Redevelopment of the Centre for Addiction and Mental Health: Do Images Speak Louder Than Words?

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Abstract

Since the advent of modern medicine and the isolation of "disease of the mind" (Prichard, 1837), specialized institutions for psychiatric care have sought to aid in treating such debilitating conditions, often with an eye to the therapeutic benefits of a specific site, its design, physical form and environs beyond. Recent literature suggests prioritizing flexible, therapeutically minded design, which includes normalization through community integration. Though architecture that can promote psychosocial wellbeing has been studied extensively in the modern age, the civic planning of healthcare facilities as part of the texture of an urban environment and its private interests has seen limited scrutiny. In light of past focus on therapeutically minded architectural determinism, the physical environment, and its limitations as a treatment, planners should consider the value of a focus on vulnerable stakeholder empowerment over conceptualizations of therapeutic design. This paper highlights the ongoing historical legacy of top-down decision making for healthcare facilities. The way in which real estate and design imperatives obfuscate the need for human compassion through technocracy is a critical issue for planning to face up to. Realizing its limited scope in affecting behavior and instead its potentially significant role in empowering commonly ignored stakeholders is critical for planning to contribute towards the formation of a decision making environment that values justice and pursues commonly shared prosperity.

This paper constitutes a critical analysis of the redevelopment of the Centre for Addiction and Mental Health (CAMH) on Queen Street (in Toronto) in light of the earliest history of the site's planning and use as an asylum. It seeks to assess whether normalizing and deinstitutionalizing psychiatric campuses and their clients through a focus on site design has provided developers with a *carte blanche* in terms of inserting their private residential and commercial projects into the psychiatric milieu. My research uncovers and demonstrates the ways in which a focus on site design and broad aspirational visions obfuscate planning's communicative role, and weaken its potential for advocacy through an examination of the redevelopment of CAMH's Queen Street psychiatric facility.

Foreword

During my time in York's Faculty of Environmental Studies Masters in Planning program, I have had the great privilege to explore environmental design through many different lenses presented by my peers, faculty, and the literature they have recommended to me. I wanted to examine an important subject that has a significant impact on regular everyday people's lives and so I was drawn towards planning for healthcare facilities. With an aging population, increasing isolation, alienation, and the commonality of psychologically abusive corporate control, I decided that my major paper ought to focus on mental health facilities.

Through this study of CAMH Queen Street's physical transformations and attitudes surrounding it, I have achieved my learning objectives. By placing the redevelopment in the context of the original 1850 John Howard asylum design, replacing moral treatment with recovery as a guiding theme, I have exposed the limitations of planning for pursuing social and environmental justice. A focus on supportive design and "good planning" principles may in fact obfuscate the provision of a platform for vulnerable stakeholders. Speaking with redevelopment project managers with development backgrounds helped me learn about the importance of effective communication in building consensus and creating just spaces both physically and in the abstract.

My own experiences with such places have indicated that they can be a great help but they are also a great hindrance to many of their users and victims. While design and planning are a small part of what makes mental health treatment useful or abusive, any small improvement or lesson is critical when people's lives are at stake. Planning ought to look at which silenced stakeholders suffer from decision makers' ignorance in all planning decisions and attempt to provide whatever research or platform may empower such stakeholders.

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Introduction

This paper constitutes a critical analysis of the redevelopment of the Centre for Addiction and Mental Health (CAMH) located on Queen Street (in Toronto) in light of the earliest history of the site's planning and use as an asylum. My research seeks to assess whether normalizing and deinstitutionalizing psychiatric campuses and their clients through a focus on design has provided developers with *carte blanche* in terms of inserting their private residential and commercial projects into the psychiatric milieu. My research uncovers the ways in which a focus on site design and broad aspirational visions obfuscate planning's communicative role, and, I argue, weaken its potential for advocacy in the redevelopment of CAMH's Queen Street psychiatric facility.

Mental health consumers not only present vastly different symptoms, but they are also a group of vastly different people with different identities who seek different types of treatment. Grewal (2014, p. 8-9) in their critique of transcultural psychiatry reminds us that psychiatry was born in the colonial era and is thus "tied to racialized discourses of non-European peoples from its very inception." The physiological reductionist perspective that was later brought by the advent of "miracle" drugs for undesired psychiatric symptoms in the mid-20th century reinforced a drive towards universal solutions that do not respect or celebrate our unique human identities. It is important to understand the challenging and sometimes miserable history of psychiatry to understand the importance and difficulty of designing well for people of all identities.

Yellow Bird (2001, p. 4) in their grim account of the medicalization and incarceration of First Nations in such places as the Hiawatha Insane Asylum for Indians reminds us that psychiatric medicalization and their requisite facilities and labour have been used as "pork-barrel project(s)." Mental health facilities create a development imperative that may preclude any sense of medical duty or even humane treatment of other people. Racialization continues to play a role in shaping our cities and the way different neighbourhoods and communities interact with each other and with the state (Teelucksingh, 2007). With development pressures continuing to play a role in the dispensation and design of psychiatric hospital campuses, this racialization can have disharmonious implications for patient centred care and supportive design.

Rachel Gorman's (2013) essay "Mad Nation" in *Mad Matters* discusses how racialization, among other labels of difference, can continue to be used to unnecessarily and violently impose psychiatric care against people of colour, queer people, and people with

disabilities. In some ways, recognizing these unique identities has "extended the reach of psychiatric hospitals into corners of the community they could not access in the past" in order to increase their ability to bid "for project-based health care dollars" (Gorman, 2013, p. 279-280). Hospitals ought to be designed according to the unique needs of a pluralistic population but it is important to remember that medicine is an industry like any other in that it may serve a beneficial purpose, but ultimately serves the wealth accumulation imperative. I believe this will be important to sensitively recognize the vulnerable mental health consumer population as a diverse group of individuals rather than an amorphous stakeholder as developers or practitioners may be seen with their own streamlined focuses. Geoffrey Reaume (2002) further highlights the progressive individualization of treatment and mental health services clients' identities in his article "Lunatic to Patient to Person*".* More importantly, Reaume (2002) shows how clients themselves, through organizing, helped to create a psychiatric healing environment that respects people as individuals with aspirations and identities not solely shaped by mental health challenges. Initially psychiatric consumers were granted a measure of respect by practitioners in order to increase the legitimacy of their profession: they were treating patients, not "nuts". In recounting the birth of the group We Are Not Alone at Rockland State Hospital in New York, Reaume (2002, p. 412-413) shows us how the medical establishment has resented patient organizing and sought to control and form it. Since then, mental health consumers have increasingly sought to organize and empower themselves but it continues to be important for scholars of Mad studies to understand the way practitioners may shape dialogues, studies, and their outcomes to serve practitioner empowerment at the expense of mental health services clients' empowerment.

Stigma and the Urban Geography of Psychiatric Services

According to the World Health Organization (2008), mental illness constitutes one of the leading causes of disability globally. With Infrastructure Ontario (2015) seeking to spend millions of dollars to redevelop the province's aging mental health facilities according to new scientific evidence and changing perceptions of effective mental health treatment it is essential that these moneys be well spent with attention to the role of planners in pursuing and advocating for a just process and thereby improved consumer/survivor relations, patient care, and treatment outcomes. Advances in disability studies prompted by the activism of mental health consumers/survivors

and their allies have made clear the transactional nature of mental health diagnoses and self-assessments. By focusing on consumer/survivor voices and bringing light to interlocking modes of oppression that complicate and thereby strengthen stigmatism, a critical perspective rooted in urban studies can provide insights that form the basis for improved psychiatric facility planning.

Stigma reduces self-esteem and social opportunities while also robbing mental health consumers/survivors of the opportunity to be involved in administering communities intended for their treatment. Stigma can be defined as "any attribute, trait or disorder that marks an individual as being unacceptably different from the 'normal' people with whom he or she routinely interacts, and that elicits some form of community sanction" (Corrigan, 2004, p. 614). In a study of housing preferences of consumers/survivors, a chief concern reported was "stigma when dealing with public sector bureaucracies, healthcare professionals, private landlords, and employment situations" (Forchuck, Nelson and Hall, 2006, p. 45). The systematic and technocratic world of planning and its routine dealings with what it envisions as homogenous stakeholders, flattens understandings of multiple subjectivities and relative power and therefore reduces the ability of planning to account for the effects of stigmatism.

The Mad Pride movement started in part as a protest against stigmatization at the hands of medical practitioners that reached out beyond their institutions into the city to diagnose and treat or imprison consumers/survivors. After WWII, advances in medicine and social change in advanced western countries encouraged a "new wave of therapeutic discourse" that allowed for the collapse of the repressive asylum system (Menzies, LeFrançois and Reaume, 2013, p. 3-4). Psychiatry's retreat from a focus on incarceration allowed it to spread tentacles of psychiatric categorization into more lives through the benign sounding "community mental health movement" (Menzies, LeFrançois and Reaume, 2013, p. 3-4; Shimrat, 2013, p. 144-145). As Menzies, LeFrançois and Reaume (2013, p. 4) put it, "[n]o sphere of late 20th-century life fell beyond the mandate of mental medicine to refashion self and civilization, and to make us all happy, actualized, docile, and safe."

Psychiatry's message of altruistic benevolence however was well refuted by a diversity of novelists such as Ken Kesey, psychiatrists such as Thomas Szasz, and those who had been psychiatrically categorized and who later self-identified under a range of descriptors such as survivors, Mad people, consumers, and service-users (Menzies, LeFrançois and Reaume, 2013,

p. 6; Burstow, 2013, p. 83). Grassroots organizing resulted in the growth of a number of groups such as the Mental Patients Association which evolved into a "major force for human rights causes, housing and social support, and progressive democratic action" (Menzies, LeFrançois and Reaume, 2013, p. 6; Beckman and Davis, 2013, pp. 50-54). As a result of this empowerment, survivors/consumers have spoken out about their experiences of oppression through psychiatry which has helped to establish Mad theory as an indispensable component of critical disability studies.

By understanding mental health diagnoses and self-assessments as a social phenomenon produced by cultural constructs rather than as individual deficits or internal weaknesses, stigma can be reduced and multiple subjectivities and relative power realized. Marino (2014, p. 8) explains that "[f]eminist intersectionality frameworks allow for exploration of multiple identities and the interconnectedness of various systems of oppression." Intersectionality indicates that the processes of psychiatric stigmatization are intimately connected to other processes of oppression that focus on sex, sexuality, gender, race, etc.

