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Under blue skies : the social construction of intellectual disability in Western Australia

Errol Cocks (Ed.)

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UNDER BLUE SKIES

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of intellectual disability
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COCKS FOX BROGAN LEE

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disability in Western Australia

Edited by Errol Cocks, Charlie Fox, Mark Brogan and
Michael Lee

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Contents

List of Plates	iv
Contributors	v
Foreword	viii
Introduction <i>Mark Burton</i>	1
1 Living in Fremantle Asylum: The Colonial Experience of Intellectual Disability 1829-1900 <i>Norman Megahey</i>	13
2 'Once a Defective, always a Defective': Public Sector Residential Care 1900-1965 <i>Christina Gillgren</i>	53
3 Normalisation and Beyond: Public Sector Residential Care 1965-1990 <i>Leonie Stella</i>	92
4 The Response of the Law to Intellectual Disability in Western Australia 1829-1993 <i>Moirra Rayner and Judith Cockram</i>	137
5 Crime and Punishment: Justice Administration and People with Intellectual Disabilities 1900-1989 <i>Guy Hall and Jillian Bavin-Mizzi</i>	166
6 Doctors, Psychologists and Educators: The Professions and Intellectual Disability <i>Kylie Carman-Brown and Charlie Fox</i>	205
7 Making a New Profession: Social Trainers and Intellectual Disability <i>Norman Megahey</i>	248
8 Discourses of Disability <i>Errol Cocks and Matthew Allen</i>	282
Index	319

List of Plates

- Plate 1 Fremantle Asylum showing inmates and warders, 1897.
- Plate 2 J Ward, 'where the children go', Claremont Hospital for the Insane, circa 1950s.
- Plate 3 Pyrton Training Centre, opened 1966.
- Plate 4 Living in the community, circa 1985.
- Plate 5 Male Dormitory, Claremont Hospital for the Insane, 1912.
- Plate 6 Male Dormitory, Swanbourne Hospital, 1977.
- Plate 7 Attendant, Claremont Hospital for the Insane, circa 1920.
- Plate 8 Opening the Slow Learning Children's Group Minbalup Occupation Centre, 1954.
- Plate 9 The Stoneman empire in prospect, 1928.
- Plate 10 Announcing Hawkevale Farm Colony for Mentally Retarded Children, 1957.
- Plate 11 Demonstrating at Tresillian, 1976.

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Foreword

Research into the history of people with intellectual disabilities in Western Australia has been a sporadic undertaking. Scholarship to date has been mainly institutional in character and often undertaken as an adjunct to the study of mental illness. The people themselves have remained mostly invisible. In 1989, the Editors conceived of a social history research project in which, for the first time, an attempt would be made to document the lives of people with intellectual disabilities in Western Australia. The project would also aim to describe the institutional, social, political and professional history we identify with mainstream historical scholarship.

The Editorial Committee's decision to embark on a social history acknowledged an important weakness in existing scholarship: the way in which 'progress' is measured in the proliferation of institutions and programmes over time. A better barometer exists in the lives of the people themselves, and *Under Blue Skies* is founded in the value of case study in historical method. As the work of the project developed, the Committee and the contributors became aware of the pervasive influence of ideology and professional self-interest on all aspects of management, and these are also important themes which underlie the work.

The history of service provision for people with intellectual disabilities has involved periods of activity and whole decades of inactivity. The illusion of 'progress' has been ever present. Often, apparently humane and well intentioned policies have miscarried, or provided window dressing to social engineering or professional goals, which by contemporary standards most would regard as repugnant. In this sense, much of the history of service provision is ironic and the Editors explicitly acknowledge this irony in their selection of a title for this book of essays. *Under Blue Skies* has been sourced from a quotation appearing

in Guy Hall and Jillian Bavin-Mizzi's chapter on 'Crime and Punishment'.

As originally conceived, *Under Blue Skies* was extremely ambitious and intended to document both the history of private and public sector service provision. By 1990, it was recognised that recent activity in the documenting of private sector service provision, including the histories of Activ Foundation and Nulsen Haven, had addressed part of the project's brief. Consequently, it was decided to reduce the scope of the work to public sector programmes, the law, the history of professional involvement, and those broad understandings we define as discourses of disability. We have, however, still not been as comprehensive as we would have wished. The history of special education is one notable omission from this book. The course of State intervention in the employment of people with intellectual disabilities and the role of the Commonwealth are others. In addition, the profound changes in the nature of public policy and service provision in the mid 1990s have not been dealt with as systematically as they deserved. We hope that this book will act as a catalyst to further research and writing.

A mixture of pseudonyms and real names have been used in reference to persons whose case histories appear in this work. Where cases are documented on the public record — this typically applies where the case history involves legal proceedings — contributors may have used real names. Where individuals concerned have co-operated subject to their privacy being respected, or access to personal information was supplied on a confidential basis, pseudonyms have been adopted. Readers should also note that most documentary research was undertaken prior to the introduction of freedom of information legislation in Western Australia. Under access policy in operation at the time, researchers working under the auspices of the project were mostly refused access to name-identified data less than 70 years old. Access policy therefore impeded the project and the nature of this history may well have been different if a more relaxed policy had been in operation during the project's research phase.

People with intellectual disabilities have been known as 'feeble-minded', as 'idiots', 'imbeciles', 'mental deficient', and by other kinds of terminology over recorded history, much of which seems pejorative today. For reasons of historical authenticity, this terminology has been used throughout this book and readers are accordingly cautioned. Some contributors have sought to distance themselves from terminol-

ogy by the use of parentheses and where used, the Editors have respected this wish. Wherever terms are used, readers should be mindful that terminology has as much to say about those who originally used it as it does about the subjects it is used to describe.

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There have been many people who have assisted this project since it began eight years ago. First and foremost we must thank our contributors for their work, their forbearance and their patience. Several organisations gave us invaluable financial support: the then-Authority for Intellectually Handicapped Persons (now integrated into the Disability Services Commission), the School of Social Sciences at Murdoch University (Professor Brian de Garis), the Public Purposes Trust of the Law Society of Western Australia, the Centre for Disability Research and Development at Edith Cowan University and the University's General Purposes Research Fund, and Apple Computers (Guy Hickey, now of Activ Foundation).

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Errol Cocks
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Introduction

*Mark Burton**

Introduction

For some years in the late 1970s and early 1980s, Western Australia was considered by many to have some of the most progressive services for people with intellectual disabilities in the world. That contrasted with the situation in the immediate post-war period when almost the only option available was commitment to a ward at the Claremont Hospital for the Insane. Now, in 1996, there is much more diversity. Various service models coexist which have origins at different points in the evolution of policy, practice and philosophy over the last 30 years. If Western Australia has at times led much of the world in its service provision, we can learn from trying to understand what made that possible and what limited the evolution.

This book appears at a time when services in much of the West are undergoing a new contortion as they switch from a bureaucratic, State-run model to a market, social market, or quasi-market model.¹ In Western Australia at the time of writing, there is a similar introduction of elements of the market — purchaser-provider splits, the 'contract culture', competitive tendering and 'outsourcing' — in imitation of changes made elsewhere. This is leading to uncertainty and a lack of clear direction. Now is perhaps a good time to stand back and review how the system evolved to its present condition, to understand the intentional and unintentional factors that shape this sector, and to use

I am grateful to the Centre for Disability Research and Development in the Faculty of Health and Human Sciences at Edith Cowan University for a Visiting Fellowship that enabled the writing of this introduction.

that understanding in striving with people with intellectual disabilities and their allies for a better deal.

The system of services in Western Australia has five distinctive features. First, there was no inter-war development of specialist 'hospital-type' institutions for people with intellectual disabilities. Until 1967, people — children included — went to Claremont Hospital for the Insane, and the last did not move out until 1984 (see Stella's chapter). Western Australia rejected the 'intellectual disability hospital' phase early, although the first phase of the new Pyrrton development was perhaps little different in style.² Second, the specialist intellectual disability services in Western Australia were developed independently of traditional medical control (see Carman-Brown and Fox's chapter). Third, a new occupational group was established in the 1960s: the social trainers. These staff subsequently became semi-professionalised (see Megahey's chapter 'Making a New Profession'). The social trainers in effect occupied the niche that intellectual disability nurses have filled elsewhere, but their specific developmental and functional orientation could be asserted some 10 to 15 years before this became dominant in nursing circles in Britain and eastern Australia. Fourth, a specialist authority was established in 1986, separate from health and social services. This was based on the *Authority for Intellectually Handicapped Persons Act 1985*, a separate legislation covering people with intellectual disabilities which was independent of mental health legislation (see Rayner and Cockram's chapter). A final key characteristic of the Western Australian scene is the existence of a large not-for-profit sector based on parent groups.³

The following chapters provide an unusual chance to study the evolution of a service system from its early days up to the present. In looking to the past, what concepts can we use to understand the process of service system evolution? The remainder of this introduction will introduce some ideas and frameworks that might be helpful in making sense of the broad canvas of change and development. The specific chapters visit these themes in different ways for particular periods or sectors. The final chapter (Cocks and Allen) introduces a complementary framework, that of deconstructional discourse analysis.

Perhaps the most obvious conceptual distinction to make is that between general factors influencing service system evolution in all societies — or at least all Western societies — and specific factors that are unique to Western Australia. Having made that distinction it can be

immediately blurred by noting that while Western Australia has some specific factors of its own, there are also Australia-specific factors such as the common colonial legacy and the division of labour between Commonwealth, State and local governments.

General Factors

Among the general factors we can identify the following. People with intellectual disabilities are typically accorded less worth than competent citizens in many societies,⁴ and this seems to underpin the typical experiences of segregation, congregation, rejection, loss of control, deindividuation, compromised identity, the high risk of abuse and so on (see the chapter by Cocks and Allen). The reasons for this societal devaluation are unclear — does it reflect some sort of universal human tendency to construct an out-group⁵ or is it the product of stratified social relations? Similar debates occur in attempting to understand the relationship between the oppression of women⁶ and of ethnic groups⁷ and other related categories of analysis such as class. Whatever the origins, it is argued that societal devaluation shapes the society's management of people with intellectual disabilities and similar groups, and this in turn structures the services provided.⁸ An example is the creation of distance, both through space (isolated institutions with barriers) but also through the paraphernalia of badges of status (e.g., uniforms), role casting, the use of territory (the office in the ward or hostel, or the staff sleep-in room in the group home), and the construction of a 'portable environment'⁹ for service users through imagery, language, failure to remediate problems of body use, and so on.

A second general factor is found in the system requirements and contradictions of capitalist societies. Megahey ('Living in Fremantle Asylum') draws attention to the work of Scull and of Rothman, who relate the construction of specialist asylums to large-scale social change. Scull relates this phenomenon to the impact of the nineteenth century market economy on mutual social obligations.¹⁰ That system broke down with the development of a market in labour, which turned labour into a commodity sold by workers to the owners of capital. Those unable to participate in these unequal contracts had to be distinguished from those regarded as unwilling to work, and this led to, first, the establishment of work houses, and subsequently to the construction of specialist institutions.¹¹ The classification of disabling conditions, by

this account, also came out of this administrative imperative. There is an interesting connection here with the impetus for the colonisation of Australia itself, which was in part a response to the social consequences of other aspects of capitalist development in Britain: the uprooting of the peasantry as land tenure was changed and the construction of an impoverished 'reserve army of labour' in the towns and cities.¹²

The general explanation based on political economy can be extended through the course of the twentieth century. Here, Scull's work on deinstitutionalisation¹³ is rather one-dimensional,¹⁴ with a failure to link the ideology to the economics. However, his central point is that institutions became increasingly unviable because of cost pressures (e.g., wages paid to unionised labour, deteriorating buildings) and the concurrent availability of an alternative — and now ideologically palatable basis — for financially supporting many people with intellectual disabilities outside the institution: the welfare payment. Some such general factor is likely to account for much of the impetus for deinstitutionalisation and care in the community during the 'welfare capitalist' phase from the post-war settlements after 1945 to the collapse of consensus around the 1980s.

However, those of us who have participated in and promoted service system change know that such explanations at the level of political economy do not tell the full story.

The chapters by Gillgren and Brogan, Hall and Bavin-Mizzi, Rayner and Cockram, and Cocks and Allen all draw attention to the influence of the eugenic movement in the inter-war period. This has been discussed elsewhere in relation to the social constitution of 'mental deficiency' as a category¹⁵ and the construction of psychology around the methodology of intellectual testing.¹⁶ There is a connection between eugenics and the evolution of the capitalist economy; Darwin arguably drew the metaphor of natural selection from the stark individualistic competition for survival under nineteenth century capitalism.¹⁷ Darwinism was then used to legitimate, as Social Darwinism, these exploitative social relations,¹⁸ and eugenics — closely associated with Darwin's cousin and pioneer of psychometrics Francis Galton — developed from this ideological discourse.¹⁹

From the 1950s onwards there has been an emergence of a variety of progressive service ideologies, philosophies, and practices. This had a number of strands, which are identified and explored in the chapters by Stella, Megahey, and Carman-Brown and Fox. The development of

progressive service philosophies has been based on developmental, behavioural, and social role or deviancy theories. It is difficult to capture on paper the excitement and optimism created by these new ways of understanding the capacities, needs, interests, rights and social position of people with intellectual disabilities. This 'philosophical shift'²⁰ had five defining elements. First, the impact of social movements stemming from the 1960s concerned with civil rights and related issues. Second, the mounting critique of institutions,²¹ together with the impact of developments initially in Scandinavia and subsequently in North America and Britain that pioneered smaller-scale residential units.²² Third, the impact of early intervention programmes and behavioural teaching approaches.²³ Fourth, the development of explicit positive philosophies such as least restrictive alternative, personalisation and the evolution of the normalisation concept.²⁴ The final general factor, only having an impact in recent years, has been the rise of the New Right, which has been characterised in human services by an economic fundamentalism (social policy as secondary to wealth creation); a managerialist ethos that combines central State control of expenditure, policy and strategy with decentralisation of operational management; a distrust of professional and worker interest groups; a rhetoric of individual responsibility and choice, with service users likened to consumers in a commodity market; and the introduction of the market model through various kinds of quasi-markets.²⁵

Specific Factors

If those general factors have influenced the broad content of system change in Western Australia, the particular paths taken there must be understood in terms of factors specific to the State.

First, Western Australia is isolated, both from the rest of the world and from the rest of Australia. This isolation is less marked now with the advent of mass air travel and telecommunications, but it is still significant. As Guy Hamilton, the instigator of the developments of the 1960s and 1970s puts it, the Nullarbor prevented the traditionalists then running services in the Eastern States from interfering in what was being done in Perth.²⁶ There has perhaps been more to it than distance alone. Western Australia has a small population base, and this lack of a critical mass meant that service development started late in both the incarceration phase (Fremantle Asylum, 1857, Claremont Hospital for

the Insane, 1907 — both for all kinds of mental disorder) and in the development of specialised intellectual disability services (Pyrton, 1967).

Second, the system of government in Australia would itself appear to influence system evolution. State governments themselves take on functions that elsewhere might be either national or local government responsibilities. This allows a degree of system integration in the form of State-wide models of provision and the potential for close integration between the different sectors. However, providing a system of services on a population base of 1.6 million (and other States are larger) presents difficulties for ensuring responsiveness to local community characteristics. This issue is only now being addressed through the advent of local area co-ordination, a recent innovation that blends elements of case management, direct funding to individuals and families, and community development. Until now the centralised governance of the system at State level has been something of a recipe for a bureaucratic model of provision. The Australian system of government also creates an emphasis on legislation as a means of change implementation. As Gillgren and Brogan's chapter illustrates, legislation can fail (although this was a blessing in the case of the eugenicist 1929 Mental Deficiency Bill) and it can be inadequate to the needs of those legislated for — even as late as the *Mental Health Act 1962* people with intellectual disabilities were not distinguished from those with other psychological disorders. The *Authority for Intellectually Disabled Persons Services Act 1985* is a positive example of the role of legislation in framing a positive understanding of the rights and capacities of people with intellectual disabilities but, as Rayner and Cockram and Hall and Bavin-Mizzi demonstrate in their chapters, it also had its omissions and flaws.

The characteristics of the Western Australian population comprise a further specific influence. The selective effects of immigration on age and disability yield a relatively young population of people with intellectual disabilities. We can speculate on the effects of this on service priorities and on the nature of the influence from parent activists, who will themselves be relatively younger than those in most other Western societies.

When trying to identify the influences on service system evolution, it is important that we do not ignore the influence of the actors themselves, and in particular those in leadership roles. The inspired leadership of Guy Hamilton is documented in the chapters by Stella and

Megahey. Others in leadership roles have also influenced the course of events, and not always benignly (see the discussion of Dr Birmingham by Rayner and Cockram, and of Ethel Stoneman by Carman-Brown and Fox).

The introduction of human action into the account of the origins of change raises some fundamental issues that will be explored in the following sections.

Agency and Structure

Two tendencies can be distinguished in social and psychological theory, as well as in the writing of history. One is to attribute change (or its absence) to structural factors such as the balance of social forces, the economy, the role of dominant ideologies, or simply the cumulative consequences of the system's evolution to date. Such factors are typically seen as external to the actors in change. The opposite tendency attributes change (or its absence) to the voluntary action of people, either as individuals or groups. Which tendency is favoured can depend on the balance of optimism or pessimism about the prospects for principled change — there is perhaps a tendency to seek structural explanations after defeats, particularly if such structural theories imply the inevitability of progressive change. Work by Bhaskar and by Giddens offers a resolution. As Bhaskar states:

people do not create society. For it always pre-exists them and is a necessary condition for their activity. Rather, society must be regarded as an ensemble of structures, practices and conventions which individuals reproduce or transform, but which would not exist unless they did so.²⁷

Giddens makes a similar point through his notion of the 'duality of structure': structures constrain our options but also provide us with the tools for creating change.²⁸ Those who promoted change in Western Australia worked with the bureaucratic and legislative systems that less creative actors would have been constrained by. Of course they also mobilised others, but again this meant working with what was given in terms of skills, knowledge, belief, interest, identity and affiliation.

The Role of Social Movements

As the following chapters illustrate, the social history of intellectual disability is not just a history of human services. It concerns the interplay between the State and its organisations, the economy, civil society, and the life experiences of people with intellectual disabilities and their allies. In recent years there has been an increasing awareness that a better deal for people with intellectual disabilities involves more than a change in mode of human services, but a change in our society and its communities. That is not a matter for a vague and distant future but concerns us all today. Recent innovations in Western Australia affirm the key role of community development,²⁹ a domain that is alive and well in Australasia.³⁰ Certainly if people with intellectual disabilities are to be more than just clients of the welfare system, work has to be done to make communities more competent at including them,³¹ and this indeed calls for social change.³²

For social change to take place and for its gains to be maintained requires the mobilisation of a social movement.³³ Progress in the intellectual disability arena can be understood in relation to the emergence of alliances that cohere around key ideological positions.³⁴ In the recent Western Australian context we can identify the following aspects of coalitions for change.

First, there was the significant role of the parental lobby. This wing of the movement set the ball rolling in many ways through the establishment of new service models that over time were either taken over or funded by the State. The establishment of the hostels in the 1960s — at that time a ground breaking development — came about through a broad alliance for community-based provision that in various forms shaped the agenda of the system through the 1970s and 1980s. This is best regarded as a fairly loose coalition between parents, professionals, managers, academics, legislators and advocates that had a general consensus about the desirability of development, opportunity and community living.³⁵ Such ideologies, when consistently promoted, take on concrete forms in the form of practices, policies and services; so we can see the succession of service models as both providing images of possibility but also in constraining the imagination of how to implement the rather abstract philosophy. There are, of course, tensions in such alliances since the constituent parties have different interests and, moreover, the achievements of the movement (as services) engender

particular identities and commitments. Over time, however, the philosophy evolves, and Western Australia followed a fairly typical course from the custodial model prior to the 1960s, via an emphasis on development and training, to an increasingly sophisticated and theorised philosophy of living in the community with provision of service and non-service supports to do so.³⁶ However, as is typical, the coalition for progressive and principled change has had its strongest bases in the service system itself, and is therefore vulnerable to destabilisation from forces transmitted through the power structures. This is what appears to have happened in New South Wales in the late 1980s and in Victoria in the early 1990s: events that Western Australian reformers could take heed of in considering how best to respond to the changed context of today.

Looking Ahead

In the present, there is, then, a need to renew and rebuild an alliance for the late 1990s and beyond. This would benefit from inclusion of people with intellectual disabilities, as well as the generally more politicised movement of people with physical disabilities; while the quasi-market ideologues tend to emphasise the empowerment of users of services, this tends to be via the market mechanism of 'exit' rather than through the civic channel of 'voice'. The movement should also continue to include relatives of people with intellectual disabilities and those involved in service provision who share the progressive vision. If the alliance can be rebuilt, renewed, and broadened, then it will be in a good position to seize the opportunities presented when the quasi-market model reveals its own contradictions. This will not mean a return to the 1970s or 1980s but an ongoing struggle to establish effective but 'post-bureaucratic' services and supports.

As the following chapters illustrate for the Western Australian experience, the social history of intellectual disability can be understood in different sectors and periods in terms of the interplay between ideology and understanding, economy and politics, and institutional and organisational changes. These influences have both general or global, and specific or local dimensions, as explored in the foregoing pages. While some argue that little is learned from history, the alternative view is that an understanding of the forces that shaped human experience can help us take some control over the kind of experience we

have in the future. If the yardstick of a society is the way in which it treats its least powerful members, then the capacity of those in Western Australia to learn from this social history of intellectual disability could be of some critical importance in shaping the kind of society that Western Australia becomes in the early twenty first century.

Notes

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1 Living in Fremantle Asylum: The Colonial Experience of Intellectual Disability 1829-1900

Norman Megahey

Introduction

On April 20 1850, the *Sophia* set sail from Plymouth, England, bound for Western Australia.¹ On board were 246 passengers, mostly young and single, for whom the seven-week long voyage ahead would lead to an uncertain future in a new land. How unequally life dispenses its favours is exemplified in the stories of two of these passengers.

For George Randall, a 19-year-old carpenter emigrating with his 19-year-old wife Jane, the voyage was but the first stage along a route which would lead to financial success as a businessman and, later in life, an active political career which would reach its apex in his appointment as Colonial Secretary in 1898. For Annie Casey, apparently travelling alone, the voyage of the *Sophia* began a journey which would lead, in July 1858, to the Fremantle Asylum where she was declared perfectly 'imbecile' and 'idiotic', 'almost totally incapable of doing the most trivial work' and where she was to live out the rest of her life.² Thus did George Randall and Annie Casey find themselves at opposite ends of the social pyramid which, in 1850, was being constructed in the colony of Western Australia.

Much has been written about the George Randalls of colonial Western Australia. History abounds in the success stories of early pioneers who, often against the odds, not only survived but went on to attain positions of influence and power. George Randall's obituary proclaimed him a 'self-made man' and lauded his undoubtedly deserved and hard won achievements.³ Annie Casey, on the other hand, did not have an obituary. Her death, like her life, passed unnoticed in a world which cared little for failure. She died a 'pauper lunatic', not

even surviving as a statistic, for the Asylum record keeping was shoddy and incomplete.

This essay is about Annie Casey and others like her whose only crime against society was to be a person with intellectual disabilities, to whom society could offer no hope beyond life-long incarceration. These were the people at the bottom of the social pyramid who, by contrast with the high achievers of nineteenth century Western Australia, were considered utterly hopeless. Consequently, they were hidden away lest they disturb the balance in an emerging society which needed, above all else, social stability.

Changing definitions of difference, says Joanna Ryan, constitute the history of people with intellectual disabilities.⁴ These changing definitions are reflected in the variety of terms which have been used to describe people with intellectual disabilities throughout history: terms ranging from 'fool', 'idiot', 'imbecile', 'moron', 'mentally subnormal' to the current preferred 'intellectually disabled'. The terms themselves reflect a variety of interpretations of the phenomenon of intellectual disability, interpretations which have been determined by the values and traditions of the society in which they emerged. Consequently, as Sarason and Doris point out, when we talk about intellectual disability:

we are talking about a concept that not only is a creation of that society but also illuminates that society as much as it does the objects of its concern.⁵

This chapter will examine the phenomenon of intellectual disability in nineteenth century Western Australia. Specifically, it will look at the lives of some people with intellectual disabilities, describing how they were classified and treated, and the political and social values which helped determine their fate. Since social values are never static, I will also show how conditions for people with intellectual disabilities altered as changes in the political and social climate of Western Australia took place. Intellectual disability, however, had existed for a long time before colonisation. Therefore, in order to place the Western Australian experience into context it is necessary to turn to Europe and America and consider events there both before and during the nineteenth century.

Pre-Nineteenth Century Historical Perspective

Robert Ingalls considers the period before 1800 as pre-history in the study of intellectual disability.⁶ Most other writers begin with the growth of scientific interest at the end of the seventeenth century and credit the French alienist Jean-Etienne Esquirol with being the first to distinguish between intellectual disability and insanity. However, as Ryan points out, to write off the period before the nineteenth century is to misrepresent the past.⁷ Lewis notes that the distinction between intellectual disability and insanity is to be found in the thirteenth century common law of England 'which distinguishes between the "natural fool", witless from birth and the lunatic who, "hath understanding but by disease, grief or other accident, hath lost use of his reason"'.⁸ Furthermore, Paracelsus, a Swiss physician who lived between 1493 and 1542 and who is credited by some with being the first to describe cretinism, wrote the following:

God allows those who he has redeemed...the same to be born as foolish men: cannot recognise or understand...and are robbed of all reason and the wisdom that belongs thereto...Now there are many causes for this...It is all the more difficult when fools are born and there is no disease, they are incurable...we have no stone or herbs with which to make them bright...Besides, so Christ healed many sick, possessed, lepers, and all sorts of misery. But to restore fools, there nothing has been found. From its nature it is not possible.⁹

This description is significant for a number of reasons. First, it clearly makes a distinction between intellectual disability and mental illness. Second, the reference to those born 'as fools' being 'redeemed' refers to a notion which has existed at different times throughout Europe that people with intellectual disabilities were innocents, incapable of sin. Finally, the description is significant for its reference to fools as being 'incurable', an attitude which, in Western Australia, continued well into the twentieth century.

Nor was Paracelsus the only one to write in detail about intellectual disability. Felipe Montalto, a Portuguese physician writing in the early seventeenth century, dealt with description, diagnosis, prognosis and

cure of intellectual disability, which he termed 'stupidity' or 'dullness'. In an examination of one of his major works, Woolfson shows that Montalto:

made a coherent attempt to cope with the issue of mental retardation early in the seventeenth century...Montalto deserves his place in the history of the care and study of mental retardation.¹⁰

It is clear then that aspects of intellectual disability were recognised and examined as long ago as the sixteenth century — nearly 300 years before Esquirol. Apart from these coherent attempts to come to grips with the phenomenon, many myths have existed about the origins of what has been known variously as 'idiocy', 'dullness', 'retardation' and 'subnormality'. Within these myths, those so-labelled have shared status with other people with disabilities: the deaf, mute, blind, epileptic and people with mental illness. One myth, already alluded to, was the belief that people with intellectual disabilities were somehow closer to God. Ingalls cites the astronomer Tycho Brahe who:

retained a fool as a close companion and frequently sought his advice, much as the ancient Greeks sought counsel from the Oracle of Delphi, who was apparently an epileptic.¹¹

In contrast, a belief especially prevalent in the Middle Ages was that children with intellectual disabilities had no soul. Ryan, for example, cites Martin Luther's belief that the devil stole children from their cradles and substituted himself for them. The changeling infant became a punishment for the sin of the parents. Ryan continues:

Changelings, more obnoxious than 10 children with their crapping, eating and screaming, were just lumps of flesh with no soul; Luther even recommended killing them.¹²

Ryan makes the point that this is an early example of associating 'idiots' with animality — 'no soul and over dominant bodily functions'. Such an association was certainly present well into the twentieth century.¹³

Nineteenth Century European and American Experience

Despite an awareness of the distinction between intellectual disability and mental illness which can be traced back to the thirteenth century, by the beginning of the nineteenth century that distinction had become blurred. So, for example, in 1801, the French alienist Phillipe Pinel considered that 'idiocy' might originate from 'profound sorrow, intense study', thus making clear that 'idiocy' and 'insanity' were aspects of the same kind of disorder.¹⁴ The late eighteenth and early nineteenth centuries, however, saw an increase in concern for people with intellectual disabilities in both Europe and America. There were two main developments during the period. First, emphasis began to be placed on improving the conditions of people with intellectual disabilities. To this end, a large number of educational institutions were established specifically to meet the needs of these individuals. Second, the distinction between intellectual disability and mental illness was made quite explicit and the threefold grading of the former into 'idiot', 'imbecile' and 'feeble-minded' gradually emerged.

In an early manual for doctors written in 1895, George Shuttleworth, Superintendent of the Royal Albert Asylum in England, wrote of:

the curious coincidence that almost simultaneously in France, Switzerland and Germany, independent efforts were inaugurated for the benefit of the mentally deficient class.¹⁵

History, however, cannot be content with curious coincidences. Social phenomena have both a cause and an outcome, and so we must consider the social and political climate in which these changes took place.

The changing status of people with intellectual disabilities during the nineteenth century is well illustrated by a series of quotations from the writings of the main protagonists. In 1806, Pinel described 'the idiot' as:

a sad wreck of humanity...it is to be regretted that this species of mental disorganisation is for the most part incurable.¹⁶

Similarly, Esquirol in 1845 could 'conceive of no possibility of changing this state'.¹⁷ Yet in 1846, Edouard Seguin, the French alienist and educator, could write:

while waiting for medicine to cure idiots I have undertaken to see that they participate in the benefits of education.¹⁸

Seguin is thus both conceiving the possibility of a cure and proclaiming the benefits of education.

A number of writers have pointed to the influence of social and political thought on changing attitudes towards people with intellectual disabilities in the nineteenth century. Joachim makes the point that this was a time when spokesmen were advancing the causes of the oppressed throughout Europe and North America.¹⁹ Mahendra considered the Ideologues — an alliance of physicians and philosophers which drew inspiration from the sensationalist thought of the French philosopher l'Abbé de Condillac — as 'arguably the most important group of the eighteenth century'.²⁰ Furthermore, he argues, it was the entire 'social, political and therapeutic climate of France of the Revolution and the early nineteenth century that propelled mental subnormality into prominence...'²¹

The philosophy of the British Associationists, in particular John Locke, was undoubtedly a further influence. The influence of both Locke and Condillac has been examined by Bero who traces this influence on the work of Seguin and another French alienist Jean-Marc Itard.²² According to Locke, all ideas derive from sense experience:

I see no reason to believe that the soul thinks before the senses have furnished it with ideas to think on.²³

Condillac, a disciple of Locke, developed this philosophy even further, placing even greater emphasis on the role of the senses. Bero cites Condillac's metaphysical use of a statue to explain knowledge acquisition:

Condillac's statue man had all of the human faculties except for sense impressions. One by one the sense organs, smell, sound, taste, sight and hearing, are all brought to life. Each of the senses and their effect on one another is

examined in turn. Condillac shows through his statue man that all knowledge and all the faculties of the human mind are simply transformations of original sense impressions.²⁴

The significance of this is, of course, the recognition that the environment plays a crucial role in the learning process. From this recognition, it is only a short step to suggest that by manipulating the environment it may be possible to direct learning and develop specific skills. As Bero says, Locke and Condillac 'suggested that it might be possible to remake man (or in this case the idiot) by remaking the environment'.²⁵ This was the challenge taken up by Itard when, in 1798, he began the task of educating Victor, the so-called 'Wild Boy of Aveyron', diagnosed by Pinel as an 'incurable idiot'.

Itard was medical director at the Institute for Deaf Mutes in Paris. Training programmes for the senses, based on Condillac's theories, had already been carried out in Paris by Jacob-Rodriguez Pereirie in the education of deaf children. According to Bero, Pereirie's success was such that he 'practically made his pupils hear through the skin, and to utter exactly what they heard'.²⁶ The nature and success of this work was well known to Itard when, in 1778, a child of 11 or 12 years of age who had been found wandering wild in the forests at Aveyron was brought to him. Itard believed that Victor's mental state was a result of social and educational deprivation, and he recommended an educational programme based firmly on Condillac's theories. He taught basic social skills such as dressing and eating. Itard's efforts resulted in some success. According to Ingalls, after five years Victor had been transformed:

from an incontinent, insensitive, emotional animal to a partially civilised human, who could recognise objects and understand many words.²⁷

Itard, however, considered that he had failed because he had not taught Victor to speak. Victor was eventually institutionalised. Nevertheless, as Mahendra points out:

Itard's work did away with the paralysing sense of hopelessness and inertia that kept the medical profession and

everybody else from trying to do anything constructive for mental defectives.²⁸

Itard's work did not end there. In 1837, Seguin, one of his students, in collaboration with Itard, undertook the education of an 'idiot' boy, a collaboration which profoundly influenced the education of people with intellectual disabilities. As a result of his success, Seguin began to treat more children with intellectual disabilities and in 1846 he published *Traitement Moral, Hygiène et Éducation des Idiots*, his important book on training and treatment.²⁹ In 1848, Seguin emigrated to America where, under his influence, a large number of residential schools were established in which his educational ideas were put into practice.

The basis of Seguin's treatment was what he later termed the 'physiological method'. Seguin regarded the senses of the 'idiot' as being dull and underdeveloped rather than 'defective'. What was required was a programme to awaken the senses. The emphasis was consequently on muscular and sensory development. Shuttleworth summed up Seguin's rationale thus:

Starting with the axiom that "the education of the senses must precede the education of the mind", he argues that the true physiological method of tuition for persons whose nervous system is imperfectly developed is (1) to exercise the imperfect organs so as to develop their functions and (2) to train the functions so as to develop the imperfect organ.³⁰

Seguin's importance is twofold. First, his physiological method demonstrated that people with intellectual disabilities could be taught to do a good deal more than anyone had hitherto thought possible. Furthermore, the method contained much of what nowadays is practised by psychologists, physiotherapists, special education teachers and social trainers. Ryan makes the point that psychologists in the 1960s and 1970s have had to rediscover much of what was already known and practised in the 1860s. She continues:

it is difficult not to feel that if many of these early educational recommendations were put into practice now, we would achieve more than we have done so far.³¹

Seguin's second importance, as Mesibov points out, lay in his personal characteristics, which enabled him to become a driving force behind the establishment of residential schools and organisations for those working with people with intellectual disabilities in North America.³²

The second important development during the nineteenth century concerned the explicit distinction drawn between intellectual disability and mental illness, and the subsequent emergence of the threefold classification widely used by 1900 which graded intellectual disability into 'idiotcy', 'imbecility' and 'feeble-mindedness' according to perceived levels of severity. While, as has already been shown, it is evident that a distinction had been recognised in times past, it is equally clear that by the beginning of the eighteenth century thinking on the matter was confused. This confusion was further complicated by the lack of understanding about mental illness, which resulted in terms such as 'idiotcy', 'dementia' and 'mania' being used in different contexts.

The first explicit statement of the difference between intellectual disability and mental illness is usually credited to Esquirol who declared in 1838:

a person with dementia is deprived of possessions he has once enjoyed...the idiot has always been in misfortune and misery. The state of the demented person may vary, that of the idiot is always the same.³³

While Esquirol may be credited with being the first to make this distinction explicit, he was only one of many authors who wrote extensively on the subject of intellectual disability such that 'a distinction [was] hammered out, and a grading established' by the end of the century.³⁴ Cardno traces the progress towards classification through the writings of a selection of prominent authors and argues that this progress was influenced by:

romantic theories of mental subnormality, concern over the provision of institutional care, interest in moral inadequacy and the prevalence of terminology which is emotive rather than factual.³⁵

The result was a classification system which reflected both lack of real understanding and the prevailing nineteenth century moral climate, as well as a standardised system based firmly on nineteenth

century principles of scientific observation and classification. A clear example of the way in which this combination influenced the nineteenth century study of intellectual disability was the identification of the condition later labelled Down syndrome, by the British asylum superintendent Dr Langdon Down in 1866. Langdon Down interpreted this condition as an example of regression from a higher race (Caucasian) to a lower race (Mongol) and hence gave the name Mongolism to the syndrome. Langdon Down found it 'difficult to realise that he [the idiot] is the child of Europeans'.³⁶ Similarly, Tredgold attempted to identify negroid, Egyptian and Aztec types of mental defects. In short, though the nineteenth century witnessed the discovery of new clinical forms of intellectual disability, aetiological influences, in Scheerenberger's phrase, 'remained shrouded in a veil of uncertainty and moral conviction'.³⁷

To summarise thus far, the first half of the nineteenth century witnessed an upsurge of interest in, and concern for, people with intellectual disabilities. Intellectual disability became clearly distinguished from mental illness and attempts were made to classify according to levels of disability. A major step forward was taken when, influenced by new educational theories and the growth of humanism, Itard, Seguin and other reformers helped establish residential schools for the education of people with intellectual disabilities. Kott terms the mid nineteenth century a 'period of unrestrained optimism'. He argues:

the prevailing attitude was that with training and education all mentally retarded persons could be returned to the community.³⁸

The point has already been made that attitudes towards intellectual disability have fluctuated considerably throughout history. Before the nineteenth century had come to a close, further fluctuations had taken place. The 'unrestrained optimism' had not been sustained, early promises were unfulfilled and by the turn of the century the residential schools which had begun with such noble intentions had become custodial institutions. People with intellectual disabilities had become the victims of a new era of protective isolation. So, in the space of 50 years, the pendulum had swung from a position in which people with intellectual disabilities were regarded as irredeemable and ineducable,

to one which both recognised and demonstrated the benefits of education, and back again to the position described by Dr Barr of the Elwyn School in Pennsylvania, who believed that there was 'a consensus that abandons hope long cherished of a return of the imbecile to the world'.³⁹ To understand why these fluctuations occurred, we must examine more closely both the attitudes of the mid nineteenth century reformers and the social context in which they operated.

Mesibov suggests that the main reason for the development of custodial over residential educational care was that the initial claims of Seguin and other reformers were too strong and unrealistic — 'consequently they were quickly proven to be unfounded'.⁴⁰ Others argue that the expected rate of return of the pupils from the educational institutions to their communities never transpired. Davies claims that even after several years of training, only a small percentage of these school students were returned to their communities.⁴¹ One result of this was that many parents demanded that the schools continue to maintain their children indefinitely. This is, however, disputable. White and Wolfensberger argue that the early schools which were 'small, home-like and located in the heart of the community' were remarkably successful and had a high discharge rate of pupils back to the community.⁴²

One very real reason for the eventual development of a custodial model of care over an educational one is to be found in the increasing number of people with intellectual disabilities coming to the attention of the authorities. Ryan points out that virtually all nineteenth century writers commented on the increasing number of 'idiots'. As a result of these reports, residential institutions grew in size and overcrowding became a regular feature.⁴³ This of course thwarted any attempts at education along the lines advocated by the reformers, resulting in the shift in focus to the provision of permanent care.

But increasing numbers alone do not account for the dramatic shift to custodial care. In her illuminating analysis of the philosophies of Seguin and others, Ryan argues that the seeds of custodial care can be found in the ideas of the reformers themselves.⁴⁴ Seguin, for example, was ambivalent in his thinking as to the nature of intellectual disability, extolling on the one hand the humanity of the 'idiot' who 'is endowed with moral nature and is influenced by the same thing as the rest of humanity', yet describing 'idiots' as 'fashioned in the shape of man but shorn of all human attributes, breathing masses of flesh'.⁴⁵ Ryan makes

the point that this ambivalence was the basis on which the case for their education depended:

For Seguin the purpose of their education is to lift them from such a weak animal state...the problem is that if for any reason the expected improvement does not take place then the way is open for concluding that idiots are not so human after all.⁴⁶

Thus it was that towards the end of the nineteenth century, people with intellectual disabilities once again found themselves sharing status with animals. Descriptions of their appearance and behaviour — for example in medical texts and asylum records — are laced with phrases like ‘animal-like behaviour’, ‘animal instincts’ or ‘brute-like’.⁴⁷ However, these dehumanising analogies — while not new — contained more sinister undertones. Whereas previously the so-called animal nature of ‘idiots’ had been attributed to incompetence and irrational thinking, now there was a strong moral tone underpinning theories and attitudes. Ryan accounts for this new development in terms of reflecting the contemporary Victorian identification of sexuality with the perceived animal nature of human beings, and the supposed conflict between civilisation and nature, ‘the former being achieved only at the cost of the latter’.⁴⁸ People with intellectual disabilities thus came to be regarded as more prone to sin and therefore constituted a potential threat to society. From there, argues Ryan, it is only a short step to demand that they be controlled.

In sum, two aspects of the mid nineteenth century reformers’ thinking contributed towards the development of institutionalisation and the advent of the era of isolation. First, the educational ideas left the way open for attaching blame for failure on people with intellectual disabilities. Further, in Ryan’s words:

from Seguin’s “he will not but we will for him” it is only a short step to total domination.⁴⁹

Second, the moral underpinnings of the ideas which resulted in people with intellectual disabilities being regarded as a threat to society made their eventual life-long incarceration imperative.

While these explanations go a long way in helping us understand nineteenth century developments, they are on their own inadequate.

The nineteenth century saw the rise of public institutions of all kinds. People with intellectual disabilities were only one of several groups who found themselves incarcerated. For a more complete picture, we must therefore consider both the phenomenon of the rise of the asylum and the social context in which this occurred. This will be done with particular reference to the Fremantle Asylum which was established in 1857. First, however, it is necessary to turn to the Western Australian experience of intellectual disability in the nineteenth century.

The Western Australian Experience 1829 to 1900

John Bostock, in his history of psychiatry in Australia, refers to the obscurity which surrounds the lives of 'mental invalids' in the Australian colonies. He states that this situation was particularly apparent in Western Australia. He continues:

It amounts to almost total darkness. Concerning the period 1829 to 1857, the reader must reach his own conclusion.⁵⁰

If obscurity surrounds the lives of 'mental invalids', how much more obscure are the lives of people with intellectual disabilities who formed just one part of this all encompassing category? There are obvious reasons for this obscurity, especially in the early years of the colony — demographic factors not being the least of these. By the end of 1830, the total European population of Western Australia was a mere 1,500 people. Of these, Ellis suggests that there would only have been two or three 'insane'.⁵¹ When the first census was taken in 1848, it showed that only 4,622 European settlers resided in the colony. According to Virtue, there were no more than 12 'lunatics' at any one time during the 1840s and 1850s, an estimate which appears to be based on the Blue Books.⁵²

During the 1850s and 1860s, the white population increased fourfold; but this increase was accompanied by a doubling of settled land which meant a more widely scattered population.⁵³ In short, the population was both small and scattered and many settlers lived in isolation. With such a demographic picture, it is small wonder that the lives of people with intellectual disabilities are hidden from us. Yet exist they did. Available evidence allows us to bring their lives into some sort

of focus and to draw conclusions concerning both the quality of those lives and society's response to them. Thus, although people with intellectual disabilities may have been hidden from the mainstream of life in their own times, they need not be hidden from history forever.

A further important factor contributing to the obscurity surrounding the lives of people with intellectual disabilities in colonial Western Australia was the failure on the part of the authorities to distinguish accurately and consistently between mental illness and intellectual disability. Confusion as to whether or not 'idiocy' was a form of insanity continued into the twentieth century in Western Australia. The 1871 Lunacy Act, modelled on the British Lunacy Act of 1845, defined lunacy as follows:

Lunatic shall mean and include every person of unsound mind and every person being an idiot.⁵⁴

This definition remained in place until the passing of the 1903 Lunacy Act which dropped the term 'lunatic' and replaced it with 'Insane Patient'; the definition of which made it clear that intellectual disability was considered a form of insanity.⁵⁵

Another clue to reasons for the obscurity surrounding people with intellectual disabilities is to be found in the labels attached to inmates of the Fremantle Asylum. As Ryan points out, the assertion of difference between people is seldom neutral — it almost always implies some kind of social distance.⁵⁶ Thus we find asylum inmates suffering from such disorders as 'masturbational insanity', 'religious mania' and in one intriguing instance 'morbid sensuality'. These categories reflect some sort of deviancy or incompetence in relation to particular social values. Furthermore, the traditional association of insanity with criminality and immorality meant that people with intellectual disabilities shared a common status with petty criminals, paupers, alcoholics and even foreign aliens. It is into this pool of social outcasts that we must delve in order to recover fragments from the lives of people with intellectual disabilities in nineteenth century Western Australia.

It is convenient to divide colonial Western Australia into two periods: 1829 to 1857, the period between first settlement and the establishment of the Fremantle Asylum; and 1857 to 1900, the period which covers most of the life of the asylum.

The Period 1829 to 1857

The presence of 'lunatics' in gaol and in the Colonial Hospital is recorded in the Blue Books of the 1840s. One person who found himself in the Colonial Hospital in May 1841 was John Kellum, diagnosed as 'incurable...mania and dementia'.⁵⁷ Kellum arrived in the colony on the *Lotus* on 6 December 1829. He was 28 years old. What happened to him in the intervening years between his arrival and his admission to the Colonial Hospital is unclear but he must have come to the attention of the authorities as Sholl, the Colonial Surgeon, reported in 1841 that Kellum had been 'for some years in a state of imbecility!'⁵⁸ Whatever the circumstances, after three weeks in the Colonial Hospital the following letter was sent by Sholl to the Colonial Secretary:

In consequence of the noise made by John Kellum nightly, and the destruction caused by his filthy habits to the bed and bedding of the hospital, I am compelled to request you will be good enough to remove him, if possible, he is not a fit case for a hospital of general diseases, as the patient suffers from want of rest and no possible good can be done to himself, his case being perfectly incurable.⁵⁹

Kellum's case is significant not because he may have been a person with intellectual disabilities — though the reference to him being 'perfectly incurable' would suggest that he was — but for a number of other reasons. First, it highlights the colony's inability in terms of accommodation and treatment to deal with people suffering from mental illness. The final decision on admissions to and discharges from the Colonial Hospital lay not with the Colonial Surgeon but with the Governor; hence Sholl's plea to Governor Hutt. However, if Kellum was not a fit case for the Colonial Hospital, the only other alternative open to the Governor was to gaol him.⁶⁰ That the Governor recognised the unsuitability of the Colonial Hospital as a place for people with mental illness is evident in his refusal, on other occasions, to admit such people when they had friends or relatives to whom they could be sent. Kellum, however, appeared to have had no friends or relatives and so he remained in the Colonial Hospital. Conditions had not changed 14 years later when Dr John Ferguson, the then-Colonial Surgeon, wrote to the newly appointed Governor Kennedy:

There is in my opinion an insuperable objection to their removal to the Colonial Hospital, viz, the impossibility of treating any serious disease...where lunatics are concerned.⁶¹

It was to be a further two years before a temporary asylum was provided, and eight years before the establishment of a permanent institution: the Fremantle Asylum.

The second significant point about Kellum's case is what it tells us about available treatment for unmanageable patients. Virtue calls the period prior to 1850 one of 'colonial primitivism in relation to the mentally ill'. 'The struggling colony', he argues, 'could not afford to devote time, effort and money to the introduction of suitable facilities'.⁶² Furthermore, the absence of medical and psychological knowledge made seclusion and restraint unavoidable. Consequently, Dr Sholl instructed Mr Brown, the hospital assistant, to secure John Kellum to his bedstead with straps around his ankles and wrists. Unfortunately for Kellum, this unavoidable seclusion and restraint was to prove fatal. One morning, Mr Brown — having some hours previously tethered Kellum to his bed — discovered the unfortunate man dead, apparently accidentally strangled by the cord used to restrain him.⁶³

A third significance in Kellum's case is the glimpse it provides of public attitudes. Some weeks before Kellum's death, the Registrar General, Mr G. F. Stone, wrote to the Colonial Secretary complaining of 'the loud and increasing ravings of some person we suppose to be the lunatic' which had kept both him and his wife awake for several nights. He continued:

I am informed that he repeatedly makes his escape, the knowledge of which keeps Mrs Stone in a continued state of nervousness...I have said this much to show you how greatly we are and have been disturbed and I hesitate not to say that the Hospital is a public nuisance to the neighbourhood while he is there.⁶⁴

What is obvious in this letter is the lack of sympathy with Kellum and his predicament. Kellum emerges not as someone in desperate need of help but rather as a disruptive element whose presence in the hospital caused that place to be 'a public nuisance'.

In summary, the period up to 1857 is extremely unclear as far as people with intellectual disabilities are concerned. We cannot name them, describe their circumstances or estimate their numbers. Any people with intellectual disabilities that did exist and who came — for whatever reason — to the attention of the authorities are lost among what Virtue calls ‘the corpus of degenerates’ which was made up of criminals, paupers, deaf mutes and the ‘insane’.⁶⁵ What John Kellum’s story shows us is the early colony’s inability to cope with individuals who were considered socially disruptive; an inability which stemmed from both lack of scientific knowledge and lack of money. The outcome was confinement in gaols or hospitals with no treatment other than mechanical restraint.

The Period 1857 to 1900

According to Ellis, it was not until after the introduction of the convict establishment in 1850 that the problem of the ‘insane’ began to be regarded as a major nuisance.⁶⁶ In the years immediately following 1850, increasing numbers of ‘criminal lunatics’ were reported and there were frequent calls for the establishment of separate accommodation for these people. The year 1857 marks a watershed as the year when the Fremantle Asylum opened and asylum records began. It is through a close study of these records that the lives and that which determined the quality of the lives of people with intellectual disabilities begin to come to light.

However, we only receive a glimpse of these lives. In fact, we are denied a more complete picture by the very things which denied people with intellectual disabilities a more complete life in their own times: medical and legal confusion about distinction between intellectual disability and mental illness, and a lack of medical and psychological knowledge concerning intellectual disability and mental illness. To this can also be added the poor quality of record keeping. Entries on the surviving Fremantle Asylum case books are brief and often incomplete.

Legal confusion as to whether or not ‘lunacy’ was synonymous with intellectual disability has already been mentioned as evident in the Lunacy Act of 1871. It is clear that there was confusion also among the medical doctors. One of the earliest inmates of the Fremantle Asylum, for example, was Annie Casey. The Admissions Register recorded the following description of her:

Diminutive in body with contracted cranial development, laughs in an idiotic manner when spoken to. Hangs down her head. Evidently has little or no memory, tells her age, states she can read and write and when a book is brought reads tolerably well, though laughing and crying all the time.⁶⁷

Subsequent records described Annie Casey as 'imbecile', 'idiot', 'female lunatic' and 'of unsound mind'. It seems clear from this that 'idiocy' was regarded as one form of 'lunacy'. However, not everyone fitted neatly into this typology.

How William Frankleton first came to the attention of the authorities is unclear, though it seems likely that he was first detained for vagrancy or petty theft. On 15 November 1858, he was pronounced 'imbecile and unfit to take care of himself' by a Medical Board which then recommended his admission to the asylum.⁶⁸ The Asylum Case Book records the following information:

as far as any information can be gained he has not possessed any more wit or intelligence than he has now since he arrived in the colony, and as far as can be judged from appearances he was probably so from birth, what is commonly called a natural. He has an imbecile expression, and possesses very little intelligence...⁶⁹

Six months later, a second Medical Board reviewed Frankleton's case:

the majority viewing him as free from any symptoms of insanity and as being only naturally simple-minded...he should be removed from the asylum.⁷⁰

However, this was only a majority decision as there was some disagreement between the two doctors on the Medical Board, Dr George Attfield and Dr D. F. Rennie. While Attfield took the majority view, Rennie dissented, arguing that Frankleton should remain in the asylum. Rennie's minority view was recorded on the Medical Board's Report in which he questioned whether the Board was:

justified in attempting to draw a line of demarcation, as far as precautions and treatment are concerned between imbecility of mind accompanied by delusions and the imbe-

cility of mind unaccompanied by delusions — the former being usually denominated Insanity, the latter Idiocy.⁷¹

Because of the disagreement, the case was referred to the Governor who — for reasons we shall come to later — refused to sanction the Medical Board's findings and so William Frankleton was to spend a further 10 months in the asylum before being discharged in March 1860.⁷²

There are two main points of interest in Frankleton's story so far. The first concerns Attfield's entry in the Asylum Case Book, reporting the Medical Board's finding that Frankleton was free from any symptoms of insanity, though being 'naturally simple-minded'.⁷³ It would appear then, that Attfield was distinguishing between intellectual disability and mental illness. However, in his journal for 15 April 1858, he refers to Frankleton as a 'local lunatic', thus suggesting that he, Attfield, was confused in his own mind about the nature of 'simple-mindedness'.⁷⁴

Second, the Medical Board's findings — that 'being only naturally simple-minded' Frankleton should be released from the asylum — would suggest a recognition of the asylum's unsuitability for this class of person. Yet just over two years later, Frankleton was readmitted to the asylum despite a third Medical Board still finding him 'free from ordinary signs of insanity'. On this occasion, however, he was considered 'incapable of self-control' and prone to 'fits of anger'.⁷⁵ These findings were deemed sufficient grounds for his inclusion among the asylum population. There is no mention on this occasion of the asylum being unsuitable for the 'naturally simple-minded' Frankleton, who was clearly sane.

Nor does the question of Fremantle Asylum's suitability as a place for people with intellectual disabilities appear to have been raised over the next three decades, when records show increasing numbers of admissions. Because of the poor system of classification and the inclusion of intellectual disability under the umbrella of 'lunacy', it is not always easy to identify those individuals with intellectual disabilities who were housed in the asylum. However, careful scrutiny of the existing records does produce profiles of inmates with intellectual disabilities and, while it is not possible to produce precise figures, two things are clear. First, the numbers of people with intellectual disabilities steadily rose through the 1870s and 1880s and second, the age at which they were admitted steadily fell. By the 1890s, Fremantle

Asylum was home to a number of children whose ages ranged from nine to 15 years.

The presence in the asylum of these children and other adults with intellectual disabilities raises a number of important issues concerning the circumstances surrounding their admission, social attitudes towards intellectual disability and the quality of their lives as inmates of an institution. Before seeking answers to these questions, it would be useful to consider the actual concept of the asylum. Fremantle Asylum developed out of the Convict Establishment in response to an increasing number of supposedly 'insane' prisoners reportedly being sent out from England. However, the introduction of an asylum in Western Australia can be seen as inevitable: a part of the total cultural package introduced by colonisation.

The rise of the asylum has been examined by, among others, Rothman⁷⁶ in America and Scull⁷⁷ in Europe. While their respective approaches differ, they are not mutually exclusive and both are relevant to Western Australia. Scull links the growth of the asylums in England with the growth of the capitalist market economy, while Rothman sees the move towards asylums in America as a response to the need to create order and stability in the midst of change. The introduction of the asylum in Western Australia can be seen as a response to both economic and social conditions, both factors evident in the presence of people with intellectual disabilities within that institution.

Scull, in his analysis, is much concerned with the impact of the capitalist market economy on social relationships. This impact is evident in England, he argues, in the disappearance of social obligation to the poor which resulted in a strain on the family-based system of support. This in turn gave rise to institutional means of managing the indigent. However, for middle-class reformers, the conditions of the emerging labour market necessitated a distinction being made between able-bodied and unable-bodied poor; the new economy required a large labour pool. Initially, the workhouse served as the means for making this separation by removing the able-bodied poor from the community in order to teach them the discipline of labour. However, the order and discipline necessary for the proper functioning of the workhouse was threatened by the presence of the 'madman' who could neither be persuaded nor induced to conform to regulations. The

'madman's' presence in general hospitals and gaols created similar problems. Therefore, a distinction among inmates had to be made.

The relevance of this account for Western Australia is obvious when we consider how similar needs gave rise to the first plan to erect a lunatic asylum. It was only after the introduction of the convict system in 1850 that the need for an asylum began to be voiced. The convict system itself was introduced in response to a shortage of labour but its economic function was threatened by the presence of 'lunatic' prisoners among the convict population. Thus, Thomas Dixon, Superintendent of Fremantle Prison, reported on the lack of facilities for control of 'lunatic' prisoners and complained of:

their bad effect on other prisoners, the impossibility of employing them on working parties...and the absolute necessity of separating the sane from the insane prisoners.⁷⁸

Rothman's account of the rise of the asylum in the USA deals with prisons and poorhouses as well as lunatic asylums. Rothman is concerned with the American colonists' attitudes towards social deviancy and he sees the rise of the asylum as:

first and foremost a vigorous attempt to promote the stability of the society — an effort to ensure cohesion in newer and changing circumstances.⁷⁹

By the 1830s, says Rothman, Americans were writing about the origins of deviant and dependent behaviour and attributing these to faulty organisation in the community:

To control abnormal behaviour promised to be the first step in establishing a new system for stability in the community.⁸⁰

This, for Rothman, was the crucial element that led to the rise of the asylum. However, the American colonists were also concerned about the economic effect of deviancy. Thus, a variety of cases — 'lunacy' being just one — were made part of the definition of the poor:

The lunatic came to public attention not as someone afflicted with delusions or fear, but as someone suffering from poverty.⁸¹

Considering the special category of insanity and its position in the social order, Rothman points out that while medical men agreed that insanity was a disease of the brain, they assigned its first cause to social factors, for example, masturbation or religious anxiety. To understand insanity, then, one had to look at the workings of the society.

Elements of both Rothman's and Scull's analyses are evident when we turn to consider the Fremantle Asylum. That it functioned as a repository for individuals who — rather than being 'insane' — presented a perceived problem to society in the form of economic and/or moral threat is clear. Perhaps the most striking example of this is the presence of a substantial number of Asian inmates during the 1880s and 1890s.⁸² Most of these men arrived in Western Australia as indentured servants and, upon termination of their contract, caused the authorities some alarm by their presence in the community as freemen. The perceived danger — both moral and economic — to the European community from the presence of people considered to be of inferior race is well documented in the Parliamentary Debates, Acts of Parliament and newspaper articles.

Most of the Asians in the asylum had been sent from the Northern Districts under orders signed by resident magistrates and with such diagnoses as 'weak intellect' or 'mental aberration'. Dr J. W. Hope, Acting Superintendent of Fremantle Asylum, appeared before a Civil Service Commission in 1894 and declared:

if a chinaman in the Northern Districts is very troublesome, he is made to feel miserable and sent down to the asylum without proof whether he is sane or not.⁸³

In fact, two years earlier Dr Hope had examined Tua Ah Hing — who was sent down from Carnarvon with a medical certificate stating 'mental aberration' — and could find no evidence of any mental illness. Upon asking for further information from Carnarvon, the reply came back: 'This man was violent and I don't know what else I could have done!'⁸⁴ However, this was no problem for Dr Hope who duly proc-

essed another certificate declaring Tua Ah Hing, whom he had already said showed no signs of any mental condition, delusional.⁸⁵ Subsequently, this man languished for five years in the Fremantle Asylum before being shipped back to Singapore with 16 of his countrymen and fellow inmates.

The plight of the Asian inmates of Fremantle Asylum highlights two problems for the colonial authorities. On the economic front, they were faced with the prospect of paupers becoming a financial burden on the fragile economy of the colony. Besides this there was the desire to promote stability and cohesion in an emerging society, hence the necessity of controlling social deviancy.

The same economic and moral factors can, of course, be seen at work in the presence of the non-Asian inmates. A high percentage of the asylum population, for example, had pauper status. Indeed, the 1871 Lunacy Act declared that: 'Every asylum shall in the first place be appropriated to the reception of pauper lunatics'.⁸⁶ As Ellis notes, 'only when these had been tidied up would private paying patients be admitted'.⁸⁷ Further moral factors are evidenced in the diagnosis and causes listed in the Fremantle Asylum records. Those cited earlier — including 'masturbational insanity', 'religious mania', 'social isolation' and 'morbid sensuality' — are all there. Consideration of these factors, it must be stressed, does not preclude the existence of an underlying condition. The point being made is that many individuals came to light, in the first instance, not as people suffering from clearly definable mental illnesses but rather as people either unable to provide for themselves — namely paupers — or in some way constituting a threat to society.

The question which needs to be addressed now is how the foregoing analysis worked with people with intellectual disabilities at the Fremantle Asylum in the nineteenth century. Specifically, we need to know how those people came to the attention of the asylum authorities; what the circumstances were surrounding their admission; why it was deemed necessary to incarcerate them and in the asylum; and finally, what was their ultimate fate? Such questions are best answered not by analysis of official statistics, nor by merely examining the asylum records but by describing the experiences of the people themselves. Presented below are the stories of six such people.

William Frankleton

William Frankleton, whom we have already encountered, arrived on the Western Australian scene around 1852, aged 20 years. He arrived from England on a Ticket of Leave. Whether or not he ever gained employment is unclear though it seems unlikely from subsequent events that he would have held a job for any length of time. In 1859 Thomas Symmons, the colony's Sheriff, could report that he had known Frankleton for several years 'as a person of weak intellect and as not responsible for his actions'.⁸⁸ Frankleton had numerous convictions and terms of imprisonment for petty theft. On one occasion, shortly after being released from prison, he was found starving on the streets of Perth and pleaded to be sent back to gaol. His request was duly granted 'to secure him from the more serious consequence of a legal conviction which he would undoubtedly have incurred'.⁸⁹ It was soon after this, in November 1858, that he arrived in the Fremantle Asylum on the recommendation of a Medical Board which, as we have seen, found him to be unfit to take care of himself.

The Medical Board's findings and those of a subsequent Medical Board held in May 1859 have already been discussed. A third Medical Board meeting was held in March 1860. As a result of the Board's findings, Frankleton was discharged from the asylum.⁹⁰ In September of the following year, he was arrested in St Georges Terrace, charged with vagrancy and sentenced to three months in the Convict Establishment.⁹¹ The following May he was again admitted to the asylum and was transferred to the Invalid Depot three and a half years later.⁹² William Frankleton disappears from the records after this time.

Annie Casey

Annie Casey was received into the Fremantle Asylum on 12 July 1858. Little seems to have been known about her from the time of her arrival in the colony eight years previously. A statement sent with her merely stated: 'arrived in the colony unsound in mind and gradually getting worse'.⁹³ When she arrived at the asylum, she was described by Dr Attfield as 'obedient and docile...in good health' and having an 'imbecile and idiotic expression'.⁹⁴

Glimpses of Annie Casey's life within Fremantle Asylum can be gleaned from Dr Attfield's entries in the Female Register and from the

Surgeon's Daily Journal. It is apparent that some efforts were made to train her in the performance of basic self-care activities. One entry, for example, reports that 'great trouble is taken by the Matron and Attendants to keep this patient tidy in her dress and make her more intelligent'.⁹⁵ Some measure of success was made as six months following her admission — when she had been described as incapable of doing the most trivial work — Dr Attfield recorded that she was 'generally kept employed in cleaning'.⁹⁶ Later reports have her 'assisting in hemming handkerchiefs and washing cloths and cleaning rooms'.⁹⁷ Despite this, Dr Attfield records in August 1870 that she 'remains perfectly imbecile' although 'she dresses herself, combs her hair, eats her food (mechanically)'.⁹⁸

Although described as generally docile yet cheerful, there were occasions when she experienced sudden outbursts of anger and became violent, often directing the violence towards the Matron. On these occasions, she was restrained with the use of a straitjacket. For Annie Casey, Fremantle Asylum was to be home for the rest of her life. The last mention of her in surviving asylum records is dated October 1892, over 14 years after her admission, and says simply 'Quite idiotic, able to feed herself but nothing else'.⁹⁹

Alice Halliday

Alice Halliday emigrated to Western Australia with her parents and brother in 1853. On 1 September 1868, aged 26 years, she was received into the Fremantle Asylum after a Medical Board found her 'insane, incapable of taking care of herself and subject to fits'. The asylum records declared her to have been 'insane from childhood' and described her as:

dwarfed in figure but very muscular and strong. Completely irrational in talk and behaviour...has fits about once a week.¹⁰⁰

Twelve years later, the Asylum Case Book states that she 'remains the same year after year without any alteration'.¹⁰¹ The years continued to pass, and in 1886 we have the last surviving comment on the life of Alice Halliday:

This chronic imbecile has now been 18 years in the asylum. Her bodily health is good. Mental state can never improve.¹⁰²

Elizabeth Edwards

In the same year that Annie Casey arrived in the Fremantle Asylum, Elizabeth Edwards was born in the town of York. In November 1869, aged 13 years, she joined Annie Casey as an inmate of that institution. The asylum records describe her as follows:

Has been semi-imbecile since birth, is dwarfed and crooked in figure — intellect very weak. Appears to understand a few of the simplest questions, but is quite incapable of giving rational answers. Sometimes shouts and cries, has an awkward ambling gait — voracious appetite and dirty in habits.¹⁰³

Shortly after her arrival, she was observed to have extremely poor eyesight. She was unable to feed or dress herself and from all accounts was quite helpless.¹⁰⁴ However, as with Annie Casey, some attempts appear to have been made to train her. Seven months after her admission, she was reported to be 'cleanly as regards to former offensive habits'.¹⁰⁵ Elizabeth Edwards was more fortunate than Annie Casey in that she had a caring family. She was visited regularly by an aunt and cousins, although no mention is made of her immediate family.¹⁰⁶ Nevertheless, she was to spend the rest of her life within the asylum. The last mention of her from surviving records states:

this case of chronic idiocy remains of course without mental change. Bodily health robust.¹⁰⁷

Emily Randell

Emily Randell was only 10 years of age when she was received into the asylum. When she was three years old, she had a fall and hit her head. Her disability as a result of this accident took the form of muteness, irrational behaviour and occasional violent outbursts. She appears to have been considered a danger as much to herself as to others. The Asylum Case Book recorded that 'she has had several risks of being

drowned and burnt by her inability to understand'.¹⁰⁸ Emily was fortunate in that — probably on account of her age — she received the care and attention of other inmates in the asylum. One in particular, Ann Cummings — diagnosed as suffering from puerperal mania following the death of her newborn infant — appears to have taken Emily under her wing, a kindness which was probably therapeutic for her as much as for Emily. Dr Barrett, reporting on the improvement in Ann Cummings' condition, added that Cummings 'looks after the child Randell and feels the responsibility'.¹⁰⁹

As Emily grew bigger and older, she proved to be an increasing problem for the asylum attendants, requiring constant supervision. At the age of 17 she was described as stout and fit.¹¹⁰ Several instances are recorded of her attacking fellow inmates and, in particular, her habit of biting. She was also prone to aggression directed against herself. One entry in the Asylum Case Book states that she 'strikes herself and is a terrible looking object'.¹¹¹ To control these outbursts she was given Mist Chloral — though it would appear with little effect. She was also fitted out with a straitjacket 'to restrain her for her own safety'.¹¹² Emily Randall was transferred to Claremont Hospital for the Insane in 1908.¹¹³

Isobell Hough

The youngest person on record to be admitted into the Fremantle Asylum, Isobell Hough, was aged only nine years on her admission in July 1896 — an 'utterly hopeless case of idiocy with disgusting history and habits'.¹¹⁴ Prior to her admission, Isobell was the subject of a four-month long wrangle between the Colonial Surgeon, Dr Lovegrove, the Superintendent of Relief, Mr Dale, and the Under Secretary of State, Mr O'Brien, as to the suitability of the asylum for her detention.¹¹⁵

Isobell first came to the notice of the authorities as a result of a request from her father, Joseph Hough, who farmed a small holding in the Bunbury area. His first wife, Isobell's mother, had died and he had subsequently remarried. On the birth of a child by his second wife, Joseph considered that he could no longer keep Isobell at home as she required a level of supervision which neither he nor his wife could provide. Dr Lovegrove recommended that Isobell be sent to the Poor House where, if given proper training, she 'would make a good washerwoman'. Furthermore, he considered the Fremantle Asylum unsuitable as 'she will be impressed by the more violent patients'. Mr

Dale was against this recommendation, basing his argument on his belief that the Poor House would be unable to provide suitable supervision. The matter was taken to the Under Secretary and finally to the Premier, to whom the solution was quite simple:

it seems clear that the girl Hough is not a fit person to be in the Home. If she is imbecile she should go to the asylum.

