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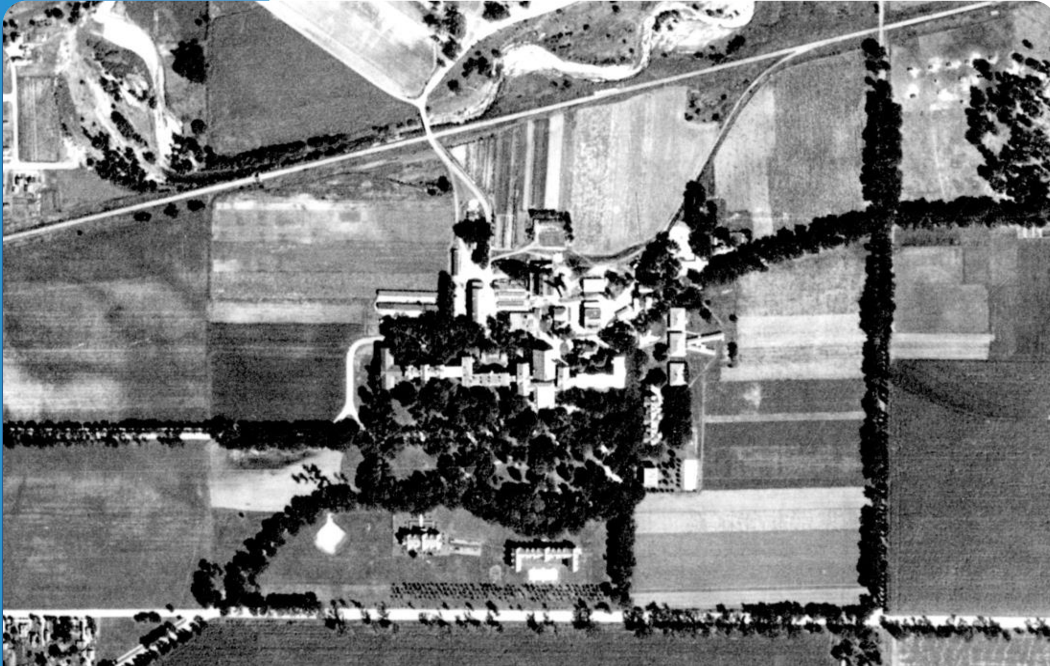

ROCHESTER STATE HOSPITAL, 1879-1982 HISTORIC CONTEXT STUDY

Rochester, Olmsted County, Minnesota

Prepared for the City of Rochester

May 2024 FINAL

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ROCHESTER STATE HOSPITAL, 1879-1982
HISTORIC CONTEXT STUDY
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Rochester, Olmsted County, Minnesota
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Cover Image: Aerial photograph showing Rochester State Hospital Campus, courtesy Minnesota Historical Aerial Photographs Online, Image WB-2A-105, 1940.

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1.0 MANAGEMENT SUMMARY

1.1 Project Background

On May 5, 2023, the City of Rochester issued a Request for Proposals (RFP) for the "research and development of a context study for the Rochester State Hospital, in operation 1877-1982."

The project was awarded to Pigeon Consulting, a historic preservation consulting firm located in Saint Paul, Minnesota. The project is funded in part through a grant funded by an appropriation to the Minnesota Historical Society from the Minnesota Arts and Cultural Heritage Fund.

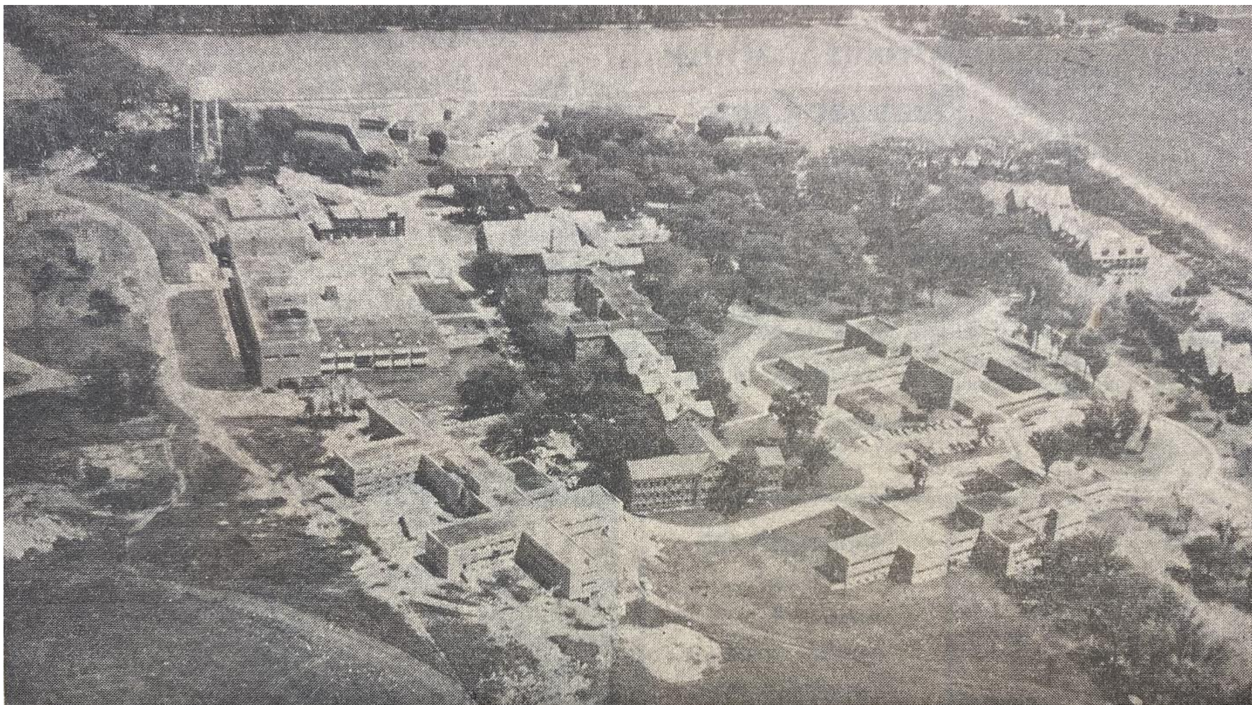
1.2 Project Objectives

The primary objective of this investigation is to develop a historic context that will provide the City of Rochester with an analytical framework for identifying and evaluating potential historic resources associated with the Rochester State Hospital during the property's tenure as a state-owned mental health facility.

This historic context study covers more than 100 years and numerous building and grounds campaigns at the Rochester State Hospital during its operation by the State of Minnesota between 1877 and 1982. The Rochester State Hospital was the second hospital in the Minnesota State Hospital system to be constructed for the care and treatment of the mentally ill. Construction of the hospital began in 1877, the hospital opened in 1879 and was expanded throughout the 1880s and 1890s. By the end of this period of expansion, the campus included a Kirkbride-style central building, a 500-acre farm, a rock quarry, and cemetery among other buildings. Following World War II, the campus was expanded again to accommodate a growing population of elderly patients. By the 1960s, the Rochester campus was known throughout the state hospital system for its surgical unit, which was at least partially staffed by surgeons from the Mayo Clinic. Typical of national trends to "modernize" mental health care practices and facilities, the majority of the campus was demolished and rebuilt during the 1950s and 1960s and replaced by new medical facilities. In 1965, approximately half of the farmland was sold to the City of Rochester and developed into Quarry Hill Park. The Rochester State Hospital closed in June 1982. Again, this major change aligned with national trends, in this case the transition to community-based mental health services rather than institutionalization. The development, operation, growth, and

decommissioning of the Rochester State Hospital between 1877 and 1982 is reflective of the broader state and national trends in mental healthcare.

The State of Minnesota began offering state-funded mental health care with the opening of its Saint Peter facility in 1867 and has continued to offer mental health support in various formats through the present day. The medical, social, and political understanding of "mental illness" has evolved over time. Documenting and analyzing the evolution of mental healthcare and its practice at the level of a statewide system, as well as the development and evolution of mental healthcare's place within a larger statewide general healthcare system, is beyond the scope of this project. This project focuses on the development and evolution of the Rochester State Hospital Campus, while also providing sufficient historical context of broad trends in American mental health care to situate the Rochester campus.



Aerial image of Rochester State Hospital campus in 1957, part way through the large mid-century rebuilding campaign. Image via Rochester Post-Bulletin*, June 25, 1957.*

1.3 What is a Historic Context?

A historic context is a framework for evaluating properties for historic significance. A historic context focuses on a geographical area, a historical time frame, and related historical themes or subjects. A historic context also identifies associated property types, the relevant physical characteristics associated with each property type, and discusses the relationship between the context theme and National Register of Historic Places designation criteria.

A historic context is not an exhaustive list of properties eligible for historic designation. It is also not a National Register of Historic Places nomination or local landmark designation study. Rather, it serves as the basis for historic designation by providing the background information against which a property can be evaluated to determine whether or not it has historic significance.

1.4 A Note on Sources and Language

The context that follows relies heavily on Gerald Grob's seminal work *The Mad Among Us: A History of the Care of America's Mentally Ill*, one of the first and only comprehensive and non-sensational texts chronicling and analyzing the history of mental health care in the United States. Carla Yanni's *The Architecture of Madness*, which discusses some of the built forms associated with mental health care was also invaluable.

The Minnesota Historical Society (MNHS) currently has possession of extant state hospital records including some patient records, employee records, and miscellaneous materials including administrative, architectural, and general records. MNHS notes that materials are inconsistent from hospital campus to hospital campus. They also explain that that during their years of operation, hospitals did not all keep the same records but that they did maintain destruction schedules for various types of documents. The authors of this report did not attempt to access any holdings related to employee or patient records. The authors did access available issues of the employee newsletter *The Bulletin*.

The Olmsted County Historical Society also retains some records related to the Rochester State Hospital, including issues of an employee newsletter, and significant newspaper clipping files.

Social and medical attitudes toward mental health and the treatment of mental health have evolved significantly over the past century and a half. Because this historic context quotes primary source material, it uses language contemporary to those sources. This language could have pejorative connotations today and is not a reflection of the authors', the Minnesota Arts and Cultural Heritage Fund's, or the City of Rochester's understanding of mental health today.

2.0 STATEMENT OF CONTEXT

2.1 Summary Statement

The Rochester State Hospital was the second hospital in the Minnesota State Hospital system to be constructed for the care and treatment of the mentally ill. Construction of the hospital began in 1877, the hospital opened in 1879 and was expanded throughout the 1880s and 1890s. By the end of this period of expansion, the campus included a Kirkbride-style central building, a 500-acre farm, a rock quarry, and cemetery among other buildings. Following World War II, the campus was expanded again to accommodate a growing population of elderly patients. By the 1960s, the Rochester campus was known throughout the state hospital system for its surgical unit, which was at least partially staffed by surgeons from the Mayo Clinic. Typical of national trends to "modernize" mental health care practices and facilities, the majority of the campus was demolished and rebuilt during the 1950s and 1960s and replaced by new medical facilities. In 1965, approximately half of the farmland was sold to the City of Rochester and developed into Quarry Hill Park. The Rochester State Hospital closed in June 1982. Again, this major change aligned with national trends, in this case the transition to community-based mental health services rather than institutionalization. The development, operation, growth, and decommissioning of the Rochester State Hospital between 1877 and 1982 is reflective of the broader state and national trends in mental healthcare.

Themes:

- Architecture
- Health/Medicine
- Social History

Geographic Parameters:

- The study's geographic parameters are confined to the limits of the Rochester State Hospital campus. The size of the Rochester State Hospital campus has changed drastically over time and the geographic boundary of this context is intended to encompass the campus's largest iteration – inclusive of the medical facility, farmland, quarry, and cemetery that were all associated with the site over time.

Temporal Limits:

- Temporal boundaries of the project are 1877 – 1982. This time period encompasses the Rochester campus's life as a State-owned and operated mental health facility.
  - The context will also discuss the period of 1866 – 1878, which includes the establishment of the Minnesota State Hospital System and initial land acquisition for the Rochester State Hospital.

2.2 Historic Context

2.2.1 Mid-Nineteenth to Early-Twentieth Century American Mental Health Care

The Moral Method (c. 1840s-1920s)

In nineteenth-century America, mental health care was a young and rapidly developing field. The first state-run mental hospital was founded in Virginia in 1773, however "asylums" as they were commonly called, did not begin dramatically increasing in number and popularity until the final decade of the Jacksonian Era (1828-1854). During the 1850s and 1860s "the cult of the asylum" was sweeping the nation and by 1890 nearly 70 asylums had been built in the United States.[1] By the early twentieth century the fervor for asylums had diminished, though they remained in high demand, with state-run mental health care systems continuing to expand along with the population.

The Jacksonian Era (1828-1854) is characterized as a period of broad changes to United States society. This period saw the extension of voting rights to all white men, the religious fervor of the Second Great Awakening, a dramatically expanding rail network, and the economic and social changes that accompanied a society experiencing ever increasing levels of industrialization and urbanization. A combination of practical and moral factors along with the rise of psychiatry as a profession led to the development of robust private and state-run mental health care systems during the mid-nineteenth century.

[1] David Rothman, *The Discovery of the Asylum,* (Boston: Little, Brown and Company, 1971), 130.; Carla Yanni, *The Architecture of Madness,* (Minneapolis: University of Minnesota Press, 2007), 78.

