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RE/MOVING FORWARD?: SPACING MAD DEGENERACY AT THE QUEEN STREET SITE

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This article explores the site of the Queen Street Mental Health Centre (now CAMH) in Toronto. The building of Ontario's first asylum in 1850 on this site was a result of moral interventions in order to build Canada as a respectable nation. The site became and has remained a "problem" space in public discourse, legitimizing heavy surveillance and policing of the buildings and bodies that populate this site. The article also analyses the recent proposed reconstruction of the Queen Street site, a 21st century re-visioning of the space that contributes to a never-ending project of attempting to spatially regulate and contain madness.

Cet article examine le site du Centre de toxicomanie et de santé mentale (CAMH; anciennement le Queen Street Mental Health Centre) à Toronto. La construction du premier asile en Ontario en 1850 sur ce site a été le résultat d'interventions morales visant à faire du Canada une nation respectable. Le site est devenu et demeure un espace « trouble » dans le discours public, légitimant une forte surveillance des bâtiments et corps qui peuplent le site. Cet article analyse également la proposition récente visant la reconstruction du site de la rue Queen, un ré-envisagement vingt-et-uniémiste de l'espace qui contribue à un projet interminable de tentatives de réglementation et de contrainte spatiale de la folie.

This article traces a history of the Queen Street site, a piece of land in downtown Toronto that has housed carceral sites of mad containment for over 150 years. Using a feminist framework, and drawing on Foucault's work on mad, bad, and sick spaces, I explore this site's history and its spatial (re)incarnations. I argue that the site and its built spaces have contributed to

metanarratives of Canada as a white, middle-class nation that needs to protect its citizens from a mad degenerate underclass. Further, that problematizing the site as a "leaking" space allows for heavy interventionist practices towards both the site and the mad who populate it.[1] I approach urban planning in Toronto as a colonial project that uses architectural design to create a built space that not only represents a European present and future, but also recalls a European past, a tool through which colonial rule is legitimized. I view sites of carceral containment as part of this colonizing project. In 1850, The Provincial Lunatic Asylum was the first site for mad containment built in Ontario. The asylum was considered a "problem" from its inception. The never-ending reform that has since plagued the site has left a spatial legacy for a continued history of revisions that contributes to unrelenting intervention and regulation of the mad in Toronto.

Framing a Problem

In order to understand Canada as a nation, one has to trace Britain's colonial history, the mapping of "Canada," and the making of it as a British nation, for as Jane M. Jacobs notes, space exists within the context of imperialism and is "formed out of the cohabitation of variously empowered people and the meanings they ascribed to localities and places" (Jacobs, 1996, p. 5). The Canadian nation has actively built a history that begins with discovery, as if it were a land of empty wilderness before British arrival. The colonial project was to create and solidify a "history of whiteness" in Canada in order to legitimize colonial rule. Nativist discourses were drawn on to create the idea of a native Anglo-Canadian people, and to "naturalize British ideas about law, the state and religion" (Valverde, 1991, p. 118). In order to create the Canadian nation, actual natives were violently killed or rounded up into institutions of exclusion. Violence and segregation were the systems of control used to establish British dominance – a spatial process, where pass systems, reservations and residential schools were set up and maintained outside of colonial (white, civilized) settlements. Beyond white settler space, the native "problem" was contained through geographical banishment and resulted in the "nearly absolute geographical separation of the colonizer and the colonized" (Razack, 2000, p. 97). The spatial containment of natives was necessary in order to produce Canada as a "pure white" nation. The colonies were also actively identifying and segregating other bodies that were feared to pose a threat to this purity.

In Victorian England, notions of the degenerate Other burgeoned within the context of 19th century imperialism. The idea of "the degenerate" worked to project a racial and biological inferiority onto its external enemies in the colonies, and to justify the colonial violence that ensued. Of equal importance is how notions of degeneracy were concerned with "internal enemies," people living within a nation who were conceived as a threat to its respectability, such as European Jews and gypsies. In Canada, people existing outside of the Victorian ideal (the poor, the mad, the criminal, the deviant) became of central concern to those building the nation. Mary Lou-

ise Fellows and Sherene Razack explain how the degenerate Other emerged to represent the antithesis of white middle class respectability within the Victorian model: "Respectability and its converse, degeneracy, were part of the nineteenth-century ideological language expressing relations of domination and subordination. Respectability became an assertion of membership in the middle class and the basis on which one had the right to dominate others, those classified as degenerate" (Fellows and Razack, 1998, p. 346). Degeneration became a crusade that the respectable were entrusted with to fight, and in Canada the middle class set out to organize their power in order to protect themselves from the internal dangers that threatened this new and vulnerable nation. Respectable citizens looking to ensure that the Victorian model was instilled in the colonies set to work: men spent their work time mapping out methods to maintain a clean population, while women, most often through charity work, took on the role of restoring those bodies that had gone astray.

