

The Institutional Remains: Transinstitutionalization of  
disability & sexuality

by

Megan Quaglia Linton

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## **Abstract**

This research investigates access to sexuality for disabled people in Ontario. To understand sexual access, this research uses frameworks of disability justice and critical carceral studies to make explicit the pervasive the ongoing institutionalization of disabled people. Critically analyzing transinstitutionalization policy reveals surveillance, spatial regulation, and the criminalization of sex work as prohibitive barriers in disabled people's realization of their sexual desires. The City of Ottawa serves as a case study to interrogate the municipal regulation of sexuality through Minimum Separation Distance bylaws. The findings of this study illustrate the shared use of policy tools to invisibilize disabled people and sex workers through spatial regulation and segregation. These shared policy tools demonstrate the need for coalitional politics between sex workers and disabled people. The harms associated with transinstitutionalization and criminalization demand urgent action. Abolition responds to this urgency, demanding decriminalization, deinstitutionalization and decarceration.

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## **Chapter 1: The Sexual Politics of Transinstitutionalization**

“So keen were the officials that there be no possibility of sex or propagation by these deviants that upon death men and women were sometimes buried in separate burial grounds” (Williston, 1971, p. 24).

Large-scale institutions for disabled people in Ontario were never closed, they were privatized. Decades of ongoing investment in the privatization and expansion of institutions, alongside the erosion of the social safety net has resulted in the warehousing of thousands of disabled people across the province. The COVID-19 pandemic has laid bare the lived consequences of such institutionalization, and as of May 2021, more than 5,000<sup>1</sup> people have died in Ontario institutions from COVID-19 (Loreto, 2021). However, even prior to COVID-19, higher than average death rates across institutions continued to be “somehow morally acceptable” (Chapman, 2014, p. 39). This system of institutionalization marginalizes, confines, and kills disabled people. This tragedy demands an urgent movement towards deinstitutionalization.

Deinstitutionalization is a political project demanding the end of institutions and their associated logic (Ben-Moshe, 2020). Deinstitutionalization requires substantial academic and financial investments to make possible the significant social change required. In Ontario, momentum towards deinstitutionalization was quelled by the closure of public institutions. The closure of public institutions came with the promise of inclusion and community living for disabled people. This promise has never been

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<sup>1</sup> This number is presumed higher, as it does not include people who died in institutions because of the conditions of COVID-19, but not from the disease. For instance, this number does not include people who used Medical Assistance in Dying within institutions during COVID-19.

realized; today, more than 2,900 persons labelled with intellectual/developmental disabilities (I/DD) are forced to live in long-term care institutions alone (Lin et al., 2019).

In this thesis, I critique failed promises of deinstitutionalization and interrogate how disabled adults in Ontario continue to be institutionalized across a complex system of social services. The first question this research asks is: *Where do disabled people live in Ontario?* To answer this question, I construct a typology of transinstitutionalization in the province and use systems mapping to articulate the nuances of this phenomenon.

While contemporary academic research has constructed the conceptual frameworks of transinstitutionalization, it has thus far failed to identify the mechanics of the system.

This research makes explicit the pervasive system of institutionalization in Ontario and the urgent need for change to better address the rights of disabled adults in the province.

To answer this first research question, I employ a systems approach (Canadian Centre on Substance Abuse, 2014) to construct a systems map of the transinstitutional landscape of residential disability supports in Ontario. I identify and describe the institutional sub-systems in Ontario of: psychiatric (Dubé, 2016; Farkas & Coe, 2019; Suttor, 2016); forensic psychiatric (Joseph, 2015c; Penney et al., 2019); developmental services (Dubé, 2016; E Lin et al., 2019); geriatric (K. Jones, 2015; Ouellette-Kuntz et al., 2017) and homelessness (Joseph, 2015b; Muscati, 2017) systems. Further, I identify the varying actors, regulations and policies that compose the transinstitutional landscape.

Building from the typology, I interrogate the impact of institutionalization on the lives of disabled peoples; more specifically, I use the lens of sexuality to understand the lived impacts of transinstitutionalization on disabled people. I ask the question: *How does transinstitutionalization impact disabled peoples' access to sexuality?* As sociologist

Anna Finger observes, “sexuality is often the source of our deepest oppression; it is often the source of our deepest pain” (1992, p.2). As such, my focus on sexuality is useful and relevant to this exploration of transinstitutionalization. Moreover, sexuality is an important policy legacy to trace within disability policy analysis; institutions in the late 19<sup>th</sup> century were primary sites of the development and practice of eugenics and as such, were developed at least partially to control, restrict, and remove disabled sexuality (MacMurchy & Ontario. Dept. of Education, 1915; McLaren, 1990).

After situating where disabled people live in Chapter 2, I consider institutional and governmental policies impacting the sexuality of disabled people. In Chapter 3: Sex, Surveillance and Criminalization, I contribute to the development of “bonds of solidarity” between sex workers and disabled people that have emerged within Critical Disability Studies (Fritsch et al., 2016). Carceral systems have prevented disabled people and sex workers from fulfillment of sexual, social, and economic desires (Fritsch et al., 2016). Paternalistic policies jointly impact both sex workers and disabled people— two groups that are deemed simultaneously at-risk/risky by the state. In Chapter 3, I trace the role of the transinstitutionalization of disability and the criminalization of sex work by analyzing contemporary policies that prevent sexual access, justice, and autonomy.

Along with transinstitutionalization, the ongoing criminalization of sex work through the *Protection of Communities and Exploited Persons Act (PCEPA; 2014)* presents barriers for disabled people in meaningfully accessing sexuality (Fritsch et al., 2016). Critical Disability Studies and Critical Carceral Studies have identified and problematized the use of surveillance and spatial regulation against disabled and sex working populations, demanding a coalitional approach. The criminalization of sex work

leads to transinstitutionalization and debilitation of sex workers, under the auspices of paternalistic, protectionist policy (van der Meulen & Durisin, 2008). As such, in Chapter 3, I use Critical Policy Analysis to critique how policies which seek to protect “at-risk” people, fail to consider their own role in positioning disabled people and sex workers to be “at-risk” in the first place.

My fourth chapter, “Erogenous Zones and Bylaws: The Municipal Regulation of Sexuality” is a case study, applying the frameworks I developed in the previous chapters where I interrogate municipal regulation of sexuality. Tracing the role of municipal regulation in the sexual lives of disabled people, sex workers and dancers, I analyze the use of exclusionary zoning and surveillance of group homes, adult entertainment parlours, and homeless shelters. Municipalities became increasingly important actors in the lives of disabled people following the federal and provincial transition towards new public management (NPM) and neoliberalism beginning in the 1990s. In this chapter, I describe how NPM has shifted the identity of the government from that of a service provider, towards that of administration and management, seeking to empower other agencies to provide services (Conteh, 2016). While municipalities are tasked with provision of social services, so too have they downloaded responsibilities onto non-governmental actors (Fanelli, 2014) .

Municipal bylaws have the power to regulate property as opposed to people (van der Meulen & Valverde, 2013). For example, I interrogate how Minimum Separation Distance (MSD) are used to prevent the overconcentration of certain populations (Agrawal, 2012). I argue that these planning tools target sex working and disabled populations, resulting in a city that segregates and polices disabled people and sex

workers (Sanders, 2009). I analyze the City of Ottawa as a case study to examine the impacts of the zoning regulations and surveillance architecture.

Shared policies of confinement, surveillance, segregation, and criminalization unite disabled people and sex workers in demands for justice and liberation. Too often conversations have happened in silos; bringing these conversations together illuminates the need for the joint project of abolition in the liberation of disabled people and sex workers alike. In Chapter 5, my thesis concludes with considerations for further research and policy recommendations. Despite significant victories of the deinstitutionalization movement, disabled people remain confined and segregated into institutions.

Contemporary abolitionist movements provide an opportunity to challenge ongoing institutionalization. To present opportunities for future research, and considerations for policy changes, I apply the “Historic Declaration To Divest From Policing And Prisons And Build Safer Communities For All” to deinstitutionalization. The Declaration, authored by abolitionist organizations across Canada, is a commitment to defund and dismantle carceral systems and to build radical, alternate futures without policing or prisons (Anti-Carceral Group et al., 2021). I use the Declaration to demonstrate the necessity of coalition building between abolitionist and deinstitutionalization movements.

In order to situate my findings and ground the study, in the following sections, I outline the theoretical frameworks which guide this research: Disability Justice, Critical Disability Studies, Critical Carceral Studies, and Sexual Citizenship. Then, I outline my chosen methodological framework of Critical Policy Analysis. In particular, I discuss the importance of applying theories that address disability issues as well as issues of incarceration/abolition to Critical Policy Analysis investigating disability policy.

## 1.1 Disability Justice

A Disability Justice framework “understands that all bodies are unique and essential, that all bodies have strengths and needs that must be met” (Berne & Sins Invalid, 2016). Disability Justice is a framework and movement lead by queer, gender-non-conforming and disabled people of colour (Berne & Sins Invalid, 2016; Piepzn-Samarasinha, 2018). In developing this framework, they developed ten principles of Disability Justice<sup>2</sup> (Berne & Sins Invalid, 2016); in what follows, I highlight how the theoretical principles of anti-capitalist politic, interdependence, cross-movement solidarity, and collective liberation are particularly relevant to this thesis.

Disability Justice is a commitment to anti-capitalist politic (Berne & Sins Invalid, 2016). Capitalism enforces productivity as a determinant of worth, value, and desirability (Berne & Sins Invalid, 2016). Capitalism<sup>3</sup> labels disabled people who are unable to produce as “unfit”, “invalid”, and “useless eaters” (Chapman & Withers, 2019; Mostert, 2002). In the 19<sup>th</sup> century, Francis Galton mobilized this designation of “unfit” to support his theory of eugenics. Eugenics sought to further capitalist societies through the elimination of the “unfit” through selective breeding (Galton, 1883). Disability Justice recognizes that disabled people will never be free as long as the system of capitalism prevails.

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<sup>2</sup> Intersectionality, leadership of most impacted, anti-capitalist politic, cross-movement solidarity, recognizing wholeness, cross-disability solidarity, interdependence, collective access, and collective liberation (Berne & Sins Invalid, 2016).

<sup>3</sup> Of which, the development and dominance of capitalist economies was dependent on the capture, confinement, and subjugation of Black and Brown people (Berne & Sins Invalid, 2016).

Interdependence is a central principle of Disability Justice that rejects and contrasts our current system of neoliberalism. Neoliberalism is the “theory of political economic practices proposing that human well-being can best be advanced by the maximization of entrepreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, unencumbered markets, and free trade” (Harvey, 2007, p.22). Neoliberalism’s focus on individualism contests disabled people’s need for community to fulfill individual needs. This interpretation of disability has led to what theorist Kelly Fritsch (2015a) names as the neoliberal “gradations of debility and capacity.”

Neoliberalism has allowed disability “to be differentially included through modes of debility and capacity that are not clearly defined along traditionally normalizing abled/disabled binaries” (Fritsch, 2015a, p. 14; Puar, 2012). Disabled people who have become capacitated through biomedical advancement are considered neoliberal success stories, with success being defined by both the ability to produce and live independently. Conversely, disabled people who are unable to be recapacitated into the workplace, or require community supports to live are prescribed what theorist Lauren Berlant (2007) names “slow death”. Slow death is the way in which individuals experience the “destruction of life, bodies, imaginaries, and environments by and under contemporary regimes of capital” (p. 764). This gradation of debility and capacity has seen that “disabled people are increasingly included and integrated into western neoliberal economies and social life and, yet, disability simultaneously remains a deeply and profoundly undesirable category of being” (Fritsch, 2015a, p. 44; 2015b). The concept of slow death is particularly relevant to this thesis; throughout the chapters, I explore how

the tools of segregation, forced labour, enforced poverty, and abhorrent living conditions are integral components of contemporary transinstitutionalization of disabled people and sex workers in Ontario.

Disability Justice demands collective liberation, recognizing that we must move together to ensure that nobody is left behind. Collective liberation is integral to the visions of deinstitutionalization that Disability Justice activists hold today. Demands for the closure of disability institutions were not part of the wider abolitionist movement demanding for an end to carceral systems (Ben-Moshe, 2020). Deinstitutionalization is dependent on the closure of all forms of institutionalization that seek to confine and segregate people and demands collective liberation for all people confined and subject to carceral systems.

Collective liberation is only possible through cross-movement solidarity. Cross-movement solidarity, or a coalitional politic, means working together with movements demanding justice (Berne & Sins Invalid, 2016). Cross-movement solidarity brings together racial justice, decolonial, 2SLGBTQIA\*, and feminist movements to demand radical change. Through this research, I demonstrate the need for Disability Justice movements and sex worker justice movements to work together to challenge the shared sites of oppression. Moreover, I demonstrate the need for the prison abolitionist movement to take up the call for deinstitutionalization.

## **1.2 Critical Disability Studies**

Critical Disability Studies (CDS) is a diverse, interdisciplinary field of study, methodology and theoretical framework (Schalk, 2017). CDS scholars “use the method to both describe the socio-political constructions of disability and track the impacts of these

constructions on oppressed persons, including but not limited to those to whom the concept ‘disability’ attaches” (Hall, 2019, p.1). CDS demands the critical interrogation of both the practice of institutionalizing disabled people and the political construction of the disabled person becoming institutionalized; as such, CDS is a highly relevant and appropriate framework for me to use in answering my stated research questions. CDS as a methodology is particularly important to rigorous academic inquiry today, in a socio-economic system of neoliberalism which can obfuscate the state’s role in the production of disability through slow death (Berlant 2007; Fritsch, 2015a).

Given the expansive nature of CDS, I take up two tenets which are most relevant and crucial to a study of institutionalization and policy analysis: interdisciplinary approaches and political engagement (Goodley et al., 2019; Hall, 2019; Schalk, 2017). A small but growing body of literature integrates the intersections of CDS and Critical Carceral Studies (Ben-Moshe et al., 2014; Ben-Moshe, 2020; Boyd et al., 2016; Linton, 2021b; Spivakosky, 2017). In this thesis, I blend Critical Carceral Studies and CDS as a productive way to reconceptualize systems of institutionalization and their connection with carcerality and criminality. CDS calls for political engagement, activism, and praxis; this research is part of a project demanding political change towards the justice and liberation of disabled people. By centering policies as the focus of this research, I offer specific analyses and recommendations which are applicable for urgent policy change. The practicality of a policy focus has allowed for me to engage this research and recommendations with all levels of government, and several political parties; this research has already been mobilized by activist collectives to achieve policy change.

### 1.3 Critical Carceral Studies

Institutionalization is the carceral response to the needs of disabled people; deinstitutionalization is a political and social movement only possible with the enactment and realization of Disability Justice. In this thesis, I specifically focus on the phenomenon of *transinstitutionalization*, which is the process of reconfinement and consists of the transfer of persons from large-scale, publicly operated institutions to other forms of custodial institutions like long-term care homes or prisons (Spagnuolo, 2016; Struthers, 2017). This particular system of institutionalization relies on “carceral ableist logic” (Ben-Moshe, 2020, p.15) which legitimizes the mass confinement of disabled people by rationalizing institutions as necessary to care for disabled people (Ben-Moshe, 2020).

Critical Carceral Studies<sup>4</sup> calls for an expanded understanding of the various sites of confinement beyond the walls of prisons (M. Brown & Schept, 2017). Critical Carceral Studies emerged from the work of the prison abolition movement lead by Black and Indigenous political prisoners (Adema, 2016; Critical Resistance, 2021; Davis & Rodriguez, 2000). Over the past 10 years, CDS scholars have operationalized Critical Carceral Studies to interrogate various sites of “disability incarceration” (Ben-Moshe et al., 2014). The application of Critical Carceral Studies through a Disability Justice and CDS lens by Liat Ben-Moshe, Syrus Marcus Ware, Chris Chapman, and Alison Carey makes this research possible (Ben-Moshe et al., 2014). In this thesis, I build from these seminal theoretical works on disability incarceration – studies at the intersection of CDS

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<sup>4</sup> Critical Carceral Studies has emerged from the work of the prison abolition movement lead by Black and Indigenous political prisoners see for instance: Davis & Rodriguez (2000), the Critical Resistance (2021), Free Lands Free Peoples (2020).

and Critical Carceral Studies – to more specifically examine the operation of transinstitutionalization in Ontario.

Applying this framework, institutionalization can be understood as the mass confinement of disabled people into total institutions<sup>5</sup> in an effort to: 1) segregate them apart from society (Williston, 1971); 2) further eugenics through limiting biological reproduction (MacMurchy & Ontario. Dept. of Education, 1915) and; 3) advance the production of Canadian nation-building (Chapman & Withers, 2019). The logic that created institutions was such that disabled people need to be totally isolated and segregated to facilitate Canadian nation-building (Burghardt, 2018).

Critical Carceral Studies aims to support the project of abolition. Abolition calls us to reconsider institutions as “an inevitable and permanent feature of our social lives” (Davis, 2003, p.9). Abolition is a “political vision with the goal of eliminating imprisonment, policing, and surveillance and creating lasting alternatives to punishment and imprisonment” (Critical Resistance, 2021). Abolitionist praxis “is grounded in a Black radical genealogy of revolt and transformative insurgency against racial chattel enslavement and the transatlantic trafficking of captive Africans” (Rodriguez, 2019, p. 1576). Abolition offers a mobilization of this urgency, as “both a practical organizing tool and a long-term goal” (The Critical Resistance, 2021).

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<sup>5</sup> The concept of the total institution was originated by Erving Goffman, who defined it as “a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formerly administered round of life” (Goffman, 1961: xiii).

Abolition makes necessary the closure of institutions and their associated logic (Ben-Moshe, 2020). The current context of the COVID-19 pandemic has foregrounded the urgent need for reimagined responses to care for disabled people. The failure of over 150 years of reforms to sites of institutionalization, alongside the acceleration of slow death, demands the urgency of abolition. In applying an abolitionist framework from Critical Carceral Studies alongside Disability Justice and CDS, I contend that the project of abolition should extend to the abolition of transinstitutionalization and should consider how people are incarcerated within a complex web of institutions that work alongside prisons.

Further, abolitionist praxis is central to the thriving of sex workers and is therefore relevant to my analysis at the intersection of disability and sexuality – especially in Chapter 4 of this thesis. Despite the radical roots of abolition, anti-sex work campaigns continue to misappropriate language of abolition and “sexual slavery” to promote criminalized approaches to sex work (Maynard, 2018, p.281). Robyn Maynard intervenes that “the (ab)use of the term abolition by anti-prostitution crusaders appropriates Black suffering, exacerbating the harm toward Black women in general and towards those with perceived or real involvement in the sex industry” (2018, p.282). Maynard instead argues for decriminalization of sex work and coalitional organizing between sex workers movement and abolitionist movement (2018). Maynard concludes by offering that “it is only in allying ourselves to end the state’s war on Black women, including Black trans women and Black sex-working women, that we can call ourselves abolitionists” (2018, p. 289). The coalitional politics inherent to abolitionist organizing contribute to the development of generative “bonds of solidarity” between sex workers and disabled

people in working towards collective liberation (Fritsch et al., 2016). I apply these coalitional politics – which are integral to both Disability Justice and Critical Carceral Studies – throughout this thesis by interrogating how disabled people and sex workers are controlled and oppressed through the same policy mechanisms; this is especially pertinent to my analysis in Chapter 4 where I critique municipal bylaws in Ottawa.

#### **1.4 Sexual Citizenship**

The sexual culture (Siebers, 2012) of disabled people has become a growing research field since the emergence of feminist disability studies (Mairs, 1986; 1996) and the debut of Shakespeare et al.'s *The Sexual Politics of Disability* (1996). Internationally, research has focused primarily on sexual facilitation policies (Earle, 1999; Kulick & Rydström, 2015; Shuttleworth & Mona, 2000; Wilkerson, 2002). Sanders (2017) and Bahner (2019) introduce the notion of sexual citizenship, originating out of queer theory (Evans, 1993), as a tool to advocate for sexual freedom and sexual expression of disabled people. The historical oppression and suppression of disabled sexuality calls for an understanding of disabled people as a sexual minority (Siebers, 2012). Siebers (2012) argues that disabled people should also be considered a sexual minority “recognizing their status as sexual citizens will advance the cause of other sexually repressed groups” (p. 38). Siebers (2012) advocates for the inclusion of disabled people as sexual minorities because, 1) “disabled people experience sexual repression”, 2) possess minimal sexual autonomy, and 3) experience legal and institutional barriers to accessing sex. I apply this theory throughout this thesis by analyzing the control, suppression, and oppression of sexuality as a primary tool of the state for disabled people and sex workers alike.

The history of eugenics has made sexuality an ongoing site of struggle for disabled people. The institutional use of sexual and geographic segregation (Radford & Brown, 2015), forced sterilization (Reaume, 2000), and targeting youth admission to institutions<sup>6</sup> (MacMurchy, 1914; McLaren, 1990) were used to prohibit the sexuality and reproductive justice of people labelled with disabilities (Williston, 1971, p. 22). At the same time, institutional environments facilitated wide-scale sexual abuse (Rossiter & Clarkson, 2013; Rossiter & Rinaldi, 2018). As Shakespeare et al. (1996) explain, “disabled people’s right to sexual expression on the one hand, and to freedom from sexual abuse, on the other hand are not assured in the majority of residential settings” (p. 35).

Access to sexuality, autonomy and justice for disabled people are fundamentally limited by the ongoing transinstitutionalization of disability and criminalization of sex work. This is a particular concern to disability anthropologist Russel Shuttleworth, who considers sexual access as the ability to access spaces where sexual and intimate relationships can emerge (Shuttleworth & Mona, 2000). The low social assistance rates for transinstitutionalized disabled people<sup>7</sup> limit the ability for disabled people to access the spaces and places from which sexuality emerges.

Sexuality is an important part of our lives— it can foster community, reduce pain, and promote pleasure (Gregory, 2019; Shakespeare et al., 1996; Silverberg et al., 2016).

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<sup>6</sup> The intention behind institutionalizing children was to isolate them before they became a “eugenic threat” (McLaren, 1990).

<sup>7</sup> Disabled people living in institutions on ODSP receive \$149/month (MCCSS, 2018).

Access to sexuality is also a critical component of reproductive justice<sup>8</sup> (Gruskin et al., 2019; Kafer, 2013). However, institutional, municipal, provincial, and federal actors enforce confinement and control over disabled people and sex workers' access to sexuality.

Dominant research in disability and sexuality studies operationalizes the discourse of citizenship (Bahner, 2019; Bamforth, 2012; Ignagni et al., 2016; Sanders, 2009). Yet, applying CDS to *sexual* citizenship reveals its limitations. Disabled people historically and contemporarily have been excluded from this citizen-making process through the ongoing use excessive principles (Joseph, 2015a). Migrant justice scholar and organizer Harsha Walia contests the mobilization of the “discourse of citizenship” (Walia, 2010, p.80). And Walia (2010) explains that part of the violence of citizenship “is part of the way in which the state determines and regulates who is part of the national community” (p. 80). This determination of who is part of the national community has fundamentally sought to exclude Indigenous peoples, disabled people and racialized people<sup>9</sup> (Joseph, 2015a; Valverde, 2008). As such, Walia (2010) instead urges for a coalitional politics of solidarity focusing on *sovereignty* instead of citizenship. Future research should consider alternatives to citizenship labels.

### **1.5 Methodology: Critical Policy Analysis**

To mobilize these theoretical frameworks, I apply a Critical Policy Analysis methodology in this study. Traditional Policy Analysis (TPA) relies on and values

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<sup>8</sup> Briefly, reproductive justice is the movement towards the realization of bodily autonomy as it pertains to the right to have a child, the right to not have a child and the right to parenthood (SisterSong, 1994).

<sup>9</sup> Particularly Black and Asian people (Maynard, 2018).

scientific inquiry and empiricism (Pal et al., 2021). TPA seeks to exclude values and bias (Pal et al., 2021). Public Policy Scholar Leslie Pal defines policy analysis as “the disciplined application of intellect to public problems” (Pal, 2014, p. 15). This reliance on empiricism and practicality makes it difficult to perform analysis on challenging problems, what the field names “wicked problems” (Pal, 2014). Wicked problems are “problems that are so complex and controversial that no practical solution appears to be possible” (Newman & Heady, 2014, p. 40). This view of policy and policy analysis prevents the necessary radical change that is needed to address complex challenges like transinstitutionalization and its associated harms.

Critical Policy Analysis (CPA) emerged amidst growing social movements demanding radical political change in the 1960s and 70s (Smith & Orsini, 2007). Growing social movements encouraged the development of critical theory in the academy; CPA was a response to the need to practically mobilize large theoretical concepts. CPA applies theoretical questions and critiques to develop practicalities (Fischer et al., 2015). Practicality in CPA is distinct from practicality in TPA. Practicality within TPA refers to the maintenance of status quo, whereas CPA understands practicality as a politically agile mobilization of complex theorizations. This research engages both CDS and Critical Carceral Studies as theoretical frameworks to develop more liberatory policies towards liberation. Theoretical questions and critiques from these frameworks have conceptualized transinstitutionalization and deinstitutionalization. However, there remains a gap in the realization and mechanics of these theorizations. I operationalize CPA to fill this void, through rigorous primary research and analysis.

Along with knowledge and political mobilization, CPA challenges the “‘rational’ model of positivist policy analysis and in fact–value its’ dichotomy” (Fischer, 2003; Fischer et al., 2015). The empirical grounding of TPA is concerning given the reliance on data-based analysis (Linton, 2021d). Data is not neutral, and disabled people are frequently invisibilized in governmental data (Linton, 2021d); as such, CPA is a more appropriate methodological framework which aligns with both the stated aims of this research as well as my chosen theoretical frameworks. The employment of CDS and Critical Carceral Studies refuses positivist analysis. Instead, both fields celebrate and encourage the incorporation of values of justice, liberation, anti-capitalism, and abolition. Further, the analysis of empirical data using TPA would be enormously challenging given gaps in data collected about institutions and the challenges that disabled people face. In previous research on data and adults labeled with intellectual/ developmental disabilities (I/DD), I found “persistent gaps in government data for adults with developmental disabilities. These data gaps contribute to ongoing challenges in the developmental services sector in Ontario” (2021d, p. 120). Positivist analysis is difficult to muster if there is no empirical evidence. As a disabled person, I cannot make positivist statements about the use of transinstitutionalization and criminalization. I have watched too many of my kin be killed by these systems.

CPA hopes to “speak truth to power” and challenge policy elites (Smith & Orsini, 2007, p. 1). This research exposes many truths and that I hope that it can be part of a movement demanding truth and justice. We are in a time of radical change, and radical policies make possible these demands for truth and justice. As we exit the COVID-19 pandemic, we must make space for institutionalized people to speak their truth to power.

I hope that the archival and empirical research in this thesis can help support the truth-speaking process.

## **Chapter 2: The Institutional Remains/The Institution Remains: Towards a typology of transinstitutionalization of disability in Ontario**

“An institution is not just a place, it is the way people think.”- Pat Worth<sup>10</sup>

Despite the clever wording of deinstitutionalization in Ontario, institutions for disabled people never closed in the province. Today, adults labelled with intellectual/developmental disabilities (I/DD) and “mobility problems [have] 3.6 times greater odds of living in high-support settings” (Cleaver et al., 2008, p.253).

Contemporarily, institutions have been reconstituted to be smaller, privately operated, and are more widely dispersed across jurisdictions and ministerial mandates (Leblanc Haley & Temple Jones, 2020; Linton, 2021a, 2021c; Spagnuolo, 2016). People First Canada<sup>11</sup> and the Canadian Association for Community Living (CACL) define an institution as:

An institution is any place in which people who have been labelled as having an intellectual disability are isolated, segregated and/or congregated. An institution is any place in which people do not have or are not allowed to exercise control over their lives and their day-to-day decisions. An institution is not defined merely by its size. (Deinstitutionalization Task Force, n.d.)

The ongoing reliance on institutionalization as a response to disability has been documented across governmental and institutional reports (Dubé, 2016; E Lin et al., 2019; Linton, 2021c; Ouellette-Kuntz et al., 2017). Transinstitutionalization is a result of

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<sup>10</sup> Pat Worth (1955-2004) was an author and speaker. An institutional survivor, he was a leader in the deinstitutionalization movement in Canada.

<sup>11</sup> People First Canada is the national advocacy organization for people labelled with intellectual/developmental disabilities.

persistent shortages in accessible and affordable housing<sup>12</sup> supply alongside enforced poverty.

This chapter works to understand—where do disabled people live in Ontario? Shockingly, there is no available answer to this question. So, I began constructing a typology of transinstitutionalization to begin to understand the living conditions of disabled people. To do so, I use systems mapping to identify the various “sites and shapes of transinstitutionalization” (Leblanc Haley & Temple Jones, 2020). Presently, we do not know how many disabled people live in institutions in Ontario (Linton et al., 2021). Nor do we know how many institutions for disabled people there are in Ontario. There is neither a national nor provincial dataset or inventory of institutions for disabled people. These data gaps<sup>13</sup> invisibilize and exclude transinstitutionalized disabled in the policymaking process (Linton, 2021d). Moreover, data gaps obfuscate the extent of transinstitutionalization within the province. This chapter seeks to make known the persistent and extensive usage of institutions to house disabled people across the province.

Throughout this chapter, I historically situate the sites of transinstitutionalization. To evaluate deinstitutionalization and social inclusion in Ontario, I identified the systems of ongoing institutionalization. Disabled people (Invisible Institutions, 2021), stakeholder

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<sup>12</sup> Affordable rental housing has shown an increasingly diminishing supply resulting in an affordable rental housing crisis. Given that disabled people are more likely to be low-income, 30% of disabled adults live in rental housing (Suttor, 2016). Amongst the remaining available affordable rental units, few are accessible, and “people with disabilities are more often living in poorly maintained rental housing” (Novac, 2006). The low levels of affordable rental housing have yet to impact the shelter rates for people on Ontario Disability Support Program, which remains at \$497, despite average costs for one-bedroom apartments in Ottawa at \$1,178 (Canadian Mortgage and Housing Corporation, 2020).

<sup>13</sup> Data gaps are when certain populations are absent from the policy making process.

groups (Crawford, 2005; Inclusion Canada, 2020), and repeated Auditor General Reports (1987; 2014; 2016) have outlined the need for this centralized framework for the past 50 years (Williston, 1971). It is necessary to name and make known the conditions of institutionalization in Ontario to contextualize deinstitutionalization.

## **1.6 Methods: Systems Mapping**

The ongoing absence of a systems map for transinstitutionalized disability in Ontario is a barrier for people navigating the system, their families, policymakers, journalists and evaluators (Auditor General, 1987; Dubé, 2016; Sylph et al., 1976; Welch, 1973). A systems approach allows for a complete overview of a complex ecosystem of services and supports (OECD, 2017). System mapping is a tool of the systems approach, which “makes complex systems more approachable, which is particularly valuable given the scope of services and supports involved in a comprehensive continuum of treatment” (Canadian Centre on Substance Abuse, 2014, p.1).

In order to construct this systems map I first surveyed literature to identify the various systems that have been included in disability confinement: the carceral system (Isaacs et al., 2014; Ware et al., 2014), the forensic psychiatric system (Joseph, 2015; Penney et al., 2019), the transinstitutionalization of people labeled with intellectual/developmental disabilities (Dubé, 2016; Lin et al., 2019), the psychiatric and mental health system (Dubé, 2016; Farkas & Coe, 2019; Haley, 2017; Suttor, 2016<sup>14</sup>), the

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<sup>14</sup> Greg Suttor makes a significant contribution towards a typology of Mental Health and Addictions housing support in Ontario. This model is limited to psychiatric disabilities and omitted what is often considered temporary housing. However, the temporary nature of many of these institutions is contested, the 2016 Ombudsman Report illuminates ongoing reliance on temporary institutions as permanent homes for up to 22 years in some instances (Dubé, 2016).

geriatric system (Lunsky et al., 2014; Oullette-Kuntz et al., 2017), and the homelessness system (Joseph, 2015; Muscati, 2017). Thorough review of relevant policy, literature, and open datasets provided foundational details for the systems mapping process. For institutions absent from literature, web-scraping - the extraction of data from websites - helped fill out further details, including: the number of institutions, the number of beds, and the density within institutions.

This research creates the framework for a central database of institutions for disabled people. I bring together data from Auditor General reports, MOHLTC datasets on psychiatric and long-term care facilities, provincial regulations, governmental and civil society reports. I narrowed my scope to omit institutional settings such as addiction treatment facilities, the community carceral system and congregate settings for youth which also include disabled people. The persistent data gaps across sectors emphasizes both the necessity of this mapping, and the invisibilization of disabled people in the policy cycle. Each of these systems has their own network of institutions, for which I identify the following attributes:

1. Density (low: 1 resident/room; moderate: 2 residents/room; high: 3+ residents/room);
2. Size: institutional population;
3. Quantity: number of this type of institution;
4. Target population: who the space is designed for;
5. Regulatory authority: body responsible for inspections and licensing;
6. Associated ministry: body responsible for providing funding and mandates;
7. Ownership: not-for-profit, private for-profit or publicly operated.

The results of this survey are in Appendix A. I use a cross-disability approach (Berne & Sins Invalid, 2016), Critical Disability Studies (Goodley et al., 2019) and

Critical Carceral Studies (Ben-Moshe, 2020; Ben-Moshe et al., 2014) to understand the various sites of disability confinement.

### **1.7 The Psychiatric System**

Institutionalization began through the emergence of incarceration as a response to crime, in addition to the existing practice of corporal punishment through the late 18th and 19th century (Frankenburg, 1982). We can therefore consider institutionalization beginning with the 1792 statute that “a Gaol and CourtHouse shall be erected ... in each and every District” (Oliver, 2000). Following the development of country gaols, the 1810 vagrancy laws furthered institutionalization by stating “all and every idle and disorderly person, or rogues and vagabonds, and incorrigible rogues, or any other person or persons who may by law be subject to be committed to a House of Correction, shall be committed to the said common gaols” (McCoy, 2012).

Prior to the development of the Asylum disabled people were incarcerated in county gaols (Moran, 2001). In 1830, Upper Canada agreed to transfer funds to county gaols for the cost of supporting people labelled as “insane” (Oliver, 2000). Increasingly, there were concerns about the integration of prisoners and people with mental illness, spurring a public demand for asylums, led by reformers.

The issue of the prisons housing both non-disabled and disabled incarcerated people was heightened by an increasing public awareness of the conditions in county gaols (Brown, 1981; McCoy, 2012). This prompted an 1830 bill on the development of asylums (Brown, 1981). The 1830 bill was motivated by the desire to segregate and confine disabled people, and to provide specialized moral treatment. The institutionalization of disabled people in Upper Canada was part of a colonial governance

trend towards data collection, standardization, and categorization of the population, particularly of those labelled as deviant.