Reluctantly, Lovegrove conceded and agreed to have her admitted to the asylum, 'there being no other institution in which to place the Hough child'. Isobell's fate was sealed when William Timperley R. M. and Dr Flynn signed a Lunacy Certificate. She joined Emily Randell in the asylum and was transferred to Claremont Hospital for the Insane in 1908, where she lived the remainder of her life.¹¹⁶

According to Steven Gelb:

mild subnormality developed as a scientific hence natural explanation for the socially unacceptable behaviour of economically marginal people.¹¹⁷

Unacceptable social behaviour and economic marginality are prominent ingredients in the life stories of most people with intellectual disabilities incarcerated in Fremantle Asylum in the nineteenth century. Of the six people whose stories have just been recounted, all came to the attention of the authorities on account of one or both of these factors. William Frankleton, in particular, posed a problem to the authorities to the extent that the Governor — the final arbiter in the matter — was not prepared to have him released even though there was no medical or legal justification for his detention.

Marginal people, of course, present special problems for any society. They cannot be easily placed into any particular category. These are the people who often end up being shunted from one agency to another, each agency arguing that they do not meet a required criterion. While the need for social control in an emerging society such as colonial Western Australia may have been more acute, the solution was relatively simple. There were few options. In the case of Isobell Hough, for example, there was no dispute that she needed institutional care. The argument centred around which of the two institutions — the Poor House or the asylum — was the more appropriate. The final

decision to send her to the asylum rested on the fact of 'there being no other institution'. Significantly, this decision was made at the political level and not by the medical doctors who, in fact, disagreed with it but had to comply.

A further important feature of these six stories is that once in the asylum, people with intellectual disabilities remained there. In fact it seems that for all inmates, getting into the Fremantle Asylum was far easier than getting out. This fact concerned one member of the Legislative Assembly who remarked during an 1891 debate that 'lunatics' were placed in the asylum by a process of law, 'but once there, it seemed to him, that we did our very best to prevent them ever coming out'.¹¹⁸ What then was life like for people with intellectual disabilities within the asylum? Considering that many of them spent most of their lives within its confines, what was the quality of their lives?

We have already caught glimpses of this reality in the life of Annie Casey to whom — according to Dr Attfield — the asylum staff devoted much effort in an attempt to 'make her more intelligent'. The influence of Dr Attfield's personal philosophy towards the 'insane' was undoubtedly a factor which worked in favour of providing — to some degree — a humane and caring environment in the 1850s and 1860s. Dr Attfield was Surgeon Superintendent of the Asylum from 1857 to 1870. His philosophy was based firmly on the concept of 'moral management' which had been introduced to European asylums. 'Moral management' emphasised the humanity of the 'insane' and the benefits of self-discipline, cleanliness and recreation, and the abolition of mechanical restraints. In his Annual Report for 1860, Attfield was able to state that in the Fremantle Asylum:

Books are regularly supplied and a good proportion of the men read daily; several games at ball, such as fives or cricket together with draughts in the evening, constitute their chief amusement. Washing, serving and housework constitute the chief employment for the women; these I regard as most probably incurable, and being hopelessly imbecile.¹¹⁹

On the abolition of mechanical restraint, Attfield had many disagreements with Dr Rennie, his immediate superior. In these he stands out as strongly opposed to both seclusion and mechanical means of

restraint, and in the same annual report he declared: 'It has not been necessary during the whole year to use any mechanical restraint'.

During the 1850s and 1860s then, life within Fremantle Asylum though certainly not idyllic — appears to have been relatively comfortable and the standard of care at a reasonably good level. However, despite his noble intentions and obvious humanitarian qualities, three forces were working against Dr Attfield and thus against the people with intellectual disabilities under his care. In the first place, though he disliked the use of seclusion and mechanical restraints, circumstances on occasion compelled him to resort to these measures. Thus, after a sudden outburst of anger and violent rage from William Frankleton, Attfield wrote in his journal:

I have no alternative but to keep this man in seclusion, though I do not approve of the principle.¹²⁰

Similarly, when Annie Casey became violent she was fitted with a straitjacket. In short, although philosophically opposed to such treatment, the absence of alternatives in existing medical and psychological knowledge made recourse to them inevitable.

The second force working against Attfield's idealism arose out of an ambivalence in his own thinking. Despite, for example, efforts being attempted — as with Annie Casey — to 'make her more intelligent', there remained the underlying belief in the utter helplessness of training people with intellectual disabilities. The asylum records abound with references to these people as 'utterly helpless' or 'totally incurable'. Nevertheless, while the number of inmates remained at a manageable level — which it did throughout the 1860s — it was possible to provide some degree of individual care and training.

The third and final force working against Attfield concerns the nature of the asylum itself. We need to remember that the Fremantle Asylum grew out of the Convict Establishment and remained, until 1886, an integral part of that institution. Therefore, its guiding concept — as Virtue points out — was a penal one.¹²¹ The Surgeon Superintendent was responsible to the Comptroller General of prisons and the attendants were selected for their considerable experience as gaol warders.

The existence of these underlying forces, together with certain developments during the 1870s — the Lunacy Act of 1871, chronic

overcrowding and Government complacency — were to considerably lower the quality of the lives of the asylum inmates, and particularly for the inmates with intellectual disabilities. Their fate as life-long recipients of custodial care was sealed.

Significantly, the Lunacy Act of 1871 passed through the Legislative Assembly undebated.¹²² It sought to provide for:

the safe custody of, and prevention of crimes by, persons dangerously insane; for the care and maintenance of persons of unsound mind; and for the care, management and disposal of the property and estates of such persons.¹²³

While the Act sought to provide proper legal safeguards against wrong detention and to promote the welfare of inmates by establishing a Board of Visitors and Board of Inquiry, it had several shortcomings. For example, there was no provision made for the appointment of a full-time surgeon superintendent. The asylum doctor was engaged on a part-time basis, answerable to the Colonial Surgeon who in turn was answerable to the Colonial Secretary. As Ellis points out, this power structure prevented the Asylum Superintendent from making any innovations in treatment:

In effect it placed control of the asylum in the safe and steady hands of the senior doctor in the colony and the Colonial Secretary.¹²⁴

Furthermore, the Act failed to stipulate whether ultimate jurisdiction lay with the Imperial or Colonial governments. According to Virtue:

until improved curative techniques were developed and a medical model of insanity replaced the legalistic one, the Act served to perpetuate custodial care.¹²⁵

The intentions of the Lunacy Act were further impeded by a second development in the 1870s, namely chronic overcrowding. The Fremantle Asylum was designed to accommodate 45 inmates, but by 1870 it accommodated an average of 85 inmates daily. By 1887, this number had risen to 119.¹²⁶ Dr Barnett, the Asylum Superintendent after 1872, constantly complained in his annual reports of overcrowding but his pleas for improved facilities fell on deaf ears. Barnett was particularly

concerned about the impossibility of segregating the 'quiet and curable from the noisy and incurable ones'.¹²⁷ His 1884 report makes it clear that the term 'incurable' refers to inmates with intellectual disabilities:

I would again respectfully urge the necessity which exists for the separation of the curable from the incurable patients...At present noisy and congenital idiots are of necessity associated with patients whose affliction is only temporary.¹²⁸

Despite extensions to the asylum in 1895, the annexation of The Knowle as an overflow asylum, and the purchase of Whitby Falls as an asylum for 'quiet and chronic' male patients, Fremantle Asylum remained hopelessly overcrowded. In 1900, the government set up a select committee to enquire into conditions at the asylum. This committee handed down a report declaring the asylum to be so unfitted for its purpose that nothing short of a new building would remedy things. One expert called before the committee, Dr Black, recommended that:

the whole system, including the Lunacy Act, should be wiped out, a new asylum built, and a new Lunacy Act framed.¹²⁹

The final factor working against providing anything other than purely custodial care after 1870 was increasing government complacency. One reason for this was the cessation of convict transport in 1868 which, according to Hasluck, 'had caused the British Government to curtail expenditure in Western Australia'.¹³⁰ Also, as Virtue points out, in that year the British Government had begun plans to transfer the Convict Establishment to the Colonial Government, and so was reluctant to spend money on improvements.¹³¹ The Legislative Assembly, for its part, was apathetic towards the issue of 'lunacy', an apathy which merely reflected public indifference. This indifference can be accounted for by reference to the broader social context of a still young colony, politically immature and, until the discovery of gold in 1885, struggling to survive economically. Such a social climate would tend to produce little sympathy for misfits. Further, the convict era may well have hardened attitudes towards those considered social misfits. Virtue argues:

the fact that the convict system came late to Western Australia was one factor retarding progressive attitudes to social problems behind those of other colonies.¹³²

It was not until after 1886 — when the Convict Establishment was finally transferred to the colonial authorities — that the Legislative Council, albeit slowly and reluctantly, began to consider seriously what steps to take to remedy the crises within the Fremantle Asylum. The 1890s saw increased debate within the Legislative Assembly. A select committee was set up in 1891 to inquire into conditions in the asylum;¹³³ an inquiry into ill treatment took place in 1898 following a campaign by the *Sunday Times* newspaper;¹³⁴ and in 1900, the Vosper Committee was appointed to inquire into affairs at the asylum.¹³⁵ The end result of all this was increased public awareness and changes in attitudes which, during the first decade of the twentieth century, helped to bring about long needed reforms. These included the passing of a new Lunacy Act in 1903 and the building of a new asylum as recommended by Dr Black during the Vosper Committee hearings.

In short, the period 1870 to 1900 witnessed a dramatic deterioration in the quality of the lives of people with intellectual disabilities at Fremantle Asylum. The chronic overcrowding — which increased to the point where in 1896 there were 190 inmates — was a potent force working against the interests of these unfortunate people.¹³⁶ Legislative Assembly debates, newspaper editorials and committees of inquiry during the late 1880s and 1890s all attest to the atrocious conditions within the asylum. Chronic overcrowding prevented meaningful classification of inmates and rendered futile attempts at treatment. The *West Australian*, calling for the setting up of a completely new asylum, expressed sympathy with Dr Barnett:

To him, in his regular visits, the sight of so much suffering for which he knows the remedy, but which nevertheless it is not in his power to supply, must be most painful.¹³⁷

Eighteen months later, another leader in the same newspaper reporting a 10 per cent recovery rate from Fremantle Asylum as compared with a rate of 50 per cent from English asylums declared that:

Our lunatics are allowed to moan away their miserable existence within the walls of an institution where they are worse off than the vilest prisoners.¹³⁸

Such was life's reality for Emily Randall, Isobell Hough and other people with intellectual disabilities locked away in Fremantle Asylum at the end of the nineteenth century. Furthermore, despite the growing climate for reform during the late 1880s, the future for these individuals remained bleak. Stigmatised as 'incurable', no one even questioned why they should be institutionalised. What Joachim says concerning the history of intellectual disability in America is true of Western Australia at the turn of the century:

The institutional movement dominated and today intellectually disabled people are still suffering its legacy.¹³⁹

Conclusion

In order to draw any meaningful conclusions concerning the history of intellectual disability in nineteenth century Western Australia, we need to reiterate briefly what has been said about the European and American experiences.

The considerable discussion among doctors and educators in the nineteenth century about the nature of intellectual disability provides some valuable insights. What they reveal is the gradual emergence of a clear distinction between 'insanity' and 'idiocy', followed late in the century by attempts to establish a scientific classification according to grades of disability. Parallel with these developments, efforts were being made to train people with intellectual disabilities and to this end, small residential schools were established. However, for reasons already discussed, this period of 'unrestrained optimism' was short-lived and by the end of the century those same schools had become custodial institutions.

The Western Australian experience differs significantly from development elsewhere. In the first place, there was no clear distinction made throughout the nineteenth century between intellectual disability and mental illness. It is true that from time to time individual doctors suggested a difference, but there was no consistency in this thinking and no agreement between doctors except to regard intellectual disability

ity as 'incurable'. Because of this, the need for residential educational facilities along the lines of those in America and Europe was never considered.

Neither was the need for any type of separate facility — other than the lunatic asylum — voiced until 1898 when Dr Hope, as Acting Superintendent of the Fremantle Asylum, suggested that the 'weak-minded' should go to homes or charitable institutions.¹⁴⁰ This suggestion seems to have been motivated as much by the need to reduce numbers in the asylum as by the desire to improve life for the 'weak-minded'.

How do we account for these differences between the Western Australian experience and development elsewhere? Part of the explanation is to be found in the power structure within the colony itself and, more specifically, within the Convict Establishment. The significance of the asylum having developed out of the Convict Establishment has already been discussed. An important legacy of this was that even following the dismantling of the establishment in 1886, the asylum remained politically rather than medically administered. In 1895, when the Medical Department was established and the post of Principal Medical Officer created, the Colonial Secretary — as we saw with Isobell Hough — had final jurisdiction.

Furthermore, the post of Surgeon Superintendent throughout the life of the Fremantle Asylum was a part-time position. Dr Barnett, in addition to being superintendent of the asylum, was Colonial Surgeon at Fremantle and ran a private practice. Dr Hope, acting superintendent between 1897 and 1900, came under severe criticism in Parliament because of the number of part-time positions he held:

The crying need at Fremantle Asylum is some medical supervision. It is a scandal that the official who has supervision should hold half a dozen billets, and not have time to attend one.¹⁴¹

The significance of this is that nobody had specialised knowledge. According to Virtue:

Western Australia was at a distinct disadvantage in relation to the two major colonies in not having a superintendent with the authority, prestige and comprehensive medical knowledge of a Manning or a Beattie-Smith.¹⁴²

Evidence of lack of knowledge, as Virtue points out, was clear during the 1891 select committee hearings.¹⁴³ The debates taking place in America and Europe were not referred to, scientific classification of mental disorders being developed in Europe were seemingly unknown, and there was little awareness displayed of the development taking place elsewhere in Australia.

Finally, the treatment of people with intellectual disabilities in colonial Western Australia was, in most respects, on a par with treatment afforded the mentally ill and other 'social deviants'. The policy was one of segregation within an institution. However, in one crucial respect, the fate of these people differed from that of the other social miscreants. Being considered hopeless, helpless and in need of protection, they were fated by definition to spend their entire lives within the asylum. The outlook for these individuals as the new century dawned was indeed bleak.

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2 'Once a Defective, always a Defective'¹: Public Sector Residential Care 1900-1965

Christina Gillgren

Introduction

There is both paradox and irony in the history of people with intellectual disabilities in the first six decades of this century. On the one hand, the recognition that insanity and disability were different conditions at last found root in Western Australia. On the other, people with intellectual disabilities in State care were still mixed promiscuously with people branded 'insane' and locked away in Claremont Hospital for the Insane. The medical model of treatment which is implied in the title Claremont Hospital for the Insane — a title which altered the treatment of the 'insane' by defining insanity as a disease — was also in principle applicable to people with intellectual disabilities. In effect, the lot of people with intellectual disabilities in Claremont Hospital for the Insane remained practically the same as it had in Fremantle Asylum because medicine regarded disability as hereditary and incurable. The irony is that those who recognised the difference between insanity and disability explicitly claimed that the 'treatment' of people with disabilities should take place in separate and segregated surroundings. But nothing ever happened; governments did not make separate provision for such people. Yet, for the most part, the wishes of the segregationists were achieved. Segregation in Claremont was the destination of most people with intellectual disabilities.

From a study of table one, which gives a detailed classification of mental diseases of patients who were treated, discharged or who died in Fremantle Asylum during the year 1900, it can be seen that those defined as 'mental defectives' — the 'imbeciles' and 'weak-minded' according to the medical classification — were included among people with mental illness.² However, at no point was residential care modi-

TABLE ONE

Showing the form of Mental Disease of Patients Treated, Discharged, and Died in the Asylum during the year 1900.²

Mental Disease	Remaining in the Asylum on 1 January 1900		Admitted during the year 1900		Treated			Discharged									Died			Remaining in the Asylum on 31 December 1900		
	Recovered			Relieved				Not Relieved														
	Males	Females	Males	Females	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
Circular Insanity	...	...	1	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1
Dementia	...	...	6	...	6	...	6	1	...	1	2	...	2	3	...	3	...	...	...	...	...	...
Dementia, Primary	6	3	...	...	6	3	9	...	...	...	...	...	...	1	...	1	...	2	1	5	2	7
Dementia, Chronic	18	12	...	...	18	12	30	...	...	...	...	...	...	...	...	...	2	...	2	16	12	28
Dementia, Senile	4	1	2	...	6	1	7	...	...	...	...	...	...	...	...	3	...	3	3	1	4	
Delusional Insanity	8	8	35	10	43	18	61	9	2	11	2	3	5	9	...	9	2	...	2	21	13	34
Epilepsy	5	4	2	2	7	6	13	...	1	1	...	...	...	...	...	...	1	1	7	4	11	
General Paralysis of Insane	...	...	1	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	1	...	1	
Hypochondriasis	...	2	1	...	1	2	3	...	...	...	...	...	...	...	...	...	...	...	1	2	3	
Hypochondriasis, Sexual	1	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	1	...	1	
Hypochondriasis, Gastric	1	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	1	...	1	
Hysteria	...	...	...	2	...	2	2	...	2	2	...	...	...	...	...	...	...	...	...	...	...	...
Insanity, Puerperal	...	1	...	2	...	3	3	...	2	2	...	1	1	...	...	...	...	...	...	...	...	...
Insanity due to Syphilis	1	...	1	...	2	...	2	...	...	...	...	...	...	1	...	1	1	...	1	...	...	...
Insanity following Fever	...	...	1	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	1	...	1	
Imbecility	3	5	2	2	5	7	12	...	...	...	1	...	1	...	1	1	1	...	1	3	6	9
Injury to the Brain	...	...	1	...	1	...	1	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...
Mania	46	16	10	2	56	18	74	3	3	6	2	...	2	4	...	4	3	...	3	44	15	59
Mania, Sexual	...	...	1	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	1	...	1	
Mania, Recurrent	5	...	...	...	5	...	5	2	...	2	1	...	1	1	...	1	...	...	1	...	1	
Melancholia	22	14	17	4	39	18	57	6	2	7	1	...	1	8	1	9	3	1	4	21	15	36
Melancholia, Acute	...	...	1	...	1	...	1	...	...	...	...	...	...	1	...	1	...	...	...	...	...	...
Melancholia following Fever	...	...	1	...	1	...	1	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...
Meningitis	...	...	1	1	1	1	2	...	...	...	...	1	1	...	...	...	1	...	1	...	...	...
Neurosis	1	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	1	...	1	
Neurosis from Insomnia	...	...	1	...	1	...	1	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...
Paralytic	1	...	1	...	2	...	2	...	...	...	...	...	...	...	...	...	1	...	1	1	...	1
Toxic Insanity (alcohol)	4	...	15	1	19	1	20	12	...	12	3	...	3	...	...	...	...	...	4	1	5	
Toxic Insanity (opium)	2	...	1	...	3	...	3	...	...	...	...	...	...	2	...	2	...	...	1	...	1	
Weak-minded	16	8	6	2	22	10	32	3	1	4	...	...	...	3	...	3	1	...	1	15	9	24
Weak-minded from want	1	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	1	...	1	
Not Insane	...	...	1	...	1	...	1	...	...	...	...	...	...	1	...	1	...	...	...	...	...	...
TOTALS	145	74	109	28	254	102	456	39	12	51	12	5	17	34	2	36	18	3	21	151	80	231

fied to reflect the classification of the disease other than to shift those labelled 'chronic' to the back wards where they lived out of sight and mind.

At the turn of the century scandalously inadequate financial support was the major factor in restricting improvements or changes to public sector residential care. Fremantle Asylum was so chronically overcrowded, understaffed and underfinanced that the Acting Superintending Medical Officer called it 'unfit for its purposes'.³ However, the colonial press launched a sustained campaign in 1900 to appeal to the public's social conscience on conditions in Fremantle. In an article printed in early October, the *Sunday Times* delivered an emotive plea to the public:

will all be deaf to the voice of humanity and none come to the help of the helpless? Have the people of this colony hearts of stone that they should tolerate a frightful evil in their midst?⁴

It is within this framework of restraints on finance, ambivalence in government policy towards people with intellectual disabilities and the occasional stirring of public sentiment that the development of public sector care for people with intellectual disabilities took place. Within this period, changing medical knowledge and heightened public awareness also prompted debate but did not significantly shift the primary objectives of legislators, which were containment and frugality.

Establishment of Claremont Hospital for the Insane

After some initial resistance to the idea, the Forrest Government bowed to public sentiment and began to search for a replacement for the Fremantle Asylum, probably in the last years of the nineteenth century. New regimes of diet, exercise, recreation and work were plainly out of the question at Fremantle, and the old asylum came increasingly to be regarded as an embarrassment and a barrier to rehabilitation of its 'insane' population. The Vosper Inquiry into conditions at Fremantle was the final nail in its coffin. It recommended a new regime for a new century, a new superintendent and a new institution. Dr Sydney Montgomery, a 30-year-old Irishman and specialist in the treatment of the 'insane' with an interest in the design of asylums, was appointed as

Superintendent of the Fremantle Asylum in 1901.⁵ Montgomery can be credited with the establishment of the first major public sector residential institution since 1857 and the first major overhaul of lunacy legislation since the 1870s: the new Lunacy Act.

Planning for a new 'hospital for the insane' began with selection of a site. Montgomery rejected the option of isolated and ramshackle Whitby Falls, which already provided farm colony facilities for a small number of people with intellectual disabilities. Instead he chose a site in Claremont. It was here that the then-Government set aside 92 acres of crown land and £35,000 for the new institution in 1902. A start was made on the buildings in 1903 when workshops and stores were built. Indeed, some of these buildings were used to accommodate the overflow patients from Fremantle, including some 40 men who were put to work preparing the site. Progress was slow but through 1905 and 1906 the administration building, dining and recreation rooms, and male and female attendant blocks were finished. In 1907, the machinery block and all the female blocks were completed, and the female inmates at Fremantle were transferred. The new hospital was all but completed in 1908 and the rest of Fremantle's inmates moved over, although a new 'Chronics' block was added in 1910 to hold 250.⁶ Henceforth, Claremont Hospital for the Insane held centre stage in the treatment of people with mental illness and intellectual disabilities in Western Australia for half a century.

Western Australians must certainly have been impressed by the size of the new hospital. An architect's impression published in the *Western Mail* in 1907 shows a conglomeration of buildings several hundred metres long with 10 wards in two wings — five for males and five for females — radiating out from the administration block and Montgomery Hall. The machinery block, laundry workshops, drying grounds and the sewing room were located behind these buildings. The architect's drawing embodies openness and space. In the accompanying text an enthusiastic journalist wrote of:

undulating country, the bush in all its loveliness...terraces of garden plots, with shrubs, flowers and turf all growing at an amazing rate.⁷

Claremont had a farm located nearby which served to provide work of an intended therapeutic kind for the hospital inmates while

helping to finance the hospital itself. It was no small operation. In its first full year of operation it produced vegetables, fruit, meat and eggs to the value of £1,666.⁸

Montgomery was aware of the stigma that surrounded asylums and wanted to depart from the naming conventions of the past. He wrote:

The present places of detention and reception for lunatics are not asylums merely, but hospitals for the treatment of mental disease.⁹

And Claremont was accordingly named a 'hospital for the insane'. But the nomenclature change was more than an attempt to throw off the shackles of the past; it reflected the developing international trend toward medicalisation of both intellectual disability and mental illness. In Western Australia, the dominant role of medical professionals in the development of policy and provision of services lasted for six decades without any fundamental change. Montgomery pioneered the application of medical and psychiatric knowledge to the problem of 'mental deficiency' in Western Australia. Claremont was to be administered by doctors. It would use complex aetiological and diagnostic classifications of patients and its female nurses would wear nurses' uniforms (the implication of medicalisation will be pursued in the chapter by Carman-Brown and Fox).

Montgomery brought some of his ideas from Britain and acquired others as he travelled through Australia. His ideas about the nature and treatment of mental illness and 'mental deficiency' influenced both his choice of location and architecture for the new hospital. First, the new residential facility had to be in but not *of* Perth; a suitable compromise between the need to segregate people with mental illness from the community and to provide the necessary infrastructure support for a major hospital. Whitby Falls was too isolated, and Montgomery quickly concluded that Claremont fulfilled this basic requirement. At the time, the proposed site was not in a suburb. The suburbs spread to surround Claremont. Montgomery was keen to secure a hilltop site so that the cooling sea breezes might disperse those miasmas still thought to cause disease. He was also keen to ensure that the new hospital would have the advantages of a farm colony and therefore opted for a

site with an abundance of surrounding natural bush. Country life, air and nature were important for the soothing of troubled souls.

At the time, Claremont Hospital for the Insane was the biggest single institution to be constructed in Western Australia. Its scale meant that Montgomery was planning for the future, for a much larger 'insane' population. Its physical design showed how Victorian moral values and contemporary concerns about the hereditary origins of mental illness and 'mental deficiency' dovetailed in the physical separation of males and females into separate wings, imposing a defacto policy of celibacy. Montgomery shared the contemporary educated man's revulsion at the prospect of sexual relations within populations of people with mental illness and intellectual disabilities.

Common diagnostic and aetiological classifications together with administrative considerations also found their expression in architectural plans. In the male wing and furthest from the hospital's centre was the ward for the 'violent and noisy'. The epileptics' ward was in front of this ward, followed by the ward for the 'sick and infirm', the 'recent and acute', then, strategically closest to the administrative centre, the ward for the 'quiet and the chronic'.¹⁰ Wards were large scale and afforded no privacy. Their conception was firmly rooted in the economies of scale identified with contemporary general hospitals, and the effect can only have been dehumanising. Early photographs show them to be devoid of individuality and decoration. The windows were barred. Beds were lined up in regimented rows. Food was consumed en masse and bodies were washed en masse.¹¹ The plans for the 'quiet and chronic' block for men show a three-storey building of nine dormitories: six with 12 beds and three with 19 beds. On each floor were single rooms, one of them half-padded. There were common bath and dressing rooms and strategically placed attendants' rooms, giving the staff a clear view of each dormitory.¹²

Claremont 1908 to 1929

When Claremont was officially opened in 1908, it already housed 700 patients: 500 males and 200 females. By 1920 it housed 1100, made up of 750 males and 350 females.¹³ It is very difficult to assess how many of this population comprised people with intellectual disabilities. The Annual Report of the Fremantle Asylum in 1900 shows that out of 231 people resident there on 31 December, nine suffered from 'imbecility'

and 24 were 'weak-minded'. Giving evidence to the Select Committee on the Mental Deficiency Bill in 1929 the Acting Inspector General of the Insane, Dr Ernest Thompson, referred to 123 'mentally defective residents' comprising 67 'imbeciles', 50 'idiots', three 'feeble-minded' and one 'moral'. The Annual Report of the Inspector General of the Insane shows a steady stream of admissions of people with 'congenital deficiency' or who were classified as 'idiots and imbeciles'.¹⁴

Claremont was not the only facility for people with intellectual disabilities. According to Moira Fitzpatrick there were 12 private sector institutions for children known to have been operating in the 1920s, and some of these took in children with intellectual disabilities:

The Waifs Home, Parkerville; St Joseph's Roman Catholic Orphanage, Subiaco; Church of England Girls Orphanage, Adelaide Tce.; Swan Boys' Orphanage, North Midland Junction; Clontarf Roman Catholic Orphanage, Victoria Park; The Red Hill Industrial School, Midland Junction; Salvation Army Industrial School for Boys and Girls, near Collie; Children's Ward, Perth Hospital; House of Mercy; Government Industrial School, Subiaco; Seaforth Boys Home; Castledare-on-the-Canning.¹⁵

In as much as habilitation programmes may be said to have existed at these institutions, they were concerned with the teaching of industrial skills, personal hygiene and grooming. The existence of non-Government programmes was precarious. Red Hill closed in 1929, and the Castledare school for boys with disabilities established by the Catholic Church in the same year lasted only four years.¹⁶

At the time of writing, access restrictions placed on official records effectively precluded detailed description of the daily lives of people with intellectual disabilities at Claremont. Nonetheless, some of the early twentieth century records open a window into the lives of some of its first inmates. What follows are the briefest accounts of parts of their lives.

In June 1907, Walter C. was transferred to Claremont Hospital for the Insane from the Fremantle Asylum. Aged 31, he was classified as 'a high grade imbecile...childish...quarrelsome...dangerous'. The Asylum Case Book describes Walter as having 'a degenerate face and head with massive jaw, unusually long arms, very prominent Darwin's tubercles on both ears'.¹⁷

Walter C. made several attempts to escape and was either recaptured and returned to Claremont or else foiled in the attempt. The records describe him as:

foolish but a willing worker...stupid...useful man...restless...works well...obedient...very troublesome of late...behaves well for a while and then becomes impulsive.¹⁸

This 'impulsive' behaviour usually occurred before an escape attempt was made.

In the case of Ethel M., the Female Case Book records the cause of her disability as 'syphilis congenital' and the description of her physical condition as 'nose flattened, Forehead somewhat square, hearing good, Lateral incisors are "peggtopped"'.¹⁹

Louis S., a 'mongolian imbecile' (cause stated to be congenital), was described in his case file as having 'small ears of monkey shape flabby pouting lower lip with tongue partially protruded...squat flabby nose, Mongolian eyes'.²⁰

Comparisons with animal physiognomy were not restricted to physical features. Arthur H., an 'imbecile', was described as a 'blasphemous young hound'.²¹

In Emily R.'s case file she is described as an epileptic whose condition was attributed to 'injuries to head and fright'. Whilst at Claremont she often inflicted injuries upon herself.²² The entry in the Female Day Reports dated 7 February 1904 describes her as 'troublesome, knocking her head against the ground on the Airing Court'.²³ Emily 'fell in a fit and cut her head' on 10 May 1904. She would not keep the dressing on and had to be restrained in a jacket. Over the next two weeks, whilst her wound was dressed, Emily had to wear the jacket to allow her wound to heal. The records state that she was 'troublesome rubbing wound and making it bleed'.²⁴ At nights, she was given a 'draught' which would send her to sleep until morning.²⁵ At no stage was any attempt made to find the cause of her behaviour or to link this with the 'cause' of her epileptic condition. Emily was often 'noisy and troublesome', 'dull and stupid', or 'excitable and violent'; she sometimes bit other patients and she was punished with one hour of seclusion on 23 May. Whenever she became 'violent', Emily was

removed to a single room; the case book contained no entries on her condition for at least a few weeks.²⁶

Ann H., an 'imbecile', was described on admission to Claremont from Fremantle as 'quiet, demented'. She was also given a 'draught' after being 'noisy and troublesome' and was 'removed to a single room' whenever she misbehaved.²⁷ One entry recorded her as being 'mentally bad — noisy using bad language'. Ann H. did 'a little work' or 'worked fairly well'; and on other occasions was 'working a little' or 'lazy'.

Two years of records of Ann H. show:

10.2.11	no change;
10.5.11	is very dull and stupid;
10.8.11	is very excitable tears her clothes;
10.11.11	is dull and stupid becomes very excited at times;
10.2.12	is destructive at times;
10.5.12	is very dull and stupid;
10.8.12	is troublesome at times;
10.11.12	is very troublesome tears her clothes;
10.2.13	no change. ²⁸

Ann H. seems to have been examined by the hospital doctor only once every three months.

Plainly, these records give us little more than a glimpse of life in Claremont. To add more detail and texture to the picture of the history of Claremont we must rely upon a succession of inquiries and investigations.

The Royal Commission on Lunacy (1922), of which Dr William Jones was Chairman, highlighted the inadequacy of accommodation for patients.²⁹ The Commission's report confirmed that overcrowding was a chronic problem and wards were extended only when the problem became acute. Rather than providing for future intakes of patients, extra buildings or wards were erected only when existing facilities were stretched well beyond their limits. The report reiterated that nothing had been done to improve the cramped and unsatisfactory living conditions of patients. As with conditions in the Fremantle Asylum at the turn of the century, this overcrowding discouraged effective treatment. However, the predominantly custodial nature of care provided did not figure in the report. Accommodation was the real

issue. The Commission found that based on its original capacity, the Claremont Hospital for the Insane contained 'no fewer than 337 patients too many'.³⁰ The design and scale of wards, which were 'built for too many patients', were also criticised.³¹ The farm colony for males at Whitby Falls was better equipped to handle its 40 patients but because of the age of the buildings, which dated from 1860, facilities such as water could not be relied upon.³²

The Royal Commission showed clearly that professionals and legislators recognised that conditions at Claremont detracted from 'the best interests of the patients towards recovery'. In an oblique way, the Commission raised the spectre of whether Claremont had in fact been a planning mistake. Specifically, it saw in Claremont with 'its large barrack rooms, barely and badly furnished, its prison-like conditions and continually locked doors...great contrast with the institutions in other States of the Commonwealth'.³³

The Commission also investigated allegations of mistreatment of patients. Hospital officials maintained that methods of restraint were used only for medical and surgical reasons to prevent 'self-mutilation' by patients. The Commission appears to have accepted this testimony as accurate. It rejected claims of ill-treatment as based on hearsay and on the whole adopted a defensive and dismissive stance towards all evidence to the contrary.³⁴

The Commission did not question the current policy of common custodial care provision for the 'insane' and 'mentally deficient'. The issue of whether the Lunacy Department should have responsibility for people labelled as 'mental deficients' was raised as a consequence of a Parliamentary Select Committee investigation into the Mental Deficiency Bill in 1929. Witness and Acting Inspector General, Ernest Thompson, objected to a proposal to take 'mental defectives' out of the hands of the Lunacy Department. The following exchange offers an interesting insight into the economic thinking underlying the Department's perspective. 'A fair proportion of these persons', Thompson claimed, 'can be, and are carefully employed at the institution':

Q. But none of these would be idiots? — No

Q. Are very few of them imbeciles? — A fair percentage of them were quite useful. For instance, Mongolian imbeciles can be usefully employed. I admit they are of a fairly low grade, but they can be

usefully employed and it is economically sound to employ them. Without being able to do so, we would have to increase the paid staff. We employ these imbeciles in the kitchen and in the garden, on the farm and in the laundry. It certainly saves us from the standpoint of staffing.

Q. By Miss Holman: What are the ages of these people? — They vary considerably. The ages would be from about 15 to 40.

Q. By Mr Sleeman: They do a lot of work in the dairy too? — Yes, some are employed on yard work as well.³⁵

The very first inmates at Claremont worked. Work probably formed part of the daily routine of generations of people with intellectual disabilities. And, ironically, it was to a large extent because of this unpaid and exploited labour that institutions like Claremont survived.

The Law, Ideology and Politics 1903 to 1929

If it was the conservative pragmatism of John Forrest which permitted the closure of Fremantle and the search for the new broom, it was the radical liberalism of politicians like Walter James which launched Western Australia on its new century of lunacy reform. The ideologies of the new liberals — social reformers who believed in the right of all humanity to pursue freedom and happiness and the duty of the State to protect that right — were manifested not only in lunacy reform but also prison reform, the passage of factory acts and industrial arbitration, pensions, infant welfare and public health programmes. The *Lunacy Act 1903* testified to this world view.

The *Lunacy Act 1903* did little or nothing for people with intellectual disabilities but was an important step in distinguishing and distancing the 'insane' from the 'criminals'. 'Lunatic asylums' became 'hospitals for the insane'.³⁶ For the first time detailed guidelines for incarceration were set down. These included medical certificates which specified the facts upon which a medical practitioner's opinion of insanity had been based, and distinguished these from facts communicated to him by others. There is a vast difference between these and previous circumstances when:

a case of supposed insanity is reported to the police, who make an arrest, and lodge the person in a Police cell. The individual is brought before a Magistrate the following day, and a medical man is called in to certify as to the mental state of the subject.³⁷

The Act also opened the way for the appointment of a superintendent in every 'hospital for the insane', who was to be a medical practitioner.

The Act also provided a number of safeguards against the wrongful committal of patients. This included the stipulation that two medical certificates were necessary, except in emergencies. It also sought to eliminate the profit motive from wrongful incarceration by including provisions that no medical practitioner signing the committal certificate could board or attend an 'insane' person. The Act set out guidelines for the committal and management of people of 'unsound mind'. It reappraised the definition of 'insane', restricting it to those who were incapable of managing their own affairs. In practice this included 'mental defectives', and the Act made no special provision for them,³⁸ but another branch of liberalism did. Since the new Act ignored people with intellectual disabilities, the eugenicists took them to be their main target.

The 'science' of eugenics grew in late nineteenth century Western Europe from middle-class fears about the way in which capitalist societies were developing, and the processes of industrialisation and urbanisation. The optimism of earlier liberal thinking gave way in many instances to deep anxiety in the face of an apparent social crisis — social and political conflict, poverty, illness, crime — which seemed to be out of control. That older stream of thought which believed in the perfectibility of the human condition through either education or environmental reform was confronted by a sense of the intractability of the problems and a search for new ways of finding solutions. The emergence of genetics in the early twentieth century fuelled a belief in the importance of heredity, race and evolution in social development and also a commitment to the idea that the application of scientific principles might rectify this apparent social chaos. To many progressives and reactionaries, Laborites and Liberals alike, eugenics provided that scientific solution.

Eugenics, then, was about breeding a way out of chaos. In early twentieth century Australia, it seemed to take on added urgency

because of a declining national birth rate which saw the average issue of mothers fall from seven in the 1860s to about three by World War One. Worldwide eugenicists believed that their own white race was being outbred by the more freely populating and dangerous Africans and Asians. The language of 'race suicide' was freely used as the 'better classes' convinced themselves that within their own national boundaries the 'inferior classes' were outbreeding them. Eugenicists also saw (or rather imagined) links between crime, vice, poverty and 'mental deficiency'. The eugenicist programme took two directions. The first encouraged the breeding of the 'fit' through a host of State interventions in family and social life such as infant health clinics, physical education, vocational guidance and intelligence testing. The other was the more fundamental and important imperative of stopping the 'unfit' from breeding by first locating, then registering, and finally segregating or sterilising them.³⁹

The eugenic solution to this host of imagined problems in Western Australia surfaced in 1911 when Dr W. Birmingham of the Lunacy Department produced a report on his extensive overseas investigations of asylums for people with intellectual disabilities in several European countries and the USA. Birmingham began his report by defining his terms and explaining the classification system of the day:

Using the term defective in a general sense, it may be said to include all those whose mental equipment is inferior to that of the average amongst their fellows; the condition may be either congenital or acquired. Of the congenital defectives, there are three grades, idiot, imbeciles and feeble-minded. The *idiot* is a defective in mind as to be unfit to guard himself from ordinary physical dangers. *Imbeciles* are persons who, owing to mental defect existing from birth or from early life, are unfit to earn their own living, though they can guard themselves from ordinary physical dangers. *Feeble-minded* are persons who, through mental defect existing from birth or from early life, are not fit to compete with the average person in the struggle of life, though they may be capable of earning their living under favourable conditions...⁴⁰

From then on his report is classically eugenicist. He established the 'incurable' and 'genetic' basis of 'mental deficiency'. He imagined all

the usual dangers: the proclivity of 'defectives' to crime, of heightened sexuality and promiscuity among females, the threat to the nation and to the white race. But he also had much to say about possibilities. He believed that 'defectives' could be educated, not in the three R's, but in industrial skills to fit them for a life of work. He believed that large institutions were the only appropriate place for this, both because the institutions would be a place in which to segregate 'defectives' and because he believed that they slipped back into bad habits if released. His proposals for Western Australia, then, were for identification of all people with disabilities, their collection, then their institutionalisation. He imagined an institution of cottage homes and of industrial education and workshops where residents might be graded, educated to their abilities, then placed in appropriate work. The entire system would be supervised by a medical superintendent from the Lunacy Department. He opposed sterilisation so he could be seen as a moderate in eugenicist politics. He finished his report with this ringing call to arms:

I cannot conclude without urging with all the power that is in me, the adoption of the only effective means of dealing with the feeble-minded and epileptic by compulsory and permanent segregation. The evil arising from the unchecked increase in defectives is growing and spreading throughout the civilised world, forcing its way into all classes of society and vitiating the health of the nation. We are careful that no black skins be found in our white Australia, but we are doing nothing to protect the transmission of degenerate brains to those who come after us...We have amongst us those who, for no fault of their own, are unfit for the battle of life and lead a wretched existence...We can place these poor people when their feeble minds can be guided along lines that they can follow, when the darkened intellect can be enlightened as the weakness will allow, and when they will be safe from pitfalls of life and crime that are so thick along their pathway, and that their poor, half-blind intellects cannot see to avoid...Knowing as I do the benefits that would follow the introduction of proper institutional treatment of feeble-minded and epileptic I have no hesitation in urging our legislators to grapple with the imminent danger to our future greatness as a nation and wipe out this dark blot on our civilisation.⁴¹

As a prescription for change, the Birmingham Report did not raise a ripple in the stagnant pond of Western Australian lunacy reform, but eugenics continued to grow and prosper in the post-World War One period. Fears of racial degeneration gained momentum as the birthrate continued to fall and the supposed social cataclysm approached. In 1919, the Angwin Select Committee on the Claremont Hospital for the Insane recommended the establishment of a Board of Commissioners for the State's 'mental defectives' and the building of a separate institution for them.⁴² The *West Australian* of 11 November 1920 raised these issues when reporting the likely increase in this population as men returned from the war. This increase, it claimed, should be:

a matter of the gravest concern to every citizen and especially to those responsible for the various policies, financial and economic, which might affect it.⁴³

Concerns for the education, home care, hygiene and health of young children required that the public conscience be roused:

Particular attention is drawn to the significance of the discovery that a large proportion of the children specially classed as being in poor general health belonged to families of six or more children, viewed in the light of our needs for an increased population, and...concerning the number of imbeciles discovered, their origin, and their destiny.⁴⁴

The article left no doubt that 'feeble-minded' parents reproduced themselves and that 'these homes produced the problem children who were neglected and spread disease'.⁴⁵ These sentiments were echoed more strongly in an article in the *West Australian* on 12 March 1926 which reprinted the opinions of 10 'known' medical men regarding sterilisation of the 'mentally unfit':

We consider it to be the duty of the medical profession to impress upon the public the immense importance of hereditary tendencies in dealing with mental defectives...we are strongly of the opinion that sentiment and ignorance should not be allowed to interfere with a means of treatment by which the capacity to produce an imbecile progeny would be arrested...⁴⁶

Segregation of people with intellectual disabilities, supposedly for 'the safety of the public and the future well-being of the race', was a major theme of the Royal Commission on Lunacy of 1922.⁴⁷ The Royal Commission had been set up to investigate three areas of public concern, namely the accommodation for patients in 'hospitals for the insane'; the administration — particularly the control, treatment and rights — of patients; and legislation relating to the 'insane'. It was the first official document which acknowledged that there was 'so to speak, nothing between sanity and Claremont'.⁴⁸ The report stated that there were 'degrees intervening which must be recognised and provided for'.⁴⁹ The stigma of certification was believed to act as a deterrent to those patients who might otherwise consider voluntary committal. In their interests, it was recommended that a reception house be established, situated 'away from the environment of Claremont...in a reasonably accessible position'.⁵⁰

The patients under treatment in this hospital should not be transferred to any institution for the insane, or certified as insane whilst there is any reasonable probability of early recovery.⁵¹

Reception houses were not meant to be sorting houses 'for all varieties of mental disorder'. They were to be reserved for 'recent and recoverable cases only' and hence not for people with intellectual disabilities who were, of course, 'incurable'.⁵² The idea of reception houses for 'recoverable cases' was the founding principle of Heathcote Reception Hospital in Applecross, which opened in 1929.

In response to the 1922 Royal Commission, the Government passed the *Mental Treatment Act 1927*. This Act dealt specifically with the establishment of hospitals or wards in hospitals for 'the reception and treatment of persons suffering from mental or nervous disorder who have not been found, declared, or certified to be insane'.⁵³ Dr Athelstan Saw, member for Metropolitan-Suburban Province, described the aims of this Bill in this manner:

I take it that its object is, firstly, to encourage the early admission for hospital treatment of cases of mental disorder, and secondly, to remove from cases of mental disorder, that may be of only temporary nature, the stigma of

certification as being insane. I believe it is not intended, and I hope it will never be, to use the proposed new hospital at Point Heathcote for the reception of mental deficient or for confirmed cases of insanity.⁵⁴

As James Bentley, the then-Inspector General of the Insane stated, the establishment of Heathcote Reception Hospital in 1929 — a 'home for the reception of recoverable patients and not for senile, epileptic or mentally deficient patients' — did not help people with intellectual disabilities.⁵⁵ Indeed, as Ellis suggests:

the use of Heathcote for recoverable patients implied that those who went to Claremont were not recoverable, and this policy produced a bad effect on Claremont for 50 years.⁵⁶

The eugenicist programme for people with intellectual disabilities came closest to fruition in the 1929 Mental Deficiency Bill which proposed to segregate them into their own custodial institutions. The Bill was introduced by the then-ALP Minister for Health, S. W. Munsie. During its second reading in the Legislative Assembly, a Select Committee was appointed to give it a more detailed consideration.

Medical professionals appointed to the Committee were united in the belief that 'once a defective, always a defective'.⁵⁷ Dr Ernest Thompson, the Acting Inspector General of the Insane, stated that he understood one of the objectives of the Bill to be the prevention of 'the propagation of mentally deficient children in the State'.⁵⁸ For this reason, he felt that 'defectives' should never pass beyond the control of the Board of Visitors at Claremont. Even if a 'defective' was discharged from Claremont, the Board should still have the final say in issues such as marriage.⁵⁹ Birmingham had expressed these same concerns in his 1911 report. He had stated that the weight of evidence overwhelmingly showed that, once established, 'mental defectiveness' became 'hereditary: that the feeble-minded parent tended to have feeble-minded children'.⁶⁰ For this reason, segregation would facilitate control of their sexual activities and prevent the reproduction of more 'mental defectives'. He had not, however, supported the extreme remedy of sterilisation. Birmingham had pointed out that there was:

very little use in dealing with one member only of a tainted family, and leaving the others to propagate the defect. That they should all be unsexed [was]...unthinkable.⁶¹

This argument was lost on some of those giving evidence, who argued that segregation was a costly and ineffective way of ensuring that 'defectives' did not propagate themselves, and who believed that only sterilisation could provide adequate control. The Select Committee recommended segregation but balked at compulsory sterilisation, suggesting instead a ban on the marriage of 'mental defectives' and voluntary sterilisation for those who lived outside the new institutions.⁶²

Whilst there was consensus on the control issue, the arguments in favour of segregation or sterilisation dominated the parliamentary debate. One of the most eager proponents of the sterilisation solution, Arthur Lovekin — a former owner of the *Daily News* and the member for Metropolitan Province in the Legislative Council — regarded the Bill as a step towards dealing with what he considered to be one of the most serious social problems threatening the human race. He asked: 'Why should we undermine the race by allowing mental deficient to breed?'⁶³

For Athelstan Saw, while sterilisation would ensure the inability of 'defectives' to procreate, segregation was necessary to ensure the removal of 'defectives' for their own 'protection'. But even more importantly, he argued that segregation would ensure that society would 'be protected from the evils inflicted on it by the mentally deficient'.⁶⁴

Edmund Gray, the member for West Province, tried to direct debate towards 'the very great duty the community owe to the mentally afflicted'. Arguing that facilities for the proper care of 'mental deficient' in Western Australia were very limited, he claimed that the establishment of a separate home for these patients would remedy this shortcoming. He also pointed out that in cases where parents could not cope with children with intellectual disabilities, the only alternative was Claremont Hospital for the Insane. It was not unusual, he said, for such children to be accommodated with women who were 'insane'. Yet financial stringency was put forward in opposition to the construction of a new home for these children. He also raised concerns that such an establishment in Western Australia would mean that other States

would dump their 'mental deficient' here and thus prove another burden to the State. Gray felt that the public demanded the Bill's passage, including the provision for sterilisation, because of what he believed to be the 'increasing burden of expense occasioned by those unfortunate people'.⁶⁵

The distinction drawn in the debates between intellectual disability and insanity was not regarded by everyone as desirable. As we saw earlier, the segregation of people with intellectual disabilities from 'lunatics' was seen by the Acting Inspector General of the Insane as robbing Claremont of some of its 'staff'. He made it very clear that Claremont's future depended on their unpaid labour.

W. H. Kitson, the Honorary Minister in the Collier Cabinet, sought to defuse the strong feelings on sterilisation by arguing that it was only a minor matter within the total Bill. Lovekin's retort was that he would oppose the Bill if sterilisation was not included because without it the legislation would be 'merely a source of expense to the State to build institutions that can do no good in the long run'.⁶⁶

Eventually the Parliament allowed the Bill to lapse. As James Cornell, member for South Province, stated: 'there is not the slightest doubt that the Bill met its fate on the principle of sterilisation'.⁶⁷

This may have been so, but as other members observed, the needs of the growing number of unemployed workers were greater, and in a time of financial stringency — particularly with the onset of the Great Depression — it was difficult to justify expenditure on 'mental deficient's'. The Bill was never re-introduced.⁶⁸

The furore caused by the failed Bill resulted in an airing of public opinion on intellectual disability. The heated debates had raised the issue to a high level of awareness and expectation within the community. However, the needs of people with intellectual disabilities became entangled and lost in the controversy. The issue of sterilisation in particular was a politically sensitive and highly emotive issue which legislators found too problematic and polemical to handle.

Then, from the beginning of the Great Depression, the influence and impact of eugenics in Western Australia began to decline. Unemployment, Langism, foreign debt, women and work, education, and war were the issues which turned people's minds away from the false problems and fake solutions offered by the eugenicists. Unfortunately, in consequence, the issue of intellectual disability was pushed into the background. Ultimately, the inter-war eugenicist solutions were dis-

credited by the crimes of German Nazism. But the strategic goal of segregation had clearly achieved orthodoxy in the minds of politicians, health administrators and sections of the community, with consequences for the provision of services for decades to come. In the wake of the Depression, discussion of social policy pertaining to people with intellectual disabilities became sporadic to say the least. Even the murder of a boy with intellectual disabilities by his father in 1936 did not affect the atmosphere of uninterest.

Interregnum 1936 to 1949

In November 1936, Joseph O'Sullivan was convicted of the murder of his son, aged three years and nine months. According to a family member, the boy 'suffered from convulsions and fits. You could not understand what he said...he could not be left alone'.⁶⁹ Mrs O'Sullivan testified in court that:

His father was most devoted to him. He used to bathe him at night while I washed up the dishes. After his bath, my husband used to nurse the boy in front of the wireless, till he went to sleep.⁷⁰

The boy's doctor, who attended him at the children's hospital between February 1935 and March 1936, described him as 'mentally deficient'. He thought the condition was 'hereditary'. In the court depositions he stated that 'he got adult doses of sedatives as treatment, up to three grains of luminal with bromide...he was incurable'.⁷¹

O'Sullivan shot his son three times: in the left breast, the left side of the head and through the right eyebrow. 'I had to do it', he said to his neighbour who drove him and his dead son to the police station. On arrival, the neighbour spoke to a constable explaining that there had been 'a shooting incident'. He also told the police that he knew the 'little fellow' and had seen him in fits. 'Of late months, he was getting worse. The boy was getting stronger and the fits more frequent and longer.'⁷²

O'Sullivan did not deny shooting his son. In giving details to the constable, he stated:

He takes fits. I've had him to, I think, all the doctors in Perth and I can't cure him. The child was an awful strain on his mother. He had a bad fit before I shot him.⁷³

He went on to say that he had had to get drunk to do it and that, anyway, the boy was much better off. 'There was no care for him.'⁷⁴

O'Sullivan was faced with the dilemma of his wife's inability to cope with a growing child with disabilities or the choice of an institution — in his opinion, no alternative at all. O'Sullivan thus gained considerable public sympathy; 45,596 people signed a petition asking for a lighter sentence — he had been sentenced to death but was subsequently committed to life imprisonment with hard labour. According to the *West Australian* the petition was rejected by the Justice Minister on the grounds that there was no fresh evidence to be considered and that 'people had not known what they were signing'.⁷⁵ This response caused a widespread controversy in which the Acting Premier, M. F. Troy, chided the Justice Minister that his slighting remark was the 'gravest reflection on many professional men who had signed the petition'.⁷⁶ O'Sullivan was suddenly unconditionally released from Fremantle Gaol in 1939 after having served only three years and 17 days of his sentence.

Intellectual Disability After the War

After the war, when the issue of people with intellectual disabilities resurfaced, the tone of the debate changed. Mass migration programmes reduced the strength of that old racial consciousness — although it was by no means ended. With regard to children with intellectual disabilities, Bessie Rischbieth, President of the Women's Service Guild, argued that:

pressure should be brought to bear on the Government to force it to provide a modern psychological clinic and accommodation where small groups of backward children could be housed. It was wrong that children in various stages of abnormality should be brought together beneath one roof.⁷⁷

Conditions at Claremont were once again attacked as being 'entirely unsatisfactory'. F. Huelin, a member of the Mental Welfare Committee of the Claremont Hospital for the Insane, claimed that half of the 60 to 70 'abnormal children' who were in the hospital 'could be considerably improved and perhaps made useful members of the

community if they were segregated and afforded expert psychological care'.⁷⁸

The then-Liberal Minister for Health, Mrs Cardell-Oliver, responded to these statements in a way which must have disappointed those promoting such ideas. In November 1949, she asserted that of the children at Claremont:

Ninety per cent were of the lowest grade, which meant that nothing beyond care and comfort could be done for them. The remaining four or five were slightly better and were receiving some training, but the possibility of their being returned to outside life as useful citizens was remote.⁷⁹

Whilst the Minister recognised the urgent need for a home or institution for children with intellectual disabilities, she felt that 'important as the problem was, housing needs must be given priority for the present'.⁸⁰

Once again, economic considerations were put forward which show the low priority given to the needs of people with intellectual disabilities.

In the same year, 1949, a *Sunday Times* reporter acquired a position as an attendant at Claremont Hospital for the Insane. The editor of the newspaper had detailed this assignment because he believed that 'for years the public conscience has been uneasy' about conditions at the hospital.⁸¹ The reporter, L. R. Turner, wrote that whilst most of what he saw was a credit to the hospital authorities and staff, there were instances of brutality that should not have been tolerated. Turner described the long block of wards at the rear of the administrative offices in which the majority of the 1,200 patients were housed. Each ward, containing as many as 120 patients, was sealed off from the others. The wards faced into 'huge airing courts or exercise yards where most of the patients idle out the day'.⁸² High brick walls enclosed three sides of the yard and, except for the lunch break, this was where most patients spent the better part of their time. According to Turner they would 'just pace monotonously around the yard'. More than half the patients were male and these ranged from small boys to men in their eighties. A large kitchen block separated the male and female sections, and attendants — male attendants for men, female nurses for women — exercised 'custodial care' over the patients. Turner reported that:

In some instances, men who have been found not guilty of murder on the grounds of insanity, and other criminal lunatics mix with men whose only letdown is an occasional fit.⁸³

He described the highly regimented life lived by patients in the hospital. They bathed or showered once a week and some 'were lucky enough to receive visitors on Sunday and Wednesday afternoons'. Unless otherwise provided by visitors, foodstuffs and cigarettes were rationed by the administration. On Tuesday nights, hundreds of men, women and children would be 'marched to the mess-hall for a picture show' and occasionally there would also be a patients' dance with an orchestra.⁸⁴ On these occasions, male and female patients were allowed to intermingle and dance together. Turner was particularly perturbed by incidents of violence which, though infrequent, upset him. Padded cells had been eliminated because they attracted vermin, and straitjackets were rarely used. Turner was officially advised that:

Regulations stipulate that if a patient becomes violent, the most an attendant can do in retaliation is to restrain him — by pinning his arms and putting him into a straitjacket if necessary. Attendants are not allowed to strike a patient. If they do so they face instant dismissal.⁸⁵

However, Turner was told, presumably by other staff, that this was 'alleywash'. If a patient became too aggressive, the attendants would give him an 'aeroplane spin' to the ceiling, 'several of us kicking him in the guts as he comes down'. Following these 'spins', the patient would be given 'as much salts and magnesia' as they could pour down him. This usually had the desired effect of completely subduing a restless or troublesome patient. In all of this, Turner was advised that he must never mark a patient or the doctors would discover what had happened. For this reason, he was advised to wear rubber-soled and heeled shoes as leather ones left 'marks on the patient for the doctors to see'.⁸⁶

Although Turner did not witness an 'aeroplane spin', he was involved in an incident with a patient who 'seemed an obvious imbecile, incapable of coherent speech and unable to understand much of what was said to him'.⁸⁷ This patient was slow to wipe soap from his face. As a result the attendant swore at him and, failing to elicit a

coherent response, 'swung a savage kick that struck the patient in the vicinity of the genitals'.⁸⁸

Turner's exposé did not result in immediate change but did persuade Cardell-Oliver to establish a Royal Commission into his allegations. After its inquiry, the Commission made four recommendations to which the Government gave its full attention. They included the appointment of extra medical officers to Claremont (bringing the total to six psychiatrists and two medical officers) as well as the appointment of three welfare officers and the tightening of scrutiny by the employment of 'responsible' personnel officers. There was little mention of people with intellectual disabilities. In effect, custody and segregation were still the principles underlying their treatment.⁸⁹

The Beginnings of Reform 1952 to 1965

In 1952, with money donated by Nathaniel Harper — the father of a man with Down syndrome — the Mental Health Department took 50 children with intellectual disabilities from Claremont, bought two houses in Guildford, and sent them there for education and training. As the first public sector residential facility since Claremont, Nathaniel Harper Homes marked the modest beginning of new era of service provision. Children at Nathaniel Harper were to be involved in a special education programme operated by the Education Department. Resurrection of the idea of special or remedial education was an advance over the notion that people with intellectual disabilities could only be trained for basic industrial work. The Department had first introduced remedial classes at Perth Infants' School in 1910 but this and other programmes had been abandoned as the influence of eugenics on public policy grew (see Carman-Brown and Fox).

The establishment of Nathaniel Harper Homes owed as much to citizen action as to recognition by policy-makers, bureaucrats and politicians of the need for change. By 1951, citizen concern at the inadequacies of service provision found expression in the formation of a pressure group destined to become a major player in the politics of intellectual disability and also to become a service provider in its own right.

The Slow Learning Children's Group (SLCG) was the first and ultimately the biggest of the parents' groups. Its origins lay in an informal meeting of several parents of children with intellectual dis-

abilities who were involved in a special education class run by the Psychology Department of the University of Western Australia. Unhappy with the level and quality of State education, they organised two large and well-attended meetings in 1951 from which the Slow Learning Children's Group (SLCG) was formed. Soon it was registered, incorporated, and had its own constitution. In 1952, it began pre-school classes. Over the next two years it set up occupational centres for older children, one of which was named Minbalup; a testing and diagnostic centre which later became known as Irrabeena; an assessment board to assess applicants for its services; its own speech therapy clinic; and a parents' discussion group.

By 1954, it had its own farm colony at Hawkevale. By 1956, its clinic team comprised four doctors, a psychologist, psychiatrist, social worker, occupational therapist, speech therapist, education officer, and parents' relations officer. Four years later, it ran a training and residential centre for older girls in Subiaco. In the next year, Irrabeena — the institution for which it claims credit — was setup. By 1963, it had added a respite centre for short-term stays, a day minding centre and another centre for long-term residential care. In 1964, the Mental Health Department of the State Government took control of Irrabeena, but the role of SLCG and the scope of its activity continued to expand. Although nominally a private sector service provider, much of this expansion was Government funded.⁹⁰

The significance of the establishment of the SLCG extended beyond the introduction of a private sector service provider. It was the product of disillusion, a definitive rejection of the economic parsimony and political ambivalence which had characterised public policy in the first half of the twentieth century. Paradoxically, the nature of care provided was not revolutionary. Hawkevale would have been recognisable to Birmingham as a farm colony. Nevertheless, the intervention of parents in search of better futures for their children remains one of the most important interventions in the twentieth century history of intellectual disability in Western Australia.

When Allan Stoller of Victoria's Mental Hygiene Department presented his report on the provision of mental health services to the Commonwealth Government in 1955, Nathaniel Harper Homes was home to 45 people: 15 older girls, five babies, and 25 other children and adults. Three teachers from the Education Department taught both practical and occupational skills and academic subjects. It was run by

11 nursing staff with visits from a Claremont psychologist. Although Stoller referred to it as a colony and it was still plainly an institution, his final remark indicates its wide social acceptance:

It is interesting to note that the community was more involved in this centre than would have been the case had it been part of Claremont Hospital.⁹¹

Stoller also reported on conditions at Claremont. Despite the establishment of Nathaniel Harper Homes, approximately 400 people with intellectual disabilities still remained locked into the hopelessness of Claremont. Short, concise and couched in restrained official language, Stoller's findings were nonetheless as damning as Turner's. He condemned the chronic overcrowding, understrength staff, crowded administrative facilities, disorganised and inadequate recreation, underdeveloped social services, inadequacies in clinical psychology and dentistry, inefficient ward services, and appallingly run down or out-of-date amenities like kitchens, pantries, laundries, floors and hand basins.⁹² Appointed Senior Medical Officer in 1962, Dr Guy Hamilton gave the following first hand account of the human tragedy underlying Stoller's findings on Claremont:

The care was appalling. In the male children's ward, J Block, there were people who lay in bed with bed sores until they died; there were cot cases for whom little but basic nursing was provided; there was no policy of training and the care of 40 people in a ward by two or three rostered staff was inadequate. At meal times, they were seated at arm's length from each other, so that they couldn't grab each other's food, which I suspect they did simply because they were hungry. Many who were incontinent were often hosed down outside, even in winter in the so-called airing court. There was no individual care, there was no love, there was no care at all and all bad behaviour was coped with in the medical fashion, using what some used to call 'chemical warfare' against them. This was a medical response to abnormal behaviour; there was little psychological treatment or training. It was the only place in the world that I have found children as young as two years being referred to simply by their surnames...They

were receiving worse treatment than animals and most certainly were not being treated as children.⁹³

The retreat from large institutions and the de-medicalisation of service delivery were to prove very slow processes. Only the beginnings of change are to be found in the period to 1965. Attempts at legal reform within this period were also tentative and, in some instances, poorly conceived.

