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## The Growth and Decline of Institutions for People with Developmental Disabilities in Ontario: 1876–2009<sup>1</sup>

[Authors' note: Some of the terms used in this chapter were used in the past to describe conditions roughly similar to what we call developmental disabilities today. Such terms have taken on different, and mostly pejorative, meanings over the intervening time, and thus we use them in different ways today. Still, they are used in this chapter in some places for reasons of historical accuracy and because they were integral to the conceptualization of disability at the time.]

## Abstract

*Building and operating large institutions for people we describe today as having developmental disabilities spanned 133 years in Ontario, from the opening of the first asylum in 1876 to the closing of the final three facilities in 2009. Institutions were strongly supported by economic and cultural trends, and accompanying philosophical rationales, in Europe and North America, and it seemed natural for Canada to follow these trends. Institutions were intended to promote health, safety, training, and other aspects of growth and well-being, and many successes were noted. As time went on, however, overcrowding, underfunding, lack of demonstrated success, and philosophical, economic, and social changes resulted in a long decline of institutions. The philosophy of normalization, which claimed people with disabilities had the right to live in communities, became popular in the 1970s in Ontario, and resulted in the dramatic growth of community services and housing options. Community living gradually replaced the long tradition of institutional living in Ontario.*

On March 31, 2009 the government of Canada's most populous province, Ontario, announced it had closed its three remaining institutions for people with developmental disabilities. This was a very significant event, as it brought to a close the era of institutions that began in 1876 and that was characterized by housing people with disabilities in institutions, away from their families and their communities. Here, we take a look back through history to provide an overview of how and why institutions were built and operated for 133 years in Ontario, and of how and why they were closed.

<sup>1</sup> Portions of this article were adapted or reprinted, with permission, from Radford, J. P. (2011). Towards a post-asylum society: A brief history of developmental disability policy in Ontario. In I. Brown & M. Percy (Eds.), *Developmental disabilities in Ontario* (3<sup>rd</sup> ed.) (pp. 25–40). Toronto, ON: Ontario Association on Developmental Disabilities.

## Understanding the Roots of Institutionalization

The institutional era needs to be understood not only as the operation of a series of large and separated building complexes (called asylums until recent decades), but also as a state of mind. This state of mind emerged from the values and ways of thinking that created and fed the industrial revolution that burst into being and expanded dramatically throughout the 18<sup>th</sup> to 19<sup>th</sup> centuries. Industrialization was possible because of the adoption of rational thinking and scientific innovation to guide everything from the way work was done to moral philosophy. Once it was accepted that invention and change were the basis of progress, and were valued as such, innovation and change fed upon themselves at an increasingly rapid pace to invite ever more new ideas and innovation.

One way of conceptualizing these changes is through the lens of modernity. Modernity involved the centrality of the concept of the market but was deeply rooted in ideas of progress, creative destruction, surveillance, and rational bureaucracy and technique (Radford, 1994). The result was not only the creation of new challenges to the lives of people with developmental disabilities, but also the founding of new ways of responding to these challenges. Such responses were sometimes innovative and far sighted. More often, they turned out to be aggressive and hostile, as people with disabilities came to be regarded as “inefficient” and dangerous. Medical and other “scientific” research carried out at universities and other centres of learning often provided authoritative justification for horrendous policy innovations. Indeed, it is possible to conceive of the modern university as the epitome of Enlightenment thought, while the asylum represents the darker side of the Enlightenment (Radford, 2000).

Innovation and change brought about new ways of doing things. The numerous new and efficient machines quickly made the manual production methods of former centuries obsolete. But they also resulted in a dramatic change to the way that people lived. New commercial prospects mushroomed, and this soon expanded to international exploration and trade. The small established towns and cities expanded dramatically in size, and new ones sprang up rapidly to accommodate the many new factories that housed the machines, and the many

workers that were required to operate them. These towns and cities were mostly unplanned and, as a consequence, sanitation and air quality were poor, overcrowding and crime were common, and workers (including children) were exploited by requiring them to work long hours for low wages. Production was valued, but human well-being, especially among the lower classes, was not. Although almshouses, insane asylums, work houses, and other forms of “services” developed over time, the new cities and towns were ill-equipped to accommodate, or even to recognize, the economic, health, and social hardships suffered by a great many people. Although there is little existing evidence of how people with disabilities lived in these towns and cities, it seems highly likely that they did not fare well.

A solution to these unprecedented urban problems emerged from the metaphor of the machine itself. Just as a machine works well and is able to be efficient only when each of its component parts has a function and works well, so too society came to be seen as a giant machine with separate parts that all had important and connected functions (Brown & Brown, 2003). If people who could not flourish in urban environments were housed separately in asylums, in locations that featured clean air and country living, such places would surely constitute a valuable cog in the larger social machine. The practical idea of creating a valued place for a series of well-functioning types of asylums within a society was, in the beginning, promoted and acted upon by people who were for the most part both well-meaning and innovative.

Such thinking was supported by other concurrent social trends. Three of the most influential for the development of asylums for people with disabilities were: (1) the expansion of the value of education and its possibilities for human development; (2) the rise of humanitarianism; and (3) the strong acceptance of eugenics in the latter decades of the 19<sup>th</sup> century.

### Expansion of the Value of Education and Its Possibilities for Human Development

Learning and human development have been practised and valued in a variety of ways throughout recorded human history, but the

rise of rational thinking and innovation during the industrial era brought about an expansion in learning and development. Although the most prominent applications of this were in the area of industrial innovation, doors were opened to people who were not previously considered able to learn through new teaching methods and broader understanding of learning potentials. A rich philosophical groundwork for this evolved, such as Condillac's sensationalism, which claimed that learning results from information gained from using our five senses and from our internal thinking and imagining (Buell, Weiss, & Brown, 2011). The ongoing Christian tradition of care and charity toward people with disabilities also supported the development of learning (Gearheart, 1972).

The best known example of broadening understanding of the potential for human development, perhaps because it was very influential at the time, was Itard's description of the learning of Victor, the so-called "wild boy" of Aveyron. Victor had been discovered in 1797 after living about 10 years presumably in the wild on his own, and appeared to have sought help from others in the cold of January 1800. Itard surprised the world by describing how a boy who was found walking naked on all fours with no knowledge of language or the social conventions of the time could learn, over the course of five years, to dress himself, eat with utensils and drink from a cup, and understand the basics of communication (although he did not learn to speak) to an acceptable degree (Gearheart, 1972).

Itard's student, Eduoard Sequin went on to develop systematic methods of education for the "feebleminded" at Salpêtrière Hospital in Paris (Harbour & Maulik, 2010). These and other successes raised the hope that people with disabilities (especially intellectual, blindness, and deafness) could be taught many new things that had previously been considered to be impossible. As a consequence, an important rationale for building and operating asylums – and one that made them especially important cogs in the larger social machine – was to provide specialized rehabilitation training for people with disabilities. With these "modern" foundations, special schools and asylums that included education and training, and featured the exploration of new teaching methods as

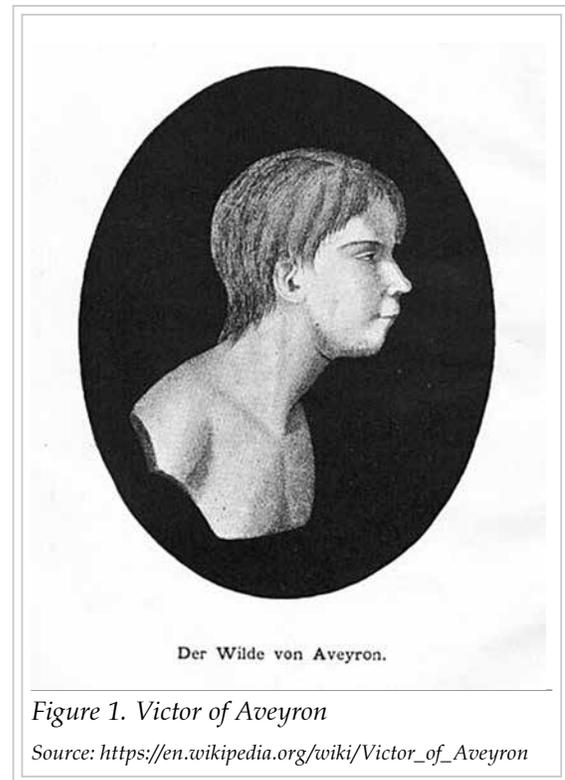


Figure 1. Victor of Aveyron

Source: [https://en.wikipedia.org/wiki/Victor\\_of\\_Aveyron](https://en.wikipedia.org/wiki/Victor_of_Aveyron)

part of what they did, were built and expanded dramatically over time (Brown & Brown, 2003).

