A Thesis

entitled

A Room for History: Professionalizing the Archives Room at Northwest Ohio Psychiatric Hospital to Create the Toledo State Hospital Museum

by

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Submitted to the Graduate Faculty as partial fulfillment of the requirements for the Master of Arts Degree in History

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An assortment of historical artifacts and documents currently reside at the Northwest Ohio Psychiatric Hospital (NOPH). NOPH is an operating state psychiatric hospital located on the site of the original Toledo Asylum for the Insane, later named the Toledo State Hospital (TSH). There is potential for this collection to be transformed from a room of interesting objects into a professionally operating museum. The location of the museum, on the historic grounds of the TSH, provides an opportunity to create a unique sense of place to connect NOPH residents, staff, and the greater Toledo community to the often hidden histories of the Toledo State Hospital, mental illness, and institutionalization.

The Toledo Asylum for the Insane received its first patient in January of 1888, during the peak of asylum building in the United States. The facility, constructed on the cottage plan, represented a new approach in the treatment and care of individuals with mental illness. A detailed history of the institution, gathered through state and local public records, reveals its significance both locally and more broadly representing themes and changes in the field of care for people with mental illness.
Disability history and public history set the backdrop for the proposed museum and the application of museum standards and best practices create the framework to professionally exhibit and interpret the history.
Dedicated to my loves, David and Owen.
Acknowledgements

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Chapter 1

Introduction: The Archives Room at the Intersection of Disability History and Public History

History offers ways not only to communicate political ideology and group identity, or to make a profit, but also to orient oneself in the environment. Public histories provide meaning to places. Whether a film showing a Civil War battlefield or the designation of a local historic site or district, all connect stories of past events to a particular present environment. Historical consciousness and place consciousness are inextricably intertwined; we attach histories to places, and the environmental value we attach to a place comes largely through the memories and historical associations we have with it.¹

On October 17, 1883, the Lucas County Commissioners proposed and passed a motion to donate “150 acres of the Infirmary Farm to the State of Ohio for the purpose of erecting thereon an Insane Asylum…”² From the late nineteenth century through the end of the 1970s, most states funded and operated institutions for individuals with mental health diagnoses. In Toledo, Ohio, the land on the southwest corner of Detroit and Arlington Avenues donated by the County Commissioners, became the site of the Toledo Asylum for the Insane, later named the Toledo State Hospital (TSH). Today, over a century later, this same land houses the Northwest Ohio Psychiatric Hospital (NOPH).

Inside NOPH, one room—The Archives Room—contains artifacts, documents, and images associated with the hospital’s history. Much of the historical research and writing on mental health has centered on the medical or institutional history of mental illness, rather than the people with mental illness and their individual stories. The histories of these individuals has often been overlooked because they have left few records of their lives. However, using the items and documents in the Archives Room, it is possible to


² Lucas County, Ohio Board of County Commissioners, 1883, Commissioners’ Journals, Microfilm: reel 222, Bowling Green State University, Center for Archival Collections.
transform the room into a museum exploring these individual stories as well as local history, the hospital’s history, medical, and institutional history.

It is critical that this museum is developed within the current state hospital for multiple reasons. First, as historian David Glassberg suggests, historical consciousness and place consciousness are inseparable. The connection between the artifacts, archival documents, and images depicting the hospital history and the physical space are so intertwined that removing them to another exhibit space would disrupt the sense of the past that is created by preserving them within the historical place they have always resided. Second, maintaining the exhibit within the hospital is important because it provides direct access to those whom the history is closest, the current patients residing or seeking treatment at NOPH, their families, as well as the caregivers and mental health providers. The opportunity to connect the current patients and caregivers to the history of mental health offers the potential to build a better understanding between patient, caregiver, and the history, but more importantly it affords the possibility to instill a sense of empowerment among a group whose history has been hidden and often disregarded. Further, opening such an exhibit in NOPH allows for public access and the potential to broaden awareness of mental health history.

Douglas Baynton once wrote “disability is everywhere in our history, once you begin to look for it, but conspicuously absent in the histories we write.” This statement is equally applicable to the histories we see in museums, historic sites, or other forms of history presented for public viewing. Although the last 50 years have brought forth a

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3 Glassberg, “Public History and the Study of Memory,” 17.

multitude of more inclusive histories that move beyond portraying only the viewpoints of the elite, there is still much room for growth. The social history movement, beginning in the 1960s, revised the traditional top-down approach to researching and writing history to consider a variety of perspectives. Social historians focused on everyday people and society to write the histories of the people and events previously overlooked. Women’s history, African-American history, Latino history, labor history, gender history, and urban history are a few examples of the subfields that resulted. More recent scholars, both in academia and in public history have begun to explore the histories of people with disabilities. The intersection of disability history and public history provides the theoretical backbone to support the development of the Archives Room at Northwest Ohio Psychiatric Hospital.

There is no one metanarrative that covers all of disability history, nor is there one linear narrative that tells a steadily progressive story, but instead the field is comprised of various and sometimes conflicting histories of people, events, and stories. 5 Disability studies and the history of disability do not have a firm, exact definition. There is no one way to categorize the people and events that might fall into disability history. Among historians, academics, advocates, as well as the general public, the definition of disability has meant different things depending on the context. Similar to other socially constructed categories, such as race or gender, the label “disabled” has been interpreted in various ways. As society changes, so do the meanings and interpretations of disability as do the concepts of what is considered “normal.” It is the vastness of the field, the shifting

concepts of disability, the social limitations and controls placed on people with disabilities, and the everyday stories of people that make up the history of disability. Because the field encompasses so many experiences, it is necessary to further breakdown the particular histories into groups based on condition. One such example is the history of individuals with mental illnesses. Just as with disability history as a whole, there is no one narrative that can capture the entire experience of a group of people, but the intent is to ask questions, find similar experiences and themes, while also bringing forth the individual experiences.

The history of people with mental illness in the U.S. has been a relatively unexplored topic, even within the history of disability. One reason may be the limitations on primary source material, either because the sources were lost, destroyed, or because of privacy laws such as HIPAA. Also, mental illness, even in the early twenty-

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8 The Privacy Rule, part of The Health Insurance Portability and Accountability Act (HIPPA) took effect in 2003. This rule created national standards to define Protected Health Information (PHI) and established regulations for covered entities including health plans, health plan clearinghouses, health care providers, or related business associates. These regulations dictate how and when PHI can be shared. In terms of historical research, the Privacy Rule had direct implications for researchers and archivists working with medical records. Although the act included accommodations for researchers that permitted access and use of data, many covered entities prohibited access because of misunderstandings of the law, fear of regulations, or extra work to provide researchers with de-identified information. (Lawrence, Access Anxiety, 459). For researchers, the confusion and difficulty of access was further complicated by the original definition of PHI which did not specify if or when information was no longer considered protected. Instead, the information was considered protected in perpetuity. Changes to the law in 2013 provided some clarity when the time limit on protected information was defined as 50 years following the day of death. Although this may allow researchers to gain access to historical medical records, it does not guarantee a clear path as many state laws continue to limit access to PHI of deceased individuals for a longer or undefined period of time. Susan C. Lawrence, “Access Anxiety: HIPPAA and Historical Research,” *Journal of the History of Medicine and Allied Sciences*, 62, no. 4 (2007): 459, http://muse.jhu.edu/journals/jhm/summary/v062/62.4lawrence.html (accessed December 5, 2013); U.S. Department of Health & Human Services, “Health Information of Deceased Individuals,” *Health*
first century, is stigmatized and misunderstood. Historian Kim Hewitt states that, “unlike many disabilities, mental illness is seldom physically visible, tangible, or measurable and yet insidiously impairs mental functioning and behavior in ways that are often difficult for a lay person to grasp.”9 The media is partially to blame for the misunderstandings associated with mental illness by sensationalizing the extreme cases of individuals with mental illness as well as perpetuating negative stereotypes.10 Mental health history, explored in all of its complexities, can provide audiences with a more complete understanding of the past.

Most commonly, scholars have researched mental health history through medical perspectives. The medical model provides only one lens from which to look at disability history and focuses on changing medical practices, treatments, and medical interpretations. These studies generally centralize mental illness as a disability that

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10 A 2004 Literature Review examined research on the portrayals and stigmas of mental illness in the media. According to the article, early research, conducted in the 1980s, predominantly studied portrayals in television shows. This research found a large percentage of characters portrayed as having a mental illness depicted as violent and dangerous. Later research, in the 1990s and 2000s, looked at various U.S. media outlets including newspapers, magazines, film, and the internet. This research, compared with earlier research, found a decreased connection between mental illness and violence; however dangerousness and violence remained top themes across media portrayals. Similarly, negative accounts of individuals with mental illness in the media outnumbered the positive in both media aimed at adults and children (See Wahl, 2003 of children’s media research). Patricia A. Stout, Jorge Villegas, and Nancy A. Jennings, "Images of Mental Illness in the Media: Identifying Gaps in the Research," Schizophrenia Bulletin 30, no. 3 (2004): 543-561, http://schizophreniabulletin.oxfordjournals.org/ (accessed September 30, 2013); Otto Wahl, Amy Wood, Parin Zaveri, Amy Drapalski, and Brittany Mann, "Mental Illness Depiction in Children's Films," Journal of Community Psychology 31, no. 6 (2003): 553-560.
necessitates medical intervention, exploration, and cures and privileges the perspective of professionals, rather than individuals diagnosed or considered mentally ill. As Paul Longmore and Lauri Umansky state, “if people with disabilities appear in these narratives, they surface typically as ‘patients,’ ‘afflicted’ with disease or undergoing treatment for injuries.”

Examining the history of disability through only the medical lens is both inaccurate and limiting; however it is an important topic to consider, especially when discussing the influence of medicine and pathology on the creation of social constructs and social understandings. Additionally, the history of institutionalization shares a symbiotic relationship with medicine and treatments for mental illness. The professionalization of medicine and later, the development of the specialization of psychiatry further justified the creation of institutions as places of treatment and medical study, while the institutions created a need for medical superintendents and psychiatrists to treat the patients.

Historian Gerald Grob, who has researched and written on mental illness in America, states that in the colonial and early national eras of the United States, “distracted people” or “lunaticks” were cared for by their families, worked within the community when able, and received community support when labor was not an option.

In some cases, if the individual was considered a possible threat to the community, there


13 Terms such as lunatick or distracted were the recognized and commonly used language in seventeenth and eighteenth centuries to describe a person considered mentally ill. Later, terms such as insane, mad, or more familiar spelling of lunatic would become more common during the nineteenth and early twentieth centuries. These words will be used interchangeably throughout the thesis without quotations.
may have been judicial rulings to keep the individual confined, but generally this meant confinement at home.\textsuperscript{14} The most problematic concern for these early communities was the potential economic consequences and possible risks to safety. Until the early 1700s, this community centered, home-based approach to mental illness remained dominant.\textsuperscript{15}

The smaller, mostly rural communities that comprised early American colonial settlements were not conducive to institutions for the insane. The first hospital built exclusively for the purposes of housing and providing treatment for the insane was opened to patients in 1773; however at the time this was an exception and consequently had little influence on changing any colonial practices associated with the mentally ill.\textsuperscript{16}

In England during the same time period, insane asylums were more common. Institutions for the mad such as London’s infamous Bethlehem Hospital, also known as Bethlem or Bedlam, had existed since the early fifteenth century.\textsuperscript{17} By the eighteenth century, England established numerous other hospitals and retreats for the insane including Bethel Hospital for Lunatics (1712), St. Luke’s Hospital for Lunaticks (1751), as well as facilities in Manchester, York, and Liverpool.\textsuperscript{18}

Institutionalization in the United States was, in general, a culmination of many social and economic factors especially as small communities grew and isolated settlements gave way to larger urban centers. Although the home-based, family approach

\begin{itemize}
\item \textsuperscript{14} Grob, \textit{The Mad Among Us}, 16.
\item \textsuperscript{15} Ibid., 21.
\item \textsuperscript{16} Ibid., 21.
\item \textsuperscript{18} Ibid.
\end{itemize}
of care still existed, many communities sought to create more formal ways to care for citizens with disabilities or those requiring public assistance.¹⁹ Early institutions such as almshouses served a wide population within a community including those in poverty, older adults, orphans, unwed mothers, as well as those with psychological, cognitive, and physical disabilities.

The pace of asylum building in the United States began to pick up in the first half of the nineteenth century. Many privately funded institutions such as the McLean Asylum for the Insane (1826) in Charlestown, Massachusetts, Friends Asylum (1817) in Philadelphia, or Hartford Retreat (1824) in Connecticut were created to provide organized, humane care to the insane.²⁰ The groups advocating for the creation of such institutions, mostly comprised of medical professionals and religious leaders, were inspired by the Second Great Awakening which emphasized the moral approach to treating insanity. These advocates conducted surveys and studies, finding living conditions for the insane in their towns rather miserable and often neglected. Further, the surveyors determined that the mentally ill individuals often placed an extreme burden and stress upon their families, friends, and communities which only created an even more desperate situation for not just the individual, but the entire community.²¹ In addition, Enlightenment ideals that spread throughout the colonies during the eighteenth and early nineteenth centuries placed a high value on applying science and reason to solving social concerns, provided the arguments needed to facilitate successful private fundraising.


efforts to establish such asylums.\textsuperscript{22} Although privately funded asylums did not disappear, the rise of the state funded, public insane asylum dominated the last half of the nineteenth century.

As institutionalization became a more popular solution to addressing social issues, specialized institutions began to replace the almshouse. These specialized institutions included options for children such as orphanages, children’s homes, and reform schools. For unwed mothers, maternity homes provided assistance and shelter. Many states across the U.S. funded specialized institutions including schools for the blind and deaf, penitentiaries, public lunatic asylums, asylums for the feeble minded, and facilities for people with epilepsy.\textsuperscript{23} Gerald Grob argues the growth of these organizational structures, including the public insane asylum, were a result of public “fears that traditional informal mechanisms no longer sufficed, and a faith that new institutions would resolve long-standing problems.”\textsuperscript{24}

During the nineteenth century, the professionalization of medicine played a critical role in the creation of such institutions. Doctors worked to develop professional organization such as the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) founded in 1844, the first medical specialty organization which later became the American Psychiatric Association. Additionally, professional journals, such as \textit{The American Journal of Insanity}, first published in 1844 and later known as the

\textsuperscript{22} Ibid., 23-26.


\textsuperscript{24} Grob, \textit{The Mad Among Us}, 41.
American Journal of Psychiatry, were well received in both the U.S. and Britain.\textsuperscript{25} The medical specialization of psychiatry developed during the mid-nineteenth century. Initially, these specialists created a model of insanity that included science, medicine, and moral values. Treatment for insane patients in institutions consisted of regimented routines, treatment, and medication.\textsuperscript{26} However, by the end of the 1800’s, pathology, physiology, and pharmacology all contributed to a new institutional psychiatry that continued for decades.\textsuperscript{27} Exploring the history of mental illness through the lens of institutionalization provides one way to view the lives of everyday individuals labeled insane or diagnosed with a mental illness. However, Longmore and Umansky argue that “we expect to find people with disabilities in medical institutions, but we neglect to look for them in other social settings.”\textsuperscript{28} Therefore, to discuss the history of individuals with mental illness only through institutional history is limiting.

The history of mental illness can be examined through professionalization of Social Work within the United States. Organizations such as the National Conference of Charities and Corrections, founded in 1874, were concerned with implementing policies related to issues of social welfare and those considered social dependents, including the insane. This and similar organizations, for example, the Ohio Board of State Charities or Massachusetts Board of State Charities, researched a community’s effectiveness at caring


\textsuperscript{26} Grob, The Mad Among Us, 57-60, 65.

\textsuperscript{27} Ibid., 140.

for its social dependents, made suggestions on ways to improve the health of the community, and suggested policy changes that needed to take place so that these individuals, including the insane, would not cause more burden. The fear of many social welfare groups was that social dependents might become immoral and utterly dependent and it was the responsibility of these social workers and groups to find ways to curb immorality and teach financial stability to such people so they did not become a burden to the community.

Mental health history can also be viewed through the lens of public policy and governmental acts. From the colonial era through the present, many local, state, and national policies have been enacted that both help and limit the lives of people with mental illness. In colonial America, no centralized welfare programs existed, instead each local government took responsibility for its citizens unable to care for themselves. The care for the poor varied across communities, but among Puritan settlements, as well as others in early New England villages, such care was extended to include distracted persons or lunaticks. The so-called Poor Laws, adapted from English legal codes,

29 For more information on the Ohio Board of State Charities and its creation see the First Annual Report of the Board of State Charities to the Governor of the State of Ohio, (1867), 11-12. The report discusses the conditions at the infirmaries across the state with some described as "simply brutal “and others depicted well kept and well managed. The Board maintained hope that these conditions could improve with the addition of new asylums across the state and the enactment of “enlightened policies” to correct the existing asylums in Columbus, Newburgh (Cleveland), and Dayton, Ohio. The Longview Asylum in Cincinnati was state supported, but was not purchased by the state until 1877.


32 Nielsen, A Disability History of the United States, 21-22; Grob, The Mad Among Us, 5-8.
placed the responsibility of care upon the local government provided through the
collection of local taxes.\footnote{Herndon, \textit{Unwelcome Americans}, 4.}

For the state of Ohio, poor laws were derived from those that existed in the
Northwest Territory, prior to statehood. In 1805, Ohio enacted a new law “for the relief
of the Poor” creating the position of Overseer which, in conjunction with township
trustees, was responsible for the care and management of all paupers within each
township. Additionally, this act granted the power to “each and every township at the
annual township meetings, to lay such tax as shall be found necessary for the support of
the poor and compensate the said overseers for their services.”\footnote{Acts of the State of Ohio, Passed and Revised, First Session of the Third General Assembly, (Chillicothe, OH, 1805), 272-278.} Early Ohio poor laws did
not necessarily account for “idiots, non compos, lunatic or insane” people. Instead a
separate law, “An Act, for the appointment of guardians to lunatics and others,”
established a process by which family or friends might report to the courts a person
suspected as being an idiot, non compos, lunatic or insane and outlined the process by
which the courts would declare the person as such. Further, the act granted the courts the
ability to appoint a guardian to “take care of said person and his estate, both real and
personal.”\footnote{Ibid., 163-166.} However, by 1814, the Ohio poor laws and acts covering the care of the
insane became more blended. In this year, the original act covering the appointment of
guardians to the insane was replaced with “An Act, to provide for the safe keeping of
Lunatics, and for other purposes.” Overseers of the poor became partially responsible for
reporting to the courts an “idiot, non compos, lunatic or insane person” within the
township who might be in danger of “destroying his or her own life or property, or the life or property of others; and where such person ought to be put into close confinement or not.” If the court determined that the person did not need to be placed in close confinement, the overseer became responsible for the care and maintenance of the person “agreeably to the provisions of the act, entitled ‘An act, for the relief of the poor.” If the person was determined a danger, then the individual was committed to the county jail, “unless friends or relations of such person shall give bond, with security, for the safe keeping of such person…”

From the early nineteenth century, Ohio legislators designed laws to care for the poor that became inextricably linked to the care for the insane as well.

Examining disability history through policies and laws focuses mainly on public agencies, governments, or philanthropists while people with disabilities are acted upon. Policies and laws were sometimes enacted with the intents of providing care and support to individuals with disabilities, but at other times such policies were created with the primary purpose of protecting society and developed without the input of the people on the receiving end of these policies.

Some scholars, however, have explored the agency of people with disabilities in acting or reacting to laws pertaining to them. Disability historian Kim E. Nielsen provides examples within colonial court documents of individuals perceived as insane

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36 Acts Passed at the First Session of the Thirtieth General Assembly of the State of Ohio, (Chillicothe, OH, 1814), 161-162.

37 Aileen Elizabeth Kennedy, The Ohio Poor Law and Its Administration (Chicago, IL: The University of Chicago Press, 1934), 24.

receiving assistance from the local government. For example, Erik Vorelissen of Pennsylvania was viewed as “quyt madd” and as a result of a local statute was provided for financially by the city.\textsuperscript{39} Further, there are cases that document individuals attacking the laws and policies used to reduce individual free will or forced institutionalization. Gerald Grob discusses Elizabeth Packard who “launched her crusade against arbitrary commitment procedures” and “wanted to strengthen the legal rights of patients.”\textsuperscript{40}

Lastly, and arguably most importantly, mental health history can be explored through the individual voices and stories of people with mental illness. Geoffrey Reaume states, “for the most part, historians of psychiatry have not been particularly keen on taking seriously the views of the very core group of people without whom this history would not exist.”\textsuperscript{41} Reaume argues that in order to move past the stigmas and stereotypes of people deemed mad, historians must seriously examine the history from the perspective of the people who lived those lives.\textsuperscript{42} Approaching the history of mental illness from the perspective of the individual validates and humanizes the experiences of people considered mad, but as Reaume suggests, this approach additionally has the potential to connect the history of madness to current experiences of people diagnosed with mental illnesses.\textsuperscript{43}

\textsuperscript{39} Nielsen, \textit{A Disability History of the United States}, 25.

\textsuperscript{40} Grob, \textit{The Mad Among Us}, 131.


\textsuperscript{42} Ibid., 173.

\textsuperscript{43} Ibid., 175.
Over the last few decades, public historians have incorporated disability history into their work further helping to both uncover the often hidden histories of people with disabilities and also making this history accessible to wider audiences.\textsuperscript{44} Public history, in general, is the way that professional historians present interpretations of the past for consumption by the public. It moves beyond the traditional academic forms of historical presentations and seeks to transmit the history of people, places, and events to the entire community, both academics and non-academics. Robert Archibald states, “public history can become the basis for inclusive dialogue and shared stories. This is not the imposed ‘master narrative of old’ that defined insiders and outsiders, but instead a process of story making that creates room for the diverse and multiple perspectives that exist in consequence of our individuality.”\textsuperscript{45} Public history provides a venue where history can become a dialog between historians and their audiences. In addition, many of its practitioners seek to present the history of diverse people to diverse audiences.