The first Asylum in Upper Canada was built in Toronto in 1844. Although this asylum was intended to provide care for persons with mental illness, it was used to confine a range of people perceived as oppositional to nation-building (Reaume, 2000). And while magistrates pushed for asylums to create space in prisons, jails and prisons continued to confine people with mental illness long after the development of the Asylum (Moran, 2001). Shortly after the Asylum was built, reports came out about the deplorable conditions of the Asylum experienced by “patients” (Reaume, 2012). In an 1849 report, the conditions of the Asylum described how "patients" were without clothing, beds, baths or bathrooms, and complete lack of ventilation. After decades of reform, deplorable conditions persisted, however, asylums in Ontario expanded (Reaume, 2012).

The primary treatment for people labelled with psychiatric disabilities was institutionalization in large-scale public psychiatric hospitals until 1959 (Simmons, 1982). In Ontario, these institutions had a population size between 1,000 and 5,000 people (Hartford et al., 2003). By 1965, there were 23,968 inpatient beds in Ontario (Sealy & Whitehead, 2004). Multiple governmental commissions and reports continued to advocate for a divestment from these institutions towards community living (Farkas & Coe, 2019; Greenland & Mcneel, 1961; Hartford et al., 2003). The primary justifications

for psychiatric deinstitutionalization were the introduction of neuroleptics<sup>15</sup> and the Graham Report (Hartford et al., 2003; Simmons, 1982).

The Graham Report was a provincial report on the transition towards community services for people labelled with psychiatric disabilities (Graham, 1988). The Report introduced both the “consumer” label and the label of “seriously mental illness” (Hartford et al., 2003). Those capacitated through biomedical advancements—anti-psychotic pharmaceuticals— were labelled as “consumers”. This “consumer” label positioned the capacitated-disabled as neoliberal subjects<sup>16</sup> (Fritsch, 2015a), while those labelled with “serious mental illness”, maintained a persistent inability to be neoliberal subjects (Fritsch, 2015a). They were prescribed “slow death” through ongoing institutionalization, which results in persistent lower than average life expectancies (Berlant, 2007; Fritsch, 2015a; Sylph et al., 1976).

The decentralization of the psychiatric system in Ontario began in the 1960s as deinstitutionalization of psychiatric institutions progressed (Brown, 1981). The Graham Report (1988) found the following barriers in the shift to community living: 1) lack of access to data; 2) jurisdictional inconsistency, and 3) lack of inter-ministerial communication. Jurisdictional inconsistency is a recurring theme in Ontario policy regarding persons with disabilities. The challenge of data gaps for disabled people has persisted over several decades. The commissions responsible for evaluation of deinstitutionalization were repeatedly refused access to the data necessary to provide

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<sup>15</sup> Neuroleptics are a form of anti-psychiatric medication. They were first developed in 1954, and were believed to be one of the catalysts of deinstitutionalization (Reaume, 2000).

<sup>16</sup> Neoliberal subjects are expected to be individualistic, self-sustaining, and entrepreneurial (Harvey, 2007).

adequate evaluation (Hartford et al., 2003). Following the closure of most psychiatric institutions, the dominant policy response was custodial congregate care.

The custodial institutions that exist today, Homes for Special Care and Domiciliary Hostels, were established in the 1960s and 70s. These were largely funded by the Ministry of Health and Long-Term Care which remains the central ministry for psychiatric care. During the 1980s and 1990s supportive housing and supportive apartments became more popularized (Tabol et al., 2010). This era was characterized by privatization of services and the shift of social housing into the private market (Hackworth & Moriah, 2006). Increasingly, private landlords were given subsidies by the province for having supported units within their building (Tabol et al., 2010). These generations of policy responses for people with psychiatric disabilities resulted in an inconsistent framework opposed to a centralized housing policy. In 2014, the auditor-general found that “the lack of a housing policy framework to guide the provision of mental health supportive housing contributes to the Ministry’s and the LHINs’<sup>17</sup> difficulty in sufficiently overseeing and coordinating the delivery of supportive housing services to Ontarians” (387).

Psychiatric or mental health housing refers to any form of subsidized housing that provides some psychiatric level of support that received some form of government funding. There are a wide range of types of institutions and housing, which I identified through a scoping review of Auditor General Reports (1987; 2012; 2014; 2016); relevant

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<sup>17</sup> There are 14 regional Local Health Integration Networks (LHINs) in the province, who are responsible for the distribution of funding and accountability across health services (*Local Health Integration Network Act*, 2006).

systems maps (Lin et al., 2019; Suttor, 2016) and Critical Mad Studies literature (Abbas & Voronka, 2014; Daley et al., 2019; Hanna, 1998; Leblanc Haley & Temple Jones, 2020).

### **1.7.1 Psychiatric Institutions**

Psychiatric institutions are standalone structures governed by Ontario's Mental Health Act (1990) and funded by the Ministry of Health and Long-Term Care. They are regulated by LHIN, and the Psychiatric Patient Advocate Office (*Mental Health Act*, 1990). Psychiatric institutions have varying numbers of residents per room; some have shared occupancy rooms, while others have single rooms. These are highly institutional environments with regulated mealtimes, and high-surveillance levels. There are four different types of psychiatric institutions: public psychiatric hospitals, private psychiatric hospitals, addiction treatment centres and long-term psychiatric care.

#### **1.7.1.1 Public Psychiatric Institutions (885 beds)**

There are four public psychiatric hospitals in Ontario. The hospitals are: Waypoint Center, the Royal Ottawa Center, the Centre for Addiction and Mental Health (CAMH) and Ontario Shores (Ministry of Health and Long-Term Care, 2012). These hospitals receive the majority of their funding from the Ministry of Health and Long-Term Care (MOHLTC). Established in 1871 as the Provincial Lunatics Asylum<sup>18</sup>, CAMH services the Toronto area and has 235 inpatient beds (CAMH/CAMH Foundation, 2021; PriceWaterHouseCoopers, 2020). Seventy-six percent of their funding comes from government grants through the Ministry of Health and Long Term Care, and they are

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<sup>18</sup> For a fulsome history of CAMH see Reaume (2000), and Abbas & Voronka (2014).

accountable to the Toronto Central LHIN. Waypoint Center for Mental Health Care Services Northern Ontario is located in Penetanguishene. It has 301 inpatient beds, receives 87% of its funding from the Ministry of Health and Long Term Care, and is accountable to the North Simcoe Muskoka LHIN (Waypoint Centre for Mental Health Care, n.d.). Ontario Shores is in Whitby, Ontario and has 329 beds, and is accountable to the Central East LHIN (Ontario Shores Centre for Mental Health Sciences, n.d.-a). The Royal Ottawa Hospital operates two campuses: the Royal Ottawa Hospital with 186 beds and the Brockville Mental Health Centre with 163 beds (Langill, 2005).

### **1.7.2 *Private Psychiatric Hospital (300 beds)***

There is one private psychiatric institution in Ontario—the Homewood Health Centre. Established as a private psychiatric institution in 1883, Homewood Health Centre is a private psychiatric institution in Guelph, Ontario with 300 beds (Moon et al., 2006). Despite being a private institution, they rely on funding from the Waterloo Wellington LHIN (Wellington Waterloo LHIN, 2014).

### **1.7.3 *1.1.4 Addiction Treatment Facilities***

Addiction treatment in Ontario does not have a consistent policy framework for residential treatment facilities (Office of the Auditor General, 2017). Section 7 of the *Ministry of Health and Long-Term Care Act* gives the ministry the authority to make agreements for the provisions of health care in the province (1990). The *Local Health Systems Integration Act*, 2006 gives LHINs the legislative authority to plan, coordinate and fund local health systems. Addiction treatment facilities are operated by private, public and not-for-profit actors (Addictions and Mental Health Ontario, 2017).

Addictions and Mental Health Ontario outlines the various forms and levels of public treatment available in their 2017 Provincial Standards (Addictions and Mental Health Ontario, 2017). However, they do not include private addiction treatment facilities, which are increasingly common as a result of the significant waitlists for accessing public services (Auditor General, 2017). Further research should construct a systems map and political economy of the addiction treatment system.

#### **1.7.4 Psychiatric Wards**

Psychiatric wards are designated hospital units in general or regional public hospitals. Public hospitals are governed by the *Public Hospitals Act* (1990), while psychiatric units are additionally under the authority of *Mental Health Act* (1990). Funding flows directly from regional LHINs to designated hospitals. Psychiatric wards can be either specific floors within a hospital, or in the case of a campus-style hospital may be entire wings or attached buildings. Psychiatric wards have mandated 24-hour supervision; however, the level of observation varies based on the subcategorization of wards and whether a patient is a voluntary or involuntary admission. According to The Ottawa Hospital, 80-85% of their patients are involuntary admissions, while length of stay varies between 11 days to multiple years (The Ottawa Hospital, 2021). The Report of the Ontario Ombudsman (2016) found that “Ontario’s general hospitals and psychiatric units have become hosts to hundreds of adults with developmental disabilities” (Dubé, 2016). While many hospitals have a singular psychiatric unit, there are many who have subcategories of psychiatric units.

#### **1.7.4.1 Dual Diagnosis Unit**

Dual diagnosis units are psychiatric units for disabled people jointly labelled with mental illness and intellectual and/or developmental disabilities (I/DD)<sup>19</sup> (Lunsky & Balogh, 2010). These units exist within both general hospitals and psychiatric hospitals. These units are designed for short-term<sup>20</sup> stays. These units are supported by both the Ministry of Health and Long-Term Care and regional Developmental Services Ontario (DSO) funded through MCCSS (E Lin et al., 2019). Case management for people labelled with dual diagnosis is provided by one of eight regional Community Networks of Specialized Care (CNSC), which are accountable to the MCCSS (The Ottawa Hospital, 2021).

#### **1.7.4.2 Geriatric Units**

Geriatric psychiatric units focus on service provision for aging people who are experiencing “disturbances in cognition with responsive behaviours related to their mental health, addictions and/or dementia diagnoses” (Kay, 2017, p. 9). Funding for these units is provided by the Ministry of Health and Long Term Care’s Acute Mental Health program as opposed to geriatric supports (CNSC, n.d.). There are several different models and names for these units: Acute Geriatric Psychiatric Units, Tertiary Dementia Specialty Units, Tertiary Non-Dementia Geriatric Psychiatric Units. The name diversity

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<sup>19</sup> Ontario research has found that “compared to the MHA [mental health and addictions]-only subgroup, adults with [developmental disabilities]-and-MHA are five times more likely to have an alternate level of care, nearly 11 times more likely to be in a long-term care facility and almost three times as likely to die prematurely” (Lin et al., 2019, p. 40).

<sup>20</sup> In this instance, some hospitals have a maximum stay length. At the Thunder Bay Regional Hospital, they have set an upper limit of 2 years. However, as outlined in the Ontario Ombudsman Report (Dubé, 2016) adults labelled with I/DD have lived in hospitals psychiatric units for multiple years.

reflects different approaches taken by psychiatric institutions, rather than unique programs. People labelled with dementia diagnosis experience high rates of surveillance, particularly around their sexuality (Grigorovich, 2020).

### ***1.7.5 Custodial Housing***

Custodial housing emerged in the 1960s following the wide scale “deinstitutionalization” of psychiatric institutions in Ontario (Suttor, 2016). At the time, custodial housing supports were viewed as the most affordable alternative to psychiatric institutions. However, since 1987, the government has been recommended to transition away from custodial institutions (Auditor General, 1987). As a result, “though community-based and freed from many of the former administrative and other restraints, the HSC [homes for special care] in fact inherit the mental hospitals' earlier custodial role” (Sylph et al., 1978, p. 223). CAMH defines custodial housing as “models in which residents are cared for in a standardized and routinized fashion with the goal of maintenance rather than recovery” (Community Support and Research Unit, 2012, p.1). Custodial institutions have 24-hour supervision, standardized meals provided at set times, and are high density (Ministry of Health and Long-Term Care, 2014). Today, 20% of mental health housing is custodial housing (Auditor General, 2016).

Abject poverty within these institutions is endemic and enforced (Hwang et al., 2009). Landlords are responsible for the provision and distribution of personal needs allowances for tenants, a total of \$149/month (Ministry of Health and Long-Term Care, 2011; Marrelli, 2018). This \$149 compares provincially to similar programs in Manitoba, for example, who give \$350/month. Internet is at the cost of the tenant, which can be a prohibitive and thus result in a stark lack of access for residents. Further, residents have

reported that they often had to use their allowance to pay for basic necessary living needs, such as toilet paper, dietary supplements, and soap (Priel et al., 2016). The poverty wages they receive creates a cycle of institutionalization that often becomes difficult to escape.

There are two forms of custodial housing in Ontario: Homes for Special Care and Domiciliary Hostels<sup>21</sup>. In 2012, CAMH calculated that

...6,025 custodial housing beds available to people with mental illness in Ontario. This consists of 1,450 Homes for Special Care beds, 852 beds funded by Habitat Services, and approximately 3,723 domiciliary hostel beds. In total, for every ten supportive housing units in Ontario (10,000), there are six custodial housing beds. (p. 3)

However, this calculation uses data from the 2007 domiciliary hostel survey (Community Support and Research Unit, 2012) and there is presently not a foundational dataset for the municipally administered Housing with Related Supports program (Linton et al., 2021). Custodial housing is routinely criticized for its lack of privacy and over-surveillance (Community Support and Research Unit, 2012; Greenland & Mcneel, 1961; Marrelli, 2018; Ontario et al., 1992). Custodial housing often forces residents to share bedrooms, creating a lack of privacy and personal space. Journalist Megan Morelli went on a tour of a Home for Special Care and described the room of one tenant, which has “a sizable sheet of plywood from Home Depot and a dark wood dresser that’s taller than his bed separates him from his two roommates” (2018).

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<sup>21</sup> Though similar forms of institutionalization, domiciliary hostels are presently situated among the homelessness system.

### **1.7.5.1 Homes for Special Care (1450 beds)**

The Homes for Special Care program is a custodial housing program funded by the Ministry of Health and Long-Term Care and is regulated by 9 psychiatric institutions in Ontario (Office of the Auditor General, 2016). Homes for Special Care was developed in the 1960s amidst the deinstitutionalization of psychiatric institutions to house “homeless mentally disabled people” (Sylph et al., 1976, p. 223). Ten years into the program, they found that 25% of discharges from the program were a result of resident death, despite the average age of residents being 56 (Sylph et al., 1976, p. 224). The proliferation of Homes for Special Care was a result of “the fundamental logic of the program [being] in fact economic: scarce resources of trained manpower are conserved for those whom they can benefit” (Sylph et al., 1976, p. 223)

The *Homes for Special Care Act* (1990) sets out regulations and guidelines for the program. The homes themselves are operated by private landlords on either a not-for-profit or a for-profit structure (Community Support and Research Unit, 2012). Funding flows from the Ministry of Health and Long-Term Care to the private landlords, who receive funding for both room and board (Homes for Special Care Act, 1990). There are 117 Homes for Special Care, with a per unit cost of \$20,226 (Auditor General, 2016). The ministry spent 29% of their supportive housing funding on Homes for Special Care in 2016 (Auditor General, 2016).

Additional funding flows through regional LHINs to 9 psychiatric institutions, who have Homes for Special Care field offices (Ministry of Health and Long Term Care, 2003). The field offices refer people to Homes for Special Care given they meet the criteria of 1) having been labelled with a psychiatric diagnosis and experienced

psychiatric hospitalization; 2) compliance with treatment orders<sup>22</sup>; 3) are abstinent from drugs and alcohol; 4) do not require the amount of care provided by long-term care (St. Josephs, 2013).

Following the 2016 Report of the Auditor General, the Ministry of Community and Social Services reported a desire to better align the program with the Supportive Housing Policy Framework (Auditor General, 2018). The 2018 Follow-Up of the 2016 Report noted that there were changes afoot for the program, beginning in Southwestern Ontario. Through the changes, Homes for Special Care changed their name to Community Homes for Opportunity (St. Josephs, 2018). As Sylph et al. (1976) concluded in their assessment of Homes for Special Care, “changing the name of the mental hospital from asylum to active treatment centre does not alter the needs of the chronically mentally ill or reduce their numbers” (p. 237). The St. Joseph’s Hospital in London led the changes, explaining that the “goal of modernization was to integrate the program into the community mental health and addictions supportive housing sector. This allows tenants of the program to have greater integration and access to community programs which assist them to live as independently as possible” (St. Joseph’s, 2018). There has not yet been an evaluation of the changes in the program.

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<sup>22</sup> This may include therapy, medication, or other psychiatric treatments (Fabris, 2011) .

**Figure 1: Bedroom in a Home for Special Care**



Image description: A picture of a room with 3 single beds close together, and a low ceiling (Daring Residential Services Inc, 2013).

#### **1.7.5.2 The Habitat Services Program (931 beds)**

The Habitat Services Program is a form of custodial housing unique to the City of Toronto, operated by Habitat Services, a not-for-profit organization (Suttor, 2016). The program is funded through the Toronto LHIN, while tenant subsidies are cost-shared between the City of Toronto and the Ministry of Health and Long-Term Care (Habitat Services, n.d.). The program arose as a response to the increasing use of boarding houses among psychiatric survivors (Habitat Services, n.d.). The program is a commercial contract between Habitat Services and private and not-for-profit owners of boarding houses in the City of Toronto. The contract has nutritional, building and residential services standards that are enforceable, and are continuously monitored by Habitat Services workers. The program provides housing for 931 people in the City of Toronto (Habitat Services, 2020).

### ***1.7.6 Supported/Supportive Housing (23 000 people)***

Housing with support emerged in the 1990s as the prominent model for providing services, supports and housing for psychiatric survivors and people who have problematic substance usage (Rog, 2004). Supportive housing is defined within the Ontario *Mental Health and Addictions Strategy* as “the combination of a safe and stable home with the offer of additional supports that enable a person to stay in their home, live independently, and/or achieve recovery” (Addictions and Mental Health Ontario, 2017). Supported housing is the most decentralized form of housing, with the MOHLTC responsible for administration and funding for the 115 not-for-profit agencies that either operate housing or contract with private landlords (Auditor General, 2014). The same not-for-profits are funded and regulated by the regional LHINs for their role in providing services and supports (Auditor General, 2014).

Supportive housing’s use of surveillance limits residents’ freedoms which is concerning given the lack of affordable housing alternatives. This program only offers permanent housing, something that has increasingly been challenged by residents who desire a transition out of supportive housing (Auditor General, 2014; Haley, 2017). The demand for affordable housing continues to grow; 168,700 households are presently on the waitlist for affordable housing in Ontario (Auditor General, 2014). This means that “every year there are about three times as many people who sign up for affordable housing as there are housing offers made” (Glowacki, 2020). These long waitlists, of 4-22 years (Glowacki, 2020), result in people remaining in overly supportive and surveillant homes despite their desire for alternatives (Boyd et al., 2016).

### **1.7.6.1 Supportive Apartments**

Supportive apartments are entire apartment buildings owned and operated by not-for-profit agencies (Suttor, 2016). Supportive apartments offer on-site resources and support, and residents are also followed by case managers through either Mental Health Community Services or the Assertive Community Treatments Program<sup>23</sup> (Suttor, 2016). Supportive apartments are funded and regulated through regional LHINs and the Ministry of Health and Long-Term Care. However, specific apartments for housing insecure people with psychiatric disabilities are funded through the Community Homelessness Prevention Initiative (CHPI). The CHPI provides flexible funding to municipalities through the Ministry of Municipal Affairs and Housing (Ministry of Municipal Affairs and Housing, 2014)

### **1.7.6.2 Satellite Apartments**

Satellite apartments are the most decentralized form of supportive housing, thus involving the widest net of actors. Private landlords have contracts with not-for-profit service providers, to provide units or a cluster of units for people with psychiatric disability and/or problematic substance use (Ontario CMHA, 2014). Services are then provided to the resident by a LHIN-sponsored not-for-profit mental health agency (Auditor General, 2014). The landlord-tenant relationship is regulated by the *Residential Tenancies Act* (2006) under the direction of the Ministry of Municipal Affairs and Housing. Satellite apartments are increasingly popular given the low social housing

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<sup>23</sup> Assertive Community Treatment is “a client-centered, recovery-oriented mental health service delivered by multidisciplinary treatment teams, designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia” (George et al., 2009).

stock, making private landlords increasingly prevalent in service provision for disabled people. Private involvement in the provision of services and housing for disabled people – especially because of the use of surveillance – is problematic (Green et al., 2016) . Green et al.'s (2016) study of similar housing networks in the UK found that landlords use Closed Circuit Television (CCTV) and behavioural monitoring to surveil residents, leaving residents with a lack of privacy. Despite being labelled the most independent living situation compared to other restrictive alternatives, ongoing use of surveillance continues to impede disabled people's privacy (Boyd et al., 2016).

### **1.7.6.3 Social Housing**

Social housing is a responsibility of municipalities, who operate not-for-profit housing corporations. Social housing prioritizes vulnerable populations, including disabled people (Hackworth & Moriah, 2006). The Auditor General (2014) identified that social housing does not guarantee access to supports, which is only provided if the resident has a preexisting relationship psychiatric services, or if the social housing unit already has an agreement with a regional LHIN (Auditor General, 2014). There are no data available on the number of units devoted to residents with psychiatric disabilities, and waitlists are maintained municipally. There is still a level of resident surveillance within this program; as Green et al. (2016) note, “there are mechanisms for social landlords to exercise control to modify tenants' antisocial behaviour as well as a responsibility to promote well-being among tenants” (Green et al., 2016).

### **1.7.6.4 Group Homes (Support within Housing)**

Mental health group homes are operated by not-for-profit agencies and are funded by regional LHINs and municipalities (Auditor General, 2016). Group homes have high

levels of surveillance because of the high staff-resident ratio (Haley, 2017). People access group homes by applying through a central access point. For instance, in Ottawa it is the Social Housing Registry (The Registry - Centre d'enregistrement, 2014). Group homes are intended for longer stays of up to 4 years (Ottawa Salus Corporation, 2018). Houses typically have between 4 and 10 residents and 2 staff workers, signifying high levels of surveillance (Ottawa Salus Corporation, 2018). There is no publicly available information about access to privacy or number of people per bedroom within group homes in Ontario.

## **1.8 The Forensic Psychiatric System**

The forensic psychiatric system is a marriage of the *Mental Health Act* (1990) and the *Criminal Code* (1985) (Bettridge & Barbaree, 2004). There are many ministerial actors responsible for the forensic psychiatric system—including the Ministry of Children, Community and Social Services, the Ministry of Health and Long-Term Care, the Ministry of the Solicitor General, the Ministry of the Attorney General and the Ministry of Community and Social Safety.

The Ontario Review Board (ORB) is responsible for hearings that determine if someone is deemed Not Criminally Responsible (NCR)<sup>24</sup> under the federal *Criminal Code* (1985). The *Criminal Code* mandates that there must be no fewer than five committee members. Of the five members, one must be a psychiatrist, another member who must have experience in the mental health field, and a chairperson who is a judge

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<sup>24</sup> The Criminal Code states: “No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.” (16.1)

(Joseph, 2015c). The chairperson is accountable to the Ministry of Health and Long-Term Care (Ontario Review Board, 2017). The ORB determines both the type of institution a “patient”<sup>25</sup> will reside in, and the type of security applied (Ontario Review Board, 2017). The different forms of institutionalization include locked wards, forensic units, hospital wards, and within the community. There are 10 designated institutions in Ontario under the *Criminal Code* (MCCSS, 2020). I further classify these as psychiatric hospitals, psychiatric wards, psychiatric wards within prisons, group homes and stand-alone forensic psychiatric institutions. Forensic psychiatric institutions’ such as CAMH identify that their “primary clinical goals are to maximize rehabilitation and recovery for individuals under our care, while maintaining the safety of the community at large by helping patients recover, including managing risk for violence” (CAMH, 2017). Presently, the ORB is responsible for 1,500 people confined in the forensic psychiatric system (Ontario Review Board, 2017)). This population has been increasing by approximately 10% per year, which is disproportionate growth when compared to both population growth and general arrest rate (Ontario Review Board, 2017). This growing population is increasingly living with comorbidities and are racialized (Penney et al., 2018). An analysis of forensic hospitalization from 1987 to 2012 and found that there was a disproportionately large Black population in psychiatric detention. Black people in forensic detention are primarily diagnosed with schizophrenia (Penney et al., 2018). Evidence demonstrates that in white-dominated countries (Gara et al., 2012), Black

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<sup>25</sup> The ORB defines a “patient” as an “accused persons in respect of whom a verdict of not criminally responsible on account of mental disorder or not fit to stand trial has been rendered and who have been placed in the custody of a psychiatric hospital pursuant to a disposition order under the *Criminal Code of Canada*”.

people have historically been disproportionately diagnosed with psycho-affective disorders<sup>26</sup> (Tortelli et al., 2018). Contemporarily, racialized people are more likely to be admitted to in-patient services and are more likely to be admitted to higher security settings (Flora et al., 2012).

While all people detained within forensic psychiatric institutions are disabled, there is a disproportionate representation of people labelled with intellectual/developmental disabilities (I/DD) (Lin et al., 2017). Lin et al., found that 12.2% of Ontario forensic inpatients are labelled with I/DD, despite being 0.8% of the general population (2017). Further, their study reports that people labelled with I/DD have longer stays as compared to their non-disabled peers.

Life within forensic psychiatric units is characterized by the highest rates of both behavioral and physical surveillance, associated with limited access to liberties (Gara et al., 2012). There has been a carceral trend of shifting people out of prisons and into treatment facilities as a means of further expanding carceral structures, what Maier refers to as “Canada’s Open Prisons” (Maier, 2020). While prisons in Canada do not have the ability to convict someone to a life sentence, forensic psychiatry is able to detain people indefinitely (*Criminal Code*, 1985).

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<sup>26</sup> Dr. William Lawson has written and researched extensively on the overdiagnosis by psychiatrists of Black men with schizophrenia. Lawson has found that psychiatrists have a lower threshold for diagnosing Black men with schizophrenia compared to their white counterparts (2012).

### **1.8.1 Specialty Psychiatric Hospitals**

Specialty psychiatric hospitals are standalone<sup>27</sup> psychiatric institutions that provide observation and treatment of people with “mental disorders”. They are public hospitals regulated by the *Public Hospitals Act* (1990). Specialty psychiatric hospitals receive funding through Local Health Integration Networks (LHINs) which are funded by the Ministry of Health and Long-Term Care. Four specialty psychiatric hospitals account for more than 50% of psychiatric beds in the province; Ontario Shores Centre for Mental Health Sciences, The Royal Ottawa Health Group, The Centre for Addiction and Mental Health (CAMH), and the Waypoint Centre for Mental Health Care (Office of the Auditor General, 2016). Of the 10 designated institutions in Ontario under the *Criminal Code*, five are specialty psychiatric hospitals, the four listed above and the Brockville Mental Health Centre<sup>28</sup>. Within specialty psychiatric hospitals, there are specific wards, and units for forensic services. For instance, CAMH has six different forensic units (CAMH, n.d.) which are concentrated within the 101 Queen St. West facility (as outlined in Appendix B).

Forensic psychiatric services within specialty psychiatric hospitals operate different units, which have varying levels of privacy and freedoms. The Waypoint Centre is the only institution with high security forensic psychiatric detention (Waypoint Centre, 2019). The 160-bed high security forensic detention centre has individual rooms each with “a mirror at the corner of the ceiling (made of safety glass) so staff can see every bit

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<sup>27</sup> Standalone institutions meaning they are in a distinct building not attached to a non-psychiatric hospital.

<sup>28</sup> The Brockville Mental Health Centre is operated by the Royal Ottawa.

of the room from the hall” (Clairmont, 2018). Secure Treatment Units are medium secure institutions, and General Treatment Units are the least secure (Bettridge et al., n.d.). Some units are mixed gender, but most often they are concentrated by gender (Joseph, 2015c). Rooms vary between segregation, singles and custodial rooms with 5 people (Clairmont, 2018; Seppänen et al., 2018).

**Figure 2: A single room at the Royal Health Centre, Brockville**



A small, single room at the Brockville psychiatric hospital. The single bed fills the entire length of the room, where an incarcerated person lies with a stuffed animal (TVO, 2014)

### **1.8.2 General Hospitals**

General hospitals are regulated through the *Public Hospitals Act* (1990), and are funded through LHINs. General hospitals often operate as campuses with several buildings, often psychiatric units are detached buildings (Seppänen et al., 2018). General

hospitals with forensic units are: St. Joseph's Healthcare Hamilton<sup>29</sup>, Providence Care<sup>30</sup>, the North Bay Regional Centre, and the Thunder Bay Regional Health Sciences Centre (Ministry of Health and Long-Term Care, 2012). The North Bay Regional Centre operates 44 beds and the Thunder Bay Regional Health Sciences Centre operates 20 beds (Bettridge et al., n.d.; North Bay Regional Centre, n.d.). Neither St. Joseph's nor Providence Care offer publicly accessible information about their number of beds.

### ***1.8.3 Stand-Alone Forensic Psychiatric Institutions***

Stand-alone forensic psychiatric institutions are institutions that exclusively offer services to people who are deemed unfit to stand trial or NCR (Ontario Review Board, 2017). There is only one site of this form of institution in Ontario—the Southwest Centre for Forensic Mental Health Care, a subsidiary of St. Joseph's Health Care London (*Mental Health Care*, 2013). The Southwest Centre has 89 beds, broken down into the Forensic Assessment Unit, the Forensic Treatment Unit, Forensic Rehab Readiness Unit, and the Forensic Rehabilitation Unit (*Mental Health Care*, 2013).

### ***1.8.4 Prison-Psychiatric Institution Hybrid***

Prison-psychiatric institution hybrids are institutions that exist on the same campus, or the same building as prisons (Ontario HIV Treatment Network, 2015). The St. Lawrence Valley Correctional and Treatment Centre (SLVCTC) is a true marriage of a psychiatric institution and a correctional institution; it is an agreement between the Ministry of Community Safety and Correctional Services (MCSCS) and the Royal

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<sup>29</sup> St. Joseph's is operated by the Catholic Health Association of Ontario.

<sup>30</sup> Providence Care is operated by the Catholic Health Association of Ontario.

Ottawa Health Care Group (Ministry of the Solicitor General, 2018). This shared agreement means that the Ministry of Health and Long-Term Care funds the psychiatric medical staff, while MCSCS funds the correctional workers (The Royal, 2020). The institution is a Schedule 1 Psychiatric Institution<sup>31</sup> with 100 beds (Ministry of Health and Long-Term Care, 2012; The Royal, 2020).

As opposed to institutions providing services for people labelled NCR or unfit to stand trial, incarcerated people from any provincial correctional institution who are experiencing acute mental illness are transferred to this institution. SLCVTC has both medium and maximum-security classifications, and isolation units. Media coverage of the SLCVTC has celebrated the therapeutic landscape, and modern design compared to typical prisons (Ontario HIV Treatment Network, 2015; “St. Lawrence Valley Treatment Centre”, 2011). However, the SLVCTC construction and use of solitary confinement contradicts this therapeutic design. Solitary confinement has been found to produce psychological distress and “greater levels of isolation is associated with a higher rate of suicide” (Mussel & Rumpersaud, 2020). Solitary confinement is torture, not therapeutic design; however, it is employed by the SLVCTC and branded as therapy (United Nations Office on Drugs and Crime, 2015).

**Figure 3: The isolation unit at St. Lawrence Valley Treatment Unit**

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<sup>31</sup> A Schedule 1 Facility refers to public hospitals and other health facilities that provide observation, care and treatment for patients experiencing mental health disorders (Ministry of health and Long-Term Care, 2013).



A white man smiles as he stands in a small, empty, green room with a drain on centered on the otherwise bare floor (“St. Lawrence Valley Correctional and Treatment Centre,” 2011).

### ***1.8.5 Forensic Psychiatric Group Homes***

Group homes are supervised residences often used as transitional housing. This form of housing is part of a continuum of care philosophy thought to support the transition out of institutional living into the community (Desai et al., 2012). Provincially, ORB requires people to reside in a unit that is part of the Transitional Rehabilitation Housing Program (TRHP) and be supported by the Forensic Outreach Team in their region (Ontario Review Board, 2017). TRHP is regulated by the *Residential Tenancy Act* (2006) and the Ministry of Municipal Affairs and Housing. Funding flows from the Ministry of Health and Long-Term Care through LHINs to partnership programs between public psychiatric hospitals and service provider agencies<sup>32</sup> (Bettridge et al., 2015).

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<sup>32</sup> Typically operated by not-for-profit agencies such as CMHA, the John Howard Society and the Elizabeth Frye society.

Legislative best practices see that forensic mental health patients transfer from the larger institution into 24-hour supervised community living homes (Cherner et al., 2013).

Along with the provincial funding for the TRHP, the Ministry of Children, Community and Social Services funds group homes for people involved with the justice system labelled with a dual diagnosis (CNSC, n.d.). Service coordination and delivery are administered through the Complex Network for Specialized Care (CNSC, n.d.). These services are administered through a third-party provider who is accountable to the regional Developmental Services Ontario (“Networks Of Specialized Care,” n.d.) .

Homes are funded and monitored in several different ways. Correctional Services Canada (CSC) has approximately 200 contracts with non-governmental partners for Community Based Residential Facilities (CBRF) (Correctional Service of Canada, 2012). An unknown portion of these being specifically dedicated to people labelled with mental disorders and/or developmental disabilities (Correctional Service of Canada, 2012). Along with CSC transitional housing, the ORB also partners with community agencies to provide community support residences. Information on the number of transitional residences is sparse.

### ***1.8.6 Satellite Apartments***

After living in congregate housing through TRHP, residents transfer to satellite apartments (Cherner et al., 2013). Satellite apartments are units in private apartments operated by service provider agencies, which are also responsible for meeting with residents. Residents are expected to continue engaging in group activities and therapy through TRHP, although most residents do not continue attending (Cherner et al., 2013). While satellite apartments are the most independent, there are ongoing concerns about the

role of private landlords as service providers. The shift towards private landlords as service providers, follows the trend of the commercialization of post-institutional treatment (Isaacs et al., 2014).

## **1.9 Developmental Services System**

Presently, housing for people labelled with intellectual/developmental disabilities (I/DD) is operationalized in two ways. The formal provision of services for adults labelled with I/DD is Developmental Services Ontario, which falls under the Ministry of Children, Community and Social Services. However, as 15,700 people are on the waitlist for residential services, there are informal secondary service providers. These informal developmental service providers include all of the institutions discussed throughout this typology; psychiatric institutions, wards, and hospitals, long-term care, and so forth (Dubé, 2016; Spagnuolo & Earle, 2017).