### The Rise of Humanitarianism

Related to the growing interest in education in the 18<sup>th</sup> century was a corresponding growth in humanitarianism. Humanitarianism is a philosophical perspective that shows concern for the welfare of humanity. It views the differences among people in a kindly, sympathetic manner and promotes treating people with differences in humane ways. It implies a commitment to improving adverse human conditions and to illustrate social progress of the human race by showing concern for those least able to help themselves.

The growth of humanitarianism in Europe during this period represented a change from previous philosophy that attributed differences to various causes – even, at times, to possession by the devil that warranted punishment (Brown & Radford, 2007). It promoted the Christian value of spiritual and moral equality – that every person's soul was of equal value – that had been borrowed from early civilizations, particularly the Greeks. Over time,

humanitarianism served as the primary rationale for many social causes: anti-slavery; abolition of child labour; fairer treatment of labourers, people with mental illness, criminals, and those who were poor, old, or homeless; and even to the more humane treatment of animals.

For people with disabilities, humanitarianism helped propel political, industrial, educational, and spiritual leaders to advocate for the use of resources to construct large, well-equipped asylums away from the unhealthy conditions of the dirty and crowded cities. These self-contained communities provided opportunities for work, skill development, and social support, and offered many other advantages (Buell, Weiss, & Brown, 2011; Simmons, 1982). Many were model communities that attracted social and educational leaders in teaching, learning, and human welfare.

### The Strong Acceptance of Eugenics

Eugenics was a term coined in 1880 by Sir Arthur Galton, who was a cousin to Charles Darwin. Darwin's views on plant and animal evolution, best known through his popular 1859 book *On the Origin of Species*, summarized both his own extensive research and other scientific thinking of his time by claiming that it is the individual members of a species that best fit their environments that are most likely to survive and procreate, thus leading to a gradual evolution of the species. Eugenics built upon this idea and applied it to society as a whole. The central idea here was that it is the people and structures of society that best fit their environments that are most likely to survive, gradually changing society into new forms that are better adapted to ongoing progress. Applying this idea solely to human resources, eugenics held that society could be assisted in its evolution toward progress by encouraging the procreation of those most fit and by discouraging procreation of those least fit. People with disabilities were among those groups of people considered to be least fit.

Numerous methods of discouraging procreation, especially among the less desirable classes, were used. Moral codes that highlighted the evils of sexual activity were supported and actively promoted by leaders in religion, education, health, social services, politics, and many

other areas of life. Masturbation and promiscuity were said to cause insanity and all manner of physical ills. The breakfast cereal Corn Flakes was devised as a breakfast food that was thought to be bland enough to curb the sexual appetites on inmates in a mental health asylum in Michigan whose medical director was Dr. John Kellogg (Woodill, 1992). Men and women were housed separately in asylums and sexual contact was actively discouraged or prohibited altogether. These and many more examples provided strong barriers and a strong message for people with disabilities and many other "undesirable" groups: we do not want you to procreate.

Eugenics beliefs were widely held throughout industrialized countries, with only some minor opposition (see Box 1; Woodill, 1992). They influenced thinking over almost every aspect of life and social organization to a degree that it is difficult for us to imagine today. In Germany, as early as 1921, the idea emerged that some people in society were only "useless eaters" (Mostert, 2002), but the unequal value of people was broadly accepted in all industrialized countries. The horrors of the holocaust and the concentration camps that were discovered at the end of World War II jolted most industrialized countries into shifting away from eugenics and toward the values of social equality and human rights. However, elements of the eugenic philosophy have continued in our thinking and practice to the present day (Brown, 2014).

### Other Factors that Influenced the Development of Institutions

There were other factors, as well, that influenced the development of special schools and asylums in the mid-1800s for children and adults with disabilities. Pioneers of these institutions had the decades of experience with the mental illness and other asylums to guide them, and undoubtedly their professional ambitions played a part in fostering enthusiasm for the new facilities in which they could develop their expertise. Also, the managers of the mental illness asylums had been complaining that people who were mentally defective, with whom they were burdened, were not responsive to their treatment programs, seemed largely "incurable," and were therefore wasting the energies of their staffs. Wherever possible, *mental defectives* — as opposed to those

## Eugenics

The word “eugenics” was first used by Sir Francis Galton in the late 19<sup>th</sup> century to designate a policy, based as he claimed on “scientific principles” of intervening in the rate of reproduction of particular social groups. Charles Darwin had already pointed out that modern medicine and charity interfered with traditional Malthusian checks on the reproduction of the poor. Galton argued that unless this was remedied by assisting nature in weeding out the “unfit,” society would continue to be plagued by poverty, prostitution, slums, and other problems. Prominent among the “problem populations” were people with low intelligence, especially those marginally “subnormal” and lacking physical stigmata – a group newly identified as the “feeble-minded.”

Eugenic ideas in their various forms permeated British society up to World War II. Both of the most commonly proposed solutions to the “problem of the menace of the feeble-minded” – birth control and forced sterilization – met with technical, legal and moral barriers. One alternative was to establish criteria whereby obvious “offenders” could be detained in asylums during their reproductive years on grounds of low intelligence. The Mental Deficiency Act of 1913, although less draconian than what eugenic activists wanted, laid the legal groundwork for this and, in the 1920s, a huge expansion took place in the number and size of custodial institutions in response to demands created by referrals from social workers, physicians and magistrates.

Eugenic ideology was adopted in the United States, where implementation was much more rapid. Some states established institutions that were explicitly eugenic in inspiration. One example of this is the Asylum for Feeble-minded Women at Newark, NY, set up to restrict women “of childbearing age.” In addition, programs of involuntary sterilization of both males and females were instituted in 30 states by 1940. These programs rested on dubious legal grounds until 1927 when the US Supreme Court sanctioned involuntary sterilization of “imbeciles,” especially if their condition could be shown to have been “passed down” beyond two generations. Sterilization and custodial segregation were jointly implemented as eugenic control measures.

Canada experienced the same trends, but generally later and less intensively. Sterilization programs were established in Alberta in 1928 and British Columbia in 1933. More than two thousand people were sterilized under the Alberta law before it was repealed in 1971, a large proportion of them after 1955. A similar law was recommended by a commission in Ontario in 1929, but was never passed and the province relied instead on segregation. Yet, given the position of numerous officials in Ontario (including professional bodies such as the Ontario Medical Association, and key figures like H. A. Bruce, Lieutenant Governor from 1932 to 1937), it seems unlikely that the province remained free of eugenic sterilization procedures.

Source: Radford, 2011. See also, McLaren, 1990.

considered to be insane (or mentally ill, as we would call it today) – were placed in separate annexes or wings of the insane asylums, where they often received nothing more than basic custodial care. Specialized institutions for people who were labelled *idiots* or *mentally defective* seemed to be the answer.

Today, it is almost impossible for us to understand the scale on which asylums were part of the way the more economically advanced

countries of the world were organized. There were workhouses, poorhouses for people who could not pay their debts, insane asylums for people with mental health problems, orphanages, hospitals and asylums for those with limited intellectual capacity, and many others. Photographs that remain today show clearly that large amounts of money were spent on these building complexes, which were often very substantial and extensive (see Figure 2 for an example). They housed and provided daily

activity for hundreds of thousands of people who were deemed not to be able to cope with the demands of modern life. There seems little doubt that institutions of various kinds were the major way the newly-industrialized countries took care of their social problems (although emigration and deportation were also widely used), and were valued for this reasons.