Social norms and standards are dictated and reinforced through various outlets including art, movies, books, and advertisements, as well as parents, role models, peers, and teachers. What is considered beautiful, normal, desirable, or ideal is often created and supported through such social outlets. Public historians are not free from perpetuating such mythic standards and have been guilty of depicting historic human representations


as only able-bodied and healthy.\textsuperscript{46} Although disease, injury, and illnesses are a large part of the past, these characteristics are often overlooked in creating images, illustrations, and displays for public history exhibits and instead the human form is presented in an idealized manner. Susan Burch and Katherine Ott write, “difference was everywhere, yet it is missing from the history we present to the public.”\textsuperscript{47} It is the responsibility of public historians to move beyond a safe, idealized version of history and instead portray and represent a realistic past. Museums, historic sites, documentaries and other forms of public history are created to not only connect viewers and visitors with the past, but more importantly to prompt dialog, generate questions, evoke self-reflection, and bridge the past, present, and future. However, what happens when visitors and consumers cannot form a connection with the histories represented? What happens when museums resolve to portray an idealized form of history, a safer, less controversial interpretation? Burch and Ott suggest that until public historians understand and include a diverse representation of humanity and our past, those who are unrepresented, including individuals with disabilities, may feel unwelcome and unconnected to these places and presentations.\textsuperscript{48}

Although many traditional museums have taken strides to make in order to portray a representative history inclusive of individuals with disabilities, there are a growing number of online museums and archives specifically related to disability


\textsuperscript{47} Ibid., 21.

\textsuperscript{48} Ibid., 24.
history. The online format can be aptly suitable for the presentation of disability history because it allows for the vastness of the field to be represented and displayed in one place. Such expansive representation might otherwise be impossible to achieve in a physical space. Although coordinating digital representations of artifacts, photographs, and documents presents its own challenges, it can be easier to bring various digital images into one web-based setting than to coordinate tangible objects in a physical setting. Not only are these resources convenient for visitors because they are accessible at all times, but technology brings the benefit of providing various tools to further increase accessibility including screen readers, magnifiers, and audio clips.

Two examples of such online museums are The Disability History Museum and The Disability Social History Project. The Disability History Museum provides visitors with the tools necessary to expand their “understanding of human variation and difference” and to explore how different cultural, social, and legal influences have affected the lives of people with disabilities throughout history. In order to accomplish this goal, the website offers a searchable library, including a variety of documents and visual stills. Additionally, the website offers teaching tools and lesson plans based on the primary sources within the collection. The website’s large, and easily searchable collection serves as its major attraction. It can be browsed through a topic list, searched by keyword, or date range. The site has the potential to provide visitors with a general


50 Ibid., 93.

overview of disability history or to direct someone with a specific interest to the numerous available resources. For example a keyword search of “asylum” returns over 280 results or a keyword search of “psychiatric disability” produces over 300 results.

The Disability Social History Project attempts to take up where public historians, museums, and the media have left out or misrepresented people with disabilities. The website’s mission is to provide a place where people with disabilities can tell their own complex stories, on their own terms, by “reclaiming” the history. The Disability Social History Project and its exhibits, projects, and resources are a collaborative effort between the website creators and the community. The website encourages active participation of visitors, to share their own artifacts, images, and stories to expand the website content. Through exhibits that highlight disability heroes and historical figures, and links to published sources and bibliographies, the website directs users to where they might learn more about a particular disability topic. This website is much less comprehensive than The Disability Museum, but it does take a unique approach to presenting disability history by incorporating user contributions. However, like many websites in general, the site appears to lack regular updating and maintenance. Although the content on the site is interesting, without continued improvement and updating, engaging returning visitors will be difficult.

Aside from museums and exhibits, archival collections exist to preserve historical documents and make them available for the public. The Society of American Archivists describes archives as the “non-current records of individuals, groups, institutions, and

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governments that contain information of enduring value.” Archivists, like other public historians, have the opportunity to be selective in the materials that they deem important or containing “enduring value.” Therefore, archivists must concentrate their effort to collect and preserve documents and records from various people and perspectives. In Northwest Ohio, the Regional Disability History Archive Project stands out as a successful effort to actively address the void that existed among both local and national archival collections in relation to disability history. Diane F. Britton, Barbara Floyd, and Patricia Murphy explain that since the beginning of the social history movement in the 1960s, archivists have become more active, directed, and intentionally inclusive in developing their collections. However, they further argue that despite these efforts, many archives lack collections related to or documenting the history of people with disabilities. A collaborative effort of the University of Toledo Disability Studies Program, History Department, Ward M. Canaday Center, and The Ability Center of Northwest Ohio resulted in the creation of the Regional Disability History Archive Project. This cooperative partnership led to the creation of a resource that benefits researchers, but more importantly a place where the voices of individuals with disabilities have been made accessible. This project is one example of archivists, historians, and community partners bringing to light the history of people with disabilities, there is still much to be done.

Archivists must make a concerted effort to locate, collect, preserve, and make available the records of disability in their communities in the same manner that

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54 Britton, Floyd, and Murphy, “Overcoming Another Obstacle,” 219.
they have sought to document other minorities. Historians—both disabled and able-bodied—must begin to undertake scholarly analysis of the disabled at the local level and place such history in the larger context of disability in the United States. And public historians must work to bring the history of the disabled to the community in ways that are meaningful.55

It is with this charge, that “A Room for History” begins to take shape.

Across the U.S. there are current and former examples of museums or exhibits related to mental health history. For example, The Indiana Medical History Museum, housed inside the Old Pathology Building on the campus of the former Central State Hospital in Indianapolis, maintains and exhibits an extensive collection related to scientific psychiatry. The scope of this museum extends beyond psychiatry, with a mission to “educate the community concerning health care, health careers, and life sciences in Indiana during the nineteenth and first half of the twentieth centuries.”56

Among the Indiana Medical History Museum’s collection are several artifacts related to disability history and more specifically mental health history, including many brain specimens from patients at Central State Hospital. Although an extremely fascinating collection, the museum’s main focus is medical history and offers little insight into the daily lives of residents at the Central State Hospital or perspectives from individuals diagnosed as insane.

In 2001, the Jefferson County Historical Society in Madison, Indiana in collaboration with the Madison State Hospital developed the Gatehouse Museum on the campus of Madison State Hospital. With a $50,000 grant, the historic gatehouse at the east entrance of the hospital was renovated to create an exhibit exploring mental health

55 Ibid., 224.

history at Madison State Hospital. Unfortunately, the museum closed in late 2007. One staff member at the local historical society suggested that people were not interested in seeing and learning about an unflattering past of mental health medical treatments. While it was not fully clear why the hospital was unsuccessful, low attendance and high costs of maintaining a historic building and artifacts were surely key factors.

One of the most recent mental health museums to open to the public is the Oregon State Hospital Museum on Mental Health, located in the restored Kirkbride building on the campus of the Oregon State Hospital and filming location for the 1975 movie *One Flew Over the Cuckoo's Nest.* The museum houses a collection of artifacts, photographs, and documents from the Oregon State Hospital and from former state hospitals that have ceased operation. The museum opened in late 2012 with the mission to “…create and operate a museum within the Oregon State Hospital campus where people may learn through artifacts and stories an awareness of and connection to the people who lived at and worked at the hospital.” As the mission statement suggests, part of the significance of this museum is its physical location within the Oregon State Hospital campus and to create a dialogue between visitors and the voices of the past.

This is closely related to the goals of the proposed project “A Room for History.” Not only does this project aim to create a true sense of history by housing an exhibit at the Northwest Ohio Psychiatric Hospital, site of the original Toledo State Hospital and to uncover the voices and hidden histories through exhibits and displays; it also brings

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58 Staff at Jefferson County Historical Society, conversations with author, October 2013.

together the present and the past by emphasizing the importance of access to history. Robert Archibald describes the necessity of a museum to practice “inreach” as opposed to outreach. Rather than seeking to deliver services through outreach programs, inreach is about building relationships and allowing the community to reach into the museum and facilitate meaningful conversations, powerful discussions, and hopefully a better understanding of both the past and present.\footnote{Archibald, \textit{The New Town Square}, 209.} As Archibald says “history belongs not to us, the professionals, but to the community” and it is with that idea that “A Room for History” proposes to create an exhibit not only for the general Northwest Ohio community, but for the Northwest Ohio Psychiatric Hospital community.\footnote{Ibid., 211.}

In January of 2013, The Toledo State Hospital (TSH) celebrated 125 years of serving Northwest Ohio. The Archives Room at NOPH contains a small, but fascinating collection of furniture, artifacts, books, photographs, and documents. The current project presents the plans needed to bring the Archives Room at NOPH from a random collection of interesting items, to a space used to interpret the history of the hospital and to share the many stories of the patients, staff, and community. The project will create “A Room for History,” within the walls of NOPH, where not only the expansive past of the TSH is explored, but its connections to mental health and disability history across the U.S.

It is vital that the space for the exhibit be located within the current NOPH because the history of TSH occurred on those grounds and within that community. The history and the space are connected. According to historian David Glassberg, “historical consciousness and place consciousness are inextricably intertwined; we attach histories to
places, and the environmental value we attach to place comes largely through memories and historical associations we have with it.\textsuperscript{62} For the Archives Room, the sense of place becomes even more relevant because the hospital is still a functioning mental health hospital. The artifacts belong inside the hospital walls because they are familiar in that setting and thus create a sense of connectedness between the objects, the place, the stories, and the visitors. As a public history exhibit, one of the goals is to make relevant connections between the historical events and present experiences of people diagnosed with mental illnesses; creating this exhibit within the state psychiatric hospital will make such connections between historical consciousness, place consciousness, and present-day connections even stronger.

A detailed history of the Toledo State Hospital reveals its significance as both a local institution and as an indicator of larger changes in the field of care for people with mental illness. Chapter two examines the era from 1821-1914, when the rise in incidences of insanity led to the practice of asylum building. By the turn of the century, the state of Ohio mandated publicly supported state institutions for the insane. This resulted in the construction of the Toledo Asylum for the Insane, which was built on the cottage system. Planners considered this design as the most humane approach to house and care for people with mental disabilities.

Chapter three continues the narrative from the early twentieth century when a growing number of professionals were increasingly doubtful of the effectiveness and sustainability of institutionalizing the insane in large numbers. The rise of the Mental Hygiene movement emphasized a preventative approach paired with a focus on medical

and pharmaceutical interventions for insanity, as well as larger community based support systems that encouraged re-integration into society for those individuals considered cured. As state resources shifted in support of these newer professional theories, the state hospital was no longer the center of care for individuals with mental illness. The hospital conditions deteriorated and resident populations declined. A careful examination of local and state records reveals much about the day-to-day lives of individual who lived and worked at the Toledo State Hospital, and whose stories, for the most part, have been forgotten. The fourth chapter argues that these previously hidden histories deserve to be revealed. The application of professional museum standards and best practices provide the framework for the proposed Toledo State Hospital Museum to be located at the NOPH. Doing so allows those most connected to the history—patients and staff, but also families and other community members—to understand the importance of place in learning about the past.

Finally, it is necessary to discuss the language used through this thesis. Just as the ideas of disability have changed over time, so have the words and labels used to describe a person with disabilities. Words such as “insane,” “mad,” “distracted person” and “lunatick,” were commonly used in the past, but in today’s society are seen as both harsh and offensive. Many of these words are used throughout this thesis in order to better express the historical notions and social constructs at the time. Although these labels are inaccurate and offensive in our current society, at the time, these were the socially, medically, and commonly accepted ways to describe a person with a mental illness.
Chapter 2
1821-1914: The Rise of Insanity and Insane Asylums

Are we to keep on building more and larger asylums, or are we in the future to turn our thoughts and endeavors to the prevention of the unfit class of society? Our insane are now cared for better in institutions than they can be cared for in their own homes; this is as it should be, the state should accept the responsibility, but the state should also accept the fact that insanity is on the increase and that we have a great many more delinquent and feeble-minded that we dreamed of in former years.¹

Dr. George Love closed his 1915 article, “History of the Institutional Care of the Insane,” with these words.² At the time, state institutions for the insane were prominent across the county, including in Ohio. Nearly 100 years earlier, in 1821, Ohio state legislators passed “An act establishing a commercial hospital and lunatic asylum for the state of Ohio” which appropriated $10,000 to Cincinnati Township in Hamilton County to build an asylum that would “at all times be open to the reception, safe keeping, comfort, and medical treatment of such of the idiots, lunatics, and insane persons of this state.”³ As a result of this new law, Ohio established and constructed its first institution specifically to house the insane, starting a trend that would continue over the next 150 years.

Institutions were not the state’s first attempt at providing care for this population. During the early years of statehood, Ohio enacted laws to provide for the insane through


² Dr. George Love was the second superintendent at Toledo State Hospital from to 1906 to 1919.

³ Acts Passed at the First Session of the Nineteenth General Assembly, of the State of Ohio, (Columbus, OH, 1821), 61.
the appointment of guardians and, later, overseers of the poor.\textsuperscript{4} As early as 1814 Ohio had laws on the books to confine those deemed to be insane or lunatics and a danger to themselves or others in county jails.\textsuperscript{5} County infirmaries and jails were commonly used during the nineteenth and early twentieth century to house residents of the county deemed insane, as well as residents unable to live on their own including the elderly, ill, poor, orphaned, feeble-minded, and epileptic.\textsuperscript{6}

In 1867, Governor Jacob D. Cox created the Ohio Board of State Charities to operate as a five person committee tasked with “investigating the whole system of the public charitable and correctional institutions of the State” and providing an annual report with observances, recommendations, and suggestions for additional requirements so these institutions could run efficiently and economically while providing good care.\textsuperscript{7} State Charities included county infirmaries, jails, insane asylums, and other public institutions. From its early years, the Board members were proponents of housing the insane in state asylums, rather than infirmaries or jails. Further they advocated that an “enlightened” approach to treating the insane would be the most successful model of care and treatment. In 1867, three state asylums existed in Columbus, Cleveland, and Dayton. A fourth asylum in Cincinnati was a quasi-state facility, but was primarily considered a county facility. In its first year, the Board recommended increasing accommodations at the state

\textsuperscript{4} Acts of the State of Ohio, Passed and Revised, First Session of the Third General Assembly, (Chillicothe, OH, 1805), 163-166.

\textsuperscript{5} Acts Passed at the First Session of the Thirtieth General Assembly of the State of Ohio, (Chillicothe, OH, 1814), 161-162.

\textsuperscript{6} First Annual Report of the Board of State Charities to the Governor of the State of Ohio, (1868), 11-12.

\textsuperscript{7} Third Annual Report of the Board of State Charities to the Governor of the State of Ohio, (1869), 3.
asylums in Columbus, Cleveland, and Dayton, building an additional asylum, and correcting for the sometimes “brutal” conditions that the insane were exposed to in county infirmaries and jails. An expressed need for asylum expansion and increased capacity remained a reoccurring theme in the Board’s annual reports from 1867 through the early 1900s.

A fire destroyed the Columbus asylum in 1868 and capacity at the remaining asylums became an even larger concern. In 1871, the Northwest Ohio Hospital for the Insane, located in Lucas County, contracted with the state to help reduce the overcrowding in the three existing asylums. The Board suggested to the General Assembly that Northwest Ohio Hospital temporarily incorporate with the Northern Asylum, in Cleveland, to help relieve overcrowding. According to the annual report, “the suggestion did not meet with favor,” yet the Board passed a resolution allowing Lucas County Commissioners to organize a county asylum paid for by the state. The Board members were not entirely pleased with this resolution and felt it gave preference to Lucas County residents rather than helping to relieve overcrowding on the Northern Asylum.

In 1872, the Ohio legislature passed an act abolishing the Board of State Charities, but the construction of a new asylum in Athens, Ohio continued and opened for patients in 1874. When Governor Rutherford B. Hayes reenacted the Board in 1876, once

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8 The existing Ohio asylums in 1871 included Northern Asylum (Cleveland), Southern Asylum (Dayton), Longview (Cincinnati); *Fifth Annual Report of the Board of State Charities to the Governor of the State of Ohio*, (1871), 77.

9 Ibid., 48-49.

10 Ibid., 49.

11 Ibid., 49.
again, the concern of providing additional accommodations for the state’s insane became a primary issue for the group. In 1876, the Board’s Secretary, Dr. Albert G. Byers reported the insane in county infirmaries were often housed in buildings separate from the main building. Conditions were described as “devoid of comfort, and without possible facilities for the proper care of the unfortunate classes consigned to them.”\textsuperscript{12} Secretary Byers’ described these buildings as places where “the violent and the filthy are securely locked, and frequently left, abandoned of all care, save that they are fed.”\textsuperscript{13} He maintained that the people living in these conditions demanded attention and though improvements had been made, much work remained to be accomplished. He, along with the Board, continued to make a case to transition the insane from county infirmaries into state asylums where better care could be afforded.\textsuperscript{14}

In July of 1879, the Board presented to the Ohio General Assembly a persuasive argument entitled “Our Public Institutions.” It highlighted the issues that plagued the state’s asylums and care for the insane. At this time, the asylums were over capacity, housing nearly 3,400 patients with at least another 750 identified as residing outside of state care.\textsuperscript{15} The Board began its argument by acknowledging the “Ohio Idea,” which declared it was the state’s responsibility to provide the most complete care to all citizens “thus afflicted” regardless of their ability to pay for services, nationality, or color. Under

\textsuperscript{12} First Annual Report of the Board of State Charities to the Ohio State General Assembly, (1876), 14.

\textsuperscript{13} Ibid., 15.

\textsuperscript{14} Ibid., 17.

\textsuperscript{15} In 1879, Ohio had five Insane Asylums including Athens, Cleveland, Columbus (completed in 1877), Dayton, Longview (Cincinnati), and Northwestern Asylum (Previously Northwest Ohio Hospital for the Insane). Ibid., 10, 32.
this plan, the state provided care free of charge and “guaranteed exactly uniform
treatment by every State official.”16 Board members commended the progressiveness of
the Ohio Idea and argued it was imperative for the state to continue moving forward by
identifying a solution to better care for the dependent classes, especially the insane.
Board members determined building another new asylum was too costly. Instead, the
This plan included building supplemental outbuildings at existing state asylums to house
an additional 250 people, intended for the hospital’s long term chronic cases of insanity.
The Ohio Board saw this as the most cost effective measure to providing additional
accommodations without building an entirely new hospital.17

By 1880, the Board continued to express a need for additional accommodations at
the state’s hospitals in order to remove the insane, idiot, and epileptic residents from
county infirmaries into specialized state institutions. The 1880 report stated, “the
infirmaries, with these classes present, never can be made comfortable for dependent sick
and poor.” Secondly, it suggested that “these classes, neither of them, can, without great
expense to the counties, be properly provided for, and so our entire system of care for the
poor will be subject of the more or less frequent occurrence of those horrors of neglect
and abuse which have so long and so shamefully disgraced our care of the poor,
dependent and helpless.”18

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17 Third Annual Report of the Board of State Charities to the Ohio State General Assembly, (1878), 9-10.

18 Fifth Annual Report of the Board of State Charities to the Ohio State General Assembly, (1880), 31-32.
In 1882, the Board reported that 1,086 insane persons resided in infirmaries across the state with at least another 80 in the jails.\textsuperscript{19} Further, the report concluded that “additional accommodations for at least one thousand insane” were called for in order to meet the “constitutional obligations to the insane of the state.”\textsuperscript{20} Board members recognized in order to gain approval from the legislature, the cost of the new asylum needed to be between $300 and $500 per capita. This price was far less than any other Ohio asylum built in the past. For example, the reconstructed Columbus Asylum had cost $2,000 per capita and the least expensive asylum built in Ohio cost $1,500 per capita.\textsuperscript{21}

The Board’s cost conscious proposal was successful and as a result, the Ohio General Assembly passed House Bill 909 in April 18, 1883 “to provide for additional accommodations for the insane of the state.”\textsuperscript{22} The bill created a commission charged with determining and implementing plans for either the expansion of current state asylum facilities or selecting a new site. Further, the bill determined an initial budget of $500,000 to complete the project. Section five of the bill “authorized and empowered” County Commissioners to “sell or donate and convey to the state, for asylum purposes, any lands owned by their respective counties.”\textsuperscript{23} On October 17, 1883, the Lucas County Commissioners answered that call when they passed a motion to donate “150 acres of the Infirmary Farm to the State of Ohio for the purpose of erecting thereon an Insane

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\item \textsuperscript{19} Seventh Annual Report of the Board of State Charities to the Ohio State General Assembly, (1882), 5.
\item \textsuperscript{20} Ibid., 5.
\item \textsuperscript{21} Eight Annual Report of the Board of State Charities to the General Assembly of the State of Ohio, (1882), 5.
\item \textsuperscript{22} The State of Ohio General and Local Laws and Joint Resolutions Passed by the Sixty-Fifth General Assembly, (Columbus, OH, 1883), 181.
\item \textsuperscript{23} Ibid., 182.
\end{itemize}
In late 1883, “after much deliberation” the state appointed commission accepted the land donation from Lucas County.

In addition to selecting the location, the state commission determined the asylum’s architectural design. The previously constructed asylums in Cincinnati, Cleveland, Dayton, Columbus, and Athens, as well as many other asylums across the country, followed a congregate plan, in which patients and staff lived under one roof. Congregate plans varied, but by the mid-1800s, the Kirkbride plan in particular was the standard for asylum building across the United States.

Named for Dr. Thomas S. Kirkbride, the Kirkbride plan provided a linear building design containing connected wings arranged in a V shape. All of the previously constructed Ohio asylums, except for Cincinnati, were built on the Kirkbride model. Like other congregate buildings, both administrative functions and patient care took place within one facility, but the Kirkbride model set clear standards for location of the institution, layout of the grounds, construction of the building, size of rooms, window placement, capacity, staff, and many other details. Generally, the center of the building contained the business offices, staff space, medical offices, dormitory space for the superintendent’s family and other staff, as well as a public parlor, reception room for

24 Lucas County, Ohio Board of County Commissioners, 1883, Commissioners’ Journals. Microfilm: reel 222. Bowling Green State University, Center for Archival Collections.

