/11-p-1009.html

Taunton Lunatic Hospital. (1857). Third Annual Report of the Trustees of the State Lunatic Hospital, at Taunton, December, 1856. William White. https://archives.lib.state.ma.us/items/c5efce1b-8df6-4a00-9f5a-d7c9552cb6a6

Taunton Lunatic Hospital. (1899). Forty-Fifth Annual Report of the Trustees of the Taunton Lunatic Hospital, for the Year Ending September 30, 1898. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/685c0de7-7aed-440a-9ea4-2e52e7a952f0

Taunton State Hospital Records Department Staff. (2024). [Personal communication].

Teoli, D., & Ghassemzadeh, S. (2023). Patient Self-Determination Act. StatPearls Publishing LLC. https://www.ncbi.nlm.nih.gov/books/NBK538297/

The 72-Year Rule. (2024, September 3). U.S. Census Bureau. https://www.census.gov/about/history/census-records-family-history/census-records/72-year-rule.html

The Closing of Willowbrook. (n.d.). Disability Justice. Retrieved October 28, 2024, from https://disabilityjustice.org/the-closing-of-willowbrook/

The Department of Developmental Services 115 CMR 4.00: Records (2009). https://www.mass.gov/regulations/115-CMR-400-records

The Department of Mental Health 104 CMR 27.00: Licensing and Operational Standards for Mental Health Facilities (2021). https://www.mass.gov/regulations/104-CMR-2700-licensing-and-operational-standards-for-mental-health-facilities

The Gilder Lehrman Institute of American History. (n.d.). Indenture agreement, 1742: A Spotlight on a Primary Source by John Reid Jr. Retrieved October 28, 2024, from https://www.gilderlehrman.org/history-resources/spotlight-primary-source/indenture-agreement-1742

The Harvard Law School Cyberlaw Clinic. (2024a). Access to Burial Records [Personal communication].

The Harvard Law School Cyberlaw Clinic. (2024b). Review of Massachusetts Law on Third-Party Access to Government-Held Healthcare Records [Personal communication].

The Western Front Association. (n.d.). Shell shock and the evolution of psychological trauma. https://www.westernfrontassociation.com/

Thompson, J. (n.d.). A Short History of Medfield State Hospital, 1890-2016. https://www.lspa.org/assets/Blog_Photos/Medfield_Hosp_Tour/short%20history%20of%20medfield%20%20state%20hospital.pdf

Traveling clinic case files, 1921-1955 Walter E. Fernald State School. (n.d.). The ArchiveGrid. https://researchworks.oclc.org/archivegrid/collection/data/83176307

Turner, K. (2024). Kim's Turner's Search for Family Records at Fernald [Personal communication].

UMass Amherst Libraries. (n.d.). LibGuides: Genealogy: Massachusetts Vital Records. Retrieved October 29, 2024, from https://guides.library.umass.edu/c.php?g=672399&p=4737621

Understanding the Affordable Care Act. (n.d.). American Medical Association. https://www.ama-assn.org/health-care-advocacy/access-care/understanding-affordable-care-act#:~:text=The%20Affordable%20Care%20Act%20(ACA,a%20better%20health%20care%20system

U.S. Centers for Medicare & Medicaid. (2024, September 10). The Mental Health Parity and Addiction Equity Act (MHPAEA). https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity

U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General—Executive Summary. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services, Office for Civil Rights. (n.d.). Your Rights Under Section 504 of the Rehabilitation Act. https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf

U.S. Department of Justice, Civil Rights Division. (n.d.). Olmstead: Community Integration for Everyone. https://archive.ada.gov/olmstead/olmstead_about.htm

U.S. Department of Justice Civil Rights Division. (2024, October 29). Guide to Disability Rights Laws. ADA.Gov. https://www.ada.gov/resources/disability-rights-guide/

U.S. Department of the Interior. (n.d.-a). National Historic Preservation Act. National Park Service. https://www.nps.gov/subjects/historicpreservation/national-historic-preservation-act.htm

U.S. Department of the Interior. (n.d.-b). National Register Database and Research. National Park Service. https://home.nps.gov/subjects/nationalregister/database-research.htm

U.S. Department of the Interior. (n.d.-c). National Register of Historic Places. National Park Service. https://www.nps.gov/subjects/nationalregister/index.htm

U.S. Department of the Interior. (2022, December 21). Documentation: Cemetery Preservation Course. National Park Service. https://www.nps.gov/articles/000/cemetery-preservation-course-documentation.htm

Veterans burial allowance and transportation benefits. (2024, October 1). U.S. Department of Veterans Affairs. https://www.va.gov/burials-memorials/veterans-burial-allowance/#:~:text=If%20you're%20eligible%2C%20you,to%20the%20final%20resting%20place

Veto of the Vocational Rehabilitation Bill. | The American Presidency Project. (1973, March 27). https://www.presidency.ucsb.edu/documents/veto-the-vocational-rehabilitation-bill

Vocational Rehabilitation and Other Rehabilitation Services, 29 U.S.C. Ch. 16 §§ 701-796i (1982).

Waite, F. C. (1945). Grave Robbing in New England. Bulletin of the Medical Library Association, 33(3), 272.

Walsh, K. E. (2024, July 10). Letter to the Special Commission on State Institutions [Personal communication].

Walsh v. Ohio Dept. of Health (Court of Appeals of Ohio February 1, 2022). https://www.supremecourt.ohio.gov/rod/docs/pdf/10/2022/2022-Ohio-272.pdf

Walter E. Fernald State School. (1941). WPA school records project files, 1940-1941. WorldCat. https://search.worldcat.org/title/904289307

Waltham Community Preservation Committee staff. (2024). [Personal communication].

Warner Jr., J. D. (2024). Archivist of the Commonwealth of Massachusetts [Personal communication].

Westborough Insane Hospital. (1887). Second Annual Report of the Trustees of Westborough Insane Hospital, for the Year Ending October 30, 1886. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/45683b9a-b768-4eb5-b74e-c82d51f9cc8c

Westborough Insane Hospital. (1891). Sixth Annual Report of the Trustees of Westborough Insane Hospital, for the Year Ending September 30, 1890. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/4155ef64-eb32-410a-bd8b-d3237bb81430

Westborough Insane Hospital. (1896). Eleventh Annual Report of the Trustees of Westborough Insane Hospital, for the Year Ending September 30, 1895. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/0cd7e313-fbcd-4e6a-853e-4ec69eda46fe

Whorf McGuiggan, A. (2019). Finding Emma: My Search for the Family My Grandfather Never Knew. Small Batch Books.

Wiseman, F. (Director). (1967). Titicut Follies [Documentary]. Zipporah Films.

Worcester State Hospital. (1919). Eighty-Sixth Annual Report of the Trustees of the Worcester State Hospital For the Year Ending November 30, 1918. Wright & Potter Printing Company. https://archives.lib.state.ma.us/items/4bc2f91a-6d8f-4223-8360-1867297bf41c

Wrentham Developmental Center staff. (2024). [Personal communication].

Wrentham State School. (1934). Annual report of the Trustees of the Wrentham State School for the Year Ending November 30, 1933. Wright & Potter, State Printers. https://archives.lib.state.ma.us/items/66ec02e7-59f4-481d-b277-766a5508f340

Zigman, L. (2024). Laura Zigman's Search for Sister Cheryl's Records [Personal communication].

Appendices

1. Institutional Sites
2. Relevant Countway Library Contents
3. Correspondence between the Special Commission on State Institutions and Governor Healy/Secretary Walsh
4. Letter from DDS Regarding Access to Burial Information at MetFern Cemetery
5. Memo from Harvard Law School Cyberlaw Clinic to the Special Commission on State Institutions
6. Cemetery Profiles
7. Information about the Pines Cemetery in Tewksbury
8. Memorandum from DMH Commissioner Doyle regarding a Best Interest Determination regarding access to DMH records for the purpose of reconstructing Foxborough Cemeteries Records
9. Report Relevant to Property at the former Glavin Developmental Center and Associated Cemeteries
10. National Association of State Mental Health Program Directors – Position Statement on Hospital Cemeteries and Their Preservation and Restoration
11. Willowbrook Mile

Appendix 1: Institutional Sites

State Schools for the Developmentally Disabled

1. Walter E. Fernald Developmental Center, (1848–2014)
   - Alternate Names:
     - Experimental School for Teaching and Training Idiotic Children
     - School for the Feeble Minded
     - Massachusetts School for Idiotic Children
     - Massachusetts School for the Feeble Minded
     - Walter E. Fernald State School
2. Monson Developmental Center (1852-2012)
   - Alternative Names:
     - Monson Almshouse
     - State Primary School
     - Massachusetts Hospital for Epileptics
     - Monson State Hospital
3. Templeton Developmental Center, (1899–2015)
   - Alternate Names:
     - Templeton Farm Colony
4. Wrentham Developmental Center (1910–present)
   - Alternate Names:
     - Wrentham State School
5. Belchertown State School, (1922–1992)
6. Paul A. Dever Regional Center (1946-2001)
7. Hogan Regional Center (1967-present)
8. Glavin Regional Center (1974-2013)

State Hospitals

1. Worcester State Hospital (1833-1991)
   - Alternative Names:
     - Worcester Insane Asylum
     - Worcester Lunatic Asylum
2. Boston State Hospital (1839-1979)
   - Alternative Names:
     - Boston Lunatic Hospital
     - Boston Insane Hospital
3. Bridgewater State Hospital (1852-present)
   - Alternative Names:

    - Bridgewater Almshouse for Paupers (1852-1866)
    - Bridgewater State Workhouse (1866-1867)
    - State Asylum for Insane Criminals
    - State Farm (1887-1919)
    - State Farm of the Bureau of Prisons (1919-1955) known as Bridgewater State Hospital
    - Bridgewater Prison for the Criminally Insane
4. Tewksbury Hospital (1852-present day)
    - Alternative Names:
        - Tewksbury Almshouse
        - Tewksbury State Hospital
        - Tewksbury State Infirmary
        - Tewksbury State Hospital and Infirmary
5. Taunton State Hospital (1854-present)
    - Alternative Names:
        - State Lunatic Hospital at Taunton
6. Northampton State Hospital (1856-1993)
    - Alternative Names:
        - Northampton Lunatic Asylum
        - State Hospital at Northampton
        - Northampton Insane Hospital
7. Danvers State Hospital (1874-1992)
    - Alternative Names:
        - State Lunatic Hospital at Danvers
        - The Danvers Lunatic Asylum
        - The Danvers State Insane Asylum
8. Westborough State Hospital (1884-2010)
    - Alternative Names:
        - Westborough Insane Hospital
9. Foxborough State Hospital (1889-1975)
    - Alternative Names:
        - Massachusetts Hospital for Dipsomaniacs & Inebriates
10. Medfield State Hospital (1892-2003)
    - Alternative Names:
        - Medfield Insane Asylum
11. Grafton State Hospital (1901-1973)
    - Alternative Names:
        - Grafton Farm Colony
12. Gardner State Hospital (1902-1975)
    - Alternative Names:
        - State Colony for the Insane

    - Gardner State Colony
13. Metropolitan State Hospital (1927-1992)
14. Gaebler Children's Center (1955-1992)

Reform Schools with evidence of supporting a substantial number of people with developmental disabilities or mental health conditions

1. State Reform School for Boys in Westborough Massachusetts (1848-1884)

Other types of institutions in MA supporting a substantial number of people with developmental disabilities or mental health conditions

1. Perkins School for the Blind (1829 – present day)
    - Alternative Names:
        - New England Asylum for the Blind

The following Almshouses, or almshouse programs were reported to support people with mental health conditions or developmental disabilities. Date ranges of operation are not known. All were confirmed to be in operation in 1898 during visits from the State Board of Lunacy and Charity (Massachusetts State Board of Lunacy and Charity, 1899).

1. Austin Farm, Boston, MA[86]
2. Amesbury
3. Andover
4. Ashby
5. Ashland
6. Athol
7. Ayer
8. Barre
9. Bedford
10. Belchertown
11. Bellingham
12. Billerica
13. Blackstone
14. Bolton
15. Braintree
16. Brewster
17. Bridgewater
18. Brimfield
19. Brockton
20. Buckland
21. Cambridge
22. Canton
23. Carver
24. Charlton
25. Chelmsford
26. Chicopee
27. Cohasset
28. Conway
29. Dana
30. Dedham
31. Deerfield
32. Dennis
33. Dracut
34. Duxbury
35. East Bridgewater
36. Easthampton
37. Easton
38. Fairhaven
39. Fall River
40. Fitchburg
41. Framingham
42. Gardner
43. Georgetown
44. Gloucester
45. Goshen
46. Grafton
47. Greenfield
48. Greenwich
49. Groton
50. Hadley
51. Hanover
52. Hanson
53. Hardwick
54. Harvard
55. Harwich
56. Haverhill

[86] Legally an almshouse, although described in fact an asylum for the chronic insane (*Almshouse Reports*, n.d.).

57. Hawley
58. Hingham
59. Holden
60. Holliston
61. Holyoke
62. Hopkinton
63. Hudson
64. Ipswich
65. Kingston
66. Lancaster
67. Lawrence
68. Lee
69. Leicester
70. Lenox
71. Leominster
72. Littleton
73. Long Island, Boston, MA
74. Lowell
75. Lunenburg
76. Lynn
77. Mansfield
78. Marblehead
79. Marlborough
80. Marshfield
81. Mattapoisett
82. Maynard
83. Medfield
84. Medford
85. Medway
86. Middleborough
87. Milford
88. Millbury
89. Millis
90. Milton
91. Monson
92. Montague
93. Monterey
94. Nantucket
95. Natick
96. New Bedford
97. Newburyport
98. Newton
99. North Adams
100. Northampton
101. North Andover
102. North Attleborough
103. Northbridge
104. North Brookfield
105. North Reading
106. Norton
107. Norwell
108. Orange
109. Oxford
110. Palmer
111. Pembroke
112. Pepperell
113. Pittsfield
114. Plymouth
115. Provincetown
116. Quincy
117. Randolph
118. Reading
119. Rehoboth
120. Rochester
121. Rockland
122. Rockport
123. Salem
124. Sandwich
125. Seekonk
126. Sharon
127. Sherborn
128. Somerset
129. Southbridge
130. Spencer
131. Springfield
132. Sterling
133. Stoneham
134. Stoughton
135. Stow
136. Sturbridge
137. Sudbury
138. Sutton
139. Swansea
140. Taunton
141. Templeton
142. Tewksbury
143. Townsend
144. Uxbridge
145. Walpole
146. Waltham
147. Ware
148. Wareham
149. Warwick
150. Watertown
151. Wayland
152. Webster
153. Wellesley
154. Wellfleet
155. West Boylston
156. West Bridgewater
157. West Brookfield
158. Westford
159. West Newbury
160. Weston
161. Westport
162. Weymouth
163. Woburn
164. Worcester
165. Wrentham
166. Yarmouth

Appendix 2: Relevant Countway Library Contents

Center for the History of Medicine, Countway Library

Owner	State Records	Collection Type	Creator	Collection Title	Collection Number	Institutions Found in Records	Description of Records	Harvard Library Catalog or Finding Aid Link	Access Policy	Series/Boxes to consult
Boston Medical Library	Yes	Professional papers	An individual person (Clemens Benda)	Clemens E. Benda papers, 1925-1966	B MS c97	Walter E. Fernald School; Wrentham State Hospital; Metropolitan State School	Benda directed the Wallace Research Lab for the Study of Mental Deficiency at Wrentham State School; director of Children's Unit of Metropolitan State Hospital; director of research and clinical psychiatry at Fernald State School. **Box 1**: correspondence with guardians re: permission for participation in experiments at Fernald; list of names of participants; results of tests with names attached. All "calcium isotopes" folders in the box appear to be state records. **Box 18**: detailed autopsy reports of people who died at Fernald, photographs of brains that seem to belong to Fernald patients. Almost all have full names attached.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/7856	No access. We do not provide access to Boston Medical Library-owned collections.	Records from the "radiation studies" conducted at the Fernald School under the headings “calcium isotopes” (Box 1, Folders 34-40) and “myotonia dystrophia” (Box 5, Folders 257-262). Metropolitan State School folder (Box 4). Series III: Wrentham State School files (Box 17). Series IV: Fernald School files (Boxes 18-20)
Boston Medical Library	Yes	State records	Massachusetts State Sanatorium (Rutland, Mass.)	Special Investigation, Commission on Economy and Efficiency, Fall 1913	B MS b260.3	Massachusetts State Sanatorium	Documents to do with special investigations into the running of the sanatorium. Bulk of the volume concerned with claims and counterclaims surrounding J. Hitchens, one-time employee of the sanatorium as a painter.	https://id.lib.harvard.edu/alma/990127709830203941/catalog	No access. We do not provide access to Boston Medical Library-owned collections.	
Harvard Medical Library	Maybe	Professional papers	An individual person (Dwight Harken)	Dwight E. Harken papers, 1911-1993 (inclusive), 1940-1975 (bulk)	B MS c118; H MS accession 2012-068	Massachusetts Rehabilition Commission	Half of collection owned by Harvard (the patient records). **Patient files series**: Box 14: no patient files seen from state institutions. Mostly from Mount Auburn and Peter Bent Brigham Hospital. Box 24: Mount Auburn patient files. Box 44: PBBH and Mt Auburn patient files. One Mass. Rehab. Commission patient treated at PBBH. Box 54: PBBH and Mt. Auburn patient files. Box 59: Mostly from Quincy City Hospital, Jordan Hospital, PBBH. Some copies of purchase orders for services completed for Mass. Rehabilitation Commission patients. **Box 10**: MA State Employment claim for unemployment insurance employer's copy of form (filed by former employee of Harken). **Box 64:** 1 invoice for services to Westborough SH (Harken's copy). **Box 72:** Folder of correspondence discusing Mass. Medical Tribunal system, not state	https://hollisarchives.lib.harvard.edu/repositories/14/resources/6668	The BML-owned part of the collection is not accessible. The Harvard-owned part of collection is open to research. Patient records are closed for 80 years from the date of record creation unless access is approved by the Longwood Campus IRB. State records in the BML-owned part are mixed in with other manuscript materials.	Mass. State Employment Tax Forms (box 10) Westborough State Hospital correspondence (box 64) Mass. Medical Tribunal (Box 72 1 f).
Harvard Medical Library	Maybe	Professional papers	An individual person (Carl Walter)	Carl Walter papers, 1933-1992, 1996 (inclusive)	H MS c150	Boston Psychopathic Hospital; Lakeville State Hospital; Boston State Hospital; Mass. State Laboratory Insitute; UMass Medical School Teaching Hospital; Mass. Dept. of Health; Mass. Dept. of Public Health; Mass. Dept of Health Committee on Surgical Implants	Walter inspected hospitals for infection control. **Box 7** Folder 46: 1 small folder of committee files for Mass. Dept of Health Committee on Surgical Implants. **Box 14**: Consulting work for the state: Inspection reports for operating room safety Lakeville State Hospital. Planning for new hospital building ay UMass. **Box 30**: Copy of draft of prospectus for formal collaboration between HMS and Mass. State Lab. Inst. No patient or case files. **Box 31**: Correspondence re: Walter's inspection of and findings re: Boston Psychopathic Hospital operating rooms. Correspondence re: named staff and conditions of Boston SH operating room. Report of findings.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/6539	Open to research; Mass. State Archives not contacted. Walter was a consultant and while occasional records are present that could be argued as work for hire, they were also generated and received as a product of his professional activities. No PII or PHI present.	Offsite. Mass. Dept. of Health Box 7. Series IIA, Consultations Records: Boston State Hospital folder Box 13. Lakeville State Hospital, Pondville Hospital, UMass Teaching Hospital folder Box 14; Mass. Dept. Public Health Box 18. Mass. State Laboratory Institute Box 30
Harvard Medical Library	Maybe	Professional papers	An individual person (Roy Graham Hoskins)	Roy Graham Hoskins papers, 1907-1965	H MS c210	Boston State Hospital; Worcester State Hospital	Hoskins served as director of the Memorial Foundation for Neuro-Endocrine Research, a private foundation that conducted research at Worcester SH and HMS. Hoskins was on staff of WSH and Boston SH as a consultant. **Box 2:** Board correspondence and minutes for the Memorial Foundation. Reports on one named patient, husband of woman funding the Foundation. Copy of inventory of items belonging to Foundation that were left with WSH. Annual reports including descriptions of research conducted at WSH, no identifying information. Tables of patients studied as WSH, identified by initials. Copy of report of WSH Research Project. All seem to be records of the private Foundation. BSH research protocols memo.	https://id.lib.harvard.edu/alma/990006035900203941/catalog	Records created under the auspices of the Foundation, including Foundation-funded research, are open to research. Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Box 2 folders 4-6
Harvard Medical Library	Yes	Professional papers	An individual person (Myrtelle Canavan)	Myrtelle Canavan papers, 1898-1945	GA 10.20	Taunton State Hospital, Fernald School, Boston State Hospital, Foxborough State Hospital, Medfield State Hospital, Bridgewater State Hospital	Assistant bacteriologist at Danvers SH, resident pathologist at the Boston SH, pathologist to the Mass. Dept. of Mental Diseases. Acting director of labs of Boston Psychopathic Hospital. **Box 1:** 1 folder of autopsies done for other hospitals including the following state institutions: Taunton SH, Fernald School, Boston SH, Foxborough SH, Medfield SH, Br[idgewater?] SH. **Box 5**: Scans of brains labeled "criminal." Folders do not have documentation on where the images came from; unclear if they came from state institutions. Folder Bridgewater Anatomical Investigation logs has State Board of Insanity official chart of deceased inmates information IDed by number only	https://hollisarchives.lib.harvard.edu/repositories/14/resources/4606	Open to research. While Canavan was a state employee, the collection is the product of Canavan's work as a bacteriologist, pathologist, researcher, and curator of the Warren Anatomical Museum at Harvard Medical School. Her professional research is derived from patients of state institutions, but the patient information has been decontextualized and the photographs may not originate with the state. Some records and images found in the collection are available in Canavan's publications. In the event a record was found with a patient name, and had no state institution associated with it, it would be closed 80 years from the date of creation. Per Research & Instruction: "Southard and Canavan’s state info have been used/published many times over. There was one researcher who had access to Boston State in 2002, but there isn’t any documentation of their approval. We also have contact at Worcester for their records, we’ve used them directly for requests (mainly direct decendents.)"	Box 1: F13 autopsies Box 5: scans of brains, F8

Owner	State Records	Collection Type	Creator	Collection Title	Collection Number	Institutions Found in Records	Description of Records	Harvard Library Catalog or Finding Aid Link	Access Policy	Series/Boxes to consult
Harvard Medical Library	Yes	Professional papers	An individual person (George Gay)	George Gay papers, 1906-1920	GA 31	Wrentham State School	Box 1 Folder 1: Wrentham State School inspection reports to the State Board of Insanity. Includes evaluations of patients with names attached.	https://id.lib.harvard.edu/alma/990006036560203941/catalog	Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Box 1
Harvard Medical Library	Yes	Professional papers	An individual person (E.E. Southard)	E. E. Southard papers, 1892-1940 (inclusive)	GA 81	Boston State Hospital, Danvers State Hospital, Foxborough State Hospital	Southard was Director of Boston Psychopathic Dept. at Boston State Hospital; Asst. phys. and pathologist at Danvers State Hospital; director of Mass. State Psychiatric Institute. **Box 1**: Anatomical monographs (70+ folders) contain some case reports of patients at BSH, Foxborough SH, Danvers SH. Some ID'ed by name, some by number only. Folders including "cases" usually have state patient info.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/6613	Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. Per Research & Instruction: "Southard and Canavan's state info have been used/published many times over. There was one researcher who had access to Boston State in 2002, but there isn't any documentation of their approval. We also have a contact at Worcester for their records; we've used them directly for requests (mainly direct decendents.)"	Box 1
Harvard Medical Library	Yes	Professional papers	An individual person (Joseph Murray)	Joseph E. Murray papers, 1919-2011 (inclusive)	H MS c113	Massachusetts Crippled Children's Service; Lemuel Shattuck Hospital; Medfield State Hospital; Pondville State Hospital	Papers are the product of Murray's activities as a plastic surgeon, transplant surgeon, laboratory director, author, and Harvard Medical School alumnus.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/6679	Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Box 50: Mass. Crippled Children's Service patient records. Box 56: Fernald School (1 f). Box 59: Lemuel Shattuck Hospital (1 f) Box 60: Mass. Dept. of Corrections 1 f, Mass. Crippled Children's Services. Box 64: Pondville SH folder. Box 79: Medfield SH folder, Pondville SH folder.
Harvard Medical Library	Yes	Professional papers	An individual person (Grete Bibring)	Grete Bibring papers, 1929-1977	H MS c159	Metropolitan State Hospital	Psychiatrist who lectured at and did consulting work for state institutions. **Box 12**: folder Metropolitan State conference includes copies of case studies of named underage patient issued as conference discussion material.	https://id.lib.harvard.edu/alma/990006035990203941/catalog	Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Boston State Hospital folder (box 10); Mass. Dept. of Public Health folder (Box 11); Mass. Mental Health Center (box 12, Box 43).
Harvard Medical Library	Yes	Professional papers	An individual person (L. Vernon Briggs)	L. Vernon Briggs papers, 1774-1940 (inclusive), 1911-1938 (bulk)	H MS c162	Boston State Hospital, Bridgewater State Hospital, Danvers State Hospital, Westborough State Hospital, Worcester State Hospital	Briggs served on the Mass. State Board of Insanity and worked at Camp Devens. **Box 7**: Correspondence between Briggs and superintendent of Bridgewater State Farm re: investigation of the superintendent done by others. Recommendations for number of staff to hire for Boston SH. Correspondence re: support for state funds for new hospital. **Box 9**: Narrative of Bridgewater State Farm case (with name). Employee affidavits from Boston SH. Westborough SH named patient case. Boston SH folders: Statistics, copies of trustee correspondence, BSH blueprints, personal correspondence reporting abuses to named patients. Brief abstracts of patient records. Memos of doctors re: patient care. Copy of trustees meeting minutes. Food procurement receipts. Copy of report of trustees' visit. **Box 13**: Copy of state auditor's official report on Worcester SH. Case notes about named patients at Worcester SH. Personal correspondence containing reports of absuses at WSH. Publically published Boston SH trustees reports and newsletters. **Box 18:** Copy of report on Dept. of Mental Health, appears to have been publically published. More copies of reports that appear to have been publically published. Publically published SH newsletters. Folder "State Positions on Smoke" contains application materials for civil service job. **Box 24:** Metropolitan SH floorplans on copper plate.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/6622	Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Norfolk State Hospital folder (Box 7). Boston, Worcestor, Bridgewater, Danvers State Hospitals, Governor's Commission (Boxes 9-13). Reports on State Hospital (Box 18). Floorplans of Metropolitan State Hospital (Box 24).
Harvard Medical Library	Yes	Professional papers	An individual person (Elliott Carr Cutler)	Elliott Carr Cutler papers, 1911-1948	H MS c170	Tewksbury Hospital	Cutler was a Trustee of Tewksbury Hospital (TH). Box 10: Correspondence re: consulting staff, interns, hiring. Reports of executive staff committee meetings. Accreditation inspection report copy. Weekly report of Patient Labor Department. Correspondence re: named patients. Patient case information. Correspondence re: construction of new building. Correspondence re: hiring of staff for nurses' training school. Drafts of procedure manuals (called precedent books). Minutes of board of trustees meetings.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/4556	Collection created as a product of Cutler's administrative, teaching, research, and professional activities of Elliott Cutler, Moseley Professor Surgery at Harvard Medical School and Surgeon-in Chief of Peter Bent Brigham Hospital. Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Tewksbury files (Box 10)

