The Asylums in Toronto
Reflections on Social and Architectural History
An Exhibit
Saturday March 6 - Sunday June 20
Market Gallery
Curated by TRAC

This exhibit affords us an excellent opportunity to reconsider the place that two great medical institutions have played in our lives. It will feature much art work and text that was not used or not known when the book was prepared. We will broaden our approach to include space to speak for those who have been affected by the institution.

TRAC members will receive an invitation to the opening reception.

Admission is free to the Market Gallery on the second floor of the South St. Lawrence Market, 95 Front Street East. Gallery hours are Wednesday through Friday 10am-4pm, Saturday 9am-4pm and Sunday noon-4pm. Closed Mon. & Tues.
For more details, please call: 416-392-7604

Our thanks to Pam Wachna and staff of the Market Gallery

Queen Street Asylum/Centre for Addiction & Mental Health
TRAC’s submission to the open ideas competition: what could be saved of the asylum wall and grounds. A neighbourhood artist’s response. Why the grid will harm this site. Why P3s will harm this institution.

HOSPITALS
and DEVELOPMENT
former Riverdale Hospital at Bridgepoint Health Centre
Our Lady of Mercy at St. Joseph’s Health Centre
TORONTO HOSPITALS AND DEVELOPMENT

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Editor: S.J. Russell

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Are you interested in contributing to ACT? [ ]
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What programming, advocacy or research would you like TRAC to do?

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<tr>
<th>NEW CORPORATION</th>
<th>SITE NAMES</th>
<th>FORMER CORPORATIONS</th>
<th>LOCATIONS</th>
<th>HSRC DIRECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre for Addiction and Mental Health Services (ID March 9, 1998)</td>
<td>ARF Site Clarion Clinic The Donwood Site Queen Street Site</td>
<td>Addiction Research Foundation Clarke Institute Psychiatry Donwood Institute Queen Street Mental Health Centre</td>
<td>33 Russell St. 250 College St. 175 Brentcliffe Rd 1001 Queen St.</td>
<td>Yes</td>
</tr>
<tr>
<td>Humber River Regional Hospital (ID January 1, 1997)</td>
<td>Church Street Site Kewitt Street Site Finch Avenue Site</td>
<td>Humber Memorial Northwestern General York Finch General Hospital</td>
<td>Weston Toronto Brampton</td>
<td>Yes</td>
</tr>
<tr>
<td>North West GTA Hospital Corporation (ID August 1, 1998)</td>
<td>Etobicoke Hospital Campus Georgetown Campus</td>
<td>Etobicoke General Hospital Georgetown &amp; District Memorial Peel Memorial Hospital</td>
<td>Etobicoke Georgetown Brampton</td>
<td>Yes</td>
</tr>
<tr>
<td>North York General Hospital (ID May 1, 1998)</td>
<td>General Site Brampton Site</td>
<td>North York General Hospital North York Brandon Hospital</td>
<td>4001 Leslie St. 665 Finch Ave. W.</td>
<td>Yes</td>
</tr>
<tr>
<td>Rouge Valley Health System (ID August 1, 1998)</td>
<td>Centenary Health Centre Site Ajax and Pickering Health Centre Site</td>
<td>Centenary Health Centre Ajax and Pickering General</td>
<td>Scarborough Ajax</td>
<td>Yes</td>
</tr>
<tr>
<td>St. Michael's Hospital (ID April 6, 1998)</td>
<td>Wellesley Central Hospital Site</td>
<td>Wellesley Central Hospital St. Michael's Hospital</td>
<td>160 Wellesley St E 30 Bond St. 333 Sherbourne St.</td>
<td>Yes</td>
</tr>
<tr>
<td>Sunnybrook &amp; Women's College Health Sciences Centre (ID June 26, 1998)</td>
<td>Orthopedic and Arthritic Campus Women's College Campus</td>
<td>Orthopedic and Arthritic Hospital Women's College Hospital</td>
<td>Toronto Sunnybrook Health Science Centre</td>
<td>Yes</td>
</tr>
<tr>
<td>Toronto Hospital (The) (ID January 1, 1998)</td>
<td>General Division OCP/PMH</td>
<td>OCP/PMH</td>
<td>Toronto Western Hospital Princess Margaret Hospital</td>
<td>Toronto Cancer Institute 585 University St. 999 Bathurst St. 610 University 610 University</td>
</tr>
<tr>
<td>Toronto Rehabilitation Institute (TRI) (ID November 2, 1998)</td>
<td>Lyndhurst Centre Hillockrind Centre University Centre Queen Elizabeth Centre Rumsay Centre</td>
<td>Lyndhurst Hospital Rehabilitation Inst. of Toronto Rehabilitation Inst. of Toronto Rehabilitation Inst. of Toronto Rehabilitation Inst. of Toronto</td>
<td>520 Sutherland Ave. 47 Austin 520 University 345 Flymsey Rd 130 Dunn</td>
<td>No</td>
</tr>
<tr>
<td>Trillium Health Centre (ID April 1, 1998)</td>
<td>Mississauga Site Queenway Site</td>
<td>Mississauga Hospital Trillium Health Centre</td>
<td>Mississauga Hospital Etobicoke</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Of hospital buildings and politics

This issue of ACT makes the case for three current hospital sites worth saving. We begin by documenting the pressures that hospitals are under which jeopardize hospital services, fracture temporal and geographic continuity —the spirit of the place—and jeopardize the historic buildings and settings where that spirit resides. Hospitals are not like other corporations, although the management textbooks of the day may disagree. But the public knows that the hospitals, like schools and charities, belong to them as part of a public trust. It is these institutions that build for citizens a city a worth living in. And the built form of these institutions is not mere window-dressing. It has often been developed with the care, and idealistic elan that present institutional stakeholders can only dream of mustering for their coveted capital projects. Here then are the forces arrayed against historic hospitals:

### Arguments of Functionality

As hospital buildings age there comes pressure to replace them with something, "more functional." This is understandable and especially in healthcare it is a powerful persuader. However if we heed the cyclic chorus every so many years that a building has again become non-functional we will lose every hospital ever built, including ones now under construction. Perhaps we need perspective on what we call functionally —often a code for more subjective, less damning judgements, like "ugly" or "old" or "inconvenient" and occasionally "stigmatized." When planning for hospitals with grand atria and mall-like spaces and detailing, hospital boards and ministries are not obsessing with functionality. Nor are they particularly planning for the ages —those atra from the 80s already look dated. In contrast, the process of renovating significant buildings is immanently sensible. Let hospital boards and private and public re-use experts carefully judge heritage hospital buildings for any opportunity of reuse before consideration is given to demolition. In the end, if there is no practical use within the hospital corporation for a significant hospital structure then the institution should be mandated to look for compatible community or institutional uses like LTC, hospice, shelter or assisted housing and partner with or lease the building to the interested party.

### Recent Corporate changes

Restructured hospitals have been around for real since 1997 but are still physically consolidating. Restructuring orders were given by the Health Services Restructuring Commission (HSC) which was empowered by Ontario Regulation 272 "To advise the Minister on matters relating to the development and establishment of an effective and adequate health care system" which in practice was the authority to require hospitals to close, amalgamate or trade duties. Supporters of the HSC will claim triumph: the self-interest of each institution appropriately vanquished, the bold new corporatations can serve all stakeholders more efficiently. The actual results, if not always functional, were always expensive.

You could be forgiven for viewing the changes as a large step sideways with both good and bad in evidence on the sidelines. Distinct sites and merged cultures have yielded puzzling entities that may indeed be simplified at the Ministry level, but no farther. And some judgements were awful. In the case of Wellesley Hospital's closing, residents of St. James town find themselves no longer served by a hospital locally, even though high-rise neighbourhoods are in greater statistical need of hospital services than any other residential or commercial neighbourhood.

Of hospital buildings and politics

**Coming next ACT: More institutional architecture threatened by condo towers. 33 Charles East, Children's Aid Society. Elegant programme of modernism to nurture and protect. The history, site, architects, plans, photos, demolition and 41-storey condo development scheme, institutional and political background.**

**Coming soon to TRAC a College Street Tour and a Market Gallery exhibit (see back page).**
And the costs were more than anticipated as hospitals figured they may as well come out ahead after all the struggle. Hospital boards under direction to change by the HSRC took the opportunity to pitch for redevelopment as the cost of the change, and the onus sank straight down on the government to pony up. Furthermore, hospitals that preemptively merged are engaged in expansions as well. There are 8 billion dollars worth of expansion plans in the works and the overall pace of the redevelopments is in some cases 5 years behind schedule. The Ministry of Health in 1998 expected all work to be complete in 2003-2004 (p1/Enterprise Canada for OHA). Nor do these cost estimates include much of the $350 million capital redevelopment, financed mainly by a $280 million private bond issue, at the University Health Network (a pitifully generic renaming of the storied Toronto General, Toronto Western and Princess Margaret Hospitals) (p38/HCFWG for OHA).

<table>
<thead>
<tr>
<th>Capital need</th>
<th>Budget (billions)</th>
<th>MOHLTC funding</th>
<th>Hospital funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSRC projects</td>
<td>$3.2</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>Capital redevelopment</td>
<td>$3.1</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>$1.5</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Public Private Partnerships**

Here the obvious problem for Hospital corporations is to fund not only these massive capital projects but to pay down their operating deficits, never knowing whether the two levels of government will have ability or disposition to provide predictable funding.

The stark experience for HSRC projects has been that even essential and government-mandated capital projects simply will not be built or required relying on public funds and traditional procurement processes alone. Private finance, whether or not coupled with other P3 elements, will likely be the only way to build these projects. This realization has led to this examination of the potential private role in the design, build, finance or operations of Ontario hospital capital assets. (p11/Bennett Jones for OHA)

In Ontario healthcare parlance P3s are superficially simple: facilities built by private enterprise, and leased to a government tenant while operated and managed by private enterprise. The lease will be 20 to 30 years and then the facility will revert to public ownership.

There are several things worth noting about P3s in the literature, which is usually generated by consultants and professional associations — governments remain circumspect about what they reveal. The Ontario Hospital Association is resigned to the fact that P3s seem more politically palatable than do higher taxes. On that basis they are fully engaged in the move to create P3s as fast as they are permitted, several trial projects immediately if you please, and they are not clear on when or how they would reconsider the trial projects once 30-year leases had been signed.
Disposition of Hospital Assets: The Legal Issues (excerpts) By Mark Bain and Heidi Visser

In the halcyon days of Canadian healthcare, governments funded a large proportion of a hospital’s asset acquisitions. Assets were routinely acquired, but seldom financed and rarely disposed of. Now we are experiencing declining levels of public funding and significant restructuring of hospitals, accompanied by mergers, asset disposals and the introduction of private financing structures such as sale-leaseback transactions. The existing hospital infrastructure was put in place in the belief that hospitals would be permanent, stable and growing institutions, and so the rules for transferring or disposing of hospitals’ assets are not yet well established.