### The Roots of Institutionalization in Canada

The lands that are now known as Canada have been home to numerous native peoples for thousands of years, but were quickly dominated over the course of a few centuries of colonization, first by people from France (mainly in what is now Quebec, New Brunswick, and Nova Scotia), and later by people from the British Isles. The priority of the early European settlers in Canada was to establish themselves and to take advantage of the resources and opportunities the country had to offer and, aside from Christian charity, it is perhaps not surprising that there was little formal provision for children or adults with disabilities before the middle of the nineteenth century. But economic and social ideas from

Europe increasingly predominated in Canada, as they did in other countries that were settled by migrating Europeans and this, no doubt, included the idea that institutions hold a legitimate and valued place within the social order.

### The Growth of Asylums in Ontario

Ontario experienced a large growth in its population during the period 1825–1875 due to the settlement of immigrants who arrived mainly from England, Scotland, and Ireland. These immigrants, like the earlier European settlers in Ontario, were accustomed to the idea of asylums as an acceptable part of the human social order. The need for asylums was not great, initially, as most people lived in rural communities where people with disabilities could be housed naturally with their families. Still, such a need was anticipated, and in 1839 the Ontario government enacted a law that set the stage for later building of institutions. The law was called *An Act to Authorise the Erection of an Asylum within this Province for the Reception of Insane and Lunatic Persons* (Ontario Ministry of Community and Social Services, 2012a). Although this law specif-



Figure 2. Southwell workhouse, established 1824

Source: Gavin, J. A. (2013). *The Workhouse, Southwell, Notts, UK*. Retrieved from [https://commons.wikimedia.org/wiki/File:Workhouse\\_Southwell.JPG](https://commons.wikimedia.org/wiki/File:Workhouse_Southwell.JPG)

ically referred to “insane and lunatic persons” and not to “idiots,” the door had been opened for asylums of all types.

There were many models available for Ontario, especially in England and the United States, where asylums of various types had already been constructed. The benefits of building and operating asylums were widely accepted and followed. It was an easy shift of thinking for people in Ontario in the mid-1800s to consider building asylums for people referred to as lunatics and idiots.

Only a small proportion of people diagnosed as idiots, and later as feeble-minded or mentally deficient, were actually institutionalized, but this was due mainly to lack of space and resistance to the level of public spending that would have been required. It was widely agreed that, in a perfect society, all such people would be “put away,” and it was often said of those who remained in the community that they “belonged in an asylum.” The asylums created a place for mental deficiency within the social order, and it was widely believed that this place was both proper and beneficial for all. Such beliefs provided the rationale for Ontario’s first asylum for idiots.

## Ontario’s First Asylum for Idiots

In 1876, the Orillia Asylum for Idiots opened just outside the town of Orillia, north of Toronto (see Figure 3). It initially occupied a building that had functioned earlier as a branch of the Toronto Lunatic Asylum on a plot of land on Lake Couchiching. This was the first asylum specifically for idiots in Ontario, although many idiots were previously housed in asylums for the insane in Toronto, London, Kingston, and Hamilton, which, in 1876, housed a total of 1,753 males and females in almost equal numbers. According to the Ninth Annual Report of the Inspector of Asylums, Prisons, and Public Charities for the Province of Ontario for the Year Ending 30<sup>th</sup> September, 1876 (Ontario Sessional Papers, 1877)

The building [the Orillia Asylum] was ready for patients on the 25<sup>th</sup> September, when the idiots confined in the Branch of the London Asylum [for the insane], numbering thirty-five, were at once transferred to it, and immediately following, all that were in custody in the Common Gaols, together with the most urgent cases that had been reported from private houses. At the date of writing this report [30<sup>th</sup> September], there are one hundred and three inmates in the Asylum... In



Figure 3. The Orillia Asylum for Idiots, 1914. © Queen’s Printer for Ontario, 2012b

Source: Ontario Ministry of Community and Social Services (2012b).

addition, to the inmates in residence, admission has been awarded to 17 idiots, who had not then been brought forward, but when admitted would increase the population to 120, leaving only 30 vacant beds in the Asylum. (p. 38)

The inspector made it clear that education and training were to be a priority for the younger people in the Asylum:

Of this number of inmates, no less than 26 are under the age of fifteen, a large proportion of whom are susceptible of training and instruction. It is for this class of idiotic persons that better and more suitable provision should be made...The class of idiots for whom it is most desirable that something should be done in this province, are the youths between the ages of 5 and 14. These idiotic and imbecile children, of whom there cannot be less than from 200 to 300 in Ontario, are now growing up without any training or instruction... (p. 38)

It is also interesting to examine the report's proposed budget of the Orillia Asylum for Idiots for 1877, when it was expected there would be 150 patients (see Figure 4). Supplies, including medicines, food, fuel, bedding and furniture, farm feed and fodder, and repairs, totalled \$14,800, or \$98.67 per person for the year. Salaries of asylum personnel, totalled \$22,518, or \$150.12 per person for the year (Ontario Sessional Papers, 1877).

Its capacity of 150 "patients" was soon exceeded, and in 1885 the government purchased 150 acres of land a mile south of the town for development as a large custodial institution. Frequent expansion of the site and construction of new buildings brought about an every-increasing number of patients in the Orillia Asylum. By 1890, it had 309 residents, and by 1902 that number had risen to 652. In 1934, the number of residents was 1,916 and, at its peak in 1961 it had 2,800 residents, although this declined to 2,600 by 1968. The staff numbered 1,120 (Radford, 2011). Throughout, thousands of people diagnosed as *mentally deficient* had lived out their entire lives in these segregated facilities. "Patients," separated according to gender and diagnosis, were allocated beds in one of more than a dozen buildings, some of which contained several wings and corridors. These became so overcrowded that beds were lined up in rows, and many patients spent most of their time living in their beds (see Figure 5 on the following page).

ESTIMATE OF ASYLUM EXPENDITURE FOR THE YEAR 1877.			
Details.			
5. ASYLUM FOR IDIOTS, ORILLIA.			
(For 150 Patients)			
	To be Voted for 1877.	Voted in 1876.	
	\$ cts.	\$ cts.	
Medicine and medical comforts.....	200 00	200 00	
Fuel.....	2,000 00	2,000 00	
Butchers' meat.....	2,500 00	2,500 00	
Flour.....	1,500 00	1,500 00	
Butter.....	1,200 00	1,200 00	
Gas and oil.....	500 00	250 00	
Groceries.....	2,000 00	1,750 00	
Fruit and vegetables.....	600 00	500 00	
Bedding, clothing and shoes.....	1,500 00	1,500 00	
Furniture and furnishings.....	400 00	400 00	
Laundry and soap.....	400 00	300 00	
Farm, feed and fodder.....	400 00	400 00	
Miscellaneous.....	600 00	400 00	
Repairs and alterations.....	400 00	400 00	
Milk.....	600 00	300 00	
	<b>\$14,800 00</b>	<b>\$13,400 00</b>	
Salaries and Wages.			
	No. of officers and employees.		
Medical Superintendent.....	1	1,600 00	1,600 00
Bursar.....	1	800 00	800 00
Matron.....	1	300 00	300 00
Engineer.....	1	600 00	600 00
Assistant Engineer.....	1	240 00	240 00
Carried forward.....	5	18,340 00	16,940 00
49			
Brought forward.....	5	18,340 00	16,940 00
Chief Attendant.....	1	300 00	300 00
Night Watcher.....	1	240 00	240 00
Ordinary Male Attendants.....	4	960 00	960 00
Gardener.....	1	300 00	300 00
Messenger and Porter.....	1	240 00	200 00
Females.			
Chief Attendant.....	1	200 00	180 00
Ordinary Female Attendants.....	4	480 00	480 00
Night Attendant.....	1	120 00	120 00
Cooks.....	2	252 00	252 00
Laundresses.....	2	252 00	252 00
Housemaids.....	4	384 00	384 00
Seamstress.....	1	200 00	
Extra Assistance.....		250 00	
	<b>28</b>	<b>\$22,518 00</b>	<b>\$20,908 00</b>

Figure 4. Estimate of Orillia Asylum for Idiots spending for 1877

Source: Ontario Sessional Papers (1877) 2, 48-49

In addition to the 120 acres occupied by buildings, the facility had 318 acres that "patients" used for growing crops, and a further 220 acres of bush. A goal of this facility, like others in Ontario and other countries, was to be as self-sufficient as possible. Farmland and farm buildings were used to grow food crops and animals to feed residents and staff, as well as to sell for profit. Considerable effort was put into this aspect of operating the asylum and, as a result, the produce was often considered of high quality and the methods innovative. Wood was gathered from the on-site bush for heating. Domestic chores, such as laundry, cleaning, and repairs were also carried out. Residents provided much of the labour required for the agricultural and domestic aspects of running the asylum, a factor that later worked against rehabilitating people to community settings and contributed to over-crowding.