Writing about the rapid growth of the asylum system during the Jacksonian period, architectural historian Carla Yanni (partially quoting historian Gerald Grob) explains that for many people asylums served a practical purpose:

> In its origins, the mental hospital – irrespective of its specific medical role – was primarily an institution designed to serve more densely populated areas and to assume functions that previously had been the responsibilities of families. The geographical separation of the workplace from the home tended to create smaller and more specialized families and "undermined their capacity to care for needy and especially elderly members." [2]

As American society became increasingly urban and industrial, the social safety net previously provided by small, tightly knit, agrarian communities became less accessible. Grob explains that at a systemic level:

> In the emerging urban-industrial society the care of the insane proved far more complex than it had been in the rural areas and villages of seventeenth- and eighteenth-century America. The dramatic growth of population was accompanied by a proportionate increase in the number of insane persons. In densely populated areas insane people were more visible, and public concern about security increased. The spontaneous and informal manner in which most rural communities dealt with sickness and dependency did not operate as well in urban areas. High rates of geographical mobility tended to weaken social cohesion as neighbors became more anonymous, and the efficacy of informal and traditional means of alleviating distress diminished. These considerations militated against reliance on informal responses by families and community, and favored more systematic policies to deal with mental illnesses.[3]

Yanni notes that at a more personal level, in urban communities,

> It was time-consuming and expensive for anyone to care for a relative; assuming healthy, concerned persons needed to work for a living, they would have to pay for private nurses to tend their ill relatives while they were out working, or they would have

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[2] Yanni, *The Architecture…,* 5.
[3] Grob, *The Mad Among Us*, (New York: The Free Press – A Division of Simon and Schuster, Inc., 1994), 24.

to seek treatment for them in an asylum. As the numbers of displaced and family-less people increased with industrialization, so did the need for state care.[4]

Further, changing ideas about philanthropy and "proper" family life made it socially unacceptable to keep mentally ill relatives at home, or to house the mentally ill in almshouses or jails since those locations did not provide medical care.

The rise of psychiatry as a profession occurred in tandem with the development of asylums. Author Nancy Tomes characterizes Jacksonian asylums as "the only site of practice for psychiatrists in the mid-1800s," and goes on to explain that "[psychiatrist's] very claims to be medical specialists depended on [the] institutional legitimization"[5] that the asylum system provided. Yanni notes that "asylums were 'culturally legitimate' because doctors claimed that insanity could not be treated inside the home and that cures could only be achieved in institutions."[6] In fact, psychiatrists of this period generally went by the title "medical superintendent." Described as "autocratic leaders within their asylums;" medical superintendents had the authority to shape everything from care methods to architecture at their asylums.[7]

The prevailing care philosophy espoused by medical superintendents in the 19th century is now referred to as the "moral treatment" or the "moral method." The moral method of mental health care rose to prominence primarily in the United States, and to a lesser degree in Europe, during the 1840s and 1850s. The method remained popular through the end of the 19th century, though in some hospitals, aspects of the moral method continued to be standard through the end of World War II. The treatment was based in the idea of environmental determinism – "nineteenth-century thinkers clearly believed the environment could not only influence behavior but also cure a disease."[8] Thus, "psychiatrists considered the architecture of their hospitals, especially the planning, to be one of the most powerful tools for the treatment of the insane."[9] Important aspects of the moral method included emphasis on order, cleanliness, discipline, and work in patient's daily lives, as well as a

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[4] Yanni, *The Architecture…,* 5.
[5] Tomes, *The Art of Asylum Keeping,* (Philadelphia: University of Pennsylvania Press, 1994), introduction to the 1994 edition, xi.
[6] Yanni, *The Architecture…,* 6.
[7] Yanni, *The Architecture…,* 7.
[8] Yanni, *The Architecture…,* 8.
[9] Carla Yanni, "The Linear Plan for Asylums in the United States before 1866," *The Journal of the Society of Architectural Historians, 62 (March 2003) 24.*

commitment from hospital staff to refrain from using the punitive or neglectful methods historically associated with asylums or almshouses. Advocates of the moral method believed that the busyness, disorder, and immorality of urban environments contributed to mental illness, so hospitals adhering to the moral method were built in bucolic, rural settings.

To early psychiatrists "…confinement in a well-ordered asylum was indispensable. In such an institution the regimen [of moral treatment care] could be employed in ways that would persuade patients to internalize the behavior and values of normal society and thus promote recovery."[10] Asylum architecture of the second half of the nineteenth century was seen as integral to the successful deployment of the moral treatment and tended to take two distinctive built forms – Kirkbride Plan Hospitals and Cottage Plan Hospitals (see also Section 2.2.2). Along with their residential and medical buildings, asylums of this time period often included working farms staffed by asylum patients. These farms supported asylum operations either through the income provided by the sale of farm goods or by providing food directly to the asylum kitchens.

The Progressive Critique (1890s-1920s)

Despite its wild popularity, by the 1870s critiques of the asylum system and the moral method were surfacing. Overcrowding and a lack of funding had led to endemic understaffing in asylums. Staff lacked supervision; patients were subject to neglect, abuse, and methods of physical restraint – the use of which moral method practitioners had originally sought to put an end to. As Grob explains:

> Intended as small curative institutions that fostered close relationships between the medical and lay staff and patients, hospitals grew in size and complexity, and considerations of order and efficiency began to conflict with therapeutic imperatives. The vision of a harmonious institution proved difficult to implement. The realities presented by an increasingly diverse patient population that included individuals who sometimes behaved in bizarre and disruptive ways led to friction with the medical and lay staff. In theory all patients were to receive the same quality of care. In practice the variables of class, race, ethnicity, and gender resulted in internal distinctions.[11]

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[10] Grob, *The Mad Among Us*, 27.
[11] Grob, *The Mad Among Us*, 79.

By the time the Progressive Era began (circa 1890s-1920s), outspoken reformers were quick to broadcast the shortcomings of the asylum system to the general public.

However accurate their critiques, the Progressives failed to offer a coherent alternative. David Rothman explains that a complete lack of systemic innovation or alternatives caused the asylum system and many of the standard practices of the moral treatment to remain in place:

> Not only were the conveniences of asylum care attractive, but the most benevolent minded citizens of the period continued to subscribe to the notion that institutions were the lesser of the evils or, more enthusiastically, that they could be upgraded and redesigned to accomplish good. Rehabilitation remained so appealing a goal, that its prospect sustained the legitimacy of insane asylums."[12]

Critiques of the asylum system aside, demand for beds in institutions across the country was ever increasing. Writing about the history of medicine for Ohio State University, author Zeb Larson puts example numbers to the problem – the Oregon State Hospital population quadrupled from 412 patients in 1880 to 1,200 in 1889. In New York, the inpatient population was 33,124 in 1915 and 47,775 by 1930. [13] Nationally, the inpatient population of state institutions was 187,791 in 1910 and 425,000 by 1939.[14]

Custodial Care and Chronic Mental Illness (1880s – 1945)

Historian Gerald Grob explains that "the creation of asylums in the early nineteenth century rested on the assumption that mental disorders, if identified early and treated promptly, were curable. This optimistic faith, however, had little basis in fact. Many insane persons – whether treated or ignored – failed to improve or recover, and the duration of their illnesses was often measured in decades rather than weeks or months."[15] This reality was reflected in asylum populations - "by 1923, for example, 54

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[12] Rothman, *Conscience and Convenience,* (Boston: Little, Brown and Company, 1980), 40.
[13] Zeb Larson "America's Long-Suffering Mental Health System" for Ohio State University's Origins: Current Events in Historical Perspective series, https://origins.osu.edu/article/americas-long-suffering-mental-health-system?language_content_entity=en. Accessed November 2023.
[14] Grob, *The Mad Among Us*, 166.
[15] Grob, *The Mad Among Us*, 103.

percent of patients in mental hospitals had been there five years or more; only 17.4 percent had been institutionalized for less than twelve months."[16]

The early twentieth century also saw a dramatic increase in elderly patients at state hospitals. A combination of increasing lifespans, continued urbanization, and geographic mobility of younger generations, with the closing of local and county level almshouses left a gap in care and housing options for the elderly. To an extent, state hospitals became "surrogate old age homes" and continued to serve that function through the 1940s.[17]

> The large numbers of chronic and aged patients led to a fundamental transformation in the character of mental hospitals. To be sure, their therapeutic functions were by no means obliterated. But the presence of large numbers of chronic long-term patients had dramatic consequences. Internally, it resulted in a more depressing environment. To cure and discharge patients was associated with an aura of optimism and achievement; to care for those who rarely manifested improvement and would ultimately die was hardly consistent with twentieth-century images of medical and scientific progress.[18]

From a clinical perspective, the psychiatrists who had espoused the moral treatment approach and anticipated "rehabilitating" their patients were also becoming frustrated with the existing system:

> Combined with changing patient demographics, hospitals were increasingly serving as custodial institutions. Doctors working with patients suffering from dementia or late-stage neurosyphilis could not expect those in their care to improve. The role of medical professionals shifted from therapy to caretaking.
>
> Discontented with the idea of being mere caretakers, psychiatrists began to work toward cures and preventative techniques in the late 19th and early 20th centuries.[19]

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[16] Grob, *Mental Illness and American Society, 1875-1940*. (Princeton: Princeton University Press, 1983), xii.
[17] Grob, *The Mad Among Us*, 124.
[18] Grob, *The Mad Among Us*, 127.
[19] Larson "America's Long-Suffering Mental Health System…"

"Between 1880 and 1940 psychiatrists responded to their critics by altering the basic foundation of their specialty. They identified new careers outside of institutions; articulated novel theories and therapies; expanded jurisdictional boundaries to include not only mental disorders but the problems of everyday life; and defined a preventative role."[20] The shift toward "a new psychiatry" as it was often called resulted in both philosophical and physical changes to psychiatry broadly and state hospitals specifically.

Philosophically, a popular new trend at the turn of the century was known as the mental hygiene movement. The National Committee for Mental Hygiene was founded in 1909 by a group of leading psychiatrists and Clifford W. Beers, a former mental hospital patient. "Instead of focusing on the treatment of mental illness, mental hygienists emphasized early intervention, prevention, and the promotion of mental health."[21] Historian Gerald Grob notes that mental hygiene was an attractive concept to psychiatrists as its "diffuse and protean character gave it multiple meanings" and because it allowed them "an important role to play in the creation of a new society that would maximize health and minimize the possibility of disease."[22] At its height, the mental hygiene movement encompassed a breadth activities including research, lobbying for policy implementation, the promotion of eugenics, and efforts to bring the treatment of substance abuse, intellectual disabilities, and "vices" such as crime and prostitution under the purview of psychiatrists. [23]

In addition to the mental hygiene movement, psychiatry saw the development of multiple new somatic therapies during the 1930s and 1940s. This new set of treatments included malarial therapy, fever therapy, insulin therapy, Metrazol and electric shock therapy, and lobotomies. These new therapies "quickly found enthusiastic and widespread acceptance in the United States…they appealed to psychiatrists who practiced in an institutional setting that precluded extensive labor-intensive individual psychotherapies. Equally important, the introduction of the new somatic therapies

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[20] Grob, *The Mad Among Us*, 130.
[21] "Mental Hygiene" https://www.encyclopedia.com/medicine/psychology/psychology-and-psychiatry/mental-hygiene.
[22] Grob, *The Mad Among Us*, 153-154.
[23] Allan V. Horwitz and Gerald Grob, "The Checkered History of American Psychiatric Epidemiology," *The Milbank Quarterly: A Multidisciplinary Journal of Population Health and Health Policy,* 89(4) 628-657, December 2011 via National Institute of Health National Library of Medicine, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3250636/ accessed January 2024.

suggested that mental hospitals could shift their focus and become therapeutic rather than custodial institutions."[24] Additionally, these treatments "could be understood by [psychiatrists'] medical colleagues, thus hastening the integration of psychiatry into medicine."[25]

Physical changes included a move away from the construction of new "asylums" and the well-known Kirkbride architectural form which had come to be associated with custodial care to new overtly "medical" buildings housing laboratories, "research institutes" and "psychopathic hospitals" that were intended to look and feel like more generalized healthcare facilities. Often, these new building types were added to existing state hospital campuses.

Grob notes that:

> The transformation of psychiatry and creation of a mental hygiene movement in the early twentieth-century did not, at least in the short run, lead states to abandon their large mental hospital systems…The resiliency and persistence of hospitals was largely a function of their ability to provide care for large numbers of individuals whose mental illnesses rendered them dependent upon others. …
>
> The apparent stability of mental institutions, nevertheless, concealed a variety of problems and tensions. The depression of the 1930s and ensuing global conflict discouraged investment in the public sector as a whole. A decade and a half of fiscal neglect would lead to a deterioration of a mental hospital system responsible for an inpatient population that by 1940 approached nearly half a million, the majority of whom were in the chronic category. Institutional decline had the paradoxical effect of both stimulating the rapid introduction of radical somatic therapies and magnifying friction between psychiatrists who administered mental hospitals and state legislators and officials concerned with economy and accountability. In the interwar years the contradictions within the mental health system were for the most part ignored, if only because Americans were preoccupied with the problems of depression and war.[26]

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[24] Grob, *The Mad Among Us*, 178.
[25] Grob, *The Mad Among Us*, 183.
[26] Grob, *The Mad Among Us,* 165-166.

