

CANADIAN JOURNAL OF

Disability Studies

Published by the Canadian Disability Studies Association · Association Canadienne des Études sur l'Incapacité

Canadian Journal of Disability Studies

Published by the Canadian Disability Studies Association
Association Canadienne des Études sur l'Incapacité

Hosted by The University of Waterloo

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cjdseditor@uwaterloo.ca

Opening Ontario's "Saddest Chapter:" A Social History of Huronia Regional Centre

Dr. Kate Rossiter, Assistant Professor of Health Studies, Wilfrid Laurier University, Brantford, Ontario
krossiter@wlu.ca

Annalise Clarkson, Masters Student, Social Justice and Community Engagement, Wilfrid Laurier University, Brantford, Ontario

Abstract

In 2010 the residents of Huronia Regional Centre, Rideau Regional Centre and Southwestern Regional Centre launched three separate class action lawsuits against the government of Ontario. These lawsuits allege that residents of these provincially-run centres, the majority of whom were diagnosed with some form of intellectual disability, were subjected to multiple forms of abuse and inhumane treatment. This paper contextualizes these lawsuits by providing a social history of the Huronia Regional Centre – the first centre to launch a class action lawsuit. The purpose is threefold: firstly, to explore the social context of Canadian institutions as exemplified by the history of Huronia Regional Centre, secondly, to outline the bureaucratic organization of institutions related to the social context of institutionalization, and thirdly, to understand the social and historical milieu that lead to the maltreatment and neglect of institutionalized persons in Ontario. As such, this paper attempts to make clear the importance of the lawsuits and other current historical justice-related pursuits undertaken by institutional survivors.

Key words

Institutionalization; Intellectual Disability; Class Action Lawsuit; History of Disability; Ontario

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Introduction

"Remember this: After Hitler fell, and the horrors of the slave camps were exposed, many Germans excused themselves because they said they did not know what went on behind those walls: no one had told them. Well, you have been told about Orillia."

Pierre Berton, Toronto Star, 1960

In July 2010 a class action law suit was certified in the province of Ontario on behalf of former residents of the Huronia Regional Centre, a provincially-run centre for the containment and ostensible care of people with intellectual disabilities (ID). This suit alleges that between the years of 1945 and 2009 the residents of these centres were treated inhumanely and subjected to emotional, physical and psychological abuse. In 2011, two further class action lawsuits were also certified, launched by former residents of Rideau Regional Centre and Southwestern Regional Centre. The defendant, the Province of Ontario, is alleged to have failed in the care and protection of the class, which resulted in injuries including "psychological trauma, pain and suffering, loss of enjoyment of life, and exacerbation of existing mental disabilities" ("Koskie Minsky," 2013). The goal of these suits is to call the Ontario government to account for the negligence that allowed abuse to occur in these institutions. Advocates of these institutional survivors believe that the Ontario government's neglect "will go down as one of the saddest chapters in [the] province's history" (Teixeira, 2013).

Importantly, these lawsuits also serve the broader social purpose of giving public voice to the complicated and troublesome histories of institutions and institutionalized peoples in Ontario. The lawsuits do more than reconcile past wrongs through the demand for apology or financial compensation, but also provide legitimatizing space for the historically-silenced narratives from

people with ID about institutionalization to emerge and be entered into public record. In this, the lawsuits may serve a liberatory function beyond their stated goals of retroactive compensation. As the class action lawsuits await trial, this paper works to challenge dominant historical views regarding institutionalization and to assemble and cohere some of the alternate social and historical evidence necessary for understanding the class action lawsuits as one important piece in the pursuit for historical justice in regards to institutionalization.

Institutional abuse has been studied extensively (see, for example, Blatt & Kaplan, 1974; Park, 1990; Firsten, 1991; Reaume, 1997; Park & Radford, 1998; Sussman, 1998; Stewart & Russell, 2001; Malacrida, 2005; Chupik & Wright, 2006; Simpson, 2007; Broderick, 2011; Burghardt, 2012) but current knowledge lacks a comprehensive account of the social and historical context of institutionalized persons with ID in Ontario. The purpose of this review is threefold: firstly, to explore the social context of Canadian institutions as exemplified by the history of Huronia Regional Centre (Huronia), secondly, to outline the bureaucratic organization of institutions related to the social context of institutionalization, and thirdly, to understand the social and historical milieu that lead to the maltreatment and neglect of institutionalized persons in Ontario. To be clear: the aim of this paper is in no way meant to exonerate abusers or justify the unconscionable treatment of people with ID that occurred within institutions; rather, the goal of this work is to provide enough social and historical context to make sense of the class action lawsuits and understand their potential importance in terms of historical justice.

To do so, this paper focuses on the history of the Huronia Regional Centre (referred to as “Huronia” or “Orillia”) as reflective of broader practices and beliefs regarding the care of people with ID in Ontario. The decision to use Huronia as a focal point was made for several reasons. First, former Huronia residents were the first in Ontario to launch a class action lawsuit against

the Provincial Government. Second, Huronia was Ontario's "first and largest mental handicap asylum" (Park, 1990, p. 60) and historically stood as a pillar for specialized care for persons with ID in Canada (Chupik & Wright, 2006). Huronia's staff, policies, and practices guided the care of people with ID in Ontario, and thus the historical treatment of Huronia residents is likely to be indicative of the treatment of residents of institutions across Ontario.