Historically tracing developmental services begins after the development of the Asylum. It is important to contextualize the history of institutionalization, as “models of institutional care continue to structure other care arrangements for people with all types of impairments, even if services are delivered in smaller settings that are designed to be home-like and endorse community-oriented frameworks” (Kelly, 2015). There was an increasing desire to categorize people labelled as insane apart from people labelled as “feeble-minded” (Ben-Moshe, 2020). Part of this was the popularization of IQ testing in the early 20th century as the use of intelligence testing “was popularized as a tool to implement eugenic measures” (Beit-Hallahmi, 1994; Roige, 2014). In a society that was increasingly moving towards the promotion of scientific thought “IQ tests gave the eugenicists the proof they claimed for their racial theories”(Doc & Film International,

2011). Asylum Superintendents demanded that “Asylums for Idiots” (henceforth referred to as Institutions) be built to address the fear of contagion from "patients" labelled as idiots to "patients" labelled as insane who might otherwise be incarcerated together. The first Institution was opened in 1876 in Orillia with a capacity for 150 "patients" (Radford & Brown, 2015). The Institution population grew quickly, as did the acquisition of land; by 1890 the Institution had over 150 acres and 309 "patients" (Martin & Ashworth, 2010; Radford & Brown, 2015). Institutionalization of people labelled as feeble-minded increased over time, particularly as eugenic ideology grew in Canada into the 20<sup>th</sup> century (McLaren, 1990).

The development of eugenic ideology in Upper Canada was championed by protestant social reformer<sup>33</sup> Helen MacMurchy, a prominent eugenicist. MacMurchy’s strategy for eugenics identified: 1) the need for wide-scale testing for feeble-mindedness, 2) reforms to the marriage act<sup>34</sup>, 3) sterilization, and 4) the need for social isolation (MacMurchy, 1915). During her time as the Special Inspector, she sought to test all students in public schools and children in orphanages, (Wright et al., 2013); the policy motivation behind confining and segregating children was fueled by a eugenic desire to remove them from society before they became a “eugenic threat” (MacMurchy, 1915). Once tested and admitted to Orillia Asylum, disabled people were confined in sex-segregated wards. This first wave of institutionalization took place in the Orillia Asylum

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<sup>33</sup> Social reformers were professionals, clergyman, social workers, temperance activists, and other well-educated English Canadians. They were part of the social purity movement “which, along with temperance and Sunday observance, helped to constitute a powerful if informal coalition for the moral regeneration of the state, civil society, the family, and the individual” (Valverde, 2008).

<sup>34</sup> To prevent disabled people from being able to legally marry (MacMurchy, 1915).

for Idiots, D'Arcy Place and the Oxford Regional Centre, incarcerating approximately 2500 people across the three sites.

Public support for eugenics began to decrease in Upper Canada as the links between eugenic ideology and Nazism became more apparent in the late 1930s (McLaren, 1990.). However, institutions continued to grow until the 1970s (Welch, 1973). The growth of the institution in post-World War II Canada was a result of a desire for the containment of deviance, desire for conformity, and an increase in responsibility for the nuclear family (Burghardt, 2018. p. 67). Families under heightened government surveillance, particularly poor, Black, Indigenous, racialized, and immigrant families, were not given the opportunity to keep their children at home; instead, if their children were labelled as disabled, they would be forcibly institutionalized without the family's consent (Strong-Boag, 1993). The continued pressure to institutionalize disabled children resulted in a growth in both the number and size of institutions (Radford & Park, 2015).

As institutional populations grew, concerns of overcrowding became public (Burghardt, 2018). In response, the government opened three more institutions throughout the 1950s: the Rideau Regional Centre, the Pine Ridge Centre, and the Durham Centre (Radford & Park, 2015). The Rideau Regional Centre (RRC) was a large-scale institution designed similarly to the Orillia institution, with 156 hectares of land and sex-segregated cottages. While the RRC had a maximum capacity of 2000 people, overcrowding within the residences was common, and it is estimated that at its peak it confined over 3000 people. Institutions continued development and mass confinement throughout the 1960s and 1970s as the province invested in the development of five more institutions (Radford & Park, 2015). The province estimates that at the peak of

confinement in 1971, over 10,000 people were living in government institutions. This is a contested number as it only accounts for the maximum occupancy capacity<sup>35</sup> (Radford & Park, 2015).

Residential institutions were places of violence; physical, emotional and medical abuse and neglect were both common and known (Burghardt, 2018). Institutions reflected Goffman's Total Institution: geographically isolated closed systems, where people are unable to make their own decisions (Goffman, 1990). Overcrowding, underfunding and lack of staff resulted in leaking roofs, lack of access to sanitation such as washrooms and showers, and holes in floors, roofs and walls (Berton, 1959). Institutionalized people were force-fed, ridiculed, and given no autonomy—decisions such as what they ate, who their care provider would be, when they would bathe and how they would spend their time were forced upon them (Rossiter & Clarkson, 2013).

Chronic underfunding and subsequent understaffing resulted in exploitation of "patient" labour (Simmons, 1982) "Patient" labour was justified as occupational training for residents yet was used to replace the need for staff. Unpaid residents completed the laundry and kitchen tasks, general household duties and manual labour (Rossiter & Clarkson, 2013). Thus, perpetual gross underfunding undermined any benevolent intentions of institutions and actively harmed the welfare and health of residents (Rossiter & Clarkson, 2013). "Patient" labour emerged out of the tradition of incarcerated forced labour that was first used in prisons, such as the construction of the Kingston penitentiary

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<sup>35</sup> The number only accounted for the maximum population of institutions and as does not include the "overflow".

by prisoners in the 1830s (McCoy, 2012). Similarly, "patient" labour was also mandated within asylums; Reaume (1997) documented the usage of "patient" labour to construct the wall surrounding the Toronto Asylum in the 1860s and 1880s. Labour of incarcerated populations was justified by moral reformers as a means to "to make idle and unemployed workers whole again, ready to rejoin society as productive citizens" (McCoy, 2012, p. 19).

Along with indentured labour inside the institutions, indentured labour became a popular way to move "patients" out of the institutions. A public inquiry, entitled *The Williston Report (1971)* reported on the cases of Frederick Elijah Sanderson and Jean Marie Martel who were both indentured labourers from Institutions. Sanderson was a 19-year-old Cree man who was confined in the Rideau Regional Centre and died while on work-leave from the institution. Despite Sanderson repeatedly expressing a desire to learn to read and write, and not participate in farm labour, he was continuously forced to return to the farm. At the farm, he slept in quarters "not fit for human habitation" (Williston, 1971, p. 12) and worked for \$0.14/hour doing farm labour. He died by suicide after being forced to return to the farm for a third time (Williston, 1971). Jean Marie Martel was a Franco-Ontarian, who was incarcerated at the age of 14, for "mental retardation with disease and condition due to unknown prenatal influence" (Williston, 1971, p.15). After attending school, Martel was forced to work 12-15 hours a day as a farmhand. The family he worked for locked him in his bedroom, forced him to wash outside in -20C temperatures, and fed him only calf-starter, ketchup and macaroni (Williston, 1971). Martel tried to escape the farm five times, and each time was apprehended and returned

(Williston, 1971). These two cases demonstrate the institutional violence that extended outside of the walls of the institution.

The forced labour, abhorrent living conditions and segregation were accompanied by experiences of medical, emotional, physical, verbal and sexual abuse. A class-action lawsuit filed against the province of Ontario made the atrocities that were committed against persons with disabilities public, citing “high rates of sexual violence against people with intellectual disabilities; routine degrading treatment, such as group showers; the routine use of physical force, such as electric cattle prods; medical violence, such as forced or coerced sterilizations and teeth extractions” (Spagnuolo, 2017). Rossiter & Rinaldi (2018) conceptualize the two types of violence that occur in total institutions as: 1) institutional violence and 2) extreme and shocking violence. The conditions that allowed for extreme violence include “reforming residents, limited institutional resources, social and geographical isolation, social hatred and suspicion of residents, and the twinned denial of bodily autonomy through regimented daily routines and unfettered access of staff to incarcerated bodies.” (p.37). Institutional violence exists as long as the structure and logic of institutionalization remain. Large-scale institutionalization dominated Canadian policy between 1876 to 2009 (Rossiter & Clarkson, 2015).

Deinstitutionalization was the large-scale mobilization of disability rights activists, parents of disabled children, and allied organizations to close segregated institutions in favour of community living (Niles, 2013). The beginnings of deinstitutionalization came as a result of increasing public awareness and developments in scientific thought. The increasing public awareness began with a 1959 Toronto Star

exposé of the conditions of the Huronia Institution. Journalist Pierre Berton concluded the piece with the stark warning;

Remember this: After Hitler fell, and the horrors of the slave camps were exposed, many Germans excused themselves because they said they did not know what went on behind those walls; no one had told them. Well, you have been told about Orillia. (Berton, 1959)

Along with increased media attention, the development of the National Institute for the Mentally Retarded (NIMR) became the central research and information centre on developmental disabilities (Brown & Radford, 2015). NIMR worked with leading academic Wolf Wolfensberger to extend the principles of normalization to the North American developmental sector<sup>36</sup> (Wolfensberger et al., 1972). Normalization was the revolutionary theory that “means making available to all people with disabilities patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life or society” (Wolfensberger et al., 1972). Public awareness and developments in scientific thought brought forth necessary friction to create policy change.

The policy changes necessary for deinstitutionalization began with two watershed government commissions. The provincial inquiry entitled *Present Arrangements for the Care and Supervision of Retarded Persons* commenced in 1971 (Williston, 1971). The Williston Report investigated the context of residential institutions and made several recommendations that would set the stage for the new policy direction in Ontario (Williston, 1971). The 1973 report *Community Living for the Mentally Retarded in*

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<sup>36</sup> Normalization had become the prominent developmental model in Scandinavian countries as a result of the work of Swedish physician Dr. Nrije (Wolfensberger et al., 1972).

*Ontario: A New Policy Focus* outlined the need for a new policy focus in Ontario, stating “Wherever feasible, services should be provided in a community setting as an alternative to institutionalization” (Welch, 1973, p. 2).

Following the Welch report, the first Act supporting community living was developed. *The Developmental Services Act (The Act)*, 1974, represented a major shift in government policy with three primary impacts (Brown & Radford, 2015). First, *The Act* (1974) transferred the responsibility of institutions from the Ministry of Health to the Ministry of Community and Social Services (MCSS) (*The Developmental Services Act*, 1974). Second, the Act promised funding for community living. Finally, the Act recognized the need to transition away from the institutional model of disability. Beginning in 1977, the first five-year plan to close institutions commenced with the closure of the Nipissing Regional Centre (Ministry of Community and Social Services, 2012). Following the *Developmental Services Act*, the 1983 Ontario budget promised the creation of 500 new beds in community living facilities, and a plan to begin transitioning away from institutions (F. Miller, 1983). For the next 35 years, the government incrementally closed institutions, halted new admissions to institutions, and prioritized funding community living alternatives (Radford & Brown, 2015) .

The shift towards deinstitutionalization occurred concurrently with the rise of neoliberalism (Ben-Moshe, 2020; Sonpal-Valias, 2019). The growth of neoliberalism both in policy and ideology were foundational to the development of the new disability services sector that emerged in the wake of the deinstitutionalization. Sonpal-Valias’ (2019) identifies the four components of the neoliberalization of the disability services sector: “program cutbacks and limitations; a new structure for program delivery;

increased family and individual responsibility; and managerial techniques for scrutiny and accountability” (p.2).

The shift to decentralized care was largely a piecemeal process that began in the 1980s following the independent living movement, which gained momentum throughout the 1970s (Pettinicchio, 2019). As Fritsch (2015a) notes, the independent living movement emerged alongside neoliberalism, intertwining deinstitutionalization with privatization, decentralization and commercialization (Fritsch, 2015a). In both watershed reports on the conditions within residential institutions, the cost of institutions is highlighted. The province was increasingly concerned with the high costs associated with residential institutions, the ability to privatize group homes, and the lower costs associated with decentralized care (Welch, 1973; Williston, 1971).

Currently, there are several different forms of community living funded by MCCSS: group homes, independent living, host families and intensive support residences. Through the government’s “Passport Program”, the effort is to help “adults with a developmental disability be involved in their communities and live as independently as possible” (Developmental Services, 2014). The Passport Program provides funds for caregiver respite, person-directed planning, and activities of daily living (MCSS, 2009). However, this shift towards decentralized care also saw less data collection as personal support workers are independent workers without a regulatory body and with minimal oversight mechanisms (Kelly, 2015).

Currently there are waitlists of up to 22 years for people to access residential services through Developmental Services Ontario (Dubé, 2016). In 2014, the Office of the Auditor General of Ontario found that there were almost as many people on the

waiting list as those receiving housing supports (Office of the Auditor General, 2014).

Recently, an increased investment of residential services by 14% totaling \$1.4 billion was intended to increase housing access for 1000 adults, however it only resulted in 240 additional beds across the province (Office of the Auditor General, 2016).

### ***1.9.1 Group Homes***

While group homes are only one facet of provincial residential support for disabled people, they account for 56% of supportive housing for adults labelled with I/DD (Auditor General, 2014). Currently, there is an exponential increase in demand for supportive housing but the developmental service sector residential stock increases less than 1% annually (Ontario Developmental Services Housing Task Force, 2017). This increased exponential growth in demand has not been met with proportional supply—the developmental service sector residential stock increases at less than 1% annually (Auditor General, 2016).

Group homes are municipally regulated and funded by the province through regional LHINs (*Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, 2008). Group home funding and services are provided through five Developmental Services Ontario departments, which oversee 240 residential service providers. The 240 service providers may run multiple homes and are a combination of public, private for-profit, and private not-for-profit corporations (Auditor General, 2014). Developmental Services Ontario is responsible for obtaining data on applications for proper oversight and evaluation purposes and in order to prioritize services for “high needs” persons (Kelly, 2015).

It is difficult to find information about the size and density of group homes for adults labelled with I/DD. Provincially, thdefine group homes as residents with more than 3 residents. However, there is not an upper limit on the capacity (*Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, 2008). As a result, there is significant diversity in both the size and density of group homes (*The Ottawa-Carleton Association for Persons with Developmental Disabilities (OCAPDD)*, n.d.). Regulation 299 sets out the Quality Assurance Measures for service providers for developmental services (*Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, 2008). The regulations do not specify the maximum number of residents per room, but notes there needs to be “sufficient space to keep their personal possessions and to pursue hobbies and interests without unwanted or unwarranted intrusion from others” (*Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act*, 2008).

Group homes are contested by disabled people on the grounds that they maintain carceral/congregate models of care provision (Chapman et al., 2014), low levels of autonomy (Chin, 2018), and ongoing abuse (Donovan, 2000). Group homes were proposed in the *Welch Report* (1974) as more financially feasible than the increasingly costly large-scale institutions. They were intended to increase autonomy and independence for residents; however, Welch cautioned that as group homes grow in size, they have risk of becoming institutional settings.

Contemporary group homes maintain many of the forms of institutionalization it was envisioned they would address and improve upon. Persistent concerns have emerged about lack of autonomy, segregation and abuse. Residents have been subject to “being

dragged down stairs, being left in the cold without blankets, being prevented from seeing family and friends, experiencing neglect relating to medical needs and having their cherished personal belongings stolen” (Joffe & Kerzner, 2008). Many group homes enlist their residents in shelter workshops (Picard, 2015). Shelter workshops are employment centers that primarily or exclusively employ people labelled with I/DD and are exempt from protections in the *Employment Standards Act*, 2000. This allows employers to pay disabled people sub-minimum wage and exempts them from paying overtime, and offering basic workplace protections (Gillmore, 2018). For instance, the Ottawa Carleton Association for Persons with Developmental Disabilities financially<sup>37</sup> benefits from contracts by under-paying disabled people (Picard, 2015). Adults labelled with I/DD have stated that they prefer living independently, in community settings with both disabled and non-disabled people, often called integrative housing, rather than in congregate settings (Ontario Developmental Services Housing Taskforce, 2018).

### **1.9.2 Intensive Support Residence**

Intensive support residences are small, one or two person homes operated by non-governmental agencies (*Social Inclusion Act*, 2008). Funding flows directly from the province to transfer payment agencies<sup>38</sup>. As of 2016, there were 328 people living in

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<sup>37</sup> Picard explains a contract between Library Archives Canada, who paid the “Ottawa-Carleton Association for Persons With Developmental Disabilities \$124,600 a year. With that money, the OCAPDD operates a sheltered workshop, where its clients get work experience and are paid an “honorarium.” The stipend is roughly \$2,000 a year, the equivalent of \$1.15 an hour” (2015).

<sup>38</sup> The government transfer payments to “to recipients external to government to fund activities that benefit the public and are designed to achieve public policy objectives” (Ontario Treasury Board Secretariat, 2019).

intensive support residences, and 197 people were on the waitlist (Office of the Auditor General, 2016). There is no centralized data on the number of homes or operators.

### **1.9.3 Specialized Accommodation**

Specialized accommodation makes up 2% of total Ministry of Community and Social Services residential services spending (Auditor General, 2014). These accommodations are defined as “transitional or permanent specialized settings, including residential care, structured support, planning and treatment for individuals with a developmental disability and a co-existing mental illness or behavioural challenges.” No other information is provided by Developmental Services Ontario (DSO), or in Auditor General reports. It seems many of these programs were established following the 2016 Ombudsman Report (Dubé, 2016). Thus, there has not been evaluations or audits of these institutions. These programs include the Community Networks of Special Care, which “provide direct complex coordination to adults with developmental disabilities with high supports and complex care needs, or who require appropriate diversion from the Justice System” (CNSC, n.d.). Further research and evaluation should identify the complexities of these new forms of residential services.

### **1.10 The Geriatric System**

Contemporary institutions for aging people are divided between three primary government agencies. The Ministry of Health and Long-Term Care is responsible for regulation, funding and monitoring of long-term care as outlined by the *Long-Term Care Act* (2007). The Ministry of Seniors and Accessibility is responsible for overseeing the Retirement Homes Regulatory Authority, a non-governmental regulatory authority. The

Ministry of Children Community and Social Services (MCCSS) is responsible for housing support for low-income seniors (Ministry of Health and Long Term Care, 2019).

Institutions for older people have been established and enacted by a patchwork of governmental and non-governmental actors since development in the late 19th century (Daly, 2015). As industrial capitalism emerged, older people became increasingly displaced as traditional community networks of care collapsed. Initially, older people without access to community support were housed in the large-scale Houses of Industry operated by largely Protestant religious organizations (Daly, 2015; Struthers, 2017). However, religious organizations did not believe Houses of Industry were appropriate for elders. Resultantly, they developed houses of refuge; institutions specific to the needs of older people (Struthers, 2017). In the 1940s, as the welfare state emerged, life expectancy grew. The Ontario government passed the *Homes for the Rest and Aged Act*, 1948. This gave municipalities the responsibility to operate at least one home<sup>39</sup>(Daly, 2015). The municipal homes had increasing waitlists, which was at tension with municipalities desiring to transfer aging hospital residents to long term care (Struthers, 2017).

The lack of residential institutions meant that cities began developing what Struthers refers to as an “an unintended partnership of convenience” (2017, p. 174). Beginning in the 1960s, growth of private long term care homes surpassed the development of public homes.

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<sup>39</sup> These homes were focused on the provision of services for poor aging people, as opposed to disabled aging people.

As baby boomers continue to age, the demand for care work in the form of long-term care home beds and home care has risen year over year, with an expected peak demand in 2035 (National Institute on Ageing, 2019). Despite the focus on long-term care home capacity, the vast majority of aging people report a desire to age in their homes (Gibbard, 2017.; Ipsos, 2018). However, the policy response to the increasing aging population has specifically focused on increasing the number of beds and institutions “faster” (Office of the Premier, 2018, 2020) .

### ***1.10.1 Long-Term Care Homes***

Long-term care (LTC) homes are regulated by the *Long-Term Care Home Act* (The Act), (2007) and refers to any private, public or First Nations owned long-term care home. The Act came into place in 2010 replacing the *Nursing Homes Act*, the *Charitable Institutions Act* and the *Homes for Aged and Rest Homes Act* (Daly, 2015). There are 626 homes that operate in Ontario, of which 58% are for-profit, 24% are not-for-profit, and 16% are operated by municipalities (Ministry of Health and Long-Term Care, 2019). People access long-term care through 14 Community Care Access Centres (CCACs) (Ministry of Health and Long Term Care, 2019). CCACs determine admission eligibility, prioritize cases and arrange placements upon openings. CCACs are funded by LHIN and regulated by The Act. There are 77, 000 long-term care home residents, and the waitlist in 2019 was 34,834 people, 85% of new cases were from people over the age of 75 (Ministry of Health and Long Term Care, 2019; Ontario Long Term Care Association, 2019).

Funding flows from the federal government through the Canada Health Transfer. Under the *Canada Health Act* (1985) basic rooms must be publicly subsidized, while semi-private and private rooms are charged out-of-pocket. Accommodation rates for LTC homes are provincially determined. In Ontario, standard rooms cost \$1,891.31, semi-private cost \$2,280.00 and private cost \$2,701.61 (Government of Ontario, 2020). Subsidies of up to 100% are provided by the province based on income testing, through the Long-Term Care Home Rate Reduction Program. Long-term care homes are licensed by LHINs (Ministry of Health and Long Term Care, 2019). The MOHLTC funds LTC based on a per-diem level of care (LOC). The LOC premium includes four envelopes: Nursing and Personal Care (NPC), Program and Support Services (PSS), Raw Food (RF) and Other Accommodation (OA). A variety of other subsidy programs are run by the province for long-term care providers, including the Bad Debt Reimbursement Program, and various furniture and equipment programs as covered by the Long-Term Care Home Service Accountability Agreement (Government of Ontario & Ministry of Health and Long-Term Care, 2017).

Long-term care institutions have been used to house people labelled with I/DD for at least 50 years (Hartford et al., 2003). The Office of the Ombudsman explains, “they were not developed with the needs of those with developmental disabilities in mind and are another form of institutionalized care often used as a stopgap solution when more appropriate residential placements are unavailable” (Dubé, 2016, p. 238).

Transinstitutionalization has resulted in people as young as 15 being placed in long-term care facilities, with 3200 people in Ontario under the age of 55 in long-term care in Ontario (Lin et al., 2019).

There are persistent data gaps regarding the use of long-term care home for adults with I/DD, as these data are not included in the MCCSS data collection system (Dubé, 2016). The Report of the Ombudsman of Ontario followed the case of Patrick, a 24-year-old, who was transferred to a long-term care facility after waiting for months for appropriate care options (Dubé, 2016). After contacting Developmental Services Ontario and MCCSS, the Ombudsman reported that the department “had no idea Patrick had been moved to a long-term care home or that he had reportedly been the victim of sexual assault” (Dubé, 2016, 73). Patrick was forced to continue living in the long-term care facility for three more years until appropriate community housing was available (Dubé, 2016). Evidence shows that long-term care facilities house people with developmental disabilities (Dubé, 2016), however, the ongoing data gaps make it difficult to understand the severity of the problem.

Long-term care homes have high levels of surveillance and low levels of privacy (Tufford et al., 2018). Tufford et al. (2018) scrutinize the use of locks, locked wards and privacy in long term care, and their role in creating institutional settings. Private rooms are not covered by subsidies, thus are unavailable for people who cannot pay the additional \$27/day (Roblin et al., 2019). This creates a hierarchy for those who can access privacy, and those who must share rooms with multiple people. While quadruple occupancy rooms have not met design standards for at least a decade, they remain in routine use, as older buildings remain a dominant feature of the long-term care landscape (Stall et al., 2020).

Long-term care homes have increasingly replaced unionized nurses with non-unionized personal support workers (Zeytinoglu et al., 2017). Personal support workers

have minimal job and income security, along with lower wages, higher rates of sick days, intensified work and high rates of stress (Sayin et al., 2019). Meanwhile, residents have experienced concerning trends of chemical incarceration<sup>40</sup> (Fabris, 2011; Walker et al., 2020), negligence (Pedersen et al., 2020) and abuse (Favaro, 2018).

**Figure 4: Quadruple Occupancy Room in Long-Term Care**



A picture of a quadruple occupancy room, with four beds with different coloured blankets, and windows. (Ontario Long Term Care Association, 2017)

### **1.10.1.1 Private Homes**

Long-term care homes are primarily and increasingly operated by for-profit corporations. There are 363 for-profit homes, of which most are concentrated in companies with more than one home (see Appendix C). The largest lobby representing for-profit LTC is the Ontario Long Term Care Home Association, which represents 70% of all long-term care homes in Ontario (OLTCHA, 2019). For-profit corporate ownership and management within the LTC sector in Ontario has “grown by 80.3% between 1989

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<sup>40</sup> Scholar Eric Fabris (2011) names chemical incarceration as the over prescription of sedatives in settings where people do not have autonomy over their medication.

and 2013” (Daly, 2016, pp. 13). Ownership was further concentrated in large companies following an increase in regulatory regimes that necessitated economies of scale to be feasible. Harrington et al. (2012) found that “corporate chains made up a larger share of the for-profit market in Ontario (82%) than in Canada overall and have a strong political influence” (p.5).

For-profit LTC homes are associated with worse patient outcomes as compared to not-for-profit homes (Daly, 2016; Fisman et al., 2021; Stall et al., 2020). Indicators of worse outcomes include higher use of restraints, higher incidence of bed sores, higher mortality rates and higher rates of acute hospitalization (Harrington et al., 2012; McGrail et al., 2007; McGregor et al., 2006). Further, for-profit LTC homes are associated with lower staffing rates, particularly of registered nurses (Harrington et al., 2012). The problems within long-term care homes came to the surface during the COVID-19 pandemic. In Canada, as of April 2021 deaths in long-term care were 69% of all fatalities (Canadian Institute for Health Information, 2021). Private, for-profit LTC homes were at increased risk for more fatal and severe COVID-19 outbreaks (Fisman et al., 2021).

#### **1.10.1.2 Municipal Homes**

There are 102 municipally operated homes in Ontario, with a total of 17,000 residents (Ministry of Health and Long Term Care, 2019). The *Long-Term Care Home Act* (2007) along with the *Municipalities Act* (1990) mandated that upper and single tier municipalities operate at least one long-term care facility. Both Southern and Northern municipalities have the option to jointly operate a long-term care facility, so long as they are in the same territorial district and have approval of the government.

Municipally operated homes emerged following the passage of the *Homes for the Rest and Aged Act*, 1948. These homes were designed for low-income older people in communities. Municipalities were responsible for maintaining one such homes, with provincial funding. The Act specifies that “every upper or single-tier southern municipality is required to maintain at least one municipal home, individually or jointly, while northern municipalities may operate one individually or jointly” (AdvantAge, 2017). Following the passing of the *Long-Term Home Act*, 2007, private, for-profit and municipal homes became regulated, administered and overseen by the same body.

### **1.10.1.3 Not-for-profit Homes**

Religious homes began the settler response to aging in Canada, particularly the Society of Friends in Upper Canada (Daly, 2015). Until 2010, not-for-profit homes were regulated under the *Charitable Institutions Act*, 1990 and the *Homes for the Rest and Aged Act*, 1948 (Daly, 2015). There are approximately 150 not-for-profit homes all of which are run by either charitable or religious organizations. Not-for-profit and municipal long-term care homes are jointly represented by AdvantAge, a lobby which serves over 580 homes (AdvantAge, 2018).

### **1.10.2 Retirement Homes and Communities**

Retirement homes are privately owned residential buildings, where; a) the majority of residents are over the age of 65 and, b)at least 2 services available for residents (Retirement Homes Act, 2010). There are more than 750 retirement homes in Ontario (Retirement Homes Regulatory Authority, 2020). Retirement homes are regulated under the *Retirement Homes Act*, 2010. The *Act* established the Retirement Homes Regulatory Authority, a third-party, not-for-profit, self-funded authority that is

responsible for home inspections, and resident and family complaints (*Retirement Homes Act*, 2010). Along with the *Retirement Homes Act*, they are regulated by the Residential Tenancies Act, 2006 which sets out regulations for “care homes” (Residential Tenancies Act, 2006) .

While retirement homes are designated for “residents over the age of 65”, disabled people continue to live in retirement homes. This is a result of shortages in hours for attendant care and lack of affordable housing (Kelly, 2015). For instance, in January 2021 Chris Gladders, a 35-year-old disabled man, died using medical assistance while in a Niagara Falls retirement home (Polewski, 2021), where he was forced to live in abject conditions. His brother directly connected institutionalization and MAiD—stating, “I believe, in my heart, that him being in that place played a big toll on his decision. I really do” (Polewski, 2021).

### ***1.10.3 Supported Housing***

Supported housing is rental housing with additional supports. Supportive Housing for Aging People is coordinated and funded by regional LHINs and are operated by municipalities and not-for-profit actors (The Age-Friendly Housing Committee, 2019). Personal support is available in supportive housing and is paid for by the Ministry of Health and Long-Term Care. Supported housing can either be a cluster of apartments in an apartment building, or an entire building. For example, Ottawa Community Housing Corporation, the largest social housing provider in Ottawa, has 11 buildings that operate as supported living for seniors (The Age-Friendly Housing Committee, 2019). Rent is paid for by the tenant and subsidies are available through the Ministry of Housing.

Another form of supportive living is operated by not-for-profits, such as the Shepherds of

Good Hope, a Christian not-for-profit organization, which operates a 93-bed supportive housing facility (Shepherds of Good Hope, n.d.).

### **1.11 Homelessness System**

As neoliberalism grew in the 1980s, so too did the homeless population. This resulted in a growing industry of shelters across North America (Lyon-Callo, 2004). The increasing rates of homelessness continued through the 1990s, at a time when social spending was being cut significantly. A significant year for homelessness in Canada was 1999, when municipalities met in Winnipeg to declare homelessness an emergency; the federal government launched the National Homelessness Initiative<sup>41</sup>, and Ontario's Harris government designated municipalities "service system managers" (Sancton, 2000). Simultaneously, the Harris government<sup>42</sup> cut spending on social services and expanded the role of municipalities (Albo & Evans, 2019). The expanded role of municipalities came at the same time they were mandated to significantly cut the number of civil servants. This decided shift towards neoliberalism necessitated the use of large charities to deliver public services. The subsequent subsidization and reliance on the not-for-profit sector results in a strong role for Christian organizations in the lives of disabled people (Mulder, 2004).

#### ***1.11.1 Emergency Shelters***

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<sup>41</sup> The NHI was responsible for distributing \$753 million over three years, which largely funded non-governmental service delivery in communities (Human Resources and Development Canada, 2003).

<sup>42</sup> Artist Scott Sorli created a detailed graph of the role of the roll out of the Commonsense Revolution and the number of homeless people who died, showing a strong correlation (Toronto School for Creativity & Inquiry, 2007).

While built as a temporary or transitional living space, a backlog in affordable housing<sup>43</sup> has seen an increase in longer stays at shelters<sup>44</sup>. Shelters are a form of congregate housing that serve more than 12,000 people in Ontario annually, of whom an estimated 4,000 to 9,000 are disabled (Government of Canada, 2018). In Ontario, there are 149 homeless shelters with 6,898 beds (Government of Canada, 2018). Homeless shelters are the responsibility of municipalities, but the operations and service provisions are enacted by largely Christian nonprofit organizations. Emergency shelters all too often serve as housing for disabled people, particularly those labelled with I/DD or psychiatric disability. The 2016 Report of the Ombudsman found that the “insufficient crisis beds and supports can result in individuals remaining in unstable and unsafe homes or shuttled off to homeless shelters, where their vulnerability continues to place them at risk” (Dubé, 2016, p.2). Additional data suggests that 45% of people experiencing homelessness are disabled (Morris et al., 2018), while a Street Health Toronto report found that 55% of people experiencing homelessness were disabled with a serious health condition (Shartal et al., 2005).

Shelters are homes to the most marginalized citizens, who represent the nexus of multiple domains of oppression. Shelters generally consist of dormitories and overflow; dormitories are smaller rooms with bunk beds housing 4-12 people (Ottawa Boothe Centre, 2019) while overflow serves 30-60 people on floor mats and beds (Shepherds of

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<sup>43</sup> The Quakers were the first group to start major shelters, forming several Houses of Industry in Toronto, Kingston, and Wellington among others (Schrauwers, 2009).

<sup>44</sup> There has been a growth in chronic homeless, with an average number of days of homelessness at 206 (City of Ottawa, 2018).

Good Hope, 2019). As a result of this overcrowding, there is a higher likelihood of infectious diseases such as tuberculosis (TB) despite low prevalence in the Canadian population. The high infection rates and overcrowding contribute to debilitation of residents, of whom 67% identify as living with at least one health condition (City of Ottawa, 2018). Over the past ten years, there has been an increase in the number of homeless newcomers<sup>45</sup> to Canada, particularly newcomer families. Shelters simultaneously create disability, through poor living conditions, while being a crucial form of housing for disabled people.

The lack of access to community living results in emergency shelters as a dominant form of institution. In Ottawa, the two municipally operated shelters account for less than 25% of the emergency shelter beds (Government of Canada, 2020). Shelters are primarily concentrated in the inner-city. Yet, municipal shelters operate outside of the downtown core, leaving the inner-city shelters exclusively operated by Christian charities. The remaining nine shelters are operated by not-for-profit, Christian organizations accounting for 750 of the shelter beds in Ottawa (Statistics Canada, 2020). Critiques of the use of Christian charities for service provision have been robust; Indigenous activists have long decried the use of Christian charities by municipal governments, Nahanni Fontaine spoke against the City of Winnipeg funding the development of a Christian drop-in in downtown Winnipeg:

To suggest that the same institution who on the one hand is complicit in the total destruction of Aboriginal peoples' culture, traditions, land, economies and language, can on the other hand, be the ones offering change and healing is absolutely ridiculous and insulting (Toews, 2017).

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<sup>45</sup> 25% of shelter residents are newcomers to Canada.

Christian street-level bureaucrats are the primary contact point for a disproportionate number of Indigenous people in Ottawa. Indigenous peoples account for 24% of homeless residents in Ottawa, despite making up on only 2.5% of the population (City of Ottawa, 2018). As a result of colonization, genocide, and the environmental destruction of their ancestral territory, there is a disproportionate number of Indigenous people who are shelter residents. More than 90% of Indigenous people accessing shelters are disabled (City of Ottawa, 2018).

### ***1.11.2 Domiciliary Hostels/Residential Services Homes (4700 beds)<sup>46</sup>***

MCCSS was responsible for administering the Domiciliary Hostel Program until 2009. They created the first framework for municipal policies; Domiciliary Program Framework (2006), which prompted development of new regulations following these guidelines (Kanellakos & Community and Protective Services, 2006).

In 2013, the program was shifted to the Ministry of Municipal Affairs and Housing (MMAH) where it was placed amongst the Community Homelessness Prevention Initiative (CHPI) (Ministry of Municipalities and Housing, 2014). In 2014, the CHPI released the Guide to the Housing with Related Supports Service Category, an updated framework for service provision, which mandated municipalities update their service provision policies by 2016 (Ministry of Municipal Affairs and Housing, 2014).

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<sup>46</sup> The last count of domiciliary hostels occurred in 2007 prior to deinstitutionalization (Hwang et al., 2009; Linton, 2021).

Municipal bylaw officers enforce these policies and public health inspectors are responsible for inspection and licensing enforcement (Priel et al., 2016).

Domiciliary hostels are cost-shared between the province and municipalities. The province funds 80%, and municipalities fund the remaining 20% (Priel et al., 2016). These are larger institutions, particularly in rural areas<sup>47</sup>, with between 10 and 170 residents (Cleaver et al., 2008; Linton et al., 2021). Municipalities are responsible for intake, assessment, monitoring of admissions and making agreements with hostel operators (City of Ottawa, 2016). Similar to Homes for Special Care, landlords of domiciliary hostels are responsible for providing tenants \$149 monthly as their personal needs allowance (City of Cornwall & The Counties of Stormont, Dundas and Glengarry, 2017).

