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# From criminalisation to individual choice: Policy responses to changing constructions of intellectual disability in Western Australia

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## ARTICLE

# From Criminalisation to Individual Choice: Policy Responses to Changing Constructions of Intellectual Disability in Western Australia

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This article uses an historical perspective to explore how constructions of disability influenced policy and services for people with intellectual disabilities in Western Australia (WA) from the time of British colonisation until the present day. The authors approach the discussion from a critical disability perspective in the analysis of disability constructs, political responses and social change, incorporating the Foucauldian concept of biopower to explain the physical infrastructure, classification and dividing practices that produced 'docile subjects'. The authors argue that changing social constructions of disability since the 18th century affected the lives of people with disability in WA and continue, through their embodiment in infrastructure, to influence present-day practices, even after policy has changed. This approach illuminates the interplay between metaphorical and literal constructions of disability and allows the legacy of past assumptions to be examined.

**Keywords:** Intellectual disability; Western Australia; social construction; policy; Foucault

**A note on terminology.** Throughout the article the abbreviation ID is used for intellectual disability. The terms 'insane', 'feeble-minded', 'idiot' and 'imbecile' are used in the context of the historical account of ID and are not used as accepted terms by the authors. The authors acknowledge the first human inhabitants of WA as Indigenous Australians. The reference to the 'colonisation' of WA refers to British colonisation, as 'white settlers' on the land.

## Introduction

Historically, the lives of people with intellectual disability (ID) have been influenced by socially accepted beliefs and attitudes, resulting in oppression and discrimination because of social difference (Barnes & Mercer 2003; Cocks & Allen 1996; Gillgren 1996). Some previous constructions of disability included criminality, madness and insanity. Language and discourse were used to describe people who were 'different' from 'normal society', devaluing and constraining them through knowledge and power (Cocks & Allen 1996). Dominant constructions of disability informed the ideologies of the policy makers in each era (Cocks & Allen 1996). Nirje and Wolfensberger's work on 'normalisation', and later 'social role valorisation', addressed the devalued roles that people with ID were allocated, redirecting the 'problem' of disability away from people with disability, directing it instead towards the societal and political realm (Cocks & Allen 1996).

The societal and political response to disability has moved from deviance and containment (in prisons, asylums and workhouses), to welfare and containment (in hospitals and institutions) and then to health and social services (Drake 1999). Drake (1999: 54) suggests, 'The overriding aim of welfare was to "rehabilitate" or "normalise" disabled people'. Policies in each era became embedded in social and physical (built) infrastructure (e.g., asylums), which outlasted the policies that informed their construction decades earlier. Permanency of the structure and cost considerations meant that, despite adaptations, the legacy of ideologies of disability from previous eras remained in the fabric of buildings long after the beliefs that informed their design had been repudiated. This is illustrated in the discussion of the use of Claremont Hospital, retained and used long after policies 'redirected' services away from institutional care (Gillgren 1996; Martyr 2011b).

This article examines the legacy of constructions of disability and the resulting social and built infrastructure, bringing together previous accounts of the history of ID in Western Australia (WA) since British colonisation early in the 19th century. The history is explored over time using eras defined by dominant social constructions of ID in each era (see **Table 1**). This approach provides a framework for the discussion in this paper. Discussion also explores the relationship between contemporary ideals of the National Disability Insurance Scheme (NDIS), introduced in Australia in 2013,

**Table 1:** Policy, infrastructure and discourses on disability in WA.

Era	Social construction	Political ideology	Policy response	Infrastructure	Societal perception
Colonial 1800s to early 1900s	Criminality, insanity.	Punishment, containment, cured through therapy.	Incarceration, hospitalisation.	Seclusion, prisons, asylums and hospitals.	ID as insane, deviant, defective.
Early-20th Century (1900–1940s)	Unfit to breed.	Medical treatment and prevention.	Eugenics, deportation and invalid pensions.	Seclusion, asylums and hospitals.	ID as insane, feeble-minded, mental retardation, personal tragedy.
Mid-20th Century (1950s–1970s)	Developmental delay, ability to learn, normalisation, having rights, advocacy.	Education and training, disability is socially constructed, human rights in a welfare state.	Disability on the 'world stage' (United Nations), access to education, sheltered workshops, deinstitutionalisation, support to live at home, welfare.	Segregated special schools, parental involvement, training for adults with ID, welfare, alternative housing and training facilities.	ID as 'child' able to learn, with human rights, contribute economically to society.
Late-20th Century (1980s–1990s)	Advocacy and self-advocacy, rights and inclusion.	Integration and access, policy underpinned by normalisation.	Deinstitutionalisation, disability reform, neoliberalism and globalisation.	Group homes, supported housing, privatisation and social agencies.	ID as being able to speak for themselves, more choices in support.
Early-21st century	People with disability as consumers, individualised services.	Rights as a consumer, person-centred practices, self-directed funding, move away from welfare state.	Disability rights, disability standards, Australia ratifies the UNCRPD and introduces the NDIS.	Individualised funding and services provided in a 'market'.	ID as adult with consumer rights.

to provide a positive change for people with a disability (Kendrick, Ward & Chenoweth 2017) and the physical and intellectual legacy of previous policy.