Owner	State Records	Collection Type	Creator	Collection Title	Collection Number	Institutions Found in Records	Description of Records	Harvard Library Catalog or Finding Aid Link	Access Policy	Series/Boxes to consult
Harvard Medical Library	Yes	Professional papers	An individual person (Albert Warren Strearns)	Albert Warren Stearns papers, 1912-1959 (inclusive)	H MS c543	Danvers State Hospital; Mass. Dept. of Mental Diseases; Norfolk Prison Colony; Tewksbury State Hospital	Stearns was a Commissioner of the Mass. Dept. of Corrections and worked at Danvers State Hospital. **Box 30:** Named patient case info for parole consideration. Copy of minutes of Department of Mental Diseases commionssers meeting with patient names. Copy of annual report of Norfolk Prison Colony medical dept. **Box 31**: Multiple folders of inmate records. Idenitified by number only. Age, family background, criminal history detailed. Correspondence to his office of a mixed professional/nonprofessional character. **Box 34**: Redacted patient records in this box are private practice. **Box 42:** Case files with named patients from consultations for Tewksbury SH.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/7949	Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Series IIB, Massachusetts Department of Correction (Boxes 31-33); Box 42 (Tewksbury State Hospital folder); Box 30 (Norfolk Prison Colony, Mass. State Police Academy, Dept. of Mental Diseases folders). Series III: restricted patient info, unclear if related to patients in state-administered facilities.
Harvard Medical Library	Yes	Professional papers	An individual person (Edward Delos Churchill)	Edward Delos Churchill papers, 1840-1973	H MS c62	Rutland Heights State Sanatorium; Westfield State Sanatorium	Patient files from many hospitals and sanatoria, state and private. **Box 58:** Case files, correspondence about named patients at Rutland State Sanatorium, Westfield State Sanatorium treated by Churchill at Boston City Hospital. Copy of report about tuberculosis from Westfield State Sanatorium. Correspondence about appointing Churchill consultant at Tewksbury (not state records). **Box 66:** 1 folder of Tewksbury Hospital appointment letters only. Not state records.	https://hollisarchives.lib.harvard.edu/repositories/14/resources/4615	Patient records are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB. State records mixed in with other manuscript materials that have PII or PHI are closed for 80 years from the date of creation unless access is approved by the Longwood Campus IRB.	Series VI.B (Box 58). Box 66 (Tewksbury Hospital folder)
Harvard Medical Library	Yes	Professional papers	An individual person (William Hinton)	William Augustus Hinton papers, 1915-1990 (inclusive)	H MS c652	Wasserman Laboratory, Massachusetts Department of Public Health.	Annual reports, fiscal reports, procedure documents, for the Wasserman Laboratory, part of the Mass. Dept. of Public Health. Patients test results (older than 80 years). List of employees. State employee service record.	https://id.lib.harvard.edu/alma/990080587890203941/catalog and https://hub.catalogit.app/7083/folder/7f3ebfa0-dee1-11ed-9e1b-bd75ef7ce5f6	This collection was digitized by the Public Health Museum in Massachusetts in 2023 with the support of a grant from Mass Humanities, which provided funding through the Massachusetts Cultural Council (MCC). After digitization, the collection was transferred to Harvard. Because the collection was digitized, there are no access restrictions.	
Harvard Medical Library	Yes	Published Language Material (Book)	Danvers State Hospital	Laboratory Papers, 1910	19.O.1910.3; Film Med 28494	Danvers State Hospital.	"Reprinted from the Boston Medical and Surgical Journal, Vol. clxiii, No. 5, pp. 150-227, Aug. 4, 1910"--T.p. Report of the Laboratory Work from 1888-1910, and other papers about the Hospital.	https://id.lib.harvard.edu/alma/990062396550203941/catalog	Available to researchers (published material)	
Harvard Medical Library	Yes	State records	Massachusetts Department of Public Health	Fluoridation Study, 1975-1985	H MS c235/MC 512	Massachusetts Department of Public Health	No information available.	https://id.lib.harvard.edu/alma/990077624440203941/catalog	Closed to research. (Collection is unprocessed.) Study might have been conducted in partnership with Harvard.	
Harvard Medical Library	Yes	State records	Grafton State Hospital	Records, 1880-1960	MC 327 (HD)	Grafton State Hospital.	Patient records, autopsy protocols, commitment papers (superintendents reports to trustees, annual reports, 1880s-1960 (inclusive). Declared as "surplus records" by the state in 1973 and "released" to Countway.	https://id.lib.harvard.edu/alma/990006036210203941/catalog	Mass. State Archives contacted for permission to access patient records (has been no to date).	
Harvard Medical Library	Yes	State records	Massachusetts Department of Mental Health	Patient records of the Thom clinic of the Massachusetts Department of Mental Health held in the Francis A. Countway Library of Medicine	MC 510 (HD)	Massachusetts Department of Mental Health.	Patient records	https://id.lib.harvard.edu/alma/990075141950203941/catalog	Closed to research. (Collection is unprocessed.)	
Harvard Medical Library	Yes	State records	Massachusetts Department of Mental Health	Patient records of the Thom clinic of the Massachusetts Department of Mental Health held in the Francis A. Countway Library of Medicine.	MC 511 (HD)	Massachusetts Department of Mental Health.	Patient records.	http://id.lib.harvard.edu/alma/990075360530203941/catalog	Closed to research. (Collection is unprocessed.)	
Harvard Medical Library	Yes	State records	Massachusetts Department of Public Health	Records of the Laboratories, 1930-1959 (bulk)	No collection number assigned (HD)	Massachusetts Department of Public Health.	Includes administrative files of the Antitoxin and Vaccine Laboratory; correspondence of the Department of Public Health Commissioner; financial records; and a considerable amount of other material. Presence of PII or PHI unclear.	https://id.lib.harvard.edu/alma/990006036140203941/catalog	Closed to research. (Collection is unprocessed.)	
Harvard Medical Library	Yes	University records; State records	Harvard Medical School [corporate entity]	Records of the Harvard Medical School Department of Psychiatry at the Massachusetts Mental Health Centers	n/a.	Massachusetts Mental Health Centers (MMHC)	**Box 1:** Faculty appointment files. See Box 10. **Box 10:** Faculty appointment files for Dept. of Psychiatry. Some correspondence from state institutions re: requests for appointments, resident evaluations. **Box 14:** Faculty appointment files. Includes some grant files applicable to personnel. See Box 10. **Box 17:** Faculty appointment files. **Box 20:** Files of Miles Shore, Bullard Prof. of Psychiatry at MMHC (letterheard joint State and Harvard). Research on different models of care for MMHC. Reports on MMHC and institutional mental healthcare broadly. Copy of Dept. of Public Health 5 year plan. Joint Harvard/MMHC grant applications. MMHC budget requests. Study data from Boston SH. MMHC symposium and other events. **Box 22:** Previous faculty appointments.	https://id.lib.harvard.edu/alma/990080587890203941/catalog	Closed to research. (Collection is unprocessed.)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Daily Census of Men, 1900-1915	H MS b118.01 (MC 096)	Boston State Hospital	Entries of admissions, discharges, and visits.	https://id.lib.harvard.edu/alma/990131340170203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Daily Register, 1910-1928	H MS b118.03 (MC 096)	Boston State Hospital.	Entries of patients' admittance and release with other notes.	https://id.lib.harvard.edu/alma/990131364630203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Register of Deaths, 1885-1929	H MS b118.06 (MC 096)	Boston State Hospital.	Notes of patient names and causes of death with some additional information.	https://id.lib.harvard.edu/alma/990131365010203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Weekly Summary, 1908-1911	H MS b118.10 (MC 096)	Boston State Hospital.	Entries of patients admitted and discharged.	https://id.lib.harvard.edu/alma/990131340260203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Record of Visits, Escapes, and Returns, 1925-1939	H MS b118.11 (MC 096)	Boston State Hospital.	Entries of patient data.	https://id.lib.harvard.edu/alma/990131341400203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Sick Call Register, 1925-1930	H MS b118.13 (MC 096)	Boston State Hospital.	Entries for patients visited by Catholic clergy.	https://id.lib.harvard.edu/alma/990131340550203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Infirmary Register, 1912-1915	H MS b118.15 (MC 096)	Boston State Hospital.	Admission and discharge details for patients. [Related to Insane Hospital?]	https://id.lib.harvard.edu/alma/990131364630203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	

Owner	State Records	Collection Type	Creator	Collection Title	Collection Number	Institutions Found in Records	Description of Records	Harvard Library Catalog or Finding Aid Link	Access Policy	Series/Boxes to consult
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Admission Records, 1887-1897	H MS b118.21 (MC 096)	Boston State Hospital.	Details of patients including admission, nationality, diagnosis, and result of treatment.	https://id.lib.harvard.edu/alma/990131343650203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Nurses Record, 1904-1946	H MS b118.22 (MC 096)	Boston State Hospital. Training School for Nurses	Notes on students attending nursing school.	https://id.lib.harvard.edu/alma/990131346980203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Record[s] of Restraint, Seclusion, and Packs, 1938-1954	H MS b118.24 (MC 096)	Boston State Hospital.	Entries for treatments given to patients.	https://id.lib.harvard.edu/alma/990131346890203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	
Harvard Medical Library - Deposit	Yes	State records	Boston State Hospital	Psychopathic Department records, 1943-1976	MC 092	Boston State Hospital.	Minutes of the Board of Trustees, 1943-1976.	https://id.lib.harvard.edu/alma/990079995980203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	Box 1
Harvard Medical Library - Deposit	Yes	State records	Massachusetts State Board of Health	Records	MC 520 (HD)	Massachusetts State Board of Health.	No information available.	N/A	Closed to research. (Collection is unprocessed.)	
Harvard Medical Library - Deposit	Yes	State records	Worcester Lunatic Hospital. Worcester Insane Hospital. Worcester Lunatic Asylum.	Records, 1833-1913	MC 911	Worcester Lunatic Hospital	Records the first eighty years of operation of the institution through patient registries, admission record books, reports, and case books split into male and female volumes. Includes bibliographical references.	https://id.lib.harvard.edu/alma/990090653980203941/catalog	Access by permission of the Mass. State Archives (has been no to date)	

Appendix 3: Correspondence between the Special Commission on State Institutions and Governor Healy/Secretary Walsh

SCSI Massachusetts Special Commission on State Institutions

March 27, 2024

Via Email

Honorable Governor Maura Healy
Massachusetts State House
24 Beacon St, Room 280
Boston, MA 02133

Kate Walsh
Secretary, Executive Office of Health & Human Services
1 Ashburton Place
Boston, MA 02108

Dear Governor Healy and Secretary Walsh:

The Special Commission on State Institutions has been charged with locating and reviewing existing records that are in the possession of the Commonwealth related to the network of current and former state institutions for people with intellectual or developmental disabilities or mental health conditions.

As the chairs of the Special Commission on State Institutions we are writing to you on behalf of the Special Commission, which voted in favor of this letter, to express our serious concerns for the circumstances and procedures that surround the closing of state-run institutions in Massachusetts. We request that there are actions taken to address the security of confidential documents of former residents found on the grounds of the Fernald Developmental Center in Waltham, as discussed in recent *Boston Globe* articles, and at other institutional sites and offices that have been previously closed or that will be closed in the future where personal records may exist.

This exposure of highly sensitive, personal information is a violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which prohibits disclosure of personal health and identifiable information. Not only is this an infringement of privacy, but it is also a violation of human dignity of former residents who have passed and for those that still live. In fact, The Department of Developmental Services provided a HIPAA Breech notification for the former Fernald Developmental Center on March 11, 2024.

Sadly, this is not the first time that confidential documents of former patients and residents have been mishandled during and after the closing of a state-run facility. For example:

- In 2000, the *Sun Chronicle* reported of the closed Foxboro State Hospital, "[a]bout the only documentation the Massachusetts Archives has of the former state-run psychiatric hospital is a series of annual reports and some general summaries of the facility."' A supervisor at the State Archives stated, "There are no case files for Foxboro … we've seen similar situations for other facilities." The article also speaks to the burdensome process for family members of former patients in obtaining records. "If a relative of a patient who was believed to be buried on the grounds of the former Foxboro State Hospital were to try to identify which numbered stone belonged to a family member, it would likely be an unattainable task". Unfortunately, even if a ledger that matched patient names with numbers had been found, the search is still rather cumbersome due to the many restrictions that apply under state law since a lot of the information contains sensitive medical information. Oftentimes a family or estate must seek a court order to obtain access to the information.
- In 2014, Fox Undercover investigated this same topic and reported that confidential records were found in the Paul A Dever School and the Metropolitan State Hospital by "urban explorers." One of the urban explorers interviewed said he had "found hundreds of private records in various state institutions," records he says "definitely should have been moved. I have found plenty of information, personal information, medical records …

I would have thought they would have at least been moved to an active facility, some secure facility." The urban explorer provided pictures of files full of records at several former state-run mental hospitals.

The Special Commission recognizes that the closure of any state-run facility is a complex undertaking that requires planning and coordinating between multiple state agencies and municipalities across the Commonwealth. Nevertheless, it is of utmost importance to always protect and respect the dignity of individuals who at one point in time received services at these facilities.

We appreciate the recent efforts of the Department of Developmental Services (DDS) to respond to the situation on the former Fernald grounds by securing documents in accessible buildings. We understand that some of the buildings are unsafe to enter due to their conditions and are encouraged to hear that a demolition company will be brought on to assist with the remaining records on the Fernald grounds. We respectfully request that any records that are found on site are collected, stored, and preserved at a secure location unless their condition requires their destruction due to their condition instead of being disposed of as part of the demolition waste.

The Special Commission on State Institution requests the Executive Office of Health and Human Services, the Department of Developmental Services, the Department of Mental Health (DMH), and the state's Division of Capital Asset Management and Maintenance (DCAMM) to address these ongoing issues by:

a) Conducting an inventory of closed state institutions formerly operated by DDS and DMH to determine whether and where records are stored on the premises, including a sweep of all buildings and subterranean tunnel systems.
b) Documenting what will be done to address any issues with record security at closed state institutions identified during the above process and the associated timelines.
c) Developing an accessible, consistent, and clear process for former service recipients to request their own records, as well as for their immediate family members or estate to make such requests on their behalf, with the right safeguards to ensure family members or estate have the proper rights to the information.
d) Developing a transparent process for the handling, storage, and retention of confidential records, as well as the terms under which disposal is permitted and how it is to be conducted, so that this type of situation does not arise again in the future.
e) Creating an accounting of the records from closed institutions that may be stored at government offices or state-run facilities still in operation.

The Special Commission Members are willing to assist with anything that is within the Commission's capacity and purview. We hope that you will consider taking these steps to address these long-standing issues and respectfully request that you provide the Commission with a written preliminary response within 90 days of the date of this letter.

Respectfully submitted on behalf of the Special Commission of State Institutions.

Evelyn Mateo
Co-Chair, Special Commission on State Institutions

Matthew Millett
Co-Chair, Special Commission on State Institution

Cc:
Jane Ryder, Commissioner, Department of Developmental Services
Brooke Doyle, Commissioner, Department of Mental Health
Adam Baacke, Commissioner, Division of Capital Asset Management and Maintenance

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MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

KATHLEEN E. WALSH
SECRETARY

July 10, 2024

Dear Members of the Special Commission on State Institutions,

The Executive Office of Health and Human Services (EOHHS) is grateful to the members of the Commission for their dedication to its mission to study and report on the history of state institutions for people with intellectual or developmental disabilities or mental health conditions in the Commonwealth.

In March, my office received a letter from the Commission's two co-chairs, Evelyn Mateo and Matthew Millett, on behalf of the Commission, which referenced the discovery of records on the grounds of the former Fernald facility in Waltham. EOHHS has been working with all relevant parties to conduct a thorough review of the Department of Mental Health (DMH) and Department of Developmental Services (DDS) past practices and records retention policies for its former and current facilities, and appreciates the opportunity to provide the Commission's members with the following preliminary updates on the points raised in the letter:

a) Inventory of closed state institutions formerly operated by DDS and DMH

DMH and DDS have conducted inventories of closed state institutions formerly operated by each agency to determine whether and where records were stored on the premises. In all cases, DMH and DDS confirmed that records of those who resided at the facilities were relocated to secure DMH and DDS facilities prior to the facilities' closures and transfer of ownership.

On campuses where facilities only partially closed, such as Medfield State Hospital, EOHHS has been working with relevant parties to survey those campuses. For example, at Medfield State Hospital, DMH's survey was limited due to safety concerns, but it will be working with the Division of Capital Asset Management and Maintenance (DCAMM) to determine whether DMH can access apparently unsafe areas.

b) Documentation of what will be done to address any issues with record security at closed state institutions identified during the inventory process

Based on the inventories of closed facilities, EOHHS has not identified issues with record security at former DMH and DDS facilities, beyond what has been reported regarding the Fernald Developmental Center. Should any issues arise, DMH and DDS will address them in a timely manner consistent with federal and state policies.

c) Development of accessible, consistent, and clear processes for records requests

EOHHS is committed to working with the Commission and family members of former service recipients to develop straightforward, clear processes for accessing individuals' records and to streamline the process for requesting former and current service recipients' records.

Current procedures for former and current service recipients to request their own records, as well as for their immediate family members or estate to make such requests on their behalf, appear on both the DMH and DDS Mass.gov webpages:

DMH

- DMH medical record request: https://www.mass.gov/dmh-medical-record-request.
- Records request form for clients and legally authorized representatives (LARs) is available through the link immediately above and at: https://www.mass.gov/doc/dmh-request-to-inspect-form-hipaa-f-9/download.

DDS

- DDS client files can be requested by emailing "DDS.filerequests@mass.gov" directly.
- Additionally, DDS service recipients can contact their DDS Service Coordinator or local Area Office to request a copy of their records.

Under state law, family members may obtain medical records of DMH and DDS clients when: the family member is the client's legally authorized representative, such as a custodial parent, court appointed guardian, and court appointed personal representative of a deceased client's estate; the disclosure is otherwise ordered by a court of competent jurisdiction; the client authorizes the disclosure; or the commissioner determines that it is in the best interest of the client to provide the records to the family member.

d) Development of a transparent process for the handling, storage, and retention of confidential records

Detailed policies for the handling of client and patient records exist for both DMH and DDS.

DMH

DMH's Privacy Handbook sets forth rules regarding the handling, storage and retention of confidential records. The Handbook, consistent with state and federal law, requires that staff preserve the confidentiality of Protected Health Information (PHI) created and/or maintained by DMH.

Handling and Storage: The DMH Privacy Handbook outlines the physical and technical safeguards that must be followed when PHI is being used or disclosed. When using hard copy PHI, existing policies require that all reasonable efforts be made to avoid inadvertent disclosures to others, and PHI must be kept in a secured location such as a locked office and/or filing cabinet.

Retention and Disposition: DMH follows the Massachusetts Statewide Records Retention Schedule for guidance on retention and disposition, a copy of which is available on the Secretary of the Commonwealth's webpage:
https://www.sec.state.ma.us/arc/arcpdf/MA_Statewide_Records_Schedule_updated2022-10-31.pdf.

The statute governing retention of medical records sets a 20-year retention period. Medical records cannot be destroyed or transferred to the State Archives without permission from the Records Conservation Board (RCB) overseen by the Secretary of the Commonwealth. See process for obtaining permission and required forms at the Secretary of the Commonwealth's Agency Records Department:
https://www.sec.state.ma.us/divisions/archives/records-management/agency-records.htm.

DDS

DDS's process for handling, storage and retention of confidential records is guided by the DDS HIPAA Privacy Handbook (2019), which requires DDS staff to preserve the confidentiality of Protected Health Information (PHI) created and/or maintained by DDS.

Handling and Storage: Existing DDS policies outline the physical and technical safeguards that must be followed when PHI is properly being used or disclosed. When using hard copy PHI, existing policies require that all reasonable efforts shall be made to avoid inadvertent disclosures to others. PHI shall be kept in a secured location, if possible in a locked office and/or filing cabinet. A tracking system is to be used to identify when a record has been removed, who took the record, and where it is located.

Retention and Disposition: DDS follows the Massachusetts Statewide Records Retention Schedule for guidance on retention and disposition, a copy of which is available on the Secretary of the Commonwealth's webpage:
https://www.sec.state.ma.us/arc/arcpdf/MA_Statewide_Records_Schedule_updated2022-10-31.pdf.

e) Creating an accounting of the records from closed institutions that may be stored at government offices or state-run facilities still in operation

Both DMH and DDS have detailed accounts of records and can access such records that are still in its possession, including records in the State Archives.

EOHHS values the work of the Commission and looks forward to maintaining an open dialogue with its members on ways in which the Commonwealth can better serve its residents with intellectual, developmental disabilities, or mental health conditions.

Sincerely,

Kathleen E. Walsh
Secretary

Cc: Maura Healey, Governor
Jane Ryder, DDS Commissioner
Brooke Doyle, DMH Commissioner

SCSI Massachusetts Special Commission on State Institutions

November 18, 2024

VIA EMAIL

Kate Walsh
Secretary, Executive Office of Health & Human Services
1 Ashburton Place
Boston, MA 02108

Dear Secretary Walsh:

The Special Commission on State Institutions thanks you for your reply to our letter about finding records at the old Fernald Developmental Center, which we got on July 15, 2024.

We are happy to hear that the Executive Office of Health and Human Services (EOHHS) is willing to work with us to make it easier for people to ask for records of former and current service users. We would like to help by forming a group to work with EOHHS. This group will look at the current process for getting records and find out where the problems are, especially for former patients or their families. We also want to look at the process of redacting (removing) information when records are shared.

We are also asking for more information from EOHHS, the Department of Developmental Services (DDS), the Department of Mental Health (DMH), and the Division of Capital Asset Management and Maintenance (DCAMM):

1. The dates when each facility searched for records. Please include when DMH and DCAMM will work together to look at the Medfield State Hospital buildings and other campuses that are only partially open. Also, let us know what DCAMM has found since our last letter.
2. Where the records are stored now and what types of records are kept.
3. The condition of the places where the records are stored.
4. Why these records are not stored in the Archives.
5. The rules for keeping records from DDS and DMH about people who died more than 50 years ago.
6. A clearer explanation of what counts as "medical records" and what does not.

The Commission Members are happy to help with anything that is within our ability and responsibility. We kindly ask that you send us a written reply within 90 days of the date of this letter.

Respectfully submitted on behalf of the Special Commission of State Institutions.

Kate Benson
Co-Chair, Special Commission on State Institutions

Matthew Millett
Co-Chair, Special Commission on State Institutions

Cc:
Sarah Peterson-Commissioner, Department of Developmental Services
Brooke Doyle, Commissioner, Department of Mental Health
Adam Baacke, Commissioner, Division of Capital Asset Management and Maintenance

Appendix 4: Letter from DDS Regarding Access to Burial Information at MetFern Cemetery

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Developmental Services
1000 Washington Street
Boston, MA 02118

MAURA T. HEALEY
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Area Code (617) 727-5608
Video Phone: (857) 366-4179
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January 2, 2025

VIA ELECTRONIC MAIL ONLY

Jennifer Fuglestad, M.Ed
Sr Quality Improvement Specialist
Center for Developmental Disabilities Evaluation and Research (CDDER)
Eunice Kennedy Shriver Center
UMass Chan Medical School
55 Lake Avenue North S 3-301
Worcester, MA 01605
Jennifer.Fuglestad@umassmed.edu

Re: Request for MetFern Cemetery Registers

Dear Ms. Fuglestad,

I am writing in response to your November 4, 2024, request to the Massachusetts Department of Developmental Services ("the Department" or "DDS") wherein you, on behalf of the Special Commission on State Institutions ("SCSI"), requested "to view the cemetery register that is currently held at the MA Archives.

- Record Group Number: HS14.02
  Fernald State School Cemetery registers, 1947-1979.
  Identifier: HS14.02/2649X".

Enclosed please find a redacted copy of the requested records.

DDS is a covered entity under the Heath Insurance Portability and Accountability Act ("HIPAA"). A covered entity may not use or disclose protected health information ("PHI"), except as permitted or required under the law. 45 CFR 164.502(a). A covered entity must comply with the requirements of HIPAA with respect to the PHI of a deceased individual for a period of 50 years following the death of the individual. 45 CFR 164.502(f).

In accordance with G.L. c. 123B, §17 and 115 CMR 4.06(2)(f), DDS finds that is in the best interest of the deceased individuals to disclose the cemetery registers to SCSI. DDS has redacted the information of individuals who have not been deceased for fifty or more years.

DDS reserves the right to retrieve any exempt, privileged, or otherwise protected materials inadvertently included in this production. Any such production is not, and shall not be considered or deemed, a waiver of any applicable privileges or protections from disclosure.

Please feel free to contact me by email or at 617-429-5414 if you have any questions or require additional information.

Sincerely,

Gabriella Eisner

Gabriella Eisner
Assistant General Counsel

Enclosure(s)

Appendix 5: Memo from Harvard Law School Cyberlaw Clinic to the Special Commission on State Institutions

CYBERLAW CLINIC
CLINIC.CYBER.HARVARD.EDU

MEMORANDUM

To: Emily Lauer, UMass Chan Medical School
Jennifer Fuglestad, UMass Chan Medical School

From: Pedro R. M. Silva, Harvard Cyberlaw Clinic

Cc: Mason Kortz, Harvard Cyberlaw Clinic

Date: December 18, 2024

Re: Review of Massachusetts Law on Third-Party Access to Government-Held Healthcare Records

PRIVILEGED AND CONFIDENTIAL
ATTORNEY WORK PRODUCT

1. BACKGROUND & SUMMARY

This memorandum analyzes how Massachusetts laws apply to records of patients in institutions supervised by the Department of Mental Health ("DMH"). It is written to serve the interests of the Special Commission on State Institutions ("SCSI") and its partners. It analyzes how SCSI and its partners might access patient records as well as how SCSI might support access by family members of deceased patients.[1]

The memorandum provides a summary of SCSI's background and its mission (Part 2). It then describes the relevant statutes and regulations applicable to the disclosure of patient records controlled and regulated by DMH (Part 3). In doing so, it reflects the interests of SCSI and its partners as expressed in communications shared with the Harvard Cyberlaw Clinic. Two primary theories are pursued: first, the memorandum analyzes how access may be obtained pursuant to laws specifically regulating DMH facilities, and second, how access may be obtained under public record laws. Next, the memorandum analyzes the application of these statutes and their caselaw to SCSI's mission (Part 4). The memorandum then provides a series of legal recommendations that may assist SCSI and its associated entities in strengthening their legal case for accessing DMH patient records (Part 5) and offers a brief conclusion (Part 6).

Briefly, few laws and regulations are directly applicable to the records in question. For most of these laws, there are only a few cases discussing their requirements as understood by the courts. As such, the analysis in this memorandum examines underlying trends and animating theories across the existing court decisions and regulations. Ultimately, we recommend that SCSI advocate for legislative and regulatory reform based on prior state commissions' work.

2. SPECIAL COMMISSION ON STATE INSTITUTIONS STATUTE

2.1. Statutory Authorization

In 2022, the Massachusetts legislature passed legislation to set up "a special commission to study and report on the history of state institutions for people with intellectual or developmental disabilities or mental health conditions in

1 There is a general understanding under the law that someone working on behalf of a person or entity (an "agent") has the same rights and responsibilities of the person or entity that enlisted them (the "principal"). For the purposes of this memorandum, this means that wherever SCSI has a right or a responsibility, its designees at the Center for Developmental Disabilities Evaluation and Research (CDDER) is expected to have the same rights or responsibilities. Likewise, a designee of the DMH Commissioner is expected to have the powers that the Commissioner would have.

the commonwealth." The legislation created a number of requirements for this new commission. Relevant here, these responsibilities include obligations to review existing records in the possession of the state related to the network of certain state institutions and to examine the availability of records from former residents of such state institutions to the residents' family members and the public. Additionally, the commission is required to "[d]esign a framework for public recognition of the commonwealth's guardianship of residents with disabilities throughout history."

The commission is expected to file a "report of its findings and recommendations" to various state bodies no later than June 1, 2025. Notably, however, the statute does not include provisions granting the commission explicit access to records. Thus, SCSI is required to consider its own options for legal access, as well as the routers available to family members, researchers, and the public when considering options for disclosing patient records from state institutions. Additionally, SCSI is expected to consider future modifications for the existing laws. The research and analysis below reflect these requirements.

2.2. August Decision

In August, Brooke Doyle, Commissioner of the Department of Mental Health issued a "Best Interest Determination" (hereinafter, "the Determination") stating that, with certain constraints, it was in the best interest of patients that SCSI and CDDER have access to records from former Foxborough State Hospital patients who have been deceased for over fifty years and who are buried in Foxborough cemeteries with only a grave number. The access outlined in the Determination was bound to "an appropriate confidentiality agreement" and SCSI is tasked at least in part with "identifying the names of the patients buried in the Foxborough cemeteries." In its assessment, the Determination outlines that SCSI's access would "memorialize and provide dignity and respect to the lives and deaths of those who have been in [the institutions'] care."

2.3. Department of Corrections Response

In November, a representative of the Massachusetts Department of Correction ("DOC") denied a record request made by CDDER pursuant to Public Records laws the month prior (hereinafter, "the DOC review"). In its response, the DOC representative stated that the information sought in the request included "medical records" that "are not public records" and that the DOC does not have "the authority to authorize the viewing of these records." As an explanation for the decision, the DOC representative recognized that "CORI laws are lifted upon death for institutional records," but that medical records remain exempt from disclosure under Mass. Gen. Laws ch. 4, §7 (26)(c).

3. RELEVANT STATUTES AND REGULATIONS

3.1. DMH Records Statutes

3.1.1. Statutory Text

The primary Massachusetts statutes applicable to SCSI's access to patients' healthcare data are in Chapter 123 of the Massachusetts General Law, Part I, Title XVII (hereinafter, "Chapter 123" or "the Chapter"). Generally, the Chapter's sections govern certain procedures of the state's Department of Mental Health ("DMH"), including the collection, handling, and disclosure of patient data stored by DMH.