2.2.2 Mid -Nineteenth to Early-Twentieth Century State Hospital Architecture

Kirkbride Plan Hospitals: circa 1840-1920

Discussing the architectural development of state hospitals, historians Dee Ruzicka, Polly Tice, and Lesleigh Jones explain that:

> As a building type, mental hospitals are a relatively new architectural program. While hospital have been constructed since ancient times, there were no buildings specifically built to treat the mentally ill until the end of the eighteenth century, with the insane placed in prisons or poor houses prior to that time.
>
> …In the 1840s, Dorothea Dix became a strong advocate for the humane treatment of the mentally ill in America, and Dr. Thomas Story Kirkbride (1809-1883), the superintendent of Pennsylvania Hospital for the Insane, incorporated such ideals into mental hospital design. Dr. Kirkbride was one of the thirteen founding members of the Association of Medical Superintendents of American Institutions for the Insane, the forerunner of the American Psychiatric Association. He served first as secretary, then later as president of this organization. Through this association and his writings, Kirkbride promoted a standardized method of asylum construction and mental health treatment, popularly known as the Kirkbride Plan, which significantly influenced the entire American asylum community during his lifetime.[27]

The Kirkbride plan hospital is also known as the linear plan hospital, and is made up of small, connected pavilions roughly arranged in a V shape. Kirkbride and his ideas were so influential in mid-nineteenth century America, that between the 1840s and 1880 Kirkbride plan asylums were almost ubiquitous, and the book Kirkbride published on asylum management went through multiple printings. Of particular note is the fact that the Kirkbride plan was a distinctively American building type.[28] Contemporary European hospitals were built of similar sized pavilions, but the pavilions were not connected and were arranged in U or E formations rather than Vs.

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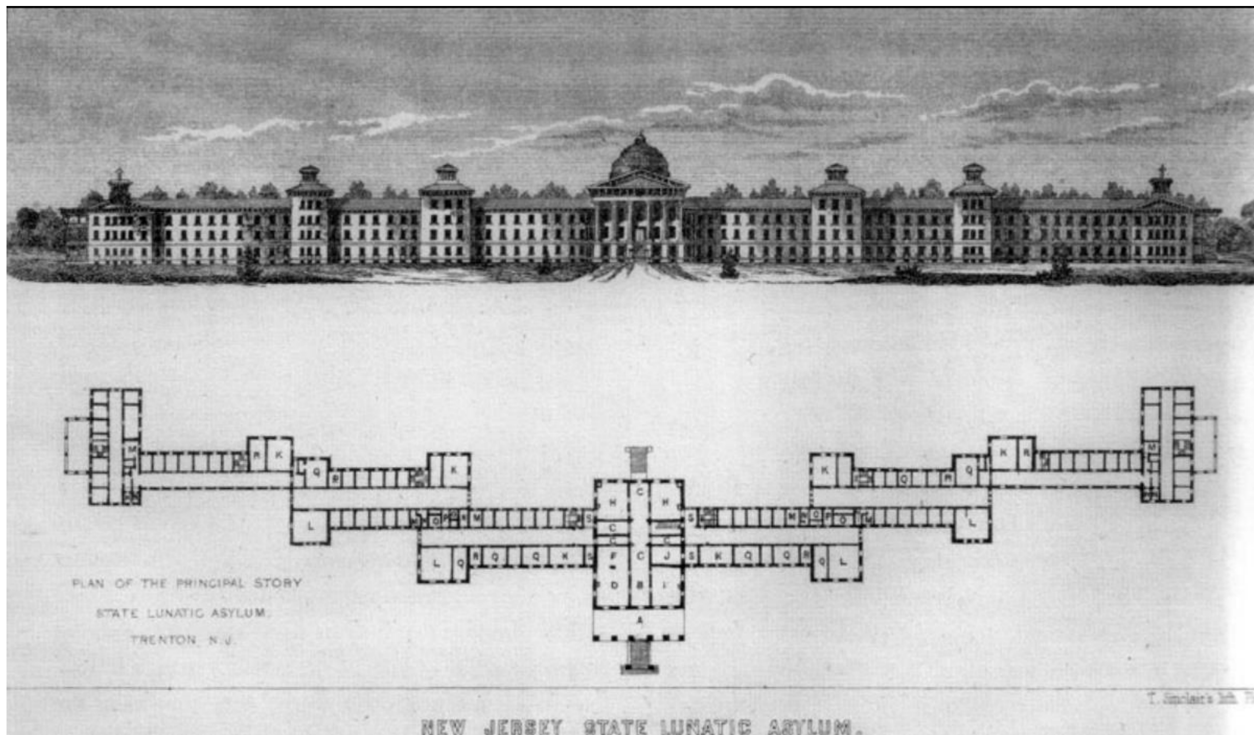
[27] Mason Architects, Inc., *Context Study for the Hawaii State Hospital,* prepared for the Department of Health, 2018. https://health.hawaii.gov/amhd/files/2018/05/Kaneohe-State-Hospital-Historic-Context-March-19-2018.pdf (last accessed May 2024).
[28] Yanni, *The Architecture…,* 51.

Kirkbride plan asylums, such as the New Jersey State Lunatic Asylum (image below) were conceived of as an integral component of the moral treatment. The building type is characterized by a central pavilion, which might have housed administrative functions for the hospital such as a receiving room for families and new patients, offices for physicians, housing for the superintendent and other staff, a kitchen and dining hall, a library, and a chapel. Small hallways connected the administration pavilion to the patient wards, which were housed in symmetrical wings on either side of the central pavilion. These wards had long central halls, with individual rooms for patients lining either side. Individual wards were limited in size, and joined together in the echelon formation, rather than allowed to extend longer distances as a continuous space. While the interior designs of Kirkbride hospitals were standardized, their exteriors allowed for a significant amount of variation in style. Subsequently, exterior design and ornamentation were applied as seen fit by various architects and institutions. Typically buildings were designed in one of the architectural revival styles popular during the late 19th and early 20th centuries (i.e. Colonial Revival, Tudor Revival, Spanish Mission Revival).



Architectural rendering of the Kirkbride Plan New Jersy State Lunatic Asylum, image via Wikipedia.

Aerial image of the Kirkbride Plan Fergus Falls State Hospital. Image via The Forum *(Fargo-Moorhead), https://www.inforum.com/newsmd/fergus-falls-landmarks-future-in-doubt.*

The final important component in the design of a Kirkbride hospital was the siting. Whenever possible, these hospitals were built in rural areas on extensively landscaped grounds. The fast pace of life, and low morals of urban environments were seen as leading causes for insanity in the 19th century; moving to a rural environment was understood to be an indispensable component of moral treatment, with manual labor such as gardening or farm work often prescribed as part of patient's cures. Landscaping plans for asylums were often designed during the hospital's planning stage, with influential landscape architects such as Frederick Law Olmstead and Alexander Jackson Downing providing designs for some east coast asylums.

Cottage Plan Hospitals: circa 1860-1900

As a young field, 19th century mental health care practices and philosophies were constantly evolving, and the architectural manifestation of mental hospitals reflected this. In fact, multiple hospital types enjoyed popularity simultaneously, as can be seen with the rise to prominence of the cottage plan during a period while the Kirkbride plan was still popular.

Cottage plan hospitals, which were made up of several small, free-standing units (cottages), were in part a reaction to the large monolithic Kirkbride plan buildings. This change in architecture was not, however, accompanied by any real change in treatment philosophy. As Yanni, in part quoting historian Andrew Scull, explains:

> The cottage plan was not all that revolutionary, as it left 'intact the essential structure of the existing system,' while claiming an 'absurd and self-contradictory endeavor to eliminate the institutional aspects of the institution.' Furthermore, ...it promoted "the illusion that [the asylum] represented an approach toward community care' when in fact the patients were still living in an institution.[29]

While moral treatment was still the norm in cottage plan hospitals, this change in architecture did allow for some alterations in the way that these institutions operated. Cottages encouraged the development of a slightly more fluid and home-like atmosphere in asylums. Additionally, cottages allowed for more sophisticated segregation of patients based on gender and type or severity of illness, which was seen as a positive change at the time.

Cottage hospitals were sometimes built as completely new institutions, though frequently a hospital program was inserted into an existing building or buildings, which had been repurposed for mental health care. Just as often, cottages were added as new construction to the campuses of existing Kirkbride plan hospitals. Cottages were architecturally diverse, reflecting this combination of repurposed vernacular buildings and additions to existing hospitals.

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[29] Yanni, *The Architecture...*,79, partially quoting: Scull, Andrew*, Decarceration*: *Community Treatment and the Deviant - a Radical View, (*Englewood Cliffs, N.J.: Prentice Hall, 1977).

Top: Aerial view of the Cottage Plan Anoka State Hospital in 1937. "Aerial view of Anoka State Hospital, Anoka" via Minnesota Historical Society Collections Online.

Bottom: An Individual Cottage at the Willmar State Hospital in 1920. "Women's Building, State Hospital, Willmar" via Minnesota Historical Society Collections Online.

These smaller structures were also seen as positive economic choices, as they were frequently wood-framed, cheaper to build, did not require the services of an architect, and did not require the complicated heating and plumbing that the large Kirkbride plan buildings needed.[30] Simultaneously an attribute and an affliction, was the fact that additional cottages were easily added to an asylum's campus, allowing the institution's population to grow without the physical restraint provided by a Kirkbride building's limited capacity. The fact that these buildings lacked rigorous design and specialized plans drew criticism from many contemporary experts. In a time when environmental determinism was still seen as an integral part of the moral treatment model, these critics argued that the community feel provided by cottages was not enough to make up for the lack of the highly designed environment provided by the Kirkbride plan.[31] Yanni elaborates on this criticism by explaining that cottages were intended by reformers to be built at a "domestic scale," while in reality they tended to be large enough to house 50-100 patients[32], a number not that different than the one represented by an individual ward in a Kirkbride plan building.

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[30] Yanni, *The Architecture...*,79.
[31] Yanni, *The Architecture...*, 83.
[32] Yanni, "The Linear Plan...", 44.

Farm Hospitals

An important sub-category of both Kirkbride plan and cottage plan hospitals in the nineteenth-century was the farm hospital. Since physical labor, strict scheduling, and a rural setting were all seen as important components of the moral treatment, working farms were often incorporated into asylum campuses. These farms varied in size and type of food produced, however, in many cases they contributed the majority if not all of the food needed to run the asylum.

"Cow Barn at Fergus Falls State Hospital," approximately 1923, via Minnesota Historical Society Collections Online.

2.2.3 The Second Minnesota Hospital for the Insane

1876-1930s

Rochester, Minnesota is located roughly 90 miles south of the Twin Cities' metropolitan area. The area's first Euro-Americans arrived in 1854, with the town developing quickly thereafter due to "its strategic location at the confluence of two overland routes that brought settlers into the area prior to the arrival of the railroads."[33] By 1890, Rochester boasted 5,321 residents, a significant business district, a thriving agricultural center, and the first general hospital in southeastern Minnesota.[34]

On March 2, 1866, the Minnesota State Legislature passed an act authorizing the establishment of an "asylum for the insane." "Town leaders across Minnesota responded to the search committee's call for a suitable site for the hospital. The initial donation to the state, they realized, would attract major state investment in the long term. A 210-acre farm in St. Peter purchased by citizens for $7,000 won out due to its open land, attractive landscapes that would sooth troubled minds, the natural protection provided by the nearby bluffs, and access to abundant water and wood."[35]

By the spring of 1867, newspapers were already reporting that "Applications for new patients come in everyday, but the [St. Peter] Hospital is already crowded to its utmost capacity…", however the Minnesota legislature did not move to open additional facilities until five years later.[36] In 1873 the legislature approved a $10 yearly tax on liquor dealers to be used "for the creation of a fund for the erection and maintenance of an inebriate asylum."[37] In April 1876, the Commissioners of the Inebriate Asylum visited Rochester to view potential sites for the new asylum. Newspaper reports indicate that after touring half a dozen sites, the commissioners accepted an offer from local resident Jacob Rickert to purchase for $9,000 "160 acres on which he thought the Asylum would look splendidly."[38] The article goes on to describe the property as "among the best land in the county, and Silver creek runs through it.

[33] 106 Group, *Rochester Historical Contexts*, prepared for City of Rochester, July 2014, 10.
[34] Ibid., 10-13.
[35] Sasha Warren, "St. Peter State Hospital," MNOpedia, https://www.mnopedia.org/place/st-peter-state-hospital, Accessed July 2023.
[36] *Rochester Record and Post,* (Rochester, Minnesota), 25 May 1867.
[37] *Rochester Record and Post*, (Rochester, Minnesota), 17 December 1875.
[38] "The Inebriate Asylum" *Record and Union*, (Rochester, Minnesota), 21 April 1876.

There is a nice elevation in the center, evidently put there as a building site."[39] Later articles further describe the location of the property as "a quarter section on the extreme eastern edge of the city, about 120 acres of it south and 40 acres north of the railroad."[40]

During the summer of 1876, the Commission advertised to architects to submit building design bids. In September, the Commission chose noted St. Paul-based architect Leroy Buffington for the project. Newspapers reported that

> The erection of the building will be commenced at once, there being already a fund of $16,000 in the treasury for that purpose. The building, when completed, will cost about $50,000 and according to architect Buffington's plans, really consists of six separate edifices, as follows: The main building, two "high paying patient Buildings," two hospitals, and one amusement hall. In size the building will be 375 x 155 feet, with a basement of stone, the main building being three stories high, and the other five buildings being two stories high each. The material will be the very best brick with stone trimmings, and a tower eighty feet in height will add to the architectural beauty.[41]

Construction contracts were bid and awarded during the winter of 1877, with construction of the basement for the "main building" beginning that spring.