As a result of Stoller's report of 1955, the Commonwealth Government made £10 million available to the States of Australia to upgrade mental institutions. In Western Australia, land was purchased in Guildford in 1956 for a new institution. In 1960, members of a planning committee established by the Minister for Health recommended that in order to relieve the overcrowded conditions at Claremont, 400 people — 'all children, mental defectives, and...senile persons not primarily admitted for mental disease' — should be taken out of the hospital. The committee also recommended a transition away 'from...custodial care...to early active treatment and early return of patients to the community'. The 'mental defectives' were to be relocated on the outskirts of the city in a proposed 'colony' which, when it was finally established, became known as the Pyrtton Training Centre (see Stella).⁹⁴

This decision was an expression of the revived belief, expounded especially by the Labor spokesperson on mental health, Ruby Hutchinson, that 'mentally retarded children...[should be] given proper training in a setting completely divorced from the mentally ill'.⁹⁵ She argued that people with mental illness needed active medical treatment while the 'handicapped' needed training in social skills and in productive work within their capacities. She also demanded that the two groups be treated separately.

However, the administration of the Mental Health Services was marked by uncertainty and confusion and a lack of public confidence during the period prior to 1964. A major part of the funding made available through the *States Grants (Mental Health Institutions) Act 1955* remained unspent. There was disagreement over how best to reduce the overcrowding at Claremont Hospital and about when, whether and how to build the new institution.⁹⁶ In 1962, the Inspector General for Mental Hospitals, Dr Digby Moynagh, urged the Government to support the assessment and referral centre established by the SLCG (Irrabeena) and the provision of a separate 'colony for defectives'.

However, he also stated that his preferred option for reducing overcrowding at Claremont was to reduce the admission rate through the provision of more day hospital facilities and therapeutic-community services.⁹⁷ The other members of the Ministerial committee established in 1960 disagreed and supported the commencement of the Guildford hospital project immediately in the belief that the public would be more impressed by 'big new buildings than anything a little bit more nebulous like policy'.⁹⁸ The issues were highly politicised and involved conflict between members of the Labor and Liberal parties. Moynagh resigned on the eve of the State election and in the midst of the debate on the *Mental Health Act 1962* on the grounds that his authority was being undermined.⁹⁹

Dr W. B. C. Gray, superintendent of the Havelock psychiatric clinic, was appointed Acting Inspector General until Dr Archie S. Ellis, Deputy Superintendent at Royal Park Melbourne, was appointed to the position in August 1963. Under the terms of the newly drafted *Mental Health Act 1962*, which repealed the *Lunacy Act 1903*, his title was changed to that of Director of the Mental Health Services and he was to have direct access to the Minister for Health.

The 1962 Mental Health Act, the product of the Brand Liberal Ministry, reflected the same major concern as the *Mental Treatment Act 1927* with the stigma of certification and particularly its association with the Claremont Hospital. The Act provided for the detention, treatment and protection of people with mental illness, and there was a general agreement that Western Australia had 'lagged behind more than all other States' in its approach to treatment and care of people with intellectual disabilities.¹⁰⁰ However, the concern with Claremont permeated Parliamentary debate to such an extent that it clouded all other issues; in particular, the implications of the Act for treatment of people with intellectual disabilities. In an attempt to demolish the old section of the institution, Ruby Hutchinson, member for Suburban Province, went so far as to state:

I hope no attempt will be made to preserve or alter the old part of the Claremont Mental Hospital. It could well be written off and wiped from memory in this State.¹⁰¹

After the establishment of Heathcote in 1929, no major capital works had been carried out to improve mental institutions in Western

Australia. This state of affairs, whilst deplored all round, was presented as enabling the State to gather the latest information and investigate the best course to improve mental health services. Yet, as one member put it, the Act really only dealt with 'taking a patient to hospital, giving him treatment and discharging him'.¹⁰² Members believed that the stigma of certification and the fear that was 'in the minds of the public' regarding institutionalisation were preventing those needing care and/or treatment from seeking assistance.¹⁰³ George Bennetts, the member for South-East Province, described a visit to Claremont Hospital to see a patient who was only 'mentally deficient at certain times'. He had been unable to help the patient on that occasion. After a 10-year lapse since that visit, Bennetts explained that he did not know how the patient had been since then because he 'got such a horror of the place' that he had not been back.¹⁰⁴ This 'horror' of Claremont often resulted in failure to come to terms with the situation for patients with intellectual disabilities. More often the outcome was a desire to forget.

Much of the fear and stigma concerning Claremont stemmed from procedures which necessitated the certification of patients on admission. The 1962 Act dispensed with these procedures. It legislated for the removal of distinctions 'between hospitals or between classes of mental disorder — namely, mental illness, mental deficiency, and inebriacy'. Words and phrases such as 'lunacy, insanity, asylums, mental institution [and] inmates' which had 'unpleasant associations' were deleted.¹⁰⁵ According to Leslie Logan, Minister for Local Government, the 'Act was designed in the first place to safeguard the interests of patients and to ensure they were not committed unnecessarily'.¹⁰⁶

In seeking to diminish the 'dread of treatment' and in order to encourage patients and their relatives to seek treatment sooner, the Act sought to decrease formalities associated with treatment, particularly for voluntary patients. Safeguards were introduced against unduly long, compulsory detention or supervision, and admission procedures were overhauled. The guidelines for voluntary admissions, compulsory detention and referral by the Criminal Court were changed so that, in each case, a person had to be examined by the controller and a psychiatrist and observed for a period not exceeding 72 hours before a patient was admitted. However, admission procedures still did not differentiate between mental illness and intellectual disability. The aim of these changes was to 'bring mental illness into line with ordinary

physical illnesses'.¹⁰⁷ A person could now consult his or her medical practitioner and then be recommended to a specialist for treatment.

Frederick Lavery, the member for West Province, praised the new Act for doing away with the 'closed and locked doors' and the 'strait-jackets or other horrors of the past'.¹⁰⁸ The establishment of a day hospital at Graylands was seen as a step to more open institutions and it 'brought comfort to a great number of people'.¹⁰⁹ The old closed door system of mental hospital treatment at Claremont was criticised by James Hislop, member for Metropolitan Province. He claimed that the isolation of mental patients was still too alive within the context of this Act. Hislop's argument was backed by John Brady, the member for Swan in the lower house, who did not 'believe that the staff should be the only ones to deal with the patients'.¹¹⁰ He criticised the difficulty patients encountered in trying to contact people outside the institution. The Act stipulated that letters written by a patient and addressed to functionaries of the State, legal or medical professionals were to be forwarded unopened. Also in the patient's interests, provision was made to 'guarantee a patient an interview' with a medical officer within three days of the request being made.¹¹¹

In assessing the impact of the Act, Hislop concluded that it did not cover 'the whole of mental treatment within the State'.¹¹² He saw it as covering only the hospital treatment of people with mental illness. The Act attempted 'to grade patients according to their methods of admission and according to their state of mental illness'.¹¹³ It also meant that classification of mental illness was a matter of degree of incapacity with the cause/reason for the patient's state being obscured. Within this framework, 'mental infirmity due to old age or physical disease' was classified under 'mental disorder' and resulted in a situation where little girls were 'still with the old mentally-afflicted women'.¹¹⁴ The placing of children with sick aged patients was an indignity and cruelty to both groups.

The definitions of 'mental illness' and 'mental deficiency' have been differentiated by health care professionals since the turn of the century, yet there was no reflection of this in the new Act. In fact, many legislators were still hampered by their inability to distinguish between the needs of the two. Ross Hutchinson's definition was one of the more educated expressed in the 1962 debate:

the mentally ill person retains his full intelligence, while the mental defective is of limited intelligence, but not mentally ill.¹¹⁵

Hutchinson raised the important issue of developing 'an independent service for the mental defectives'. He argued that it was a mistake to house people with mental illness and people with intellectual disabilities in the same institution.¹¹⁶ As with previous efforts to address the specific needs of the latter group, this argument was ignored. The Act still grouped both categories together under the heading of 'mental disorder'.¹¹⁷

Nevertheless, despite this apparent confusion, the 1962 Act represented the transition from custodial care to active early treatment and retention of some of the lesser 'afflicted' patients within the community under adequate guidance and supervision.¹¹⁸ This trend was assisted by the advent of new therapies and drugs. Reference was made by Logan to a 'vastly different regime of treatment', but the unavailability of records makes it difficult to assess this statement. From the debates it seems that, in practice, the State was moving away from long supervision and custody in institutions and towards the provision of alternative accommodation for some of the patients of Claremont Hospital, namely people with intellectual disabilities. The path for these people was such that:

where mental health services deal with them at the Claremont Mental Hospital, some are sent to the Nathaniel Harper Homes and some to Whitby Falls. They form only a portion of the total number of mental defectives in this State, and only consist of those who are admitted to the Claremont institution.¹¹⁹

For the purpose of expanding public sector residential care for people with intellectual disabilities, financial provision was made in the Act for a new residential institution at Guildford (Pyrton), a new day hospital at Shenton Park, and further additional accommodation at Whitby Falls. Logan suggested that this would result in a reduction in congestion and overcrowding at Claremont and that conditions could then be improved.¹²⁰

In as much as it failed to make any distinction between 'mental illness' and 'mental handicap', the *Mental Health Act 1962* was inher-

ently flawed. The saying 'once a defective, always a defective' still lingered in the background of the debates as did the notion of 'hopeless' unfortunates who could not contribute to life or to society — the 'beings of no worth'.¹²¹ If Governments could not recognise their worth as human beings by addressing their needs, how could one expect public perception to change? This failure may have been a contributing factor in the case of Maurice Benn, where lack of understanding and the fear of institutionalisation seem to have played an important role in his mind when he decided to kill his son.

Similar to the case of Joseph O'Sullivan in the mid 1930s, Maurice Benn was found guilty of the wilful murder of his four-year-old son with intellectual disabilities in March 1964. Giving the primary reason for his actions, Benn stated that 'it was better that the child was dead rather than spend his life in an institution'.¹²² The child was described as being 'guilty of violent, irrational conduct'. Benn had taken his son to a university psychologist who examined him and thought he was 'a backward child'. He also described a visit to Princess Margaret Hospital to have his child assessed. He had gone there with his wife 'with the hope that the result might be favourable'. They were shattered to learn that 'it would never be possible for him to go to a normal school, an ordinary school'. A children's physician did not help matters in stating unsympathetically that the child was 'not a complete idiot. He can walk'.¹²³

In deciding to end his son's life, Benn told how he 'completely lost all hope that the boy might turn out right'. He believed that his son would have a 'very tough time in modern society' and that the boy would have to be 'institutionalised for his own safety', a step which Benn interpreted as confining his son to an 'asylum'. Assuming that the child would go through his whole life in a condition of 'mental derangement', Benn felt that he had to 'save him from such a terrible fate at all costs'.¹²⁴ The boy had 'no prospect of a reasonable happy life'. This impression was reinforced by the remarks of Benn's doctor that the child was hyperactive: 'Such children as this may have to be drugged later on in order to make them controllable'.¹²⁵

As was the case with O'Sullivan, Benn was deeply concerned about his wife's state of mind. The 'terrible nervous strain' of coping with a child with intellectual disabilities drained her of all physical and mental resources, and Benn feared for her sanity. The callousness of some of the medical professionals consulted by the Benns must have reinforced

his fears and added to his state of worry. Whilst Irrabeena had been recommended, Mrs Benn had 'a kind of horror' of the place. Neither Benn nor his wife seemed to have much knowledge of organisations like the Slow Learning Children's Group, or of the existence of alternatives to Claremont.¹²⁶

In summing up the case, the judge focused on the couple's failure to come to terms with their son's condition. According to the judge, the difficulty that they faced in accepting their son's disability acted as a barrier to their seeking proper advice and help for the child. All their efforts with doctors had centred on the hope of a denial of the child's intellectual disability. Benn was sentenced to death and this was later commuted to 10 years imprisonment with hard labour. A petition seeking his release was presented to Premier Brand in December 1964. This was unsuccessful but agitation for his release continued until he was set free just before Christmas 1968 and reinstated with his previous employer.¹²⁷

Benn's case in the early 1960s mirrors that of O'Sullivan's in the mid 1930s. Although a 30-year gap separates the two, the same motives drove the fathers to take the lives of their sons. In both cases, the death sentence was commuted due to a public outcry which recognised the desperation of parents confronted with children with severe disabilities. G. Hawkins, a lecturer in criminology at the University of Sydney, commenting on 'mercy killings', was quoted in the *Bulletin*:

There is no available residential care awaiting families who have been brought to the point of desperation trying to live with a mentally retarded child who is beyond control...the inability to get proper care for subnormal children was driving desperate parents to the choice: "Go mad or shoot them".¹²⁸

In analysing Benn's court case, Hawkins focused attention on the 'gross and shameful deficiencies in the provisions made in our society for the care of its weakest and most pitifully vulnerable members'. In defence of Benn, who was accused of not being aware of existing facilities, Hawkins claimed that he could hardly have failed to be aware of the 'hopeless inadequacy of the diagnostic, educational and vocational provisions for those handicapped in this way'.¹²⁹

Conclusion

Benn's case placed clearly in public focus the unchanging nature and inadequacy of 65 years of public policy and residential care for people with intellectual disabilities in Western Australia. In conjunction with Claremont Hospital's first Open Day in 1965, the possibility of significant change through a re-examination of the philosophy of care and improved public funding had been created. But what are we to make of the half-century which began so optimistically with the establishment of Claremont in 1908 but ended with expressions of public indignation similar to those first heard in 1900?

Much of the history of the period in terms of the provision of public sector residential facilities can be seen in economic terms. The introduction of new facilities such as Claremont, Heathcote and later Pyrron occurred during or following periods of sustained economic growth. In times of economic stagnation, there was no growth in facilities, and policies adopted would now be described as economic rationalism. In 1929, Acting Inspector General for the Insane, Ernest Thompson, had argued, in part, against segregation of people with intellectual disabilities from people with mental illness in terms of the adverse impact that this would be likely to have on the financial position of Claremont. However, economics not only worked against segregation from people with mental illness; it dictated that the provision of custodial care could be most cost effective in large institutions where economies of scale applied. Economic argument, in this sense, sat comfortably with the professional concerns of the medical profession which were advanced by the medicalisation of intellectual disability and the construction of 'hospitals for the insane'.

The medicalisation of intellectual disability in Western Australia — a process which had begun in the nineteenth century — accelerated with the arrival of eugenics in the early twentieth century. As the Birmingham Report demonstrated, the medical profession was quick to recognise the opportunities afforded by eugenics. Eugenicist ideas about the hereditary nature of 'mental deficiency' and the menace it posed to society were employed by the medical profession to generate demand for residential services. However, things did not always go the profession's way. In the decade beginning in 1920, the profession's monopoly of expertise for the care and treatment of people with intellectual disabilities was unsuccessfully challenged by the emerging

profession of psychology through the office of State Psychologist. The failure of this early challenge is dealt with elsewhere in this book and will not be commented on further. Suffice to say that the dominant role of the medical profession in the formation of policy and residential care services is clearly recognisable throughout the surveyed period.

In conclusion, this historical survey has shown that the formative influences in public sector residential care in Western Australia during the period 1900 to 1965 were economics, bogus science in the form of eugenics, the continued failure of the authorities to recognise the differences between mental illness and intellectual disability, and the medicalisation of residential care. None of these factors promoted the dignity or better quality of life for people with intellectual disabilities who were unfortunate enough to be committed to public sector residential care. Because people with intellectual disabilities were regarded as 'incurable', little attempt was made by the Government to understand their needs or to provide appropriate services. In common with other devalued social groups of the time, people with intellectual disabilities were largely ignored, misunderstood, popularly perceived as threatening, and deemed entirely expendable. The only positive outcomes of this period were the intervention of parents in the politics of disability, in the form of SLCG, and the establishment of Nathaniel Harper Homes.

In the first half of this century, Western Australia's record in the field of public sector residential care for people with intellectual disabilities can only be described as deplorable. Overcrowding, poor patient conditions and adverse public perceptions of institutions had failed to give genuine impetus to reform. The 1962 Act did not significantly alter the lot of people with intellectual disabilities in public sector residential care or efficiently address the problems of effective care and treatment for people with intellectual disabilities — an indictment of insensitive Government and its inability to grapple effectively with a complex social question. The State was still too driven by frugality, a want of imagination and the dead weight of the past.

Notes

1. For reasons of historical accuracy, this chapter uses nomenclature specific to the period of history under investigation. Terms now regarded with repugnance, such as 'mental deficient', 'idiot' and 'imbecile' have therefore been retained. The phrase 'Once a defective, always a defective' is drawn from the Select Committee

- on the Mental Deficiency Bill. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1929*, Volume 2, Paper A2, p. 2.
2. Annual Report of the Fremantle Asylum for the Year 1900. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1901*, table p. 11
3. Annual Report of the Fremantle Asylum for the Year 1900. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1901*, p. 3. In 1901, Dr Sydney Montgomery from the Nottingham City Asylum was employed as the first full-time Superintendent of the Fremantle Asylum.
4. *Sunday Times*, 7 October 1900, p. 7.
5. Virtue, R. (1974). *Lunacy, Law and Conscience: An Aspect of Social Reform in Western Australia, 1886-1903*. Bachelor of Arts Dissertation: University of Western Australia. pp. iv-vi.
6. An outline history of Claremont's construction can be found in successive Reports of the Inspector General of the Insane from 1903 to 1911. These can be found in *Western Australia Minutes, Votes and Proceedings of the Parliament* for the appropriate year.
7. *Western Mail*, 11 May 1907, p. 24.
8. Report of the Inspector General of the Insane for 1909. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1910-1911*, Volume 2, p. 6.
9. Quoted in Ellis, A. S. (1975). 'Montgomery of Claremont — The first fifteen years.' *Early Days. Journal of the Royal Australian Historical Society*, 7(7), p. 47.
10. *Western Mail*, 11 May 1907, p. 24.
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49. This statement refers to degrees of 'mental deficiency' where some patients were not sufficiently 'retarded' as to need the constant custodial care provided at Claremont. Many 'deficients', while 'feeble-minded', were regarded as harmless.
50. Report and Appendices of the Royal Commission on Lunacy, 1921-1922, p. 7 (PROWA ref: AN 537, ACC 2961/1).
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3 Normalisation and Beyond: Public Sector Residential Care 1965-1990

Leonie Stella

Introduction

- There have been extraordinary changes in the lives of people with intellectual disabilities in Western Australia in the last 30 years. At last governments recognised the distinction between intellectual disability and insanity, and they did so in an ideological environment which promised to liberate people with intellectual disabilities from decades of oppression. In the years before World War Two, the distinction was driven by the bogus science of eugenics; in the 1960s and beyond, it was
- driven by the new discourses of deinstitutionalisation and normalisation in which models of care based on education and training replaced the medical and custodial models. These models had hitherto consigned people with intellectual disabilities to Claremont Hospital for the Insane and Fremantle Asylum.

There were changes too in the place within the system of care for people with disabilities and parents of children with disabilities. This period begins in the wards of Claremont Hospital, with parent groups on the outside agitating for changes to government policies. It ends with community representatives at most levels of the formulation and administration of government policy, and with powerful and vocal lobby groups successfully advocating change. This period also begins with concepts of care in which the notion of basic human rights for people with intellectual disabilities was ridiculed. It ends with rights factored into most aspects of care, with agencies set up to advocate for people with disabilities, and soon after with legislation protecting their rights. This period begins with the existence of a few institutions for people with intellectual disabilities and ends with hundreds of residences; yet it is not possible to say that these transitions have been

smooth, unproblematic or preordained. Historical processes are never smooth and never unfold to predetermined ends even if the ends remain the same. Deinstitutionalisation and normalisation proceeded almost by trial and error, structured by imperfect and contradictory understandings of their meanings; changes in their meaning through elaboration and experience; the influence of new professions 'on the make'; decidedly ambivalent public understandings of disability itself; and constant constraints on funding. This chapter charts this uncertain process, not just by analysing changes in community attitudes and government policy, but also by using case histories. After all, it is through understanding the historical experiences of ordinary people — the 'clients', as modern managerial jargon terms them — that we can see the successes and failures of particular policies, and see the way forward to empower the hitherto powerless.

The growth of human and civil rights movements across the Western world and in Australia during the 1960s underpinned these changes in the field of disability. In the USA, President John F. Kennedy's special interest in the well-being of people with intellectual disabilities resulted in a greater awareness of their needs.¹ Kennedy established a special advisory committee on 'mental retardation' to act as an agent to promote change, and this encouraged research into methods aimed at improving the provision of services. In 1969, this advisory committee published *Changing Patterns of Residential Services for the Mentally Retarded*, which contained articles on normalisation principles by Bank-Mikkelsen, Bengt Nirje and Wolf Wolfensberger: three thinkers whose ideas were to lead to a profound change in attitudes towards people with disabilities and provision of services.

According to Nirje, normalisation meant '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'.² In the early 1970s, the principle of normalisation was further elaborated through the work of Wolfensberger and others in Canada and at Syracuse University in the United States. In 1972, Wolfensberger published *The Principle of Normalisation in Human Services*, the first major text dealing comprehensively with the principle.³ Subsequently, in 1983, Wolfensberger suggested that the term 'social role valorisation' be adopted as better reflecting the development of the normalisation principle between the 1960s and early 1980s.⁴

In Western Australia, as elsewhere, normalisation and social role valorisation have been extremely influential in the development of residential and other services for people with intellectual disabilities. Social role valorisation describes and explains the phenomenon of social devaluation, through which people who are perceived as socially deviant both lose valued social roles and are accorded devalued roles. The primary intent of social role valorisation is to support processes which enable devalued people to attain and keep valued social roles, such as 'worker', 'friend', 'consumer', and avoid negative roles, such as 'dole bludger', 'client' or 'patient'. More than this, it was a concept that could be applied to the provision of services. Wolfensberger was adamant that social roles could not be valued or enhanced whilst people with intellectual disabilities and other devalued groups continued to be congregated with each other and segregated from society. It was essential that service providers discontinue the practice of institutionalising people and provide training to counteract the effects of past practices.

Western Australia Since 1960

Throughout the 1960s, Claremont Hospital for the Insane remained the major facility offering a residential service for people with intellectual disabilities. Mental Health Services implemented early active treatment and industrial rehabilitation workshops to enable psychiatric patients to return to the community, but provided no specialist service for people with intellectual disabilities, especially those regarded as 'incurable' or 'ineducable'. Claremont continued to run on the 'medical model', with a heavy emphasis on psychiatric approaches to treatment.⁵

People with intellectual disabilities were therefore categorised according to their potential to be cured by medical treatment. People considered to be 'curable' were offered some rehabilitation through training or education, but this usually only enhanced their ability to become useful as workers within the locked hospital in which they lived. People considered to be 'incurable' were passive recipients of medical care, frequently confined to their beds or cots if they were unable to move without assistance.

According to psychiatric nurses employed at Claremont in the early 1960s, the conditions were as they had always been: Dickensian.

Many psychiatric nurses were conscientious and caring, but their training, together with roster arrangements which moved them from ward to ward at 14-day intervals, gave them little opportunity to get to know those under their care. The sexes were still segregated. The 80 children, adolescents and older women in the female juvenile ward were receiving better care than the boys but still living in unpleasant conditions. Some of the older people were used to assist with others, there were only three or four toilets with no doors on them, and little training was carried out.⁶

During this period, medical practitioners still held the view that children with severe or profound disabilities were 'incurable', and continued to advise parents to place their children in an institution; but many parents preferred to struggle with the provision of 24-hours-a-day care alone at home.⁷ One parent remembered:

There was little knowledge about intellectual disability or about ways and means of providing services...There seemed to be a real dearth of professional people ready to tackle the social issues confronting people with intellectual disabilities and their families.⁸

A. S. Ellis was appointed Director of the Mental Health Department in 1963. He considered his first job was to 'restore public confidence in the administration of the Mental Health Department', encourage 're-socialisation of psychiatric patients' and reduce the stigma associated with mental illness.⁹ He organised Claremont Hospital's first open day which, by coincidence, was held only a few weeks following the death of Bernard Benn (see Gillgren and Brogan), and consequently drew more than 2,500 inquisitive visitors.¹⁰ Ellis believed not only that the public was entitled to know how the joint State and Commonwealth funding allocated to upgrade mental institutions was being spent, but hoped that by opening the institution to the public, fear and stigma could be reduced. He anticipated that increased public awareness of the need for improvements would result in a greater response on the part of the Government. During his years of service, from 1963 to 1979, he therefore encouraged the media to expose conditions at Claremont but also believed that progress could best be made by working within the existing political structure rather than through a confrontationist approach.¹¹

Among the official orders given to Ellis on his appointment was close Claremont and develop plans for the building of a training centre for people with intellectual disabilities at Guildford.¹² It was not practicable, according to Ellis, to close Claremont whilst there was no alternative. In fact, even after his retirement, he remained unconvinced that the institution should have been completely closed down. Using unallocated funding that had been 'left over from the previous 10 years' within the first 18 months, he modernised accommodation according to suggestions made by Dr Eric Dax.¹³ However Ellis was not, by his own admission, an expert in the field of intellectual disability.¹⁴ He was a psychiatrist by vocation and, perhaps because of his limited understanding of intellectual disability, was initially opposed to the separation of services for people with intellectual disabilities from psychiatric services provided by Mental Health Services.

In 1964, however, Ellis supported the appointment of Dr Guy Hamilton to the new position of superintendent of the newly created Mental Deficiency Division of Mental Health Services. As a parent of a child with disabilities, Hamilton had unique insights into the nature of intellectual disability and the necessity for reform of service provision, beginning with separation from mainstream psychiatric services.

The creation of the Mental Deficiency Division (MDD), together with its assumption of responsibility for the administration of the SLCG's assessment centre, Irrabeena, was a step towards acknowledging the special needs of people with intellectual disabilities. It also acknowledged that the service required was too great for the SLCG to manage alone. The parent lobby groups ensured that the provision of residential care and support services became an increasingly political issue. One professional working in the field commented in 1991 that 'Dr Hamilton could have asked for the moon on a plate and he would have got it'.¹⁵

As Physician Superintendent of the Mental Deficiency Division, Hamilton was able to influence the Government's policies on the allocation of funding, residential care, training programmes, deinstitutionalisation and integration into the community. By the mid 1960s, he was finding that his own ideas about the provision of services were being confirmed by overseas research, which eventually became known as normalisation.

Hamilton was motivated to improve the residential care of people with disabilities not only by his awareness of their individual rights and

needs but also by reading an early paper by Wolfensberger which questioned the use of intelligence testing. In addition, he had also read about the experiments with children with intellectual disabilities being conducted at Brooklands, England by psychologist Jack Tizard.¹⁶ Tizard wrote in 1960 that some children 'from impoverished homes' would be better off in more stimulating institutions. He argued that in order to give the child what 'he gets from a good normal home', such an institution must supply the following:

- Affection and interpersonal interest; understanding of his defects; care for his future; respect for his personality and regard for his self-esteem. Stability; the feeling that he can expect to remain with those who will continue to care for him until he goes out into the world on his own feet.
- Opportunity for making the best of his ability and aptitudes, whatever they may be, as such opportunity is made available to the child in the normal home.
A share in the common life of a small group of people in a homely environment.¹⁷

Tizard had removed 16 children from the Queen Elizabeth Hospital in London and put them in a house with relatively untrained staff on the ratio of one to four during working hours. Their speech, mobility and other skills improved enormously. These articles confirmed Hamilton's view that treating children with intellectual disabilities in much the same way as other children would result in a marked improvement in their development and quality of life. Hamilton, therefore, suggested that this model should be followed in developing new units of residential care in Western Australia. He had a vision of hostels in every suburb.¹⁸

Hamilton, like Tizard and Wolfensberger, was questioning the necessity for experts to 'know everything' and suggesting that children and adults with intellectual disabilities should be treated primarily as 'normal' people with disabilities, rather than as handicapped people who were not 'normal'. Hamilton also agreed with Wolfensberger that if people with disabilities were to be treated in the same way as 'normal' people then they ought to be able to live in the community.¹⁹

In 1967, Hamilton delivered a paper at an interstate conference on his preference for treating people with intellectual disabilities as 'normal' people. He remembers how he was greeted with ridicule and disbelief from colleagues of the Australian Group for the Scientific Study of Mental Deficiency (AGSSOMD) and for the next 10 years subjected to adverse criticism. This irked him so much that he could not discuss his ideas without becoming increasingly impatient and angry. Later he asked his more even-tempered colleague and deputy, psychologist Errol Cocks, to attend future conferences on his behalf. Cocks, who held similar views to Hamilton, was appointed deputy superintendent in 1974. During this period, members of the Mental Deficiency Division were pleased with their isolation from the rest of Australia, which afforded them the opportunity to implement elements of the normalisation philosophy with little interference. However, as Hamilton admits, complications sometimes arose and mistakes were made.²⁰ As Physician Superintendent of the Mental Deficiency Division, Hamilton regularly shared information with international leaders in the field of disability and reported to the Perth authorities that Western Australia was considered to be 'well ahead of most of the rest of the world'.²¹

Ministerial Committee 1968

The establishment of a register of people with intellectual disabilities at Irrabeena resulted in increasing numbers of people being officially labelled as 'handicapped'. By 1967, the number of people requiring specialised services was increasing at the rate of 170 people per year and showed that there were approximately 4,000 people with intellectual disabilities in Western Australia.²² The Mental Deficiency Division was faced with the problem of how to improve the quality of care and address fundamental inadequacies in the training of care providers within the context of increasingly inadequate resources. Hundreds of people, including children, were still at Claremont Hospital despite the opening of Pyrtton Training Centre in 1967 (see below). Hamilton's priority was 'to get all the kids out' of Claremont. His initial steps were to refuse new admissions. This policy was challenged, especially by members of the SLCG, who wanted respite and assistance with long term care. A compromise was therefore reached by planning the movement to Pyrtton of all the youngest children by 1967 and younger

adults by 1972.²³ Hostels were established for more 'capable adults' and 'special care' hostels for children with multiple disabilities.

In 1968 the Liberal Minister for Health, Graham MacKinnon, appointed a special committee to develop a 'comprehensive service for all ages and all grades of retarded persons, including those with severe physical handicaps'.²⁴ MacKinnon took a keen interest in the problems facing families and Government policy-makers, and the provision of services benefited from his liaison with Cabinet members. Both Ellis and Hamilton found that he was a good ally. Responding to the arguments of parliamentarians, members of the SLCG, the Mentally Incurable Children's Association (MICA) and the staff of the Mental Deficiency Division — mainly as a result of the Benn case — the committee recommended the implementation of a 'five year plan' by the Division at a cost of five million dollars.

The plan recommended that the Government supervise the financial needs and methods required for treatment, placement and accommodation of people with intellectual disabilities; the provision of education and training; the development of appropriate staffing for centres and institutions; and the siting and suitability of buildings for such facilities. Amongst the new services it recommended were segregated activity centres, sheltered workshops, the expansion of Irrabeena and Pyrton, increased services to country areas, and the creation of a special ward at Princess Margaret Hospital for those requiring specialised services. Hostels were also to be provided to raise the number of places available from 167 to 700.²⁵

Relocation of everyone from Claremont Hospital meant that inmates had to be assessed by Irrabeena and transferred to Pyrton or placed in hostels as soon as possible. This process took time and was not completed until 1984. Some of the older people, most with only moderate disabilities, were not considered capable of moving directly into the community as they had received so little training or encouragement to develop social skills. They were transferred to Pyrton or into hostels which were graded according to the level of skills attained. People with severe or profound disabilities went into what were called 'special care hostels'.²⁶

Hostels

While the Pyrton Training Centre was being set up, the first hostel for

adults from Claremont Hospital was also established. Croyden, in Subiaco, was opened in 1968. These units, either built or purchased especially for the purpose, were intended for more or less permanent residents with varying degrees of disability. Each person was assessed in terms of their skills and independence, and if training improved their levels of skills they graduated to a 'higher skill' hostel. By 1973, the Division was responsible for residents in Belmont, Croyden, Scarboro, Dorset, Kentucky, Epsom, and Milford Hostels, Pyrton Training Centre, and Nathaniel Harper Homes. It still had some responsibility for over 200 people at the Claremont Hospital.²⁷ A reorganisation of Claremont in 1972 divided the section for psychiatric patients from those with intellectual disabilities. The psychiatric section was to be known as Graylands Hospital, and the section for people with intellectual disabilities, Swanbourne Hospital. The Government believed that this would help reduce some of the social stigma previously associated with Claremont Hospital. Whether it made much difference to the lives of the remaining patients with intellectual disabilities is another matter.

When Croyden — an attractive older middle-class house in Subiaco — first opened, it was run by an untrained supervisor, Mrs Dorothy Rigg. According to staff, Rigg was of the 'old school' and ran a 'tight ship'; her common sense and experience earning her the respect of residents and staff alike. By 1990, Croyden had expanded dramatically. It had a supervisor and a senior social trainer, nine or 10 full-time social trainers and two others working part-time.²⁸ Modern extensions, including an office, bathroom and short-term stay rooms were added on to the rear, which, it must be said, detracted from the homely image of the building and suggested that the hostel was a hospital rather than a house. White Place, a separate 'crisis respite centre' on the same piece of land, was supervised by the same staff.²⁹

Alice

Alice was a Croyden hostel resident who moved from Swanbourne in the early 1970s. Alice had spent 40 years of her life in Claremont (later Swanbourne). She was not considered to have profound disabilities, and the conditions that had affected her adversely were the lack of personal property, privacy and dignity. She had also been subjected to abuse by overzealous staff forcing her into unpleasant bathroom facili-

ties in order to attend to her personal hygiene. As a result of these experiences, she initially had difficulty in settling at the hostel; she was afraid others would steal the possessions she had gradually acquired and was terrified of the bathroom. She also insisted on wearing only pretty summer clothing all-year-round because thick, warm clothing reminded her too much of the ill-fitting, uncomfortable hand-me-downs she was forced to wear at Swanbourne. She eventually settled in well, her independence improved, and her fears dissipated to the extent that she was able proudly to show visitors her own sleeping area which she decorated with her own soft furnishings and ornaments.³⁰

As part of the policy of encouraging as normal a routine as possible, all residents at this hostel went out to work in sheltered workshops or to day placement centres. They also had home days for one to three days a week. The residents did not go out to work or leisure centres against their wishes. Some of the early residents of this hostel went on to live in flats when they became more independent. Several who had been in Swanbourne later moved into the community, settled down, and married. At a function at the hostel during the late 1980s, approximately 70 people comprising ex-residents, family and friends returned to celebrate the retirement of a senior staff member.³¹

The initial aim of the Division in establishing hostels was to keep them relatively small — no more than 16 beds — in order to encourage a more 'normal' lifestyle. It was, however, difficult to provide enough units to do this because of the costs involved and the increasing need for accommodation. In 1974, Hamilton reported that the Division was continuing to grow but that the growth of facilities was falling 'far behind the rate demanded'; there was an increase in waiting lists and only extremely urgent cases would be considered for accommodation. He also noted an increase in the demand for services — in particular the recent practice of sending staff to visit country towns — and the growing numbers of new registrations at Irrabeena Diagnostic and Referral Centre.³²

Division for the Intellectually Handicapped

In 1977 the Mental Deficiency Division was renamed the Division for the Intellectually Handicapped and by 1978 it ran 17 hostels providing accommodation for 350 people. This was, however, still insufficient and many parents continued to support their children at home, strug-

gling either with the heavy work load or with the vexing question of when or whether their family members could or should be placed in residential care. By the end of 1979, there were still 134 people in Swanbourne who had been assessed as requiring placement. The hostel system was also developing problems.³³

The grading of residents according to their levels of skills and subsequent training to develop those skills was aimed at allowing a progression of residents from a so-called low grade hostel, through a middle grade, on to a higher grade, and eventually into the community. The one underlying philosophy was that people had to earn graduation by gaining the necessary skills for community living. This was a major shift in attitude from the institutional policies of the past as it signified that people with intellectual disabilities had both the potential and the right to become full community members, albeit that this graduation was dependent on set criteria.

As part of this policy, a detailed skill evaluation was developed by professionals in the Division with criteria set for different hostels and for movement into the community. Over time, greater emphasis was put on interpersonal relations, recreation, practical social skills and compensatory mechanisms. For example, people were taught how to elicit assistance from others if they did not have the necessary skills to be involved in particular aspects of community life.³⁴ As part of the process of moving into the community, a Community Residential Support Service was established which involved social trainers working with people in their own community homes and flats. The social trainers assisted with budgeting, shopping and household tasks, and provided training for independent living.

Throughout the 1970s and into the early 1980s, this policy resulted in several hundred people moving out of Irrabeena and SLCG hostels and into their own flats and houses within the community. This was a considerable achievement as many of these people had been institutionalised for up to 40 years but were now managing their own lives and participating in general community life. It also had the effect of opening up many places in the hostels, allowing for some reduction in the numbers waiting for residential care.

However, as people moved out of the hostels and into community housing, it became apparent that many lacked social skills, particularly in the areas of human relations and sexuality. In addition, it was apparent that there had been insufficient attention given to individual

decision-making so that as people moved into the community, they found it very difficult to make decisions.³⁵

In response to these concerns, a major initiative was launched in the area of human relations and sex education led by Helen Macartney and Sue Robertson, with courses being developed for people in the community or those about to move into the community.³⁶ This was an extremely sensitive area as parents were very concerned about their sons and daughters becoming sexually active and possibly exploited. Meetings and workshops were held with parents and people with disabilities to explain the concepts involved in human relations and sex education, and a policy was drafted which was disseminated widely for comment. This ultimately resulted in the first policy in this area in Australia. The policy was used as a model for other States.³⁷

The movement of people directly into society meant that the community was exposed to many people with intellectual disabilities. As people were chosen carefully and given considerable support, there were few problems. This had the effect of considerably increasing the push for deinstitutionalisation as both Division staff and families could see that it worked, and policy-makers could argue for funds from the Government based on successful experience.

However, some difficulties were built into the system. Training was slow for many people, and the movement of one person into a hostel required the movement of another into community housing. Inevitably, there were times when no one could be moved. In addition, the growing numbers of an ageing population — partially caused by an increase in life expectancy — had not been taken into account during the planning of residential facilities.³⁸

The grading system also came under criticism from within the ranks of those who had implemented it. It was criticised for unduly influencing staff attitudes and the morale of the residents. In addition to this, the movement of residents was often disruptive, affecting their well-being and skills, such as the ability to familiarise themselves with support services, the physical environment and transport systems. The progression model was clearly producing problems. A partial solution came with the rotation of staff rather than residents. This overcame an additional problem: the element of compulsion. Residents now had the opportunity to choose who they lived with, as they would in a 'normal' adult life.³⁹ But changing the staff instead of moving the residents did

not help all residents. Parents of young people with multiple disabilities found that regular changes of staff frequently affected their children's training, behaviour and independence.⁴⁰

During the 1970s, the Division became increasingly concerned about its inability to meet the demands for residential services. Staff morale was also reported to be 'suffering'. Hamilton stated:

It is known world-wide that this Division has pioneered many aspects in the field of mental retardation; specifically, clinical engineering, domiciliary services, and the use of specially trained non-nursing personnel in primary care and training. It is disappointing to see these pioneering services beginning to fail because of their very success in meeting the needs of clients' demand outrunning supply.⁴¹

Hamilton also reported that the capital cost of providing new buildings had reached such an exorbitant figure that alternative methods of providing residential accommodation were being considered. He noted that hostels were not only costly but that their use was not in line with the principles of normalisation. He argued that it was time to consider assisting people to manage with occasional support in houses, flats or townhouses.⁴² He acknowledged that there was an urgent need to relocate people with profound disabilities from Princess Margaret Hospital. Some of these children were amongst those relocated in an old Nedlands maternity hospital — Tresillian.

Tresillian

In the grading system of people with intellectual disabilities recommended by the 1968 Ministerial Committee, Group A were classified as having profound disabilities, 'immobile', 'untrainable' and 'ineducable'. Mental Health Services considered that there was a desperate need for hostel accommodation for 'quite a number of fairly severely physically and mentally handicapped persons' living at Swanbourne, Princess Margaret Hospital and in the community.⁴³ There were about 250 people in this group. In an interview in 1979, the decision to provide a new kind of residential care was justified by Ellis:

There was a theory, I'm glad to say that it is not on now, that all these people ought to be looked after in their own homes...I mean yes...they can be looked after in their own homes up to a point...But some of these are very severely handicapped people who can't move hand or foot and have to be hand-fed day after day after day for 'x' years, because they get such good care now and there are antibiotics, they live much longer. And this is an enormous strain on a family...all right, we agree institutions are not the answer and I think Hamilton has got the answer here by these 16-bed hostels...I think [there is] one with 32 but this gives a sort of family atmosphere, looked after by skilled people who know what they're doing, and relieves the families enormously.⁴⁴

Thus, Ellis acknowledged the power of the idea of normalisation but believed it was necessary to offer larger residential facilities in some circumstances. The ideal, according to Hamilton, was to establish hostels based on the Tizard model. Although the increase in demand was affecting this goal, Hamilton was meeting with some success in setting up hostels in several suburbs. However, some local councils refused to co-operate in re-zoning applications intended to allow for hostels and homes to be run within existing residential areas. Most councils required residential areas to consist of homes occupied by 'normal' nuclear families. The Division carried out public relations negotiations with such councils and, in the case of Dorset Hostel in Armadale, was able to overcome these early difficulties.⁴⁵ But others resisted. Frustration with this attitude led to the formation of a group called Watchdog towards the end of 1973. The aim of this group was to alter legislation so that local Government could not prevent the establishment of hostels in residential areas.⁴⁶

Just before Christmas in 1973, the Health Department offered the use of its redundant Tresillian Hospital to the Mental Health Services. The Division had become increasingly concerned about the placement of children, some of whom were resident at Princess Margaret Hospital and faced a life-time in residential care under the supervision of nursing staff. They became residents at Tresillian because Hamilton was desperate to find alternative accommodation. When the Health Department offered Tresillian he 'jumped at it'.⁴⁷ In hindsight, he and Ellis both acknowledged that it was probably a mistake not to have negoti-

ated with the Council and local residents. But in discussions with the administrators of the Health Department, they had been assured that this should not be necessary as the hospital had already been used by the Health Department for older people, some with intellectual disabilities or mental illness. They also acknowledged that Tresillian was limited in the facilities it offered but it was a hospital with beds, in good condition and in pleasant surroundings.⁴⁸ According to historian Geoffrey Bolton:

it fulfilled all the requirements considered acceptable for an institution of this type...It was a good example of accommodating handicapped people within a suburban community.⁴⁹

The movement of young people into Tresillian was carried out at Christmas in 1973, when Nedlands Council was in recess and on the eve of the State elections. The new hostel was in the electorate of the then-Leader of the Opposition, Sir Charles Court, and it is doubtful that the incident would have become such a controversial affair had it been in any other electorate.⁵⁰ Some residents of Nedlands sought the support of Court to have the hostel moved out of his electorate. A petition was produced, its language reflecting age-old ideology regarding people with intellectual disabilities, depicting them as 'animal-like' and 'disgusting'. Local householders were also concerned that property surrounding Tresillian would be devalued. Ellis, as Director of Mental Health Services, went into the homes of some of the Nedlands residents and agreed that they had a right to live in peace and quiet but concluded that their worries about people wandering and making noise were unfounded. He supported Hamilton's view that he did not have to justify putting people with profound disabilities in the community or that the community needed protection.⁵¹

The staff at Tresillian, led by Matron Elaine Brooks, invited residents and interested groups to visit the hospital. Local schools and church groups demonstrated an interest, and a Friends of Tresillian group was formed.⁵² Dr Harry Cohen was a very vocal spokesperson for this group, as was Mrs Jenny Guhl of Watchdog. For nearly three years, members of the Watchdog committee, Friends of Tresillian, staff at Tresillian, sympathetic trade unionists and the media, backed up by some professional service providers, fought for the rights of the resi-

dents to remain where they were. The new Liberal State Government, elected in March 1974, appointed Norman Baxter as Minister for Health. He demonstrated less interest in the welfare of people with intellectual disabilities and mental illness than his predecessors.⁵³ However, the newly elected Government did claim that the defeated Labor Government had been merely applying stop-gap measures to the problem of providing residential services and that it would be providing accommodation for all.⁵⁴ Ironically, this was also the aim of Ellis and Hamilton and, according to Ellis, this was why they 'dug in their toes'. It was not only that they defended the rights of people with intellectual disabilities to live in a 'normal' urban community. What Hamilton really wanted was, as he put it, 'more accommodation, not alternative, but additional'. Ellis added:

We wanted it to be quite clear that anywhere else we went was in addition to Tresillian and this is why we were never happy about moving people out of Tresillian.⁵⁵

According to Ellis, the use of Tresillian had always been considered a temporary measure, but the Division needed all the facilities it could get and did not want to relinquish Tresillian. The Court Government offered Tresillian to the Nedlands Council for purchase in 1974, but at that stage it could not raise the funds. The Council offered an alternative site to the Division near Karrakatta Cemetery which was totally unacceptable to parents and staff alike.⁵⁶ By mid 1975, other Councils were also raising objections. The Melville City Council thwarted attempts to establish a hostel within its boundaries, and the Belmont Shire obtained an injunction to prevent the movement of Tresillian residents to Kareeba, a C Class hospital in Rivervale which Baxter tried to convince Hamilton and Ellis to use.⁵⁷ A few weeks earlier, the SLCG had warned that 'if a few Nedlands residents are successful in applying pressure to have the mentally retarded moved from Tresillian, then the precedent is set for residents in other local authorities to do the same'.⁵⁸ The Nedlands Council purchased Tresillian from the State Government in June 1975 using Federal Government funding.⁵⁹

The best alternative building was the five-year-old Ross Memorial Hospital at Forrestfield. The Minister for Health arranged for the purchase of the hospital towards the end of 1975 and offered it to Mental Health Services.⁶⁰ Pro-Tresillian supporters, especially parents and

staff, objected to Ross Memorial because it was isolated, provided no sense of community living and was difficult to access.⁶¹

During the next 12 months controversy raged. Watchdog and Friends of Tresillian initially felt they had little public support from professionals associated with the provision of services for people with intellectual disabilities. They encouraged media involvement to the point that radio, television and press seemed to be directing the events. Media coverage generated tremendous sympathy and public awareness of the difficulties facing people with intellectual disabilities and their families. There was dissension within the Government, with several members disassociating themselves from the decision to remove the residents to Forrestfield. The Hospital Employees Union said members would not move the children without parents' approval, or work at Forrestfield.⁶² Baxter's response to this threat was to counter-threaten:

Staff at Tresillian hostel who attempt to obstruct the moving of patients to new quarters in Forrestfield will be sacked and the mentally handicapped children in their care will be returned to their homes.⁶³

On 11 July 1976, the Government announced that Tresillian would close on 21 July. The parents and friends held a public meeting outside the hospital and demanded a State-wide referendum.⁶⁴ The Government responded by financing a full-page advertisement for an Open Day at Ross Memorial on 17 July. The idea was to convince the public that it was a very suitable building. Approximately 500 people attended. The Government controlled access to a meeting with parents and used police to deter protesters. Hamilton was not invited. Parents were not impressed by speeches from Court or Baxter, and Ellis could get no co-operation from them until he agreed to call Hamilton to the meeting. Eventually, the group acknowledged that the premises were very good but maintained their position that the residents had the right to remain where they were and that the Ross Memorial Hospital was in the wrong place. The deadline of 21 July remained.⁶⁵ The Premier called Ellis to meet with him that morning to consider the logistics of moving residents without the support of staff as drivers. The Minister for Police, Ray O'Connor, and the Minister for Industrial Affairs, Bill Grayden, were also present. There were hundreds of people picketing

Tresillian, and Court and Baxter were worried about how vehicles could be driven past them. Eventually a compromise was reached.⁶⁶

Court asked for the statistics regarding people with intellectual disabilities who still needed urgent accommodation. Ellis advised him of the numbers still in Swanbourne, Princess Margaret Hospital and within the community. According to Ellis, Court then suggested that Ross Memorial be used for people from Swanbourne and the community, and that the people from Tresillian should move at the end of the following year into a new hostel, Sussex, already under construction in the suburb of Innaloo. The people at Tresillian could remain until the new hostel was ready for them. Hamilton and two representatives from the parent groups were called in. At nine o'clock that night, the problem was resolved. In the meantime, Court lost the support of his colleague Ray Young, who resigned his position as Cabinet Secretary.⁶⁷

The picketers and press waiting outside the hospital on this cold wintry night were jubilant. The new hostel was to be within a suburban community and additional accommodation was available for those still in need. Fifteen residents from Swanbourne and four others from their own homes went to Ross Memorial while 31 children from Princess Margaret Hospital went to a new hostel in Yokine at Christmas time. The Premier required and received an unqualified assurance from Mental Health Services and parents that, when it was time to move from Tresillian, there would be no objections or interference.⁶⁸

The Tresillian episode revealed the diverse attitudes existing within the community to people with intellectual disabilities. Some regarded them as 'dangerous deviants' best put out of sight. Alternatively, there were many people prepared to fight for their rights. Hamilton certainly achieved his goal of additional accommodation. Parents were also satisfied, at least in the short-term and probably in the long-term, as newer and more suitable premises were provided. Nedlands also gained the use of Tresillian for purposes other than the housing of people with intellectual disabilities. And 10 years later, in 1986, Ray Young was appointed Chairman of the Board of the Authority for Intellectually Handicapped Persons.⁶⁹

All the hostels established during the 1970s and 1980s have histories of their own, but it is not possible to recount them all here. Some, like that of the old Cottesloe Maternity Hospital, Devonleigh, were unsuitable premises where staff had problems with maintenance and vermin, and parents lobbied the Government to improve the laundry

service. The hostel was run on an institutional model and staff found it ironic that while they were attending lectures given by Wolfensberger when he visited Perth in 1981, the children at Devonleigh were wearing clothing stamped with MHS in large letters.⁷⁰ Milford was so dilapidated that within its first year, 1974, half its residents had to be moved out.⁷¹ Earlsferry was burnt down as a result of a 'misadventure' on the part of a resident. Some, like Epsom, newly built especially for 'clients', remained reasonably comfortable and pleasant.⁷²

The establishment of hostels as part of the movement to relocate the people from Swanbourne was certainly beneficial to people who would otherwise have spent their lives in an institution. Others have suffered as a result of overcrowding, community prejudice and a poor quality of building. All the hostels — by nature of their administration, routines, staffing, numbers of residents and congregation and segregation of people with similar disabilities — remained mini-institutions. The worst perhaps were the converted dormitories at Pyrton, one of which still housed over 60 people in 1990.

Pyrton Training Centre

In 1966, Mental Health Services opened Pyrton Training Centre to house the first of the children being removed from Claremont. With the building almost ready for occupation, MHS turned its attention to the provision of suitable staff. It had become apparent that neither general nor psychiatric nursing staff were appropriate given the need for social training for people with intellectual disabilities. Nurses trained in so-called mental deficiency programmes in Sydney, Melbourne and in the United Kingdom were given no information about people with intellectual disabilities during their first year of training. This, together with Hamilton's knowledge of the success of overseas experiments using unqualified, non-nursing staff, led to the recruitment of a group of workers to be specially trained. The Child Welfare Department had already initiated a service for its group homes, and Hamilton had taken part in their training lectures. From here he developed the idea for training assistants whose status was later upgraded through a Diploma course at the then-Perth Technical College (see Megahey 'Making a New Profession'). They were given three weeks concentrated training at Pyrton, introduced to children from Swanbourne by the staff from

Nathaniel Harper Homes, and instructed to make the unused, unfurnished dormitories as homely as possible.⁷³

The initial building at Pyrton was the Primary Unit — later altered and renamed Myoora — which consisted of four dormitories. It was built in a style similar to other 1960s Government hospitals: a single storey of unattractive cement blocks with a low flat roof. The Secondary Unit, eventually renamed Pindarra, had a six-foot fence, wire gates and sparse grounds with little vegetation. The Tertiary Unit, renamed Carramar, was not built until 1975. It was built to provide more living space and a more homely environment, and was considered 'the show piece of Pyrton' by social trainers who worked there. A work wing and production area, later named Workpower, was added to Carramar to provide residents with work experience. Each unit had been built for 64 beds. Hamilton's aim was for the residents to 'progress' through the Primary, Secondary, Tertiary units by developing social skills and eventually be able to leave the institution, live in hostel accommodation or return to their families.⁷⁴

The centre was established under the guidance and control of professional staff: Hamilton, Superintendent Psychologist Bill Lake, senior nursing staff, occupational therapists and physiotherapists. All worked in conjunction with the social trainers. Pyrton was a vast improvement on Claremont Hospital, but because of its isolated location on the outskirts of the eastern suburbs of Perth and the segregation and congregation of large numbers of residents with multiple disabilities, it retained an image of a 'colony of defectives'.

The hurried planning of the buildings and the lack of experience and knowledge used in the implementation of new theories of treatment and training led to an approach best described as trial and error. The first social trainers assembled the beds as they were delivered and prepared the dormitories with soft toys, books and personal effects. However, this careful planning left them unprepared for the disarray which met them at the end of the first day. The social trainer who had offered to be first on night duty met the next shift 'pale, dishevelled and mumbling incoherently [as] she made a valiant attempt to describe her first night'.⁷⁵ The children were very active and their lack of previous training at Claremont meant that they almost wrecked their new environment. Social trainers were quickly allocated one young child each to train as best they could. While the social trainers feared they might be sacked because of their inability to control some of the

children's behavioural problems, Hamilton encouraged them, assuring them that in the future they would be proud to be known as 'pioneers'. Pyrton was officially opened in April 1967 by the Minister for Health, Graham MacKinnon.⁷⁶

In January 1967 a second intake of training assistants joined the staff, and another dormitory opened for 'immobile' children. The assistants were rostered, including night shifts at five-week stretches, and were confronted with another new experience: the 'posturing' and 'patterning' of 'twisted fragile little bodies' according to a printed list of names and instructions. Under the direction of the 'inexhaustible' physiotherapist, Mrs Pat Slee, the trainers exercised the children for hours on end. In writing of this experience one social trainer said: 'No wonder some of those kids got up and walked'.⁷⁷

The first social trainers had been taken to Claremont to observe the conditions of the children. One of the first social trainers recalled that:

When we got the little kids from Claremont some of them, they were all under the age of 12, had lived all their lives in Claremont...and so they came to us [without] any sense of identity. They didn't know who they were; they certainly didn't know anybody...that they had any self-worth; they didn't know what to do. Most of us had little kids of our own when we started...[but] we were battling to make eye contact...So what we are talking about is real basic stuff...teaching people who had lain in cots for eight years how to walk...teaching them how to feed themselves...We started off by saying we are just going to love these kids to death because we are really going to make them feel like they're loved and have rights...For about the first 12 months that's what we did...⁷⁸

Within a short while, the social trainers and professionals realised that although some of the children had begun to develop a feeling of self-worth, they didn't know how to behave appropriately. They had been allowed freedom of expression but given little discipline. One social trainer remembered that when the children were asked to carry out instructions or stop anti-social behaviour 'they didn't know what to do'.⁷⁹

So in Pyrton's early days, training seemed to have little impact on the development of the children's social skills. Assistance was therefore

sought from psychologists. Psychologist Superintendent, Bill Lake, influenced by the writings of Carl Jung, had been encouraging people to express themselves in order to 'get things out of their system'. However, some staff felt that this encouraged chaos.⁸⁰ In 1969, Dr Jay Birnbrauer, a leading behavioural psychologist from the United States, undertook sabbatical leave at Pyrton and introduced behaviour modification techniques. The use of reward systems and negative consequences had some beneficial results, especially in controlling the behaviour of people whose actions were life-threatening.⁸¹ Lake became convinced of the value of this approach and encouraged the use of behavioural techniques. He followed the literature in the field and began to implement some of his own behavioural programmes after Birnbrauer returned to the United States.

The residents of Pyrton had for the most part come direct from Swanbourne Hospital where individual attention was impossible. Attention-seeking behaviour was therefore common-place, distressing and difficult to control. This was apparent in cases of self-mutilation, when residents would strike themselves with clenched fists or hit their heads against walls. The failure of conventional methods of control, such as the use of padded cells, led to experimentation with more radical methods. The literature in the field had shown that the use of a contingent electric shock was effective in reducing self-mutilation, so a 'cattle prod', which delivered a very painful but safe shock, was used on several residents whose behaviour was considered a danger to themselves.

Support for the use of aversive techniques was not uniform among staff members, many of whom had been taught a Jungian philosophy of love and self-expression. The use of aversive techniques resulted in considerable introspection. Jill Elliot was one who was decidedly ambivalent:

I think that psychologists in that day and age would have felt very much on the defensive and said "Okay I am here, it is my job to do something about this" and so anything they could find...that stopped people from banging their heads [they would use]...I couldn't use those methods...I just couldn't...but I could see how that stopped that behaviour. Whatever else it did it stopped people from killing themselves.⁸²

Tension between the staff and psychologists and even between psychologists became acute. Psychologist Di Tann resigned and Bob Jackson was appointed to replace her in December 1970. Jackson felt that the use of aversive therapy was useful in controlling self-destructive behaviour but agreed with staff that its use should be minimised. In 1971, Bill Lake left the service, later to be replaced as Psychologist Superintendent by Jackson.⁸³

By 1974, Jackson had come to the conclusion that there were no clear underlying guiding principles for the institution, and no clarification about its purpose nor its goals. He came to believe that the individual potential of residents was not being developed. With the assistance of psychologist Neville Sparrow he submitted a proposal for the restructuring of Pyrton. Hamilton, as Physician Superintendent of the Mental Deficiency Division, approved its implementation. They wanted to bring in specific training schemes for each individual and make staff accountable for their progress. The social trainers who had been used to working in an autonomous fashion were unhappy — according to Jackson — not only with a relative newcomer but also with the fact that he brought with him what they regarded as a ‘horrid range of new hair-brained schemes’ for them to carry out. Gradually a rapport was built up.⁸⁴ Jackson’s system was called the AIMS system. A set of skills was worked out for each person to achieve according to his/her capabilities and needs, and staff were accountable to parents for each resident’s progress. The system was in line with the idea of progress through the units and eventually out of the institution and into hostels or the community. It enabled parents to see improvements in their children’s skills through recording and reviewing at regular periods.

These experiments with new methods of teaching undoubtedly went some way towards improving people’s capabilities. However, an evaluation — carried out by the then-Western Australian Institute of Technology and using a Programme Analysis of Service Systems (PASS) designed by Wolf Wolfensberger — indicated that despite the intentions of the staff the institutionalised way of life continued to be inherently damaging.⁸⁵

Sections of the general community regarded Pyrton as a terrible place. Although this was partly due to fear of people who are different, it was also a result of the gradual congregation and segregation of nearly 200 people with multiple disabilities behind fences and walls,

despite the attempts to provide as 'normal' a lifestyle as possible. As Bob Jackson remembered:

there is nothing more silly that I can think of than to put a group of people with a similar disability together. I mean, who are they going to model? The image impact is enormous. You walk into something like Pyrton and you are overwhelmed with the disability, but if you saw one of those people in a group of people like us you probably wouldn't notice.⁸⁶

Despite this poor image, Pyrton during the 1970s was considered by many parents and professionals as *the* place for providing care and training for people with intellectual disabilities. Many doctors and nurses who identified a child as having a disability referred them to Irrabeena and advised parents to 'put them away, forget you've had them', 'You cannot cope. Let us do it for you'.⁸⁷ The residential service had improved greatly since the days of Claremont Hospital; yet the validity of such a suggestion was rarely questioned. As a senior social trainer recalled:

What we did to parents in those days, not knowing what we were doing, still makes me sort of wonder. When you talk to parents who put their people in Pyrton in those early days and what they've sort of gone through and how they feel about things...what we were actually saying to parents was "you've failed with this kid so give him to us...you can forget about it"...we didn't make parents part of the whole process...We would have them toilet trained and think that we were pretty smart and pretty clever, leaving the parent with this horrible feeling that they had failed...We thought we were doing the right thing.⁸⁸

In 1977, Sue Harris, a social worker, was appointed to the staff of Irrabeena. Her previous experience had been at Gladesville in New South Wales working with people with intellectual disabilities and mental illness:

That's where I learned what it is like to have a child in residential care. I met families...50 families most of whom

'did not care', according to the system, and I soon found these families were desperately caring...⁸⁹

Harris had set up liaison systems in NSW with the families, staff and hospital management and worked on issues such as placing children in schools. She also contacted parents of long-term adult residents. Some of these people had had no contact with their families for 20 years but when they were reunited, she recalls:

it was as if they had only left home yesterday and I learnt that it is the system that cuts families off rather than families themselves not wishing to have contact.

In Western Australia Harris found the same situation. She was initially given an office at Irrabeena and told to work with the families of over 100 people living at Pyrton, 30 people with multiple disabilities at Boston hostel and 40 children attending an activity school. With Hamilton's support she moved to an office at Pyrton. She found it impossible to see 150 families as this would mean only one visit per family per year. She found that some parents did not trust her as she was seen as being on the side of other professional staff whom they felt had discouraged their interaction with their own children. In order to improve relations between staff and parents she started a newsletter within Irrabeena, arguing that the more information parents had, the more likely they were to become more involved. She also provided opportunities for parents to form support groups and to speak out about what they wanted to achieve. Psychologist Bob Jackson used the newsletter to keep parents advised about the levels of skills developed and the methods of improving them.⁹⁰

Harris also believed that lessons could be learned from the provision of residential services for young able people:

There was this whole body of knowledge about residential care...but residential care for those who were intellectually handicapped was totally isolated from that...so while "normal" childcare people were agonising about issues like admission procedures, how to do it to be kind to the child, make them feel comfortable and be kind to the parents etc...we hadn't even started. In our experience it

was largely a clerical matter...Irrabeena wasn't even considering professional staff based in residential services while somewhere like Parkerville Children's Homes had two or more social workers, psychologists and an education officer apart from the direct care staff for 30 children. Handicapped people were being treated as a devalued population...they were good on training but it did or didn't happen and the provision of loving care which was a priority for other children in care, was left to the goodwill of the social trainers...some of them got stomped on because there wasn't room for that sort of thing.⁹¹

During the late 1970s and early 1980s there was obviously a power struggle going on at Pyrton.⁹² The motives of people like Hamilton, members of the SLCG and the first social trainers were to improve the quality of life for a hitherto oppressed group of people. No less altruistic, many psychologists concentrated on providing people with a level of skills to enhance their ability to survive in a 'normal' environment. The heavy emphasis on achievement often conflicted with the desire to provide as 'normal' and home-like an atmosphere as possible. Many of the staff also became aware that the inherently damaging effects of institutionalisation could not be counteracted and that the residents' 'quality of life' was not improving.⁹³ Plainly, the Pyrton approach had to be reassessed.

Pyrton was part of the hostel system which used the progression model. Thus, all hostels were experiencing similar problems. There was a growing awareness that in emphasising the levels of skills achievement and systems of grading, people were being forced to earn the right to move out and live in the community. Some critics had also suggested that the small numbers of people actually integrated into the community did not justify the amount of training provided.⁹⁴

Pyrton staff initially resisted any changes that would jeopardise the quality of the training programmes, but the influence of ideas concerning people's right to make choices for themselves led to changes. The psychologists gradually became less involved in all-day, everyday training and, when the complex was restructured to provide hostel and group housing, the social trainers became the key personnel. By the early 1980s the population had also aged, and there were no longer children in residence. Adult education, leisure activity centres and employment training centres were established. The senior social trainer

interviewed at Carramar advised the author that professional staff no longer worked on wards but were called in as consultants. Residents were taught to cook for themselves and were integrated into the wider community through employment, leisure and sporting activities such as bowling and bushwalking. The standards of the housing environment depended on the individual social trainer as she/he acts as the primary caregiver and supervisor of everyday matters such as budgeting, medication and organisation. Residents now paid for their own accommodation and cost of other maintenance through their invalid pensions.⁹⁵

The AIMS system collapsed when the position of senior social trainer — whose task was to co-ordinate AIMS and monitor and collect data — was removed. Jackson believes the AIMS system assisted people to develop skills but in hindsight he recognised its deficiencies:

We put an enormous amount of effort into an institution and no amount of good intent can make up for the fact that it has been harming people...[there is] no way of restructuring it so that it won't harm people — it simply has to go.⁹⁶

The present facilities at Pyrton have not lost their appearance as a 'colony for defectives', but they are being closed as part of the Government's commitment to deinstitutionalisation. Myoora, the first unit built, was recently closed and previous residents are living in the community. Pindarra unit is currently being devolved (1996) and Carramar has been listed for future budgets.⁹⁷

Diane and the Pyrton Experience

Diane Y, a resident of Pyrton, was born in 1958, the third child of four siblings. For the first 17 years of her life she lived in the care and security of her own family. However, she had multiple disabilities and as she grew older, her mother found it difficult to attend to all her needs as well of those of the rest of her family. Mrs Y informed the author that:

it got to the stage where it wasn't easy for me to keep her at home...her health was deteriorating...it often took two or more people just to get her into a bath....Pyrton was the

obvious choice at the time, it was either Claremont [Swanbourne]...or some private place which I was not happy with...⁹⁸

Initially Diane lived at Pyrton for short periods until she got used to being away from her family. This was a traumatic experience for both her and her family. However, Mrs Y believed that it was the right decision as she considered that Diane would need residential care for the rest of her life. Her parents were concerned that as they grew older they would not be able to provide her with the necessary training and supervision.