1. Who owns the assets?
In Ontario, the assets of a public hospital are generally owned by an independent non-profit corporation known as a hospital corporation, which is a non-share capital corporation, either incorporated under the Corporations Act, or through a private act of the provincial legislature. A smaller number of hospitals remain owned by religious orders. (...) Nonetheless, the owner of the hospital assets is almost invariably a non-profit entity with a volunteer board of directors, which is responsible for the ownership and care of the hospital’s assets as well as for the hospital’s operation and patient care. (...) Looking through the hospital’s corporate structure, one wonders who really owns the assets? For business corporations incorporated under the Business Corporations Act (Ontario), the shareholders are generally entitled to receive the corporation’s remaining assets upon its dissolution, after paying the creditors. Hospital corporations have no shareholders, and in many cases their articles of incorporation or letters patent, incorporating acts or regulatory rules do not contemplate either the disposition of assets or the dissolution of the entity. For those hospitals established as charitable trusts, there may be specific rules for the disposition of assets which provide for purposes similar to the original charitable purposes.

2. Who may authorize the transfer or sale of hospital assets?
The board of directors of a hospital corporation must authorize an asset disposition. The powers of the board may be delegated to the president or another executive officer of the corporation. (...) In Ontario, the Minister of Health must also consent to the sale, lease or mortgage of any asset of a hospital corporation comprising its land, buildings, premises or any part thereof. With the introduction of the Savings and Restructuring Act, 1996, the Ontario Ministry of Health gained expanded powers, under section 6 the Public Hospitals Act, to direct the hospital in restructuring transactions to engage asset disposals, without the Minister’s consent to be in the public interest. (...) Since a hospital corporation has no shareholders, defining the respective rights of the stakeholders of the successor company becomes difficult. (...)

3. What is the liability of the board members who authorize these transfers?
The board of directors of a hospital has duties mandated under the Public Hospitals Act, extending to both the hospital corporation and to the greater public who fund the hospital and use its resources. In certain circumstances, corporations may be held to owe a duty of care to provide basic services to the public’s needs first. Some board members view their duty as being more akin to the standard required of a trustee and are held accountable to a business corporation’s director. While this is not necessarily true, in the case of conflict some hospital directors will favour the public interest - the most conservative course and the path most likely to avoid liability. Section 13(1) of the Public Hospitals Act provides protection from liability for directors who acted in “good faith.” (...)

4. How are the sale proceeds distributed?
The proceeds of sale should be distributed to the vendor, the hospital corporation. The conclusion is less clear if the hospital corporation simultaneously dissolves, is amalgamated with another hospital corporation, or is nationalized. (...) In an amalgamation context, the process is not treated as a disposition and so there are no sale proceeds. The successor amalgamated company assumes the ownership of the assets, along with any other liabilities of the predecessor corporations. (...) It is generally acknowledged that a hospital is a charitable organization; however, it is not entirely clear whether, in this capacity, it holds its assets in its own right, or as trustee for a charitable purpose. In the 1988 Ontario case Re Centenary Hospital Association, the court held that the Centenary Hospital held the land which it wanted to develop into a medical arts centre as its own property, and not subject to a charitable trust. If the hospital had held its land as a trustee, the Public Trustee would have had jurisdiction under the Public Charities Accounting Act. (...)

How does this all (really) work?
(...)

5. Disposition without closure: A restructuring of this sort generally involves the broad use of the term “disposition”: i.e., a lease or mortgage. For example, with the Minister’s consent, certain assets of a hospital may be leased to an entity in which a non-hospital healthcare corporation held an interest. Copyright 1989 Mark Bain & Heidi Visser, HOSPITAL QUARTERLY SUMMER 1990 VOL.1 NO.4 J0957

The Ontario Association of Architects is much more amiable, noting that the cost of developing a bid for a P3 project can be several million dollars for a consortium, much of it carried by the design, engineering and contracting firms. The OAA notes many problems of P3 initiatives in the United Kingdom, where they’re known as PFI (private finance initiatives), including the fact that “the build and architectural quality of many of the buildings has been broadly criticized” (p8/OAA). And that’s an understatement according to Michele Landsberg’s article on page 12 of this issue of ACT. The main pro-P3 argument hinged in ever mutating democratic-ese, is that of “risk allocation.” A lesser benefit is that in using P3s to deliver infrastructure a government may be entitled to keep those costs out of the realm of public debt and off the books. A third less well-argued on justification is that of “value for money”. From the Bennett Jones/OHA report:

One of the primary goals of P3 structures is to capture additional value for money by allocating risks to a private partner, where the private partner may be able to assess, price or mitigate the risk more effectively than could the traditional public partner. The prevailing orthodoxy is that project risks should be allocated to the party best able to manage the risk. (p4)

But does risk transfer really make projects cheaper than traditional methods for the government client? Cost overrun is a major risk that the private sector absorbs in P3s. In order to compare cost-efficiencies such a risk is afforded an imaginary cost of around 18%. From the OAA: when costing P3 versus design-build, cost overruns of design-build must be accounted for, but...

The trick is in that quantification, of course. The most recent information from the UK indicates that a factor of 18% is added to reflect their experience in traditional delivery models. Were that factor alone reduced, it could tip the balance in favour of the 'design-bid-build' model. (p20)

3
The points of compare between P3 and ordinary tender are simply not agreed on. The costs over the long term are 'discounted' to a 'net present value' for the comparison. All future costs related to the operation, management and refurbishment are discounted to today's value, as are the benefits of the project. The rate selected is subjective to much debate and can directly influence whether this analysis will favour the P3 or the traditional approach. (p18/0A)

It seems to the TRAC board that the biggest problem does indeed have to do with that "long term"—the length of time which is signed away to a single supplier. No wonder these deals are profitable to the private sector. At some point over those 30 years it is not inconceivable that the product or service or both may become in some way unsuitable, despite their being specified in contract and developed initially by both parties. This inflexibility could be a big problem for such undertakings.