The analysis undertaken in this paper employs the Foucauldian concept of 'biopower' as a tool to explicate the relationship between ideas of disability and physical structures. For an analysis of ID, biopower is particularly relevant as it objectivises people as 'subjects', providing some explanation for the design of historical infrastructure, the classifying and dividing practices and the methods of exclusion and constraint that were used to control and contain the population that differed from the 'norm' (Tremain 2015). The analysis undertaken is also from a critical disability perspective, which focuses on equality, social justice and 'genuine inclusiveness, not just abstract rights' (Pothier & Devlin 2006: 2). This analysis will provide an account of the interplay between policy, legislation and infrastructure in the context of ID to improve understanding of contemporary practices and future directions. Foucault's conception of power as a productive 'bottom-up' power enables the critical examination of the 'relationship between impairment and disability' to see beyond the social model of disability to a more critical perspective (Tremain 2015: 18).

## Background

Several publications explore the history of disability in WA (e.g., Atkinson & Walmsley 2010; Cocks et al. 1996; Gillgren 1996; Hudson-Rodd & Farrell 1998; Martyr 2011b; Maude 2013; Megahey 1996; Piddock 2016), whilst other authors discuss policy more generally (Chenoweth 2000; Fisher & Purcal 2017; Grover & Soldatic 2013; Hallahan 2015; Lindsay 1996).

Poor record keeping means there are gaps in the social history of disability in early colonised WA, and the surviving records were from the perspective of the authorities (Hudson-Rodd & Farrell 1998). The history of ID in WA has been subsumed within historical accounts of psychiatry and mental illness, from a medical perspective (Atkinson & Walmsley 2010). Furthermore, due to the inability of authorities to differentiate between mental illness and ID, records fail to provide a clear picture of the lives of people with ID living in colonial WA (Megahey 1996). Despite this, available literature provides sufficient information for the purpose of this analysis.

Foucauldian analysis conceptualises disability as a construct produced by power and discipline (Pezdek & Rasiński 2017). Foucault defined power as a 'disciplinary power' from a societal relationship perspective (Pezdek & Rasiński 2017). For Foucault, power objectivises human life, and he coined the term 'biopower' (Hughes 2015; Meekosha & Shuttleworth 2009; Pezdek & Rasiński 2017; Tremain 2015). An example of this is when statisticians measure the biological characteristics of individuals (i.e., births, deaths and fertility), then apply the measurements to divide and

categorise people as 'normal or abnormal' (Tremain 2015). Biopower describes how people are medicalised, classified, managed and measured in terms of their variance from the 'norm' (Hughes 2015; Meekosha & Shuttleworth 2009).

Foucault linked biopower to control, or governmentality, contending that biopower normalised and legitimised particular procedures and practices in institutions, such as the classification, management and control of the people who resided there (Meekosha & Shuttleworth 2009), the policies that legislated these practices, as well as the physical design of buildings. Foucault defines government as 'any form of activity that aims to shape, guide or affect the conduct of some person or persons' (Tremain 2015: 16). Tremain explains that this broad meaning of government can apply to oneself, within interpersonal relationships, within social institutions and communities, as well as political and social governance. Examples from WA's history, discussed later, will illustrate how Foucault's theories explain the control, segregation and diagnosis of people who differed from the 'norm'.

The language and discourse used to describe and classify people with ID in different historical eras portray the constructions and societal perceptions of ID, seen in the use of the terms 'insane', 'feeble-minded' and 'idiot' (Carlson 2015). These terms elicited particular systems of control and specific infrastructure. Language and discourse used changed over time, often meaning different things in different eras (Cocks & Allen 1996); control systems changed but buildings remained. Foucault's work on 'madness' explains how people who were unemployed, poor or sick or those with physical and intellectual disability were classified in one category, as 'insane' (Carlson 2015). Foucault argued that, in history, society had developed new terms for people with disability and new ways of regarding them (Cocks & Allen 1996). This often led to terms being used interchangeably due to a lack of understanding of characteristics of mental illness and ID (Megahey 1996).