During the early years of Diane's time at Pyrton, Mrs Y found that the use of behaviour modification techniques was traumatic for Diane and of little benefit to her. Amongst those techniques were the 'time out' periods, which Diane found to be isolating and frightening, and the restraining of her arms by strapping them down with a belt. Diane had developed the habit of scratching staff members. Eventually, the staff realised that Diane scratched when she was distressed and in pain. As she is profoundly deaf and cannot speak, this was the only way that she could gain attention. Her mother and staff at Pyrton later found it more appropriate to simply place strong mittens on Diane's hands when she was in a state that was likely to cause her to injure staff. Diane did not scratch other residents; only those, including her mother, who could do something to alleviate her distress. Psychologists suggested new programmes for the elimination of this problem, but Mrs Y challenged the suggestions on the grounds that the problem was being adequately dealt with and the initiation of any new programme would only put Diane 'through it all again'.⁹⁹

Diane's mother found that the most beneficial aspect of living at Pyrton has been the fact that Diane 'no longer has a cranky mother' and when they are together, such as when she comes home to visit or is taken on outings or a shopping expedition, they get on much better together. The more negative aspects of the experience, she feels, have occurred because 'experiments' failed, were stressful, or were a waste of time.

Mrs Y also feels that Diane lost a lot of her freedom at Pyrton. When she was living at home she was taken out and had more social contact with friends and relatives. Diane has also learnt many skills but lost others. Often she would be taught such skills as picking up her clothing or turning off bathroom taps but, if the staff person who taught her these

skills left the hostel, the replacement often commenced teaching other skills and the early ones were neglected. Mrs Y believes more one-to-one activity programmes would be beneficial.

Mrs Y has maintained close contact not only with Diane but with the staff at Pyrton and does appreciate the level of care provided for her daughter. Nevertheless, over the years, she has challenged both social trainers and psychologists, especially during the years of behaviour modification and in response to the effects of changes in staff and policy which disrupted the continuity of skills training.¹⁰⁰

Diane's parents' main concern is to prepare her for living independently. However, they feel the level of independence being encouraged, especially in group homes, may put Diane at risk because of the tendency to use only one staff person who sleeps while on overnight duty. Many residents have 'fitting' problems, wander about, or are vulnerable to abuse from others, and 'sleep shift staff' may be unable to provide adequate observation. Mrs Y believes that for residents 'to survive with dignity they must have an appropriate level of supervision'. She was involved in the plans to devolve Pyrton and was delighted that Diane and her 15 co-residents left what she regards as:

terrible out-of-date old hospital dormitories which have been chopped up into sections with partitions...[and have] a very small living space...nothing like a "normal" home.¹⁰¹

Diane is among those residents who moved into the community when Myoora closed. Mrs Y found discussions organised by the Government concerning arrangements being made prior to the devolvement of Pyrton to be very helpful and was optimistic about Diane's new residence.

Sarah

Sarah A, who has Down syndrome, was born in the early 1970s and classified as 'severely handicapped'. She has lived at home with her parents and their other children for the past 20 years. At the time of interview she was working in a sheltered workshop. Mrs A was referred to Irrabeena when Sarah was six weeks old, and the assistance offered in those days consisted of counselling and regular medical reviews. The emphasis was evidently on medical considerations rather

than educational or practical assistance. Mrs A thought this was inadequate. She also required regular respite care for Sarah.¹⁰²

Initially, respite residential care was obtained two or three times a year, for two to three weeks at a time. Sarah had been a temporary resident in various Government hostels, including one at Pyrton, as a pre-schooler, school-age child and as an adult. In her mother's opinion, Sarah's classification as 'severely intellectually handicapped' impeded her development, especially during her school-age years. When she was in hostels for people with severe disabilities she was vulnerable to physical abuse from other residents who were suffering from the trauma of having been institutionalised at Swanbourne. This caused her parents great distress, and they pressed the authorities to place Sarah in hostels with people with mild to moderate disabilities.

At the age of 18, Sarah proved to be capable of working in a sheltered workshop amongst people with less severe disabilities than herself. Her family believed that this was very beneficial to her. Placement within a hostel with people with less severe disabilities was, however, more difficult to obtain. Mrs A believes this was partly due to individual social trainers or hostel supervisors being able to choose who they would have living in 'their' hostels. For example, the staff in two hostels, one for school-age children and one for adults, took Sarah on a trial basis but then refused to have her again on the grounds that they could not cater for her needs. This situation was further complicated when Sarah began to menstruate at the age of 12 years. Sarah and her mother found it difficult to cope with the heavy and painful bleeding which was often accompanied by difficult mood changes. Sarah was unable to cope with her own personal hygiene without one-to-one supervision and assistance. When she was 16 years old, Mrs A sought medical advice.

The most usual and acceptable medication used for young women like Sarah provided no respite to her problems, so staff at the Authority recommended injections of Depo Provera. Mrs A refused permission because of its insufficiently researched side-effects. She was therefore advised to seek a solution of her own. With the assistance of a local medical practitioner she eventually found that the best way to cope with the problems was for Sarah to take a low-dose contraceptive pill so that she had only one period of menstruation every three months. Mrs A had to take responsibility for this and used the drug to avoid

causing staff of hostels additional work by planning Sarah's periods so that they did not occur while she was living in a hostel.¹⁰³

Mrs A finds it ironic that the continual use of hormonal therapy or Depo Provera — with risks of cancer and other side-effects — is encouraged by policy-makers and service providers who do not approve of medical intervention such as hysterectomy. The latter would prevent reproduction and it is considered to be an infringement of the individual rights of women with severe disabilities.

Sarah's family believe they have done everything in their power to provide her with the best life possible. Mrs A feels Sarah has suffered from having been labelled 'severely handicapped' and in practice, whenever she has been placed in a situation with people whose abilities were greater than her own, she improved markedly. Mrs A has fought her way through many obstacles and, with the support of her husband, has provided quality care for her daughter. She has also lobbied Members of Parliament and Cabinet Ministers, and fought for access to education, work experience, respite care and residential placement. She has foregone any claim to a career of her own or a 'second chance' education and has spent 20 years balancing her role of mother, teacher, trainer, problem-solver, advocate and therapist at home. She has also worked as a voluntary fund raiser, attended national conferences, and sat on Government committees and councils. At the time of interview with the author, Mrs A was 'worn out' and had resigned all her voluntary commitments. She feels she has little to offer, especially as she believes she is regarded by some people in positions of authority as a 'damned nuisance'. This label, she feels, is probably justified as she continues to fight for the rights of her daughter.

Mrs A informed the author that although she has had many difficult and unpleasant experiences in relation to the provision of services, she has also been given positive assistance from individual psychologists, social workers and social trainers employed by the Authority. Her main criticisms were that there was not enough flexibility in the implementation of policies which, she argued, should take into account individual family differences as well as the rights of individual clients. The Authority's strict waiting list has also caused her frustration. Each time Sarah's name has come up for placement in a Government residence, someone else has been considered to be in greater need. She asked:

What should I do...pretend to be going mad so that my daughter can be regarded as being in danger? Or have myself committed to hospital? There have been times when I have wanted to just walk away before I go mad and before pretending becomes reality.¹⁰⁴

At the time of writing, Mr and Mrs A were approaching retirement age and Mrs A felt disillusioned with the Government's provision of residential services. They still live with the fear that their daughter may not be cared for adequately after their deaths. They believe that they are not overprotective but are realistic about their daughter's ability to cope without them and the limited services available to her, especially as Sarah continues to be labelled 'severely handicapped'.

Less Restrictive Alternatives

Group homes or duplexes were initially established as the 'top end' of the progression model for people whose independence skills had developed to the point where they were considered to be capable of living in a less restrictive or supervised environment. In 1974, the Mental Deficiency Division was responsible for only two duplexes and two flats which were rented by a total of six women.¹⁰⁵ By 1989, the Authority for Intellectually Handicapped Persons — which replaced the DIH in 1986, which in turn replaced the Mental Deficiency Division in 1978 — was responsible for 138 group homes and duplexes. Some residents had moved into their own flats or homes. There were also many privately run but Government subsidised and licensed homes run by churches or the Slow Learning Children's Group.¹⁰⁶ The lifestyle of group homes is less restrictive than hostels and institutions, although group homes continue to group people with the same disabilities together. The AIH has been closing down some of their older or overcrowded hostels to place people in group homes or duplexes. But the growth of this service has been restricted by financial resources and community attitudes.¹⁰⁷

Group homes can be houses with three to five residents. The residents are given part-time or full-time support from social trainers, depending on their needs. Duplexes are similar. The old hostel, Fairholme, has been converted into three duplexes housing 48 people. The Bennet Brook cluster of group homes and duplexes is located near

Pyrton. It is a mixture of 10 duplexes and houses and 65 people live there in a village complex. In some duplexes, arrangements are made for non-staff families to live adjoining a group of clients to act as support.

Glenys

Glenys was admitted to Claremont Hospital for the Insane as a child in the 1950s, when her mother died, and was classified as having a moderate disability. Today she shares a duplex with other people with disabilities. She often talks about her unhappy experiences at Claremont and also in a privately run hostel. In 1985, Glenys asked a social worker to assist her in finding a more suitable residence than the private hostel she was living in. The social worker arranged for Glenys to have an independent voluntary advocate from the Citizen Advocacy service because she was unhappy with the hostel. Her advocate lobbied the Minister for Health and other authorities involved and she has since been placed in an Irrabeena duplex. She is now much happier and is also enjoying her friendship with the advocate.¹⁰⁸

In the late 1980s Peter Klein, a 'client' of AIH, demonstrated the benefits of living in a group home by participating in the production of a Government-sponsored video shown on public television in 1990. Peter told the public that he had been a resident of an institution all his life and was delighted to have the opportunity to live in a group home — a place to call his own. He had lived in a hostel in West Perth, a two-storey converted mansion, where he had to share a bathroom with 18 other people and a lounge room with 22. He said fighting sometimes broke out and there was no place for quiet conversation. The worst aspect was the depressing atmosphere and the fact there was 'no escape from each other'. Peter pointed out that some residents had unreal expectations of what life might be like in a two-storey mansion but he was very happy to be where he was. He enjoyed the independence of having his own money to spend as he wished and being able to go shopping without supervision.¹⁰⁹

There are many people with intellectual disabilities who are very happy with their lives and the choices they are now able to make. This phase of the implementation of principles of normalisation in Western Australia is still in a state of transition, and many people have yet to be successfully integrated and provided with appropriate accommoda-

tion. One senior social trainer admits that 'we have dreams' of placing people in residentials that best suit their needs, but that many hostels, such as Cromane, remain unsuitable. Financial resources are not meeting the need. The ideal cannot be met for many people.¹¹⁰

The provision of these residential placements has also been open to people who have not previously been institutionalised but whose parents have died or who, on reaching adulthood, have wished to leave home and lead a more independent life. In some cases, parents have objected to their children leaving home, but legal advice has confirmed their right to choose where they want to live.¹¹¹ Parents who oppose such changes are generally regarded as being overprotective and cautious about their children's capacity to take risks. Other parents, such as those of Benjamin, a young man with intellectual disabilities, regard such a choice by their adult son as a sign that he is willing to take responsibility for himself. They 'rejoice for him'.¹¹²

Risk-taking does sometimes cause problems. Wolfensberger pointed out that risk-taking enhances personal dignity and recommends, for example, that people with intellectual disabilities be encouraged to find their own way home when visiting or at work. This has undoubtedly been a successful technique when implemented with proper support and an improvement in community attitudes. In Perth, a young woman with Down syndrome who lived at home with her family became lost on her way home from work. Fortunately she was rescued, in a state of distress, by a public transport bus driver and his peak-hour passengers and taken home to her mother.¹¹³ Without denying the beneficial aspects of such risk-taking, it is clear that deciding the level of independence to be encouraged requires much planning and support. Other people with intellectual disabilities have been subject to exploitation or abuse.¹¹⁴

By 1990 AIH was rarely being asked to 'place' children or young people because of the growing acceptance of their right to live at home. In fact, the Authority actively discourages such placement; their 'wait list' is for 'critical cases' such as those who lack a support network or those whose elderly parents suddenly die.¹¹⁵ However, providing care 24 hours a day at home can still be very stressful, especially for mothers who are often the primary caregivers.

In January 1990, a mother of two adolescent sons with physical and intellectual disabilities was charged with attempted murder. She had become so stressed with the emotional and physical demands that she

lost her temper and struck one of her adolescent sons. The boys, of course, have a right to be protected from such abuse and were taken into respite care. Their mother admitted losing her self-control and her husband described her as a 'loyal and devoted mother for 17 years...a super mum'. The charge against her was reduced to one of unlawful wounding in a court decision which acknowledged her difficulties. The boys returned home. After her court appearance she advised parents in a similar situation: 'Don't try to cope alone...get help'.¹¹⁶

Authority for Intellectually Handicapped Persons

In 1979, the Division for the Intellectually Handicapped was relocated to a new multi-million dollar building in West Perth. An increasingly specialised and bureaucratic structure was developing. The Irrabeena Assessment and Referral Centre had grown from one small house in West Perth to a 'labyrinth of houses' by the 1970s. The number of staff increased from 300 to 700. Hamilton himself worried about the loss of a personalised service and the possibility of a breakdown in communication but observed that there was no alternative to growth as it was required by the demands of the community.¹¹⁷ Lobby groups such as Watchdog, the SLCG and professional staff continued to call for a separation of the Division from the Health Department.

The International Year of Disabled Persons in 1981 brought the needs and rights of people with disabilities to the attention of the wider community. During the year, the State Government commissioned the Beacham Report on the delivery of services to people with intellectual disabilities. Its main recommendation was that a statutory authority should be established to assume overall responsibility for the protection and promotion of the rights of Western Australians with intellectual disabilities.¹¹⁸

Four years later, in October 1985, legislation creating the Authority for Intellectually Handicapped Persons was passed by the Western Australian Parliament. The Authority superseded the Health Department's Division for the Intellectually Handicapped and came directly under the responsibility of the Minister for Health. The staff, functions and facilities of the Division were transferred to the Authority.¹¹⁹ Irrabeena, the name given to the first assessment and treatment centre, was retained by the Authority and used for referrals to the service sector. The Act of 1985 allowed for the appointment, by the Minister for

Health, of a Board of Management consisting of a chairperson and five other members. The Act also included a provision that an assessment and review would take place in 1990.

The Authority commenced operations on 1 January 1986 and defined its 'mission' as:

being to advance the rights, responsibility, dignity, development and community participation of people with an intellectual handicap in Western Australia. The Act defines a person with an intellectual handicap as any person who "has a general intellectual functioning which is significantly below average and concurrently has deficits in adaptive behaviour, such conditions having become manifest during the developmental period". Any person who meets this criteria is therefore considered to be eligible to receive services through the Authority.¹²⁰

The Authority operated through five city Regional Centres and a Country Division. As part of the commitment to community involvement in the formulation of policies and service priorities, Regional Advisory Councils comprising people with intellectual disabilities, their families and community members, were established in 1986.

The Authority acknowledged the rights of people with intellectual disabilities by encouraging access to accommodation that best met their individual needs and their right to participate in the everyday life of the community. Normalisation, deinstitutionalisation and integration into the community continued to underpin policies.¹²¹ In 1989, Irrabeena, the service arm of the Authority, provided support services, funding and co-ordination for both Government and private residential facilities. A total of \$66.8 million was spent providing services for 4,622 clients. This included \$37 million expended for the provision of residential services to 1,175 people. The accommodation provided by Irrabeena itself was of two types: extended stay where a person might live for an indefinite period, and short stay where the person required only temporary accommodation.¹²² During 1989 and 1990, the Authority acknowledged that although the current policy was to discourage families from seeking a Government residential service, a constant demand for such a service could not be fully met.¹²³ Such a policy, while in line with the principle of normalisation, assumed that families were willing and able to provide for family members with disabilities. Many

senior staff members of Irrabeena appeared to believe that this was no longer a Government responsibility but the parents' responsibility.¹²⁴ However, a review of the Authority published in 1990 pointed out that as a result of an ageing population, the demand for residential services will continue to increase, a natural consequence of the:

decline in availability of family carers, particularly parents. This will mean that demand for adult support services in areas such as accommodation...will further escalate.¹²⁵

Services in Country Areas and the Movement to Non-Residential Options

Developments in residential service provision in country districts of Western Australia have closely followed suburban regions. Historically, there has been little Government-owned residential accommodation outside the metropolitan area. Most accommodation has been provided by SLCG in the form of hostels which allowed children to attend regional special schools. For the families of children not able to attend hostels, their only alternative has been to keep their children at home with little or no support, or to send them to a hostel or institution in Perth. For the most part, regional activity has relied upon the resources of the SLCG — renamed Activ Foundation in 1988 — supplemented by Irrabeena with its visiting country teams. Typically, these teams have provided a service based on visits to country districts two or three times per year for a few days each time, during which professional assessments take place and advice provided to families. Not surprisingly, people in non-metropolitan areas have found services to be inadequate, forcing many families to move to Perth. Relocation has often been traumatic for both clients and their families, making the transition to a new environment difficult.

The inadequate nature of regional services has been particularly apparent in some large country centres with significant populations of people with intellectual disabilities. Community pressure from the Bunbury region resulted in the placement of a team of professional staff and several social trainers, aimed at providing a similar level of service enjoyed by people living in Perth. The success of community action in Bunbury prompted calls for action elsewhere. However, in Albany,

community pressure was unsuccessful; the cost of service provision has been deemed by the Government to be prohibitive in times of financial stringency.

From the mid 1980s, the escalating cost of providing residential services has driven the development of new models of service delivery in Western Australia and around the world. In Western Australia in 1990, it cost \$78,000 to keep one person in a hostel and \$33,000 for each person living in a group home.¹²⁶ In Canada and the USA, more flexible methods of service provision have developed around the idea of directly funding individuals with intellectual disabilities and their families to supply services to meet their needs, or to support the generic community services to provide for people with intellectual disabilities and their families. With the pressure from the Albany district and strong urging from some members of the Authority Board — particularly Errol Cocks and Jenny Guhl — Irrabeena decided to pilot a new service approach in 1987.

Peter Dunne, principal of the local special school, was appointed in Albany with the task of working directly with people with intellectual disabilities and their families. Dunne fulfilled the task of Local Area Coordinator, a role requiring him to discuss with each individual and their families their needs and difficulties, then work with the available services in the community to meet those needs. While this seemed to be an impossible task, it was found that for many families the need was not for residential placement but rather some opportunity for a break or respite: meaningful daytime occupation, involvement in clubs and recreation activities, support to attend the regular school and so on. The service was received very positively by families who, for the first time, found someone directly interested in their individual concerns and prepared to do something about them. The cost of the service compared favourably with residential placement — an important budgetary consideration.

Encouraged by the success of the Albany experience, in 1989, the Authority sent two senior staff, David Hounscome and Eddie Bartnik, on an information gathering trip to the United States. Subsequently, Eddie Bartnik produced a paper on 'Future Directions', setting out a proposal for re-focusing services away from buildings to the needs of people and their families.¹²⁷ The thrust of the proposal was accepted by the Board of the Authority and, as a result, Irrabeena restructured country services with the allocation of one or more staff members —

known as District Co-ordinators — to each region, working with approximately 70 people and their families. From 1991, the scheme was extended to the city, with staff positions reallocated from the traditional professional teams to the new service of local area co-ordination.

The 'post-bureaucratic' shift to local area co-ordination has the potential to have a major influence on residential services into the next decade. While devolution of hostels into smaller group home accommodation has continued, the total number of residential places has not been increased for some years and, in fact, is decreasing as direct support to families has been increased. Time will tell whether the new service form will be more effective in meeting the needs of people with intellectual disabilities and their families, but it is clear that the cost of residential accommodation will preclude the possibility of a never-ending growth of residential places.

There have also been recent developments in the general provision of residential services. In order to receive services, people with intellectual disabilities have been, and still are, required to be registered and assessed through Irrabeena or, as it later became known, the Disability Services Commission. Not all families agree to this and in preference to having family members labelled as welfare recipients, some have provided for the family members alone. A process of de-registration has also been instituted, enabling some AIH clients to de-register themselves as a result of becoming more independent and making their own living arrangements. Others have never been registered because they or their support network feel intimidated by what they regard as increasing State interference in their lives.¹²⁸ By 1990, there was evidence that some community members considered that in order for people with disabilities to be treated in the same way as other people, the provision of services should be mainstreamed. This would mean that housing would be provided by Homeswest and private real estate arrangements; indeed, in the 1990s Homeswest did begin building houses for people with intellectual disabilities.

Summary and Conclusion

During the 1960s, the Western Australian Government accepted the major part of the responsibility for providing community services specifically for people with intellectual disabilities; an historical shift from the predominantly private parent-based group method of service

delivery which had grown in the 1950s as parents searched for an alternative to Claremont. This shift took place during a period of growth in welfare provision apparent all over Australia. The Government's provision of services during the 1970s involved increasing numbers of professional experts such as psychologists, therapists and social workers. The establishment of a special Division and eventual separation of the service from Mental Health Services enabled an increasingly specialised organisation to develop a residential service that was considered to be far ahead of the rest of the world. This increased the demand for residential services and, despite efforts to improve the quality of life for people with disabilities and nominal embracing of the idea of normalisation as the basis for planning service delivery, many clients became locked into an institutionalised way of life.

Attempts to implement more radical challenges to the idea that people with disabilities required institutionalisation were not apparent until the 1980s. However, limited financial resources and the pervasiveness of negative attitudes towards people with intellectual disabilities hampered the process of deinstitutionalisation. The most persistent of these attitudes were those which regarded people with intellectual disabilities as vulnerable 'children' requiring protection or 'dangerous deviants' who posed a threat to the wider community. By 1990, the priority of policy-makers, parent groups and other community-based organisations who supported normalisation or social role valorisation was to ensure the protection of the rights of people with intellectual disabilities and the provision of adequate support services to meet individual needs. Deinstitutionalisation remained in a stage of transition and the logistics were complex. At the same time, there was criticism that integration of people with intellectual disabilities into the community entailed a relinquishing of Government responsibility for residential services.

The period 1960 to 1990 saw marked changes in the perception of people with intellectual disabilities by service providers, which reflected a similar development in community attitudes. The misery of Claremont Hospital, its culture of custodial care, its 'protection' of the community from people with intellectual disabilities, could only be justified if people with intellectual disabilities were regarded as sub-human. Through the Tresillian affair and changes in service provision and philosophy during the 1970s and 1980s, a changed perception

based on the notion of people with intellectual disabilities as human beings with human rights is evident. The development of Pyrtton and the hostels reflected a clear change in these attitudes, with the culture changing to one where the people were expected to learn, develop and earn their way to a better quality of life and ultimately into the community. This change in attitude did result in many people moving into the community, but it reflected a belief that they did not automatically have a right to be part of the community. They could only join the community if they met the community's standards.

This was followed by a reaction to the total focus on training, partly as a result of staff concerns but also from people who moved into the community and wanted to get on with a 'normal' life without continually being trained. A major movement towards rights occurred, with the focus changing to the development of relationships, taking responsibility and living a 'normal' life. This was a major change in attitude with people being seen as having the right to live in the community, have 'normal' relationships including intimate ones, and not to have to earn the benefits of life that ordinary citizens took for granted. From being seen as a genetic threat that the community had to be protected from, this was indeed a major change. Residential accommodation reflected the 'normal' community styles with group homes and duplexes rather than hostels and institutions, and even those with the most severe disabilities were seen as having the right to a life in the community with support, even though they might never become fully independent. However, this accommodation still reflected the belief that while they could live in the community, they should be congregated 'with their own kind', albeit with only a few others. The new service developments in local area co-ordination reflect a change in this attitude, with people having services based around their individual needs and community inclusion recognised as a key need for all human beings.

While changes in attitude of such magnitude are extraordinary when we consider that the change has occurred over just 30 years, it is a sobering thought to consider that many individuals continue to live out their lives in circumstances which reflect old attitudes, and many families continue to struggle on with little or no meaningful support. There is a gap between rhetoric and reality of which we need to be mindful. Whilst we can plot with certainty changes over time in ideology, policy and infrastructure aimed at improving the quality of

life of people with intellectual disabilities and their families, the impact of these changes has sometimes been slight or even negative, realities all too often glossed over in the pursuit of professional or sectional goals.

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4 The Response of the Law to Intellectual Disability in Western Australia 1829-1993

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This chapter examines the response of the law to intellectual disability in Western Australia since the time of European settlement. It begins with an account of how the statute law of the State of Western Australia addresses the definition of intellectual disability. We then discuss the purpose of the law as it relates to people with intellectual disabilities and finally examine the historical development of the legal rules and institutions meant for, or affecting, people with intellectual disabilities in Western Australia.

Defining Intellectual Disability: Statute Law Definition

In recent times the condition of intellectual disability has been defined in different ways according to the legal, professional or administrative purpose that calls for a definition. In law, intellectual disability might be relevant to a person's access or entitlement to services provided by the State; their civil competence to manage their own affairs (make a will, for instance, enter into a hire purchase contract, or decide where and how to live); or determination of criminal responsibility or appropriate sentencing.

Law in the form of legislation has been of prime importance in bringing recognition to intellectual disability by defining it as a distinct concept of the law. In bringing the defining function of the law to bear on intellectual disability, parliaments seek to describe a state of affairs which exists independently of such definition. This is not an instance where the law creates a concept; rather it seeks to describe a human condition. The question therefore must arise whether the law adequately

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describes the facts as known. A further question is whether the state of knowledge is sufficient to allow the formulation of an adequate statutory definition.

A widely accepted non-statutory definition of intellectual disability is that of the American Association on Mental Retardation which reads:

Mental retardation refers to substantial limitations in present functioning. It is characterised by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academic, leisure and work. Mental retardation manifests before age 18.¹

However, the first concept to be introduced in the statute law of the State of Western Australia in addition to 'mental disorder'² was that of an 'intellectually defective'. It was defined in the *Mental Health Act Amendment Act 1965* to mean 'suffering from arrested or incomplete development of mind'.³

The *Mental Health Act 1981*, which was never proclaimed, introduced the concept of an 'intellectually handicapped person' for the first time. That was defined to mean:

a person who has a general intellectual functioning which is significantly below average and concurrently has deficits in his adaptive behaviour, such conditions having become manifest during the developmental period.⁴

It was this definition which was inserted into the *Mental Health Act 1962* by an amendment effected in 1985 and which continues in force in that Act today.⁵

Another relevant Act, the *Guardianship and Administration Act 1990*, sets down certain criteria which must be met before a guardianship order can be made. It must be established, in addition to the need for a guardian, that the person is 'incapable of looking after his own health and safety' or 'unable to make reasonable judgements in respect of matters relating to his person' or is 'in need of oversight, care or control in the interests of his own health and safety or for the protection of

others'.⁶ In the case of administration the person must be 'unable, by reason of mental disorder, intellectual handicap, or other mental disability to make reasonable judgements in respect of matters relating to all or any part of his estate', in addition to being in need of an administration.⁷ 'Intellectual handicap' is defined to mean 'a handicap whereby a person is a person with an intellectual disability within the meaning in s. 3 of the *Authority for Intellectually Handicapped Persons Act 1985*'.⁸ This latter Act has been repealed by the *Disability Services Act 1993*⁹ so that the reference is now ineffective, but it may be that Parliament will provide for substitute cross-reference to the definition in the latter Act.

The *Disability Services Act 1993* has taken a new approach to the question of definition with the introduction of the following, which is more a definition of disability than intellectual disability per se:

"disability" means a disability —

- (a) which is attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment, or a combination
- (b) which is permanent or likely to be permanent;
- (c) which may or may not be of a chronic or episodic nature, and
- (d) which results in —
 - (i) a substantially reduced capacity of the person for communication, social interaction, learning or mobility;
and
 - (ii) a need for continuing support services.¹⁰

A different approach has been taken in the *Freedom of Information Act 1992*, which contains certain provisions relating to information concerning persons who are 'intellectually handicapped' but which does not seek to define, either by cross-reference to other legislation or in terms, the description so used.¹¹

The criminal law is the source of still further definition. The Criminal Code, as amended by the *Acts Amendment (Sexual Offences) Act 1992*, provides:

- (1) In this section a reference to an incapable person is a reference to a person who is so mentally disabled or intellectually handicapped as to be incapable —

- (a) of understanding the nature of the act the subject of the charge against the accused person; or
- (b) of guarding himself or herself against sexual exploitation.¹²

Discrimination on the grounds of impairment (added to the *Western Australian Equal Opportunity Act 1984* in 1988) is described as:

- (a) a defect or disturbance in the normal structure of functioning of a person's body;
- (b) a defect or disturbance in the normal structure of functioning of a person's brain; or
- (c) any illness or condition which impairs a person's thought processes, perception of reality, emotions or judgement or which results in disturbed behaviour, whether arising from a condition subsisting at birth or from an illness or injury...¹³

Several observations can be made about the use of the law to provide these definitions. First, there is no apparent uniformity in definition or statutory usage. There is a need to develop a definition that is uniform, practical and which reflects the key legal issue of capacity for decision-making. Second, intellectual disability is not a condition created by definition at law. It is a condition which it is necessary for the law to describe in words to achieve recognition for it. In the 1993 Burdekin Report on the Rights of People with Mental Illness, it was said that in most jurisdictions 'mental illness' was not defined at all or was defined in a way which was inadequate in light of modern knowledge. The report recommended that 'there should be a clear and consistent definition of mental illness in each jurisdiction's Mental Health Act, providing specific criteria which apply in all jurisdictions'.¹⁴ The same is true of intellectual disability.

Purpose of the Law

The purpose of the law is to regulate social behaviour. In principle, it does not trespass into the 'private' domain; traditionally one of those areas has been the responsibility of custodial parents for their children.

After some decades of industrial and social turmoil in the nineteenth century it became obvious that it was not always in the children's or the States' interests not to provide some sort of regulation or monitoring of parental responsibilities, and that the State had a 'welfare' role to play. Children have also been subject to the criminal law; but that tradition tolerates (as adults do socially) some anti-social conduct in children, especially in young children, which it does not tolerate in adults. This is because it is believed that this conduct is transient and it is expected that this irresponsibility will pass with maturity. Even an older offending child is likely to be dealt with more leniently than an adult in the twentieth century. However, children with intellectual disabilities might not adapt socially, as quickly as other children. The community has tended to see people with intellectual disabilities as 'children who will not grow up', and therefore it has not been as tolerant of them.

The response of the law over time has been to provide special rules which convey rights and liabilities for people with intellectual disabilities, but these rules tend to be inconsistent with one another. There is no legal concept of total 'incapacity' arising from intellectual disability. Legal incapacity in one area does not mean, necessarily, incapacity in another. Incapacity to make a will, for example, does not necessarily mean that the person does not have the legal capacity to decide whether he or she would like to live in a particular institution or undertake a particular medical treatment. A civilly incompetent person might find themselves fully criminally responsible for their acts or omissions because they are not legally 'insane'. Sometimes these varying rules lead to apparent injustice.

The Development of Legal Rules

The story of the law's development in the area of intellectual disability is one of conflicting social policies which developed at different times for different social objectives. Some laws developed when the protection of the possession of land was all-important, others when the State valued commercial certainty, such as the rules about 'soundness of mind' and the capacity to contract. Sometimes they developed when social control and protecting the welfare of the individual were valued, for example, when the criminal provisions restricting sexual activity with 'idiots' were enacted. The medical profession's understanding of the very different nature of psychiatric disorder, brain damage caused

after the developmental period, temporary disorder of reasoning processes and intellectual disability is not, however, reflected in the development of the law. The law lags behind scientific and social developments because, until the growth of dedicated law reform and policy development in the 1960s and 1970s, explicit, comprehensive and independently informed legal policy-making was rarely possible.

Another factor in the development of the law is the role of professional beliefs and their relative influence on law-makers and scientific opinion. For example, before World War Two, many medical professionals were enthusiasts of eugenics, and were convinced that disability was 'incurable' and that people with intellectual disabilities were 'dangerous' (see Gillgren and Brogan). In 1929, this belief led to the introduction of the Mental Deficiency Bill, which sought to establish a Board of Control that would organise a register of every 'mental defective' in the State and set out provisions for the 'care and control' of these people.¹⁵ This response is no longer socially or professionally acceptable. Nor is the exploitation, neglect or abuse of people with intellectual disabilities. What has brought about this change in public attitudes was not changes to law, but the effective advocacy for the interests of people with intellectual disabilities.

Professional groups can help to frame the legislative rules or make their own informal ones, which may perhaps avoid legislative rules altogether. They also influence the views of those who, in legal proceedings, interpret common or statute law. In addition, they use their own rules, definitions and guidelines in that huge sphere of activity where the legal rules are never called into relevance. One area of real concern is that of eligibility assessments, which can be crucial for the individuals concerned. On the one hand, identification is perceived to be undesirable because it carries with it negative connotations and therefore places a stigma on the individual. On the other hand, families sometimes seek to have a child or adult identified as having intellectual disabilities because of the benefits and support services to which the person becomes entitled. For an individual at the borderline of criteria for defining intellectual disability, the meaning of those criteria and the accuracy with which they are measured can have an immeasurable effect on an individual's life. A serious problem in eligibility assessment, therefore, is that a person may be considered eligible for services not on the basis of whether or not a real need exists, but on how the definition is interpreted.

This makes it difficult to separate the concept of service needs from the availability of service provisions. The way is thus open for any political or economic advantages that might be associated with defining a given proportion of the population as having intellectual disabilities. The lower the IQ limit that is set on 'significantly subaverage', the fewer people will be assessed as eligible; conversely, a higher limit will increase the number of people targeted for support services. In times of economic stringency, constraints on service provisions may influence, albeit unintentionally, the interpretation of assessment procedures to exclude some persons who do have a genuine need, or for whom there may be some other option in the provision of services.

Professional guidelines, therefore, have a practical significance well beyond legal definitions. Those people who need services to support them to live in the community may not be able to access them because the agency exercises discretionary control over those resources. It must be recognised, however, that many in this group of people are peculiarly dependent and entitled to the law's special attention.¹⁶ Such guidelines should therefore have a statutory base. They should be demonstrably appropriate for not only professional and resource allocation decisions, but should also fit into a system of rules and services which work together as a whole. It is quite unacceptable that some people with intellectual disabilities may not qualify under the informal, professional guidelines for access to services, yet under explicit legal rules may be found to be civilly incompetent, incapable of standing trial, liable to different outcomes if charged with criminal offences—for example, if they are 'insane', which may require that they be housed with psychotic or psychopathic offenders—or otherwise civilly unable to manage their own affairs. The importance of the role of the professional in practice, as well as in the rule-making role, cannot be overestimated.

It can be seen, then, that there can be different meanings of 'intellectual disability' at law and for administrative purposes. These meanings may overlap in some areas and leave gaps in others. Services for people with intellectual disabilities who break the criminal law, for example, tend to leave great gaps. The reason is simple. The purpose and policy behind each rule, each definition, each 'test', is different, and no uniform understanding of the needs and rights of the accused with intellectual disabilities as particularly vulnerable citizens has been

developed. This confusion and lack of uniformity is still a feature of legislation today.

The meaning of intellectual disability at law has changed over time. Since 1829 we have moved from minimalist regulation to the creation of separate institutions, bureaucracies and services. As this chapter will show, this is not merely because medical knowledge and increasingly sophisticated social and economic systems have enlightened us. An essential element was the organisation of interest groups made up of families and supporters of people with intellectual disabilities. These organisations initially focused on education for their children, then, as their children grew older, developed accommodation and vocational services.

As the twentieth century draws to a close, it is important to understand the manner in which society thought about, perceived and treated people with intellectual disabilities, and the response of the law to that treatment. In the remainder of this chapter we examine the historical development of those legal rules and institutions meant for or affecting people with intellectual disabilities in Western Australia in light of the expressed or explicit policy and attitudes of the time.

The Colonial Inheritance

The last half-century has seen a dramatic improvement in the quality, variety and quantity of services for, and in the status of, people with intellectual disabilities. However this was not the case when the colony was first settled.

The Swan River Colony was established on 29 February 1829, but Captain Stirling had left Britain before the passage of legislation to commission a Governor and establish a legislature for the colony. The whole of English customary law and statutes (the common law) then in force formed the first 'law' of the colony when Stirling declared on 18 June that year that:

the Laws of the United Kingdom as far as they are applicable to the circumstances of the case do therein immediately prevail and become security for the Rights, Privileges and Immunities of all His Majesty's subjects.¹⁷

Many ancient laws and a whole legal tradition of thinking thus applied in Western Australia. That legal tradition was not particularly sensitive to the needs of people with intellectual disabilities. For example, though the law provided a means of appointing guardians for people with intellectual disabilities, it did so primarily for the purpose of protecting their property. Its first purpose was to ensure the orderly devolution of land, on which the authority (and financial stability) of the Crown originally rested. It is important to remember this tradition because it makes sense of otherwise confusing legislative provisions and lack of provisions at the date of settlement.

For instance, one of the earliest statutes providing for guardianship of people of 'unsound mind' can be traced back 700 years to a statute recognised in the *Statute de Praerogative Regis* at the end of the Reign of Henry III. That statute provided that the King would have the custody of the lands of 'natural fools'; 'taking the profits without waste, finding them unnecessaries and after their death restoring them to their right heirs'.¹⁸ That law recognised only two conditions of 'unsound mind', namely 'idiocy' and 'lunacy'. In the former case, the right of guardianship was a profitable right analogous to the right of wardship. In the latter case, it was in the nature of a duty and no profit could be made from it. Gradually the two conditions assimilated and jurisdiction passed from the Exchequer to the Chancellor. An Act of 1744 gave justices the power to confine 'lunatics', and this led later in the century to controls on asylums in London and Middlesex through responsibility being vested in a committee elected by the College of Physicians. Many of these asylums were private facilities.¹⁹

Gradually, however, there was a change in the nature of the civil provisions for the protection and guardianship of people with intellectual disabilities. The Court of Chancery undertook the guardianship role with respect to children. Over time its wardship functions became assimilated with the practice of awarding guardianship of people who were 'incompetent persons'. By the end of the eighteenth century the Court of Chancery — rather than Treasury — was responsible for overseeing the exercise of guardianship rights generally. Before a guardian could be appointed, a Commission of Inquiry as to the person's state of mind and legal competence had to be held.

An Act of 1800 provided that people who were 'insane' and indicted for crimes could be detained, though it did not say where; some were detained in prisons at His Majesty's pleasure. In 1806 Sir George

Paul, the prison reformer of Gloucestershire, addressed a memorial to the government on the terrible condition of these 'criminal lunatics'. The result was an Act of 1808 — the title of which was An Act for the Better Care and Maintenance of Lunatics, being Paupers and Criminals — which addressed the perceived problem of the detention of the 'insane' in gaols, poor houses and houses of industry or correction by enabling the establishment of lunatic asylums in various counties by direction of Courts of Sessions.²⁰ It is most probable that the term 'insane' included people with intellectual disabilities.

What James Stirling brought with him to the Swan River Colony, then, was a tradition of guardianship of the property of people with intellectual disabilities for reward; similar in every respect to that provided for people with mental illness and other people whose public behaviour required some sort of social control. The only means of control provided by law was the removal of control of the property of the individual and restraint or seclusion of his or her person, in company with other 'socially difficult', particularly 'lunatic' people.

In 1834, however, the Western Australian colony formally adopted an English Act: the *Imperial Act Adoption Act 1834* (6W IV No 4) was assented to on April 11 1836. The Act 11 Geo IV and IW IV C 65 related to 'property belonging to infants, feme-covert, idiots, lunatics, persons of unsound mind or incapable of managing his affairs'. The Act demonstrated the traditional concern with the property of the person and s. 24 made very specific provision for the lease, encouragement of building upon, and the repair and maintenance or improvement of land and improvements owned by a 'lunatic', a generic term encompassing all forms of 'mental disorder'.

In the early colony there were undoubtedly not only people with mental illness but also adults and children with intellectual disabilities. As we have seen in Norman Megahey's chapter, 'Living in Fremantle Asylum', no specific provision was made for their care. They were either supported by family or friends or, if necessary, detained. Detention was the primary legal response — fundamentally as a method of preserving social order — and all people with 'mental disorders' were detained together.

In practice, however, pragmatic divisions were made among 'types' of the 'mentally incompetent' who were confined. The 1865 Fremantle Asylum Administration Report reported that management concerns — and perceptions of the likelihood of cure — had led to the division of

inmates into: '(1) quiet and chronic; (2) maniacal and dangerous; (3) melancholic and suicidal; and (4) the idiotic, paralytic and epileptic'. It suggested that those amenable to treatment had to be separated from the 'incurable, congenital idiots and noisy maniacs'.²¹

Early Western Australian Legislation

The first enactment made by a Western Australian Parliament was the *Lunacy Act 1871*; an Act which in substance established many of the procedures for commitment or restraint of the person which are still in force today in the *Mental Health Act 1962*. The Lunacy Act was intended to provide for the 'safe custody' or the prevention of offending by the 'insane' who were thought to be a risk to others, and the care and maintenance of persons of 'unsound mind'. It provided for the apprehension of a person found in circumstances suggesting that they were mentally ill or had intended to commit suicide or another crime. He or she could be committed to a gaol or public hospital by two justices of the peace upon consideration of the opinions of medical practitioners. The Act also provided for civil commitment of non-dangerous but 'insane' people, but there is little evidence of how these discretions were exercised. Bottomley suggested that in New South Wales justices of the peace, as influential landowners, might exercise this power in pursuit of what he calls 'pastoral capitalism', another manifestation of the desire to profit from the property of people with mental illness.²² However, there appears to be little evidence in Western Australia to support this supposition.

Western Australia's *Lunacy Act 1871* made no distinction between persons of 'unsound mind' and 'idiots'. Both were included in the definition of 'lunatic'. The Act provided special procedures for dealing with 'pauper lunatics'; established some procedural requirements in certifying whether there were facts upon which to base a medical practitioner's opinion that the person was an 'idiot', 'lunatic' or person of 'unsound mind'; and provided for visitors to oversee the discharge and detention of all patients. It also provided that management of the estates of such persons be instituted by way of a court's finding that the person was incapable of managing his/her affairs, and that it was 'just and reasonable or for the lunatic's benefit' to place control of the property in the hands of a manager or committee, subject to the supervision of the Master of the Supreme Court.

Following the Vosper Inquiry into Fremantle Asylum (see Megahey, 'Living in Fremantle Asylum'), the State Parliament passed the *Lunacy Act 1903*, which came into operation on 1 January 1904 and endured through to the present era. For the first time the legislation drew a distinction between a person who was 'insane' and a person who was 'incapable'. The former was a person found to be 'insane' or of 'unsound mind' and incapable of managing himself or his affairs; the latter was a person found to be incapable of managing his affairs through mental infirmity arising from disease or age (s. 4). The Parliamentary Debates show that the members debating the Bill had some awareness of the distinction between the 'insane' and 'idiots and feeble-minded people' and the undesirability of trying to house or 'treat' both together.²³ The Act, however, concerned itself with the full range of people who were unable to care for themselves, including people with intellectual disabilities and 'habitual drunkards' (included within the 'insane' definition). It distinguished between the 'insane' and 'imbeciles' and provided measures for the removal from penal discipline of those who could not comply with prison discipline.²⁴ And for the first time the Act clearly provided that the court, in determining whether a person was in need of a guardian, was required to take into account matters relating to the physical well-being of the person as well as the management of the estate.²⁵ The terms 'insane', 'imbecile', 'idiot', 'lunatic' or person of 'unsound mind' were, however, used variously and inappropriately throughout the legislation, indicating that there was still a degree of uncertainty about the varying states and types of 'mental disorder' meant to be covered by the Act. So far as the criminal was concerned, the Act made provision for the establishment of hospitals for the 'criminally insane'. In this way the close connection between lunacy and criminal lunacy was maintained. However, it was in the criminal law as enacted in the Criminal Code that the principal provisions relating to persons with 'mental disorder' were contained.

The Lunacy Act was amended in 1915, several years after Claremont Hospital for the Insane had replaced the decrepit Fremantle Asylum, and six years after the publication of an influential report by the English Royal Commission Into the Care of the Feeble-Minded which highlighted the quite different type of care needed by the 'insane' and the 'feeble-minded'. However, the new Act did not adopt any such formal distinction and extended the civil commitment powers and procedures for the apprehension of a person 'not under proper control'. Doctors

were not required to attend personally before the justices of the peace to give their opinion. The Act also provided that the Supreme Court could release a person if it were satisfied that that person was not now 'insane'. Nonetheless, if satisfied that the person was still 'insane' and that it was desirable that he or she be kept under restraint either for his/her own protection or benefit, or for the protection of any other person or the public, the Court could order that person's detention or care. This in effect meant that the Court could retrospectively legitimate what would otherwise be an unlawful detention, by an appropriate order.²⁶

There was, of course, a considerable stigma in being detained in a 'hospital for the insane', and institutionalisation was seen by many as an absolutely last resort. This stigma was recognised in the *Mental Treatment Act 1917*, which sought to relieve the stigma of 'certification'. The Act provided that persons suffering from 'mental disorder' brought about by wounds, shock, disease, stress, exhaustion or other cause could be received for medical treatment for the 'insane' without being 'certified' under the Lunacy Act. People with intellectual disabilities thought to be 'incurable' could be 'certified' at birth in some instances, and many of these infants spent the whole of their lives in mental hospitals with psychiatric patients.

By the 1920s there was evidence that the Parliament was becoming concerned at the management of Claremont Hospital for the Insane. During the debates that year on amendments to the Lunacy Act, some members of the Western Australian Parliament expressed some unease about the control of the process of admission, detention and treatment by the medical bureaucracy.²⁷ The Angwin Committee — a Select Committee to Enquire into the Management of Claremont Hospital for the Insane — was established in 1919 to investigate the management of the Lunacy Department in general and Claremont Hospital in particular. Its report dealt with conditions within the hospital and the rate of recovery of the patients. The report extensively covered the evidence of Dr Birmingham about the findings from his 1911 tour of facilities for people with intellectual disabilities in the USA and Europe (see Gillgren and Brogan), and recommended that there be a Board of Commissioners for all 'mental defectives' in the State, though it was unclear whether that included the 'insane' as well as people with intellectual disabilities.²⁸ Dr Birmingham's recommendations for a separate institution for 'defectives' and the establishment of workshops for the teaching of

trade skills to unskilled patients and other therapeutic facilities for people with intellectual disabilities met with no response.

Until the late 1920s, the response of the law to people with intellectual disabilities could be seen to be either in the protection of their property (if they had any) or the protection of the community from what legislators believed was the social disruption caused by those who were in need of 'control' or economic support. Custodial options were the prime interest of legislation because of a prevailing belief that nothing else could be done. Custody meant the deprivation of liberty. The power to commit a person because of their 'mental condition' was by this time a judicial discretion.²⁹ But the overall administration of hospitals was conducted by medical professionals, and the assessment of the person's condition which might warrant a judicial commitment was the subject of a professional medical opinion, on which judicial officers relied. The very broad and general application of that legislation gave doctors a considerable authority.³⁰

In 1922 the Royal Commission into Lunacy recommended the establishment of a new institution 'for the recent and recoverable cases only', and further that:

the medical profession should be inhibited from sending unsuitable cases there...The institution is not meant to be a sorting house for all varieties of mental disorder. Such cases as senile dement, well-marked congenital defectives, obviously chronic insanity, general paralysis and epilepsy should not be admitted...the keynote must be medical treatment...

In other colonies and States, special provisions had been made for children with intellectual disabilities, and the Commission made reference to Kew Cottages for 'imbecile' children in Victoria and the need for restraint and seclusion.

The *Mental Treatment Act 1927* was intended to put the Commission's recommendations into effect. The Act introduced a new concept into legislation: that of 'mental disorder'. It also recommended the establishment of hospitals for the treatment of patients who had not been found or certified to be 'insane', where people could be treated without the stigma of certification of lunacy. These hospitals were spoken of in terms of 'halfway houses'.³¹ Thus, in 1929, Heathcote Reception Hospital in Applecross was opened as a hospital for 'curable'

patients in line with the Commission's recommendations. As we saw in Gillgren and Brogan's chapter, the clear implication of this was that those people who remained in Claremont Hospital for the Insane were considered to be 'incurable'. For people with intellectual disabilities, nothing changed.

Intellectual Disability and Child Protection

In 1929 the State Government also established the State Psychological Clinic with Ethel Stoneman at its head. Dr Stoneman was particularly concerned about young women with intellectual disabilities and delinquent adolescents. In an early report she commented that:

their presence in the community entails very deplorable consequences both to themselves and to their associates. The serious defective girl constitutes a grave menace to normal family life and relationships.³²

This 'menace' presumably relates to their somehow being responsible for their own vulnerability to sexual abuse by men. She was also concerned about women with intellectual disabilities giving birth to children who, she assumed, would also be 'defective' and a burden on the State. She advocated a training scheme with a day occupation centre, residential and day schools, a training centre for delinquents, farm colonies for the 'backward' and for prisoners with intellectual disabilities, and in particular, she recommended the establishment of a system of registration and surveillance of people with intellectual disabilities.³³

It was not extraordinary that sexually active unmarried (and perhaps unmarriedable) women were seen as a threat to society. To some, sexually active unmarried women still are. Such thinking continues to underlie much of the discrimination women, especially young women, experience in Australian society generally, and perhaps the differential treatment afforded 'wayward girls' and delinquent boys by the juvenile justice system. It was comparatively late — towards the end of the nineteenth century — that Western Australia provided any real statutory protection for vulnerable women (particularly young women and, by 1902, women with intellectual disabilities) from sexual exploitation. To understand the debate about the 1929 Mental Defi-

ciency Bill for which Stoneman was largely responsible (see Gillgren and Brogan) it is important to have some idea of the development of other laws constraining sexual activity with vulnerable people.

Early English protective legislation was intended to protect young women (particularly those with property entitlements) from forced or premature marriage, or sexual relations which could not be legitimated by marriage. Canon law prohibited marriage with a person incapable of understanding the nature of the marriage ceremony or contract. In common law at the time of settlement of the Swan River colony, the age of consent to marriage was 12 years and to sexual relations 10 years.³⁴ Sexual relations without consent was rape, for which the penalty in 1829 was death. A woman with intellectual disabilities may or may not have had the capacity to consent. However, it was almost impossible for a minor or a woman — and especially if one were both — to give credible evidence in a Court of Law. Evidentiary and procedural requirements required that their evidence be corroborated, implying that they were likely to lie. A woman with intellectual disabilities would have had a nearly impossible task to establish the facts given such entrenched attitudes.

In 1892, the Parliament also passed legislation to make 'Better Provision for the Protection of Women and Girls', which created a variety of 'immorality' offences.³⁵ The *Criminal Code* 1902 created specific offences in relation to sexual relations with 'idiots' and 'imbeciles', which were subsequently repealed and re-enacted in the present *Criminal Code* 1913 but substantially amended in 1988.³⁶

In the nineteenth century, the State also began to take a more active role in protecting the interests of children. The traditional common law approach had been to leave them in the care of their parents, whose rights to custody were a sufficient claim to autonomy from State interference except where general criminal laws were infringed. Over the second half of the nineteenth century, the State began to take steps to intervene civilly if a child was found to be in need of protection, particularly economic support, but also protection against physical cruelty or neglect. Of course, children with intellectual disabilities were particularly vulnerable to exploitation or neglect. In many respects, adults with intellectual disabilities were considered to be children who had failed to mature and who needed similar protection.

In 1907, the Western Australia Parliament enacted the State Children's Act which provided for State intervention to protect children

from physical abuse and neglect.³⁷ Until that time, industrial and health legislation had dealt with some aspects of child protection.³⁸ The new Act established a State Children's Department and made provision for the apprehension by the State of children who seemed to be neglected or abused, on grounds closely allied to ancient English 'vagrancy' provisions. Similar grounds for apprehension still appear in the *Western Australian Police Act 1892*. The provisions were based on a belief that the homeless were liable to drift into a life of 'vice or crime'.³⁹ Much the same fears were expressed about homeless people with intellectual disabilities.

The 'protective' approach of the criminal and developing 'child welfare' law was, however, only partly consistent with the views expressed in 1929. During the debates about the Mental Deficiency Bill, the Parliament's primary concern was the 'protection' of society and the 'race' from both the behaviour of sexually active women and the continued 'breeding' of mental and physical 'defectives'.

A Select Committee of the Legislative Assembly was established to consider the Bill's provisions. The committee members sought to extend the registration provisions of the Bill into a system of social control well beyond its original intent. The Bill's most controversial aspect was s. 26(14) which provided for the conditional release of a 'defective' from an institution; the condition was surgical sterilisation. The Select Committee enthusiastically recommended that the clause be amended to also require sterilisation of sexual deviants, paedophiles, murderers and rapists, and women who had been pregnant with illegitimate children on two or more occasions but who were unable to name the child's father. As we saw in Gillgren and Brogan's chapter, the Bill was allowed to lapse. One reason was the expense of the expanded proposal, but it could also perhaps have been attributed to the fact that Stoneman, one of its most ardent advocates, was a clinical psychologist rather than a doctor, and also a woman. Fortunately, the Bill's proposals for the registration, incarceration and surveillance of women and children with intellectual disabilities came to nothing.⁴⁰

The Late 1920s to the 1950s

From the late 1920s until the 1950s there is very little evidence of legal change, development or innovation regarding people with intellectual disabilities. Children with intellectual disabilities could receive in-

struction at 'special schools' (see Carman-Brown and Fox); but though the medical profession separated, to some extent, the care of psychiatric patients and people with intellectual disabilities, there was no separate administration of those services. A considerable number of people with intellectual disabilities continued to be accommodated in mental hospitals and were subjected to the same regime as patients with mental illness. Some had been admitted at birth under the provisions of the *Lunacy Act 1903*, and some as a result of apprehension by police or appearance in a court upon a committal for trial of an offence.⁴¹ Such offenders could be detained in the same way as the 'criminally insane'.⁴²

However, great changes were beginning. First, the Government began to consider a comprehensive approach to the law about 'mental disorder'. The *Mental Treatment Amendment Act 1940* and the *Lunacy Act Amendment Act 1950* indicated an intention to consolidate legislation concerned with 'mental disorder'.⁴³ The latter was prompted by the findings of the Royal Commission into alleged brutality at Claremont Hospital for the Insane which found that there were inadequate procedural safeguards to the patients' rights of complaint of ill-treatment. One member of the Board of Visitors was particularly criticised because he had failed to inform himself that a 10-year-old boy had been detained for at least six months in a ward with criminals and violent patients. Had the Visitors seen every patient, to give them the opportunity of complaint as they were obliged to do, this would not have occurred. Medical advice was that the boy would not have been capable of making a complaint.⁴⁴

Second, as we have seen in Gillgren and Brogan's chapter, there had been persistent calls for the provision of services for people with intellectual disabilities to be separated from services for people with mental illness. In April 1951 the Slow Learning Children's Group was formed and in 1953 it established Irrabeena as a treatment and assessment centre. In 1954, with the support of Nathaniel Harper, the Government set up the Nathaniel Harper Homes for children with intellectual disabilities at Guildford. The Stoller Report (1955) commented favourably on the development of skills by individuals with intellectual disabilities at the home.⁴⁵ However, the law did not reflect the special nature of services for people with intellectual disabilities. Nor did the health bureaucracy. Separate administrative bodies were not established until the 1960s, following the establishment of separate community residential care facilities for children with intellectual

disabilities. This facility was established not by Government, but by the Slow Learning Children's Group on its own initiative.

The 1960s Onwards

The enactment of the *Mental Health Act* 1962 and the consequent repeal of the *Lunacy Act* 1903 heralded the beginning of the modern approach by the law to 'mental disorders'. The Act defined 'mental disorder' to mean mental illness, arrested or incomplete development of mind, 'nervous disorder', psychopathic disorder or any other disorder or disability of mind, however acquired. The definition included alcohol and drug addiction and mental infirmity due to old age or physical disease. The Act, like its predecessors, established an administration; contained provisions for services and hospitals and private services; made provision for the admission, detention and discharge of patients and their protection; and also provided for the care and management of the estates of incapable persons.

Section 47 of the Act provided:

- 47 (1) Where a person who, being committed to stand trial for any offence, —
 - (a) is found by two medical practitioners to be suffering from mental disorder to the extent that he ought not to stand trial;
or
 - (b) is found, under section six hundred and fifty-two of The Criminal Code, not to be of sound mind, the Chief Secretary may direct, by order under his hand, that he be admitted as a patient to an approved hospital and there be detained until the superintendent or another psychiatrist certifies that he is fit to be discharged; and the Chief Secretary shall, thereupon, order that the patient be removed to the place whence he came prior to admission as a patient.
- (2) The fact of a person being a patient under this section does not operate as a bar to his subsequent indictment and trial.

Section 48 provided for the admission of persons ordered to be kept in custody until Her Majesty's pleasure was known or during the Governor's pleasure. In the *Mental Health Act Amendment Act 1964* 'mental disorder' was re-defined to mean 'any illness or defect that substantially impairs mental health'. It applied a new section to persons incapable — by reason of any mental illness, defect or infirmity, however occasioned — of managing his affairs.⁴⁶ The *Mental Health Act Amendment Act 1965* inserted the word 'intellectual' into the definition of 'mental disorder'. It introduced the definition of mental illness as meaning 'a psychiatric or other illness that substantially impairs mental health' and a further definition of 'intellectually defective' as 'suffering from arrested or incomplete development of mind'.⁴⁷

These amendments have been detailed because they demonstrate that even in very recent times the State has been struggling to have the law accurately describe the variety of 'mental disorder'. Intellectual disability, as we now understand it, was simply not separately recognised in the law.

The late 1960s and early 1970s proved to be a turning point in the reshaping of public attitudes to people with intellectual disabilities and how best they might be supported. As we saw in Leonie Stella's chapter, during this period Australia was being influenced by a number of social and philosophical forces including the influence of parent advocacy, the beginnings of the normalisation principle, the growth of the human rights movement world-wide, and increased government funding and involvement. These developments presented a strong and coherent challenge to the prevailing views of disability that supported the custodial and institutional approaches to services resulting in congregation and segregation of people with intellectual disabilities.

In 1971, Australia became a signatory to the United Nations Declaration on the Rights of Mentally Retarded Persons and, in 1975, to the UN Declaration of the Rights of Disabled Persons. These Declarations emphasised that people with disabilities should have access to opportunities that are available to all citizens: to the 'inherent right to human dignity', to 'enjoy a decent life, as full and normal as possible', and to services which 'enable them to develop their capacities and skills to the maximum and hasten the process of their social integration and re-integration'. The proclamation of 1981 as the International Year of Disabled Persons provided a further impetus for governments, con-

sumers and service providers to re-examine their attitudes towards the way services were being provided to people with disabilities.

Change in the 1980s

Following the International Year of Disabled Persons, calls for reforms to help people with disabilities overcome the disadvantages they still experienced gained momentum, and from the mid 1980s considerable legislative development — especially in enabling and anti-discrimination and protective legislation — was passed through Australia's parliaments.

The involvement of the Federal Government in disability policy until the 1980s was largely restricted to the payment of pensions, benefits and direct services through the Commonwealth Rehabilitation Service; the support of sheltered workshops; and the provision of funds to non-government organisations through the *Handicapped Persons Assistance Act 1974*.⁴⁸ However, in 1983, the new Labor Federal Minister for Community Services sponsored three initiatives that were to have a profound effect on disability service delivery throughout Australia. The first was the funding of an Australian chapter of Disabled Peoples' International; the second the establishment of the Disability Advisory Council of Australia that consisted of people with disabilities and their advocates; and the third was the setting up of the Handicapped Programs Review. The latter has been acclaimed as a landmark development in the field of disability in Australia and resulted in the enactment of the *Disability Services Act 1986*. This Act provided, for the first time, recognition of personal aspirations, realisation of potential, and the enhancement of independence and self-esteem. The transition from institutional to community based services became a major purpose of the new Act and the policies surrounding it.⁴⁹

In 1981, The Hon. Ray Young, then-Minister for Health in the Liberal Government in Western Australia, submitted a memorandum to Cabinet which stated:

It has been accepted that intellectually handicapped persons are not ill and in the main should not be treated under the auspices of Mental Health Services unless they in fact also suffer from some form of mental illness.

The Government then set up a Working Party on the future delivery of services for people with intellectual disabilities in Western Australia with Professor Arthur Beacham as Chairperson. This Working Party was one of three which were part of a wide-ranging Government Mental Health Legislation Review. The Review was to consider three pieces of enabling legislation: changes to the law dealing with the care and treatment (including compulsory detention) of people with psychiatric illness; adult guardianship legislation; and the establishment of a statutory authority for intellectual disability. After canvassing a number of options, the Beacham Report recommended the establishment of a statutory authority under the direction of a Minister, and in 1985 the *Authority for Intellectually Handicapped Persons Act 1985* was passed by Parliament.⁵⁰

With this enactment, statute law in Western Australia gave positive recognition to people with intellectual disabilities for the first time. The Act removed the definition of 'intellectually defective' from the Mental Health Act and re-defined 'mental disorder' in that Act to exclude intellectual disability. The recognition by law that intellectual disability was not mental illness and that people with intellectual disabilities had the full range of human rights and dignities was a major achievement in a State where previously the primary legal response had been to detain this group and forget them.

However, the Mental Health Legislation Review's recommendations were not fully implemented. The new guardianship legislation was eventually proclaimed in 1990, but there is still no outcome of the reforms recommended to the Mental Health Act. In addition, not every aspect of the special needs of people with intellectual disabilities was fully addressed. Of great concern was the Government's failure to address the problem of people with intellectual disabilities who offend. Western Australia had no provision for 'diminished responsibility', and such offenders had either to take advantage of the defences available to all offenders under the Criminal Code, or seek to have their intellectual disability taken into account in some way in mitigation of sentence. The Code's provisions dealing with the liability of people deemed by the court to be 'insane' were not reviewed at the same time as the civil aspects of mental health law.

In 1989, Michael Murray QC conducted a Review of the Western Australian Criminal Code and also made recommendations about the defence of diminished responsibility and the custody of people with

intellectual disabilities who offend. In 1991, the Western Australian Law Reform Commission was asked to review the law with respect to 'mental disorder' as a defence to criminal charges. Given that the Commission recommended that the 'insanity' defence remain the same, it must be of serious concern that no special provision has been made for the detention, treatment or punishment of people with intellectual disabilities who offend. The Disability Services Commission (previously the Authority for Intellectually Handicapped Persons) does not have the capacity, nor the statutory duty, to provide custodial care or detention for people with intellectual disabilities; nor does Psychiatric Services, since the removal of 'intellectual disability' from the purview of the *Mental Health Act 1962*. The result is that persons found to be guilty of a criminal charge, not capable of standing trial, or guilty but not capable of being sentenced for a crime because they are legally 'insane' must be detained at Her Majesty's pleasure. Normally this means in prison, which is surely not appropriate for people with intellectual disabilities. People with mental illness who offend can be treated in an appropriately secure psychiatric hospital or forensic facility. A person with intellectual disabilities, unless also mentally ill, cannot. The development of separate services and administration of services for people with intellectual disabilities has not changed the nature of the penal provisions of the criminal law, nor the operation of mental health law generally. Because of the splintering of the reform initiatives in 1984, it has had an unintended effect of removing a refuge — the psychiatric facility — for people with intellectual disabilities who offend who are otherwise confined within an inappropriate penal system. The failure to review the whole of mental health law defeated the apparent purpose of government at that time to provide a comprehensive overview of all mental health legislation. (For an extended historical account of the criminal law and intellectual disability see Hall and Bavin-Mizzi.).

Two more statutory changes occurred in Western Australia in the late 1980s. First, in 1988, amendments to the Criminal Code extended (and updated) the Code provisions prohibiting sexual relations with people whose condition made them unable to give a free and genuine consent. The amendments to the Code also removed the now offensive terms 'idiot' and 'imbecile' while retaining their protection. Second, the *Equal Opportunity Act 1984* was amended. Under that Act it now became unlawful to discriminate in employment, education, accommo-

dation, goods, services and facilities, and clubs on the basis of 'impairment'. 'Impairment' was defined to include mental illness, brain injury and intellectual disability.

There were also three important initiatives by the Federal Government in disability policy in the early 1990s. First, in 1991, all State and Commonwealth Ministers signed the Commonwealth-State Disability Agreement. This rationalised the roles of each level of government on disability matters. The Commonwealth became responsible for funding all employment services to people with disabilities, and the States were responsible for accommodation and support services. The Commonwealth-State Disability Agreement also proposed and encouraged a national legislative framework by requiring all States and Territories to pass legislation similar to the *Disability Services Act 1986*.