25 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1884), 6; Eighth Annual Report of the Board of State Charities to the Ohio State General Assembly, (1883), 11-12.


patients, and kitchen.\textsuperscript{28} Patients were housed in wards within each of the wings that extended from both sides of the center building.\textsuperscript{29} The design, rural location, and features of a Kirkbride facility were created with a moral treatment system in mind, which included providing adequate space for patients to both inside and outside, treatment areas, and a pleasant atmosphere.\textsuperscript{30} During the mid-1800s the Kirkbride plan and moral treatment were considered by asylum professionals to be the highest standard of care. In 1851, the plan was adopted and endorsed by the Association of Medical Superintendents of the American Institutions for the Insane as the primary plan to use in the construction of new asylums.\textsuperscript{31}

By the latter part of the nineteenth century, treatment approaches to insanity were changing along with institutional practices and architectural design. Toward the end of the 1800s, some hospitals across the country had moved from a singular, linear, main-building to a blended construction type that incorporated both the main linear building and additional buildings across the campus. The first asylum constructed on a blended plan was Illinois Eastern Hospital for the Insane at Kankakee, Illinois which included plans for both a main Kirkbride facility and cottages across the campus for the chronic cases.\textsuperscript{32}

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\begin{itemize}
\item \textsuperscript{28} Ibid., 54-55.
\item \textsuperscript{29} Grob, \textit{The Mad Among Us}, 72; Yanni, \textit{The Architecture of Madness}, 51; Kirkbride, \textit{On the Construction}, 55.
\item \textsuperscript{31} Ibid., 8.
\item \textsuperscript{32} Yanni, \textit{The Architecture of Madness}, 91.
\end{itemize}
Construction on the Toledo Asylum for the Insane began in 1884. The asylum became not only the first non-Kirkbride built in Ohio, but the first in the country constructed completely upon the detached ward, or “cottage” plan. This design differed from the Kirkbride plan and “instead of aggregating the whole institution under one roof, it segregated [sic] [the patients] into about forty different buildings, constituting a small village occupying about forty acres of ground.” The Board of State Charities noted “this institution is rather unique in its arrangement of buildings, carrying the segregate system farther than any other institution in the country.” The asylum’s Superintendent of Construction, James Winans, observed the Toledo plan was one “with which so few are familiar,” which made planning for construction necessities and provisions more difficult.

Toledo Asylum planners used the cottage plan for many reasons. The Second Annual Report discussed the benefits of the design as providing a way to sequester and classify patients in detached buildings rather than all under one roof. Additionally, trustees contended that the cottage plan was more humane and therapeutic, compared to the Kirkbride plan, and it allowed more flexibility as “the capacity of this institution can be increased at any time.” Architectural historian Carla Yanni described “Kirkbride’s


34 Eighth Annual Report of the Board of State Charities to the Ohio State General Assembly, (1883), 8.


36 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1884), 28.
shallow V as uniquely suited to what he believed were the needs of the curable insane when he devised the plan in 1847; in fact, the plan was so highly specialized that linear plan hospitals could not be reconfigured for other uses."38 Further, critics of the linear plan argued that the detached plan provided patients with more independence and a more “social atmosphere.”39 Lastly, the cost of building the asylum on the cottage plan was far more economical than constructing the massive linear model.

An asylum’s surrounding grounds were equally important to the institution and treatment of its residents. The location for the Toledo Asylum, being remote yet close enough to a major city, was approved as it fit into the general ideal of asylum building at the time. The grounds provided an even surface and dry soil that could be readily farmed once the underbrush and tree stumps were removed. Agriculture provided an important source of food for the asylum and by the late nineteenth century, voluntary employment, including farm work was “generally accepted as a proper and favorable means for recovery.” Additionally, the Toledo location, near Swan Creek afforded “ample means for perfect drainage” into which the sewer main would empty.40

In early 1884, Ohio Governor George Hoadly appointed a Board of Trustees comprised of five Toledo area members to oversee the construction of the asylum. Ohio Attorney General, James Lawrence, determined the first construction contract with Miles, Cramer & Horn to be invalid and requested the Trustees accept a second round of bids.

37 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1885), 5; Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1886), 11.
38 Yanni, The Architecture of Madness, 142.
39 Ibid., 79.
40 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1884), 6, 28.
Michael J. and William Malone submitted the lowest bid and the Trustees awarded the contract on June 13, 1884. The Malone bid was $100,000 under the approved budget of $500,000 and the Trustees proposed the use of the additional funds to secure the wards from risk of fire and to add basements under the wards and pavilions. However, shortly after construction began, workers found areas of quick sand beneath the site, rendering it unsafe for building foundations. Additional funding was necessary to safely build the foundations, so the Board entered into yet another contract with the Malones to reflect the increased cost.\footnote{Ibid., 8, 32.} In September of 1884, the Board and the Malones signed the final construction contract. Superintendent of Construction James Winas reported that the setbacks related to the foundation caused a three-month delay in construction, but “with a corresponding gain in having the foundation of every building safe for all time.” By the end of the year, workers built a spur from the Wabash, St. Louis & Pacific Railroad on the grounds to accommodate direct delivery of construction materials.\footnote{Ibid., 26-27.}

E.O. Fallis of Toledo and J.W. Yost of Columbus designed the new asylum. Fallis, a prominent architect throughout the late nineteenth and early twentieth century, had designed other buildings across Northwest Ohio including the downtown Toledo Valentine Theater, Williams County Courthouse, homes within Toledo’s west end, sections of the Wood County Home & Infirmary, Victory Hotel on South Bass Island, and Toledo’s Nasby Building, the city’s first sky scraper.\footnote{Theodor J. Ligibel, “E.O. Fallis: Master Architect in Perspective” (MA thesis, Bowling Green State University, 1981), 187-191.}
The contract contained plans for 34 structures, including an administration building, chapel, kitchen and bakery, two strong wards, and 20 cottages. Delays and setbacks plagued the construction of the Toledo Asylum. The initial timeline projected a completion date of October 1886, however the opening did not occur until January of 1888. Recommendations from the Asylum’s Board of Trustees included building additional structures, adding electricity across the facilities and grounds, and changing from coal to natural gas heating in part caused the asylum’s delayed opening, along with delays in approval from the State Legislature purchase approvals.\textsuperscript{44}

As construction continued, the Trustees made preparations to receive patients. In December 1886, they appointed Dr. Henry Archibald Tobey as Superintendent of the Toledo Asylum. Many fellow physicians, and “other persons of high standing in civil life,” strongly recommended Dr. Tobey to the Board. He was an Ohio native with prior experience in the treatment of insanity. His previous appointments as assistant physician at the Columbus Asylum for the Insane from 1877-1880 and Superintendent at the Dayton Asylum for the Insane from 1880-1884 provided him with experience in asylum care and management.\textsuperscript{45}

One last delay in the summer of 1887 brought another setback in the opening of the facility. In August, “a violent tornado” made its way across Northwest Ohio and through the asylum grounds and caused an estimated $1,200 in damages to buildings and

\textsuperscript{44} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1886), 6-7; Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1887), 10-11.

The Toledo Asylum for the Insane was opened to receive patients on January 6, 1888, less than five years after House Bill 909 called for the expansion of the State’s care of the insane. On this date, 160 male and 180 female patients were transferred from Columbus Asylum to Toledo. On January 20, 74 males and 52 females moved from the Cleveland Asylum to Toledo and on the first day of the following month 57 female and 66 male patients were transferred from the Dayton Asylum. The Asylum received an additional 172 patients from various county infirmaries. By November of 1888, the Toledo Asylum’s patient population reached 868, with the capacity to care for another 1,000 individuals. The state was still under contract with the Northwest Ohio Insane Asylum where 90 patients remained until the contract ended in February 1889 and the patients were transferred new Toledo Asylum.

The Toledo Asylum and Dr. Tobey approached the care and treatment of insanity by “allowing the patients the largest amount of liberty and the greatest number of privileges consistent with their respective conditions, and to substitute self-control for restraint to as great an extent as possible.” The Board of State Charities Annual Report described the Toledo Asylum:

Meanwhile, no form of mechanical restraint whatever is employed. A female patient reported at the time of her transfer as ‘violent and destructive,’ was placed in one of the strong rooms, where she made havoc of everything destructible. The following day the superintendent remonstrated kindly, asking the patient ‘not to


49 Ibid., 11.
tear the house down.' 'Well,' she said, 'if you don't want me to do it, put on your harness,' intimating the crib by night, and straight-jacket by day. She was told no such means would be employed; that she must endeavor to restrain herself, that every help in this direction possible would be given.  

Further promoting the concept of increased liberties, the hospital instituted “privilege cards” which allowed those who earned the right to freely access the asylum grounds without supervision for an extended period of time. Dr. Tobey noted in his report that “besides patients having privilege cards, there are many others of both sexes who are allowed to go out from their cottages and wards unattended.” Although institutionalization was and still is a reduction of personal liberties, the approaches taken at the Toledo Asylum for the Insane attempted to allow and encourage patients to retain as much freedom as possible. The Board suggested these practices for use across the state, but not all institutions had implemented them to the degree that Toledo did.

During the construction of the Toledo Asylum for the Insane and even upon opening, Board members, Government officials and members of the public had doubts about the cottage plan. Many did not believe that such a facility could be constructed for a cost so drastically lower than prior hospitals. Others doubted that the layout would be successful in caring for the insane dubbing it “Foster’s Folly” after Ohio Governor

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51 Ibid., 12.

52 Board of State Charities Annual Report 1887 included recommendation to asylums across the state which included limiting the use of physical restraints, while not replacing physical restraints with narcotics and drugs, instead it was suggested that patients should have daily work, exercise, open air, good, plain food, good ventilation, warm, light rooms and halls for exercise. Further the board noted that fear and intimidation tactics should not be employed by attendants and those attendants who are “harsh or ill tempered” should be dismissed. Other recommendations include having female physicians for the female ward and an emphasis on cleanliness and sanitary conditions. *Twelfth Annual Report of the Board of State Charities to the Sixty-Eighth General Assembly to the State of Ohio*, 1887, 16.
Charles Foster who had supported the use of the cottage plan in Toledo. In the hospital’s fifth annual report, Dr. Tobey recounts his own doubts concerning the hospital’s building plan:

Persons experienced in the care of the insane have generally, I think, entertained very grave doubts as to the practicability or advisability of the plan and special features of this asylum, and the opening and occupying of it was regarded as a good deal of an experiment, and I must confess that I, to a certain extent, partook of this feeling myself.

However he concluded, in the same report that “ten months’ experience has been sufficient to satisfy all who are familiar with its operations that such apprehensions were not well founded.” Not only was Dr. Tobey convinced of the success of the cottage plan in Toledo, the Board of State Charities was also pleased with the facility. The year following the opening of the institution, the Board of State Charities recommended construction of an additional asylum in the eastern part of the state as the population of people with insanity continued to grow. The Board suggested “such an asylum should be constructed upon the cottage system, which experience at Toledo has shown to be more economical in construction and superior in accommodations to any other and we believe at present prices need not cost more than $450 for each patient provided for.” The Toledo Asylum’s cottage plan was a success in terms of building on a budget, meeting

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54 *Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane*, (1888), 10.

55 Ibid., 10.

56 *Fourteenth Annual Report of the Board of State Charities to the Ohio State General Assembly*, (1889), 11.
capacity expectations, and treatment for the insane. By the late 1880s, many other states moved away from the Kirkbride plans and built institutions based on the cottage plan.

The Toledo Asylum for the Insane admitted patients for a variety of both psychological and physical conditions. Officials documented the causes of insanity for each patient and aggregated these each year in the Annual Reports. The 1890 Toledo Asylum annual report listed “moral” causes of insanity such as domestic troubles, anxiety and worry, grief, love affair, financial troubles, or religious excitement. It also listed “physical” causes of insanity including hereditary influences, previous attacks of insanity, senility, accident or injury, intemperance in drink, over exertion, or other bodily diseases.57

At the time that Toledo Asylum for the Insane opened, it was not uncommon for local newspapers to report on citizens declared insane by the probate court. For example, the Stark County Democrat published a short piece on Mrs. Kurcher, the wife of a local farmer, who was driven “violently insane by the furious weather” while traveling. The article further stated “application has been made for her admission to Toledo Insane Asylum.”58 Another article in the same newspaper, entitled “A Loving Wife,” described the wife of a “highly respected family” who “finally succumbs to the influence of jealous disposition.” She claimed to hearing voices and admitted to setting her husband’s bed on fire because she believed her neighbors were plotting to take away her husband and family. The probate court deemed her insane and sent her to the asylum in Toledo.59

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57 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1890), 26.

These newspaper reports provide a limited view at individuals who lived in the state’s asylum.

In addition to newspaper articles, the Annual Reports provide clues to what daily life was like for patients at the Toledo Asylum for the Insane. They include details about foods and drinks purchased each year, food raised or grown on site, purchases for amusement purposes, as well as outdoor recreation, exercise, social gatherings, on site employment, and group outings. For example, Figure 1. shows a baseball game on the asylum’s recreational grounds. Dr. Tobey was adamant in his report to the Board of Trustees that patients needed a separate facility for amusement purposes. In both 1888 and 1889, he requested funds to build an amusement hall stating, “the importance of having a suitable place where patients may be congregated and provided with amusement and entertainment, is so generally understood that it is unnecessary to present any

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60 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1893).
argument.” However, even without an amusement hall the Asylum hosted weekly dances under a tent during the summer and in the dining hall during winter months. Other forms of entertainment included a cornet band composed of patients and staff that performed twice a week during the summer. In 1889, the Fourth of July was celebrated with a baseball game and fireworks in the evening. In 1893, Christmas Eve festivities included an “elaborate Christmas tree” in the amusement hall where “upwards of 750 patients were in attendance and each one received some remembrance.”

Patients took outings as well, including a boat ride on the steamer ‘Pastime,’ which traveled along the Maumee River from Toledo to Perrysburg (see Figure 2).

*Figure 2. The Pastime 1898. Courtesy of Toledo Lucas County Library Images in Time Collection.*

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61 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1888), 17.

62 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1888), 17; Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1889), 15.

63 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1893), 11.

Other amusements included trips to the Lucas County fair which over 300 hundred patients attended in 1889, on-site concerts from local groups including the Speranza Minstrel Company of Toledo, amateur theatrical groups, and “a number of like entertainments were given by home talent.” The hospital’s budget included funds to be used for patient recreation and amusement. Purchases included band instruments, masks and wigs for masquerade dances, playing cards, baseballs, tickets to Barnum’s show, and fireworks.

Beginning in the Asylums first year, visiting ministers from various denominations held weekly chapel services. As the Asylum population grew, officials moved these services from the chapel to the amusement hall. Reverend A. G. Jennings was a regular visiting minister from 1893-1913 and Father Charles Herr of St. Charles Catholic Church conducted Catholic services monthly.

Local residents and publishers donated journals, magazines, and periodicals providing additional sources of entertainment and education for the patients. Dr. Tobey noted that these publications “contributed so much to the pleasure and entertainment of the patients from their respective towns and counties—many of the patients looking

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65 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1889), 16.
66 Ibid., 41; Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1891), 29.
67 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1888), 19.
68 Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1899), 16.
69 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1893), 17; Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1899), 19; Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1905), 17; The Ohio Board of Administration Annual Report, (1913), 93.
forward to the arrival of their papers with as much eagerness as they would for a letter from home.\textsuperscript{70} Although it is difficult to glean individual voices from these sources, it is possible to see that daily life at the asylum had the potential for various forms of entertainment and amusement, especially with a Superintendent who was an advocate for such recreation.

The cottage plan included a congregate dining hall, where all patients and staff gathered at the same time for daily meals. This dining arrangement was vastly different from earlier asylum designs, such as the Kirkbride layout, where patients and staff ate in separate dining rooms each located in their own wing. Dr. Tobey’s initial concerns with the cottage system focused on his apprehensions about the new dining setup, calling it the most impractical feature of the cottage plan. However, he came to appreciate the congregate dining hall, after seeing it in use.\textsuperscript{71} Initially Dr. Tobey was concerned that bad weather might deter patients from walking to a meal (see Figure 3), but after talking

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{patients_en_route_to_meals.jpg}
\caption{Patients en Route to Meals. Scanned Image.\textsuperscript{72}}
\end{figure}

\textsuperscript{70} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1889), 23.

\textsuperscript{71} Ibid., 13.
with patients, he found “that general pleasure is expressed, as they say a disagreeable day gives them no license to remain in, but that fresh air is compulsory in order to get something to eat.”

The hospital kitchen staff cooked and served the patients a variety of food and drink. The Asylum’s annual reports included detailed statements of disbursements describing the array of meats, vegetables, fruits, grains, cheeses, spices, and drinks offered to the patients and staff at meal time. Figure 4 shows the planned meals for the week of April 22, 1894. Asylum residents raised vegetables, much of it used for their

![Figure 4](Scanned Image)

*Figure 4. Toledo Asylum for the Insane Bill of Fare for the Week of April 22, 1894. Scanned Image.*

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72 *Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane,* (1893).

73 *Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane,* (1888), 11.
own meals, on several acres of land. As farming operations expanded, excess quantities of produce were taken to market and sold.\textsuperscript{75}

In addition to farming and raising livestock, residents were employed in other areas of the asylum. This included work in the “kitchen, dining rooms, laundry, stables, green house and upholstering department.”\textsuperscript{76} Further, “the grading and beautifying of the grounds and the construction of the miles of roads and walks has been done entirely by patients’ labor.”\textsuperscript{77} In 1889, Dr. Tobey stated that “it has been our aim to give every patient as far as possible some healthful employment, believing that there is nothing more prejudicial to a person’s well-being, sane or insane, than enforced idleness; therefore every person has been encouraged to do something.”\textsuperscript{78} Dr. Tobey asserted that no residents were required to work, but those who were able were encouraged to take on chores or tasks. Employment was considered a valuable tool in the treatment of insanity. Further, reports openly discussed resident employment as an approach to decrease the financial burden of the asylum on the state.\textsuperscript{79} Dr. George Love, the superintendent succeeding Dr. Tobey, similarly felt employment was a valuable form of treatment.

\textsuperscript{74} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1894), 7.

\textsuperscript{75} Ibid., 10.

\textsuperscript{76} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1892), 10.

\textsuperscript{77} Ibid., 10.

\textsuperscript{78} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1891), 14.

\textsuperscript{79} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1892), 9-10.
stating, “all patients do better when given some useful employment.”\textsuperscript{80} Until the second half of the twentieth century, employment at the Asylum was a part of many residents’ daily lives. Money raised from the sale of goods or foods produced from patient labor was used to purchase items for the residents or cottages and included books, recreational items, pictures, and other decorations.\textsuperscript{81}

The length of stay for patients at the Asylum varied based on the diagnosis, perceived recovery by physicians, and the availability of support from friends or family. For many patients deemed chronically insane, the institution became a second home. It was not uncommon for patients to spend many years at an asylum and in some cases, decades. For others, who were decidedly well enough to go home, asylum physicians might keep the patients on the registration books which made reentry into the institution easier by bypassing the courts or full admission process.\textsuperscript{82} Other patients deemed recovered were sent home, but the concept of “recovery” was a subjective determination. Dr. Tobey mentioned his frustrations with the lack of standardized definitions for recovery across institutions.\textsuperscript{83}

Opening the Toledo Asylum for the Insane helped reduce the number of insane housed in local county infirmaries and jails, and the over-crowding at the other state asylums. In 1890, Dr. Tobey stated, “no insane person for whom application has been

\textsuperscript{80} Ohio Board of Administration Annual Report, (1913), 88.

\textsuperscript{81} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1892), 10.

\textsuperscript{82} Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1892), 8-9.

\textsuperscript{83} Ibid., 8; Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1895), 8.
made has been denied admission, whether they were old or young, rich or poor, educated or ignorant, kind or vicious, or their insanity was of recent occurrence or long standing.”

However, within two years, he noted, “the demands of the asylum district have exceeded the capacity of the asylum and during the year it has been necessary to return a number of persons to county infirmaries in order to make room for recent and urgent cases.”

The number of residents voluntarily and involuntarily seeking asylum residency continued to grow while the number of recovered and released patients did not off-set the demand on the hospital’s available space.

The theme of institutional overcrowding continued to be consistent at both the local and state level. State officials commissioned another asylum in Massillon, Ohio, that opened in 1898 in an effort to provide additional accommodations for the insane. However, on April 26, 1898, state legislators passed a law to take effect June 1, 1900 “making it unlawful to receive or maintain insane or epileptic persons in county infirmaries,” which included over 1,500 residents. The new hospital in Massillon could not care for all of these individuals. The Board of State Charities and Superintendent Tobey pleaded for additional funds to expand the current asylums by adding cottages.

In 1901, Dr. Tobey claimed “the existing asylums of the state are all crowded beyond

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84 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1890), 12-13.

85 Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1892), 13-14.

86 Twenty-Third Annual Report of the Ohio Board of State Charities, (1898), 21.

87 Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1898), 21-22; Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1892), 13; Annual Report of the Board of Trustees and Officers of the Toledo Asylum for the Insane, (1893), 15-16; Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1894), 3, 13; Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1896), 8.
their capacity, and...there are a thousand or more insane persons in the County Infirmarys and jails that are still unprovided for."88

The immediate need for capacity decreased slightly by 1905 as many of the State Hospitals, including Toledo, built additional cottages. 89 The members of the Board of State Charities reported, “it has been possible to receive most of the insane in the county infirmarys who have been awaiting removal according to law. At no time in the history of the State were the insane persons more universally cared for by the State than at present.”90 However, they followed this optimism with a cautious prediction of the future stating, “even if the ratio of insane persons does not increase, there will be an increase in numbers, due to increased populations of the State. For this reason it is necessary to look forward to greater capacity for this class of our defective population. This Board recommends that a hospital be created for the care of Insane Criminals and Dangerous Insane.”91

In 1906, there was a noticeable change in Dr. Love’s approach toward treating individuals deemed insane and the continued rise of the patient population. He suggested that insanity itself was not necessarily increasing, although the layman might think so.

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88 Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1901), 15.

89 Toledo Asylum for the Insane officially changed its name to Toledo State Hospital in 1894 as a result of House Bill Number 58. The legislation called for all Ohio institutions caring for the insane to be renamed to state hospitals. The State of Ohio General and Local Acts Passed and Joint Resolutions Adopted by the Seventy First General Assembly, (Columbus, OH, 1894), 23-24. The name change was an effort to align the asylums with the medical field and bring “scientific attention by the medical faculty” to the residents at these institutions. The Ohio Board of Administration (1913), 87.


91 Ibid., 9.
Instead, he implied that insanity was more readily recognized and these cases were more promptly referred to State hospitals for treatment. Dr. Love stated:

Formerly the insane hospital was looked upon in horror, and, as a result, the milder forms of insanity were not sent to institutions for medical treatment, but were kept at home and guarded closely. At the present time nearly all forms of mental trouble, as soon as they are recognized, are immediately sent to the sanitarium or hospital for the insane where they receive much better care and treatment than accorded under home environment. This is why all our state hospitals are crowded.\(^2\)

Dr. Love was a proponent for institutionalization and believed that the best care for the insane could be afforded in a State Hospital, but as he indicates in his 1915 essay, “History of the Institutional Care of the Insane,” the state had many more insane, delinquent, and feeble-minded people than it had ever imaged. He suggested in addition to treatment of the insane, there should be a higher emphasis on medical studies of insanity and especially “the study of the prevention of insanity.”\(^3\)

Between 1867 when the Board of State Charities was organized and Love’s 1915 essay, the state’s approach to caring for and treating the insane changed, but for much of this time, institutionalization remained central to the state’s plan to manage insanity. However, as the number of those deemed insane continued to rise, it became evident that institutionalization, on such a large scale, was not sustainable.