Most relevant to third-party access to DMH patient data, Chapter 123 Section 36 requires DMH to keep healthcare records of persons admitted to the facilities under DMH's supervision, and that these records shall be private unless certain exceptions apply. Mass. Gen. Laws ch. 123, § 36; *see also* Mass. Gen. Laws ch. 123, § 1 (providing definitions for Chapter 123). Relevant to SCSI's interests, exception (3) provides that the DMH commissioner may "permit inspection or disclosure when in the best interest of the patient or resident as provided in the rules and regulations of [DMH]." Other sections of Chapter 123 provide more detail on DMH records: Section 36A provides details for disclosure under judicial proceedings, Section 36B provides liability rules around duties of healthcare workers to disclose the healthcare data, and Section 36C governs the transmission of patient data to department of criminal justice services.

3.1.2. Statutory Caselaw

A comprehensive search of Massachusetts cases discussing Section 36 reveals few relevant cases. No particular case appears to address the application of the Section's exceptions to third-party circumstances akin to those of SCSI. However, the cases do generally support the conclusions that privacy protections are based on a balance of interests, and that the discretion of the DMH Commissioner will be factored into that balance.

The decision in *Commonwealth v. O'Brien* offers some insight into how Massachusetts courts will evaluate Section 36 protections against public needs for disclosure. 27 Mass. App. Ct. 184, 536 N.E.2d 361 (1989). The defendant in the case, Paul O'Brien, had been convicted of assaulting a minor patient at the time he worked the night shifts at a DMH institution. *Id.* at 185–86. In an appeal for his conviction, O'Brien argued that he had been "improperly denied access to material which would have been helpful to his defense," as the trial court had maintained the confidentiality of the patient's records at the DMH institution. *Id.* O'Brien had sought to use the records, as he asserted that they

"contained information about the victim's prior false statements of sexual assault which the defendant would have [had] the right to explore for possible use at trial." *Id.* at 189. The trial court, after reviewing the materials separately ("in camera"), decided that the victim had not made such false statements and that the only other statements the victim had made about sexual assault had led to criminal convictions. *Id.* at 189. The appellate court agreed with that review. *Id.*

Despite the conclusion that the records' contents contradicted the defendant's basis for the request, the appellate court still decided that disclosure of patient records was appropriate. *Id.* at 190. "Unquestionably," the court found, "the documents sought . . . were material to the case." *Id.* at 189. And while the court agreed with the prosecution that certain statutes — including Section 36 — provided a basis for treating the records as confidential, the court decided that the confidentiality decision should be decided through a balancing test. *Id.* At most, the court held, Section 36 "required the judge to conduct a preliminary in camera review of the [victim's] records to determine whether they were what they purported to be and to weigh their materiality against the victim's interest in privacy." *Id.* Given the materiality of the records to this case, the court "d[id] not think the policies underlying [Section 36 were] sufficiently compelling to override the defendant's right to inspect the unprivileged portions of them in preparation of his defense." *Id.*

Not all cases, however, have favored disclosure. In *John Doe v. Commissioner of Mental Health*, a court examined the requirements of a Section 36 exception allowing for a patient's attorney to access patients' records. 372 Mass. 534, 362 N.E.2d 920 (1977); *see* Mass. Gen. Laws ch. 123, § 36 (2) (providing for an "attorney access" exception). The plaintiff's daughter in the case had been treated at a DMH facility when she was a minor, and the plaintiff had "repeatedly sought," without success, "a written report from the hospital staff concerning his daughter's diagnosis, treatment, and prognosis." *Doe*, 372 Mass. at 535. The plaintiff then obtained his daughter's written consent and, acting as his daughter's attorney, sought the same records from the facility through the explicit "attorney access" exception. *Id.* Nonetheless, DMH again denied the requests, finding that "Mr. Doe's interest as parent overrode his interest as attorney," and that Mr. Doe could only obtain access to his daughter's records through court order. *Id.* at 535–37. The plaintiff sued, challenging the decision in court. *Id.* Much of the challenge concerned DMH's requirement for written consent from the patient. *Id.*

The court found that Section 36 "was intended to protect patients from the potentially detrimental impact of disclosure of records to third parties." *Id.* at 537; *see also Globe Newspaper Co. v. Doe*, No. 003790, 2000 WL 33171055, at *8 (Mass. Super. Dec. 4, 2000) (examining healthcare data statutes, including Section 36, and finding that "[t]he legislative import is clear: to protect the

confidentiality of these records, unless it is necessary to make them public"). The court also found that generally, "[t]he Commissioner of Mental Health . . . has the discretionary power to permit inspection when such disclosure would be in the best interests of the patient." *Id.* Although the text suggested that this discretion was inapplicable to the attorney access exception, the court found that the Commissioner's additional requirement should be upheld for being "entirely consistent with the legislative intent to protect the privacy interests of patients." *See id.*

Although the decisions in *Doe* and in *O'Brien* may at first appear to point in different directions, they share important commonalities. Both recognized that Section 36's privacy protections were not absolute, and that courts should examine the statutory protections through a balance of interests. As *O'Brien* discussed, the balance should be between patient privacy interests on one side, and other compelling interests in disclosure of the data on the other. In Doe, the latter interests were non-privacy patient interests in efficacious legal assistance; in *O'Brien*, they were the public interest in the fair resolution of criminal cases. Although Doe concluded with a decision imposing greater barrier to access to the data, it qualified that barrier by recognizing the government's need (expressed through the exercise of the Commissioner's discretion) could be determinative.

3.2. DMH Records Regulations

3.2.1. 104 Massachusetts Code of Regulations Chapters 27, 28.

Chapter 123 also provides that the DMH shall, following certain procedures, "adopt regulations consistent with [the Chapter]." *See* Mass. Gen. Laws ch. 123, § 2. The regulations most relevant to legal access can be found under Title 104 Chapters 27 and 28, which are promulgated by DMH to address standards for mental health facilities and community programs, respectively.

Under Chapter 27, DMH facilities are required to maintain patient records "including all significant clinical information for each patient admitted to the facility." 104 Mass. Code Regs. 27.16.01. Such records are to be "private and not open to public inspection" unless exceptions apply. *Id.* at 27.16.07. With a few exceptions, patients and their legally authorized representatives have the right to access a patient's own records. *Id.* at 27.16.08.

Chapter 27 also establishes procedures for inspection by or disclosure to third parties. *Id.* at 27.16.09. Paralleling some of the Section 36 exceptions discussed above, the regulation provides for access to patients records upon a proper judicial order or with authorization from the patient or their legally authorized representative. *Id.* at 27.16.09 (a)–(b). Additionally, the regulation provides that "[t]he Commissioner or designee may permit inspection or

disclosure of the records of a patient where he or she has made a determination that such inspection or disclosure" would be legal and "in the best interest of the patient." *Id.* at 27.16.09 (c).

A patient's best interest is further specified — without limiting the Commissioner's discretion — as including interests in handling healthcare operations; obtaining a legally authorized representation where the patient is deemed to lack capacity to render informed consent; conducting investigations involving the patient (generally limited to labor disputes, *see* 104 Mass. Code Regs. 32, governing such investigations); engaging in research where the access is approved by DMH under the applicable regulations; making reports of communicable and other infectious diseases; and, in the case of death, the interests of coroners, medical examiners, or funeral homes. *See id.* at 27.16.09(d).

Finally, chapter 27 also provides that records may be disclosed where required by law, including, but not limited to, statutes concerning the Executive Office of Elder Affairs, the Disabled Persons Protection Commission, the Department of Children and Families, Protection and Advocacy for Mentally Ill Individuals, Mental Health Legal Advisors Committee. *See id.* at 27.16.09 (e) (citing a series of corresponding sections of the Mass. Gen. Laws).

Chapter 28 in many ways mirrors Chapter 27, also providing for the maintenance of healthcare records in DMH providers for community programs and services. It requires providers to ensure "that each of its services maintains an individual record of services provided to each person served" including "accurate, complete, timely, and relevant information." 104 Mass. Code Regs. 28.09.01. It also provides for access to a patient's record by the patient themselves, their legally authorized representatives, or their attorney. *Id.* at 28.09.02–03. As with Chapter 27, a person's records covered by Chapter 28 may also be open to inspection by or disclosure to third parties where certain conditions apply. *See id.* at 28.09.04. The conditions mirror those in Chapter 27. *See id.*; *id.* at 27.16.09.

3.2.2. 104 Massachusetts Code of Regulations Chapter 31.

Both Chapter 27 and Chapter 28 above refer to a non-exclusive list of interests that qualify as being "in the best interest" of patient when considering whether a third party may access to the patient's records in DMH institutions. Among those interests is included "research if such access is approved by the Department pursuant to 104 CMR 31.00." *See* 104 Mass. Code Regs. 27.16.09, 28.09.04.

Research qualifies under Chapter 31 where a DMH employee is part of a research, a DMH facility is used for recruitment or conduction of research, the

research involves disclosure by DMH of "private information or protected health information," or the DMH's terms in a regulation or agreement make the Chapter apply. 104 Mass. Code Regs. 31.01. "Research" itself is defined as "[a] systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge." *Id.* at 31.02.

All research activities covered by Chapter 31 must be "reviewed and approved by the [Department's Institutional Review Board (IRB)] prior to implementation" and they must meet Chapter 31's requirements and standards. *Id.* at 31.03. Among these requirements and standards is a "informed consent process" requirement, which demands that "[t]he participation of each subject in a research project requires the written informed consent of the subject or the subject's legally authorized representative unless specifically waived by the IRB." *Id.* at 31.05. The IRB, in turn, may issue such a waiver as allowed by federal and state law, as well as where it follows its own "applicable procedures and guidelines." *Id.* at 31.04.

3.3. **Public Records Law**

As cited in the DOC review, Section 7 of chapter 4 governs the scope of the access to the states' public records. Mass. Gen. Laws ch. 4 § 7.

3.3.1. Statutory Text

Section 7 of the Massachusetts General Laws provides a series of definitions used by a variety of state laws. Among them, "public records" is defined as all "documentary materials or data . . . made or received by any officer or employee" of most state entities. *Id.* cl. 26. It also includes exemptions to the definition, including, as relevant here, an exemption where the materials or data are "personnel and medical files or information . . . relating to a specifically named individual, the disclosure of which may constitute an unwarranted invasion of personal privacy," as long as it is not part of a law enforcement misconduct investigation ("exemption (c)"). *Id.*

3.3.2. Statutory Caselaw

The definition of public records has been extensively analyzed by Massachusetts courts. Public records laws are presumed to favor disclosure, and the government carries the burden of convincing courts that an exemption applies, and a record should be withheld. *See Rahim v. Dist. Att'y for Suffolk Dist.*, 486 Mass. 544, 552 (2020); *Boston Globe Media Partners, LLC v. Dept' of Pub. Health*, 482 Mass. 427, 432 (2019) (exemptions "must be strictly and narrowly construed."). Deciding whether an exemption to disclosure applies requires "careful case-by-case consideration." *WBZ-TV4 v. Dist. Att'y*

for Suffolk Dist., 408 Mass. 595, 603 (1990). Disclosure evaluations are independent of who is requesting them. *See Globe Newspaper Co. v. Boston Retirement Bd.*, 388 Mass. 427, 437–38 (1983).

Historically, Massachusetts courts have read exemption (c) as creating two separate categories of data excluded from the definition. The records covered by the first category, "personnel and medical files or information," are "*absolutely* exempt from mandatory disclosure where the files or information are of a personal nature and relate to a particular individual." *Globe Newspaper Co.*, 388 Mass. at 438 (1983) (emphasis added). Where information does not permit the identification of any individual, however, the record is not exempt from the public record laws. *Id.* When records contain information about a particular person, though not particular identifying details (such as their names), courts will review it for the "grave risk of indirect identification" and may still deny disclosure. Id; *see also Logan v. Comm'r of Dep't of Indus. Accidents*, 68 Mass. App. Ct. 533 (2007) (denying disclosure of medical files even with redactions of the names and id numbers of the subjects). Information in the records may also be severed so that some sections may remain exempt from disclosure while others remain public records. *Id.* n.18.

The second category of information under exemption (c), "relating to a specifically named individual," is exempt only if disclosure "may constitute an unwarranted invasion of personal privacy." *Id.* Under controlling law, the determination of whether disclosure constitutes "an unwarranted invasion of personal privacy" is based on a balancing test between "the seriousness of the invasion" and "the public right to know." *See Champa v. Weston Pub. Schs.*, 473 Mass. 86, 96 (2015) (quoting *Att'y Gen. v. Assistant Comm'r of the Real Prop. Dep't of Boston*, 380 Mass. 623, 625 (1980)). If "the public interest in obtaining information substantially outweighs the seriousness of any invasion of privacy, the private interest in preventing disclosure must yield to the public interest." *Id.* (quoting *Att'y Gen. v. Collector of Lynn*, 377 Mass. 151, 156 (1979)). The privacy inquiry includes considerations for potential "personal embarrassment to an individual of normal sensibilities," whether "intimate details of a highly personal nature" would be revealed, and whether the same information is available from other sources. *Id.*

The fact that the person that is the subject of the records has died, by itself, will not remove the records from the coverage of exemption (c). For instance, in *Globe Newspaper Co. v. Chief Med. Exam'r*, 404 Mass. 132, 135 (1989), the Supreme Judicial Court decided that it could not consider autopsy reports as "anything but 'medical files or information'" that were also covered by exemption (c). However, the Court has recognized that the Legislature may redefine the scope of exemption (c). "The Legislature is not unmindful of the desirability of disclosure of [medical reports after death] in limited circumstances," the Court noted. *Id.* For instance, Massachusetts laws allow

for disclosure of certain medical information to next of kin for those who die in a place of detention and for defendants in a capital case. *See id.* (citing Mass. Gen. Laws ch. 40 § 36A and Mass. Gen. Laws ch. 38 § 7, respectively).

What qualifies as "medical records" remains "abstract and general." *Rahim*, 486 Mass. at 554 n.16. Caselaw offers some insight, however. A seminal case stated that, at the very least, information on procedures performed by physicians that are "diagnostic in nature" and that "yield detailed, intimate information about the subject's body and medical condition" qualify. *Globe Newspaper Co.*, 404 Mass. at 134; *see also Viriyahiranpaiboon v. Dep't of State Police*, 52 Mass. App. Ct. 843, 848–49 (2001) (recognizing the protection for genetic information). But intimate details of a highly personal nature are not required either. *Wakefield Teachers Assn. v. School Comm. of Wakefield*, 431 Mass. 792, 800–801 (2000). Even cursory statements such as "bad back, heart problem, hypertension," when related to specific individuals, will be considered "medical information." *Globe Newspaper Co.,* 388 Mass. at 430 (1983).

That said, "[n]ot every bit of information which might be found in a . . . medical file is necessarily personal so as to fall within the exemption's protection [and] the scope of the exemption turn[s] on the character of the information sought." *Globe Newspaper Co.*, 388 Mass. at 435. In B*rogan v. School Committee of Westport*, the Supreme Judicial Court decided that Westport school committee's employee attendance were public records, even where they included "generic classifications" like "'sick day,' 'personal day,' etc." 401 Mass. 306, 308–09 (1987). The Court decided that there was a "fundamental difference" between such records and the ones held to be covered as "medical files" because the information was not inherently "of a personal nature" and "dealt only with records of absenteeism among teachers." *Id.* Likewise, a court in *Georgiou v. Commissioner Of Dept. Of Indus. Accidents* evaluated a public records request for the identification of workers in injury reports shared with the State. 67 Mass. App. Ct 428, 428 (2006). The court recognized "at least a distant kinship" to the definition of "medical files" and requested that the lower court apply a review balancing privacy interest. *Id.* at 437.

The two-classification decision, however, may no longer be applicable and updates to the law may have turned the entire exemption into a single category subject to the privacy balancing test. In 2020, the Massachusetts Legislature updated exemption (c) as part of a package seeking to increase transparency around police misconduct in the state. It passed an amendment to exemption (c), stating that it would not apply "to records related to a law enforcement misconduct investigation." *See Mack v. Dist. Att'y for Bristol Dist.*, 494 Mass. 1, 10–11 (2024). Simultaneously, it replaced a semi-colon separating "personnel and medical files or information" from "any other materials or data relating to

a specifically named individual" with the word "and." *Compare* Mass. Gen. Laws ch. 38 § 7 (2019 ed.), with *id.* (2024 ed.).2

While Massachusetts courts have not addressed the change directly, it was the existence of the semi-colon that had provided the reasoning for the separation into two categories, with the "medical files" being absolutely exempted from a "public records" definition. In *Globe Newspaper Co. v. Boston Retirement Board*, the Supreme Judicial Court established the "two categories" approach, highlighting that "[t]he use of a semicolon usually indicates that each clause is intended to be independent." 388 Mass. at 432. Although it recognized that a semicolon alone is not determinative, it pointed out that the use of the semi-colon served to distinguish the state law from a parallel federal law which did not separate the different kinds of records. See *id.* at 433–34 ("The absence of a semicolon from the Federal exemption strengthens the view that the semicolon [in the Massachusetts statute] is not without meaning. Its insertion by the Legislature in [exemption (c)] manifests a desire to ensure that the first clause would not be subject to the language of the modifying clause."); *see also id.* at 432–33 ("If the language of a statute differs in material respects from a previously enacted analogous Federal statute . . ., a decision to reject the legal standards embodied or implicit in the language of the Federal statute may be inferred.").

Indeed, some cases support this theory. In *Mack v. District Attorney for Bristol District*, plaintiffs sought records used in the investigation of police officers' killing of Anthony Harden (the plaintiff's brother). 494 Mass. at 2–3. Among the documents sought were Harden's autopsy and medical records. *Id.* at 5–6. At the trial level, the judge performed a "balancing test" and decided that public interest and equity substantially favored disclosure. *Id.* at 11.

On appeal, the Supreme Judicial Court did not discuss whether the trial court should have subjected the medical files to the balancing test in the first place. *Id.* Instead, it decided that the "law enforcement misconduct investigation" carve-out at the end of the exemption included the information and records sought. *Id.* Implicitly, however, it may have accepted the argument that the semi-colon that previously split the exemption into two discrete clauses is no longer applicable: the carve-out at the tail end of the exemption (which would be after the semi-colon before the 2020 amendments) was determined applicable to the "medical files" at the beginning of the text (which would precede the semi-colon before the amendment).

4. ANALYSIS

4.1. Private Party Access to DMH Records

As discussed above, there is support in both Massachusetts statutory and regulatory law for disclosure of patient records at DMH institutions to specific individuals or groups after a close review of the balance between a patient's privacy rights and the public interest in disclosure.

In this balancing act, courts tend to recognize that most patient record disclosure laws in Massachusetts intended to create meaningful protections for records of patients in DMH institutions. As such, to overcome a starting point favoring confidentiality, advocates for disclosure will have to find countervailing compelling interests. A decision by a DMH Commissioner on whether disclosure is in the patient's best interest is likely to carry substantial weight on the balance. Should SCSI obtain that consent from the Commissioner, access is all but guaranteed.

Here, SCSI would have a persuasive argument that its statutory need to "[r]eview existing records . . . related to the network of current and former institutions" is a sufficient countervailing and compelling interest that, in a balance of interests, justifies limited levels of disclosure. As the Determination recognizes, SCSI's work is able to provide deceased DMH patients with "dignity and respect," even where it publicly reveals the names of the patients. Indeed, Massachusetts regulations already explicitly recognize that disclosure is expected to be appropriate for certain statutorily established commissions and their duties in ways that parallel SCSI's establishment. *See* 104 Mass. Code Regs. 27.16.09 (e) (establishing approval for disclosure to the Mental Health Legal Advisors Committee and the Disabled Persons Protection Commission). Researchers, in similar fashion, may find even stronger support in arguments favoring disclosure in the regulations that explicitly grant their access wherever they meet IRB's requirements. *See* 104 Mass. Code Regs. 27.16.09, 28.09.04, 31.01–04.

From the perspective of patients' family members, however, the compelling interests are not as clear. Unlike state commissions and researchers, family members cannot point to direct or parallel text in Massachusetts statutes and regulations for clear support for their access to patient records. Aside from judicial disputes in the realm of family and estate law, family members will need to establish that their own access provides deceased patients with a level of "respect and dignity." But unlike SCSI's blanket access request in the Determination, requests by family members of patients would likely be more fact-intensive to determine what is in a particular patient's interests. As the court's decision in Doe demonstrates, a patient's "best interest" is not presumed in a family member's request, and either Commissioner or patient

approval (or both) is generally required even in circumstances (like an attorney-client relationship) that would otherwise justify disclosure. *See* 372 Mass. 534 (1977).

That said, for all parties involved, their arguments may be strengthened under certain circumstances where the patient interest in privacy may not be as acute. Specifically, a stronger argument may exist where patients have been deceased for a more extended period of time. Such an argument would be consistent with existing regulations like HIPPA's "fifty-year" cut off. *See* 45 CFR 160.103 (foregoing certain HIPPA privacy protections for patients deceased for fifty years or more).

4.2. Public Records Access

An alternative route for accessing the patient records is to argue that they are in fact "public," as thus not subject to the restrictions described above. This argument will be particularly persuasive for records that are not covered by specific protection laws (for example, Chapter 123 Section 36), as the government may be able to argue that the existence of specific protections like the ones in Section 36 imply that the same records cannot be considered public.

As discussed above, the current understanding of public records laws creates a distinction between "personnel or medical files or information" and other individualized records. This distinction is critical, as the former category is "absolutely" protected, and records will be inaccessible to the public (they may remain accessible under more restricted disclosures). In practice, government groups are likely to argue as much without judicial review.

Challenging those determinations will be difficult given courts' non-discretionary treatment of individualized medical records. One of SCSI's most available options is to argue that the information in institutionalizations do not qualify as "medical files" where they do not include specific diagnosis (such as when records offer only generic institutionalization information). This would be a novel issue, and such records would fall short of the "intimate details" described by courts in the past. However, that is a challenging argument. Looking to the available "goalposts" of the "medical files" definition, institutionalization records at hospital for a specific class of condition seem far more like the "cursory" recognition that a person has a "bad back" than the more generic statements like "sick day." Additionally, courts will likely still recognize "a strong public policy in Massachusetts that favors confidentiality as to medical data." *Globe Newspaper Co.*, 404 Mass. at 135.

Although there is reason to believe that the distinction is no longer applicable (discussed above), that argument has not yet been reviewed by courts and is

unlikely to persuade government officials before judicial review. Should that argument eventually succeed, the records will be subjected to the same balancing test that is currently applicable to the latter category. Because of the two-category distinction, however, there is no precedent on how courts evaluate the balancing test for individualized medical records and, as discussed, courts tend to favor non-disclosure of records.

5. RECOMMENDATIONS

As discussed in Part 2, SCSI is also expected to "[d]esign a framework for public recognition of the commonwealth's guardianship of residents with disabilities throughout history." Insofar disclosures of patient records (accounting for patients' privacy interests) furthers that goal, this section provides recommendations to better support ability of the commission, researchers, and family members to seek access to records from patients in DMH institutions. Its primary goal, also recognized in Part 2, is to "fill the gap" of the statute's mandate lacking clear power to the agencies in accessing patient data.

5.1. Commissioner's Approval

5.1.1. For SCSI

All entities seeking access to patient health data would evidently benefit from a decision parallel to the Determination. As established above, state law provides exceptions for the confidentiality of patient records where disclosure is in the "best interest" of the patient. In making that decision, courts and administrators must give substantial deference to the decision of the Commissioner.

This route is particularly available to state institutions and established researchers like SCSI, as state law directly mandates research by the Commission that would be highly likely to implicate sealed records. Researchers are also likely to be able to adjust to the procedural requirements established by DMH with regards to confidentiality.

This route is likely to be one of the procedurally simpler options, as it relies on the DMH Commissioner's discretion. It is unclear, however, how fine-grained decisions like the Determination must be, and whether the Commissioner will be required to issue a decision for every hospital, or if the Commissioner may issue a blanket approval for SCSI's access.

Thus, SCSI, CDDER, and like-positioned researchers should seek Commissioner "best interest determinations" as a first measure to access, and to seek guidance from DMH as to whether they may request access "in bulk."

5.1.2. For Family Members

Family members, however, will face greater difficulties. First, family members of patients may face difficulties in meeting DMH's requirements to assess a "best interest" determination. Such an argument would like build on the Determination's references to "dignity and respect" by connecting the patients to their families, but it is unclear how family members are able to demonstrate that their access will lead to the deceased patient's "dignity and respect."

Second, family members may also struggle to meet DMH's procedural requirements. It is not clear how family members are expected to request a "best interest determination" from the department, and what "appropriate confidentiality" measures family members can provide that will parallel SCSI's confidentiality agreements.

Additionally, it is not clear that DMH is able to serve individualized requests from family members. As recognized in the Determination, entities like the Foxborough State Hospital do not have clear identification procedures, and part of SCSI's task with their data access is to "identify[] the names of patients buried in the Foxborough cemeteries." Where patient records are categorized only by number and not patient identity, it may not be feasible for DMH to grant access to a specific patient's records.

Thus, while family members should also attempt to seek DMH "best interest determinations," they should do so with arguments framed around the deceased patient's interest and with further requests for DMH guidance on the procedural requirements to do so and on-going efforts that will increase accessibility to relevant records.

5.2. Improving Access Through Regulations

As discussed above, Massachusetts has in the past passed regulations allowing for certain accesses to be in the "best interest" of DMH patients. Among them, regulators have explicitly listed "persons conducting an investigation involving the patient" and "persons engaged in research if such access is approved by [DMH]." SCSI could advocate for a similar regulation that explicitly adds the Commission and its partners to the list of permitted exceptions. This effort, if successful, would remove the need for Commissioner evaluation of individual access requests, as it would build on existing accesses by past investigative bodies similarly situated, and make SCSI access presumptively in the best interest of patients.

It is important to note, however, that the exceptions listed come with accompanying requirements in other regulations. Access by investigators is governed by 104 Mass. Code Regs. 32 and access by researchers is governed by

104 Mass. Code Regs. 31. While regulators could add a provision for access by SCSI, a chapter of regulations governing that access, similar to that of Chapters 31 and 32, may be required. Such a regulation could, for instance, build upon SCSI and CDDER's confidentiality agreements it used in the Determination for the Foxborough State Hospital.

Unlike SCSI, however, patients' family members, do not have a parallel regulation to build upon. As such, patients' family members will likely face greater challenges in seeking patient access through regulations.

5.3. Improving Access Through Legislative Reform

To the extent SCSI and Section 36 create a conflict, a statue by the State legislature could resolve it and explicitly establish access SCSI's to the necessary DMH patient data. Such a statute could be based on existing laws. For instance, regulations in 104 Mass. Code Regs. 27 grant access to the Disabled Persons Protection Commission ("DPPC"), reading it as required by Mass. Gen. Laws ch. 19C, § 10. That statute accomplishes multiple purposes, including outlining certain obligations DPPC has and resolving conflicts between DPPC's record access and other sources of confidentiality like applicable privileges.

Legislative reform could be part of a broader attempt to implement greater procedures and powers for SCSI in the future, should the Commission's duty be extended beyond its current mandate. Due to the complexity in advocating for new statutes, researchers and patients' family members may be better served by the alternative options outlined above.

5.4. Improving Access Through Litigation

The interpretation of Section 36 and the Massachusetts public records laws could be resolved by a court. Regarding Section 36, SCSI could attempt to build on cases like *O'Brien* that balance the general prohibition on disclosure against the benefits of disclosure. Regarding the public records law, SCSI could argue that after the 2020 amendments "medical files" are no longer absolutely exempt from disclosure. Any denial of a public records request can be reviewed by the Massachusetts Superior Court, however, given the existing precedent, a significant change in the law might require review by an appellate court or even the Massachusetts Supreme Judicial Court.

Should SCSI pursue litigation, it will face challenges. Evaluating the interaction between Section 36, the public records law, and the privacy interests at stake will be fact-intensive and require discovery. Both theories for access call for balancing tests that require judges to make considerations concerning a subjective determination of the deceased's privacy and an elusive

demonstration of public interest. Expert testimony will likely be required, and deposition of family members and government officials may be warranted. These inquiries are likely to demand substantial investment.

Public records litigation presents a specifically significant issue. Both Section 36 and public record laws require a balance between the costs and benefits of disclosure. To the extend Section 36 allows limit disclosure to SCSI or family members, the privacy cost may be regarded as fairly small. If DMH records are deemed public records, though, the cost of disclosure is much greater. Effectively, the public records inquiry is likely to recognize substantially the same "benefit" to be had from disclosure, while finding a much higher privacy "cost." Thus, especially for disclosures limited to researchers and family members, Section 36 litigation appears to be far more promising than litigating public records requests. Specifically, a request under Section 36 from family members will be far more persuasive than that under the public records laws, as public records requests are evaluated differently based on who is seeking disclosure.

Ultimately, SCSI may not be able to establish sufficient progress through litigation because of the financial costs and time commitment. Thus, while litigation remains an available opportunity, it is not advisable for SCSI's existing needs. The option may seem more attractive should the Commission be afforded additional resources.

6. CONCLUSION

In conclusion, there are few laws and regulations that directly govern access of third parties to DMH patient data. Even fewer are judicial cases adjudicating similar kinds of access. The cases that do exist establish that public records requests are effectively a non-starter without litigation and Section 36 cases provide at best general perspectives courts are expected to consider.