The passing of the *Disability Discrimination Act 1992* was the second important initiative by the Federal Government.⁵¹ The Act came into effect in March 1993 and sought to provide uniform cover for everyone in Australia against discrimination based on a disability. It filled in the gaps in protection given by existing State and Territory legislation, and expressly preserved the operation of all aspects of these Acts capable of operating concurrently with it. The Act made it unlawful to discriminate on the basis of physical, intellectual, psychiatric, sensory, neurological and learning disability. Under the Act, discrimination on the basis of disability became unlawful in the areas of work; education; access to premises; provision of goods, services, facilities and land; accommodation; clubs and sport; and the administration of Commonwealth Government laws and programmes. The Act applied to actions by Commonwealth Government departments and authorities, State and Local Government, and corporations and others in the private sector. It established a system whereby people with disabilities who felt they had been discriminated against on the basis of their disability — such as in access to government services — could lodge a complaint with the Human Rights and Equal Opportunity Commission and obtain redress if their complaint was found to be valid.

The third initiative occurred in April 1993 when the Commonwealth Government, through the Commonwealth Office of Disability, undertook a process to develop an Australian Disability Strategy based on United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities and the *Disability Discrimination Act 1992*. The Australian Disability Strategy builds on the enabling, anti-dis-

crimination policies of the Disability Discrimination Act in proposing a national process for the attainment of equal opportunity goals for people with disabilities.

In that year in Western Australia, the *Authority for Intellectually Handicapped Persons Act 1985* was replaced by the *Disability Services Act 1993*, which established an independent statutory body. By integrating two previous disability agencies — the Authority for Intellectually Handicapped Persons and the Bureau of Disability — the Disabilities Services Commission came into being in December 1993. The *Disability Services Act 1993* widened its definition of disability to include intellectual, psychiatric, cognitive, neurological, sensory or physical impairment. The Disability Services Commission had become the only autonomous government organisation in Australia with specific responsibility for people with disabilities.

Conclusion

It is one thing to prohibit discrimination and another to ensure that services and structures for vulnerable people are appropriately structured and funded. Legal rules have dealt very poorly with the many different aspects of intellectual disability, and it is difficult to perceive any coherent policy behind them. It may be unrealistic to hope for legislation of a coherent nature about a condition that still makes uninformed people feel uncomfortable. The growth of dedicated law reform and policy development bodies in the 1960s and 1970s seemed to offer hope of explicit, comprehensive and independently informed legal policy-making. That it has not eventuated seems to reflect the noticeable lack of enthusiasm of all governments in the 1990s for putting the money that is necessary into agencies established to promote social change and the improvement of the quality of life of those who cannot advocate their own interests well.

For most of the century following settlement of the colony, intellectual disability was perceived as an 'incurable' condition, dealt with either by restraint or seclusion. This response is no longer socially or professionally acceptable. Because the laws were inadequate or silent, professional groups made their own informal arrangements, for example, by administrative separation of people with mental illness and residents with intellectual disabilities in Claremont Hospital for the Insane. Professional opinions on 'treatment' and care are influential in

informing judicial decision-makers in legal 'protective' and other processes. Professional rules, definitions and guidelines also limit or widen access to services for people with intellectual disabilities, even if those people might fall within statutory definitions. Those rules could mean a very big difference in the lives of people with intellectual disabilities.

Professional standards should have a recognised function in the legal rules governing intellectual disability. They should be demonstrably appropriate for not only professional and resource allocation decisions but also a system of rules and services, so that they work together as a whole. The situation where some people with intellectual disabilities may not qualify under the informal, professional guidelines for access to services, and yet, under explicit legal rules, be civilly incompetent, incapable of standing trial, or liable to different outcomes if charged with criminal offences is unacceptable. It may well be that professional guidelines or codes of conduct should be established in the form of a statutory professional description of intellectual disability. Even people with intellectual disabilities are categorised, professionally, according to their level of disability. The law has a responsibility to protect the rights of dependent people. If it is not to be avoided by informal, professional rule-making or bending of rules, law must attract professional as well as community support.

New services and legislation for people with intellectual disabilities did not arise because the medical professions decided they should. The response by the law in the late twentieth century to intellectual disability is a success story for families and ordinary citizens who formed interest groups, demanded government action, and who were prepared to go out and start the service themselves. They should not be left unresourced and excluded as 'volunteers' or clients. They should be a part of the rule-making, service-development process.

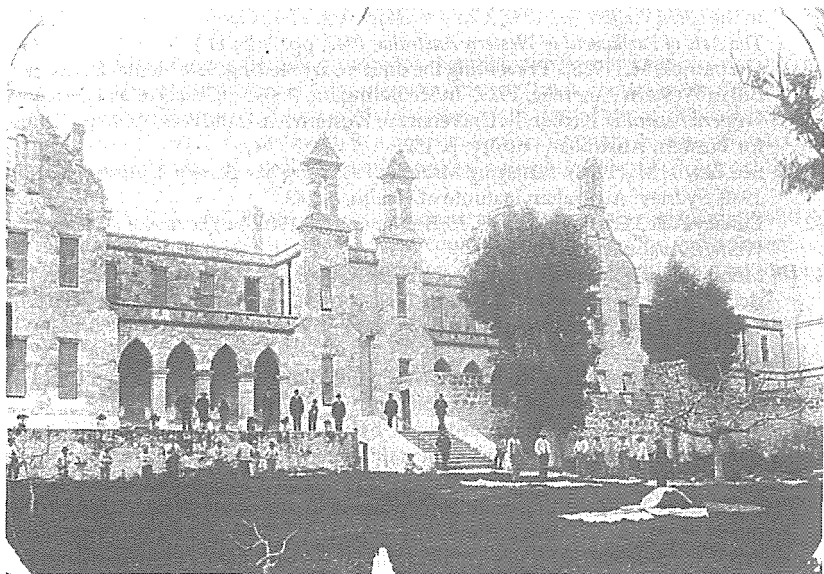
A humane and just society ensures that the rights of its most vulnerable members to dignity and respect are promoted and protected. The sophistication and proliferation of claims to special consideration in our highly geared (and economically rationalist) society means that this protection cannot be left solely to legal or medical professionals. Conscious, informed, and independent policy development which involves people with intellectual disabilities, their carers and friends is most likely to result in real and comprehensive reform.

Notes

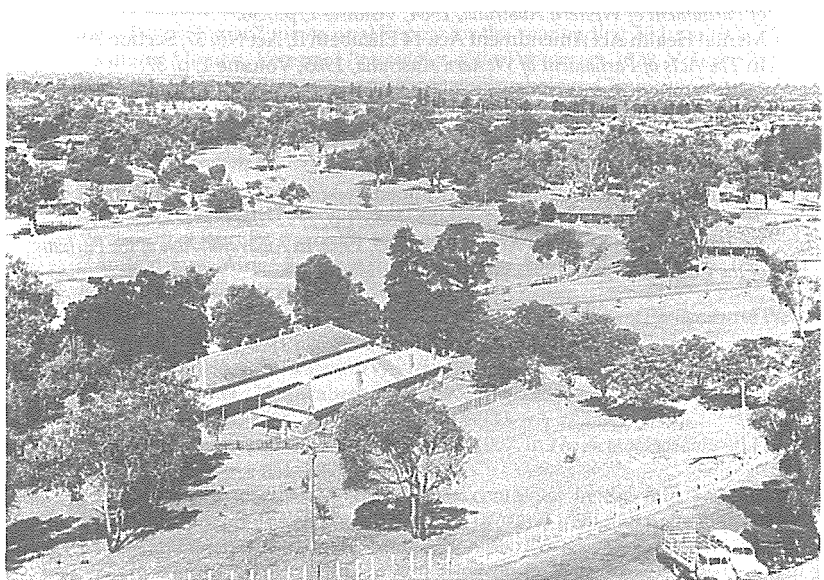
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20. *ibid.*, pp. 80-81
21. Ellis, A. S. (1984). *Eloquent Testimony: A Story of Mental Health Services in Western Australia*. Nedlands: University of Western Australia Press. p. 27.
22. See Bottomley, S., *op. cit.*, p. 37.

23. The member for West Province, Mr Briggs, seeking the establishment of schools for children with intellectual disabilities. *Western Australia Parliamentary Debates*, Volume 23, 1903, p. 533.
24. See for instance s. 84, which provided that the Governor may appoint wards/cells for observing prisoners who were 'insane' or 'from mental imbecility may be supposed to be unfit for penal discipline' until they were certified either fit or 'insane' and fit for detention in a hospital for the criminally insane. The Act also provided for the boarding out of 'harmless' patients (Lunacy Act., op. cit., Section 99).
25. Section 146 required the Master to examine any 'insane' patient personally and the Court, acting on the Master's advice, could make orders for the appointment of a guardian or otherwise for the protection, care and management of the person or of the estate.
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27. See *Western Australia Parliamentary Debates*, Volume 63, 1920, p. 2623 for the comments of The Hon. J. E. Dodd (South) who remarked that 'it seems we are almost entirely in the hands of the experts with regard to the administration of the institutions'.
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29. See *Williamson v. Brown* 18 CLR 433 per Griffiths C. J. at 423.
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38. The relevant protective legislation was contained in the four Industrial and Reformatory Schools Acts passed between 1874 and 1893, and part of the *Health Act 1898* which related to Infant Life Protection (see Rayner, M. E. (1991). 'The history of the law's response to incest.' In Hetherington, P. (Ed.). *Incest and the Community: Australian Perspectives*. Nedlands: Centre for Western Australian History.).

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44. The Report of the Royal Commission Appointed to Inquire into Alleged Cases of Brutality at Claremont Mental Hospital, Transcript of Evidence, 32.
45. In 1954, Dr Alan Stoller was seconded by the Commonwealth for the Federal Minister for Health to report on mental health facilities and needs throughout Australia. An outstanding feature of his report was the documentation of the existence of overcrowding caused by a shortage of something like 10,000 beds. The report caused a public outcry and led the Federal Government to fund the States to upgrade the standards of mental hospitals to at least those of general hospitals. Stoller, A. (1955). *Report on Mental Health Facilities and Needs of Australia*. Commonwealth Government of Australia: Canberra. For the resulting legislation see *Mental Institution (State Grants) Act 1955*.
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51. Disability Discrimination Act. Act No. 135, 1992. In *Australia, Acts of the Parliament of the Commonwealth, 1992*, Volume 3, pp. 2792-2849.



1 *Fremantle Asylum showing inmates and warders, 1897. Courtesy Battye Library, Perth.*



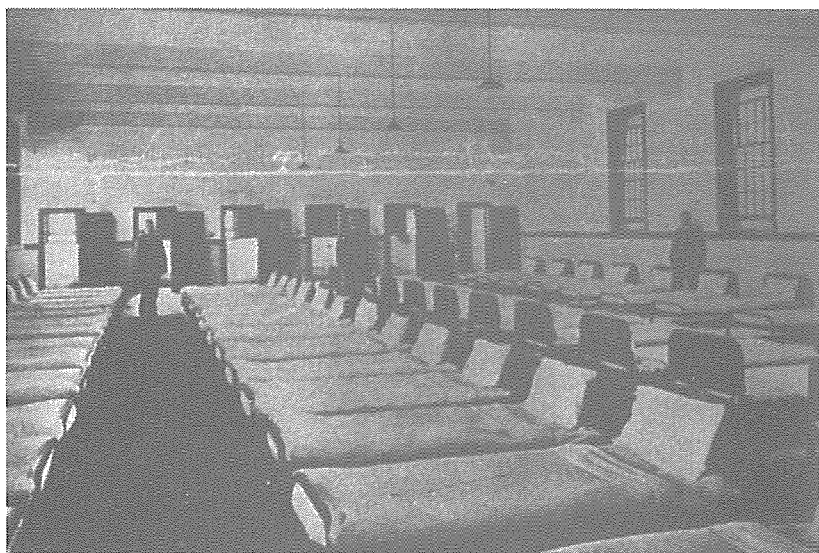
2 *J Ward, 'where the children go', Claremont Hospital for the Insane, circa 1950s. Courtesy Mental Health Museum, Graylands Hospital.*



3 *Pyrtton Training Centre, opened 1966. Courtesy Disability Services Commission.*



4 *Living in the community, circa 1985. Courtesy Disability Services Commission.*



5 *Male Dormitory, Claremont Hospital for the Insane, 1912. Courtesy West Australian Newspapers.*



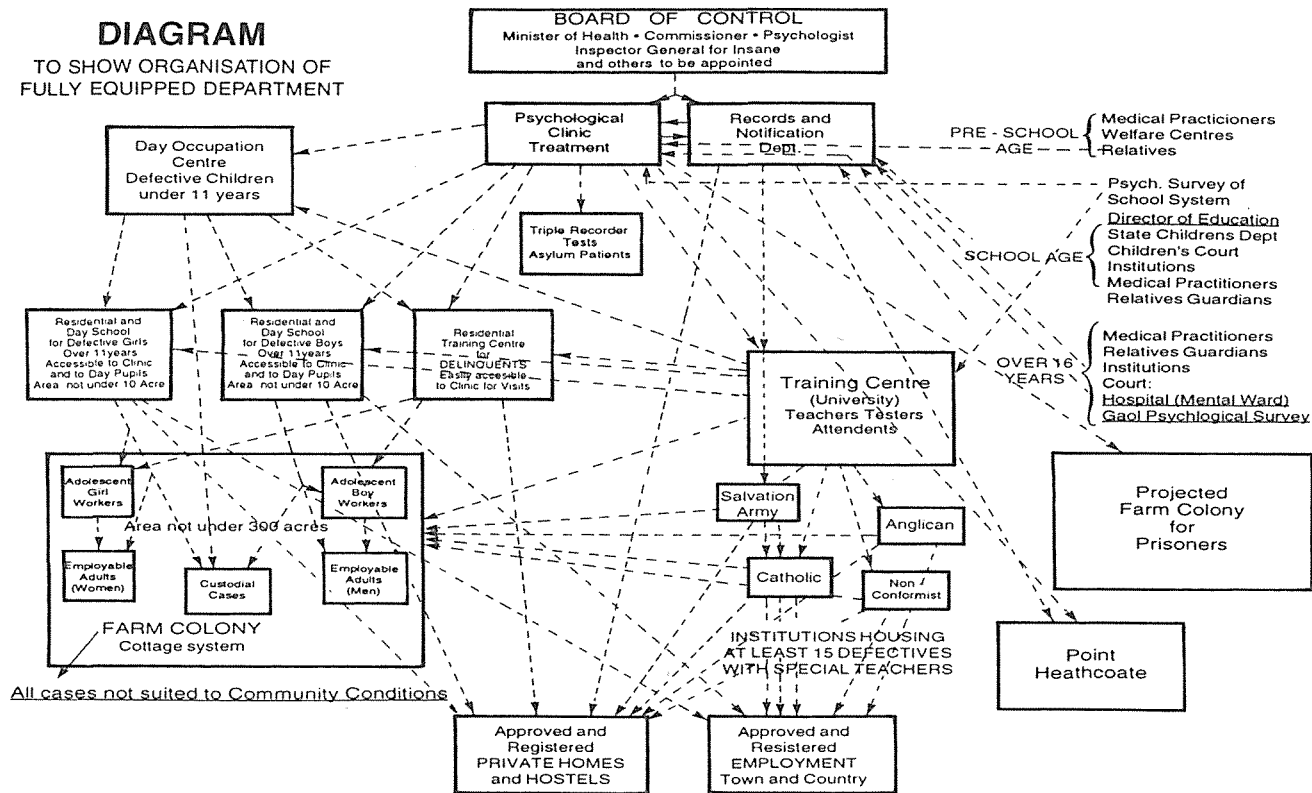
6 *Male Dormitory, Swanbourne Hospital, 1977. Courtesy West Australian Newspapers.*

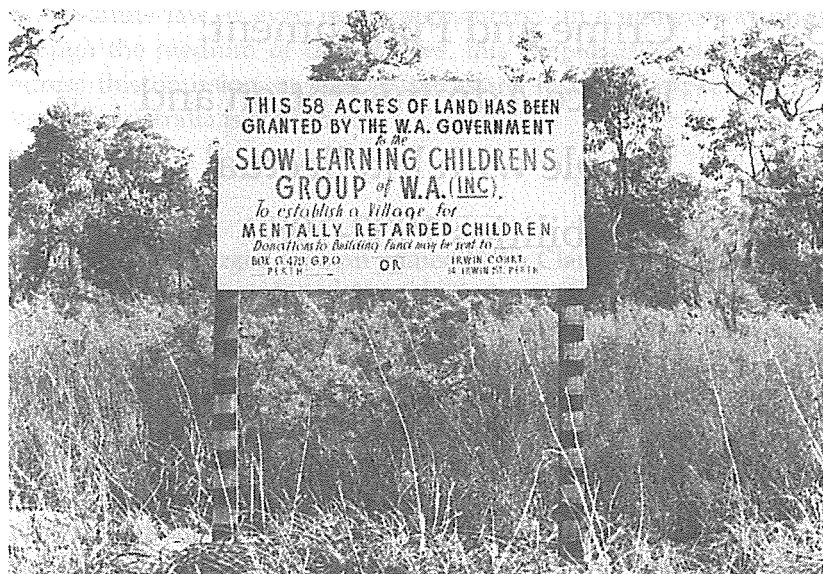


7 *Attendant, Claremont Hospital for the Insane, circa 1920. Courtesy Mental Health Museum, Graylands Hospital.*



8 *Opening the Slow Learning Children's Group Minbalup Occupation Centre, 1954. Courtesy Activo Foundation.*





10 Announcing Hawkevale Farm Colony for Mentally Retarded Children, 1957. Courtesy Activo Foundation.



11 Demonstrating at Tresillian, 1976. Courtesy West Australian Newspapers.

5 Crime and Punishment: Justice Administration and People with Intellectual Disabilities 1900-1989

Guy Hall and Jillian Bavin-Mizzi

Introduction

Contemporary debate on the criminal justice system and people with intellectual disabilities extends across many issues: apprehension and arrest; fitness to plead and to be tried; court procedure; sentencing and disposition, to name only the most talked about and prominent on the reform agenda. A stimulus to this work in the Australian context has been the scholarship of Susan Hayes and others, which has pointed to the over-representation of people with intellectual disabilities in our prison population.¹ Bedevilled as it is by methodological and other problems, professional agreement has not yet emerged about the correct statistical statement of this problem. However, Hayes confidently points to an over-representation of people with intellectual disabilities in the prison population of some three to four times that of the general community and a similar over-representation among victims of crime.² While such findings have given valuable impetus to research, to changes in procedure and the beginnings of law reform, what can be said of our efforts to document the history of interaction between people with intellectual disabilities and the criminal justice system? It would be pleasing to report progress in the Australian context. But a review of the literature shows that what little history has been written belongs to the revisionistschool, may be said to be mostly administrative in kind and is often incidental in content on people with intellectual disabilities; in other words, it is primarily intended as a history of psychiatry. The record on justice administration, where historical exposition is mostly limited to retrospective studies of rel-

evant statute law, is even more fragmentary. In a limited way and through the medium of case studies, this chapter is an attempt to redress this omission, at least as far as the historical experience of Western Australia is concerned.

Case of Jack Moon

In 1905, a middle-aged woman named Delia Clarke moved into Jack Moon's house as his defacto wife. While she tended to the housework and raised poultry, Moon spent his working week away from home, gardening for a local landowner. He returned home each weekend. From the time they shared house together, the couple quarrelled frequently. Neighbours often heard their rows and over the next few years were occasionally approached by both Moon and Clarke with accounts of their domestic 'troubles'.

A local constable, P. C. Young, received a telephone call from Delia Clarke late one night in June or July 1907 'making a complaint' about her 'husband'. The following day, Moon visited Young and said that he was glad no one came out to investigate the complaint. Moon explained that 'it was only the old woman and myself having a row which we often have'. He told Young that Clarke was a big woman who 'always got him down' but this time he 'got her down and had given her a good doing to show that he was the boss'.³ A few weeks later Clarke said to her neighbour Mary Edwards, 'my life is in danger of that man'.⁴ Clarke was not alone, however, in either her fear or experience of domestic violence. In August, Frederick Nairn, their next-door-neighbour, found Moon on his doorstep with a bloodied arm, too frightened to return home. According to Moon, Clarke had attacked him with a shovel when he told her that he had lost his job.⁵

By November of that year Delia Clarke decided to leave Moon. On Wednesday 20 November she visited two land agents, showing them a Certificate of Title for some land in Guildford and inquiring about the cost of building a one-roomed cottage. Both agents told her that they would prepare quotes for her by Monday.

On the Saturday night before Clarke was due to collect these quotes, the next-door-neighbours were sitting on their front veranda with a friend. They heard Clarke cry out, 'Oh Jack, Oh Jack!' Thinking that Moon and Clarke were again quarrelling they went inside and shut their door. The next day, Moon told them that Clarke had come to him

and said, 'Goodbye Jack. I am going. We might have lived better together but never mind. Say nothing about it'. Moon broke down and cried, saying 'With all our rows I wish she were here now'.⁶

When Clarke had not returned by the following Saturday a neighbour informed the police that she was missing. Two constables went to Moon's house and found Clarke's clothes, her only pair of earrings and her wedding ring. Later that day they returned with Detective Mann.⁷ The detective decided to search the house again. He found Clarke's bank book and her Certificate of Title for the Guildford property. An even more important find, in his eyes, was the string of rosary beads that he found locked in a trunk. He told Moon that he was sure Clarke was dead because, as a Catholic, she would rather have cut her hand off than leave the beads behind.

While Detective Mann was speaking to Moon about the rosary beads, one of the constables called him into the kitchen. Constable Frazer had removed some linoleum, exposing a freshly disturbed area of earthen floor. Frazer began poking the ground with a three-foot broom handle. Moon offered to sharpen the handle for him so that it would penetrate deeper into the earth. He took out his pocketknife and sharpened the wood. After prodding for a while longer to no avail, the three policemen left.

Late that night Moon's brother-in-law, Charles Hunt, telephoned Inspector Connell. Hunt claimed that Moon had come to him and admitted killing Clarke after she had rushed at him with an axe. Hunt tried to dissuade Moon from fleeing to Coolgardie, imploring him to give himself up to the police. Moon had then returned home, he believed, to consider this advice.

Inspector Connell called Detective Mann and arranged to meet him at Moon's house. They arrived at 2 a.m. and found Moon lying in bed reading the paper. When Mann placed him under arrest for the wilful murder of Delia Clarke, Moon retorted, 'You will have to prove it'. Moon then thought for about a minute, became very excited and said, 'I will tell you all about it. You know where she is, Mann. You found her this afternoon'. He told them that Clarke had come to say goodbye with an axe concealed in her clothing. When she struck at him with the axe he wrestled it from her, punched her in the stomach and strangled her. Moon pointed to the kitchen floor and said, 'She is down there seven feet in the ground lying face downward'. As they left the

house he added, 'I've had an awful time of it and I've slept better this last week than I did for three years before'.⁸

On Sunday 1 December Detective Mann supervised the exhumation of Clarke's body. She was lying face down — as Moon had said — encased in lime. Clarke was naked and there was no wedding ring on her finger.

The early newspaper reports of this case paid particular attention to Moon's temperament. They cited Moon's sister, Mrs Hunt, who claimed that her brother's temper was a 'nasty one' and she had often feared that 'in some more vigorous quarrel her brother would lose control of himself, and do something dreadful'.⁹ While the *Daily News* accepted that Moon had this 'nasty temper', it immediately repudiated any suggestion that he had 'lost control of himself'. The report stressed Moon's calculated disposal of Clarke's body and the 'callousness' with which he slept in a bed directly above her makeshift grave.¹⁰

According to the press, Moon knew precisely what he was doing when he killed Mrs Clarke. The *Daily News* cited Moon's taunts to the police as evidence of his 'cunning'. Moon, it claimed, seemed to have derived some satisfaction from the fact that even though Frazer shoved the stick the full length into the sand it was still three feet above his victim. The *West Australian* reiterated this sense of 'calculation', reminding the public that Moon had been so thorough in covering up his 'inhuman deed' that he had nearly escaped detection.¹¹

In the proceeding months, however, the *Daily News* claimed that Moon was increasingly showing signs that his 'mental balance was unhinged'.¹² There was some question as to whether he was fit to plead. The Attorney General instructed the Inspector General for the Insane, Dr Montgomery, to examine him. After interviewing Moon in Fremantle Prison Montgomery concluded that he was quite capable of understanding the nature and consequence of his plea.¹³

The case was heard in the Perth Supreme Court on 24 March 1908. After witnesses for the prosecution had given their evidence, Mr Clifton Penny spoke for the defence. Penny argued that Delia Clarke had been killed accidentally when Moon sought to defend himself from her attack. This, he claimed, was sufficient defence to acquit any man. At the same time, however, he introduced another, quite separate line of defence. Penny told the jury that Moon had been examined in February by Dr Montgomery, and while he was pronounced fit to plead there was

still some doubt as to his state of mind. Jack Moon was a person with intellectual disabilities. Penny called upon Montgomery to relate the findings of his examination.

Dr Montgomery testified that Moon was not a man of 'ordinary intelligence'. He was 'weak-minded' and 'childish' and — although ordinarily he would understand what he was doing — he could not prevent himself from losing control. He would not have killed Clarke in a fit of temper but in a moment of mental weakness. In Montgomery's estimation, Moon 'had never had a proper brain'. He was 'mentally defective' from birth.¹⁴

After Montgomery had given his diagnosis, Penny read out the section of the *Criminal Code* 1902 relating to diminished criminal responsibility on the grounds of insanity. According to s. 27 of the Code:

A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission he is in such a state of mental disease or natural mental infirmity as to deprive him of capacity to understand what he is doing, or of capacity to control his actions, or of capacity to know that he ought not to do the act or make the omission.¹⁵

Penny then asked Montgomery whether, in his opinion, Moon's case came within the meaning of this section. Montgomery believed that it did. He argued that while Moon was not 'insane' — he was not suffering from any 'mental disease' nor was he ordinarily incapable of understanding what he was doing — he was suffering from a 'natural mental infirmity' which deprived him of the 'capacity to control his actions'.¹⁶

In his address to the jury, the Attorney General dwelt upon the same argument outlined in the local newspapers. He claimed that Moon's behaviour after killing Clarke implied that he knew what he was doing and was in control of his actions. The presiding Judge, Justice Rooth, supported this position. In his summing up, Rooth said that:

the man who they had been told, could not in moments of excitement, control his actions, calmly stripped the body and buried it seven feet in the ground, covering it first with a few inches of lime. It was true that the prisoner said he

did that while in a frenzy but his frenzy did not prevent him from remembering what he had done and misleading the detectives.¹⁷

Rooth and the Attorney General found Montgomery's 'expert' diagnosis problematic. The point of contention was not whether Moon knew what he was doing at the time of the killing — all, even Montgomery, were convinced that he did. The difference of opinion lay, rather, in the question of his 'loss of control' and its connection to intellectual disability.

Justice Rooth conceded the possibility of some mental weakness. At the same time, however, he told the jury that 'just because a man was excitable or of weak intellect, it did not entitle him to go about murdering people'.¹⁸ With this, Rooth directed the jury to the central legal issue under debate. Section 27 of the Code, he argued, was designed for the protection of the 'insane' and no one, not even Montgomery, had claimed that Moon was 'insane'. Rooth informed the jury that if, as the Attorney General suggested, Moon knew the difference between right and wrong and knew what he was doing, then they would not be justified in finding him free from criminal responsibility under s. 27 of the Code.¹⁹ When the jury returned a verdict of manslaughter and Rooth sentenced Moon to 10 years imprisonment, the defence counsel challenged Rooth's interpretation of s. 27 and lodged an appeal to the Full Court. The appeal was dismissed.²⁰

Jack Moon was sent to Fremantle Prison to serve his 10-year sentence. At this time, the prison had only a rudimentary system of classification based on the length of a prisoner's sentence.²¹ The 'mentally weak' were not segregated within the prison system and there were no special programmes or policies for their care or rehabilitation. Within the historical record, then, Moon merged into the general prison population. Aside from his receiving one formal punishment during his first three years in Fremantle Gaol for fighting with another prisoner, little information concerning Moon's prison life is retrievable.²²

The absence of policies and programmes for the care of people with intellectual disabilities who offend reflected a more general dearth of policy development in Western Australia. In 1912, four years after Moon's trial, Dr Montgomery was asked by his departmental Under Secretary, F. D. North, to outline the general methods used in handling

people with intellectual disabilities in the State. Montgomery wrote back to North stating that there were 'no methods adopted here dealing with persons who are mentally deficient, although not sufficiently so to be regarded as insane'.²³

This lack of policy development was not through want of trying on Montgomery's part. In 1911 he and his assistant at Claremont Hospital for the Insane, Dr Birmingham, attempted to persuade the State Government to recognise the special position of the 'feeble-minded'. That year, Montgomery requested funding by the Chief Secretary's Department to send Birmingham to Britain and the United States to investigate their methods for dealing with people with intellectual disabilities.²⁴ The Chief Secretary's Department agreed to this request. Birmingham spent the following months questioning prominent British and American psychiatric 'experts', visiting their institutions and compiling a report of recommendations for future policy development. He returned in November 1911 and presented his report to the Chief Secretary's Department.²⁵

As has been described in Gillgren and Brogan's chapter, the Birmingham Report reflected eugenicist fears of 'race suicide'.²⁶ In his report Birmingham claimed that the 'mentally deficient', by producing 'abnormally large' numbers of 'deficient', 'insane' and 'epileptic' children, would inevitably bring about the 'degeneration of the race' if left to go unchecked within the community.²⁷ Birmingham concluded that the only effective means of preventing such degeneration was the 'compulsory and permanent segregation of mental defectives'.²⁸ He was particularly adamant that 'criminal mental defectives' be permanently segregated.²⁹ Birmingham recommended that they be confined in special homes under the control of the Inspector General for the Insane. If funding was unavailable for the provision of these special homes, a separate portion of the Fremantle Prison should be allocated to 'mental defectives', where guidance rather than punishment could form the basis of management.³⁰

Birmingham claimed that, as things stood, 'defectives' lacked the control to conform to prison discipline. When they breached discipline they were punished by ordinary prison methods, few of which had any reformatory or deterrent effects upon them. Under the circumstances, he concluded, 'it is about as irrational to put a defective into prison as to take out the tooth of a person who has a broken leg'.³¹ In a system where 'mental defectives' were expected to bear the full responsibility

for their crimes, many were repeatedly convicted for petty offences, with their central problem of 'deficiency' being overlooked. This high rate of recidivism would continue, Birmingham argued, until the 'deficiency' was recognised and the offender permanently segregated, 'not as a criminal but as a defective'.³²

Birmingham's view of the connection between crime and intellectual disability had a long pedigree, beginning with the work of the Italian criminologist Cesare Lombroso in the nineteenth century. Lombroso had argued the case that the tendency to criminal behaviour was organically caused and passed from parents to children by the process of heredity. Other European and North American criminologists and eugenicists believed that they had found irrefutable evidence of links between crime and inherited 'feeble-mindedness'. But it was the North American eugenicist H. H. Goddard who developed the most radical position. L. J. Ray, the British educational historian, has summarised Goddard's research and findings in the following terms:

Briefly, Martin Kallikak, a soldier in the American Revolutionary War, had a child by an "unmarried feeble-minded girl", and after the war married a "Quaker girl from an honest and intelligent family". Some 496 descendants of the Quaker girl were traced, Goddard asserted, amongst whom there were no criminals, and all except one had been normal. 486 descendants of the feeble-minded girl were traced, only 46 of whom were normal, although Goddard claimed to have "conclusive proof" of feeble-mindedness in only 143 of the rest. Among the 486 he claimed that "36 have been illegitimate, 33 sexually immoral persons, mostly prostitutes; 24 alcoholics; three epileptics; 82 died in infancy; three criminals; and eight kept houses of ill-fame." What this means, he says, is that, "criminality is often made out of feeble-mindedness", and that, comparing the normal and defective family lines, "we must recognise that the human family shows varying stocks or strata that are as marked and that breed true as anything in plant or animal life". Thus feeble-mindedness is responsible for "social sores", such as "paupers, criminals, prostitutes, drunkards and other social pests".³³

As we shall see, this supposed connection was developed much more fully later in the century.

Emergence of Indeterminate Sentencing

While Birmingham was making his recommendations concerning people with intellectual disabilities, Captain C. E. D. F. Pennefather had been commissioned to investigate the penal system. In his 1911 report, Pennefather recommended the introduction of a system of indeterminate sentences for habitual criminals.³⁴ Neither report had any immediately visible effect upon people with intellectual disabilities who offend. Several years later, however, Birmingham's recommendation to segregate the 'mentally defective' prisoner was linked to Pennefather's policy of indeterminacy in a move which had far-reaching effects upon their management and detention. In 1918, Pennefather's recommendation was debated in the Legislative Assembly. The Attorney General, Robert Robinson, proposed an amendment to the Criminal Code. Section 662 of the Criminal Code would allow indeterminate sentences in certain circumstances. It specified that:

When any person apparently of the age of 18 years or upwards is convicted of any indictable offence, not punishable by death (whether such person has been previously convicted or not), the court before which such person is convicted may, if it thinks fit, having regard to the antecedents, character, age, health or mental condition of the person convicted, the nature of the offence or any special circumstances of the case —

- (a) direct that on the expiration of the term of imprisonment then imposed upon him be detained during the Governor's pleasure in a reformatory prison; or
- (b) without imposing any term of imprisonment upon him sentence him to be forthwith committed to a reformatory prison, and to be detained there during the Governor's pleasure.³⁵

The category 'mental condition' ensured that indeterminacy could be used in cases involving people with intellectual disabilities who offend.

Opposition to the proposed Bill raised three important issues. The first was the concern that prisoners sentenced to a few months imprisonment could be detained for years, if not forever.³⁶ This fear of excessively long terms of imprisonment encouraged some debate within the Assembly. However, Robinson quelled much anxiety by informing members that the policy of indeterminacy had been successfully practised in Victoria for well over a decade.

Philip Collier, the member for Boulder and future Labor Premier, raised a second line of opposition when he asked the Assembly to consider the emotional effects that indeterminate sentencing might have. He requested that a fixed sentence be imposed so that individuals might look forward to their release. Collier claimed that:

the sentencing of a person to a term, the duration of which he does not know, will have a detrimental effect, in fact a heart-breaking effect.³⁷

Collier's argument was not addressed by other members of the Assembly. Perhaps they were preoccupied with the more expedient objective of the Bill. The mover of the Bill had himself admitted that indeterminacy was designed to keep these people 'out of the way'.³⁸

The third issue raised in opposition to the Bill concerned the proposed 'reformatory prison'. Robinson accepted Birmingham's contingency plan which suggested that rather than building a new institution, a portion of the Fremantle Gaol be set aside for those undergoing indeterminate sentence.³⁹ Opponents to the legislation argued that the prison was unsuitable for reformatory purposes and the staff not sufficiently trained for the special treatment required.⁴⁰ The member for Kanowna, Thomas Walker, led this opposition. He argued, as Birmingham had done, that they should be permanently placed within special institutions where they could be given appropriate treatment. The proposed amendment, he claimed, stressed the element of segregation but failed to guarantee specialised treatment.⁴¹

But such concerns carried little weight with the Government, which had clearly identified the social engineering implications of indeterminacy as a means of dealing with habitual criminality, deviancy and perceived genetic threats. In response to Walker's concerns, Robinson told the Assembly that both he and the Colonial Secretary agreed with the policy of segregating the 'mentally deficient' and:

would be glad to see the day — and have the money — when we could establish segregated farms in the country for these people, under the blue skies...where persons who are mentally deficient, or are morally insane, may be treated humanely for their own benefit, and certainly for the benefit of the community.⁴²

In the meantime, he argued, action must be taken. With the stress upon segregation 'for the benefit of the community', the amendments were passed in 1918. A section of the Fremantle Gaol was to be set aside as a 'reformatory prison' and Western Australia committed itself to the policy of indeterminacy, a policy which some historians claim has ever since 'permeated the entire administration of criminal justice in the State'.⁴³

Birmingham's reaction to the adoption of indeterminate sentencing is unclear from the records on which this chapter is based. What is clear is that along with overseas contemporaries — such as Walter Fernald, Superintendent of the Massachusetts School for the Feeble-Minded in the USA, and Goddard — he energetically promoted the interconnectedness of notions of 'mental deficiency', 'criminality' and 'heredity' and was influential in a society increasingly affected by the bogus science of eugenics. In Birmingham's writings one can also see an underlying concern with the 'menace' posed by the 'moral imbecile': the 'feeble-minded' person without a functioning moral faculty. The portrayal of menace and the devaluing of people with intellectual disabilities through stereotyping were undoubtedly influential with judges and magistrates, as other case studies suggest.

According to the 1918 plan, prisoners awarded indeterminate sentences in the 'reformatory prison' were to be kept apart from the rest of the prison population. It is evident from the annual reports, however, that they spent their working hours at least alongside the other prisoners.⁴⁴ Indeed, there is no evidence to suggest that people with intellectual disabilities who offended were institutionalised, as Birmingham had hoped, in an environment of specialised care rather than punishment: as 'defectives' rather than 'criminals'.

Diminished Responsibility and the Criminal Code

In 1927, a Bill to amend the Criminal Code was introduced by the Member for Perth, Henry Mann, the one time detective who had

brought Moon to trial for the murder of Delia Clarke. Now, as a Member of Parliament, Mann maintained his interest in both the criminal justice system and people with intellectual disabilities.⁴⁵ He proposed the withdrawal of the death penalty for the 'mentally deficient'.⁴⁶

Throughout the debate over the proposed Bill, Mann struggled to impress upon his colleagues the difference between the 'insane' and the 'mentally deficient', and the importance of extending to the latter group some of the concessions already existing for the former.⁴⁷ The Minister for Justice, John Willcock, assisted him with a precise definition of those whom the Bill was intended to protect. Willcock explained to the Assembly that there were three classes of what he termed 'subnormal people': 'imbeciles', who had a mental age of a child of two; 'idiots', with a mental age of about six; and 'mental defectives', who had the mentality of a child up to about 12 years of age. This Bill, he claimed, dealt with the third and largest category, the first two already being covered under s. 27 by way of their 'obvious' lack of mental capacity.⁴⁸

Mann argued that this third group, although they should still be held responsible for their actions, should not be subjected to capital punishment. In an appeal to the Assembly he said that:

While we would not hang a lad of 10 or 12 years of age, we hang adults whose minds are not more fully developed than is that of a lad of 10 or 12 years of age.⁴⁹

It was acceptable, he argued, to place such people in gaol to 'prevent them throwing any progeny on the world and to prevent a repetition of the crime', but to take their life was 'vicious'.⁵⁰

Mann's Bill passed through the Assembly with little opposition. Most members expressed the belief that a Bill of this kind was necessary, if not somewhat overdue. The Bill's passage through the Council, however, was not so smooth. Strong opposition was raised concerning the potentially widespread effects of the Bill on the utility of capital punishment. The Member for Metropolitan Province, John Nicholson, argued that such an amendment to the Criminal Code would be cited in so many defences that the death penalty would become practicably redundant.⁵¹ Further, he argued, there had been no stirring of public sentiment in favour of any such measure.⁵²

Nicholson quoted large passages from a paper prepared by Dr Athelstan Saw, the Member for Metropolitan-Suburban Province. Due to illness, Saw was unable to present his own case against the proposed Bill. Through his paper, however, he delivered powerful arguments against the amendments, arguments which perhaps more than any other led to the defeat of the Bill. Saw described in detail some of the tests applied to determine 'mental deficiency'. Offenders, he claimed, were asked to complete a series of simple tasks. For instance, they might be asked to:

1. arrange five boxes in order of weight;
2. copy two designs from memory;
3. criticise absurd commonsense quotations;
4. use three words in two sentences.⁵³

Saw argued that such tests were often inappropriate for the detection of 'mental deficiency'. More importantly, however, was the timing of the testing. The tests were applied to men and women after they had been convicted but before the sentence was passed. In other words, Saw suggested, the tests were being given to a convicted criminal whose 'prospect of success in saving his neck depends on his convincing the psychologist that he is of low mentality'. Would such a person, he asked the Council, be 'likely to cooperate in these tests?'⁵⁴ The Council voted to reject the Bill in its second reading.

In 1929, two years after the defeat of this Bill, Mann introduced an almost identical measure into the Assembly. This time, however, he called for an independent board to assess the offender's mental state. The board would examine the offender before the court hearing. The Bill passed through the Assembly. When it reached the Council both Nicholson and Saw spoke for, rather than against, the Bill. Their earlier misgivings were dispelled by the proposals to establish an independent board and to examine prisoners prior to conviction.⁵⁵

There was little opposition to the Bill from members of the Council. It passed through the second reading after Nicholson proposed and was granted three amendments. The first two dealt with certain subclauses of the Bill, and the third proposed to repeal and replace s. 188 of the Criminal Code dealing with punishment in carnal knowledge cases. Section 188 had specified that prosecution in such cases must commence within six months after the offence had been committed.

The amendment proposed to extend this period to nine months.⁵⁶ When the Bill was returned to the Assembly, however, this third amendment was ruled 'beyond the scope of the Bill'.⁵⁷ The Council refused to accept the Assembly's ruling and would not withdraw the amendment.⁵⁸ While both Houses were prepared to abolish capital punishment for people with intellectual disabilities who offend, their deadlock over an issue of parliamentary procedure meant that the Bill was allowed to lapse.

The 1927 and 1929 Bills were introduced at a time of increasing public concern about 'mental deficiency'. Western Australian newspapers, in particular the *Daily News*, fuelled this interest by making mental deficiency central in its eugenicist discussions. In December 1928, for instance, a *Daily News* article suggested a connection between 'mental deficiency' and criminality in order to canvass support for the segregation of all 'mental defectives':

Defectives, when improperly cared for are liable to become a heavy charge upon the community through their tendency to lapse into delinquency in adolescence and into serious crime when older. To minimise this tendency towards criminality is not only demanded from us from a humanitarian viewpoint, but it is worthwhile from the lower consideration of economic finance.⁵⁹

This economic imperative loomed large in the campaign for segregation. People with intellectual disabilities were portrayed 'across the board', one historian declares, 'as a sore festering on the social body'.⁶⁰

While the 1929 amendments concerning capital punishment for 'mental defectives' were still being debated, the Mental Deficiency Bill was introduced into the Assembly by the Minister for Health, Mr S. W. Munsie. As Gillgren and Brogan have shown, the Bill proposed the segregation of all 'mental defectives' into specialised institutions, and again suggested the creation of a separate establishment for 'mentally deficient criminals and delinquents'.⁶¹ Munsie argued that 'mental defectives' threatened the financial well-being of all Western Australians. If they continued to increase in number, he claimed, the 'economic load accruing to this State from mental deficiency will grow heavier and heavier'. Munsie considered costs for the care of 'defectives' in schools, asylums and prisons to be both excessive and unproductive⁶² but, as has

been described, the Bill failed and relatively little interest was taken in the issue again until after World War Two.

Indeterminate Sentencing Extended to Juvenile Offenders

It was not until 1945 that Parliament passed the first Bill concerning people with intellectual disabilities who offend since the introduction of the 1918 indeterminacy legislation. The 1945 Bill recalled the issue of indeterminate sentencing. It sought to amend s. 662 of the Criminal Code by withdrawing the requirement that offenders liable to indeterminate sentences be 'apparently of the age of 18 or upward'.⁶³ This meant that offenders of any age could be sent, with no fixed sentence, to the 'reformatory prison'. This amendment to s. 662 was introduced as a 'minor amendment' in a Bill dealing primarily with punishment for negligent driving.⁶⁴ It was included on the recommendation of the Justices' Association. Judges claimed that they needed greater powers to deal with youth offenders.⁶⁵ The amendment was presented to both Houses as a 'gap' in the existing law; an 'error' which had, until then, been overlooked.⁶⁶ The Bill passed through Parliament with little debate. It was perceived as a necessary extension of an already existing control rather than an introduction of a new form of control. Perhaps, for this reason, it escaped the controversy raised by the 1929 Bills. In the following decades, the criminal justice system remained preoccupied with the issue of indeterminacy and displayed little interest in its implications in terms of human rights.

In *Imprisonment in Western Australia: Evolution, Theory and Practice*, J. E. Thomas and Alex Stewart claim that by the end of the 1950s the Indeterminate Sentence Board was being phased out.⁶⁷ Rather than pursuing a definite policy of indeterminacy, they claim:

the position was arising when the only reason why a prisoner continued to be locked up was that there was nowhere for him to go...Such a situation easily arises where prisoners are docile, sentences are indeterminate and after-care arrangements haphazard.⁶⁸

This suggests the essential vulnerability of people with intellectual disabilities to indeterminate sentencing. In 1963, to address the problem of repeat offending by alternate means — namely through the

provision of after-care services for prisoners — the State Government enacted the *Offenders Probation and Parole Act 1963*. As Thomas and Stewart note, the *raison d'être* of this change of direction lay with the proposition that 'the offender is helped to survive in the community by a sympathetic counsellor'.⁶⁹ The prison system in the late 1960s and early 1970s was also characterised by the growth of non-uniform staff such as psychologists, social workers and welfare officers.⁷⁰ One would expect, therefore, that by the late 1970s — with judicial disfavour of indeterminate sentencing, the availability of after-care services and the development of treatment programmes — the possibility of prisoners with intellectual disabilities becoming lost in the prison system was becoming remote. The case of David Illich suggests that unfortunately this was not the case.

*Case of David Illich**

At the end of World War Two, the Illich family fled the troubles in Eastern Europe and sought refuge in Australia.⁷¹ Although neither husband nor wife could speak English they felt that Australia offered them a much better life than war-torn Europe. At the end of their journeys they settled in Western Australia with few friends and even fewer resources. Mr Illich, however, could not adjust to the new country. He settled into a pattern of severe alcohol abuse and regular unemployment, contributing little to his family.⁷²

By 1950, they had two children. The oldest, a girl, grew up in two different cultures: that of her parents' homeland and the new Australia. Her story is similar to many migrants. David Illich, born at the end of 1950, has a very different story. His case demonstrates how easily a person can get lost in the system through the use of indeterminate sentencing, even when the intent is honourable.

David Illich's sister recalls that his mother was worried about him right from his birth.⁷³ His birth had been long and difficult. He was born with a cleft palate and clearly disfigured face. He was difficult to raise because he did not reach any of his milestones at the expected time. His mother coped as best she could. She did not speak English and was not aware of services that were available to her. When Illich went to school,

*pseudonym

she raised some of her concerns but language differences meant that little recognition was given to Illich's problems.⁷⁴

Illich did not enjoy school nor did school enjoy him. He was difficult to teach, he was restless, and he had a tendency to be aggressive. Illich was frequently in trouble but it is not known what actions were taken in those early years. On 1 March 1962, at the age of eleven and a half years, Illich was admitted to Mental Health Services and placed at Claremont Hospital. According to a report by the Senior Consultant Psychiatrist at the Department of Corrections:

He was initially admitted there because of his uncontrollable behaviour at home and his frequent absconding from day care centre. At the time he was considered to be emotionally deprived as well as mentally backward.⁷⁵

Illich's entry into the criminal justice system started in June 1976. At the time he was in a training unit at what had become Swanbourne Hospital. On the day of the offence, he followed a staff member into the toilet and asked her to strip. He carried an iron bar with him and threatened her with it. The groupworker told Illich that they should go into her office. Once in the office Illich closed the blinds and tore at her blouse. The blouse and her bra came undone and Illich touched her breasts. He then grabbed her purse and ran away. The victim called out to him to stop and come back.⁷⁶

Illich ran off. He was quickly apprehended by the police at a nearby park. At that time he had been hospitalised for 15 years and had very little knowledge of the community around him. Illich gave a quick and ready confession to the Police.⁷⁷

Illich was charged with indecent assault and stealing with violence. In January 1977 he pleaded guilty as charged and was placed on probation for five years.⁷⁸ Although he had been estimated to have a mental age of about 10 years, it was decided by the court that he was fit to plead. The probation order included two special provisions: that he should submit himself to psychiatric or psychological treatment, and that he should reside for a period of 12 months at Swanbourne Hospital. Illich resisted this treatment and was reported to be 'unco-operative' and a 'management problem'.⁷⁹ He was subsequently convicted of a breach of probation in April 1977. The breach of probation was not based on Illich re-offending but his lack of co-operation at Swanbourne

Hospital. Thus, on a report from Mental Health Services that he was not complying with the special conditions of his order, he had to face the court again for further sentencing. His case was referred to the Supreme Court.

There was considerable discussion between the sentencing judge and the defence and prosecution. Another probation order was ruled out because it required full consent from the probationer and the court, and prosecution did not feel that this would be forthcoming. The conundrum for the court was that it wanted Illich to be detained in an institution even though it did not have the power to order that nor could it rely on Illich to go there voluntarily. Consequently, they devised a method to have Illich returned to Swanbourne under a court order that did not require his consent. It was argued by the prosecution and the court that an indeterminate sentence under s. 662(b) of the Criminal Code with no finite term would result in Illich being sent to Swanbourne by order rather than by consent. In effect, Illich would be imprisoned, but a transfer from prison to Graylands could take place immediately through an administrative arrangement between Corrections and Mental Health Services.⁸⁰

Illich's defence counsel, however, was not convinced of the merits of this proposal. He noted:

It was my plea which I suppose sent him to Swanbourne. I had at that time made a lot of enquiries of my fellows at the Bar, and it seemed to all practical purposes to those persons there who are expert in these matters, this referral from Fremantle to the other institution just does not take place. There is rivalry between the two departments and, as my learned friend says, it relies on the good grace of the superintendent at the hospital. That was the reason basically that there was a direct committal to Swanbourne.⁸¹

Defence counsel went on to argue that Illich should be committed directly to Graylands Hospital — another institution of Mental Health Services and the 'other half' of the now defunct Claremont Hospital — using a Probation order.⁸² Counsel accepted that Swanbourne could not handle Illich but stated that Graylands had the necessary secure facilities. He recommended that Illich be ordered to Graylands instead of Swanbourne. Counsel noted to the court that when he made his initial enquiries regarding Illich's placement, the Superintendent of

Swanbourne and the Superintendent of Graylands thought that Graylands was more appropriate. It was certainly evident, therefore, that at this early stage no one in Mental Health Services really wanted Illich in their care. While it was clear that Mental Health Services was ambivalent about Illich, counsel was aware that the sentence as suggested was problematic. After some discussion about the court's power to send Illich to Graylands on a Probation order, His Honour made the observation that the court could not order Illich to have treatment without his consent. On the issue of Illich being able to give consent his Honour stated:

Having regard for what we now know it does raise a question really as to whether any agreement of the offender could be considered as a true agreement having regard for his lack of understanding.⁸³

Illich's counsel argued that Illich did understand what was happening and had made it clear that he did not like Fremantle Prison and wanted to return to Swanbourne. His Honour ignored counsel and continued with his line of reasoning that an indeterminate sentence would be most appropriate since it would allow for Illich to be transferred from prison to Graylands immediately. His Honour went on to argue that if the authorities did not transfer Illich then the Parole Board could release him upon the condition that he go straight to Graylands. Counsel's response to this suggestion was:

That may be so, sir, but again it is an "if" sort of thing — "if they are prepared to do this". There is no reason why the Parole Board should be used to this end. I mean, in this case they are saying: "If you don't do that we threaten we will turn him loose". I don't think that the Parole Board would do that, sir.⁸⁴

His Honour did not heed counsel's advice, and after further discussion between the court and both counsels the court finally sentenced Illich — without imposing any term of imprisonment — to be committed to a reformatory prison under s. 662(b) of the Criminal Code. His Honour was aware that Illich's was a special case and expected the authorities to take into account the issues raised in court. In particular, he made the following comment:

This is a special type of case and those responsible for [Illich] in the future should read not only the transcripts of this morning's proceedings but other transcripts and also the various reports and written material which has come to the surface in relation to him. It will be seen from that the reason for the order which I am making.⁸⁵

Illich was sentenced on 6 April 1977 and taken to Fremantle Prison. After two and a half months he was transferred to Graylands Hospital. Although the delay may have been excessive, the transfer was clearly what the court had determined it wanted. Indeed, the matter should have rested there with only the discharge of his indeterminate sentence to be dealt with.

The Parole Board sat in July 1977 to consider Illich's case. The Board had the option at that time to follow the course recommended by the court. It could have — and one might well argue that it was morally bound to have — ordered his release on parole subject to the special condition that he remain at Graylands Hospital. The Board, however, did not follow the course that had been laid down by the court. Instead of ordering his release, its decision was to 'review in July 1978' for a 'positive parole plan'. It ended up taking more than five years to determine just what a 'positive parole plan' might mean in Illich's case.

The Psychiatrist Superintendent of Graylands Hospital wrote to the Superintendent of Fremantle Prison in a letter dated 22 May 1978:

I have to advise you that the above named has now concluded the treatment referred to in your letter of June 27 1977 and is now ready for discharge. Would you be good enough to advise me on what date you will be able to return him to your custody?⁸⁶

Illich was returned to custody in Fremantle Prison on 6 June 1978.⁸⁷

The Department of Corrections attempted to have Illich ordered back to Mental Health Services but was unsuccessful. The Parole Board considered his case again that year and requested a special report be prepared for the Attorney General. In the report it was noted that:

[A]pparently on the basis of his continuing to be a management problem, of his inability or unwillingness to co-operate with and respond to treatment programmes, and

on the basis of a legal ruling on his status as a convicted person, the Department of Corrections was obliged to accept him back.⁸⁸

This report was the first to label Illich 'dangerous'. It stated:

[A]ll reports clearly state that he is a mental defective who cannot cope in an open community; in fact he is a danger there. He is a person in need of ongoing treatment. He is a person not able to cope even in restricted environments, as is clear from the offence which brought him into this situation.⁸⁹

This report went unchallenged, harbouring misconceptions that were to hinder Illich's release for many years.

The first and most serious of these was that Illich was dangerous. In fact, other than the offence, there was no evidence to support this allegation. Indeed, the victim had stated that she was never really afraid of Illich during the assault. Second, it was stated that he was in need of ongoing treatment. No one ever specified the treatment necessary for people with intellectual disabilities. Indeed, even in the same report it was noted that although he was 'severely retarded' he did not have a diagnosable mental illness. The lack of diagnosable illness was the rationale that was used by Mental Health Services to have him removed from their care to incarceration in Fremantle Prison. Finally, the report noted that he was 'not able to cope even in a restricted environment'. But this statement again could not be sustained on the facts. Illich had been living in Swanbourne Hospital for 14 years. He may have had some difficulties but it was clearly incorrect to state that he was incapable of coping within that environment.

The report finished with an unequivocal plea to the Attorney General to have Mental Health Services take Illich into its care. While the Parole Board was of the opinion that Illich should not be in prison, as was clearly the intention of the sentencing judge, it had attached to Illich a series of labels and observations that became difficult to remove.

The report from the Board went to the Attorney General who in turn passed it to the Minister for Health. The Minister called for a report from Mental Health Services. Given that they had already refused to take Illich twice before, once whilst on probation and then when a

sentenced prisoner, the response was predictable. The memo from the Director of Mental Health Services to the Minister for Health stated:

While Solomon might provide the answer I fear his friend Rothschild would be required to underwrite the required infrastructure...A number of aspects of the correspondence cause me concern. My first reaction is a strong *déjà entendu* reaction — of having heard it all before, as indeed many of us have done.⁹⁰

The Director then went on to repeat all the labels wrongly attributed to Illich: that he was dangerous, that he could not live in an open community, and that only maximum security could contain him. He also described Illich as a 'chronic anti-social offender' on the basis of one offence as an adult and one offence as a juvenile!

The Director ended his submission to the Minister with the following rebuff:

Finally, the Parole Board's report makes reference to Illich as "a person whom the Court clearly intended to direct to an asylum." Apart from pondering the Parole Board's interpretation of the term "asylum", I must point out that Mr Justice [Judge's name]'s order of April 6 1977, read that Illich "be FORTHWITH COMMITTED TO A REFORMATORY PRISON under s. 662(b) of the Criminal Code."⁹¹

The Director made this reference even though the whole of the court case was dominated by the court's desire to ensure that Illich did not go to prison but rather to Mental Health Services. His Honour had made the statement that 'there is no imprisonment ordered here at all'. Indeed, in the same passage in which sentencing occurred, the sentencing judge had made the warning that those responsible for Illich should read the whole transcript and note the reason for the order he was about to make. By selective quotations, the Director had given the impression that Illich should be in prison rather than in the care of his Department even though this was unequivocally not the court's intention.

The response from the Director of Mental Health Services was written on 15 February 1979. It was received by Corrections on 6 August of that year. In the intervening period the Chief Secretary (responsible

for Corrections) and the Minister for Health had considered Illich's position. The result of the deliberations were noted in a memo from the Chief Secretary to the Attorney General and Minister for Health dated 2 August 1979. It stated:

This is to confirm that following our deliberations relative to the disposition of this inmate, we are mutually agreed that there appears to be no acceptable alternative other than for the inmate to remain in Fremantle Prison for the moment.⁹²

It is interesting to note that the Department of Corrections was not given the report from the Director of Mental Health Services until after the Ministerial deliberations. In effect, Illich was 'disposed' of to Fremantle Prison on the basis of this poorly researched and inaccurate report without the opportunity of input from Corrective Services.

At that time Illich had already spent more than one year in Fremantle Prison. His disposition by the Chief Secretary to Fremantle meant that the only way out for Illich would be through the powers of the Parole Board to release him. This was the sentencing Judge's safeguard against Illich being 'caught up in the system without being able to move one way or the other'; a safeguard of which Illich's counsel was not convinced. Illich's next review by the Parole Board was not to take place until 13 June 1980, after he had already spent three years in prison.

In the intervening period between the placement to Fremantle and the June 1980 review by the Board, Illich remained mostly at Fremantle. He was transferred to Albany Prison in December 1978 in an effort to start some movement out of the system. Unfortunately, Illich lasted only four days in Albany. The small prison could not handle his special needs and he was transferred back to Fremantle.⁹³ Illich was held in a special handling unit within Fremantle. Reports indicate that he was at risk from other prisoners who often teased him and took advantage of his vulnerability. However, a large number of prisoners had also demonstrated concern about his circumstances and gave him considerable support. Prison officers had learnt to take into account his limited ability and his special needs. For them the major problem with Illich was his tendency to hug staff on meeting them. He was reported to be co-operative and easily managed.⁹⁴

He was reviewed by the Department's Case Conference in June 1979 which recommended that he remain in Fremantle Prison. The Conference had requested a psychologist's report on Illich's progress for his next review. The report, dated 13 May 1980, outlined some of his limitations and his progress within prison. The Clinical Psychologist summed up his circumstances as:

His main problem is that he is unacceptable everywhere except the one place that can't turn him out — Fremantle Prison. This doesn't seem to be an adequate reason for continued imprisonment.⁹⁵

The Parole Board reconsidered Illich's circumstances on 13 June 1980. They recommended to Cabinet that it request the Governor to use the provisions of the *Mental Health Act 1962* to have Illich admitted as a patient to an approved hospital. In effect, the Board again tried to force Mental Health Services to accept responsibility for Illich. The matter was referred to the Department of Corrections in August 1980.

The Legal Officer for the Department of Corrections pointed out that the provisions of the Act did not allow for such a transfer to take place. In examining the legal technicalities of transferring Illich, he made the following observations:

There is little on file concerning the circumstances of the prisoner's original offences (indecent assault and stealing with violence) or the usual treatment that is afforded to the condition which he suffers (Klinefelter's Syndrome) nor is there much information on file whether persons with this condition are usually dangerous and violent. Although the prisoner is described as aggressive from time to time, on the file his clinical records consist only of current offences and a stealing conviction recorded against his name in 1961 in the Perth Children's Court (when he was 11).⁹⁶

This report prompted the Department to investigate further the behaviour of Illich whilst in Prison.

The Supervising Clinical Psychologist in Fremantle Prison compiled a report on Illich dated 12 January 1981. He noted:

At Fremantle the prisoner's behaviour has created management difficulties. Specifically, he has been subject to teasing by other prisoners which has provoked aggressive behaviour on his part. However, few reports of overt violence are recorded...

Although Illich has had limited contact with female staff at Fremantle it is worth noting that no difficulties in this area have been reported. The Occupational Therapist, with whom he has had regular contact for the past six weeks, reports that she has not experienced any problems with him.⁹⁷

The report concluded with the recommendation that Illich:

be transferred to the care of the Mental Health Services, Division of (sic) the Intellectually Handicapped where steps towards his re-socialisation with his limitations might be undertaken.⁹⁸

The Medical Officer, also asked to review the case, reported that Illich did not exhibit violent or aggressive tendencies.⁹⁹

These reports were the watershed in Illich's sentence. The label that he was aggressive and violent had been attached to him in December 1978. It took over two years for it to be formally noted that this was not the case. The report by the Supervising Clinical Psychologist also pointed the way out. Illich would have to undergo a re-socialisation programme with the hope that the Division for the Intellectually Handicapped (DIH) could take him as a routine client.

The option for placement with DIH was not suggested earlier in his sentence because the Division had no secure facilities. Without secure facilities and 'approved' hospital status, Illich could not be kept there as a 'prisoner'. If he were to be transferred to a hostel within the DIH, he would need to be released on parole. For Illich to be released on parole he would need to progress through the system from maximum to minimum security and to have a 'positive parole plan'. These were the expectations of the normal prisoner.

Illich's move through the system began in May 1981 when the Review Board¹⁰⁰ recommended that he be transferred one day per week to the minimum security prison at Barton's Mill.¹⁰¹ The first transfer

took place on 31 June 1981. He was initially placed there as a temporary prisoner with frequent returns to Fremantle Prison. He was finally held at Barton's Mill seven days per week in December 1982. Reports indicated that he progressed well and was easily managed.¹⁰²

The Department's Medical Officer contacted DIH in August 1982 to start proceedings for Illich to be placed in one of their hostels.¹⁰³ The Division undertook some enquiries, including interviews with Illich, and replied to the Department in October.¹⁰⁴ The Superintendent of DIH noted that all their clients were voluntary and, as such, had the right to leave their facilities if they wished. Probation and Parole would need to take responsibility for any conditions that the Parole Board might impose. He further stated that they could accommodate Illich immediately and he should make a successful resident.¹⁰⁵

Ten months later, on 15 August 1983, Illich was finally released on parole when moved into a hostel run by DIH. He had some initial difficulties adjusting to hostel life but reports indicated that he was mainly well behaved and co-operative. Illich had learnt in prison that one way to resolve difficulties was to fight other inmates. He tended to try to resolve problems with residents in the hostel in a similar manner. However, this became less of a problem as time went by.¹⁰⁶

The final entry to the Parole Officer's Progress Sheet was:

A tragedy that Illich was "caught up" in the system for so long. Parole completed 14/8/84. File was retained in chance of seeing Illich again. Now time to file away. 10/7/85¹⁰⁷

Illich had spent five years four months in prison, three years six months of these in maximum security, when the original sentence had been a probation order.

Criminal Responsibility

Chapter V of the Criminal Code, which deals with criminal responsibility, has three sections that are pertinent to people with intellectual disabilities who offend. Sections 27 and 29 both emphasise that a person cannot be criminally responsible if they do not have 'the capacity to know' or the 'capacity to understand' that they ought not do an act or make an omission.¹⁰⁸ Section 26 makes the presumption that every

person is of 'sound mind' unless the contrary is proved. The chapter has a fundamental presumption that the ability to understand what one is doing is a prerequisite for being held criminally responsible.

The criminal responsibility of people with intellectual disabilities who offend was determined by Moon's appeal against conviction. The appeal had been made on the grounds that Moon came within s. 27 of the Code. During the trial, Dr Montgomery had suggested that Moon, although not 'insane', did not have the full capacity to understand what he was doing. The Full Court debated whether a person of 'weak mind' should be held criminally responsible for their actions. The Court noted that the application of the Code was a matter for a judge — not a doctor — to decide, and determined that intellectual disability could not be interpreted as a 'natural mental infirmity' that would 'deprive him of the capacity to understand what he is doing'. People with intellectual disabilities were, therefore, 'not free from criminal responsibility'.¹⁰⁹

Following this precedent, Illich was also found to be of 'sound mind'. However, the court's ruling was not entirely consistent. While the Court recognised that there was some deficit that may have affected his 'capacity to understand' the nature of a probation order, this diminished capacity was not thought to interfere with his ability to understand the criminal nature of his actions.

There would, therefore, appear to be some ambiguity in the determination of criminal responsibility for people with intellectual disabilities who offend. In principle, the decisions in the Moon and Illich cases regarding their responsibility should have been based on their ability to understand. However, the general ruling by Mr Justice McMillan — that all people with intellectual disabilities who offend fall outside s. 27 — does not appear to be consistent with the *intention* of that of Chapter V: that each individual should be judged on the basis of their 'capacity to understand'. Thus, in some cases, there may be circumstances where people with intellectual disabilities who offend should be found not guilty.