Methodology

This paper both theoretically and methodologically locates itself within the field of social history (see Howell & Prevenier, 2001; Fox-Genovese & Genovese 1976). This is to say that this analysis focuses on two major areas. First, it is interested in the broader structural conditions and forces in which the Ontario institutions existed, as opposed to individual biographies or life histories. Second, this analysis works to illuminate dynamics of power that have generally been obscured by dominant historical discourses (for example, public propaganda about the institutions from the Ontario government), and to give voice to those who have traditionally been rendered voiceless by such power dynamics. As such, this paper is both unapologetically political and aspirational: this work is in service of the larger goal of "recovering the history of those whom traditional history writing [has] ignored" (Howell & Prevenier 2001, p.113), and providing context for emergent narratives about institutionalization from institutional survivors.

Thus, this paper knits together a variety of sources regarding institutionalization in Ontario, including the few primary sources about Huronia that currently exist. Until recently very little scholarly attention has been paid to the history of institutionalized people with ID in Ontario. This paucity of sources poses difficulty in terms of providing a comprehensive historical account of this area, but also points to the necessity of this kind of account. We have

chosen to mediate this by including a broader range of resources in this review in order to provide a clearer historical picture of institutionalization in Ontario, including primary historical documents (including newspaper articles and policy documents) and pre-existing secondary sources having to do with the history of Ontario's institutions. Further, while we have used sources about Huronia as much as possible, where we have been met with *narrative* gaps (as opposed to gaps in policy or governance which are unique to each institution) we have included stories about residents at other institutions (including psychiatric facilities) because they provide important detail regarding the lives of residents of large-scale, government-run mental health facilities. In order to remain faithful to the goal of understanding local histories that have led to the class action lawsuits we have not included narratives from private institutions or institutions outside Canada.

These narrative gaps, of course, suggest the necessity for further research and advocacy regarding the histories of institutionalized people with ID in Ontario. While this paper makes conceptual space and provides context for narratives which may emerge from the process of the class action lawsuits, we have not collected first-hand stories for this work. It is our hope that the proceedings of the class action lawsuits will be one way for testimonies regarding institutionalization to be made public. Further, this paper stems from a larger research project designed to collect and document narratives from Huronia survivors. Thus, this work provides a lens through which to understand emergent narratives regarding institutionalization, whether they come from the lawsuits or research and, as such, marks the beginning of a larger social historical pursuit to preserve and publicize the history of Huronia survivors.

Finally, a note on language. Over time the ways in which ID has been taxonomized has shifted in accordance with the ideals of modern social governance (Simpson, 2007). These shifts

are not inconsequential: language used to describe people with ID has not only changed dramatically over time, but has also been culturally employed as a means of further injuring and marginalizing people with ID. However, in order to capture the shifting nature of this language, and the social and ideological changes regarding the care and control of people with ID that these changes reflect, this paper will use historical terminology that has been ultimately hurtful to people with ID, including terms such as ‘idiot’ and ‘feebleminded’. We include this language to draw attention to the ways in which language acts as a means to repress, humiliate and exclude people with disabilities from broader social participation.

Early Institutional Care in Ontario

The modern rise of the state wrought many changes in terms of understanding and caring for those who are vulnerable. One such change has been the development of large-scale, state-run institutions such as hospitals and asylums. In Canada, institutions were placed under provincial control and management following the confederation of Canadian provinces in 1867 (Park, 1990). In Ontario, the Department of Provincial Secretary was responsible for asylums, charities, prisons and public institutions until 1931 when responsibilities were transferred to, and shared by, the newly created Departments of Health and Public Works. However, Simmons (1982) argues that the development of “mental retardation policy” began in 1831 when bureaucrats became concerned with four broad goals concerning people with ID:

to provide asylum for mentally retarded people who could not physically survive in the community without government help; to educate mentally retarded people define as being educable; to impose some kind of social control on mentally retarded people who were defined as delinquent or immoral, and to provide social welfare for mentally retarded people who would have been physically capable of surviving in the community but could not do so because of lack of employment [due to] personality or behavioural traits which led the community to reject them...(p. xiii)

In 1839 the provincial government authorized the establishment of the first asylum for people with ID and called it an asylum for “insane and lunatic persons” (Ministry,” 2012). In 1857 the government of Ontario used a refurbished hotel in Orillia as a branch of the Toronto asylum and called it the “Convalescent Lunatic Asylum” (Williston, 1971). However, in 1870 the asylum suffered a gross loss of revenue and closed with the remaining patients transferred to London Ontario's “Idiot Branch” in 1873 (Park & Radford, 1998; Broderick, 2011). However, in response to overcrowding and growing demographic pressures, a new site, then called the “Orillia Asylum for Idiots,” opened its doors in 1876 under the guidance of superintendent Dr. Wallace (“Ministry”, 2012), who believed that care for ‘idiots’ (people with ID) demanded more space, seclusion and social removal than ‘lunatics’ (people with mental illness). Given the increasing demand the Orillia Asylum expanded from 175 acres in 1880 to 456 acres by 1911 (Park, 1990).