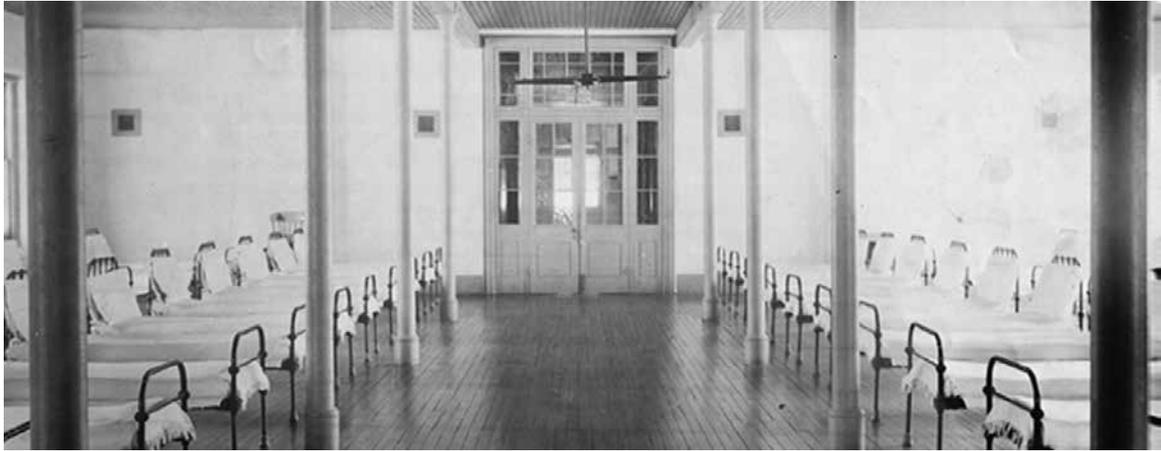


Figure 5. Ward in an Ontario institution. © Queen's Printer for Ontario, 2012b

Source: Ontario Ministry of Community and Social Services (2012b).

The reasons for continued demand for increased space at Orillia in the first half of the 20<sup>th</sup> century were partly demographic. Not only was Ontario's population increasing, but also medical improvements extended life expectancy for vulnerable people. However, political and social changes were more important. Beginning around the turn of the century, some of the earlier stereotypes were newly reinforced by "scientific" research. Social Darwinists suggested that too many of the "unfit" were surviving beyond infancy, resulting in larger numbers of disabled people requiring care. An influential body of opinion argued for limiting the birth rate of people with low intelligence. The rise of intelligence testing, applied to recent immigrants as well as school children, and the medical testing of military recruits, suggested that the overall level of intelligence of the population was at stake. This line of thinking was common in Britain, the United States, Canada, and elsewhere. It placed the so-called *feebleminded* at the centre of the eugenic movement.

The name The Orillia Asylum for Idiots was later "modernized" to the Orillia Asylum, then to the Ontario Hospital School, Orillia. In the decades prior to its closing in 2009, it was known as Huronia Regional Centre.

This was the first of numerous asylums that were constructed and operated throughout Ontario. In a sense, it served as a prototype for the others. Ironically, though, by the time

Ontario opened its first specialized idiot asylum in 1876, the early era of optimism for their success in England, the northern United States, and elsewhere was largely over. Still, such was the strength of the thrust of institutionalization in society as a whole in the 1800s that this was only the first of 20 institutions for people we now refer to as having developmental disabilities that were built in Ontario as late as the 1960s.

### The Growth of Other Asylums and Institutions in Ontario

The facility at Orillia remained the only large asylum in Ontario until the 1950s, although smaller institutions had opened: Oxford Regional Centre in Woodstock in 1905, and D'Arcy Place in Cobourg 1920. Plans to develop a large asylum at Smiths Falls date back at least to 1934; however, the asylum did not open until 1951, one year after another small institution had opened in Aurora. The Ontario Hospital School, Smiths Falls, as this institution was first called, was renamed Rideau Regional Centre in 1974. It quickly became the second largest facility in Ontario, eventually reaching a peak resident population of 2,650.

The other very large institution in Ontario was built in a rural area south of Chatham. It opened in 1961 and was originally called The Ontario Hospital School for Retarded Children at Cedar Springs, later changing its name to Southwestern Regional Centre. Its population in

1971 was 937 residents, and it continued to operate until its closure in 2008 (Ontario Ministry of Community and Social Services, 2012b).

Many other facilities were opened over the next 20 years, reflecting a concerted effort by the Ontario government to effect a program of regionalization (see Table 1 on page 17 and Figure 6 on page 19). What came to be called Schedule 1 Facilities – mostly large sets of buildings with high resident populations – were operated directly by Ontario’s Ministry of Community and Social Services and staff were Ministry employees. Schedule 2 Facilities were for the most part smaller institutions that operated more at arm’s-length from the Ontario government, in that they were directed and operated by independent Boards of Directors but received their funding from the Ministry of Community and Social Services.

At the height of the asylum era, about 1970, Ontario had 20 institutions, almost half the number that existed in Canada (see Table 2). More than 10,000 people lived in them, both children and adults. From the opening of the first institution in 1876 to the closure of the last ones in 2009, over 50,000 people with a developmental disability had lived in these institutions.

### Other Institution-Like Programs

Besides the more formal institutions described above, there were numerous smaller institution-like programs throughout Ontario. These were run by various municipalities and charitable organizations. An example was The Haven, a residential program for the Toronto Prison Gate Mission. The Haven was established in 1878 to serve women labelled as “friendless” and “fallen,” but some of its residents would probably have been recognized as mentally deficient in some way. In 1909, its superintendent reported in a letter (Gunn, 1962):

The branch of our work which has increased greatly...is the care of the feeble-minded... In recognition of what we are trying to do for them in the way of mental and industrial training, the Ontario Government has given us a special grant.

This function was given official recognition in a 1918 amendment that added the “custodial care of the feeble-minded” to its mission statement.

Table 2. *Canadian Institutions (1970)*

<i>Province</i>	<i>Institutional Population</i>	<i>No. Reporting Institutions</i>
Prince Edward Island	19	1
Nova Scotia	421	5
New Brunswick	165	1
Quebec	3736	6
Ontario	7256	20
Manitoba	1417	2
Saskatchewan	1463	2
Alberta	2342	2
British Columbia	2270	2

*Source: Dominion Bureau of Statistics (Health and Welfare Division) (1970)*

The purpose of The Haven was revised in 1925 to admit “retarded” children under six years of age from other Toronto care-giving institutions pending their admission to Orillia.

### Rationale for Continued Expansion of Institutions

Part of the rationale for continued institutional expansion was a fear, or a sense of threat, to society. The 1876 view of the Inspector of Asylums, Prisons, and Public Charities (Ontario Sessional Papers, 1877) that “idiotic and imbecilic children...are constantly contracting vicious habits, and in many cases dangerous propensities” (p. 38) continued for a century. This view was fueled for several decades by the eugenic philosophy – held and perpetuated by leaders of almost every area of society – that feeble-mindedness can and should be curbed to the greatest extent possible for the benefit of society as a whole.