By the 19th century, doctors in the United States and Europe considered idiocy curable and used a continuum of ID as 'idiot', 'imbecile' and 'feeble-minded' (Megahey 1996). The introduction of IQ tests provided a means of classification of levels of intelligence (Carlson 2015) as a tool for biopower and governmentality. In the United States after the mid-19th century, the 'insane' were separated from the paupers and criminals in purpose-built asylums. These were established to educate the 'curable' cases of idiocy and to shelter and supervise the 'incurable' (Carlson 2015). The 'curable' would ultimately be returned to 'productive lives' in society (Megahey 1996). Carlson (2015: 141) argues that 'all inmates were subjected to a form of disciplinary power that both characterised and justified the institution's existence'. Foucault's work refers to this disciplinary power and provides an explanation of how discourse about disease and the generation of knowledge led to the institutions designed specifically to educate, shelter and supervise people categorised as 'insane', 'feeble-minded' or 'idiot' (Carlson 2015). Throughout his work, Foucault inextricably links knowledge with power (Tremain 2015).

### **Discourses on Disability in Western Australia**

Five distinct eras were identified by the authors that illustrate the interplay between discourse, political ideology and policy responses that led to the development of infrastructure, which in turn reinforced societal perceptions of disability in WA in each era (see **Table 1**). The table illustrates how infrastructure and societal perceptions often remained as a legacy that spanned more than one era. For example, ID as insanity was a dominant discourse in the 19th century and early 20th century, resulting in institutionalisation in purpose-built asylums. These physical buildings reflected discourses of danger and remained to reinforce this perception to the public long after the expert construction of ID had changed.

#### ***Colonial (1800s to early 1900s): ID as criminality and insanity***

When the Swan River colony was established in 1826 (at the site of the present capital of WA, Perth), the dominant discourse in Europe constructed disability as a form of criminality or insanity, and policy responses emphasised seclusion and the segregation of people diagnosed as insane from the rest of the population (Piddock 2016). Secure facilities modelled on prisons (such as asylums), were built for containment and management of the inmates in a response to both social and economic conditions (Megahey 1996; Piddock 2016).

The Swan River colony experienced low population growth, which slowed economic growth (Piddock 2016). To overcome this, the settlement was declared a penal colony in 1849, anticipating that able-bodied convicts would provide labour for free settlers and stimulate economic growth (Maude 2013; Piddock 2016). Financed by the English Parliament, convicts began to arrive in the colony in 1851. However, an increasing number of convicts were classified 'insane' upon their arrival, and some had previously been admitted to lunatic asylums in England (Piddock 2016).

The Round House Gaol in Fremantle was built in 1831 and housed inmates categorised as insane alongside criminals, local Indigenous people and the poor (Maude 2013), but order and discipline were difficult to maintain (Megahey 1996). The governor of the colony ordered a purpose-built asylum to house all insane patients, including newly arrived insane convicts (Megahey 1996; Piddock 2016). Plans for the new asylum were developed in the 1850s after the Round House Gaol and other temporary asylums became overcrowded (Maude 2013; Piddock 2016).

The Fremantle asylum opened in 1865 and was the first purpose-built institution for people with ID in WA. The penal roots of the system meant that patients were treated as prisoners (O'Donoghue & Chalmers 1998). Children were admitted to the asylum from the age of nine years (Megahey 1996; O'Donoghue & Chalmers 1998). The asylum's superintendents

raised complaints in parliament about overcrowding in the asylum and about practices of accommodating children and adults together; however, these were ignored (O'Donoghue & Chalmers 1998).

Separate institutions for the 'feeble-minded' had been introduced in the United States from the mid-19th century (Carlson 2015). In Europe, a belief emerged that the insane could be restored to sanity through appropriate training and treatment. Emphasis was placed on the space and use of rooms within the purpose-built asylums (Piddock 2016). Foucault argued that the rise of the medical clinics to treat patients gave rise to new institutions and provided a new discourse about disease and classification through the generation of medical knowledge (Carlson 2015). This is illustrated by the 'epistemic shift' that occurred in the classification of ID, from criminal to medical (Carlson 2015). This change was not reflected in the physical appearance of Fremantle Asylum or in its system of management of inmates at its inception.

In 1871, the WA government introduced the *Lunacy Act*, modelled on the *British Lunacy Act* of 1845 (Megahey 1996). The act did not differentiate between lunacy (insanity) and idiocy (ID), even though at the time of its introduction people classified as idiots were thought to be educatable (Megahey 1996). Despite emerging medical discourse, the Fremantle Asylum functioned to control inmates and segregate people who were perceived to be a moral or economic 'threat' to society (Megahey 1996). The distinction between 'insanity' and 'idiocy' that was a dominant discourse in Europe and the United States throughout the 19th century was not evident in the buildings or the systems of management that operated in 19th century colonial WA, where the different needs of people with ID were not considered (Megahey 1996).