By the mid-nineteenth century, the treatment of people with ID increasingly fell under the purview of science and medicine, and thus diagnosis, classification and treatment of people with ID became an occupying concern. The development of medical practice, pedagogical notions of “physiological treatment” (see Stuckey, 2013, p. 237) and rehabilitation sciences ushered the development of new methods of treating and educating ‘idiot’ and other ‘backward’ children based on seemingly indisputable models of biological deficiency (Williston, 1971). For example, French-born physician Dr. E. Séquin published a paradigm-shifting text entitled *Traitement moral des Idiots* in 1866. While earlier classification systems were vague and left little room for distinction between mental illness, developmental disability, and ID, Dr. Séquin’s work honed the classification system and divided people diagnosed as ‘idiots’ into four sub-grades based on development and occupational ability. He believed that ‘idiocy’ resulted from a

failure of the will and developed training techniques that were thought to heighten cognitive development (Trent, 1994).

Nineteenth century North American doctors found Séquin's taxonomy lacking and created new classifications that encompassed both the moral and functional dimensions of 'idiocy' and the newly identified pathological, typological, and 'degenerative' properties of ID (Simpson, 2007). In 1916 Alfred Binet developed psychological testing that singled out 'mentally backward' children, and prevented them from "fully profiting from the education or ordinary school" (Binet and Simon, 1916, p. 8). Mental defectives, according to Binet and Simon (1916), were divided into two categories: the less pronounced 'feeble-minded' individual who, "may pass through the education system unimproved... [entering] into society...[and] propagat[ing] their kind", and the more easily marked 'ill-balanced' individual for whom, "if not specially looked after... in later life would become a menace to society" (Binet and Simon, 1916, p. 8). These forms of testing were important as they subjected different groups of already-marginalized people to diagnoses that led to life-long institutionalization. Further, an enormous range of intelligence testing developed over the twentieth century that expanded on Binet's original work cast a wider diagnostic net across the general population and contributed to increased identification and thus overcrowding of institutions.

In Canada, the impact of testing led to the growth of specialized institutions such as the Orillia Asylum. This testing provided a medical mechanism for identifying and segregating those who deviated from middle class social norms, including those struggling with the damaging effects of poverty. Urban centres such as Toronto established education systems based on new "scientific methods of intelligence testing" which helped to rank and separate "defective" children, calling on and perpetuating the popular notion that 'feeble-mindedness' was an

increasing urban threat (Chupik & Wright, 2006, p. 80). The diagnostic procedures that identified many individuals as in need of institutional care paved the way for later issues. Williston (1971), for example, argues that early beliefs regarding the diagnosis and care of people with ID in Canada caused three damaging institutional tendencies that remained throughout their existence: isolation, overcrowding, and perpetual cost containment. In their public reports Williston (1971), and others, argued that these early trends at the Orillia Asylum paved the way for much larger issues including gross neglect and maltreatment – issues that form the backbone of the allegations laid in today’s class action lawsuits.

Like many institutions, Ontario’s centres for people with ID were founded with optimistic, yet nonetheless marginalizing, beliefs regarding the segregated care of people with ID. Stuckey (2013) argues that the Victorian-era “medico-pedagogic method” (p. 237) that informed the growth of institutions in North America at this time was based on progressive ideals of well-rounded education for people with ID. Armstrong (2002) locates the growth of vocational training within the bureaucratic development of asylums and workhouses as a method of rendering institutionalized populations both productive and controllable. These views stood in contrast with earlier beliefs, in which ‘idiocy’ was a social, legal and even religious concern, but not a concern of medicine or education: “It was considered a regrettable and incurable condition about which medical practitioners, both orthodox and unorthodox, could do little” (Wright, 2011, p. 28).

Early Twentieth Century: Growth of the Orillia Asylum for Idiots

Given pervasive views regarding the treatment of people with ID, Ontario care-related policies during the early twentieth century generally promoted segregated, custodial care within

closed institutions (Park, 1990) for the twinned purposes of education of people with ID, and for the putative protection of the broader society (Park, 1998, Williston, 1971). Advocates of institutionalization, including Dr. MacMurchy, Provincial Inspector for the Care and Control of Feeble-Minded, prioritized weeding out the 'feeble-minded' and 'moral deviants' from schools (Park, 1990). Feeble-mindedness was deemed the cause of juvenile delinquency, adult crime, sexual deviancy, illegitimacy and other forms of social ills. Dr. MacMurchy and others believed that temporary homes and training schools were being overrun by mental defectives and made repeated attempts to transfer students to Orillia based on the current standards of intelligence testing. Consequently the Orillia Asylum was chronically overcrowded with residents who had been removed from the educational system (Chupik & Wright, 2006) and elsewhere.

Thus, a small majority of those admitted to the Orillia Asylum came directly from home while most came from a variety of welfare institutions including Children's Aid Society, Toronto General Hospital Mental Hygiene Clinic, and various orphanages (Chupik & Wright, 2006). While the asylum housed people of all ages, during the first decade of the twentieth century the average age of individuals committed to Orillia began to decrease, although the minimum age of admission was 6 years old¹ (Chupik & Wright, 2006, p. 82). Rather than defining itself as a catch-all institution, Orillia's emergent aims were to provide care and treatment for children and adolescents rather than full grown or elderly people (Park, 1990). Park (1990) asserts that this shift reflected a growing belief in early detection and intervention as a means to "control feeblemindedness" (p. 98). This may also be in part due to the fact that other social service providers, such as the Children's Aid Society, turned to the Orillia Asylum as both a last resort for very difficult children, and a secure housing option when children became too old for public

¹ This minimum age decreased over time, and by the mid-twentieth century much younger children were routinely committed to the institution.

assistance (often around age 12): “a diagnosis of 'mental defectiveness' and admission to Orillia... would secure permanent public funds for these older children” (Chupik & Wright, 2006, p. 83). Parents were actively discouraged from visiting, and the Asylum’s geographical seclusion meant that patients were extremely isolated, and even regular interaction with families, which was generally discouraged, was made very difficult, if not impossible (Park, 1990).