Unsurprisingly, liquor dealers were opposed to the $10 yearly tax, and in 1878 succeeded in lobbying for its repeal. The legislature re-established the Rochester Inebriate Asylum as the "Second Minnesota Hospital for the Insane," though a wing was dedicated to treating inebriates. The hospital opened on January 1, 1879, with a patient population of 68, all of whom had been transferred from St. Peter.[42]

Rochester expanded quickly, with a women's wing added in 1880, and the "east wing" added in 1882. The appropriation to construct and furnish the east wing was $66,000. An article in the Minneapolis Tribune described the planned project as:

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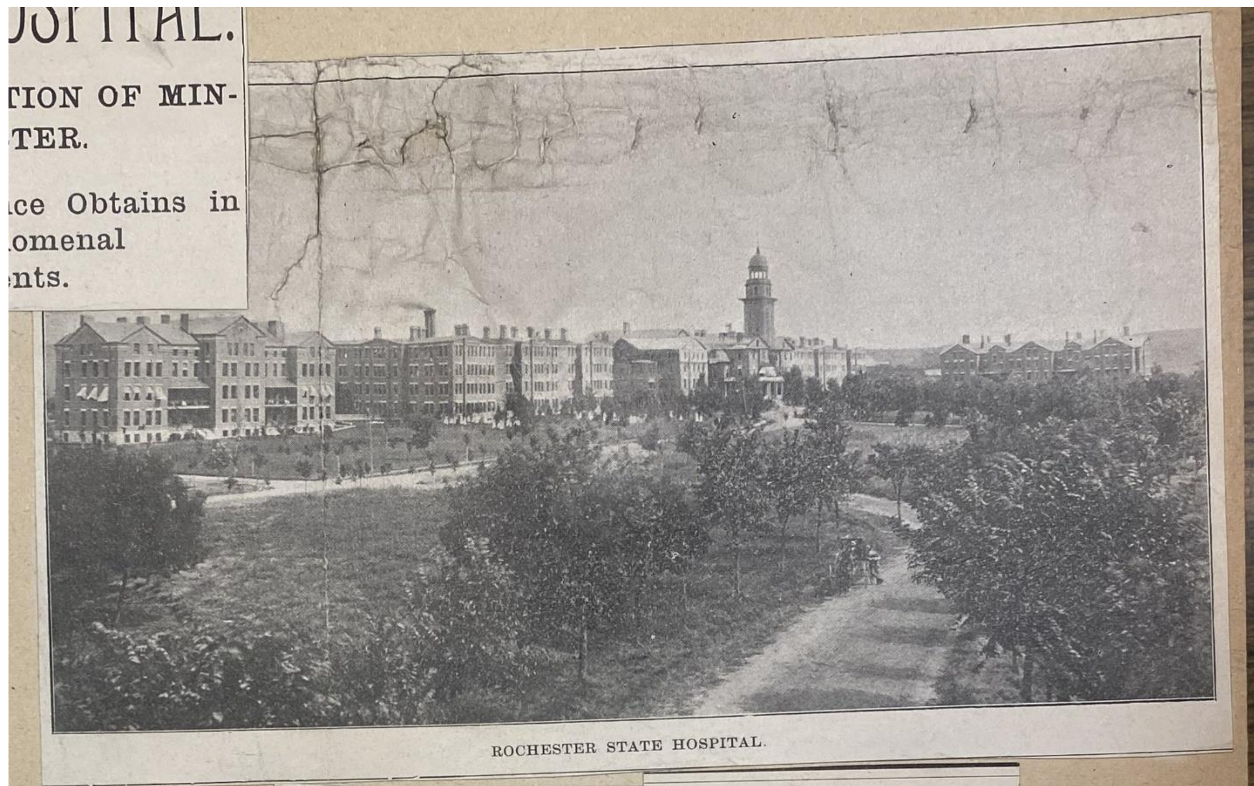
[39] "The Inebriate Asylum" *Record and Union*, (Rochester, Minnesota), 21 April 1876.
[40] *Rochester Post*, 22 April 1876.
[41] "The Inebriate Asylum – Plans Adopted and Contract Let" *Rochester Post*, (Rochester, Minnesota), 23 September 1876.
[42] Minnesota Department of Human Services, "The Evolution of State Operated Services" circa 2007, https://mn.gov/mnddc/past/pdf/00s/07/07-DHS-ENG.pdf. Accessed January 2024.

A most beautiful and imposing structure. …when erected will be 662 feet in length, including the present buildings which are 193 feet. The height is four stories, or the same as that of the old buildings. The style of architecture for the additions is to be of a new design, and the wings or additions will be strictly fireproof, constructed of brick, with flat metal roofs. The east wing will be constructed first and will accommodate about 200 patients. It will be connected to the main building by a corridor forty feet long.[43]



View of the Rochester campus in 1896s. Image published with the article "The Insane Hospital," Rochester Daily Post, May 8, 1896 via Collections of the Olmsted County Historical Society, Rochester State Hospital Newspaper Files, Box D-118.

[43] "The Rochester Asylum," *The Minneapolis Tribune* (Minneapolis, Minnesota), 22 April 1881, 4.

A "west wing," designed at the same time as the east wing, followed in 1883-1884. The west wing housed female patients and "completed the design of the main structure, with a capacity for 600 patients."[44] By 1886, the "state lunacy commission's" annual report indicated that there were 603 patients housed at Rochester roughly half men and half women.[45] A new detached women's ward was authorized by the legislature in 1887 and opened to patients on February 12, 1896.[46]

In 1889, Rochester dominated the news state-wide after a patient named Taylor Combs was killed during an altercation with two hospital attendants. The attendants and hospital superintendent were tried before a grand jury by the state and later in district court where one of the attendants was found guilty of second-degree manslaughter and the other of second-degree assault and both were sentenced to time in prison. The incident led to a statewide investigation of the state hospital system but did not ultimately curb the need for custodial care in the state.

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[44] "The Insane Hospital," *Rochester Daily Post* (Rochester: Minnesota), 8 May 1896.
[45] "State Lunacy Commission's Report on the Insane Hospitals" *The Saint Paul Globe* (Saint Paul, Minnesota), 8 April 1886, 4.
[46] "The Insane Hospital," *Rochester Daily Post* (Rochester: Minnesota), 8 May 1896.

11

JUNE 1890
ROCHESTER
MINN.

Cultivated Fields.

Barn Yard.

Detached Female Ward.

FEMALE WARD.

MALE WARD.

Detached Male Ward.

Laundry

SECOND MINNESOTA STATE HOSPITAL for the INSANE.

1½ MILES E. OF ROCHESTER P.O.

Asylum Grounds.

The Rochester campus in 1890. “Rochester, Minnesota” Sheet 11, Sanborn Fire Insurance Company, 1890.

To accommodate an ever-increasing patient load, construction proceeded almost constantly on the Rochester campus during the 1890s. By 1900, Rochester housed 1,207 patients.[47]

An 1896 article in the Rochester Daily Post notes that the chapel, assembly hall, and congregate dining hall had "just been erected:"

> The basement contains the bakery and general kitchen. The first story is occupied as a congregate dining room, to be used by 300 patients and by a large dining room for employees. The second story contains the chapel, assembly hall and stage. This has been one of the greatest needs of the institution, as it is now necessary to use one of the wards for Sunday services and week day [SIC] amusements.[48]

The article goes on to list the following extant physical improvements to the campus:

Interior of the cave cellars, undated photograph, collections of the History Center of Olmsted County, Box D-175 Hospitals: Rochester State Hospital.

- Engine House and chimney
- Store House
- Coal House
- Gas House
- Ice House
- Laundry
- Carpenter Shop
- Green House
- Hose House
- Cold Storage Plant
- Cave cellars "excavated in the sandrock bluff with bins capable of holding thousands of bushels of vegetables, together with a chamber for the storage of butter and another that holds two car loads of apples"[49]

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[47] State Lunacy Commission's Report on the Insane Hospitals" *The Saint Paul Globe (*Saint Paul: Minnesota*)*, 8 April 1886, 4.
[48] Ibid.
[49] Ibid.

The article also describes the hospital farm as follows:

"Farm Buildings, Rochester State Hospital," approximately 1940, via Minnesota Historical Society Collections Online.

The hospital farm consists of 520 acres, in addition to which there are 460 acres rented. Forty acres are used in the cultivation of garden tuck. The farm furnishes pasture for 100 head of Holstein cows…"[50]

In 1885, a limestone quarry was opened on the campus. Labor at the quarry was provided by two state employees and between 25 and 55 patients.[51] Limestone from the quarry was used in campus construction and also sold locally. A rock crusher was added to the operation in 1900 and a second in 1909.[52] Aggregate from the crushers was also used locally in concrete mixtures.

"During the early decades of the twentieth century, the hospital erected a variety of buildings to house patients with communicable diseases such as tuberculosis and diphtheria."[53] A new nurses' quarters was constructed in 1907 and a "receiving building" in 1912.[54] Two wings were added to the receiving building in 1932.

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[50] State Lunacy Commission's Report on the Insane Hospitals" *The Saint Paul Globe (*Saint Paul: Minnesota*)*, 8 April 1886, 4.
[51] City of Rochester Parks and Recreation Department, School District #535, and Friends of Quarry Hill Nature Center Incorporated, "Quarry Hill Park Historical Guide," https://www.qhnc.org/docs/historical-guide.pdf (last accessed May 2024).
[52]"Second Crusher Purchased," *Olmsted County Democrat* (Rochester: Minnesota), May 21, 1909.
[53] Louis Berger & Associates, Inc. "Federal Medical Center, Rochester, Minnesota, Section 106 Documentation and Demolition of PORT and Old Receiving Buildings," prepared for U.S. Department of Justice Federal Bureau of Prisons, May 1998, 2. Available Minnesota State Historic Preservation Office.
[54]Ibid.

Top: Nurses' Home (later known as the PORT Building" at the Rochester State Hospital circa 1928 (left) and 1998 (right). Bottom: Receiving Building in 1998. Both buildings were designed by state architect Clarence Johnston.

Images via Minnesota Historical Society Collections Online and Louis Berger & Associates, Inc. "Federal Medical Center, Rochester, Minnesota, Section 106 Documentation and Demolition of PORT and Old Receiving Buildings available Minnesota State Historic Preservation Office.

As was the case throughout the country, little happened in terms of physical updates to the campus during the years of the Great Depression and World War II. The single exception was the demolition of the Main Building's central tower:

"Administration Building of the Rochester State Hospital" circa 1930, prior to demolition of the tower. Image via Minnesota Historical Society Collections Online.

One of Rochester's landmarks for nearly half a century soon will be no more. Deteriorated after 47 years, the tower on the administration building of the Rochester State hospital is being torn down, upon the recommendation of W.B. Dunnell of Minneapolis, architect employed by the state board of control. For many years the tower was the first sight seen when travelers came into Rochester and the last when they left.[55]

[55]"State Hospital Tower, Landmark for Nearly Half a Century, Being Razed," *Rochester Post Bulletin* (Rochester: Minnesota), 9 October 1937.

2.2.4 Mid-to-Late-Twentieth Century American Mental Health Care

Post-War Shifts Toward Community-Based Mental Health Services (1945-1969)

"After 1945 there was a concerted attempt to shift the care and treatment of the mentally ill from the asylum to the community. In many respects this development represented a radical departure, for it was intended to diminish the significance of the asylum, which had been the centerpiece of public policy for more than a century."[56] Important factors leading toward this change were threefold - the experience and influence of young psychiatrists who were trained in the field during WWII; the a series of exposés documenting the conditions in understaffed and underfunded mental hospitals; and the National Mental Health Act of 1946, which marked the entry of the federal government into the mental health policy arena.

Psychiatrists serving in the military during WWII treated a vast number of service people and found that they needed to adjust their methodologies to do so effectively. They observed that "neuropsychiatric disorders were far more pervasive and serious than had been previously recognized, that environmental stress associated with combat contributed to mental maladjustment, and that early and purposeful treatment in non-institutional settings produced favorable outcomes.[57] After the war, many of these psychiatrists transitioned to civilian practice where they practiced the techniques they had learned in the field and lobbied the American Psychiatric Association to acknowledge the efficacy of what became known as psychodynamic and psychoanalytic therapies. Additionally, by the end of the 1940s, this group of psychiatrists had taken "control of virtually all university departments of psychiatry, thus assuring that an entire generation that matured in the 1950s and 1960s would share their views.[58]

While these internal changes were fomenting within the psychiatric profession, a series of journalistic exposes and about the conditions in mental hospitals - which had been uniformly underfunded during the Depression and WWII - caught the attention of the public and politicians and generated widespread support for community treatment.

The passage of the National Mental Health Act in July 1946 constituted the final major indicator that changes were coming to American mental health care. Prior to the passage of

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[56]Grob, *The Mad Among Us,* 191.
[57] Grob, *The Mad Among Us,* 191.
[58] Grob, *The Mad Among Us,* 202.

this act, the federal government had not been directly involved in the administration of mental health services or policy. The legislation:

- Supported research relating to the cause, diagnosis, and treatment of psychiatric disorders;
- Provided fellowships and grants for the training of mental health professionals;
- Provided grants to states to assist in funding clinics and treatment centers;
- Created a National Mental Health Advisory Council;
- Created the National Institute of Mental Health.