Municipalities each have their own standards, licensing program, names<sup>48</sup> and guidelines. Originally, the program operated as an alternative to long-term care facilities for aging people who did not yet qualify for long-term care (Ministry of Municipalities and Housing, 2014). The program transformed as deinstitutionalization expanded without an increase in community living options. In 2007, more than 75% of residents were under 65, while 23% had a I/DD diagnosis (Hwang et al., 2009).

Domiciliary hostels have shared bedrooms, bathrooms, and common spaces. While some have private rooms, the most common are shared, with a maximum of three residents/room (Appendix A). Residents have cited lack of freedom, lack of funds, lack

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<sup>47</sup> As a result of municipal zoning codes, see Chapter 4.

<sup>48</sup> Some municipalities use the name domiciliary hostels, while others have transitioned in recent years to residential service homes, housing with supports and supportive housing.

of autonomy, and dislike of prepared meals as problems (Hwang et al., 2009; Lowndes et al., 2013; Priel et al., 2016). Further, Hwang et al. (2009), found there was little resident engagement in the social arena; 85% never attended a drop in, 81% never visited the library, and 71% never went to a park.

### **Figure 5: Bedroom in a Residential Service Home**



A picture of a bedroom with two single beds, and two nightstands with lamps. There is a doll on one bed, while the other one is close to the radiator, which has books stacked on it. (CityOfOttawa DomHost, 2012)

### **1.12 Limitations**

This mapping identifies several provincial data deficits that prevented further analysis. There are no foundational datasets for: the domiciliary hostel program; forensic psychiatric group homes; group homes for adults labelled with I/DD; psychiatric group homes; and psychiatric wards. Additionally, the dataset for Homes for Special Care is six years old and does not identify the size of the institutions. There are significant ongoing federal data gaps that contribute to the shortages, as Statistics Canada does not administer the long form census to collective dwellings (Government of Canada, 2019). This research could not explore transinstitutionalization for children and youth with

disabilities. However, there is a complex system of transinstitutionalization for children and youth that merits further research. Moreover, this typology does not include residential services for acquired brain injury, or independent living centres administered through Community Independent Living Toronto.

### **1.13 Conclusion**

Institutions can appear as starkly different built structures. Decentralization has resulted in a large constellation of disability institutions (Conteh, 2016). While these are distinct institutions, it is important to understand their interconnectedness. For instance, more than 9,000 adults labelled with I/DD live in group homes in Ontario today, while more than 15,700 adults are on the waitlist to receive access to care. While on the waitlist, increasingly disabled adults are forced into other forms of custodial care such as long-term placements in psychiatric institutions, inappropriate placements in long-term care facilities, emergency shelters, and prisons. Upon incarceration, prisons are often unwilling to release disabled inmates, even after they have served their sentence or have not been criminally charged, because they have no place to go while they remain waitlisted for a community home (Dubé, 2016). Positioning institutions that confine and control disabled people together seeks to challenge popular discourse of deinstitutionalization.

A complex web of services, service providers, jurisdictional boundaries and responsibilities make up the decentralized transinstitutional landscape in Ontario. The complexity of the current system is well documented. Decades of governmental reports and audits have identified that one must be an expert in these policies to understand the system of services (Daly, 2015; Dube, 2016; Sylph et al., 1978; Welch, 1973; Williston,

1971). The construction of this typology was a labourious process involving the analysis of more than a century of archival documents, hundreds of hours of web-scraping<sup>49</sup>, and extensive consultation with stakeholders.

People often do not have the resources required - two years, institutional access, and professional network - that were necessary for me to make sense of this complex ecosystem, nor should require this much work or resources to make sense of our social service system. For this reason, this chapter makes several key contributions to Critical Disability Studies, Critical Carceral Studies and Disability Justice efforts in Ontario. First, disabled people should be able to know who is administering their care. Disabled people and their communities should be able to know who is responsible for receiving complaints and concerns. Disabled people and their families should be able to make informed decisions about where they live and what supports they receive. Informed decisions are only possible with a complete picture of the various systems and supports. Many disabled people are not given the opportunity to decide where to live. The typology I present here is an important contribution to excruciating gaps in academic and political literature and can help individuals to identify rights, accountability processes, and policies within this complex social system.

Second, this framework can serve as a guide for media, reporters, and analysts to appropriately identify and cover institutions. While there has been substantial media coverage of many of these institutions, they are often misidentified because accurate details are difficult to determine. (Egan, 2008). For instance, domiciliary hostels and

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<sup>49</sup> Data-scraping is the process of extracting data from websites.

Homes for Special Care are frequently referred to as group homes by media (Invisible Institutions, 2021).<sup>50</sup> This conflation dismisses critical factors such as ownership, profit structure, and history. Such conflation fails to make known the systemic nature of abuse within some forms of institutions. With this framework, media and scholars alike will have a more accurate and appropriate set of language to identify and critique these institutions.

Third, this chapter can be used as a tool for stakeholders and advocacy groups to demand deinstitutionalization. This typology makes explicit the connections between the carceral system and the disability system. Past works in the field (Ben-Moshe et al., 2014; Ben-Moshe, 2020) have identified the need for solidarity in organizing against confinement. This chapter makes evident the need for an interconnected abolitionist and deinstitutionalization movement. The carceral system is intricately intertwined with the disability system—forensic psychiatry, and the developmental service systems’ specialized care networks are entire systems dependent on the carceral system. Simultaneously, the carceral system is used as an institution of last resort for disabled people when there are no available beds or services elsewhere. If carceral logic persists, any type of institution can and will be used to contain disabled people.

The deinstitutionalization movement succeeded in closing large-scale public institutions for disabled people. Deinstitutionalization is possible, but it is also ongoing. It is important to recognize that although policy developments in the 1970s and 80s did

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<sup>50</sup> Specific language is critical for context— group homes operate as not-for-profit structures whereas domiciliary hostels and Homes for Special Care are predominantly for-profit.

respond to public cries against the abhorrent conditions of institutions in Ontario, the response did not result in the deinstitutionalization that advocates called for; continuing to name institutionalization as such, regardless of its decentralization, is important in the continued fight for better lives for disabled people. Today, the explicit policy response is no longer institutionalization. However, this research makes evident the extent of the ongoing reliance and commitment to institutionalization. Today, the fight for deinstitutionalization continues.

## **Chapter 2: Sex, Surveillance & Criminalization**

In 1967, Justice Minister Pierre Elliot Trudeau became famous for the proclamation, “there’s no place for the state in the bedroom of the nation” (Trudeau, 1967). But the reliance on institutionalization as a response to disability positions the state in the bedroom of disabled people. Through the development of the *Transinstitutional Typology*, I was able to understand the various bedrooms of disabled people. These range from bachelor apartments to emergency shelters. In doing so, I make explicit the varying actors, policies, and institutions intertangled in the lives of disabled people. Through this chapter I take up the question of *how does transinstitutionalization impact disabled peoples’ access to sexuality?* Carceral policies of surveillance and criminalization prevent both disabled people and sex workers from fulfilling social, economic, and sexual desires.

### **2.1 Transinstitutionalization and Sexuality**

Transinstitutionalization has resulted in the ongoing regulation of disabled peoples’ intimacy and sexuality. Amidst COVID-19, this has been particularly true for transinstitutionalized disabled people, many of whom have been unable to be hugged, touched or fucked in over a year (Kupfer, 2021). Policies enforcing transinstitutionalization limit access to privacy (Kulick & Rydstrom, 2015; Shakespeare et al., 1996), enforce normative sexuality through surveillance (Chin, 2016; Gill, 2015), and perpetuate the ongoing segregation of disabled people (Abbas & Voronka, 2014; Chapman et al., 2014; Cleaver et al., 2008). Along with transinstitutionalization, criminalization of sex work significantly impacts access to sexuality for disabled people. Responding to the calls of Fritsch et al. (2016), to develop “bonds of solidarity” between

sex workers and disabled people, I consider how carceral policies jointly impact these communities.

Enforced and endemic poverty within institutions limits access to the spaces and places where sexuality emerge (Shuttleworth & Mona, 2000). The Personal Needs Allowance of \$149/month for institutionalized disabled people makes it challenging to afford the essentials to survive, let alone being able to afford dates, safer sex supplies or sexual supports. Despite the low rate of the Personal Needs Allowance, privacy within institutions is a commodity and privilege (Marrelli, 2018; Tufford et al., 2017). The province subsidizes shared rooms in long-term care facilities, retirement homes and high support housing.<sup>51</sup> Private rooms are available at an increased cost (Lichtenberg, 2014; Tufford et al., 2018). In these facilities, sexual access and privacy are determined by the resident or their family's income.<sup>52</sup> Many institutions continue to use quadruple occupancy rooms<sup>53</sup>, especially long-term care, psychiatric and forensic psychiatric institutions, Homes for Special Care and domiciliary hostels. In shared bedrooms, disabled people must navigate the schedules of roommates, attendant care, and inflexible mealtimes. These conditions provide limited opportunity for spontaneity, community, and intimacy. For instance, in one long-term care home, a resident wanting to watch pornography was told he would need to give at least 24-hours of notice to staff and

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<sup>51</sup> Including Homes for Special Care (Marrelli, 2018) and, Domiciliary Hostels (City of Ottawa, 2016).

<sup>52</sup> Intimate ties are critical here, as residents only receive \$149/month, thus requiring external monetary support.

<sup>53</sup> Apart from Homes for Special Care, which continue to permit quadruple occupancy rooms (Darling Residential Services, 2013).

roommates (Howard et al., 2020). However, even after following all the steps, the resident reported being walked in on by staff while masturbating (Howard et al., 2020).

The line between private and public spaces in institutions is blurred (Kulick & Rydström, 2015). Policy and procedure do not consider the blurred continuum of private and public space—sex or sexual behaviours within spaces assigned public are disciplined as “challenging behaviour” (MCCSS, 2017). The containment and control of disabled sexuality are frequently part of the “control” function of institutions that seek to therapeutically reform disabled people through characterizing behaviours as problematic (Chin, 2018; Johnson et al., 2006). Institutions such as group homes, shelters, psychiatric wards, and supportive housing have access to control mechanisms such as chemical restraint, confinement and violence (Government of Ontario, 2018; Haley, 2017; Spivakovsky, 2017), so long as it is done under the auspices of therapeutic, or rehabilitative intervention (MCCSS, 2017). Shelters can expel clients who demonstrate “disorderly behavior”, thereby creating a standard of behaviour that is enforced through surveillance by workers, and the ability to evict clients onto the street (Stuart, 2014).

### **3.2 Surveillance**

Integral to the maintenance and success of carceral systems is surveillance architecture. Carceral logic rationalizes surveillance as a response to the perceived risk of disabled people and sex workers (Bruckert, 2015; Fish, 2016). The innovation behind the development of institutions was partially their ability to have permanent, ongoing surveillance (Foucault, 1982). Institutions that maximize surveillance are predominately those with labelled people—people labelled with I/DD, psychiatric disabilities, or with criminal labels. LTC institutions, emergency shelters, psychiatric wards and institutions,

prisons, and forensic psychiatric settings deploy traditional panoptic surveillance mechanisms; such as the use of central desks, which are designed to monitor the maximum number of residents with the least number of staff (Foucault, 1982; Linton, 2021b; Wrublowsky, 2018).

Surveillance is not benign observation. Rather, it seeks to classify behaviours as disorders or problems to be solved (Haggerty & Ericson, 2000). Disability institutions contain a multitude of different surveillance mechanisms. This includes behavioural, and generalized surveillance such as CCTVs, 24-hour staff monitoring and guest logbooks. Saltes (2014) brings these systems together through what she names, “disability surveillance”— “the practice of collecting, documenting, monitoring and, classifying personal data that pertains to the embodied characteristics and attributes of impairments” (p. 56).

Implementation of CCTV is legitimized by a desire for safety and protection of property (Piza et al., 2019). The use of CCTVs perpetuates the criminalization of disabled people, which contributes to the institution-prison pipeline, where disabled people are shifted between institution and prison (Cooper, 2017). While it has been made evident that CCTVs do not prevent the occurrence of crime, they can be used by police to evaluate people’s probation, enforce bylaws and ticketing, and as evidence in criminal proceedings (Loftus, 2018). CCTV can also impact the safety of people who use drugs by deterring them from using in areas where CCTVs are located. This can force people who use drugs into more hidden away spaces, which put them at risk of overdose without intervention (Smith, 2016).

The social service system is a site of increasing securitization, marked by the use of CCTV, private security guards and the relationship with street level bureaucrats (Lipsky, 1980; Piza et al., 2019). For instance, shelter clients experience surveillance efforts by street-level bureaucrats such as police, neighborhood security details<sup>54</sup>, and private agencies including private security companies and shelter staff.

Employment of surveillance systems often happens following major public incidents. In long-term-care institutions, there is an increasing trend towards families installing hidden security cameras in their loved ones' rooms (Pedersen et al., 2020). Families cite the problem of neglect and abuse within these institutions as the justification for their installation (Pedersen et al., 2020). Long-term-care residents and elder advocates have fought against the use of such cameras, citing violations of privacy (Nursing Homes Abuse Center, 2019). In 2013, the death of Aron James Firman resulted in an increase in institutional installation of CCTVs. Aron was a 27-year-old disabled man killed by an Ontario Provincial Police Officer's fatal use of a taser outside the domiciliary hostel in which he lived (Office of the Chief Coroner, 2013). In the province's inquiry into his death, they recommended that "closed circuit TV (CCTV) cameras should be considered for installation around the perimeter of the premises of domiciliary hostels and similar facilities funded under CHPI, at the expense of the owner/operator" (2013, p.2). Conversely, there were no recommendations about removing tasers from officers. I am not sure how a CCTV would have prevented Aron

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<sup>54</sup> In this case, The Byward Market Ambassador Program, which "provides first and foremost, a safety and security function in the form of front-line response, first aid treatment and maintaining a safe and secure environment in the ByWard Market" (Brownridge et al., 2010).

from being killed by police, but I do know that disarming police would have dramatically reduce the threat to Aron's safety. Regardless, many municipalities now mandate CCTV usage outside domiciliary hostels.

While generalized surveillance considers the physical and technical structures of surveillance, behavioural surveillance refers to the street-level bureaucrats'<sup>55</sup> ability to watch, and police behaviour. Behavioural surveillance is normalized in institutions through carceral ableist logic that deems disabled people as in need of constant supervision (Boyd et al., 2016; Grigorovich, 2020; Smith, 2016; Spivakovsky, 2017). Behavioural surveillance in some systems<sup>56</sup> includes the monitoring of and intervention in "inappropriate sexual behaviours"<sup>57</sup> (Johnson et al., 2006). Behavioural surveillance and intervention can force disabled people to have more secretive relationships, which may contribute to the high rates of exploitation, particularly amongst disabled women (Chin, 2018).

Within long-term care facilities, staff surveillance of sexuality is often triggered by diagnostic label (Howard et al., 2020). This need for surveillance is made apparent in an Ontario municipal long-term care home guide on the "Best Practices & Approaches to Intimacy and Sexuality" (2007). The guidelines highlight the role of staff as bureaucratic surveillance, it explains that "it is important that staff observe, monitor situations, and assess level of sexual behaviour to determine if interventions are necessary for the

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<sup>55</sup> "street level bureaucrats" refers to service providers and frontline governmental officials given the role of interpreting policy and then implementing those policy interpretations at ground level.

<sup>56</sup> Developmental, forensic psychiatric, carceral, psychiatric and geriatric systems

<sup>57</sup> Inappropriate sexual behaviours are cited as being "unacceptable within the social context in which it is carried out" (Johnson et al., 2006). However, when limited to a social context, such as an institution, there are few or no social contexts for which sexuality is considered appropriate.

resident's well-being" (p.5). This mobilizes a paternalistic understanding of disability that once again positions surveillance as for the benefit of the disabled person. However, this form of surveillance limits the rights of residents, particularly their right to private family visits<sup>58</sup> (Tufford et al., 2018). Institutions remain structures of surveillance that negatively impact access to sexuality.

## **2.2 Criminalization, Paternalism and Sex Work**

Access to sex work for disabled people supports autonomy and quality of life (Fritsch et al., 2016; Sanders, 2007; Shakespeare et al., 1996). Sanders (2007) found in her research with disabled men who purchase sex, that accessing sex work "highlighted sexual options, rights and sexual pleasure as central to a full life" (p. 447). Some sex workers specialize in services for disabled clients (Fritsch et al., 2016; Ottawa Independent Companions, 2021). These services can be "another way in which disabled (and non-disabled) people can affirm and express their sexuality" (Fritsch et al., 2016, p. 89). However, the simultaneous criminalization of sex work, alongside the transinstitutionalization of disability prevents these affirming possibilities.

Importantly, "Supporting Sexual Health and Intimacy in Care Facilities: Guidelines for Supporting Adults Living in Long-Term Care Facilities and Group Homes in British Columbia, Canada" offers insights into the legal and ethical responsibilities of institutions in providing sexual supports. The guidelines<sup>59</sup> introduce the provision of sexual supports as a responsibility of institutions so long as they are legal (VCHA, 2009,

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<sup>58</sup> This right is enshrined in the *Long Term Care Home Act* "Residents' Bill of Right"s, "Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy" (2007).

<sup>59</sup> The guidelines emerged from a partnership between Public Health Canada, the BC Ministry of Health and Vancouver Coastal Health Authority (VCHA).

p.10). The guidelines classify sexual support as: 1) assisting with sexual activity; 2) obtaining sexual materials; and 3) “supporting residents to access paid sex work” (VCHA, 2009, p.13). However, the guidelines have not been updated to reflect the changes to the criminalization of sex work in 2014 (*PCEPA*, 2014). Based on the guidelines necessitation of legality in providing sexual supports, institutions would no longer be able to support residents in accessing paid sex work.

The present policy context for sex work in Canada is criminalization-based. In 2013, the *Attorney General v. Bedford* ruling found that provisions in the *Criminal Code* which previously criminalized sex work<sup>60</sup> were unconstitutional. The Conservative government quickly responded to this ruling by enacting *PCEPA* (2014). This new legislation amended the *Criminal Code* (1984) to criminalize purchasing sex (2004, c.15, s.108, 11.(2)), communicating with the intention to purchase sexual services (R.S., c. 51, s.286.1(1)), advertising sexual services (s. 164.8), and third party involvement (2010, c. 3, s.3, 279.02(1)).<sup>61</sup> This legislation is consistent with the Nordic Model of prostitution, which has become popularized in high income countries over the last decade (Vuolajärvi, 2019). The policy goal of this approach to sex work is the complete elimination of the industry, rooted in the belief that “exploitation is inherent in prostitution” (*PCEPA*, 2014, preamble).

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<sup>60</sup> For a full analysis of the Bedford ruling see C. Bruckert & Hannem, (2013); Craig, (2011); Hudson & van der Meulen, (2013).

<sup>61</sup> For a more fulsome policy context see: Durisin et al., 2018; Lam, 2018; van der Meulen & Durisin, 2008)

Sex worker collectives (Bruckert & Chabot, 2010) and their allies (Pivot Legal, 2015) were quick to condemn this legislation, recognizing that sex work is not inherently exploitative (CASWLR, 2015). The primary impacts of the legislation on sex workers are the increased risk of violence, harm and the inability to exercise charter protected rights including the freedom of association and expression (CASWLR, 2015; Pivot Legal, 2015; van der Meulen & Durisin, 2018).<sup>62</sup>

The policy practice of *PCEPA* has significantly impacted safety and wellbeing of body rub parlours and sex workers. Following *PCEPA*, access to health and community services by sex workers decreased by 40% (Argento et al., 2020). This is particularly true for migrant sex workers who fear criminalization and deportation when interacting with the health care system (Argento et al., 2019; Lam, 2018). Reduced access to health care post-*PCEPA* occurs alongside problematic criminalization of harm reduction supplies and strategies (Lam, 2018). Indoor sex workers have reported that they are not allowed to have safer sex supplies such as condoms within the establishment, as they can legitimize arrest or fines (Lam, 2018). An interviewee in Lam's (2016) study explained:

“In addressing HIV/Aids prevention, the barrier - which is very strong - is the criminalization of condoms. ...If condoms are found by the police or the municipal bylaw enforcement officer, as evidence of sex work, it means that only condoms in massage parlours are criminalized... So, outside the massage parlours, condoms are perfectly legal; inside the massage parlours, they are illegal... That is shocking to everybody...”

The criminalization of condoms within indoor sex workspaces places workers at risk of HIV/AIDS, hepatitis and other sexually transmitted infections (Goldenberg et al.,

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<sup>62</sup> In February 2020, the Ontario Court of Appeals found that laws under *PCEPA* were found unconstitutional (Pivot, 2020).

2015). Migrant sex workers are most often the target of police and RCMP raids (Lam, 2018). This targeting is often justified by the police and RCMP as a rescue mission for exploited people. Butterfly, an alliance of Asian and migrant sex workers condemns this assumption noting that instead of protecting vulnerable people, *PCEPA* (2014) places migrant workers at increased risk for violence and death, while limiting their ability to access justice and health care (Zippay & Thompson, 2007).

Alongside the criminalization of migrant workers, people who purchase sex became criminalized for the first time through *PCEPA* (2014). The legislation assigns the role of predator to all people who purchase sexual services (Ministry of Justice, 2014). This criminalizes disabled people who require sexual supports provided by sex workers. This entanglement of criminalization of both disabled people and sex workers makes evident the need for coalitional politics demanding decriminalization of sex work (Fritsch et al., 2016).

While *PCEPA* (2014) is a federal policy, it is largely operationalized through municipal regulations (van der Meulen & Durisin, 2018). Municipalities equipped with licensing, zoning codes, and bylaws bring the policies of *PCEPA* into practice. Police, bylaw officers and social service administrators are the street-level bureaucrats responsible for enforcing this criminalization. Through the next chapter I use the City of Ottawa as a case study to analyze the role of municipal policy and *PCEPA*.

### **2.3 Policy Gaps**

The prevalence of policies that limit and criminalize sexuality are in stark contrast to the lack of policies supporting sexuality. There is a persistent absence of formal policy frameworks regarding sexual support and facilitation for disabled people. Policy studies

(Pal et al., 2021) affirm that policy gaps, or inaction, are indeed active responses. This policy gap is motivated, in part, by the ongoing societal desexualization of disabled people (Shakespeare et al., 1996). Such inaction enforces the need for political action demanding change.

There are no provincial policies regarding the provision of sexual support by attendants or PSWs for disabled people (Silverberg & Odette, 2011). Many disabled people require assistance with activities of daily life.<sup>63</sup> Assistance comes in various forms—a wheelchair for mobility, medication, a grabber for retrieving hard to reach items, an attendant to help with dressing (Fritsch, 2010). While these forms of assistance are covered by government programs, they do not include access to sexual support services. Sexual supports<sup>64</sup> consist of various activities relating to the needs of disabled people to access sexual culture (Earle, 1999; Shakespeare et al., 1996; Siebers, 2012; Silverberg et al., 2016).

This policy gap places the onus on individuals to engage in conversations about sexuality, which can be difficult given the power dynamics within user/provider relationships (Kulick & Rydstrom, 2015; Odette & Silverberg, 2011). Both disabled people and personal support workers (PSWs) exist along lines of marginalization. Personal support work is a precarious and underpaid job, and PSWs are predominantly racialized women (Baines & Armstrong, 2019; Berta et al., 2018; Zeytinoglu et al., 2017). The precarity of work alongside a lack of sexuality-specific policy puts both

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<sup>63</sup> Activities of daily life (ADLs) include eating, bathing and cleaning, and are what are considered essential to independent living (Katz, 1950).

<sup>64</sup> These categorized by Bahner (2019) as: 1) preparing for sex; 2) assistance during sex; 3) post-sexual support; 4) contextual assistance.

attendants and disabled people at an increased risk of sexual harassment, abuse, and discrimination (Odette & Silverberg, 2011; Kelly, 2015). The rights and needs of service users and service providers are often presented as diametrically opposed rather than interconnected (Bahner, 2019; Kelly, 2015; Odette & Silverberg, 2011). Both users and providers benefit from clear policies that outline the rights of both users and providers. Clear policies remove the individual burden of navigating discussions about sexuality and supports (Earle, 1999).

## **2.4 Conclusion**

The ongoing transinstitutionalization of disabled people and criminalization of sex work limit the autonomy and sexual expression of both sex workers and disabled people. These systems demonstrate the role of carceral systems in controlling the lives of disabled people and sex workers. The use of restraints enforced poverty, and surveillance systems within institutions reinforce the carcerality of these settings, and the need for deinstitutionalization. Moreover, this demonstrates the ongoing policy legacy of institutions limiting and controlling access to sexuality for disabled people. Alongside the challenges of transinstitutionalization, criminalization of sex work presents a barrier to the generative “bonds of solidarity” between sex workers and disabled people.

Persistent sexuality policy gaps have been identified for at least twenty years (Shapiro, 2002). Yet, simply developing sexuality policies within institutions will not guarantee sexual freedom for disabled people. Regardless of the particularities of the policy, transinstitutionalization will continue to prohibit access to sexuality.

Deinstitutionalization of disabled people and decriminalization of sex work are the only paths forward.

## **Chapter 3: Erogenous Zones and Bylaws: The Municipal Regulation of Sexuality**

What do strip clubs and group homes have in common? More than you might think. Ontario municipalities have been given increasing responsibility over the past 30 years, resulting in an increasing role in the citizen-making power of “street level bureaucrats.” The term “street level bureaucrats” refers to service providers and frontline governmental officials given the role of interpreting policy and then implementing those policy interpretations at ground level. The actions a police officer chooses to take in each situation, for example, are “street level bureaucratic” interpretations of policy. Neoliberalism has resulted in municipalities having increased responsibilities for social service provision and regulation. Municipalities have shifted these responsibilities onto largely non-governmental street-level bureaucrats (Lipsky, 1980). For disabled people who use social services regulated by municipalities, their sexual access is regulated by private security guards, shelter workers, bylaw officers, and group home workers among others.

Municipal policies collectively impact disabled people, sex workers, dancers, and housing insecure people. Using the frameworks of Disability Justice, Critical Disability Studies and Critical Carceral Studies, I perform critical policy analysis on municipal zoning codes and bylaws to examine the regulation of sexuality and disability. Through

this chapter I examine two forms of municipal regulations that impact sex workers and disabled people: minimum separation distance (MSD) and surveillance policies.

MSDs are a form of spatial regulation that prohibit the concentration of certain types of businesses by imposing minimum distances between two businesses. Disabled people and people working in the sex industry disproportionately experience this form of regulation (Appendix D). This is evidenced by the use of MSDs to spatially regulate adult entertainment parlours (AEPs), body rub parlours, emergency shelters and group homes (Finkler & Grant, 2011; Ranasinghe & Valverde, 2006; van der Meulen & Valverde, 2013). Along with the use of MSDs, surveillance within municipalities is a growing trend. Through the last chapter I examined surveillance policies impacting disabled people. I continue this examination of surveillance policies by analyzing the City of Ottawa's implementation of surveillance policies for indoor sex work establishments (Lam, 2016, 2018; van der Meulen & Valverde, 2013).

Municipalities serve as an important site to investigate regulation of labelled populations. While municipal codes vary, there are patterns in regulatory regimes across Canada.<sup>65</sup> In 2019, the City of Ottawa changed its slogan to “All of Canada in One City,” seamlessly tying together the role of national mythmaking and the capital city (CBC News, 2019b). Julie Tomiak, who has done extensive research on the settler-colonial construction of Ottawa, argues that “Settler colonial city-making takes on heightened significance in the context of the national capital. As the capital, the City of Ottawa has

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<sup>65</sup> See for example, Toronto body rub parlour regulations (Lam, 2017), Vancouver regulations (City of Vancouver, License By Law No. 4450), Manitoba group home policies (New Directions, 2015).

been constructed as the centre within the socio-spatial scaffolding of formal political power in the Canadian nation-state” (Tomiak, 2016, p.10). While this slogan is new, it draws upon historical understandings of Ottawa as representative of Canada<sup>66</sup>, despite the vast regional diversity, distinct Indigenous nations and linguistic diversity of the country. National mythmaking is essential for settler colonial states to draw attention away from violent origins and ongoing inequities (Lodoen, 2019). Canada has desperately tried to distance itself from its settler roots, which had to be done “urgently, visibly and defensively” (Mackey, 1998, p.22) in order to control the national narrative. Canada seeks to market itself as a tolerant liberal society.

Disability is part of this marketing and mythmaking. Hutcheon and Lashewitz (2019) argue that white, physically fit, disabled men such as Terry Fox<sup>67</sup> “are used to elicit discourses of a ‘united’ Canada, exalting Anglo-Canadian ways of life including superior tolerance of disability” (2019, p.11). Meanwhile, many disabled people<sup>68</sup> have been forcibly invisibilized from Canadian urban centres (Dyck, 2015; Hutcheon & Lashewitz, 2019; McLaren, 1990).

As the national capital of a settler colonial state, Ottawa has a significant stake in national mythmaking. In many ways, the city could be understood as the shimmering façade of the rest of Canada—a city that spends millions of dollars on the maintenance of parks and landmarks, while still in land claim negotiations with the custodians of the

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<sup>66</sup> As mobilized contemporarily by the usage of “Ottawa” as a synonym for federal government.

<sup>67</sup> Nowhere is Terry Fox more visible than Ottawa- his bronze statue looks out onto Parliament Hill.

<sup>68</sup> Primarily intellectual/developmental disabilities.

land, the Algonquins of Ontario.<sup>69</sup> Ottawa is also a leader in various municipal policy trends, including urban sprawl, amalgamation, and city council composition.

### **3.1 Policy Context: Amalgamate and Privatize**

Municipalities have increasingly absorbed the role of social services (Fanelli, 2014). Throughout the 1990s, the Mulroney and Chretien governments downloaded responsibilities such as social housing onto the provinces (Ranasinghe & Valverde, 2006). Compounding this federal move, Ontario's Conservative Harris government took power from 1995-2003; this government set the course for neoliberalism in Ontario, part of which was the process of amalgamating municipalities<sup>70</sup> (Sancton, 2000).

Amalgamation became popular in the 1990s with a rationale of cost cutting, smaller government and less competition between municipalities (Rosenfeld & Reese, 2003).

Amalgamation was mandated by the Harris government in 1999 when the region was given 90 days to come up with a restructuring plan (Sancton, 2000). A Harris appointee recommended that the 12 cities in the Ottawa-Carleton region merge into a single megacity (Rosenfeld & Reese, 2003). This amalgamation resulted in Ottawa becoming the largest geographic city in Canada occupying 400% more land than Toronto, despite having roughly one third of the population (City of Ottawa, 2018; City of Toronto, 2017)).

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<sup>69</sup> The city itself was an important meeting and trading place for Indigenous nations as the Gatineau, Ottawa and Rideau rivers meet there. This land claim settlement would be the largest in Ontario. However, the province has tried to split the claim along the Quebec border.

<sup>70</sup> The amalgamation of municipalities resulted in a loss of nearly half the municipalities, more than half the city councilors, and more than half the school board trustees.

Following the decision to amalgamate the Ottawa-Carleton region, the Harris government appointed a transition team. The team was primarily composed of accountants and included only one member of a local government (Reese & Rosenfeld, 2003).<sup>71</sup> The transition team appointed the whole suite of new senior officials, including the city manager. Referred to as the “Gang of Seven” (Reese & Rosenfeld, 2016) the team made unilateral decisions not usually placed in unelected hands. While local governments were removed from the process, businesses were involved in the restructuring, as the new municipal arrangement hoped to have a more intimate connection with the business community (Baxter, 2010). The cost of the amalgamation was justified by significant cuts to social services, and residents were recommended to “adjust their expectations regarding service responsiveness” (Raymond & Reese, 2003). Despite the slashing of many services, the amalgamation was beneficial to the Ottawa Police Service. The amalgamation resulted in an increase in the police budget, complete with larger salaries, increased spending on weapons and technology, and reduced regulations (Kiedrowski, 2016).

At the same time the Harris government was making financial cuts to municipal governments, they downloaded responsibilities for “social services, public school services, non-profit housing, roads, public infrastructure, long-term healthcare, childcare, shelters, children’s aid societies, ambulance, fire and police services, waste collection, as well as public health and transportation” (Fanelli, 2014, p.11) onto municipalities. This

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<sup>71</sup> The appointed member was from Gloucester, a mostly white suburban area that was already committed to smaller government and lower taxes.

shift gave municipalities an increased responsibility in service provision for disabled people, placing institutions and housing provisions for disabled people under their purview.

The City of Ottawa is now responsible for administering and regulating sites of disability including long-term care institutions, group homes, rooming houses, domiciliary hostels, supportive housing, emergency shelters, and halfway houses (See Appendix A) (Fanelli, 2014). While regulated and administered by the City, transinstitutional sites are increasingly operated by private and not-for-profit organizations.

Municipalities do not have the ability to regulate relationships or personal acts. Municipal power instead rests in the ability to regulate both private and public property (van der Meulen & Valverde, 2013). Municipalities can amend and create zoning codes, and assess licensing fees, all of which allow for the enforcement of spatial regulation and the funding of police and policing efforts (Ottawa Municipal Code, 2020). Disability scholars (Finkler, 2013), Critical Carceral Studies Scholars (Bruckert & Dufresne, 2002; van der Meulen & Valverde, 2013; van der Meulen & Durisin, 2008) and urban studies scholars (Agrawal, 2012; Finkler & Grant, 2011) have studied the use of municipal regulation to police deviant populations. However, the fields have failed to recognize the interconnection in common policy tools used by municipalities. Therefore, this chapter makes an important contribution to Critical Disability Studies, Critical Carceral Studies and Disability Justice. These interconnections are important in the building of cross-movement solidarity to oppose such regulatory efforts. Through this chapter I consider

municipal policy tools that simultaneously contribute to the transinstitutionalization of disabled people, and the ongoing violence against sex workers.

These shared policy tools are imperative to investigate because of their direct impact on the lives of people who experience multiple forms of marginalization. Disabled, sex working, and housing insecure populations are at the nexus of marginalization often reinforced by the state. Disabled, sex working, and housing insecure populations commonly meet at the intersections of racialization, precarious immigration status, gender divergence, and substance use. Group homes, emergency shelters, adult entertainment parlours (AEPs) and body rub parlours are all subject to municipal regulation, street level bureaucrats and moral discourse (Bruckert & Dufresne, 2002; Law, 2015).