Finally, what is the actual evidence such as it is in the United Kingdom for or against P3s? For hospitals specifically there is virtually no positive financial evidence despite the consultants most ardent efforts to report some:

A key study conducted by Professor Christine Whitehead of the London School of Economics in conjunction with Arthur Andersen, concluded that the PFI program across various industry sectors delivered a 17% risk adjusted savings as against the public comparator. The empirical evidence of value for money in the hospital sector is still relatively scarce and anecdotal, the hospital sector being one of the last to adopt the PFI model. (p86/Bennett Jones OHA)

And then many pages later...

The only way to prove or disprove the theory that hospital P3 projects would deliver value for money in Canada is to establish pilot projects. Discussions should begin immediately on the risk allocation and valuation matrix, as well as the appropriate discount rate to be employed in determining value for money, to avoid the debate in the U.K. on this point. (p90/Bennett Jones OHA)

"Avoid the debate"? Little doubt that the OHA tends to view P3s optimistically, focusing on the immediate benefits of P3 implementation.

Already some very strange hybrids are out there. In June 2001 the TGH/UHN sold their Darling and Pearson College Street Wing and the land it sits on to a non-profit medical research-related corporation known as "MARS". The precinct will be a "Discovery District", as you may have noted from the street signs. U of T, a partner in MARS, had expected the transaction to cost between $20 and $35 million. The Ontario Government has provided $20 million in funding to MARS, paying in essence to buy the heritage hospital building and the land on which it sits from the hospital corporation and deliver it to an interested third party. For heritage, the outcome is neutral or negative to some degree: most of the building will be retained in a modified state. For the hospital some short-term cash was realized. It's not a terrible deal, perhaps it's even exemplary of a practical way to save heritage hospitals from demolition. And yet you don't help but notice the shift of public assets further from public control, while at every step the public pays handsomely for the dance. (AsT)

SOURCES

— HOSPITAL CAPITAL NEEDS STUDY, Enterprise Canada Research for the Ontario Hospital Association, July 1999
— FUNDING & FINANCING HOSPITAL INFRASTRUCTURE RENEWAL, Hospital Capital Funding Working Group for the Ontario Hospital Association, April 2000
— PUBLIC-PRIVATE PARTNERSHIPS FOR ONTARIO HOSPITAL CAPITAL PROJECTS, Bennett Jones LLP for the Ontario Hospital Association, August 2001
— A P3 PRIMER, Ontario Association of Architects, 2003
— METROPOLITAN TORONTO HEALTH SERVICES RESTRUCTURING REPORT, HSRC/Queen's Printer, July 1997

Original Mount Sinai Hospital to be absorbed into condo tower project. Public Meeting Jan 14 2004.

100 Yorkville avenue, the site of the original Mount Sinai Hospital is getting the condo treatment. A plan by Harini Pontarini Architects calls for the remains of the hospital—a bit more than a facade but quite a bit less than a building—to be incorporated as a crust on the new street level townhouses. In the centre of the site will rise an 8-storey and an 18-storey condo tower. The Georgian-Revival-type-of-Deco 1934 Mount Sinai facade (Kaminiker & Richmond) will be moved onto the street while excavations take place, then repositioned back.

Two groups have launched a joint appeal to the Ontario Municipal Board: ABC (Avenue-Bay-Cottingham) Residents' Association and Save Yorkville, a community heritage organization. According to Mary Helen Spence, a director with both organizations, the main objections have to do with the height of the towers. It has been a great achievement of groups like this and the city's Planning Department as well, to pilot higher projects onto the main thoroughfares, keeping the Yorkville side streets more-or-less free from towers.

The appellants are relying on planners and architects to volunteer their time as expert witnesses at the hearing scheduled to run for 8 days over two weeks beginning on February 16th, 2004. It would cost as much as $35,000 to pay for such testimony, money the groups probably won't have time to raise. If you can volunteer your expertise to Save Yorkville, or make a financial contribution, contact them at 416-920-2589.

Save Yorkville is hosting a public meeting on January 14th 2004 at the Heliconian Club, 35 Hazelton Avenue, 7:30pm (refreshments at 7pm). There will be guest speakers and opportunity to ask questions and make your views known.

Down the street the unfortunately reclad Victorian row which has housed 'The Riverboat' and several bona fide boutiques in its day will be demolished and replaced by a 9-storey 'boutique' hotel. York Rowe Ltd. was given permission by the OMB on September 23 2003 to proceed with their plans without major revisions. Architects are Page + Steele. (AsT)

MIMICO ASYLUM BOOK UPDATE

Research on our companion volume of Toronto asylum histories has wrapped up and the project is proceeding to the writing and editing stage.

Visit the TRAC asylum exhibit at the Market Square Gallery from March 6 to June 20 2004 for a preview of some of the findings.

Our first asylum book The Provincial Asylum in Toronto: Reflections on Social and Architectural History (2000) is still in print. It may be mail-ordered from TRAC or purchased at Book City.

Cost by mail order is $30, shipping included. Dedicated to the memory of its editor, our Edna Hudson. (AsT)
St. Joseph’s wants to build a new 4-storey facility with a 40,000 square foot floorplate on the site of OLM. A quick look at the site shows how 40,000 square feet could be built practically anywhere, especially on top of the new, large and low 50,000 square-footprint Barnicke Wing marked “B”.