The middle class established institutions that worked to register, monitor, and train the new Canadian citizen. Michel Foucault refers to these institutions as carceral systems: built sites that are engineered to train and discipline deviant bodies through coercive technologies. Schools, hospitals, prison systems and asylum spaces are understood as built spaces that are used to contain, supervise, survey, discipline, coerce, rehabilitate and/or normalize degenerate bodies. These sites are spaces in which bodies pass through or are held, and dominant social principles are inscribed. Foucault understood the spatial intervention of carceral systems as a way of containing a degenerate outbreak. Any body could be subject to such an intervention. Foucault explained this spatial exclusion of the degenerate and the mapping of the social through the archetype of the plague. In order to contain an outbreak, authorities developed a system of permanent registration, and called for a complex network that detailed the intricacies of the social body: "Rather than the massive, binary division between one set of people and another, it called for multiple separations, individualizing distributions, and organization in depth of surveillance and control, an intensification and a ramification of power" (Foucault, 1977, p. 198). The plague needed to be met and governed by order for it to be contained; the leper not only needed to be spatially contained, but also everyone (including those segregated) needed to recognize that their exclusion was executed in the name of the pure community. Thus the image of the plague came to represent all forms of confusion and disorder that a pure population needed to guard itself against. And the leper came to stand as the symbol for all Other individuals (the mad, the criminal, the racial and sexual degenerates) that a community needed to organize itself against.

By mid-nineteenth century the mad began to be viewed as ailing due to a collective failure in society: abject bodies ruined by the pressures of modernity. Madness was framed through an understanding of degenerative illness as hereditary deviance, which lurked in the body, and was passed down through tainted genes: "incubated by the parents and visited upon the children, it had no precise borders, but it involved a progressively intensifying tyranny of the

body over the spirit or soul" (Pick, 1989, p. 51). In addition, mad bodies were understood as degenerative vessels that were caused by society, and had to be kept from the social in order to protect its purity and progress. This mad degeneracy that lurked in the body with the potential to threaten the community became a philanthropic project – one which sought to contain madness in order to protect the new Canadian citizenry. Thus mad degenerates were met with middle-class intervention that called for discipline, regulation, and temperance in the name of nation-building. When those interventions failed, they were often sent to built sites of carceral containment, institutions such as Ontario's early jails, hospitals, prisons, and to which Upper Canada added with its first asylum site in 1850.

Much of Toronto was designed and built at a time when the British were preoccupied with both the design of healthy cities and their Other, urban decay. Town planning and architecture came to value sunlight, fresh air, and clean water as a response to the development of anti-contagionist theories of disease. In order to keep a population healthy, intervention was required to design, build, and maintain the physical environment, and this intervention was undertaken primarily through state, professional, and philanthropic work (Sutcliffe, 1980, p. 6). The need to design and regulate the urban built environment as healthy was a response to the "problem" of urban decay, thought to be especially prominent in mid-century London. Colonial authorities in Canada were set on building a Toronto free of degeneracy in response to the decay that they saw as occurring in the metropoles, and worked to prevent overcrowding, vice, and slums from developing in this new city. Through the act of regulation, both of the population and the built environment, these colonial, professional and middle-class subjects came to know themselves as upholders of respectability. Thus, as Sutcliffe notes, "urban crisis" allowed for a "more active intervention in the urban environment by the directive elements of society, to protect themselves against the direct effects of a general deterioration" (Sutcliffe, 1980. p. 6).