### ***3.1.1 The Measuring Tape: Minimum Separation Distances***

A connecting fibre of municipal regulation is the use of Minimum Separation Distances (MSD) by the City of Ottawa to deter disability housing and sex industry establishments. MSD is a planning tool used by municipalities to enforce a minimum distance between two of the same types of property<sup>72</sup>, or between one type of property, such as an AEP, and another type of facility, such as a school. Shelters, group homes, AEPs and body rub parlours are all subject to MSD in the Municipality of Ottawa. MSDs are an exclusionary planning tool, often used to shift unwanted populations out of areas they are believed to be over-congregated in. Specifically, as municipalities are not allowed to create bylaws forbidding certain people from areas, they instead target the

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<sup>72</sup> While originally used for agricultural odours, it quickly expanded into urban areas (Finkler, 2013).

property, as a form of technical loophole for municipalities to continue discriminatory bylaws (van der Meulen & Durisin, 2013). This loophole is known to municipalities, including a former Ottawa city manager who argued for MSDs stating that “While zoning cannot regulate behaviour, it can regulate land uses” (Schepers, 2008).

MSDs have been used as a method of exclusionary zoning practices, which have directly impacted the lives of disabled people and sex workers. The use of MSDs for supportive housing and group homes has had several impacts: 1) intensified the spatial isolation<sup>73</sup> of disabled people and 2) resulted in undue delays in the creation of housing for disabled adults. Along with the impacts on disabled populations, these regulations adversely impact sex workers by 1) impacting the safety of sex workers (van der Meulen & Durisin, 2013) and; 2) contributing to the decline of regulated sex work (Hayes, 2018).

The Province of Ontario was initially supportive of the deinstitutionalization movement and the development of group homes. In 1978, the province began the “Interministerial Working Group for the Mentally Handicapped”, which outlined the role of municipalities in creating bylaws and zoning ordinances (O’Mara, 1982). The outcome of these meetings resulted in a report entitled *Challenges and Opportunities: Community Living for persons with Developmental Handicaps*, which outlined the use of “minimum separation distances” between group homes, and a maximum number of persons in group homes per zoning area (Interministerial working group on group homes, 1978). These

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<sup>73</sup> Spatial isolation refers to geographic concentration of marginalized populations in more hidden and isolated spaces (Deering et al., 2014).

policy recommendations were an attempt to balance public backlash against group homes with the need for alternative housing (Association of Municipalities of Ontario, 1981).

Following this report, the *White Paper on the Planning Act* (1978) maintained that municipalities should be responsible for regulations and policy relating to group homes (Hitchcock, 1980). The belief was that an umbrella provincial policy could potentially isolate municipalities that were opposed to group homes. This gave oppositional municipalities the freedom to determine their own bylaws (Association of Municipalities of Ontario, 1981). As large residential institutions had been intentionally located outside of large municipalities, urban neighborhoods felt threatened by the sudden influx of disabled people migrating to urban centres. Finkler & Grant (2011) interviewed Ontario city planners responsible for MSDs who claimed they were focused on “integration, not over-concentration”, and preventing ghettoization (Dear & Laws, 1986).

This fear of over-concentration was both ableist and classist. Schwartz (1984) summarized the concerns raised by Mississauga residents in a 1984 Ontario Municipal Board hearing. The primary concerns were fear of violence, but others raised concerns including “I don’t want to live on R\*tard Row”, “I don’t want [my child] to be subjected to their kind”, “male and female residents would be cavorting nude on the front lawn” (Schwartz, 1984, A16). At the time, there was much media focus on the neighbourhood of Parkdale, in Toronto (Whitzman & Slater, 2006). Following the closure of the Queen

Street Asylum<sup>74</sup> near the neighbourhood of Parkdale, survivors of institutionalization sought affordable living, and remained in the network of South Parkdale, which had large numbers of rooming houses, and 39 licensed group homes (Slater, 2004). Residents and businesses of Parkdale formed an opposition<sup>75</sup> to the increase in disabled residents, protesting the supposed “social service ghetto” (Whitzman & Slater, 2006). Parkdale was the frontline of deinstitutionalization, and subsequent exclusionary zoning laws cited Parkdale to illustrate the risk of deinstitutionalization (O’Mara, 1981)

The development of group homes was stalled in municipalities such as Ottawa, Gloucester, and Vanier. These municipalities responded to the development of group homes by evoking not-in-my-backyard-ism sentiments to prevent the creation of group homes (Finkler & Grant, 2011). This had previously been a successful tactic in the 1950s, to prevent the construction of housing developments primarily occupied by racialized people (Ontario Human Rights Commission, 2009). Throughout the 1980s in Ontario, both concerned citizens and elected officials protested the proposed development of group homes (Agrawal, 2012). At one council meeting, a Peel city councilor argued against the construction of group homes, proclaiming "It's not a sin to protect your residents” (Finkler & Grant, 2011; O’Mara, 1981).

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<sup>74</sup> Originally the Provincial Lunatic Asylum, it was renamed the Asylum for the Insane in 1871, then the Hospital for the Insane in 1905, followed by the Ontario Hospital, Toronto in 1919, the Queen Street Mental Health Centre in 1996 and today it is called the Centre for Addiction and Mental Health (CAMH) (Abbas & Voronka, 2014). While the Asylum was deinstitutionalized, today there are 235 inpatient beds and they operate multiple community living projects. For an expansive history of the Asylum, see Geoffrey Reaume’s *Remembrance of Patients’ Past*, 2012.

<sup>75</sup> This opposition has been maintained to the present day, as Parkdale remains a site of immense gentrification. In the 1990s, the city invested \$600 000 in tearing down affordable housing in Parkdale. In the 2000s, the city sought to transform Parkdale from “ghetto” to “village” by banning multi-unit dwellings and implementing sweeping gentrification policy (Slater, 2004).

The Association of Ontario Municipalities brought forward two major concerns about the creation of group homes: 1) the impact on property values, and 2) the safety of the “family”, and particularly the child” (Association of Ontario Municipalities, 1981). However, studies have persistently found that property values are not affected by group home development in neighbourhoods (CitySpaces Consulting, 1995; Interministerial Working Group; 1981). Regardless of the results of the studies, the employment of NIMBYism, ableism and classism tactics were successful in passing exclusionary zoning policies.

MSDs have been used to prevent the “over-concentration” of disabled people, through an enforced spatial dispersion across municipalities (Finkler & Grant, 2011). This has meant that construction and development of new group homes has had to be part of the growing urban sprawl in Ottawa (CBC News, 2011). The benefit of centrally located group homes is their proximity to social services and access to transit. The dispersal of group homes is additionally problematic given the barriers among the current transit system in Ottawa, as access to transport is crucial for independent living, health care and economic and social integration (CBC News, 2019a). Para Transpo is the public transit service operated by the City of Ottawa and OCTranspo, that provides service for disabled people who are unable to use buses and the O-Train (OC Transpo, 2020). Para Transpo has repeatedly been an issue of concern for Ottawa residents. Mismanagement and budgetary constraints have resulted in increased trip cancellations, deliberate understaffing and barriers to entry and the booking system (CBC News, 2019a). MSDs displace disabled people, and limited access to transportation only causes further isolation.

Similarly, MSDs spatially isolate sex workers and dancers. Throughout the *Bedford v. Canada* (2010) case, Justice Himmelman recognized that location of work had a significant impact on the safety and wellbeing of sex workers. Justice Himmelman found that “factors that may enhance the safety of a prostitute include being in close proximity to people who can intervene if needed” (*Canada v. Bedford*, 2010). As there are already three AEPs in downtown Ottawa, any proposed new location would be forced to be pushed to the edge of the city. The safety of sex workers is negatively impacted by spatial regulations which force AEPs and body rub parlours to the city limits.

Spatial regulation used to target marginalized populations extends beyond the disability sector. Along with the contemporary spaces of disability, the sexual industry is subject to municipal regulation. Some areas of the sex industry, such as street-based sex work, are regulated by police. However, AEPs and body rub parlours have licensing and zoning specificities outlined in the municipal code. AEPs and body rub parlours are subject to the same spatial regulation under the shared term of “adult entertainment facility”, while being subject to separate licensing terms as per their distinct operations.

AEPs present an important space for analysis as “they are also the product and focus of dynamic social and legal processes including judicial regulatory practices and moral discourses. This complex location provides a particularly rich space to see governmental tactics” (Bruckert & Dufresne, 2002, p. 69). Currently Ottawa has licensed 9 locations to be AEPs, but only 3 remain open. AEPs have been subject to municipal regulation over the past 50 years.

Several court rulings<sup>76</sup> in the early 1970s set the stage for development of AEPs (Bruckert & Dufresne, 2002). In 1970, the Playmate Club became the first AEP built in Ottawa<sup>77</sup>(Bruckert & Dufresne, 2002). NIMBYism began a new battle against the development of AEPs in suburban areas (Bruckert & Dufresne, 2002; Valverde, 2008). Throughout the 1980s neighborhoods and their city councilors began mobilizing against the development of AEPs (Buckert & Dufresne, 2002).

A criminal court ruling found that municipalities could not impose an outright ban on AEPs (Buckert & Dufresne, 2002). However, they could put a cap on the number permitted in the city. Those same municipalities<sup>78</sup> that limited the number of group homes to one also limited AEPs to one (Bruckert & Dufresne, 2002; O'Mara, 1981). Following a ruling that permitted lap dances in strip clubs, Premier Mike Harris gave advice similar to municipalities about AEPs that was given about group homes "there may be other mechanisms available to municipalities and we're certainly not discouraging those." (Meaghan, 2000). With Harris' encouragement, municipalities began imposing MSDs for AEPs.

Along with AEPs, body rub parlours also experience municipal regulation. Body rub parlours are one of few sites of regulated indoor sex work. Indoor sex work has been found to be both safer and more prevalent than street-based sex work even amidst criminalization (Goldenberg et al., 2015). Public health studies have repeatedly found

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<sup>76</sup> The *Johnson v. R* ruling allowed women to be publicly nude, while another ruling gave AEPs the right to serve liquor.

<sup>77</sup> At the time, it was in the municipal enclave of Vanier. Vanier was amalgamated into Ottawa in 2001.

<sup>78</sup> Vanier, Gloucester, and Nepean.

that there is a “role of safer indoor sex work environments as venues for public health and violence prevention intervention” (Krusi et al., 2012).

Regulatory efforts against body rub parlours escalated in the early 2000s. Body rub parlours are defined in the municipal code as,

any premises or part thereof where a body-rub is performed, offered or solicited in pursuance of a trade, calling, business or occupation, but does not include any premises or part thereof where the body-rubs performed, offered or solicited are for the purpose of medical or therapeutic treatment and are performed or offered by persons otherwise duly qualified, licensed or registered so to do under the laws of the Province of Ontario. (Emergency and Protective Services Committee, 2005)

Municipalities maintain a “vener of ignorance” (van der Meulen & Durisin, 2013) to permit body rub parlours. They maintain this veneer by establishing legal parameters that parlours cannot provide sexual service, while recognizing that they will continue to provide sexual services. Body rub parlours have the potential to decrease violence to sex workers. Instead, current regulations enforce precarious labour.

Failed AEPs are largely located outside the urban centre. AEPs cannot be developed in the urban centre, as spatial regulations prevent AEPs from being within 500 metres of “residential use building, day care, place of worship, school, library, community centre, community health and resource centre or park, or any residential, institutional, open space or leisure zone” (Chiarelli, 2006). These regulatory efforts seek to steer clubs away from “‘inappropriate’ locations, inevitably pushing it towards less valued neighbourhoods” (Hubbard & Colosi, 2015). These inappropriate locations, according to the City of Ottawa, constitute the vast majority of the city. The locations deemed appropriate by the city for the development of body rub parlours and AEPs are the same places that put workers at risk.

Along with spatial isolation, MSDs have contributed to the reliance on larger forms of institutionalization, such as hospitals and residential service homes. The Ontario Human Rights Commission (OHRC) opposes the use of MSDs, and argue that they adversely impact the affordable housing stock by forcing supportive housing out of affordable neighborhoods (OHRC, 2011).

A tension for municipalities is that by creating discriminatory policies against permanent housing, they are reinforcing the need for temporary emergency housing such as shelters. The City of Ottawa recently ratified their 10-year “Housing and Homelessness Plan”, with a stated vision of decreasing homelessness by 25% (VanBuskirk, 2020). This plan emphasizes “inclusionary zoning”<sup>79</sup>, and seeks to increase the stock of affordable and supportive housing but makes no mention of the city’s exclusionary zoning policy.

The use of exclusionary zoning has challenged the stock of AEPs, despite a year over year increase in the US (IBISWorld, 2019). MSDs, along with other forms of punitive licensing<sup>80</sup> have resulted in the monopolization and near extinction of AEPs. A former AEP owner in downtown Toronto, Mr. Auger, explained part of the reason for the steep decline of the stripping industry, “If you take a map of the downtown area of the city and draw circles over every school, residential area and so on, and look for gaps ... that is where you can relocate...In the end, there are no areas available” (Hayes, 2018).

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<sup>79</sup>Inclusionary zoning is “a land use planning policy tool to create mixed-income developments in areas of the city where the market has not provided for a mix of housing prices and rents on its own” (City of Toronto, 2019).

<sup>80</sup> Along with MSDs, high licensing fees cause a barrier to entry for new AEPs.

This spatial regulation means that the three companies that can operate in the City of Ottawa form a monopoly. This monopoly is a result of the high barriers to entry which makes it difficult for new locations to open. Monopolies can result in wage stagnation because of the absence of competition (Covert, 2018). Along with wage stagnation, monopolies create conditions that allow for worse working conditions. For dancers, this means that if they are experiencing poor working conditions in one club, there are few alternatives. Moreover, dancers also face increased stigma entering the workforce outside of the sex industry (Bruckert, 2000). Monopolies enforce precarity for workers, allowing for wage stagnation, poor working conditions, and exploitation. The prevalence of monopolies in the AEP industry makes evident the need for evidence-based policy that supports dancers in accessing rights, fair wages and work conditions.

Sex work will continue to exist regardless of criminality (McBride et al., 2020). Presently, it is estimated that there are almost twice as many unlicensed body rub parlours as there are licensed parlours (Spalding, 2018). The prohibition of body rub parlours through both MSDs and caps have not resulted in a decrease in demand<sup>81</sup>, instead they increase the number of unregulated parlours. Evidence shows that attempts to regulate and criminalize sexual services through municipal licensing will not prevent sex work, but rather will force workers into more precarious, unsafe work environments (Anderson et al., 2015).

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<sup>81</sup> The Canadian criminalization regime for sex work seeks to end sex work through criminalizing demand of sex work as opposed to supply. This regime, called “end-demand” is used by municipalities by attempting to “limit” demand through minimizing the amount of indoor sex work that occurs.

The use of MSDs as a loophole to prevent the concentration of disabled people, housing insecure people, dancers and sex workers has faced growing resistance particularly in their application for group homes. This has resulted in the repeal of MSDs in Toronto, Kitchener, Hamilton, Sarnia, and Smith Falls, largely as a result of a settlement at the Human Rights Tribunal of Ontario with the Dream Team. The Dream Team is an organization of psychiatric consumers/survivors who advocate for increased access to supportive housing in Ontario. In 2010, the group filed human rights applications against the cities of Toronto, Sarnia, Kitchener and Smiths Falls with the Human Right Legal Support Team. Sarnia eliminated their MSDs for group homes following the application, and Kitchener followed suit two years later. Toronto was preparing to fight the Dream Team when a study deterred them. The study, submitted at the request of the City Solicitor's Office of Toronto,<sup>82</sup> concluded that it "...could not find a sound, accepted planning rationale behind the current definition and separation distance included for group homes in the City of Toronto's zoning by-law" (Agrawal, 2012). Resultantly the City of Toronto withdrew their challenge and removed MSDs for group homes. While the success in the four municipalities<sup>83</sup> resulted in the eliminations of MSDs from those municipalities, the pre-hearing settlements meant that other municipalities across Ontario, including Ottawa, would not be compelled to remove their MSDs.

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<sup>82</sup> "Opinion on the Provisions of Group Homes in the City-wide Zoning By-Law of the City of Toronto".

<sup>83</sup> And others, such as Hamilton, who responded to the potential case by removing their MSDs for group homes.

### 3.1.2 *The Magnifying Glass: Surveillance*

Through chapter 3, “*Sex, Surveillance and Criminalization*” I identify the pervasive use of surveillance across sites of disability confinement. Municipal surveillance policies are particularly focused on the regulation of the sexual industry. Presently, body rub parlour operators and workers must register for a license through the City of Ottawa, and present their identification, and a Police Records Check for the Service with the Vulnerable Sector (By-law No. 2002-189-20, 2008). This same policy was proposed for dancers working at AEPs during the changes to the bylaws and licensing following the *R V. Pelletier*, 2001 ruling, which determined that lap dancing was permitted. Dancers organized during the ruling and impending changes, forming the Dancers Equal Rights Association (DERA) (Bouclin, 2006). The organization of workers had a significant impact on the development of policy as DERA became stakeholders in the policy development process. The City proposed a license that would be required for dancers along with a criminal record check. DERA opposed this licensing regime asserting that it would make it difficult for dancers who had a criminal record, could ostracize dancers, and increase surveillance (Bouclin, 2006). The city agreed with DERA and struck that condition from the bylaws.

Conversely, when the Council discussed the bylaws and licensing of body rub parlours, there were no stakeholders representing workers (City of Ottawa, 2007). Lam’s (2016) study on the impact of licensing on Chinese sex workers in Toronto found that “the licensing regulations makes possible the harassment and abuse of sex workers and leaves workers unable to seek the protection from the police.” (p. 102). Presently, the bylaws and licensing aimed at preventing sexual services can exacerbate the harm caused

to workers (Lam, 2016). In Lam's 2016 study she identified several components of licensing that lead to direct harm to workers: the permission for bylaw officers and police to inspect the premises at any time, the inability to have safer sex supplies on site and the prevention of doors that lock. These harmful bylaws are prominent across municipalities in Canada, including the City of Ottawa.

The ongoing surveillance efforts of body rub parlours is evident in the 2015 Ottawa Police raids of local body rub parlours. The Canadian Border Services Agency (CBSA), Ottawa Police Service Human Trafficking Unit and Ottawa Bylaw Enforcement conducted raids of 20 parlours (McIntyre, 2015; National Post, 2015). The raids culminated in 11 bylaw fines and 11 arrests after 4 months of investigations into specifically Asian-owned body rub parlours. All 11 women were detained, and some faced immediate deportation (CBC News, 2015). Sex workers rights groups responded to the arrests noting that "Deporting the women is exactly what makes migrant sex workers vulnerable to violence and exploitation"(CBC News, 2015). Prior to the raids, the Ottawa Police Services Human Trafficking Unit was under review (Post Media, 2015). However, following the raids, Chief Bordeleau highlighted that "The priority (to extend the unit) should be pretty high" (McIntyre, 2015). It is challenging to map the growth of the Human Trafficking Unit, as Neighborhood Resource Teams have also been tasked with "responding to Human Trafficking issues"(Ottawa Police Service, 2020).

Surveillance of disabled people and sex workers in Ottawa came together in April 2019 following a shooting in front of the BareFAX Gentlemen's Club, in the ByWard Market (Spears, 2019). Ottawa Mayor Jim Watson responded to the shooting with a proposal for a widescale installation of CCTVs in the Market. This proposal came

despite abundant evidence from the UK and the US that demonstrates in the inability of CCTV to prevent violent crimes (Piza et al., 2019; Robin et al., 2020). The study that followed the proposal was endorsed by the Market BIA. In an interview, one member shared their belief that; “I actually think it will deter some of the people that we don’t really want down here” (Sali, 2019). The deterring of people that “they don’t want here” is a continued effort of the Market BIA, evident in their active efforts to erase sex workers, homeless people, disabled people and people who use drugs from the Market (Baxter, 2010; Business Improvement Area, 2020).

The highest concentration of beds is the Byward Market (The Market), where three homeless shelters have 449 beds, representing 69% of the total stock of emergency shelter beds (Statistics Canada, 2020). The Byward Market is one of Ottawa’s most popular tourist destinations, a result of its proximity to Parliament Hill, the densely packed bars and restaurants and the historical public market. It has thus been a vision for the City to transform “once derelict spaces that attracted mostly homeless people, into bustling centers of the district” (Project for Public Spaces, 2013).

Over the past 40 years, gentrification efforts have been underway in the Market, most notably with the introduction of The Byward Market Business Improvement Area<sup>84</sup> (BIA). All businesses located within the BIA become members of the BIA, creating a united stakeholder group for the commercial lobby. Throughout the late 1990s The Byward Market BIA began advocating for moving the homeless shelters out of The Market citing negative impact on property values and high incidences of crime (Baxter,

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<sup>84</sup> The Byward BIA is within Ward 12, the Rideau-Vanier Ward.

2010). While the plan failed, in 2006 the BIA joined the “Community Action Plan on Homelessness” with the support of the councilor for the area, Georges Bedard (Schepers, 2008). Councilor Bedard, with support of both the Ottawa Police Service (OPS) and the BIA, began a campaign against homelessness. Through this they called for a moratorium on social services in The Market, a decrease in bus shelters, and fines for public nuisance.<sup>85</sup> In 2008, the “Rideau-Vanier Ward 12 Interim Control Bylaw Study and Zoning Bylaw Amendment” made several<sup>86</sup> recommendations regarding emergency shelters that were subsequently implemented. This placed a limit on the number of shelters in the Rideau-Vanier Ward<sup>87</sup> and increased the MSD between shelters to 500m (Schepers, 2008). While these regulations targeted types of properties, councilor Bedard’s provocation that “These people are there because all the agencies they need are there, so why would they leave?” identifies the clear target of these policies (2006).

While the City of Ottawa has thus far refrained from the implementation of CCTV throughout the Market<sup>88</sup>, widescale surveillance is prevalent across the Market. The municipal downloading of the responsibilities onto not-for-profit actors has permitted the proliferation of surveillance and security systems. CCTVs are used by the four shelters congregated in the Byward Market, dotting their perimeter, and covering several floors, apart from sleeping quarters and washrooms (DeVerteuil, 2003; Lofstrand, 2015).

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<sup>85</sup> Supported by both the Byward Market BIA and the OPS would fine people \$300 for “loud, boisterous, threatening, abusive, insulting or indecent language” (Bedard, 2010).

<sup>86</sup> Ottawa Municipal Code, Bylaw 2008-250: Section 134.

<sup>87</sup> Given that there are four shelters in the Market, this prevents the development of additional shelters.

<sup>88</sup> The CCTV project was shifted from the City to the OPS in late 2019, with no new details emerging.

Along with an increase in CCTVs, the securitization of the Market has been a municipal response to issues of criminalization of drugs, poverty, lack of access to washrooms, and “negative behaviour” (BIA, 2017). Beginning in 1997, the Market BIA launched their Ambassador Program to bring additional security to the Market. Funded by the Canada Summer Jobs program<sup>89</sup>, six students are hired to serve as Ambassadors for the summer (Business Improvement Area, 2020). The Ambassadors categorize the people they interact with as either “clients” - housing insecure, disabled, and sex working Market residents, and “tourists” – assumed to be in the Market to consume. They further classify their interactions as “positive” or “negative” (BIA, 2017, p.12). “Negative” interactions constitute loitering, substance use, “disruptive behaviour” or “nuisance behaviour.” Negative interactions are responded to with a call to either the BIA private security<sup>90</sup>, foot patrol, or the police.

Despite an increasing presence and budget, year after year Ambassadors see an increase in the number of “negative behaviours”. The interactions with the Ambassadors are important to note, because as they state, “The clients (homeless) that the Ambassadors deal with in collaboration with Ottawa Police Service are often actively using drugs and/or have mental health issues that cannot be properly addressed without formal addiction services and/or mental health programs.” (BIA, 2017, p.23). The

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<sup>89</sup> A federal program focused on youth employment.

<sup>90</sup> The Market began using private security in 2017. They have retained private security guards ever since citing “an overall success”. Ambassadors cited security as positive, having it decreased their personal interaction with homeless “clients”, who resultantly had higher rates of interaction with the private security (BIA, 2017).

implementation of the BIA is part of a broader securitization of the Market area, which responds to disability punitively.

The increased securitization and surveillance of the Market deters the people who rely on the social services in the area. Moreover, this securitization ignores the importance and history of the area as a place where street-based sex workers have “peacefully co-existed with working class inhabitants of the Byward Market area for over 150 years”(Bruckert & Chabot, 2010). The use of surveillance and securitization deters the very communities who have called the Market home for generations. The Market is a space with a rich history of sex workers and dancers existing alongside social service users and shelter residents. Today it is home to one strip club, the only 24-hour supervised consumption site in the city, and the highest concentration of emergency shelters.

### **3.2 Conclusion**

As a result of neoliberalism, municipalities have an increased role in the lives of disabled, sex working, racialized and housing insecure populations. Ottawa’s claim to be “All of Canada in One City”, alongside the use of MSDs, surveillance and securitization illustrate the ongoing desire to erase disabled people, sex workers and racialized people from national mythmaking of Canada.

Municipalities’ ability to regulate property results in the creative employment of policy tools to geographically control populations. While academics have not positioned MSDs as intersections between sex workers and disabled people, policymakers certainly have. This is made evident by shared tactics of spatial regulation, and shared rhetoric denouncing “over-concentration”. In the last 20 years the use of spatial regulation

expanded to include group homes and strip clubs. This chapter demonstrates that these policies are possible to fight—the success of the Dream Team makes that evident. In Ottawa, disabled people, sex workers, and dancers must work together to create new policy regimes that support workers, provide greater autonomy and freedom. Solidarity between sex workers and disabled people is essential to successfully challenge policies that cause collective harm.

The possibility of generative municipal policy is made evident in Edmonton. Formerly, Edmonton used similar spatial regulation bylaws to curb demand for body rub parlours. But, beginning in 2015, the City shifted to a harm-reductionist approach to the sex industry. In doing so, workers had translation supports, access to public health workers, safer sex supplies, and licensing compliance grew to 95% of locations (Omstead, 2020). The successes of harm-reductionist approaches demonstrate the possibility and urgent need for the decriminalization of sex work; lives depend on it.

Group homes, emergency shelters, body rub parlours and AEPs experience municipal regulation that prevent further development. Group homes, emergency shelters and AEPs are contested sites partially resulting from the intertwinement of the state and private actors, and the institutional structure that they uphold. Given their contested nature, this brings us to the question, should we be developing more?

## **Chapter 4: Deinstitutionalization & Abolition**

The current climate of transinstitutionalization and criminalization demonstrates the clear need for change. Disabled people, particularly those labelled with intellectual/developmental disability and/or psychiatric disability experience persistent transinstitutionalization. The successes of the deinstitutionalization movement are not to be discounted. But carceral ableism is highly adaptable. It shifts to accommodate growing social and political demands for deinstitutionalization by producing a new system of publicly funded, privately operated institutions. Today, transinstitutionalization relies on a large system of both privately operated, for-profit, and not-for-profit actors. Persistent governmental investment in institutions contradicts decades of evidence and best practice frameworks that prove the failure and risk of institutional settings. Institutional settings enforce poverty, segregation, and the confinement of disabled people. Transinstitutionalization relies on neoliberal disasters—the housing crisis, enforced poverty and a failed social safety net to coerce disabled people into living in institutional settings.

The decades of development of these new systems of institutionalization have not been met with critique, resistance, or beneficial research. Take for instance domiciliary hostels; one of the largest yet least researched forms of warehousing disabled people in Ontario. More than 1,200 disabled people live in these institutions in Ottawa alone (Linton et al., 2021). More than 1, 200 people are administered \$149/month in social assistance by their landlord (Linton et al., 2021). Hundreds of people live in cramped

bedrooms shared with 3 strangers, a meter apart. Over a thousand people share bathrooms with more than 10 people, some with up to 150 people (Linton et al., 2021).

Policies of institutionalization kill disabled people. This is particularly concerning amidst the passage of Bill C-7, which expanded access to Medical Assistance in Dying for disabled people, regardless of proximity to death (Beaudry, 2020). For instance, Truchon, a transinstitutionalized disabled man, explained his rationale in seeking medical assistance in dying<sup>91</sup> by summarizing his daily life in a long-term care facility:

[TRANSLATION] “They come to give me my pills at 8:00 a.m. I eat breakfast around 9:00 a.m. I am given 15 minutes to digest. After that, I try to catch someone as they are going down the hall to lower the head of my bed and my feet too. After that, they roll me onto my side because it’s more comfortable for me and there’s less pain. Now it’s 11:00 a.m. They get me up, get me dressed, and put me in my armchair. At noon, they feed me.” (Truchon c. Procureur général du Canada, 2019).

Transinstitutionalization and criminalization accelerate “slow death”—indicated by higher premature mortality and higher proportion of comorbidities (Berlant, 2007). So, what is the alternative to transinstitutionalization? Through this chapter, I reflect on the contributions of this research, and the possibilities of coalitional abolitionist movements.

This project began with a desire to answer the question—where do disabled people live in Ontario? To answer this question, I recognized the necessity of understanding the lived and material conditions of disabled people (Shakespeare et al., 1996). In doing so, I asked a second question—what policies are impacting disabled people’s access to sexuality in Ontario? The answer was not clear from government data,

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<sup>91</sup> Institutionalization has been a factor in several concerning Medical Assistance in Dying cases, for more information see Inclusion Canada’s “Cases of Concern” (2021).

academic literature, or stakeholder groups. Stubbornly, I was determined to construct a typology of the expansive system of transinstitutionalization in Ontario. I read together the carceral, geriatric, developmental, psychiatric, forensic psychiatric and homelessness systems to understand the ecosystem of disability services. These experiences of transinstitutionalization need to be read together, as disabled people are indiscriminately shuffled against them (Dubé, 2016; Sylph et al., 1979).

Through this research, I identified transinstitutionalization and criminalization as prohibitive policy regimes preventing access to sexuality for disabled people and sex workers. These policy regimes limit access to desire and pleasure by controlling access to privacy, surveillance, and segregation. Privacy itself has been privatized through the commodification of housing and healthcare. Surveillance within these institutions further jeopardizes access to privacy. Surveillance is rationalized by protectionism and paternalism, both of which put disabled people and sex workers at higher risk for violence and abuse.

Applying the frameworks developed in the first three chapters, I interrogate sexuality for disabled people in Ottawa, Canada. National capitals have historically served as sites of national mythmaking. Canadian mythmaking has long relied on the erasure and invisibilization of populations deemed undesirable—including sex workers and disabled people. Historically, institutionalization was a beneficial tool in this erasure. Contemporarily, sex workers and disabled people are displaced within the nation's capital through minimum separation distance policies. Today, the development of AEPs and group homes is pushed outside the city. This spatial regulation serves to segregate sex workers and disabled people and place them at higher risk of violence and abuse.

More than 150 years of reforms in institutional settings makes explicit the fact that reform of carceral, institutional settings is not possible. We do not need alternatives to institutionalization that maintain carceral logic. In reflecting on the deinstitutionalization movement Ben-Moshe (2020) argues that “abolition is not an alternative, and neither were deinstitutionalization or antipsychiatry” (p.283). Abolition is not an alternative; it is a radical new path forward. Ben-Moshe argues, is a “project of building”, an “ethical commitment”, and a demand for coalitional organizing (Ben-Moshe, 2020, p. 283). Disabled communities are already building abolitionist futures (Piepzna-Samarasinha, 2018). Further research is required into the potential for deinstitutionalization as opposed to reforms of the current system. This demands academic and financial investments towards the abolition of institutions (Abolition and Disability Justice Coalition, 2020).

#### **4.1 Towards Abolition**

The conditions of confinement documented throughout this research has haunted me as a disabled person. Endless articles document abuse, fires, neglect, infestations, malnourishment, and financial abuse across institutions in this province. Unearthing these records of abuse, confinement, and neglect as COVID-19 ravaged these settings made apparent the urgency of this work. Recognizing this urgency, I contacted an endless stream of researchers, stakeholder groups, departments, politicians, and civil servants in vain. I was desperate to find other people who simply knew about the presence of these institutions.

Eventually, it became obvious that I had to stop asking if anyone knew about the systems of transinstitutionalization. I had to begin the process of making explicit this

process of transinstitutionalization. I focused my efforts on domiciliary hostels and Homes for Special Care, which are at particular risk for COVID-19<sup>92</sup> (Landes et al., 2020; Linton et al., 2021). I presented this research to stakeholders responsible for vaccine rollout, public health units and multiple levels of government. I shared this research across civil society, focusing on abolitionist coalitions, disability stakeholders, mutual aid networks and grassroots movements. Together, the Disability Justice Network of Ontario, the Criminalization and Punishment Education Project, the Abolition Coalition and local grassroots campaigns supported me in hosting a press conference to demand vaccine access and deinstitutionalization (Tunney, 2021).

The answer to the question of where disabled people live in Ontario still demands answers. I still do not know how many disabled people are institutionalized in Ontario. I still do not know how many institutions exist across the province. I have begun the long and arduous process of counting the number of disabled people and institutions across the province. Fortunately, I am not doing this work alone. Working together with the “COVID-19 Tracing COVID-19 Data Project” (Lauriault, 2021) and civil society organizations, we have facilitated more than ten hackathons. These hackathons harness tools of Open Science<sup>93</sup> to develop a database of domiciliary hostels in Ontario (Lauriault, 2021). These data and their story were broadcast across the country through dozens of media interviews, blog posts, articles, and panels.

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<sup>92</sup> These institutions are at higher risk for COVID-19 given their density, size, and population.

<sup>93</sup> Open science harnesses citizen power to both answer scientific inquiry and to make “transparent, accessible, reliable, trusted and reproducible science” (Hunter & Lauriault, 2020).

Institutionalization never becomes an easier story to tell. The most difficult part of this journey was sharing with disabled people, institutional survivors, and their communities. I have been told I have ruined people's days, weeks, and months with this information. And it has, it has ruined many days and weeks for me. The reality of institutionalization across this country is devastating.

This devastation is not in isolation; the crisis of capitalism, colonialism and confinement have culminated in a global movement towards social change and justice. The endless work of Black and Indigenous peoples has brought calls to defund the police and decarcerate prisons to the mainstream. The movement for abolition is invigorated, engaged, and growing. Hundreds of organizations across Turtle Island signed onto "Choosing Real Safety: A Historic Declaration To Divest From Policing And Prisons And Build Safer Communities For All" (Anti-Carceral Group et al., 2021). The Declaration uses a "three-prong approach: Defund/Dismantle/Build" (Anti-Carceral Group et al., 2021). Focusing on 1) defunding police and the carceral system; 2) dismantling carceral systems and their involvement with social services; 3) building alternatives through investing in community and returning land and sovereignty to Indigenous peoples (Anti-Carceral Group et al., 2021). This firmly abolitionist approach makes both short-term and long-term goals towards building communities of care. The abolitionist movement provides generative opportunities to dismantle all forms of carceral logic, including carceral ableism.

Despite the palpability for radical change, mainstream movements for justice in long-term care have maintained reformist approaches to systemic problems. Characteristically, reformist demands focus on increased funding for staff and

accountability mechanisms. Absent from these movements and demands are disabled people and elders. The movement has been led by unions, doctors, academics, and political parties (Canadians for Long Term Care, 2021; CUPE, 2021; Doctors for Justice in Long Term Care, 2021; Ontario NDP, 2021).