However, despite stated aims, Simmons (1982) notes that Orillia was a “jumble” and “always much more than the hospital and training school it claimed to be” (p. 134) and therefore housed a much wider variety of people with a far greater range of disability and need than could be supported by the limited resources provided. For example, in the 1930s, “Orillia...[housed] a certain number of senile old, severely retarded, multiply handicapped, or syphilitic people – those who for physical and mental reason would not survive outside an institution,” (p. 134) as well as an assortment of people who were not disabled but simply required social welfare, including orphans, teenage mothers and “indigents” (p. 134). Regardless of the route, the Orillia Asylum was populated with children and adults for whom the isolated Orillia Asylum became a life-long place of residence.

Built to impress the public from afar, the Orillia Asylum, which was renamed the “Orillia Hospital School” in the early twentieth century², suggested a level of grandeur and elegance. From outside the gates of Orillia, the property boasted a long driveway leading to a magnificent-looking château built in the countryside along the shores of Lake Simcoe where it was thought patients would benefit from constant contact with fresh air and pastoral farmland settings, as well as social and geographical isolation. But in reality, the Orillia Asylum was overcrowded and underfunded, particularly in comparison to facilities which housed mentally ill patients (Park,

² The exact date of this name change is unclear. Simmons mentions the name being in use as early as 1929 (while other sources credit the name change as happening in the early 1930s, however, the precise date seems to be missing from current records).

1990) and facilities abroad. In fact, Simmons (1892) notes that the per patient cost of care at Orillia at the beginning of the 20th century was among the lowest in the world (p. 32) – in some cases less than half of what was paid per patient at similar institutions in the United States. Simmons (1982) explains that these dramatic differences in cost reflected a reliance on in-house labour (i.e. using patient labour to support the facility) and a chronically small and underpaid staff complement. Indeed, the average monthly wage for an Orillia staff person was \$29.32 while his or her American counterpart made \$73.82, and the staff-to-patient ratio was 1:14 versus 1:7 at US asylums. Even at this time officials noted that these cost containment strategies negatively impacted the level of care provided at Orillia. Provincial inspector O'Reilly noted that American caregivers were superior to those in Ontario and "the asylums were furnished more expensively with more money spent on books, periodicals, newspaper and amusements" (Simmons, 1982, p.33). Further, care for the facility was shared by the Department of Public Works, which maintained responsibility for determining the size, location, design, construction of the site, and the Department of Health, which oversaw the management of the Hospital School in terms of staff and resources. However, there was little coordination between the two departments and necessary changes and upgrades were slow and poorly planned (Williston, 1970; Berton, 1960).

The putative healthful and therapeutic benefits of rural isolation and vocational training (see Park, 1990, p. 43) provided ample justification for the instatement of onsite farming and other forms of unpaid labour as a practice at Orillia. As of 1880 farm colonies for people with ID became accepted practice, and "the belief became prevalent that with enough land, an institution could become self-supporting" (Williston, 1971, p. 23). This practice was doubly beneficial to administrators: it kept patients occupied and reduced the need for staff. Unpaid

residents completed the laundry and kitchen tasks, general household duties and manual labour. Thus, perpetual gross underfunding undermined any benevolent intentions and placed the health and welfare of residents in jeopardy. Park (1990) notes that by 1931 the conditions at Huronia were described as impoverished and unsanitary (p. 46). At institutions like Orillia's Hospital School, chronic understaffing became the norm, as "higher grade" patients cared for "lower grade" patients, performed cleaning and maintenance duties, and produced food for the institution, all without remuneration. Williston (1970) notes that "those capable of being absorbed into society constituted a major labour force for the institution and were too valuable to be released." (p. 24).

Interestingly, the reliance on patient labour is noted on the Ontario Ministry of Community and Social Service's current website; however, in these documents it is described in glowing terms ("useful, practical work was an important part of life in early institutions") and fails to note the ways in which patients were exploited for their efforts by larger administrative and governmental forces ("Ministry," 2012). Further, current government documentation does not account for the ways in which in-house patient labour allowed for substantial savings to outgoing costs such as food (patients worked on the Orillia farm and dairy) or clothing (they also manufactured clothing), and nor does it recognize the substantial neglect endured by patients due to cost containment: "patients at Orillia were given less meat, fish and poultry than those at other asylums" (Simmons, 1982, p. 34).

From their inception, life within Canadian institutions was unrelentingly oppressive; however, many years of financial strain, provincial neglect, chronic overcrowding and prevailing cultural attitudes of fear, abjection and the need for social isolation left people with ID in institutions vulnerable to widespread abuse. Staff frequently used physical abuse as forms of

punishment (Stewart and Russell, 2001). As early as 1906 C.K. Clarke, Superintendent of the Toronto Hospital for the Insane, claimed that amenities such as toilets and bathing facilities were, "a menace to the health of the inmates" (Reaume, 1997, p.79). Secluded areas, "between doors" or "cross hall" were used to hide abuses from incoming family or friends who were often abruptly escorted out of the building. Sexual assault was common within institutions. For example, one resident vividly accounts her violent abuse in a letter written to asylum officials at the Toronto Hospital for the Insane:

the idea of having men like Carson and others to play with a woman as they have with me and you laugh[.] I have a good memory of what it ment to me to be locked up in that Prison house of Satan for 5 years....you had no Business to take me into that Prison or touch my head or Body to do dispite to me... what you have done and allowed done to me...(Reaume, 1997, p.66)