That said, both SCSI and its research partners have strong arguments for accessing DMH patient information. Although no law clearly mandates their access, statutory and regulatory text provides sufficient support for a persuasive argument to both the DMH Commissioner and a court to establish that access is either implicated by or supported by existing law. Patient's family members, however, are unlikely to be granted access to records outside of judicial proceedings.

In terms of advocacy, all groups would benefit from advocating to DMH Commissioners that disclosure is in the patients' best interests, although patients' family members will have to seek further guidance and may need to wait until individualized access is more feasible. SCSI and researchers may also try to build upon existing regulations to establish their access, and

statutory amendments remain available should the legislature seek to renew SCSI's obligations into the future. Given our existing understandings of feasibility, SCSI is likely best served in advocating to the DMH Commissioner in the shorter term, and to the state legislature in the medium-to-longer term.

Appendix 6: Cemetery Profiles

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Boston State Hospital

Name of Cemetery: **Mount Hope Cemetery**
Location of Cemetery: 355 Walk Hill St., Boston
Institution open date: 1839 **Institution closing date:** 1979

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: 1839 **Closing Date/last burial:** To be determined - Research in Progress

Estimated number of burials: Unknown

Current Owner of Property: The City of Boston

Current Manager of the Property: The City of Boston Cemetery Division

Description of the Cemetery:

The City of Boston offered public burial space for the poor at Mount Hope Cemetery. Five acres were reserved for this use and the space was designated the City Cemetery. The public burial space was differentiated from the rest of the cemetery by a pair of square granite posts and a wooden fence, a separate entrance on Canterbury Street, and no headstones or monuments on the grounds.

Signage:

New section and street signs were installed at Mount Hope Cemetery in Boston, MA in September 2024.

Roadway/walkway:

There are both roadways and walkways.

Gate or other way to prevent access?

There is a gate at the main entrance on Walk Hill Street, on the cemetery's northern boundary.

Is there Evidence of Maintenance?

The Cemetery is maintained by the Cemetery Division. Different community groups have made efforts to address conditions at Mt Hope Cemetery overtime.

Is there a Memorial?

Over the years, special monuments have been erected to honor special groups such as veterans from the Grand Army of the Republic to the present, Elks, Boston Police, and the Odd Fellows. There is no memorial for the former patients that were buried there.

How are the graves marked?

A large expanse of land at the rear of the cemetery contains the unmarked graves of the City's indigent.

Are records available that contain person's name, cemetery section, plot #?

Available at the City of Boston Cemetery Division.

Evidence of Vandalism:

In March 2019, several memorials at Mount Hope Cemetery were vandalized, including the Boston Police Relief Association Memorial.

Efforts to Address Cemetery Conditions Over Time:

Many different groups have made efforts to improve conditions of the cemetery:

Chinese Historical Society of New England (CHSNE) Restoration Project
In 1989, community leaders initiated efforts to restore the burial grounds, leading to the founding of the Chinese Historical Society of New England (CHSNE) in 1992. CHSNE partnered with the Boston Parks and Recreation Department for ongoing maintenance, including tombstone cleanup and resetting, with support from UMass/Boston students and the Coalition of Asian Pacific American Youth (CAPAY). In 1998, CHSNE

created the Mount Hope Cemetery Chinese Immigrant Memorial Committee to secure funding for a new memorial, resulting in a $120,000 grant from the City of Boston's Edward Ingersoll Browne Fund. The memorial design, by Twinspine Architects, was unveiled in September 2000, with additional funding from various organizations. Construction began in 2006 with Ng Brothers Construction, Inc., and the Chinese Immigrant Memorial was dedicated in March 2007. The Boston Parks and Recreation Department plans to enhance the area with landscaping, while ongoing projects focus on cleaning and photographing tombstones and creating a database that links burial records in English with Chinese inscriptions. In 2007, CAPAY and CHSNE received a $10,000 "Save Our History" grant from The History Channel for their project "Honoring Our Pioneer Ancestors," aimed at preserving community history and developing a high school curriculum about the memorial and cemetery's significance.

Expansion Plan

The City of Boston Public Works Department hired BSC Group to design a master plan for a two-acre expansion of the cemetery. The plan included installing lawn crypts, adding ornamental fencing and masonry improvements at the entrance and managing soil spoils to allow for future burials.

Headstone Cleaning and Repair

The Sons of The American Legion and other civic groups have cleaned and repaired headstones and placed flags on the graves of veterans.

Unmarked Graves:

A large expanse of land at the rear of the cemetery contains the unmarked graves of the City's indigent.

Where are Records Maintained?

In 1980 the Cemetery Division created a microfiche of the records held by the Cemetery Division which is held by the City of Boston Archives. The collection of records filmed includes interment cards, lot index cards and lot plan cards. The interment cards are filed alphabetically and may include name, lot #, location, proprietor, date of interment, age, date of death, place of death, cause of death and undertaker. The 19th century cards do not provide cause of death. The Lot plans and index cards provide information on the owner of the lot and on the physical arrangement of the lot. The original cards remain in the custody of the Cemetery Division. This series also includes microfilm index sheets that were compiled at the time of filming. The index sheets include contents of film with index point.

Links:

https://www.boston.gov/cemeteries/mount-hope-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Bridgewater State Hospital

Name of Cemetery: **Prison Cemetery or State Farm Cemetery**

Location of Cemetery: Conant St., Bridgewater

Institution open date: 1855 **Institution closing date:** Still in operation

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1939 **Closing Date/last burial:** 1988

Estimated number of burials: 347

Current Owner of Property: Commonwealth of MA

Current Manager of the Property: Department of Corrections

Description of the Cemetery:

Located across from 625 Conant St in Bridgewater is a cemetery containing 325 markers on 3/4 acres. There are 227 names of former State Hospital or Defective Delinquents patients listed in the cemetery register held at the Massachusetts State Archive. Burials took place between 1939 and 1982.

Signage:

There is no signage present.

Roadway/walkway:

There is no walkway or roadway.

Gate or other way to prevent access?

There is no gate. The cemetery is accessible from Conant St.

Is there Evidence of Maintenance?

There appears to be periodic maintenance of the cemetery.

Is there a Memorial?

There is a large granite cross on the site.

How are the graves marked?

Graves are marked with a concrete block with a number. Many of the concrete blocks have sunk into the ground or have started to disintegrate.

Are records available that contain person's name, cemetery section, plot #?

There are 227 names of former State Hospital or Defective Delinquents patients listed in the cemetery register held at the Massachusetts State Archive. Burials took place between 1939 and 1982.

Evidence of Vandalism:

There is no evidence of vandalism, but there is damage to the stones closer to Conant St. There is a basketball net on the street adjacent to the cemetery.

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

The State Archives has 1 volume in partial box arranged chronologically. Register documents deaths for all Bridgewater institutions, from the latter days of the State Farm (including almshouse, prison, and State Hospital) to the Massachusetts Correctional Institution, including the addiction center, until the time that the State Hospital separated as an independent institution, and a few years before MCI Bridgewater ceased to exist as an administrative entity. Entries include name of deceased, institution number, dates of death and burial, and disposition of body, including funeral home removing the body and officer in charge. Later entries

also give religion, date of birth, age, cause of death, and officiant at funeral. Grave number given if burial was onsite at the Morgue Cemetery (1933-1939) or the Conant Street Cemetery (1939-1984).

Links:

https://www.findagrave.com/cemetery/2406076/state-farm-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Bridgewater State Hospital

Name of Cemetery: **The Morgue Cemetery**

Location of Cemetery: Prison Complex behind the Chapel on the Hospital grounds

Institution open date: 1855 **Institution closing date:** Still in operation

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1853 **Closing Date/last burial:** 1988

Estimated number of burials: 50

Current Owner of Property: Commonwealth of MA

Current Manager of the Property: Department of Corrections

Description of the Cemetery:

To be determined - Research in Progress

Signage:

To be determined - Research in Progress

Roadway/walkway:

To be determined - Research in Progress

Gate or other way to prevent access?

To be determined - Research in Progress

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

The Morgue Cemetery has no markers.

Are records available that contain person's name, cemetery section, plot #?

There are 28 names of former State Hospital patients listed in the cemetery register held at the Massachusetts State Archive. Burials took place between 1932 and 1939.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

In 1981 13 human skulls and skeletons were found at a construction site on the grounds of Bridgewater State Hospital for the Criminally Insane. The bodies were found near a mausoleum, which dates back to 1898, and were on the grounds of a farm. The bodies were apparently stored there in winter when the ground was frozen and buried in the spring. Reportedly there is no record of a cemetery existing at that location.

Where are Records Maintained?

The State Archives has 1 volume in a partial box arranged chronologically. Register documents deaths for all Bridgewater institutions, from the latter days of the State Farm (including almshouse, prison, and State Hospital) to the Massachusetts Correctional Institution, including the addiction center, until the time that the State Hospital separated as an independent institution, and a few years before MCI Bridgewater ceased to exist as an administrative entity. Entries include name of deceased, institution number, dates of death and burial, and disposition of body, including funeral home removing the body and officer in charge. Later entries also give religion, date of birth, age, cause of death, and officiant at funeral. Grave number given if burial was onsite at the Morgue Cemetery (1933-1939) or the Conant Street Cemetery (1939-1984).

Links:

None

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Danvers State Hospital

Name of Cemetery: **Danvers State Hospital Main Cemetery**

Location of Cemetery: 1101 Kirkbride Dr., Danvers

Institution open date: 1878 **Institution closing date:** 1992

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1879 **Closing Date/last burial:** 1992

Estimated number of burials: 677

Current Owner of Property: The DSF Group owns the Danvers State Hospital property in Massachusetts, which includes the cemetery.

Current Manager of the Property: The DSF Group

Description of the Cemetery:

Located at the Danvers State Hospital is a cemetery containing the graves of patients who died at the hospital. The people buried there are believed to be patients who didn't have any relatives to claim their body. The oldest graves are five graves from 1878, when the hospital first opened.

Signage

A large granite stone sits at the entrance of the cemetery.

Roadway/walkway:

There is a dirt walk way leading down to the main cemetery.

Gate or other way to prevent access?

No gate to prevent access

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

The entrance to the main cemetery is located down a steep path on the southeast side of the former state hospital property and is marked by a large boulder etched with the words "Danvers State Hospital Cemetery: The Echoes They Left Behind". The wall of remembrance lists the names of the patients who are known to be buried in one of the two cemeteries but the exact grave they are buried in couldn't be determined. There is a memorial area near the residential section of the property that provides a seating area and a granite memorial that includes historical information about Danvers State Hospital.

How are the graves marked?

The main cemetery has 677 graves, with 542 of those patients identified and 354 of their graves have been identified and located.

Are records available that contain person's name, cemetery section, plot #?

The burial record of those buried between 1878 and 1929 has been permanently lost. The records are incomplete, and it is not possible to determine the exact burial place. The MA State Archives holds the Death Registers for the period covering 1909-1950.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

In February of 1998, Pat Deegan started the Danvers State Memorial Committee, an advocacy group composed of former patients and locals, to identify the patients buried in the graves and help preserve the two cemeteries. One of the group's slogans became, "It could have been me buried in there." Soon after, the Department of Mental Health offered the group $5,000 towards clearing the cemetery of overgrowth, which was

clumsily done with a bulldozer, much to the group's dismay. The group continued to plan, design and raise awareness for the cemetery and by the summer of 2000 had been awarded $44,000 by the state to clear and maintain the two cemeteries for a three-year period. In 2001, the committee had a series of meetings with the Department of Mental Health Commissioner, Marylou Sudders, during which they argued that although it used to be common practice to mark a mental hospital patient's grave with a number instead of their name in order to protect their privacy, they believed this practice was actually disrespectful and the patients should be identified by name, according to the group's January 2002 issue of their newsletter, titled It's About Time. Fortunately, Sudders agreed and supported the plan to put the patient's names on their graves. By 2002, the group succeeded in discovering the names of more than three-quarters of the patients buried in the two cemeteries, identified and located the majority of their graves in the main cemetery and erected three granite markers with bronze plaques as a "wall of remembrance" at the main cemetery.

Unmarked Graves:

Contrary to news reports about the property, there are no unmarked graves in the two cemeteries, only graves that are marked by numbers rather than names because it is not known exactly who is buried in that particular grave.

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://historyofmassachusetts.org/danvers-state-hospital-cemetery/
https://www.danversstatehospital.org/cemeteries
https://www.findagrave.com/cemetery/2186316/danvers-state-hospital-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Danvers State Hospital

Name of Cemetery: **Middleton Colony Cemetery**

Location of Cemetery: Corner of Gregory St. and Middleton Rd., Middleton. A path leads to the cemetery which is in the middle of the field and is surrounded by a fence in a cluster of trees.

Institution open date: 1878 **Institution closing date:** 1992

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1903 **Closing Date/last burial:** 1992

Estimated number of burials: 93

Current Owner of Property: To be determined - Research in Progress

Current Manager of the Property: To be determined - Research in Progress

Description of the Cemetery:

The Middleton Colony was an addition built for long term female patients, and a second cemetery was established. The cemetery is in a cornfield rented from the state of Massachusetts by a local farm. To get to the cemetery, it is necessary to walk through the cornfield. The cemetery is not visible in the summer, but it is easily visible after the harvest. There is no parking. The cornfield is located next to a juvenile detention center, and it is marked "Authorized vehicles only".

Signage:

There is no signage present that identifies the cemetery.

Roadway/walkway:

To be determined - Research in Progress

Gate or other way to prevent access?

There does not appear to be a gate or other way to prevent access.

Is there Evidence of Maintenance?

The cemetery is in a cornfield and is not visible during the summer months but is visible after the fall harvest.

Is there a Memorial?

There is a commemorative plaque which lists 83 names of those interred there, while there are 92 markers. There is room near the bottom to add more names if/when they become known.

How are the graves marked?

The smaller cemetery has 92 numbered grave markers, with 8 of those patients identified, but it could not be determined which graves they are buried in.

Are records available that contain person's name, cemetery section, plot #?

The burial record of those buried between 1878 and 1929 has been permanently lost. The MA State Archives holds the Death Registers for the period covering 1909-1950.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

Contrary to news reports about the property, there are no unmarked graves in the two cemeteries, only graves that are marked by numbers rather than names because it is not known exactly who is buried in that particular grave.

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://www.findagrave.com/cemetery/2676745/middleton-colony-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Foxborough State Hospital

Name of Cemetery: **Rock Hill Cemetery**

Location of Cemetery: South St., Foxboro

Institution open date: 1889 **Institution closing date:** 1975

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: 1906 **Closing Date/last burial:** 1933

Estimated number of burials: 243

Current Owner of Property: Foxborough Cemetery Corporation

Current Manager of the Property: Foxborough Cemetery Corporation

Description of the Cemetery:

Some patients of the Massachusetts Hospital for Dipsomaniacs and Inebriates or its successor, the Foxborough State Hospital, did not have known family or family able to afford a burial upon their death. Subsequently, between 1906 and 1915, the Commonwealth of Massachusetts purchased six multi-grave lots on this hillside of Rock Hill Cemetery with the intent of providing a final resting place for these patients. Although there are no grave markers of any kind present, there are 125 patients buried within this hillside. Another 118 patients are buried throughout Rock Hill Cemetery, predominantly within separate family plots. In 1933, as needs increased during the Great Depression, the Foxborough State Hospital Cemetery on Cross Street was developed to continue to fulfill this intention.

Signage:

There is a sign at the entrance of the cemetery.

Roadway/walkway:

There are walkways and roads throughout the cemetery.

Gate or other way to prevent access?

To be determined - Research in Progress

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

The 2019 annual report for the Town of Foxborough listed a new historic marker for the State Hospital section of Rock Hill Cemetery in the planning stages.

How are the graves marked?

To be determined - Research in Progress

Are records available that contain person's name, cemetery section, plot #?

To be determined - Research in Progress

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://www.findagrave.com/cemetery/91521/rock-hill-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Foxborough State Hospital

Name of Cemetery: **Foxborough State Hospital Cemetery**

Location of Cemetery: Cross St., Foxboro

Institution open date: 1889 **Institution closing date:** 1975

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1933 **Closing Date/last burial:** late 1960's

Estimated number of burials: 1100

Current Owner of Property: To be determined - Research in Progress

Current Manager of the Property: To be determined - Research in Progress

Description of the Cemetery:

In 1933, as needs increased during the Great Depression, the Foxborough State Hospital Cemetery on Cross Street was opened.

Signage:

There is a Memorial Plaque.

Roadway/walkway:

There is a dirt walkway between the two adjoining cemeteries.

Gate or other way to prevent access?

There is no gate to prevent access.

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

The stones in this cemetery do not have names. They are inscribed with two sets of numbers. The first number indicates the order in which the burial took place. The second number is the DMH client identification number.

Are records available that contain person's name, cemetery section, plot #?

A Cemetery plot does not exist. The SCSI is working with DMH to examine historical records to determine if there is enough information to identify who is buried in the two cemeteries.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

The second cemetery is up a dirt path in a wooded area that was for many years overgrown with dense foliage but was cleared of brush and trees several years ago by local youths as part of an Eagle Scout project.

Unmarked Graves:

There is an anecdotal story of a patient who had been buried alone, because they had some type of "communicable disease." No one knew the identity of this patient, where they were buried, or if it was true at all. More than likely the disease was smallpox because in 1903, there was a look-out notice posted for an escapee from the hospital who had been staying in an annex that was under quarantine for smallpox.

Where are Records Maintained?

The SCSI is working with DMH to examine historical records that are held at Taunton State Hospital.

Links:

https://www.findagrave.com/cemetery/2380722/foxborough-state-hospital-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Gardner State Hospital

Name of Cemetery: **East Gardner Colony – State Hospital Cemetery**

Location of Cemetery: May St., Gardner

Institution open date: 1902 **Institution closing date:** 1976

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1902 **Closing Date/last burial:** 1976

Estimated number of burials: Confirmed list of 132 people but there may be as many as 600 people buried there.

Current Owner of Property: Commonwealth of MA

Current Manager of the Property: North Central Correctional Institution

Description of the Cemetery:

A hidden field, set back from a seldom used and badly rutted road. The Cemetery is also used by the Department of Corrections where patient inmates are buried.

Signage:

To be determined - Research in Progress

Roadway/walkway:

The cemetery is accessed by a badly rutted road.

Gate or other way to prevent access?

To be determined - Research in Progress

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

A large crucifix with the words “In Memory of” atop two framed pegboards, which list the first initial and last name of each individual buried in the graveyard. Next to the name is a tag number which corresponds to the number on each plastic grave cross.

How are the graves marked?

Plastic crosses mark each grave.

Are records available that contain person’s name, cemetery section, plot #?

To be determined - Research in Progress

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://www.findagrave.com/cemetery/2450255/gardner-state-hospital-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Glavin Developmental Center

Name of Cemetery: **Hillside West**

Location of Cemetery: 38 Hillside Dr., Shrewsbury

Institution open date: 1964 **Institution closing date:** 2013

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1925 **Closing Date/last burial:** Mid 1980's

Estimated number of burials: 214

Current Owner of Property: The Town of Shrewsbury

Current Manager of the Property: Dept. of Developmental Services

Description of the Cemetery:

This is one of two cemeteries associated with Worcester State Hospital and Glavin Developmental Center. The other is Hillside East Cemetery. This cemetery is the smaller of the two cemeteries.

Signage:

The name of the cemetery is carved into a granite pillar adjacent to the front gate at the entrance of the cemetery.

Roadway/walkway:

There is a walkway leading to the cemetery.

Gate or other way to prevent access?

There is a gate and a simple stone wall around the cemetery.

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

All 217 former patients interred here have proper headstones which list the person's name and dates of birth and death.

Are records available that contain person's name, cemetery section, plot #?

There are records available and allowed for headstones to be placed at the grave for each resident of Glavin Developmental Center buried there.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over time

The Department of Developmental Services initiated a renovation project and Hillside Cemetery West was rededicated in 1999.

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

Listing of names can be found here. (Unconfirmed):
https://www.nekg-vt.com/Shrewsbury/Hillside/hillsidelist.htm

Links:

https://www.findagrave.com/cemetery/2364523/hillside-west-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Grafton State Hospital

Name of Cemetery: **Hillcrest Cemetery**

Location of Cemetery: Centech Blvd., Shrewsbury

Institution open date: 1901 **Institution closing date:** 1973

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1917 **Closing Date/last burial:** 1973

Estimated number of burials: 1041

Current Owner of Property: To be determined - Research in Progress

Current Manager of the Property: The cemetery is located in Shrewsbury MA. It is unclear who is responsible for the upkeep of the cemetery.

Description of the Cemetery:

The cemetery, several acres in size, is now accessible to visitors from Centech Boulevard, where there is a sign and walkway. Until recently, the cemetery was difficult to see from the road, but a large swath of woodland has been thinned out, making the area visible. A massive stone water tower identifies the location.1041 patients of the former Grafton State Hospital, fourteen of them veterans, were buried here (all were unclaimed by relatives). A white obelisk in the center is joined to a bronze marker, listing the veteran's names and grave numbers. They are now also identified by a United States flag marker. Graves are marked with a 6X12 inch granite marker. Only a few of those buried within have actual names and date.

Signage:

There is a sign present on the grounds of the cemetery.

Roadway/walkway:

There is a walkway leading to the cemetery from Centech Blvd.

Gate or other way to prevent access?

To be determined - Research in Progress

Is there Evidence of Maintenance?

The town of Grafton DPW and private citizens will periodically provide maintenance. There are a number of volunteers who periodically maintain some of the graves.

Is there a Memorial?

There is a memorial plaque listing the veterans buried in the cemetery. A permanent directory listing all the names and gravestone numbers of those buried in the cemetery is being planned for installation at the site. Three who were originally buried there have been removed to another burial site by their families.

How are the graves marked?

There is a number on a 5x5x10 inch block set in rows. There are a handful of markers with names.

Are records available that contain person's name, cemetery section, plot #?

Unofficial records are maintained at the Town Clerk's office.

Evidence of Vandalism:

According to the Grafton Cemetery Department, there is vandalism that occurs on the water tower.

Efforts to Address Cemetery Conditions Over Time:

In 2008 the Hospital Cemetery was restored by students and staff of the Home Builders Institute program at the Grafton Job Corps Career Academy. About 50 students cleaned up debris from fallen tree trunks, limbs, yard waste and years of neglect. The students found approximately 1,000 graves.

Unmarked Graves:

The graves are not unmarked but there is no way to determine who is buried in each plot.

Where are Records Maintained?

Unofficial records are maintained at the Grafton Town Clerk's office.

Links:

https://www.telegram.com/story/news/local/east-valley/2009/05/28/job-corps-spruces-up-cemetery/51981418007/
https://www.findagrave.com/cemetery/91085/grafton-state-hospital-memorial-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Hogan Regional Center

Name of Cemetery: **No Cemetery reported**

Location of Cemetery:

Institution open date: 1967 **Institution closing date:** still in operation

Institutional or Public/Municipal:

Cemetery Open date/first burial: **Closing Date/last burial:**

Estimated number of burials:

Current Owner of Property:

Current Manager of the Property:

Description of the Cemetery

Signage

Roadway/walkway:

Gate or other way to prevent access?

Is there Evidence of Maintenance?

Is there a Memorial?

How are the graves marked?

Are records available that contain person's name, cemetery section, plot #?

Evidence of Vandalism:

Efforts to Address Cemetery Conditions Over time

Unmarked Graves:

Where are Records Maintained?

Links:

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Medfield State Hospital

Name of Cemetery: **Medfield State Hospital Cemetery**

Location of Cemetery: Medfield State Hospital Cemetery is located on state land off Route 27 just before the Sherborn town line and the Charles River.

Institution open date: 1896 **Institution closing date:** 2003

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1918 **Closing Date/last burial:** 1988

Estimated number of burials: 850

Current Owner of Property: The Town of Medfield purchased the State Hospital Cemetery from DCAMM in 2014.

Current Manager of the Property: The Town of Medfield

Description of the Cemetery:

The town of Medfield pressured the state to build their own cemetery for the State Hospital during the height of the Influenza Epidemic in 1918. The current state hospital cemetery is located at the north end of the town off of Route 27, overlooking the Charles River.

Signage:

There is signage present.

Roadway/walkway:

The cemetery is not accessible by car. There is a short walkway leading up to the cemetery gate.

Gate or other way to prevent access?

There is a gate.

Is there Evidence of Maintenance?

The cemetery has seasonal maintenance.

Is there a Memorial?

There is a memorial on a granite stone outside of the cemetery that reads “Remember us for we too have lived, loved and laughed.”

How are the graves marked?

Each grave is marked with a name, date of birth and death.

Are records available that contain person’s name, cemetery section, plot #?

Records are available at the Town of Medfield Cemetery Commission.

Evidence of Vandalism:

No evidence of vandalism.

Efforts to Address Cemetery Conditions Over Time:

In 2005, the Medfield State Hospital Cemetery Restoration Committee was formed. Boy Scouts undertook Eagle Scout projects to clean out the brush and debris. The Restoration Committee brought awareness of the cemetery’s condition and with appropriated monies, granite stone markers were placed on each of the hospital grave sites. Research was done and the people’s names, along with their birth and death dates, were placed on the granite markers. A contest was held to come up with an appropriate quote to be used on a stone marker to be placed at the cemetery’s entrance. The political science students at Medfield High School took part and came up with a variety of quotes. The one selected read: “Remember us for we too have lived, loved and laughed.” That is now located on the impressive granite stone at the entrance to the cemetery.

Unmarked Graves:

Each grave is marked.

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://www.findagrave.com/cemetery/91221/medfield-state-hospital-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Medfield State Hospital

Name of Cemetery: **Vine Lake Cemetery**

Location of Cemetery: Vine Lake Cemetery is the cemetery for the Town of Medfield. It is located in the center of town.

Institution open date: 1896 **Institution closing date:** 2003

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: 1896 **Closing Date/last burial:** 1918

Estimated number of burials: 544

Current Owner of Property: Town of Medfield

Current Manager of the Property: Town of Medfield

Description of the Cemetery:

When Medfield State Hospital opened in May of 1896, those residents who died at the hospital and who did not have another burial location were buried in Medfield's Vine Lake Cemetery on the knoll across from Cemetery Pond. Today, that knoll is the resting place for over 500 hospital residents who died between the years 1896-1918. Hospital burials generally stopped in Vine Lake Cemetery in 1918 during the Influenza Epidemic.

Signage:

There is signage present.

Roadway/walkway:

There are walkways and roadways throughout the cemetery.

Gate or other way to prevent access?

The roadways have a simple chain to prevent vehicle access.

Is there Evidence of Maintenance?

Vine Lake Cemetery is regularly maintained.

Is there a Memorial?

The town of Medfield erected a memorial for the patients buried at Vine Lake Cemetery.

How are the graves marked?

The graves are not marked.

Are records available that contain person's name, cemetery section, plot #?

The Town of Medfield maintains the records for who was buried in the cemetery.

Evidence of Vandalism:

There is no evidence of vandalism.

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

There is an online listing of patient names, DOB and DOD buried at Vine Lake Cemetery on the Medfield Historical Society Website. https://vinelakecemetery.medfieldhistoricalsociety.org/research/burial-records/

Links:

https://www.findagrave.com/cemetery/91808/vine-lake-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Metropolitan State Hospital and Fernald Developmental Center

Name of Cemetery: **Mount Feake Cemetery**

Location of Cemetery: 302 Prospect St., Waltham MA

Institution open date: 1848 **Institution closing date:** 2014

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: To be determined **Closing Date/last burial:** To be determined - Research in Progress

Estimated number of burials: To be determined - Research in Progress

Current Owner of Property: City of Waltham

Current Manager of the Property: Waltham Cemetery Commission

Description of the Cemetery:

The history of Mount Feake Cemetery dates to 1856. When the patients of both Fernald and Metropolitan State Hospital were re-classified as residents of the city of Waltham, then-Mayor Arthur Clark agreed to give the patients a right to be buried in the town's Mt. Feake Cemetery.

Signage:

There is a sign at the entrance of the cemetery.

Roadway/walkway:

This public cemetery has walkways and roadways. This cemetery has a wheelchair accessible entrance.

Gate or other way to prevent access?

The cemetery is surrounded by a stone wall and there is a gate at the entrance.

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

There is not a memorial.

How are the graves marked?

To be determined - Research in Progress

Are records available that contain person's name, cemetery section, plot #?

To be determined - Research in Progress

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://www.findagrave.com/cemetery/91246/mount-feake-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Metropolitan State Hospital and Fernald Developmental Center

Name of Cemetery: **Metropolitan State Hospital Cemetery Also known as Metfern Cemetery**

Location of Cemetery: Beaverbrook North Reservation, along Trapelo Rd behind Mackerel Hill in North Waltham.