The 1950s saw the continuation of post-war optimism for improvements to the mental health care system. The decade also saw the beginning of actual change in how treatment was approached, with the rediscovery of Milieu Therapy and the development of psychotropic drugs. Regarding novel treatments, the

> simultaneous development of psychotropic drugs and milieu therapy – in addition to electroshock, psychosurgery, and psychotherapy – seemed to hold out the promise that severely mentally ill institutionalized patients, with appropriate treatment, might be able to be released and live in the community. Moreover, these new therapies also weakened the traditional distinction between psychological and biological interventions.[59]

Advancements in pharmaceuticals included the development of Thorazine, a new class of tranquilizers, and early antidepressants, the use of which can be directly related to the virtual elimination of psychosurgery by the end of the decade.

Many mental health professionals began to conceive of patient treatment as part of a "therapeutic community" where teams including doctors, social workers, the patient, medications, and "the community" were all understood to be active participants in a care plan. Subscribers to this type of treatment also advocated for "day hospitals" where patients participated in their treatment program at a hospital during the day and were able to return home in the evening.

Grob explains that these changes in treatment methods combined with the ongoing "shift from institutional to community practice, however welcomed, inadvertently began to alter

[59] Grob, *The Mad Among Us,* 223.

professional boundaries and set the stage for a rapid expansion of such mental health occupations as clinical psychology, psychiatric social work, and psychiatric nursing."[60] This diversification of professional opportunities would support to continued move away from institutionalization in the following decades.

The 1950s were also notable for the way that the federal and state governments funneled an influx of capital to state systems both for the improvement of existing facilities and the expansion of community treatment programs. Between 1946 and 1960, the national per capita expenditure for patient maintenance in state hospitals increased 284 percent.[61]

The 1960s saw both public sentiment and professional opinions continuing to lean toward anti-institutionalization and increased community-based treatments. "Community psychiatry became the term that best defined some of the distinguishing characteristics of these years. Faith in the redemptive qualities of modern psychiatry was fused with other goals: a demand for social justice; an end to structural barriers that impeded the realization of the full potentiality of individuals; and the realignment of mental health services at the community level where a professional-public partnership could function more effectively."[62]

At the federal level, the newly elected Kennedy administration focused its efforts on directing funding into research, training, and community programs related to what was then termed "mental retardation." Following a series of studies and drafts of separate pieces of legislation related to funding social and medical programs for mental retardation and mental health, the legislature eventually passed the single Mental Retardation and Community Mental Health Centers Construction Act of 1963, which provided $150 million in funding for the construction of new community-oriented "preventative, diagnostic, treatment, and rehabilitation facilities" between 1965 and 1967.[63]

"The context of policy-making in the early 1960s reflected a faith that a community-oriented policy could overcome the intrinsic and unchanging defects of mental hospitals."[64] Unfortunately, optimism and reality did not entirely align. The transition away from institutional care presumed that individuals currently treated at inpatient state-run mental hospitals did, in fact, have a personal support system in place that would allow for them to

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[60] Grob, *The Mad Among Us,* 237.
[61] Grob, *The Mad Among Us,* 232.
[62] Grob, *The Mad Among Us,* 250.
[63] Grob, *The Mad Among Us,* 256-258.
[64] Grob, *The Mad Among Us,* 258.

live in their communities. In reality, many patients did not have the necessary support of family or friends to fall back on and lacked the basic necessities of safe housing, financial solvency, reliable transportation, and after hours care that would allow for a community-based treatment plan to be successful.

This situation was exacerbated by the inevitable difficulties of rolling out a new public program at the national scale. The language of the enacting legislation was purposefully vague, leaving the community based mental health centers significant leeway in the services they provided and the clients they served. Many of the centers ultimately directed their efforts toward substance abuse and did not provide a one-to-one alternative to institutional care. Additionally, "the funds for construction and staffing [of community mental health centers]… declined as the Vietnam War escalated. The gap between authorization and actual funding widened rapidly…by 1980 the total number of centers receiving grants was 754, a figure that fell far short of the original goal of 2,000."[65]

Post-War Shifts Toward Community-Based Mental Health Services (1970-1982)

By 1970, world events and a new presidential administration led to the beginning of a slow loss of momentum for federal support of mental health care programs. The public's focus on the Vietnam War coupled with the tumultuous changes in policy direction that marked the transitions between the Johnson, Nixon, Carter, and Reagan presidencies resulted in government inertia with regard to mental health care throughout the 1970s.

Mental health care was affected by other federal legislation - notably the 1972 amendment to the Social Security Act marked a tipping point in the expansion of the Social Security Disability Insurance Program and the Supplemental Security Income for the Aged, the Disabled, and the Blind to a point where the programs "encouraged states to discharge severely and persistently mentally ill personal from mental hospitals, since federal payments would presumably enable them to live in the community."[66] In October 1980, the Carter administration managed to pass the Mental Health Systems Act, which was promptly gutted by the Reagan administration, which reduced both federal funding for mental health care and federal involvement in mental health policy. "Between 1970 and 1986, the number of

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[65] Grob, *The Mad Among Us,* 262.
[66] Grob, *The Mad Among Us,* 290-291.

inpatient beds in state and county institutions declined from 413,000 to 119,000…" and by 1983 general hospitals accounted for nearly two-thirds of all inpatient mental health stays.[67]

Grob concludes that:

> Mental health policy changed dramatically after 1965, but not in the manner envisaged by those active in its formulation. After World War II there was a decided effort to substitute an integrated system of services for traditional mental hospitals. The system that emerged in the 1970s and 1980s, however, was quite different. First, mental hospitals did not become obsolete even though they lost their central position. They continued to provide both care and treatment for the most severely disabled part of the population. Second, community mental health programs expanded dramatically, and inpatient and outpatient psychiatric services became available in both general hospitals and CMHCs. Finally, a large burden of supporting severely mentally ill persons in the community fell to a variety of federal entitlement programs that existed quite apart from the mental health care system. Since the 1970s, severely and persistently mentally ill persons have come under the jurisdiction of two quite distinct systems – entitlements and mental health – that often lack any formal programmatic or institutional linkages.[68]

2.2.5 Post-War State Hospital Architecture

The Post-War State Hospital Campus

Scholarly literature analyzing the architecture of post-war psychiatric hospitals in general and state hospitals in particular is an underdeveloped body of work. The United States Department of Veteran's Affairs (VA) has documented the development of its own post-war building campaign, which included psychiatric hospitals, in a National Register of Historic Places Multiple Property Documentation Form. [69] The VA's post-war building campaign included the both the development of new hospital sites and the introduction of new buildings to its existing campuses - much of the discussion is also relevant here.

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[67] Grob, *The Mad Among Us,* 291.
[68] Grob, *The Mad Among Us,* 292-293.
[69] Row 10 Historic Preservation Solutions for United States Department of Veterans Affairs, *National Register of Historic Places Multiple Property Documentation Form for United States Third Generation Veterans Hospitals, 1946-1958*, 2018, available https://www.cfm.va.gov/historic/UnitedStatesThirdGenerationVeteransHospitals-1946-1958-MPSsigned.pdf.

Post-war changes to treatment methods, volume of patients served, the average duration of hospital stays, and government funding and oversight all affected the ways that hospitals operated and the ability of existing infrastructure to serve society's needs. New medical facilities were needed across the country, and architects were faced with the challenge of developing functional buildings. With regard to psychiatric hospital design in particular, the VA found that:

> …[post-war] psychiatric care had shifted from housing patients in large wards in rural settings to treating patients with the goal of returning them to society, but the requirements for specific treatments shifted constantly. Hospitals constructed in the late 1940s often contained spaces for hydrotherapy, a treatment method that was drastically reduced by the mid-1950s. Architects struggled with finding accurate information on the approved treatment methods that would impact their designs and plans for the mental hospital; as characterized by one architect, the architect 'must lead, for there is virtually nothing he may follow.'[70]

The changing psychiatric treatment landscape notwithstanding, architects were able to coalesce around some standard design choices for post-war medical facilities. Primary sources such as newspaper articles generally describe these new buildings as looking "modern" and "medical" – a far cry from the "residential" nature of earlier mental health care buildings. The VA notes that typical characteristics of new hospitals (both general and specialty) included:

- Adoption of International Style architectural language including a lack of exterior ornament, geometric massing, ample windows, and flat roofs.
- Single-story entry pavilions, or primary entrances marked by flat awnings and colonnades.
- For low to mid rise buildings, T, V, X and Y shaped floor plans were used to maximize natural light and segregate interior functions.
- For low to mid rise buildings, the ground level was devoted to "public" functions such as reception, waiting areas, dining rooms, rest rooms, and administrative offices.
- For low to mid rise buildings, the upper levels housed "private" functions such as doctor's offices, specialized treatment rooms, overnight patient rooms, and centrally located nurses' stations.[71]

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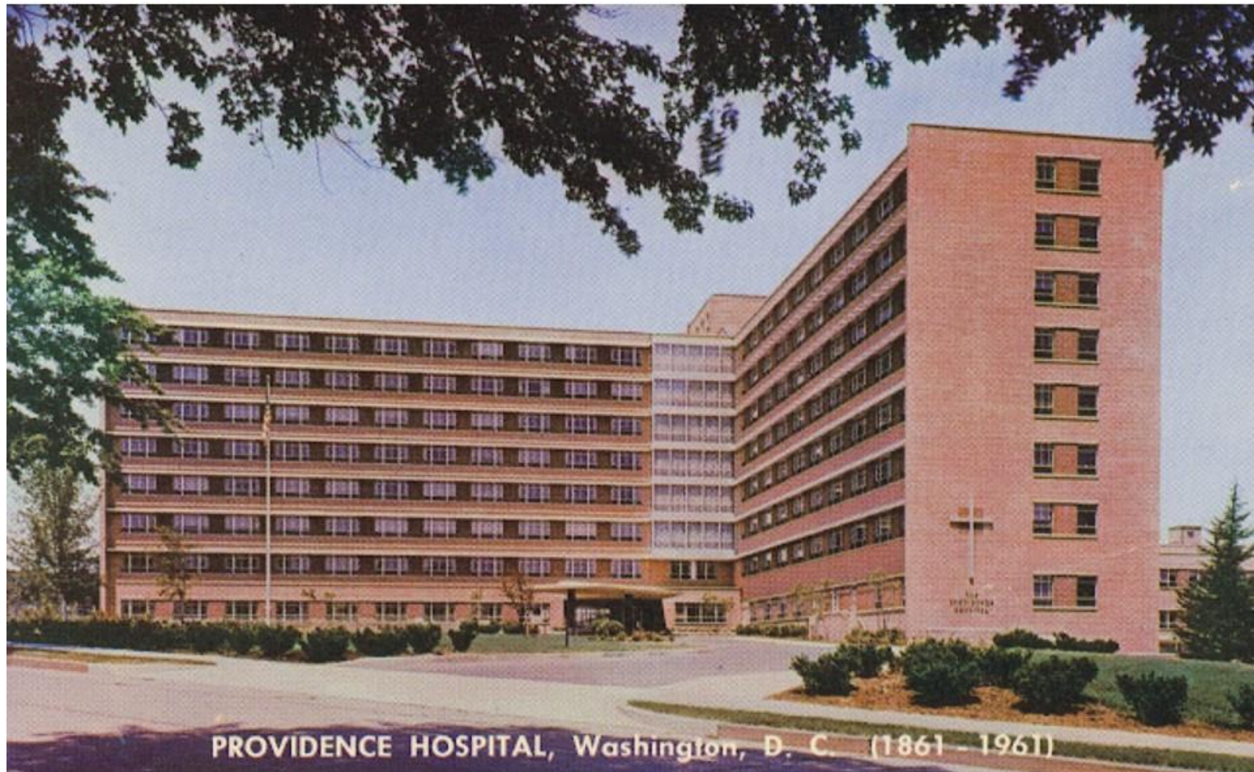
[70] Row 10, *United States Third Generation Veterans Hospitals…,44.*
[71] Ibid, 38-45.



Top: Providence Hospital, Washington, D.C., constructed 1956. Photo courtesy www.streetsofwashington.com

Bottom: Veteran's Administration, Main Hospital Building, Denver, CO., constructed 1951, photo 1965, United States Third Generation Veterans Hospitals, 1946-1958, page 109.

Contemporary literature regarding hospital design, did also make an attempt to address psychiatric hospital design.

> Extended treatises on hospital design for this period, such as architects Isadore Rosenfield's *Hospitals: Integrated Design* and Charles Butler's *Hospital Planning*, devoted chapters to special hospitals including mental hospitals. For the most part, room layouts [a primary concern of Thomas Kirkbride and the moral method adherents] were disregarded in favor of general recommendations. Butler's recommendations included spaces designated for court hearings as well as social work, using durable, impervious flooring, and heavy gauge wire screen instead of bars. Rosenfeld advocated for all doors to open outwards to prevent a patient from barricading himself within…[72]

In a stark departure from the environmental determinism of the late-nineteenth to early-twentieth century asylum architecture, Rosenfield notes that architects likely struggled with designing psychiatric hospitals because "psychiatric architecture…consists of a multitude of details which are as frequently negative as positive…they are a matter of what not to do as well as what to do."[73]

2.2.6 The Rochester State Hospital

1937 - 1982

Indicative of changing attitudes toward mental health care, The Second Minnesota Hospital for the Insane was renamed the Rochester State Hospital in 1937. During the Great Depression and World War II little else was reported about the facility beyond requests for funding appropriations and numbers of patients. Hospitals within the state followed the national trends of underfunding and overcrowding, as the country gave its time, energy, and attention to the war effort.