By 1851 Toronto had grown to 30,775 inhabitants and was the largest city in Ontario (Noel, 1990, p. 24). Much of Toronto's architecture was made up of Neoclassical, Romantic, and Gothic stylings (Arthur, 1991, p. 75). These were all designs that recalled and idealized the distant "motherland" of Europe. As Lawrence Vale asserts, architecture is often used to legitimate a national identity and to solidify national unity. Vale contends that the architecture of government buildings is used to legitimate particular ruling and to support specific regimes. They "serve as symbols of the state...[and one can] learn much about a political regime by observing closely what it builds" (Vale in AlSayyad, 1992, p. 316). Further, that "every design solution is, to some extent, an idealization of the political realm" (Vale in AlSayyad, p. 331). Thus, architectural design connotes more than just aesthetic preference: it is an active process of framing a space as belonging to whatever culture, time, or rule that the architecture symbolizes. By building Toronto up through colonial architecture, white settlers were working to build a city that naturalized and legitimized their presence in it. Further, *what* gets built

matters. When a city builds a prominent court house, it tells the good community that it cares for law and order; it also tells the deviant that there will be consequences for criminal acts. When a city builds a prominent hospital, it tells the good community that there is care for the sick; it also threatens the diseased with quarantine. When a city builds an asylum, it tells the good community that they take care of the mad; it also offers the threat of incarceration to anyone daring to deviate outside of the realm of reason. Further, citizens come to know *what* they are through *where* they are: outside of the prison, the hospital, the madhouse, the respectable are built as law-abiding, healthy, sane subjects. Conversely, the degenerate are created through their engagements with these built sites: the criminal is made through prison, the sick confirmed through hospitals, the mad condemned through asylum stays. Without these sites to demarcate the degenerate, the social realm has no marker to differentiate the bad, mad and sad from its respectable citizenry.

Building a Solution

The new theories of mad degeneracy as a biologically-based medical problem began to impact what was built to contain them. Architects began to design institutions for the degenerate that were meant not only to confine, but also to cure. This new design, termed "moral architecture," combined medical and moral reform theory, and produced the nineteenth-century asylum. Throughout the nineteenth century, asylum spaces were built on a large scale and resembled prison structures. Within these institutions medicalized notions of madness impacted how the mad were understood, categorized, and segregated. The mad were first divided along gender lines, and separate wards or wings were built to accommodate them. Gender segregation was crucial to mad spaces because it responded to the fear that mad degenerates might reproduce and proliferate.[2] This form of segregation was rooted in eugenics and the "belief that mental illness was a result of brain disease, usually caused by "faulty genes." The possibility of reproducing yet more diseased brains, therefore, was to be discouraged at all costs" (Gittins, 1998, p. 19). Once genders were separated, architects had to build space for the different medical classifications of the mad: "Basic subdivisions in design between the male and female sides, or between the curable and the incurable, also needed to take into account...more detailed classifications, e.g., the violent and the calm, the noisy and the quiet, the infirm, the convalescent, etc." (Gittins, 1998, p. 21).

Through such design, professionals were able to monitor the mad in order to punish, discipline, know, and cure through built space. The moral architecture of these institutions came to embody "principles and techniques which were increasingly influential in the discourses of social policy: a faith in the moral power of design; an emphasis on the surveillance of individual conduct; and an attempt to cultivate a sense of self-discipline amongst those to be trained" (Driver in Jones and Porter, 1994, p. 120). For example, Jeremy Bentham's famous "Panopticon" architectural design worked to give those contained in total institutions the sense that they were under constant surveil-

lance, while often being unable to see those who were watching them. Thus, the incarcerated learned to assume that they were *always* being watched, and governed their behaviours accordingly. Foucault noted that the Panopticon was a "direct way of expressing 'the intelligence of discipline in stone': of making architecture transparent to the administration of power" (Foucault, 1977, p. 249). The art and science of psychiatric architecture remains today as pivotal a measure in the process of providing cure for the mad as it was in its early inception, although its ideals have shifted. Both within Europe and North America, "this concept has changed gradually from the large psychiatric hospital, through the cottage type villas, to the mental health centre in the community and the psychiatric unit in the general hospital" (Seager, 1972, p. 11).

The architect John Howard's design was chosen as the winning plan proposal and became the blueprint for the Provincial Lunatic Asylum. The structure was pure London, neoclassical in style and based on the terrace pattern endemic to London (Keefer in Hudson, 2000, p. 96). The structure that came to be known as the Howard building had a classic and understated design, recalling the authority of Cambridge University. It was serious but not threatening, "for as a residential clinic where the ill were to be cured, neither should it be frivolous – a mere resort" (Keefer in Hudson, 2000, p. 96). Howard decided on a U-shaped building that would comfortably house 300-400 mad, which was built on an axis parallel to Lake Ontario. At 584 feet, the building was massive for its time. It was a huge undertaking for the local government to commit to building an asylum of such size, magnitude, and cost.