Institution open date: 1930 **Institution closing date:** 1992

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1947 **Closing Date/last burial:** 1986

Estimated number of burials: 296

Current Owner of Property: Commonwealth of MA

Current Manager of the Property: Department of Conservation and Recreation

Description of the Cemetery:

The Metfern Cemetery contains the remains of approximately 300 people who resided at the Former Fernald State School and the former Metropolitan state Hospital. The MetFern Cemetery had burials between 1947 and 1979. The cemetery is situated near where Met State's pathology lab was located at the foot of a steep ledge. The area was marshy, with a small depression that often turned into a pond during the spring season. It was colloquially known as "MetFern Cemetery," as patients from both institutions were buried here throughout the years. Two sections exist at the cemetery, categorized by the religion of the deceased. The only two options were Catholic or Protestant. The caskets were simple pine boxes made at the wood shop and burials occurred with little ceremony. With its high water table, graves would occasionally become inundated with groundwater shortly after being dug; sometimes they weren't even pumped out before the body was laid to rest. A small concrete marker engraved with the patient's number served as a headstone.
MetFern's last official burial took place in 1979, except for a single instance in 1986 when two preserved human heads were discovered in Fernald's pathology lab and buried in the cemetery.

Signage:

There is a sign from DCR marking the cemetery.

Roadway/walkway:

The cemetery is difficult to access due to limited walkways and the steep incline.

Gate or other way to prevent access?

There is a stone wall around the cemetery.

Is there Evidence of Maintenance?

Volunteers provide periodic maintenance.

Is there a Memorial?

There is not a memorial at the Cemetery.

How are the graves marked?

The vast majority of these interred are identified on monuments only with a letter ("C" or "P") followed by a number. "C" indicated Catholic, and "P" indicated Protestant.

Are records available that contain person's name, cemetery section, plot #?

The MA State Archives holds the cemetery registers for Fernald Developmental Center for the period covering 1947-1979.

Evidence of Vandalism:

To be determined - Research in Progress

Massachusetts State Institution Burial Grounds Profiles

Efforts to Address Cemetery Conditions Over Time:

In 2019 Community Preservation Act funds were awarded for the restoration of the cemetery. Proposed funds would be used to locate, reset and repair the cemetery monuments, repoint the adjacent stone walls, conduct an inventory of the individuals interred, remove debris and erect historically accurate signage with the interred full names. Requested funds amounted to $80,000.

Unmarked Graves:

It is unclear where Fernald patients were buried prior to 1947, though it is likely they were interred in or near Mt. Feake Cemetery in Waltham. Funeral expenses do not appear in Fernald's Annual Reports until the year 1902.

Where are Records Maintained?

Records are maintained at the Massachusetts State Archives.

Links:

None

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Monson Developmental Center

Name of Cemetery: **New Hope Cemetery**

Location of Cemetery: 224 State Ave., Monson

Institution open date: 1898 **Institution closing date:** 2012

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1898 **Closing Date/last burial:** 1993

Estimated number of burials: 76

Current Owner of Property: Commonwealth of MA

Current Manager of the Property: DCAMM

Description of the Cemetery:

The New Hope Cemetery is on the grounds of the former Monson State Hospital and contains the graves of a number of former patients of the facility. The hospital eventually came to be known as the Monson Developmental Center until its closure in 2013.

Signage:

There is a sign at the entrance of the cemetery

Roadway/walkway:

To be determined - Research in Progress

Gate or other way to prevent access?

There is an iron gate around the cemetery

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

There are memorial plaques at the entrance of the cemetery that list the names of the people buried in the cemetery and which row they are buried in.

How are the graves marked?

To be determined - Research in Progress

Are records available that contain person's name, cemetery section, plot #?

To be determined - Research in Progress

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://www.findagrave.com/cemetery/2586796/new-hope-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Northampton State Hospital

Name of Cemetery:

Northampton State Hospital Burial Grounds. Also called Hospital Cemetery and Hillside Cemetery

Location of Cemetery: Off Burts Pit Road, Northampton MA

Institution open date: 1856 **Institution closing date:** 1993

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1858 **Closing Date/last burial:** 1921

Estimated number of burials: 181 confirmed and possibly 413 more

Current Owner of Property: The City of Northampton obtained a 99 year lease from the Department of Food and Agriculture and subleased the field to Smith Vocational Agricultural School for training in agriculture.

Current Manager of the Property: Smith Vocational Agricultural School, the land is protected by a permanent restriction for agricultural use, the field is currently used for instruction in haying, which is beneficial for maintenance of the field.

Description of the Cemetery:

The Northampton State Hospital burial ground was in use from the founding of the institution in 1858 until 1921. Patients who died and were not claimed by family or friends for burial elsewhere were buried there. After 1921 patients not claimed for burial by family or friends were listed as "Chapter 113 of general law" or "Chapter 77 of regular law," which were new state laws permitting citizens who die in state hospitals, asylums or prisons to be sent as cadavers to medical schools.

Signage:

There is no signage present.

Roadway/walkway:

The burial ground is accessed by a series of dirt roads that start at Burts Pit Road and extend toward Mill River. The burial ground is an open field surrounded by a dirt road except on the south side, where the field ends in woods.

Gate or other way to prevent access?

There are no gravestones, paths, entrance ways or fences in the field indicating the locations of graves or boundaries of the cemetery.

Is there Evidence of Maintenance?

The burial ground is now a hayfield.

Is there a Memorial?

There is a bench surrounded by two yews. Plaque on one side of bench, "State Hospital Burial Grounds 1858-1921, Rest in Peace"; plaque on other side, "Dedicated in memory of those individuals known and unknown interred on this hillside. Bench erected 1959 by William J. Goggins, Jr Northampton State Hospital. Restored 2002 Northampton Historical Commission".

How are the graves marked?

The markers are no longer visible; the area is used as a hayfield.

Are records available that contain person's name, cemetery section, plot #?

Research by Elizabeth Kroon for the Department of Mental Health (DMH) in June 1997 confirmed the presence of 181 burials on the hospital grounds by cross referencing death records in hospital casebooks with extant mortuary slips, death registers of the City of Northampton and local cemetery records with 413 more possible (disposition "Northampton" or left blank). DMH will not release the names of those interred here. No map or plot book has been found. Records at the hospital of burials and the layout of the cemetery have disappeared. The cemetery's location is verified by the one documentary reference to the burial ground found to date in the institution's records. A November 1933 entry in Superintendent's Reports described what used to be the hospital cemetery as land that needed draining as "land that borders on Mill River and runs up towards the spring in back of the barn."

Massachusetts State Institution Burial Grounds Profiles

Evidence of Vandalism:

As of December 2014, the bench has been sawed into pieces and the plaques have been stolen by vandals

Efforts to Address Cemetery Conditions Over Time:

On October 21, 2017, The Northampton Historical Commission dedicated a new bench in memory to the Northampton State Hospital Burial Ground. The bench overlooks Cemetery Hill.

Unmarked Graves:

Archaeological reconnaissance survey of the site confirmed the location of the burial ground that was previously identified through oral history. Squarish soil deflations were found extending in 2 to 3 fairly straight nearly north-south rows from the woods on the south edge of the field northerly along the top of the hill. Further, very distinctive squarish to rectangular patches of very green ground cover about 1" high were found where the taller straw-colored hay in the rest of the field did not grow. The long axis of the patches of low green vegetation extended roughly east-west, which is the traditional direction for Christian burials. Further, the patches roughly formed rows running north-south as is typical in Christian cemeteries. Further archaeological reconnaissance and subsurface testing such as resistivity testing are recommended to identify the boundaries of the cemetery. Further archaeological reconnaissance in the area might also locate small, unmarked gravestones of the types once seen in the burial ground. Further documentary research is recommended to find the cemetery plot records and map that were seen years ago at the Northampton State Hospital.

Where are Records Maintained?

Death records for Northampton State Hospital are available online until the year 1910.

Links:

Extensive documentation about the burial site is listed in The Preservation Guidelines for Municipally owned Historic Burial Grounds and Cemeteries by DCR on the Mass.gov site.

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Paul Dever State School

Name of Cemetery: No Cemetery reported

Location of Cemetery:

Institution open date: 1952 **Institution closing date:** 2002

Institutional or Public/Municipal:

Cemetery Open date/first burial: **Closing Date/last burial:**

Estimated number of burials:

Current Owner of Property:

Current Manager of the Property:

Description of the Cemetery

Signage

Roadway/walkway:

Gate or other way to prevent access?

Is there Evidence of Maintenance?

Is there a Memorial?

How are the graves marked?

Are records available that contain person's name, cemetery section, plot #?

Evidence of Vandalism:

Efforts to Address Cemetery Conditions Over time

Unmarked Graves:

Where are Records Maintained?

Links:

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Taunton State Hospital

Name of Cemetery: **Mayflower Hill Cemetery**

Location of Cemetery: Broadway/E.Britannia, Taunton

Institution open date: 1854 **Institution closing date:**

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: 1862 **Closing Date/last burial:** 1962

Estimated number of burials: 1000

Current Owner of Property: City of Taunton

Current Manager of the Property: City of Taunton

Description of the Cemetery:

This cemetery was established in the mid-1800s. It shares its western border with Saint Joseph Cemetery. Patients from Taunton State Hospital were buried in the Potter's Field at Mayflower Hill Cemetery. Potter's Field is the local term used for the free grounds/pauper's graves of Mayflower Hill Cemetery. It was used between 1862-1962. There are 1,015 markers (many rusted pieces of metal) and many more unmarked graves.

Signage:

There is a sign at the entrance of the cemetery

Roadway/walkway:

While there are walkways and roadways in the cemetery, Potter's Field is set back and is in a field.

Gate or other way to prevent access?

There is a gate and wall around the cemetery, though it is unclear if the potter's cemetery is similarly gated.

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

The markers in the field are rows of numbers on decaying metal, and none of the graves have names.

Are records available that contain person's name, cemetery section, plot #?

Records are available at the City of Taunton Cemetery Commission.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

It is likely that there were multiple burials in the same grave.

Where are Records Maintained?

To be determined - Research in Progress

Links:

None

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Templeton Developmental Center

Name of Cemetery: **Pine Grove Cemetery**

Location of Cemetery: Patriots Rd., Templeton

Institution open date: 1899 **Institution closing date:** 2015

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: 1983 **Closing Date/last burial:** 2020

Estimated number of burials: 45

Current Owner of Property: Town of Templeton

Current Manager of the Property: Town of Templeton

Description of the Cemetery:

The State purchased burial plots for the residents of Templeton Developmental Center in the Old Section of Pine Grove Cemetery.

Signage:

To be determined - Research in Progress

Roadway/walkway:

To be determined - Research in Progress

Gate or other way to prevent access?

To be determined - Research in Progress

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

There is not a memorial at this time.

How are the graves marked?

To be determined - Research in Progress

Are records available that contain person's name, cemetery section, plot #?

Records are available from Pine Grove Cemetery

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

To be determined - Research in Progress

Links:

None

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Tewksbury Hospital

Name of Cemetery: **The Pines Cemetery**

Location of Cemetery: East St., Tewksbury

Institution open date: 1854 **Institution closing date:** Still in operation

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1890 **Closing Date/last burial:** 1933

Estimated number of burials: 8,500-10,000

Current Owner of Property: The Town of Tewksbury

Current Manager of the Property: The Town of Tewksbury

Description of the Cemetery"

Located at the site of the Tewksbury Hospital and former State Almshouse is a cemetery containing the graves of paupers, unwanted illegitimate children, formerly enslaved people, and people who were patients of the state mental asylum. The Pines Cemetery, which holds over 8,500 burials from about 1890 to 1933, spans roughly 3½ acres and needs repair. Since November 2016, community members have been dedicated to restoring the cemetery. The Town of Tewksbury aims to make "The Pines" Cemetery a welcoming place for visitors while preserving its historical significance and providing open space for the community. In 2004, a key law was passed that designated certain lands in Tewksbury, including the cemetery, for conservation and public recreational use, covering nine parcels and 410 acres. This law supports forest management, open space protection, and passive recreation, linking to the proposed Bay Circuit Trail. In 2007, the Bay Circuit Trail Alliance secured permission from the Tewksbury State Hospital to build the trail on newly conserved land, leading to a formal agreement. By 2016, Tewksbury volunteers completed a new boardwalk, moving the trail closer to completion. After this, town staff and the Open Space Committee updated the agreement with the State Hospital to allow for kiosks, trail markers, directional arrows, and parking areas.

Signage:

There is a small sign for the cemetery on East Street.

Roadway/walkway:

There is a parking area for the town recreational area and walking trails into and along the cemetery.

Gate or other way to prevent access?

The cemetery is surrounded by town recreational fields and there are hiking trails along and around the cemetery. There are no gates to prevent access.

Is there Evidence of Maintenance?

Volunteer groups maintain the cemetery.

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

The primary marker on the graves are metal medallions - a cross encircled in leaves. Graves are in rows that are numbered and lettered.

Are records available that contain person's name, cemetery section, plot #?

The cemetery operated from 1854-1930, though records for the first 30 years have yet to be located. The History of Public Health Museum maintains the records of patients from the Tewksbury State Hospital.

Evidence of Vandalism:

The cemetery is adjacent to public recreational trails and town playing fields. There are reports of school children damaging the grave markers.

Massachusetts State Institution Burial Grounds Profiles

Efforts to Address Cemetery Conditions Over Time:

The cemetery is in need of much repair, as the sheer size (roughly 3 ½ acres) of it is difficult to maintain. Community members have been actively involved since November 2016 to assist in the restoration of the cemetery to its former state. Two CPA grants for the project: the first was an award of $39,000 for removal of dead and dying trees from the historic cemetery, and the second was $4,200 for a broad application of herbicide throughout the cemetery.

Unmarked Graves:

Due to the age and size of the cemetery, there is a possibility of unmarked graves in The Pines.

Where are Records Maintained?

Records are maintained by the Museum of Public Health.

Links:

https://www.tewksbury-ma.gov/532/Tewksbury-Hospital-The-Pines-Cemetery-Tr

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Tewksbury Hospital

Name of Cemetery: **Livington St Cemetery AKA "No Name Cemetery"**

Location of Cemetery: Livingston St., Tewksbury

Institution open date: 1854 **Institution closing date:** Still in operation

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1935 **Closing Date/last burial:** 1965

Estimated number of burials: 1000

Current Owner of Property: The Town of Tewksbury

Current Manager of the Property: The Town of Tewksbury

Description of the Cemetery:

To be determined - Research in Progress

Signage:

To be determined - Research in Progress

Roadway/walkway:

To be determined - Research in Progress

Gate or other way to prevent access?

To be determined - Research in Progress

Is there Evidence of Maintenance?

Litter now collects around the edges, and minor damage from heavy equipment used to install a sewer line nearby is visible.

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

There are three sections to the cemetery apparent only through the A, B, or C notation on the grave markers. Each marker is stamped with a number and a letter and is made of a mixture of cement and mortar.

Are records available that contain person's name, cemetery section, plot #?

The History of Public Health Museum maintains the burial records.

Evidence of Vandalism:

There cemetery is adjacent to public recreational trails and town playing fields. There are reports of school children damaging grave markers.

Efforts to Address Cemetery Conditions Over Time:

The town, through the use of Community Preservation Act (CPA) funds approved by Town Meeting in October of 2009 and May 2010, had planned to erect a wrought iron-style fence around the cemetery, finally delineating it from the surrounding fields used by Wynn Middle School students. The land, already used for athletic fields and open space purposes, is now restricted to remain only for recreational and open space use, protecting it from being sold for future development.

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

Cemetery Records are maintained by the Museum of Public Health.

Links:

None

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Various State Institutions

Name of Cemetery: **Pine Hill Cemetery**

Location of Cemetery: 774 Chandler Street, Tewksbury

Institution open date: NA **Institution closing date:** NA

Institutional or Public/Municipal: Private

Cemetery Open date/first burial: Approximately 1906 **Closing Date/last burial:** Currently open

Estimated number of burials: To be determined - Research in Progress

Current Owner of Property: Sections of the property are owned by Harvard Medical School, Boston University Medical School and UMass Chan Medical School.

Current Manager of the Property: The property is managed by a board made up of representatives from each medical school's anatomical gift program.

Description of the Cemetery:

This is the cemetery for the remains of the people whose bodies were donated to science. The cemetery is located adjacent to a residential neighborhood. After 1999, all bodies donated to science and buried at Pine Hill have been cremated. It is reported that the last time a deceased patient was donated under the Anatomical Act of 1921 was about 75 years ago.

Signage:

There is a sign outside of the cemetery gate.

Roadway/walkway:

There are walkways throughout the cemetery.

Gate or other way to prevent access?

The cemetery is fenced in. An electronic gate was added after neighbors complained about teens accessing the land to drink/party.

Is there Evidence of Maintenance?

The cemetery is regularly maintained.

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

If the decedent or the family did not provide a marker, the grave is unmarked.

Are records available that contain person's name, cemetery section, plot #?

Records are maintained on paper and in a database.
Burial Agent would be the keeper of the records. Older records are not very detailed.

Evidence of Vandalism:

No evidence of vandalism since the addition of an electronic/key pass gate.

Efforts to Address Cemetery Conditions Over Time:

To be determined Research in Progress

Unmarked Graves:

Graves are known but may not be marked if a marker was not provided.

Where are Records Maintained?

Records are maintained by the local burial agent.

Links:

None

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Westborough State Hospital

Name of Cemetery: **Pine Grove Cemetery**

Location of Cemetery: 106 South St., Westborough

Institution open date: 1886 **Institution closing date:** 2010

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: late 1800's **Closing Date/last burial:** 1986

Estimated number of burials: 700

Current Owner of Property: To be determined - Research in Progress

Current Manager of the Property: To be determined - Research in Progress

Description of the Cemetery:

A portion of the Pine Grove Cemetery in Westborough, Massachusetts is the site of approximately 700 unnamed graves. The majority of those buried there were people who died while committed inpatient at the Westborough State Hospital. People began being buried in these "potter's" graves from the early 1900s, up until as recently as 1987. No family came to claim them, and the state institution would only pay the minimum for burial arrangements.

Signage:

There is a sign marking the cemetery.

Roadway/walkway:

To be determined - Research in Progress

Gate or other way to prevent access? To be determined - Research in Progress **Is there Evidence of Maintenance?**

To be determined - Research in Progress

Is there a Memorial?

In 2015, a memorial service was held in the cemetery to honor the more than 700 patients who died at the hospital and were buried there. The service was part of an effort to identify the patients and put names to their graves. In 2023, seven stone pillars were installed as part of the Westborough Cemetery Memorial Project.

How are the graves marked?

Graves are marked with a concrete block with a number indicating the order in which they were buried.

Are records available that contain person's name, cemetery section, plot #?

The lead researcher on the Westboro Cemetery Memorial Project has been able to identify and verify close to 700 people's names buried at the Potter's field by searching the Pine Grove Cemetery ledger and cross- referencing the names with Town records of death certificates in order to verify those who were reported buried at Pine Grove's Potter's field. Over 100 additional people are being researched and could be added.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

DMH provided $27K in August of 2023 to purchase and install 7 large granite pillars. The millstone center piece of the environment was also added to and enhanced. The last phase of the project is to raise an additional $45,000 to pay for the 7 bronze plates, one for each pillar. Each plate will have 125 names of people buried in the field beyond. The Memorial project committee is currently raising funds to pay for the bronze plates and to have the names engraved on the bronze plate. Eagle Scout projects included finding and marking unidentified graves.

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

Town records and Pine Grove Cemetery ledgers.

Links:

https://westboroughcemeteryproject.org/index.html

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Worcester State Hospital

Name of Cemetery: **Hope Cemetery**

Location of Cemetery: 119 Webster St., Worcester

Institution open date: 1833 **Institution closing date:** 1991

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: 1833 **Closing Date/last burial:** 1918

Estimated number of burials: To be determined - Research in Progress

Current Owner of Property: The City of Worcester

Current Manager of the Property: The City of Worcester Department of Public Works

Description of the Cemetery:

Unclaimed decedents from Worcester State Hospital were buried at Hope Cemetery starting in the 1830s. In 1919, the annual report for Worcester State Hospital stated that the City of Worcester no longer had space available to bury patients and requested the hospital to build their own cemetery for the State Hospital during the height of the Influenza Epidemic.

Signage:

There is a sign at the entrance of the cemetery.

Roadway/walkway:

There are walkways and roadways throughout the cemetery.

Gate or other way to prevent access?

The cemetery has both a gate and stone wall.

Is there Evidence of Maintenance?

The cemetery is regularly maintained by the DPW and the Friends of Hope Cemetery committee.

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

To be determined - Research in Progress

Are records available that contain person's name, cemetery section, plot #?

To be determined - Research in Progress

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

To be determined - Research in Progress

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

To be determined - Research in Progress

Links:

https://www.findagrave.com/cemetery/91121/hope-cemetery

Massachusetts State Institution Burial Grounds Profiles

Institution Name: Worcester State Hospital

Name of Cemetery: **Hillside Cemetery East**

Location of Cemetery: Lake Street, Shrewsbury

Institution open date: 1833 **Institution closing date:** 1991

Institutional or Public/Municipal: Public

Cemetery Open date/first burial: 1925 **Closing Date/last burial:** Mid 1980's

Estimated number of burials: 1200

Current Owner of Property: The Town of Shrewsbury

Current Manager of the Property: The Town of Shrewsbury

Description of the Cemetery:

This is one of two cemeteries associated with Worcester State Hospital and Glavin Developmental Center. The other is Hillside West Cemetery. This cemetery is the larger of the two cemeteries. Both are located in an area that was the former farm of Worcester State Hospital.

Signage:

The cemetery name is carved into a granite pillar at the entrance of the Cemetery.

Roadway/walkway:

There is a dirt roadway leading to the cemetery.

Gate or other way to prevent access?

Gates and pillars have been installed with the cemetery's name on them.

Is there Evidence of Maintenance?

To be determined - Research in Progress

Is there a Memorial?

To be determined - Research in Progress

How are the graves marked?

Efforts are being made to provide headstones for each grave. A small percentage of the graves have headstones in place.

Are records available that contain person's name, cemetery section, plot #?

Research has turned up the names and dates of birth and death for all of the people buried here. It is unclear if there are records of burial plots.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

Restoration of this cemetery is still in process. It's surrounded by an old stone wall that has had to be restored, and a lot of landscaping has been necessary to cut back the forest which had encroached upon it.

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

Listing of names can be found here. Unconfirmed https://www.nekg-vt.com/Shrewsbury/Hillside/hillsidelist.htm

Links:

https://www.findagrave.com/cemetery/2364635/hillside-east-cemetery

Institution Name: Wrentham Developmental Center

Name of Cemetery: **Louise Johnson Memorial Cemetery**

Location of Cemetery: off Emerald St., Wrentham

Institution open date: 1910 **Institution closing date:** still in operation

Institutional or Public/Municipal: Institutional

Cemetery Open date/first burial: 1926 **Closing Date/last burial:** 2013

Estimated number of burials: 440

Current Owner of Property: Commonwealth of MA

Current Manager of the Property: Wrentham Developmental Center

Description of the Cemetery:

Small cemetery located across the street from Wrentham Developmental Center and behind an athletic complex. The cemetery was rededicated in 1997 and renamed the Louise Johnson Memorial Cemetery.

Signage:

There is a small sign marking the cemetery.

Roadway/walkway:

There is a short driveway.

Gate or other way to prevent access?

There is a white fence defining the cemetery.

Is there Evidence of Maintenance?

DDS pays for the ongoing maintenance of the cemetery.

Is there a Memorial?

There is a memorial on the grounds called Wrentham State School Memorial Walk, dedicated October 22, 1994. There are four memorial walls with four sides each with the name of deceased individuals. Located in the front of the facility many people walk by and spend time looking and remembering. There is also a water fountain in the middle of the walkway.

How are the graves marked?

All markers are uniform in size, color and shape. A small flat rectangle with a number in the left-hand corner and a letter in the right hand corner. The name in all capital letters centered in the middle, and a birthdate to the bottom left and the death date on the bottom right. Some had specific dates others only stated the year of birth and the year of death. Some have been there since the early 1900's.

Are records available that contain person's name, cemetery section, plot #?

Records are available at Wrentham Developmental Center.

Evidence of Vandalism:

To be determined - Research in Progress

Efforts to Address Cemetery Conditions Over Time:

The cemetery was rededicated in 1997 and renamed the Louise Johnson Memorial Cemetery.

Unmarked Graves:

To be determined - Research in Progress

Where are Records Maintained?

Records are available at Wrentham Developmental Center.

Links:

None

Appendix 7: Information about the Pines Cemetery in Tewksbury

S 2427

Chapter 206

THE COMMONWEALTH OF MASSACHUSETTS

In the Year Two Thousand and Four

AN ACT DESIGNATING CERTAIN LANDS IN THE TOWN OF TEWKSBURY FOR CONSERVATION, AGRICULTURE AND PASSIVE PUBLIC RECREATIONAL PURPOSES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The parcels of land in the town of Tewksbury described in section 2 and under the care, custody and control of the department of public health, are hereby dedicated to the public for the purposes and uses of forest, agriculture and open space protection, management and conservation, environmental education and public access for passive recreation and enjoyment and shall be held solely for these purposes and uses. The department of public health, in consultation with the board of selectmen of the town of Tewksbury or its designee may develop reasonable rules or promulgate regulations for the appropriate conduct and manner of public access under this act that is consistent with the mission of the department and the purposes of this act. For purposes of this act, the phrase "passive recreation" shall include activities and uses related to the Tewksbury Hospital Equestrian FARM, Inc. and its therapeutic equestrian programs.

SECTION 2. The parcels hereby dedicated are identified as follows: All of the lands, including lands under water, in the town of Tewksbury, as described in town of Tewksbury's Assessor's Maps: Map 78 lot 16, Map 90 lot 1 and 2, Map 89 lot 1, Map 88 lot 24, Map 88 lot 21 and 32, Map 87 lot 1, Map 76 lot 27, approximately 19 acres on Map 74, Lot 2, further defined as Lot 74-2-1, as shown on map entitled "Plan of Land in Tewksbury, Massachusetts, Surveyed for Tewksbury Hospital, October 25, 2000", excluding parcels 11, 12, 13 and 14 necessary to protect the quality of the hospital's water supply as shown on map entitled "Tewksbury Hospital: Parcels for Current and Future Development or Protection Under Article 97 of the Massachusetts Constitution, March 2004" on file at the department of public health and excluding approximately 13 acres shown on Tewksbury's Assessor's Map 86, being a portion of Map 87, Lot 1, known as State Field, beginning at a point of intersection

of land now or formerly of Olson and the easterly side of Livingston Street; thence North 09 degrees 02' west along the easterly side of Livingston Street a distance of nine hundred and twenty (920) feet + or - to a point; thence along land of town of Tewksbury south 89 degrees 04' 18" east a distance of four hundred and twenty (420) feet to a point; thence along land of said town of Tewksbury 69 degrees 07' 48" east a distance of two hundred and seventy two and 63/100 (272.63) feet to a point; thence southeast one hundred and fifty (150) feet + or - to a point; thence south 16 degrees 47' 08" west a distance of two hundred and twenty three and 74/100 (223.74) feet to a point; thence south 16 degrees 47' 08" west a distance of sixty nine and 30/100 (69.30) feet to a point; thence south 05 degrees 28' 41" east a distance of forty five and 54/100 (45.54) feet to a point; thence south 62 degrees 49' 59" east a distance of fifty two and 80/100 (52.80) feet to a point; thence south 00 degrees 46' 33" east a distance of fifty six and 77/100 (56.77) feet to a point; thence south 87 degrees 38' 47" west a distance of twenty five and 74/100 (25.74) feet to a point; thence south 68 degrees 18' 36" west a distance of seventy eight and 54/100 (78.54) feet to a point; thence south 23 degrees 06' 10" west a distance of two hundred six and 58/100 (206.58) feet to a point; thence south 67 degrees 13' 54" west a distance of ninety one and 99/100 (91.99) feet to a point; thence along land of Olson a distance of approximately two hundred thirty (230) feet to the point of beginning.

House of Representatives, July 8, 2004.

Passed to be enacted, [signature] Speaker.

In Senate, July 13, 2004.

Passed to be enacted, [signature] President.

July 28, 2004.

Approved, at 2:31 PM

[signature]

Governor.

MEMORANDUM OF UNDERSTANDING

The Department of Public Health / Tewksbury Hospital (Hospital) hereby enters into a Memorandum of Understanding (MOU) with the Bay Circuit Alliance (Alliance) for the purpose to construct and use a trail by granting public access through land owned by the Commonwealth of Massachusetts.

The Alliance is a private non-profit organization dedicated to the establishment of the Bay Circuit, a recreational footpath known as the Bay Circuit Trail and its associated Greenway. The Bay Circuit was established by state legislation in 1956 and includes 50 communities surrounding metropolitan Boston, including Tewksbury. The Alliance is located at 3 Railroad Street, Andover, MA 01810. The authorized trail in question is shown on the map in Exhibit A, attached hereto (the "Premises").

The creation of this trail and the granting of public access have been deemed by the Hospital as being in compliance with the intent of use as passive recreation allowable under (legislation). The Hospital defines passive recreation as non-motorized activities that:

- Offer constructive, restorative, and pleasurable human benefits that foster appreciation and understanding of Open Space and its purposes;
- Are compatible with other passive recreation uses;
- Are compatible with the long-term preservation and restoration of natural, cultural, and agricultural resources;
- Occur in an open space setting, which is an integral part of the experience; and
- Require minimal or no modification to the natural landscape.