The recent shooting death of Andrew Loku by police, and the circumspect and limited internal investigation, crystalize the synergistic stigma experienced by non-white people who have been psychiatrically categorized as unwell. Loku had been living in a residence shared by people who held in common the experience of psychiatric categorization and when police were called about a dispute, police behavior shows evidence of prejudice. As witnesses testified to the internal investigation, the dispute had been resolved prior to police arrival. Witnesses claim police immediately assumed a threatening stance believing that the dispute involving a black man was ongoing. It can be assumed from their behavior that police considered him unpredictable not only due to stigma regarding skin colour, but also his living in a place known to house consumers/survivors. Compounding this damning eyewitness testimony, the executive director of the Canadian Mental Health Association has gone public in reporting that they too shared evidence with the internal investigation showing that even they had categorized Loku as well only hours before (Da Silva, 2016). It would therefore appear that Loku was not only targeted as a recipient of violent "de-escalation" because of his skin colour, but also because of the responding police's knowledge of Loku's and his fellow tenants' psychiatric categorization.

We can additionally hypothesize that this identification gave cause to discount eyewitness testimony and thusly incited the Canadian Mental Health Association to action.

Navigating these interwoven modes of oppression and internalizing them within disability studies has been difficult which represents a challenge for planners who already struggle to act on, let alone realize, the uneven power of various stakeholders in planning's contested terrain. Tam (2013, p. 285) notes that there are varying effects of the political economy of "madness" on different populations. As proof of this point, Shimrat (2013, pp. 150-154) draws upon notes accumulated in a community mental health clinic to find particular forms of oppression affecting groups such as elderly women, children, adolescents, and Aboriginal Canadians. Gorman (2013, p. 271) explains that there has been a dearth of work in the area to the detriment of non-white middle class communities. Considering the "matrices of social work, psychiatric, and juridical surveillance" in communities of people of colour, Gorman (2013, p. 272) asks, "How then to decenter whiteness… if people of colour cannot afford to take on the identity?"

One such way may be a greater emphasis in the Mad movement on drawing out stories of incarceration and oppression through psychiatry experienced by people who are not white and middle class. Many consumers/survivors identifying under a number of banners have shared their stories of psychiatric oppression, stigma, and abuse which have provided the raw material that unites Mad people and proves their shared experiences as a component of a pattern of oppression. Stigma and poverty are common experiences but empowerment can reduce stigma and improve recovery as demonstrated in a qualitative study with 59 consumer/survivor participants undertaken by Nelson, Lord and Ochocka (2001). Understanding the trauma and alienation experienced by consumers/survivors, and the unique political economy of madness as applied to already stigmatized identities, is critical for planning to realize the importance of respectful partnership with survivors/consumers. Uncovering the historical reason for the skepticism and even hostility that consumers/survivors may hold against not only the medical administration but also the bureaucracy is important to creating the conditions for fair partnership.

Historical reasons particularly prescient to planning can be found in study of the changing geography of mental health over time. Since the advent of modern medicine and the

isolation of "disease of the mind" specialized institutions for psychiatric care have sought to aid in treating such debilitating conditions, often with an eye to the therapeutic benefits of a specific site, its design, physical form and environs beyond (Prichard, 1837). Historically, prompted largely by stigma, people experiencing distress or considered undesirable or dangerous, were moved out of the city, out of sight to rural or ex-urban institutions (Philo, 1997, p. 259). Geographers have actually discovered a direct correlation between the remoteness of historical asylums and the number of people incarcerated (Philo, 1995, p. 152). Not all inmates however were dissatisfied with their living conditions as a result of removal from general society. Exposure to gardens, forests, and fields as a moral therapy was also cited as a driver of these geographies of incarceration. Some inmates are recorded as enjoying elements of the asylums they lived in such as outdoor amenities (Reaume, 2010). Ultimately these asylums demonstrated a design tension between comfortable, relaxing aesthetics and surveillance and securitization (Parr, Philo and Burns, 2003, p. 345). Reaume's (2010) analysis of patient files from the Toronto Hospital for the Insane, between 1870 and 1940, demonstrates that within the facility and among patients, class superiority and resulting relative power, may have allowed some inmates to enjoy more freedom and amenities during their incarceration, as in general society.

By moving away from the asylum model and into the community while also claiming to listen to consumers/survivors, the medical establishment has been able to justify the individualization of mental health support sought by conservatives who wish to retreat from funding mental health clinics and consumer/survivor groups. Everett's (1998, p. 80-81) look at Ontario's shuttering of psychiatric hospitals demonstrates that consumers/survivors were exploited by policymakers and planners when their offer of strategic partnership was used to legitimize defunding of helpful mental health supports. Everett (1998, p. 90) comes to the conclusion that consumers/survivors may actually make more efficient use of what little funding remains in their own self-help and support systems. Indeed, other researchers have polled consumers/survivors and found that geographies of informal settings such as soup kitchens and lunch counters may contribute more greatly to the comfort or recovery of consumers/survivors than centralized comprehensive psychiatric hospitals (Tomes, 2006, p. 725).

As a result of these policy changes, contemporary geographies of mental health have generally shifted from large closed concentrated institutions to a "maze" of small scale facilities

"dispersed across the space of regular neighbourhood communities" (Philo, 2005, p. 588). While this has had positive effects of bringing an often hidden cohort into broader society, it has provided the institution of psychiatry with greater leverage for imposing psychiatric categorization "into corners of the community they could not access in the past" (Gorman, 2013, p. 279). Additionally, a focus on property values and moral purity has compelled a NIMBY movement that sees mental health services as noxious neighbours that will lower property values and bring a threat of violence (Boeckh, Dear and Taylor, 1980; Smith and Hanham, 1981). These factors, combined with defunding have made services less useful for consumers/survivors as small scale facilities tend to cluster into "psychiatric ghettoes" and reduce the opportunity for involvement in broader civic life which is repeatedly cited as not only a component of recovery but simply a component of an enjoyable life (Milligan, 1996).

Complicating the spatiality of mental health services are findings that being close to urban hospitals in the neoliberal city is out of reach for many consumers/survivors. Criticisms of Florida's creative city as neoliberal smokescreen, have demonstrated the "exclusionary production" of urban landscapes (Leslie and Catungal, 2012, p. 118-119). This applies well to the notion of marginalized static psychiatric ghettoes removed from a jovial progressive public with its continuing technological advancements and increasingly enriched public spaces. Geographies of gentrification exclude many consumers/survivors from living near central urban psychiatric hospitals such as the Centre for Addiction and Mental Health (CAMH) on Queen Street West in Toronto. In a review of housing preferences of psychiatric consumers/survivors, stigma was the chief concern reported with distance from service providers as a secondary key concern. Being close to support centers was important to many who were interviewed though "low income housing is not centrally located" (Forchuck, Nelson and Hall, 2006, p. 48). Compounding this point, others said "If you spend five years on the list for geared-to-income housing, you may as well say it doesn't exist" (Forchuck, Nelson and Hall, 2006, p. 46).

Planners would do well to listen to comments like these and consider how they can avoid legitimizing enduring geographies of stigma. The political economy of how madness is applied to various groups, many of which are already stigmatized, is an undertheorized aspect of the Mad movement and so planners must tread with sensitivity if they are to listen well. Understanding the many unique experiences and variations of stigma is essential to creating a respectful

partnership that can assist consumers/survivors in designing and building infrastructure that puts their needs before those of the institution of psychiatry.

Urban Planning and Mental Health Facilities

The ethical responsibilities of effective planning for psychiatric hospital campuses are best illuminated through conceptions of social justice as theorized by urbanists such as David Harvey (2009), Paul Davidoff (1964), and Susan Fainstein (2000, 2009). These scholars all describe how the planning process and outcomes are largely dictated by power differentials among urban stakeholders. Their theories of social justice help to illuminate the role and responsibility of planning in prioritizing the views and voices of survivors and clients in the planning and design of psychiatric hospital campuses.

Harvey's (2009, p. 98) conception of social justice is concerned with "a just distribution, justly arrived at" for urban resources. For Harvey, medicine is an essential resource after other basics such as food and shelter, and since he is foremost concerned with spatial distribution of urban political focus and investment, his outlook applies well to the specialized environment in and around psychiatric facilities. The increasingly popular campus style of psychiatric facilities in Ontario, housing not only explicitly public medical facilities but also commercial ventures, and often created through public-private partnerships are ripe for a planning analysis that draws on social justice.

Davidoff's (1964) advocacy planning theory and practice is chiefly concerned with the politicization of planning in order that it serve a plurality of interests rather than operate as a tool of the dominant elite and its narrative through technocratic legitimization. According to Davidoff (1964), planners should provide a plurality of plans representing the needs of diverse groups that are generally overlooked in the planning process. Krumholz (1994) experiences with advocacy planning and his perspective on its potential to "move the center" indicate that planning could play a realistic role in road mapping ethical and effective psychiatric hospital design. It is important to acknowledge that advocacy planning does not preclude the involvement of stakeholders but ought to seek to empower vulnerable stakeholders and improve their ability to contribute to planning decisions.

Davidoff's (1964) conception of advocacy planning provides planners with a lens for understanding their role in promoting attention to the supportive design needs of vulnerable populations who are often at a disadvantage in the highly contested realm of planning decisions. The concept has been generally applied to racialized populations although some medicalized groups such as Alzheimer's patients have also seen focus from planning academics and practitioners (Blackman, 2003; Cohen, 1993; Passini et al., 1998; Teelucksingh, 2003). Mental health services clients have been largely ignored in planning literature and it is difficult to understand why with the growing body of research on how the built environment and community integration affect mental health treatment outcomes.

This lack of attention leads us to question what systemic barriers may prevent planning from advocating for therapeutic environments for mental health services clients and how these barriers can be overcome. David Harvey (2009) and Susan Fainstein (2000, 2009) show how the spatial distribution and configuration of urban resources are highly contested and affected by social processes. Fainstein's (2000, 2009) works on planning theory incorporates Habermasian communicative theory to describe how social justice in urban planning, despite open participatory and advocative elements, remains greatly affected by the uneven positionality of stakeholders. Like Harvey (2009), she is concerned with how the pursuit of economic growth among private entities often triumphs over the pursuit of wider social benefits. Her focus on communicative theory provides a backbone for an investigation of the intersection of planning and survivor and client advocacy which is based on the experiences and voices of survivors and clients themselves. In what ways might supportive and patient centered design contradict the aims of other stakeholders involved in planning decisions for mental health facility production and what policies triumph as a result? Can design solutions mediate these differing needs between stakeholders and among mental health services clients themselves or do they simply obfuscate the need for planning to actively listen?