### **Early-20th Century (1900–1940s): ID as a medical problem**

The rise of the medical professions and the subsequent recognition of medicine as a specialised profession led to the dominance of the medical model of disability by the beginning of the 20th century in Australia (Carman-Brown & Fox 1996). As 'insanity' became recognised as a treatable condition, asylums became hospitals and the specialisation of psychiatry emerged (Carman-Brown & Fox 1996). ID was diagnosed by doctors as 'incurable', which led to policy and practices to prevent disabilities through eugenic practices of sterilisation and segregation (Carman-Brown & Fox 1996; Gillgren 1996).

In 1900, following repeated calls for a Royal Commission into the conditions within the Fremantle Asylum, a select committee was appointed to make recommendations to improve the living conditions for people living within the asylum (O'Donoghue & Chalmers 1998). The *Lunacy Act 1871* was replaced by the *Lunacy Act 1903*, and a new asylum modelled on a hospital was planned in the Perth suburb of Claremont (Megahey 1996). The 1903 *Lunacy Act* differentiated between mental illness and ID, however little changed in the way patients were treated (Gillgren 1996). The Claremont Hospital for the Insane opened in 1907 and, reflecting the dominance of the medicalisation of disability, the hospital was administered by doctors and staffed by nurses (Gillgren 1996).

Foucault's concept of biopower manifests in the hospital setting as 'medical power', 'dividing practices' that classify patients as 'either sick or healthy, curable or incurable, complete or incomplete, normal or abnormal' (Sullivan 2015: 30). The wards within the Claremont Hospital for the Insane were a reflection of this 'medical power', with wards for patients specific to their diagnosis and divided by their diagnosis (Gillgren 1996). According to Foucault, the practice of classification of individuals and the dividing practices that ensued transformed humans into 'subjects' (Hughes 2015).

Medical diagnosis informed the introduction of the *WA Immigration Restriction Act 1897*, whereby immigrants who were diagnosed as insane could be deported back to their country of origin, with no limitations on the time since arrival (Martyr 2011a). After Australian Federation in 1901, the Commonwealth government passed the first *Federal Immigration Restriction Act* with the same deportation criteria for insane immigrants. In 1924 and again in 1932, changes were made to limit the diagnosis of insanity within three years and five years, respectively, since arrival (Martyr 2011a). By 1939, 112 patients had been deported from Claremont Hospital for the Insane to their country of origin under this legislation (Martyr 2011a).

Eugenics (employing Darwinian concepts of survival of the 'fittest' to justify programmes to decide who should reproduce) emerged in Western Europe in the late-19th century in response to moral panic about the threat posed to society by rising poverty, illness and crime (Gillgren 1996). This discourse was employed in the Australian context in the preceding decades on people with ID and used as a way to prevent the 'unfit from breeding by first locating, then registering, and finally segregating or sterilising them' (Gillgren 1996: 65).

Legislation enabling permanent segregation had been introduced in Britain and Australia by 1913 and in most Western countries by the 1920s for people deemed 'mentally deficient' (Garton 2017). Legislation that enabled sterilisation gained less support, though countries such as Germany, Sweden, Norway, Denmark, Japan, two provinces in Canada and 30 states of the USA had legislated sterilisation by the beginning of World War Two (Garton 2017).

According to Gillgren (1996), in the early-20th century eugenics had taken on an added urgency in Australia as the birth rate dropped dramatically by the commencement of World War One. In WA, legislation to authorise sterilisation was proposed to Parliament in the *1929 Mental Deficiency Bill* (Gillgren 1996). However, despite consensus on the issue of control over people with ID, there was some debate over sterilisation and segregation (Gillgren 1996). The bill failed to gain enough support and was defeated partly due to the economic environment of the 1930s (Garton 2017; Gillgren 1996; O'Donoghue & Chalmers 1998). In addition, there were concerns that if the bill was passed people with ID would come from other states to institutions in WA, increasing the financial burden on WA (Garton 2017; Gillgren 1996).

According to Gillgren (1996: 71), the debate over the failed bill 'resulted in an airing of public opinion on intellectual disability'.

### **Mid-20th Century (1950s–1970s): Education and training**

By the mid-20th century, the dominant construction of ID changed to developmental delay. The dominant belief was that people with ID could be trained to work and contribute economically to society; therefore, policy emphasised education and training. The systems management and infrastructure changed in response to this. Infrastructure was modelled on schools for children and sheltered workshops for adults who were supervised to undertake 'industrial training' and simple manual work tasks. Adults with ID were constructed as 'children' in need of supervision.

Prior to the 1920s in WA, children with ID received little formal education, even though facilities in Europe and North America had provided specialised education for children with ID since the mid-19th century (O'Donoghue & Chalmers 1998). In 1952, the Education Department of WA introduced policies to provide access to formal education for children with ID and segregated 'special schools' were introduced (O'Donoghue & Chalmers 1998).