Howard paid particularly close attention to factoring in spatial dividers within his design in order to ensure that different classifications of the mad would not meet:

> He took enormous care, by designing discrete systems of staircases that separately connected from each floor to the ground, that each floor could accommodate a different class of patient. These exclusive staircases by-passed all the other floors above and below. This feature perhaps uses space extravagantly, but it is designed to contain each "class" of patient within his or her own environment (Hudson, 2000, pp. 209-210).

This careful calculation of built division illustrates just how seriously fears of pollution were taken, especially the fear that the incurable mad would reproduce or pollute the curable. The design was effectively used as a eugenic tool to prevent the mad from multiplying. Further, it shows just how differently asylum architecture was thought of when compared to the architecture of other sites of carceral containment. Howard himself said that the Provincial Lunatic Asylum was "not a place of 'incarceration'; it was instead the embodiment of a powerful and humane value system" (Keefer in Hudson, 2000, pp. 99).

When the Provincial Lunatic Asylum opened its doors in January of 1850, construction of the Howard building had yet to be completed. Because of the already high cost of construction (more than fifty thousand pounds), the government refused to commit more funds to the project. Thus the institution opened in an unfinished state, and despite the pleas of Howard and others, no money was made available to build the stately portico or the two crucial southward-extending patient wings (Morriss in Hudson, 2000, p. 123). The patient wings were central to the system of mad categorization, and without them, the architectural symmetry that was to work hand in hand with moral therapy proved elusive. Money was, however, found to build a grand wall to encircle and close off the grounds. In 1851 funds were allocated for the construction of a ten foot wall, which would eventually fully enclose the site (Crawford in Hudson, 2000, p. 61). The labourers that built these walls were often the mad themselves, an early example of mad labour that was not provided with financial compensation (Reaume, 2000).

Still a Problem

Soon after its opening, the Provincial Lunatic Asylum was branded as a failure, both by medical authorities and the public. According to site superintendent Joseph Workman, who occupied his position for 22 years, "not only did the architecture of the Toronto Asylum fail in many ways to enhance the condition of the insane but until about 1856 the institution actually constituted a major health hazard for its patients" (Moran, 2000, p. 84). To begin with, the asylum was overcrowded. A space built to confine at most 400 mad people was housing more than700, "with violent inmates mixed in with the more harmless and vulnerable" (Everett, 2000, p. 26). Because the two patient wings had failed to materialize, the mad were settled within the institution in ways that were at best disorganized. Two serious bouts of cholera had swept through the institution between 1850 and 1852, calling into question the ability of the architectural design to contain illness. Workman announced that the mad population far exceeded its capacity, and declared the asylum to be a dangerous space (Moran, 2000, p. 67). Workman insisted that,

> neither the mental nor the bodily health of the patients [could] be expected to improve as under more favourable circumstances they would do: consequently the institution must become comparatively inoperative for the great and humane purpose for which...it [had] been established (Moran, 2000, p. 68).

Complaints made by Workman, the mad, and their families gained the attention of the public, who had been taxed heavily for the asylum's erection and continued to pay for its maintenance, and eventually the authorities had to act (Moran, 2000: 75).

A committee was set up to investigate conditions in the asylum, and came up with four major problems: the water quality was poor; the construction of toilets was flawed; the ventilation system was defective; and something was afoul in the basement, given the "very offensive odour arising under the

floor" (Moran, 2000, p. 85). The asylum was condemned by many authorities as unsound and lacking in engineering design. Workman was convinced that the frequent outbreaks of illness that haunted the mad could be traced "to local causes, connected with the structure and condition of the house" (Moran, 2000, p. 85).

While searching for the cause of the bad quality of air and water in the building, Workman discovered that the distance of the pipe which eliminated the "discharge" from the asylum was only one hundred feet from the pipe that supplied the asylum with fresh water from Lake Ontario. This meant that the foul water was mixing with the fresh, and then being pumped back into the institution. These were not the only water problems at the site. Investigating the pungent smell emanating from the basement "revealed that the drains had never been connected to the city sewer system, and for three long years a huge cesspool of excrement had been collecting under the building's floors" (Everett, 2000: 26). Workman became the most vocal advocate calling for the reform of the Howard building, and was convinced "that there was a connection between the 'type of bodily and mental disease which prevailed throughout the establishment' and the existence of 'some prolific source of miasma' emanating from the asylum" (Moran, 2000, p. 86). In essence, Workman and other authorities declared the expensive Provincial Lunatic Asylum to be a leaking sick building, causing instead of curing degenerative disease.