This public access is granted with the following conditions:

- The Commonwealth of Massachusetts/Tewksbury Hospital retains full rights of ownership to the property and this access will not interfere with the Hospital's need to maintain or improve access to its property in the future.
- Either party may cancel this MOU within 90 days upon written notice to the other party.
- The Bay Circuit Alliance ~~will be responsible~~, in working with the local town officials and their conservation committee, assure the hospital and the Commonwealth, that this proposed trail ~~has been properly reviewed and is in~~ compliance with all applicable conservation requirements. Such approval is to be obtained and made part of this agreement.

- The Bay Circuit Alliance shall have the right to permit the public to pass over said trail on foot during daylight hours only and subject to such rules and regulations as the Hospital deems appropriate and necessary, including the following prohibitions:
    - Access by motorized vehicles, including, but not limited to, snowmobiles, dirt bikes, motorcycles and all-terrain vehicles, shall be prohibited; and
    - Littering, removing or injuring plants or trees, injuring or harassing wildlife, building fires, hunting and trapping shall be prohibited;
- The trail shall be located as shown on the map attached as Exhibit A, as may be amended from time to time by mutual consent;
- The Alliance shall, upon approval from the Hospital, post the trail with notices stating the rules and regulations governing its use by the public, and stating further that the property over which it passes is Commonwealth of Massachusetts property and that, in permitting its use by the public, the liability of the landowner is limited by Massachusetts General Laws Chapter 21, Section 17C, as amended, and any other laws relating to liability of the Commonwealth;
- All maintenance and/or improvements needed for this public access will be the responsibility of the Alliance or its designee. Any such improvements must receive prior written approval by the Hospital. The Hospital will not bear the costs of such improvements;
- The Alliance will use reasonable good faith efforts to police, control and otherwise limit use by the public to the extent necessary to avoid material damage to the surrounding property, excessive noise, interference with use of the surrounding property, or disturbance to the Hospital, or any of its tenants and/or licensees;
- The public will enter this property at its own risk; and
- The Bay Circuit Alliance or its designee agent will maintain appropriate trail markings to ensure that the public will utilize the approved access.

This Agreement shall not give rise to any enforceable rights or obligations on the part of the Department of Public Health or the Commonwealth.

This Agreement shall be subject to review every two years and may be amended by the mutual consent of the parties.

8/1/07
Date

John Auerbach
Commissioner
Massachusetts Department
of Public Health

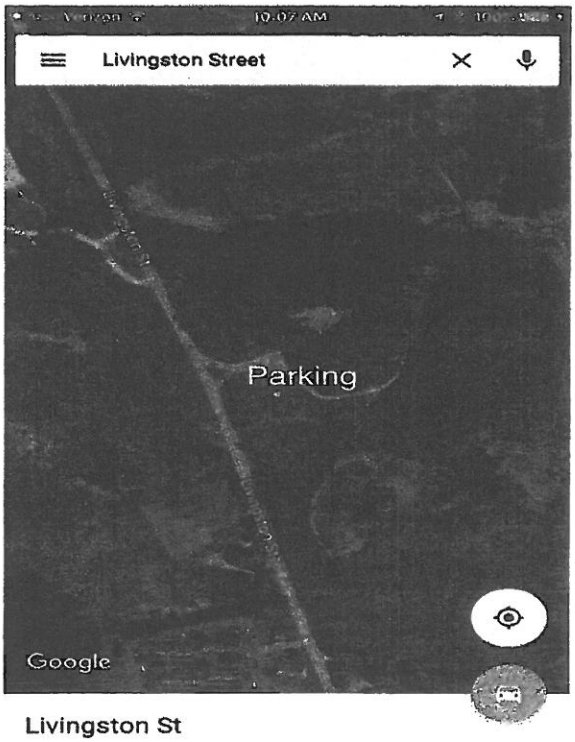
7/7/07
Date

Alan French, Representative
Bay Circuit Alliance

ADDENDUM

This Addendum is subject to all the terms and conditions of the Memorandum of Understanding signed 8/1/07 between the Department of Public Health/Tewksbury Hospital ("Hospital") and the Bay Circuit Alliance ("Alliance") hereinafter referred to as the "MOU". Subject to said terms and conditions of the MOU, the Alliance is hereby authorized to implement the following:

1. Publish maps online showing designated trail parking areas and all trails, with parking areas to be shown at:
   a. Pinnacle Street remote control airfield
   b. Existing parking area on Livingston Street, as shown below

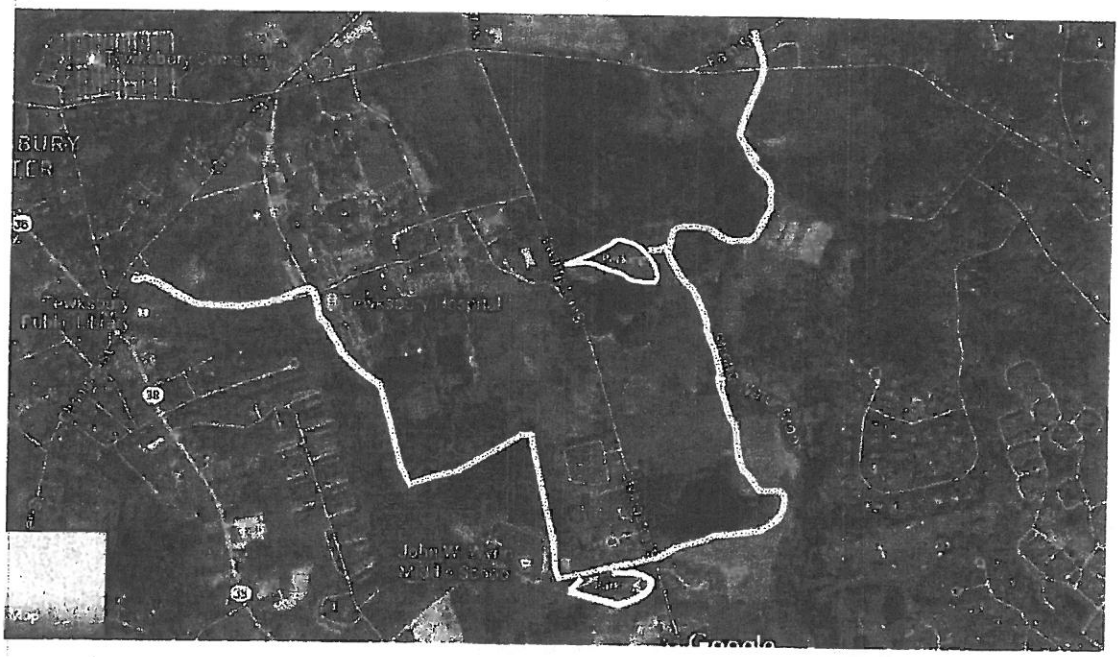


   c. East Street next to the Tewksbury State Cemetery
   d. Livingston Street at trailhead across from Greenhouse Road.

2. Install informational Kiosks at the following locations:
   a. Pinnacle Street trail head
   b. East Street trail head near gate to field
   c. East Street parking area next to Tewksbury State Cemetery (this kiosk will offer historical, as well as trail information.)
   d. Along trail at the "back" of Tewksbury State Cemetery (this kiosk will offer historical, as well as trail, information

e. Livingston Street parking area at trailhead across from Greenhouse Road.
f. Existing Livingston Street parking area as shown in 1b. above

3. Designate the portions of the wooded route from Livingston Street to Chandler Street that are on Hospital grounds: Bike path to Wynn Middle School, into woods to Hospital parking, back into woods, across brook, into field on Hospital Road, along sidewalk on Hospital Road to Chandler, as a portion of the Bay Circuit Trail. (Please see Map below.



4. Designate a new, short section of trail from the Maple Street parking/trailhead to the stone bridge near the horse arena.

5. Install trail markers as needed to ensure hikers will be able to follow trails easily. Trail markers to consist of three types:
   a. Bay Circuit Trail Disks
   b. Tewksbury Trail Disks
   c. Directional Arrow Disks

6. Bay Circuit representatives will meet with Strongwater Farm representatives to agree upon trail usage protocols that will support the objectives of both organizations.

7. As funding permits, the Alliance, in cooperation with the Town of Tewksbury and the Hospital, will establish fitness stations to enhance the enjoyment of trails located on Hospital land.

Approved by Tewksbury Hospital: [signature]

Title Chief Executive Officer

Date May 19, 2017

Approved by Appalachian Mountain Club: [signature]
(successor to the Bay Circuit Alliance)

Charles Johnston
Chief Financial Officer

Date: June 15, 2017

TOWN OF TEWKSBURY
MASSACHUSETTS

Tewksbury Hospital
Conservation Restriction Area

Please review the Rules and Regulations for the use of Tewksbury Conservation Land prior to your visit.

- Proposed Bay Circuit Trail
- "The Pines" Cemetery Trail
- Side Trails
- Trail Access
- Parking

0 0.25

MILES

Revised:
November 2023

Prepared By:
Tewksbury Engineering Division

Appendix 8: Memorandum from DMH Commissioner Doyle regarding a Best Interest Determination regarding access to DMH records for the purpose of reconstructing Foxborough Cemeteries Records

The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Mental Health
Office of the General Counsel
25 Staniford Street
Boston, Massachusetts 02114-2575

MAURA T. HEALEY
Governor

KIMBERLY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

BROOKE DOYLE
Commissioner

ROBERT R. WAGNER
Acting General Counsel

(617) 626-8236
Fax (617) 626-8242
www.mass.gov/dmh

MEMORANDUM

To: Brooke Doyle, Commissioner

From: Debra Leggett, Deputy General Counsel/Director of Privacy and Data Access

Date: August 19, 2024

CC: Robert R. Wagner, Acting General Counsel

Re: Best Interest Determination – Foxborough Cemeteries

Issue:

Cemeteries in Foxborough, MA contain the graves of former patients at the Foxborough State Hospital, which are identified only by numbers on grave markers. The Special Commission on State Institutions (SCSI) has requested that the Center for Developmental Disabilities Evaluation and Research (CDDER), which would perform work on behalf of SCSI, be provided access to Foxborough State Hospital records to permit them to learn the names of the patients associated with the grave numbers, so the patients in these graves can be identified by name.

HIPAA permits the disclosure of protected health information (PHI) for patients who have been deceased for a period of 50 years; however, Foxborough State Hospital records are not organized by date of patient death and hence record access would need to be broader to allow for culling of the limited information that is permitted to be disclosed and is needed for this project. Because access must be broader, a confidentiality agreement with CDDER is needed. It would state that CDDER would only be permitted to take, and make public, the names of individuals identified using their grave numbers who have been deceased for a minimum period of fifty (50) years.

The purpose of this best interest determination is to memorialize DMH's authority to provide the requested access to, and limited disclosure of, PHI.

Legal Background and Analysis:

The Commissioner, or designee, may permit disclosure of PHI of a patient/client where they have made a determination that such disclosure (1) would be in the best interest of the patient/client; and (2) is permitted by the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164; M.G.L. 123, § 36; 104 CMR 27.16 (9)(c) and 104 CMR 28.09(4)(c).

As a matter of public policy, you may determine that DMH has a responsibility to memorialize and provide dignity and respect to the lives and deaths of those who have been in its care, and that providing access to PHI for the purpose of identifying the names of patients buried in the Foxborough cemeteries furthers this responsibility.

Under HIPAA, 45 CFR 164.502 (f), a covered entity may disclose PHI of an individual after a period of 50 years following the death of the individual.

Conclusion:

Based on the foregoing, you may determine that disclosure of PHI to CDDER, who will perform work on behalf of the SCSI, for the purpose of identifying by name former Foxborough State Hospital patients who are deceased for a period of at least fifty (50) years and are buried in Foxborough cemeteries with only a grave number, is in the best interest of the patients/clients, and the patients in these graves may be publicly identified by name (i.e., these names may be disclosed); provided, however, that access to Foxborough State Hospital records will be subject to an appropriate confidentiality agreement.

If you make this determination, please sign below and return a copy of this memo with your signature to me.

Finding of the Commissioner Designee:

Pursuant to M.G.L. c. 126 §36, and 104 CMR 27.17 and 28.09, I have determined as a matter of public policy that disclosure of Foxborough State Hospital records to the Center for Developmental Disabilities Evaluation and Research, who will perform work on behalf of the Special Commission on State Institutions, for the purpose of identifying by name former Foxborough State Hospital patients who are deceased for a period of at least fifty (50) years and are buried in Foxborough cemeteries with only a grave number, is in the best interest of the patients/clients, and the patients in these graves may be publicly identified by name (i.e., these names may be disclosed); provided, however, that access to Foxborough State Hospital records will be subject to an appropriate confidentiality agreement.

Brooke Doyle _____ 8/22/24

Brooke Doyle, Commissioner
Massachusetts Department of Mental Health

Date

Appendix 9: Report Relevant to Property at the former Glavin Developmental Center and Associated Cemeteries

Central Massachusetts Regional Planning Commission

Town of Shrewsbury – Glavin Center PDA

Purpose of Analysis

Priority Development Areas (PDAs) are areas within a municipality that have been identified as capable of supporting additional development or as candidates for redevelopment. These are areas on which a town is focusing its energy and resources to promote thoughtful economic development that is closely tied to the community's goals.

PDA assistance projects are intended as a "next step" following the completion of a prioritization project. Planning funds from the District Local Technical Assistance (DLTA) Program support the effort and up to 25 hours of technical assistance may be provided to each interested community. Specifically, the objective of this project is to provide participating communities with a packet of information for a PDA that can be used to guide them in identifying possible zoning changes, development of a Chapter 43D application[1] or other grant applications (MassWorks), promotion to developers, as a template for future analysis of additional PDAs, and other purposes as may be desired or needed by the town. CMRPC staff worked with each participating community to ensure that the technical assistance provided was tailored to the town's specific needs.

The Irving A. Glavin Regional Center (GRC) for the Developmentally Disabled[2], previously a Massachusetts Department of Mental Health facility, was identified as a Priority Development Area (PDA 271-16) in the 2011 495 Metrowest Development Compact Plan. From the PDAs identified in Shrewsbury, the Town selected the GRC, formerly owned by the Massachusetts Department of Mental Health and currently controlled by the Commonwealth's Division of Capital Assets and Management and Maintenance (DCAMM).

The Town has asked CMRPC to focus on the area north of the Rural AA Zoning line, particularly the section in the Limited Commercial Business Zoning District. (The Green area in Figure 1 - Lake Street - Glavin Center Proposed Zoning Districts, February 28, 2011) The Town began studying the area about five years ago when the state deemed the property surplus and no longer needed for a state purpose. In 2011, the Town voted at Town Meeting to rezone the parcel into two new zoning districts, Limited Commercial Business and Rural-AA; and in 2014, voted to expand the Limited Commercial Business

[1] www.mass.gov/hed/business/licensing/43d
[2] Hereinafter referred to as the "Glavin Center" or "GRC"

Zoning District and reduce the Rural AA (Figure 2- Proposed rezoning voted at annual town meeting 2014) based upon the lease plan (Figure 3 - Lease Plan of Land, April 30, 2013.)

FIGURE 1 - LAKE STREET - GLAVIN CENTER PROPOSED ZONING DISTRICTS, FEBRUARY 28, 2011

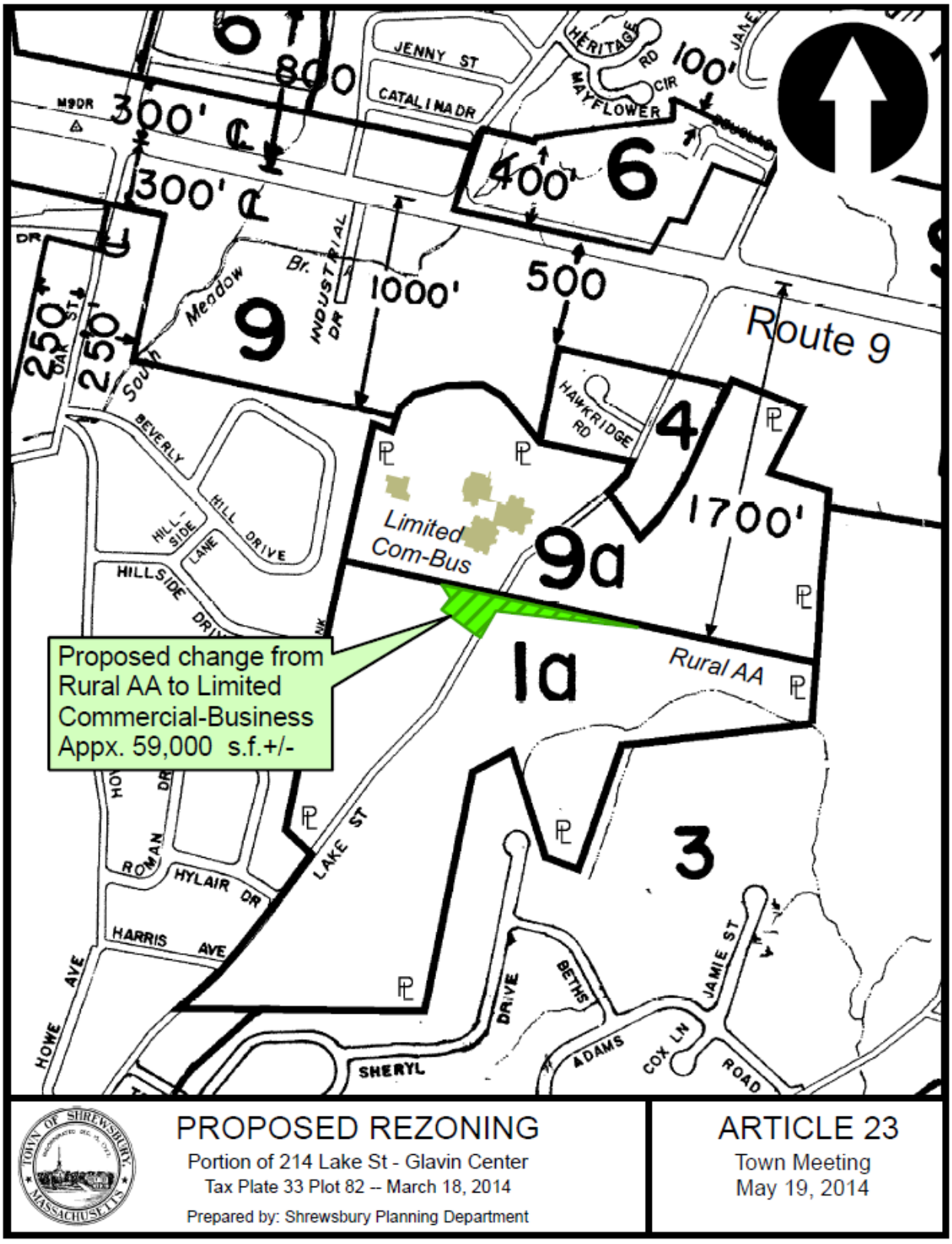


FIGURE 2- PROPOSED REZONING VOTED AT ANNUAL TOWN MEETING 2014

The Glavin Center Reuse Committee comprised of representatives from the Town of Shrewsbury Board of Selectmen and Planning Board and the Commonwealth's Division of Capital Assets and Management and Maintenance (DCAMM) have been meeting since March 2014 to consider the decommissioning of the property. This report has been developed for the Town of Shrewsbury at their request. The purpose of this report is to provide useful planning information as Town representatives provide input to DCAMM on the property's reuse. In particular, the Town hopes to better understand the existing conditions of the property and surrounding land uses, to consider possible zoning adjustments, to review current and likely future transportation and site access alternatives, to create a vision for the site/area, and to create one or two development scenarios.

The Town of Shrewsbury is not, and likely will not be the owner, of the property. However, long term lease agreements with DCAMM are in place whereby the Town leases the athletic fields in the southern portion of the site (Parcel A in Figure 3 - Lease Plan of Land, April 30, 2013) and then sublets these fields to the Shrewsbury Youth Soccer leagues and also leases the agricultural buildings and fields on the east side of Lake Street (Parcel B in Figure 3 - Lease Plan of Land, April 30, 2013) that are likewise sublet to a local farmer. Finally, in 2014, the Town will enter into an 18-month lease for the former day care facility located on the GRC site for use as a temporary site for the Shrewsbury Public Library during its reconstruction. In 2014 Annual Town Meeting, residents voted to request a home-rule petition to purchase the approximately 21 acres from the Commonwealth for $1.00.

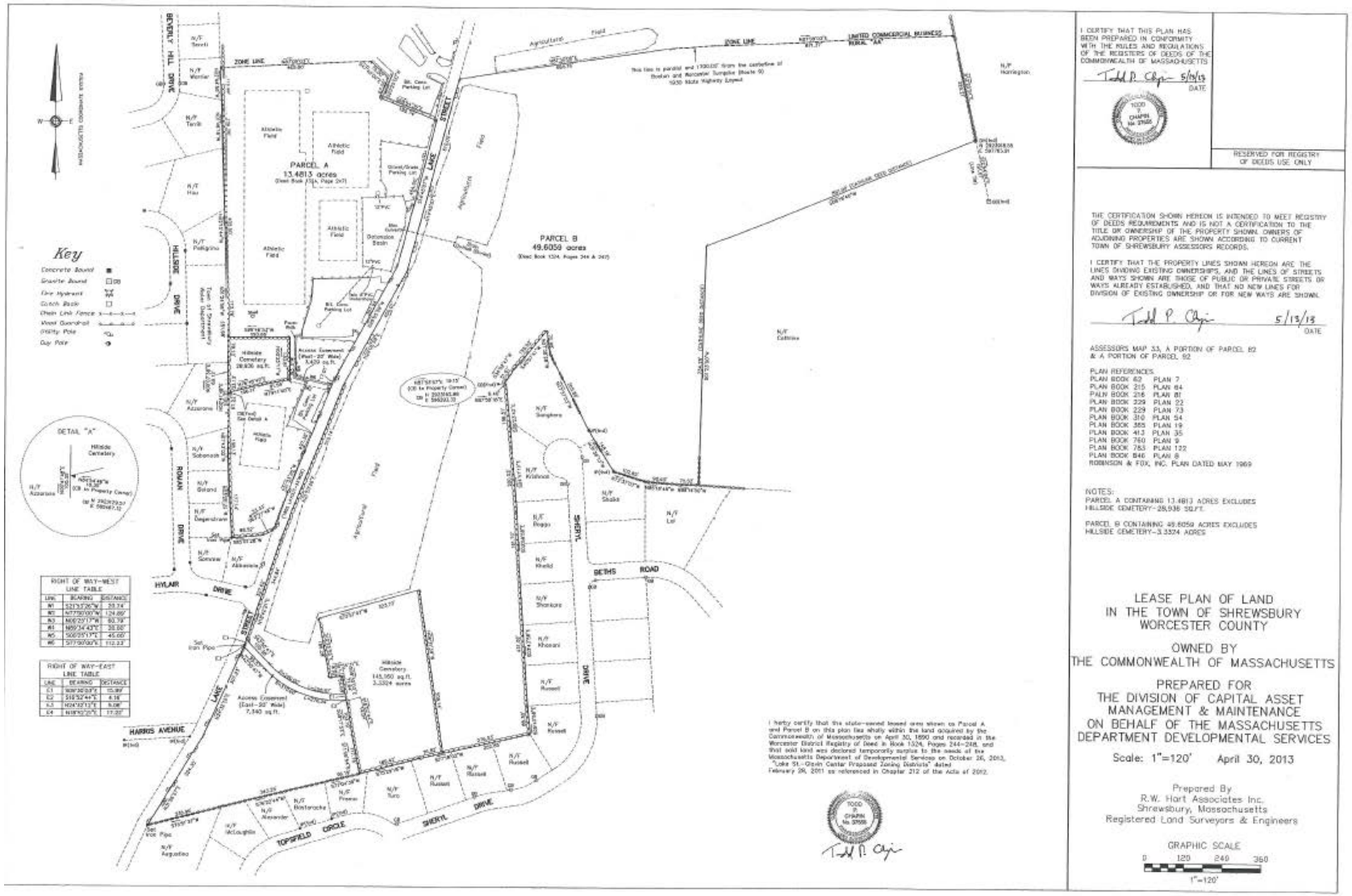


FIGURE 3 - LEASE PLAN OF LAND, APRIL 30, 2013

Study Area

The Glavin Property, located at 214 Lake Street in Shrewsbury consists of two parcels totaling 120.83 acres in area. The two primary parcels include- 33 082000 on the west side of Lake Street and 33 092000 on the east side of Lake Street. The 2014 assessment for these parcels was $16,807,000 (Book Page 1324/244 (Sale dates 04 30 1990)). The Glavin Center is currently in two zoning districts – Limited Commercial Business and Rural-AA.

The subject site consists of four primary buildings constructed in 1971 to house the "Worcester School for the Mentally Retarded". The facility includes two residential buildings with therapeutic facilities, and administration building, and a nursery school.

The Town's assessing records indicate that the property has an approximate living area of 60,000 sf, in two finished upper stories and a basement and includes a one story barn as an outbuilding The entrance to the main facility is located approximately 0.4 miles south of the Boston Turnpike (MA Route 9) and approximately two miles south of the Shrewsbury Municipal offices on Maple Street. The west parcel has almost 2,350 feet frontage on Lake Street, while the east parcel has almost 3,280 feet frontage on Lake Street.

Building Conditions Report Summary

The Property Condition Report prepared for the Glavin Center was completed in June 2013. Following a, public records request to DCAMM, a copy of the report was obtained by CMRPC (Full copy to be provided to the town for its use). According to the report, the property is in good condition; however masonry walls have begun to deteriorate and should be repaired immediately. Additionally site paving has deteriorated and should be repaired to avoid increasing damage and escalating repair costs. For expedited short term occupancy as an office buildings (for three of the four buildings), the facility can be expected to accommodate 225 to 270 office workers.

Eight (8) items are listed as required to be completed to occupy and use the facility safely and in compliance with applicable regulatory requirements for a period not exceeding three years. If converted from its current use into an office buildings for more than three years and to accommodate 270 to 320 office workers, eight (8) additional items of work are recommended to provide an efficient office facility that complies with current standards. As with most facilities of this size and scale, significant capital expenditures can be expected within the 20 year study period including repaving and replacement of low slope roofing systems. For details regarding these items of work, in cost and scope, please refer to the complete report. Sebesta Blomberg considers the property as possible "Group"/Class B Office Space.

A Class B property is typically average quality office space. These buildings do not usually contain the same high-quality finishes and fixtures, architecture, and common area as Class A space does, but they are generally nicely appointed and maintained buildings with fully functional facilities.[3]

The following is a summary of projected expenses, not including engineering, consulting or design fees.

Table 1 – Summary of Expenses for Glavin Center

Summary of Expenses	**Estimated Cost**
Immediate repairs and upgrades (1-3 year occupancy)	$614,010
Major Renovations (4-10 year occupancy)	$6,992,898
Reserve Expenses (Years 4-20)	$2,212,886
Total	**$9,819,794**

(Sebesta Blomberg, 2013)

[3] Their locations, building systems and property managers are described as average to above average. Therefore, Class B space tends to command average market rent. The majority of Class B buildings are less than four stories tall, and are often found in the suburbs or on the outskirts of large financial districts. Another consideration that separates Class A and B buildings is age. Many Class B buildings are a little older, and may be experiencing minimal deterioration or breakdown. Some buildings start out with a Class A grade, but are downgraded after 10 years or so once signs of wear and tear become apparent.
(http://realestate.about.com/od/commercialbizbasics/a/space_classes.htm)

Farm Buildings

Four (4) farm related buildings are located on the east side of Lake Street. Building A seems to provide interior workspace and garage space, Buildings B and C provide storage and garage space and Building D's use is uncertain.