The story of the Toledo State Hospital (TSH) reflects larger historical trends. The mid-to-late 1800s gave rise to wide-spread, state operated, specialized institutionalization including asylums for insane, epileptics and feeble minded individuals, schools for the deaf and blind, as well as orphanages, veteran homes, detention homes, and

\(^2\) Annual Report of the Ohio Board of Administration, (1911), 87.

\(^3\) Love, History of Institutional Care of the Insane, 13.
penitentiaries. TSH was one, among many institutions built during the 1800s within the state of Ohio and across the country to provide treatment for rising populations of the insane. At the same time, the TSH is a unique example within this history as it was the first institution in the United States built completely on the detached ward or “cottage” plan. The TSH became the benchmark for asylum building across the state, as the cottage system proved to be a cost effective method to housing thousands of patients in one state hospital. The trend of asylum building continued across the country until the early twentieth century. However, by 1915, medical professionals became less certain of the effectiveness and sustainability of institutionalizing the insane in large numbers and began to place priority on new approaches in the treatment of insanity.

Chapter 3

1914-2014: Mental Hygiene Movement through the era of Institutional Decline

In this day we are recognizing that hygiene extends to mental conditions, as well as to physical, that it is necessary to regulate life for the prevention of insanity quite as much as for the prevention of scarlet fever or smallpox. We know that some cases of insanity can and should be prevented by the proper regulation of the social environment, of the work, and of the recreation, of the individual, just as certainly as we have prevented, in the United States army thousands of cases of typhoid fever by preventive vaccination, so we can prevent thousands of mental break-downs by mental prophylaxis.¹

Dr. Thomas Haines, Clinical Director of Juvenile Research in Columbus, Ohio presented at the 1916 Annual State Conference of Charities and Correction and articulated in his speech themes and approaches toward mental illness that were common in both Ohio and across the United States by the mid-1910s. As he suggested, prevention and control of insanity were central to addressing the problems of mental illness and mental hygiene was the ideal approach to solving mental health issues in communities. Further, his statement showed the increasing influence of medical theories and interventions on mental healthcare. Although asylum care during the 1860s through the early 1900s approached insanity with the goals of treatment and recovery, the mental hygiene method put prevention and controlling the spread of insanity as the primary focus. Dr. Haines represents a shift in the approaches toward insanity that lasted for decades. The history of the Toledo State Hospital (TSH) over the last 100 years reflects these shifts as well as many other themes including the changing models of institutionalization, the effects of a rising institutional population and later rapid decline.

on the facilities, patients, and communities, and the varying public opinions, both positive and negative, of state hospital care.

The TSH was built at a time when state officials believed that institutions were the ultimate answer to the problems of insanity. Public officials and community members believed that institutions could provide comfortable care, healthy environments, medical treatments, and a place where residents were secluded from society and their minds could recover. Dr. Tobey wrote in the 1905 annual report, “the more the mind can be supplied with natural thought the less it will be occupied with unnatural thought; and the more natural the surroundings can be made the more natural a person must be to adapt himself to the surroundings. There is no medicine for the mind except environment; therefore, the more natural the environment the better the opportunity for the recovery of the patient.”

Treatment and recovery were the ideal result of the asylum, but in reality, many patients did not recover and remained in the institution for years. Although doctors discharged recovered patients, many returned presenting with the same symptoms at a later date. According to historian Gerald Grob, “chronic illness required care and management for periods that could sometimes span decades…yet the fact of the matter was that significant numbers of mentally ill persons failed to recover.” More and more these institutions, including TSH, became places of long-term custodial care. However, during the mid-1910s, a new movement began to change the opinions of many state hospital administrators and public officials. By 1915, the second superintendent of TSH, Dr.

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2 Annual Report of the Board of Trustees and Officers of the Toledo State Hospital, (1905), 9.

George Love, called for a prevention approach rather than focusing solely on housing and treating the insane. 4

Most historians consider the 1909 founding of the National Committee of Mental Hygiene to mark the beginning of the mental hygiene movement. Businessman Clifford Beers, who struggled with mental illness for much of his life, helped to organize the National Committee. After an extensive stay in a state hospital in New York, Beers initiated a campaign to improve the treatment of patients in hospitals and published an autobiography of his illness, recovery, and suggestions to change the system. He worked closely with psychologist William James and psychiatrist Adolf Meyer. Beers credited Meyer in selecting the term “mental hygiene” to characterize the movement which expressed both the idea of improving the conditions in institutions and the prevention of mental disorders. 5 Grob indicates that mental hygienists viewed disease as a product of the environment, heredity, and individual deficiencies that required scientific approaches to prevent and control the problems of mental illness and therefore create a better society for all. 6 For psychiatrists these new concepts in mental hygiene “opened up new vistas and shifted attention away from custodial role and inability to cure admittedly vague disease entities.” 7

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7 Ibid., 150.
The populations at Ohio’s state hospitals continued to grow throughout the early 1900s and overcrowding remained a consistent theme as it had in the last half of the previous century. The construction of additional state asylums had not provided the answer to the state’s insanity problems, but instead, more and more individuals were being institutionalized and less were being released as recovered. The 1914 Annual Report of the Ohio Board of Administration states:

The board has also given consideration to the subject of prevention. Improved treatment of the insane within an institution neither decreases the number of the insane nor increases perceptibly the number of cures. The reason is that underlying causes are not reached by hospital care. Among these causes, heredity plays the most important part, and social conditions are of great significance. While it may be a question whether the state should attempt, except by segregation, to prevent one generation from passing on to another such a defect as insanity there can be little doubt that for the cases committed to an institution, care should be continued after discharge as a safeguard both against relapse and also against further transmission.8

The Board clearly had doubts about the methods utilized to treat or cure insanity cases in the state’s institutions as the populations in these facilities continued to rise. Instead, members suggested prevention as a solution to reduce the number of insane. More specifically, in the 1914 report, the Board began to consider how far the state should intervene in hereditary “transmission” of insanity.

Control and prevention of mental illness was a central concern in the 1910s and 1920s and paralleled the rise in public health campaigns that promoted a variety of health improvements from access to clean water to improved living conditions. For some professionals working in the area of mental health, prevention and control took a different form. Dr. Eugene F. McCampbell, Secretary and Executive Officer of the Ohio State

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8 Annual Report of the Ohio Board of Administration, (1914), 25.
Board of Health, wrote an article for *The Ohio Bulletin of Charities and Correction* in April 1914 stating:

There is no question that the propagation of physical and mental defectives should be prevented if we are to adequately conserve the public health. Four ways are proposed, namely, education, legislation of a restrictive character, segregation and surgery. The first, education has proven a failure as far as the defective is concerned…It is very important that the rightminded [sic] and thinking public be educated as to the fact that defectiveness is preventable. The second, restrictive legislation, has also failed, generally speaking, as a preventive measure…Illegitimacy also frequently results among mental defectives when marriage is prevented by law. The third, segregation, would seem to be an admirable way of handling the situation, but it is an enormous and impracticable proposition to segregate all our mental and physical defectives. To separate the fit from the unfit, mentally or physically, is no easy task. The fourth, surgery, has many possibilities, but the artificial sterilization of mental and physical defectives may be open to some abuse. It must be admitted that where properly applied it is effective. Many states now have laws providing only for sterilization of mental defectives. It would seem that this is one of the best ways which society has of protecting itself. It perhaps cannot be advocated as yet in the case of those who are physically, but not mentally defective.  

Dr. McCampbell moved beyond alluding to potential methods of control or vague references to prevent further transmission of insanity. Instead he clearly defined the options available to control and prevent insanity and other defective conditions. His concern was to protect the public health of the country and he saw “the number of defectives, outside of those suffering from chronic diseases or the results of disease, in this country” as “appalling.”  

Dr. McCampbell was careful in discussing the fourth option of forced sterilization, recognizing the power this procedure gave doctors. However, for him, this option appeared to be the most appealing and effective to prevent the spread of insanity and therefore protect society.

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10 Ibid., 21.
Among Ohioans, Dr. McCampbell was not alone in his belief that eugenics could provide the answer to an increasing population of what he considered, defective citizens. Dr. Ora Fordyce, the third superintendent at TSH from 1919-1946 read his essay, “Sterilization of the Unfit,” at the December 28, 1910 State Hospital Conference.\(^{11}\) He too believed heredity played a large part in the growing population of insane. Dr. Fordyce stated, “we find that in those forms of insanity in which heredity plays the most important part are the least likely to recover. Practically all our custodial patients belong to this class. How preposterous it would seem to spend time and money in laboratories trying to find out the cause of those heredity diseases when we know the defect has been transmitted from their ancestors!”\(^{12}\) Fordyce expressed concern for the growing population of “abnormal people,” the rising cost of institutional care, as well as the congested conditions at the state’s “benevolent institutions,” paired with the “disposition of the degenerate to multiply.” He concluded that “we spend thousands of dollars and years of time in advancing the best methods of breeding livestock, and in this have reached a point of almost perfection, yet feeble efforts have been made to check the growth of degeneracy in this country. For conditions to go on unchecked ultimately means a weakening of our nation.”\(^{13}\) Dr. Fordyce’s proposed solution was sterilization among certain “degenerates” and “eugenics to its fullest extent” to “be taught in all our institutions of learning and in the home.”\(^{14}\)


\(^{12}\) Ibid., 16.

\(^{13}\) Ibid.

\(^{14}\) Ibid., 17.
By 1921, the conversation in Ohio regarding the state hospitals and the insane continued to focus on the rising population in the state’s institutions, but little was accomplished in addressing this issue. In this same year, The Ohio Board of Administration addressed the Governor of Ohio stating:

We believe that insane hospitals are not meeting the needs of the times. With few exceptions, the medical work is woefully inadequate, and research and investigation is almost entirely neglected. Preventive work has hardly been started. The prompt recognition and correction of medical and surgical diseases, coexistent with disordered mental states, will undoubtedly result in cures in many early cases and improvement in others sufficient to permit of their early discharge from the institutions. Money effectively spent to this result will be a good investment, because the state will reap the benefit of restoring these persons to economic independence, while at the same time, maintenance cost and capital outlay for additional buildings will be lessened. The cost of maintaining the state hospitals in 1920 was over three million dollars. There were over two thousand eight hundred ninety-five insane patients admitted for the first time in 1920; the next year three thousand more and so on with each succeeding year. These people are our relations, our friends, our neighbors. Their number is ever increasing and will continue to increase unless we begin definite efforts to stem the tide.\textsuperscript{15}

The Board suggested methods to implement preventative measures at the state hospitals including the establishment of mental clinics “where persons in the early stages of insanity can receive advice and treatment.” Additionally, it suggested implementing field workers to identify potential cases of insanity among community members and to supervise patients after they have left the hospital providing “social service follow-up work.”\textsuperscript{16}

The 1921 Ohio Board of Administration report on State Institutions discussed its dissatisfaction with the all of the institutions’ “inadequacy of the medical situation” including the lack of medical care, treatment, scientific research, and preventative work.

\textsuperscript{15} Annual Report of the Ohio Board of Administration, (1921), 17.

\textsuperscript{16} Ibid.
The Board suggested “this has resulted in our state hospitals remaining comfortable custodial institutions for the mental cases, but has prevented them from becoming modern psychopathic hospitals where intensive efforts may be made to improve and cure these cases.” Improvement and cure may seem reminiscent of the dialogue used to discuss patients in the late 1800s, however, the Board was not suggesting this for the entire population and instead adamantly insisted on the strict differentiation of chronic cases from potentially curable, or, acute cases. The debate between categorizing and providing different treatments for chronic cases and acute cases was not new to the 1900s and had been the center of many debates throughout the late 1800s. However, during the Mental Hygiene movement, the chronic versus acute debate took a different shape. Most professionals believed that recovery among chronic cases was not possible, but rather these cases should be housed and isolated from society. According to the Ohio Board report:

> Those who are physically or mentally unable to support themselves should be removed from the community and institutionalized or colonized in such a way as to result in a minimum expense to the state. We believe that the morally and physically diseased should be so controlled as to prevent their mingling in the community to the detriment of the health and well-being of society. While the question of unsexing may be repugnant and possibly cannot be given serious consideration for years to come, other methods approximately as effective should be applied to this class of moral and physical defectives.

The recommendation from the report was to focus resources, research, and efforts on those who could be cured. The Board suggested that “the state will be practicing the highest type of economy when it makes every reasonable effort and expenditure looking

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17 Ibid., 23.
18 Ibid., 32.
to the cure of all those persons who can be cured and restored to society, and to the prevention of the acquirement of physical, mental and moral attributes.”19

In 1921, the Ohio State Department of Public Welfare (SDPW) began oversight of the state’s institutions and a year later called attention to “dealing with the state care of the insane” as one of the most important tasks. Its recommendation was to develop “curative agencies in all the hospitals.”20 Additional staff and medical equipment were added to each of the state hospitals to accomplish this. Like its predecessor, the Board of Administration, the SDPW agreed with the mental hygiene approach and emphasized the importance of prevention and cures. The Department’s staff had ambitious hopes that the approach would be the answer to the state’s mental health and institutional concerns. Their 1922 report claimed, “we are already securing very gratifying results and there is no doubt that if this program is carried to its completion, we shall be able to turn back into society an unprecedented number of patients who will be able to function normally in society again.”21

By the early 1920s, the shift to the mental hygiene perspective was evident at the TSH. A Toledo Blade article, “Facilities Improved at State Hospital,” published on April 4, 1922, described additions of personnel and laboratory space for the increased study of patients. Staffing additions included a social worker “whose duty it is to study the social aspects of cases that come to hospital" including investigating home conditions in order to “learn possible contributory causes of their ailments.” Further, the social worker would keep in touch with patients released on “trial visits” and monitor their conditions once

19 Ibid.


21 Ibid., 7.
released. The hospital’s Social Service Department additionally worked to coordinate services for patients across many local agencies including the American Red Cross, YMCA, Florence Crittenden Home, and Toledo Catholic Charities. The purpose of this was to assist both patients and their families, but also to build and maintain “a closer association between the hospital and those agencies which represent the uplift of general standards in the community.”

In addition to the trial visitation program, the hospital established a Psychiatric Clinic in 1920 that operated once a week out of the District Nurses Association. These preventative, community based clinics were recommended for all communities in the 1921 Board of Administration annual report as a way to provide “advice and treatment to early cases of nervous mental disease of the community” with the hope that early treatment could reduce or eliminate the need for institutionalization. For Toledo, the clinic was initially developed to serve “out-patients” from the TSH in the trial visitation program, however, general community members found the services of the clinic useful and “cases presenting psychiatric problems were accepted”.

The 1920s brought other medical centered approaches to the treatment of insanity in Toledo, further evidence of the influence of the mental hygiene movement. This included a clinic for the treatment of neuro-syphilis and malarial therapy in 1925 and the use of occupational and recreational therapies in 1926. Examples of occupational therapy

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22 Toledo (OH) Blade, “Facilities Improved at State Hospital,” April 12, 1922, Toledo Lucas County Public Library Newspaper Clippings Collection on Toledo State Hospital, (TLCPL Clippings).


24 Annual Report of the Ohio Board of Administration, (1921), 25.

included the production of furniture, rugs, paintings, and needle work, much of which was sold in the hospital’s gift shop. The money raised from these sales was used to purchase additional supplies for the occupation therapy program or items for resident entertainment. Recreational therapy included calisthenics, basketball, and other sports. The article stated that occupational therapies were widely prescribed to hasten the recovery from disease or illness and “it is now generally recognized by the medical profession as being a very great value in the treatment of nervous and mental diseases.” Further, Superintendent Fordyce, suggested that such therapies were equally important “when it is found that a patient is incurable and perhaps will be a permanent resident in the institution.”

A *Toledo Times* article published nearly ten years later indicated that, the Occupational Therapy program was thriving with nearly 2,500 patients. It also noted that this type of therapy was not necessarily one used in hopes of curing individuals, but instead to “train the hand and enliven the brain to act in harmony and by this gentle stimulation assist the mind in restoring harmony” and “approach normalcy.” Dr. Fordyce said the purpose of the occupational program was not to cure patients of their illnesses, but rather to help patients feel “normal” by engaging their minds.

During his tenure at TSH, Dr. Fordyce was a strong proponent of introducing new and innovative medical treatment to his patients. In 1937, he advocated for the use of insulin shock therapy and the use of the drug Metrazol, in the treatment of dementia praecox, now known as schizophrenia. In 1938, the *Toledo Blade* highlighted the

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26 *Toledo (OH) News Bee*, (unreadable title), January 30, 1926, TLCPL Clippings.

27 *Toledo (OH) Times*, “Skilled Hands Helping 2,500 Retain Life Grip at Hospital,” October 24, 1937, TLCPL Clippings.

28 Ibid.
reported successes of these treatments and boasted in the headline “4 More Incurables Cured!”29 By 1941, TSH introduced electric shock therapy as a treatment and its 1942 annual report stated, “with the liberal use of shock and other therapies, considerably more patients than ever before are being released on trial visits as recovered.30 The Toledo Blade, in 1945 claimed, “the miracle of shock therapy is a daily occurrence at TSH.”31 According to Dr. Joseph Duty, superintendent at TSH beginning in 1946, 90 percent of depression patients treated with electro shock therapy recovered. He also stated that psycho-surgery or prefrontal lobotomy was prescribed at TSH for some patients.32 Although controversial and not fully understood, shock therapies and psycho-surgery were popular forms of treatment used with patients at TSH, as well as at other hospitals in Ohio, and across the country.

Medical interventions and treatments were generally the center of TSH annual reports and local newspaper articles, but this was not the full extent of patient care. Evidence of daily life at the hospital emerges from these publications as well. For example, a December 1930 Toledo Blade article, “Toledo State Hospital to Get Talking Pictures,” described TSH as the first of the state’s 22 institutions to install talking picture equipment. The first film shown was Dixiana and regular showings of movies twice a week were planned. TSH was also the first state institution to provide a radio in each

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ward. Other recreational activities included a “modern nine-hole golf course” used by both patients and community members during the summer. In the article Dr. Fordyce explained, “mentally ill persons enjoy the same kind of music and other entertainments as normal persons. Music, talking pictures and golf aid in keeping the patient in a happy frame of mind, which is necessary to his recovery.”

In 1925, TSH established a beauty shop. Women from the Ritter School of Beauty Culture in Toledo came weekly and donated their services “in administering the beauty needs to a large class of patients.” The beauty shop was intended as more than a place to receive a haircut, but as a form of therapy. Annual reports referred to the concept as “Beauty Parlor Therapy.” The hospital professionals believed “mental diseases are usually evinced by some carelessness in dress and loss of interest in personal pride and appearance. The lack of adequate facilities on the wards for improving the personal appearance, especially for women, adds to the degradation of habits and personal pride.” The beauty shop was intended to provide not only cosmetic services, for both male and female residents, but also a form of approved therapy to aid in their recovery.

A patient library collection provided reading material for employees and patients. In 1929 donors expanded the library holdings by contributing 200 new books. Twice a week, a staff hospital employee distributed and collected library material throughout the wards. Works Progress Administration (WPA) workers completed construction of a

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33 Toledo (OH) Blade, “Toledo State Hospital to Get Talking Pictures,” December 25, 1930, TLCPL Clippings.

34 Report of the Department of Public Welfare, (1926), 254


library building in 1939 to house the medical, nurses’, and patient library holdings. Donations from Perrysburg Public Library, Toledo Public Library, and other community organizations and individual donors increased the patient library collection from 2,000 books to over 8,000.\(^{37}\)

Similar to the early years of operation, visiting clergy representing various Protestant denominations conducted regular religious services until the hospital hired a permanent chaplain in 1942. In addition, an appointed Catholic chaplain offered masses throughout the year.\(^{38}\) The 1944 hospital’s annual report mentioned the proceedings of funeral services for patients who were unable to afford burials outside of the hospital:

Appropriate funeral service for all indigent patients of Protestant or Hebrew faith who are buried in the hospital cemetery, are conducted in the chapel room. Flowers are provided from the institution greenhouse. The relatives and friends are invited to attend. A nice, but inexpensive casket is made and furnished by the hospital. The chapel room is very appropriately designed and nicely equipped for such service. Frequently the fellow patients who knew the deceased are permitted to attend the services. This recognition and provision is highly appreciated by the relatives who are financially unable to bear the funeral expense and furthermore by the friends and patients generally throughout the hospital. Arrangements have been made with local Catholic Diocese whereby indigent Catholic patients dying in the hospital are provided with appropriate funeral services and the remains are removed to a Catholic cemetery for burial.\(^{39}\)

Between the late 1890s and the 1970s, many patients who died while at the hospital were buried in the two hospital cemeteries. As the 1944 report suggests, these were not elaborate ceremonies, but services with basic amenities. Each grave was marked with a rectangular stone engraved with a number corresponding to the number of burials in the cemeteries.


\(^{39}\) Ibid., 393-394.
Further insight into patient life can be seen through a 1931 article published in the *Sunday Times* written by a former TSH patient.\(^{40}\) It provides glimpses into the daily life of patients and contains themes consistent with the mental hygiene movement, including the importance placed on medical interventions for treatment. The title, “Hospital Replaces ‘Madhouse,’” itself reveals a desire to convey to the public at large the transition of the institution from an antiquated asylum to a professional, medical hospital. According to the author, “‘Hospital’ in present-day thought is not a misnomer for the retreat of the mentally afflicted. The unbalanced mind no longer is regarded as a disease outside the scope of medical science but is treated from a psychopathic standpoint as other disorders of the human being should be.”\(^{41}\) The author discussed the pleasant surroundings of the grounds, the well-constructed buildings, and appealing décor “equal to that of a first class hotel.”\(^{42}\) He described the handcrafts and art produced by patients including needlework, paintings, rugs, and furniture and the classes and guidance provided by professional artists or artisans from the community. The article continued in a second installation placing some emphasis on the medical approaches and treatments used at the hospital. It described the smoothly running functions of the hospital, highlighting “one department that is much superior to one in any outside regular community—the medical department.” According to the author, “every patient entering the hospital undergoes a thorough diagnosis or examination. Any illness, physical or mental, that human flesh is heir to receives special attention of skilled physicians,

\(^{40}\) *Sunday Toledo (OH) Times*, “Hospital Replaces ‘Madhouse’,” Part 1, May 17, 1931, TLCPL Clippings. The author remains unnamed, but the Editor’s note reveals the author was a male veteran of the Spanish-American War

\(^{41}\) Ibid.