In 1945, the State of Minnesota announced a new program to rebuild the entire state mental hospital system. The "needs of the institutions were arrived at by a special legislative interim committee following a tour of the hospitals and consultations with Carl H. Swanson, state director of institutions, and his hospital superintendents."[74] In 1947, the committee submitted their final report to the state legislature. The report accused the hospitals of failing to offer

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[72] Row 10, *United States Third Generation Veterans Hospitals…,45.*
[73] Isadore Rosenfield, Hospitals: Integrated Design (New York: Reinhold Publishing Corporation, 1947), 210.
[74] "State Hospital Rebuilding Suggested", *Rochester Post Bulletin* (Rochester: Minnesota), March 12, 1946.

sufficient treatment to their patients and went on to state that “none of the state’s facilities met even the minimum standards for mental hospitals that have been established by the American Psychiatric Association…” The report continued by describing the conditions in hospitals:

> …in some wards [the possibility for patients to spend time in a sitting position] is impossible because of the lack of chairs or benches. Many patients were not provided with underwear, shirts, socks, or shoes. Sanitary conditions were abysmal, with soap, toothbrushes, and toilet paper in short supply. Only one institution had seats on its toilets. Physical restraints, including strait jackets, mitts, cuffs, shoulder straps, roles and chains, were applied to one out of every thirteen patients in the system…"[75]

Upon receiving this damning report, Governor Luther Youngdahl (who had assumed office in 1946) commenced a series of unannounced "fact-finding visits" to the various state hospitals. Simultaneously, the *Minneapolis Tribune* began its own investigation of the situation. Reporter Geri Hoffner (Joseph) and photographer Arthur Hager visited each state hospital and published a series of critical articles during the spring of 1948 that both corroborated the commission's report and captured the public’s attention.

Ultimately, the Rochester campus underwent the most comprehensive reconstruction in the system, and between 1948 and the mid-1960s the state spent eight-million-dollars to almost completely demolish and rebuild the campus. “By 1952, new buildings included two geriatric facilities, a reception center, an administration/clinical building, a services facility, and a warehouse. By 1961, the hospital had completed the construction of three ‘continuous treatment buildings as well…” and also began demolition of the 1880s era east and west wing additions to the original building.[76]

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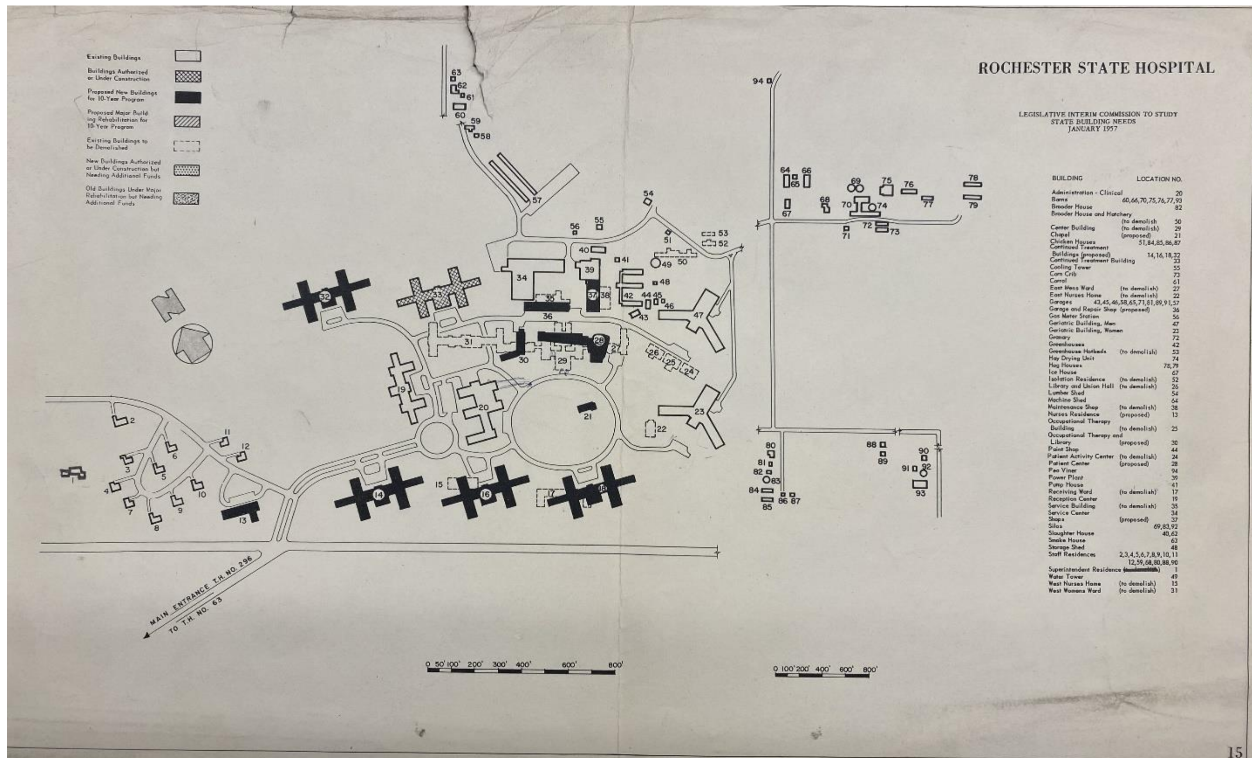
[75] Ibid.

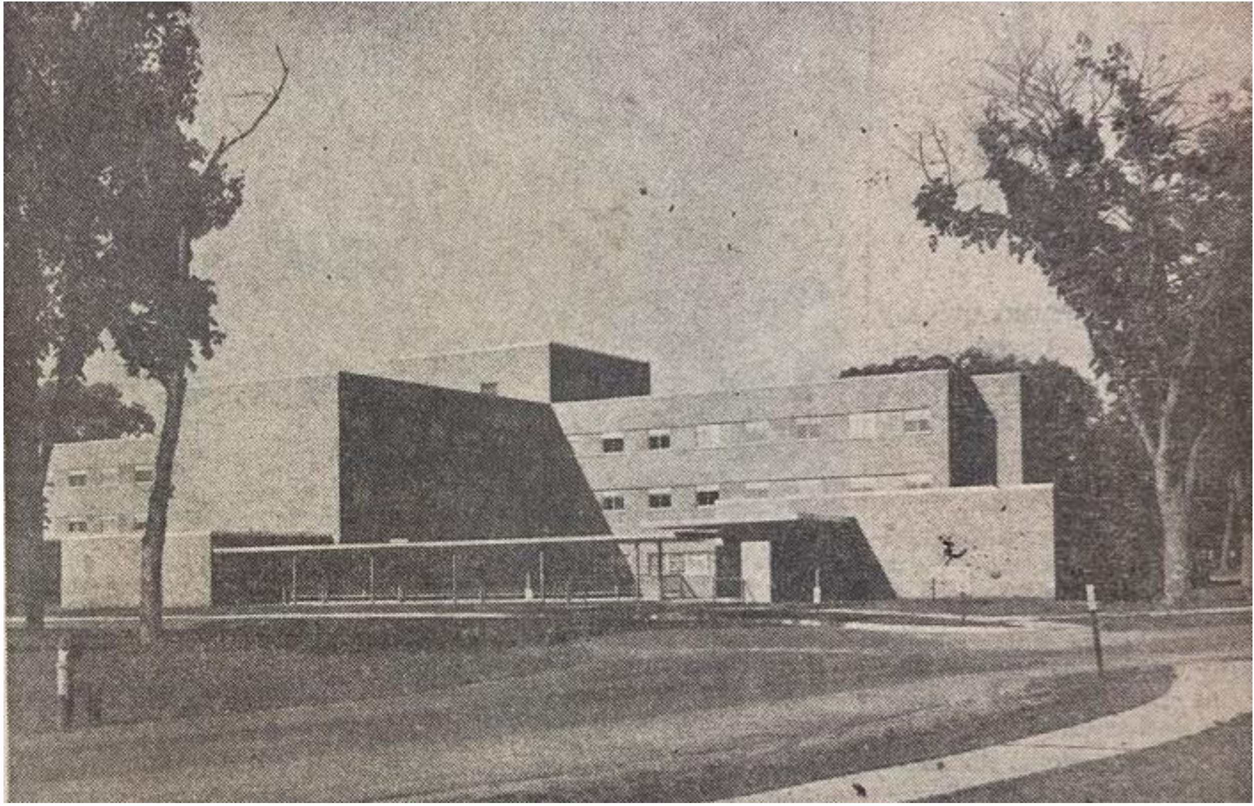
[76] Louis Berger & Associates, Inc …. 2.; “Landmarks of Past Sit Empty at State Hospital Waiting Destruction,” *Rochester Post Bulletin* (Rochester: Minnesota), 17 November 1961.

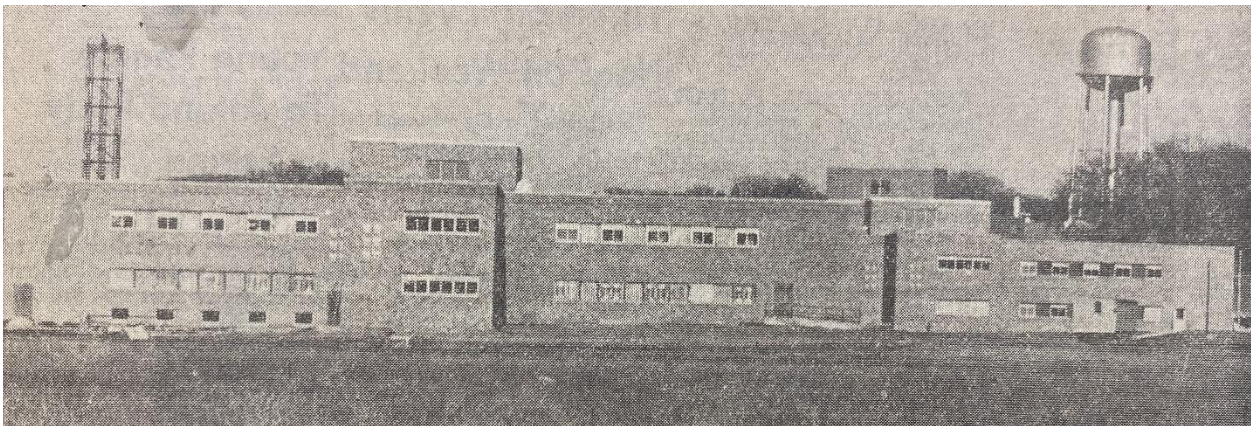


1957 map of the Rochester State Hospital campus. Existing buildings in white, buildings under construction hatched, buildings proposed for construction within the following 10 years in black. Collections of the History Center of Olmsted County, Box D-175 Hospitals: Rochester State Hospital.

Later alterations included construction of a new power plant, 11 staff houses, a greenhouse, an exterior lighting system, updates to water and sewage facilities, new tunnels, and updates to landscaping and the entrance road.[77] As of 1975, an article in the Rochester Post Bulletin reported that the only remaining "early buildings" included "the red brick carpentry shop on the northeast corner of the grounds" and "some unused farm buildings [that] still stand on land owned by the regional DNR…the regional DNR headquarters is housed in the old hospital dairy barns."[78] Though not identified in the article, the 1907 Nurses' Home and 1912 Receiving Building were also extant.

[77] "Rochester State Hospital's 75th Year Observed", *Rochester Post Bulletin* (Rochester: Minnesota), 25 June 1954.
[78] "Old State Hospital Records Show Differences" Rochester Post Bulletin November 27, 1975.





New buildings on the Rochester State Hospital Campus. Top: Administration and Clinical Building. Bottom: Second Continuous Treatment Building.

Rochester Post Bulletin, *June 25, 1954 and April 23, 1959, both images via Collections of the Olmsted County Historical Society, Rochester State Hospital Newspaper Files, Box D-118.*

At the same time as the core of the campus was being reconstructed, changes were also being made to the larger acreage. The rock quarry was closed in 1950 due to safety concerns and in 1955 the quarry's rock crushing facilities were demolished. Farming operations wound down throughout the 1960s, with 1962 marking the last year that patients participated in agricultural work and operations completely ceasing in 1967.[79] In March 1965, 160 acres of land "north of U.S. 14" were transferred to the State Junior College Board.[80] When all farming operations ceased in 1967, the state retained ownership of the campus's remaining agricultural lands, leasing them to a local farmer.