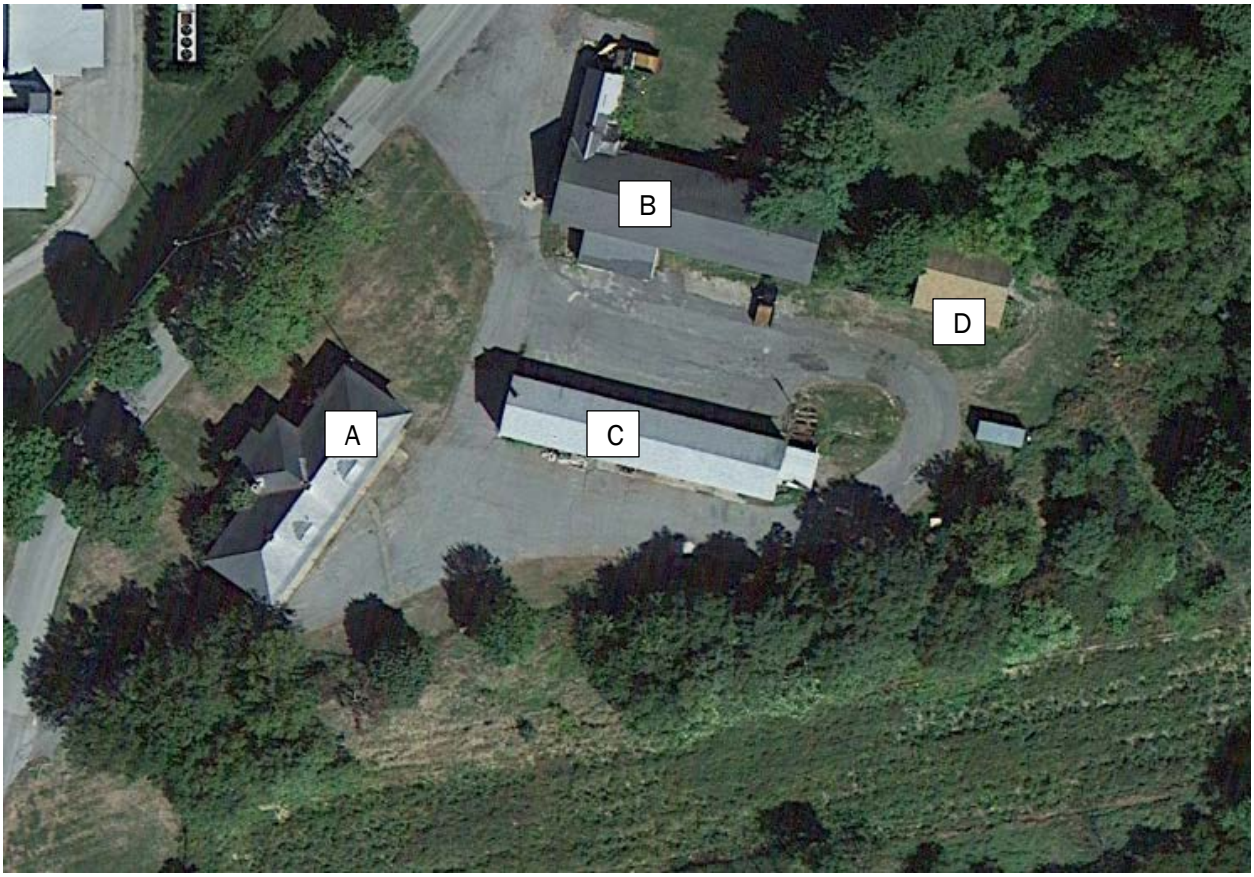


FIGURE 4 - GOOGLE AREAL OF FARM BUILDINGS

FIGURE 5 - MULTIPLE PHOTOS OF FARM-RELATED BUILDINGS, MARCH, 2014

The farm-related buildings appear structurally sound from the exterior with typical wear for their age. Their use for farming purposes or storage should still be viable.

Table 2 - Farm Building Summary[4]

Building	Use	Size	Year Built
Building A	Dormitory/Garage	5352sf	1916
Building B	Barn/ Animal Storage	6,988sg	1924
Building C	Maintenance/Carpentry Shop/Garage	5,520sf	1945
Building D	Manure Storage Shed	1,292sf	1921

However, given the age of the buildings, and the use and nature of activities likely performed in this area; there is some potential for subsurface soil and or groundwater contamination. Servicing of vehicles, likely presence of above or below ground oil or gasoline storage tanks, storage and handling of pesticides or other chemical for agricultural use, possible presence of asbestos or lead in building structure provide ample cause for concern for increased re-use or redevelopment costs, particularly given the proximity to nearby residential properties. A preliminary site investigation consistent with Chapter 21E site assessments is highly recommended.[5] Re-use of the buildings will require the assessment, estimation of remediation of costs, and remediation if necessary. Federal or state brownfield assessment funding may be available to assist with this task in support of the possible site redevelopment.

Infrastructure

Water and sewer service is available in the study area. Water is provided by the Shrewsbury Water Department to the site via a six (6) inch water line; sanitary sewer is provided by the Town of Shrewsbury Sewer Department and the site is served by a "lateral sewer line eight (8) inch. Wastewater is treated with primary and secondary treatment at the regional Westborough Treatment Plant.[6] In 2012 water main construction was bid out for the Boston Turnpike, Lake Street, and Oak Street areas. Some of the existing water main was replaced. Remaining water system work on Stone Avenue, Lake

[4] Information provided by Stephen Wright, Glavin Regional Center, July 7, 2014

[5] The Glavin Regional Center is listed in the Massachusetts Department of Environmental Protection's database of Waste Sites as a Closed Site. http://public.dep.state.ma.us/SearchableSites2/Site_Info.aspx?textfield_RTN=2-0011877&searchType=ALL&CurrentPage=1. A reportable release of gasoline occurred on some part of the property in 1997. A Response Action Outcome Statement was issued in 1998 to "close" the file.

[6] Shrewsbury Water and Sewer http://www.shrewsbury-ma.gov/department/?fDD=36-0

Street and Oak Street was completed Spring 2012.[7] The Hillside water tank is located in the vicinity of the Glavin Center.

Land Use

The land use map below shows current uses of the subject area parcels.

[7] Town of Shrewsbury Water Department, 2012, Annual Drinking Water Quality Report

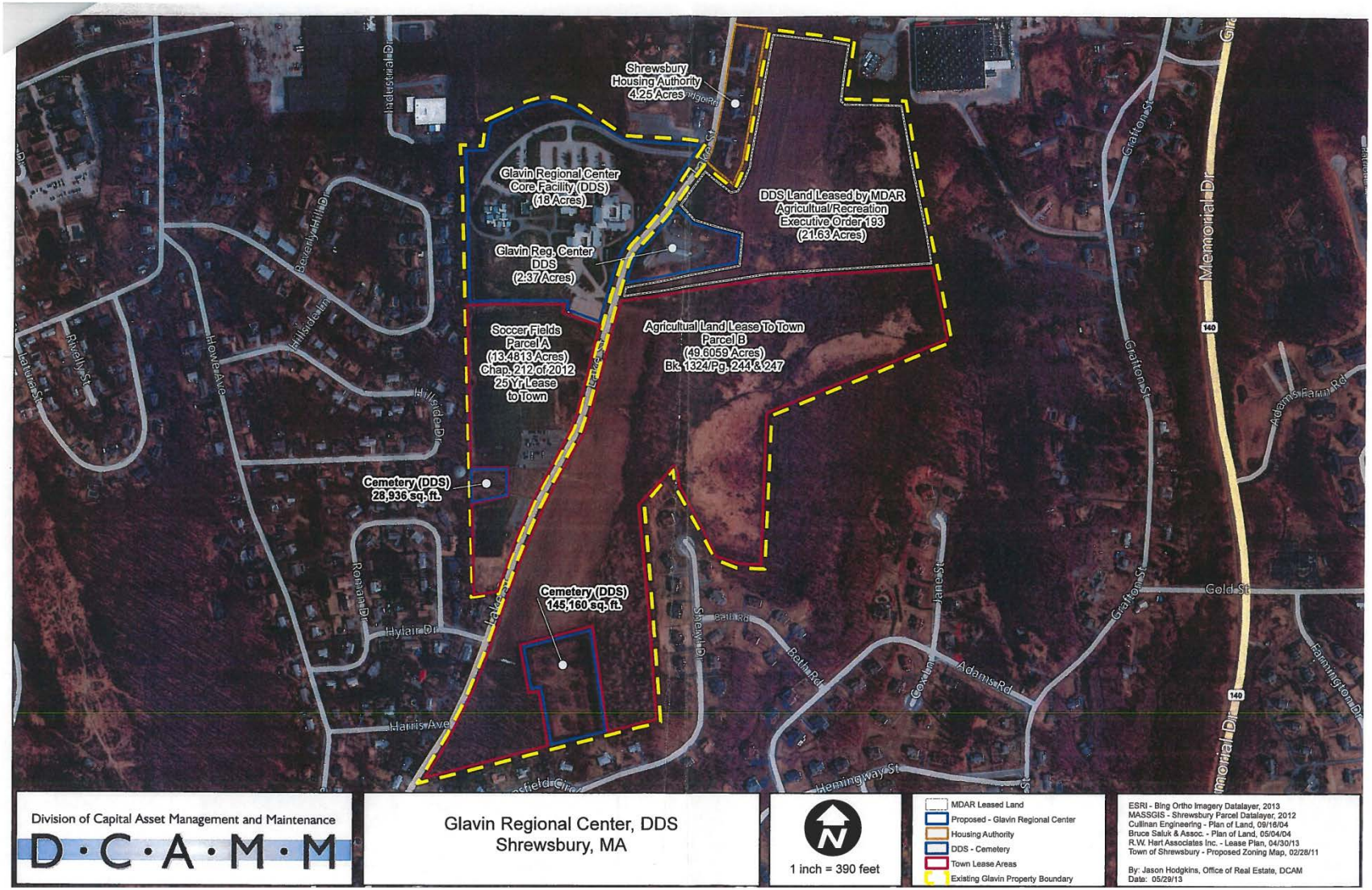


FIGURE 6 - LAND USE GLAVIN CENTER, SEPTEMBER, 2012

Uses in the Surrounding Area

The study area is located approximately 0.4 miles south of MA Route 9, a heavily traveled and densely developed state highway. Development along Route 9 reflects the zoning along the major highway and is primarily commercial and industrial, but in some pockets is residential or undeveloped. The topography of the area is steep and hilly presenting development challenges but offering valuable and desirable scenic views. Businesses on the southeast side of the Route 9- Lake Street intersection include small scale retail in a strip mall which includes Patel Brothers grocery store, Pepperoni Express, Mass Dojo (Karate Studio), AT&T Customer Center; a Home Depot; a Jiffy Lube; a Sunoco Gas station; The Flooring Warehouse; and Cassa Stone. Businesses on the northeast side of the intersection in close proximity include the Shrewsbury Crossing Shopping Center with Newbury Comics, Fidelity Bank, Super Stop and Shop, Big Picture Frame Store, Scrub-A Dub car wash, and a Valvoline Oil Change. An undeveloped and overgrown parcel is located on the northwest corner of the intersection. Adjacent to that to the west is a home based business and an apartment complex. Off of Route 9, west, south, and east of the Glavin center the land uses are primarily residential or rural residential. On the southwest corner of the intersection is a Buffalo Wild Wings restaurant which is adjacent to the Greater Worcester Food Bank. West of the Greater Worcester Food Bank is vacant and undeveloped land where the Nardella Realty Company, LLC, is advertising 15 acres for lease. This parcel directly abuts the Glavin Center property.

FIGURE 7 SIGN ADVERTISING LAND FOR LEASE (PHOTO - TRISH SETTLES, CMRPC)

Zoning

The Glavin property consists of the two parcels highlighted in Figures 1 and 2 above. The western parcel (depicted as "9a" on Figure 2 or in green on Figure 1) is zoned Limited Commercial Business and the eastern parcel (depicted as "1a" on Figure 2 or in pink in Figure 1) is zoned Rural AA. Starting to the north and going clockwise, the study area is bordered by Residence B-1, Commercial Business, Residence A, and again Residence B-1 Zoning Districts.

The Limited Commercial-Business (LCB) district is intended to provide goods and services for residents, transients and/or tourists as well as office uses. The Rural AA District is intended as a residential district for detached single-family homes and open space, recreation, and conservation areas in addition to planned residential developments. The Commercial-Business (CB) District is intended to provide goods and services for transients or tourists and non-consumer goods and services. The Residence A, B-1, and B-2 Districts are intended as districts for rural, residential and non-commercial uses.

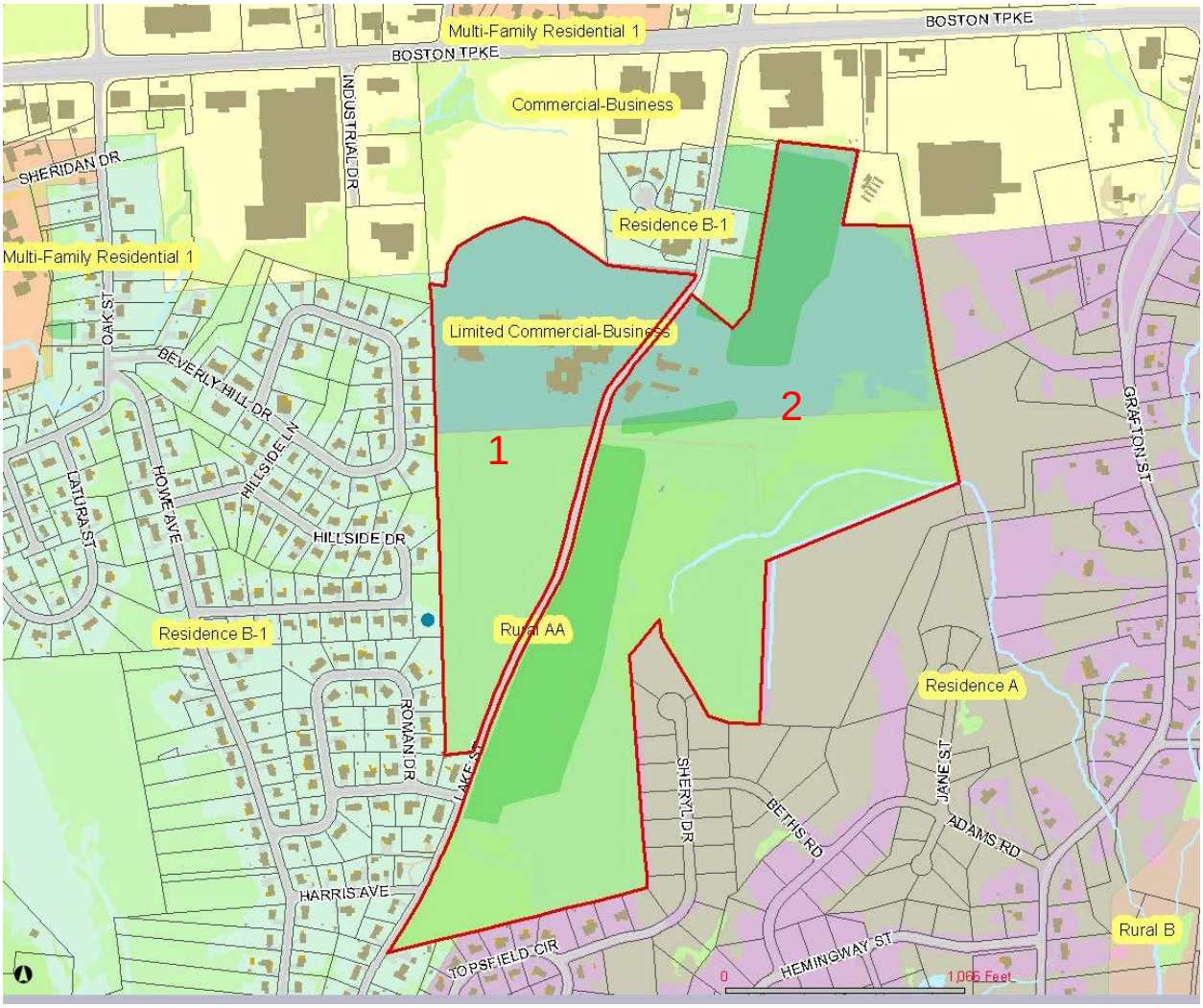


FIGURE 8 - GLAVIN PROPERTY ZONING DISTRICTS

At its May 2014 Annual Town Meeting, Article 23-Rezoning of a small portion of land from Rural AA to LCB (Figure 2- Proposed rezoning voted at annual town meeting 2014) was voted favorably. This amends the above map.

ZONING DISTRICT (USE)		MIN. LOT AREA (Sq. Ft.)	MIN. LOT FRONTAGE (Feet)	MIN. FRONT YARD (Feet)	MIN. SIDE YARD (Feet)	MIN. REAR YARD (Feet)	Min Open Space of Lot Area	MAX. BLDG HT (Feet) / STORIES	Max Lot Coverage
Limited Commercial Business (Generally commercial and business oriented)	All uses	40,000	150	40[8]	15 (100 when abutting a res dist)	25 (100 when abutting a res dist)	20%	40 / 3	50
Rural AA (Generally residential	One family All other uses	45,000 45,000	150 150	50 50	30 30	50 50	25 25	35 /2 -1/2 40 /3	15 40%

TABLE 1- EXCERPT FROM SHREWSBURY ZONING BYLAW (AS AMENDED THROUGH OCTOBER 21, 2013)

[8]The minimum tract size for a Continuing Care Retirement Center, Country Club, or Day or Overnight Camp shall be five (5) acres, and each such tract shall have a minimum of one hundred (100) feet of frontage.

The Limited Commercial Business (LCB) Zoning District, which is zoning classification of the study area, allows the following uses by right:

Residential uses

- None allowed by right

Agricultural, Conservation, and Recreation Uses

- Certain conservation areas and picnic areas
- Fields and pastures,
- Certain small facilities for display and sale of agricultural products.
- Recreation, including golf courses, ski runs, parks (but not an amusement park), boating, commercial or club fishing and hunting (where legally permitted), and any non-commercial open-air recreation use. Storage uses shall be located subject to the same provisions which apply to farm buildings. (with restrictions)
- Veterinary hospitals, stables, and kennels used for commercial purposes, raising or breeding animals for sale, and boarding animals subject to the same conditions applicable to the location of farm buildings and to the grazing of farm animals.

Institutional Uses

- Public and non-profit schools and accessory uses
- Religious uses
- For profit schools, nursery schools and kindergartens, and colleges with or without dormitory facilities, including dance and music studios, provided adequate off-street parking areas in accord with Section VII D are provided, there is no external change of appearance of any dwelling converted for such use, and that no activity is carried on which results in objectionable noise audible off the premises.
- Museums (with restrictions)
- Nursing homes
- Assisted living residence (with restrictions)
- Non-profit medical science research laboratories and accessory uses thereto

Business uses

- Retail stores or service establishments
- Gift shops and places for display or sale of handicrafts
- Indoor or outdoor farmers markets
- Business or professional offices
- Offices for physicians, dentist or other health care practitioner
- Banks

- Banking machines, where public access is available from within a building and is operated in connection with other uses in the same building
- Membership clubs

Research and Industrial Uses

- Large scale ground mounted solar photovoltaic installation and appurtenant structures
- Printing or publishing establishments, photographic processing studios, medical or dental laboratories
- Electronic data storage centers

Accessory Uses

- Professional office or customary home occupations
- Other normal accessory uses
- Other cafeterias operated in connection with another permitted use.

The Limited Commercial Business Zoning District allows the following uses by special permit:

Residential Uses

- Senior housing

Agricultural, Conservation, and Recreation Uses

- None

Institutional Uses

- Hospital, sanitarium, ambulatory surgery center, outpatient medical clinic, including diagnostic lab as an accessory use (planning board permit)

Business Uses

- Banking machines, as a standalone structures or where public access is available via a drive up window or from outside the building
- Restaurants or other places for serving food within the structure
- Hotel, motel
- Bed and breakfast
- Funeral home
- Mortuaries or crematories
- Auditoriums, athletic facilities, health clubs, and other places of amusement or public assembly where activities take place inside the building
- Auditoriums, athletic facilities, health clubs, and other places of amusement or public assembly where activities take place outside the building
- General outdoor entertainment/assembly

- Theaters
- Passenger depots

Research and Industrial Uses

- Warehousing and distribution
- Utility structures greater than 200 square feet
- Wireless telecommunications towers
- Wireless communications antenna
- Parcel distribution centers and wholesale distribution plants

Accessory Uses

- Overnight storage, parking, or garaging of commercial vehicles of more than 14,000 pounds gross vehicle weight
- Restaurants, provided that their uses is in connection with a permitted use

Notable uses not allowed include the following:

- Continuing/continuum care retirement community
- Planned residential development?
- Country clubs
- Extended stay hotel
- Basic research and development, production and product assembly, laboratory testing and related uses
- Health care and educational facilities
- Mixed use developments

Rural AA District

The various uses allowed in the Rural AA district are quite typical for this type of zoning district which includes a variety of residential and agricultural uses. The following are *allowed by right:*

- One family detached dwellings,
- Certain conservation areas and picnic areas
- Fields and pastures, and other typical agricultural uses
- Certain small facilities for display and sale of agricultural products.
- Public and non-profit schools and accessory uses
- Religious uses
- For profit schools, nursery schools and kindergartens, and colleges with or without dormitory facilities, including dance and music studios, provided adequate off-street parking areas in accord with Section VII D are provided, there is no external change of appearance of any

dwelling converted for such use, and that no activity is carried on which results in objectionable noise audible off the premises.
- Certain accessory uses typical to allowed uses
- Cafeterias for employees and other normal accessory uses when contained in the same structure as a permitted use.

The following are allowed by *special permit* from the Planning Board:

- Accessory or in-law apartments,
- Senior housing
- Planned residential developments
- Day camps, and the like where tents are used for a shelter (with restrictions)
- Country clubs, provided that any buildings in connection therewith are located subject to the same conditions as apply to farm buildings. (with restrictions)
- Recreation, including golf courses, ski runs, parks (but not an amusement park), boating, commercial or club fishing and hunting (where legally permitted), and any non-commercial open-air recreation use. Storage uses shall be located subject to the same provisions which apply to farm buildings. (with restrictions)
- Veterinary hospitals, stables, and kennels used for commercial purposes, raising or breeding animals for sale, and boarding animals subject to the same conditions applicable to the location of farm buildings and to the grazing of farm animals.
- Museums (with restrictions)
- Cemeteries
- Hospital, sanitarium, ambulatory surgery center, or outpatient medical clinic, including diagnostic laboratory as an accessory use
- Nursing homes
- Assisted living residence (with restrictions)
- Indoor or outdoor farmers markets (special permit not by Planning Board)
- Business or professional offices
- Office for physician, dentist or other health care practitioner
- Bed and Breakfast
- Professional office or customary home occupation

The following are notable uses not *allowed*:

- Auditoriums, athletic facilities, health clubs, and other places of amusement or public assembly where activities take place inside the building.
- Auditoriums, athletic facilities, health clubs, and other places of amusement or public assembly where activities take place outside the building.
- General outdoor entertainment assembly

In 2011, the Town created a new use district, Rural AA, which provides for a density bonus by right (except for single-family homes) in developments that preserve at least 60 percent of the land for permanent open space. The first property placed in the district is a portion of the Glavin Center. Anticipating the Glavin Center's eventual closure and sale, Shrewsbury took steps to encourage appropriate reuse of the land by offering more density in exchange for mixed residential uses and open space. (Town of Shrewsbury Housing Production Plan, 2012)

The study area does not lie in the Shrewsbury Aquifer Protection Overlay District (April 5, 2012), the Flexible Development Overlay District (March 17, 2009), the Route 20 Overlay District (August 31, 2005), the Edgemere Village Overlay District (August 31, 2005), or the Lakeway Overlay District (May 2004). There are also no official town trails that intersect the area.

Site Development Standards

Of note are the site development standards for the Limited Commercial Business (LCB) district as applied in the north portion of the site as it abuts Residence A or Residence B-1 districts. The purpose of the district is to "*provide consumer goods and services*."

Due to the size, location, and layout of the site, there appear to be few site development requirements that could act as a constraint on re-use or redevelopment of the site. The residential uses to the west are buffered from the site with mature natural vegetation serving as a buffer between the service road of the site and the rear yards of residences. The residential use to the north has less vegetative buffer but there is sufficient land between the service road and the property line to establish a sufficient buffer. The use of privacy fencing or walls is also an option where a natural buffer is not sufficient or would take time to mature. Note that LCB requires a ten (10) foot buffer zone along the rear yard but as noted above, this should not be an issue for this site. Note that additional requirements are applied for uses such as hotels, or motels; Continuing Care Retirement Center; Country Club; or Day or Overnight Camps.

The LCB district dimensional standards allow a 3 story or 40 foot structure to be built on site. Other than a 20 percent open space requirement and a 50 percent lot coverage limitation, there are redevelopment opportunities which could allow additional density on site beyond what exists. However, the town may wish to consider an overlay district which could permit additional density and allow a developer to take advantage of the views afforded the hilltop location by allowing additional height (provided this was not problematic for abutting residential uses).

The juxtaposition of the Rural AA and other residential districts to the Limited Commercial Business that hosts the former Glavin Center Residential Campus can be developed in such a way that the uses allowed by right and those by special permit can coexist in harmony and even supportively. Parcel line

buffers and setbacks and site plan review will be important. Landscaped areas will help in creating smooth transitions between uses.

Vision and Long Range Planning in the Study Area

The Town's last Master Plan was completed in April 2001. In December 2003, the Town completed a Community Development Plan (under EO 418). This plan indicated that the town desired to consider allowing multifamily housing if supported with financial incentives if the state were to dispossess the former Grafton State Hospital property. There was also indication that the town had an interest in promoting office and research park space at the former Allen Farm and office and R & D in a campus like setting in the vicinity of I-290. At that time the Glavin Center was still in operation and presumably not considered for either housing or office space or R&D facilities. As of the writing of this report, May 2014, the Town is in the process of preparing a new Master Plan with the assistance of the Horsley Witten Group Note that a comprehensive market study of the site was not conducted as part of the Master Plan project and thus any analysis provided by the consultant is preliminary. Consultant recommends that a market study be conducted to provide the Town with a more detailed assessment of specific development opportunities by sector.

Housing Objectives: The Town of Shrewsbury has 6.1% of its year round housing units classified as subsidized housing units for the purposes of Massachusetts General Law (MGL) Chapter 40B.[9] The town has completed a housing production plan in 2012 certified by the Massachusetts Department of Housing and Community Development (DHCD).

Economic Development Objectives: The Master Plan consultant indicated that the Town wished to pursue commercial reuse or redevelopment opportunities on the portion of the Glavin property where the Glavin Center is located.

Open Space Objectives: The Master Plan consultant indicated that the Town wished to preserve much of the Glavin property as open space. The site including the Glavin Center currently has extensive green space surrounding the campus and the Town would like to see this remain largely undeveloped and preserved as is. The remainder of the PDA site includes athletic fields and cemeteries and these are proposed to remain as well.

Development Suitability
The site has many advantages for economic development:

- Municipal water and sewer is on site

[9] Comprehensive Permit; Low or Moderate Income Housing (760 CMR 56)

- Route 9 is a well-established commercial/industrial corridor. However, the site is located off of this extensively developed commercial corridor and due to lack of visibility and access may not be suitable for certain commercial uses that require these criteria.

- The study area is approximately 0.4 miles from Route 9, 2.5 miles from the University of Massachusetts Medical School, 1.9 miles from Route 20 via Lake Street, and 4.3 miles to Route 290 in Worcester or 3.4 miles to Route 290 in Shrewsbury, giving the site convenient access to all of the region's major transportation routes.

- The site has advantages related to elevation giving it prominence both for excellent views from the site of the region and for visibility if a signature building were developed on the property.

- The site already possesses commercial zoning and the municipal land use plan recommends commercial, office, or mixed-use development on the site.

An additional consideration when analyzing commercial development suitability is traffic: the number of cars that travel past or in close proximity to the site. MassDOT shows a traffic count from 2012 of 38,000 ADT[10] just east of Quinsigamond Avenue. That is the closest count they have to Lake Street on Route 9. This is significant, providing further incentive to develop the area. Regional traffic flow west of Lake Street on Route 9 was greater than 30,000 and to the east of Lake Street was 15,000 to 30,000. However, Route 9 in the vicinity of Lake Street was described as having Pavement Conditions in need of Structural improvements which can impact the average speed of traffic. Between 2001 and 2010, the observed morning peak hour average speeds east bound were 20-29 mph and west bound were 30-49 mph. Between 2001 and 2010, the observed evening peak hour average speeds east bound were 30-49 mph and the peak hour average speeds west bound were 30-49 mph. The average intersection delay at Lake and Route 9 was 2500 to 7500 car minutes per hour (The total number of minutes that drivers as a group wait at the intersection during the AM+PM hours), which is greater than 1,786 the average of all intersections studied between 1996 and 2010.[11] Since 2010, the intersection at Route 9 and Lake has been renovated. Lake Street however is a narrow and curvy road with poor sight lines and little to no shoulder and steep grades. It should be noted that community members have indicated varying opinions on the cutting of trees along Lake Street; some finding them aesthetically pleasing and traffic calming; while others consider them traffic hazards.

The Worcester Regional Transit Authority (WRTA) provides Fixed Route service from Union Station in Worcester to Shrewsbury Town Center via Maple Avenue and Main Street on Route 15. This closest flag

[10] Average Daily Traffic

[11] Regional Transportation Plan, 2012, Central Massachusetts Regional Planning Commission & the Central Massachusetts Metropolitan Planning Organization

stop location to the Glavin Center is approximately 1.3 miles away from the Fairlawn Plaza on Maple Avenue. [12]

Development Constraints

There are no Areas of Critical Environmental Concern (ACECs); Natural Heritage and Endangered Species Program (NHESP) Priority Habitats or Natural Communities; certified vernal or potential vernal pools; Biomap2 Critical Natural Landscape or Core Habitat; Outstanding Resources Waters or Public Water Supplies in the study area. There does not appear to be land subject to the 100 foot or 200 foot Riverfront Area, and nor land in the 100 and 500 year flood plain.[13]

Development constraints primarily relate to:

- Wetlands and other water resource areas. There are two wetland resource areas connected by a small stream on the lower eastern section of the farmed area east of Lake Street.
- Permanently protected open space. (There are two cemeteries on the lower section)
- Developed land (a constraint if existing development not marketable or re-useable and if redevelopment not financially feasible).
- Leased agricultural land
- Leased recreational land
- Land with slopes in excess of 25%. The study area has some sections where slope may present challenges depending on the nature of the development.