Parent-led groups were formed in the early 1950s, the largest of which in WA was the Slow Learning Children's Group (SLCG) (Gillgren 1996). The SLCG acted as advocates for children with ID and provided services in their own right, firstly pre-school education, diagnostic and therapy services, then training and residential services (Gillgren 1996). Gillgren (1996) argues that the establishment of the SLCG was brought about because of the disillusionment of the parents with a child with ID and concerns regarding the inadequacy of existing service provision.

Despite the change in discourse, many people with ID were still living in Claremont Hospital. Poor living conditions at Claremont Hospital caused concern throughout the 1950s, and eventually people with ID were transferred from Claremont to alternative accommodation that provided training and treatment (Gillgren 1996), and antipsychotic medication meant some patients were discharged back into the community (Martyr 2011b). Throughout this period, alternative accommodation options were being built to provide residential services and training options through sheltered workshops and activity therapy centres for people with mild to moderate ID (Tuckerman et al. 2012).

In 1962, the *Mental Health Act* replaced the *Lunacy Act 1903* in WA. The *Mental Health Act* advocated for early intervention and accommodation for people with ID within the community (Gillgren 1996). In the late 1960s, hostel style accommodation was built to rehouse people from the Claremont Hospital. The *Mental Health Act 1962* made provisions for the building and establishment of accommodation facilities and day hospitals to reduce overcrowding at Claremont. In 1966, a new accommodation and training facility, Pyrtton Training Centre, was opened for children and young adults (Gillgren 1996). Pyrtton Training Centre still segregated people with ID from the rest of the community, though with a focus on training that might enable people to undertake roles in society that could reduce the financial burden on social welfare costs (Cocks & Allen 1996). However, it should be noted that Claremont Hospital was still used at this time.

Prior to the 1960s, disability in Western societies was constructed as a 'personal tragedy and a social problem or burden for the rest of society' (Barnes & Mercer 2003: 1). Policy had supported the medical view of disability, which sanctioned segregated living within institutions away from society (Barnes & Mercer 2003). The shift from seeing disability as the 'medical problem' of an individual to a 'social problem' of society emerged as a dominant model from the 1970s onwards. The social model of disability is based on the principle that disability is socially constructed and any disadvantage that people with disability experience is a result of the social environment (physical, institutional and attitudinal) that does not meet their needs (Hosking 2008). Significant social change, and the developing politicised conceptions of disability, countered the previously medicalised view (Hughes 2015; Tremain 2015). Foucault's work assists with the understanding of disability as a socially constructed concept (Hughes 2015). However, from a critical disability perspective, a 'synthesis of the medical and social models' balances the biological, personal and social impact of disability (Hosking 2008: 7). According to Hosking (2008), critical disability theory acknowledges that the medical model and the social model both contribute to how an individual experiences the impairment of disability, their personal responses to their disability and the social environment that hinders full participation in society.

From the 1960s, the exclusion of people with disability from 'normal' society had become a moral and socio-political problem, meaning that politics became an essential tool to enable change (Simons & Masschelein 2015). The idea of ID as developmental delay (and deficiency) was challenged by normalisation and advocacy perspectives from the 1970s onwards. Both these perspectives emphasised the rights of people with ID. Bengt Nirje (1969: 19) wrote about normalisation, which he defined as 'making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society'. Over the next decade, and as a result of further development of the normalisation principle, Wolf Wolfensberger suggested the use of the term 'social role valorisation', which focused on the value of the social roles of people with disability (as opposed to the person themselves) (Wolfensberger 1983: 238). Nirje (1969) believed residential services should be viewed as homes to avoid segregation and to allow social integration for people with disability. Policy based upon normalisation led to deinstitutionalisation, and infrastructure began changing to group home accommodation. Applying Foucauldian analysis, deinstitutionalisation was a change in the way 'power' was distributed, from a 'top down' sovereign power, to a 'bottom up' modern power that is both positive and productive (Drinkwater 2015), exemplified by the closing of institutions and rehousing people with disability into community housing (Stella 1996).

Internationally, normalisation and the rights of people with disability influenced the *United Nations Declaration on the Rights of Mentally Retarded Persons* in 1971 and the *Declaration on the Rights of Disabled Persons* in 1975 (Chenoweth 2000). In Australia, federal policies included the *Handicapped Persons Assistance Act 1974*, which superseded previous legislation for people with disability. People with ID were no longer physically segregated in large institutions. Normalisation and social role valorisation principles also informed the provision of education services to people with ID (Simons & Masschelein 2015). Australian disability strategies focused on inclusivity and 'the social', which led to integration of children into mainstream education instead of special schools (Simons & Masschelein 2015).