\(^{42}\) Ibid.
surgeons, dentists and specialists of the eye, ear, nose and throat.” The author paints an optimistic picture of the hospital, which may or may not be the whole story, but the article reveals activities and opportunities for residents as well as the influence of the mental hygiene movement on hospital operations.

The decades between 1910 and 1950 were difficult for many state hospitals. One reason was that the population for hospitals on average continued to rise and overcrowding remained an issue among the state’s institutions. TSH was not immune to such adversities, Figure 5 shows the steady rise of the average daily population at institution from the 1920s through the 1950s. By 1940, the average daily population was nearing 2,800 patients. The hospital’s estimated normal capacity for the same year was 2,054.

![Figure 5. Graph Representing Average Daily Population of TSH from 1911 –1950. Figure created by author with statistics from annual reports.](image)

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43 *Sunday Toledo (OH) Times*, “Hospital Replaces ‘Madhouse’,” Part 2, May 17, 1931, TLCPL Clippings.

By the following decade, the population at TSH reached nearly 3,100, while its capacity remained at 1,962 residents, further pushing the limits of the hospital’s ability to provide care and space for its patients.\textsuperscript{45} Growth in hospital populations was expected, in proportion to a state’s growing population, however, for Ohio the institutional population rose more rapidly than that of the general population and caused concern among hospital administrators and government officials.\textsuperscript{46}

Additionally, during this period, hospitals across the country, including the TSH saw a disproportionate number of older adults admissions compared to the general population. According to Gerald Grob, “the most striking development during the first half of the twentieth century was the conversion of the mental hospital into a surrogate home for elderly and other kinds of chronic cases.”\textsuperscript{47} The 1924 Report of the SDPW stated:

\begin{quote}
The number of elderly people committed continues to be a striking feature of the admission table...There is an ever increasing tendency to send the old folks to the State Hospitals when they become childish and troublesome. Home conditions have changed. The childish grandparents are in the way. They increase the already high cost of living. They interfere with the family social plans. Hence, they are sent to the hospital to be cared for.\textsuperscript{48}
\end{quote}

For example, in 1922, 23 percent of patients admitted to TSH were over the age of 60 and nearly 12 percent were over the age of 70, compared with 7.5 percent of the general population that was over the age of 60.\textsuperscript{49} The 1926 TSH Annual Report included similar

\begin{itemize}
\item \textsuperscript{45} Annual Report of the Ohio Department of Mental Hygiene and Correction of Public Welfare, (1955), 10.
\item \textsuperscript{46} Report of the Department of Public Welfare, (1939), 156.
\item \textsuperscript{47} Grob, Mad Among Us, 120.
\item \textsuperscript{48} Report of the Department of Public Welfare, (1926), 23.
\end{itemize}
statistics with 19.5 percent of the admitted population diagnosed with “either senile psychoses or psychoses with cerebral arteriosclerosis, or both.” Dr. Fordyce declared that “this percentage is entirely too high. Many of the elderly patients admitted during the year could have been cared for safely at home, and should not have been committed.” TSH administrators introduced a variety of measures over the next two decades aimed at reducing patient populations. In 1926, it was the hospital’s “policy to encourage the relatives of senile patients, to take them home in so far as the mental status of the patient would permit. We have been more liberal in releasing senile patients on trial visit than any other class of patients.” However, ineffectiveness of this voluntary approach resulted in more direct measures including requests to the Probate Judges in the hospital’s district “calling attention to the overcrowded situation and requesting that they be more conservative in commitment of patients in this institution.” The administration wished to reduce the number of patients diagnosed with senile psychoses and felt “the hospital

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50 Both senile psychoses and cerebral arteriosclerosis were known as the psychoses of old age. Cerebral arteriosclerosis results from the thickening and hardening of the walls of the arteries in the brain. “Cerebral arteriosclerosis is also related to a condition known as vascular dementia, in which small, symptom-free strokes cause cumulative damage and death to neurons (nerve cells) in the brain. Personality changes in the elderly, such as apathy, weeping, transient befuddlement, or irritability, might indicate that cerebral arteriosclerosis is present in the brain.” (National Institute of Neurological Disorders and Stroke, “NINDS Cerebral Arteriosclerosis Information Page,” http://www.ninds.nih.gov/disorders/cerebral_arteriosclerosis/cerebral_arteriosclerosis.htm (accessed November 1, 2014). Studies in the 21st century have drawn causation links between cerebral arteriosclerosis and Alzheimer disease. (Alex E. Roher, Chera Esh, Afroza Rahman, Tyler A. Kokjohn and Thomas G. Beach, “Atherosclerosis of Cerebral Arteries in Alzheimer Disease,” Stroke 35 (2004): 2623-2627, http://stroke.ahajournals.org/content/35/11_suppl_1/2623 (accessed November 1, 2014).


52 Ibid., 251.
should be used primarily for the treatment and care of the curable patients and those who are too menacing or dangerous to be at large.”

Even with these measures in place, overcrowding remained a concern at TSH over the following 10 years. In 1935, Dr. Fordyce noted:

Because of overcrowded conditions, for several years restrictions have been placed upon the admission of elderly persons 70 years and above, also physically ill invalid persons requiring ambulance transportation. Unless provision is made quite soon to substantially increase the capacity, greater restrictions upon admission will become imperative. It is very difficult for the patients to get well under the existing circumstances. The elimination of the overcrowded condition should come first in the improvement program, and is absolutely necessary if a satisfactory recovery rate is to be expected. The important question suggests itself: Should the Toledo State Hospital continue to admit patients under the existing overcrowded conditions and thereby jeopardize the treatment, and recovery of the patients already in the hospital? Shall we keep on taking patients as heretofore, or shall greater restrictions be placed on admissions?

By 1942, the situation continued to worsen as more people applied to institutionalize their older family members. The hospital administration believed this increase to be “largely caused by the exigencies of the war and the changes in home conditions.” At application, families attempting to commit senile patients often stated the “people in the home are all working and there is no one left to care for the old folks.” In the same year the TSH devised another plan to counter the rising institutional population. The hospital sent patients with mild cases of insanity to convalescent or county homes. In exchange, TSH made arrangements with those facilities to take on the “more disturbed senile cases.”

Yet, this strategy had little immediate influence, as the 1945 annual report indicated,

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nearly 26 percent of the patients admitted were diagnosed as Senile Psychosis or Psychosis with cerebral arteriosclerosis.\textsuperscript{56}

Overcrowding was not only an issue of too many people in too little space, but of inadequate services delivered to patients. Clinical work, innovative treatment developments, and preventative care all took “a back seat to simply caring for all the patients in the hospital.” This, in turn, forced the hospital “into that vicious cycle of attempting on a very small scale to do preventative work, but constantly meeting defeat because of the basic program of custodial care.”\textsuperscript{57} Although overcrowding did not result in the elimination of therapeutic work, it made it difficult for the hospital to provide.

State hospitals across the nation faced other challenges during this time period that had negative implications for both the physical facilities and patients. First, because the mental hygiene movement placed a large emphasis on prevention, medical intervention, and patients who were potentially curable, it left little discussion for patients deemed chronic, severely mentally ill, or older patients with mental illness resulting from aging.\textsuperscript{58} This divide between acute and chronic care was further fueled by the growing division between the field of psychiatry and state hospital management across the nation. In prior decades, state hospitals were inextricably linked to the field of psychiatry, however, by the 1920s, the individuals associated with the profession were more concerned with the professionalization of psychiatry, as a medical subset, and began to disassociate with mental hospitals. The “old-fashioned hospital superintendent” was a thing of the past, and the mental hygiene movement, with its emphasis on prevention and

\begin{itemize}
\item \textsuperscript{56} Report of the Department of Public Welfare, (1945), 399.
\item \textsuperscript{57} Report of the Department of Public Welfare, (1939), 549.
\item \textsuperscript{58} Grob, Mad Among Us, 159.
\end{itemize}
medical intervention, was the necessary boost the field needed to align itself more with the field of medicine and less with the institutions upon which it was originally founded.\textsuperscript{59} The transition of psychiatrists away from state hospitals was a concern for Ohio institutions as noted in the 1939 SDPW annual report which recalled that for many years “the number and quality of its medical personnel” in Ohio have been exceptionally low and further declining as those interested in the field of psychiatry have moved to other states that offered better opportunities.\textsuperscript{60} The lack of quality doctors and psychiatrists to work in the state hospitals had negative implications for the care of patients in hospitals across the country, including in Ohio.

Lastly, during this period of time, the many aging institutions, including TSH, faced physical neglect. Grob describes the post-depression years as the hardest period of time for the nation’s institutional buildings. Repairs and new construction were limited because of a lack of resources.\textsuperscript{61} For TSH, the same held true, although the WPA projects in 1936 and 1937 improved a number of buildings and grounds areas; as Dr. Fordyce noted, many of these repairs were needed five or six years prior, but due to the economic circumstances and shortage of funding in the early 1930s, these repairs and other general maintenance had been limited or completely halted.\textsuperscript{62} Grob suggests that the deferred maintenance at many institutions across the nation did not bode well for the future.\textsuperscript{63} At

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{59} Ibid., 159, 162-164.
\item \textsuperscript{60} Report of the Department of Public Welfare, (1939), 148.
\item \textsuperscript{61} Grob, Mental Illness and American Society, 289-291.
\item \textsuperscript{63} Grob, Mental Illness and American Society, 289-291.
\end{enumerate}
\end{footnotesize}
the TSH, the neglect of facilities accumulated and by the 1950s and 1960s, many of the original buildings and cottages were beyond repair and unfit for patients, but the hospital continued to use them.

Evidently, the push toward medical intervention, prevention, and recovery did not provide the answers to the state’s concerns with institutions as populations continued to rise. In an effort to find a successful solution, hospitals began to shift care from institutions to the community and placed an emphasis on acute treatment. In 1946, the Ohio Assembly passed legislation that encouraged the SDPW to develop receiving hospitals for the mentally ill, “especially those whose condition is incipient, mild or of possible short duration.” The SDPW institutional doctors believed this to be the best approach for many reasons. They hoped that it would permit a more streamlined approach to diagnosis, treatment, and recovery. Additionally, it allowed for a renewed focus on acute care and treatment of mentally ill patients. Lastly, it was a way to “bring mental health closer to the community” which was important in reducing stigma and encouraging individuals to seek treatment earlier. Under this model, acute care continued to take primary importance and the chronic or “incurable” cases were considered by hospital administration as custodial patients that would remain at the hospital for years to come.

Under the new leadership of Dr. Joseph E. Duty, workers built part of the new receiving hospital in 1948, but it took five more years to complete construction on all five wings. The receiving hospital was used for the acute cases, while the cottages were used

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64 Grob, Mad Among Us, 191; Report of the Department of Public Welfare, (1952), 177.

generally for longer-term patients. In November 1953, the *Toledo Blade* reported that an audience of over 600 listened to state director of Public Welfare, John Lamneck, declare that, “with this unit available, I am safe in saying that as much is being done for the mentally ill right here at Toledo State Hospital as anywhere else in the state and probably the nation.”66 Although excitement and optimism surrounded the receiving hospital approach implemented at TSH, as well as other Ohio state hospitals, it did not address the larger issue of overcrowding because it only accounted for acute cases, not the chronic, longer-term patients.

At both the national and local level, the mental hygiene movement, new approaches towards treating insanity, the expansion of psychiatry, and professionalization of other fields such as social work, each attempted to address the issues faced by many institutions including reducing overcrowding, increasing recovery rates among the acute cases, and finding a solution for the chronic patients. However, these issues remained consistent and for many patients, the state hospital remained a long term home rather than a temporary place for recovery, as many professionals had hoped. Nationally, the population of mental hospitals reached nearly half a million patients by 1940.67 During the 1950s the TSH average daily population reached its highest point and exceeded three thousand patients. During the 1940s and 1950s the issues at many of the state hospitals, including overcrowding, understaffing, an aging institutional population, and low recovery rates were publicly discussed in newspaper exposés. Some public officials took

66 *Toledo (OH) Blade*, “Receiving Unit Dedicated at Toledo State Hospital,” November 2, 1953, TLCPL Clippings.

a renewed interest in these institutions too in an attempt to create a new political agenda focused on solving these problems.\footnote{Grob, Mad Among Us, 203.}

Toledo newspapers published stories about the TSH to capture the attention of the public and highlight the challenges faced by the hospital. For example, a Toledo Blade article by Thomas Reynders discussed, in detail, state auditor James Rhodes’ report after a visit and evaluation of TSH. The Rhodes report described the TSH as “ancient” with “decrepit buildings and dirty, rusty equipment,” which “make adequate patient treatment impossible.” He noted instances of facility neglect and decay, fire hazards throughout multiple buildings, and evidence of inadequate staffing and severe overcrowding. According to Rhodes, the new receiving hospital was being used as “a 100-bed addition to TSH,” rather than its intended purpose. The report depicted patient living conditions as so severe that some individuals had to sleep on straw ticks laid out on floors, benches, or in closets. Some bedrooms were so crowded that patients had to crawl over other beds to reach their own. Although Rhodes’ assessment of the TSH was critical, he did not place blame solely on Dr. Duty or his staff. Instead, he called for attention from the state to make the necessary corrections. Reynders received comment from Dr. Duty who agreed with most of Rhodes’ conclusions and stated that he “would not place the blame, but suggested that it is the responsibility of the public itself” because the “legislatures will do what the people want, but the public is generally apathetic toward state hospitals.”\footnote{Thomas P. Reynders, “Rhodes Report Assails Toledo State Hospital,” Toledo (OH) Blade, August 1, 1957, TLCPL Clippings.}

The 1950s and 1960s for many state hospitals, including TSH, represented a time of both severe crisis and a turning point. Hospital populations across the country reached
their highest levels during the 1950s, but within a few short years the numbers began to fall. At the TSH, average daily populations were less than 500 by the end of the 1980s. Although the reduction of patients in the state hospital was intended to bring treatment and assistance to the community level and reduce the state’s role in custodial care, this change, like those prior, had multiple unintended implications for the patients and community.

During the 1950s and 1960s, the medical and psychiatric community welcomed a new approach to treating mental illness chemically. The trial success of the first psychiatric drug, chlorpromazine, along with developments of tranquilizing drugs, and later antidepressants became the preferred approaches to treating mental illness, which resulted in the abandonment of prior methods such as shock therapies and psychosurgery. A 1956 Toledo Blade article described the use of chlorpromazine and reserpine as part of the hospital’s plan to reduce overcrowding. Dr. Duty claimed that at least “100 minds have been clarified,” but he cautioned that these patients may face a harsh reentry into the community as many had been institutionalized for, in some cases, as long as twenty years. In order to facilitate a smooth transition and provide needed medical and mental health care outside of the institution, the TSH planned to partner with Toledo District of Nurses Association to provide aftercare services.

Across the country, in order to help transition and provide community based services for individuals with mental illness, the number outpatient mental health facilities

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70 Grob, Mad Among Us, 229-230.

and social service agencies steadily increased beginning in the 1950s.\textsuperscript{72} In Toledo, between the 1950s and 1960s, new outpatient organizations providing a variety of mental healthcare services included, the Mental Hygiene Clinic or West Center for Mental Health and Cummings-Zucker Center, (which later merged to become Harbor Behavioral Healthcare), Zepf Center, East Center for Mental Health and Ruth S. Ide Center (which later merged to become Unison Behavioral Health), Family Services of Northwest Ohio, and COMPASS.\textsuperscript{73}

During the same period, state hospitals made strategic efforts to move their older adult populations out of the hospitals to reduce overcrowding. TSH followed this trend by moving the older adults who did not require psychiatric care from the state hospital to nursing homes. In 1960, Governor Michael DiSalle implemented a program with the goal of moving 4,000 patients over the age of 65 to private nursing homes throughout the state. A 1960 \textit{Blade} article stated that 120 patients were identified for transfer, including some patients who had resided at the TSH for over 50 years.\textsuperscript{74} The Social Security Amendments of 1965 became law when President Lyndon B. Johnson signed H.R. 6675 on July 30, 1965 which established the Medicare and Medicaid programs.\textsuperscript{75} These programs further facilitated the transfer of older adults from psychiatric facilities to nursing homes.\textsuperscript{76} They covered psychiatric benefits, but federal payments for older adults

\textsuperscript{72} Grob, \textit{Mad Among Us}, 236.

\textsuperscript{74} Toledo (OH) \textit{Blade}, “State Hospital Chooses 120 for Aged Transfer,” March 4, 1960, TLCPL Clippings.

was higher to residents in nursing homes compared to state hospitals, thus encouraging the transition of patients in many states.\textsuperscript{77}

In 1968, Dr. Jankiel Barg accepted the position of TSH superintendent and like his predecessors, he considered the hospital population was “far too large” and hoped to find ways to reduce it.\textsuperscript{78} By 1972, a \textit{Toledo Blade} article stated that Dr. Barg had reduced the TSH population by 900 patients through “intensification of treatment and return of patients to society as speedily as possible.”\textsuperscript{79} Further contributing to the reduction of patients in the state hospitals was a program enacted by Ohio Governor James Rhodes that called for the development of Geriatric Centers to provide care for older adults. These facilities were not nursing homes, but instead centers where the older patients could “relearn how to live in society” on their own. The statistics in a 1973 \textit{Toledo Blade} article indicated that patients moving into the Dayton geriatric center were, on average, 74 years old and had resided in the state hospital for an average of 13 years.\textsuperscript{80} In 1972, the Social Security Act was further amended to provide financial assistance to individuals unable to work as a result of disability. The criteria included individuals diagnosed with some mental illnesses. As a result, hospitals “discharged severely and persistently mentally ill persons from mental hospitals, since federal payments would presumably enable them to live in the community.”\textsuperscript{81} From 1970 to 1973 the number of individuals

\textsuperscript{77} Grob, \textit{Mad Among Us}, 265-266.

\textsuperscript{78} Ray Bruner, “State Hospital Chief Knows Human Sorrows,” \textit{Toledo (OH) Blade}, 1968, TLCPL Clippings.


\textsuperscript{80} \textit{Toledo (OH) Blade}, “Geriatrics Center Project Started,” 1970, TLCPL Clippings; \textit{Toledo (OH) Blade}, “State Overestimates Cost of Building Geriatric Unit,” 197?, TLCPL Clippings.
across the state enrolled in community based mental health programs increased from 22,000 to 55,000 as the populations in state hospitals continued to fall. Administrators and professionals believed their patients could be better served in the community by outpatient centers and social service programs. Governor John Gillian suggested that although “community mental health programs are a relatively new concept in Ohio…they are succeeding where the old system could not.”82 Communities and mental health consumers both benefited as the state hospitals systems were phased out and services became community based, however, there were many individuals who struggled during these years of deinstitutionalization. In some cases, individuals were ill prepared to care for themselves or navigate the system of community based support organizations, other individuals had limited or no support systems. Not every community was prepared to help these patients succeed outside of the hospital.83

In 1971 the state created the Ohio Department of Mental Health and Mental Retardation. The state additionally changed the names of the state hospitals to mental health centers which further reflected the transition from the historic custodial care of the state hospitals to a community based. The Toledo State Hospital became the Toledo Mental Health Center (TCMH). In 1975, the state created the position of Medical Director at all state mental health centers, including TMHC, in an effort to separate medical and administrative duties. This transition was intended to allow the Medical Director to dedicate more time to medical care and planning. Dr. Barg moved from

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82 “Ohio Department of Mental Health and Mental Retardation,” *Ohio Directory of Mental Health Programs*, (1973), 1.

83 Grob, *Mad Among Us*, 292-293.
Superintendent to Medical Director and in 1976, Dr. Lawrence Benson began as the new Superintendent overseeing staff and administrative functions of TMHC. During Dr. Barg’s tenure, he oversaw the transition of hundreds of patients from the TMHC to community program, however, from the 1970s to the 1990s, reducing the mental health center’s population was not the only concern. As the TMHC population declined, so too did federal and state funding. By the 1970s, mental health treatment was no longer centered at the local state hospital, but instead spread across various community agencies and inpatient units at medical hospitals. Problems within the administration, financial cutbacks, and lack of oversight resulted in an investigation by the Ohio Highway Patrol in 1976 that revealed staff crimes including theft and patient abuse that resulted in the prosecution of seven TMHC employees.

During the 1980s, the financial struggles of TMHC and its inadequate resources became a regular topic of local newspaper reporting. Articles detailed problems with understaffing, outdated policies and procedures, poor record-keeping, and TMHC’s failure to pass the 1988 federal Medicare insurance inspection. Similar themes characterized the 1990s, while the hospital’s population continued to drop. In 1993, a Toledo Blade article quoted then TMHC CEO Terry Smith as stating that only 141 beds


were occupied, compared to twenty months prior when 370 beds were full. Smith attributed this dramatic decrease in patients to the Ohio Mental Health Reform Act, which further moved care “from the state mental health department to local mental health agencies.”\(^8^7\) As of 1995, the projected annual population was 88 patients, with a maximum capacity of 96.\(^8^8\) This continued decline resulted in additional staffing cutbacks by the mid-1990s and sparked much debate throughout the community. Even into the early 2000s, the hospital, which underwent another name change to Northcoast Behavioral Healthcare, faced threats of closing as funding from the state was uncertain. In 1988, Ohio operated 17 state hospitals, but by 2001, only nine remained.\(^8^9\) The state considered shutting down the facility in Toledo, but when Governor Bob Taft allocated an extra 23 million dollars to the state’s Department of Mental health budget, the Toledo center was spared.\(^9^0\) Since 2001, three more state hospitals have closed, and by 2014, Ohio operated only six hospitals across the state. Toledo’s Northwest Ohio Psychiatric Hospital (NOPH) provides “short term, intensive treatment to patients in both inpatient and community-supported environments” and is located on the same grounds—at the intersection of Arlington and Detroit avenues—where the Toledo Insane Asylum opened 126 years ago.\(^9^1\)

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\(^9^0\) Ibid.