St. Michael’s Hospital downtown managed a very similar expansion adding 160,000 sq ft over 4 floors (Diamond & Schmitt, 2002) on top of an operational 10-storey hospital building for $51.7 million. The St. Michael’s expansion had the technical challenges of being built high up and also on a much tighter site so it is more expensive per square foot than an ordinary hospital building like the proposed replacement for OLM. But that doesn’t take into account the demolition cost for OLM, nor the land value. St Joseph’s should consolidate in order to resolve the incoherencies of their layout, but they should do so on the current footprint... otherwise it’s not consolidation it’s subsidized sprawl, made artificially cheap at the expense of viable heritage buildings not to mention pots of Ministry cash—“the largest funding ever received by a hospital of St. Joseph’s size – the Government of Ontario is putting us well on our way...” (St. Joseph’s website, Jan 2003)

“It is proposed that the second floor of the new building be created as two Surgical Inpatient Units of 34,000 gross sq. ft... While this is not a direct requirement of the HSRC program it is felt that the opportunity to create a new building on the site, at this time, is an advantage that will not rise again in the near term...”
(g7, Bregmann + Hannam report, April 2, 2001)

Perhaps then these plans may be overly ambitious and St. Joseph’s, which makes uncomfortable claims to be “aggressively patient focused” elsewhere on their website, could stand to be a little less aggressive, and tend a bit more to the extant fabric of their institution, neighbourhood and city. The resignation of CEO Marilyn Bruner in mid-2003 coupled with the decisive reshaping of the west end political landscape in the recent election make it a good time to reconsider the OLM scheme.

Expand on top of or between other low buildings; build on the prime lakeview frontage and put the oversized parking lot underground where it belongs. (St. Joe’s has cultivated an excess of cheap parking in order to discourage people from cruising the neighbourhood. Perhaps a different, more environmentally sensitive strategy could be developed. St. Joe’s to the Bloor Subway by streetcar is as quick on average as Western Hospital to the Bloor Subway according to the TTC. Western has hundreds fewer parking spaces). As befits an institution named for a carpenter know and love your materials, build thoughtfully for your future, honour your past.
The Objective:

To provide many reference points from which we may all consider the long and complicated history of the precinct within the walls.

To produce a program that will be nature-based and in large measure self sustaining and self generating;

To enhance the existing wall so that it attracts passers by and excites their curiosity;

To animate the site through the use of massed plantings of vibrant colours and various textures demonstrating that this place is special and important;

To soften and humanize the site so that visitors will feel welcome to stop and able to interpret it from many new perspectives;

As Found.

The brick walls that survive on the east, south and west perimeter of 1001 Queen Street were constructed to give people who resided and worked there a heightened sense of personal security.

The east wall has the highest profile of the three. That part that is unaltered—the southerly 70% is a powerful but elegant monument to the men and women who lived and worked within these walls.

The walls must be respected and protected to serve as lasting memorials to the lives of all those who have entered the precinct. As a designated public structure the wall should be treated in accordance with international charters dealing with historic sites and monuments. Therefore no part of the extant wall will be demolished.

The north 30% of the wall has been lowered by about 1/2 metre. The original natural stone cap was replaced with a concrete version. This intervention has undermined this part of wall and led to its deterioration. Water penetration has caused many bricks to spall.
Recommended Action Plan.

1. The north 30% of the east wall should be rebuilt and repaired so that it matches completely the surviving 70%. The entire wall should remain in its un-cleaned state, unless a professional conservation authority determines that the soot is seriously threatening the wall.

2. A below ground irrigation system should be installed down the full length of the boulevard that exists in the road allowance between the wall and the sidewalk.

3. The boulevard should be prepared for the planting of a garden. The entire east line of the boulevard should be planted adjacent to the sidewalk with boxwood the width of the pier. By pier we mean the projecting buttresses that support the wall at 14 foot intervals.

4. A list of flowering perennials should be developed in consultation with the community, garden historians and the City of Toronto staff. Factors that will influence the master plant list will include species that:
- are used in homeopathic medicine;
- are indigenous to the region;
- will provide a broad, full seasonal and colour display.

5. Once a selection has been made and the number of species is known, then these will be planted between each set of piers. Each set will be outlined with boxwood, with the wall forming the backdrop. The number and length of these sections may vary depending on the species.
DOCTORS' HOSPITAL MEDICAL CENTRE CRANG AND BOAKE, 1963

An exceedingly urbane low-rise to the south of the main building on Brunswick Avenue, populated by a large Henry Moore. Institution and building now gone.

The most visible corner of the new University Health Network's Toronto General Division's building appears to have been forgotten. As mute as the building above is inviting. Pedestrians at University and Gerrard can look up and marvel at sky gardens, wall sconces and 'just-so' off-centre rough-bewn lintels but as for a nod to the street, you're lucky to get a corner to pee in, let alone a window or door (which is always helpful on a slushy day in the University Avenue wind tunnel).

Witness this plaza to nowhere. We had to take a very particular angle so as to not get the over-size semi-permanent "Parking this way" sandwich board. But do not those on foot deserve such attention?
The Bridgepoint complex will be expanded and consolidated under a masterplan by Perkins Eastman Black, the Canadian arm of US architectural giant Perkins Eastman who by virtue of their healthcare and institutional portfolio were the 6th highest grossing US firm in 2003, just behind Kohn Pedersen Fox.

It is too early in the process to have any specifics of the 1962 Riverdale Building's retrofit, but Ian Sinclair Bridgepoint's VP of Planning says it will happen as the complicated pieces, not the least of which is the $144 million budget, fall into place. Enthusiasts of local modernism will be relieved that it is known in the Bridgepoint literature as "the landmark building" of the site. Others like the Hastings Building to the south will likely be demolished and a new building that rides the valley's edge, concave to the expressway, will take the place of the parking lot. A two level 230 space garage will be built underground beneath St. Matthew's Lawn Bowling, itself an interesting property. The cottage clubhouse (Robert McCallum, 1906) and the green will be retained. Much of the land on which the current Bridgepoint sits is city land leased to the former Riverdale Hospital, the notable exception is the old Don Jail (William Thomas, 1859), bought outright by Bridgepoint. It will be rehabilitated for use as the administration building, with public access to certain restored areas. This is the most challenging technical part of the plan and we wish them well.

The Bigger Picture.

1. The program as outlined should be used as the model to shape the future of the west and south walls.

2. All redevelopment should be shifted away from the west end parkland. The land along Queen Street between the west margin of Brookfield Street and the west wall should be preserved as parkland. The depth of this park will be identical to that of the east park section.