Centre for Addiction and Mental Health Redevelopment Discourses

Urban planning plays a key role in the configuration, placement, and neighbourhood design of healthcare facilities so it is important to understand how planning currently promotes the design and integration of therapeutic environments with the larger city and what potential exists for

furthering this practice. There are a number of reasons for planners to concern themselves with the planning of campus style mental health facilities and their stitching together with surrounding neighbourhoods. Their spatial footprint alone suggests the necessary inclusion of planning specialists but more importantly, planners need to consider how their decisions could affect mental health services clients' health outcomes according to emerging criteria for therapeutic design, especially as it relates to the normalization of psychiatric treatment. While individual components of physical design and neighbourhood setting such as colours and textures, types of sound and noise, access to outdoor natural settings, lighting, and integration with the larger community have been isolated as playing a role in effective healing, it is lesser known how planning can systematically provide an approach that is cognizant of these effects. It is self-evident that normalization cannot happen within a specialized site alone and that the way the site, social community, and built environment within it relate to corresponding factors in the surrounding environment have an impact on normalization and therefore treatment effectiveness.

Newer facilities tend to speak of physical and social integration with the surrounding community as a goal in their visioning statements. Recent iterations of psychiatric facilities such CAMH Queen Street in Toronto are commonly known to have internalized these developments with specialized facilities for effective management and treatment that still have a focus on normalizing qualities and fluid relationships with their surrounding environments. The facility is anecdotally considered a design and planning success story though formal research on effectiveness post-occupancy is limited.

The site on which CAMH Queen Street now sits opened as The Provincial Lunatic Asylum in 1850. The name changed many times over the years according to society's changing views of consumers of mental health services and the site was whittled down from 50 acres to 27 today as green buffers gave way to development. The hospital was run solely by the province until the 1990s when provincial restructuring led to the creation of CAMH.

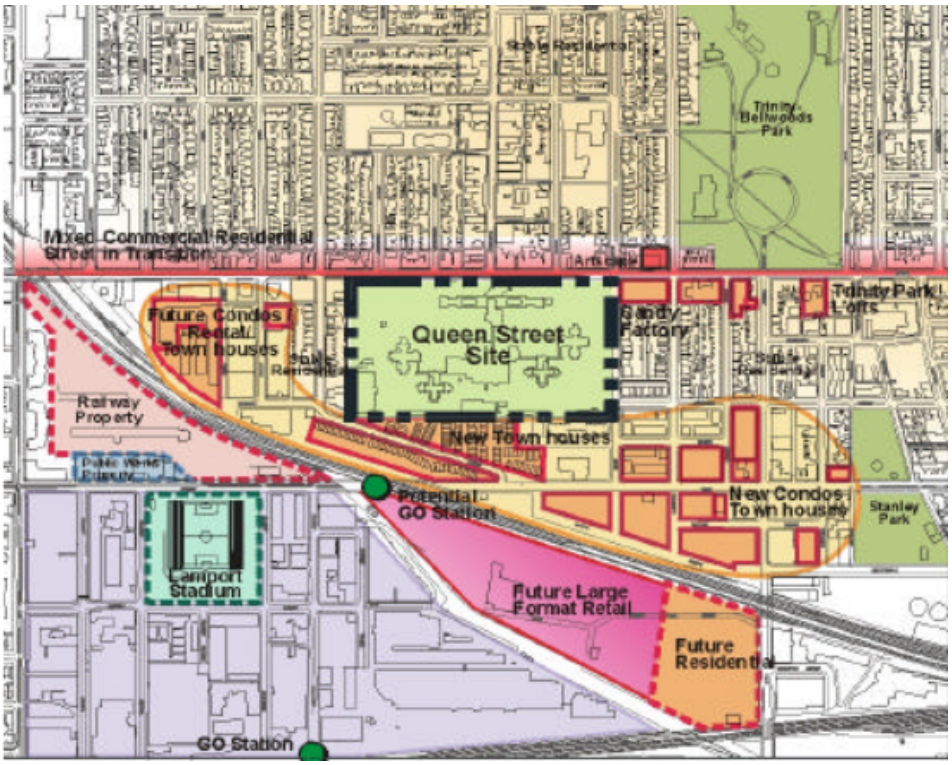

Figure 1: CAMH Neighbourhood Context
(Source: Urban Strategies Inc., 2002).

Though there have been mental health facilities on the site since 1850, CAMH's modern forms are differentiated by their unique valuations of normalizing qualities in terms of their physical and social integration with surrounding urban fabric, exterior design, and their internal uses. A gentrifying neighbourhood in transition, the area has experienced densification to the south, west, and the east to a lesser extent, with new residential developments (fig. 1). It may be worth noting that CAMH Queen Street's master plan was created by a Toronto firm, Urban Strategies, which works on diverse projects including several university campuses and downtown revitalization. The 2007 guidelines for the development of non-CAMH lands suggest that "[p]rofessionals on their way to the office will rub elbows with people on their way to a support group session." CAMH Queen Street has retained small patches of green space while their master plan designates half of the 27 acre site to non-CAMH uses such as commercial and residential. The initial site layout (fig. 2) and respective phasing diagrams (figs. 3, 4, 5) indicate a substantial loss of green space to physical structures for non-CAMH uses. The full buildout (fig. 6) manifests physical integration of CAMH and non-CAMH uses and the opening of the site

Figure 2: Original Layout of CAMH site
(Source: Liang, A. and C3 Community Care Consortium, 2006).

Figure 3: Phase 1 of proposed redevelopment
(Source: Liang, A. and C3 Community Care Consortium, 2006).

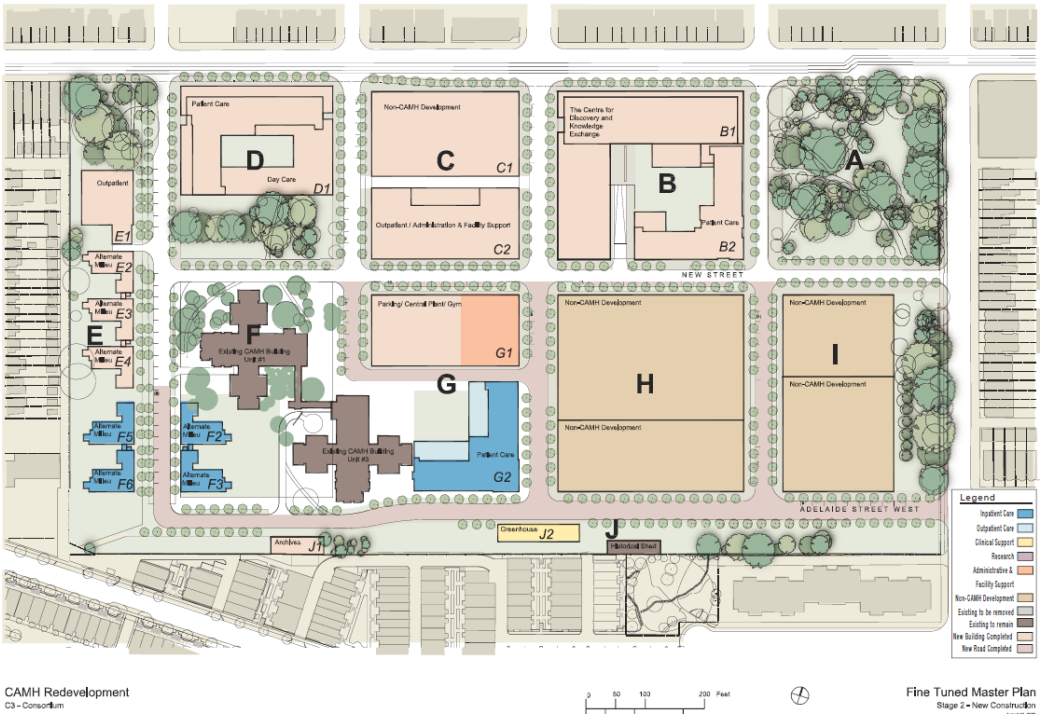

Figure 4: Phase 2 of proposed redevelopment
(Source: Liang, A. and C3 Community Care Consortium, 2006).

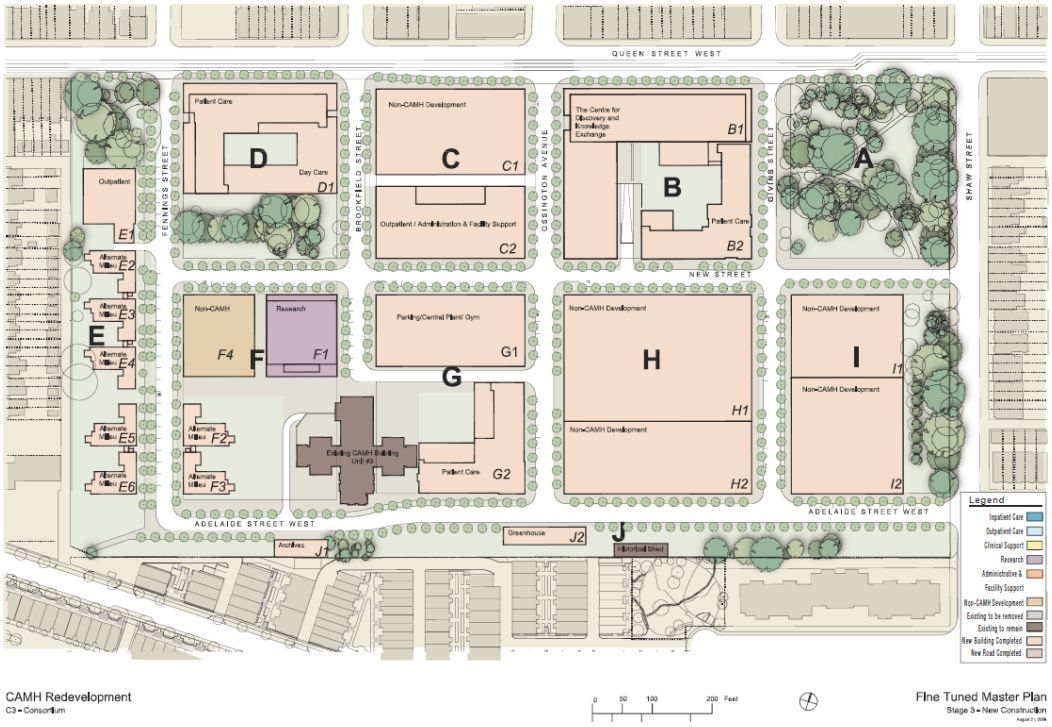

Figure 5: Phase 3 of proposed redevelopment
(Source: Liang, A. and C3 Community Care Consortium, 2006).