Not only was the architectural design and construction of the asylum deemed faulty, so too was the geographical placement of the building. Workman complained that "far from being in a salubrious location conducive to good patient health, the Toronto Asylum grounds were scarcely above the level of the lake, rendering the soil constantly damp. Moreover the low level of the ground interfered with the drainage of the asylum's refuse into the lake" (Moran, 2000, p. 86). Consequently, stagnant water frequently settled underneath the asylum. Workman attributed half the deaths in the asylum since its opening to stagnant sewer water, but the danger did not end there. Workman remarked in one of his many reports to the Executive Council that, "the source of morbific agency [was] not merely adequate to destroy the health of the asylum, but even of the neighbourhood" (Workman in Moran, 2000, p. 87). Thus the surrounding neighbourhood, filled with respectability and innocence, fell pray not only to the mad that were being contained within the asylum, but to the faulty structure itself. The site was construed as structurally leaking degeneracy into the surrounding neighbourhoods, placing respectability under threat, and consequently underscoring the need for constant monitoring of the site.

Throughout his tenure, Workman fought to "improve" the asylum and turn it into a working curative carceral site for the mad. More than anything, Workman envisioned the asylum as a curative space, but with things as they were, the asylum was only providing custodial care: the scientific space of cure was operating at a level no higher than that of a prison. Pressure from Workman and families of those contained in the asylum finally resulted in

the two wings being added in 1867 (Moran, 2000, p. 88). Unfortunately, the asylum had by then come to be viewed not only as a space that contained degeneracy, but as a degenerate site in its own right. The failure of the asylum to cure led to a number of early interventions, both within the Howard building as well as with the construction of altogether different asylum sites in rural Ontario in the hopes of getting it right elsewhere.

One of Workman's last revisionings was to change the official name of the asylum from the Provincial Lunatic Asylum to, in 1871, the Asylum for the Insane, Toronto. Workman started an enduring trend at the site. The renaming of "sensitive spaces" is more than commonplace; and this space was to undergo such a process seven times in its now 157 year history (Reaume, 2000, p. 6). Through its existence the institution has been called: Provincial Lunatic Asylum, 1850-1871; Asylum for the Insane, Toronto, 1871-1907; Hospital for the Insane, Toronto, 1907-1919; Ontario Hospital, Toronto 1919-1966; 999 Queen Street West, 1966-1976; Queen Street Mental Health Centre 1976-1998; and in 1998 Queen Street Mental Health Centre merged with other sites to form the Centre for Addiction and Mental Health (CAMH) (Everett, 2000:, p. 38 and Reaume, 2000, p. 6). In this context, "renaming acts as a strategic gesture which marks and signals the reappropriation of a space," an act that attempts to bury a past that the present nation aspires to break with (Leach, 2002, p. 94). Just as renaming a nation can work to denote a break from its prior self, here the constant renaming of this carceral site works to disassociate from a history of violence and a failure to cure. Renaming is a way in which a nation tries to harness its histories into "official stories," histories that work best with whatever representation it is trying to project. In an effort to simplify, the site will henceforth be referred to as the Queen Street site.

Removing the Problem

The Queen Street site remained almost structurally unchanged throughout the first half of the twentieth century. By the time the centennial of the Howard building was celebrated, the old age of the edifice was becoming increasingly apparent. Over the decades, the Queen Street site had maintained a bad reputation in the city, and continued to be a problem site both within the community and inside the institution. The Howard building came to represent a century of incurable degeneracies, as well as a century of violent "therapies" that took place in the building: arsenic, insulin, and metrazol "therapies," electroconvulsive shock, and lobotomies were all performed on site in the first half of the twentieth century (Fisher, 2000, pp. 34-35). The Howard building held "reminders that the building contained therapies that were useless, [and] of the often futile nature of their efforts to help the insane" (Hudson, 2000, p. 214). The space acted as container for which the violence of forced confinement, surgeries, drug therapies and eugenic sentiment all congregated. Instead of locating the problem in the way that the mad were being treated, the social instead directed its attention to the building itself. Planners began to apply the theory of architectural determinism to the

Howard building, claiming that "architecture can cause social unease," both for the mad and the community it occupies (Hudson, 2000, p. 214).