Mr Justice McMillan was concerned that if responsibility was waived in cases involving 'mental defectives' then, in effect, all criminals could shirk justice; they would be able to commit any crime with impunity if it could be demonstrated that they were not of 'the highest grade of intellect'.¹¹⁰ In the sense that the same observation might have been made in the context of people with mental illness who offend, McMillan was open to the criticism of inconsistency or, at worst, being

influenced by the wider community sentiment concerning the danger to society posed by the supposed criminality of 'high grade' and 'moral imbeciles'.

How, then, should criminal responsibility be interpreted? The Criminal Code makes the presumption of 'sound mind' and requires the defence to show that the accused does not have the 'capacity to understand'. In both our cases there appears to be evidence that they knew their behaviour was wrong, and the correct determination may well have been made. It is noted that soundness of mind was determined, in part, by the degree of planning and intent that could be judged from the cases. Moon's disposal of the victim's body was taken to indicate a degree of ability. Similarly, Illich had cornered his victim in an isolated position and had carried a weapon to the scene. None of these actions could be ascribed to a person who did not have 'the capacity to understand what he is doing'. Hence, a 'sound mind' can be determined by the degree of planning and intent. Given this interpretation, there is no need for the more general approach that people with intellectual disabilities who offend are either all of 'sound mind' or all not of 'sound mind'. Each case can and should be determined individually.

It should be noted that any other interpretation may not necessarily be in the best interest of people with intellectual disabilities. If they were to be found not guilty under s. 27 then they could be detained in prison indefinitely under s. 653 of the Criminal Code. Section 27 was originally inserted into the Code, as Justice Rooth noted in Moon's case, to afford protection to the 'insane'. Section 653 then automatically imposes indeterminate detention which may be in an approved hospital but can also be in a prison. In practice, release from indeterminate detention for persons held under this section occurs when the individual is no longer of 'unsound mind'. If people with intellectual disabilities were to be held under this section, it would be very difficult to argue that their 'natural mental infirmity' had improved and that they should be released from detention.

Historically, the courts in Western Australia have been inclined to consider people with intellectual disabilities who offend as being of 'sound mind' and, therefore, fit to plead. However, the courts have recognised that these offenders are in some way different and have resorted to variations in sentencing to take into account their special

needs. In particular, it would appear that the Courts have resorted to s. 662 of the Code, which allows for indeterminate sentencing.

The debate regarding the sentencing of people with intellectual disabilities who offend has been centred around two conflicting issues: the protection of the offender and the protection of the community. Section 662 of the Code, which imposes an indeterminate sentence, has been used to meet both of these ends.

Indeterminacy was introduced in 1911 for habitual offenders and was extended to include the 'mentally deficient' in 1918 by the introduction of s. 662. It was noted that the debate on this Bill included arguments that indeterminacy was for the good of both the offender and the community. However, it would appear that the major thrust was based on the benefits to the community. The Bill had the effect of allowing people with intellectual disabilities who offend to be segregated from the community, thereby surreptitiously imposing a policy of eugenics.

Even in circumstances where the sentence had been imposed for the benefit of the individual, it acted against their best interests. The court recognised in Illich's case that special provisions needed to be made so as to assure that he was not imprisoned, but rather detained in a Mental Health Services institution. Nonetheless, he spent over five years in prison for an offence that originally incurred a non-custodial sentence.

Contention over the use of s. 662 culminated in 1988 in Chester's case in the High Court of Australia. Here the High Court ruled:

[i]t is now firmly established that our common law does not sanction preventive detention. The fundamental principle of proportionality does not permit the increase of a sentence of imprisonment beyond what is proportional to the crime merely for the purpose of extending the protection of society from the recidivism of the offender.¹¹¹

And

s. 662 should be confined to very exceptional cases where the exercise of power is demonstrably necessary to protect society from physical harm. The extension of a sentence of imprisonment which would violate the principle of proportionality can scarcely be justified on the ground that it

is necessary to protect society from crime which is serious but non-violent.¹¹²

The High Court made frequent note of the extraordinary nature of punishment by indeterminate detention and the extraordinary powers of the court which required the sentencing judge to be cautious in the use of s. 662. The High Court stated that the use of this section required that the person sentenced to indeterminate detention under this section be a constant danger to the community.

The High Court also confirmed that an indeterminate sentence was an additional punishment imposed on an individual and could not be construed as being beneficial to the offender or 'bring about reform or improvement'. This ruling would have precluded the use of s. 662 in Illich's case since he had not been described as being a serious and violent threat to the community.

Changes to the *Offenders Probation and Parole Act 1963* made by the *Acts Amendment (Imprisonment and Parole) Act 1987* were implemented in 1988. They removed the determination of the length of a minimum term from the court's discretion. The courts retained the authority to order that a person be eligible for parole, but the length of the period in prison and subsequent parole period were then to be established administratively through the operations of the Act. The significance of this amendment was the removal of the option for the courts to set a very low minimum term with a long maximum term, with the view that the offender should spend some considerable time on parole under supervision. That is, in Illich's case, an alternative for the court would have been to have sentenced Illich to a very short sentence — say one day — and a long maximum sentence with the intent that the Parole Board could order his release subject to him being transferred to an appropriate institution, which was the original intention of the court.

The principles established in Chester's case and the effect of the *Acts Amendment (Imprisonment and Parole) Act 1987* have precluded the option of unusual periods of detention, that is, indeterminate detention or exceptionally long periods of parole. These changes are consistent with the principles of equity and proportionality, and protection of people with intellectual disabilities against unreasonable and unrealistic sentences.

The appropriate place of detention for prisoners with intellectual disabilities remains a contentious issue. The mental health system has

demonstrated quite clearly that it would not accommodate persons other than those who have a diagnosable and treatable condition. There is no indication of any change in this policy even with the building of a forensic unit within the mental health system. The arguments that precluded Illich from being held at Graylands have not altered with the new unit. In addition, neither the Authority for Intellectually Handicapped Persons nor its successors have offered secure facilities. It is not in their charters to hold persons against their will. It would seem, therefore, that people with intellectual disabilities who offend will continue to be held in the prison system.

Prisons

An often cited criticism of prisons is that they foster institutionalisation. Prisoners develop skills that are the antithesis of those necessary to normal community survival. In a sense, prison life offers few opportunities to practice or develop skills necessary for living outside of the prison. The skills necessary for 'successful adaptation' to imprisonment are rudimentary and for some, easily acquired. Furthermore, the prison system can operate reasonably efficiently in helping persons adapt to its daily routine. In effect, the prison system can cope, with some minor difficulties, with people with intellectual disabilities. However, this only holds true if the person is not identified as a person with intellectual disabilities. Once identification occurs, the system is required to take special note and to handle them in a special manner. Furthermore, as noted in Illich's case, this special handling results in greater levels of security than otherwise would have been the case.

The reason special handling results in more restriction is because prison systems tend to operate on a principle of least restrictive custody. This is not for any humanitarian principle. The least restrictive principle equates with greatest ease. It means lowest costs for the organisation, fewer security checks, less supervision, fewer and less detailed reports, and fewer and less complex decisions for the custodians. Thus, the least restrictive principle means that the system operates at a level which is at the lowest level of intrusion and control over prisoners that is possible. Now, if prisons are operating at the limit of least intrusion, any other form of supervision must be more intrusive. If a prisoner is identified as special and requiring non-routine supervision, then that

supervision must be more intrusive and restrictive since routine supervision is already at the limit.

Prisoners with intellectual disabilities, therefore, are subject to more intrusive and restrictive regimes if they are identified. If not, then it is likely that they will be absorbed into the system. In most cases, they are not likely to be identified once they are absorbed since the skills necessary for survival are within their abilities. The problem for prisoners with intellectual disabilities who are not subject to special supervision is that they must be able to cope with the social order of prisoners.

The social world of prisoners is neither benign nor caring. People with intellectual disabilities are at risk of being sexually, physically and emotionally abused. Most prisoners with intellectual disabilities realise that if they seek help to avoid the abuse, they may become subject to 'special' supervision. They realise that this special supervision is more restrictive. They know that the system will avoid placing them in a situation where they are at risk. Transfers to lower security institutions become difficult because these institutions do not allow for special supervision. However, without this special supervision the system views these prisoners at risk of abuse from other prisoners. Yet transfer to lower security is frequently a prerequisite to release on Parole. Correctional authorities often argue that prisoners need to be able to demonstrate their ability to survive in minimally supervised (low security) situations. For prisoners at risk of abuse, the system argues that they need closer supervision and therefore are not suitable for placement in minimum security.

These operations were evidenced in Illich's case. Illich could not be released on parole until he had a 'positive parole plan'. Such a plan could not be developed until he could demonstrate that he could survive in minimum security. However, he had to remain in maximum security for three years because he needed special supervision. Even when he was granted permission for transfer to a minimum security institution, he had to wait another 18 months before he was allowed to stay there without intermittent returns to maximum (and special) security. The irony is that when he was placed there, he was reported to be a prisoner in need of only limited special supervision.

The rub for prisoners with intellectual disabilities is that they are faced with either restrictive supervision or with a higher than normal risk of abuse. Clearly, neither option is acceptable and solutions have

eluded prison systems. Corrective Services in Western Australia has attempted to manage the problem by developing a team within the system whose task it is to ensure that the needs of special prisoners are met as much as is possible. The team works on a principle of dispersal of special needs prisoners. The aim is to move these prisoners throughout the system and design programmes for them in the institutions within which they are placed. This team was introduced in the late 1980s and only started to function as was planned in 1990. There is no prior historical evidence to indicate that the problems of physical and sexual abuse of prisoners with intellectual disabilities and prisoners with mental illness exercised the minds of prison authorities.

Conclusion

As suggested earlier, we are now living through a period of comparative interest in issues in justice administration with implications for people with intellectual disabilities. An underlying but seldom articulated explanation of this concern is to be found in the abuse of human rights and apparent denial of natural justice which typifies much of the historical experience, even in our 'enlightened' times. For the most part, people with intellectual disabilities have figured in the history of justice administration in Western Australia in the context of debates concerning indeterminate sentencing and fitness to plead. The evidence contained in political debate and judicial decision-making regarding both suggests that the social engineering possibility afforded by prisons was clearly recognised from the time of the Birmingham Report in 1911. As 'expert' opinion pointed to 'mental deficiency' as a cause of criminal behaviour and recidivism — unameliorable and a genetic threat to the 'normal' community — people with intellectual disabilities who offended became vulnerable to imprisonment and disproportionate sentences. In broad terms, the adoption of indeterminate sentencing achieved through amendments to s. 662 of the Criminal Code in 1918 coincided with community concern about race and genetic issues: a concern fostered by the protagonists of eugenics.

Dominated as it is by a preoccupation with indeterminacy and fitness to plead, the historical record is silent on the relative readiness of people with intellectual disabilities to incriminate themselves during interviews with police. In the ordinary course of events, the psychological pressure of criminal investigation requires a strong will to refuse to

give evidence. Add to this the ready acceptance and answering of questions by people with intellectual disabilities, who then become especially susceptible to agreeing to almost anything, including things they did not do. The pressure need not be deliberately applied. The mere presence of authority, not even expressly used, may well be enough for people with intellectual disabilities to admit guilt. Admitting that one has committed an offence means an end to the questions — which they may not clearly understand and may be threatening — and an end to isolation. Even with the best will it may be difficult for the police to get a fair confession without some form of extraordinary protection.

In Illich's case he gave evidence and pleaded guilty to a charge of unlawful and indecent dealing and one of armed robbery with violence. From the description of the offence, one could have argued that the indecent dealing was a component of the second charge or *vice versa*. In effect, a more sophisticated person may have been able to argue that there was only one offence rather than two. The issue is that a lack of understanding of the criminal justice system does result in people with intellectual disabilities giving evidence and accepting guilt too readily.

There have been several solutions offered to this problem. The first is to train police to recognise people with intellectual disabilities. The suspect must be made fully aware of his or her rights and represented by someone capable of protecting those rights. Procedurally, this would mean an end to the use of uncorroborated confessions by police. Second, police could make greater use of their discretion to caution suspects, make greater use of summons or take no action at all.

Special procedures, including wider discretionary powers for both police and courts, have the potential both to protect vulnerable people and to deny them certain rights. The variable outcomes of indeterminate sentencing for people with intellectual disabilities and people with mental illness illustrate this issue. The Victorian Office of the Public Advocate in 1988 clearly argued for the priority of people with intellectual disabilities being accorded their rights to the protection of due process of law. It concluded:

When a person is not charged, on [the above] grounds, they are being denied the right to an open examination of their guilt or innocence. They are denied the possibility of acknowledgment of any mitigating circumstances in rela-

tion to the possible offence. They are possibly condemned to periods of additional social control or restriction of possibilities for development which might otherwise be open to them e.g., denial of participation in particular vocational or residential programmes on the basis of a 'difficult' reputation.

The right of the person with an intellectual disability to an open examination of the instances leading to an incident can only be safeguarded by proceeding through the normal legal procedures of charging and trial.¹¹³

At another level of consideration, justice administration and, in fact, the entire spectrum of human services, face the difficulty of protecting the rights and integrity of vulnerable people, including people with intellectual disabilities, and also ensuring the safety and well-being of the wider community. In the context of the evidence contained in this brief history, we find that the pace and nature of changes to the justice administration system in Western Australia have been dictated by a concern to protect the community to the exclusion of all else. As we look today at the disturbingly slow progress of reform, we must recognise that we live in an era when politicians and decision-makers in the justice administration system are under increasing pressure to reaffirm their role as protectors of the community. The historical experience briefly described in this chapter is much more immediate than is generally realised.

Notes

1. For an introduction vide Chapter 1 of Hayes, S. C. and Craddock, G. (1992). *Simply Criminal*. (2nd Ed.). Annandale: The Federation Press Pty Ltd. p. 297
2. *ibid.*, p. 36.
3. Case of Jack Moon, Supreme Court Records of Western Australia, 24 March 1908.
4. *ibid.*
5. *Daily News*, 24 March 1908, p. 3.
6. *ibid.*
7. Detective Mann had acquired a reputation for solving murder and missing persons cases. *Daily News*, 2 December 1907, p. 3.
8. *Daily News*, 2 December 1907.
9. *ibid.*, p. 3.
10. *ibid.*
11. *West Australian*, 2 December 1907, pp. 7-8.
12. *Daily News*, 24 March 1908, p. 3.
13. *ibid.*

14. The West Australian Law Reports, Volume X, 1908, p. 64; *The Australian Digest*, Volume 5, Column 175; *West Australian*, 27 March 1908, p. 2, 4 April 1908, p. 2; *Daily News*, 26 March 1908, p. 3.
15. Criminal Code. 1, 2 Edw VII, Act No. 14, Section 27, 1902. In *The Acts of Parliament of Western Australia, 1901-1902*.
16. The West Australian Law Reports, Volume X, 1908, p. 64; *The Australian Digest*, op. cit.
17. *West Australian*, 26 March 1908, p. 2.
18. ibid.
19. ibid.
20. The West Australian Law Reports, Volume X, 1908, p. 64.
21. Gaols and Prisons Annual Report, 1901. *Western Australia: Minutes, Votes and Proceedings of the Parliament*, 1902, Printed Paper No 6; Thomas, J. E. and Stewart, A. (1978). *Imprisonment in Western Australia: Evolution, Theory and Practice*. Nedlands: University of Western Australia Press. p. 68.
22. Fremantle Gaol Punishment Book, 1906-1911, entry for the 5 February 1910 (PROWA ref: AN 358/1, ACC 1156/20).
23. Letter to the Under Secretary from Dr Montgomery (PROWA ref: AN 24, ACC 752/1911/3881).
24. Letter to the CSD from Dr Montgomery dated 2 March 1911 (PROWA ref: AN 24, ACC 752/1911/1108).
25. The CSD was then extremely reluctant to provide the promised funding. It took months before Birmingham was remunerated. Letters relating to funding (PROWA ref: AN 24, ACC 752/1911/1108).
26. As late as 1929 the Western Australian newspapers were still keeping an eye on the declining birth rate. (*West Australian*, 14 August 1929, p. 14.).
27. The Birmingham Report, pp. 8-9 (PROWA ref: AN 24, ACC 752/1911/1108).
28. The Birmingham Report, p. 49 (PROWA ref: AN 24, ACC 752/1911/1108).
29. The Birmingham Report, p. 37 (PROWA ref: AN 24, ACC 752/1911/1108).
30. The Birmingham Report, p. 38 (PROWA ref: AN 24, ACC 752/1911/1108).
31. The Birmingham Report, p. 22 (PROWA ref: AN 24, ACC 752/1911/1108).
32. The Birmingham Report, p. 11 (PROWA ref: AN 24, ACC 752/1911/1108).
33. Quoted in Ray, L. J. (1983). 'Eugenics, mental deficiency and Fabian socialism between the wars.' *Oxford Review of Education*, (9)3, p. 219.
34. Thomas, J. E. and Stewart, A., op. cit., pp. 84-85; Stevenson, L. (1983). *Fremantle Prison in the 1890s*. Master of Arts Dissertation: University of Western Australia. p. 150.
35. Criminal Code Amendment Act. 9 Geo V, Act No. 32, Section 662, 1918. In *The Acts of Parliament of Western Australia, 1918-1919*.
36. *Western Australia Parliamentary Debates*, Volume 58, 1918, p. 476. Opposition speech by W. C. Angwin, Member for North-East Fremantle.
37. *Western Australia Parliamentary Debates*, Volume 58, 1918, p. 473.
38. *Western Australia Parliamentary Debates*, Volume 58, 1918, p. 383.
39. *Western Australia Parliamentary Debates*, Volume 56, 1917-1918, p. 356.
40. *Western Australia Parliamentary Debates*, Volume 58, 1918, pp. 382-384.
41. *Western Australia Parliamentary Debates*, Volume 58, 1918, p. 383.
42. *Western Australia Parliamentary Debates*, Volume 58, 1918, p. 398.
43. Thomas, J. E. and Stewart, A., op. cit., pp. 99-100.
44. ibid., p. 106.
45. Mann cited cases during this debate that he had witnessed in his years as a detective. (*Western Australia Parliamentary Debates*, Volume 26, 1927, p. 563).
46. *Western Australia Parliamentary Debates*, Volume 26, 1927, p. 553.
47. *Western Australia Parliamentary Debates*, Volume 26, 1927, pp. 552-555, 563.

48. *Western Australia Parliamentary Debates*, Volume 26, 1927, p. 733.
49. *Western Australia Parliamentary Debates*, Volume 26, 1927, p. 556.
50. *Western Australia Parliamentary Debates*, Volume 26, 1927, pp. 558, 564.
51. *Western Australia Parliamentary Debates*, Volume 26, 1927, p. 1780.
52. *Western Australia Parliamentary Debates*, Volume 26, 1927, p. 1781.
53. *Western Australia Parliamentary Debates*, Volume 26, 1927, p. 1784.
54. *Western Australia Parliamentary Debates*, Volume 26, 1927, pp. 1784-1785.
55. *Western Australia Parliamentary Debates*, Volume 83, 1929, pp. 1581-1582, 1793.
56. *Western Australia Parliamentary Debates*, Volume 83, 1929, p. 2044.
57. *Western Australia Parliamentary Debates*, Volume 83, 1929, p. 2126.
58. *Western Australia Parliamentary Debates*, Volume 83, 1929, pp. 2126-2127.
59. *Daily News*, 13 December 1928, p. 14.
60. Fitzpatrick, M. (1988). 'Preventing the unfit from breeding: The Mental Deficiency Bill in Western Australia, 1929.' In Hetherington, P. (Ed.). *Childhood and Society in Western Australia*. Nedlands: University of Western Australia Press. p. 157.
61. *Western Australia Parliamentary Debates*, Volume 82, 1929, pp. 739-742; *Western Australia Parliamentary Debates*, Volume 83, 1929, p. 1452.
62. *Western Australia Parliamentary Debates*, Volume 82, 1929, pp. 739-740.
63. 9,10 Geo VI, Act No. 40, 1945. In *The Statutes of Western Australia, 1945*.
64. *Western Australia Parliamentary Debates*, Volume 116, 1945, pp. 1707, 1709.
65. *Western Australia Parliamentary Debates*, Volume 116, 1945, p. 2133.
66. *Western Australia Parliamentary Debates*, Volume 116, 1945, pp. 1709, 2265.
67. Thomas, J. E. and Stewart, A. op. cit., p. 117.
68. *ibid.*, pp. 117-118.
69. *ibid.*, p. 150.
70. *ibid.*, p. 163.
71. David Illich's sister, interview with authors, 14 August 1989.
72. *ibid.*
73. *ibid.*
74. *ibid.*
75. Report of Senior Consultant Psychiatrist, Department of Corrections, dated 27 October 1976. Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 13).
76. Probation and Parole Services (Department of Corrective Services ref: AN 77/00061, Folio 9, 10).
77. Probation and Parole Services (Department of Corrective Services ref: AN 77/00061, Folio 11, 12).
78. Probation and Parole Services (Department of Corrective Services ref: AN 77/00061, Folio 18).
79. Report from the Parole Board to the Hon. The Attorney General dated 15 December 1978, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 79).
80. *R v. Illich*, Supreme Court of Western Australia, Prisoner's File, Illich (PROWA ref: AN 76/3258, Folio 21).
81. *R v. Illich*, Supreme Court of Western Australia, Prisoner's File, Illich (PROWA ref: AN 76/3258, Folio 24).
82. In 1972, Claremont Hospital was divided into Swanbourne Hospital, which provided residential care for people with intellectual disabilities and Graylands Hospital, which provided residential facilities for the mentally ill. Refer to Stella, this volume, for an account of this separation.
83. *R v. Illich*, Supreme Court of Western Australia, Prisoner's File, Illich (PROWA ref: AN 76/3258, Folio 25).

84. *R v. Illich*, Supreme Court of Western Australia, Prisoner's File, Illich (PROWA ref: AN 76/3258, Folio 26).
85. *R v. Illich*, Supreme Court of Western Australia, Prisoner's File, Illich (PROWA ref: AN 76/3258, Folio 27).
86. Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 47).
87. Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 47).
88. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 79).
89. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 79).
90. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 93).
91. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 95).
92. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 107).
93. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 69).
94. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 64).
95. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 127).
96. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 147, 148).
97. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 156).
98. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 157).
99. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 154).
100. The review Board had the function of overseeing all the transfer decisions in the prison system.
101. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 176).
102. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 315, 317, 318).

103. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 315, 317, 318).
104. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 334, 335).
105. Report from the Parole Board to the Hon. the Attorney General, 15/12/78, Prisoner's File — Illich (Department of Corrective Services ref: AN 76/3258, Folio 334, 335).
106. Probation and Parole Service, Prisoner's File No. 77/00061, Parole Officer's Progress Sheet notes.
107. Probation and Parole Service, Prisoner's File No. 77/00061, Parole Officer's Progress Sheet notes.
108. Section 27 deals with insanity while s. 29 deals with immature age.
109. The West Australian Law Reports, op. cit., p. 64; *The Australian Digest*, op. cit., Column 174.
110. *ibid.*, p. 66.
111. *Chester v. The Queen*, High Court of Australia, copy of Court's judgement, p. 9.
112. *Chester v. The Queen*, High Court of Australia, copy of Court's judgement, p. 10.
113. New South Wales Law Reform Commission (1992). *People With an Intellectual Disability and the Criminal Justice System*. Issues Paper, no IP8. Sydney. p. 32.

6 Doctors, Psychologists and Educators: The Professions and Intellectual Disability

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Introduction

In the history of intellectual disability, three disciplines have played a crucial role. First medicine, then psychology and lastly education can be considered to have been at the centre of the development and delivery of policies for the care and welfare of people with intellectual disabilities. They have also constructed intellectual disability as a field of knowledge such that they could claim exclusive authority to deal with it. The medical model dominated the field probably until the 1970s in Western Australia when it was displaced by a developmental model which accompanied the new policies of normalisation and integration, which were the province of a range of new professionals. Given the conditions under which people with intellectual disabilities lived when they lived their lives in the purview of the medical model, it is little wonder that developmental approaches are regarded as such major advances. Hence, today the lives of people with intellectual disabilities in the 1990s would be unrecognisable to those doctors who ran Claremont Hospital of the Insane in the first 60 years of the century. Yet history is not necessarily progress. Questions were and still are asked about some of the advances in the conditions of people with intellectual disabilities, and new questions need to be asked about their relationships with those who build their worlds. This chapter, by utilising new approaches to the study of the professions, attempts to understand the reality and the implications of these relationships.

Medicine

Prior to and during the Industrial Revolution, the medical profession was not the organised, largely self-regulating industry it is today. It was divided between physicians, theoretically trained men who generally catered to the rich and were famed for their insularity, surgeons and apothecaries. It was to the latter that the majority turned during illness if the front line defence remedies of the local herb woman failed. Physicians and apothecaries, particularly in France and Britain, were renowned for their antipathy. Physicians jealously guarded their territory and tirelessly campaigned to restrict apothecaries to the preparation of remedies alone, labelling them quacks and charlatans. However, many physicians were no better, particularly those who made their livings out of prescribing extraordinarily expensive remedies containing substances such as opium, mercury and imported herbs.¹

During the Industrial Revolution, the practice and power of medicine grew, mostly due to the explosion of the European population. With a growing population, a divided group of medical practitioners, a rapidly intruding market economy and the rise of secular rationalism, it became possible for university trained doctors to lay claim to the exclusive right to treat illness. In *Museums of Madness*, Andrew Scull sets out an explanation for the emergence of insanity as an institutionable disease which takes account of all the above factors. In his view, the rise of secular rationalism was a precondition for the emergence of the modern medical profession. As an integral part of the capitalist transformation of society, rationalism shifted the emphasis away from supernatural explanations to natural explanations of illness and deviance — explanations based on the diagnosis and treatment of defects in the human mechanism — allowing the establishment of a class of men trained 'scientifically', to exclude all others from practising medicine. Their claims were usually supported by the State, which legislated in favour of doctors' exclusive right to practice medicine.²

This brief introduction to the rise of the medical profession is intended to sketch out events in Europe which allowed the history of intellectual disability in Western Australia to unfold as it did. But its baldness concedes a contested process; doctors did not acquire their monopoly of medicine without a struggle. The history of the medical profession in Australia parallels the histories of the other great and not so great professions. It features the formation of professional associa-

tions or lobby groups which would also police the behaviour of members and establish the boundaries of the occupation's sacred knowledge; the passage of legislation through Parliament giving monopoly powers to doctors to practice as legally qualified practitioners; and the establishment of courses of study at educational institutions, the passing of which entitled one to membership of the association and the legal right to practice.³

In the nineteenth century, doctors in Australia set up branches of the British Medical Society. Other specialist bodies like the Royal College of Surgeons — the designation 'Royal' giving them both the Royal seal of approval and high status in the respectable and loyal middle-class world in which doctors moved — were established in the twentieth century. Melbourne and Sydney Universities began to train doctors in the nineteenth century, and medical degrees were amongst the first degree courses established as the other colonial and State Governments set up their own universities. Often after many attempts, each colonial or State Government passed legislation restricting the designation 'Doctor' and the right to practice to duly qualified practitioners. Once such effective legislation was passed, the circle was complete: a body of knowledge taught at a university, a degree entitling one to practice and to be a member of a medical association, and laws entitling only those with the degree to the right to practice. Orthodox medicine then moved confidently against its opponents.⁴

Of these, it had many. Homoeopaths and hydropaths were but two branches of alternative medicine which orthodox medicine fought and defeated in the late nineteenth and early twentieth centuries. It marginalised midwives in the twentieth century and secured a monopoly over childbirth, which has only recently been broken. It took on and defeated the Friendly Societies which hired doctors on contract and set their fees. And its intervention in public health issues and increasing control over the applications of science and technology to medicine gave it a cultural legitimacy which seemed set to ensure its permanent place at the top of the medical hierarchy.⁵ However, intervention by the State through Medicare and a much tighter control of hospital finances, the rebirth of alternative medicines, the revolt of nurses, and division within the profession itself have turned this process on its head. The medical profession finds itself once again under siege.

By 1900, the medical profession had all but won its battle to monopolise illness as an industry. The battle to secure deviance as an industry began at the same time as doctors began their push for scientific legitimacy. It is fruitful to consider Andrew Scull's work as a theoretical base from which to view the unfolding of Western Australia's history of intellectual disability.

Scull argues that the common explanation for the emergence of madhouses in Britain — the rise in urban industrial culture where private and familial care was no longer workable — is flawed. Urbanisation was not as far advanced as supposed when asylums for the 'insane' emerged. But despite this, the demand to segregate people with mental illness was still strong. In fact, the majority of voluntarily opened asylums in the early 1800s were in small rural counties.⁶ Rather:

the main driving force behind the rise of the segregative response to madness (and to other forms of deviance) can be more plausibly asserted to lie in the advent of a mature capitalist market economy.⁷

The switch to wage labour as the determining set of relations in society reduced the capacity of the poor to withstand hardship. A non-productive family member, whether 'insane' or 'disabled', became a great burden. The rising numbers of people turning to poor relief, coupled with the middle-class idea that providing relief to the poor promoted dependence, gave rise to an attraction towards an institutionally based system of poor relief.⁸

The new poor houses served as an economic solution to the problem of the poor, and provided a means of monitoring and controlling inmates who were considered to be lazy, rebellious or ingenuine. Conditions were planned to be so appalling that they were supposed to deter all but the deserving poor who had no option but to put up with them. In practice, this did not happen. The institutional solution to an undifferentiated problem population inevitably led to distinctions among that population:

The fundamental orientation of the system, besides profit, was towards restraint in an economical fashion of those posing a direct threat to the social order.⁹

The differentiation of deviance within this new institutional framework inevitably created the preconditions for the establishment of new professions claiming the scientific expertise with which to deal with the demands of inmates and emphasising their rehabilitation within the institutions. The rise of these institutions led directly to a guaranteed market for expert services, which in turn buttressed the expert's claim for sole legitimacy in dealing with the problem.¹⁰

Such was the evolution of the medical professions' takeover of the trade in madness in Europe. Stephen Garton has shown how the takeover occurred in Australia as insanity became recognised as a 'curable' condition, as asylums became hospitals for the 'insane', and as medical men began to administer and hire medically trained staff at these hospitals. The doctors who worked with people with mental illness and people with intellectual disabilities in these early years were not clinically trained in psychiatry. Rather they were alienists — doctors with a general training who had interested themselves in insanity and whose interest won them positions in the new mental hospitals. As Garton points out, most early alienists were State functionaries. Alienists were replaced later in the twentieth century by psychiatrists — medically trained doctors with specific specialisation in the diagnosis and treatment of mental illness.¹¹

Psychiatrists, who often were enthusiasts of eugenics, opted for the prevention of disabilities through either sterilisation or segregation, convinced, as were all eugenicists, that disabilities were 'incurable' and that people with disabilities were dangerous. Diagnosis was not much more than seeking out the 'dangerous' population, a task which was performed in the early years of the century in schools by general practitioners who were often part of Education Department Medical Services. Nevertheless, doctors did diagnose what they regarded as a disease, albeit an 'incurable' one. The influential English neurologist Dr A. F. Tredgold, writing early this century, called intellectual disability 'amentia' and defined it as:

A state of restricted potentiality for, or arrest of, cerebral development, in consequence of which the person affected is incapable of maturity, of so adapting himself to his environment or to the requirements of the community as to maintain existence independently of external support.¹²

From this definition he developed complex aetiological, pathological and clinical classifications of people with disabilities which abound, as was so common in the period, with a confusion of moral, medical and physical judgements.¹³ The findings of researchers such as Tredgold and Goddard (see Hall and Bavin-Mizzi) found ready acceptance in the medical establishment because they promoted its interests. Western Australia in the first three decades of the century was no different.

The conjunction of the treatment of mental disease and intellectual disability in Western Australia meant that the doctors who ran Claremont for the treatment of people with mental illness also ran it for the treatment of people with intellectual disabilities. By default, then, a medical model of disability was imposed on Western Australia (although it is doubtful whether the separation of the two would have made any difference, such was the state of medical knowledge of disability). Thus, Doctors Barnett, Hope and Lovegrove ran the Fremantle Asylum, and each of them combined administration and private practice. Montgomery, the superintendent of Fremantle, Whitby Falls and later of Claremont, was perhaps the first of the specialist alienist administrators to administer the new hospital for the insane. His successors — Anderson, Bentley and Thompson and Gray — were similar, although Ellis refers to Thompson's later role as consulting psychiatrist to the Prison Department.¹⁴ The specialism of psychiatry within the medical profession did not develop in Australia until 1936 when the University of Melbourne set up a Diploma of Psychological Medicine.¹⁵ Henceforth, administrators at the top level of the administering bodies and the institutions seem to have been psychiatrists, at least until Dr Guy Hamilton was appointed Physician Superintendent of the Mental Deficiency Division, Mental Health Services in 1964.¹⁶

Education

It is in the education system where children are graded according to their ability to produce work to a standard predetermined by education professionals. When a child does not produce to that standard, he or she can be labelled and treated differently. The education system therefore acts as a sieve which both divides children on the basis of presumed abilities and separates 'normal' children from 'subnormal' children. In Western Australia at the beginning of the century, the sieve had caught at least nine children who were all sent to Perth Infants' School to form

a remedial class. This class represents the first major attempt by authorities to deal with children with intellectual disabilities.

The visibility of these children by 1900 was due to three factors. Over the previous decade, enrolments in the State education system had risen from 3,352 to 20,458. Compulsory attendance had been enforced for some time following the passage through Parliament of Acts requiring that State education be free, secular and compulsory, while an age grade system of classification of students was instituted.¹⁷ Although the problem of intellectual disability was generally solved by exemptions, the Education Department felt it was necessary to identify and classify children who were not considered 'normal'. This led to the institution of the school medical service in 1906. Weiland argues that medical inspections were established as a result of the 'need for persons other than teachers, who were not held in high regard within the community...to identify defects, and the only people considered able to do this at the time were medical practitioners'.¹⁸ This situation was to change eight years later.

The Perth Infants' School class for children with disabilities opened in 1910. It began with nine students and had increased to 19 within a year. The school was formed purely by the efforts of Chief Inspector Walton, and aimed at improving general performance and basic social communication skills. The children's first teacher was a woman who would become very well known in the history of special education — Lorna Hodgkinson. The head teacher, Miss Amy Alder, noted in May 1910 that while some beneficial effects were apparent, more could be achieved if the children were medically examined on admission and regularly thereafter.¹⁹ It was arranged for Dr Weihaan of the Health Department and the School Medical Officer to examine the children the following month.

His report disclosed that of the 13 children examined 'a large proportion were found to have one or more physical defects'.²⁰ Dr Weihaan's descriptions reveal why the children were placed in a remedial class and also betray the doctor's wider views about intellectual disability. For instance, Charles Flynn's mental condition was ignored in favour of his family history. Charles' brother was an institutionalised kleptomaniac, his father an alcoholic and his mother the 'myscoedematous type'. Charles had 'dirty habits', 'bad behaviour' and was liable to 'fits of passion'. Only after Weihaan's description was it made clear that Charles suffered from 'cretinism'.²¹ The implication

to be drawn from the order of Weihaan's description is that Charles' condition was assumed to be the result of his parents' poor genes. In the eugenicist framework in which he seems to have been operating, Weihaan's unstated conclusion would simply have been common sense.

Only one other child in the class, Maud Blakers, suffered from an obviously physiological disability: she had suffered head injuries at birth. The other 11 children suffered from poor hearing or vision, although Phillip Stone seemed to Dr Weihaan to be 'suffering chiefly from parental neglect', while he regarded Henry Harmer's 'defectiveness' as the result of 'physical weakness'.²² It can be concluded that the remedial class served more as a collection point for children who, for whatever reason, did not fit within the mainstream education system.

The closure of the class in 1912 was the result of Walton's resignation. J. A. Miles, who became responsible for Perth Infants' School, was entirely unsympathetic. He stated that:

I consider our efforts in this direction to be somewhat premature. The supernormal are of more importance to the State than are subnormals, whose value can never rise much above zero.²³

As Walton had taken personal responsibility for a class that was not a Government policy based innovation, it inevitably folded.

A year before the establishment of the class at Perth Infants' School, the State Government sent Dr W. P. Birmingham on a tour of mental institutions in Germany, England and the United States. The aim of Birmingham's tour was to report on the best methods for dealing with people with intellectual disabilities and epilepsy, and how the methods could best be transposed to Western Australian conditions. Birmingham's report, which has been examined in chapter two by Gillgren and Brogan, was written in the context of the challenge of science, empirical methodology and rationalism to the religious world view of the past. The nineteenth century had fostered many remarkable intellectual developments which challenged the Book of Genesis. Of particular note were Lyell's discovery of geological differences over time, Darwin's theory of evolution and Gregor Mendel's study of genetics. These three theories were expressions of the objective scientific method. It has been indicated earlier how Scull considers claims to scientific knowledge and expertise legitimised custodial care and the medical model.

From its inception, science and its supposed values of objectivity and verifiable fact have served social purposes. In particular, it buttressed the medical profession against all alternate forms of healing and therefore economic competition. Events in the history of intellectual disability in Western Australia followed the pattern of professionalisation based on scientifically backed claims of sole expertise, which in turn supported the theory of social control originally proposed by Galton in 1869. Galton aimed for the systematic and general improvement of the white race through the study and use of biological laws; hence, he legitimised sanctions against the 'weaker' and 'undesirable' classes — paupers, prostitutes, criminals, the 'insane' and people with intellectual disabilities — on the basis of scientific fact.²⁴

Birmingham was well acquainted with this ideology of selective breeding, and its basic tenets were displayed in the way in which he classified people with intellectual disabilities and his conclusions. Having decided that permanent compulsory segregation was the best solution to what he saw as the problem of 'mental deficient', he included a number of justifications for segregation in his report. Being in the hereditary camp of the eugenics movement, Birmingham believed that the environment had little influence in shaping the responses of the 'socially defective' population. In his own words:

defectives are defective from birth...and no amount of training will, or can ever make a healthy mind if the brain is of a defective type to start with.

He did believe, however, that what he called 'defectives' could be trained to contribute to their own support under supervision, rather like a monkey or a dog.²⁵

Perhaps it was sentiments like these, perhaps her ideas had just reached Perth, or perhaps the lack of interest in special education by the Education Department had caused an increase in the number of children with intellectual disabilities in Claremont, but in 1919 the Hospital set up a Montessori School for its resident children. Little or nothing is known of this school, and despite apparently 'good results' it was closed in 1921 due, it seems, to lack of funds.²⁶ A kindergarten teacher had also been appointed to Claremont in 1918 to instruct nurses in the teaching of 'imbecile' children. However, considering that Claremont's nurses worked a 104-hour fortnight with one day off, it is doubtful

whether they gave specialised attention to any inmate, let alone the children with intellectual disabilities.²⁷

Psychology

The 1920s was the decade when interest in intellectual disability reached a peak. And it was the 1920s when professional psychology began to enter the field of intellectual disability. Psychology as an intellectual discipline originated in Australia in the late nineteenth century and was taught as part of philosophy at the Universities of Sydney and Melbourne. It remained subsumed in philosophy in every Australian university until the 1940s except, that is, at Sydney University and at the University of Western Australia where, from the late 1920s, it was taught as a degree course. The early graduates of such courses became State functionaries, at first employed in State education departments. Others entered the burgeoning field of industrial psychology, being employed by companies to habituate workers to company aims. It was World War Two, however, which gave this emerging profession its biggest boost. The Federal Government hired many psychologists both to develop and apply aptitude tests for applicants to the military and cognate jobs after the war, and to work with the demobilised troops on their rehabilitation. After the war, psychology split between those working as employees for large Government and private institutions — and these split between those increasingly engaged in clinical psychology and those who applied IQ tests to client populations — and those who went into private practice. In the 1960s, more psychologists joined mental health departments as these were expanded by Governments. In these, they often worked as the handmaidens of psychiatrists in clinical work, but later in developing policy and delivering services.²⁸

Psychology developed as a profession in much the same way as medicine. An association of psychologists, the Australian Association of Psychology and Philosophy, was formed in the 1920s — the combination of the two disciplines in the title reflecting the subordinate role psychology played to philosophy at the time. But in 1944, a new society was formed, the Australian branch of the British Psychological Society (which finally threw off its Colonial image in 1966). W. M. O'Neil — the historian of the profession and one of the first psychologists to call for an association — observed that it was needed 'to confer some professional status' on psychologists and to 'improve the status' of the

profession in Australia. The Association did what such associations always do: it wrote itself a code of ethics; it set standards by which psychology graduates could become members; it established journals to produce and delimit professional knowledge; it engaged universities in discussion about appropriate courses of psychological knowledge; and ultimately it lobbied Governments to legislate for the registration of duly qualified practitioners. Most State Governments did legislate, but only in the 1970s and 1980s.²⁹

O'Neil argues that Australian psychology has always been functional, empirical, observational and 'strongly applied', and perhaps its first application in Australia was in the identification of so-called 'mental defectives' in the schools in the new mass State education systems.³⁰ Thus, the Tasmanian Government established a State Psychological Clinic in 1922 — the first State to do so — to identify 'mentally defective' children so they could be segregated from the so-called 'normal'.³¹ In doing this, they were replacing those Education Department doctors who used rudimentary observation to identify children with intellectual disabilities. The eugenic frame of reference, then, was present at the birth of psychology in Australia. But psychologists soon extended their influence beyond people with intellectual disabilities in schools. In a process which the 1930s academic Alexander Mackie called the 'psychological capture of Australian education', psychologists moved from identifying people with intellectual disabilities to testing entire student populations for intelligence, and so, at one remove, streaming children into what were considered to be appropriate education destinations. Education, it seemed, had been colonised by the science of measurement and the doctrines of social efficiency, where students were tested for and streamed on the basis of individual and inherent difference.³² As McCallum suggests, psychology was used to give scientific authenticity to 'differences between "normal" individuals'.³³ Later, teachers became the testers and psychologists the experts, composing and supervising the application of the tests and interpreting the results.

In Western Australia, the question of what to do with children with intellectual disabilities really only began receiving serious attention after the end of World War One. The Annual Reports of the Education Department showed increasing concern over the numbers of children with intellectual disabilities in schools. The medical inspections which had been established in 1906 and which introduced doctors into the

schooling process were partially formalised between 1913 and 1918, and included a separate report by teachers on mental capacity. Children were rated using vague, undifferentiated terms such as 'bright' or 'dull' and so on. In fact, the year 1918 seems to mark a substantial turning point in the history of intellectual disability. A year earlier, the Department recommended the establishment of a boarding school for those who could not take 'an independent part in the battle of life', in order to train them to be happy and productive.³⁴ By 1918, however, the Annual Report stated:

Recent enquiries have shown that it is from such defectives that criminals and prostitutes come. It would not only be better for the health and morals of the community but it would be in the end far cheaper to segregate these unfortunate children instead of allowing them to become a social menace.³⁵

In one year, the Education Department had changed its attitude to children with intellectual disabilities from one of a degree of benevolence to one where what it defined as 'societal welfare' was paramount.

Ethel Stoneman and the State Psychological Clinic

This apparent change in policy nearly but not quite coincided with the arrival in Perth of perhaps the most influential figure in the history of intellectual disability between the wars: Ethel Stoneman. Stoneman arrived in 1919 to teach at Claremont Teachers College and was one of the first women to graduate from the University of Western Australia with an Honours degree in Arts. She then travelled to America where she completed an MA in Psychology under Lewis Terman, a leading American eugenicist. She was also involved in the mass intelligence testing of US Army soldiers during World War One. A few months after Stoneman's arrival, Thomas Hill arrived having completed an MA at Clarke University in USA. From 1922 to 1923 he acted as consultant psychologist to the State Children's Department and the Education Department. He was also sent to Sydney to undertake further training in abnormal and experimental psychology, the history of IQ measurement, hereditary theory, and the practice of special education.³⁶ The differing attitudes and approaches of Stoneman and Hill were to

dominate developments in the education of children with disabilities over the next decade.

Stoneman was a clinical psychologist who advocated mass intelligence testing of school children, preferably by trained psychologists like herself, as the first step towards an institutional solution to intellectual disability. As early as 1918, she was giving lectures on 'mental deficiency' to interested teachers with a background in psychology. Stoneman's professional concern was to establish psychology and its practitioners as the only qualified professionals to deal with intellectual disability. In this, she made few friends, particularly among parliamentarians and educationists.³⁷

It was Stoneman who established IQ testing in Western Australia as the standard procedure for determining the degree of disability. However, she was adamant that the administering of IQ tests was to be done by psychologists. In a letter to the then-Premier in 1920 she wrote:

Permit me to remind you that feeble-mindedness cannot be cured and is transmissible. The seriousness of diagnosing such defect is therefore manifest. May I also further remind you that the various degrees of feeble-mindedness...are not pathological states and cannot be diagnosed by medical practitioners.³⁸

In a similar letter to the Minister for Education, she pointed to the multiple mistakes made by doctors and teachers in diagnosing the mental condition of children.³⁹ In essence, she believed that the role of professional psychologists was to identify those who were considered to be socially incapable and to treat their minds accordingly. Stoneman was virulently opposed to medical practitioners using IQ tests, despite the fact that there seemed to have been little opposition by doctors to the emergence of psychologists. This was probably due to the fact that doctors were never formally employed by the Education Department and thus did not have their livelihood directly threatened. Western Australia is unusual in this respect, as American and European developments were marked by such struggles. Freud himself was deeply engaged in this issue and wrote that '[a]s long as I live, I shall resist that psychoanalysis be swallowed by medicine'. He instead envisaged a 'profession of lay curers of souls who need not be doctors and should not be priests'.⁴⁰

In 1986 the American sociologist W. S. Barnett hypothesised that the rise of custodial institutions in the USA was attributable to the role of professionals generating demand for their expertise. Barnett argued that:

[t]he basic historical evidence regarding the industry providing residential facilities is consistent with the economic model of a public industry monopolised by a profession.⁴¹

In this model, a profession is able to generate demand for its services by having a monopoly over information and expertise. By controlling the flow of information to the public, the profession is able to influence the social perceptions of disability and therefore the appropriate social response. This process is very clear in Stoneman's letters and lectures. For example, in a letter to the Director of Education she wrote:

There is abundant evidence in the letters I receive and the inquiries constantly made that the development of a public conscience has progressed very satisfactorily.⁴²

She then recommended that IQ norms for Australia should be established in Western Australia through the mass testing of school children under her guidance.

While relying heavily on IQ tests as a diagnostic tool, Thomas Hill differed sharply from Stoneman in his approach to children with intellectual disabilities. Unlike Stoneman, who favoured institutionalisation, Hill believed that at least some children could maintain themselves as economically independent adults. The programmes which he designed for the Salvation Army's Seaforth School reflected this belief. He had four aims which he tried to implement.

Firstly, to train the defective to live better. Secondly, to produce in him an attitude of mind which will give him the greatest amount of happiness; thirdly to bring out latent abilities and fourthly to make him self-supporting.⁴³

Perhaps the only common element between Stoneman and Hill was their emphasis on IQ testing.

The first modern intelligence test, devised by the Frenchmen Alfred Binet and Theophile Simon in 1905, was intended as an

atheoretical diagnostic instrument to assess a child's intellectual level. It was not intended to be a statement of potential or of limits or of how those limits came to exist.⁴⁴ However, by the time the Americans standardised the Binet test — the Stanford-Binet Test was published in 1916 — the IQ test was being used as a measure of innate, congenital intelligence.⁴⁵ The proof of 'feeble-mindedness', as proved by the IQ test, became the foundation for a whole series of social policies aimed at curtailing the rights of the so-called 'defective' not only in Europe and the USA, but also in Australia. In Western Australia, the 1920s were littered with proposals about how best to control people with intellectual disabilities. The most significant example was the 1929 Mental Deficiency Bill, which represented Ethel Stoneman's own views, and sought to segregate and institutionalise people with intellectual disabilities as well as other classes that could be considered 'socially inefficient'.⁴⁶ As discussed by Gillgren and Brogan in chapter two, the Bill failed due to complex reasons of ethical considerations, personality clashes between parliamentarians and between those called to give evidence to a select committee on the Bill, and the advent of the Great Depression. However, its introduction and survival to the second reading show that parliamentarians and professionals were deeply concerned with the issue of intellectual disability. As Garton has pointed out:

The science of IQ tests allowed for the determination of 'dangerous' or 'deficient' classes before they had committed antisocial acts. The replacement of a discourse of 'badness' and 'morality' by one of 'deficiency' and 'illness' favoured the intervention of the State to prevent social problems.⁴⁷

The Mental Deficiency Bill is an excellent example of how science, promoted by professionals, was used to underwrite social policy and to further a profession's monopoly on services.

Ethel Stoneman had been appointed to the position of Western Australian State Psychologist in 1926 by the Collier Labor Government, and she continued to use eugenic arguments to promote her own work, particularly with regard to women with disabilities. In the Annual Report of the State Psychological Clinic for 1929, she wrote that 'the seriously defective girl constitutes a grave menace to normal family life and relationships'.⁴⁸ She also wrote of several cases of 'defective girls'

of 'easy virtue', stating that if there was legislative control and institutionalisation of 'mental defectives' such situations would never have occurred.⁴⁹ It is no mere coincidence that Stoneman drafted the Mental Deficiency Bill, her aim being to establish an empire where psychologists — through the State — could locate, classify, then segregate people with intellectual disabilities in a range of new institutions, in effect under Stoneman's control.

However, the period of the State Psychological Clinic was marked by serious rifts between Stoneman, Hill, the Director of Education Wallace Clubb, and the Minister for Education. Weiland suggests that the Clinic was established to 'consider and advise the government in regard to the application of the science of psychology, the various social features of the work of government departments'.⁵⁰ Rarely had the connections between science and social policy been so clearly drawn. It is interesting to note that so early in its introduction to Western Australia, psychology was afforded the legitimacy both of science and of the State statute books. The existence of the clinic was a manifestation of a common belief that a trained psychologist was a necessary addition to the complement of professionals that advised the State. Stoneman recognised this and sought to exploit her opportunities. She wanted control over the mental examination of children, the organisation of special classes and teacher training, all of which were the province of the Education Department. She attacked Hill's qualifications and berated him for his attention to literacy and numeracy in the Seaforth curriculum. Her relationship with Wallace Clubb reached the point of no return when she applied directly to the Minister, complaining of being ignored. It seems that Stoneman's insistent abrasiveness harmed the development of education for children with intellectual disabilities as the Department virtually suspended all initiatives until Murray Little took over as Director in 1940.⁵¹

It is worth noting that Stoneman was one of few women in the State at the time who held a position of obvious responsibility. Part of her persistence in putting her opinion so strongly was probably due to the fact that as a woman operating professionally in the public sphere, she may have been the object of male derision. The Conservative Government of James Mitchell abandoned the psychological clinic in 1930, prompted no doubt by the financial crisis of the Great Depression and the hostility to both Stoneman and psychology by such prominent local citizens as Walter Murdoch.⁵² Historians' verdicts on Stoneman and the

clinic are mixed. Alison Turtle describes her as a 'pathbreaker' whose successes were 'astonishing' and whose work was 'effective', and credits her with the honour of successfully applying overseas based intelligence tests to Australian conditions and promoting progressive, segregated institutions for 'defectives'.⁵³ Gaynor and Fox, on the other hand, criticise her eugenic principles, her segregationist policies, and the reproduction of a divided and unequal labour force to which her ideas were put.⁵⁴

Education and Eugenics Before 1939

While much debate was being carried out by parliamentarians, psychologists and some medical professionals, the files of the Education Department show what services were being provided for people with intellectual disabilities. Throughout the files from the 1920s are letters from concerned and distressed parents wanting advice or asking for treatment for their children with disabilities. Two extreme examples are the cases of David Slayford and Mrs J. Davies. Slayford was one of the children from North Fremantle Infants' School examined by Dr Roberta Jull in 1918. He was classed as 'defective' and, after he broke into his school, he was committed to an institution until the age of 18. His parents' pleas for his release were refused. Slayford was nine years old.⁵⁵ In her report Dr Jull wrote:

The neighbourhood is said to be a poor one and no doubt bad home conditions, want of proper nutrition and lack of parental care and control play their part: it is clear that adequate provision should be made to segregate these children...and to train them to at least partly support themselves in a colony of some kind. They can never become useful citizens...⁵⁶

Given such advice, it is no wonder the authorities refused the Slayfords' request. Mrs Davies, on the other hand, wrote requesting the release of her son from Claremont Hospital for the Insane. A Dr Love had transferred him from the Salvation Army Boys' Home because he believed excitement would aggravate his fits. Davies had been an inmate at Claremont for several years, was misbehaving, and receiving no schooling, despite the fact that there was a school there. The Director of Education helpfully suggested to Mrs Davies that as her son was too

dangerous to attend an ordinary school, she should try to get him readmitted to Seaforth, the Salvation Army Home.⁵⁷

From the initial class at Perth Infants' School, the Education Department slowly expanded its provision for children with intellectual disabilities. A second class began at Princess May Infants' School in Fremantle. By 1926, a letter from the Director of Education to Ethel Stoneman shows that 121 children were receiving special instruction at four schools in the metropolitan area. The same letter states that there were no established guidelines for teachers to deal with people with intellectual disabilities, that there was no special equipment provided, and that there was no record kept of teachers who had indicated interest in teaching children with disabilities.⁵⁸ In the 1930s, three special opportunity classes were established, beginning with the Special Domestic Class for girls at Highgate. These classes, and others for boys, were expanded and aimed at preparing 'dull' or 'disabled' children to take on low grade industrial work.⁵⁹ The emphasis was on a utilitarian basis of English comprehension and arithmetic. Teachers spent a large proportion of their time teaching technical skills such as upholstery, dressmaking and millinery for girls; and woodwork forging or mechanical drawing for boys.⁶⁰ These classes were given glowing reports by visitors.⁶¹ However, despite their success, the Education Department was not prepared to incur the expenses necessary for more of them, particularly during war time.⁶²

The Depression years also witnessed the first rumblings of activity regarding the establishment of a farm colony for so-called 'defectives'. The State authorities had realised that Western Australia was the only State in the Commonwealth that did not make any institutional provision for children with intellectual disabilities and that, except for those coming under the care of the Child Welfare Department, there was no way of exerting control over people with intellectual disabilities. An inter-departmental committee set up in 1937 to inquire into the problem recommended the enactment of mental deficiency legislation, the establishment of a farm colony and residential school, and the re-opening of a psychological clinic, measures which were in essence a recapitulation of Stoneman's 1926 plans.⁶³ The committee considered the recommendations to be part of a conceptual package where the implementation of one would be of no value without the others. Of particular interest was the committee's insistence on the need for a State psychological clinic; a suggestion which indicates both that Stoneman's work was

remembered and valued, and that psychology was becoming increasingly respected as a profession. It also indicates that in the minds of the authorities, the problem of people with intellectual disabilities had become a specialist problem. It would thus appear that Stoneman's sometimes imperious insistence on the need for IQ testing by trained psychologists had become an accepted precondition of correct treatment.

The committee proposed to redevelop Whitby Falls Asylum as part of this plan, intending it to be a farm colony for 200 people with disabilities. It chose Whitby partly because it was an established and productive farm but mostly because it was situated at Mundijong, sufficiently distant from the city. The conviction of medical and psychological professionals that intellectual disability was hereditary and unimprovable, that people with disabilities were likely to be immoral, and that they probably had criminal tendencies, led them to the belief that segregation of people with disabilities was crucial to protect society from them and them from society. Asylums, institutions and colonies were therefore best placed out in the country, with people of all classes of disability committed there. However, the committee's proposals never came to fruition despite the urgent unmet needs of people with intellectual disabilities.

It is now constructive to ask whether there was any opposition to the eugenic programme for people with intellectual disabilities. There was, but it was both sporadic and unorganised. The most comprehensively expressed opposition was written by G. Maclean, President of the State School Teachers' Union:

Let us beware in our enthusiasm for legislating for mental deficient, that we do not set up an itch for finding mental deficiency where it does not exist...Let us beware of a superstitious veneration for intelligence tests. They have a place, an important place, in educational method but they have their limitations. Let us also beware how we rank a child as deficient simply because he will not fit into our educational mould. We will do well to be on our guard against legislative complexities until we are in a position to be guided by a much larger body of expert opinion than we have in the State at this time...Let us beware of exaggerated statements and above all, let us exercise a little common sense...⁶⁴

The columnist Walter Murdoch also attacked the discipline of psychology in scathing terms. He called psychologists 'mischievous charlatans' whose 'incompetence almost, but not quite equals [their] effrontery'. But he reserved his special contempt for Ethel Stoneman, her intelligence testing, and the way she labelled children as 'defective'. He wrote:

only the future will show what sort of intelligence [a boy] has; it will do no harm to let him alone. The only harm you can do him is to treat him as a mental deficient. The chances are that if he is left alone to follow his own bent he will grow up to be at least as intelligent as the 'expert' who pronounced him defective. (That, I admit, is not saying much).⁶⁵

Various surveys conducted throughout the twenties show that many teachers shared Maclean's and Murdoch's doubts, and were wary of classifying students as 'intellectually disabled' for fear that it would permanently and negatively label them. A letter from Thomas Hayes, Manager of St Kevin's Industrial School, to the Education Department states: 'Were I to class as mentally defective children who are dull or even very stupid in class, I should perhaps be branding them for all time'.⁶⁶ Indeed if Ethel Stoneman's segregationist vision had survived its second reading in Parliament, such children would have been branded and institutionalised for life.

Thus, at the beginning of World War Two, the same kind of confusion about people with intellectual disabilities reigned as it always had. None of the plans to segregate people with intellectual disabilities had had any effect and, with regard to school-age children, the Director of Education informed the Australian Council of Education Research that Western Australia made no provision for children with intellectual disabilities who had been excluded from school, but that religious bodies such as the Salvation Army provided some State subsidised care.⁶⁷ In reality, the Salvation Army provided accommodation for boys with intellectual disabilities at Seaforth, while boys with IQs below 70 were sent to Claremont and girls were either sent to Claremont or to orphanages, regardless of their IQ. The Roman Catholic church administered its own institutions such as Castledare, and the State did provide 'opportunity classes' for the people with mild intellectual disabilities as discussed earlier.⁶⁸ For the more wealthy,

there were specialist one-to-one trainers. Employing trainers was recommended to the mother of Pamela Pulley. Pamela was six years old when her IQ test labelled her an imbecile and therefore excluded her from all educational opportunities.⁶⁹

Education After the War

The same inertia which had characterised policies towards people with intellectual disabilities during the 1930s was carried over into World War Two. After the war, it was teachers who began to agitate for change. In 1947, the State School Teachers' Union placed pressure on the Education Department to upgrade its facilities to deal with people with disabilities. In a newspaper report, the Union laid out plans for the establishment of another psychological clinic to deal exclusively with children with disabilities. It also urged the Government to introduce specialist teacher training, uniform definitions of people with disabilities across the States, subsidised teaching aids, and class sizes limited to 20. It also noted the establishment of numerous special classes in other States, particularly in New South Wales.⁷⁰

The origins of major post-war changes in educational policy regarding people with disabilities had their genesis in the appointment of Murray Little as Director of Education in 1940. Unlike previous directors, he considered the education of people with disabilities to be the sole responsibility of the Education Department. His directorship was marked principally by the creation of the Careers Research Branch in 1941, headed by James MacCall. This branch was formed in response to the 1937 Royal Commission into youth unemployment and pressure by teachers to provide vocational guidance to school leavers. MacCall was a trained psychologist from the University of Western Australia and all branch staff were required to have completed psychology units at a tertiary level. By 1944, the branch had 11 staff. While the branch began as a vocational guidance service, by 1947 officers were dealing with a significantly increasing number of what it called 'special cases'.⁷¹ In fact, half of its time was spent with so-called 'backward, retarded and problem children'. These developments, combined with the use of a staff literate in psychology which operated the branch, can be considered both a diversification and consolidation of the psychological profession. Children with intellectual disabilities were now firmly the responsibility of the State to train, a situation that Stoneman pushed for

but never obtained. The role of psychologists in the Education Department was now virtually secured. In 1949, MacCall wrote that:

the officers of the Careers Branch have become, by their training and by the nature of the demands for their services, the general practitioners of psychology in the Department.⁷²

While the Branch still applied IQ tests, MacCall stated that:

A rigid adherence to the common sense attitude is rapidly gaining the confidence of teachers and parents. It will result in the effective use of a science often over publicised and frequently misrepresented.⁷³

Presumably, the 'common sense' approach meant attempting to meet expressed needs, which in turn relied on a system of classification of people with intellectual disabilities that was both broad but accurate.

Assessment and classification had become slightly more sophisticated since Ethel Stoneman's era. Children with difficulties were referred to the Education Department and were assessed on the basis of their age, physical health, intelligence, attainment in basic subjects, their parents' attitude and influence, and emotional and social difficulties. They were then placed in one of four categories. The 'socially ineducable' were those that would require lifelong care and supervision. 'Slow learners' were those who were capable of autonomous citizenship but who could not assimilate the curriculum at an ordinary rate. The 'educationally retarded' were described as those who were 'retarded' due to a period of long illness or some other cause, while the fourth category included those with special sensory defects such as the blind, the 'spastic' or the epileptic.⁷⁴ In response to this classification system, classes were designed specifically for each of the four categories. In 1949, there were two classes for the 'mentally backward' at North Perth Infants' School and Highgate Senior School. The 'retarded' were allocated seven classes in the metropolitan area while there were six classes for children with rubella, and one sight-saving class. Children with polio were brought by ambulance to the post-polio centre, while children with physical and psychological disabilities on the Eastern goldfields were taught at the Boulder Special Education Centre.⁷⁵

It can be seen in these classifications that professional thinking regarding people with intellectual disabilities had diversified, becoming much broader than the systems advocated by Stoneman and Birmingham. Birmingham's 1911 report, in particular, relied on the description of physical symptoms alone for diagnosis. The 1947 system of classification departed most significantly from its predecessors in its rejection of Darwinian terminology and the assumption that people with intellectual disabilities required institutionalisation as a matter of course. It also separated people with intellectual disabilities from those with other disabilities who had previously been grouped together under the broad heading of 'congenital defect', a practice that was most obvious in the incarceration of epileptics in mental hospitals. But it also separated children with intellectual disabilities from those 'normal' children in the education system by setting up special and segregated classes in 'normal' schools and a system of training centres for those deemed to be trainable but not educable. By 1951, MacCall had been given responsibility for the creation and administration of special classes. This was the result of the successful experimental class which he formed at the University of Western Australia in 1948, but he very clearly distinguished between 'care' and 'education' in the formulation of his policies:

The Department has not accepted full responsibility for the care, keep and control of handicapped children, nor would it be wise to do so except in extreme cases where parental care is detrimental to the child.⁶⁶

Care, including medical care, was therefore seen to be the responsibility of the family, voluntary organisations such as the SLCG and, in the last resort, institutions administered by Mental Health Services. It must be remembered that those children with intellectual disabilities receiving such training were only a small minority. Many were still incarcerated at Claremont and subjected to a life of exploitation and oppression, or else were left at home without any support services given to the families. It was not until the 1960s that Western Australia took the first tentative steps towards the policy of deinstitutionalisation, with its emphasis on returning people with disabilities to the community. Thus, deinstitutionalisation challenged fundamental conceptions about the nature of intellectual disability and, importantly, it also

provided fertile new ground for psychologists to expand their interest in the field. It is therefore both intriguing and ironic that deinstitutionalisation in Western Australia was promoted and directed by Guy Hamilton, a doctor.

Psychology, Behaviourism and Intellectual Disability

Hamilton believed his role as the Head of the Mental Deficiency Division of Mental Health Services was to rid disability of the medical model — the idea that disability was a disease which doctors could diagnose, name and treat in medical institutions where extra problems could be dealt with by medical means. In Western Australia, ridding disability of the medical model meant removing people with intellectual disabilities from hospitals, reducing the influence of medical institutions like Claremont and PMH, and removing the power of those who were representatives of the medical model: doctors and psychiatric nurses. Hence, when the Government assumed responsibility for Irrabeena, when Hamilton began to remove children from Claremont, when he created the occupation of social trainers, and when he began to exclude doctors from policy-making within Irrabeena, he was introducing a new model of dealing with intellectual disability: what he now calls a socio-education model or what others call the developmental model. This is not to say that doctors, for instance, now had no place within the field of disability. Hamilton wanted doctors to remain at Irrabeena but only in areas where their expertise was appropriate, such as the diagnosis and treatment of purely physical conditions, or in doing research.⁷⁷ For example, Athol Hockey, Senior Medical Officer at Irrabeena for many years, made significant contributions through her research in genetics. Also, doctors like paediatricians often diagnose disabilities in babies and presume to advise parents on their babies' future (sometimes it must be said from ignorance). Further, as we will see below, doctors continued to play a role in particular circumstances within the education field.

Psychologists took the place of psychiatrists in policies and practices dealing with people with disabilities. So in essence, psychologists bore the new ideologies of deinstitutionalisation which began to have an effect in Western Australia in the 1960s. Psychiatry, with its emphasis on psychotropic drugs, incarceration and clinical contact with 'patients', was more suited to the institutional setting which the new

policies were dismantling. Also, psychiatrists had always regarded 'treating' people with mental illness rather than people with intellectual disabilities as their main function. Nevertheless, that psychologists would 'take over' the field was by no means pre-ordained. That they became so influential was because psychology brought to disability services a new technology, a 1960s and 1970s equivalent of psychometrics — behaviourism.