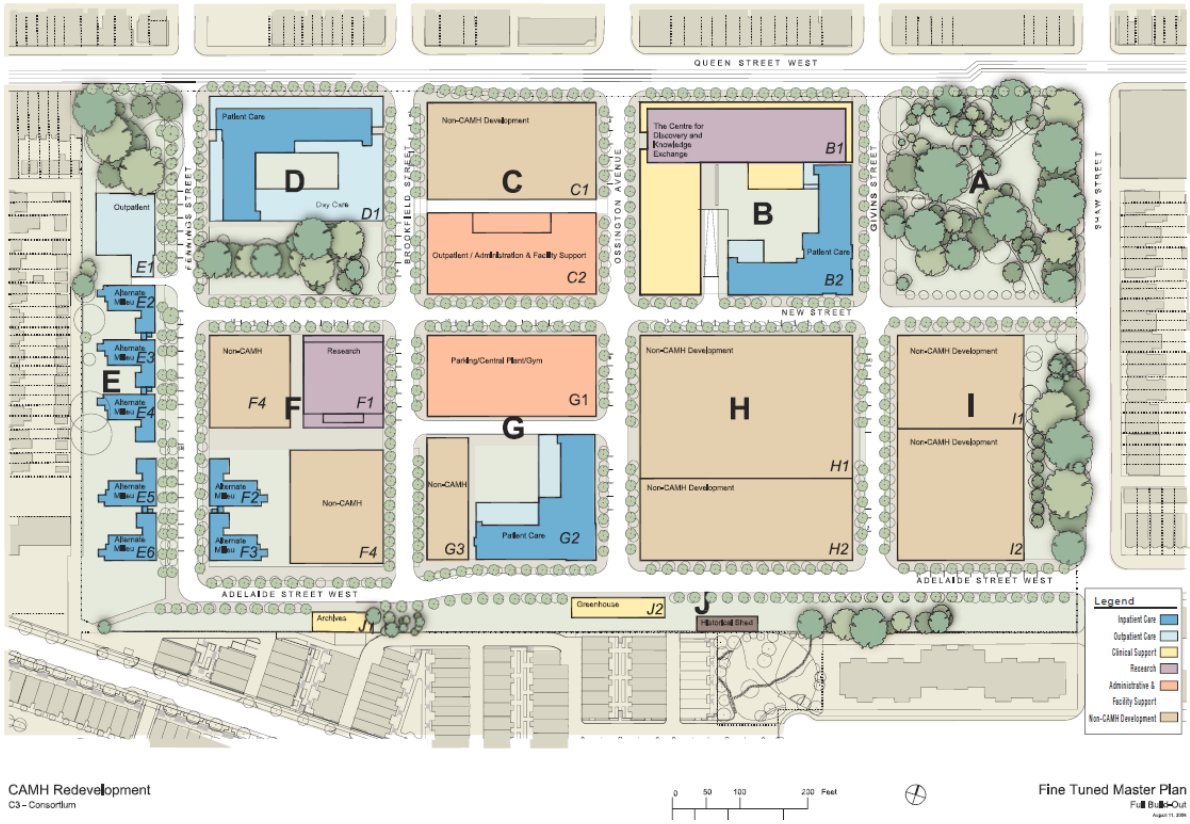

Figure 6: Full Buildout of CAMH site
(Source: Liang, A. and C3 Community Care Consortium, 2006).

to the city's roadways. One wonders if the only difference between past severances and this repurposing is the way it is presented. Are non-CAMH uses truly integrated with normalizing purpose that is complementary to CAMH's mission, supportive design, and patient centred care?

Popular Notions of the CAMH Redevelopment

"CAMH is transforming lives." With this curative silver bullet slogan, CAMH has amalgamated service delivery for addictions and mental health with grand new buildings and new residential and commercial neighbours where it was once the sole tenant. Most recently known as the Queen Street Mental Health Centre, the new CAMH Queen Street has adopted this trademarked tagline to suggest that a majestic physical renewal and opening up of the hospital site to private residences, commercial research, and retail along with new connective roadways, will allow for new types of treatments that promise life transforming recoveries for its clients, both voluntary and involuntary. The apparent altruism displayed in CAMH's redevelopment marketing

campaign masks a number of controversies and issues that detractors of the redevelopment project claim run counter to its mandate.

Canadian newsmedia has been largely flattering and ignorant of a number of divergent critical voices since the redevelopment project's inception. However, some substantive criticisms have been raised by activists, survivors and consumers, neighbours, as well as a small number of journalists. They have taken conflicting stances on its private-public funding model, centralization, non-medical uses, and the level of capital investment when the operating budget for therapeutic personnel is shrinking and the wait list for affordable housing increasing.
The narrative CAMH has created for itself sidesteps these criticisms by claiming that the new physical development is of therapeutic purpose because community exposure is central to recovery. Recovery, the new guiding principle of psychiatric health professionals, performs well for marketing and outreach but makes invisible and inconsequential the significant number of survivors and clients who may never recover or who may view recovery as a false panacea. Recovery also ignores the many survivors and clients that are imprisoned against their will. Many outpatients may desire or benefit from compassionate treatment and may require or desire assistance in accessing, affording, and maintaining private residence despite being opposed to a notion of recovery, owing to pride in their unique mental perspective. The standout improvements from clients' and survivors' perspectives actually seem to be very basic and unrelated to the largesse of the redevelopment. Large windows that open and private bathrooms are the main aspects that inpatients are quoted as enjoying (Spurr, 2012). A quick review of survivors' criticisms makes clear that many recognize their unique mental outlook is not expected nor necessarily desired to be cured; what is desired beyond basic livable inpatient settings is access to comfortable, safe housing, and access to compassionate therapeutic human professionals, not a slick centralized hospital campus designed for the use of the larger community (Menzies, LeFrançois and Reaume, 2013). In fact, even CAMH's 2012 (p. 3) internal report *Road to Recovery* states "There are about 10,000 supportive housing units in Ontario… [and] the wait-list in Toronto for low- and medium-level support is more than 5,000 long... Evidence suggests supportive housing for people with mental illness reduces hospital re-admissions, psychiatric symptoms and substance use". If CAMH's stealthy new appearance benefits any patients, it would be outpatients alone that draw any value from the normalization of the hospital.

CAMH's public juxtaposition of physical and personally curative transformation is somewhat surprising based on anecdotal evidence related to the inception of plans for new developments at CAMH Queen Street. The lengthy project has been overseen by two CEOs. From 1998 to 2009 Dr. Paul E. Garfinkel led as the first CEO of the amalgamated Queen Street Mental Health Centre, Donwoods Institute, Addiction Research Foundation, and The Clarke Institute of Psychiatry. Garfinkel was charged with smoothing out the amalgamation under austerity measures pushed by the Harris Conservatives which were unseated in 2002. Doctor Catherin Zaun took the reins in 2009 shortly after construction had begun. Both have given credibility to the redevelopment as therapeutic in nature. However, news articles from 1999 indicate that this was a neoliberal decision based on the need to privatize under the Harris Conservatives. The Harris Conservatives reduced the number of mental health hospitals in Ontario from nine to three (Barber, 1999). When the idea of selling portions of the Queen Street site was first made public, "news of the possible sale came as a surprise to CAMH officials" (Barber, 1999). Only five years later, CAMH officials said that the current buildings and configuration did not allow physicians to "continue in good conscience to practise medicine here" (Milroy, 2004). Despite the renewal and centralization being prompted by an ascetic provincial government focused on reducing healthcare spending, CAMH's leaders have created the narrative that a new physical environment is what survivors and clients have been waiting for, not better access to long term housing, nor compassionate therapists, advocates, and counsellors.

While physical renewal does provide a nod towards respect for survivors and clients, many have viewed it as a prestige pet project for the Ontario government that allows for apparently economy boosting public-private investment. At the 2010 Hats Off To Harry gala of hobnobbing high flying Torontonians, Dr. Zain's companion, Dr. Michael Baker shared with the Globe and Mail staff reporters (2010) "CAMH is rebuilding Queen Street West – that kind of investment is about making the city more attractive. I'd like to hear more about that from [politicians]". It is hard to believe this is being done for the central benefit of patients when even doctors close to the project's leadership describe it as beautification for the city at large and visioning statements display glossy Queen St. W. frontages of glass, steel, and red brick (fig. 7). Dr. Garfinkel (2007) noted that "the existing buildings are unacceptable in the 21st century of health care; they are cramped, undignified, disrespectful of the needs of individuals, and hardly

inspiring of hope". All parties agree that renewal was required, largely because of very basic shortcomings of inpatient quarters, but many parts of the partially completed project and the viewpoints that prompted community participation lead one to question if patients are truly at the centre of the transformation's goals.

Judging from the comments of community members, developers, and urban designers, the transformation has been largely for non-clients, non-survivors, and the community that had stigmatized and scorned the mental health hospital for years. When the idea of redevelopment became public in 1999, John Barber of the Toronto Star stated that "[r]eal or imagined fear of the Centre is behind a new plan to tear down the current buildings and extend Ossington, Adelaide and other streets into the isolated block." Local shopkeepers echoed that idea in a 2007 (Scrivener) interview: "It's great that they're moving the visible portion of the Centre off of Queen." Indeed, the transformation appears to be more about erasing the existence of mental illness and a shameful history of stigmatization and imprisonment in Toronto to assuage guilt about mistreatment and allow for physical revitalization of this one strip that interrupts trendy Queen Street West. Christopher Hume (2011) wrote for The Toronto Star that the Queen Street site upon completion "will have been returned to the city as an entire campus, a whole new neighborhood, a mid-rise development like many others in the city, only nicer, more urban and thoughtful."