During the 1950s and 60s, the Queen Street site underwent a number of architectural alterations in order to improve the fledgling site. By 1967 a master plan for "reconstruction" of the Queen Street site was designed, and by the early 1970s, reconstruction had begun. Various additions and other nineteenth century structures were demolished in order to make room for four treatment units and a community facility, all of which were built around the Howard building. The new units (along with the large administrative building that was added in the 1950s), proved to work as architectural "others" to the old Howard building: introducing modernity to the site, the image of the old Howard building conveyed all that was obsolete. From the beginning of reconstruction, it was clear that the Howard building was on its way out. The old and the new were in direct competition, and the promise of a progressive future that could best hold madness through scientific progress and modernity was winning.

Public controversy flared when the final stage in reconstruction called for the razing of the Howard building. Indeed, the demolition seemed to have little to do with necessity and more to do with purging the Howard building from memory. As the head of the Department of Psychiatry expressed in letters to the editor of both the Toronto Star and The Globe and Mail, the Howard building's forbidding "presence is a highly visible reminder of a previous era of treatment of the mentally ill from which, thankfully, we have emerged," and thus demolition rightfully closed the chapter in the history of antiquated methods of treating the mad (Museum of Mental Health Services, 1993, p. 21). Others felt that the Howard building should be restored, thereby preserving the history of the origins of mad treatment in Canada: "The history of Queen Street Mental Health Centre is an inalienable part of the history of Canadian psychiatry.…[T]o witness the renovation and reoccupation of old structures is now a part of life" (Museum of Mental Health Services, 1993, p. 21).

It became clear that the debate was not about whether the building was structurally secure, nor was it about the cost to the government. What was really at stake was an opportunity to demolish a building that leaked a history of mad degeneracy. It became difficult to argue that containing the mad in such a deteriorating site was an act of medical kindness. The biomedical carceral containment of the mad in such a "backward" building ran contrary to the metanarrative of confining the mad as "health care," and of Canada as a compassionate nation seeking to help, and not simply segregate, the degenerate. Helping the degenerate through spatial control became a crucial component in preserving Canadian mythology, and it was also "intertwined with a national narrative about who the real citizens are – respectable, self-contained, healthy, in relation to the bodies to be contained and controlled – the degenerates, the profligate, the diseased. Containment of degeneracy occurred spatially, as well as enabling a story about salvation and civilization by white people" (Newman, 2002, p. 8). In order to frame mad containment

as a benevolent gesture from a compassionate Canada, the sites in which the mad were held needed to pass as modern, medical, and an investment to which the nation and its taxpayers were willing to commit.

The Queen Street site remained a burden to white middle-class respectability, to the Canadian psychiatric community who were ardent in building themselves as professionals within the medical community, and to the neighbourhood that it occupied. Dr. Robert Pos, a professor of psychiatry at the University of Toronto, outlined what the Howard building represented to the nation, the city, and the Parkdale neighbourhood in which it is located:

> The old Queen Street suffered not only from the elemental stigma associated with all mental hospitals but its public image was also damaged by two additional factors. The first has to do with the composition of its patient population throughout its history: the poorest, the sickest, and the most hopeless cases have always ended up there. Because it is a provincial hospital, Queen Street has, until recently, been constrained to accept all patients brought to its doors and was regarded as a "dumping ground" for the mentally ill in Toronto. A second factor was the forbidding and massive appearance of this "bastion of insanity." The dark, fortress-like 1850 building was the focus of many local horror stories and for years children were threatened with incarceration at Queen Street if they misbehaved....The hope was expressed by most of the staff and patients at Queen Street that the new environment, combined with the new programs it helped stimulate, would create a better public image for the hospital: "when we pull the old building down, we will pull down the old mythology with it" (Kelner, quoted in Pos, 1975, p. 2).

The Howard building was a symbol within the community, a structure embedded with derelict madness that tied the neighbourhood to a long history of poor, hopeless suffering. The Howard building became something that "should not be maintained since in the main it was not something of which we, as a society, should be proud of." Further, "restoration would only continue to perpetuate a building full of bad memories for a great many people in Toronto and the province, leaving 999 Queen Street as a reminder of the "bad old days" when we are trying so hard to change the image of mental illness and delivery of care in this field" (Ministry of Government Services, quoted in Pos 1975, p. 1). Evidently, the demolition of the Howard building represented an erasure of "the bad old days" of mad care, and the new structures represented an ushering in of progress. Neil Leach refers to this logic as the Berlin Wall syndrome: when a built structure becomes a monument associated with one regime/discourse so intensely, it seems that the only solution is to "somehow purge the site of the memory of evil" by eradicating the physical fabric of the building (Leach, 2002,p. 81).