The centrepiece of this movement has been the call for the publicization of long-term care. But, the maintenance of even public institutions fails to address the systemic issues that cause institutionalization—lack of access to housing, homecare and community supports. The maintenance of institutions fails to consider the loss that communities experience when disabled people and elders are segregated into institutions. The maintenance of any form of institutions, regardless of ownership, signifies an ongoing investment in institutional models of care. Prisoners, psychiatric and institutional survivors can attest that public ownership fails to guarantee safety or community. Publicization does not contest the carceral logic that rationalizes mass confinement of disabled people.

I conclude this research by applying the Declaration’s three prong<sup>94</sup> strategy “to commit to building a society that chooses to meet people’s needs instead of locking them away.” I map out possibilities of what is necessary, and what academic investment is required.

#### **4.2 Defund**

Abolition demands an end to government investment in the expansion of all institutions and their infrastructure. This demands a moratorium in the construction and

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<sup>94</sup> Defund, dismantle, build

licensing of psychiatric institutions and wards, domiciliary hostels, Homes for Special Care, forensic psychiatric institutions and wards, emergency shelters, group homes, private addiction treatment institutions, long-term care facilities, prisons and immigration detention centres. Stop increasing budgets to pay security, police, institutional executives, health care administrators and doctors. Commit to a drastic reduction in federal, provincial, and municipal spending on institutional forms of care.

The demand for defunding requires significant academic investment. Significant trailblazing is required, particularly given Critical Carceral Studies and Critical Disability Studies relative adolescence. Decades of rigorous academic research have produced rich political economies of the carceral system (Gilmore, 2007). In Canada, prisons have remained largely centralized allowing for a clearer picture of the carceral system.

### **4.3 Dismantle**

Reduce the number of people in long-term care and prisons over time, with the goal of complete abolition in a lifetime. End to the use of for-profit institutions: Homes for Special Care, LTC, domiciliary hostels and addictions treatment facilities. End non-consensual treatment and institutionalization. This means an end to the use of physical and chemical restraints in all institutions. This means an end to the use of solitary confinement in all institutions. It is possible to immediately deinstitutionalize domiciliary hostels, Homes for Special Care, and group homes, but it must come alongside the expansion of the affordable housing stock.

I feel excited by the significant further research required. I feel I have only just begun unravelling this system of transinstitutionalization across Ontario. A political economy of the for-profit addiction treatment industry in Ontario would help make

explicit the size and use of these institutions. This research focuses on adults, but there is a substantial institutional system for disabled children. A political economy of both public and private institutional systems for disabled children would help to understand the scope and mechanics of this system. Given the ongoing disproportionate practice of segregating Black and Indigenous children through the education system, a Critical Race Studies approach would be beneficial. Dismantling these systems should not come without accountability. Further investigation, compensation to victims and accountability should be conducted to understand the extent of harms encountered within these settings.

#### **4.4 Build Alternative Futures**

Invest funds in alternatives to institutions, towards building real care for disabled people. This includes investments in accessible housing, universal pharmacare and allied health services, access to desired food and clean water, and free public transit. This also means investment and empowerment of workers, through developing a care-based economy. Invest in access to consent-based, non-coercive mental health care, support services and health care. This means the development of community care hubs, where people can access varying forms of services within their community. Invest in community forms of care, led by Black, Indigenous and disabled communities, who have long been resisters to institutionalization and dreamers of deinstitutionalization. Honour Indigenous sovereignty—this means creating space for and investment in Indigenous traditional medicine and healing practices. Invest in land redistribution for former sites of disability institutions, led by the Indigenous people whose land it is on.

Disabled people demand freedom, justice, and community. Abolition and deinstitutionalization are only possible if we “move together” in solidarity and struggles.

As long as one form of institutions exists, disabled people cannot be free. As long as the criminalization of sex work persists, disabled people and sex workers cannot be free.

Exiting the pandemic, the violence of institutionalization and criminalization demands the dreaming and building of new, radical futures.

## Appendices

### Appendix A Transinstitutional Survey

#### A.1 Acronyms

ORCA	Ontario retirement community agency
MOHLTC	Ministry of Health and Long-term Care
MMAH	Ministry of Municipal Affairs and Housing
SIPDDA	Social Inclusion for Persons with Developmental Disabilities Act
MCSS	Ministry of Community and Social Services
MHA	Mental Health Act
MCSCS	Ministry of Community Safety and Correctional Services
MOU	Memorandum of understanding
CSC	Correctional Services Canada
CRF	Community Residential Facility
RTA	Residential Tenancy Act
MSG	Ministry of the Solicitor General
MCSCS	Minister of Community Safety and Correctional Services
MCSA	Ministry of Correctional Services Act
AMHO	Addiction & Mental Health Services Ontario
RATF	Residential Addiction Treatment facility
P	Provincial
F	Federal
M	Municipal
CHA	Canada Health Act
PHA	Public Hospitals Act
CHRI	Community Homelessness Reduction Initiative
MI	Mental Illness
ORB	Ontario Review Board
CNSC	Community Network of Specialized Care
SU	Substance Use

## A.2 Psychiatric System

Institution type			Quantity	Density	Size	Operator	Target Population	funding bodies		Regulatory Body		Ministry	Related legislation	sources
	Subtype 1	Subtype 2						F	P	P	M			
Psychiatric Institution							MI			MOHLTC; LHIN		MOHLTC	MHA	(MOHLTC, 2012)
	Public		4	low-high	235-329	Public	MI	CHA	MOHLTC				MHA	(CAMH, 2021)
	Private		1	low-high	300	Private	MI		LHIN				MHA	(Moon et al., 2006)
	Addictions Treatment Centre						SU			AMHO			OPSARAS	(AMHO, 2017)
		RATF					SU						OPSARAS	(AMHO, 2017)
		RATF		high		Private	SU					MOHLTC	OPSARAS	(AMHO, 2017)
		RATF		high		Public	SU	CHA					OPSARAS	(AMHO, 2017)
				high		NFP	SU							(AMHO, 2017)
		Supportive residential programs					substance use					MOHLTC		(AMHO, 2017)
	Long-Term Psych		1	low-high	64 beds	Public	stable mental illness and/or physical limitations	CHA	MOHLTC	LHIN		MOHLTC	PHA; MHA; LTCHA	(Lougheed, 2005)
Psychiatric Ward				low-high	varies	Public Hospital	Acute MI	CHA	LHIN	LHIN		MOHLTC	PHA, MHA	(The Royal, 2020; PHA, 1990).
	Dual Diagnosis Units		5	high	10-14 beds	Public Hospital	Acute MI+ I/DD	CHA	LHIN; DSO	DSO; LHIN		MCCSS; MOHLTC	PHA, SIPPDA, MHA	(Lin et al., 2019)
	Geriatric Unit			high			MI + I/DD	CHA	LHIN	LHIN			MHA	(Kay, 2017; The Royal, 2020)
		boarding homes	45	high	1-30	Landlord and NP	MI		MOHLTC	habitat				(Habitat Services, 2019)
		apartments	15	low	1-4	landlord	MI		MOHLTC	habitat				(Habitat Services, 2019)
	Group Home			medium		NP	MI		MOHLTC	MCCSS		MOHLTC; MCCSS	MHA; RTA	2014; Suttor, 2016)
	Satellite Apartment		7,368	low	single family		MI		MOHLTC				MHA; RTA	(Auditor General, 2014)
		Private		low	single family	landlord			MOHLTC	LHIN			MHA; RTA	(Suttor, 2016)
		private rental		low	single family	landlord	MI		MOHLTC	LHIN		MMAH; MOHLTC; RTA	MHA; RTA	(Suttor, 2016)
		private rental headlease		low	single family	landlord	MI		MOHLTC	LHIN			RTA	(Suttor, 2016)
		social housing w supports		low	single family	landlord and NP	MI		MOHLTC	MMHA	Bylaw	MMAH	RTA	(Suttor, 2016)
		social housing w supports & referral agreements		low	single family	landlord and NP	MI		MOHLTC		Bylaw	MMAH	M RTA	(Suttor, 2016)
	Supported Apartment			low	single family	landlord and NP							RTA	(Ontario CMHA, 2014)
	Boarding Homes			high	single family	landlord	MI				Bylaw & licensing	MMAH; municipalities	RTA	(RTA, 2006)
Residential/custodial	Homes for Special Care		122	high	1-47	For-Profit	MI		LHIN; MOHLTC	LHIN		MOHLTC	HSCA	(Auditor General, 2016; Community Support and Research Unit, 2012)
	Habitat Services					NP						MOHLTC & City of Toronto		(Habitat Services, 2019)

### A.3 Forensic Psychiatric System

Institution type	Subtype	Size	Density	Sex-segregated	Target Population	Ownership	Quantity	Ministry	Regulating bodies			Related legislation	Notes, details, sources
									F	P	M		
Speciality Psychiatric Hospital					Mental disorder and interaction with the carceral system	public	4	MOHLTC; MCSS; CSC	PS C	LHIN; OSG		Criminal Code; PHA; MHA	(CAMH, 2017; Joseph, 2015b; MOHLTC, 2012)
	general		high	no		public		MOHLTC; MCSS; CSC	PS C	LHIN; OSG		Criminal Code; PHA; MHA	(CAMH, 2017; MOHLTC, 2012)
	secure		high	no		public		MOHLTC; MCSS; CSC	PS C	LHIN; OSG		Criminal Code; PHA; MHA	(Bettridge & Barbaree, 2015)
	medium		high	no		public		MOHLTC; MCSS; CSC	PS C	LHIN; OSG		Criminal Code; PHA; MHA	(MOHLTC, 2012)
General Hospitals			high	no	Mental disorder	public	7	MOHLTC; MCSS; CSC	PS C	LHIN; OSG		Criminal Code; PHA	(MOHLTC, 2012)
Stand-Alone Forensic Psychiatric Institutions			high	yes		public		MOHLTC; MCSS; CSC		MCSCS		Criminal Code; MHA	(CAMH, 2017; MOHLTC, 2012; St. John's Health Centre, 2013)
	provincial	89	high	yes	men who are deemed unfit to stand trial or NCR	public	1	MOHLTC, OSG, MCSS, MCSCS	PS C	LHIN; ORB		Criminal Code; MHA	(St. John's Health Centre, 2013)
Prison-Psychiatric Institution Hybrid		100	high	yes	provincially sentenced adult male offenders who suffer from a major mental illness and includes persons with developmental disabilities	public	1	MOHLTC & MSG & MCSC		LHIN; ORB		Criminal Code; MHA	(Ontario HIV Treatment Network, 2014; "St. Lawrence Valley Correctional and Treatment Centre")
Community-based forensic psychiatric institutions			medium	yes		public		CSC				Criminal Code; MHA	(Correctional Services Canada, 2012; Maier, 2020)
	CRFs		medium	yes	people discharged by the Ontario Review Board with "mental disorders" who have been involved with the criminal justice system.	non-profit		MCSS		ORB		Criminal Code; MHA	(Correctional Services Canada, 2012; ORB, 2017)
	TRHP		medium	no	people discharged by the Ontario Review Board with "mental disorders" who have been involved with the criminal justice system.	private				ORB		Criminal Code; MHA	(CMHA, 2017; Correctional Services Canada, 2012)

### A.4 Developmental Services System

Institution type	Quantity	Density	Size	Operator	Target Population	Funding	Regulatory Authority		Ministry	Related legislation	Notes, details, sources
							Provincial	Municipal			
Intensive Support Residences	164-328	low	1-2	CNSC; non-prof	I/DD; Complex needs	DSO; LHIN; CNSC	DSO; CNSC	SIPPDA QAM	MCCSS; MOHLTC; MCSCS	SIPPDA; Criminal Code	(Auditor General, 2014; Auditor General, 2016)
Supportive Group Living Residences	240 providers	medium	4-44	Non-Profit	I/DD	DSO	DSO	SIPPDA QAM	MCCSS	SIPPDA	(Auditor General, 2014; Auditor General, 2016)
Specialized Accommodation			462 ppl served		I/DD	DSO	DSO; CNSC	SIPPDA QAM	MCCSS	SIPPDA	(Auditor General, 2014; Auditor General, 2016; CNSC, n.d.)

## A.5 Geriatric System

Institution type	Ownership	Density	Size	Quantity	Target Population	Funding			Regulating bodies			Ministry	Related legislation
						Provincial	Municipal	Federal	Provincial	Municipal			
Long-Term Care		shared: quad or double	30-472		Long-term specialized care needs	MOHLTC			LHIN		MOHLTC	LTCHA	
	Private		30-473	360	Long-term specialized care needs	MOHLTC			LHIN		MOHLTC	LTCHA	
	Non-profit		30-474	162	Long-term specialized care needs	MOHLTC			LHIN		MOHLTC	LTCHA	
	Municipal		30-475	101	Long-term specialized care needs	MOHLTC	CMSM		LHIN	CMSM	MOHLTC	LTCHA	
Retirement Homes			10-420	750	65+ with some care needs						MMHA		
	Private	low-high			65+ with some care needs				RHRA		MASA	RHA	
	Private				65+ with some care needs						MASA	RHA	
Supportive Housing					seniors and people who live with complex mental health challenges.	MCCSS							
	Non-profit	high	93		seniors and people who live with complex mental health challenges.	CHPI				bylaw	MMHA		
	Municipal	high			seniors and people who live with complex mental health challenges.	CHPI				bylaw	MOHLTC		

## A.6 Homelessness System

Institution type	Subtype 1	Quantity	Density	Size	Operator	Target Population	funding bodies			Regulating bodies			Ministry	References
							Federal	Provincial	Municipal	Federal	Provincial	Municipal		
Emergency Shelter		149	High	10-900 ppl		homeless	Reaching Home	MMAH	Family & Social Services			Bylaw	MMAH	(Government of Canada, 2018)
	non-profit		High	10-900 ppl	NGO	homeless	Reaching Home						MMAH	(Government of Canada, 2018)
	public		High	10-900 ppl	City	homeless	Reaching Home						MMAH	(Government of Canada, 2018)
Domiciliary Hostel	private		High	10-190 ppl	Private LL	Homeless; Mental illness; chronic health condition; I/DD	Reaching Home	CHRI	Family & Social Services			Bylaw	MMAH	(City of Cornwall & The Counties of Stormont, Dundas and Glengarry, 2017; City of Ottawa, 2016; Hwang et al, 2009)
	non-profit		High	10-190 ppl	Private LL	Homeless; Mental illness; chronic health condition; I/DD	Reaching Home	CHRI	Family & Social Services				MMAH	(City of Cornwall & The Counties of Stormont, Dundas and Glengarry, 2017; City of Ottawa, 2016; Hwang et al, 2009)

## Appendix B Survey of the forensic psychiatric system

Name of Hospital	Name of Unit	Number of inmates	Security level
CAMH	General rehabilitation unit	22 men	
CAMH	Forensic Assessment & Triage Unit		Medium secure
	Observation and Treatment Unit/Women's Secure Unit		
	Forensic General Unit A (1-2)	30 people	medium
	Forensic General Unit B (1-3)	31 men	medium
	Forensic General Unit D (1-5)	16 people	Medium + increased care
Waypoint	Forensic Assessment Program	40 people	
	Brébeuf Program for Regional Forensics	20 people	
Ontario Shores	Forensic Assessment Unit	22 people	secure
	The Forensic Assessment and Rehabilitation Unit	20 people	secure
	Forensic Rehabilitation Unit	20 people	secure
	Forensic Psychiatric Rehabilitation Unit	26 people	general
	Forensic Transitional Unit	25 people	general
	Forensic Community Reintegration Unit	25 people	general
The Royal (Ottawa)	Forensic Treatment Unit		
The Royal (Brockville)	Forensic Treatment Unit	61 people	

## Appendix C Private Long Term Care Ownership

Company	Number of homes
Revera	76
Chartwell	23
Sienna	27
Rykka	14
Southbridge	27
Extendicare	34
Total	201

## Appendix D Ottawa Minimum Separation Distances

Type of Building or Business	Minimum Separation Distance
Condominium	5m
Payday lender	1000 m
Payday lender & racetracks or casinos	300 m
Payday lender & educational facility	300m
Waste Processing	300m
Non-residential towers	23m
Residential towers	12m
Adult entertainment parlours & residential use building, day care, place of worship, school, library, community centre, community health and resource centre or park, or any residential, institutional, open space or leisure zone	500m
Adult entertainment parlours	1000m
Shelters	500m
Group Homes (urban)	300m
Group Home (rural)	1000m

## References

- Abbas, J., & Voronka, J. (2014). Remembering Institutional Erasures: The Meaning of Histories of Disability Incarceration in Ontario. In L. Ben-Moshe, C. Chapman, & A. C. Carey (Eds.), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (pp. 121–138). Palgrave Macmillan US.  
[https://doi.org/10.1057/9781137388476\\_7](https://doi.org/10.1057/9781137388476_7)
- Abolition and Disability Justice Coalition. (2020, August 6). Crippling Abolition. Alternatives to Policing Based in Disability Justice.  
<https://abolitionanddisabilityjustice.com/opening/>
- Addictions and Mental Health Ontario. (2017). *Ontario Provincial Standards for Adult Residential Addiction Services* (p. 98).
- Adema, S. (2016). More than Stone and Iron: Indigenous History and Incarceration in Canada, 1834-1996. *Theses and Dissertations (Comprehensive)*. 1826.  
<https://scholars.wlu.ca/etd/1826>
- Adese, J. (2012). Colluding with the Enemy? Nationalism and Depictions of “Aboriginality” in Canadian Olympic Moments. *American Indian Quarterly*, 36(4), 479. <https://doi.org/10.5250/amerindiquar.36.4.0479>
- AdvantAge. (2018). *Advantage Ontario—Advancing Senior Care*.
- Agrawal, S. (2012). *Minimum Separation Distance Bylaws for Group Homes: The Negative Side of Planning Regulation - ProQuest*.  
[http://search.proquest.com/docview/915265044?accountid=9894&rfr\\_id=info%3Axri%2Fsid%3Aprimo](http://search.proquest.com/docview/915265044?accountid=9894&rfr_id=info%3Axri%2Fsid%3Aprimo)

- Albo, G., & Evans, B. (2019). *Divided province: Ontario politics in the age of neoliberalism*.
- Anderson, S., Jia, J. X., Liu, V., Chatter, J., Krüsi, A., Allan, S., Maher, L., & Shannon, K. (2015). Violence prevention and municipal licensing of indoor sex work venues in the Greater Vancouver Area: Narratives of migrant sex workers, managers and business owners. *Culture, Health & Sexuality, 17*(7), 825–841. <https://doi.org/10.1080/13691058.2015.1008046>
- Anti-Carceral Group, Abolition Coalition, Anti-Poverty NL, Black Lives Matter-Toronto, Criminalization and Punishment Education Project, East Coast Prison Justice Society, Free Lands Free Peoples, Indigenous Joint/Joy Action Committee, Justice Exchange, Prisoner Correspondence Project, Saskatchewan-Manitoba-Alberta Abolition Coalition, SMAAC, Toronto Prisoners' Rights Project, & Wellness Within. (2021). *Choosing Real Safety: A Historic Declaration To Divest From Policing And Prisons And Build Safer Communities For All. Choosing Real Safety: A Historic Declaration To Divest From Policing And Prisons And Build Safer Communities For All. Choosing Real Safety*
- Argento, E., Goldenberg, S., Braschel, M., Machat, S., Strathdee, S. A., & Shannon, K. (2020). The impact of end-demand legislation on sex workers' access to health and sex worker-led services: A community-based prospective cohort study in Canada. *PLoS ONE, 15*(4). <https://doi.org/10.1371/journal.pone.0225783>
- Armstrong, P., Armstrong, H., & MacLeod, K. K. (2016). The Threats of Privatization to Security in Long-Term Residential Care. *Ageing International, 41*(1), 99–116. <https://doi.org/10.1007/s12126-015-9228-0>

- Association of Municipalities of Ontario. (1981). *Planning Guidelines for Group Homes*.
- Auditor General. (1987). *Report of the Auditor General of Ontario*. Office of the Auditor General of Ontario.
- Auditor General. (2014). *3.10: Residential Services for People with Developmental Disabilities*. 30.
- Bahner, J. (2019). *Sexual Citizenship and Disability: Understanding Sexual Support in Policy, Practice and Theory*. Routledge. <https://doi.org/10.4324/9780429488993>
- Baines, D., & Armstrong, P. (2019). Non-job work/unpaid caring: Gendered industrial relations in long-term care. *Gender, Work & Organization*, 26(7), 934–947. <https://doi.org/10.1111/gwao.12293>
- Bamforth, N. (2012). Sexuality and citizenship in contemporary constitutional argument. *International Journal of Constitutional Law*, 10(2), 477–492. <https://doi.org/10.1093/icon/mor065>
- Barnes, C. (1992). *Disabling imagery and the media: An exploration of the principles for media representations of disabled people*. BCODP.
- Baxter, W. (2010). *Sold out: How Ottawa's downtown Business Improvement Areas have secured and valorized urban space* [M.A., Carleton University (Canada)]. <http://search.proquest.com/docview/742462563/abstract/F187585FC5DD47DFPQ/1>
- Beaudry, J.S. (2020, December). Bill C-7, assisted dying and “lives not worth living”. Policy Options. <https://policyoptions.irpp.org/magazines/december-2020/bill-c-7-assisted-dying-and-lives-not-worth-living/>

- Beit-Hallahmi, B. (1994). Science, Ideology, and Ideals: The social history of IQ Testing. *The Centennial Review*, 38(2), 341–360.
- Ben-Moshe, L. (2020). *Decarcerating Disability: Deinstitutionalization and Prison Abolition*. University of Michigan Press.
- Ben-Moshe, L., Chapman, C., & Carey, A. C. (2014). *Disability incarcerated: Imprisonment and disability in the United States and Canada*.  
<http://site.ebrary.com/id/10951721>
- Berlant, L. (2007). Slow Death (Sovereignty, Obesity, Lateral Agency). *Critical Inquiry*, 33(4), 754–780. JSTOR. <https://doi.org/10.1086/521568>
- Berne, P. & Sins Invalid. (2016). *Skin, tooth, and bone the basis of movement is our people: A disability justice primer*. Sins Invalid.
- Berta, W., Laporte, A., Perreira, T., Ginsburg, L., Dass, A. R., Deber, R., Baumann, A., Cranley, L., Bourgeault, I., Lum, J., Gamble, B., Pilkington, K., Haroun, V., & Neves, P. (2018). Relationships between work outcomes, work attitudes and work environments of health support workers in Ontario long-term care and home and community care settings. *Human Resources for Health*, 16(1). Gale Academic OneFile.  
[http://link.gale.com/apps/doc/A546243117/AONE?u=ocul\\_carleton&sid=zotero&xid=2c373655](http://link.gale.com/apps/doc/A546243117/AONE?u=ocul_carleton&sid=zotero&xid=2c373655)
- Berton, P. (1959). *Huronian: Pierre Berton warned us 50 years ago*. Thestar.Com.  
[https://www.thestar.com/news/insight/2013/09/20/huronian\\_pierre\\_berton\\_warned\\_us\\_50\\_years\\_ago.html](https://www.thestar.com/news/insight/2013/09/20/huronian_pierre_berton_warned_us_50_years_ago.html)

- Bettridge, S., Barbaree, H., & Centre for Addiction and Mental Health. (2015). *The forensic mental health system in Ontario: An information guide*.  
<http://www.deslibris.ca/ID/467760>
- Bettridge, S. & Barbaree, H. (2004). *The forensic mental health system in Ontario*. 65.
- BIA. (2017). *Final Report Summer 2017 Byward Market Ambassador Program*. ByWard Market Business Improvement Area.
- Bouclin, S. (2006). Dancers Empowering (Some) Dancers: The Intersection of Race, Class, and Gender in Organizing Erotic Labourers. *Race, Gender & Class*, 13(3/4), 98–129.
- Boyd, J., Cunningham, D., Anderson, S., & Kerr, T. (2016). Supportive housing and surveillance. *International Journal of Drug Policy*, 34, 72–79.  
<https://doi.org/10.1016/j.drugpo.2016.05.012>
- Brown, T. E. (1981). *“Living with God’s Afflicted”: A History of the Provincial Lunatic Asylum at Toronto, 1830-1911* [Ph.D., Queen’s University (Canada)].  
<http://search.proquest.com/docview/303200467/abstract/C6690161F74B4CC2PQ/1>
- Brown, M., & Schept, J. (2017). New abolition, criminology and a critical carceral studies. *Punishment & Society*, 19(4), 440–462.  
<https://doi.org/10.1177/1462474516666281>
- Brownridge, M., Hanrahan, K., Feuerstack, J., & Bourget, P. (2010). *ByWard Market Ambassador Program End of Season Report*.  
<https://app06.ottawa.ca/calendar/ottawa/citycouncil/opsb/2011/05-30/item3attb.htm>

- Bruckert, C., & Chabot, F. (2010). Challenges: Ottawa area sex workers speak out. *POWER (Prostitutes of Ottawa-Gatineau, Work, Educate and Resist)*.  
[https://scholar-google-com.proxy.library.carleton.ca/scholar\\_lookup?title=Challenges%3A%20Ottawa%20area%20sex%20workers%20speak%20out&publication\\_year=2010&author=Bruckert%2CC&author=Chabot%2CF](https://scholar-google-com.proxy.library.carleton.ca/scholar_lookup?title=Challenges%3A%20Ottawa%20area%20sex%20workers%20speak%20out&publication_year=2010&author=Bruckert%2CC&author=Chabot%2CF)
- Bruckert, C., & Dufresne, M. (2002). Re-Configuring the Margins: Tracing the Regulatory Context of Ottawa Strip Clubs, 1974–2000. *Canadian Journal of Law and Society*, 17(1), 69–87. <https://doi.org/10.1017/S0829320100007006>
- Bruckert, C., & Hannem, S. (2013). Rethinking the Prostitution Debates: Transcending Structural Stigma in Systemic Responses to Sex Work<sup>1</sup>. *Canadian Journal of Law & Society / La Revue Canadienne Droit et Société*, 28(1), 43–63.  
<https://doi.org/10.1017/cls.2012.2>
- Bruckert, C. M. (2000). *Stigmatized labour: An ethnographic study of strip clubs in the 1990s* [ProQuest Dissertations Publishing].  
<https://search.proquest.com/docview/304586019?pq-origsite=summon>
- Burch, S. (2021). *Committed: Remembering native kinship in and beyond institutions*. University of North Carolina Press.
- Business Improvement Area. (2020, May 27). *ByWard Market*. Facebook.  
<https://www.facebook.com/TheByWardMarket/posts/at-the-may-25-2020-byward-market-bia-board-of-management-meeting-councillor-math/10158353416561552/>
- The Developmental Services Act, 1974*. (1974). 15.

- CAMH. (n.d.). *Forensic General Units*. CAMH. <https://www.camh.ca/en/your-care/programs-and-services/forensic-general-units>
- CAMH. (2017). *Forensic Assessment and Triage Unit*. CAMH. <https://www.camh.ca/en/your-care/programs-and-services/forensic-assessment-triage-unit>
- CAMH/CAMH Foundation. (2021). *Annual Report to the Community*. CAMH/CAMH Foundation. <https://www.camh.ca/en/driving-change/about-camh/performance-and-accountability/annual-report-and-financial-statements>
- Canada Health Act (1985)., c-C.6 R.S.C., 1985. <https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html>
- Canada (Attorney General) v. Bedford, 3 SCR 1101 (Supreme Court of Canada 2013). <http://canlii.ca/t/g2f56>
- Canadian Centre on Substance Abuse, A. (2014). *Systems Approach Workbook: System Mapping Tools*. 33.
- Castle, N. G., & Fogel, B. (1998). Characteristics of Nursing Homes That Are Restraint Free. *The Gerontologist*, 38(2), 181–188. <https://doi.org/10.1093/geront/38.2.181>
- CBC News. (2006, July 21). *Ottawa councillor calls for moratorium on downtown homeless services*. CBC. <https://www.cbc.ca/news/canada/ottawa/ottawa-councillor-calls-for-moratorium-on-downtown-homeless-services-1.621706>
- CBC News. (2011, May 11). *No room for disabled in Ottawa Valley group homes*. CBC. <https://www.cbc.ca/news/canada/ottawa/no-room-for-disabled-in-ottawa-valley-group-homes-1.978986>

- CBC News. (2015, May 11). Ottawa massage parlour raids hurt sex workers, not employers, groups say | *CBC News*. CBC.  
<https://www.cbc.ca/news/canada/ottawa/sex-workers-further-victimized-by-deportations-groups-say-1.3069626>
- CBC News. (2019a). *Para Transpo vacancies caused service to suffer, union says*.  
<https://www.cbc.ca/news/canada/ottawa/paratranspo-bus-service-holds-thirty-vacancies-for-year-1.5363485>
- CBC News. (2019b, June 14). *Ottawa has a new slogan—And here’s what you think about it*. <https://www.cbc.ca/news/canada/ottawa/city-ottawa-new-slogan-canada-in-one-city-1.5176001>
- Chapman, C. (2014). Five Centuries’ Material Reforms and Ethical Reformulations. In L. Ben-Moshe, C. Chapman, & A. C. Carey (Eds.), *Disability Incarcerated*. Palgrave Macmillan.
- Chapman, C., Carey, A., & Ben-Moshe, L. (2014). Reconsidering Confinement: Interlocking Locations and Logics of Incarceration. In *Disability Incarcerated: Imprisonment and Disability in the United States and Canada*. Palgrave Macmillan.
- Chapman, C., & Withers, A. J. (2019). *A violent history of benevolence: Interlocking oppression in the moral economies of social working*.  
<https://www.deslibris.ca/ID/458073>
- Cherner, R., Nandlal, J., Ecker, J., Aubry, T., & Pettey, D. (2013). Findings of a Formative Evaluation of a Transitional Housing Program for Forensic Patients

Discharged into the Community. *Journal of Offender Rehabilitation*, 52(3), 157–180. <https://doi.org/10.1080/10509674.2012.754826>

Chiarelli, B. (2006). *Ottawa City Council Minutes*. Ottawa City Council. <https://app06.ottawa.ca/calendar/ottawa/citycouncil/occ/2006/04-26/minutes57.htm>

Chin, N. (2016). *Group Homes as Sex Police and the Role of the Olmstead Integration Mandate*. N.Y.U. Review of Law & Social Change. <https://socialchangenyu.com/review/group-homes-as-sex-police-and-the-role-of-the-olmstead-integration-mandate/>

City of Cornwall, & The Counties of Stormont, Dundas and Glengarry. (2017). *The Domiciliary Hostel Standards Framework* (p. 20). The Social and Housing Services Department.

City of Ottawa. (2007). *Sandy Hill Interim Bylaws*. <https://app06.ottawa.ca/calendar/ottawa/citycouncil/ec/2007/03-27/ACS2007-PTE-POL-0007.htm>

City of Ottawa. (2018). *Everyone Counts Ottawa's 2018 Point-in-Time Count*. [https://documents.ottawa.ca/sites/documents/files/Point%20in%20Time%20Report%20EN\\_0.pdf](https://documents.ottawa.ca/sites/documents/files/Point%20in%20Time%20Report%20EN_0.pdf)

City of Toronto. (2017, November 14). *Toronto at a Glance* (Toronto, Ontario, Canada). City of Toronto; City of Toronto. <https://www.toronto.ca/city-government/data-research-maps/toronto-at-a-glance/>

CityOfOttawa DomHost. (2012, December 13). *Watford House*. <https://www.youtube.com/watch?v=fMv5J7dezbQ&t=1s>

- CitySpaces Consulting Ltd. (1995). *Toward More Inclusive Neighbourhoods*. the Housing Ministry.  
[http://www.housing.gov.bc.ca/pub/htmldocs/pub\\_neighbour/partner1.htm](http://www.housing.gov.bc.ca/pub/htmldocs/pub_neighbour/partner1.htm)
- Clairmont, S. (2018, March 15). Treating the dangerous mentally ill offenders differently | TheSpec.com. *Hamilton Spectator*.  
<https://www.thespec.com/opinion/columnists/2018/03/15/treating-the-dangerous-mentally-ill-offenders-differently.html>
- Cleaver, S., Ouellette-Kuntz, H., & Hunter, D. (2008). Relationship Between Mobility Limitations and the Places Where Older Adults With Intellectual Disabilities Live. *Journal of Policy and Practice in Intellectual Disabilities*, 5(4), 253–258.  
<https://doi.org/10.1111/j.1741-1130.2008.00186.x>
- CNSC. (n.d.). *About Us*. Community Networks of Specialized Care. Retrieved March 29, 2021, from <https://www.community-networks.ca/about-us-2/>
- Community Support and Research Unit. (2012). *From This Point Forward: Ending Custodial Housing for People with Mental Illness in Canada*. Centre for Addiction and Mental Health. <https://www.eenet.ca/sites/default/files/wp-content/uploads/2014/12/Community-Support-and-Research-Unit-2012-From-This-Point-Forward.pdf>
- Conteh, C. (2016). Rethinking accountability in complex and horizontal network delivery systems: Accountability in Network Delivery Systems *Canadian Public Administration*, 59(2), 224–244. <https://doi.org/10.1111/capa.12168>

- Correctional Service of Canada. (2012, December 15). *Community-Based Residential Facilities (CBRFs)*. <https://www.csc-scc.gc.ca/facilities-and-security/001-0001-eng.shtml>
- Covert, B. (2018, March 12). Monopolies Harm WORKERS Too: *The Nation*, 306(7), 28.
- Craig, E. (2011, October). Sex work by law: Bedford's impact on municipal approaches to regulating the sex trade. *Review of Constitutional Studies*, 16(1), 97-. Gale Academic OneFile.
- Critical Resistance. (2021). What is the PIC? What is Abolition? <http://criticalresistance.org/about/not-so-common-language/>
- Daley, A., Costa, L., & Beresford, P. (2019). *Madness, violence, and power: A critical collection*. <https://www.deslibris.ca/ID/457587>
- Daly, T. (2015). Dancing The Two-Step in Ontario's Long-Term Care Sector: Deterrence Regulation = Consolidation. *Studies in Political Economy*, 95(1), 29–58. <https://doi.org/10.1080/19187033.2015.11674945>
- Daring Residential Services Inc. (2013). *Photo Gallery Our Home*. Daring Residential Homes Inc. <https://daringresidentialhome.webs.com/apps/photos/album?albumid=15139829>
- Davis, A. Y. (2003). *Are Prisons Obsolete*. Seven Stories Press.
- Davis, A. Y. (2005). *Abolition democracy: Beyond empire, prisons, and torture* (Seven Stories Press 1st ed). Seven Stories Press.
- Davis, A. Y., & Rodriguez, D. (2000). The Challenge of Prison Abolition: A Conversation. *Social Justice*, 27(3 (81)), 212–218.