The Claremont Hospital was officially closed in 1972 and reopened as two facilities: Graylands Hospital for Mental Health and Swanbourne Hospital for people with ID (Martyr 2011b). The change of name was intended to reduce stigmatisation of people with disability living within Claremont Hospital (Stella 1996). Reflecting a change of terminology, the Mental Deficiency Division was renamed the Division for the Intellectually Handicapped (DIH) in 1977. The DIH ran other hostels and was responsible for policy to keep people living in their own homes or moving them from hostels into the community (Stella 1996). In 1986, Swanbourne Hospital, which was built as Claremont Asylum, finally closed.

### **Late-20th Century (1980s–1990s): Advocacy and self-advocacy**

By the late-20th century, discourse and policy development in Australia focused on integration and access, underpinned by normalisation principles (Cocks & Allen 1996). Infrastructure was influenced by neoliberal ideology, and services for people with disabilities began to focus on consumer choices (and user payments). In 1983, the federal government reviewed Australian disability programs and services (Lindsay 1996) and committed to major reform. The government of WA also commenced a reform of disability services. Advocacy and self-advocacy organisations and groups were formed, which meant that some people with ID had opportunities to have a voice about their services (Atkinson & Walmsley 2010), though they became increasingly reliant on formal services subject to economic rationality (Cocks & Allen 1996). However, Hughes (2015: 80) argues that while Foucault's work illustrates the 'medical, administrative and legal practices' that medicalised and supervised people with ID transforming them into a 'docile target of power', he underestimated their ability to transform themselves through self-advocacy.

The *Commonwealth Disability Services Act* was introduced in 1986, influenced by the principles of normalisation and social role valorisation (Chenoweth 2000; Lindsay 1996). Historical practices of segregation and institutionalisation were making way for integrated services into mainstream society (Lindsay 1996), and open employment services and supported workplaces for people with ID were being introduced (Tuckerman et al. 2012).

The newly elected Australian Labor government had a budget deficit and enacted policy changes that were intended to break down the expensive institutional care model into smaller community-based services (Lindsay 1996). This meant that to be eligible for Commonwealth funding, organisations had to close hostels and provide alternative accommodation for residents. The focus on the infrastructure of normalisation meant this was pursued without offering residents any meaningful choice about where they lived (Chenoweth 2000). Chenoweth (2000) argues that deinstitutionalisation failed to achieve the goal of actual participation in community life and, instead, achieved only a physical presence.

Policy implementation was influenced by the discourse of neoliberal ideology, which shaped the politics of Australia and other Anglophone countries from the 1980s. Economic policies drove social policy and resulted in a market-driven approach for goods and services, often resulting in lower quality services for people with disability (Sakellariou & Rotarou 2017) for which users were charged. One rationale for market-driven services was that it would benefit service users because they would have more choice. The same policy stated that users ought to pay for services, and this had adverse consequences for some people with ID who were no longer assured housing, support or health services (if they could not pay), which increased barriers to service access (Sakellariou & Rotarou 2017).

The *National Disability Services Standards* were introduced in 1994, and changes to federal and state-based policies ensued. The Disability Services Commission (WA) was formed in 1993 by the *Western Australian Disability Services Act 1993*, which addressed equality, rights, accommodation and employment choices among the items for reform (Disability Services Commission 2009).

Following the introduction of the federal *Disability Discrimination Act* in 1992, it was criticised for focusing on the 'shift from equal *opportunities* to equal *responsibilities*' for people with disability as long as they 'do not make too many economic demands on the system' (Campbell 2015: 115). The neoliberal view of 'abled and non-abled bodies' meant that people with disabilities were viewed as 'costly' and 'potentially financially burdensome' on public services (Sakellariou & Rotarou 2017: 3). The new legislation was premised upon the assumption that people with disability ought to contribute to society economically and should transform the 'unproductive disabled body' into a 'productive' one, to reduce the demands on the welfare state (Campbell 2015). According to Foucault, biopower has an objective to 'render bodies docile' so that they may undergo practices that 'train' them to be productive (Sullivan 2015: 29).

### **21st Century: People with disability as consumers**

Discourse on normalisation and rights gave way in the 21st century to the concept of people with ID (or their guardians) being consumers. The state withdrew as a service provider and funding was provided to 'consumers' to purchase services from non-government providers (either for-profit or not-for-profit). Infrastructure became a responsibility of the service provider and the consumer, rather than government.

Under the *Commonwealth State/Territory Disability Agreement 3rd Agreement 2002–2007*, state governments were responsible for accommodation services and respite services (AIHW 2007). For people with disability, the availability and distribution of funding and services depended on the state in which they lived. In 2008, a public consultation process informed the development of the *National Disability Strategy 2010–2020* to direct collaborative action between federal, state and territory governments and 'to close the gap between the lived experience of people with disabilities and the rest of the Australian community' (Productivity Commission 2011: 1). Intended as a 10-year plan, the *National Disability Strategy 2010–2020* was informed by the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD) (United Nations 2006), which the Australian government ratified in 2008. The *National Disability Strategy* identified areas for action to advance reform within the disability sector. These included accommodation options providing support for people with high and complex needs, supported and community living options and support for family living choices (Commonwealth of Australia 2011).