3. The footprint in the sidewalk that clearly shows the site of the piers of the demolished north wall should be perpetuated, and its existence acknowledged and protected by adding it to the historic designation.

4. The planting program for the regeneration of the east and west parks, while not part of the competition, will be characterized as natural, indigenous, pre-European settlement in the east park. In the west it will be post-European settlement or orchard / well cultivated garden.

5. While some culling of old growth may be necessary, these changes will be done incrementally, largely through attrition.

Exceptions:

the re-creation of the stream bed that ran through the east park; the removal of the tennis court in the west park will afford an opportunity to intervene early in the west, orchard / cultivated garden.

6. The highest density redevelopment should be adjacent to that part of the south wall that has been demolished. ACT

the site...

The fact the Bridgepoint exists at all is miraculous. One of only two hospitals ordered closed by the HSRC that managed to successfully petition the Ministry of Health and Long Term Care directly for a renewed mandate, Riverdale made the emphatic case that more Long Term Care was needed in the Toronto region and they offered to develop a new facility to meet the expected demand (this will be the new construction to the west along the valley). They also clearly sold their expertise in Complex Continuing Care and Rehabilitation which are hospital-based levels of care currently offered in the 1962 Chapman & Hurst main building, where they'll remain after the planned renovations.

Mr. Sinclair offers these definitions of the current health care designations:

CCC patients are typically patients who have been discharged from an acute care hospital and they often have several "co-morbidities" (more than one disease or disability at a time). They may have total kidney failure, be an amputee and have diabetes or have HIV/AIDS and a series of related illnesses due to an immune system problem, (cancer etc). The average length of stay for our CCC patients is about 13 months, however, we have many patients who will stay here their entire life.

Rehabilitation patients range in age from 18-100 and can be here to get rehab after a stroke, a bad car accident or a neurological impairment. They stay on average, 30 days.

Palliative Care is still a current designation, defined as end of life care. It is not a rigid subset of the others, but rather offered when needed in any context—hospital facilities, Long Term Care facilities, in specialty hospices or at home and is usually offered over several months as needed. Bridgepoint has 20 or so palliative care beds. ACT
The Asylum doctors its image... by Gene Threndyle, Oct. 2001

It's no mystery why the arts community in downtown Toronto has taken a last stand in the vicinity of the mental hospital on Queen West. It's about rent. Further east Queen Street was main street for bohemians in this city in the seventies and eighties. As the rents went up the artists went west. No one's expecting FTV to do a street style shot anytime soon from the corner of Ossington and Queen but if the management at the Centre for Addiction and Mental Health has its way, the intersection will resemble Queen and John by the end of the decade.

Someone with a taste for community meetings can keep themselves busy at least two nights a week in Toronto. The whole process of public consultation has become a mini-industry complete with jargon like 'stakeholders' and 'clients' and 'linkage' and 'renewed focus'. Finally, if you're like most people you need more than a taste, you need a strong constitution and a cast iron stomach and going to a year's worth of Power Point presentations, styrofoam models and otherwise dreary circus productions on the proposed changes to Queen Street mental hospital site, I feel like I may change my own status from stakeholder to client. As a neighbour, I have been offered cookies and juice, sandwiches and fruit in an effort to draw out my concerns and opinions. This is not so that they can be addressed but so that they can be spun like straw into gold.

At one of the first meetings that I went to, a company called Urban Strategies who have been hired to mastermind this change described the neighbourhood as it exists now. The nice man talked about many things but never once mentioned the visual arts or any arts. I pointed this out and suggested that if they were successful in their ambitions they would drive the arts community further west into Parkdale. That maybe inevitable anyway but Queen and Ossington is low rent not because of the stigma of the Mental Health Centre so much as the fact that crazy people don't have a whole lot of money, generally speaking. Many store fronts are becoming restaurants and galleries sending up rents and re-sale value as new people move in.

None-the-less, one of the driving forces behind this re-development is the removal of the 'stigma' of mental illness. To do this they are going to extend Ossington Street, Adelaide Street and two other streets through the site. Much of the green space will be lost and they would like to remove the wall along Shaw Street. They want to include a grocery store and a coffee shop, an art gallery, townhouses, underground parking and oh yeah, a medium security jail. That's there now and it's getting bigger.

They want to do all of this within 10 years and they are willing to consult. The more public input the better since it's much easier to spin 500 separate voices that 50 united voices. If you can make development and land speculation like neighbourhood improvement all the better. Who cares about trees and green space when you can remove the stigma of mental illness.

The wall along Shaw was originally further east and enclosed inmates of the asylum and the fields that they worked. Previously to this the insane had been kept shackled and in jail on Yonge Street. The asylum was an improvement, a place of relative safety and refuge. That wall kept out the rigidity and meanness of Victorian Toronto and gave some freedom to the mentally ill before the age of medication.

When the fields were sold off in the last half of the 19th century, the patients were made to take it apart and rebuild it brick by brick where it stands presently. If that wall is a reminder of something nasty in our collective mind perhaps we shouldn't be so willing to wipe it out and forget it. That wall is a monument to generations of people misunderstood, locked away and conveniently forgotten. That wall does not mark their grave, but it marks their lives.

The Queen Street Campus should be improved but by not seeing the importance of the things that exist there now like the green space and the wall, we commit the same error as previous generations. Although the land is not being sold, the last of the land is being taken. The existing buildings that replaced John Howard's doomed asylum were meant to remove this same stigma as was the removal of the wall along Queen Street. That didn't and it's a safe bet that this won't either.

materials...