The community at large for whom the transformation seems to be intended, have shaped the development in multifarious ways. A grocery store which might be useful to working class residents, clients, and survivors has been eschewed in favour of a preference for restaurants, boutique retail, and art galleries. Visioning and master planning exercises favoured a grocery store and stated that preferential access would be granted for tenants who operated with functions complementary to CAMH's goal of providing opportunities for recovery. So far the only commercial establishment explicitly providing work opportunities is the Out Of This World Café (fig. 8; artist's rendition titles signboard café 999) which is run and operated by CAMH clients and survivors as it had been prior to the redevelopment. Some clients and survivors have expressed frustration and offense at the idea of a minimum wage service job as being uplifting. The Concerned Neighbours of CAMH, made up of local residents and shopkeepers, took CAMH to the Ontario Municipal Board and through mediation, ensured that the redevelopment would not include a grocery store, fast food, a hotel, or a methadone clinic (Brunet, 2004). It is

noteworthy that a methadone clinic will have to be removed from the up and coming neighbourhood when CAMH has stated that centralization and providing a one stop shop were a significant part of the amalgamation.

This centralization is another aspect that has been criticized for making access to treatment more complicated for people who cannot afford to live in Toronto's downtown core. CAMH says that a one-stop shop for mental health patients and survivors is a critical component of the redevelopment, despite being essentially mandated by the Harris Conservatives before the redevelopment project took shape. Contradicting the importance of centralization, CAMH has disbanded its physiotherapy clinic claiming that a $100,000 expense could not be justified by the ~100 patients it served (Boyle and Rogers, 2012).

Developers desires have been more in line with the Concerned Neighbours of CAMH. When it was first announced in 1999 that a redevelopment would commence, reporter John Barber quoted one developer who unsurprisingly was cited anonymously, as saying "my gut feeling is that I would love to do a beautiful low-rise community there". Lo and behold, CAMH has been filling in with low rise condominiums and offices and billed as the "first large-scale 'urban village' mental-health facility in the world (Scrivener, 2007). It is noteworthy that the owners of North York's chic Shops at Don Mills, Cadillac Fairview, have touted their property as 'Toronto's first open air urban village." This marketing tagline is indicative of the role planners and developers have envisioned for CAMH Queen Street, despite CAMH insisting that the development is premised upon promoting client and survivor recovery.

With these lofty commercial goals (and increased condominium development on Queen Street West), it becomes difficult to see the neighbourhood around CAMH remaining as a place that is affordable to live for people who require or desire regular access to mental health treatment. So far, the building at the south west corner of Ossington Avenue and Queen Street which also houses the Out of This World Café is composed largely of affordable rental units but one wonders how long affordability in the neighbourhood will last. Frank Lewinberg (2015), a partner with Urban Strategies, the planning firm which conducted the visioning and master planning for all phases of the redevelopment says in a short video about combating stigmatism, (hosted on CAMH's website) that he would like to see the hospital site become a successful mixed neighbourhood analogous to his past work producing the St. Lawrence Market neighbourhood. It is noteworthy that while this neighbourhood does provide a mix of housing

types and tenures, it is now composed of largely above Toronto market average rental and ownership prices.

Nearby developments have also been having an impact on development. For example, 1030 King Street West is providing $152,000 as part of a section 37 agreement to be applied to one of the last remaining green spaces at what had been a well treed sanctuary in the heart of the city (Yu, 2008). When it was found that the north west corner of the site contained soil contaminated by burned refuse in its past life as a city dump, neighbours of CAMH sided with environmentalists in opposing the removal of 100 year old maple trees (Grewal, 2007). In an area already short on green space, one wonders if these few remaining green spaces, well enjoyed by clients and survivors, will be shaped for the needs of nearby residents and their pets.

Indeed, many clients have taken great enjoyment in the outdoor environment, one of the few places clients and survivors felt any ownership for, but in a paternalistic sign, indicative of their planning attitude, CAMH has forbade the consumption of tobacco in these areas. CAMH has already been roundly criticized for reducing the amount of green space to just 20% of the site's total area, and now clients and survivors are told they cannot even smoke in one of the few parts of the city they have always been welcome. The smoking ban is representative of the larger civic desire for superficial beautification that is absolutely ignorant of the lives and freedoms of clients and survivors. As Dr. Stylianos, a Toronto doctor who opposes such draconian measure, reported to the Toronto Star in 2007, "I don't know of any literature showing an improved health outcome among these individuals as a result of smoking bans… It is still a legal product. There has to be some modicum of respect for the rights of individuals and personal autonomy."

CAMH likes to talk about respect for patients but this kind of ignorance may be representative of the paternalistic attitude that has remained through the redevelopment project. Toronto Star reporter Joe Fiorito (2010) who visited the park to interview CAMH clients and survivors, often a champion of clients and survivors, inadvertently echoed this attitude and revealed the rarity of publicized exposition of critical client and survivor views: "Two guys were talking on the path. One said he was a resident. The other said he came weekly for chapel. The resident said he liked the changes. The chapel man did not."

Figure 7: Rendering of CAMH's Centre for Discovery and Knowledge Exchange

At left is CAMH's Intergenerational Wellness Centre, prior to construction, and facing it, the only remaining significant green space. Facing south-west from Queen St. W. (Source: Liang, A. and C3 Community Care Consortium, 2008).

Figure 8: Rendering of CAMH's Complex Care and Recovery Building

Survivor and client run café at ground, prior to construction. Facing southwest at Queen St. W. (Source: Liang, A. and C3 Community Care Consortium, 2008).

CAMH Visioning and Master Plan

Though there has been a psychiatric treatment facility at the Queen Street site since 1850, its name, mission, and focus have shifted along with public attitudes towards mental health. Asylum gave way to incarceration, and innovations in drug treatment led to a fragmented community support model. These unique characteristics not only provided for different treatment models but also correlated designs position within urban systems and the civic hierarchy.

In 1998, with social services in Ontario slashed and many programs downloaded to local municipalities at the behest of Mike Harris administration, facilities geared towards the care, treatment, or incarceration of those deemed psychiatrically unsound found themselves reeling from cutbacks. Previous governments had already taken advantage of new thinking in mental health treatment that suggested centralized facilities were outdated. Advances in pharmaceuticals allowed them to retreat from spending on housing as a mental health support and fragmented community treatment and drop in centres became the order of the day. With the direction of the Health Services Restructuring Commission, the system would change again as the Clarke Institute of Psychiatry, Donwoods Institute, and Addiction Research Foundation merged with the Queen Street Mental Health Centre at its historic 999 Queen St. West Site, now 1001 Queen St. West and rebranded as CAMH: The Centre for Addiction and Mental Health (C3 Community Care Consortium, 2002).

Despite these changes being brought about by an austere provincial regime, leaders of these facilities sought to turn lemons into lemonade. Initially CAMH oversaw these four separate sites but there were multiple existing issues with each of these fragmented facilities. The Health Services Restructuring Commission found that patient rooms and corridors were smaller than current Ministry of Health standards, washrooms were not typically barrier free, and that deferred maintenance and the poured concrete skeleton of many structures made renovation prohibitively expensive. In agreement with the provincial government, CAMH agreed that the separation of these facilities was inefficient.

In tune with a social shift that recognized that mental health disturbances and addiction were widespread and interconnected, CAMH sought to create a hub for care, promotion, research and education. In seeking a place for such a hub, the CAMH Queen Street site was selected because of its proximity to the downtown core which provided for easier access of clients and

survivors as well as its underutilized suburban campus. Finding the existing built environment inadequate for the diversity of tasks and volume of work, CAMH set out to plan a vibrant new layout and structure in line with current attitudes towards addiction and mental health treatment that sees recovery as a universal goal and reintegration with the larger public as a key component of achieving recovery.

In its strategic assessment, CAMH found that a "rationalization of land holdings was important to optimize care and organizational operations" (C3 Community Care Consortium, 2002). In an era of private public partnerships for investment of public infrastructure, the spacious site, once green in service of the site's stakeholders, was deemed underutilized. With current research showing community integration as a key component of recovery, CAMH felt justified in converting these green spaces into commercial opportunities which through leases, could help fund the redevelopment: "The size of the Queen Street site provides the physical space flexibility to build the kind of facility needed to respond to the newest knowledge about the best treatment and healing environments for people with mental health and addiction problems" (C3 Community Care Consortium, 2002).

From the outset, three main themes were identified for the site's master plan as well as a range of potentially integrated funding models for financing the redevelopment that would not require a politically unattractive one time public or private investment. It was determined that the site should function as a hub where "where client centred care is facilitated through collaboration and interaction between program and services as well as education, research and health promotion" (C3 Community Care Consortium, 2002). The facility would be laid out as an urban village design that would be "integrated with the City to normalize the treatment environment that will help to remove the stigma inherently associated with the Queen Street site" (C3 Community Care Consortium, 2002). Finally, the landscape would be respected with the "creation of an environment of healthy and inviting green spaces for clients, staff and neighbours" (C3 Community Care Consortium, 2002).

CAMH Queen Street's master plan was crafted by George Dark and Frank Lewinberg of the Toronto firm Urban Strategies. It was designed by the C3 Community Care Consortium, composed of three Toronto architectural firms: Kuwabara Payne McKenna Blumberg Architects,

Montgomery Sisam Architects Inc. (specialized in designing mental health and addiction facilities), and Kearns Mancini Architects Inc.

Figure 9: Rendering of Main Entrance with Green Donor Wall
(Source: Liang, A. and C3 Community Care Consortium, 2008).

Figure 10: Rendering of Short Term Stay CAMH Residences and Outpatient Services Building
Residences are at left and outpatient services at right. Foreground inaccurately depicted as park. Facing west across White Squirrel Way, prior to construction. (Source: Liang, A. and C3 Community Care Consortium, 2008).

Figure 11: Rendering of CAMH's Crisis and Critical Care Building
Facing south east across Queen St. W. (Source: Liang, A. and C3 Community Care Consortium, 2008).