In 2008, the proposal for a fully funded National Disability Insurance Scheme (NDIS) for people with disability was accepted by the Australian government (Reddihough et al. 2016). The scheme commenced in 2013 (2014 in WA), signifying a major change in the distribution of disability funding from 'block funding' to service providers, to individualised funding offering choice and control to people with disability (Foster et al. 2016), aligning with neoliberal principles of the free market through a market-driven approach to disability care and services (Carey et al. 2017). The NDIS also signified a change in the neoliberal use of the term 'consumer' or 'customer' to 'participant' under the NDIS.

The NDIS individualised funding model is Australia's first major social policy that utilises a self-directed, personalised model for the purchase of services to meet the needs and goals of the participants (Carey et al. 2017). Similar policies have been implemented in the UK and Europe; however, Carey et al. (2017) question whether self-directed care has led to improvements in the lives of people with disability or if it will address the inequitable system of service provision in Australia. From a critical disability perspective, Hallahan (2015) questions whether the NDIS will reinstate the 'welfare' focus of earlier disability reform and policies and redirect the focus from the wider reform of community inclusion and economic participation.

### **Discussion**

Competing social constructions of disability persist in contemporary practice despite disability reform and changes to policy and practice. Outdated policy and infrastructure are still evident in current practice, submerged in contemporary ideology. In the discussion we focus on three issues: firstly, the changing influence of infrastructure on how services are delivered for people with ID; next, new discourse and reinvented dividing practices, illustrated in discussions about genetic testing and supported employment; and lastly, the issues raised by the implementation of the NDIS, which has supported the concept of 'choice' without sufficient consideration of the contextual factors that make choice meaningful.

#### **Embodied infrastructure**

Physical infrastructure, in particular the Claremont Hospital for the Insane, influenced how services were delivered to people with ID long after the philosophy that supported its design changed. Even as philosophies of ID changed to medicalisation, then to an education response, the existence of this building influenced provision of services and was used with modifications until its closure. The presence of the building also reinforced the public perception of people with ID as needing segregation and containment away from 'normal' people. Training facilities, such as Pyrton, were less physically imposing, but their architecture affirmed the desirability for segregation of people with ID.

There is a marked difference in the appearance of group homes that replaced the imposing structures of earlier institutions. Group homes house people with ID in 'normal housing' within the community and are intended to provide accommodation that closely as possible resembles ordinary family life. There are no name boards or outward markings to distinguish the houses from surrounding properties. The closure of Claremont hospital and the training facilities removed the tyranny of architecture and external symbolism that shaped public perceptions about how services for people with ID ought to be provided.

However, the literature on services for people with ID indicates that whilst some issues may have been resolved, others remain. The first issue is that deinstitutionalisation commenced when the large institutions were closed, but the necessary support services were not fully funded, leading to a lack of alternative housing stock (Bostock & Gleeson 2004). This led to the over-representation of people with ID in prisons and among the homeless population, which arguably cater less well to their needs (Bostock & Gleeson 2004). Group homes, the most common form of supported accommodation for people with ID outside of the family home in WA, continue to isolate people with ID within the community and fail to offer a choice of where they can live (Bostock & Gleeson 2004; Chenoweth 2000). Drinkwater



(2015) suggests that supported accommodation, such as group homes, don't serve as an example of emancipation or humanitarian reform, but represent modern power, biopower at a population level. From a Foucauldian perspective, the problem is that although dividing practices of incarceration, segregation and seclusion have changed, they have not disappeared. According to Foucault, modern power 'administers bodies and manages life', still evident in the 'benign regime' of supported accommodation (Drinkwater 2015: 236). The next section examines new discourse and new dividing practices.

### ***Emergence of new discourse and reinvented dividing practices***

This section argues that although many of the older discursive practices that separated people with ID from the 'normal' population have been discredited, new discourses have arisen to perform the same function. Here we will briefly illustrate this with a discussion of the discourse around two issues: firstly, genetic testing and ID and secondly, supported employment and ID.

The explicit discourse of eugenics, dominant in the first half of the 20th century, is no longer supported in mainstream thinking; however, a related discourse about genetic testing has arisen and, in many ways, serves as a replacement 'dividing practice' that singles out people with inherited ID as 'other'. Normalisation has permeated all aspects of society, evident in the accepted practice of genetic testing and selected abortion, resulting in a discourse, policy and practice that involves decisions about what is 'normal' and what is not (Waldschmidt 2015) and 'which lives are worth living' (Taylor 2015: 373). Genetic testing is a private and individual choice and may provide parents with the benefit of foresight to better prepare for additional needs of their child. In contrast, societal assumptions are that positive results mean parents can selectively abort unborn children to reduce the risk of passing on inherited conditions. Described by some authors (Baker 2002; Taylor 2015) as the 'new eugenics of the contemporary world', genetic testing is a dividing practice that remains as a legacy of eugenic thought.