Behaviourism had its origins in the early years of this century and arrived in Australia probably from the USA and probably in the forms promoted by Clark Hull and, more famously, B. F. Skinner. Behaviourism quickly took hold in Australian universities for reasons which are broadly similar to those underlying its success in the USA: its context in post-war ideologies of efficiency, progress and optimism; its usefulness to psychologists who wanted to be useful to society; and its apparent 'scientificness' in the sense that it was based on observation as opposed to the unobservable inner workings of the mind. Most of all, it was pragmatic and practical.⁷⁸

Generations of university psychology students practised and practise behaviourism in laboratories with rats: learning to observe their behaviour and ultimately to control it. In the sense that behaviourism could explain the way people (and rats) adjusted to their circumstances, it was plainly a potent way of explaining why people behaved the way they did. But it was also a practical way of altering behaviour; hence we can think of it in its application to people with disabilities in terms of concepts like operant conditioning, aversion therapy and reinforcement. Its essence was control, its *modus operandi* was just like industrial psychology — it was applied psychology.

Psychology was well suited to use in large scale institutions like Claremont, where psychologists laboured under psychiatric direction. Its popularisation as a 'scientific' technology, however, coincided with the new policies being advocated by parents, politicians and those like Guy Hamilton. His own preference was not for psychologists to become the leading profession, however, but for social workers to take up the role. Hamilton believed that only social workers could consider the truly social nature of the problems. He ascribes the fact that social workers did not become a leading profession to their reluctance to think socially, their concentration on individuals and families, their relative youth as a profession, and their failure to develop a coherent body of knowledge useful to the field.⁷⁹ Other vocations which expanded their

involvement in intellectual disability in the 1960s and 1970s included physiotherapy, speech therapy, occupational therapy, podiatry and audiology. However by the 1970s, psychology was well established at the point of delivery and at the top of the administrative tree.

Bill Lake's career was evidence of this process. He was a behavioural psychologist appointed to run Pyrton in 1966. His appointment was a pointed contrast to the situation at Claremont which was still headed by psychiatrists. In addition, behavioural psychologists like Jay Birnbrauer and Don Bear (both trained in the USA) brought up-to-date techniques with them in their time at Irrabeena. Further evidence of the ascension of psychology was provided by the appointment of Errol Cocks in 1975 to the position of Deputy Superintendent of the Mental Retardation Division, the highest position in the division to which a psychologist had been appointed. Cocks, a former teacher and guidance officer in the Education Department, had studied clinical psychology at the University of Western Australia and had risen rapidly up the Irrabeena hierarchy. His appointment did not mean that clinical psychology — the alternative school of psychology to behaviourism — was asserting a position in the disability field. Clinical psychology had few adherents interested in intellectual disability. Clinical psychologists were more interested in mental health in much the same way as were psychiatrists (with whom they conducted a fairly acrimonious rivalry). Cocks' appointment was partly symbolic because he represented the normalisation ethos, but he brought organising and policy-making skills to Irrabeena and a vision of normalisation which Hamilton, who appointed him, found congenial.⁸⁰

Although behaviour modification became the dominant tool of the psychologists, they did do other work: assessment using IQ tests which, whilst increasingly controversial, were still a fundamental part of the Irrabeena psychologist's tool kit; counselling of clients and families; and programme development attached to one or more of the various institutions Irrabeena was setting up for deinstitutionalised clients. Hamilton remembers the continuing use of IQ tests in the 1970s in the cases of children referred to the Education Department, which sent them to special schools or special classes depending on whether their IQs were over or under a particular figure. He also remembers the excessive use of aversion therapy by over-enthusiastic practitioners; for example, a social trainer who used tabasco sauce to change behaviour and a psychologist who countenanced the use of cattle prods to control

unruly clients. On the whole though, behaviourism seemed to work. Hamilton recalled that behavioural psychologists:

were doing things and we could actually see it, that this person could now walk outside and go and buy an ice cream, because they didn't drag everything off the shop counter...because we had modified their behaviour accordingly.⁸¹

The importance of behaviourism, but not necessarily of psychologists, began to decline in the 1970s and 1980s at Irrabeena. This was partly for internal professional and ideological reasons — behaviourism as both ideology and practice was coming under trenchant criticism in the profession⁸² — and partly because Irrabeena's policies of normalisation had begun to take effect. Just as psychiatry had lost its point in the smaller institutions of the 1960s and 1970s, so behaviourism lost its point in policies in which people with disabilities were being restored to the community. Behaviourism, at least in its practical use in the disability field, was being seen more commonly as a way of habituating residents to their institutions, but the institutions themselves were becoming less and less a part of Irrabeena's long-term planning.

Irrabeena, Post-Behaviourism and Management

Cocks refers to the new system which replaced behaviourism as a system or programme management approach where, rather than changing the person, programmes would change the environment in which the person lived to conditions akin to 'normal' household conditions. The directions taken by the programme management approach entailed smaller and smaller forms of accommodation for adults to the point where adults shared flats or units assisted, where necessary, by social trainers; bringing up children in their own homes with a multi-disciplinary team of professionals to advise and assist; and the development of programmes to manage these processes.⁸³ This has three clear implications for psychologists. The first is that the place of psychologists in the teams which deliver services may have been enhanced. In the next chapter Megahey describes the ways in which service provision developed within Irrabeena. He recognises that Irrabeena demanded a nominal equality within these teams as a matter of policy, but

he also argues that professionals assumed a leading role in these teams, particularly in relation to social trainers, by using their power as professionals to persuade. Accustomed to developing management strategies, given status by their class position and education, and using the technical language of their profession, it is not difficult to see how psychologists might assert both a field of expertise and a position of power in these teams. Second and to the contrary, in the context of the decline of behaviourism, psychologists had no clearly articulated technology to apply to people with disabilities, although behaviourism was never totally excluded from psychological thinking and practice. Third, management programmes imply management skills and this is the direction in which some psychologists in the disability field seemed to be going. Clearly, these kind of management skills are important, but more important are the more formal management skills which many psychologists have acquired: those in business management and administration.

In the 1970s, and at an increasingly rapid rate through the 1980s and 1990s, the old ideologies of efficiency, rationality and management from the turn of the century (and of which IQ testing was a part) have resurfaced in the western world and in Australia. Schools of management now flourish at universities and 'pump out' ever increasing Bachelors and Masters of Business Administration. Personnel and other management companies proliferate, and new and exotic management ideologies are born, circulate briefly in, then disappear with quite bewildering speed from a whole range of public and private institutions. Management as a profession was reborn as a crucial element in the professional managerial class, but there is a difference between the late and early twentieth centuries. Whereas in the early twentieth century management grew largely separately from the professions, in the late twentieth century the professions have taken management to the point at which it now provides techniques for professions on the make and qualifications for professionals on the way up. John McKnight, the American sociologist, argued that in the USA, leaders in professional services recognised what they thought was a need for management skills to end what he calls the process of 'iatrogenesis' or doctor created disease—the idea that professionals first create a problem, then deal with it.⁸⁴ This may be so, but modern management has intervened in many more institutions than professionals have power over. It seems more likely that increasing demands on Government services, redistribi-

bution of scarce resources, the growing complexity of bureaucracies with new demands in areas like health and safety and finance and human resource management, and greater accountability to Government has opened the way for managers whose skills lie in abstracted management; in technical skills which are generic in the sense that they can be applied anywhere. Professionals who move into management, of course, do so with their eyes open. They must be aware that management has different priorities than do professions loyal to their profession or to their client population.

Certainly, Irrabeena had grown rapidly in size and complexity since the Government assumed responsibility for it. The number of clients grew; its budget increased markedly, as did its staff, both professional and non-professional; and the various professions have carved out territory for themselves. At present a good proportion of those at the top are trained psychologists with management qualifications. Advertisements for the Chief Executive Officer for the new Disability Services Commission in 1993 symbolised the dominance of management. In the language of the job advertisement, tertiary qualifications and management experience are now 'essential'; experience and knowledge of policy in the field of disability services was only 'preferable'.⁸⁵

Education and Integration

From the 1950s to the 1980s, a system of education for children with intellectual disabilities developed which classified children according to a perceived level of disability, then provided an education setting thought to be appropriate to that perception. Thus, by 1972, the 'educable mentally retarded', as defined by IQ tests, were placed in special classes in regular primary schools where they learned from a modified three Rs curriculum but were included in non-academic programmes — such as sport, sewing, physical education and music — with other children. At secondary level, children with intellectual disabilities were put in the vocationally oriented classes with a view to placing them in the unskilled workforce. In both cases they would, it was hoped, benefit from social interaction with 'normal' children. The 'trainable mentally retarded' — those with IQs between 30 and 60 — were placed in what were first called occupational centres. Later, they entered training centres and special schools run by the Education

Department where they learned life skills such that they could live in the community with supervision. In 1974, there were 60 special classes in primary schools and 23 in secondary schools, and there were 14 training centres. In addition, there was the Nathaniel Harper Homes for 'trainable' children and Pyrton for the so-called 'severely handicapped child'. Otherwise, education was left to the SLCG and its day activity centres. Those children with intellectual disabilities considered 'hopeless' cases, neither teachable nor trainable, were placed in Nulsen Haven.⁸⁶

In the 1970s, the situation began to change. Prompted by new policies and practices from the USA, the popularisation of the principles of normalisation and the new notion — based largely on the United Nations proclamation on the rights of people with disabilities — that people with disabilities had rights, parent groups and Federal and State educational authorities began to look for an alternative to the practices of segregation. They searched for ways and means of integrating children with disabilities into regular schools and regular classes. The process came to be named 'integration' or 'mainstreaming'. In the 1970s and 1980s in most States and in the purview of the Commonwealth, public enquiries into education and special education had found segregation to be not only educationally ineffective but also socially inhibiting and politically unjust. Further, it was argued that mainstreaming was more effective educationally, more socially beneficial and more in keeping with contemporary ideas about human rights.⁸⁷

In Western Australia, integration seemed to have proceeded in the same piecemeal and ad hoc way as special education in the years before World War Two, until the Beazley Report into education in Western Australia in 1984 recommended its almost wholehearted adoption. The Report adopted a needs-based approach to education for children with disabilities rather than the categorical approach which had, by linking a category of disability to a kind of education, let the definition of the level of disability structure the child's education. It also adopted a rights approach by insisting that an integrated education was every child's right and that this should be written into the Education Act. But the Report was something less than unequivocal. Four caveats to full integration appeared. Integration should proceed but only if the school's resources could be adapted to its needs; if the education of so-called 'normal children' was not interfered with; if consideration was given to public resources; and if the wishes of the whole school

community (including teachers and parents) were met.⁸⁸ This was not exactly a rights approach. Nevertheless, the Beazley Report engendered a widespread feeling of optimism and hope among educators and parents of children with disabilities, and there has been acceptance of the idea of integration in the education community. At the level of ideology, the principle of integration is now the official Education Department policy.⁸⁹

As Fulcher points out, however, policy is best thought of not just as epistles from on high but as a relational practice at all levels of the educational hierarchy. There is plenty of evidence to suggest that schools exercise their power to make policy by emptying their schools of mainstreamed students.⁹⁰ Also, because Education Departments across Australia do not provide sufficient resources, mainstreaming can very easily become what Lyn Gow et al. call 'maindumping'.⁹¹ That the right of children with disabilities in Western Australia to an integrated State education can be denied is partly due to the powers the State Government gives to Directors of Education, the absence of a Bill of Rights in Australia, and to the concept of 'the most advantageous environment' — that is to say, the continuing existence of an ideology which insists that segregated classes and schools remain places to which the Education Department can recommend particular children be sent.⁹² What difference the passage of State and Federal anti-discrimination laws, particularly the Commonwealth Disability Discrimination Act, will make to these incomplete rights has yet to be fully tested. Nevertheless, since the *Education Act Amendment Act 1976*, parents have had more rights than hitherto. The Act detailed parents' rights of appeal against Departmental decisions and shifted the onus of providing education from parents to the Department.⁹³

Integration in Western Australian State schools is administered at central administration level by Educational Support which has been part of the Education Department's Social Justice unit since 1985. At school level, Education Support Schools (ESSs) provide education for students with severe disabilities; students who, it is thought, need a degree of support not available in other education settings. But today, schools like Gladys Newton are not known as special schools but by the school name. The Education Department has no curriculum for these schools, but individual schools are beginning to develop their own, and part of the Newton school's own curriculum is the exercising of formal and systemic links between certain classes and equivalent classes in

local regular schools. Perhaps because they are aware of the overwhelming literature against segregated schools, there is little sense at Gladys Newton that the school exists to hide away students with intellectual disabilities.⁹⁴

Education Support Centres (ESCs) are in effect schools within schools or school centres within regular schools. The children in these centres are integrated in subject areas they can cope with, or for a specific period per day, in arrangements which are drawn up between the school's principal and the principal of the centre. The centres usually also provide support for the school's academically weaker students. Education Support Units operate at a more intimate level still, providing support for students whose regular place is in a mainstream class. These institutional arrangements, though, are not the final word on integration. The ideal integration — now, often called inclusion — is one in which children with disabilities are integrated permanently into a regular class with or without trained help, depending on their needs, with trained help funded from Commonwealth or State Government finances, and where the whole school is involved in the process.⁹⁵

Teachers and Professional Power

In 1993, the Shean Report into the education of children with disabilities recommended what educators and teachers of children with disabilities had long called for — teachers required to have formal qualifications in the area of education support to gain employment, and all teaching degrees to incorporate a special needs component. In 1993, the Education Department's practice was to give preference to those teachers in education support with qualifications in the field of special education, but it insisted that all promotions were now based on the possession of a degree in special education.⁹⁶ Prior to 1973, Western Australian special education teachers had no formal training in teaching children with intellectual disabilities. Those who chose the field did so at their peril because special education in the 1950s and 1960s was something of a dead-end promotionally. Hence, teachers were often married women ineligible for the permanent staff and excluded from promotion by Departmental regulations; 'good hearted people', according to Formentin, 'who were prepared to take these kids'.⁹⁷ Older teachers will recall the dread they felt when the special class teacher was ill and they were called in to supervise for a day. In 1973, however, the

Education Department, perhaps responding to Hamilton's initiatives at Mental Health Services, established a graduate certificate in Special Education at Mt Lawley Teacher's College and ran it with funds provided by the Commonwealth which, following the Karmel Report, had committed itself to special education. The course was run by Keith Green, the then-principal of Balga Special School and was taught by a range of professionals all involved in the disability field. In 1975, the College took over the course and taught it as a Postgraduate Diploma to teachers whom the Education Department released on full pay for a year. In the 1970s UWA Education Faculty also began to teach special education, and in the 1980s special education began to be taught as electives within the broad Bachelor and Diploma courses.⁹⁸ By 1993, Mt Lawley campus of Edith Cowan University appeared to do most of the pre-service preparation of what are now called education support teachers, although students at all five universities in WA receive what the Shean Report calls 'some information' regarding children with special needs. Three WA universities provide a compulsory unit which addresses these needs. Only Edith Cowan University, however, offers a full course in special needs education and postgraduate study. The Education Department provides in-service and professional development, but education officers and the visiting teacher service give 'on site' support to teachers.⁹⁹ Plainly though, in the integrationist era all teachers will need a grounding in special needs teaching. Edith Cowan University now requires its Bachelor of Education students to do 26 hours in their core education unit at third year to 'sensitise' them, as Formentin puts it, to the fact that there are children with special needs, that they may find them in their classes, and will need to meet their educational requirements.¹⁰⁰

The existence of these courses and the restrictions on the right to teach to those who have done such courses are powerful indicators of the process of professionalisation. In fact the circle is almost complete. Teachers and educators have their own association, the Association of Special Education, Western Australian Chapter, and this body has its own journal. But importantly, the Association is not yet able to accredit courses in special needs nor teachers who pass through them.¹⁰¹ Professionalisation has taken 20 years so far, a short time in the history of the professions.

Nevertheless, there were early attempts to professionalise. In 1974, the Association of Heads of Special Schools established a journal called

The Exceptional Child in WA. An apparent lack of interest seemed to have caused the journal's early demise, and probably only two issues were published. Its contents were unexceptional, but an editorial in the second issue shows that this small association was already concerning itself with the future of special education and the teachers who taught it:

Will we have special classes or special schools in a few years time? It would appear that if some of our district guidance officers have their way, the vast majority of special education facilities as we know them will disappear in the near future. To those who promulgate this view I would address the following questions: How well do you understand the objectives of the various branches of special education? What research-proven alternatives have you to offer?¹⁰²

It is not clear from the journal what alternatives the guidance officers were offering. Was it a vision of integration 10 years before the Beazley Report? Were special education teachers feeling threatened? Educationists in the USA have recorded the opposition to integration of teachers, trainers and institutions involved in special segregated schooling. Formentin recalls some early concern by special education teachers that their jobs were at risk but she also argues that this has not proven to be the case. Rather, special needs teachers' jobs have been retained and extended as they now often have to work alongside regular-school teachers, collaborating and consulting on their charges' development.¹⁰³ Nevertheless, it is not clear whether the Education Department and some educationists regard the ESC as the 'real home' of students with intellectual disabilities and the regular classroom as a kind of extra. The Shean Report has also picked up this thinking and has recommended that the 'home' of children with disabilities be the regular classroom and he/she be withdrawn as needed.¹⁰⁴

Plainly the changes in education policies over the years have given teachers much more power in their relationships with other professionals, whether the teachers work in regular classes or in ESCs. Formentin remembers case conferences in the 1960s and 1970s, in which children with intellectual disabilities were placed, which worked with a clear hierarchy — doctors on top, then psychologists, social workers, other therapists and teachers on the bottom:

And if you ever saw a case conference list of who was present, the teacher was always at the bottom and generally not well attended to. The teacher would talk about the child's performance in class, the child's behaviour, the child's progress and people would make decisions on the basis of their drug regimes, their psychological tests, their home, as seen through the eyes of the social worker. Parents usually didn't get in at that stage at all. They were called in at the end and given the story about what was going to happen to their child.¹⁰⁵

That teachers became increasingly recognised as the primary providers of the child's education was not just a product of changes in the system. Teachers fought for this role, first against doctors, then often against guidance officers and psychologists in the education system who were often reluctant to acknowledge teachers' special skills and experience. Teachers at the Gladys Newton School, for instance, regard themselves as managers of their students' progress. Gregg asserts:

The trappings of [the old] medical model have receded more and more over the years as schools have become more autonomous and more confident and more experienced in their own decision-making and in this school, certainly, we've developed the model of the teacher being the programme manager and taking responsibility for all things that happen on the campus for the child.¹⁰⁶

Psychologists may be called in to develop behaviour management programmes as they have in the past in all schools, but it appears that their major role is in placement conferences; that is, the conferences which make recommendations as to where children with disabilities will go.

Teachers' power, especially special education teachers' power, has also been exercised through their association, the Australian Association of Special Education. The Association was set up in Victoria in the 1970s and has among its members teachers, academics and parents (in this sense it is not completely strictly a professional body, but it represents the education support teachers). It acts to encourage special education as a field to lobby for change for funding, resources and services, and in general, as an advocate for the field.

Fulcher suggests that — at least in the mid 1980s — the Association, acting from a base in segregated educational settings, adopted a discourse of professionalism. At the 1987 Australian annual general meeting, the Association's President observed:

A sense of pride and belief in our work as special educators comes with acknowledgment of our professionalism. Special educators must stand proud as a professional group... They must see the AASE as being an essential part of their professional growth and development.¹⁰⁷

She also claims that it adopted an educational programme based on a disability model and actively pursued segregation.¹⁰⁸ The ideological splits in special education in Western Australia from the late 1970s on make it difficult to sustain assumptions that the Association spoke or speaks with one voice on education (see below), but there is little doubt that the Association was and is implicated in the process of professionalism and the acquisition of power and influence.

Whether education support teachers exercise their powers against their clients is another matter. Certainly, the Education Act and anti-discrimination acts give parents substantial rights over the education of their children, while the Education Act at the same time gives the Education Department substantial power over the same process. But there has been little or no research in Western Australia on the way teachers in the age of integration relate to parents, let alone to children. It is difficult therefore, to know whether teachers present education to parents as a matter of technical, hence professional knowledge — as Fulcher suggests is the case elsewhere — or whether teachers share knowledge with parents in a language parents can understand.¹⁰⁹ Judging by parents' responses to the Shean Report, a greater problem was the lack of information they were given, which may indeed be the same problem in another guise. There are enough glimpses of the distance between teachers and parents to suggest that all is not well: suggestions that information is passed to parents in professional jargon or other complex languages; fears of the consequences of asserting rights; the unavailability of psychologists' reports; claims that teachers feel threatened by questioning parents; and that professional jealousy sometimes intervenes between parents and their children's education. Certainly, teachers who gave evidence to the Taskforce also felt the

same distance, commonly asserting the virtues of meetings between parents and teachers and other professionals in which both parties were equal partners.¹¹⁰

Professional power is acquired by the instrumental underpinnings of organisation, education legislation and hence exclusion. It is maintained by a cultural legitimacy acquired by language, claims to expertise and by the way in which a problem issue is constructed, or more generally, in the way knowledge itself is constructed and in the way solutions are offered. In the field of intellectual disability, knowledge was constructed by medical practitioners who defined disability as pathology and proffered medical solutions, then by psychologists who claimed the right to assess and refer by virtue of the possession of the appropriate technology: the IQ test. This tells us, we argue, that intellectual disability is a socially constructed concept. Just as Thomas Szasz argued in the 1970s that insanity was a 'modern myth' — that 'madmen' were manufactured in the passage from medieval to modern history — it is possible to see disability in similar terms. Fulcher argues persuasively that it is a '*political and social construct* used to regulate'.¹¹¹

Some of these issues surfaced in a rather acrimonious debate about education and disability in the early 1980s. In late 1979, the State Government's Council for Special Education produced a report on the present and future of special education in Western Australia. As a stage in the history of disability, it appears to sit on the cusp of segregation and integration. The point here is that the Council constructed disability by reference to a combination of IQ tests and tests of adaptive behaviour based essentially on the tests adopted and used by the American Association for Mental Deficiency.¹¹² Two responses to the report are of particular interest: the first by Irrabeena; and the second by Dr Trish Formentin, a lecturer in education at the then-Mt Lawley campus of WACAE. Irrabeena and Formentin both accused the Council of constructing a category of intellectual disability which in the educational process would thus label a child as 'disabled' and provide an 'appropriate' education. Their response was to deny the applicability of IQ testing, in line with the powerful critiques of the practice which had been developing in the USA and Britain since the 1960s, particularly where they were used as predictors of children's performance rather than as just a measure of intelligence at the time they were taken. They also criticised the accuracy and infallibility of adaptive behaviour tests.¹¹³

Plainly, there were educational implications on each side of the argument. A strict regime of testing and commitment to a logic of deficiency, of deficit, and of limits set by IQ leads on to segregation; hence the coincidence of the IQ testing movement's greatest influence and an education system distinguishing the 'trainable', the 'educable' and the 'normal'. To reject the capacity of tests to predict implies a system which refuses to understand limits and which promotes programmes based on a child's observable performance and *without* limits, or at least a belief that limits are unknowable. When this is recognised, then arguments can and do take place about the best educational setting for students to realise their potential.

There are also clear implications in these arguments for professionals. If psychologists claim a role in disability services or education based on their exclusive capacity to use IQ and other tests, then if the tests go, their power goes; indeed, so does the reason for their existence. Similarly, if teacher commitment to segregated schooling is undermined by the processes of integration, then so does theirs, unless they re-educate themselves into an integrationist model. And again, if behaviourist psychologists are committed to repressive behaviour modification while the dominant ethos is changing to environmental modification, then so will theirs. Certainly this is all too schematic. Children's IQs are still tested in Western Australia, and children are placed according to the result of these and other tests. Certainly, there are teachers still committed to forms of separation just as there are those fully committed to integration. And certainly, there are behaviourists or neo-behaviourists whose ideas have had and still have great impact on special education. At a general level though, the point remains that, as Fulcher suggests, parts of educational discourse construct children with disabilities as children with disabilities rather than as pupils.¹¹⁴

Conclusion

The subject of this chapter has been professional power. The 'lot' of people with intellectual disabilities has changed remarkably over the last 90 years, even more remarkably over the last 30, and with these changes have come changes in the population providing for them. The displacement of the medical model of treatment of people with disabilities has meant the marginalising of doctors and nurses. The arrival of the developmental model has seen the accession of professions equipped

to provide residential and educational settings, and ideologies which promise people with disabilities a degree of potential unknown 30 years ago. Yet the journey has not always been progress. The professional's client population has been the object of ideological currents which flow in then out of professional practice; currents which have not always worked to the benefit of people with disabilities yet have always worked to the benefit of the profession. This is to be expected because professional knowledge is in a constant process of change.

The question which needs to be asked is whether the relationship between the professions and people with disabilities has changed from the days when the 'lot' of people with disabilities was exploitation and oppression. Certainly, normalisation implies new rights for people with disabilities, and the recent Federal and State anti-discrimination legislation inscribes these rights in law. Certainly, too, the thinking of the newly dominant professions has been informed by similar notions of rights; so in a very powerful sense, the relationship has changed. In another more structural sense, however, it cannot change while professions organise their exclusivity and exercise their specialist knowledge in specialist language from the position of power which they have acquired. Perhaps the solution to this conundrum is more democracy: a loosening of professional privilege; a genuine sharing of knowledge; and a leavening of excluding language. But would the professions still remain as professions...?

Notes

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8. *ibid.*, p. 34.

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19. Letter from Miss Alder, 27 May 1910 (PROWA ref: AN 45/1, ACC 1497, File 1534). On Hodgkinson see Weiland, R., *op. cit.*, p. 61.
20. Doctors Report, June 1910 (PROWA ref: AN 45/1, ACC 1497, File 1534).
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7 Making a New Profession: Social Trainers and Intellectual Disability

Norman Megahey

Introduction

Modernised nations, argued the North American sociologist John McKnight, are best defined as service economies:

They are serviced societies and they are peopled with service producers and service consumers — professionals and clients.¹

Writing in the 1970s, Ivan Illich proposed to name the mid twentieth century ‘The Age of Disabling Professions’: ‘an age where people had “problems”, experts had “solutions” and scientists measured imponderables such as “abilities” and “needs”’.² This chapter will examine one aspect of the development of the comprehensive service for people with intellectual disabilities which now exists in Western Australia, namely the emergence of social trainers in service delivery. Social trainers represent what was in 1965 a new concept in care provision, and their subsequent evolution reflects to a significant degree the developing philosophies that have helped shape today’s services. Throughout, this chapter will emphasise the broader social context in which the development of professionalised services took place, namely the growth throughout the Western world of the professional service economy. And it will also consider the major question posed by McKnight, Illich and others: whether the consequences of professionalised service is enrichment or disablement.

The chapter will briefly refer to developments during the 1950s and early 1960s in Britain, events which were to influence thinking in Western Australia from the mid 1960s onward. It will then focus on

Western Australia and examine the development of 'hands-on' care of people with intellectual disabilities. It will examine the character of this care in both Fremantle Asylum and Claremont Hospital to establish the parameters of the custodial and medical models of care as they affected people with intellectual disabilities. It will then examine the reasons for the shift away from a traditional medical model which prescribed nursing care for people with disabilities, before proceeding to look at how the concept of social trainers has changed over the quarter of a century since its introduction. This will entail looking at ways in which social trainers have interacted with other professions and the effect of this interaction on service delivery. It will also entail a consideration of ways in which social trainers have consolidated their position within the newly developed framework through both industrial and educational means. Again, the implications of this for service delivery will be considered. Finally, this chapter will comment on the recent setting up of a professional organisation for social trainers and suggest possible implications of this for the future.

The Tizard Experiments

From at least the beginning of this century, the care of people with intellectual disabilities has fallen within the province of medical doctors, with day-to-day care in institutions being carried out by nurses. In Britain, specialised training for nurses led to State registration for what was called 'mental subnormality nursing'. Elsewhere in Europe, there were also specialised courses for nurses working in the field. However, the late 1950s and 1960s witnessed increasing interest in and concern for people with intellectual disabilities in both Europe and the USA, especially those institutionalised in the 'back wards' of mental hospitals. Jones calls the 1960s in Britain a 'period of unprecedented public concern and agitation about the condition of mentally handicapped people in hospital'.³

Perhaps the most important figure in England during this time was Professor Tizard of the Social Psychiatric Unit at the Maudsley Hospital, London. As we saw in Leonie Stella's chapter, Tizard strongly emphasised the social aspects of intellectual disability, and in particular he looked at ways in which people with disabilities could be kept with their families in their own homes. In a 1962 work, Tizard published the results of the Brooklands Study, an experiment carried out in a residen-

tial unit for children with intellectual disabilities.⁴ In this experiment, Tizard adopted methods of care used in residential children's nurseries. It became clear to him that many of the children's problems stemmed from emotional deprivation and lack of one-to-one relationships, rather than from their intellectual disability. These findings were important for at least two reasons. First, as Jones points out,⁵ the Brooklands Study gave empirical backing to the notion put forward by Goffman in his 1961 book *Asylums*⁶ that at least some of the problems of 'patients' with intellectual disabilities were of the hospitals' own making. Second, the Brooklands experiment marked a decisive shift away from the previously dominant medical model, a shift which was reflected in Tizard's 1964 re-definition of 'mental subnormality'. He re-defined those people previously labelled 'mentally subnormal' as people who 'require special educational and social services'.⁷

Such a philosophical and institutional shift created numerous problems. Perhaps the most obvious was the disparity between this new conception of needs and the availability of resources to provide for them. Most importantly, there was, in Jones' words, 'a quite appalling "lack of fit" between the professional personnel we have and the professional personnel we need'. Jones continued:

The persistence of the medical model of treatment means that we have a large number of people called "doctors" and "nurses" whose work does not primarily involve medical and nursing skills, and who are called on for the exercise of skills in which they are not trained.⁸

Mental Hospital Nursing in Western Australia

The winds of change began to blow through the field of intellectual disability in Western Australia in the 1950s. They needed to. For the previous 80 years the State offered little more than custodial care for people with intellectual disabilities. Within Claremont, people with intellectual disabilities were segregated. In the 1960s, a separate ward, J Ward, was set aside for 70 to 80 children under 14 years of age whose condition was considered 'hopeless'. The status of these children was reflected in their living conditions and in the training given to the nurses who were assigned to look after them. According to Dr A. S. Ellis, Director of Mental Health Services for most of the 1960s and 1970s,

J Ward during the early 1960s was appalling even by the standards of the day:

There was no activity going on, there was nothing being done, just lying around in their cots and vomiting and passing motions and wetting themselves and it was a mess.⁹

The nurses in attendance were psychiatric nurses with no special training in intellectual disability. Much of the care the children received was provided by female inmates who shared the ward with them.¹⁰

In the history of mental illness, the psychiatric nurse arrived at the same time as the mental health hospital; both were products of the medical model of insanity. The hospital for the insane superseded the asylum; the psychiatric nurse superseded the asylum attendant. When insanity became a disease to be cured, the nurse became part of the cure.

We can see this process in Western Australia, more specifically by looking at those who worked as attendants at the Fremantle Asylum. When the asylum was transferred to the Colonial Government, its male staff comprised constables, orderlies (both prisoners of the Crown) and warders (free men from the colony). Clearly Fremantle was a place for custody, not cure, and although the female side was staffed by nurses under a matron, there is little doubt that the regime remained the same.¹¹ That Fremantle resembled a prison was also clear to its medical staff later in the century. In 1900, the then-Inspector General referred to his Chief Warder thus:

He would make a capital prison warder, but I do not think he is a good man for the asylum; that is a fault you often get. They become warders instead of attendants when they have been in these places too long...There is no desire to cure. There is no sympathy at all. I do not mean to say that you should have too much sympathy in an asylum, but you certainly want some...It is the same with nurses; they get the same in time. Perhaps it happens so with doctors.¹²

That prisoners of the Crown could become asylum constables, presumably without training, set a precedent which lasted into the twentieth century. The Tratman-Davey report to the Vosper Committee in 1900

showed that of 17 male attendants, only one had any previous experience in an asylum (in Gladesville NSW). Of the nurses, four had experience at the Kew Idiot Ward in Melbourne.¹³

As we saw in Gillgren and Brogan's chapter, Claremont Hospital for the Insane replaced the Fremantle Asylum early in the twentieth century. The changing nomenclature reflected Montgomery's wish to see mental illness regarded as a disease and the hospital as a place for cure, not custody. Accordingly, warders were re-named attendants (they were still, at first, the same men), and Montgomery began educating his staff in medical and then psychiatric matters. The examination papers given to staff and printed in his annual report to Parliament in 1909 and 1910 show a shift from questions on basic anatomy, physiology and procedures to follow in emergency situations, to questions on exaltation and hallucinations.¹⁴

Montgomery was extremely proud of his record in educating the nursing staff. His reports show that in 1910, 70 per cent of his 105 staff were qualified. The fact that the number fell to 38 per cent in 1913 was more as a result of the advent of the eight-hour day and a consequent increase in staff, rather than any failure of the system.¹⁵ By the 1920s, certification had been tied to all tenets of training. Passing exams was necessary for annual movements in the first four years of a career, and full qualifications were gained after three years. These qualifications were necessary for promotion to charge attendant or nurse.¹⁶ This internal hospital certification, tied as it was to on-the-job training and lectures (generally given by medical staff), lasted until 1960 when certification was transferred to the Nurses Registration Board. Thereafter, more psychiatric nurses received additional general nursing training.¹⁷

After reading the evidence given to various committees and commissions of enquiry into Claremont up to the 1950s, one might question the actual application, or lack thereof, of this psychiatric knowledge at Claremont. One receives an overwhelming sense of an institution devoted to custody and custody alone. Attendants and nurses followed regular routines as they herded inmates around wards and airing courts. Inmates rose in the morning, were moved to the airing courts, then brought back for breakfast. This routine was followed every day as patients were returned to the airing courts (some patients went to work) after breakfast, lunch and dinner, though in winter patients were allowed in the day room before going to bed.¹⁸

Certainly, this routine was complicated by the staff's affective relations with the people in their care. On a formal level, the duties of staff were set out by the Lunacy Acts, by hospital regulations, and by the dictates of medical officers. In reality though, the dearth of doctors on the wards meant that the staff really ran the hospital.¹⁹

The staff had a difficult and often unpleasant job. Attendants were also at risk of attack from some patients, especially those who worked in the 'violent and noisy' wards which often comprised some 'ticketed' patients: the suicidal and homicidal. When one witness to an enquiry in 1919 was asked if he had seen attendants attacked, he replied, 'times without number'.²⁰ Staff were responsible for bathing, sometimes toileting, cleaning, supervising hundreds of patients at meals, restraining violent patients, and cajoling and persuading others as necessary by either the power of their presence or the use of drugs.

Yet there is plenty of evidence to suggest the almost routine use of physical force by attendants to maintain control. There were inquiries into physical abuse at Fremantle in 1898, and the Vosper Committee in 1900 also touched on it.²¹ In response to a question at the 1919 Select Committee, one charge attendant warned:

If we allowed the patients to do as they liked they would come at us again and again and we might as well hand over the keys to them if we did not punish them in some way.²²

Much of the 1921-1922 Royal Commission on Lunacy was an inquiry into allegations by patients of acts of brutality against them, or of neglect or laziness. The *West Australian* labelled one alleged practice, where several attendants picked up a troublesome patient and dropped him, the 'drop cure'.²³

The most comprehensive inquiry, though, came in 1950 as a result of allegations in the *Sunday Times*. The evidence given by the investigative journalist, Lawrence Turner, makes disturbing reading. At one stage, he described how some 'quiet and chronic' patients — some of whom we might now call people with intellectual disabilities — 'cower away' when attendants approached them. Of 17 instances investigated, the Royal Commission found 13 proved. Five attendants were charged in the Perth Magistrate's Court with breaches of the Lunacy Act and one was ultimately convicted.²⁴

How endemic this was, or whether it was, is impossible to say. The chief critic of the hospital administration at the 1921-1922 Royal Commission did admit that most attendants were 'decent humane men', and tributes to staff by relatives of inmates can also be found.²⁵ Ellis refers to the nurses who were looking after children with intellectual disabilities at Claremont in the 1960s as 'incredible really, marvellous'.²⁶ Ultimately, only the patients could tell us the true nature of their treatment at Claremont; and they were rarely asked.

The relations between staff and doctors before the 1960s seem almost archaic and inappropriate to a hospital. Ultimate authority, of course, rested with the medical superintendent who could discipline, fine or dismiss staff — though staff always had the right to appeal — in accordance with the powers given him by the Lunacy Acts. Even after an Arbitration Court award in 1921, the medical superintendent still had unfettered powers during an emergency.²⁷

The day-to-day relations between doctors and staff were distant. At least until the 1920s, male attendants were required to salute doctors when they saw them.²⁸ Doctors never spoke to the rank and file nurses and attendants, but only to the charge staff who accompanied them on their rounds. James Bentley justified this to the 1919 Select Committee:

If a man in the army wants to give an order or to find out anything, he goes to the next below him. It is the same way with us.

When asked whether charge staff spoke to the rank and file, he admitted that he did not know.²⁹

Obviously, charge staff were closer to the doctors and formally under their control, although the 1939 Royal Commission into Heathcote Hospital showed just how charge staff with presence and experience could dominate newer medical staff.³⁰ And, like any hospital, there were formal hierarchies in the staff: matrons, deputy matrons, chief attendants, their deputies, staff in charge of wards (the charge staff) and rounds men (in charge at night). Similarly, an informal hierarchy also existed where older staff exercised authority over newer staff. Again, this could be subverted as when 12 staff in 1919 complained to the superintendent about the 'harsh, overbearing and dictatorial' manner of one charge attendant.³¹

The rigidly hierarchical structure at Claremont began to alter in the 1950s when some children were transferred to Nulsen Haven and when other professions — like psychologists, occupational therapists and social workers — gradually entered the institution. Ellis remembers resistance to new initiatives by older nursing staff both in Victoria and Western Australia, but he organised seminars for them and informally tied attendance to promotion. The big breakthrough, though, came in the 1960s when he introduced ward conferences where medical, other professional staff and nurses would discuss patients' conditions before the medical officer would finally decide the patients' fate.³²

This apparent democracy accompanied four other major changes in the work of the nursing staff: the end of the historic practice of males nursing males and females nursing females; the mixing of males and females in certain wards; the employment of psychiatric nursing aides to do the routine cleaning and the like; and equal pay. Ellis ascribes the sexual division of labour to the nineteenth century belief that 'lunatics' were potentially violent and could only be dealt with by men.³³ That may have been so for male 'lunatics', but in Western Australia, female 'lunatics' had always been supervised by female nurses. As might be expected, these separate worlds of nursing had developed their own pay scales. In the 1920s a first-year male attendant was paid £208 per annum in the award, with the head attendant receiving £318. A first-year nurse, on the other hand, was paid only £78. Only at the level of deputy matron did the women's wage reach half of the male equivalent.³⁴ Equal pay took 40 years to arrive. Ellis remembers it being granted in the late 1960s.³⁵

No doubt the low pay played a part in the endemically short supply of women willing to work as mental hospital nurses. Sources refer to this in the 1920s and 1960s, as they refer to the rapid turnover of female nursing staff. On the other hand, there always seems to have been an oversupply of male attendants. Two interesting results spring from this fact. First, for women able to handle their job the chances of promotion were very good. Thus, in 1923 a nurse with just three years experience could reach a charge position. Male attendants, on the other hand, had a much harder job receiving promotions; the length of service of some of the male attendants is very striking.³⁶

Perhaps the high turnover of women staff is one of the reasons why their pay was so low. The union covering mental nurses did not seem particularly pro-active in seeking equal pay, nor did the hospital

administration seem interested in lobbying for it, but this is hardly surprising given the way unions, employers and arbitration courts in Australia combined to keep women's wages low.³⁷

Mental nurses were covered from 1912 by the Hospital and Kindred Industries Union, which probably won them an eight-hour day. However in 1923 the Metropolitan Mental Hospital Employees Union which covered only mental hospital nurses — was established. In 1928 it changed its name to the Western Australian Male and Female Mental Nurses Union, and again in the 1970s to become the Psychiatric Nurses' Association. The union covered all nurses employed in mental hospitals with the Lunacy Act's Certificate of Competency and probationer's training for the certificate; this was an important precedent for the later closed shop.³⁸

There is no evidence prior to the 1960s that mental nurses pursued the professional status of their successors in the field of disability — the social trainers — but this is hardly surprising given that workers at that time were much more conscious of their status as workers. Instead, mental nurses pursued typically unionist goals: an award, improvements in pay and conditions, and a measure of job control. Their success in the latter area was of course severely constrained by the Lunacy Act, but they were granted an award in 1921 and certification, and the closed shop did give the union some measure of job control. As we have seen, the union was more successful looking after its male members' pay than that of its female members, until equal pay was granted.³⁹

This brief survey of the history of mental nursing affirms some of the analysis made by other researchers in the field. Prior links English psychiatric nurses into the medical model of care as the handmaidens of the medical profession; first learning the intricacies of the body, administering 'treatment' and creating 'affective' relations with patients, then, as psychiatry developed, paying more attention to those patients' psyches.⁴⁰ As we have just seen, some of that process also seems to have occurred in Perth. Ryan and Thomas show how nurses in Britain's hospitals for the 'mentally handicapped' actually worked. The picture is not a pleasant one: nursing staff hemmed in by rigid management hierarchies, by the exigencies of the need to keep these huge institutions running, and by inadequate training to deal with patients dehumanised by the system. There is little sense in these places that nurses are or were the therapeutic technicians that their training

and education implied.⁴¹ As Goffman suggests, the contradictions implicit between the attendants' work, education and training; between the image of rationality the asylum presents to the world and the reality of the antagonistic social relations within it; between the notional ideas of cure and the labels attached to inmates; between the responsibilities of attendants and their lowly place in a bureaucratic hierarchy; between the regulations within which they worked and the freedom allowed them by the absence of supervision, all meant that their chief role was surveillance of a population 'dumped' in the asylum. However, Goffman underestimates the importance of collective organisation among mental hospital nurses and the power their union gave them. He completely ignored the gendered character of asylums and of hospital union nurses' work.⁴² Prior goes somewhat further to suggest that psychiatric nursing in Britain was tantamount to little more than keeping 'inmates' clean, disciplined and under control.⁴³

Staffing Pyrton

Guy Hamilton has traced the development of services for people with intellectual disabilities in Western Australia through four stages.⁴⁴ The first stage, 1953 to 1961, saw the emergence of voluntary organisations and the involvement of the Department of Education. Hamilton termed the second stage, from 1962 to 1970, the period of maximum physical expansion. It was in this period that the concept of social training emerged in embryonic form, gradually developing into a discipline which has provided the bulk of direct services since the 1970s. The third and fourth stages witnessed increased expansion of services, development of ideas and involvement of social trainers.

The decision in 1962 to establish a new residential unit for children with intellectual disabilities at Pyrton marks the beginning of the end of the reign of psychiatric nurses in the field of intellectual disability. Pyrton and the creation of the Mental Deficiency Division within Mental Health Services reflected the growing government commitment to developing a service for people with intellectual disabilities which would be separate from that in existence for people with mental illness. This commitment was further reflected in the appointment of Hamilton, rather than a psychiatrist, to head the new division. Hamilton had joined Mental Health Services in 1962 and had taken a special

interest in people with intellectual disabilities in Claremont. As the only doctor in Mental Health Services who had worked with people with intellectual disabilities, Hamilton was appointed a member of the committee which was asked to design and build Pyrton. At that time, it was planned that Pyrton would still be run along hospital lines by a medical superintendent and a staff of nurses. However, between 1962 and 1966, when Pyrton was finally opened, several factors contributed towards a change in thinking regarding the hands-on staff.

In the first place, Tizard was undertaking his important work in England which clearly demonstrated the unsuitability of psychiatric hospitals for people with intellectual disabilities. Giving further strength to Tizard's work were other studies which showed that 64 to 80 per cent of people with intellectual disabilities in psychiatric institutions needed no medical or nursing care whatsoever.⁴⁵ Hence Tizard's rejection of the medical model with all its attendant medical paraphernalia, in favour of concepts and insights from developmental psychology.

Further to this new knowledge was the changing attitude of the Western Australian government. In 1964, on Hamilton's advice, Mental Health Services took responsibility for Irrabeena, thus committing itself, in Hamilton's words:

to the development of a service as opposed to providing a facility; that is, providing a service within the community for all types and all needs, as opposed to just providing residential needs.⁴⁶

It became increasingly clear that Pyrton would function as a training centre rather than as a place of treatment. The problem for Hamilton then became how to staff such a unit. Both Ellis — the then-Director of Mental Health Services — and Hamilton agreed that conventional psychiatric nurses could only offer a custodial approach to treatment, which was unsuitable in the extreme. Apart from agreeing on this, neither man had any idea how to staff the unit.

Their first attempt was to staff Pyrton with nurses who wished to work in the field of intellectual disability. This would have been in line with the circumstances in other Australian States. However, it soon became clear that the whole of the first year of training offered by the Nursing Council consisted of little more than basic knowledge of anatomy and physiology. Hamilton described his reaction:

it was quite obvious that it was inappropriate for persons who were going to work with children who were not ill and who required training. I remember reading the curriculum proposal, starting with the anatomy and physiology of the alimentary tract — a knowledge of the enzyme Ptyalin was to be taught — and I wondered how this would help in developing the potential child.⁴⁷

This nursing model was rejected. It was obvious to Hamilton that what was required was not nurses but people who could train children with intellectual disabilities according to their individual needs and to their optimal level. However, the problem still remained of how to design and implement a course which would equip people for this task.

In an effort to solve the problem, Hamilton approached Perth Technical College, which was running one-year courses for people working in the area of child welfare. He thought that a similar course could be run for staff working with people with intellectual disabilities, and that these people could undergo training for one year before commencing work. He also thought that by moving responsibility for such a course away from Mental Health Services to an independent body, appropriate standards would be maintained and the course could be co-ordinated with those other, similar courses.⁴⁸ Ultimately, with the co-operation of Perth Technical College and in consultation with Mr Ellis Brown — a clinical psychologist attached to Mental Health Services — an initial outline of a course was developed. Unfortunately, early in 1966, Perth Technical College, having helped to formulate the new course, opted out on the grounds that the proposed pay scale for the new social trainers was so low that the course would not attract people of sufficient quality.⁴⁹

Time was fast running out. The Minister for Health, G. C. MacKinnon, was pressing for Pyrton to be opened by the end of the year, the project having been underway since 1962. A quick decision had to be made, and so it was decided to retain the curriculum developed at Perth Technical College but to reschedule it in order to offer social trainers an initial three-week course followed by teaching sessions half a day per week for a year whilst they worked.

Two final decisions remained outstanding. Once the format of the new course had been agreed upon, the matter of staff numbers had to be decided. Furthermore, there was the question of the quality of staff

— what type of person to look for. On the first question, Hamilton drew on the experience offered by the Brooklands Study: that a ratio of one 'hands-on' staff member to four children was required, in addition to supervisors and professional staff. In Hamilton's words:

it was felt that...with a reduction of staff-resident ratio below one to four...training would suffer and custodial care would supervene.⁵⁰

On this basis, it was decided that 20 trained social trainers would be required. In addition, there would be seven registered nurses employed purely in nursing work.

Having decided on numbers, it was left only to decide on the type of person best suited to fill the role of social trainer. Although in some respects, as Hamilton readily conceded in 1976, 'some of our ideas were vague', some key concepts were already in place which were to go a long way in determining this question.⁵¹ Perhaps the most important of these was that child-oriented programmes were more appropriate than a nursing approach. Hamilton's basic idea was that the children would be trained along developmental lines and, importantly, that each child would be trained individually. Children — unloved, neglected and having spent most of their lives within Claremont — would be arriving at Pyrton suffering severely from emotional deprivation. Therefore, people chosen to train these children would have to be equipped to provide the sort of care that would help compensate for this deprivation.

In accordance with the existing sexual division of labour — in which the provision of child-care fell within the female sphere — Hamilton and his co-planners decided to recruit only women. There were also economic considerations. This was the era before equal pay, when women were considerably less well paid than men; female social trainers would be cheaper. One of the earliest social trainers, recruited in 1967, later recalled the first social trainers' view of themselves as caregivers and 'being women' — not particularly powerful.⁵² It was also decided that mature women who had brought up their own children would be more suitable. The advertisement which finally appeared in the *West Australian* in October 1966 asked for applications 'from women, 21 to 50 years of age, of suitable personality and ability,

with occupational and recreational skills', and offered a starting salary of \$29.25 per week.⁵³

In short, women provided not only the traditional caring role expected of their sex but also cheap labour. Furthermore, according to one social trainer recruited at this time:

social training was very biased against men for quite a few years. This bias was partly because it was seen as a woman's job and also because most of the men coming in had no experience with kids. The social climate of the time was still that men did not do for the kids.⁵⁴

Hamilton selected from the applicants on the basis of an interview, IQ test and an aptitude test. Eighteen successful applicants began work as social trainers in November 1966. One of that number, Mary Summers, later recalled her memories of the group:

A rather apprehensive group of women gathered in the lecture room of Pyrton Training Centre in November 1966 to take part in the first Western Australian course in training the intellectually handicapped....From all walks of life and as many different countries and cultures, we had no idea of what was in store for us...united by the mere fact that we were indeed the first group attending the first course; with no guidelines to follow and no predecessors to show us the way we certainly felt like pioneers.⁵⁵

This first group of women were pioneers. Looking back 10 years later, Dr Hamilton was to comment:

we had nothing...we were very ignorant of many things in how to run Pyrton...for a couple of years at least (I wouldn't say we were floundering) but did not see our way as clearly as I do now.⁵⁶

Yet one gets the feeling that much of the pioneering spirit so obviously felt by the first group of social trainers was to no small degree generated by Hamilton himself. While Hamilton may have been unclear on some points of detail, he had enough vision to inspire those around him with a genuine sense of purpose and an enthusiasm which, under the

circumstances, was quite remarkable. A measure of this is to be found in the fact that despite the horror and shock, later recounted by one of the women, of being confronted by several emotionally deprived, institutionalised children — despite ‘picking our way through the urine and faeces covering the floor and some of the walls’ on day one of the children’s arrival at Pyrton — during the first six months there was not a single resignation from the group.⁵⁷

In January 1967, a second group of women were appointed as more children were transferred to Pyrton from Claremont. There were now 40 social trainers undergoing the first-year course. Following the initial three-week induction period, training now comprised two hours of lectures per day for five days a week over a period of one year. While the course involved learning basic medical and psychological concepts as well as occupational therapy, physiotherapy and speech therapy, the most urgent needs of the children stemmed from their appalling emotional deprivation: the result of years of custodial care in Claremont Hospital. Therefore, what was required was loving care. In the words of one social trainer, ‘loads of cuddles to try and make them feel good about themselves’.⁵⁸ That this approach paid dividends for residents and staff alike is clear from this same woman’s recollections that Hamilton’s personal attitudes, combined with the influence of the new cultural imperatives in the 1960s regarding child-care, provided a firm base on which to build a new kind of care. She continued:

It was a great developmental stage for staff. My youngest child was brought up quite differently from the other children. This was a reflection of what was happening in everybody’s lives at the time.⁵⁹

By late 1967, the basic framework around which professionalised services for people with intellectual disabilities in Western Australia was to develop was in place. Pyrton had been opened and a sheltered workshop had been established in Fremantle. Irrabeena, which was coping with an ever increasing number of new cases, was undergoing a change of role from a social agency to a purely diagnostic and referral centre.⁶⁰ Staffing at Pyrton consisted of both trained and trainee social trainers, with a team of registered nurses and a senior sister. However, staffing at Irrabeena was inadequate, with only eight professional staff to manage the medical, social and psychological needs of 2,500 ‘clients’

(as registered people with intellectual disabilities came to be known). A particular worry for Dr Hamilton, as expressed in his 1967 annual report, was the shortage of senior staff 'to supervise, direct and train junior staff'.⁶¹ And, especially given the new emphasis on the social problems of people with intellectual disabilities, the shortage of social workers was of great concern. At Irrabeena, there were only two trained and one untrained social workers, each of them part-time.

Social Trainers and the Expansion of Services

Before describing the expansion of services which took place in the years following 1967, it may be useful to briefly return to the issue raised in the introduction, of the professional service economy: the broader social context in which the development of services for people with intellectual disabilities took place. There is little doubt that we live in an increasingly professionalised society. To quote the historian M. J. Perkins:

The twentieth century is not, pace Franklin D. Roosevelt, the century of the common man, but of the uncommon and increasingly professional expert.⁶²

In his analysis of 'professional society', Perkins described two ways in which professionalism permeates society. First, he argued, professional hierarchies extend down the social pyramid to embrace occupations formerly thought to be beyond the reach of professional aspirations, a process which results in increasing specialisation. Second, said Perkins, a professional society is one permeated by the professional social ideal. While industrial capitalist societies are permeated by an entrepreneurial ideal based on acquisitiveness and competition, the professional society is permeated by a professional social ideal based on knowledge, training expertise and human capital. By claiming that their particular knowledge and expertise are indispensable to their clients or to society at large, professionals establish control of their market. Here, Perkins' key point was that professionals establish and maintain their special position by persuasion; a point McKnight also makes in his analysis of the professional service economy. But McKnight is rather more acerbic than Perkins. For McKnight, the critical political issue of modern societies is the actual manufacturing of

needs by professions in order to create a service economy and protect their own interests. The outcome, says McKnight, is a set of 'disabling effects' which are intrinsic to the modernised service economy.⁶³ With these issues in mind, this chapter will turn to look at the expansion of services for people with intellectual disabilities which took place in Western Australia after 1968, and which resulted in both an expanded role for social trainers and in an increased involvement of professionals.

In response to increasing numbers of people registered as 'clients', the Minister for Health, G. C. MacKinnon, established a Committee of Inquiry with instructions to produce a five-year plan. The plan was published in December 1968 and among its proposals were the establishment of 16 new hostels, two new day centres, six new sheltered workshops and the expansion of both Irrabeena and Pyrton. The most important part of these proposals was the decision to accommodate people with intellectual disabilities in hostels in the community as a practical step towards their ultimate integration into society. Such dramatic expansion, together with developing practical ways of applying the philosophy of integration and normalisation, inevitably brought about a greater involvement of professionals in service provision as well as an expansion of the role of social trainers.

In addition to the expansion of Pyrton in the years following 1968, Hamilton pushed hard for his Division's services to be located out in the community. To this end, and in line with the emphasis on the social needs of people with intellectual disabilities, services expanded in three main directions: residential services, community services and domiciliary services. Importantly, he decided to use social trainers as hands-on service providers across the whole range of new services. This brought them into contact with the traditional professional 'experts' in each service such as social workers, occupational therapists, speech therapists and psychologists.

According to Hamilton, the utilisation of social trainers across the range of services would have two main benefits. First, he argued, the training required by a person with intellectual disabilities was essentially the same no matter whether he or she was being trained at home, in a day centre or in a residential hostel. Consequently, the staff involved in training needed identical skills and personality.⁶⁴ Second, the provision of different staffing systems across different sites would be both divisive and administratively inefficient. With a common training scheme for persons involved in all of the areas, for example,

transfer between areas of either staff or clients would be relatively simple.

However, there was one important exception to this 'across the board' use of social trainers in service delivery. In the 1970s, several residential hostels for people with multiple disabilities were opened; that is for people with profound intellectual and physical disabilities. Until the early 1990s these hostels were staffed by registered nurses who had largely a supervisory role. The bulk of the hands-on care was provided by untrained nursing assistants and a few enrolled nurses. Hamilton considered that for people with profound disabilities, many of whom had severe physical disabilities, a more nursing structured situation was required.⁶⁵ Given the fact, however, that the residents in these hostels did undergo training programmes aimed at maximising their independence, the absence of social trainers in hostels for people with multiple disabilities needed some explaining. The arguments for employing social trainers across the whole range of services applied equally well to such hostels, and there seemed to be no reason why nurses should not be able to operate in an overall structure that would include social trainers.

A clue to the answer was to be found in the system of care provision which was initiated when Pyrton was first opened. Working alongside the trained social trainers at that time was a team of registered nurses under the supervision of a senior sister. The relationship between these two groups exemplifies the way in which inter-disciplinary rivalry can develop; one group struggling to maintain its own status, the other striving for recognition as it develops a power base of its own. One of the members of the first group of social trainers recalls that although Hamilton wanted no distinction between the two groups in terms of status, the dearth of knowledge and experience among the social trainers meant that the registered nurses were, *ipso facto*, senior. Another member of the first group of social trainers recalled later how they set out to receive the first group of children from Claremont 'under the eagle eye of Sister Masters'.⁶⁶

The situation was probably exacerbated by the fact that the first social trainers were fitted out with light blue uniforms and white aprons, thus giving all the appearance that they were indeed nurses. From all accounts, much of their daily routine comprised traditional nursing work such as sterilising and bed-making. On the other hand, the registered nurses with their training and experience were not

inclined to accept equal status with untrained and as yet inexperienced social trainers. In these circumstances, the registered nurses tended to take a supervisory role while retaining their usual and more skilled tasks such as doing medication rounds or applying surgical dressings: work for which they had been trained.

Furthermore, although equal status between the two groups may have been Hamilton's ideal, it is doubtful whether, during the first year at least, the social trainers themselves would have felt easy about accepting the responsibilities which equal status would entail. During this period, and for some time afterwards, the social trainers regularly consulted the nurses for advice on how to cope with a variety of problems. However, as they gained experience and consulted the nurses less frequently, they found that the nurses did not readily relinquish their earlier superior standing. In the words of one psychologist who worked at Pyrrton, the social trainers 'found it difficult to find their own feet and shake off the RN's'.⁶⁷

A further contributing factor to the conflict between the two occupations was the fact that when Pyrrton first opened it consisted of a single residential unit so that both registered nurses and social trainers shared the same working environment. It was only after the opening of a sick bay that the two groups became physically separated and a distinction between their respective roles thus became more apparent; the social trainers continuing to work in the residential unit and the nurses working in a hospital environment with more clearly defined nursing responsibilities.

Subsequently, there have continued to be varying degrees of tension between the two occupations. Some of this tension can be attributed to a certain territorial attitude on either side. As both groups are essentially hands-on caregivers, there is a significant overlap in their responsibilities, especially when the two groups are working in the same environment. This has sometimes led to a blurring of interdisciplinary boundaries in which calls for a level of co-operative decision-making have not always been forthcoming.

The issue of status was also a problem and it is here, particularly, that we may have an answer to the question of why social trainers were not utilised in hostels for people with multiple disabilities. From time to time, there had been attempts to use social trainers in hostels to work alongside registered nurses. However, these moves failed to reach their

aim because of disagreement as to who would be senior, social trainers refusing to work under the supervision of a Director of Nursing and nurses refusing to accept supervision from Senior Social Trainers. It is difficult not to conclude that the losers in this situation must be the hostel residents themselves who are denied the direct hands-on training which social trainers can provide.

Since the early 1990s, however, the situation has changed. The day-to-day management of the hostels is now the responsibility of social trainer supervisors who co-ordinate a team of social trainers. Registered nurses continue to be utilised with at least one rostered on each shift. Many of the people who previously worked in the hostels as nursing assistants have completed conversion courses and qualified as social trainers. The overall trend has therefore been for hostels to be more 'social training' oriented.⁶⁸

Social Trainers and the Professions

Since their introduction into service provision, social trainers have been employed in ever increasing capacities. As professionals have been brought into the various service areas, social trainers have been utilised first to assist and then to take over much of the work traditionally performed by these professionals. In June 1968, for example, a social trainer was appointed to the area of occupational therapy. Over the next six years, social trainers became involved in the areas of audiometry, physiotherapy, education and social work. According to Hamilton, it had always been intended that social trainers would be brought in to assist and ultimately take over much of the work of professional people. Apart from benefits already mentioned — of having 'across the board' hands-on workers — there was, in Hamilton's view, a very practical reason for employing social trainers in this way. In evidence before the Public Service Arbitrator in 1976, Hamilton estimated that if all the work which might be done by occupational therapists was left to the therapists themselves 'we would be doing something like a quarter of what we are doing at the moment'. He continued:

I see this going on very much more, that social trainers will become particularly skilled in a particular sphere...and that in the end many of the therapists and doctors will in fact be largely directing social trainers in their work and

the focus will not be on actually doing the work themselves.⁶⁹

This expansion of roles and the subsequent increasing specialisation of the new roles is significant for a number of reasons. As we shall see later, it was used to successfully argue for improved wages and conditions in a major industrial dispute in 1976. Furthermore, it contained the seed from which professional aspirations would later take root as social trainers sought, and still seek, to achieve professional status. Perkins' analysis is particularly relevant here:

As more jobs become subject to specialised training and claim expertise beyond the common sense layman...their occupants demand the status and rewards of a profession.⁷⁰

The question to which this gives rise is just where does this leave the professionals? To understand how their role has changed we need to go back to 1964 and the creation of the Mental Deficiency Division, and then move on to examine the concept of multi-disciplinary teamwork which was implemented in the early 1970s and through which the professionals to a large extent operate.

To begin with, the bulk of professional services were delivered through Irrabeen where psychologists, social workers, occupational therapists and doctors carried out assessments on new referrals and made recommendations regarding which services the client required. As services developed, professionals were attached to the service area whose responsibility it was to make decisions about the care and training of clients in that particular area. In a residential hostel, for example, the social trainers would consult with the appropriate psychologists who might then draw up a programme for the social trainer to implement. In those cases where it was considered that a client may be more suited to a different placement or benefit from another service, the appropriate professional could be called in to make the relevant assessment and provide advice.

There were, however, at least two problems with this arrangement. First, the mechanism made no provision for co-ordination between the various services. This resulted in, for example, incomplete transfer of information when a client was moved from one area to another.

Second, there was no one person specifically responsible for assessing the suitability of other facilities once a client was attached to a particular service.⁷¹ Both of these problems became more obvious as services grew in size and number.

In an effort to overcome these problems, it was decided that two sets of multi-disciplinary teams be established: Primary Responsibility Teams (PRT) and Administrative Co-ordinating Teams (ACT). Attached to every training or residential facility was a PRT made up of staff from that particular facility. This team was responsible for designing and implementing appropriate management plans for each client using the facility. Further, the professionals in these teams were responsible for assessing the suitability or otherwise of other facilities for individual clients; an occupational therapist, for example, assessed available resources which fell within the sphere of occupational therapy while a social worker was concerned with community resources. The Administrative Co-ordinating Team (ACT) — made up of representatives from each PRT — co-ordinated the activities of the PRTs in each service area. This team was also responsible for drawing on external resources such as those offered by voluntary agencies.

The multi-disciplinary structure of these teams was their key element and therefore needs to be discussed in more detail. The importance of multi-disciplinary teamwork has been recognised both in Australia and overseas for some time. In the area of intellectual disability, it is a logical consequence of the belief that management of people with intellectual disabilities becomes a problem of education for living and not just a medical problem. Its implementation in services for people with intellectual disabilities in Western Australia had two important consequences.

First, all team members having equal voice in discussion and decision-making, in theory at least, is something which could only enhance the position of social trainers who, in a more traditional hierarchical structure, would have undoubtedly experienced inferior standing. Second, according to Worthington, all team members experience a closer understanding and acceptance of each other's roles.⁷² This was further encouraged by the provision of in-service training procedures involving all disciplines, and a policy which required all professional staff when first employed to spend time carrying out hands-on care alongside social trainers.⁷³

While the theory behind multi-disciplinary teamwork may be sound, questions can be raised concerning its practical operation, and there are dangers inherent in its structure. In particular, when boundaries between disciplines become blurred, uncertainties can develop as to where precisely each person's responsibilities begin and end. This danger is even greater in an overall structure which takes responsibility for direct service provision away from the professionals and places it within the province of more broadly trained hands-on caregivers: in this case, social trainers. This is not to detract in any sense from the way in which social trainers perform their duties or to suggest that such dissemination of responsibilities is in itself bad, but rather is intended to point to the need for professionals to keep their specific responsibilities in focus. That this need has not always been met is evident in a paper written by two social workers who were attached to the Division in 1980. They bemoaned the absence at Pyrrton of social workers who had specific responsibility for normalising client relationships with family and community. Quoting Nage, they argued that:

a clear division of labour is a necessary condition for effectiveness of teamwork in health care, and other collaborative endeavours.