At the same time, the idea that institutions were good places for “idiotic” or “feeble-minded” people to live had a humane rationale. There was genuine professional and social concern, at a time when extremely few education and community support opportunities existed, over the burden placed on families by having

Table 1. Ontario Institutions

**Huronian Regional Centre,<sup>1</sup> Orillia**

Opened: 1876

1971 resident population: 1857

Designated as a Hospital School. Originally known as the Orillia Asylum for Idiots, this facility served all of Ontario for most of its history. By

1970, the catchment admission area was narrowed to accommodate individuals from Halton, Peel, York, Simcoe, Muskoka and Parry Sound. Classified as a residential facility providing medical intervention, education and training to people with mild, moderate, severe and profound disabilities of all ages.

**Oxford Regional Centre,<sup>2</sup> Woodstock**

Opened: 1905

1971 resident population: 317

Designated as a Mental Retardation Unit in a Psychiatric Hospital. Originally designed to accommodate epileptics and TB patients from the Orillia facility, care was also provided to residents classed as "ambulatory epileptics." Residents came from all parts of Ontario and ranged in age from 45 to 55 years.

**D'Arcy Place,<sup>2</sup> Cobourg**

Opened: 1920

1971 resident population: 281

Designated an Ontario Hospital (Mental Retardation Services Branch). Constructed in 1900 as a school and turned into a hospital in 1915. Became a mental hospital in 1920. Was appropriated to serve the southeastern planning area of Ontario and to provide training and rehabilitation for women over 16 years of age. A population with social and behavioural problems and some psychoses came to dominate this facility.

**Pine Ridge Centre,<sup>2</sup> Aurora**

Opened: 1950

1971 resident population: 190

Designated an Ontario Hospital (Mental Retardation Services Branch). Constructed in 1915 as a school for boys, the facility was taken over in 1950 to ease overcrowding at Orillia. Accommodation was for males from 16 years of age. Ambulatory care was provided for those with serious disabilities. Referrals came from all of Ontario.

**Rideau Regional Centre,<sup>1</sup> Smiths Falls**

Opened: 1951

1971 resident population: 2070

Designated as a Hospital School. Intended to serve the southeastern and northeastern region of Ontario. Designed as a residential facility for people of all ages and all degrees of disability.

**Durham Regional Centre,<sup>2</sup> Whitby**

Opened: 1950s

Provided diagnostic and counselling services for Victoria and Durham counties, as well as institutional placement.

**Northwestern Regional Centre,<sup>2</sup> Lakehead**

Opened: 1960s

1971 resident population: 300

Designated as a Mental Retardation Unit in a Psychiatric Hospital. Located in the northwestern planning region of Ontario, accommodation provided for children classified as ambulatory, educable and trainable. The adult unit had a capacity of 160 for the purpose of rehabilitation.

**Surrey Place Centre,<sup>5</sup> Toronto**

Opened: 1960s

Designated as a Diagnostic Centre. It remains open as an assessment, service, and research centre.

**Children's Psychiatric Research Institution,<sup>6</sup> London**

Opened: 1960

Designated as a Diagnostic Centre. This was the first community-centred psychiatric hospital designed for the treatment of "mentally retarded" children. This research institute provides primarily an out-patient service, but has accommodation for in-patient services.

**Cedar Springs (Southwestern Regional Centre),<sup>1</sup> Blenheim**

Opened: 1960

1971 resident population: 937

Designated as a Hospital School. Catchment area included the southwestern portion of Ontario but experienced difficulty in procuring community contact owing to its isolated location. Care was provided for all degrees of mental and physical disability as well as out-patient services for Kent County.

Table 1. Ontario Institutions (continued)

**Muskoka Centre,<sup>2</sup> Gravenhurst**

Opened: 1963

1971 resident population: 358

Established and administered as an extension to Orillia to relieve overcrowding. Care was provided to infants, adolescents, adults and geriatrics with varying degrees of disability. Residents were predominantly female. A travelling clinical team serviced Simcoe, Muskoka, Parry Sound and the northern portions of Ontario.

**Midwestern Regional Centre,<sup>2</sup> Palmerston**

Opened: 1965

1971 resident population: 216

Designated as a Hospital School. Intended as a residential facility for children over six years of age, it was outmoded by 1971 owing to the influx of an adult population. Designated to service the southwestern region of Ontario.

**Adult Occupational Centre,<sup>2</sup> Edgar**

Opened: 1966

1971 resident population: 250

Designated an Adult Occupational Centre. While originally a radar station, it became co-educational and a community preparation facility for young adults diagnosed with mild intellectual disabilities. Its goal was community placement.

**Prince Edward Heights,<sup>2</sup> Picton**

Opened: 1970

1971 resident population: 60

Designated an Adult Occupational Centre. Designed to serve the Lake Ontario planning region, accommodation was made for people at all levels of disability. Facility was designed to house 600.

**Penrose Division of the Ongwananda Hospital,<sup>2</sup> Kingston**

Opened: 1970

1971 resident population: 140

Designated as a Mental Retardation Unit in a Psychiatric Hospital. Located in the southeastern planning region of Ontario; accommodation was provided for young adults with any degree of disability, but individuals were required to be ambulatory. Also known as Ongwanada Sanatorium.

**Other centres 1950 to 1980**Bethesda Home, Vineland<sup>3</sup>Blue Water Centre, Goderich<sup>3</sup>Brantwood Resident Development Centre, Brantford<sup>3</sup>

Centre for the Developmentally Challenged, Thunder Bay

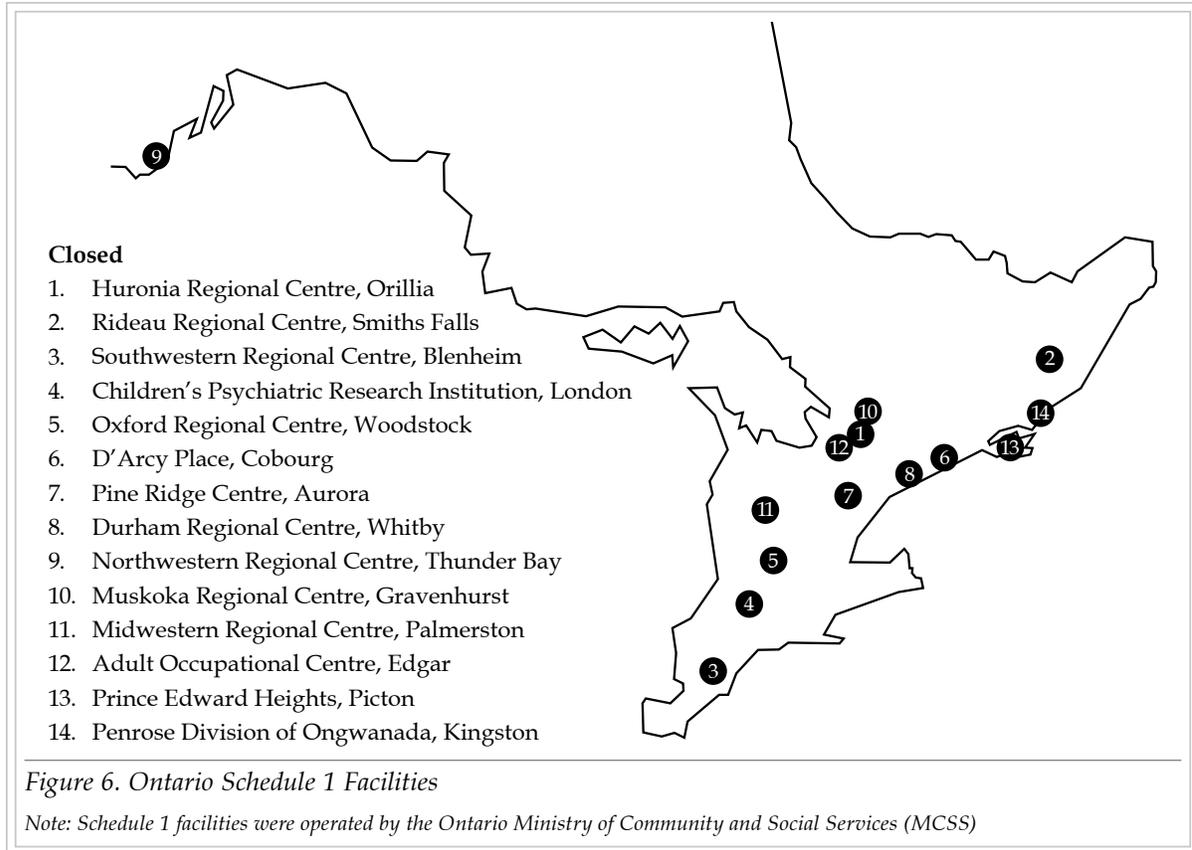
Christopher Robin Home, Ajax<sup>3</sup>Cochrane Temiskaming Resource Centre, South Porcupine<sup>5</sup>