That Mr. Hurst was a "materials man" is in great evidence in this building. The exterior signature material is Colorbel, a European enameled glass. The two colours "Mink Brown" and "Sky Grey" are used on our windows and on the spandrel coursed to form overall a checkered appearance. Demand for structural glass of this sort was waning by 1960 when the manufacture of Colorbel passed from Glaverbel Splintex who are now one of the world's biggest auto glass manufacturers to Pieterman Harglss. (It was marketed before 1960 also as "Spectra"). Jan Willem Meisien, manager of product development for Glaverbel Hardmaas, the Dutch company that inherited the manufacture of Colorbel in 1970, told us "At that time they use a spraying process to put the enamel on the glass and a hanging oven to toughen the glass afterwards. We now do it by using a roller coater and toughening it afterwards in a horizontal oven."

The windows are framed in aluminum with the opening windows and doors framed in anodized aluminum. A central anodized column also separates each bay in two to accomplish the "fold". The doors to the balconies are wood.

An "op art" agglomeration of brown ceramic pipe sections runs in a band across the south elevation—a very interesting design flourish. Interior halls have one warm brick and one plaster wall. Interior details are in teak. A glorious coloured Saico glass mosaic mural by Margit Gatterbauer which Mr. Hurst championed fills a wall of the lobby. Mr. Hurst personally characterized his design intentions as he fought throughout 1962 for a $17,000 budget for Ms.Gatterbauer's design which he felt would resolve crucial design elements of the hospital and site:

When we designed Riverdale Hospital it became obvious that the main entrance could not be in the centre of the building due to the shape and contour of the land. But it was essential that the elevator lobby be placed at the centre to provide proper access to all services etc. This resulted in the elevator lobby being somewhat remote and, due to the curve, out of view from the main entrance lobby. The lobby requires a decorative permanent wall finish and needs a positive visual connection past the tuck shop, along a corridor to the elevator lobby. A glass mosaic mural on this wall which is approximately 80 feet long would perform all these requirements...

He describes the Gatterbauer mural:

The waves, the rainbow, the sunbeams and the mountain slopes form wonderful composition lines holding this long mural together. The right group (a man, woman, children and the sun) viewed from the entrance has greatness, next the city forms a transition, draws us near to examine smaller detail, and leads us to the corridor where the treatment is simple yet very rich in detail and gives satisfaction in a confined space. (Feb.1, '62)

In letter after letter fascinating details emerge. From March 6 1962:

In this building we have worked extremely hard to produce a long-lasting building, easy to maintain with a constant vigilance to economy and a joy to behold. Part of the economy is due to the very low floor to floor heights. This has resulted in a great amount of work on our part to position the elaborate mechanical and electrical systems within very small ceiling spaces but has also resulted in very substantial savings to the owner. In the lobby the result has been a very low (8'-4") ceiling. Most large buildings have much higher lobby heights which generally produces a pleasant entrance to an important building. But this would have been a very expensive solution to the building. The standard floor to floor height in a hospital is 12' 8" while we have held this to 10' on all but one floor. This has produced a saving of 21 feet in height of the total building. In spite of this we have maintained the standard ceiling heights in the offices, service rooms and bedrooms but in the main lobby.
Asylum: institution for the afflicted, esp. insane persons; refuge; sanctuary.
- Oxford Dictionary

These almost unbelievably contradictory definitions stir one’s anger. How preposterous that an asylum should carry any good connotations, so obviously has the good will been exhausted. Those who run asylums know this. Their reflex is to de-asylum everything, to remove any trace of asylum from the business of treating mental patients. Sure in Toronto the original 1850 asylum was demolished in 1975, the institution well-dismayed by then. It is now even the idea of asylum that must fall. The idea of asylum must pay for its sins and others. Mostly others. Patients who need asylum will no longer be accommodated. They are out of date. Do not come to the practitioners seeking asylum, refuge or sanctuary. That day is done. At 1001 Queen Street we still see traces of asylum, of refuge and of sanctuary in the form of the final swath of historic asylum grounds—a decent-sized downtown park—and the remnants of an unfolding wall, inherited by the institution that survived the asylum’s demolition. These hospital holdings now face redevelopment, the trees are to be cut down by the dozens, a major road will bisect the zone and the grounds are to be sectioned into the urban grid.
Beware of privatization at mental health centres ...

The Royal Infirmary of Edinburgh has a new building, placed squarely over the site of an old mine. Whenever the rains are heavy, the mine tunnels flood and hundreds of rats make their way up to the surface and into the hospital and its grounds.

This brilliant stroke of planning was carried out by a private company. The Royal Infirmary, a hospital that once occupied four historic buildings, was redeveloped by a "private-public partnership," or PPP, or F3. Take your pick of a nickname, but take it. You'll need it as soon as F3's strike into the heart of Toronto.

And remember those rats. They seem an apt symbol to me of the ugly woes that lurk beneath every shiny new F3's endeavour.

Our health minister, Tony Clement, is very enamoured of PPPs. He loves to get private companies involved in building and running health facilities while the public pays for the actual service. And why shouldn't he love them? They are generous political donors, for one thing. And the government gets to boast about its balanced budget, because it has shuffled the cost (temporarily) out of its own books.

It's like a mortgage. We pay, but we pay slowly over the years, at about five times the true cost of the building. As taxpayers, we could borrow the capital cost and build far more cheaply and rationally than the private companies, whose sole motivation is profit.

In an uneasy and disturbing echo of the experience in Scotland, four of Toronto's key mental health treatment sites — the Denwood, the Addiction Research Centre, the Clarke Institute and the Queen Street Mental Health Centre — were merged into one, now known as the Centre for Addiction and Mental Health, or CAMH.

Now the 10-hectare site, a prime chunk of handson, well-treed real estate on highly desirable Queen St. W., is due to be redeveloped into a much-needed new hospital.