The history of the state hospital in Toledo, Ohio reflects national and state trends in mental healthcare. In examining hospital annual reports, governing board reports, newspaper articles, and archival documents, the history of the TSH reveals a varied and complex story that often parallels the challenges faced by many hospitals across the nation, but these documents also uncover unique stories of patient life at TSH, hospital administrators, medical care and treatments, and the challenges and successes of the TSH.
Chapter 4

Professionalizing the Archives Room

In contemporary culture, the notion of the museum holds diverse and contradictory meanings. Theorists, who come from many disciplines including sociology, psychology, anthropology, art history, philosophy, linguistics, literacy criticism, and gender studies, typically see the museum in multiple guises but disagree on what these guises are.¹

Various attempts have been made over the years to draw firm boundaries around the category “museums,” defining who gets in and who stays out…We may have to live with the fact that “museum” as a concept is the intersection of many complex categories, resulting in organization that people can identify intuitively but that cannot be neatly packaged in a definition.²

The Archives Room at Northwest Ohio Psychiatric Hospital (NOPH) contains an assortment of artifacts, furniture, photographs, and documents from the earliest days of the Toledo Asylum for the Insane through the current day. The room is bursting with over 125 years of local history that has the potential to tell stories of patients, the history of mental health, professionalization of psychiatry and social work, the history of institutionalization, and the unique story of the Toledo State Hospital (TSH) from local, state, and national perspectives. However, at this point, the room is no more than a collection of various objects. In a recent interview, Jane Weber, a retired NOPH staff member and current NOPH history volunteer, stated, “it’s just one big square room full of old stuff right now.” It is “without information identifying anything; no graphic displays…telling a story. You have to make up your own story when you walk in the


room, and that’s not good. We need to have the room tell its own story.”3 In order to meet the high hopes that Weber and others hold for the Archives Room it is essential to incorporate professional museum practices into the space. The fundamental components necessary to create a basic museum framework include a statement of standards, policies, and procedures. These serve as a starting place for volunteers to use in moving the Archives Room museum project forward.

What does it mean to bring professional standards to the Archives Room? Defining professionalization is as difficult as attempting to define museum; it means different things to different people. However, historian Patricia Mooney-Melvin suggested that a review of the literature on the subject reveals particular attributes related to professionalization. The four attributes that Mooney-Melvin identified are: formal training to insure quality and competency, knowledge and skills that can be demonstrated and applied, a commitment of service to society beyond the desire for personal profit, and the power to define standards as well as the obligation to insure that professional knowledge and skill will be used in a ‘socially responsible’ fashion.4 Historians Edward P. Alexander and Mary Alexander wrote in Museums in Motion, the “paramount essence of the museum profession is a common cause and goals.” They elaborated on this point: “museums have generally increased their professionalism by improving their published literature, adopting standards for museum practice, proposing guidelines for museum

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3 Jane Weber (NOPH Former Employee and TSHCRP Volunteer), interview with author, August 15, 2014.

4 Patricia Mooney-Melvin, “Professional Historians and ‘Destiny’s Gate,’” The Public Historian 17, no. 3 (Summer 1995): 12.
training courses, and agreeing upon an internal code of ethics.” For the purposes of the Archives Room museum project, professionalization means applying professional methods and commonly agreed upon museum standards and best practices.

In 1978, the American Association of Museums (now known as the American Alliance of Museums or AAM) defined a museum, for the purposes of accreditation as: “an organized and permanent nonprofit institution, essentially educational or aesthetic in purpose, with professional staff, which owns and utilizes tangible objects, cares for them and exhibits them to the public on some regular schedule.” This definition, although seemingly encompassing and succinct, did not offer a broad enough scope to fit all museums. The Institute of Museum and Library Services maintains a data file containing over 35,000 known museums in the United States alone. With so many different museums across the U.S., establishing one concise definition to include all the various types is nearly impossible.

In more recent years, the AAM moved away from the one sentence definition and now makes no attempt to define what a museum is or is not, instead it “takes the ‘big tent’ approach” meaning, “if an organization considers itself to be a museum, it’s in the tent.” Although this definition may be too broad to apply to the Archives Room museum project, it does not rule out the potential for this museum, according to AAM.

Rather than attempting a singular definition, AAM bases museum accreditation on what it considers the core standards and best practices for museums. AAM defines

5 Edward P. Alexander and Mary Alexander, *Museums in Motion* (Lanham, MD: AltaMira Press, 2008), 306.


standards as “things all good museums should live up to...not lofty goals that only a few will achieve, they are fundamental to being a good museum, a responsible nonprofit and a well-run business.” Whereas standards are considered necessary, best practices are “commendable actions and philosophies” or the “extra credit” that some museums may choose to incorporate into their operation. Not all museums will have the resources to include every best practice suggested by the AAM, but can choose the ones that fit best with their own institution.\textsuperscript{8}

In 2006, the AAM designated and labeled a set of practices as national standards for the field of museum work. Later these were published as the \textit{National Standards & Best Practices for U.S. Museums}.\textsuperscript{9} The text describes the “Characteristics of Excellence,” which outline the criteria for a well-run museum and includes thirty-eight attributes that an accredited museum should achieve. These elements are broken down into seven categories that “are adaptable for museums of all types and sizes, with each museum fulfilling them in different ways depending on their unique circumstances.” The categories include:

1. Public Trust and Accountability
2. Mission and Planning
3. Leadership and Organizational Structure
4. Collections Stewardship
5. Education and Interpretation
6. Financial Stability


\textsuperscript{9} Ibid., ix.
7. Facilities and Risk Management.\textsuperscript{10} Arguably, the AAM’s Characteristics of Excellence are the most well-known and revered set of standards among museums, but they are not the field’s only available guidelines. In \textit{Museums in Motion}, Alexander and Alexander discuss the functions of museums and their responsibilities to collect, conserve, exhibit, interpret, and serve.\textsuperscript{11} This criteria overlaps with the AAM’s characteristics, but leaves out some of the more detailed pieces that AAM specifies to encourage good business practices and long-term stability, such as financial planning and risk management. Additionally, the American Association of State and Local History (AASLH) offers small and mid-size museums or historic sites a multi-certificate workbook program called Standards and Excellence Program for History Organizations (StEPs). The StEPs workbook outlines six areas including:

1. Mission, Vision and Governance
2. Audience
3. Interpretation
4. Stewardship of Collections
5. Stewardship of Historic Structures and Landscapes
6. Management

The AASLH standards align with the national AAM standards, but the AASLH program allows museums to work in increments toward each of the eighteen AASLH certificates or towards overall AAM accreditation. The StEPs program is appealing for small

\begin{footnotesize}

\textsuperscript{11} Alexander and Alexander, \textit{Museums in Motion}, 7-11.
\end{footnotesize}
museums because it does not require an organization to have paid staff members and recognizes museums or historic sites that operate on an all-volunteer basis.\textsuperscript{12}

For museums, there are multiple options and guidelines that provide basic frameworks and guidance to creating, running, and sustaining a successful museum. The AAM, AASLH, and \textit{Museums in Motion} are only a few of these examples. Not all museums find it necessary to achieve national accreditation, but utilizing agreed upon standards, such as those published by AAM or AASLH, provides the foundation to develop a professionalized operation.

The definitions of what a museum is or is not vary depending on who is doing the defining. Among historians, both professional and avocational, scholars, museum professionals, and the public, the concept or perception of a museum may differ. Yet, in most cases, it is clear that people identify a museum as more than a place that collects and houses items, a museum preserves history, tells a story, educates, and, in the case of a small local history museum, acts as a keeper of collective memory, and connects the visitor with place.\textsuperscript{13} Currently, the Archives Room does not fully meet the characteristics of a museum, but the potential exists.

The Archives Room is one of two history related endeavors at NOPH, the second is the Toledo State Hospital Cemetery Reclamation Project. Although a more recent undertaking than the Archives Room, the volunteer-run Cemetery Reclamation Project (CRP) has achieved extensive progress in the ten years since its inception. The Archives Room does not exist as a standalone project, nor is it fully defined within the CRP’s

\textsuperscript{12} Association of State and Local History, “What is STEPs?” http://tools.aaslh.org/what-is-steps/ (accessed September 1, 2014).

mission, vision, or plan; however at the August 2014 CRP committee meeting, members agreed to incorporate the Archives Room museum project into the committee’s five year strategic plan. This is an appropriate starting place for the proposed museum, as the CRP has a dedicated base of volunteers that have proven success is attainable with minimal funding and ample volunteer hours. The CRP project serves as an example that at NOPH an all-volunteer based museum is possible.

The CRP began in 2005 after Larry Wanucha attended a conference in Columbus, Ohio on Medicaid Reimbursement for peer support services. During one session, Larry Fricks, the Director for Consumer Relations of Georgia and member of the mental health advocacy group Georgia Consumer Council, began his presentation with a story. He told the audience about a cemetery project that began in 1997 in Milledgeville, Georgia after the Georgia Consumer Council toured one of six neglected and forgotten cemeteries at the Central State Hospital used to inter over 30,000 former patients. The group took measures “to restore the cemetery, identify as many graves as possible and erect a memorial that would serve as a perpetual reminder of the horror of our past.”

Wanucha was intrigued and inspired by the cemetery project at Central State Hospital. Familiar with the TSH, having grown up in South Toledo, Wanucha returned from the conference and began to investigate if TSH had any existing cemeteries. He

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reached out to the University of Toledo, which now owned portions of the hospital’s surrounding property. The University maintenance department shared two maps with Wanucha that showed the locations of the two cemeteries used by TSH from 1888-1973. He then set out to establish a committee of interested volunteers to begin a cemetery reclamation project at TSH and to restore the two long forgotten cemeteries.

In 2005, the project began as a three-person team. Since then, the group expanded into a formal committee with members representing former and current NOPH employees and patients, persons in recovery, University of Toledo staff, and various community members with valuable skills and a passion for the CRP and TSH history. The CRP’s fiscal agent is the National Alliance of Mental Health of Greater Toledo (NAMI) and the program falls under NAMI’s 501c3, non-profit status. When the group began, the cemeteries were overgrown and nearly all the stone burial markers were sunken into the ground. To date, the CRP has found and restored the majority of the 1,100 stone markers in the newer of the two cemeteries, however the group has more work ahead of it. More than three quarters of the 900 stone markers in the older cemetery are still missing.  

The CRP began with one person asking a question. The project soon developed into a group of three individuals with a passion for bringing honor, dignity, and respect to those buried and forgotten at TSH cemeteries. Over years of persistence and work, the project evolved into a formal committee achieving real results. In the formative years, Leadership Toledo helped the CRP to develop a startup plan and develop the backbone of

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the committee structure.\textsuperscript{17} Today, CRP maintains a clear mission, vision, and set objectives for the project. The committee schedules several workdays each spring and fall to find and restore missing stones while general upkeep of the cemetery, including landscaping and maintenance, takes place throughout the year. Committee members meet monthly and provide updates on current or completed projects and plan for new ones. Each year since 2007, the committee has planned an annual Veterans’ Day Memorial Celebration to honor the many veterans buried in the hospital’s two cemeteries. The committee further fulfills its mission through regular presentations aimed at introducing the public to the existence of the cemeteries, sharing information on the history of TSH, and educating the public on mental health issues in order to reduce the stigma of mental illness. The progress and achievements of the CRP over the last ten years are undeniable.\textsuperscript{18}

The Cemetery Reclamation Project and the Archives Room, although two distinct projects, remain connected as they both seek to reveal parts of TSH history. The CRP’s stated objectives do not include specific references to the Archives Room, but do intend “to reduce the stigma surrounding mental health issues through community education” and “to serve as advocates and give a voice to descendents [sic] of those interred.”\textsuperscript{19} These two objectives closely align with the proposed goals of the Archives Room.

\textsuperscript{17} Weber, interview with author, August 15, 2014.


museum project which include preserving the TSH history, exhibiting and interpreting the collection to educate the public on mental health histories and the TSH history, and giving a voice to the former patients of the hospital. The two projects are closely linked, but more importantly, the CRP serves as an example that a small, committed group of volunteers can implement the building blocks to transform a dream and vision into a formal committee with a mission, strategic plans, and tangible results. The CRP is proof that a dedicated team of volunteers, with the support of NOPH, and the application of standards and best practices can produce measurable outcomes, even without significant funding. Museum professional, Arminta Neal writes:

> to accomplish the practical result of good plans is not something open only to affluent museums. There are big museums with big budgets that turn out exhibitions that are pedestrian or worse – and there are plenty of small museums that consistently mount thoughtfully conceived and effectively presented shows with very little money. The secret is not money, but skill and care intelligently combined.20

With standards and best practices, it is possible for the Archives Room to move from a room of curiosities to a well-maintained and professionalized exhibit space.

The CRP committee members, including Weber and Wanucha, and the NOPH administration have expressed the importance of the Archives Room and their interest and desire to move the project forward.21 As Weber stated, “I think it’s important to have, improve it, make it better, and document what we bring in.”22 Student groups doing their

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22 Weber, interview with author, August 15, 2014
rounds at NOPH often visit the Archives Room during their orientation tours. As Weber suggests, the Archives Room is an important stop for these students:

It’s (the Archives Room) a good learning experience, it tells them more than they can experience by just being on the units today...being on the units, it’s a wonderful learning experience certainly, but they can get that at any hospital, in any psych. unit, but they aren’t going to get the history, the stigma, they are not going to understand what the patients went through, and what conditions were like and what the atmosphere was like.  

The room, even as a random collection of items is already serving as a learning environment, but the potential for the room to become a place to educate, create dialog, uncover hidden histories, and give voice to the voiceless is possible, with the application of basic museum and archival professionalization standards.

According to Jane Weber, the Archives Room began its existence in the early 1990s. During this time, the hospital, in conjunction with the Ohio Department of Mental Health decided to demolish the remaining original buildings of the State Hospital. The hospital held public auctions to sell the contents of the cottages and other original TSH structures prior to demolition. One employee, and later others, recognized the threat of losing the hospital’s history as the furniture, fixtures, and objects from these buildings were sold or discarded as trash. The Archives Room evolved as an attempt to preserve the hospital history and the room became a general depository for anything related to the history of the hospital. In 2005, the room was dedicated as the Terrance Smith Archives Room, named after the outgoing NOPH CEO and avid supporter of the project to preserve TSH history.

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23 Ibid.
24 Ibid.
Although primarily a depository for TSH history, the room has remained anything but static. Over the years, the collection has grown as community members, past and current TSH staff, and volunteers have donated items to the space. Donors have contributed a variety of items including furniture, artifacts, and archival collections. For example, two donations coming from the community were items originally purchased at the TSH auctions during the demolition years. One donor’s family purchased two cast iron beds from the hospital’s auction and after speaking with Jane Weber about the room, donated these beds to the Archives Room. Another donor’s family purchased two arts and craft style rocking chairs from the auction (Figure 6). These chairs originally sat on the TSH cottage porches for patient use. She donated these items to the Archives Room after hearing about the room from Weber.

![Arts and Crafts Style Rocking Chair, TSHM Collection. Photograph taken by author.](image)

On other occasions, hospital employees have added to the collection. The NOPH custodial department lead “is always on the lookout for other items that might make sense
to bring into the history room.” In some instances, Weber or NOPH volunteers have made connections with individuals formerly associated with the hospital and obtained donations from them. Recently, the family of Pastor Walter Larson donated his diary used during his first year as chaplain at the TSH and his appointment book from the same year (Figure 7).

![Figure 7. Pastor Walter Larson’s diary, TSHM Collection. Photograph taken by author.](image)

Occasionally, anonymous individuals drop off artifacts, adding to the collection. For example, in 2014, a box of old medical supplies and medicine bottles was dropped off at the hospital’s front switchboard station and moved into the Archives Room. This is one of many donations that have simply appeared in the room with little or no information. Lastly, the room contains artifacts or partial artifacts, such as medicine

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25 Ibid.
bottles or tableware that volunteers have excavated from the surrounding property (Figures 8 and 9).  

Figure 8. Excavated Partial Porcelain Bowl, TSHM Collection. Photograph taken by author.

Figure 9. Excavated Nearly Intact Medicine Bottle, TSHM Collection. Photograph taken by author.

The contents of the Archives Room has continued to grow as donors add to the collection, but with no standard donation process in place, the provenance of such items is nearly impossible to know. Further, it is difficult to estimate the growth of the collection.

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26 Volunteers have not conducted a formal archaeological excavation. However, volunteers have unearthed items while searching for buried gravestones or along the banks of the Swan Creek.
collection over the years because no full inventory exists. The AAM’s National Standards and Best Practices translates its Collections Stewardship Policy section as:

“Know what stuff you have, know what stuff you need, know where it is, take good care of it, make sure someone gets some good out of it, especially people you care about.”

These are the big, broad, basics of museum collections practice, and will be one of the first steps for the Archives Room to accomplish.

Based on the information published by AAM, AASLH, and the International Council of Museums (ICOM) the Archives Room museum project – “A Room for History” – creates the necessary foundation to transition the room from a random collection of objects to a professionally operating museum space.

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Overview: About the Museum Project

The Northwest Ohio Psychiatric Hospital Archives Room houses a collection of artifacts including furniture, fixtures, kitchenware, patient related objects, medical equipment, and staff related objects associated with the Toledo State Hospital. Additionally, the collection contains archival manuscripts relevant to the hospital’s history. The official name of the room where these items are housed is the Terrance Smith Archives Room. Although somewhat contradictory and conflicting to the intent of the proposed museum, the official name will remain, however for the purposes of the following proposal, it will be referred to as the Toledo State Hospital Museum (TSHM).

Currently, the TSHM is not an independent 501c3, but will be operated in conjunction with the Toledo State Hospital Cemetery Reclamation Project (CRP), which functions

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under the non-profit status of National Alliance of Mental Illness of Greater Toledo (NAMI). The CRP committee will serve as the advisory board for the TSHM. In the future, it will be a goal for the museum to operate under its own volunteer advisory board, seeking representation from NOPH staff, patients, and community volunteers.

I.  Mission and Plans

A. Mission Statement

The American Alliance of Museum’s (AAM) Characteristics of Excellence states, “the museum has a clear understanding of its mission and communicates why it exists and who benefits as a result of its efforts.” In other words, “know what you want to do and why it makes a difference to anyone.”\(^{28}\) Hugh Genoways and Lynne Ireland, in their text *Museum Administration*, emphasize that a museum’s mission statement should align and inspire the staff, board, and public.\(^{29}\) The mission statement should broadly capture the primary functions of the museum and be written in a clear and concise manner so anyone reading the statement could understand the main purpose of the museum. Lastly, the museum’s mission should remain attainable and set the museum up for success. The TSHM’s Advisory Board is responsible for approving the proposed mission statement:

The Toledo State Hospital Museum is the primary organization dedicated to the collection, preservation, and interpretation of artifacts and documents related to the history of the Toledo State Hospital for the public. The museum’s location inside Northwest Ohio Psychiatric Hospital, affords it a unique opportunity to connect the current and former patients and caregivers at the hospital to the history of mental health and offers the potential to build a better understanding between patient and caregiver, while also empowering a group of individuals whose history has often been hidden or disregarded.

\(^{28}\) Ibid., 15-17.

B. Vision Statement

A Vision Statement is not a necessary piece of a museum’s framework, however according to the AAM standards a museum must plan and work to meet the museum’s mission. The vision statement complements the mission by describing the future goals of the institution and the plans to achieve these goals.\textsuperscript{30} For the TSHM, the vision statement describes the long term goal for the museum as a community asset and the more short term, five year goals:

The vision of Toledo State Hospital Museum is to become a valued historical and education resource for Northwest Ohio. Over the next five years, the museum will create exhibits and educational programming that explore and communicate the histories of the Toledo State Hospital, institutional care, and individuals with mental illness. To complement the exhibits and educational activities, it is the aim of the Toledo State Hospital Museum to open an equal access archival collection for interested researchers, including the general public, within the next five years.

II. Structure

A. Governance Structure and Representation

Museum structures vary depending upon the institution. One museum may have dozens of staff managed by a museum director who reports to a board of trustees or other governing authority, while another museum may have one person who is responsible for all operations and reports to a board. The AAM does not specify how a museum’s governance should be organized, but the Characteristics of Excellence recommend a museum’s board, staff, and volunteers, advance the mission, understand their roles and responsibilities, and ethically carry out those responsibilities.\textsuperscript{31} Museums may use an organizational diagram to visually describe the various roles of the board, staff, or


\textsuperscript{31} Ibid., 15.
volunteers and how they are all connected. A commonly used diagram illustrates a hierarchy of volunteers, interns, staff, and management reporting upward to a museum director, who is directly supervised by the Board of Directors. The TSHM organizational structure, operating fully upon volunteers, will not be as intricate and will consist of the Advisory Board, a volunteer manager, and museum volunteers (see Figure 10).

When developing a museum governing board, it is important to consider the board’s makeup, as these are the individuals responsible for overseeing the full operation of the museum. The AAM Characteristics of Excellence recommends, “the composition and qualifications of the museum’s leadership, staff, and volunteers enable it to carry out the museum’s mission and goals.” The National Standards & Best Practices text further proposes a museum’s governing agent should regularly “cycle in new people and new ideas” and be diverse to reflect the community it serves. Although the AAM does not mandate specific term limits for governing boards, it does suggest that a museum should find ways to fulfill these goals. The TSHM advisory board currently consists of former NOPH staff, current and former NOPH residents, mental health advocates, persons in recovery, and others with specialized skills and interests in TSH history. As the TSHM grows it may benefit the museum to consider adding additional members with specialized backgrounds in areas such as design and marketing, fundraising and development, law, non-profit management, and financial management to bring additional advice, expertise,

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32 Example organizational structure created by author

33 Merritt, National Standards & Best Practices, 15.

34 Ibid., 40.
and leadership to the Board. The following is the proposed governance and organizational structure for TSHM:

The TSHM Advisory Board will be responsible for all decisions pertaining to the museum including the development of policies and procedures, the management and development of financial resources, creation and evaluation of exhibits and programming, and coordination with NOPH as necessary to fulfill and advance the mission of TSHM. A Volunteer Manager will have direct oversight of the volunteers, their applications, tracking of service hours, training, and other necessary administrative tasks. The Volunteer Manager may be a member of the Advisory Board, but could be chosen outside of Board membership. The Volunteer Manager will work closely with the Advisory Board to directly communicate plans from the Board to the volunteers. Volunteers are a vital piece to the TSHM structure. These volunteers will be trained according to the policies and procedures to perform various tasks and ensure the successful operation of the TSHM. Such tasks may include record keeping, basic cleaning, participation in museum programming or events, and museum docent responsibilities.