Dr. Mackinnin Philips Hospital, Fort William Sanatorium, Thunder Bay

Nippissing Regional Centre, North Bay

Oaklands Regional Centre, Oakville<sup>3</sup>Ontario Homes for Mentally Retarded Infants, Plainfield/Plainfield Children's Home, Belleville<sup>3</sup>Rygiel Home, Hamilton<sup>3</sup>St. Lawrence Regional Centre, Brockville<sup>2</sup>St. Thomas Adult Rehabilitation and Training Centre, St. Thomas<sup>2</sup>Sunbeam Residential Development Centre, Kitchener<sup>3</sup>Thistleton Regional Centre for Children and Adolescents, Toronto<sup>6</sup><sup>1</sup> MCSS Schedule I facility, closed in 2009<sup>2</sup> MCSS Schedule I facility, closed prior to 2009<sup>3</sup> MCSS Schedule II facility, closed<sup>4</sup> Formerly an MCSS Schedule I facility, now under MCSS's Child and Family Services Act, still in operation<sup>5</sup> Formerly an MCSS operated centre, still in operation as community agencies<sup>6</sup> Now operated by the Ontario Ministry of Children and Youth Services

\* MCSS: Ontario Ministry of Community and Social Services



to care for a son or daughter with a disability. Surely, it was thought, it was better that the individual have access to constant professional care and that the heavy responsibility be lifted from the family. Because institutions were communities separated geographically from mainstream society, there was both a practical and a corresponding conceptual lifting of family and community responsibility. "Idiots" and the "feeble-minded" were set apart in people's minds as those who live elsewhere, as different, and as not one of us. Institutions were the best place for people with disabilities to live, they were the place where such people "belonged."

Also, with an increasing tendency to look upon developmental disability primarily as a medical condition, placement in specialized facilities seemed entirely appropriate. Many of the asylums were re-named "hospitals," and their division into wards and the enumeration of their capacity in terms of "beds" indicated a medical model of care. In most jurisdictions, including Ontario, asylums were run by the health authorities and staffed by medical doctors and nurses along with psychologists, dietary nutritionists, dentists, and others.

In judging history, it is important to understand that this rationale was based on perceptions and beliefs that changed over time in keeping with philosophical and scientific developments, and with evolving social and economic realities. What is perhaps most instructive, though, is to understand that this rationale did not continuously support, and in fact very often contradicted, the original idea of asylums as places of care, safety, training, and rehabilitation. It was almost impossible for asylums to succeed under these conditions.

### Why Else Did Institutions Decline?

The decline of institutions did not come about quickly or easily. No single event of reason marked their decline, but several important factors contributed to a transition in thinking and services that extended over many decades.

As has been noted, the early pioneers were primarily well-meaning people who were optimistic that their innovations would be beneficial to

both the inmates of the asylums and to society as a whole. But the optimism of the pioneers was short-lived. Old stereotypes proved durable, the reformers were unable to demonstrate many successes (Brown & Brown, 2003), and the rationale for the existence of institutions evolved over time. The need to justify their existence as therapeutic facilities led, in some cases, to setting up demonstration projects where education programs were applied only to the least disabled children. Gradually, the ideal of habilitation faded, and the managers resigned themselves to a custodial, rather than an educational, role. The asylums became places in which people grew old, and this was a powerful social symbol that mental deficiency was both permanent and incurable. As Brown and Brown (2003) noted, "Even if many institutions started out as the benign well-oiled machines they were envisioned to be, they rusted out in time" (p. 61).

Right from the beginning of the institutional era in Ontario, there was concern about overcrowding and the high cost of caring for those who lived in institutions. In his report to mark the opening of the Orillia Asylum for Idiots in 1876 (Ontario Sessional Papers, 1877), the inspector of asylums, prisons, and public charities noted that, upon opening, only 30 of the 150 beds were unoccupied. In the same report, he called for education and training to reduce the ongoing need to care, and provide housing, for adult idiots:

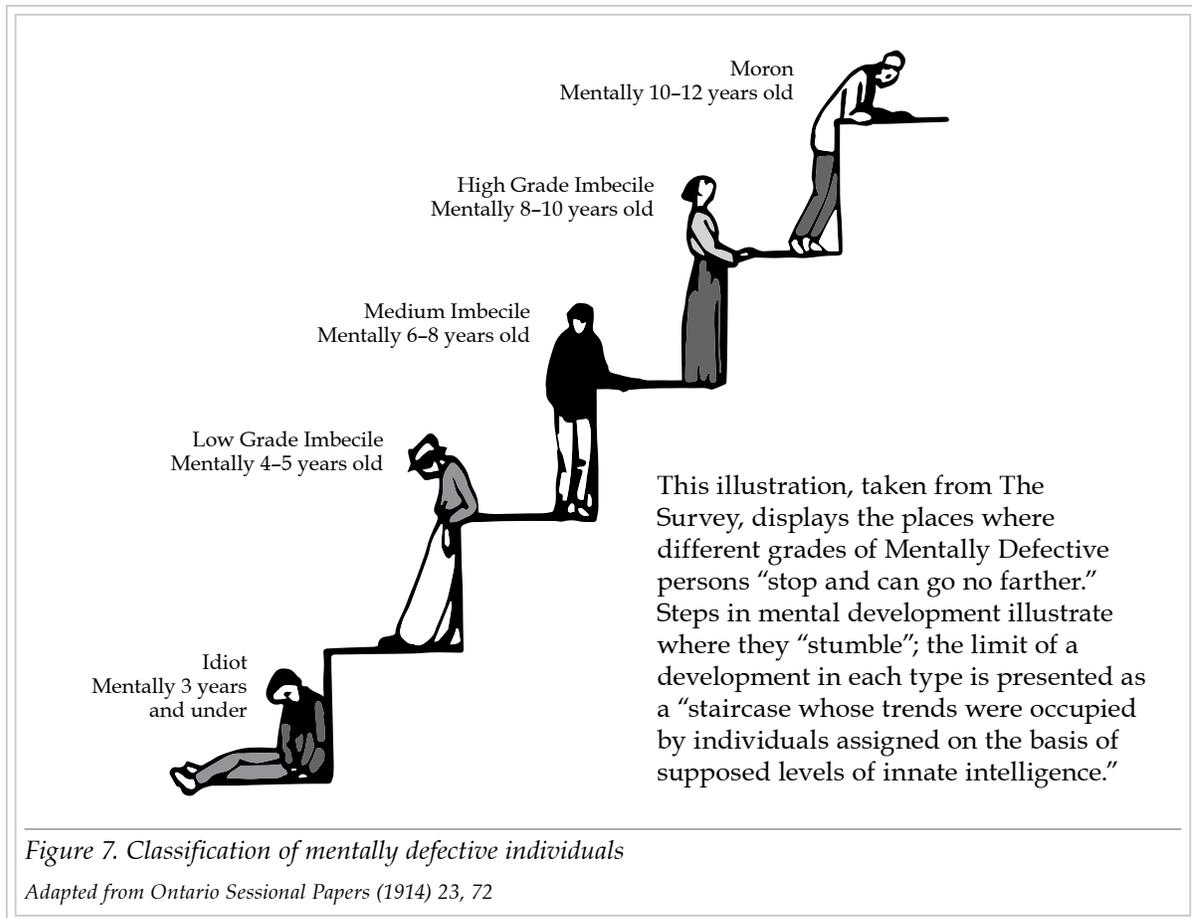
...it becomes a question for the serious consideration of the Government and the Legislature, if a well devised effort should not be made to reduce the number of adult idiots who require to be supported by the public and confined in asylums... When we consider that every adult idiot placed in an Asylum...will have to be supported for twenty or thirty years in an Asylum, at a cost of \$140 a year, even public economy suggests the adoption of the only remedy that can be provided—viz., the establishment of a training school. (pp. 38–39)

Such concern for training and rehabilitation continued throughout the twentieth century, although with lesser emphasis. For example, The Haven, referred to above, was a Toronto residential program that saw its mission change over time, but served for several decades in the twentieth century as a stepping-stone for resi-

dents of institutions (first, "wayward" women, and later men) to be rehabilitated. The women were primarily trained and supported to work as domestics in private homes. Elsewhere within institutions, there were continuous efforts to rehabilitate. As late as the 1970s, men from institutions worked on local farms as part of their "training" although some were maltreated (Williston, 1971).