1920s to 1940s: The Influence of Eugenics

If medical discourses of the late nineteenth century saw the forced confinement and isolation of people with disabilities within institutions, the early twentieth century heralded an equally monstrous turn in the employment of scientific and medical discourse in the care of disabled and institutionalized persons. Out of earlier ambivalent Victorian philosophy, which sought both to educate and control persons with ID, grew the eugenics movement, which sought to "improve" society's genetic stock through limiting the reproductive capabilities of people deemed socially undesirable. Public opinion feared that the 'feeble-minded' would overpopulate, preventing progress to a utopian nation: "[n]o political machinery can prevent an aggregate of degenerate citizens from being a degenerate nation" (Inge, 1909, p.26). As such, a growing objective of long-term institutionalization was to control the proliferation of those diagnosed as 'feeble-minded' or 'mentally deficient' (Park & Radford, 1998), two terms that extended to the

‘morally enfeebled’ and the ‘incurable,’ meaning people who had “heritable intellectual disabilities” (Park & Radford, 1998, p.318). Throughout the 1920s the Canadian public believed that the number of people with genetic abnormalities threatened to exceed the number of people with ‘normal’ intelligence and thus public debate regarding the use of mandatory sterilization policies as a form of protection rather than a means of punishment arose, continuing in some places into the 1960s (Park & Radford, 1998). For example, during the 1920s and 1930s highly influential public figures such as Dr. C.M. Hincks, director of the Canadian National Committee on Mental Hygiene (CHCMH), advocated for sterilization in a campaign that sought to end the spread of ‘mental deficiency’ and the presumed deterioration of the general Canadian race. Hincks worked closely with organizations such as the Christian Temperance Union and the Department of Public Health, and was supported by “local, provincial and national” elites across Canada (Park & Radford, 1998, p, 319).

While Ontario managed to escape the grip of legally sanctioned eugenics policies³, the social power of the eugenics movement impacted on the social climate at institutions like Orillia's Hospital School. Chupik & Wright (2006) note that this rise in “eugenic-inspired ideology... validated the institution and promoted (not always successfully) radical options to protect society from the 'taint' of 'feeble-mindedness'” (p. 78). In her socio-historical geographical work, Park (1990) provides an analysis of Orillia's Hospital School and provides a compelling analysis of the informal modes of sterilization that took place within this institution. Across Ontario male and female children identified as ‘feeble-minded’ were placed in gender-specific schools and shelters and older adolescents and adults were sent to Orillia's Hospital

³ The movement toward forced sterilization of persons with disabilities was particularly prevalent in Western provinces. In 1928 Alberta introduced the Sexual Sterilization Act, which gave a Eugenics Board permissions to sterilize persons deemed, “incompetent, sexually uncontrollable or genetically defective” and British Columbia followed suit in 1933 (Park & Radford, 1998, p. 321; Malacrida, 2006).

School for permanent isolation, "before they became a eugenic threat" (Park, 1990, p. 99).

Hospital School residents were segregated by gender to limit sexual contact and the possibility of procreation while common medical and public belief in the fecundity of 'feeble-minded' women, and the threat of heritable conditions of disability, meant that females were institutionalized for longer periods than males, often permanently (Park, 1990). In fact, in 1913 Ontario passed the "Act Respecting Houses of Refuge for Females" which, in the event of a diagnosis of 'feeble-mindedness' restricted women's rights to be discharged from custodial care (Simmons, 1982, p. 77). Park (1990) writes: "the release of women who were of feeble mind was considered by some influential reformers as not only a crime against Ontario but against the nation" (p. 136).

1940s – 1960s: Community placement and the rise of public concern

Against the growth of the eugenics movement, the global experience of World War II resulted in ideological reforms as egalitarian notions developed in response to Nazism. At the same time, the fiscal strain of institutions on the welfare state furthered the perceived need for changes to large, state-funded systems of care (Mechanic and Rochefort, 1990). Dominant views regarding the treatment of people with ID were slowly shifting toward community placement and greater independence and away from reliance on total institutions. The community placement system was developed in the United States and introduced in Ontario in 1927 to reduce the costs of care and training but required the establishment of community agencies for public assistance and supervision. In addition to training residents for work outside the institution, efforts had been made to educate and integrate patients into the community Ontario Hospital School at Orillia even as early as the 1920s. For example, in the late 1920s superintendent B. T. McGhie took a very innovative approach to the care of people with ID, advocating for what now may be termed

as special education, normalization and community integration (Simmons, 1982, p. 122).

Further, starting in 1939, a small number of 'high-grade' patients were sent to live in "approved homes" in the community, who were paid for taking custody of patients (Simmons, 1982, p. 129). However, given the very entrenched social belief in custodial care and the lingering "myth of the menace of the feeble-minded" (Simmons, 1982), the push toward deinstitutionalization did not gain traction until much later in the century⁴.