The large training facilities that were closed in the mid-20th century were replaced with legislation that supported employment of people with disability in mainstream work and sheltered workshops. In 2018, sheltered workplaces remain integral to employment for people with ID in Australia, despite international moves away from sheltered workplaces (e.g., Taylor-Gooby, Gummy & Otto 2015, in the UK) and legislation that calls for integrated employment (Migliore et al. 2007, in the USA). Tuckerman et al. (2012) suggest that sheltered workplaces disadvantage people with ID by providing little choice, low pay, repetitive work and reduced contact with the broader community. Nevertheless, they can offer enhanced workplace safety, workplace and task support, socialisation, job satisfaction and job security for people who would otherwise be unemployed (Hemphill & Kulik 2017).

### ***After the NDIS—Where to now?***

The NDIS scheme is an example of a social insurance scheme, intended to share the financial burden of disability across the whole population by the way of a levy on income (Purcal, Fisher & Meltzer 2016). Foster et al. (2016: 29) state that the NDIS 'represented a fundamental shift from a targeted, needs-based system to an insurance, universal rights-based approach'. The national scheme was introduced following recommendations from the Productivity Commission enquiry to explore funding for disability services that refocused disability support to a national level. Its purpose is to enable economic sustainability of support arrangements to allow people with disability to actively participate in society and have care and support over their lifetime (Foster et al. 2016; Purcal, Fisher & Meltzer 2016). The competitive 'marketplace' of disability services emerged as a result of globalisation and neoliberal ideology in the late-20th century and has re-emerged in the legislation that drives the NDIS. Based on 'user led' choice and control, it is expected that the disability care market will see disability services emerge from 'for-profit', non-government providers under the NDIS (Foster et al. 2016). Conceptually, it could lead to a reinvented welfare system that is more responsive to the aspirations of service users. However, according to Hallahan (2015), a legacy of a welfare-based response to disability continues to underpin the NDIS. Interpreted within the framework of neoliberal ideological assumptions, the NDIS has driven social policy that changed social services into a commodity. This approach focuses on provision of services that are provided to individuals in response to their choice, on a user pays basis, but ignores more collective possible responses that might bring benefits that cannot be realised within a framework that prioritises individual choice.

Individual choice has meaning to the extent that people are able to understand the alternatives and consequences. An individualised rights perspective would argue that people with ID should have rights to maximal autonomy commensurate with their capacity to understand what they are deciding and to avoid being taken advantage of or exploited by others. The limitations of this approach can be seen when it comes to food choices. Should people with ID be completely free to decide what they eat (on the basis of preference), or should their choices be limited to some extent because they may not have a good grasp of long-term consequences? This dilemma highlights the limitations of giving individual choice privileged status when powerful industries spend billions of dollars convincing us to act against our best interests. The answer to this dilemma is not to create special conditions and protection for people with ID (and create another dividing practice) but to offer more protection to all of us against commercial forces that make unhealthy food too readily available.

## Conclusion

This paper utilised the Foucauldian concept of 'biopower' as a tool to explore the relationship between ideas of disability and the physical infrastructure that was used to seclude, control and contain the population that differed from the 'norm' (Tremain 2015).

There have been achievements. Physical infrastructure that contained people with ID, and the socially accepted beliefs and attitudes that resulted in oppression, discrimination and segregation, no longer dominates service provision or thinking about services for people with ID. The goals of normalisation and deinstitutionalisation have been partially achieved, though legacies of ideologies that informed practices still remain. However, there are still serious gaps in practical support and in sense of community and the convivial life. Social equality is not achievable until all discursive forms of dividing practices are challenged, including new and emerging forms. Once we move away from dividing practices and see everyone as essentially human, it may be possible to see more easily how issues that were raised as concerns for people with ID may have a more general application. Neoliberal policies that treat people only as individual, rights-bearing consumers and competitive selfish, rational economic maximisers undermines conviviality and limits social connection for all. The NDIS may improve resources and services for people with disability. However, a shift from a 'welfare focus' to a broader agenda of rights and genuine inclusion in social and economic realms, a central goal of critical disability theory, is needed to ensure that policy direction remains centred on the goals of the *National Disability Strategy 2010–2020* (Hallahan 2015).

## Competing Interests

The authors have no competing interests to declare.

## Author Contributions

Wendy Simpson conducted the literature review, research regarding policy and disability history in Western Australia and Australia and constructed the first draft of the paper. All authors contributed to the conceptual design, intellectual content, drafting and revision of the paper.

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