Regarding the Rochester State Hospital's treatment programs, a 1954 article in the *Rochester Post Bulletin* noted that:

> Surgeons of the Mayo Clinic perform most of the surgery at the hospital and furnish consultant services. …Among the programs for patients are occupational therapy, recreational therapy, library, laundry sewing room, Elm Leaf (hospital patients' newspaper) and kitchen work. Also there are movies, dances, walks, social hours and parties.[81]

Despite the influx of capital for construction, the state hospital system continued to face serious challenges. A 1959 series in the *Minneapolis Star* that examined the state hospital system 10 years after the acknowledgement of the post-war crisis, noted that "Minnesota's mental hospitals, overcrowded and understaffed, are adding another problem to their list of miseries – staff morale."[82] A litany of quotes from staff members of the Rochester campus all conveyed the following sentiment "'I have the women's receiving ward to handle', said Dr. Francis Tyce, psychiatrist, 'and I simply don't have the time to do that I want with new incoming patients. Patients are coming in faster than I have time to care for them.'"[83] Likewise, an article in the *Rochester Post-Bulletin* following the completion of construction of one of the new medical buildings explained that "the second continued treatments center at

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[79] Harold Severson, "State Hospital Farm Era to end with Heifer Sale," *Rochester Post Bulletin* (Rochester: Minnesota), 12 June 1967.
[80] "The Bulletin" Vol. 1, No. 11, April 23, 1965.
[81] Ibid.
[82] Ralph Clark, "State Mental Hospitals Have Morale Problem," *The Minneapolis Star* (Minneapolis: Minnesota), 9 October 1959, 13.
[83] Ibid.

the Rochester State Hospital, built at a cost of $1,600,000, is not completed but the building cannot be used by patients until equipment and adequate personnel are obtained…"[84]

In 1960, the Minnesota State Hospital system reached its peak inpatient population of 16,355 people.[85]

Following the passage of the Community Mental Health Services Act into law, Minnesota begin work to establish a system of community-based outpatient facilities. By 1962, the state had opened 16 centers, and by 1966 the network had grown to 22. During this time period, the state also began to grow its network of state-owned nursing homes, transferring in a significant number of geriatric patients from the state hospital system.

In Rochester, construction begin on a new "Religious Activity Center" for the campus in March 1968. The $385,000 project was financed by volunteer fundraising and opened to campus residents in September 1969. In 1969, the state established "Mental Retardation Programs" on the campus. In 1971, the Rochester State Hospital was designated as the state hospital system's surgical center. In 1975 a chemical dependency treatment program was established.

In 1973, the Minnesota State Legislature passed legislation calling for the development of a comprehensive plan to decentralize the delivery of public mental health services. The act enabled county and regional governments to convene area Human Services Boards, and authorized expenditures of more than $50 million over a five-year period to help establish community-based mental health programs. In December of 1975, the Department of Public Welfare announced its plan to "get out of the mental hospital business" by placing patients in "appropriate community settings." According to the plan, the state would close six of its ten hospitals by 1980, with an eye toward completely ceasing operations following that date. By 1984, the overall Minnesota State Hospital system's inpatient population had dropped to 4,006 patients.[86]

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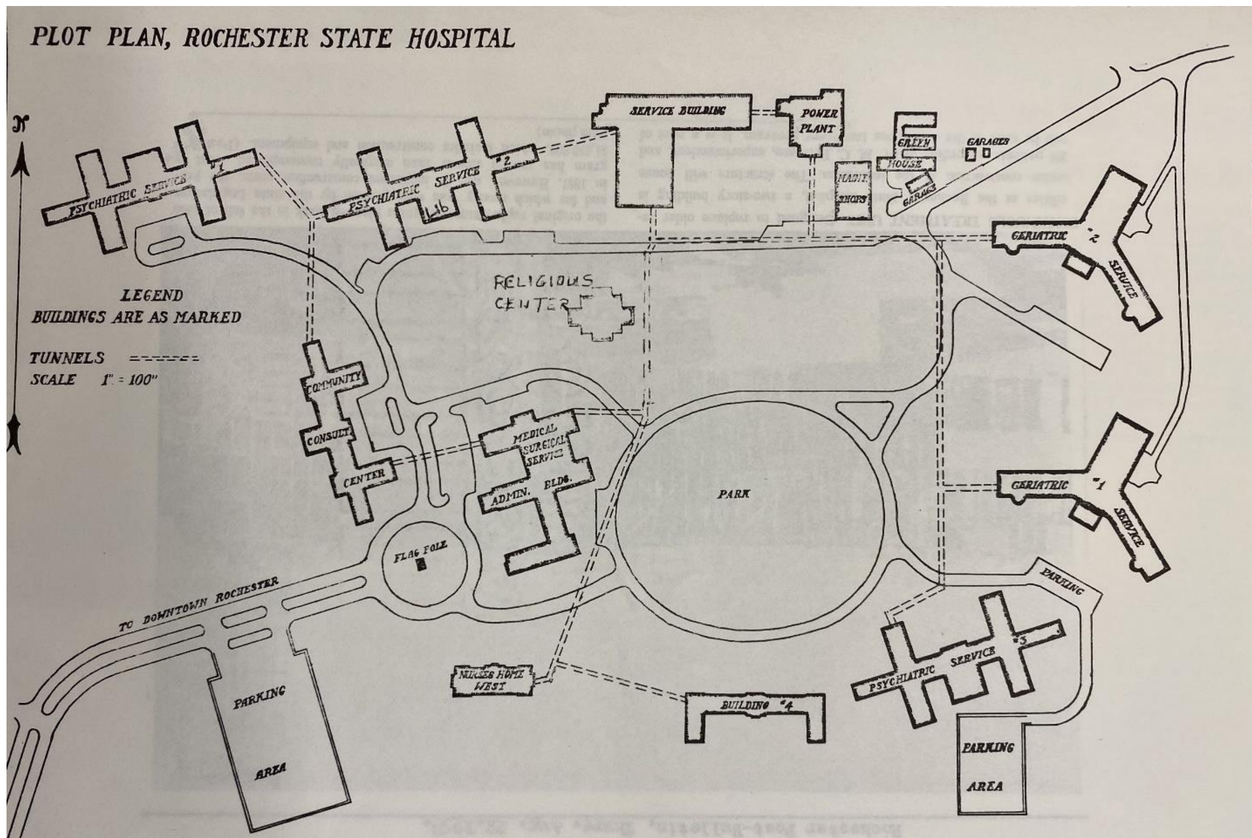
[84] "New State Hospital Building Ready, but No Funds to Staff It," *Rochester Post Bulletin* (Rochester: Minnesota), 30 September 1959.
[85] Minnesota State Planning Agency. "Minnesota's State Hospitals." 31 January 1985, 6. http://mn.gov/mnddc/learning/document/GT033.PDF.
[86] Ibid.



1975 map of the Rochester State Hospital campus. Extant buildings from the pre-World War II period are the "Nurses Home West" and "Building #4". Collections of the History Center of Olmsted County, Box D-175 Hospitals: Rochester State Hospital.

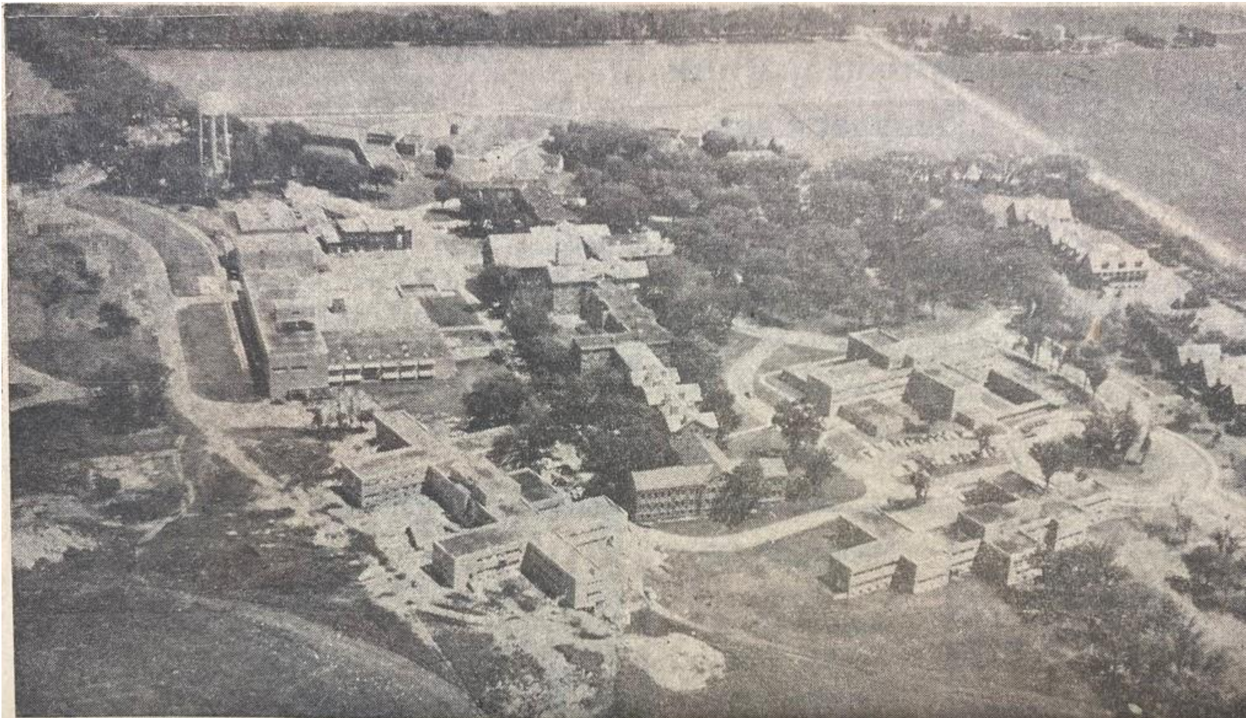
In October 1980, the closure of the medical surgical unit at the Rochester State Hospital was announced, and on April 24, 1981, a seven-member Minnesota Senate subcommittee on health, welfare and corrections unanimously voted to close the entire hospital, citing a savings of $9.3 million over the next biennium. "In deciding where to cut funds in the state hospital system, legislative staff members and welfare department officials were asked to rank the 30 treatment units at the state's nine hospitals. The weakest three were the surgery, chemical dependency and mental retardation treatment units at Rochester."[87] Between

[87] Paul Klauda, "Rochester Hospital Closure Proposed," *Minneapolis Tribune* (Minneapolis: Minnesota), 26 April, 1981, 6B.

January 1981 and April 1982, 1,344 patients were discharged from Rochester to various other state hospital facilities, community facilities and other non-state hospitals.[88]

> From the time of the actual closing date (June 29, 1982) and until a decision is made on what will happen to the buildings and land at Rochester State Hospital, a mothball crew is being maintained by the Department of Public Welfare. These employees will be responsible to finish the closing of buildings, to dispose of remaining inventories, and to maintain and protect the buildings. $1,438,293 has been budgeted for the mothball operation. This includes all costs of day-to-day operation.[89]

On December 29, 1982, Olmsted County purchased the Rochester State Hospital property from the State of Minnesota for $1.00, marking the end of the campus's life as a state-owned and operated mental health care facility.



The Rochester State Hospital Campus as it appeared upon closing in 1982. Rochester Post Bulletin, *April 1982.*

[88] "Closure of Rochester Social Adaptation Center, Rochester State Hospital, December 2, 1981," *Rochester Post Bulletin* (Rochester: Minnesota).
[89] Ibid.

3.0 PRESERVATION OVERVIEW

A historic context is a framework for evaluating properties for historic significance. A historic context focuses on a geographical area, a historical time frame, and related historical themes or subjects. A historic context also identifies associated property types, the relevant physical characteristics associated with each property type, and discusses the relationship between the context theme and National Register of Historic Places designation criteria.

A historic context is not an exhaustive list of properties eligible for historic designation. It is also not a National Register of Historic Places nomination or local landmark designation study. Rather, it serves as the basis for historic designation by providing the background information against which a property can be evaluated to determine whether or not it has historic significance.

Properties that are eligible to be formally designated as historic must meet federal, state, or local criteria for designation. In general, a property must qualify as a property type that is eligible for preservation and exhibit adequate historic significance and historic integrity for designation. This section provides an overview of federal and local designation requirements.

3.1 Federal Designation – National Register of Historic Places (NRHP)

The National Register of Historic Places is the official list of the Nation's historic places worthy of preservation. Authorized by the National Historic Preservation Act of 1966, and administered by the National Park Service, the National Register of Historic Places (NRHP) is part of a national program to coordinate and support public and private efforts to identify, evaluate, and protect America's historic and archeological resources. National Register designation is largely honorific and can provide access to historic preservation focused financial incentives such as the Historic Preservation Tax Incentives program and historic preservation focused grants.

Under Federal Law, the listing of a property in the NRHP places no restrictions on what a non-federal owner may do with their property up to and including destruction, unless the property is involved in a project that receives Federal funding, licensing, or permitting. Projects that use Federal assistance of this kind are subject to review by the State Historic Preservation Office under Section 106 of the Historic Preservation Act of 1966.

Similarly, in Minnesota, state law requires that projects at National Register-listed properties that receive state funding are subject to review by the State Historic Preservation Office under the Minnesota Sites Act. Under state law, historic resources are considered environmental resources, and it is possible to prevent the destruction of properties listed in or found eligible for the National Register of Historic Places in accordance with Minnesota's environmental laws.

To be eligible for listing in the NRHP, a property must be at least 50 years of age and considered significant under at least one of the following National Register Criteria:

> **Criterion A:** Associated with events that have made a significant contribution to the broad patterns of our history.
>
> **Criterion B:** Associated with the lives of significant persons in our past.
>
> **Criterion C:** Embodies the distinctive characteristics of a type, period, or method of construction, or that represent the work of a master, or that possess high artistic values, or that represent a significant and distinguishable entity whose components may lack individual distinction.
>
> **Criterion D:** Has yielded or may be likely to yield, information important in history or prehistory.