As the physical state of the already-overcrowded institution further degraded, public concern for the treatment of people with disabilities began to rise. In 1948 the United Nations adopted the Universal Declaration of Human Rights entitling all persons to be free from, "cruel, inhumane or degrading treatment or punishment" ("United Nations," 2013). This momentous event spurred a global civil rights crusade that birthed the disability rights movement, and grassroots organizations of families of institutionalized people began to express concern over the life-long nature of institutionalization and the desire for alternative forms of care. For example, in 1948 the grandmother of an institutionalized person wrote the following appeal in an editorial for the *Toronto Star*:

I think it is time something was done for parents, who, from a sense of faith and hope... want to keep [their children] at home, living a normal life. These are real parents, only asking a little aid and encouragement...may the Ontario government help them and their children... ("Canadian Association for Community Living," 2013).

However, despite early advances in disability rights, the belief in the benevolent power of the institution remained firm. Families, doctors and politicians alike held to the notion that institutions provided better care to 'mental defectives' than their families. Administrators of Orillia's Hospital School reiterated the importance of isolating people with disabilities, noting

⁴ Further, Simmons (1982) credits McGhie's advocacy and progressive views from preventing sterilization legislation from passing in Ontario (p. 125)

that, “families should release their children to us and not interfere with our management”
(Williston, 1970, p. 29).

Public concern was piqued when a female patient’s death at Orillia's Hospital School became publicized. A fire broke out and the supervising nurse was called to help evacuate the main building leaving patients alone in the infirmary. Unable to evacuate herself, the female patient suffocated and died (Berton, 1960). This type of incident, along with growing mistrust of institutionalized care, caused Canadian citizens to begin to organize with local and provincial associations, lobbying the government to coordinate advocacy efforts across Ontario. This growing lobby resulted in the birth of the Ontario Association for Retarded Children in 1958, (now the Canadian Association for Community Living) (Caplan, 1991). Again, medical and political propaganda of the 1960s pushed back against these efforts and maintained that “three of every 200 children born in Ontario would require institutional care” (Gutnick, 2011). Given the lack of community and social support for caring for persons with disabilities at the time, even families who were wary of institutionalization were left with few viable options.

Public opinion began to shift in 1960, when Pierre Berton, a famed *Toronto Star* journalist, made an impromptu visit to Orillia’s Hospital School. Following this visit Berton (1960) published an excoriating article where he publicized the horrific conditions of the institution. Upon entering Orillia's Hospital School Berton found almost 3000 occupants crowded into facilities “that would be heavily taxed if 1000 patients were removed” (Berton 1960). In his column he wrote that “beds [were] crammed together head to head” on the verandas, in the classrooms, and occupying the playroom. The paint was peeling off the walls, there were gaping holes in the floors and plaster, and the roof leaked. “The stench,” Berton

reported, “[was] appalling, even in winter. Many patients [were] helpless and [could not] use toilets; floors scrubbed three times a day by overworked staff” (1960).

Newer ‘cottages’ (which were, in fact, just outbuildings, and often shoddy) at Orillia's Hospital School, originally designed for integrating ‘high grade’ patients into community life, were being misused and overcrowded, each housing patients with limited mobility because newer ‘cottages’ were at less risk of catching fire than older, more flammable buildings (Berton, 1960; Williston, 1971). Berton (1960) argued that the underlying problem at Orillia's Hospital School was public and political neglect, writing that it seemed “easier to spend money on highways and airports than for living space for tiny tots with clouded minds”. Berton’s article caused a public ripple. Over the days following this publication, reporting within the *Toronto Star* verified Berton’s claims, and then-Health Minister M. B. Dymond admitted facilities were overcrowded and decrepit (“Orillia Charges True,” 1960). Blame was passed from political hand to political hand, with the Orillia Hospital’s superintendent Foster C. Hamilton attributing “at least 30 percent” of the overcrowding to MPP pressure to admit individuals, which he called a “political racket” (“Charges MPP Pressure James Mental Hospital,” 1960, para. 4). In her work, Park (1990) argues that administrative stagnation and short-term policy decisions at the time only marginally changed institutional practices which failed to address or resolve any rapidly compounding problems.

Similarly, the work of American journalists Burton Blatt and Fred Kaplan's (1966), *Christmas in Purgatory: A Photographic Essay on Mental Retardation*, caused ripples of public concern and outcry when it was distributed to family and friends of institutionalized persons with ID in the United States. The heartbreaking photo essay portrayed the negligence of residential care which disgraced the nation: “many of them grovel in their own filth on unclean straw that is

seldom changed, often stark naked and in chains, in dark, damp dungeons where no breath of fresh air can enter, under such terrifying conditions” (Blatt and Kaplan, 1966). Public expositions such as these were very influential in shifting and catalyzing social beliefs regarding the need for deinstitutionalization.

1960s – 2000s: Huronia Regional Centre's Deinstitutionalization

In response to rising concern regarding the welfare of institutionalized people, Canadian governments began to move toward deinstitutionalization, but this move was not only bureaucratically complicated but was not met with universal acceptance. Between 1964 and 1965 two policy papers in Ontario (“A Spectrum of Mental Retardation Services in Ontario” and “Conclusions and Recommendations for Mental Retardation in Ontario,” both written by Dr. Matthew Dymond, former Minister of Health and vocal opponent of large-scale institutional care for people with ID) urged the province to move from an “institutional-custodial model to a community-based model” (Simmons, 1982, p. 180), and for responsibility (including financial) of people with ID to be shared between the state (i.e. government) and the community (i.e. families). Despite laudable goals for community integration, the deinstitutionalization of persons with ID was a contentious issue amongst families, workers, administrations and the public. Staff feared institutional job loss and change, and families who feared that residents would not be able to cope with life outside the institution (see, for example Broderick, 2011; Malacrida, 2006). However, the move to community-based care was not entirely incongruent with previous institutional practices. In an effort to contain costs at provincial residential institutions across Canada, some residents had been working in the community since the 1920s, albeit in an administratively ambiguous capacity (“Ministry,” 2012). For example, local farmers occasionally

supplied room-and-board in exchange for domestic or farm labourers. The Mental Health Act provided provisions for a patient's leave of absence and discharge but provisions were unclear as they applied to community work. Administrators of Ontario institutions interpreted the Act to mean that residents working in the community for over three months were to be discharged, which often left these residents alone in the community with no supports (Williston, 1971).