- Dear, M., & Laws, G. (1986). Anatomy of a Decision: Recent Land Use Zoning Appeals and their Effect on Group Home Locations in Ontario. *Canadian Journal of Community Mental Health*, 5(1), 5–17. <https://doi.org/10.7870/cjcmh-1986-0001>
- Deering, K. N., Rusch, M., Amram, O., Chettiar, J., Nguyen, P., Feng, C. X., & Shannon, K. (2014). Piloting a ‘Spatial Isolation’ Index: The Built Environment and Sexual and Drug Use Risks to Sex Workers. *The International Journal on Drug Policy*, 25(3), 533–542. <https://doi.org/10.1016/j.drugpo.2013.12.002>
- Deinstitutionalization Task Force. (n.d.). *Definition of an Institution*. Institution Watch. <https://www.institutionwatch.ca/task-force/definition-of-an-institution/>
- Desai, A., St. Leonard’s Society of Canada, Canada, Public Safety Canada, Correctional Service Canada, & Law Foundation of Ontario. (2012). *Community connections: The key to community corrections for individuals with mental health disorders*. St. Leonard’s Society of Canada. <https://www.deslibris.ca/ID/234654>
- Developmental Services. (2014). *Passport Program: Guidelines for Adults with Developmental Disabilities and their caregivers*. Developmental Services Ontario. [https://www.dsontario.ca/assets/documents/Downloadable-Inserts/passport/Passport\\_Guideline\\_English.pdf](https://www.dsontario.ca/assets/documents/Downloadable-Inserts/passport/Passport_Guideline_English.pdf)
- Dhaliwal, R. K. (2019). Settler Colonialism and the Contemporary Coerced Sterilizations of Indigenous Women. *Political Science Undergraduate Review*, 4(1), 29–39. <https://doi.org/10.29173/psur109>
- Doc & Film International. (2011). *IQ: A History of Deceit*. [https://fod-infobase-com.proxy.library.carleton.ca/p\\_ViewVideo.aspx?xtid=52818](https://fod-infobase-com.proxy.library.carleton.ca/p_ViewVideo.aspx?xtid=52818)

- Donovan, K. (2001). Adults beaten in group homes: Hundreds of cases may just be tip of iceberg. *Toronto Star*.
- Duarte, F. (2018). *Unplugging the city: The urban phenomenon and its sociotechnical controversies*. Routledge.
- Dubé, P. (2016). *Nowhere to Turn: Investigation into the Ministry of Community and Social Services' response to situations of crisis involving adults with developmental disabilities*. Ombudsman of Ontario.  
<https://www.ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reports-on-Investigations/NTT-Final-EN-w-cover.pdf>
- Durisin, E. M., van der Meulen, E., & Bruckert, C. (2018). *Red Light Labour: Sex Work Regulation, Agency, and Resistance*. UBC Press.  
<http://ebookcentral.proquest.com/lib/oculcarleton-ebooks/detail.action?docID=5488006>
- Dyck, E. (2013). *Facing eugenics: Reproduction, sterilization, and the politics of choice*. University of Toronto Press.
- Earle, S. (1999). Facilitated sex and the concept of sexual need: Disabled students and their personal assistants. *Disability and Society*, 14(3), 309–324.
- Egan, C., & Gardner, L. (1999). Racism, Reproductive Health and Women's Freedom. In E. Dua & A. Robertson (Eds.), *Scratching the surface: Canadian, anti-racist, feminist thought*. Women's Press.
- Egan, K. (2019). 'I should have the right to marry and live my life'—Ontario guardian stops wedding of disabled woman. *Ottawa Citizen*.

- <https://ottawacitizen.com/news/local-news/egan-i-should-have-the-right-to-marry-and-live-my-life-ontario-guardian-stops-wedding-of-disabled-woman>
- Emergency and Protective Services Committee. (2005). By-Law Harmonization-Licensing- Body Rub Parlours. Ottawa City Council.
- Employment and Social Development Canada. (2019, August 8). *Highlights of the National Shelter Study 2005 to 2016* [Service description]. Aem.  
<https://www.canada.ca/en/employment-social-development/programs/homelessness/reports-shelter-2016.html#h4>
- Engberg, J., & Castle, N. (2008). *Health Outcomes Following Physical Restraint Initiation in Nursing Homes*. 110.
- Evans, D. (1993). *Sexual Citizenship: The Material Construction of Sexualities* (1 edition). Routledge.
- Fabris, E. (2011). *Tranquil prisons: Chemical incarceration under community treatment orders*. University of Toronto Press.
- Fanelli, C. (2014). *Under pressure: How public policy is constraining Ontario municipalities*. <https://www.deslibris.ca/ID/244705>
- Farkas, M., & Coe, S. (2019). From Residential Care to Supportive Housing for People With Psychiatric Disabilities: Past, Present, and Future. *Frontiers in Psychiatry*, 10. <https://doi.org/10.3389/fpsy.2019.00862>
- Favaro, A. (2018, May 2). Families sue Ontario long-term care providers over “disgusting” neglect. *CTV News*. <https://www.ctvnews.ca/health/families-sue-ontario-long-term-care-providers-over-disgusting-neglect-1.3912770>

- Finger, A. (1992, July 5). Forbidden Fruit. *New Internationalist*, 233.  
<https://newint.org/features/1992/07/05/fruit>
- Finkler, L., & Grant, J. (2011). Minimum Separation Distance Bylaws for Group Homes: The Negative Side of Planning Regulation. *Canadian Journal of Urban Research*, 20(1), 33–56.
- Fischer, F. (2003). Reframing Public Policy: Discursive Politics and Deliberative Practices. Oxford University Press. <https://doi.org/10.1093/019924264X.001.0001>
- Fischer, F., Torgerson, D., Durnová, A., & Orsini, M. (Eds.). (2015). Handbook of critical policy studies. Edward Elgar Publishing.
- Fish, R. (2016). ‘They’ve said I’m vulnerable with men’: Doing sexuality on locked wards. *Sexualities*, 19(5–6), 641–658. <https://doi.org/10.1177/1363460715620574>
- Fisman, D. N., Bogoch, I., Lapointe-Shaw, L., McCready, J., & Tuite, A. R. (2020). Risk Factors Associated With Mortality Among Residents With Coronavirus Disease 2019 (COVID-19) in Long-term Care Facilities in Ontario, Canada. *JAMA Network Open*, 3(7), e2015957.  
<https://doi.org/10.1001/jamanetworkopen.2020.15957>
- Flora, N., Barbaree, H., Simpson, A. I. F., Noh, S., & McKenzie, K. (2012). Pathways to Forensic Mental Health Care in Toronto: A Comparison of European, African-Caribbean, and other Ethnoracial Groups in Toronto. *The Canadian Journal of Psychiatry*, 57(7), 414–421. <https://doi.org/10.1177/070674371205700704>
- Foucault, M. (1982). *Discipline and punish: The birth of the prison* (Repr). Penguin Books.

Frankenburg, F. (1982). The 1978 Ontario Mental Health Act in Historical Context.

*HSTC Bulletin : Journal of the History of Canadian Science, Technology and  
Medecine / HSTC Bulletin : Revue d'histoire Des Sciences, Des Techniques et de  
La Médecine Au Canada*, 6(3), 172–177. [https://doi-  
org.proxy.library.carleton.ca/10.7202/800144ar](https://doi-org.proxy.library.carleton.ca/10.7202/800144ar)

Free Lands, Free Peoples (2020). Prairie Province Prisoner Support Fund.

<https://ca.gofundme.com/f/prairie-province-prisoner-support-fund?>

Fritsch, K. (2010). Intimate Assemblages: Disability, Intercorporeality, and the Labour of  
Attendant Care. *Critical Disability Discourses/Discours Critiques Dans Le  
Champ Du Handicap*, 2, 1–14.

Fritsch, K. (2015a). Gradations of Debility and Capacity: Biocapitalism and the  
Neoliberalization of Disability Relations. *Canadian Journal of Disability Studies*,  
4(2), 12. <https://doi.org/10.15353/cjds.v4i2.208>

Fritsch, K. (2015b). Desiring Disability Differently: Neoliberalism, Heterotopic  
Imagination and Intra-corporeal Reconfigurations. *Foucault Studies*, 43–66.  
<https://doi.org/10.22439/fs.v0i19.4824>

Fritsch, K. (2016). Crippling Neoliberal Futurity: Marking the Elsewhere and Elsewhen of  
Desiring Otherwise. *Feral Feminisms*, 5, 16.

Fritsch, K., Heynen, R., Ross, A. N., & Meulen, E. van der. (2016). Disability and sex  
work: Developing affinities through decriminalization. *Disability & Society*,  
31(1), 84–99. <https://doi.org/10.1080/09687599.2016.1139488>

Galton, S. F. (1883). *Inquiries Into Human Faculty and Its Development*. Macmillan and  
Company.

- Gara, M. A., Vega, W. A., Arndt, S., Escamilla, M., Fleck, D. E., Lawson, W. B., Lesser, I., Neighbors, H. W., Wilson, D. R., Arnold, L. M., & Strakowski, S. M. (2012). Influence of Patient Race and Ethnicity on Clinical Assessment in Patients With Affective Disorders. *Archives of General Psychiatry*, 69(6).  
<https://doi.org/10.1001/archgenpsychiatry.2011.2040>
- George, L., Kidd, S., Browne, G., Kirkpatrick, H., & Sylvestre, J. (2009). *Fidelity and Recovery: How Are Ontario ACT Teams Doing?* (p. 28). McMaster University.  
<https://www.eenet.ca/sites/default/files/wp-content/uploads/2013/10/feb-2009.pdf>
- Gibbard, R. (2017.). *Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada*. 48.
- Gill, M. (2015). *Already Doing It: Intellectual Disability and Sexual Agency*. University of Minnesota Press. <http://ebookcentral.proquest.com/lib/oculcarleton-ebooks/detail.action?docID=2011451>
- Gilmore, R. W. (2007). *Golden gulag: Prisons, surplus, crisis, and opposition in globalizing California*. University of California Press.
- Gillmore, M. (2018). End of Ontario’s sheltered workshops program drawing closer | [rabble.ca](https://rabble.ca). Rabble.Ca. <https://rabble.ca/news/2018/01/end-ontarios-sheltered-workshops-program-drawing-closer>
- Glowacki, L. (2020, February). “You’re losing the right to choose”: Changes to housing wait list panned | *CBC News*. CBC.  
<https://www.cbc.ca/news/canada/ottawa/housing-waitlist-ottawa-1.5457620>
- Goffman, E. (1990). *Asylums: Essays on the social situation of mental patients and other inmates* (1. Anchor Books ed). Anchor Books.

- Goldenberg, S. M., Duff, P., & Krusi, A. (2015). Work environments and HIV prevention: A qualitative review and meta-synthesis of sex worker narratives. *BMC Public Health*, *15*(1), 1241. <https://doi.org/10.1186/s12889-015-2491-x>
- Goodley, D., Lawthom, R., Liddiard, K., & Runswick-Cole, K. (2019). Provocations for Critical Disability Studies. *Disability & Society*, *34*(6), 972–997. <https://doi.org/10.1080/09687599.2019.1566889>
- Government of Canada, S. C. (2018, November 28). *A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017*. <https://www150.statcan.gc.ca/n1/pub/89-654-x/89-654-x2018002-eng.htm>
- Government of Canada, S. C. (2019, February 1). *Census of Population*. <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3901>
- Government of Canada, S. C. (2020, August 4). *Homeless shelter capacity, bed and shelter counts for emergency shelters, transitional housing and violence against women shelters for Canada and provinces, Employment and Social Development Canada annual (number)*. <https://www150.statcan.gc.ca/t1/tb11/en/tv.action?pid=1410035301>
- Government of Ontario. (2018). *Policy Directives For Service Agencies | Ministry of Community and Social Services*. Government of Ontario. [https://www.mcsc.gov.on.ca/en/mcss/publications/developmentalServices/policy\\_directive\\_service/support\\_service\\_directive.aspx](https://www.mcsc.gov.on.ca/en/mcss/publications/developmentalServices/policy_directive_service/support_service_directive.aspx)
- Government of Ontario, & Ministry of Health and Long-Term Care. (2017). *Long-Term Care Home Service Accountability Agreement (L-SAA)- Seniors' Care: Home, Community and Residential Care Services*. Government of Ontario, Ministry of

Health and Long-Term Care.

[http://www.health.gov.on.ca/en/public/programs/ltc/ltaa\\_policies.aspx](http://www.health.gov.on.ca/en/public/programs/ltc/ltaa_policies.aspx)

Graham, R. (1988). *Building Community Support for People: A plan for Mental Health in Ontario*. The Provincial Mental Health Committee. <https://ontario.cmha.ca/wp-content/uploads/2016/08/grahamreport.pdf>

Green, G., Barratt, C., & Wiltshire, M. (2016). Control and care: Landlords and the governance of vulnerable tenants in houses in multiple occupation. *Housing Studies*, 31(3), 269–286. <https://doi.org/10.1080/02673037.2015.1080818>

Greenland, C., & Mcneel, B. H. (1961). The Dymond Report and Chronic Patients in Ontario Hospitals. *Canadian Psychiatric Association Journal*, 6(1), 37–44. <https://doi.org/10.1177/070674376100600108>

Gregory, S. Y. (2019, December 2). Chronic Pain Made My Sex Life Better, Not Worse. *Vice*. [https://www.vice.com/en\\_ca/article/j5y77y/chronic-pain-and-sex](https://www.vice.com/en_ca/article/j5y77y/chronic-pain-and-sex)

Grigorovich, A. (2020). Governing “risky” sexualities: Representation of dementia and sexuality in the news media. *Disability Studies Quarterly*, 40(3), Article 3. <https://doi.org/10.18061/dsq.v40i3.6877>

Grob, G. N. (1962). Samuel B. Woodward and the Practice of Psychiatry in Early Nineteenth Century America, *Bulletin of the History of Medicine*, 36(5), 420–443. JSTOR.

Gruskin, S., Yadav, V., Castellanos-Usigli, A., Khizanishvili, G., & Kismödi, E. (2019). Sexual health, sexual rights and sexual pleasure: Meaningfully engaging the perfect triangle. *Sexual and Reproductive Health Matters*, 27(1), 29–40. <https://doi.org/10.1080/26410397.2019.1593787>

- Habitat Services. (n.d.). *The Habitat Model*. Retrieved March 29, 2021, from <http://habitatservices.org/the-habitat-model/>
- Hackworth, J., & Moriah, A. (2006). Neoliberalism, Contingency and Urban Policy: The Case of Social Housing in Ontario. *International Journal of Urban and Regional Research*, 30(3), 510–527. <https://doi.org/10.1111/j.1468-2427.2006.00675.x>
- Haggerty, K. D., & Ericson, R. V. (2000). The surveillant assemblage. *The British Journal of Sociology*, 51(4), 605–622. <https://doi.org/10.1080/00071310020015280>
- Haley, T. (2017). Intimate constraints: A feminist political economy analysis of biological reproduction and parenting in high-support housing in Ontario. *Palgrave Communications* 3 (50). <https://doi.org/10.1057/s41599-017-0053-9>
- Hall, M. C. (2019). Critical Disability Theory. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Winter 2019). Metaphysics Research Lab, Stanford University. <https://plato.stanford.edu/archives/win2019/entries/disability-critical/>
- Hanna, L. J. (1998). *Chronic manic depressives, schizoaffectives and their female family caregivers: The political economy of mental health care and the governance of madness*. Thesis MA - Carleton University.
- Hartford, K., Schrecker, T., Wiktorowicz, M., Hoch, J., & Sharp, C. (2003). Report: Four Decades of Mental Health Policy in Ontario, Canada. *Administration and Policy in Mental Health*, 31, 65–73. <https://doi.org/10.1023/A:1026000423918>
- Harvey, D. (2007). *A Brief History of Neoliberalism*. Oxford University Press.

- Hayes, M. (2018, September 4). The last dance: Why the Canadian strip club is a dying institution. *Globe & Mail*. <https://www.theglobeandmail.com/canada/article-the-last-dance-why-the-canadian-strip-club-is-a-dying-institution/>
- Hitchcock, J. (Ed.). (1980). *Beyond the white paper: Planning for people in the 80's*. University of Toronto.
- Shepherds of Good Hope. (n.d.). *Hope Living*. Retrieved November 16, 2020, from [https://www.sghottawa.com/hope\\_living/](https://www.sghottawa.com/hope_living/)
- Howard, L., Brassolotto, J., & Manduca-Barone, A. (2020). Navigating Tensions About Resident Sexual Expression in Alberta's Continuing Care Homes: A Qualitative Study of Leaders' Experiences. *Sexuality Research and Social Policy*, 17(4), 632–642. <https://doi.org/10.1007/s13178-019-00421-0>
- Huard, A., & Pelland, J. (2020, September). Sexual sovereignty. *Briarpatch*, 49(5). <https://briarpatchmagazine.com/articles/view/sexual-sovereignty>
- Hubbard, P., & Colosi, R. (2015). Respectability, morality and disgust in the night-time economy: Exploring reactions to 'lap dance' clubs in England and Wales. *The Sociological Review*, 63(4), 782–800. <https://doi.org/10.1111/1467-954X.12278>
- Hudson, G., & van der Meulen, E. (2013). Sex work, Law and Violence: Bedford V. Canada and the Human Rights of Sex Workers. *The Windsor Yearbook of Access to Justice*, 31(1), 115–145. <https://doi.org/10.22329/wyaj.v31i1.4318>
- Hughes, K., Bellis, M. A., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T., & Officer, A. (2012). Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational

studies. *The Lancet*, 379(9826), 1621–1629. [https://doi.org/10.1016/S0140-6736\(11\)61851-5](https://doi.org/10.1016/S0140-6736(11)61851-5)

Hunter, A. & Lauriault, T. (2020, October). Tracing COVID-19 Data: Open Science and Open Data Standards in Canada. *Data Libre*.

<http://datalibre.ca/2020/10/13/tracing-covid-19-data-open-science-and-open-data-standards-in-canada/>

Hutcheon, E. J., & Lashewicz, B. (2020). Tracing and troubling continuities between ableism and colonialism in Canada. *Disability & Society*, 35(5), 695–714.

<https://doi.org/10.1080/09687599.2019.1647145>

Hwang, S., Chiu, S., & Wilkins, E. (2009). *A Survey of Domiciliary Hostel Program Tenants in Ontario: Final Report*. St. Michael's Hospital. <https://www-deslibris-ca.proxy.library.carleton.ca/ID/217469>

IBISWorld. (2019, December 13). *Strip Club Industry Market Research, Reports, and Statistics*. <https://www.ibisworld.com/united-states/market-research-reports/strip-clubs-industry/>

Ignagni, E., Fudge Schormans, A., Liddiard, K., & Runswick-Cole, K. (2016). 'Some people are not allowed to love': Intimate citizenship in the lives of people labelled with intellectual disabilities. *Disability & Society*, 31(1), 131–135.

<https://doi.org/10.1080/09687599.2015.1136148>

Interministerial working group on group homes. (1978). *Interministerial Working Group on Group Homes: Location and Distribution Report*. Ontario Secretariat for Social Development.

Invisible Institutions. (2021). What has been said on the issue so far?

<http://invisibleinstitutions.com/faq>

Ipsos. (2018). *Homeowners Plan on Staying Put in Retirement Years: Nine in Ten (93%)*

*Seniors Want to Remain in Their Current Home*. Ipsos.

<https://www.ipsos.com/en-ca/news-polls/HomeEquity-Bank-Poll-July-2018>

Isaacs, C., American Friends Service Committee, grassroots leadership, & Southern Centre for Human Rights. (2014). Treatment Industrial Complex: How For-Profit

Prison Corporations are Undermining Efforts to Treat and Rehabilitate Prisoners for Corporate Gain. *American Friends Service Committee*.

[https://www.afsc.org/sites/default/files/documents/TIC\\_report\\_online.pdf](https://www.afsc.org/sites/default/files/documents/TIC_report_online.pdf)

Jaffee, L., & John, K. (2018). Disabling Bodies of/and Land: Reframing Disability

Justice in Conversation with Indigenous Theory and Activism. *Disability and the Global South*, 5(2), 1407–1429.

Jeffrey, L. A. (2005). Canada and migrant sex-work: Challenging the ‘foreign’ in foreign policy. *Canadian Foreign Policy Journal*, 12(1), 33–48.

<https://doi.org/10.1080/11926422.2005.9673387>

Joffe, K. & Kerzner, L. (2008) ARCH’s Written Submission to the Standing Committee on Social Policy regarding Bill 77, An Act to provide services to persons with developmental disabilities, to repeal the Developmental Services Act and to amend certain other statutes. Toronto: ARCH Disability Law Centre.

[https://www.acto.ca/production/wp-content/uploads/2017/07/Affidavit\\_Barriers-to-Adequate-Housing-for-People-with-Intellectual-Disabilities.pdf](https://www.acto.ca/production/wp-content/uploads/2017/07/Affidavit_Barriers-to-Adequate-Housing-for-People-with-Intellectual-Disabilities.pdf)

- Jones, K. (2015, March 1). A lifetime in long-term care. *Hospital News*.  
<https://hospitalnews.com/lifetime-long-term-care/>
- Jones, Z. (2013, November 12). The Salvation Army's History of Anti-LGBT Discrimination. *Huffpost*. [https://www.huffpost.com/entry/the-salvation-armys-histo\\_b\\_4422938](https://www.huffpost.com/entry/the-salvation-armys-histo_b_4422938)
- Joseph, A. J. (2015a). Historical Data—Archival Artifacts: Deportation and the Enforcement of Undesirability. In A. J. Joseph (Ed.), *Deportation and the Confluence of Violence within Forensic Mental Health and Immigration Systems* (pp. 124–145). Palgrave Macmillan UK.  
[https://doi.org/10.1057/9781137513410\\_7](https://doi.org/10.1057/9781137513410_7)
- Joseph, A. J. (2015b). Introduction: Outlining the Problem—The Confluence of Mental Health, Criminal Justice, and Immigration in the Authorization of Deportation. In A. J. Joseph (Ed.), *Deportation and the Confluence of Violence within Forensic Mental Health and Immigration Systems* (pp. 1–17). Palgrave Macmillan UK.  
[https://doi.org/10.1057/9781137513410\\_1](https://doi.org/10.1057/9781137513410_1)
- Joseph, A. J. (2015c). The Canadian Forensic Mental Health System: An Overview. In A. J. Joseph (Ed.), *Deportation and the Confluence of Violence within Forensic Mental Health and Immigration Systems* (pp. 43–54). Palgrave Macmillan UK.  
[https://doi.org/10.1057/9781137513410\\_3](https://doi.org/10.1057/9781137513410_3)
- Kafer, A. (2013). *Feminist, queer, crip*. Indiana University Press.
- Kanani, N. (2011). Race and Madness: Locating the experiences of racialized people with psychiatric histories in Canada and the United States. *Critical Disability*

- Discourses/Discours Critiques Dans Le Champ Du Handicap*, 3(0), Article 0.  
<https://cdd.journals.yorku.ca/index.php/cdd/article/view/31564>
- Kanellakos, S., & Community and Protective Services. (2006). *Domiciliary Hostel Service and Standards*. Health, Recreation and Social Services Committee.  
<https://app06.ottawa.ca/calendar/ottawa/citycouncil/hrssc/2006/02-16/ACS2006-CPS-HOU-0002.htm>
- Kay, K. (2017). *Planning for Health Services for Older Adults Living with Frailty: Asset Mapping of Specialized Geriatric Services (SGS) in Ontario* (v. 2; p. 83). RGP of Ontario. <https://www.rgps.on.ca/wp-content/uploads/2019/05/Planning-for-Health-Services-for-Older-Adults-Living-with-Frailty-SGS-Asset-Mapping-Report-FINAL.pdf>
- Kealey, G. S. (1980). *Toronto Workers Respond to Industrial Capitalism, 1867-1892*. University of Toronto Press; JSTOR.  
<http://www.jstor.org/stable/10.3138/j.ctt2tv4f4>
- Kelly, C. (2015). *Disability politics and care*. UBC Press. <https://books-scholarsportal-info.proxy.library.carleton.ca/en/read?id=/ebooks/ebooks3/upress/2016-02-12/1/9780774830119>
- Kiedrowski, J. S. (2016). *Amalgamation of police services*. publisher not identified.  
<http://deslibris.ca/ID/10050545>
- Kulick, D., & Rydström, J. (2015). *Loneliness and Its Opposite: Sex, Disability, and the Ethics of Engagement*. Duke University Press Books.
- Kupfer, M., (2021, March 15). *Vaccinated care home resident, husband await “light at the end of the tunnel”* *CBC News*. CBC.

<https://www.cbc.ca/news/canada/ottawa/long-term-care-vaccination-ottawa-regulations-1.5947303>

- Lam, E. (2016). Inspection, policing, and racism: How municipal by-laws endanger the lives of Chinese sex workers in Toronto. *Canadian Review of Social Policy*, 75, 87–112.
- Lam, E. (2018). Micromanaging the Massage Parlour: How Municipal Bylaws Organize and Shape the Lives of Asian Sex Workers. *Erotic Subjects and Outlaws*, 102–130. [https://doi.org/10.1163/9789004392298\\_007](https://doi.org/10.1163/9789004392298_007)
- Landes, S. D., Turk, M. A., Formica, M. K., McDonald, K. E., & Stevens, J. D. (2020). COVID-19 outcomes among people with intellectual and developmental disability living in residential group homes in New York State. *Disability and Health Journal*, 13(4), 100969. <https://doi.org/10.1016/j.dhjo.2020.100969>
- Langill, D. L. and G. (2005, October 15). A Public/Private Partnership: The Royal Ottawa Hospital Experience. *Healthcare Quarterly*.  
<https://www.longwoods.com/content/17695/healthcare-quarterly/a-public-private-partnership-the-royal-ottawa-hospital-experience>
- Lauriault, T. (2020). Tracing COVID-19 Data: Data and Technological Citizenship during the COVID-19 Pandemic. *Canadian Journal of European and Russian Studies*, 13(1). <https://doi.org/10.22215/CURRRG/2020.TracingCOVID19data>
- Lauriault, T. Tracing COVID-19 Data. Data Libre. <http://datalibre.ca/2020/06/01/tracing-covid-19-data-data-and-technological-citizenship-during-the-covid-19-pandemic/>

- Law, T. (2015). Licensed or Licentious? Examining Regulatory Discussions of Stripping in Ontario. *Canadian Journal of Law & Society / La Revue Canadienne Droit et Société*, 30(1), 31–50. <https://doi.org/10.1017/cls.2014.25>
- Leblanc Haley, T., & Temple Jones, C. (2020). Sites and Shapes of Transinstitutionalization. *Canadian Journal of Disability Studies*, 9(3), 1–15. <https://doi.org/10.15353/cjds.v9i3.643>
- Lichtenberg, P. A. (2014). Sexuality and Physical Intimacy in Long Term Care. *Occupational Therapy in Health Care*, 28(1), 42–50. <https://doi.org/10.3109/07380577.2013.865858>
- Lin, E, Balogh, R., Durbin, A, Holder, L., Gupta, N., & Volpe, T. (2019). *Addressing Gaps in the Health Care Services Used by Adults with Developmental Disabilities in Ontario*. Institute for Clinical Evaluative Sciences. <https://www.ices.on.ca/Publications/Atlases-and-Reports/2019/Addressing-Gaps-in-the-Health-Care-Services-Used-by-Adults-with-Developmental-Disabilities>
- Lin, Elizabeth, Barbaree, H., Selick, A., Ham, E., Wilton, A. S., & Lunskey, Y. (2017). Intellectual and Developmental Disabilities and Ontario’s Forensic Inpatient system: A population-based cohort study. *Psychology, Crime & Law*, 23(9), 914–926. <https://doi.org/10.1080/1068316X.2017.1346100>
- Linton, M. (2020, March 31). ‘We have always been disposable’: The structural violence of neoliberal healthcare. *Canadian Dimensions*. <https://canadiandimension.com/articles/view/we-have-always-been-disposable-the-structural-violence-of-neoliberal-healthcare>

- Linton, M. (2021a). Mind the Gap: Adults labelled with Intellectual and Developmental Disabilities and Data Collection in Ontario. *Carleton Perspectives on Public Policy*, 7.
- Linton, M. (2021b, January 14). On prisons and personal care: Disabled confinement and COVID-19. *Winnipeg Police Cause Harm*.  
<https://winnipegpolicecauseharm.org/blog/on-prisons-and-personal-care-disabled-confinement-and-covid-19/>
- Linton, M. (2021c, February 24). Ontario's hidden institutions. *Canadian Dimension*.  
<https://canadiandimension.com/articles/view/custodial-institutions-ontarios-hidden-victims>
- Linton, M. (2021d, May). "Mind the Gap: Data and adults with developmental disabilities in Ontario". *Carleton Perspectives on Public Policy*, 7.
- Linton, M., Chokly, K., & Lauriault, T. (2021, February 18). Invisible People and Institutions: No data about Custodial Institutions for Disabled People in Canada? *Data Libre*. <http://datalibre.ca/2021/02/18/invisible-people-and-institutions-no-data-about-custodial-institutions-for-disabled-people-in-canada/>
- Lipsky, Michael. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. Russell Sage Foundation.  
<https://catalog.hathitrust.org/Record/000724674>
- Local Health Integration System Act, c. 4 S.O. 2006 (2006).  
<https://www.ontario.ca/laws/statute/06104>
- Lodoen, S. (2019). *The Myths That Make Us: An Examination of Canadian National Identity* [Western University].

[https://ir.lib.uwo.ca/etd/6408?utm\\_source=ir.lib.uwo.ca%2Fetd%2F6408&utm\\_medium=PDF&utm\\_campaign=PDFCoverPages](https://ir.lib.uwo.ca/etd/6408?utm_source=ir.lib.uwo.ca%2Fetd%2F6408&utm_medium=PDF&utm_campaign=PDFCoverPages)

Long Term Care Home Act (2007). c. 8 S. O. 2007.

Loreto, N. (2021, May). Deaths in Residential Care in Canada by facility.

[https://docs.google.com/spreadsheets/d/1M\\_RzojK0vwF9nAozI7aoyLpPU8EA1JEqO6rq0g1iebU/edit?oid=109382957060310089589&usp=sheets\\_home&ths=true&usp=embed\\_facebook](https://docs.google.com/spreadsheets/d/1M_RzojK0vwF9nAozI7aoyLpPU8EA1JEqO6rq0g1iebU/edit?oid=109382957060310089589&usp=sheets_home&ths=true&usp=embed_facebook)

Lowndes, R. H., Angus, J. E., & Peter, E. (2013). Diabetes care and mental illness: The social organization of food in a residential care facility. *Canadian Journal of Public Health, 104*(4), e330–e330.

Lunsky, Y., & Balogh, R. (2010). Dual Diagnosis: A National Study of Psychiatric Hospitalization Patterns of People With Developmental Disability. *Canadian Journal of Psychiatry, 55*(11), 721–728.

Lyon-Callo, V. (c2004.). *Inequality, poverty, and neoliberal governance :activist ethnography in the homeless sheltering industry*. Peterborough, Ont. ; <http://hdl.handle.net/2027/mdp.39015062839496>

Mackey, E. (1998). *House Of Difference*. Routledge.

<http://public.eblib.com/choice/publicfullrecord.aspx?p=237311>

MacMurchy, H. & Ontario. Dept. of Education. (1915). *Organization and management of auxiliary classes*. [Toronto]: L.K. Cameron. <http://archive.org/details/organizationmana00macmuoft>

- Maier, K. (2020). Canada's 'Open Prisons': Hybridisation and the Role of Halfway Houses in Penal Scholarship and Practice. *Howard Journal of Crime and Justice*, 59(4), 381–399. <https://doi.org/10.1111/hojo.12365>
- Mairs, N. (1986). *Plaintext: Essays* (1st ed). University of Arizona Press.
- Mairs, N. (1996). *Carnal acts: Essays*. Beacon Press.
- Marrelli, M. (2018, July 24). *Inside the battle to modernize 1960s-era mental health housing in Ontario*. This Magazine. <https://this.org/2018/07/24/inside-the-battle-to-modernize-1960s-era-mental-health-housing-ontario/>
- Martin, L., & Ashworth, M. (2010). Deinstitutionalization in Ontario, Canada: Understanding Who Moved When. *Journal of Policy and Practice in Intellectual Disabilities*, 7(3), 167–176. <https://doi.org/10.1111/j.1741-1130.2010.00261.x>
- Maynard, R. (2018). Do Black Sex Workers' Lives Matter? Whitewashed Anti-Slavery, Racial Justice and Abolition. In E. M. Durisin, E. van der Meulen, & C. Bruckert (Eds.), *Red light labour: Sex work regulation, agency, and resistance*. UBC Press.
- McBride, B., Shannon, K., Murphy, A., Wu, S., Erickson, M., Goldenberg, S. M., & Krüsi, A. (2020). Harms of third party criminalisation under end-demand legislation: Undermining sex workers' safety and rights. *Culture, Health & Sexuality, ahead-of-print*(ahead-of-print), 1–17. <https://doi.org/10.1080/13691058.2020.1767305>
- McCoy, T. (2012). *Hard time: Reforming the penitentiary in nineteenth-century Canada*. AU Press.
- McIntyre, C. (2015, May 13). Migrant sex workers caught up in Ottawa sting facing deportation, further exploitation: Activists. *National Post*.

<https://nationalpost.com/news/canada/migrant-sex-workers-caught-up-in-ottawa-sting-facing-deportation-further-exploitation-activists>

McLaren, A. (c1990.). *Our own master race :eugenics in Canada, 1885-1945 /*.

McClelland & Stewart. <http://hdl.handle.net/2027/uva.x001861897>

MCSS. (2009). *Policy Directives For Service Agencies | Ministry of Community and Social Services*. Government of Ontario.

[https://www.mcsc.gov.on.ca/en/mcsc/publications/developmentalServices/policy\\_directive\\_service/support\\_service\\_directive1.aspx](https://www.mcsc.gov.on.ca/en/mcsc/publications/developmentalServices/policy_directive_service/support_service_directive1.aspx)

Meaghan, D. (2000). *THE POLITICAL ECONOMY OF STRIPPING: THE SOCIAL CONSTRUCTION OF SEX TRADE WORK*. Ontario Institute for Studies in Education of the University of Toronto.

*Mental Health Care: Forensic Program*. (2013). St. Joseph's Health Care London.

<https://www.sjhc.london.on.ca/areas-of-care/mental-health-care/mental-health-care-forensic-program/services>

Miller, F. (1983). *Ontario Budget*. Ministry of Treasury and Economics.

[http://www.archives.gov.on.ca/en/historical\\_documents\\_project/82-86/ONTARIO\\_1983\\_BUDGET.pdf](http://www.archives.gov.on.ca/en/historical_documents_project/82-86/ONTARIO_1983_BUDGET.pdf)

Miller, R. A. (2017). "My Voice Is Definitely Strongest in Online Communities":

Students Using Social Media for Queer and Disability Identity-Making. *Journal of College Student Development*, 58(4), 509–525.