![Figure 10. Example Organizational Structure for TSHM. Created by author.](image)

**B. Ethics**

The necessity and importance of a strong museum Code of Ethics cannot be understated. The AAM states museums are “grounded in the tradition of public service. They are organized as public trusts, holding their collections and information as a benefit for those they were established to serve.” Museums must comply with federal, state, and local laws, but “legal standards are a minimum.” A museum “must act not only legally
but also ethically.”35 There are three main characteristics in the AAM’s standards related to ethics.36 In addition to these three points, the AAM publishes a supplemental document, “The Code of Ethics for Museums,” which establishes ethical guidelines in the areas of Governance, Collections, and Programs. Further, the AAM recommends that each museum create their own ethics policy, specific to their institution, in addition to adopting the AAM’s Code.37 The International Council of Museums (ICOM) also established a Code of Ethics “based around a set of minimum standards of professional conduct and performance.” The key principles of ICOM’s Code can be found in Ambrose and Paine’s publication *Museum Basics*.38 Similar to the AAM’s recommendation, ICOM suggests that each institution supplement the Code with a specific ethics policy relative to the institution.39 Texts such as Marie Malaro’s *A Legal Primer on Managing Museum Collections* provide the novice or new museum professional awareness of laws and legislation that might apply to the museum’s collection and provide guidelines in crafting a museum’s ethics policy.40 The TSHM Board will be responsible for creating and implementing its Ethics Policy. Using the AAM’s Code of Ethics for the TSHM provides a strong foundation to build an ethics policy upon. The subsequent section is the proposed TSHM Ethics Policy:


39 Ibid., 15.

All volunteers and advisory board members will adhere to the Code of Ethics. The following is partially adapted from the AAM Code of Ethics.

1. Governance:
   
   a. All volunteers and those working on behalf of the Toledo State Hospital Museum know and support its mission
   
   b. Members of the Advisory Board understand and fulfill their roles preserving the interest of TSHM before individual interests
   
   c. The Advisory Board strives to maintain the TSHM’s physical and financial assets responsibly
   
   d. The Advisory Board is responsive to and represents the interests of society
   
   e. The Advisory Board creates, maintains, and implements professional standards and practices to guide museum operations
   
   f. Museum governance promotes the public good rather than individual financial gain

2. Collections:
   
   a. TSHM Collections support the museum’s mission and public trust responsibilities
   
   b. All collections are lawfully held, protected, secure, unencumbered, cared for, and preserved
   
   c. Collections are properly inventoried
   
   d. TSHM provides reasonable access to its collections, while maintain the privacy and confidentiality of residents or patients of TSH, as required by law
   
   e. The acquisition, disposal, and loan processes align with the museum’s mission and are conducted lawfully
   
   f. The disposal of collections by sale, trade, or research is solely for the advancement of the museum's mission. Proceeds from the sale are only used for the purposes of acquisition or direct care of collections

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g. Collections-related activities promote the public good rather than individual financial gain

h. Disagreements of title are handled openly, seriously, responsively, and with respect for the dignity of all parties involved

3. Personal Collecting:

The acts of collecting, acquiring, or owning objects related to the TSHM scope of collections by the Advisory Board or volunteers is not, in itself, unethical and can enhance professional development. However, such acts may create a conflict of interest between the TSHM and its volunteers. Rather than limit personal collecting, if associated volunteers wish to acquire, for their own personal collection, an object related to the TSHM scope of collections, the museum should be given the right of first refusal.

4. Educational Programming:

The TSHM will produce programming that aligns with the museum’s mission statement and is based in scholarly research. Programming at the TSHM encourages participation and seeks to reach a wide and diverse audience.

III. Audience and Accessibility

A. Audience

The AAM Characteristics of Excellence section on Public Trust and Accountability contains multiple points related to identifying the museum’s audience, engaging the audience, providing access to the audience, and being inclusive of diversity. A good museum will know its primary audience, but strive to engage and develop new audiences. Ambrose and Paine write, “no museums should ever be content with their present visitor, even if millions come through the door each day.” Once operating, the TSHM advisory board should develop a short visitor survey to better identify who the visitors of the museum are, who might be missing, and work to promote

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42 Merritt, National Standards & Best Practices, 15.

43 Ambrose and Paine, Museum Basics, 37.
the museum to attract additional visitors.\textsuperscript{44} The suggested policy for audience and user communities follows:

The TSHM and archival collection appeals to a wide range of visitors including Northwest Ohio Psychiatric Hospital patients and staff, general public visitors, and researchers interested in Toledo State Hospital history, psychology history, medical history, institutional history, the history of mental illness. The museum welcomes and strives to be accessible for all interested visitors.

\textbf{B. Facility}

A museum requires more than exhibit space for its collections. Areas for storage, accommodations for visitors, and room for administrative tasks are each important to operating a successful museum. The TSHM, located inside a functioning psychiatric hospital, may face unique challenges regarding space, but will also benefit from this shared space. Ambrose and Paine discuss the importance of quality visitor facilities to make guests “feel welcome and comfortable and encouraged throughout their visit to return again and again and to recommend the museum to others.” They propose that even the smallest of museums can provide basic facilities for visitors.\textsuperscript{45} NOPH has reserved some space for the TSHM collection and administrative function including room for the collection, storage, and an office for administrative purposes. As a shared hospital space, written approval from the NOPH administration will be necessary to open hospital facilities, such as guest parking and restroom access, to museum visitors. In the future, it may become necessary for the museum’s Board to negotiate with hospital administration for additional accommodations or space as the museum develops, evolves, and expands.

A brief, idealized description of the museum’s facilities follows:

\textsuperscript{44} Ambrose and Paine suggest asking four simple questions to all visitors: Where do you come from? What work do you do? Why did you come? What is one thing could increase your enjoyment of the museum? Ambrose and Paine, \textit{Museum Basics}, 37.

\textsuperscript{45} Ibid., 67.
The Toledo State Hospital Museum collection is housed entirely at the Northwest Ohio Psychiatric Hospital, in Toledo, Ohio. The primary space for the museum’s exhibits and displays is within the Museum Room on the first floor of the hospital, located directly off the hospital’s main lobby. The museum periodically uses two display cases in the hospital’s main lobby to further house exhibits. The History Office, also located on the first floor, serves as the administrative office for the museum volunteers, holds the archival and educational collections, and offers a small space for researchers. The facility has also dedicated two areas for collections storage, a closet within the exhibit room and an overflow storage room located on the third floor. NOPH offers visitor parking near the main entrance and restrooms on the first floor close to the Museum Room.

C. Hours of Operation

“To meet its basic public trust responsibilities, a museum must give the public reasonable access to the collections and their associated records.” A collection of artifacts and objects is not truly a museum unless it allows the public access to view and learn from it. Although the AAM standards do not dictate regular hours of operation to be necessary for a museum, it does specify that an institution should provide public access to its collections. For a facility such as the TSHM, working solely on the donated time of volunteers, regular operating hours becomes more challenging. The TSHM’s Advisory Board will work closely with NOPH administration to develop a mutually agreeable schedule that does not disrupt the hospital’s operations, but allows open access to the museum. The subsequent plan outlines the TSHM’s hours of operation and future plans to expand these hours:

Initially, the Toledo State Hospital Museum will not be open on a regular basis. Hours of operation and programming will be sporadic and dependent upon volunteer availability. However, within the next five years, it is the goal of the TSHM Advisory Board to establish regular, weekly hours of operation corresponding the hospital visitor hours. To operate the museum during these hours, the TSHM will develop a volunteer docent program in conjunction with the

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46 Simmons, *Things Great and Small*, 111.

Northwest Ohio Psychiatric Hospital Volunteer Program. A self-guided tour and audio tour are also long-term goals of the TSHM.

IV Collections

A. Scope of Collections

The scope of collections policy creates the framework for the museum’s collection and the future of the museum’s collection. The policy places limitations on what the museum chooses to acquire and accession into the collection. A strong scope of collections will base its guidelines on the museum’s mission. Genoways and Ireland suggest some key factors to consider in creating a scope of collections including: discipline, geography, time period, persons, groups of people, types and sizes of objects, research and interpretation, as well as considering the resources required to support the collection. The suggested TSHM Scope of Collections includes many of these factors:

1. The TSHM collection began in the early 1990s when staff at NOPH feared that history was being lost as the original buildings of Toledo State Hospital were demolished and their contents sold or destroyed. The collection continued to grow over the next twenty years through donations. During this time, all donations were accepted, but none were recorded, and most were anonymous.

2. The Toledo State Hospital Museum collects historic and modern artifacts and archival materials pertaining to the history of Toledo State Hospital, Ohio’s history of institutions formerly known as ‘insane asylums’ or State Hospitals, and the history of mental illness. The collection at the Toledo State Hospital Museum primarily dates between the mid-1800s and present day.

3. The Collection is categorized into sub-collections:
   a. The Permanent Collection – items that are historically valuable and used primarily in exhibitions. These items are properly maintained, handled, and stored to preserve their historic value.

48 Simmons, Things Great and Small, 30; Ambrose and Paine, Museum Basics, 136-137.

49 Genoways and Ireland, Museum Administration, 176.
b. The Educational Collection – items are generally not used within exhibitions, but rather within the various educational programs and presentations. Most items in this collection do not have historical significance (many are reproductions) or are less desirable duplicates of items in the permanent collection. The standards of care for these items are less rigid than items in the permanent collection.

4. The Advisory Board for the Toledo State Hospital Museum will approve all acquisitions including donations, bequests, conditional gifts, and purchases. At monthly Board meetings, potential acquisitions, loans, or conditional gifts will be reviewed, approved, or declined.

5. The Museum does not collect human remains of any kind.

B. Acquisitions Policy

Genoways and Ireland succinctly define acquisition as the “process of legally obtaining objects and their associated data for a museum through gifts, purchases, exchanges, transfers and field collecting.” A museum’s acquisitions may be incorporated into the museum’s permanent collection (accessioned) or used by the museum for other purposes such as the educational collection. The acquisition of an object also includes acquiring legal title or ownership of the piece. The acquisition policy should guide the museum in determining which items are appropriate for consideration and how to avoid illegally acquiring an item. A museum’s acquisition policy is multifaceted and includes guidelines such as: the means by which an object or item may be added to the collection, ethical and legal considerations, and the availability of resources to properly care for an item. The policy may also contain considerations such as the condition of the item, its relevance and potential, the price of the item if it is purchased, restrictions if it is donated,

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50 Ibid., 176.

51 Ibid., 176.
its provenance, or its appropriateness based on the museum’s scope of collections. The following is a proposed acquisitions policy for the TSHM:

The Advisory Board for the Toledo State Hospital Museum will approve all acquisitions including donations, bequests, conditional gifts, and purchases. At monthly Board meetings, potential acquisitions, loans, or conditional gifts will be reviewed and approved or declined.

Criteria for Toledo State Hospital Museum acquisitions:

1. The acquisition aligns with the Museum’s Scope of Collections and furthers its mission

2. The Museum is able to adequately and securely store and maintain the object or collection considered for acquisition

3. All acquisitions donated or bequeathed to the Museum require a formal, signed Deed of Gift:
   a. Deed of Gift is signed by both the party donating the item and Advisory Board representative
   b. Deed of Gift clearly states the transfer of title (from donor to Museum)

4. The Museum makes every effort to ensure that all objects or collections considered for acquisition have been legally obtained

5. The Museum may purchase acquisitions from staff, Board members, private individuals, or any other source, as long as the acquisition is approved by the full Advisory Board

C. Accession Policy

Accessioning is the formal process of adding an acquisition into the museum’s permanent collection. A museum may acquire items intended for use in the educational collection, for programming purposes, or even to sell for a profit, but the museum would not accession these items into the permanent collection. Generally, the museum chooses to accession only those pieces it intends keep and preserve for the future. The accession

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52 Simmons, Things Great and Small, 44.
policy is often part of the museum’s acquisition policy and details the processes of accessioning, including the forms or records that need to be completed. This process is unique to each institution, as each museum has its own record keeping system. A museum should develop standardized processes and documentation for cataloging and inventorying, as well as a standard nomenclature or classification for categorizing its collection. The proposed TSHM accession policy that follows is an outline of the steps necessary to completing an accession:

All accessions must first be approved through process outlined in the Acquisition’s Policy.

1. After the Advisory Board has approved the accession of an artifact, the Museum should maintain physical custody of the object

2. Donors making a gift to the museum will receive a temporary receipt after the Museum has acquired physical custody of the object

3. Title Transfer should only move forward if the title is clear and there are no questions of ownership

4. An accession will not be considered complete until the following steps have been documented:
   a. Signed Deed of Gift is on file
   b. Donor thank you letter is mailed and on file
   c. An accession number is assigned and added to the accession log
   d. Object numbers are assigned and objects are clearly marked with their unique numbers
   e. An object file is created and includes the object name, number, description, measurements, nomenclature classification, provenance information, insurance value, initial condition report, and photographs

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53 Ibid., 38.
54 Genoways and Ireland, Museum Administration, 176.
55 Ibid., 180-181; Simmons, Things Great and Small, 39.
D. Deaccessioning Policy

After an object has been accessioned into a museum’s permanent collection, the museum cannot simply discard the item if it chooses; instead, the museum should create a policy detailing the process to remove an object from the permanent collection, or deaccession it. Simmons calls deaccessioning “one of the most controversial practices in museums” but notes it is equally an “important tool for exerting control over collections.”56 The museum may choose to deaccession items from the collection for a variety of reasons including if the item is broken or stolen, is discovered to be a forgery, becomes too difficult or costly to care for, is an excessive example of the object in the museum’s collection, or laws mandate the removal of items from the collection (i.e. repatriation of items).57 Genoways and Ireland describe deaccessioning as a tool used to “reshape the collection by allowing unneeded objects to be removed, freeing needed space and funds.”58 However, if the museum adheres to the AAM’s Code of Ethics, any funds received from the sale of a deaccessioned item can only be used “for acquisitions or direct care of collections” and not for general operating expenses. According to AASLH policies, a museum may only use the profits of a deaccessioning sale for acquisitions or preservation.59 Both standards and ethics dictate a museum should not rely on its deaccessioning policy as a backup to its financial plan. The policy below outlines

56 Simmons, Things Great and Small, 51.
57 Ibid., 52.
58 Genoways and Ireland, Museum Administration, 191.
59 Merritt, National Standards & Best Practices, 70.
the process, accepted means, and standard documents or records necessary for
deaccessioning at the TSHM:

The deaccession of objects within The Toledo State Hospital Museum’s collection
will follow all ethical and legal standards set forth by the American Alliance of
Museums and all local, state, and federal laws. The Museum’s Advisory Board
will not consider the deaccessioning lightly and will take into account the best
interest of both the museum and the public before deaccessioning objects from the
collection. The Board will consult with legal counsel prior to determining the
deaccession of objects that may present legal or ethical concerns.

1. Authorization: The Toledo State Hospital Museum Advisory Board makes
   all deaccessioning decisions.

2. Records: A permanent record of all deaccessioned objects is maintained in
   the museum’s records. All records are standard in format and include the
   necessary deaccessioning forms. Furthermore, an object’s original numbers
   used in accessioning, registration, and cataloging will not be used for future
   objects.

3. Time Limit: Only items in the Museum’s permanent collection for over three
   years will be considered for deaccession. Objects that have sustained severe
damage and cannot be repaired or are too costly to repair are considered
   exceptions.

4. Donor Restrictions: If a donor has placed restrictions on an object considered
   for deaccession, the Museum will first consult with legal counsel to determine
   the ethical and legal process for deaccession.

5. Reasons for Deaccession: The Museum may consider an object’s
   deaccession in following instances:

   a. Condition of the object is beyond repair or restoration

   b. Object was stolen or lost

   c. Cost of care is beyond Museum’s means

   d. Object does not fit the Museum’s mission and scope

   e. Legal ownership of the object is in question

   f. Object is a duplicate within the collection
g. Object was accessioned by mistake or found in collections

6. **Means of Disposal:** The Museum’s interest and the public’s interest are considered when choosing the manner of disposal. The following, in preferred order, are the acceptable methods of disposing of a deaccessioned item:

   a. Transfer the object within the Museum to the education collection
   
   b. Transfer to or exchange with another museum or educational institution
   
   c. Sell at auction
   
   d. Destroy
   
   e. Generally, deaccessioned objects will not be returned to the original donor, but under rare circumstances, the governing body may authorize this return

7. **Conditions of Sales:** The sale of a deaccessioned object will be done through an auction handled by a third party. No deaccessioned items will be sold to museum staff, volunteers, board members, or their immediate family. The proceeds from the sale of deaccessioned objects can only be used for the purchase of new museum acquisitions or direct care of the collection.

8. **Donor Notification:** The Museum will not notify original owners of a deaccession, unless the donor required such notification as a stipulation in the deed of gift

9. **Found in Collections:** Prior to considering the deaccession of objects found in collection, the Board should seek legal counsel and strongly consider all future consequences of this decision. The Board has the authority to approve the deaccession of objects found in collections, but the Museum must first document a good faith effort to verify the object and locate any existing records of the object.

**E. Loan Policies**

Simmons defines a loan as one party allowing “a collection element it owns to be temporarily transferred to the custody of a second party for some length of time, without a transfer of ownership taking place.”\(^{60}\) An incoming loan is an excellent way for

\(^{60}\) Simmons, *Things Great and Small*, 69.
museums to expand collections, especially for a special exhibit. An outgoing loan enables a museum to share their collection with visitors outside the regular audience and to aid fellow institutions in enhancing their collections. The length of an incoming or outgoing loan period may vary, but professionals recommend a finite period. If the two parties agree to extend the loan, they can modify the agreement, but museums should avoid indefinite or “permanent” loans. Permanent loans are problematic for museums. The loaned object is not owned by the borrowing institution, but they are responsible for its care and storage for an indefinite period of time. In Introduction to Museum Work, author G. Ellis Burcaw strongly recommends that museum professionals build their collections upon only the items the museum has clear title and not through a loan process.61

A museum should have both a loan policy and loan agreement documents. A museum’s loan policy details who the museum agrees to loan to or accept loans from, the reasons a museum will loan items, how requests for loans should be made, which parties are responsible for insurance and shipping, and the person or persons responsible for approving loan requests and decisions.62 The loan agreement is the written contract between the two parties that clearly states the responsibilities of each and includes the duration of the loan, care and use of the loan, insurance and shipping responsibilities, and loan conditions.63

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62 Simmons, Things Great and Small, 70-71.

63 Genoways and Ireland, Museum Administration, 184-185.
The TSHM Advisory Board is responsible for approving both the loan policy and the incoming and outgoing loan agreement forms. The proposed policies for incoming and outgoing loans follow:

**Outgoing Loans:** The Museum actively works with museums and non-museums, including educational and research institutions, to loan objects from the permanent collection to expand public access to these items. Objects will be loaned for educational and scholarly purposes. Generally, all outgoing loans will not exceed one year, however if a borrowing agency requests to extend the loan period they must do so in writing 90 days before the loan terminates. Initial condition reports must be completed prior to the object leaving the Museum. A secondary condition report is completed once the object is returned.

1. **Criteria for outgoing loans:** All loan requests must be made in writing by the proposed borrowing agency to the Toledo State Hospital Museum’s Advisory Board and include a completed facilities report. The loan request should describe the proposed use of the object or reason for the loan and specific dates for the loan period. The following steps dictate the outgoing loan request process:

   a. The Advisory Board reviews all outgoing loan requests. However, if the insurance value of the object is over $5,000 NOPH administration must also grant approval for the loan.

   b. If approved, the borrowing agency is responsible for the following:

      i. Verification that proper care and security of the object(s) can be maintained. (A completed facilities report should provide this information, but additional documentation may be required).

      ii. All shipment or transportation costs.

      iii. Wall – to – wall insurance coverage

   c. Once approved, the Advisory Board will arrange to have the object ready for lending within 30 business days.

   d. Before the object can leave the Museum, the following items must be complete and on file:

      i. Signed Outgoing Loan Agreement

      ii. Initial Condition Report (prior to the object leaving the Museum)
iii. Receipt of Insurance from borrowing museum

**Incoming Loans:** The Toledo State Hospital Museum actively works with other museums and non-museum facilities to accept loaned objects and expand public access to these items. The Museum will accept loaned objects from accredited and non-accredited museums, non-museum facilities, and private collections for use in the Museum’s exhibitions or educational collections. If the Toledo State Hospital Museum’s use for the loaned object ceases prior to the expiration of the agreement, the Museum will not store the item, but will return it to the lender. The following steps dictate the process for receiving and approving an incoming loan agreement:

1. The Museum adheres to the established lending policies and procedures set forth by the lending agency, if applicable.

2. The Advisory board approves all incoming loan requests. However, if the Museum is to provide the insurance, NOPH administration approval is additionally required.

3. If approved, the Museum and the lending agency or individual will determine responsibility of costs including:
   
   a. Shipment or transportation costs. Advisory Board members may transport objects.
   b. Wall – to – Wall Insurance coverage

4. Before the object can enter the Museum, a signed incoming loan agreement must be on file.

5. It is the lender’s responsibility to inform the Museum of any changes, including change in contact information or change of ownership.

**F. Care of the Collection**

AAM’s Characteristic of Excellence state, “the museum legally, ethically and effectively manages, documents, cares for and uses the collections.”

64 In an *Introduction to Museum Work*, Burcaw declares, “caring for collections is part of the definition of a

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Part of a museum’s responsibility, in holding a collection in the public’s trust, is proper care of the collection. Care may include adequate storage of objects, appropriate environmental standards, preservation of objects, preventative conservation, proper handling techniques, and pest control. A museum’s collection policy will address each of these areas. The TSHM Advisory Board may face some challenges in creating a care policy because of its location inside of NOPH, however, the Advisory Board should work closely with NOPH administration to construct a policy that is agreeable to both entities, while maintaining and assuring the long term care of the collection.

Some of the most common causes of collections deterioration are environment, biological, pollution, and humans. Museum collections are constantly under threat of these agents of deterioration, but a museum can regularly address such threats and use preventative conservation techniques to avoid or mitigate damage. Preventative conservation seeks to reduce risks by using simple and inexpensive best practices to prevent the need for costly conservation.