Whether a nation restores or demolishes a site depends on how it decides to remember or dismember a history of oppression. The Howard building was a visible embodiment and material representation of over a century's

worth of primitive treatments and failed lives: the structure had to go. Leach explains this tendency for people to be unable to separate event from structure: "The very 'ventriloquism' of ascribing a meaning to the building is never fully acknowledged, so that in the hermeneutic moment it seems as though the content is not so much projected on to the building as inherent in the building itself. The building therefore *appears* as the concrete embodiment of certain values" (Leach, 2002, p. 85). Those in authority, as well as much of the public, were unwilling or unable to separate discourse from built space, and in 1976 the monumental Howard building came down, was paved over, and turned into a parking lot (Court, in Hudson, 2000, p. 197).

Jennifer Nelson, in her work *The Space of Africville* (2000), explores how the eradication of a "black slum space" in Halifax, Nova Scotia worked towards building the city as a clean, white, and compassionate space. Nelson posits the act of demolishing the black slum space of Africville as,

> the culmination of a moral panic at [the thought] of any possibility of an independent, sovereign blackness. The nation makes itself not through exclusionary practices alone, but through..."geographies of exclusion." Through the desecration of space as black, the appropriation of space as white, the suppression of the story of this violence and the denial of accountability, the life of Africville is grounded upon a geography of racism, and its discursive organization. Like the proverbial lie, once told, the story necessitates the telling of a chain of "maintenance fictions," complete with the management of space in such a way that the fictions prevail intact and that oppositional stories remain buried (Nelson, 2000, p. 183).

Similar to the slum space of Africville, the "geography of exclusion" that the Howard building spoke of was a story about the nation, the city, and the community that needed to be buried. No amount of renaming the site, changing the treatments, or attempts to put a positive spin on the Howard building were going to change how the site had come to be understood: as a place where confinement, violence, and failed scientific practices occurred for over a century; as a place that had to be effaced.

Reconfiguring the Problem

Despite the architectural restructuring of the Queen Street site, the more "open" concept of the contemporary units that replaced the Howard building failed to resolve the site's degeneracy. For instance, the mall area, a built space that was supposed to "bring the community in," caused new problems. Vendors of sex and drugs were said to frequent the space, providing illicit luxuries to the mad. As a result of such on-site criminal activity, as well as a number of accidental deaths of the mad in the early 1980s, security was tightened and the policing of mad space increased. The Queen Street site introduced surveillance cameras in the hospital wards and increased its number of medium security wards. The mall area was outfitted with cameras, the number of security guards was increased, and the area was effectively closed

off as only those carrying issued passes were allowed in, "to ensure that only legitimate people make use of the mall" (Greenland, in Hudson, 2000, p. 13). Degeneracy was positioned as escalating under the new "open plan." Therefore, while the appearance of a more open facility was achieved through the demolition of the custodial Howard building, the Queen Street site in fact remained a tightly guarded and heavily policed setting.

Close to 20 years later, in 1998, the Queen Street site was amalgamated with the Clarke Institute, the Addiction Research Foundation (ARF), and the Donwood Institute. All together, these four institutions became the Centre for Addiction and Mental Health (CAMH), with the Queen Street site continuing as a space of mad containment, the Clarke as psychiatric and research facility, and ARF and Donwood specializing in addictions. The Queen Street site was subsumed under the new title, CAMH, which effectively combined it with other, more respectable medical sites – fragmenting its site location, reputation, and independence by merging it with other histories.

Soon after CAMH came into being, yet another redevelopment of the site was proposed. This new project involves turning the now 27 acres of land that constitutes the Queen Street site into a modern "state of the art" medical facility and the "hub" of psychiatric care (Urban Strategies, August 2002, p. 2). The new "vision" for the redevelopment of the Queen Street site is based on three principals: "creating a hub, designing the hub as an urban village, and respecting the landscape" (Urban Strategies, 2002, p. 4). The idea is to remove the institution from the landscape and replace it with a "village" that "blends" with the urban landscape. According to the "master plan," the new site,

> will be designed as an urban village containing a mix of CAMH and non-CAMH uses and activities, a network of public streets and sidewalks, public and private open spaces and a series of blocks containing buildings each with their own street address. Casual mixing between staff, clients/patients and visitors of CAMH with the surrounding community will occur naturally on public sidewalks, parks, shared community facilities and the cafes, restaurants and shops that will occupy the street level of buildings. CAMH uses will be integrated with other uses to create a *safe, comfortable and welcoming place where the stigma of the institution can disappear into the rhythm of normal daily activities associated with city living* (Urban Strategies, August 2002, p. 5, italics mine).