At the same time, the idea continued to grow that idiocy or feeble-mindedness was a permanent state and therefore resistant to training. In 1906, Ontario was concerned about the problem of "feeble-mindedness" and appointed an Inspector of the Feeble-minded, Dr. Helen MacMurchy, who held the post until 1919. MacMurchy believed strongly in the necessity of "care and control" of the feeble-minded. For her, the keys to care and control were intelligence testing and providing adequate facilities. In her annual reports, she claimed that Ontario lagged behind Britain, Germany and several jurisdictions in the United States in these areas. She believed that the two main foci of concern should be children and "feeble-minded women of childbearing age." A classification of *mentally defective individuals* from 1914 illustrates the deterministic view of the time: once a person was placed into a "scientifically" assigned category, he or she remained there, doomed by some kind of arrested development to occupy for life a particular rung on the hierarchical ladder of intelligence (see Figure 7 on page 21). This view worked against the idea that training and rehabilitation could be successful.

The economics of supporting institutions worked against their success. Although their budgets paled in comparison to those of some other health units, the amount of government investment and staffing required to operate the facilities was sufficient to generate competition among Ontario communities whenever expansion of the institutional system occurred. In short, communities were interested in such investment because institutions took a lot of money to operate. Even so, the institutions could never keep up to the demand for placement, and the benefits of sending people with disabilities to live in institutions waned over time as the ever-increasing cost to the public was considered.



Constant demand for placement, and political reluctance to fully expand the institutional system to house all those who were feeble-minded (by the mid-twentieth century referred to as mentally deficient and later mentally retarded) led to overcrowding and to being places of last resort to live. Living conditions deteriorated, and both family members and some in the general public began to notice. Parent and other advocacy groups strongly criticized living conditions in the "hospitals for the retarded." Sometimes they called for increased funding and improved asylum programs. Increasingly, though, they argued for resources to provide care in community settings as an alternative to large institutions.

In Ontario, the most effective group was the Ontario Association for Retarded Children (OARC), formed in 1953 from a number of regional parental groups. Constant rumours about the poor conditions at the Orillia institution were brought into focus in 1959–1960,

when Pierre Berton accompanied the chair of the OARC and his son to the Orillia Hospital and wrote about his impressions (see Box 2). The fact that living conditions in this institution were experienced in a negative way by many "patients" became particularly evident in 2010 when a class action suit was initiated by former residents who claimed to have experienced ongoing abuses while they lived there.

By the 1960s, it was apparent that attitudes were changing and new policies were required. Important initiatives were undertaken at the federal level that affected all provinces. The Federal-Provincial Conference on Mental Retardation in 1964 stimulated research, and proved a catalyst in identifying needs and effecting better co-ordination of provincial services (Mooney, 1971). A significant milestone was the creation of the National Institute on Mental Retardation (NIMR) in 1967 under the authority of the Canadian Association for the Mentally Retarded (CAMR). Following the

appointment of G. Allan Roeher as its first full time director (coinciding with the move to a new building on the York University campus in 1970), NIMR quickly became an unrivalled information and resource centre, library, and research organization devoted entirely to developmental disability issues. The NIMR represented a strong willingness on the part of governments, parent organizations, academics, and disability professionals to look at new ideas in mental retardation. Conceptually, these new ideas had already moved away from institutions as a viable option.

## Community Living as a Viable and Preferred Alternative

An emerging body of theory, developed in close association with advocacy groups, lent authority to the movement away from institutions. Known as *normalization*, it set forth principles that endeavoured to demolish the restricting constructs of disability by altering the individual's environment. In the view of Bengt Nirje, one of the pioneers in the movement, disability consists of three components. First, there is the primary medical or physical condition that is usually the most visible, but that is increasingly

### Pierre Berton's Visit to Orillia

On January 7, 1960 Pierre Berton, the well-known journalist and historian, published a column in the Toronto Star reporting on a visit he had made to the asylum at Orillia. The article precipitated a series of attacks on the provincial government's policy of relying on huge, out-of-date and overcrowded institutions rather than committing resources to community facilities. It also gave great encouragement to members of voluntary associations such as the Ontario Association for Retarded Children, which had long advocated for policy changes.

In 1982, Harvey Simmons, a professor of political science at York University, recognized the pivotal role that Berton's article had played in reinforcing calls for changes in policy by featuring it in the prelude to his book *From Asylum to Welfare* (Simmons, 1982). Here is an edited version of Simmons' description of Berton's visit and his summary of the Toronto Star article:

On the last day of 1959, Pierre Berton, a well-known columnist with the Toronto Star, Jerry Anglin, institutions chairman of the Ontario Association for Retarded Children (later the Ontario Association for the Mentally Retarded) and Anglin's 12-year-old retarded son Mark drove from Toronto to return Mark to the Ontario Hospital at Orillia. Berton had heard some disturbing rumours about poor conditions at Orillia and had decided to visit the institution, but fearing the staff there might not be completely frank, he invited

Anglin to go along. While Berton and Anglin were chatting in the front seat of the car, Mark became sick and vomited in the back seat. This was his reaction to returning to Orillia. Upon their arrival, Berton was shown around the institution and given a tour of some of the oldest and worst buildings. Six days later, under the heading: "What's Wrong at Orillia: Out of Sight, Out of Mind," Berton wrote about what he had seen. There were, he claimed, 2,807 people in facilities for 1,000 while 900 of the residents were housed in 70-year-old buildings.

It is distressing to visit these older buildings ... The thought of fire makes the hair rise on your neck ... the paint peels in great curly patches from wooden ceilings and enormous, gaping holes in the plaster show the lathes behind. The roofs leak, the floors are pitted with holes and patched with plywood ... The beds are crowded together head to head, sometimes less than a foot apart. I counted 90 in a room designed for 70. There are beds on the veranda. There are beds in the classroom ... The stench is appalling even in winter. There are 4,000 names on file at Orillia and an active waiting list of 1,500 people who have written in the last year. Political considerations have made Orillia's situation more acute. The hospital was originally designed for children six years and older. It is now heavily crowded with children under that age ... Orillia's real problem is political neglect. (Simmons, 1982, p. xv)

open to medical and other scientific advances. Second, there is the broader environment — the living conditions, daily routines, economic status, and prevailing social attitudes. The third component is the identity of the disabled person, himself or herself, affected by the physical condition certainly, but not in the deterministic way often presented, and comprising self-images that are reflections of the broader environment (Nirje, 1969). Herein lay some of the key ideas at the root of the social model of disability that exploded onto the scene 20 years later.

In Nirje's view, the key to reform was to intervene in this complex inter-relationship by altering the physical and social environments. But what kinds of environments are most suitable? The answer, quite simply, was the same rich variety of social niches within which everyone else creates their life-worlds — in other words, a set of "normal" environments. People with developmental disabilities, Nirje argued, should be afforded normal daily, weekly, and yearly routines, ordinary housing, ordinary economic circumstances, and the usual life-chances. Similar ideas were advanced by other researchers, notably Wolf Wolfensberger, whose 1972 book *The Principle of Normalization in Human Services* (one of NIMR's first major publications and, arguably, its most influential) is the classic and most comprehensive statement of the concept and its application. Normalization, it was claimed, was all about abandoning the stereotypes and ideologies of difference, and substituting in their place the principle of inclusion.