As you may have heard in a recent Star news story, the hospital board is preparing to "explore" a F3 arrangement, at the government's urging. But they know that the public is highly opposed to privatizing health care — it's been a disaster wherever it's been tried — and, according to a leaked communications memo, they are determined to evade public questions about the F3 plan.

The CAMH board is actually advancing on two fronts. It has applied to city hall for rezoning,Questing after the new designation of RA, or recreation area. Basically, this rezoning would give a private developer a completely free hand to fill that site to bursting with commercial and retail buildings as well as treatment facilities. The other front is the F3. It's an abominable idea. Even the conservative C.D. Howe Institute warned last month that these private projects can be too costly and secretive to warrant public support.

England is the mothership of F3 undertakings, also known as PFI, or private financing initiatives. Many of these deals have already collapsed in a crisis of high costs and failed service. The British Medical Journal reports that the private management of hospitals has led to a 92 percent loss of beds, higher costs, more delays and staff cuts of 26 per cent.

I recently saw a video produced by Canadian hospital unions, documenting Britain's F3s. Nurses and doctors tell of collapsed ceilings, floods of dirty water into delivery rooms, construction so skewed that beds couldn't fit through hospital room doors. Secretive and fishy deals were rampant. The four Edinburgh hospital sites, valued at $345 million (Gbp), were sold to the developer for $12 million — a "mystery," says a sad-faced doctor named Simon Fraser. In a deadened voice, he goes on: "Oh, I've gone beyond frustration ... You just have to accept the fact that these private financing initiatives are going to suck away a huge part of the hospital's operating budget. But it's too late to do anything. All the contracts are tied up."

I don't think we in Ontario have to accept such a monstrous theft from the public purse. We can't afford it hurriedly. Our treatment of the addicted and mentally ill among us is already frayed, shabby and dangerous. Thanks to the ravages of the late, lamented Hospital Services Restructuring Commission, Ontario's nine provincially funded mental hospitals have been merged and downsized into only three, with an accompanying loss of beds and services. CAMH, too, has been hacking off entire wards and services.

Imagine how CAMH will look when private developers get a free hand to build the "urban village" so fondly envisioned by the hospital's board. Already, there are persistent rumour of a Loblaw, a Tim Hortons and a dry cleaner to occupy some of the grounds. Do not doubt for one moment that if a private developer is allowed to design and build the hospital, with a free-for-all zoning designation, there will soon be lucrative office buildings and light industry (how handy for workplace) crammed into the site.

People suffering with mental illness, and their families, already endure anguish and abandonment enough. Who will be left to care for and speak for them, once CAMH is privatized, the workers "contracted out" and the nursing staff cut (the better to gobble up profits, my dear)?

It's unthinkable to sell the voiceless down the river this way. The Toronto Health Coalition vows to make your voice heard — against both the rezoning and the F3 plan — if you deluge them with letters and messages. Phone 416-929-1545; e-mail torheal@direct.com; write to Toronto Health Coalition, 427 Bloor St. W., Suite B4, Toronto M5S 1X7. Act with urgency: there is very little time before it's too late to stop them. (Copyright Toronto Star, reprinted by permission of the author)
A critique of THE GRID

The 1001 Queen Street site is 27 acres; buildings and land wholly owned by CAMH. Their redevelopment office has assured TRAC that “CAMH is committed to continuing to own the land at the 1001 Queen Street site and to retain ultimate ownership of the buildings.”

In September 2003 CAMH successfully persuaded city council to rezone their facility and old asylum grounds from “institutional” to “reclamation area”. In the new Toronto plan this is the designation that allows large scale development to proceed at the fastest rate, with the minimum political impediment. It signals that the political apparatus of the city — elected and non-elected are on side with CAMH and the developers that will follow. If this park is to be saved it will take a political champion or two with some spine to remind everyone that parks aren’t just for Downsview. And it will take sensible insiders at CAMH.

In the end the idea of paving over this park, or the reality should it come to pass, will be regretted. Plus the words of Joe Pantalone (Toronto’s unfortunate official tree advocate) that the park is “like a black hole... it drains the life away from Queen street” will sound like either embarrassingly uninformed panic or cynical hucksterism far beyond the call of duty... depending which side of the argument you favour.

We don’t need to change the tide. There is no tide. There isn’t a flicker of support from any corner of any community for this redevelopment, and judged by that measure there isn’t a single redeeming feature in the CAMH plan. They can call it “city building”. Have they forgotten we already have a city? Maybe they can’t see it from their windows up there, for all those trees?
Six years of accident data are illustrated. Gerrard and Pape is a busier intersection and has one fifth the pedestrian-car accidents of Queen and Ossington. It is possible that the clients of CAMH or those simply on the street in this neighbourhood need a margin of protection from speeding vehicles.

The promotional material from Urban Strategies and CAMH casts their plan for a grid as a liberating gesture that will emancipate this socio-economically stagnant backwater tract and create spontaneous urban joie de vivre. There's no denying that it's a seductive vision, but an informed reading of 'the grid' would dispute that conventional misrepresentation.

"Contemporary discussions about the significance of the grid in urban design are often rather myopic... Experiences with the grid in history show that the grid does not necessarily generate a good society."

"It denies... indigenous landscape traditions. It imposes a rational conceptual order that transcends time and space and proclaims the control of and power of central authorities."

"As ancient Egyptian workers' quarters attest, a spatially 'egalitarian' grid may in fact house the most disadvantaged in society."

"Through the nineteenth century, as America expanded westward, the grid lost its earlier associations (as a mechanism to secure liberty and suffrage for able-bodied men) and instead became a means for turning land into a commodity for speculation."

From 'The dark side of the grid: power and urban design' by Jill Grant, prof. of environmental planning, in Planning Perspectives, 16 (2001) 219-241.

research by Lilith Finkler