CAMH Master Vision

A lengthy "master vision" (Liang and C3 Community Care Consortium, 2007) was created that positioned programming and design goals within these facilities' master plan themes. It is broken up into six chapters, focusing respectively on: a model of client focused care, the work environment, role in the neighbourhood, role in research, operating efficiency, and post occupancy evaluation. The visioning statements outline characteristics of a physical environment that works towards achieving these visions. It is noteworthy that the vision regularly justifies its goals based on referencing one client's experiences.

Following contemporary attitudes towards mental health care, client care is oriented towards active participation towards recovery. To this end, the site will incorporate building uses geared towards "recovering clients' vocational training and employment" through non-CAMH tenants (Liang and C3 Community Care Consortium, 2007). It suggests that a normalizing environment must be composed of both medical and non-medical uses for the benefit of both inpatients and outpatients. In terms of balancing privacy and security with this need for a

normalizing environment, the facility aims to avoid visible references to surveillance and securitization in order to create a dignified and respectful environment.

In terms of qualitative external experience for clients, the "master vision" suggests that healthcare facilities such as this one ought to aspire to be "place making," continuing to say that "good civic buildings enrich our daily lives" (Liang and C3 Community Care Consortium, 2007, p. 19). The "front door" should be both easily identifiable and also blending into the surrounding fabric of the neighbourhood. In terms of the entry experience, "[a]s in a hotel, the lobby and reception environment sets the tone and first impression of welcome, comfort and conviviality for clients and visitors, of diverse backgrounds" (Liang and C3 Community Care Consortium, 2007, p. 19). Though largely focused on the physical environment, "the best welcome is the human touch" and that well trained personnel should be present in the lobby to act as ambassadors (Liang and C3 Community Care Consortium, 2007, p. 19). Thoughtfully, the vision includes a view of a front entrance lobby green wall complete with public donor list (fig. 9). Healthfulness is another key component of a quality patient experience in the redeveloped CAMH. Natural light and views of nature, the city, and changing weather are considered. An artist's rendering of short term stay residences and an outpatient services building indicates peaceful park views (fig. 10). Indoor air quality and the importance of dust free environment and maximum ventilation should be considered – and so are sound and avoidance of "acoustic disturbances" through the minimization of aggravating noises. For safety and client comfort, "generous dimensions" are envisioned on corridors and in client units (Liang and C3 Community Care Consortium, 2007, p. 20).

Above all, the vision for client centered care aims to be home-like. This should be accomplished through intimate scale, cleanliness, and room designs that echo domesticity. As a temporary home, an inpatient room ought to be a safe refuge. The vision is of an institution that does not feel like an institution and instead more like a home or hotel. While these criteria are considered therapeutic, the vision goes on to elaborate on specific healing elements of design. The physical setting should provide opportunities for recreation, arts and crafts, therapeutic gardening, and leisurely strolls. A healthful environment should invite informal social interactions with "staff or peers in sitting areas off the corridors" (Liang and C3 Community

Care Consortium, 2007, p. 25). It is thought that these characteristics can "foster clients' sense of independence."

Improving the work experience for staff through their physical environment echoes many of the same characteristics that are considered beneficial for clients. The main differentiation is that staff should have their own spaces of "retreat" separate from clients where they can relax on breaks such as their own private courtyard garden or roof terrace to be with nature. Similarly, it is suggested to include informal meeting spaces such as eating alcoves off the circulation corridors or well-furnished quiet corners of a lobby where collegial exchanges may take place.

In order to take advantage of the destigmatizing characteristics of being part of a neighbourhood as envisioned, CAMH wants to "contribute to the vibrancy of the community life in the neighbourhood" (Liang and C3 Community Care Consortium, 2007, p. 44). The vision states that "incorporating retail, cultural, creative and community oriented activities" means reaching "out to the community at large" and goes on to say that this also "provisions… client employment or training opportunities… to support the continuum of care to client recovery" (Liang and C3 Community Care Consortium, 2007, p. 44). Even a depiction of the Crisis and Critical Care Building is enlivened with ground floor retail and a bustling sidewalk (fig. 11). Essentially, the CAMH campus ought to disappear into the city and its regular capitalist frenzy, undifferentiated from other neighbourhoods.

The plan of subdivision is what makes CAMH Queen Street so unique and creative in terms of contemporary healthcare facility development. Extending new streets is said to make clients and survivors feel part of the community and not isolated. It somewhat contradicts the need to have views of nature but they also note the importance of having well treed, and well lit, sidewalks. Curiously, the vision also contradicts the site plan which builds over much of the existing green space leaving only smaller fragments: "The well-established existing green spaces and significant mature trees will be preserved, protected and revitalized to remain as public accessible private open spaces or become city parks" (Liang and C3 Community Care Consortium, 2007, p. 46).

The vision for neighbourhood role does not necessarily exemplify focus on two-way integration. Much of "master vision" articulates how the new site will become more useful for the surrounding neighbourhood. Not only well landscaped gardens are envisioned for the

community's use but also corporate programmed activities such as Nuit Blanche and Luminato Festival. The "master vision" only makes a brief mention that some clients may require a "third place" or refuge that is not for the community but for clients alone, just as staff have their refuge (Liang and C3 Community Care Consortium, 2007, p. 45).

As part of its integration of non-CAMH uses, medical research is envisioned as a key element of the redeveloped campus. It is noteworthy that the vision does not consider medical research as a non-CAMH use like any other commercial venture on site, but is bundles it up with the CAMH organization. The "master vision" states that in partnership with the University of Toronto, CAMH will bring together four research areas: "Neuroscience, Clinical Research, Social, Prevention and Health Policy Research and Neuroimaging" (Liang and C3 Community Care Consortium, 2007, p. 60). While these may be useful to patients, one wonders if compensation for their participation may simply by the assurance of future benefits for society at large.

In a very brief conclusion, the "master vision" acknowledges the importance of measuring the success of the finished product according to the standards set out by the vision and related materials. They say that each phase of the development ought to be documented and measured for success. Some elements worthy of measurement are outlined. Curiously, the most controversial and unique elements such as integration with the surrounding community would presumably resist quantification. It is worth considering that these elements require subjective judgement and resist any static yardstick. "Contributing to the vibrancy" of the neighbourhood is a quality that would be uniquely judged according to the eye of the beholder.

Echoes of The Asylum's Original Planning

In many ways, the optimism of these visioning statements and their concentration on the physical environment as a foundation of treatment and recovery is not so dissimilar from the hopefulness which imbued the original John Howard design and its focus on moral architecture. Despite being part of a different time both plans make behavior modification through design a priority. While CAMH Queen Street focuses on community integration and normalization of the physical environment with its opportunities for personal development as allowing for recovery, John

Howard's asylum considered protection from the larger community and an explicitly ordered environment with opportunities for personal development as being the best treatment.

Despite the stigmatization of the Queen Street site, the public presentation of benevolence and focus on curative design were actually significant factors in the initial configuration of the Toronto Lunatic Asylum. Though the design failed in many of its missions, its public presentation bears a remarkable similarity to the face CAMH is putting on the latest redevelopment. The private public funding model, glossy marketing for private investment, focus on aesthetics as curative function, and assurance to the public that their investment is moralistic and representative of an upstanding and progressive society were mainstays of both the 1850 construction and 21st century redevelopment.

In John Howard's time architectural excellence and civic presence was just as important as it is now. What is now called place-making was an essential component of the colonial project to civilize wild Canada and show off the settler state's forward looking attitude. Similarly to current times, presenting an image of benevolence towards society's others was considered a sign of moral uprightness and righteousness. As Yanni (2007, p. 17) states: "Nineteenth-century doctors typically placed their benevolent approach to the treatment of the insane against the picture of the brutality of earlier epochs."

At the time of its construction, these buildings dedicated to the shelter and treatment of those considered defective and in need of care by larger society, were the largest non-military edifice in North America (Keefer, 2000, p. 96). Depictions in newsmedia were very positive, much like they are of CAMH's redevelopment. While inmates may have been looked down upon in popular culture, the physical building that enveloped them was widely admired. The extravagance of the building allowed society to think itself progressive, incentivized the treatment of wealthier people, drew philanthropy, and prestige for the psychiatrists, known then as alienists.

The specific design, rather than being created according to a dogma of recovery, came from the school of mental health treatment known as moral therapy. Moral therapy "did not connote that it was morally superior therapy. The term meant that the new therapies applied to the mind, not the body of the patient" (Yanni, 2007, p. 20). The term was coined by a reformer called Pinel and "*Traitement moral* referred to the benevolent approach to caretaking in which

reformers called for patients to develop self-control under the guidance of paternalistic doctors" (Yanni, 2000, p. 24).

John Howard and his contemporaries sought to create asylums that served moral treatment. His design of the Provincial Lunatic Asylum emulates London's National Gallery on Trafalgar Square, a structure of Neo-Classical style (figs. 12, 13). This style was a response to the flamboyant architecture of the high Renaissance called Baroque and Rococo. Neo-Classicism, commonly called the architecture of reason, "grew out of the intellectual movement of the enlightenment… within the rigid system of rule as absolutism... It was believed that Neo-Classicism through the built environment could be used to have a positive influence on the spirit of the people and inspire them to behave in a manner based on reason and morality" (Hudson, 2002, p. 31). Following Pinel's discovery that mental health treatment was for the mind rather than body, this architecture of reason became the *de facto* design for curative asylum structures.

The vision for experiential qualities of the design and their benefits seem to be repeated in CAMH Queen Street. According to Hudson (2002, p. 40), "Doctors agreed that patients needed light-filled halls and rooms, so they desired an abundance of windows. Small panes of glass and the avoidance of grates or bars on the windows were representational strategies." Not only removing references to imprisonment or securitization were considered similarly critical, but so were ventilation and plumbing as well. At the time indoor plumbing was uncommon and considered a luxury. CAMH providing private washrooms as an improvement over older facilities may be considered analogous. As with modern mental health facilities planners, Howard's "approach to the design was in part driven by his humanity. He was determined to do as he was charged: deliver well-lit, ventilated, private and comfortable spaces to promote the restoration of rational behavior and the return of those after treatment to society… For Howard's asylum, 'it is the representation, the setting, the cloak of its function" (Keefer, 2000, p. 99-100).