Environmental factors, such as temperature, relative humidity, and light, cause damage to a museum’s collection. Not all museums can afford to install environmental controls such as temperature-controlled facilities, humidifiers or dehumidifiers, and special lighting. However, monitoring these factors can be an inexpensive way to identify if an issue exists and the extent of the problem. A consistent, mild temperature and stable, 

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66 Ibid., 93-98; Simmons, *Things Great and Small*, 98.
moderate relative humidity are best for most collections. If temperature or relative humidity cannot be controlled, small fixes such as fans, humidifiers, or dehumidifiers can be added to regulate the temperature and relative humidity in the collections and storage areas. Light may also cause objects to fade, yellow, or weaken in structure. Based on the collection, a museum should choose the appropriate form of lighting that causes the least damage, while considering cost effectiveness. Museums may also choose to remove objects from direct light to minimize damage.69

Biological threats to a collection, such as pests, can cause extensive damage and permanently destroy artifacts or archival documents. A museum’s collections care policy should include an integrated pest management (IPM) program. An IPM program can be a cost effective way to reduce the threat of biological deterioration. An IPM program includes monitoring for pests (traps), maintaining a clean facility, identifying pests when spotted, determining appropriate steps to avoid infestation, or the necessary treatment if an infestation occurs. An IPM program generally calls for the least invasive method of eradicating the pest to reduce risks of damaging or harming the collection or the museum’s staff and visitors.70

Pollutant threats to objects come in various forms and can be more difficult to identify because they are frequently invisible or difficult to see. Pollutant threats can include various gas forms including smoke, sulfur dioxide, nitrogen dioxide, or ozone. Solid forms of pollutants include dirt, dust, small fibers, soot, or mold spores. A museum can take basic steps to mitigate the damages to a collection from pollutant threats

69 Genoways and Ireland, Museum Administration, 188; Ambrose and Paine, Museum Basics, 169-174.

70 Ambrose and Paine, Museum Basics, 176-177; Simmons, Things Great and Small, 99-101.
including regular cleaning and dusting, appropriate storage of items, and wearing gloves when handling objects. Air filtration systems and additional storage materials to buffer and reduce contamination and exposure are also available, but are generally more costly methods. A museum will have to determine the cost benefit of such methods and if they are appropriate for its institution.  

Humans present a range of threats to a collection, from accidental errors, such as dropping or misplacing objects, to more malicious actions such as intentional damage to objects or theft. To reduce the likelihood of accidental human damage, a museum should train staff or volunteers on the policies and procedures that dictate access to objects and the proper handling of objects. A museum should also practice accurate record keeping to prevent objects from being lost or misplaced within the collection. To minimize the risk of intentional damage, a museum can employ simple security precautions such as placing objects in locked cases and keeping the collection areas and storage rooms locked unless authorized staff or volunteers are present. More expensive measures of security may include a security guard, security cameras, and security systems. The following are the proposed sections of the Collections Care Policy:

1. **Environment**: The temperature in the TSHM collections room and storage facility is not accessible by thermostat. The temperatures in the room often vary and are regularly outside the moderate range appropriate for collections. Future environmental needs include monitoring the room’s temperature and relative humidity to initiate conversations with NOPH administration and discuss possible solutions to maintain a stable environment for the collection.

2. **Preventative Conservation**: The TSHM Advisory Board has identified methods the following approaches to ensure the preservation of the collection:

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a. The museum, in conjunction with NOPH, provides a safe and secure environment for the collection.

b. All volunteers working with the collection are trained in proper handling techniques and use these skills when handling items. Volunteers should wear nitrile gloves, at all times, when handling medical collection objects.

c. The Advisory Board ensures that new acquisitions will not jeopardize the existing collection.

d. The Advisory Board and NOPH guarantee museum and hospital events will not threaten the collection.

3. Pest Control: The TSHM works with NOPH to implement an Integrated Pest Control program.

G. Storage

Storage refers to the museum’s space housing the collections not on display. “High-quality storage, well organized and well managed, enhances the museum’s overall efficiency and in the long term saves money” because good storage generally ensures the care and protection of the collection.\(^73\) A strong museum will use storage as a valuable tool to employ preventative conservation for its collection, reduce the look and feel of a crowded exhibit space, and create better exhibits and experiences for the visitor. The amount and type of storage space needed for each museum is unique to each institution, but Ambrose and Paine suggest that the museum may need more space for storage than allotted for the display of the collection.\(^74\)

A museum’s storage policy may describe the current storage space available to the museum, the environmental controls, or monitoring of the space. The policy may also outline plans for storage space improvements. The storage policy may be separate or part


\(^{74}\) Ibid., 180.
of a museum’s care of collections policy. For TSHM, the current space for storage is adequate, but accommodations within the storage spaces are not. Shelving and appropriate storage materials are not available. In the future, the TSHM Advisory Board will need to consider drafting a proposal for purchasing the necessary basic supplies to properly store the artifacts and objects.

**Storage:** The current storage space available for the TSHM collection is adequate and contains one closet off the collections room and one room on the third floor. The available space is enough for the current collection, but the storage units and storage materials are in need of improvements. Future storage needs include four stable storage shelving units as well as museum and archival quality storage supplies for both artifacts and documents.

**H. Access and Use**

Providing the public access to its collections is a primary function of a museum, however, this does not imply visitors or guests of the museum have full reign over the collection. Simmons describes a museum’s access and use policy as a means for museums to balance legal responsibilities and public access to the collection.\(^{75}\) The museum’s access and use policy also dictates how, when, to what extent, and to whom access is provided. This may include access to general collections, collection records, archival documents, or storage facilities.\(^{76}\) An access policy may differentiate between intellectual access, electronic access, and physical access. Further, a policy may explain limitations in the use of photography inside the museum and the photocopying of archival collections or object records. The TSHM’s proposed access policy states:

The objects in the Toledo State Hospital Museum collection are for educational or research purposes only.

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\(^{75}\) Simmons, *Things Great and Small*, 111.

\(^{76}\) Genoways and Ireland, *Museum Administration*, 189.
1. **Intellectual Access:** An object record for objects in the TSHM collection is available to users upon request.

2. **Physical Access to the Collections**

   a. The TSHM grants the public access to the exhibited collections during the stated hours of operation. To arrange after-hours tours, private group tours, or private events in the museum’s exhibit space, please submit a request, in writing to the TSHM advisory board. The advisory board and NOPH administration will review all requests.

   b. The TSHM advisory board may grant researchers additional access to collections. Researchers requesting such access must submit a written request to the Advisory Board stating their needs, qualifications, and intentions of research. The TSHM will comply with all federal and state laws pertaining to the confidentiality of former patients of Toledo State Hospital.

   c. Unless otherwise authorized, patrons of the museum should not physically handle any items in the exhibits.

   d. Generally, collections storage access is limited to collections staff and authorized volunteers.

   e. At least one TSHM volunteer should be present in the exhibit room when the space is open or unlocked. NOPH personnel and contractors may need to access the TSHM exhibit space unaccompanied by a volunteer, however these instances should be communicated to the Advisory Board ahead of time.

**I. Risk Management Policy**

A museum’s risk management policy will guide staff and volunteers in identifying potential dangers to the collection, understanding the proactive steps to take to avoid risks, limiting any potential risks, and executing an emergency plan when a disaster or emergency does occur.\(^{77}\) Section seven of the AAM’s Characteristics of Excellence focuses specifically on facilities and risk management. One element states that “the museum has appropriate measures to ensure the safety and security of people, its

\(^{77}\) Simmons, *Things Great and Small*, 125.
collections and/or objects and the facilities it owns or uses” while another states “the museum takes appropriate measures to protect itself against potential risk and loss.”  

Risks to a collection may be dependent upon the collection itself, the facility housing the collection, the environment, or the people associated with the museum. Examples of potential risks to a collection include, arson, theft, natural disasters such as fires, floods, or tornados, infrastructure risks such as pests, water leaks, or structural deficiencies, or even risks associated with the staff and volunteers involved in the museum administration such as financial mismanagement or loss of funding. Risk management policies include ways to lessen the potential damage due to these identified risks. Preferably, the museum will identify ways to avoid or eliminate the risk, but in other cases the museum may need to establish appropriate ways to limit the risks or determine appropriate action steps if an event occurs.

A museum’s risk management policy may also include a section on insurance coverage. Prevention of loss or damage is preferable, but insurance may provide museums with the ability to replace or restore collections. Insurance is costly and not all museums are able to purchase full or even partial coverage. The TSHM advisory board will coordinate with the NOPH administration to determine what portion of the museum’s collection is covered under existing NOPH insurance plans. Once determined, the Advisory Board will document the insurance coverage in the TSHM’s Risk Management Plan. A partial Risk Management Policy follows:

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78 Merritt, National Standards & Best Practices, 16.

79 Simmons, Things Great and Small, 130.

80 Ibid., 128; Genoways and Ireland, Museum Administration, 190-191.
The TSHM Advisory Board and volunteers are aware of the many potential threats that may endanger or destroy the collection. The Advisory Board conducts regular reviews of the potential hazards including vandalism, theft, natural disasters, infrastructure risks, human error, structural deficiencies, and the steps to prevent or mitigate these potential hazards. These processes and procedures are documented in the TSHM’s Emergency Preparedness Plan. 

V. Education and Exhibits

A. Educational Policy

A museum should have a clear understanding of its educational goals and ensure that museum programming or events are aligned with these goals. Genoways and Ireland state, “although it is suggested that collections are the core around which most museums are built, education generally is regarded as the primary purpose of all museums.” Educational programming takes shape in various forms depending on a museum’s size and resources. Such programming may include exhibits, guided or self-guided tours, lectures, workshops, outreach programming, children’s camps or classes, publications, or educational resources. Museums should create an Educational Policy that outlines the museum’s education programming, educational goals, and processes to accomplish the goals. Museums may choose to work with community agencies to create educational programming. Building community partnerships to facilitate educational programming enables the museum to reach a larger audience than it could alone, while forming allies within the larger community.

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81 The TSHM Advisory Board will coordinate with the NOPH to develop an Emergency Preparedness Plan. This will be a future project for the Board, after initial standards and best practices have been established.

82 Merritt, National Standards & Best Practices, 16.

83 Genoways and Ireland, Museum Administration, 274.

84 Ibid., 275-275.
Ideally, at least one full-time staff member, such as an educational specialist or public program manager, would be dedicated to a museum’s educational work, but for many museums, including the TSHM, this is not realistic. The Toledo State Hospital Museum’s proposed Education Policy consists of three sections: the museum’s current educational programming, educational goals, and the process and plans to accomplish the goals.

1. **Educational Programming:** The educational programming at the TSHM takes place in three primary capacities: Exhibition, Presentations or Community Events, and NOPH specific programming for hospital patients and staff. Presentations involve a historical overview of the hospital, an introduction to the two historical projects (the museum and the cemetery reclamation project), and discussions on both the history mental illness in the U.S. in addition to existing stigmas surrounding mental illness.

2. **Educational Goals:** The TSHM aims to enhance the education of visitors and programming participants through exciting exhibits, interactive presentations, and enlightening interpretation of the museum’s collection. More specifically the museum wishes to:
   
a. Reach a wide audience of visitors or program participants through various community outlets including school-aged children, post-secondary students and educators, and community agencies.

b. Offer programming specific to the staff and patients at NOPH giving them a chance to connect to the history of the hospital as well as the history of mental illness in American.

3. **Educational Plans:** To accomplish the educational goals of the TSHM, the Advisory Board plans to:

   a. Seek a dedicated volunteer or volunteer base with a background in or experience with education to collaborate with the TSHM in creating and implementing effective educational program.

   b. Establish a contact person within each of the local school districts to relay information about current exhibits, educational events, or opportunities.

   c. Work in conjunction with the NOPH to include TSHM as part of new NOPH staff and patient orientation.
B. Exhibits

In the text, *Exhibits for the Small Museum*, curator Arminta Neal writes, “exhibition is the key. It is only when a museum organizes its materials into exhibits and throws open the doors of its galleries to the public that its character is finally formed.”

Museum professional, Stephen E. Weil observed,

> We have too often taken what is a necessary condition to the work of museum—the existence of carefully acquired, well-documented and well-cared for collections—and treated that necessary condition as though it were a sufficient condition...We have too often forgotten that their ultimate importance must not lie in their ability to acquire and care for object...but in their ability to take such object and put them to some worthwhile use.

Exhibition and interpretation are at the heart of a museum. A museum must go beyond displaying artifacts, but interpret or explain the items and their significance. A vast and well-preserved collection is nothing without these two components.

Museum exhibition may include permanent exhibits, temporary exhibits, or a combination of the two. Permanent exhibits are the museum’s primary and constant exhibits, while a temporary exhibit has a specific start and end period. Preparing for an exhibit is not an easy task and can be both time consuming and costly. A successful exhibit will have an identifiable purpose, a reason for the exhibit. The written text is the foundation of the exhibit and should be both concise and clear. Exhibits may also include diagrams, images, or audio-visual shows to further convey information to visitors. The design of the exhibit, including the layout, placement of objects, labels, main text, supplemental information, use of cases or display fixtures, and lighting are all

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considerations that museum staff or volunteers must decide while planning for an exhibit. For the TSHM, the following three exhibits are proposed examples of a permanent, temporary, and future exhibit:

**Permanent Exhibit – Life at the Hospital:** This exhibit interprets objects, documents, and photographs to present visitors with multiple perspectives of what life at the hospital was like for a patient, nursing school student, and a doctor during the early 1900s. From medical therapies and interventions, to recreational activities, to living and working at the hospital, this exhibit gives visitors a glimpse of hospital life at one point in time.

**Temporary Exhibit – History through Art:** Opening in May, during Mental Health Month, in partnership with the Ohio Department of Mental Health and NAMI of Great Toledo, the exhibit will invite consumers of mental health services, mental health care providers, or individuals affected by mental illness to submit original creations of art that portray the history of TSH through artistic interpretations. Artists are encouraged to share their stories, inspirations, or explanations of their artwork. The TSHM’s existing collection of patient artwork will also be on display.

**Future Exhibit – Tell Us Your Story:** Do you have a memory or story about the Toledo State Hospital that you would like to share? TSHM wants to know! Please share these stories with us in our Story Log located at the TSHM or e-mail these to us. Do you have pictures or images you’d like to include? Bring those too! In the coming months, the TSHM will design a new exhibit based on the stories and experiences our visitors shared.

**C. Evaluation**

Collection, interpretation, and education are fundamental functions of a museum, but it is important for the museum to not just perform these tasks, but also evaluate itself on the implementation of these functions. In order to improve exhibits, attract more visitors, and continue to fulfill and advance its mission, a museum must evaluate its progress to understand what is and is not working. AAM standards state that museums should assess the effectiveness of its interpretive activities and use those results to plan

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and improve its activities. Further, the evaluation process provides a museum with quantitative and qualitative evidence of its benefits to visitors and the community. The museum can then translate these benefits into supportive arguments for revenue opportunities.

Evaluation of exhibits or programming should come from visitors, guests, as well as staff and volunteers. Each of these groups can provide valuable insight and suggestions for the museum to consider implementing in the future. Creating and implementing an evaluation process that measures the outcomes of the museum can be an arduous task, but a museum can start small. Many publications and resources exist to aid museums in creating an appropriate evaluation process. Gathering visitor feedback through a post-visit survey is one way to understand a guest’s visit and experience. A museum may also ask visitors, staff, or volunteers to provide feedback on the types of exhibits they would like to see in the future or suggestions for improvements. At the close of an exhibit, presentation, or event, the museum may also seek visitor, staff, and volunteer commentary on its effectiveness or ineffectiveness of the museum on achieving its goals related to the exhibit, presentation or event.

**Proposed Evaluation Process for TSHM:**

The TSHM Advisory Board will begin a basic evaluation program by asking for visitor feedback, suggestions, and ideas for future exhibits. A visitor survey and

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91 Genoways and Ireland, *Museum Administration*, 278.

suggestion box will be available to visitors within the exhibit space. Further, the Advisory Board will create an evaluation survey for volunteers working with the museum to gather feedback about their experiences volunteering, their interest in future opportunities, as well as suggestions they have for the museum.

VI. Finances

A. Budget

Generally, the governing body and head of a museum are responsible for the financial management of a museum. A museum should have an established operating budget that includes both revenue and expenses. AAM does not dictate how a museum should manage its budget or finances, but the Characteristics of Excellence contain two points on financial stability. First, “the museum legally, ethically and responsibly acquires, manages, and allocates its financial resources in a way that advances its mission,” and second, “the museum operates in a fiscally responsible manner that promotes its long-term sustainability.” Financial practices will differ from museum to museum as will the development and management of a museum’s budget. While one museum may operate with a basic income and expenses spreadsheet, another museum may create more detailed budget. For example, a museum may separate their revenue and resources into distinct funds, such as the general fund, restricted fund, or acquisitions fund. Small museum’s may find it useful to seek budgeting resources and recommendations such as the AASLM online workshop for small museum budgeting.

Clear start and end dates to the fiscal period are important as well as regular monitoring

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93 Ambrose and Paine, Museum Basics, 258.

94 Merritt, National Standards & Best Practices, 16.

by the Board to ensure that spending and revenue plans remain on track. A museum may find it necessary to implement financial forms for non-profit agencies such as balance sheets, income statement, and statement of cash flows that are important for external audits and filing IRS 990 forms. At this point, the TSHM does not have an operating budget or revenue sources, but once established these practices will become necessary.

**B. Development Plan**

A museum has many expenses. To sustain the costs of operating a museum, a strong development plan, or strategy to raise funds, is imperative. Museums large and small can benefit from creating a development plan, regardless of the goal amount. A museum’s plan should advance the museum’s mission and remain consistent with its strategic goals. Funding sources may include individual donors, corporate donors, grants, government funding, private foundation gifts, or earned income such as admission fees, museum merchandise, dining facilities, or special exhibits. Soliciting funds from donors may also take various forms including annual giving campaigns, direct mailings, phone or in person solicitations, membership drives, or special events, such as exhibit openings, auctions, or dinners. Development is not a passive act, but one that requires planning and work. A museum’s development plan should outline the purpose of funds

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97 Ibid., 105.

98 Ibid., 122.

99 Ibid., 128-156.

100 Ibid., 132-136.
development, funding goals, specific methods to accomplish these goals, and the individual or team responsible for completing the work.

The TSHM Advisory Board is responsible for creating a five year development plan, implementing the plan, and identifying volunteers to fulfill the plan and leverage funds for the museum. The TSHM development plan will be formed carefully as to not conflict with partner agency development campaigns.

Funds raised will be used to purchase:

1. Quality museum storage solutions and preservation materials

2. Exhibition materials and supplies

3. Administrative materials including (a computer, printer, camera, scanner, office supplies, and a basic museum software program)

4. New acquisitions

5. Educational programming

6. Marketing campaigns

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These frameworks, policies, procedures, standards, and best practices contend that a museum is more than a room containing objects. A museum is more than a few signs identifying dates or places. It is more than a temporary endeavor. A museum moves beyond simply housing objects, but cares for and preserves them. It does more than identify objects, but provides education and interpretation for the public to promote discussion and discovery. A museum is a long-term project, a permanent place.

Transitioning the room at Toledo State Hospital forward and creating the Toledo State Hospital Museum requires hours upon hours of volunteer work. Further, both a firm commitment and written contract with Northwest Ohio Psychiatric Hospital as well as a dedicated volunteer Advisory Board are vital to the success of the TSHM. Using the
professional museum standards and best practices, plans, policies, and procedures, there is great potential to transform what is now a room of objects into “A Room for History.”
Chapter 5

Conclusion: A Room for History

We can find places that were built for permanence. We can mend, rather than desert, places that were important in the time before we came. They are statements of the aspirations of those now gone, messages from the past about what is important. These storied places are legacies from the past, a gift that is ours to use but not to destroy, an inheritance we are obliged to augment. For those places already lost, we can recall the stories that permeated them and seek new places, in which to remember and restore them.\(^1\)

The original cottages and buildings of the Toledo State Hospital (TSH) were lost to history years ago during multiple phases of demolition from the 1970s through the early 1990s. They became outdated, dilapidated from years of neglect, and ultimately unusable and unnecessary as the hospital population diminished. During these years of demolition, items from the buildings were auctioned off to the public, bricks from the buildings were repurposed into new buildings or other structures, and by the early 1990s little remained of what was once a bustling self-contained, city-like place.

However, the historical value of the land and place are not diminished. As historian Robert Archibald suggests, these places are filled with stories and the history can and should be restored and shared. In 2014, although the original TSH buildings are gone, traces of their existence remain. Exploration of the surrounding grounds reveals exposed foundations from the original buildings, boundary markers that once identified the TSH property, multiple ponds that once provided both an ice supply and recreational enjoyment for the TSH residents, and even a few apple trees that were once part of the hospital’s large orchard. Other evidence exists along the banks of Swan Creek, an area the hospital used for many years to dump refuse. Discarded remnants of the hospital’s...

history include medicine bottles, porcelain, building materials, and other fragments. In addition, the surrounding grounds contain two cemeteries where TSH buried more than 2,000 deceased patients in simply marked graves.

The hospital’s history is connected to these specific grounds, this specific place. Though much of what filled the original buildings is now scattered throughout the community or is lost forever, a few individuals had the foresight to save and attempt to preserve what items they could and store them in a place they called “The Archives Room.” As Archibald suggests, “for those places already lost, we can recall the stories that permeated them and seek new places, in which to remember and restore them.” The original cottages and buildings of the TSH may no longer exist, but the extant artifacts can be professionally exhibited in the proposed museum at the Northwest Ohio Psychiatric Hospital (NOPH), closest to their place of origin and where a sense of history can be incorporated. This location is where people will most connect with that history. David Glassberg wrote, “Through conversations among family and friends about past local characters, about the weather, or about work, local residents transform ordinary environments into “storied places.” Those who grew up in South Toledo remember the hospital, its grounds, the people, and the buildings. Toledo State Hospital Cemetery Reclamation Project Founder and Volunteer, Larry Wanucha, recalled riding his bike through the hospital grounds, ice skating on the ponds as a child, and playing on the hospital’s golf course. He and many others have collective memories of the TSH, the

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2 Ibid., 34.


4 Larry Wanucha (TSHCP Founder and Volunteer), interview with author, August 18, 2014
place, even though the original structures are long gone. Archibald argues, “places
become sacred to humans when the humans imbue the places with stories – stories that
attach the grand cycles of life, the continuity of time through sequences of generations,
and life’s transforming events to particular places of this earth.” These stories are a part
of the place and space that is now NOPH and the remaining artifacts and documents
belong in that same place. The proposed Toledo State Hospital Museum creates a
framework for this to become a reality. Establishing the museum will be a large endeavor
and will require the dedication of many volunteers, hours of work, donor investments,
and NOPH cooperation, but it can become a place where the history of the TSH is
interpreted and displayed, where hidden histories of individuals with mental illnesses are
uncovered, and a place where those closest to the history, NOPH residents and staff, have
an opportunity to explore the importance of the hospital and the place they live and work.
It can become A Room for History.

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