<https://doi.org/10.1353/csd.2017.0040>

Mingus, M. (2011). Disability Justice is Simply Another Term for Love. *Leaving*

*Evidence*. <https://leavingevidence.wordpress.com/tag/ableism/>

Minich, J. (2016, June 1). Enabling Whom? Critical Disability Studies Now. *Lateral*.  
<https://csalateral.org/issue/5-1/forum-alt-humanities-critical-disability-studies-now-minich/>

Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, (2008). <https://www.ontario.ca/laws/statute/08s14>

Ministry of Community and Social Services. (2012). *From institutional to community living: A history of developmental services in Ontario | Ministry of Community and Social Services*. Government of Ontario.  
<https://www.mcass.gov.on.ca/en/dshistory/index.aspx>

Ministry of Community and Social Services. (2021). *Ontario Disability Support Program Monthly Statistical Report—January 2021*. Government of Ontario.  
<https://www.mcass.gov.on.ca/en/mcass/open/sa/odspCaseLoadReport.aspx>

Ministry of Health and Long Term Care. (2003). *Operating guidelines for homes for special care*. <https://books-scholarsportal-info.proxy.library.carleton.ca/en/read?id=/ebooks/ebooks2/ogdc/2014-02-24/1/239039#page=8>

Ministry of Health and Long Term Care. (2019). *Long-Term Care Homes Financial Policy* (p. 25).  
[https://www.health.gov.on.ca/en/public/programs/ltc/docs/level\\_of\\_care\\_per\\_die\\_m\\_funding\\_policy.pdf](https://www.health.gov.on.ca/en/public/programs/ltc/docs/level_of_care_per_die_m_funding_policy.pdf)

Ministry of Health and Long-Term Care. (2012). *Designated Psychiatric Facilities under the Mental Health Act*. Government of Ontario, Ministry of Health and Long-

Term Care.

<https://www.health.gov.on.ca/en/common/system/services/psych/designated.aspx>

Ministry of Municipal Affairs and Housing. (2014, November). *Guide to the Housing with Related Supports Service Category*. Community Homelessness Prevention Initiative (CHPI). <http://www.mah.gov.on.ca/AssetFactory.aspx?did=12230>

Ministry of the Solicitor General. (2018, September 17). *Inmate Information Guide for Adult Institutions*. Corrections Policies and Guidelines.

[https://www.mcscs.jus.gov.on.ca/english/corr\\_serv/PoliciesandGuidelines/CS\\_Inmate\\_guide.html#P690\\_108106](https://www.mcscs.jus.gov.on.ca/english/corr_serv/PoliciesandGuidelines/CS_Inmate_guide.html#P690_108106)

Moon, G., Kearns, R., & Joseph, A. (2006). Selling the Private Asylum: Therapeutic Landscapes and the (Re)valorization of Confinement in the Era of Community Care. *Transactions of the Institute of British Geographers*, 31(2), 131–149. JSTOR.

Moran, J. E. (2001). *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario*. McGill-Queen's University Press. <http://ebookcentral.proquest.com/lib/oculcarleton-ebooks/detail.action?docID=3330976>

Morris, S., Fawcett, G., Brisebois, L., & Hughes, J. (2018). *A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017* (Canadian Survey on Disability Reports). Statistics Canada. <https://www150.statcan.gc.ca/n1/pub/89-654-x/89-654-x2018002-eng.htm>

- Mostert, M. P. (2002). Useless Eaters: Disability as Genocidal Marker in Nazi Germany. *The Journal of Special Education*, 36(3), 157–170.  
<https://doi.org/10.1177/00224669020360030601>
- Mulder, M. (2004). Faith-Based Homeless Shelters and “Hyper-Institutionalization”: A Case Study. *Michigan Sociological Review*, 18, 136–165. JSTOR.
- Muscatti, S. (2017). Rights Violations Associated with Canada’s Treatment of Vulnerable Persons in Immigration Detention. *International Human Rights Program*.  
<https://jfcy.org/wp-content/uploads/2013/10/Canada-UPR-Joint-Submission-2017.pdf>
- Mussell, L., & Rampersaud, M. (2020). Solitary confinement by any other name is still torture. *The Conversation*. <http://theconversation.com/solitary-confinement-by-any-other-name-is-still-torture-149670>
- N. B. R. H. Centre (n.d.). *North Bay Regional Health Centre*. NBRHC. Retrieved October 15, 2020, from <http://www.nbrhc.on.ca/programs-services/mental-health-programs-services/regional-specialized-mental-health-program/mental-health-law/>
- National Institute on Ageing. (2019). *Enabling the Future Provision of Long-Term Care in Canada* (p. 161). National Institute on Ageing White Paper.
- Networks Of Specialized Care. (n.d.). *CLH Developmental Support Services*. Retrieved March 29, 2021, from <https://www.clhmidland.on.ca/networks-of-specialized-care/>
- Newman, J., & Head, B. (2017). The National Context of Wicked Problems: Comparing Policies on Gun Violence in the US, Canada, and Australia. *Journal of*

Comparative Policy Analysis: Research and Practice, 19(1), 40–53.

<https://doi.org/10.1080/13876988.2015.1029334>

Nursing Home Abuse Center. (2019, October 23). Nursing Home Cameras—More Harm Than Good? <https://www.nursinghomeabusecenter.com/blog/cameras-in-nursing-homes/>

McIntosh, E. (2020, May 26). Military report finds gruesome conditions, abuse inside 5 Ontario long-term care homes. *National Observer*.

<https://www.nationalobserver.com/2020/05/26/news/military-report-finds-gruesome-conditions-abuse-inside-5-ontario-long-term-care>

Niles, C. (2013). *Examining the Deinstitutionalization Movement in North America*. 1, 30.

Novac, S. (2006). Justice and injustice: Homelessness, crime, victimization, and the criminal justice system. *Centre for Urban and Community Studies*.

OC Transpo. (2020). *Para Transpo*. <https://www.octranspo.com/en/para-transpo/>

ODSP Action Coalition. (2017). *ODSP Reform: Issues for People with Partners or Roommates*.

OECD. (2017). *Systems Approaches to Public Sector Challenges: Working with Change*.

OECD. <https://doi.org/10.1787/9789264279865-en>

Office of the Auditor General of Ontario. (2016). *2016 Annual Report of the Office of the Auditor General of Ontario*. Office of the Auditor General of Ontario.

Office of the Premier. (2018, April 19). *30,000 More Long-Term Care Beds for Seniors*.

Ontario Newsroom. <https://news.ontario.ca/en/release/49111/30000-more-long-term-care-beds-for-seniors>

- Office of the Premier. (2020, July 21). *Ontario Unveils New Innovative Approach to Building Long-Term Care Homes Faster*. Ontario Newsroom.  
<https://news.ontario.ca/en/release/57690/ontario-unveils-new-innovative-approach-to-building-long-term-care-homes-faster>
- OHRC. (2011). *Room for everyone: Human rights and rental housing licensing*. Ontario Human Rights Commission. <http://www3.ohrc.on.ca/en/room-everyone-human-rights-and-rental-housing-licensing>
- Oliver, P. (2000). *“Terror to Evil-Doers”: Prisons and Punishments in Nineteenth-Century Ontario*. University of Toronto Press.  
<http://ebookcentral.proquest.com/lib/oculcarleton-ebooks/detail.action?docID=3281375>
- OLTCA. (2019). *Facts and Figures*. Ontario Long Term Care Association.  
[https://www.oltca.com/oltca/OLTCA/Public/LongTermCare/FactsFigures.aspx#Ontario's%20long-term%20care%20homes%20\(June%202017\)](https://www.oltca.com/oltca/OLTCA/Public/LongTermCare/FactsFigures.aspx#Ontario's%20long-term%20care%20homes%20(June%202017))
- O’Mara, J. (1982). *Group homes for the mentally handicapped in Ontario* (Current Issue Paper No. 17). Legislative library, Research and Information Services.
- Omstead, J. (2020, May 11). Councillor wants Edmonton to consider permanent closure of body rub centres. *CBC News*.  
<https://www.cbc.ca/news/canada/edmonton/body-rub-centres-covid-19-permanently-close-1.5564036>
- Ontario CMHA. (2014). *Housing and Mental Health*.  
<https://ontario.cmha.ca/documents/housing-and-mental-health/>

Ontario, Commission of Inquiry into Unregulated Residential Accommodation,

Lightman, E. S., & Kenewell, J. (1992). *A community of interests: The report of the Commission of Inquiry into Unregulated Residential Accommodation*. The Commission.

Ontario Developmental Services Housing Task Force. (2018). *Generating Ideas and Enabling Action: Addressing the Housing Crisis Confronting Ontario Adults with Developmental Disabilities* [Final Report]. [https://cdn.agilitycms.com/partners-for-planning/htf-final-reports-pdfs/HTF%20Final%20Report%202018\\_Generating%20Ideas\\_Enabling%20Action\\_FINAL.pdf](https://cdn.agilitycms.com/partners-for-planning/htf-final-reports-pdfs/HTF%20Final%20Report%202018_Generating%20Ideas_Enabling%20Action_FINAL.pdf)

Ontario HIV Treatment Network. (2015, May 22). *St Lawrence Valley: A Hybrid Mental Health & Correctional Centre*.  
[https://www.youtube.com/watch?v=7KSjbBkQY\\_o](https://www.youtube.com/watch?v=7KSjbBkQY_o)

Ontario Review Board. (2017). *Memorandum of Understanding Between Minister of Health and Long-Term Care and Chair of the Ontario Review Board 2017-2021*.  
<http://www.orb.on.ca/scripts/en/accountability/ORBMUO-English.pdf>

Ontario Shores Centre for Mental Health Sciences. (n.d.). *Assessment and Reintegration Program (ARP)*.  
<https://www.ontarioshores.ca/cms/one.aspx?portalId=169&pageId=827>

Ottawa Police Service. (2020). *Draft Budget 2021*. City of Ottawa.  
<https://www.ottawapolice.ca/en/news-and-community/resources/2021-draft-budget.pdf>

- Ottawa Salus Corporation. (2018). *Supportive Housing* –.  
<https://www.salusottawa.org/supportive-housing/>
- Ouellette-Kuntz, H., Martin, L., & McKenzie, K. (2017). The Risk of Re-Institutionalization: Examining Rates of Admission to Long-Term Care Among Adults with Intellectual and Developmental Disabilities Over Time. *Journal of Policy and Practice in Intellectual Disabilities*, 14(4), 293–297.  
<https://doi.org/10.1111/jppi.12215>
- Pal, L. A. (2014). *Beyond policy analysis: Public issue management in turbulent times* (5th ed.).
- Pal, L., Auld, G., & Mallett, A. (2021). *Beyond policy analysis: public issue management in turbulent times* (Sixth edition.). Nelson.
- Palmater, P. D. (2011). *Beyond blood: Rethinking indigenous identity*. Purich Publishing.
- Park, D. C., & Wood, J. D. (1992). Poor relief and the county house of refuge system in Ontario, 1880–1911. *Journal of Historical Geography*, 18(4), 439–455.  
[https://doi.org/10.1016/0305-7488\(92\)90239-6](https://doi.org/10.1016/0305-7488(92)90239-6)
- Park, D. P. (1990). *Changing shadows: The Huronia Regional Centre, 1876-1934* [York University]. <http://search.proquest.com/docview/193718579?pq-origsite=summon>
- Pedersen, K., Mancini, M., & Common, D. (2020, May 7). Why some nursing homes won't allow "granny cams" that let families keep an eye on loved ones. CBC News. <https://www.cbc.ca/news/canada/covid-19-long-term-care-granny-cams-1.5553092>
- Penney, S. R., Seto, M. C., Crocker, A. G., Nicholls, T. L., Grimbos, T., Darby, P. L., & Simpson, A. I. F. (2019). Changing characteristics of forensic psychiatric patients

- in Ontario: A population-based study from 1987 to 2012. *Social Psychiatry and Psychiatric Epidemiology*, 54(5), 627–638. <https://doi.org/10.1007/s00127-018-1619-6>
- Petrella, S. (2018). Erotic Subjects and Outlaws: Sketching the Borders of Sexual Citizenship. An Introduction. *Erotic Subjects and Outlaws*, 1–18. [https://doi.org/10.1163/9789004392298\\_002](https://doi.org/10.1163/9789004392298_002)
- Pettinicchio, D. (2019). *Politics of empowerment: Disability rights and the cycle of American policy reform*. Stanford University Press
- Piepzna-Samarasinha, L. L. (2018). *Care Work: Dreaming Disability Justice*. Arsenal Pulp Press. <https://ebookcentral-proquest-com.proxy.library.carleton.ca/lib/oculcarleton-ebooks/detail.action?pq-origsite=primo&docID=5396334>.
- Piza, E. L., Welsh, B. C., Farrington, D. P., & Thomas, A. L. (2019). CCTV surveillance for crime prevention: A 40-year systematic review with meta-analysis. *Criminology & Public Policy*, 18(1), 135–159. <https://doi.org/10.1111/1745-9133.12419>
- Plummer, K. (1995). *Telling sexual stories power, change, and social worlds*. Routledge. <http://www.myilibrary.com?id=33660>
- Polewski, L. (2021, January). Hamilton man dies amid ‘disturbing’ living conditions at Niagara Falls home, says family. *Global News*. <https://globalnews.ca/news/7608179/hamilton-man-dies-disturbing-living-conditions-niagara-falls-home/>

- Post Media News. (2015). Police raid residential erotic massage parlour, leading to 76 human trafficking charges for alleged ringleader. *National Post*.  
<https://nationalpost.com/news/canada/residential-erotic-massage-parlour-police-raid-leads-to-76-human-trafficking-charges>
- Porter, R. B. (2002). The Meaning of Indigenous Nation Sovereignty Symposium on Cultural Sovereignty. *Arizona State Law Journal*, 34(1), 75–112.
- PriceWaterHouseCoopers. (2020). *Centre for Addiction and Mental Health Services Financial Statements*. <https://www.camh.ca/-/media/files/camh-financial-statements-2020-pdf.pdf>
- Priel, J.-A., Hendry, G., & Webb, S. (2016). *City of Hamilton Domiciliary Hostel Program Review (CS10036(a)) (City Wide)* (p. 129). City of Hamilton.
- Project for Public Spaces. (2013). *ByWard Market*. <https://www.pps.org/projects/byward-market>
- Puar, J. (2012). Coda: The Cost of Getting Better: Suicide, Sensation, Switchpoints. *GLQ*, 18(1), 149–158. <https://doi.org/10.1215/10642684-1422179>
- Puar, J. K. (2017). *The Right to Maim: Debility, Capacity, Disability*. Duke University Press. <http://ebookcentral.proquest.com/lib/oculcarleton-ebooks/detail.action?docID=5105862>
- Quinlan, A., & Smele, S. (2017). The ‘problem’ of abuse in Ontario’s Social Inclusion Act: A critical exploration. *Critical Social Policy*, 37(1), 85–104.  
<https://doi.org/10.1177/0261018316664468>

- Radford, J., & Brown, I. (2015). The Growth and Decline of Institutions for People with Developmental Disabilities in Ontario: 1876-2009 - ProQuest. *Journal of Developmental Disabilities, 21*(2), 7–27.
- Ranasinghe, P., & Valverde, M. (2006). Governing Homelessness through Land-Use: A Sociolegal Study of the Toronto Shelter Zoning By-Law. *The Canadian Journal of Sociology / Cahiers Canadiens de Sociologie, 31*(3), 325–349. JSTOR.  
<https://doi.org/10.2307/20058713>
- Reaume, G. (1997). Accounts of Abuse of Patients at the Toronto Hospital for the Insane, 1883–1937. *Canadian Bulletin of Medical History, 14*(1), 65–106.  
<https://doi.org/10.3138/cbmh.14.1.65>
- Reaume, G. (2012). *Remembrance of patients past: Patient life at the Toronto Hospital for the Insane, 1870-1940*.
- Reese, L. A., & Rosenfeld, R. A. (2016). *Comparative Civic Culture: The Role of Local Culture in Urban Policy-Making* (0 ed.). Routledge.  
<https://doi.org/10.4324/9781315573045>
- Residential Tenancies Act, c.17 S. 2006 (2006).
- Retirement Homes Act, c. 11 S.o. 2010 (2010).  
<https://www.ontario.ca/laws/statute/10r11?search=retirement+homes+act>.
- Robin, L., Peterson, B. E., & Lawrence, D. S. (2020). How do close-circuit television cameras impact crimes and clearances? An evaluation of the Milwaukee police department's public surveillance system. *Police Practice and Research, 1*–20.  
<https://doi.org/10.1080/15614263.2020.1772783>

- Roblin, B., Deber, R., Kuluski, K., & Silver, M. P. (2019). Ontario's Retirement Homes and Long-Term Care Homes: A Comparison of Care Services and Funding Regimes. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, 38(2), 155–167.
- Rodriguez, D. (2019). Abolition as Practice of Human Being: Foreward. *Harvard Law Review*, 132(6), 1575–1612.
- Rog, D. J. (2004). The Evidence on Supported Housing. *Psychiatric Rehabilitation Journal*, 27(4), 334–344. <https://doi.org/10.2975/27.2004.334.344>
- Roige, A. (2014, April 29). Intelligence and IQ testing. *The Eugenics Archives*.  
<http://eugenicsarchive.ca/discover/encyclopedia/535eecb77095aa0000000023a>
- Rosenfeld, R. A., & Reese, L. A. (2003). The Anatomy of an Amalgamation: The Case of Ottawa. *State & Local Government Review*, 35(1), 57–69.
- Rossiter, K., & Clarkson, A. (2013). Opening Ontario's "Saddest Chapter": A Social History of Huronia Regional Centre. *Canadian Journal of Disability Studies*, 2(3), 1–30. <https://doi.org/10.15353/cjds.v2i3.99>
- Rossiter, K., & Rinaldi, J. (2018). *Institutional Violence and Disability: Punishing Conditions*. Routledge. <https://doi.org/10.4324/9781351022828>
- Sali, D. (2019). ByWard Market business owners keen on Mayor Watson's CCTV proposal. *Ottawa Business Journal*. <https://www.obj.ca/article/byward-market-business-owners-keen-mayor-watsons-cctv-proposal>
- Saltes, N. (2013). 'Abnormal' Bodies on the Borders of Inclusion: Biopolitics and the Paradox of Disability Surveillance. *Surveillance & Society*, 11(1/2), 55–73.  
<https://doi.org/10.24908/ss.v11i1/2.4460>

- Sancton, A. (2000). Amalgamations, service realignment, and property taxes: Did the Harris government have a plan for Ontario's municipalities? *Canadian Journal of Regional Science*, 23(1), 135–156.
- Sanders, T. (2009). Controlling the 'anti sexual' city: Sexual citizenship and the disciplining of female street sex workers. *British Society of Publication*, 9(4), 507–525.
- Sanders, T. (2017). The politics of sexual citizenship: Commercial sex and disability: Disability & Society: Vol 22, No 5. *Disability & Society*, 22(5), 439–455.
- Sayin, F. K., Denton, M., Brookman, C., Davies, S., Chowhan, J., & Zeytinoglu, I. U. (2019). The role of work intensification in intention to stay: A study of personal support workers in home and community care in Ontario, Canada. *Economic and Industrial Democracy*, 0143831X18818325.  
<https://doi.org/10.1177/0143831X18818325>
- Schalk, S. (2017). Critical Disability Studies as Methodology. *Lateral*, 6(1).  
<https://doi.org/10.25158/L6.1.13>
- Schepers, N. (2008). *Rideau-Vanier Ward 12 Interim By-Law Study and Zoning By-Law Amendment*. Planning and Environment Committee Comité de l'urbanisme et de l'environnement. <https://app06.ottawa.ca/calendar/ottawa/citycouncil/ec/2008/06-10/ACS2008-PTE-PLA-0011.htm>
- Schrauwers, A. (2016). *"Union is Strength."* University of Toronto Press.
- Sealy, P., & Whitehead, P. C. (2004). Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *Canadian Journal of Psychiatry*.

*Revue Canadienne De Psychiatrie*, 49(4), 249–257.

<https://doi.org/10.1177/070674370404900405>

- Seppänen, A., Törmänen, I., Shaw, C., & Kennedy, H. (2018). Modern forensic psychiatric hospital design: Clinical, legal and structural aspects. *International Journal of Mental Health Systems*, 12. <https://doi.org/10.1186/s13033-018-0238-7>
- Shakespeare, T., Gillespie-Sells, K., & Davies, D. (1996). *The Sexual Politics of Disability*. Cassell.
- Shapiro, L. (2002). Incorporating Sexual Surrogacy into The Ontario Direct Funding Program. *Disability Studies Quarterly*, 22(4), Article 4. <https://doi.org/10.18061/dsq.v22i4.373>
- Shartal, S., Cowan, L., Kandohr, E., & German, B. (2003). *Failing the Homeless: Barriers in the Ontario Disability Support Program for Homeless People with Disabilities*. Street Health.
- Shpigelman, C.-N., & Gill, C. J. (2014). Facebook Use by Persons with Disabilities\*. *Journal of Computer-Mediated Communication*, 19(3), 610–624. <https://doi.org/10.1111/jcc4.12059>
- Shuttleworth, R. P., & Mona, L. R. (2000). Introduction to the Special Issue. *Sexuality and Disability*, 18(4), 229–231. <https://doi.org/10.1023/A:1005638025504>
- Siebers, T. (2012). A Sexual Culture for Disabled People. In *Sex & Disability*. Duke University Press.
- Silverberg, C., Kaufman, M., Odette, F., & Smyth, F. (2016). *The ultimate guide to sex and disability: For all of us who live with disabilities, chronic pain, and illness*.

<https://www.overdrive.com/search?q=60E0B7DD-EE6F-4A00-8A22-90D713ECB7F3>

- Simmons, H. (1982). *From asylums to welfare*. National Institute on Medicine.
- SisterSong. (1994). *Reproductive Justice*. SisterSong Women of Color Reproductive Justice Network. <https://www.sistersong.net/reproductive-justice>
- Smith, G. J. (2016). Life through a lens: Risk, surveillance and subjectivity. *International Journal for Crime, Justice and Social Democracy*, 5(1), 82–97.  
<https://doi.org/10.5204/ijcjsd.v5i1.281>
- Smith, M. C., & Orsini, M. (Eds.). (2007). *Critical policy studies*. UBC Press.
- Sonpal-Valias, N. (2019). History of Developmental Disability Policy in Alberta. *The School of Public Policy Publications*, 12(20). <https://ssrn.com/abstract=3422206>
- Spagnuolo, N. (2016). Building Back Wards in a “Post” Institutional Era: Hospital Confinement, Group Home Eviction, and Ontario’s Treatment of People Labelled with Intellectual Disabilities. *Disability Studies Quarterly*, 36(4).  
<https://doi.org/10.18061/dsq.v36i4.5279>
- Spalding, D. (2018). The prostitution pipeline: Cut off from loved ones, women cycled from city to city — including Ottawa. *Ottawa Citizen*.  
<https://ottawacitizen.com/news/local-news/the-pipeline-pimps-cut-women-off-from-loved-ones-shuttle-them-from-city-to-city-including-ottawa>
- Spears, T. (2019, September 5). Will CCTV cameras in the ByWard Market help curb violent crime? Hardly. *Ottawa Citizen*. <https://ottawacitizen.com/news/local-news/will-cctv-cameras-in-the-byward-market-help-curb-violent-crime-hardly>

- Spivakovsky, C. (2017). Governing freedom through risk: Locating the group home in the archipelago of confinement and control. *Punishment & Society*, 19(3), 366–383. <https://doi.org/10.1177/1462474517703968>
- St. Joseph's. (2018). *Community Homes for Opportunity (CHO)*. St. Joseph's Health Care London. <https://www.sjhc.london.on.ca/areas-of-care/mental-health-care/community-homes-opportunity-cho>
- St. Lawrence Valley Correctional and Treatment Centre. (2011, January 21). *Globe and Mail*. <https://www.theglobeandmail.com/news/national/st-lawrence-valley-correctional-and-treatment-centre/article631320/>
- Stall, N. M., Jones, A., Brown, K. A., Rochon, P. A., & Costa, A. P. (2020). For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths. *CMAJ: Canadian Medical Association Journal*, 192(33), E946–E946. <https://doi.org/10.1503/cmaj.201197>
- Stavis, P. F. (1991). Harmonizing the right to sexual expression and the right to protection from harm for persons with mental disability. *Sexuality and Disability*, 9(2), 131–141. <https://doi.org/10.1007/BF01101738>
- Steel, D. (2013). *Intimacy and Sexuality Practice Guidelines*. 30.
- Stone, D. A. (1984). *The Disabled State*. Temple University Press.
- Strong-Boag, V. (1993). *The New day recalled: Lives of girls and women in English Canada, 1919-1939*. Copp Clark Pittman.
- Struthers, J. (2017). "Home, Hotel, Hospital, Hospice: Conflicting Images of Long-term Residential Care in Ontario, Canada," in Sally Chivers and Ulla Kriebnernegg

eds., *Care Home Stories: Aging, Disability, and Long-term Residential Care*, transcript Verlag, 2017, 283-302. (pp. 283–302).

Suttor, G. (2016). *Taking Stock of Supportive Housing for Mental Health and Addictions in Ontario*. Wellesley Institute. [https://ocul-crl.primo.exlibrisgroup.com/permalink/01OCUL\\_CRL/1gorbd6/alma991022730365205153](https://ocul-crl.primo.exlibrisgroup.com/permalink/01OCUL_CRL/1gorbd6/alma991022730365205153)

Sylph, J. A., Eastwood, M. R., & Kedward, H. B. (1976). Long-term psychiatric care in Ontario: The Homes for Special Care Program. *Canadian Medical Association Journal*, 114(3), 233–237.

Tabol, C., Drebing, C., & Rosenheck, R. (2010). Studies of “supported” and “supportive” housing: A comprehensive review of model descriptions and measurement. *Evaluation and Program Planning*, 33(4), 446–456. <https://doi.org/10.1016/j.evalprogplan.2009.12.002>

The Age-Friendly Housing Committee. (2019). *Housing Options in Ottawa: A Guide for Older Adults* (p. 40). The Council on Aging Ottawa. <https://coaottawa.ca/wp-content/uploads/documents/Housing-Guide-2019-09-13-E.pdf>

The Canadian Press. (2012). *Toronto’s group-home zoning rules to be challenged* | *CBC News*. CBC. <https://www.cbc.ca/news/canada/toronto/toronto-s-group-home-zoning-rules-to-be-challenged-1.1229972>

The Ottawa Hospital. (2021, March 9). *Our Services*. The Ottawa Hospital. <https://www.ottawahospital.on.ca/en/clinical-services/deptpgrmcs/departments/mental-health/our-services/>

- The Ottawa-Carleton Association for Persons with Developmental Disabilities  
(OCAPDD). (n.d.). Retrieved March 30, 2021, from  
<https://www.ocapdd.on.ca/?ID=54>
- The Registry - Centre d'enregistrement. (2014). *Supportive Housing | Ottawa Community Housing*. The Registry - The Social Housing Registry of Ottawa, Centre d'enregistrement Pour Les Logements Sociaux d'Ottawa.  
<https://www.housingregistry.ca/supportive-housing/>
- The Royal. (2020). *Mental Health and the Law*. <https://www.theroyal.ca/patient-care-information/clinics-services-programs/mental-health-and-law>
- Todd-Giordano, N., Black, B., Moore, A., VanBuskirk, S., Sardheeye, R., Robinson, S., & Cousineau, T. (2016). *Residential Services Standards* (p. 53). City of Ottawa.  
<http://ottwatch.ca/meetings/file/368548>
- Toews, O. (2017). *Stolen City: Racial Capitalism and the Making of Winnipeg*. Arbeiter Ring Publishing.
- Tomiak, J. (2016). Unsettling Ottawa: Settler colonialism, indigenous resistance, and the politics of scale. *Canadian Journal of Urban Research*, 25(1), 8–22.
- Tortelli, A., Nakamura, A., Suprani, F., Schürhoff, F., Van der Waerden, J., Szöke, A., Tarricone, I., & Pignon, B. (2018). Subclinical psychosis in adult migrants and ethnic minorities: Systematic review and meta-analysis. *BJPsych Open*, 4(6), 510–518. <https://doi.org/10.1192/bjo.2018.68>
- Truchon c. Procureur général du Canada. (2019). QCCS 3792 (CanLII),  
<<https://canlii.ca/t/j2bz1>>.

- Trudeau, P. (1967, December 21). 'There's no place for the state in the bedrooms of the nation'. CBC TV News
- Tufford, F., Lowndes, R., Struthers, J., & Chivers, S. (2018). "'Call Security': Locks, Risk, Privacy and Autonomy in Long-term Residential Care." *Ageing International*, 43(1), 34–52. <https://doi.org/10.1007/s12126-017-9289-3>
- Tunney, J. (2021). Prioritize disabled Canadians in group homes for vaccines, says advocate. CBC News, Ottawa. <https://www.cbc.ca/news/canada/ottawa/group-home-settings-eastern-ontario-health-unit-1.5933588>
- Valverde, M. (2008). *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. University of Toronto Press, Scholarly Publishing Division. <https://proxy.library.carleton.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=468923&site=ehost-live>
- van der Meulen, E., & Valverde, M. (2013). Beyond the Criminal Code: Municipal Licensing and Zoning Bylaws. In *Selling sex: Experience, advocacy, and research on sex work in Canada*. UBC Press.
- van der Meulen, E., & Durisin, E. M. (2008). Why Decriminalize—How Canada's Municipal and Federal Regulations Increase Sex Workers' Vulnerability. *Canadian Journal of Women and the Law*, 20(2), 289–312.
- VanBuskirk, S. (2020). *Legislated Five Year Review of the 10-year Housing and Homelessness Plan*. Community and Protective Services Committee Comité des services communautaires et de protection. <http://ottwatch.ca/meetings/file/642939>
- Vancouver Coastal Health Authority. (n.d.). Supporting Sexual Health and Intimacy in Care Facilities (p. 61). Vancouver Coastal Health Authority.

<http://www.vch.ca/Documents/Facilities-licensing-supporting-sexual-health-and-intimacy-in-care-facilities.pdf>

- Waldby, C., & Cooper, M. (2008). The biopolitics of reproduction—Post-Fordist biotechnology and women’s clinical labour. *Australian Feminist Studies*, 23, 57–73. <https://doi.org/10.1080/08164640701816223>
- Walia, H. (2010). Transient servitude: Migrant labour in Canada and the apartheid of citizenship. *Race & Class*, 52(1), 71–84. <https://doi.org/10.1177/0306396810371766>
- Walker, K., Shearkhani, S., Bai, Y. Q., McGilton, K. S., Berta, W. B., & Wodchis, W. P. (2020). The Impact of the Long-term Care Homes Act and Public Reporting on Physical Restraint and Potentially Inappropriate Antipsychotic Use in Ontario’s Long-term Care Homes. *The Journals of Gerontology: Series A*, 75(4), 813–819. <https://doi.org/10.1093/gerona/glz143>
- Ware, S., Ruzsa, J., & Dias, G. (2014). It can’t be fixed because it’s not broken: Racism and Disability in the Prison Industrial Complex. In L. Ben-Moshe, C. Chapman, & C. Carey (Eds.), *Disability Incarcerated Imprisonment and Disability in the United States and Canada*. Palgrave Macmillan.
- Waypoint Centre. (2019). *Forensic Assessment Program*. [https://mhcp.on.ca/programs\\_and\\_services/forensic\\_assessment\\_program](https://mhcp.on.ca/programs_and_services/forensic_assessment_program)
- Waypoint Centre for Mental Health Care. (n.d.). *About Us*. About Us. Retrieved March 29, 2021, from [https://mhcp.on.ca/about\\_us](https://mhcp.on.ca/about_us)
- Weeks, J. (2016). The Sexual Citizen: *Theory, Culture & Society*. <https://doi.org/10.1177/0263276498015003003>

- Welch, R. (1973). *Community Living for the Mentally Retarded in Ontario: A New Policy Focus*. Provincial Secretariat for Social Development.  
<https://www.mcass.gov.on.ca/documents/en/mcass/dshistory/legislation/Welch%20Report.pdf>
- Wellington Waterloo LHIN. (2014). Multi-Sector Service Accountability Agreement with Homewood Health Centre Inc.  
<http://www.waterloowellingtonlhin.on.ca/~media/sites/ww/files/accountability/saas/msaa/msaaHomewood.pdf?la=fr-CA>
- Whitzman, C., & Slater, T. (2006). Village Ghetto Land: Myth, Social Conditions, and Housing Policy in Parkdale, Toronto, 1879–2000. *Urban Affairs Review*, 41(5), 673–696. <https://doi.org/10.1177/1078087405284673>
- Wilkerson, A. L. (2002). Disability, Sex Radicalism, and Political Agency. *NWSA Journal*, 14(3), 33–57.
- Williston, W. (1971). *Present arrangements for the care and supervision of mentally retarded persons in ontario*. Ontario Department of Health.  
<https://www.mcass.gov.on.ca/documents/en/mcass/dshistory/legislation/Williston%20Report.pdf>
- Wolfensberger, W., Nirje, B., Olshansky, S., Perske, R., & Roos, P. (1972). The Principle of Normalization In Human Services. *Books: Wolfensberger Collection*.  
[https://digitalcommons.unmc.edu/wolf\\_books/1](https://digitalcommons.unmc.edu/wolf_books/1)
- Wright, D., Day, S., Smith, J., & Flis, N. (2013). A Janus-Like Asylum: The City and the Institutional Confinement of the Mentally Ill in Victorian Ontario. *Urban History Review*, 36(2), 43–52. <https://doi.org/10.7202/1019170ar>

Wrublowsky, R. (2018). *MMP Design Guide Long Term Care Home*.

[https://www.fgiguilines.org/wp-](https://www.fgiguilines.org/wp-content/uploads/2018/03/MMP_DesignGuideLongTermCareHomes_2018.01.pdf)

[content/uploads/2018/03/MMP\\_DesignGuideLongTermCareHomes\\_2018.01.pdf](https://www.fgiguilines.org/wp-content/uploads/2018/03/MMP_DesignGuideLongTermCareHomes_2018.01.pdf)

Zabjeck, A. (2019, October 15). *Body rub parlour edmonton city council cease* | *CBC*

*News*. CBC. [https://www.cbc.ca/news/canada/edmonton/body-rub-edmonton-city-](https://www.cbc.ca/news/canada/edmonton/body-rub-edmonton-city-1.5319987)

[1.5319987](https://www.cbc.ca/news/canada/edmonton/body-rub-edmonton-city-1.5319987)

Zeytinoglu, I. U., Denton, M., Brookman, C., Davies, S., & Sayin, F. K. (2017). Health

and safety matters! Associations between organizational practices and personal

support workers' life and work stress in Ontario, Canada. *BMC Health Services*

*Research*, 17(1). Gale Academic OneFile.

[http://link.gale.com/apps/doc/A496373283/AONE?u=ocul\\_carleton&sid=zotero&](http://link.gale.com/apps/doc/A496373283/AONE?u=ocul_carleton&sid=zotero&xid=1ac7e6a4)

[xid=1ac7e6a4](http://link.gale.com/apps/doc/A496373283/AONE?u=ocul_carleton&sid=zotero&xid=1ac7e6a4)

Zippay, A., & Thompson, A. (2007). Psychiatric housing: Locational patterns and

choices. *American Journal of Orthopsychiatry*, 77(3), 392–401.

<https://doi.org/10.1037/0002-9432.77.3.392>