Howard's approach to Neo-Classism as moral architecture actually serves many of the same purposes as design elements considered for CAMH Queen Street's redevelopment. His design was "based on ordered arrangements, strong axial symmetry, a repetition of forms, clear expression of function, and a well-defined spatial and volumetric hierarchy" (Bell, 2000, p. 76). Despite the monumental scale instead of the more human scale of CAMH, these design principles are quite similar. Like CAMH Queen Street, "the principle entrance…[is] expressed as

a critical mass" while the common leisure and passive spaces are places at the extremes" (Bell, 2000, p. 77). This clarity of design, symmetry, methodical arrangement of numerous windows, and focal entrance way can be seen in a watercolor by August Kolner, painted during the asylum's construction (fig. 14). The idea of creating comfortable dignified spaces was prominent in Howard's asylum as well: "An outstanding and very beautiful feature of the Toronto Asylum was a large semi-circular verandah at each end of the building" (Hudson, 2002, p. 147). Eventually overcrowding would cause this luxurious setting to be shuttered.

These ordered arrangements are indeed common to both Howard's Asylum and CAMH Queen Street. Howard sought for his Asylum to "be well defined, logical and clear to all who approached and especially to those who entered. The prevailing impression, inside and out, should be calm and not distracting. Visitors to the site if curious and perceptive, would realize that the various sections articulated on the exterior in brick and stone related directly to different uses in the rooms behind the façade" (Keefer, 2000, p. 97-98). Subtle guidance and clarity of purpose were the design order of the day for the site then as now.

Similarly, as in CAMH Queen Street's "master vision", a focus on the restorative powers of nature featured strongly in Howard's asylum. The landscape selected for the asylum has many issues being not much higher than Lake Ontario and somewhat swampy but it was green and only slightly removed from the city and its resources. As Hudson (2000, p. 59) writes "Asylum doctors, steeped in the nineteenth-entry belief that nature was curative, wanted their patients to have views toward nature when they were not actually enveloped by the parklike grounds during their daily walks."

Ultimately, John Howard's asylum failed, not because of his design, but because funding for mental health treatment lapsed and overcrowding negated any possible benefits flowing from design elements. Relying on architecture as treatment, absent funding for more space and more compassionate practitioners, contributed to the asylum's failure (Yanni, 2007, p. 147). Despite environmental determinism around design oriented towards recovery gaining popularity, John Howard's Provincial Lunatic Asylum indicates that "the profession needed to disassociate itself from the once-grand claims of environmental determinism, because, quite evidently, the environment had not determined many cures" (Yanni, 2007, p. 147). Then as now, beautiful images were used to assure the public of the worthiness of construction expenses and ultimately

the moral majesty of their investment (figs. 15, 16). One worries that a similar fate could befall CAMH Queen Street. Though the redevelopment is marveled, the usefulness of its design features rests upon its proper maintenance and static demand that does not overburden its now assuredly limited space, half the site having been leased away for 100 years.

Figure 12: John G. Howard's Design for the Provincial Lunatic Asylum (Concept Drawing)
Watercolour and ink on paper, 1846. Facing southwest from Queen St. W. (Source: CAMH Archives in Flis 2009).

Figure 13: Perspective Concept Drawing for the Toronto Lunatic Asylum, North View
Pen and Ink, 1846. Facing south west from Queen St. W. (Source: CAMH Archives in Flis, 2009).

Figure 14: “Building the Asylum”
Watercolour on paper by August Köllner, August 15, 1848. (Source: CAMH Archives in Flis, 2009).

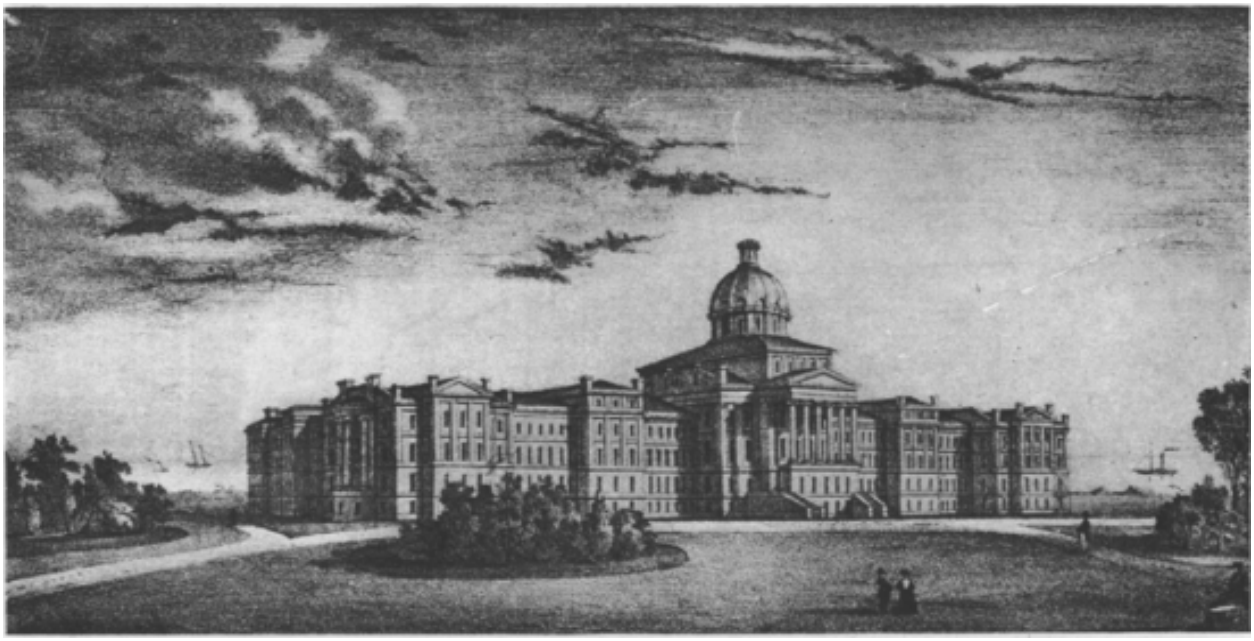

Figure 15: Scrobie and Balfour Lithograph
Commissioned by Howard in 1850 for submission to periodicals to publicize the building’s form. (Source: CAMH Archives in Flis, 2009).

Figure 16: CAMH 1870, Engraving published in *The Canadian Illustrated News*
(Source: *Canadian Illustrated News*, 1870 in Flis, 2009).

CAMH Redevelopment As Viewed by Its Managers

In order to assess veracity of these critiques and understand the challenges of planning for and with clients and survivors, two redevelopment project managers were interviewed with five broad questions to guide discussion. Douglas Weaver and Doug Campbell with development backgrounds in project management and urban planning respectively provided a rare window into the redevelopment's optimistic guiding principles and public relations strategies. The interview also provided the redevelopment project managers the opportunity to dispel some critical myths and unfounded denunciations as well as reveal the development industry's institutional biases towards critical stakeholders (Campbell and Weaver, personal communication, 2016).

The redevelopment managers expressed optimism tempered with caution in regards to the community relationship. They suggested that the relationship with neighbours started out very rocky due to poor communication from CAMH's board of directors stemming most likely from their inexperience in development. Initially CAMH set up community meetings but did not provide materials to look at for the audience which created a sense of unease and distrust. When Urban Strategies fully came on board, despite the damage done, they were able to mollify the

majority of detractors with full explanations. Douglas Weaver with his planning background explained that any planning project requires almost excessive public consultation, and most importantly, something for people to look at before they have an opportunity to create unfounded assumptions. Since that initial rocky start, project managers explained that things had steadily gotten better to the point where they experience very little opposition but they have only achieved this through vigilance and the employment of very good public relations staff.

When asked about how the site's non-medical uses (such as commercial or residential) benefitted hospital clients and positive treatment outcomes, Campbell was very bullish about the potential benefits for clients and spoke very compassionately about wanting to listen to clients and provide the best environment on their terms. He spoke about the potential for employment and vocational training though unable to provide any evidence on these opportunities actually existing simply suggesting that he thought Shoppers Drug Mart was employing some clients. Additionally, in terms of housing, neither managers were able to provide any quantifiable numbers on affordable housing on site or in the area. They suggested that this was not in their realm and the province or city would have to be contacted to find out about what percentage or requirement of units on site or in the area would be geared towards low income residents.

The renaming of streets which were supposed to be continuous, running south of Queen Street West seemed a cause for concern but Weaver quickly dispelled these concerns. The streets were renamed not because of any ignorance about their purpose in reducing stigma, but because emergency services and navigation in general could not deal well with any reverse numbering system. With street numbers running south to north, there simply was not any logical convention for numbering north to south on the other side of Queen Street West. It was suggested that they could have appended these street names with "South" but this was deemed inappropriate as these roads are still private until CAMH may desire to let the City of Toronto take ownership of them. In inquiring when these paths might continue further south over the train tracks to King Street for pedestrians and cyclists, it was claimed that this was in the works but the City of Toronto would have to be asked.

About mechanisms used by managers of CAMH as landlord to ensure that non-medical uses are complementary, it was explained that CAMH ensures complementary usage simply by

writing into the lease that the tenant must conform to the spirit of the therapeutic purpose of the community. When asked how this could be enforced, Weaver stated that their lease would be terminated or at least not renewed if they demonstrated that they were not adhering to the spirit of the agreement. It was said that there were no hard numbers on employment or training requirements, just that tenants would fall out of favour if they were not useful to CAMH clients and survivors.

When asked about how were clients', patients', survivors' visions incorporated into the planning process, the redevelopment project managers were firm that clients' and survivors' visions were included though mainly through the contribution of advocacy groups. When asked if there was a metric or post-occupancy review of the satisfaction of clients and survivors, it was claimed that there was not any need as they base their success on good planning principles found in the City of Toronto's planning documents on holistic healthy neighbourhoods.

In terms of stakeholder dissatisfaction, they expressed that the Concerned Neighbours group who took CAMH to the Ontario Municipal Board was actually composed of one person and maybe a couple of neighbours that he had persuaded to take part in his group. They were very dismissive of this person saying they did not know what his problem was but that there is always someone who wants to pick a fight. They hypothesized that he wished he could afford the cleanliness and prestige of Forest Hill but could only afford Parkdale. They were similarly dismissive of activists who took issue with elements of their planning. When asked if they were referring to Geoffrey Reaume, they shrugged but admitted that they thought he just had a chip on his shoulder and did not understand what they were doing. They said they were glad people were concerned and keeping a critical eye on their work but essentially that detractors simply were not following closely enough.