The move toward deinstitutionalization in Ontario was further mobilized in the 1970s following the death and injury of two Rideau Regional Hospital School residents. In 1971 a commission was struck by the Ontario Ministry of Health to examine the death and maltreatment of two institutionalized men, Frederick Elijah Sanderson and Jean Marie Martel, both of whom had resided at Rideau Regional Centre. Sanderson was found hanging in the barn where he was completing community work at a local farm. Martel was negligently discharged from the institution and was later found wandering the streets with gangrene and frostbite. Toronto lawyer Walter Williston headed the commission and closely examined the conditions of institutionalization across Ontario, with a particular focus on the large institutions including the Orillia Hospital School. Williston found that while the conditions of institutionalization in Ontario were very poor, no criminal case could be made against the institution or the Government of Ontario although he did place strong responsibility “on those who took in the ‘retarded person’” (p.19). Identifying that the Mental Health Act had been interpreted with negligence, Williston (1971) felt that neither Sanderson nor Martel should have been discharged and ultimately placed blame on Ontario's complex and disjointed mental health system.

The Williston report was highly influential and included several suggestions for the future care of persons with ID. First he suggested deinstitutionalization, replacing the institution with family and community services, and he advocated for a large number of small facilities to

be developed, dispersed, and integrated into the community in order to maximize interaction between staff, residents, and community members. Williston (1971) also called for comprehensive centres for research, diagnosis, medical treatment and counselling to be created in communities. Other suggested modifications to the health care system included unifying central planning and responsibility at the government level and the development of regional self-sufficiency in service delivery to persons with ID.

One year after Williston's (1971) report the Cabinet Committee on Social Development established a task force on Mental Retardation in order to document existing problems. By 1973 the Honourable Robert Welch, Provincial Secretary for Social Development, advocated for a new policy focus for the delivery of services for persons with disabilities that concentrated on community living. Welch's 1973 report did not acknowledge abuse or negligence but instead provided recommendations to overhaul service delivery in Ontario noting that "wherever feasible, services should be provided in a community setting as an alternative to institutionalization" (Welch, 1973, p.1). Further, following Welch's directives, governmental responsibility for people with ID was transferred from the Ministry of Health to the Ministry of Community and Social Services, an arrangement that is still in place today.

In 1975 Ontario announced its multi-year five stage closure plan which worked to establish comprehensive community services that gave persons with ID the opportunity to live with their families, or in group homes, or independently with a full range of supports to maintain personal autonomy (Caplan, 1991). These changes reflect public pressure, but also the development of new theoretical approaches to understanding disability, in particular theories of normalization and acceptance (see, for example, the pioneering work of activist/theorists Bengt Nirje and Wolf Wolfensberger). At this time, the Orillia Hospital School changed its name to the

Huronia Regional Centre as a means to mark a de-pathologized stance regarding the care of persons with ID (Broderick, 2011, p. 20). In 1982 a five year plan was developed to close centres, reduce bed-space, and expand community services including housing, employment programs and income maintenance. The final phase of this process, which took place from 2005 to 2009 saw the closure of the last of Ontario's large institutions: Southwestern Regional Centre, Rideau Regional Centre, and Huronia. While these advances have worked to counter and undo the horrors of institutionalization, Park (1990) and others (Mechanic and Rochefort, 1990; Broderick, 2011) argue that the quality of service delivery and provisions for funding has suffered since placing residents in group homes, and people who were vulnerable within institutions remain vulnerable within the context of community care.

While the last three decades have seen great changes in terms of the movement toward deinstitutionalization, the care patients received within institutions during this time remained problematic. Broderick's (2011) work engages both patient and former worker experiences of life at Huronia over the past three decades. Former residents and workers alike reflected on their time at Huronia with ambivalence. While the former residents recall life at HRC as “‘stressful’, ‘hard’ and ‘not nice’” (Broderick, 2011, p. 55), they also recall feeling frightened and displaced by the process of deinstitutionalization. This, of course, makes sense given that for many residents Huronia had been a permanent residence since childhood, however difficult it was.

Yet as further stories regarding Huronia have come to light, the depths of mistreatment during this time have become clearer. Patricia Seth and Marie Slark, Huronia survivors and the lead plaintiffs in the Huronia suit, describe their time in the institution as “being in jail without bars” (Blizzard, 2013, para 9). Both Seth and Slark, who spent fifteen and nine years in Huronia respectively, describe routine sedation, frequent beatings by staff and residents alike, a

dehumanizing lack of privacy and control, and humiliating punishments for minor infractions (Blizzard 2013; Gutnick, 2011). Former Huronia resident Doug Tebow alleges physical maltreatment, but also a failure on the part of the institution to provide adequate education despite Huronia's stated pedagogical aims: "I never learned to read or write," Tebow recalls (Marlin, 2010, para 2). Former resident Harold Dougall remembers residents being hit with a "leather strap" (McKim, 2009, para 19) and told to lie about the source of the bruising to doctors. Dougall remembers his 'cottage' as a "windowless dormitory, furnished with nothing but 12 beds, six on each side" (McKim, 2009). Other incidents described by Michael Callahan, former resident of Huronia, include being, "whacked with a wooden club for failing to pass [hygiene] inspections", "hit with a fly swatter and dunked upside down in ice water as punishment for not eating" and "residents [being] made to push a pink rubber eraser along the institution's floor with their noses" (Tyler, 2010).