Overall Development Opportunity

According to an analysis done as part of the 495 Metrowest Development Compact Plan, the Glavin Site has approximately 121 acres of developable commercial zoned land and/or residentially zoned land. Note that developed land should be considered potentially re-developable given market demand, other constraints, and regulatory flexibility.

[12] http://www.therta.com/schedules/route-15/ and http://www.therta.com/wp-content/uploads/2014/01/Route-15.png

[13] http://maps.massgis.state.ma.us/dfg/biomap/pdf/town_core/Shrewsbury.pdf and http://maps.massgis.state.ma.us/map_ol/oliver.php

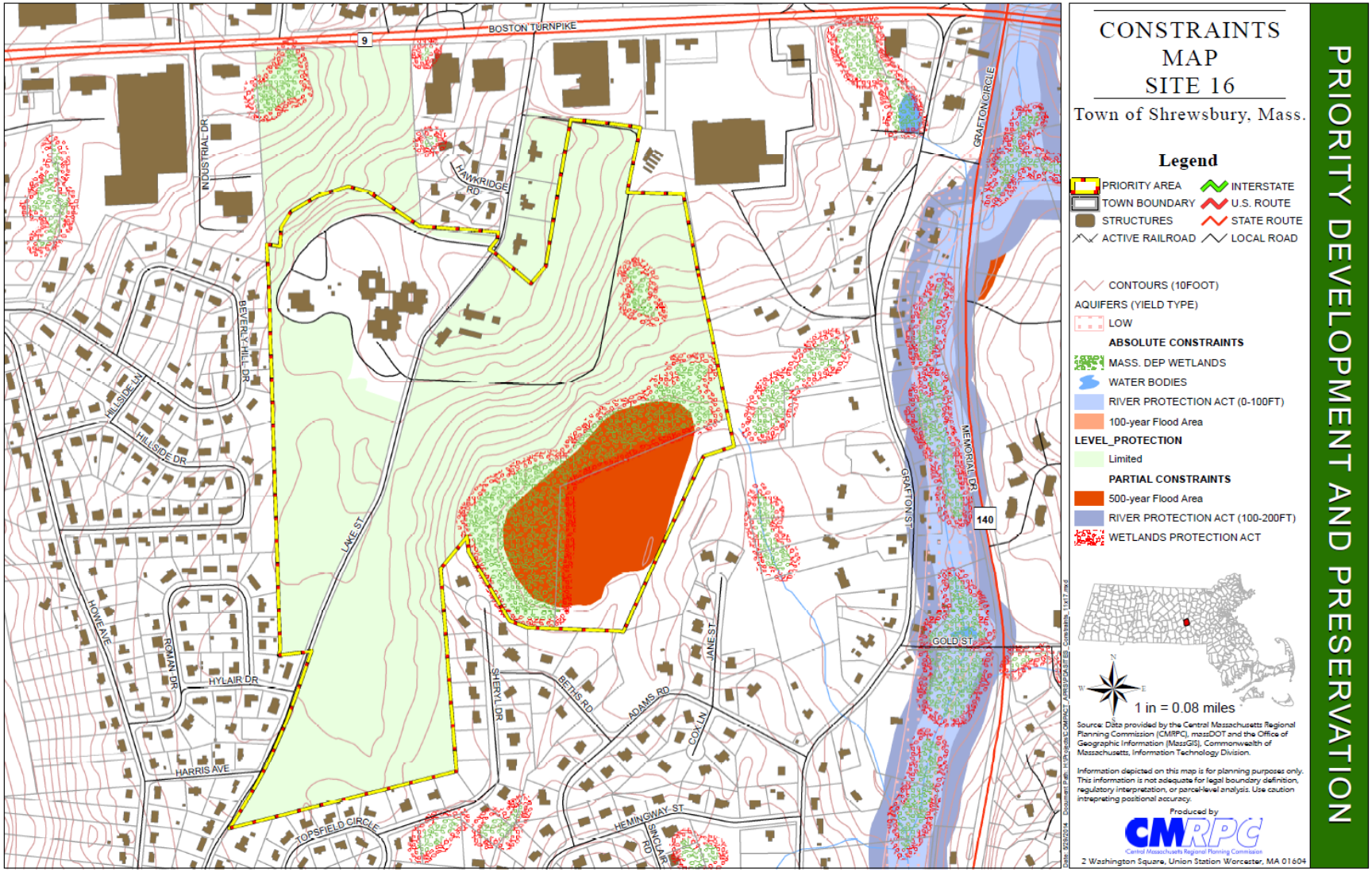


FIGURE 9 - SITE CONSTRAINTS MAP

The site use and development opportunities can be summarized as follows:

- The Glavin Center facilities could be considered for renovation and reuse given its physical condition and market attractive layout and design. A minimum of repair and rehabilitation would be necessary in order to successfully market the property to a wide range of potential institutional or office users.

- The Glavin Center grounds are also a viable redevelopment site given the dimensional standards for the LCB district. However, redevelopment is only marginally viable at this threshold of redevelopment and the Town may wish to consider upzoning to facilitate greater redevelopment opportunities (via an overlay). Redevelopment may be suitable for office or institutional uses, higher density residential uses, or some market appropriate mixed use development.

- The agricultural lands (49 acres) at the lower right portion of the site are leased for 25 years but given the zoning of Rural AA could be developed for 25 single-family homes. This site may be a good candidate for Open Space or Conservation subdivision design that could protect some of the agricultural lands for planting or pasture. Alternatively, based on the Town's desire to protect and preserve agricultural lands, it may wish to designate this for preservation and lease it for production, create a Town farm park (See Brooksby Farm in Peabody), or similar.

- The existing cemeteries associated with the Glavin Center use are presumed to be designated for protection in perpetuity. However, the relocation of these burial grounds may be an option which would allow for additional residential development opportunity or recreational fields.

- The soccer fields are leased to the Shrewsbury Youth Soccer Association (SYSA) for the next 25 years. Due to the difficulty in locating youth sports facilities, it is presumed that this use will continue in perpetuity. However, should the Town relocate these fields and terminate the lease arrangement with SYSA, an additional 13 residential units could be developed under Rural AA zoning.

Recommendations and Next Steps

As discussed above, the study area contains approximately 42 acres of developable commercial/industrial land located on Lake Street a short distance from Route 9 with access to both municipal water and sewer infrastructure and several major regional and interstate roadways. Given the obvious positive attributes of the site, the goal of this analysis is to recommend additional incentives that could encourage a prospective developer to choose this site. The Limited Commercial-Business zoning district allows a variety of commercial and industrial uses, most by-right, which indicates

the Town's desire to encourage development in the study area. However, uses should be considered which align with the opportunities and constraints that the site possesses. For example, the Master Plan consultant indicates that retail uses may not be the optimum use of the site due to its location off the Route 9 commercial corridor. However, uses such as office or mixed residential and office may be more realistic and viable in this location. One additional way the Town could attract development to the site is to designate it as a Priority Development Site (PDS) under MGL Chapter 43D, the Expedited Permitting law[14].

The site is seen as sufficiently attractively located to not require aggressive economic development tools such as Tax Increment Financing or similar mechanism. However, financial feasibility of rehabilitation or redevelopment may not be attractive enough via pure market forces. CMRPC sees the greatest opportunity presenting itself if the density were increased moderately.

Northeastern University's Dukakis Center for Urban and Regional Policy conducted an Economic Development Self-Assessment Tool (EDSAT) for Shrewsbury in December of 2013. The results of this self-assessment indicate that a long permitting process may be a disadvantage that if addressed could enhance economic development opportunities in general in Shrewsbury, and by inference for the Glavin site specifically. The EDSAT also recommended the Town develop an economic development vision for the Town that includes a marketing plan. Such a plan could also be enhanced by a comprehensive market opportunities study. Such a study could identify specific sites or parcels for develop recommendations on. The Glavin site could be one such site as the Master Plan consultant recommended. Judi did not note any specific economic development action that related to the Glavin site in our conversation or email. If Town wishes further follow up on this, we can do so.

Expedited Permitting

A Chapter 43D Priority Development Site designation is a logical next step for this site to incentivize development. In August 2006, MGL Chapter 43D Permitting was enacted into law, establishing an inventory of Priority Development Sites (PDS) on which municipalities offer a maximum of 180-day local permitting process. Cities and towns that opt into Chapter 43D are able to target areas, through a streamlined local permitting process, specific for economic development. In May of 2007, the Cen Tech Park North (Allen Property) and Cen Tech Park East in Shrewsbury were identified and approved for inclusion in this program. Shrewsbury Principal Planner, Kristen Las, is the Municipal Contact.
Other nearby communities participating in Chapter 43D:

[14] www.mass.gov/hed/business/licensing/43d

- Worcester—4 sites
- Marlborough—4 sites
- Grafton—2 sites
- Boylston—2 sites
- Northbridge—2 sites
- Sutton—1 site
- Sturbridge—5 sites
- Uxbridge – 1 site

What is a Priority Development Site (PDS)?

A "PDS" is a privately or publicly owned property that is:

- zoned for commercial, industrial, residential, or mixed use;
- eligible under applicable zoning provisions, including special permits or other discretionary permits, for the development or redevelopment of a building at least 50,000 square feet of gross floor area in new or existing buildings or structures; and
- designated as a priority development site by the state Interagency Permitting Board.

It is important for the Town to know that:

- Nothing in the law alters the substantive jurisdictional authority of local boards or departments.
- The law does not require that a permit application is approved.
- The law only requires that all decisions are rendered within 180 days.

This designation would benefit the Town and the property owner in the following ways:

- Priority consideration for state grants;
- Priority consideration for quasi-public financing and training programs;
- Brownfields remediation assistance;
- Online marketing of the site and promotion of the Town's pro-development regulatory climate;
- Technical assistance provided by the regional planning council;
- Competitive advantage for economic development opportunities.

A Chapter 43D Priority Development Site designation is a logical next step for this site to incentivize development. As an alternative to a formal 43D designation, the Town could consider a more active role in promoting the development opportunity. The Town already maintains a listing of Vacant Developable Commercial/Industrial land, which includes the Glavin Center's 120.91 acres with 1.1% lot coverage. Municipal websites are often one of the first places that site selectors look when researching locations for potential development. Actively promoting specific locations and other benefits to developing or expanding in Shrewsbury is important in this competitive market.

Concurrent with either of these processes, an analysis of the required landscaped buffers that might exist at the parcel boundaries between the residential districts Rural AA, Res A- 1 and Res B-1 and the

Limited Commercial Business District should be performed. As mentioned earlier in the report, a required buffer could be a significant requirement for some used that may have a significant impact on potential commercial or residential development proposals, particularly as the zoning bylaw does not provide for Planning Board discretion should the proposed development not warrant such significant buffers. However, it appears that the existing 10 foot buffers will be little problem for the site. For flexibility for this site and overall development review consideration, the Town could consider either including more discretion in the bylaw language, or even alter that particular area's zoning district to acknowledge its unique location as being directly adjacent to a residential zone. Perhaps a transition zone of some kind could reflect both the Town's goals for economic development as well as the proximity to residential homes. In summary, given the availability of water and sewer infrastructure, by-right zoning that promotes economic development, and its location on a well-traveled route, this portion of the Glavin site has the potential for positive development and/or redevelopment.

Summary of Recommendations

- Seek an Environmental Site Assessment consistent with Chapter 21E regulations from the current site owner, DCAMM, to identify any residual contamination from previous activities and to estimate level of investment needed to mitigate for future uses.
- Consider adopting Chapter 43D Expedited Permitting in key locations to address perception of long permitting timeframes.
- Promote the development opportunity on the Shrewsbury website.
- Consider a comprehensive market study for the Town (as would coincide with an economic development strategy recommended by EDSAT) or at minimum a market study for the site to confirm highest and best uses for the property.
- Facilitate a community design and planning charette to consider preferred design features
- Consider compatible uses joining agricultural, recreational, commercial, and residential components.
- Develop Site Plan and Design Review criteria and preferences
- Review landscape buffer requirements in the Rural AA and Limited Commercial Business District
- Consider a zoning overlay district that would incorporate use, site plan review, and buffer requirements and could provide additional density to make redevelopment more attractive.
- Promote the salvage or reuse unneeded surplus kitchen, bathroom, or medical fixtures and apparatuses

Possible Development Scenarios that could be promoted or explored include

- Maintaining as a residential institutional, senior housing, continuing care
- Educational (charter or private school)
- Mixed Retail and Office or Office Space Only (Medical Office in conjunction with any senior facility?)
- Hotel, Motel, or Resort Conference Center
- Indoor Recreational facilities

- Planned residential development (including conservation subdivision design to protect open space)
- Mixed residential (incl. senior housing) and commercial/office

References

495/Metrowest Development Compact Plan, March 2012 (In collaboration with EOHED, MAPC, MWRC, Massachusetts Audubon, and 495/Metrowest Partnership)

Greater Worcester Area Comprehensive Economic Development Strategy, 2012

Property Condition Report, Glavin Center, Shrewsbury, MA Project #700805.00, June 2013, Sebesta Blomberg

Regional Transportation Plan, 2012, CMRPC & the Central Massachusetts Metropolitan Planning Organization

Shrewsbury Open Space and Recreation Plan, 2012

Town of Shrewsbury Housing Production Plan, November 2012, Community Opportunities Group, Inc.

Town of Shrewsbury Community Development Plan, December 2003, Community Opportunities Groups with assistance from CMRPC

Town of Shrewsbury Master Plan, April 2001, Daylor Consulting, Inc.

Town of Shrewsbury, Massachusetts, Zoning Bylaw as amended through October 21, 2013

Route 9 East (Shrewsbury Westborough Corridor Profile, CMRPC in conjunction with the Central Massachusetts Metropolitan Planning Organization (CMMPO) Transportation Management Systems Programs, October 2005

Appendix 10: National Association of State Mental Health Program Directors – Position Statement on Hospital Cemeteries and Their Preservation and Restoration

NASMHPD POSITION STATEMENT ON STATE PSYCHIATRIC HOSPITAL PATIENT CEMETERIES

The members of the National Association of State Mental Health Program Directors (NASMHPD) believe that it is fundamentally important to treat all human beings with dignity and respect. States should be responsible for appropriately maintaining patient cemeteries that were created on the grounds of state psychiatric hospitals. However, some of these cemeteries have become neglected and not maintained in a manner that conveys respect and dignity. In some situations, it is impossible to locate accurately the grave sites of former patients.

Forgotten and neglected graves of persons who died in state psychiatric hospitals convey a message of devaluing the people who struggled with mental illness, contribute to the burden of stigma that people still face today, and perpetuate a negative image of the state hospital. Restoration and acceptable maintenance of the patient cemetery are important to the consumers and their families as a symbol of hope and recovery and it is important to the hospital and the mental health system as a symbol of conveying dignity for consumers. The process of restoring and maintaining the cemetery can promote healing and recovery.

Recommended Actions by States:

State mental health authorities should investigate the history and determine the condition of patient cemeteries on the grounds of state psychiatric hospitals and consider the following:

- Encourage, support, and partner with consumer organizations and other stakeholders to establish cemetery restoration projects;
- Consult the CMHC technical assistance manual that was developed by the Georgia Consumer Council and the National Empowerment Project;
- Identify potential strategies to
    - Locate grave sites and make location available to families and consumers
    - Restore cemeteries
    - Provide perpetual care
    - Construct a memorial if all grave sites cannot be located.

Approved by the NASMHPD Membership on July 31, 2001.

Appendix 11: Willowbrook Mile

The Willowbrook Mile Collaboration

The Willowbrook Mile Collaboration

Executive Summary

The Willowbrook Mile project is a collaboration among the Staten Island Developmental Disabilities Council, the primary advocacy consortium for families and service providers for people with developmental disabilities on Staten Island; the College of Staten Island; the Institute for Basic Research in Developmental Disabilities; and the Elizabeth Connelly Resource Center/Office for People with Developmental Disabilities. Prior to the initiation of this project, the Council had developed the concept of creating a walking trail commemorating the Willowbrook State School and the College created a fitness trail with landmarks based on the Willowbrook State School. With the unification of these projects, the concept was formulated for a walking trail through the three distinct campuses that were created from the original 383 pastoral acres that were once the Willowbrook State School.

The shared vision for the former Willowbrook State School property is to create a pathway for everyone to share the history of the property that would be accomplished in an inclusive, productive, progressive, and creative manner within a community partnership. The Willowbrook Mile project aims to preserve the site's history and create a visionary presence that acknowledges the deinstitutionalization movement to empty large ineffective institutions, as well as the crucial initiation of sustained rights for people with disabilities.

In the early 1970s, Willowbrook burst onto the national scene following a series of articles published by the *Staten Island Advance* detailing the deplorable conditions that Sen. Robert Kennedy compared to a "snake pit" following his 1965 visit to the institution.

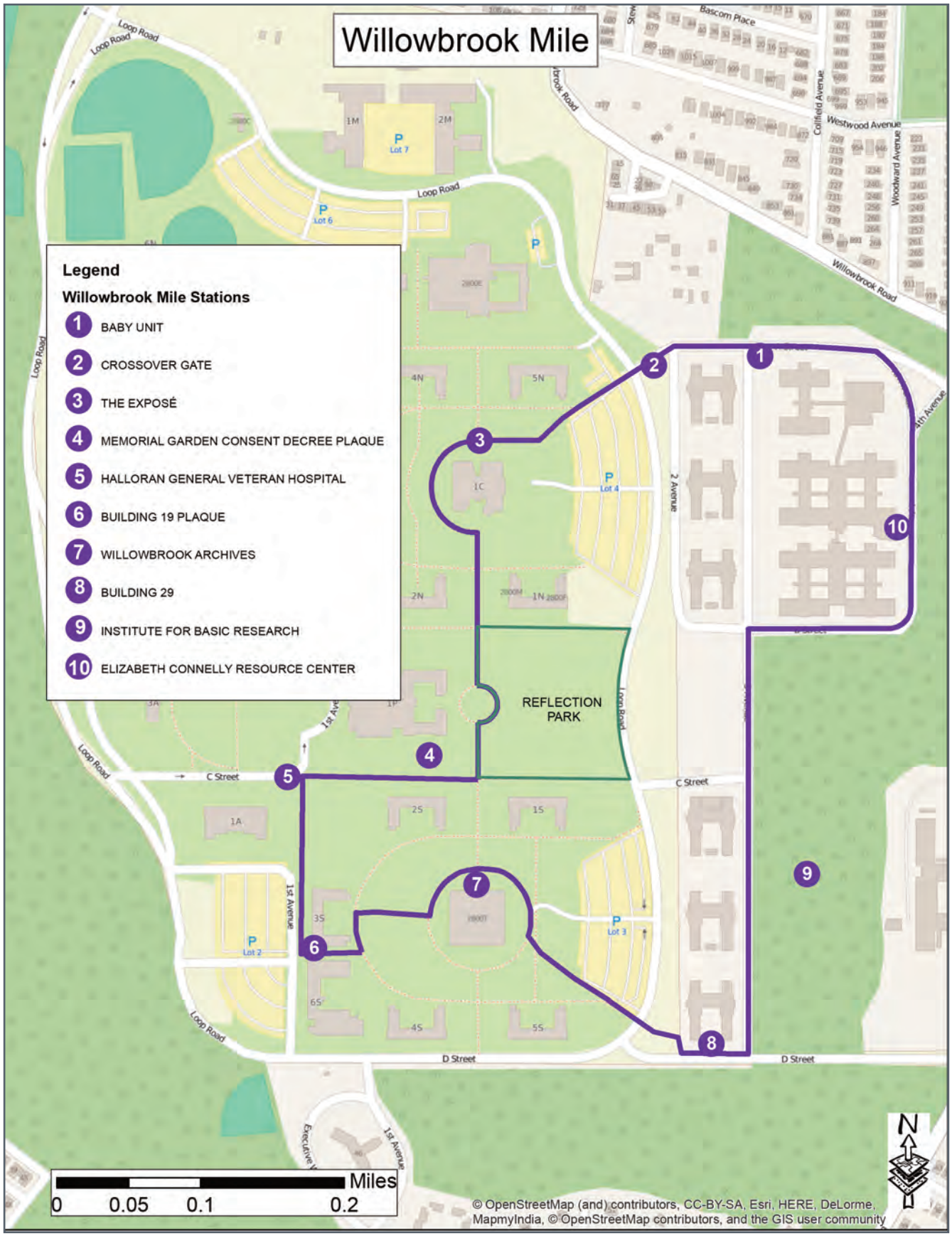
Following the Geraldo Rivera, *Eyewitness News* exposé, residents and their families joined civil libertarians and mental health advocates in a lawsuit against the state "to prevent further deterioration and to establish that residents had a constitutional right to treatment," according to *The New York Times*. In April 1975, the Willowbrook Consent Judgment was signed, and it has been used since as a model throughout the United States and in many parts of the world. This decree became a reality thanks to the commitment of families, advocates, numerous local and governmental agencies, community activists, and public officials, and the recognition by the Staten Island community that *all citizens* are protected from harm under the 8th and 14th Amendments to the Constitution of the United States.

The closing of the Willowbrook State School in 1987 ushered in a new era for the way disabled people are treated, as they transitioned from isolation and institutionalization to integration into community residences across the State. New methodologies for addressing the needs of people with disabilities have been embraced locally, regionally, and nationally, sparked by the events that took place at and because of Willowbrook.

The Willowbrook Mile uniquely creates an educational and fitness walking trail that connects the three neighboring properties. Reflection stations will be erected at sites along the pathway. The outdoor kiosks will be equipped with QAR scan code capability and contain audio, visual, and Braille signage components. At each station, visitors will be able to experience a particularly significant milestone in the history of the Willowbrook property. Some of the most notable sites include:

- the *Memorial Garden Plaque* recognizing the closing of Willowbrook and New York State's commitment to citizens with developmental disabilities;
- *Building 29*, which housed more than 100 residents whose families had originally lived on Staten Island;
- the *Willowbrook Archives & Special Collections*, sponsored by the College of Staten Island, which focuses on gathering documents that capture the experiences of Willowbrook residents, their guardians, and Willowbrook staff members at all levels with both primary and secondary materials that record the administrative history of the school;
- the *Institute for Basic Research in Developmental Disabilities*, opened in 1968 as the first large-scale institute in the world with a specific mandate to conduct basic and clinical research into the causes, treatment, and prevention of developmental disabilities; and
- the *Elizabeth A. Connelly Center Therapeutic Pool*, which commemorates the Assemblywoman's advocacy for people with disabilities. Her efforts will forever remain the benchmark for a committed political activist. The station will enumerate the breadth of present-day opportunities, which signify the focus of creating and sustaining community-based lives for people with disabilities.

The Willowbrook Mile will unite with the CSI fitness path and eventually expand to include other existing Island trails, emblematic of our interconnectedness and ever-soaring human spirit to connect and thrive.


Willowbrook Mile
Legend
Willowbrook Mile Stations
1 BABY UNIT
2 CROSSOVER GATE
3 THE EXPOSÉ
4 MEMORIAL GARDEN CONSENT DECREE PLAQUE
5 HALLORAN GENERAL VETERAN HOSPITAL
6 BUILDING 19 PLAQUE
7 WILLOWBROOK ARCHIVES
8 BUILDING 29
9 INSTITUTE FOR BASIC RESEARCH
10 ELIZABETH CONNELLY RESOURCE CENTER
REFLECTION PARK
Loop Road
C Street
D Street
1st Avenue
2 Avenue
Lot 2
Lot 3
Lot 4
Lot 6
Lot 7
Bascom Place
Westwood Avenue
Willowbrook Road
Woodward Avenue
Colfield Avenue
Miles
0 0.05 0.1 0.2
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The Willowbrook Mile Commemorative Stations 1 – 10

STATION	NAME	*Never forget . . . never again.*
1	"**Baby Unit**" – This complex was built in 1960 specifically for infants and children. Institutionalization was routinely recommended in those years by the medical community. Families agonized over the decision to place their babies in such large facilities where more than 50 children were cared for by one or two attendants in large, impersonal ward settings. The decision to institutionalize began the child's and the family's long desperate journey.	
2	"**Crossover Gate**" – Opening a Path – This gate symbolizes the crossover from institutionalization and isolation to integration into society for people with disabilities. Through this crossover, the property began to transition from acreage that once stifled growth to one that offered an enriched life with hope and opportunities.	
3	"**The Exposé**" – This station tracks the journey of the exposure of the Willowbrook experience to public scrutiny. The Robert Kennedy visit in 1965, the *Staten Island Advance* series of articles depicting the poor conditions, and then finally the ABC News exposé led by journalist Geraldo Rivera, who mounted an explosive and realistic investigation into the conditions that were plagued by understaffing, overcrowding, and the cold, stark, inhuman institutional setting.	
4	"**Memorial Garden Consent Decree Plaque**" – This plaque commemorates the closing of the Willowbrook State School. This closure was brought about by the 1975 Willowbrook Consent Judgment, which mandated the placement of Willowbrook residents in the community. Further, the Judgment required an array of services to be available in the community leading to more normalized, non-segregated care for people with special needs. This shift to the community from institutionalized care was paramount in the civil rights movement for people with special needs.	
5	"**Halloran General Veteran Hospital**" – During WWII, Halloran was the largest Army hospital in the U.S. At the War's end, it became a veteran's hospital. In 1951, the hospital closed and the property was returned to the State for its original purpose as a "school" for individuals with mental retardation and other disabilities.	
6	"**Building 19 Plaque**" – Willowbrook was a large institution covering more than 380 acres. The central plant provided heat and electricity to all of the buildings connected by steam tunnels. The mere scope and size of the facility seriously impaired its ability to provide normal, personalized comfort and care. This plaque honors every person who resided in these impersonal dormitory-style buildings. The buildings lacked basic personal and privacy considerations. Nearly 200 men lived in this building, when its original design was for fewer than 100 people. The faded painted Building Number 19 sign is preserved as a respectful remembrance.	
7	"**Willowbrook Archives**" – A Collection of Historical Documents/Artifacts-which captures the experiences of the residents, their guardians, and Willowbrook staff members. Also included are historical documents related to the construction of the site.	
8	"**Building 29**" – This building remains in an unimproved state from nearly 40 years ago. Specifically, this building housed people whose families had originally lived on Staten Island. Visual examples of institutional life, as well as an interactive media presentation to denote the strides in the field of developmental disabilities, are proposed to be housed here.	
9	"**The Institute for Basic Research in Developmental Disabilities (IBR)**" – With the opening of its first research laboratories in 1968, The Institute for Basic Research in Developmental Disabilities (IBR) became the first large-scale institute in the world with a specific mandate to conduct basic and clinical research into the causes, treatment, and prevention of developmental disabilities. The rights of all individuals who participate in IBR's research studies are protected to the utmost. In contrast, the rights of some Willowbrook residents who participated in research were violated. As a result of reforms initiated in response to research such as the Hepatitis Studies conducted at Willowbrook and other studies in the United States, and indeed, the world, today's concept of informed consent protects the human rights of research subjects with very strict guidelines.	
10	"**Elizabeth Connelly Resource Center**" – This station commemorates the Assemblywoman's outstanding advocacy for people with disabilities. It discusses the need for sustained advocacy and constant vigilance to ensure that people with disabilities continue to receive the opportunities needed to lead lives of value and worth. This station addresses the challenge to sustain a person's value through the actions of the society in which they live.	

Once people leave the Mile, it is hoped that they will now be more keenly aware of not only the struggle but also the results of the advocacy efforts over so many years.

The Willowbrook Mile Collaboration

The Staten Island Developmental Disabilities Council, the College of Staten Island, the Institute for Basic Research in Developmental Disabilities, and the Office for People with Developmental Disabilities have formed a community partnership to memorialize the former site of the Willowbrook State School, which was located on the contiguous 383 acres on which these institutions currently reside. The Willowbrook Mile project aims to preserve the site's history and create a visionary presence that commemorates the deinstitutionalization movement and the progress of all people's right to live and thrive in their communities.

The Willowbrook Mile Collaborators:

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Deputy Executive Director, A Very Special Place, Inc.

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WILLOWBROOK MILE

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The Staten Island Chapter of The American Institute of Architects (AIA)
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State of New York Assemblyman
Michael Cusick


NEW YORK
STATE OF
OPPORTUNITY.
Office for People With
Developmental Disabilities


STATEN ISLAND DEVELOPMENTAL DISABILITIES COUNCIL
ESTABLISHED 1969


THE CITY UNIVERSITY
OF NEW YORK
College of
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UMass Chan MEDICAL SCHOOL | Eunice Kennedy Shriver Center | Center for Developmental Disabilities Evaluation and Research (CDDER)

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