Thus the master plan calls for the blending of the mad site into the "natural environment" of non-mad spaces. The Queen Street site would no longer be strictly mad space, as other commercial enterprises would make up much of the site, fragmenting the site's reputation as solely a site of madness.

The Parkdale region is undergoing rapid gentrification which will only be helped along by the restructuring of the Queen Street site. The project promises to provide "an opportunity to contribute to the ongoing revitalization of the surrounding neighbourhood and address decades of stigma around

mental health and addictions" (Urban Strategies, 2002, p. 2). The proposal was approved in 2004, and redevelopment is now underway. Requiring ten years' construction, the plan calls for the entire existing site, save for two historic brick storage buildings and pieces of the original historic wall, to be demolished in three phases (Urban Strategies, 2002, p. 9). The total cost of redevelopment is projected at almost $400 million, toward which the current provincial government has committed to provide $100 million (*Toronto Star*, September 9, 2005).

This latest reconstruction of the Queen Street site should be viewed as yet another intervention. But it is important to note that these changes are the first reconstruction where the redevelopment has been met with strong resistance from Toronto's vocal and vibrant psychiatric survivor community. Moments of the mad "talking back" to psychiatry can be gleaned throughout this new rebuilding. Public meetings, oppositions, and interventions were all organized and made by psychiatric survivors and by groups such as the Empowerment Council and the Psychiatric Survivor Archives, Toronto. These acts of resistance achieved various levels of success. One such success was the campaign to preserve portions of the south, east, and west perimeter walls that were built in 1860 and 1888-89, walls that worked to surround the asylum. Thanks largely to the efforts of scholar Geoffery Reaume, portions of the brick walls that were built by patient labour and that were due for demolition have instead been salvaged. These walls have since been designated as heritage structures, and the last vestige of the original Provincial Lunatic Asylum building, through the insistence of the mad community, will remain – as a marker of the unpaid labour that the mad contributed to the site over the years. As Reaume notes, "Today, these walls, as well as portions of the original 1860 south wall, remain as a testament to the skills of the patient laborers who built them and to the discrimination and oppression so many of them experienced in their own lifetimes" (Reaume, 2006, p. 8).

The deconstruction of the Queen Street site as solely a mad space obfuscates the notion of the site as a degenerate space and allows room for the respectable to nest. Given that the mad and non-mad buildings will appear architecturally similar, the new design acts to unmark mad space and effectively conceals the hard fact of mad carceral confinement in the city. Central to the new design is the construction of storefront, small-scale structures along the south side of Queen Street West. This feature will allow for the continuation of the "main street" scale of small shops and services that are currently offered along the rest of the Queen Street West strip, which the Queen Street site currently interrupts (Urban Strategies, 2002, p. 9). By locating the sites of carceral containment behind and offset the "main street" strip, these sites are effectively hidden and rendered invisible from Queen Street and thus the consciousness of passers-by. This new design thus works to erase from the collective narrative the fact of continued mad segregation and subjugation in downtown Toronto. The new overall reconstruction promises "vibrancy, commerce, and dignity" to a site that has hitherto been known for its degeneracy: yet another built solution being offered to offset

the stigma associated with mad degeneracy and mad carceral sites. It remains to be seen whether yet another alteration will prove successful in overcoming this site's long history as a "problem" in need of a "cure."

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Notes

1. I use the language of "mad" and "madness" throughout this article as a way of disengaging from current medical-psychiatric understandings of madness. Further, my intentions are "a strategy of reappropriating a word usually regarded as prejudicial and mocking" (Parr and Philo, 1995, p. 199), and to recognize the ways in which the mad movement has emerged as a collective to campaign in socio-political arenas.
2. Much should be said about the way psychiatry pathologizes depending on gender. The ways in which gender and madness (and race, class, sexuality, ability..., etc.) interact and impact mad bodies is crucial to consider, but is beyond the scope of this paper. For work on gender and madness, please see Blackbridge, 1996; Chesler, 1972; Grobe, 1995; Thomas, 2001; and Tremain, 1996.

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