The implications were enormous. Clearly, they would involve the closing of institutions where rhythms of daily life, the life-worlds, and life-chances were antithetical to any conception of normal living. But, as Wolfensberger claimed, the effect would be felt on every aspect of "human management services," requiring the total integration of people with a disability into the community.

From our perspective in the early twenty-first century, it is difficult to appreciate why these proposals were so controversial. In the society of the early 1970s, though, people were still attuned to the "difference" of developmental disability, and normalization was widely misunderstood, or at least misrepresented.

Some charged that to portray the person with a developmental disability as "normal" was to deny reality. Here, it seemed to the critics, was another instance of unfounded optimism. Some of the opposition stemmed from a sense of protectiveness. "Normal" environments can be hazardous, and it was considered by many that some people had needs that could only be met in the safety of the asylum. Family members who had placed their relatives in closed institutions were often worried by the prospect of having to provide unaccustomed care in their homes. Many others were concerned — with some justification as it turned out — that the savings from institutional closures would not be fully re-invested in community services. The advocates of normalization responded to this by claiming that all individuals benefit from a degree of uncertainty. They grow through problem-solving and should be allowed to experience the *dignity of risk* (see especially Perske, 1972).

Despite all the reservations, the principles of normalization, consolidated first in Scandinavia, permeated almost every jurisdiction in Western Europe, North America, and other "western" countries during the 1970s and 1980s. A combination of circumstances made Ontario one of the first to incorporate them into social policy. In 1971, Walter Williston, a prominent Toronto lawyer was appointed to investigate several incidents, including a suicide that had occurred at Rideau Regional Centre in Smiths Falls. Not only did Williston undertake to visit all major mental retardation facilities in the province, as well as smaller residences and sheltered workshops, but he also heard presentations from national, provincial, and local organizations. Williston recommended the phased-in closure of all provincial hospitals for the retarded, and in doing so he was guided both by his personal observations and by the views of organizations such as the Ontario Association for the Mentally Retarded (OMAR), formerly the Association for Retarded Children. The result was to cast normalization ideas into the arena of public policy.

The commitment to community services was strengthened by the Welch report of 1973, which recommended substantial expansion of community programs and, in addition, proposed a consolidation of services by trans-

ferring responsibility for large institutions from the Ministry of Health to the Ministry of Community and Social Services. The latter objective was accomplished within a year, largely because it made the Ontario government eligible for federal cost-sharing funds under the Canada Assistance Plan. At the same time, Ontario Premier William Davis committed his government to a steady reduction in “hospital” spaces, and the development of community-based facilities in partnership with private and voluntary sectors. By 1974, then, a new direction had been firmly established in Ontario. Community living had been established as a viable and preferred alternative.

### **The Final Phase: Institutions to Community Living**

Yet the institutions proved to be more durable, and community places much harder to open up, than expected. Staffing problems, funding limitations, resistance by labour unions who feared lower standards of care as well as loss of jobs, family objections, municipal zoning by-laws excluding group homes from residential neighbourhoods — these and other obstacles had to be overcome.

In 1983, the Ontario government set out a Five Year Plan that attempted to increase the pace of change by setting target dates for the closure of St. Lawrence Centre, Brockville; Bluewater Centre, Goderich; Pine Ridge Centre, Aurora; S.T.A.R.T. Centre, St. Thomas; D’Arcy Place, Coburg; and Durham Centre, Whitby. It also projected 800 new community-based “beds” and 750 new foster care placements, in addition to 1800 vocational and pre-vocational employment training places. The trend toward community integration for people with developmental disabilities made a further gain when the Ontario government enacted Bill 82 in 1980, bringing education for children with disabilities within the domain of the public school system. What this meant was that almost all children with developmental disabilities now lived in their family homes and attended local schools.

An OAMR follow-up investigation of the former residents of Pine Ridge, Aurora, offers a valuable case study of the short term effects of insti-

tutional closure under the Five Year Plan. One year after closure, 63 of the 145 former residents lived in group homes run by Associations for the Mentally Retarded, 66 were with other community based agencies, and 16 had been transferred to other provincial institutions. Surveys of former residents, their families, and the agencies caring for them found a high degree of satisfaction among all three groups. The report concluded that the process had been conducted in a satisfactory manner, in line with the goals and philosophy of OAMR (OAMR, 1985).

Successive governments in Ontario continued the direction established in the early 1970s. Ontario’s residents who have developmental disabilities have clearly benefited from deinstitutionalization. Whether community living, in all its anticipated richness, was readily achieved is another question. For example, Laws and Radford (1998) examined narratives of a group of people with developmental disabilities in Toronto and found that they revealed little real participation in the wider community, and a high degree of marginalization. Still today, developmental disability is too closely associated with poverty, affordable housing seems elusive for many, and real inclusion in communities across Ontario is questionable for a great many people with developmental disabilities. Yet today, the voluntary sector remains strong. There is encouraging idealism in many sectors of Ontario society and, in contrast with too much of our past history, overt hostility towards people with disabilities is the exception rather than the rule. The principles of normalization that underlay the shift of the 1970s are today questioned not so much by people who think them too radical, as by those who consider that they do not go far enough.

*The Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008* (Government of Ontario, 2009) provides a coherent policy basis on which a truly post-asylum society could be created. People with developmental disabilities are increasingly becoming empowered, asserting their rights, and working to create social networks. The struggle continues, but delving into our recent history demonstrates that significant progress has been made and indicates that there is hope for the future.

## The End of the Institutional Era

On the last day of March 2009, the last three remaining institutions for persons with developmental disability in Ontario closed. The end of operations for Huronia Regional Centre (Ontario's first institution in 1876, the Orillia Asylum for Idiots), Rideau Regional Centre, and Southwestern Regional Centre, was a significant event. More than 130 years of institutional functioning had ended.

What did this ending mean? The asylum was a state of mind as well as a place. It was a physical representation of the view that people with a developmental disability, variously labelled and stigmatized, habitually treated as different and marginalized, "belonged in an asylum." The closing of the last institutions takes away this physical representation and offers us an opportunity to re-conceptualize disability in another way. Today, this opportunity has emerged as a set of values that support the overall goals of social inclusion and enhanced quality of life: respect for the place of a full range of abilities and skills within our broader culture; the value and dignity of each person's life; the right to participate fully in the community life of our choosing; opportunities from which to choose and the freedom to make choices; and the celebration of one's individuality in concert with social and cultural participation.

## Key Messages From This Article

**People with disabilities:** In the past, many children and adults who had disabilities went to live in institutions. There were some good things about institutions, and many people were quite happy there. But they were too crowded and there was not much freedom to do what you want. Some people thought they did not belong there, but could not leave. At last, everyone began to realize this was not the best way to live, so the institutions were all closed and people were moved to communities. Life in communities can be tough, but there are more opportunities to do what you want to do.

**Professionals:** In looking back at the end of the institutional era in Ontario, disability professionals should feel proud of the central role they

took in making it all happen. Today, community-based disability professionals are feeling many of the pressures that institutional staff felt years ago: increased workloads, reduced funding, and adherence by services and policymakers to accountability rules rather than the needs of people with disabilities. Understanding Ontario's past experience with institutionalization is essential to find new ways to move forward. It would be a shame if the lessons of yesterday are forgotten today, and we fail in our present quest because we neglected to understand.

**Policymakers:** The task for Ontario policymakers of moving from an institutional-based system to a community-based system of services and supports for people with developmental disabilities was a long and arduous one. But Ontario's history shows a clear dedication of purpose, over several decades, in achieving that goal. The move has clearly resulted in better quality of life for people with disabilities. At the same time, there are many indications that the overall approach to services still retains strong elements of "institutional" thinking, and Ontario faces a challenge in devising new ways that match the real lives of people with developmental disabilities as they strive to live successful and happy lives in communities throughout the province.

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