Finally on the question of where inspiration was drawn from and what were the measures of success considering that this unique project is often billed as the first large urban village hospital and there are few similar spaces to compare to, the project managers confirmed that they had not devised any specific metrics for post-occupancy evaluation but that they were following the best principles in planning literature. They said that they were creating a model based on the

latest good planning principles and that provided the best yard stick of success for such an innovative project.

Conclusion

If the rise of moral treatment for inpatients contributed to displays of civic altruism through architectural grandeur and spectacle, then the rise of community treatment and the recovery mantra has given cause for practitioners to again flatter their trade with gleaming new structures that now blend into the urban fabric. The environmental determinism of moral treatment led to orderly megalithic manors while for community based psychiatry and the resurgence of centralization, it has led to benign invisibility.

Good planning and thoughtful environmental design have benefits for mental healthcare facilities though they are clearly no panacea. When planning does not recognize the minimal role of environmental design in contributing towards effective healthcare facilities it may even be damaging. Planning's fixation with controlling space and architecture's obsession with vanity and explicit function may obfuscate the need for effective listening, the provisioning of compassionate individuals and of safe housing. In this way planning may assume a technocratic role that empowers developers, private businesses, and the government, at the expense of common people, mental health care clients, and survivors.

Perhaps if anything, architecture and positive stories about architectural determinism and thoughtful design help to inspire and attract a good staff, allow for new high quality structures, and inspire the public to feel that their tax dollars are spent on an important cause. As Yanni (2007, p. 158) in a review of asylum architecture notes: "the staff of a mental health facility is crucial to its success. A lovely building with an uncaring staff will surely fail. A poorly designed building with an excellent staff stands a good chance of succeeding". The process and the overall quality of the product are what matters most; the details of deterministic and behavior influencing architectural components only serves to enliven the planning process and imbue it with visible substantive value. But even more crucial to mental healthcare outcomes is a focus on listening to vulnerable stakeholder needs and therefore employing compassionate personnel and providing safe housing, even if it means eschewing grandiose symbols of civic benevolence.

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Appendix: Historical Chronology of CAMH's Queen Street Site

Adapted from: CAMH. Historical Chronology of Queen Street Site. Retrieved from http://www.camh.ca/en/hospital/about_camh/CAMH_redevelopment/history_of_queen_street_site/Pages/Historical_Chronology.aspx

1846: Construction begins for the first 'Provincial Lunatic Asylum' on a 50 acre portion of the Garrison Reserve (Military property). The architect was John George Howard.

August 22, 1846: The official laying of the cornerstone by the Honourable Chief Justice John Beverly Robinson.

January 26, 1850: Provincial Lunatic Asylum opens its doors to its first 211 patients, transferred from the Temporary Asylum, which was housed in a former jail on King Street.

1851: The Toronto architecture firm of Cumberland and Ridout is engaged to design a wall with lodges and an entrance gate around the asylum.

1853-1875: Dr. Joseph Workman is the asylum's Medical Superintendent.

1866-1869: Newly constructed east and west wings add to main asylum building to try to ease severe overcrowding.

1871-1905: The name of the asylum is now 'Asylum for the Insane, Toronto'.

1888-1889: Following the government's sale of 23 acres of the site for development, the east and west walls are moved and rebuilt using original materials. The site is now 27 acres, the size it is today.

1889: Two new brick workshop buildings (extant) are constructed for use by staff and patients.

1891: A new 'Asylum for the Insane, Mimico' opens as a branch of the Queen Street asylum.

1905-1911: Dr. Charles Kirk Clarke, Medical Superintendent of the now named 'Hospital for the Insane, Toronto' recommends selling and relocating the overcrowded, poorly maintained facility, without success.

1919: A new facility in Whitby opens to replace the one on Queen Street; however, both continue to be utilized.

1919: Now named the 'Ontario Hospital, Toronto'.

1954: Construction of a new Queen Street Administration Building begins.

1956: The Queen Street Administration Building is complete.

1964: The Ministry of Health announces plans to replace the Queen Street asylum structures with new buildings on the same site.

1966: Name changes to 'Queen Street Mental Health Centre'.

1970: Construction of new units begins.

1972: Active Treatment Units 1 and 2 and the Paul Christie Community Centre open.

1974: Active Treatment Units 3 and 4 are complete.

1976: The 1850 asylum building is demolished.

1978: The former Superintendent's Residence (later Nurses' Residence) is demolished.

1979: The Joseph Workman Auditorium opens.

1979: The infamous '999 Queen Street' address changes to 1001 in an effort to symbolically disconnect the new centre from its stigmatized past.

1979: The 'Asylum for the Insane, Mimico', renamed as the 'Lakeshore Psychiatric Hospital' in 1966, is closed and partly re-merges with Queen Street.

1997: The Health Services Restructuring Commission (HSRC) releases its report, which includes changes to addictions and mental health care.

1998: The Centre for Addiction and Mental Health (CAMH) is formed from the merger of the Queen Street Mental Health Centre, the Clarke Institute of Psychiatry, the Addiction Research Foundation, and the Donwood Institute.

1999-2001: CAMH's founding President and CEO, Dr. Paul Garfinkel initiates comprehensive 'visioning' workshop sessions and consultations with hundreds of key stakeholders. Study recommends the creation of a central hub for CAMH at the Queen Street site.

2001: The **Vision and Master Plan** outline the transformation of the Queen Street site into an 'urban village' – a mix of CAMH and non-CAMH uses with parks and new through streets fully integrated with the larger community.

2001: The C3 Consortium (Montgomery Sisam Architects, Kuwabara Payne McKenna Blumberg Architects, and Kearns Mancini Architects) is selected for architecture/engineering of the new CAMH.

2002: A Facilities Master Plan and CAMH's updated Functional Program are submitted to the Ministry of Health and Long-Term Care for approval.

2004: The Ministry approves CAMH's updated Functional Program.

2004: CAMH's plan to create an integrated community wins excellence awards from the Canadian Institute of Planners and the Ontario Professional Planners Institute.

2005: Together, CAMH and Urban Strategies receive the City of Toronto Architecture and Urban Design Awards' Honourable Mention.

2005: The Province announces approval and funding for Phase 1A of CAMH's Queen Street redevelopment.

April 6, 2006: The official groundbreaking for Phase 1A inaugurates the start of construction for this first phase of the Queen Street Redevelopment Project.

April 7, 2008: The four new buildings of Phase 1A have been completed and are operational.

June 26, 2008: CAMH celebrates with a grand opening of Phase 1A of its Redevelopment Project, 'Transforming Lives Here'.

July 4, 2008: Infrastructure Ontario announces a Request-for-Quote (RFQ) for companies to submit their qualifications to design, build, finance, and maintain the next phase – Phase 1B – of CAMH's Redevelopment Project.

May 2009: A Phase 1A building is officially named, The McCain Building after Michael McCain and his family in recognition of their support of the CAMH Redevelopment Project; the first ever building to be named after a donor.

June 15, 2009: Following a competitive process for the first non-CAMH building on-site, CAMH accepts a letter of intent from Forum/Verdiroc to lease CAMH property to develop and operate a mixed-use building, including affordable housing and street-level retail.

June 27, 2009: CAMH's Phase 1A receives the International Academy for Design and Health's 2009 Academy Award for Mental Health Design.

September 25, 2009: Today, the official inauguration of the Paul E. Garfinkel Park takes place. This park is the northeast block of the site that, earlier this spring, CAMH handed over to the City of Toronto as a public park.

October 29, 2009: Decommissioning ceremony for the 1956 Administration Building.

December 18, 2009: Carillion Health Solutions is awarded the contract to design, build, finance, and maintain the Phase 1B buildings.

February 24, 2010: Demolition of the 1956 Administration Building, to make way for Phase 1B construction, begins.

April 6, 2010: Official groundbreaking ceremony for Phase 1B.

September 2010: Forum/Verdiroc begins construction on the first non-CAMH building, located at Queen Street West and Ossington Avenue.

September 17, 2010: Unveiling ceremony of nine memorial plaques installed along the CAMH historic wall in honour of asylum patients whose labour was used to build the wall.

October 7, 2010: CAMH launches a street naming contest to name 'New Street', one of five new public streets being created as part of the Redevelopment Project to connect the site with the surrounding community.

January 11, 2011: CAMH celebrates the 'Topping Off' of the Gateway Building – one of the three new buildings of Phase 1B – a tradition on construction sites, signifying that the highest point of a building has been reached.

May 11, 2011: The CAMH Foundation announces that it has exceeded its goal of $100 million for the Transforming Lives Campaign, raising more than $108 million, with the help of a $10 million gift from Bell Canada. The announcement includes the naming of the Bell Gateway Building.

June 22, 2011: CAMH receives street naming approvals from the City of Toronto to apply the name Stokes Street to New Street, in honour of Professor Aldwyn B. Stokes; and to rename Freedom Street to Lower Ossington Avenue.

September 8, 2011: Shoppers Drug Mart has agreed to be an anchor tenant in the new non-CAMH building - the Ossington-Queen Street Rental Apartments.

September 27, 2011: On September 23, Premier Dalton McGuinty visited CAMH with news of the approval of the third phase of CAMH's visionary Queen Street Redevelopment Project.

November 16, 2011: The Beamish and Labatt families were recognized with a wing of the Intergenerational Wellness Centre being named after each family.

April 23, 2012: A mosaic art project to be displayed in the new Intergenerational Wellness Centre becomes a community collaboration.

June 21, 2012: Outdoor Grand Opening Celebration marks the official opening of the three new CAMH buildings of Phase 1B of the Redevelopment Project. CAMH also hosts the dedication of the cornerstone of the new Bell Gateway Building, along with an unveiling of the return of the 1846 Cornerstone Plaques from the original 'Provincial Lunatic Asylum.

September 2012: CAMH physicians, collectively known as The Associates, are honoured for their contributions to CAMH as the Utilities and Parking Building at 101 Stokes Street is named the Doctors Association Building.

2013: The silver cornerstone plaques from the 1846 'Provincial Lunatic Asylum,' long thought to be lost, are returned to CAMH and hung from the Legal Hearing Room.

March, 2015: The first step in the procurement process for the third phase of the redevelopment project, Phase 1C, to build two new hospital buildings right on Queen Street West.