Additionally, some types of properties, including cemeteries, birthplaces or graves of historical figures, structures that have been moved from their original locations, reconstructed historic buildings, properties primarily commemorative in nature, properties that have achieved significance within the past 50 years, and properties owned by religious institutions are generally not considered eligible for the National Register of Historic Places. However, designation Criteria Considerations exist to allow for exceptions in specific cases.

> **Criterion Consideration A:** A religious property deriving primary significance from architectural or artistic distinction or historical importance.
>
> **Criterion Consideration B:** A building or structure removed from its original location but which is significant primarily for architectural value, or which is the surviving structure most importantly associated with a historic person or event.
>
> **Criterion Consideration C:** A birthplace or grave of a historical figure of outstanding importance if there is no appropriate site or building directly associated with their productive life.

Criterion Consideration D: A cemetery which derives its primary significance from graves of persons of transcendent importance, from age, from distinctive design features, or from association with historic events.

Criterion Consideration E: A reconstructed building when accurately executed in a suitable environment and presented in a dignified manner as part of a restoration master plan, and when no other building or structure with the same association has survived.

Criterion Consideration F: A property primarily commemorative in intent if design, age, tradition, or symbolic value has invested it with its own exceptional significance.

Criterion Consideration G: A property achieving significance within the past 50 years if it is of exceptional importance.

If a property is determined to have significance under one of these criteria, then its integrity is evaluated using the seven aspects of integrity as identified in the *National Register Bulletin How to Apply the National Criteria for Evaluation*. The seven aspects of integrity include:

Location: The place where the property was constructed or the place where the historic event occurred.

Design: The combination of elements that create the form, plan, space, structure, and style of a property.

Setting: The physical environment of a historic property.

Materials: The physical elements that were combined or deposited during a particular period of time and in a particular pattern or configuration to form a historic property.

Workmanship: The physical evidence of the crafts of a particular culture or people during any given period in history or prehistory.

Feeling: A property's expression of the aesthetic or historic sense of a particular period of time.

Association: The direct link between an important historic event or person and a historic property.

If a property is determined to possess historical significance under one or more NRHP criteria, retains sufficient integrity to convey that historic significance, and meets any applicable criteria considerations, the property can be determined to be eligible for listing in the NRHP.

3.2 Local Designation – City of Rochester

Chapter 60.200.040C of the City of Rochester ordinance establishes the Rochester Heritage Preservation Commission (HPC) and local Evaluation Criteria for Landmark Designation. The ordinance states that "historic properties under consideration for landmark designation must have maintained historic integrity based on location, design, setting, materials, workmanship, feeling, and association. Additionally, such properties shall meet at least one of the following criteria:

1. [A property's] character, interest, or value as port of the development, heritage, or cultural characteristics of the city, state or United States;

2. [A property's] location as a place of a significant historic event;

3. [A property's] location within and contribution as an element of an existing or possible future landmark district;

4. [A property's] identification with a person who significantly contributed to the culture and development of the city;

5. [A property's] embodiment of distinguishing characteristics of an architectural style, period, form, or treatment;

6. [A property's] identification as the work of an architect or master builder whose individual efforts have influenced the development of the city or have contributed to the development of a nationally or internationally-recognized style or movement;

7. [A property's] embodiment of elements or architectural design, detail, material, or craftsmanship that represent a significant architectural innovation; or

8. [A property's] location, scale, or other physical characteristics representing an established and familiar visual feature or a neighborhood, a district, the community, or the city."

4.0 ASSOCIATED PROPERTY TYPES AND RELATIONSHIP TO DESIGNATION CRITERIA

This context is relevant to a single property – the former buildings and grounds of the Rochester State Hospital in its various iterations between 1877-1982. The campus underwent multiple periods of physical change and was substantially demolished and rebuilt following World War II. As a result of this change over time, the context is associated with two distinct property types, the 19th Century State Hospital Campus and the Post-World War II State Hospital Campus.

Properties eligible for listing on the National Register of Historic Places for their association with this context will have achieved significance between 1877 and 1982 and will demonstrate historic significance under one of more designation criteria in connection with this context. Contributing elements to these properties will have been financed by the State of Minnesota, owned and operated by the Minnesota State Hospital system, and located within the boundaries of the Rochester State Hospital campus at the time they were constructed.

4.1 Late-Nineteenth to Early-Twentieth Century State Hospital Campus

19th Century State Hospital Campuses were developed as therapeutic environments, generally in bucolic settings. Campuses tended to undergo additive construction campaigns over time but were unified by a cohesive design language – typically one of the architectural revival styles popular during the late 19th and early 20th centuries (i.e. Colonial Revival, Tudor Revival, Spanish Revival). The types of individual resources typically present within a single campus include:

- Kirkbride-Plan Central Building and/or
- Cottage-Plan Ward Buildings and a separate Administration Building
- Residential Buildings for Staff
- Formal Designed Landscape Elements on the Medical/Residential Areas of Campus such as lawns, plantings, and pedestrian circulation
- Maintenance and Plant Buildings including Tunnels
- Support Buildings such as Laundry, Kitchen, Canning Building

- Cemetery
- Agricultural Landscape and Agricultural Buildings such as Fields, Barns, Cribs, Machine Sheds
- Linear Transportation Elements such as Railroad Spurs, Service Roads

The Rochester State Hospital Campus also included a Rock Quarry and associated infrastructure, and a system of Storage Caves.

4.2 Post-World War II State Hospital Campus

Following World War II, many State Hospital campuses in Minnesota and throughout the country were expanded, or had buildings replaced. New buildings were designed with the intention of facilitating modern medical practices and were often designed in the International Style. The types of individual resources typically present within a single campus include:

- Specialty Psychiatric Hospital Buildings including
    - Clinical Buildings
    - Surgery Centers
    - Occupational Therapy Buildings
    - Specialized Treatment Units or Wards
- Administrative/Reception Buildings
- Maintenance and Plant Buildings including Tunnels
- Long-Term Residential Buildings for Patients
- Religious Centers
- Gymnasiums
- Properties may also retain elements of the Late-nineteenth to early-twentieth century State Hospital Campus
- Service Roads, Surface Parking Lots

4.3 Associated Properties' Relationship to the National Register of Historic Places Criteria

In order for a property to be considered eligible for the NRHP, it must have obtained significance under one of the National Register Criteria for Evaluation. The following section provides suggestions on how properties associated with this context might be evaluated for significance under the criteria. The term "subject property" is used to refer to properties associated with the context. For additional information, see the National Register Bulletin *How to Apply the National Register Criteria for Evaluation.*

Criterion A: Association with Significant Events

To be considered eligible for the NRHP under Criterion A, subject properties must be "associated with events that have made a significant contribution to the broad patterns of our history." These events include:

- A specific event marking an important moment in American prehistory or history.
- A pattern of events or a historic trend that made a significant contribution to the development of a community, a State, or the nation.

Some historic events and trends identified in this context include:

- The development of mental health care philosophies and practices at the national and/or state levels during the 19th and 20th centuries.
- The development and operation of a state-run mental health care hospital system in Minnesota and/or Rochester during the 19th and 20th centuries.

These events and trends are linked to several Areas of Significance defined by the National Park Service in the National Register Bulletin *How to Complete the National Register Registration Form*. These include:

- **Health/Medicine:** "the care of the sick, disabled, and handicapped; the promotion of health and hygiene"
- **Politics/Government:** "the enactment and administration of laws by which a nation, State, or other political jurisdiction is governed; activities related to the political process"
- **Social History:** "the history of efforts to promote the welfare of society; the history of society and the lifeways of its social groups"

The period of significance for a subject property evaluated under Criterion A should reflect the time period during which the property achieved significance. This would likely be a multi-year time period. The level of significance will likely be local, though it is possible that the property is the best representation of a particular trend at the state or national level. A property evaluated for significance under Criterion A under this context will include multiple built elements and fall into the historic property category of District. A property will retain sufficient historic integrity at a District level to represent its history from its period of significance.

Criterion B: Association with Significant Persons

To be considered eligible for the NRHP under Criterion B, properties must be "associated with the lives of persons significant in our past." A significant individual is one:

- Whose activities are demonstrably important within a local, State, or national historic context.

To be significant for association with an individual, a subject property must have been associated with the individual during the time when he or she achieved significance, and the property must be the best illustration of that individual's achievements. The individual must have directly influenced the conception and/or development of the property or have lived in the property while making their contributions to their respective fields. The length of association with the individual in comparison with other associated properties should also be considered.

Properties identified as the best representation of an individual's contributions linked to several Areas of Significance defined by the National Park Service in the National Register Bulletin *How to Complete the National Register Registration Form*. These include:

- **Health/Medicine:** "the care of the sick, disabled, and handicapped; the promotion of health and hygiene"
- **Politics/Government:** "the enactment and administration of laws by which a nation, State, or other political jurisdiction is governed; activities related to the political process"
- **Social History:** "the history of efforts to promote the welfare of society; the history of society and the lifeways of its social groups"

The period of significance for a property evaluated under Criterion B should reflect the time period during which the individual achieved significance and was associated with the property. The area of significance would likely be local, although properties associated with individuals with national or international reputations might demonstrate significance at the state or national level. Properties significant for association with notable architects or contractors should be considered

under Criterion C. A property evaluated for significance under Criterion B under this context may include multiple built elements and fall into the historic property category of District, or a single built element and fall into the historic property category of Building. A property will retain sufficient historic integrity to represent its history from its period of significance.

Criterion C: Design/Construction

To be considered eligible for the NRHP under Criterion C, properties must "embody the distinctive characteristics of a type, period, or method of construction, or…represent the work of a master, or…possess high artistic values, or…represent a significant and distinguishable entity whose components may lack individual distinction." Properties that represent a type, period, or method of construction are those that illustrate, through distinctive features, a particular architectural style or construction method. They might illustrate "the pattern of features common to a particular class of resources, the individuality or variation of features that occurs within the class, the evolution of that class, or the transition between classes of resources."

Properties may be linked to several Areas of Significance defined by the National Park Service in the National Register Bulletin *How to Complete the National Register Registration Form*. These include:

Engineering: "the practical application of scientific principles to design, construct, and operate equipment, machinery, and structures to serve human needs"

Architecture: "the practical art of designing and constructing buildings and structures to serve human needs."

For subject properties to be considered eligible under Criterion C for association with this context, they must exemplify design trends, methods of construction, or a class of resources specifically related to mental health care and/or state hospitals. Properties that appear representative of architectural styles (i.e. International Style, Gothic Revival Style) or the work of a master (i.e., a notable architect, engineer, or contractor), or that possess high artistic value, should be evaluated outside the parameters of this context.

The period of significance for a property evaluated under Criterion C will align with the property's date of construction. The level of significance will likely be local, though it is possible that the property is the best representation of a design trend or class of resources at the state or national level. he level of significance would likely be local. A property evaluated for significance under Criterion C under this context could include multiple built elements and fall into the historic property category of District or include a single built element and fall into the historic property

category of Building, or Structure. A property will retain sufficient historic integrity to represent its history from its period of significance.

Criterion D: Information Potential

To be considered eligible under Criterion D, properties must "have yielded, or may be likely to yield, information important in prehistory or history." Subject properties underwent multiple phases of demolition and construction over time and also included agricultural lands and a quarry. It is possible that a property may retain information important to history and related to this context.

Criterion Consideration D: Cemeteries

A cemetery that is eligible for listing in the NRHP as a contributing element of a historic district does not need to meet Criterion Consideration D.

In order for a cemetery to be individually eligible under this context, it must meet one of the following metrics:

- Association with historic events including specific important events or general events that illustrate broad patterns of history.
- If it has the potential to yield information important to history and that information is not available in other extant documentary evidence.

Criterion Consideration G: The Recent Past

The temporal period of this context study ends in 1982, less than 50 years ago as of the writing of this document. If the majority of a property's period of significance is over 50 years old, the property meets Criterion Consideration G for continued use.

4.4 Associated Properties' Relationship to the City of Rochester Local Designation Criteria

1. [A property's] character, interest, or value as port of the development, heritage, or cultural characteristics of the city, state or United States

2. [A property's] location as a place of a significant historic event

Properties which meet National Register Criterion A (see above) will likely also be significant under local Criteria 1 and/or 2.

3. [A property's] location within and contribution as an element of an existing or possible future landmark district

None of the property types associated with this context are currently located within an established Landmark District. If a property related to this context were designated as a Landmark District, contributing elements should be determined based on their association with the period and criteria of significance for the Landmark District.

4. [A property's] identification with a person who significantly contributed to the culture and development of the city.

Properties which meet National Register Criterion B (see above) will likely also be significant under local Criterion 4.

5. [A property's] embodiment of distinguishing characteristics of an architectural style, period, form, or treatment

6. [A property's] identification as the work of an architect or master builder whose individual efforts have influenced the development of the city or have contributed to the development of a nationally or internationally-recognized style or movement

7. [A property's] embodiment of elements or architectural design, detail, material, or craftsmanship that represent a significant architectural innovation

Properties which meet National Register Criterion C (see above) will likely also be significant under local Criteria 5, and/or 6, and/or 7.

8. [A property's] location, scale, or other physical characteristics representing an established and familiar visual feature or a neighborhood, a district, the community, or the city.

Local Criterion 8 is not directly analogous to any of the National Register Criteria. City of Rochester Staff, the City of Rochester Heritage Preservation Commission, and the public will be best positioned to assess whether or not properties related to this context constitute established and familiar visual features of the area.

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