These accounts are bolstered by testimonies from former workers. In her study, Broderick captures some of the troublesome dynamics between staff and residents. One worker recalls:

I remember witnessing a horrific incident over and over, and then one night it was like that's enough. That's the last time I want to see someone being force fed. Force feeding was the worst thing to both see and do. So a client won't eat their food. Grab the back of their neck. Pull their hair back and shovel it in. That was one of things that helped me to decide to leave... (Broderick, 2011, p. 26).

Further, Broderick's study points to tensions between staff groups, particularly part-time and full-time staff members. A former worker notes: "The full-time staff did not participate, did not assist, they were not interested." (p. 41) While inter-staff dynamics are obviously more complicated than indicated here, these narratives suggest very difficult power relations within the institution and varying levels of complicity in the maltreatment of residents. For example,

Firsten (1991), who writes about her own experience as a worker at a large residential institution recalls that she has, “seen alleged perpetrators treated as reliable informants” (p. 46) as allegations of abuse in a psychiatric setting are often questioned, denied, minimized, or interpreted as delusional (p. 45).

Burghardt’s 2012 emergent doctoral work also provides important insight regarding the ways in which the life-long institutionalization, and more recent deinstitutionalization, of people with ID impacted upon family members, providing further understanding of the ways in which institutionalization was disruptive at a larger social level. While the full extent of the impact of institutionalization (on residents, workers or family members) is not yet known, it is clear that the class action lawsuits will provide one vehicle for stories of abuse to be made public. If these suits go to trial, as they are expected to do, what were private, individual stories will become public record, and will be reinforced and contextualized by the testimony of expert witnesses who will speak to the history and impact of institutionalization. Thus, these trials may serve the additional purpose of aiding researchers by substantially filling many of the knowledge gaps that persist regarding institutionalization in Ontario.

Conclusions: Self Determination, Justice and the Class Action Lawsuits

Over the past 150 years, Ontario has seen the rise and fall of large-scale, total institutions for people with ID. These institutions, as detailed in this paper, were both products and producers of marginalization, isolation and stigmatization of disabled people. One important aspect of the disability rights movement has been the role of self-determination for persons with ID (Stroman, 2002). As such, current advocacy and research focuses on awareness and emancipation through social action and privileges the voices of people with disabilities. McColl

et al. (2013) challenge researchers to generate new knowledge that removes barriers and promotes social inclusion and equality. Developing more inclusive knowledge, skills and attitudes amongst individuals and community will strengthen developments for empowerment and self-determination (McColl et al., 2013).

In light of the important move toward self-determination and empowerment, the class action lawsuits serve two valuable functions. First, they help to make public the hidden histories of institutions, thereby allowing people with ID to enter public discourse as active agents rather than passive objects of care. Second, they represent a powerful act of retroactive justice for the many years of marginalization and abuse experienced by persons with disabilities. While the number of people spoken for by these lawsuits is still unclear, the institutions housed thousands of residents; in its heyday in 1968 Huronia housed a population of over 2600 residents. It is the hope of many that these suits allow the possibility that these people may receive compensation for their suffering.

Researchers (Park, 1990, Malacrida, 2006, Broderick, 2011) acknowledge that the accounts of staff and residents of institutions have gone undocumented, unrecognized, and unheard. Many former residents continue to live in the community, carrying the legacy of institutional oppression, and have little opportunity to share their experiences. Rather, the public information that is most widely available are propagandistic government accounts of the institution's history which paint a rosy picture of a pleasant, bucolic and productive, if highly medicalized, past (see, for example, "Ministry", 2012, for the Ontario government's historical account of Huronia). Buried are the more realistic portraits of this history, where overcrowding and underfunding have had disastrous consequences: "prisoners in reformatories have better facilities," noted Berton (1960, para 6).

While the class action lawsuits cannot undo the past, they do serve the possibility of surfacing previously silenced histories (for further discussion regarding the rhetorical power of surfacing of silenced narratives see Stuckey 2011). If these cases go to trial (and are not settled out of court), two important outcomes will occur that will redress historical wrongs: first, the testimonies of many institutional survivors and workers will be entered into public record. This serves both a practical and symbolic purpose: not only will the stories of Huronia survivors be preserved in public record, but survivors will be given the opportunity to speak their truth to the powerful force of the Ontario judicial system. Second, thousands of documents pertaining to the administration of Huronia will be made publicly available, revealing the reality of institutional policy and operations and filling many of the knowledge gaps that currently stymie knowledge pursuits in this area. This paper was written in hopes of supplying enough of a cultural, historical, and social context to provide groundwork for these experiences to be understood, and to make clear the absolute necessity of the class action lawsuits against the Province of Ontario on behalf of former residents of the Huronia, Southwestern, and Rideau Regional Centres such that the once-closed chapters of Ontario's history may be opened, allowing the long-ignored stories of institutional survivors may to at last be heard.

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