Among their suggestions for achieving this were clarity and specificity of roles, and specialisation with minimal overlap: practical prerequisites, they suggested, 'which at the moment are not present at Pyrrton'.⁷⁴

A further criticism which may be made of the concept of multi-disciplinary teamwork is that, despite lip-service being paid to equality in the relationships between occupations, members of the team who are basic caregivers will almost unavoidably experience inferior standing. Furthermore, as Worthington points out, though basic staff are theoretically included in the team, decisions are often made without them.⁷⁵

Again, Perkins' analysis is relevant to the point being made. A key element in his discussion is that professionals transform their expertise to power through persuasion. Since professional status depends on being able to persuade society of the value of the service provided and of the cultural legitimacy of the provider, the professional ideal could, in theory, be applied to everyone. However, despite this potential for equality, the professional society is not egalitarian. Rather, it is a collection of parallel hierarchies of unequal height, each with its own

ladder of many rungs and with a substantial distance not only within the profession, but also between professionals and non-professionals with cognate but uncredentialed knowledge. Hence, inequality between those who possessed capital and those who did not (certainly of a different kind to that typical of older capitalist societies) and rivalry persist.⁷⁶

To summarise thus far, the roles of various disciplines involved in services for people with intellectual disabilities in Western Australia have undergone significant change since 1964. Whereas the various professionals formerly carried out the sorts of roles traditionally expected of them, currently, most of the responsibilities which comprise those roles are being allocated to social trainers. Professionals, along with social trainers, continue to be involved in assessing and planning, although much of the implementation is carried out by social trainers. Importantly, social trainers remain free to consult with professionals if the need arises.

Social Trainers, Their Union and Their Education

So far, we have looked at the roles of social trainers and the various professionals involved in service provision to people with intellectual disabilities in Western Australia. We need now to return specifically to social trainers. Constituting as they did in 1964 an entirely new occupation with no past and an uncertain future, we have seen how, over the years, they have taken on increasing responsibilities over a wide range of services to become the linchpin in the current structure of service provision. However, if this were the whole story, social trainers would be mere actors passively following a script written for them by professional script writers. This would be to ignore the struggle which social trainers as a group have had in achieving recognition both of their industrial importance and of their skills and expertise across the whole range of services for people with intellectual disabilities. The first of these achievements has been brought about through trade union means and the second through advancements in educational opportunities. Both of these will be examined in more detail below: first, in outlining the main stages in each process and second, by suggesting some implications for service delivery.

Up until 1970, the wages and conditions of social trainers were determined by the Minister for Health on advice from the Department

of Labour. Although the exact criteria for deciding on appropriate conditions and salaries is unclear, three points are significant. First, one of the reasons for employing only women in the early days was that they were a source of cheap labour; this was a common practice, of course, right across industry. The second point, not altogether unrelated to the first, was that no attempt was made to base conditions and salaries on estimations of work value. The explanation for this may be linked to a third reason for employing only women: the fact that this type of work was considered women's work and therefore not considered to be of much value economically. Whatever the reasons, the Minister for Health at no time sought discussions with the Civil Service Association or any other union on conditions relating to employment.

It was inevitable that unhappiness over conditions and salaries would emerge, especially as social trainers grew in number, men were recruited, and social trainers gained qualifications and experience. However, no avenue was available through which they could air their grievances with the Ministry or negotiate for better conditions. Discussions on wages and conditions took place between representatives of the social trainers and Department of Labour officials in 1969 but nothing was resolved. Finally, in June 1970, a meeting of social trainers formally drafted their grievances and decided to approach the Civil Service Association (CSA) for assistance. In November 1970, the CSA lodged a claim with the Minister for Health on behalf of the social trainers. The full significance of this was that for the first time since the concept of social trainers was developed four years previously, an established procedure for industrial negotiation was instituted.

The details of this and further claims lodged over the years are, for the purpose of this chapter, irrelevant. Suffice to say that the most contentious issue was salaries, with the social trainers asking for government officer status which would entitle them to public service pay scales. Over the years, there have been a series of industrial disputes between the social trainers represented by the CSA and the Ministry of Health; a number have led to industrial stoppages. What is important for our present discussion are the implications of unionisation for the social trainers as a group and, more importantly, for the service which they provide.

The fact that the social trainers decided to approach the CSA for assistance in 1970 is in itself significant, indicating a reluctance on their part to become involved in militant union activity. The other avenue

open to them was through the more militant Hospital Workers Union (HWU). That consideration was given to approaching the HWU is evident in a letter written by a representative of the social trainers to the Minister for Health in which he stated: 'We notice with interest the prompt attention received by the HWU in their recent problem'. However, he added: 'The type of person engaged in our field of work are not strongly in favour of attention gaining tactics which would be detrimental to those in our care' — thus making it clear that strike action was not something which they would readily contemplate.⁷⁷

The problem for the social trainers was that given their undeniable sense of responsibility towards the people with intellectual disabilities in their charge, their negotiating power was reduced. Undoubtedly, the Ministry played upon this fact. Nevertheless, in 1972, the social trainers — having failed by other means to reach a satisfactory response from the Ministry — held a one-hour stop work meeting: the first indication of their preparedness to take strike action if all else failed. Eighteen months later, in June 1974, they stopped work again, this time staying out for eight hours and returning only after a strong appeal by the CSA to do so. On this occasion, what must have been something of a unique situation developed in that prior arrangements were made with professional staff to take over the social trainers' jobs for the duration of the stop work. In the words of one CSA official, this indicated:

the unique situation the CSA found itself in whereby one section of its membership was stopping work...and another section of our membership was going in to do their job.⁷⁸

This situation also indicated the concern not to jeopardise the well-being of clients through industrial action. Since 1974, there have been other occasions when social trainers have resorted to similar industrial action, though not always with full support from within their own ranks. The net result was a set of working conditions and a salary scale which compared favourably to those of workers in other fields such as teachers and nurses. As for the effect of the unionisation of social trainers on service provision, it is obvious that any group of workers in receipt of realistic remuneration for their services will provide better services than a group which feels itself to be undervalued and exploited.

The second direction in which the occupation of social trainer has developed is in education. The enormous expansion of their role and the widening diversity of activities in which they have been involved has, over the years, necessitated a broadening of training. Two important developments have been the increasing involvement of Tertiary and Further Education (TAFE) and the Western Australian College of Advanced Education (now Edith Cowan University). Both of these institutions now offer courses to cater for people working across a range of human services.

Much of the impetus for the creation of these courses came in the mid 1970s with the increasing emphasis on the concept of normalisation in services for people with disabilities. From this came the realisation that services for people with intellectual disabilities overlapped with services provided by other agencies. As a result, in 1977, the TAFE course leading to the Certificate in Training the Mentally Handicapped was replaced by the Certificate in Training the Handicapped. This change made it possible for people in related areas to learn together, a move which could only be beneficial to all concerned. Currently, TAFE offer a Certificate and a Diploma course in Human Services, both of which are twelve-month courses. The first six months of each course is generic in content and designed for people wishing to work across a range of human services. The second six months allows students to specialise in their particular area of interest. Social trainers follow the 'Disabilities' stream.

The reality in the mid 1990s, however, is that tertiary institutions are unable to supply sufficient numbers of graduates to meet service requirements. Moreover, most of the students who enrol in these courses are female, an indication perhaps that the concept of 'caring' continues to be seen as a female responsibility. In order to redress these imbalances, untrained people continue to be recruited as social trainer assistants and given day-release to attend the TAFE Certificate course.⁷⁹

As with the issue of unionisation, the importance here is not the details of educational opportunities now available for social trainers, but rather the consequences for service delivery. Social trainers are not the only group of caregivers for whom increasingly academic courses have been developed over the years. As knowledge expands, there is a growing demand on workers across industry to keep pace with new ideas and technologies. However, while it is unquestionably desirable

to have a body of caregivers who are well trained and knowledgeable in their field, it is arguable that the provision of academic programmes does not in itself lead to the provision of better day-to-day care. There are two reasons for this.

The first reason stems largely from an important difference between social trainers and professionals. Social training is by definition a hands-on activity — the translation of theory into practice — unlike the professions which are theoretically based. A major problem for any model of human service provision is bridging the gap between theory and practice, a problem which Hamilton himself attempted to deal with by allowing social trainers power to veto professional programmes. In his own words:

I have specifically allowed for this...many of the professionals have done an enormous amount of theoretical work. Not all of them are practical people in their work. There is a vast difference between the theory...and actually practically doing it.⁸⁰

Therefore, the problem for social trainers becomes one of applying the learning they receive from more academic courses directly to the provision of day-to-day hands-on care. The reality (witness the nursing profession) is that higher academic qualifications are invariably used to gain access to the next level in an increasingly stratified career structure. Thus, caregivers become one step further removed from the clients. The gain for the client then, to borrow a metaphor from conservative economics, comes from a trickle-down effect. The main beneficiary in terms of both status and income is the servicer, not the serviced.

The second reason for the assertion that increased educational courses for social trainers does not in itself lead to an improvement in the quality of day-to-day hands-on care provision relates to work value. That the skills involved in providing hands-on care in the area of human services are not highly valued socially is somewhat paradoxical. In part, this low status is a consequence of the fact that hands-on caregivers spend a great deal of time dealing with the basic bodily functions of the clients in their care, and so find themselves dealing with aspects of life which society finds disgusting. This low status may also, of course, reflect society's perception of intellectual disability, but this is only part of the problem. The tendency for professions to arrange themselves

hierarchically inevitably results in groups of workers such as social trainers — a relatively new discipline with no specialised body of knowledge (as distinct from specialised skills) — experiencing inferior standing. In fact, this inferior standing was established from the outset when the decision was made that social training was women's work and thus deserving of neither status nor adequate remuneration. Once again, as long as basic caregivers receive little recognition in terms of status and remuneration, there will always be a tendency to use higher educational qualifications as a means to move away from a hands-on role to higher status, non-contact roles.

Conclusion

It remains now to summarise briefly the development of professional services to people with intellectual disabilities in Western Australia, and then to discuss what conclusions we can arrive at concerning the effects of these services on the people who utilise them: the clients themselves.

The most important element in the thinking which led to the creation of services for people with intellectual disabilities was the realisation that intellectual disability was not a medical problem but a social and educational issue. From this, it followed that a service based on a medical model was entirely inappropriate. The creation of a new occupation called social trainers marked a decisive shift away from traditional nursing care, and marked an equally dramatic shift from the custodial care of the asylum or 'hospital for the insane'. As new ideas such as integration, normalisation and social role valorisation began to take hold in the philosophy of care, services increased in number and range, and a greater range of professional experts was then required in such areas as social work, occupational therapy, physiotherapy and speech therapy: all areas defined as necessary by the new developmental model. Partly for economic reasons but also in response to the thinking on integration and the wish to provide co-ordinated services, social trainers were introduced to each of these specialised areas in order to gradually take over much of the work done by professionals. Increasingly, the professionals began to act in advisory and teaching capacities and, through multi-disciplinary teams, to help direct and manage services.

The displacement of the medical model of treatment of people with intellectual disabilities by the developmental model has meant that the services which have been provided by the various disciplines over the past quarter of a century have led to a dramatic improvement in the quality of life experienced by people with intellectual disabilities in Western Australia. This has in no small way been due to the creation of the occupation of social trainers to give direct care over the whole range of services. However, there is always a need for service providers to continually reassess their service and to be aware of what McKnight and others have called the 'disabling effects' of service systems; effects such as translating perceived needs into deficiencies and locating these perceived deficiencies *in* the client, thus isolating the need from its socio-political context.⁸¹ Of particular concern for professionals and social trainers alike is what McKnight sees as the disabling effects of specialisation which, he argues, 'increasingly communicates need in terms of people as atomised parts'. This 'removes even the potential for individual action'.⁸² Furthermore, atomisation of a person puts the 'whole' person out of focus. The danger of losing focus is ever present and can result from any of the developments we have discussed. It is particularly present in the current move by social trainers to gain professional status through the formation of a professional organisation. In 1991, a group of senior social trainers and managerial staff formed the Association of Social Trainers Western Australia (ASTWA), a professional body whose prime objective is 'to promote social training amongst employer groups, consumers and the community', and whose operations 'are closely linked to social trainers' ethical concerns for their clients'. Since its formation, membership of Level One social trainers — those actively involved in hands-on work with clients — has been encouraged, with the senior founding members playing a less active role.⁸³ Reasons for such a move must be linked to issues such as desire for improved status and increased recognition. However, the issue here is not whether social trainers as a group possess the attributes commonly employed to define professions, attributes such as possession of an esoteric body of knowledge or power of self-regulation. As Larson points out:

the professional phenomenon does not have clear boundaries. Either its dimensions are devoid of a clear empirical referent or its attributes are so concrete that occupational

groups trying to upgrade their status can copy them with relative ease.⁸⁴

The real issue concerns the effect of the professionalisation of direct hands-on caregivers on the clients. McKnight points out that a very basic definition of unprofessional conduct is 'becoming involved with the client'.⁸⁵ The converse is also true. To be professional is to distance oneself from the client. This is the issue which needs to be addressed, not just by social trainers in search of professional status but by all professionals involved in care provision. As one social trainer commented, 'we have always got to have people to remind us what we are about'.⁸⁶

Notes

1. McKnight, J. M. (1976). 'The professional service business.' *Social Policy*, 8(3), p. 110.
2. Illich, I. (1977). *Disabling Professions*. London: M. Boyars. p. 11.
3. Jones, K. (1975). *Opening the Door: A Study of New Policies for the Mentally Handicapped*. London: Routledge and K. Kegan Paul. p. xv.
4. Tizard, J. (1964). *Community Services for the Mentally Handicapped*. London: Oxford University Press.
5. Jones, K., op. cit., p. 5.
6. Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Middlesex: Penguin.
7. Jones, K., op. cit., p. 5.
8. *ibid.*, p. 195.
9. Ellis, A. S. (1979). Oral History Transcript, p. 292 (BL ref: OH 396).
10. Evidence of John Anderson, Inspector General of the Insane, to the Royal Commission on Lunacy, 1921-1922 (PROWA ref: AN 537, ACC 2962, Item 2962/1).
11. Report of the Select Committee of the Legislative Council into the Proposed Transfer of the Lunatic Asylum at Fremantle from the Imperial to the Colonial Government, 1883. *Parliamentary Papers*.
12. Report of the Select Committee of the Legislative Assembly into the Condition of the Fremantle and Whitby Falls Lunatic Asylum, 1900. *Parliamentary Papers*, Volume 2, Transcript of Evidence, p. 13.
13. Report on the Lunatic Asylum of Western Australia by Frank Tratman, MD and J. S. Davey, MD. Appendix A of *ibid.*, pp. 32, 34.
14. Report of the Inspector General of the Insane 1909. *Western Australia: Minutes, Votes and Proceedings of the Parliament*, 1909, Volume 2; Report of the Inspector General of the Insane 1910. *Western Australia: Minutes, Votes and Proceedings of the Parliament*, 1910, Volume 2, p. 5.
15. *ibid.* See also the report for 1913 in *Western Australia: Minutes, Votes and Proceedings of the Parliament*, 1914/1915, Volume 2, p. 5.
16. See Arbitration Court File 15/1924, Industrial Dispute Mental Hospital Employees Union and the Government (PROWA ref: AN 1953/B, ACC 1101).

17. Ellis, A. S. (1984). *Eloquent Testimony. The Story of Mental Health Services in Western Australia, 1830-1975*. Nedlands: University of Western Australia Press. p. 173; Ellis, A. S. (1979)., op. cit., pp. 561-562.
18. Arbitration Court File 15/1924, Industrial Dispute Mental Hospital Employees Union and the Government (PROWA ref: AN 1953/B, ACC 1101).
19. The medical staff at Claremont Hospital did their rounds once daily, spending a couple of hours on the wards. However, when one reads that there were only three doctors at Claremont until the 1950s; that there was only one doctor for each of the male and female wings; that there were five wards on the male side and four wards on the female side; and that doctors rarely bothered to visit the 'quiet and chronic' block, the four-ward X Block or the back wards, then it must be obvious that these doctors only caught glimpses of most patients and staff (apart from the charge staff who accompanied them on their rounds). See evidence of John Anderson, Inspector General of the Insane, to the Royal Commission on Lunacy, 1921-1922 (PROWA ref: AN 537, ACC 2962, Item 2962/1) and Royal Commission into certain allegations as to the ill-treatment of inmates at the Claremont Hospital for the Insane, 1950, p. 9 (PROWA ref: AN 537, ACC 2943/1).
20. Evidence of Martin Turner, attendant, Report of the Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane, 1919, Minutes of Evidence. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1919, Volume 2*, p. 25.
21. Ellis, A. S. (1984)., op. cit., p. 39; Report of the Select Committee of the Legislative Assembly into the Condition of the Fremantle and Whitby Falls Lunatic Asylum, 1900. *passim*.
22. Evidence of Martin Kerin, Report of the Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane, 1919, Minutes of Evidence. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1919, Volume 2*, p. 71.
23. See the evidence of John Coulthorpe and others in Reports and Appendices of the Royal Commission on Lunacy, 1921-1922, pp. 134-158 (PROWA ref: AN 537, ACC 2961/1).
24. See Martin Turner's substantial evidence to the Royal Commission into certain allegations of mistreatment. The report was not printed in *Western Australia: Minutes, Votes and Proceedings of the Parliament* but was practically reproduced in full in *Sunday Times*, 25 June 1950, p. 5. For the results of the court cases see *Sunday Times*, 25 June 1950, p. 32. The Royal Commissioner did not recommend punishment for the men but was extremely critical of the hospital's administration. He in turn was castigated very vigorously by the then-Inspector General and the Minister for Health, Florence Cordell-Oliver.
25. Evidence of John Coulthorpe, Reports and Appendices of the Royal Commission on Lunacy, 1921-1922, p. 146 (PROWA ref: AN 537, ACC 2961/1). Several tributes are scattered throughout the second half of the report.
26. Ellis, A. S. (1979)., op. cit., p. 293.
27. Arbitration Court File 15/1924, Industrial Dispute Mental Hospital Employees Union and the Government (PROWA ref: AN 1953/B, ACC 1101).
28. Evidence of James Iliffe, Report of the Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane, 1919, Transcript of Evidence. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1919, Volume 2*, p. 36.
29. Report of the Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane, 1919, Transcript of Evidence. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1919, Volume 2*, p. 116.
30. The Heathcote inquiry was appointed mainly to investigate the relationship between Heathcote's matron and its medical staff. Report of the Royal Commis-

- sion into Heathcote Mental Reception Home and the Administration of Mental Hospital Generally (PROWA ref: AN 537, ACC 2966/1).
31. Evidence of Thomas Russell, attendant, Report of the Select Committee of the Legislative Assembly on the Claremont Hospital for the Insane, 1919, Transcript of Evidence. *Western Australia: Minutes, Votes and Proceedings of the Parliament, 1919*, Volume 2, p. 21.
 32. Ellis, A. S. (1979), op. cit., pp. 405-406.
 33. *ibid.*, pp. 403-404.
 34. Arbitration Court File 15/1924, Industrial Dispute Mental Hospital Employees Union and the Government (PROWA ref: AN 1953/B, ACC 1101).
 35. Ellis, A. S. (1984), op. cit., p. 175.
 36. Evidence of Inspector General, Reports and Appendices of the Royal Commission on Lunacy, 1921-1922, reproduced in *Sunday Times*, 25 June 1950, p. 5; Ellis, A. S. (1979), op. cit., pp. 406-409.
 37. For general arguments in this area see Frances, R. (1994). *The Politics of Work*. Melbourne: Cambridge University Press.
 38. Arbitration Court File 284/1922, Mental Nurses Registration File (PROWA ref: AN 1953/A, ACC 1101).
 39. Arbitration Court File 15/1924, Industrial Dispute Mental Hospital Employees Union and the Government (PROWA ref: AN 1953/B, ACC 1101).
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 41. Ryan, J. and Thomas, F. (1980). *The Politics of Mental Handicap*. Harmondsworth: Penguin. Chapter 3.
 42. Goffman, E., op. cit., pp. 13-117. See also Garton, S. (1988). *Medicine and Madness. A Social History of Insanity in New South Wales, 1800-1940*. Sydney: University of New South Wales Press. Chapter 8 for a discussion of the situation in New South Wales, and Marion, J. E. (1995). 'The keepers of the insane: The role of attendants at the Toronto Provincial Asylum, 1875-1905.' *Social History*, 28, May, for an interesting critique of Goffman.
 43. Prior, L., op. cit.
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 47. *ibid.*
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 49. Dr Guy Hamilton, interview with author, 1 October 1990.
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 52. J. Elliot, interview with author, 10 October 1990.
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 54. J. Elliot, op. cit.
 55. Summers, M. (1980). 'I remember Pyrton and its pioneers.' *Division for the Intellectually Handicapped Journal*, 5(1), p. 26.
 56. Hamilton, G. (1976), op. cit., p. 112.
 57. Summers, M., op. cit., p. 28.
 58. Elliot, J., op. cit.
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61. Annual Report for the Mental Deficiency Division, 1967-1968. *Minutes, Votes and Proceedings of the Parliament of Western Australia*, 1967/68.
62. Perkins, H. J. (1990). *The Rise of Professional Society: England Since 1880*. London: Routledge. p. 2.
63. McKnight, J. M., op. cit., p. 111.
64. Hamilton, G. (1978), op. cit., p. 368.
65. Hamilton, G. (1976), op. cit., p. 112.
66. Summers, M., op. cit., p. 26.
67. Robert Jackson, interview with author, 10 October 1990.
68. Meredith Johnson, Social Trainer Co-ordinator, interview with author, 26 March 1996.
69. Hamilton, G. (1976), op. cit., p. 346.
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71. Hamilton, G. (1978), op. cit., p. 382.
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76. Perkins, H. J., op. cit., pp. 3-4.
77. Social Trainers Salaries, Allowances and Conditions Agreement Appeal, 1976, Exhibit 2.
78. *ibid.*, p. 26.
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84. Larson, M. S. (1977). *The Rise of Professionalism: A Sociological Analysis*. Berkeley: University of California Press. p. xi.
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8 Discourses of Disability

Errol Cocks and Matthew Allen

The Nature of Discourses

A history of intellectual disability is, to a great degree, a history of language, knowledge and power. It recalls the languages used to describe, classify and thus constitute certain members of society as 'disabled'. It assesses the knowledges that authorised these statements and determined the actions taken by and for people classed as having intellectual disabilities. And it reviews the power relations between these people and those who were in control of them and their lives. Knowledge, articulated through language (and here language encompasses all forms of communication — visual, written, spoken, architectural, symbolic), established that people with intellectual disabilities were different from other, 'normal' members of society. And, because this knowledge and its languages were fundamentally evaluative, the 'different', 'other' members of society were accorded less social value than those in the position to judge and evaluate them. Within these structures of knowledge, people with intellectual disabilities were less powerful and less valuable. Moreover, the languages of power concealed that their powerlessness was not, in most respects, a function of some mental, physical or functional impairment; for as Wolfensberger has noted, 'devaluation...is not something which is inherent in the person'.¹ Instead, powerlessness stemmed from the manner in which people with intellectual disabilities were cast into devalued roles, and the way in which languages of disability constrained and evaluated them, under the guise of simply describing them.

A history of intellectual disability is also an account of intense personal vulnerability. Martin Luther, who is normally associated with

free and critical thought, once encountered a person whom we now might consider to have intellectual disabilities. Luther wrote that:

he did nothing but gorge himself as much as four peasants or threshers. He ate, defecated and drooled and, if anyone tackled him, he screamed. If things didn't go well, he wept. So I said to the Prince of Anhalt: "If I were the Prince, I should take this child...and drown him."

Luther justified this judgement by saying that 'the Devil sits in such changelings [as this child] where their souls should have been.'²

Today, we would consider Luther's view abhorrent and instead see the child as someone to be loved, cared for and assisted. However, Luther's pronouncements, which determined both a way of dealing with the child and, what is more important, the child's identity, were governed and given legitimacy by the system of religious thought and expression in which Luther operated. This system defined both the nature of the problem and the solution. It contained powerful assumptions and beliefs on what constituted humanness, so that, for example, if someone lacked a soul and was possessed by the Devil, then they were constituted as a subhuman 'other'. The 'changeling' described by Luther was at risk of death because he was seen by society as lacking a fully human identity and was, thus, not to be afforded the protection and status that such an identity brought with it.

People with intellectual disabilities in late twentieth century Australia are not judged entirely according to Luther's ideas. Nevertheless, their existence and treatment is still based on the same assumptions. Beliefs about what constitutes 'humanness' and what is fair and just treatment are equally important nowadays, although rather than requiring a soul to be a human, one is more likely to need a certain 'quality of life' and other characteristics, including intellectual capacity. Intellectual disabilities, just like any other physical aspect of humanity, are real, but they do not take on meaning except in the social world of language and ideas. Thus the 'truth' of contemporary ideas about intellectual disability, while it produces better outcomes for people with intellectual disabilities than Luther's view, is still contingent on perception, interpretation and, above all, on the operation of the language through which humans think about the world.

What we know about people with intellectual disabilities and how that knowledge guides our actions is a social and cultural construct. It is generated not by direct insight into the condition of disability but by the location of disability within wider social values, ideas and contexts. Whatever observations might be made of the experiences and life conditions of people with intellectual disabilities, any concepts and theories which result from that observation are merely partial interpretations that can never completely capture the lived experience of actual people with intellectual disabilities. It is for this reason that Wolfensberger, one of the most influential thinkers and practitioners in the field of intellectual disability, began his book on normalisation³ — now redeveloped and redefined as social role valorisation theory⁴ — by relocating the 'problems' of intellectual disability from the minds and bodies of people with disabilities to the 'ideologies' of those making policy about them and caring for them.

By ideologies, Wolfensberger means the 'combination of beliefs, attitudes and interpretations of reality that are derived from one's experiences, one's knowledge of what are presumed to be facts, and above all, one's values'.⁵ In other words, the disability which common sense observation 'told' us was the property of the observed person with disabilities was in fact a disability conceptualised in the minds of the observers. The 'truth' of disability, far from being entirely visible in the behaviour of the person with disabilities, was located in the values and perceptions that filtered observation of reality in the minds of the doctors, public officials and others who dealt with them.⁶ This theoretical approach emphasised the importance of language, in all its forms, in conveying roles and images about people who are devalued. Labels, descriptions and other forms of communication played a significant part in the oppression of people with intellectual disabilities. Such labels are, in effect, the creation within language of the identity of people with disabilities. In this way, a name or label that connotes inferiority — for example 'feeble-minded' or 'mentally deficient' or 'mongol' — will create in society the powerless, devalued position of the person thus named, as well as promoting the particular practices through which that position is maintained and realised.⁷

The notion that disability is a social construct does not deny the contribution of actual physical and functional impairments to the real limitations experienced by people with disabilities. However, these limitations are evaluated and responded to within a powerful social

context that may serve to ameliorate or to accentuate these impairments. The history of intellectual disability contains both the positive and harmful influences from that social context.

Michel Foucault's work provides additional insight into the operation of language and knowledge. In his various analyses of people labelled and treated as deviant by 'normal' society — 'the mad', 'the sick', 'the criminal' — Foucault sought to locate the history of deviancy in the society from which these people are placed apart, rather than in the deviants themselves. Like Wolfensberger, he concluded that deviancy from the norm is not a function of the minds and bodies of the so-called deviants, but, rather, is written onto those minds and bodies by the society in which they live. Foucault argued that *discourse* played a central role in creating knowledge of, for example, madness, which, through the meanings of the words used to describe 'the mad', determined who was mad and what was to be done with or to them.⁸ The key assertion here is that things are not what they appear to be, or, more precisely, that the words that describe things do not naturally attach to those things. Instead, discourse — a 'group of rules proper to discursive practice' — intervenes.⁹ Discourse, the mechanism through which words and things become connected in everyday practice, must be involved because words do not simply attach to things by some magical process of representation. Rather, discourse intervenes between words and things to determine what may or may not be said about a certain event. This discourse generates whatever authority or legitimacy such statements might have. Why this might not be immediately apparent, argued Foucault, is that in their self-formulation, many discourses are based upon the idea of empirical observation of the world and the true rendering of the world by representation in language. The people who speak within such discourses (nineteenth century doctors might be an example) are blind to the fact that their statements are not true or false in relation to the objective, real world, but are seen as true or false depending on whether they adhere to the rules for true statements established by discourse. The linguistic system precedes and governs observation of the real world.

The most important feature of discourses is that they change, producing different meanings for the same types of people and behaviours at different times in history. Thus, as Foucault argues in *Madness and Civilisation*, 'fools' in late medieval Europe (people who might have been either mentally ill or have intellectual disabilities) were often

regarded like the Fool in Shakespeare's *King Lear*: as having, through their disability or illness, some privileged access to knowledge about the true condition of the world. Such people were either forced or allowed to wander the countryside, or placed on 'ships of fools' where they might travel in search of their reason. In the meantime, their words and actions might be read by those around them as throwing new light on the problems of the world. Yet, in the seventeenth century, the 'ship of fools' on a journey of discovery was 'moored...[and] made fast among things and men...[It was] no longer a ship but a hospital'.¹⁰ Foucault concluded that the people on the ship and their behaviour had not changed, but that society had developed new ways of regarding, labelling and dealing with them. Instead of being tolerated and allowed to wander in search of reason, they were to be confined. They had moved from being outside society to being imprisoned within it because the discourses of madness and reason had changed.

The words used by discourses do not merely 'designate things' but 'systematically form the objects of which they speak'.¹¹ For example, for a doctor or magistrate in the nineteenth century to label a person an 'idiot' or 'imbecile', or for an educator in the twentieth century to label a person 'educable' or 'ineducable' was not a description of a pre-existing condition but the creation of that condition in the person. And here we see how a relationship of unequal power developed between the person authorised to classify and describe the 'idiot', and the person who was the object of that description. Once it was 'truly' known that a person was an 'idiot', as, for example, might be the authoritative conclusion from a psychologist's IQ test, then a whole series of actions — confinement, treatment and regulation — were sanctioned. The authority of such judgements and subsequent actions was determined by the social prestige and value of the person making the judgement; not by the actual condition of the object of the tests. Moreover, such experts continually enhanced their general prestige by making specific judgements. The objects of these judgements, which included people with intellectual disabilities, were further disempowered because their own knowledge of themselves and their physical or mental condition was, by and large, disregarded in favour of the expert judgement. Thus, to know about something was to have power in relation to the objects of knowledge, and to be knowledgeable was to be powerful.¹² This perspective developed from Foucault's lengthy and wide-ranging investigation of modern practices of science and rational thought. In the

culture of Western Europe in the past two centuries, when scientific knowledge has been highly valued, those people who become the objects of medical, psychiatric and other scientific discourses have been, and still are, particularly vulnerable to this form of power relationship.

In a world constituted by discourses, subjectivity (or identity) is only possible within one or more discourses. And a person's particular character will only emerge through discourse. Take, for example, the case of children in an advanced late twentieth century society whose measured level of intelligence is assessed to indicate that they are 'slow learners'. Having been thus categorised, they will be subjected to various actions with the aim of helping them develop their capacities and skills 'normally'. They might well be labelled as slightly 'intellectually handicapped'. Yet hundreds of years ago, before the existence of intelligence testing and near-universal education, such people would, in all likelihood, have been indistinguishable from those with whom they mixed in society. The development of a discourse of educational attainment and intelligence testing in the early twentieth century provided the possibility for the existence of a discursively created group who were at odds with the norms generated by such a discourse.¹³ In the language of paradigms or world views,¹⁴ which is similar to Foucault's work on discourse, the development of the 'psychomedical model' — a combination of a statistical view of normality with the assumptions and practices of the medical model — led to 'large numbers of children who had no biological stigmata but were from racial, ethnic, and linguistic minorities [being] diagnosed as "educable mentally retarded"'.¹⁵

To establish discourse as the basis for determining the 'truth' about intellectual disability is to refuse to accept that disability is an unchanging, natural phenomenon. For all social and cultural purposes, disability exists because there are discourses that define it, discourses that describe people with intellectual disabilities, and discourses that authorise certain actions for or against those people. Disability is a social construction, the character of which is contingent upon the particular time and place in which it is created. Thus, people with intellectual disabilities in the 1990s are, in terms of the models of action, paradigms of knowledge and languages of description, quite different to the 'retards' and 'idiots' of the 1920s and 1930s. Moreover, the growth of knowledge of intellectual disability should not be characterised as a

steady accumulation of the 'truth' and a stripping away of 'false' ideas. Rather, one set of 'true' statements has been progressively replaced by others. Discourse does not achieve its truth effect from 'the fact that it describes a "real object", but from the social practices that actually form the object about which discourses speak'.¹⁶ Thus, we should not see the development of thinking about intellectual disability as a progression from lack of knowledge to perfect knowledge through the application of scientific investigation, but as the replacement of one set of contingent, socially grounded rules for determining true and false statements about intellectual disability with another set.

While at a general level discourse theory provides insight into the mechanisms through which meaning is ascribed and identity constructed, an important question remains about *function* and *purpose*. Clearly, there are powerful dynamics associated with social devaluation that operate at many different levels, including the individual, the social systems and the society. Social devaluation serves many purposes. It may primarily reflect a constant of human behaviour — at both conscious and unconscious levels — of evaluative perception, whereby everything is weighed and measured and assigned its relative value. And we should remember that social systems and society benefit from processes of devaluation by the achievement of a kind of social stratification and order and, especially since the rise of materialistic service systems, through enormous economic and political gains based on the maintenance of a society whose members are not accorded equal value.

Perhaps, though, the function of discourses of disability is most significant in the way that individuals come together and remain together as a society. In *Madness and Civilisation*, Michel Foucault described how, through incarceration in leprosaria, European societies excluded lepers 'not to suppress it [the disease], but to keep it at a sacred distance, to fix it in an inverse exaltation' to 'normal' life.¹⁷ Even when leprosy disappeared from Europe, 'in these same places, the formulas of exclusion would be repeated [with]...poor vagabonds, criminals, and "deranged minds"'.¹⁸ And it is the same for all those people characterised and defined as 'deviant'. Although excluded bodily, their devalued identity is kept *within* society to act as a necessary 'other', in contrast to whom the rest of society confidently believes itself to be 'normal'. People with intellectual disabilities and many other groups of people held to have low social value have almost always experienced rejection, loss of autonomy and freedom, deindividualisation, and

brutalisation, along with other 'wounds'.¹⁹ Luther's desire to drown the child with intellectual disabilities is reflected in related practices such as infanticide and killing of people with intellectual disabilities, including the ancient Greek custom of abandoning children with intellectual disabilities on hill-sides;²⁰ the objectives of the eugenicists to sterilise and institutionalise;²¹ the Nazi practices of killing people with intellectual disabilities using chemicals and other technical means;²² and the contemporary 'new eugenics' and euthanasia movements where, paradoxically, death is seen as a means to maintain quality of life.²³ Thus, although their particular experiences may be differently perceived and interpreted within different social and cultural contexts and times, this common positioning of people with intellectual disabilities means their history is also an account of certain common destructive outcomes.

The Traces of Past Discourses

Language is central to the constitution of broad social beliefs about people with intellectual disabilities, and, through the processes of role expectancies and role circularity, such beliefs then contribute significantly to how they see themselves. Yet it would be wrong to think of language as solely a matter of words. Indeed, one of the major exclusionary practices imposed on people with intellectual disabilities has been society's refusal to include them in the normal processes of communication. Perhaps more than any other devalued group, people with intellectual disabilities have been rendered silent by the failure of society to find new ways to communicate with them. Their stories often have been distorted by the location and embeddedness of people with intellectual disabilities within more powerful social systems, particularly those concerned with their control and treatment. Thus, for the general community, meanings about people with intellectual disabilities come in large part from non-verbal sources created by formal service systems. These include the physical aspects of the environments provided for people with intellectual disabilities: where they were located and what they resembled; the human and physical juxtapositions of people with intellectual disabilities alongside other deviant groups; and the practices of control and treatment. These are powerful media in the service of enculturation.

It is not surprising, then, that Wolfensberger, in his critique of the historical development of contemporary institutions in America for

people with intellectual disabilities, was particularly concerned with the 'language of architecture' and the physical environments in which people lived.²⁴ The other people with whom they were grouped and associated and the activities and practices that were imposed upon them were at least as important as the words used about them in creating the images and social roles which were attached to people with intellectual disabilities.²⁵ The physical environment is especially important because, although the specific discourses that have governed the identification and treatment by 'normal' society of its 'non-normal' others have changed many times, the physical traces of past knowledge — such as buildings — have survived longer than the discourses which underpinned their construction and arrangement. Yet people with intellectual disabilities and other devalued individuals live in the context of those physical traces, and are vulnerable to being trapped in a kind of time warp in which the past is still with them as part of the formal service system in which they exist.

There is a close historical association and physical resemblance between the architectural features of the various buildings that have been used to congregate, confine and isolate different groups of deviant people in the Western world for at least two millennia. Early monastic hospices; the leprosaria, lazaretto and pesthouses for plague victims and lepers; places of quarantine for the sick and indigent; and the prisons, workhouses and multi-functional institutions of the nineteenth and twentieth centuries — some of which operate in the present in Australia and elsewhere — share common characteristics.²⁶ These characteristics included similarity of physical appearance with churches and monasteries, location distant from population centres, large size, provision of accommodation in multiples of twelve (reflecting a well known group of early Christians), and the presence of a central altar or some form of replacement such as a religious, aesthetic or utilitarian object. The ubiquitous television set, either with sound off or noisily blaring and often situated on a raised shelf away from the direct contact and control of inmates, is possibly the late twentieth century manifestation of the symbol of spiritual healing. Penal philosophies and architecture have been significantly influenced by the use of imprisonment by the Christian church and, in turn, there are strong associations between prisons and the 'bridewells' or workhouses from sixteenth century England as houses of correction for the poor and indigent.²⁷ Architectural similarities contributed to an erasure of the specific needs

and experiences of the groups so housed and the broad assumption that anyone in a hospital- or prison-like building was, first, *different* from, and second, *separate* from 'normal' society.

The need to keep inmates of prisons under continuous observation led to Bentham's plan for the Panopticon, a penitentiary, the design of which featured a central vantage point where keepers could observe the kept. This architectural feature, often expressed in circular or cross-shaped (cruciform) building design, is still common in twentieth century prisons and has been built into other institutional forms such as nursing stations, staff/observation rooms, observation towers and closed circuit television monitoring. People with intellectual disabilities still live in institutions in Australia where a staff observation booth divides a large room into a dormitory and day room. In Victoria, an institution built in the mid 1970s called Colanda has a unit that was built with virtually indestructible physical features and furnishings, and also had a closed circuit television system that allowed staff to sit outside the 'day room' and observe the residents. Whatever the specific motivation for these surveillance regimes — and they are clearly different for people with intellectual disabilities, the sick and criminals — the general perception they generate in the minds of the rest of society (which is, by and large, not under surveillance) is that all people under surveillance are, somehow, similar.

In Western Australia, the place of confinement for the first person with intellectual disabilities was the *Marquis of Anglesey*, a ship that had drifted aground near Arthur Head at Fremantle. This was to be the site of the Round House, the colony's first gaol, which was completed in 1831.²⁸ The association between this practice and the use of hulks to house criminals — the primary group of devalued people in England in the eighteenth century — is clear. Moreover, close connection between management of the convict establishment in Western Australia and the management of madness meant that, in the nineteenth century, no matter if 'deranged' or criminal, a person ended up in the same place: a prison.²⁹ Whether the specific daily lives of the inmates were the same or not (often they were, though usually not by deliberate design), from the outside — the general public's perspective — the authorities treated criminals and people with intellectual disabilities in the same way. Later on, when people with intellectual disabilities and mental illness were placed in the Claremont Hospital for the Insane, their location suggested they had some form of terrible sickness which might escape

into the general community. The hospital was about halfway between the two major population centres of Fremantle and Perth — as far away from each centre as possible — and the site was elevated to the highest area in the vicinity, suggesting that the winds would carry away the ‘miasma’ associated with mental handicap and thus reduce the threat of contagion.

The similarity of design in terms of size, location and architecture between prisons, asylums and institutions for people with intellectual disabilities contributed to a strong sense of ambiguity in the minds of the general populace about social offenders, people with intellectual disabilities and illnesses. Criminals and sick people were thought to pose dangers to the rest of society. Thus, anyone else — whether threatening or not — who was associated with these groups by dint of their physical environment could also easily be seen as a threat. Why else, the argument might have gone, were disabled people kept in prison-like surroundings? And indeed, such assumptions were not just inferred by the general community from an otherwise ‘neutral’ architecture, but were already part of the blueprint for those buildings. As Wolfensberger concluded:

Ideology must be recognised as the single most important determinant of human service environments. Values, ideologies, and role perceptions, not money or technical architectural considerations, are the ultimate source of most of the environmental features, just as they are the sources of most clinical and administrative processes.³⁰

The juxtaposition of one group of people who are ill or have disabilities with other groups who *already* are perceived to present a threat contributes to the process of ‘menacisation’ of afflicted people.³¹ There are a number of examples of the way that people with intellectual disabilities have come to occupy a place of menace in today’s society. First, services for these people were frequently located on crossroads which were known as places of public punishment and execution. Second, the strong association with leprosaria led to many of the beliefs about and practices associated with leprosy being transferred to people with intellectual disabilities. Even nowadays, there is a fear amongst the general populace of contagion from many groups of devalued people who are not actually contagious. The use of bells by lepers to

warn other people of their proximity transferred to people with intellectual disabilities and mental illness in both language ('ding-a-lings', 'ding dongs') and practices (bells in the hats of 'fools').

Another example suggests that the association between the images and functions of prisons and detention and people with intellectual disabilities contributed to the stereotyping of this group as actual or potential criminals or vagrants. In the eighteenth century, Louis XIV established the Salpêtrière and the Bicêtre in Paris, and formalised the consolidation of all institutions into the 'general hospital'. There were benefits associated with this move. For example, a plan of the Salpêtrière in 1786 showed areas allocated to four separate groups of inmates: 'recent agitated cases - curable'; 'agitated cases - incurable'; 'melancholy'; and 'idiots, escapees, sowers of discord'.³² Although grouped with political inmates and malcontents, 'idiots' were recognised and this focus allowed for some important reforming work, as we saw in Norman Megahey's chapter on 'Living in Fremantle Asylum', by people such as Pinel, Esquirol, Itard and Seguin. On the other hand, 'menacisation' was accentuated by the fact that Louis XIV made the director of one of the hospitals commander of 100 riflemen to act as guards, allowed hospices to have pillories, stocks and dungeons, and donated former prisons to be used as mental institutions.³³

The association between insanity — broadly defined to include forms of intellectual disability — and prisoners is very strong in Australia and well illustrated in Western Australia by the establishment of the Round House in Fremantle in 1831 to accommodate 'both prisoners and lunatics'.³⁴ The menace role was well supported by Calvinistic beliefs that misfortune, including mental and physical impairments, was linked with immorality.

Finally, Wolfensberger and Thomas detailed how systems and institutions that provided care and support relinquished links with high order value systems in the abandonment of religion and the adoption of a secular, scientific and more commercial approach to deviance.³⁵ Higher order value systems — Christianity, for example, perceived the 'poor' to be the 'Hidden Christ' — contained at least the potential to contribute to ideologies and practices that were positively, even kindly, disposed towards vulnerable and powerless people. Arguably, the emergence of materialistic service systems in the care and treatment of vulnerable people has been the most important influence on the lives of people with intellectual disabilities, and has reached a

high point of achievement in the late twentieth century. This issue will be taken up again below in the context of contemporary discourses of disability.

The traces of the past can also be found in other physical items and practices associated with the bodies of people with intellectual disabilities. Some of these practices sought to cure people of their supposed mental conditions by the application of 'scientific' principles and theories. In the nineteenth century, American psychiatrist Benjamin Rush invented a 'whirling' chair which was used to increase the blood flow to the head and thus improve the condition of the person with intellectual disabilities or mental illness. Other forms of 'whirling' apparatus included hollow wheels and beds. Horse riding (hippotherapy) was recommended along with other movement treatments to release 'rigidity of thoughts and ideas'.³⁶ Treatment using water was common (hydrotherapy) and could involve the complete immersion of the patient in iced water. While these practices reflected contemporary ideas about treatment, the similarity between them and common acts of punishment of prisoners ensured that, as well as attempting to cure their patients, the architects of these practices were also labelling them as dangerous, difficult and deviant. The distinction between treatment and punishment was even less clear in treatments called 'terrification', a method advocated by William Cullen in the late eighteenth century, which involved terrifying and intimidating people to control their madness. This was based on the theory that disability was caused by a frightening experience and could be cured according to the principle of 'hair of the dog'.³⁷

Other practices were more concerned with restraint and confinement, sometimes for the purposes of treatment, but also to ease the task of 'managing' the bodies of people with mental illness and intellectual disabilities. The eighteenth and nineteenth centuries saw the development and application of a great range of mechanical devices for the purposes of restraint and seclusion of inmates of institutions.³⁸ Rush also invented a restraining chair, commonly referred to as the 'Rush chair'. Esquirol developed a type of restraint recommended for 'idiots': a form of straitjacket that restrained the person to a chair, not dissimilar to the 'bellybands' in use in some institutions in Australia at least as recently as the 1970s. Yet, by the end of the nineteenth century in Australia, the use of technologies of restraint to control people with mental illness — straitjackets, chains and so on — had become less

common. This decline had reflected the changing knowledge of medical science about insanity, an emphasis on treating such people as humanely as possible, and also the development and application of tranquillising medications which represented another form of restraint. No longer were the 'insane' thought of as animals, as in the seventeenth century, and thus there seemed no need to restrain them like animals.³⁹ Yet, as Garton's analysis of mental hospitals in NSW shows, by 1940, the technologies of physical restraint had returned with a vengeance. In 1900, some 1.8 per cent of patients were 'under restraint'; 40 years later, the number was nearly 20 per cent.⁴⁰ While there was no overt resurrection of the assumption that people with mental illness were animals, the physical treatment of such people in ways that had previously been based on this assumption meant that the meaning of restraint was unclear. Although *intended* for the purposes of better 'management' (itself an unethical concept), the meaning which people drew from the use of such technology harked back to earlier times when the intention related to the supposed animality of the victim. Similarly, patients at Claremont Mental Hospital were subjected to mass feeding and hosing down in a way that, while intended to provide 'better management', in fact conveyed strong messages about the sub-human nature of these people. In addition, associated with the eugenics movement that gathered apace during the first half of the twentieth century, such treatment clearly reflected at least an implicit desire and intent to inflict punishment on people who were perceived to be a menace and threat to 'civilised' society.

The traces of discourses which no longer operate overtly but which still influence current thinking also remain in the present, written on the bodies of those whom they have made objects. For example, when reforms were instituted at Claremont Hospital to try to reduce the number of people in residence there, it was found that over 400 of its inmates were not ill at all. Nevertheless, they could not be released because they had become so thoroughly regimented and accustomed to the routines of living in the hospital that they could not live outside an institution: a phenomenon psychologists have researched as 'learned helplessness'.⁴¹ Indeed, past discourses find their way into the present, even without such physical props as bodies, buildings and technologies. In the early twentieth century, the category 'mental deficiency' began to be distinguished much more precisely from mental illness. This distinction also began to have more concrete effects. Doctors and

politicians had a particular concern that children with alleged deficiencies needed to be identified early and given special educational assistance to help them overcome their disability and function in society without the need for further care.⁴² Yet the special assistance only lasted as long as the people were still children, that is, under 18 years of age. If they had not developed sufficiently (i.e., to meet the normative standards of educational attainment), then they were regarded as 'incurable' and permanently institutionalised. Thus, intellectual disability as a category requiring some type of special care became associated with childhood. Although we no longer, in theory at least, arbitrarily remove developmental assistance at physical age 18, people with intellectual disabilities continue to be widely regarded as children or child-like regardless of their actual age or capabilities.⁴³

While Foucault described his earlier work as archaeological because it uncovered the distinct layers of historical discourses, he characterised his later work as genealogical, in part to indicate the importance of the continuity of the discursive systems that authorised the truth of the connection between words and things. In thinking about intellectual disability in Western Australia today, we need to understand that the ways in which people with intellectual disabilities were spoken for and spoken about in the past remain with us today. Thus, we now analyse the various discourses which, in the past, have provided the overall rationale for the practices just described. All have their epistemological foundation in what Foucault termed the 'episteme of modernity' and thus all are interrelated. All constructed the objects of their knowledge — for instance people with intellectual disabilities — in particular ways which related more to the wider social climate than to the actual conditions of those people. Yet the differences between them indicate that, even within discursive structures of power and knowledge, we judge some discourses to offer more promise to people with intellectual disabilities than others.

Discourses of Modernity

Modernity was born out of the period of Enlightenment in the last half of the eighteenth century in Europe. At first, the period carried with it the great hope of Enlightenment thinkers; that through education and development, humanity could free itself of the inequalities and misery which had, until then, been thought of as an unchanging natural

condition. This emphasis on education held great promise for people with intellectual disabilities, leading to the establishment of schools for children with intellectual disabilities. For example, Pestalozzi established the first school for 50 'regenerate beggar children' in 1774 in Switzerland. The first school for deaf children was founded in Paris by Abbé de Eppe in 1760, and a school for blind children in 1784. However, by the end of the nineteenth century that promise was not only unfulfilled, but a different discourse emerged that emphasised the 'menace' posed to 'normal' society by people with intellectual disabilities. The seeds of this discourse were sown in the social unrest of the eighteenth and early nineteenth centuries and the growing influence of science, professionals and formal organisations on the world view of disability and other devalued groups.

Whilst the influential scientific studies of the late nineteenth and early twentieth centuries focused on the depredations of inherited 'feeble-mindedness',⁴⁴ there was still a keen concern with the importance and potentialities of constructing environments in particular ways to aid in shaping human development. A reflection of this latter focus is captured in the story of *The Wild Boy of Aveyron*.⁴⁵ So-called 'feral children' represented an opportunity to study both the influence of their inherited dispositions and their early environments (nature versus nurture, a subject of continuing debate to the present day), and the potential of education and training. In a 1972 publication entitled *Wolf Children*, Lucien Malson listed 53 recorded cases of 'feral children' from 1344 to 1961.⁴⁶ These children were called after the animals who assumedly 'brought them up': 'bear-child', 'sheep-child', 'calf-child', 'sow-girl', 'pig-child', 'snow-hen', 'baboon-child', 'leopard-children', 'gazelle-child' and 'ape-child'. The 'Wild Boy of Aveyron' we saw in Norman Megahey's chapter, named Victor by Itard, was 'captured' in the woods of Aveyron in 1799, seven years following the French Revolution and 11 years after the European colonisation of Australia. Pinel examined the boy, not at all a fine representation of Rousseau's 'noble savage', but more a "'man-animal", whose only concern was to eat, sleep, and escape the unwelcome attentions of sightseers'. Pinel concluded that the boy was in fact 'an incurable idiot'.⁴⁷ Itard, physician to a newly established institution for 'deaf-mutes', took Victor in and proceeded to educate and train him so that after two year's instruction:

In place of the hideous creature that was brought to Paris, there was to be seen...an "almost normal child who could not speak" but who lived as a human being; clean, affectionate, even able to read a few words and to understand much that was said to him.⁴⁸

Although Victor was never considered 'cured' and was eventually abandoned by Itard, his development and the approaches to education and training adopted by Itard were very influential. Seguin and Maria Montessori were strongly influenced by Itard's ideas, and their work was to have a significant impact on the education of many children, disabled and not, into the twentieth century.

In the introduction to his translation of Itard's book, George Humphry captured the optimistic spirit of the Enlightenment times that formed the context for the story of Itard and Victor. He wrote:

The scene of the very human story described in this remarkable little book was laid in Paris at the end of the eighteenth and the beginning of the nineteenth centuries. Voltaire, the libertarian enthusiast, Montesquieu, master political analyst, Rousseau, clockmaker's son and fanatic of freedom, had all died within the generation just passing. The thought of these three great men had been transformed into action, or so it seemed, by the 'savage dreamers' of the Revolution. A new era had begun. Medieval superstition was visibly dissolving at the touch of science. Had not one daring adventurer a few years before flown into the air in a fire balloon, while another crossed the straits of Dover in a similar contrivance? Had not Franklin "brought down the thunder from the clouds"? Had not Lavoisier finally swept away the pretensions of the alchemists and found a new science by splitting water up into two gases? Still more revolutionary to all previous conceptions was that remarkable new force, electricity, which Galvani and Volta had lately discovered. To the temper of the times it seemed that nothing was impossible to science. Man himself might be transformed. Reason alone was necessary to bring him, the noblest of all creatures, to the perfection that was his birthright. For the first time, deaf-mutes might be taught to speak, and the blind to overcome their disability; Dr Pinel had shown that even

those unfortunate creatures, the insane, should be treated as curable patients, not as inmates of a human menagerie. It was a time of hope and enthusiasm for change.⁴⁹

Given that much of what we assume to be modern — even enlightened methods of treating and caring for people with intellectual disabilities do not display this enthusiasm and hope — it is humbling to consider again the educational approaches of Itard in his treatment of Victor. Itard described five ‘principal aims’ in the ‘mental and moral education of the Wild Boy of Aveyron’:

1st Aim. To interest him in social life by rendering it more pleasant to him than the one he was leading, and above all more like the life which he had just left.

2nd Aim. To awaken his nervous sensibility by the most energetic stimulation, and occasionally by intense emotion.

3rd Aim. To extend the range of his ideas by giving him new needs and by increasing his social contacts.

4th Aim. To lead him to the use of speech by inducing the exercise of imitation through the imperious law of necessity.

5th Aim. To make him exercise the simplest mental operations upon the objects of his physical needs over a period of time afterwards inducing the application of these mental processes to the objects of instruction.⁵⁰

Wolfensberger showed how the optimism and high expectations for people with intellectual disabilities which had inspired Itard and others in Europe in the eighteenth century also found expression in the United States in the period from 1850 to 1870. A number of institutions were established from about 1850 which were ‘seen as temporary boarding school[s]’. After the child was improved so as to have mastered skills necessary in society, he was to be returned to his family and/or the regular schools.⁵¹ The methods utilised by these institutions would be considered in the late twentieth century to be enlightened. For example, the ‘schools’ were kept small to avoid the congregation of deviant people, children had meals with the superintendent and interacted with family members, and they were located ‘in the very hearts of

the community'.⁵² In 1848, Samuel Gridley Howe, an eminent United States educator, argued that:

the immediate adoption of proper means of training and teaching idiots, may be urged upon higher grounds than that of expediency, or even of charity; it may be urged upon the ground of imperative duty.⁵³

Yet, this period in which the rationale for helping people with intellectual disabilities was to 'mak[e] the deviant undeviant' did not last long.⁵⁴ It was followed, during the period 1880 to 1925, by the rationales of 'shelter[ing] [the] deviant from society' and 'protect[ing] society from the deviant', rationales which characterised the eugenics era. The most important change occurred in the late nineteenth century when the aim of protecting 'normal' society became predominant. With this change came a particularly vehement devaluation of people with intellectual disabilities associated with an intensification of the processes of 'menacisation'. This period was also characterised by growing economic concerns about the cost of maintaining people with intellectual disabilities in institutions; responses to this were processes of institutional enlargement in order to achieve benefits of scale, and a focus on self-sufficiency whereby more competent institutional residents produced their own food.⁵⁵

As well as the potentialities for advancement of vulnerable people, modernity also contained the potentialities for further oppression in the adoption of a number of 'pivotal principles' including individualism, rationality and economism.⁵⁶ The Enlightenment saw the adoption of key assumptions of materialistic science as the base for services for vulnerable people.⁵⁷ In line with mechanistic views of the world based on Newtonian notions of the universe as a machine, human dysfunctions were increasingly perceived to be material — rather than, for example, spiritual or demonic — and interpreted as illness and disease. The perfectibility of the human body thus became an imperative and was cast as an essentially materialistic, technical process. Human services also became a technical enterprise with emphasis on the application of laws and principles reflected, for example, in architecture and treatment processes. Human service workers became technicians subdivided into the multitudes of professional specialties that developed during the nineteenth and twentieth centuries. Utilitar-

ian values contributed to beliefs that some people could not be 'fixed' or were not worth 'fixing' and should be discarded as 'mistakes of nature', 'genetic garbage'⁵⁸ or 'useless eaters'.⁵⁹ These values and principles provided the context for the rise of the eugenics movement in the late nineteenth century and have their continuing contemporary influence as we shall discuss below.

In the late nineteenth century, a revolutionary idea gripped the minds of many European intellectuals, politicians and public figures. Drawing loosely upon Charles Darwin and others' theories, the idea arose that the human population of the world was engaged in a struggle for existence in which only the fit would survive.⁶⁰ Today we associate such ideas with the natural selection of favourable genetic variations over extremely long periods of time and relating to classes of species, for example, reptiles against mammals. However, in nineteenth century European society and in its colonies and empires, Darwinism — often known as Social Darwinism — was seen as an explanation and justification for the immediate short-term struggle for supremacy between humans. Wolfensberger and Thomas described the powerful beliefs that underpinned the practices of this period, known as the time of 'genetic alarm' or 'social indictment', many of which had the trappings of 'science' and the support of experts.⁶¹ Mental characteristics including intelligence, personality and moral tendencies were believed to be inherited and difficult to modify. Specific families were seen to be degenerate through poor breeding practices, and 'The Law of Progressivity' ensured that each succeeding generation would become even more degenerate. Studies of the Jukes and Kallikaks families in the USA purported to prove the hereditary nature of degeneracies and were widely reported in the professional literature, the media, and in policy and legislative development and documentation.⁶² Intellectual disability was seen as both cause and outcome of degeneracy, and the increasing use of intelligence testing in the early twentieth century purported to provide evidence for the hidden menace of the 'feeble-minded'. Intellectual disability and inferior races, particularly through their over-breeding in comparison with valued groups, were seen as the most serious threat to advanced societies.

A hierarchy of races was posited, with non-Nordic 'races' seen as less advanced and more degenerate.⁶³ Celebration of Nordic physical characteristics included the best Nordic head contest held in Germany in 1927.⁶⁴ The appalling mistreatment of Australia's indigenous peo-

ples was seen as a natural, if sometimes regrettable, consequence of the Aborigines' weakness in comparison to the European 'invaders'.⁶⁵ National fitness and strength was a key component of eugenicist thinking in Australia. The colonies had to produce a genetically healthy population if they were to withstand the expected struggle with other nations for possession of the physical space of Australia. The principle threat was thought to be a Chinese, or some undifferentiated Asian, invasion.⁶⁶

In this intellectual climate, it was thought that anyone suffering a mental affliction — especially madness or disability but also including alcoholism and epilepsy — was genetically defective. Whatever else happened to such people — or so rational, concerned politicians, teachers, scientists and doctors argued — they should not be allowed to breed. Otherwise, their mental deficiency, expressed either as actual disability or a tendency for insanity, would be passed on and the future health of the nation endangered.⁶⁷ For example, Ethel Stoneman, the State Psychologist, reported to the Western Australian Parliament in the late 1920s that: '[t]he seriously [mentally] defective girl...constitutes a grave menace to 'normal' family life and relationships'.⁶⁸ While 'defectives' in Australia did not suffer from the extremes of oppression and extermination which the same eugenicist discourse produced in Nazi Germany,⁶⁹ they were still constituted by this discourse as enemies of the normal, healthy functioning of society.

In these developments, the State — the organised forces of control and government — played a significant role. Although some varieties of Social Darwinian thought aligned themselves closely with individualism and *laissez-faire* economic theories,⁷⁰ many other Social Darwinists and the eugenicists in particular looked to the State as having the power to intervene and regulate the reproductive and other 'health' aspects of the nation so as to ensure a fit and strong race of people.⁷¹ Australian educational and health departments and authorities believed that one of their tasks was to carefully assess school children so as to separate out the 'less than normal' as a category of people who required special treatment. As Garton has argued, in this discourse the most problematic group were those who appeared 'normal' because they might escape classification: 'the feeble-minded were considered to be intelligent enough to breed without necessarily coming under the scrutiny of the State'. The aim was to determine the 'defectives' 'before they had committed anti-social acts... "deficiency" and "illness" [as

categories] favoured the intervention of the State to prevent social problems'.⁷²

The actual surveillance and control of 'defectives' was also guided by the discourse of gender. 'Defective' women were characterised as particularly dangerous for the future health of the race because of the assumption that 'feeble-minded' girls and women would not be able to control some assumed urge to procreate. Hence, in seeking money for a segregated 'colony' for such people, one New South Wales teacher argued in 1923 that: '[t]hese feeble-minded girls are spreading through New South Wales, having illegitimate feeble-minded children...Something must be done to check this fearful social evil'.⁷³ This discursive formation ignored any possibility that men might be to blame for the alleged keenness to reproduce. It also meant that the efforts at control were directed principally at women's bodies — their minds, of course, were thought to be part of the problem! Both Western Australia in 1929⁷⁴ and Victoria in 1939⁷⁵ sought to enact legislation for sterilisation of the 'feeble-minded', although the principal Australian response was segregation and supervision.

The rise of eugenicist thinking, along with the growing power in society of doctors and psychiatrists, was accompanied by a shift in the institutional location of discursive authority from the courts to the hospitals. In the nineteenth century, the principle means of identifying and categorising people with mental illness or intellectual disabilities was the judicial system. Essentially, the police acted as the initial arbiters of behaviour, judging some of those whom they arrested to be 'insane' or 'defective' rather than acting with criminal intent. Until the police intervened, a person with intellectual disabilities or mental illness might live quite independently of State control and, in effect, be a 'normal' person. Then the courts would usually confirm the police's initial judgement, thus confirming the person as 'insane' and moving them into the State-run system of confinement, treatment and care. Doctors, far from being the determinants of government policy, tended to be its agents, as indicated by the repeated decisions by Australian colonial governments to ignore calls by doctors for more asylums, more staff, better treatment and care facilities and, most significantly, the separation of the 'insane' and people with intellectual disabilities.⁷⁶

But from the late nineteenth century onwards and in a gradual shift over many years, doctors and science became more important than police, judges and the law. One consequence was that, just as the

doctors were beginning to win their fight (though not in Western Australia) for practical recognition of the separate categories of 'mentally ill' and 'mentally defective', which might have assisted the care of people with intellectual disabilities, a further binary categorisation became popular which turned on the notion of 'curable' and 'incurable'. The notion of curing was central to the medical discourse which, in part, informed and constructed knowledge about mental afflictions. Doctors were most of all interested in working out whom they might cure — creating objects for their practice and language — and how they might cure them. Thus, any people with intellectual disabilities whom doctors labelled as incurable — either because of the apparent severity of their intellectual disabilities or because they had been living with it for a long time and no change had occurred — were relegated, by and large, to the 'back wards' of mental hospitals.⁷⁷ Such a segregation allowed doctors to concentrate on those patients whom they thought might successfully recover or, more to the point, be recovered *by* the doctor. For the medical discourse established the doctor as the most privileged, knowledgeable person within that discursive system, as many nurses and other medical personnel have found to their cost in terms of authority and career rewards. It also located the doctor as the active, intervening party; the patient's role was to remain passive (except when ordered to do otherwise) and allow the doctor direct access to the symptoms and conditions of the ailment so as to alleviate or remove them. Those classified as incurable were no longer of much interest to the doctors and they were then relegated to even worse conditions of incarceration and custodial care, with little hope of release.

One of the most important debates within Social Darwinist thinking concerned the relative importance of heredity and environment in determining human development. In Australia, environment was held to be more significant. There was a general tendency to see the development of the 'Australian' type of the generic Anglo-Saxon genetic stock as a consequence of the transplantation of a European people to a different environment. Moreover, the idea that environment could overwhelm and alter ingrained genetic characteristics also allowed Australians to deal adequately with the shame of the convict ancestry of many European settlers. The Australian natural environment had purged the bad qualities from this convict heritage and distilled a more pure and stronger essence which, some thought, was superior to the original Anglo-Saxon race in Britain.⁷⁸ So, as Garton found, by the

1930s, strictly genetic eugenicist views were less well received among doctors and policy-makers than they had been before World War One.⁷⁹ Principally because of the financial stringencies of the Depression and World War Two, this new discourse did not find practical expression until after 1945.

An important outcome for the care and provision for people with intellectual disabilities was a renewed emphasis on training and development, especially as the ideas of behavioural psychology began to be assimilated into Australian medical practice after World War Two. The dominant discourse moved from custodialism to training and education, reflecting a number of post-World War Two influences including the parent and civil rights movements, and the development and articulation of influential principles and theories such as normalisation and least restrictive alternative.⁸⁰ For example, in 1960, the Pyrron Training Centre had been established in Western Australia.⁸¹ Such training establishments continued to segregate those classified as 'slow learners' or 'retarded', but with the aim of using segregation to allow a special programme of training to enable the inmates — for the centres often resembled carceral institutions for young criminals — to learn enough to participate 'normally' in the community. The training establishments continued the long history of positioning people with intellectual disabilities as 'children', since both were still undergoing education and training. Yet they also suggested the concern by governments to reduce the costs of provision for such people. Once trained, they might work and generate enough money to reduce the financial 'burden' — as most social welfare costs are characterised in a capitalist system — on the rest of the community. Here again, gender discourse played its part, with a strict division of appropriate training replicating wider social divisions of labour between men and women.

Social Roles

In all these discourses, people with intellectual disabilities are rarely constituted as speaking subjects by the discourse and remain primarily as objects of knowledge. They are objects in the sense that they might be managed, moved around, housed, restrained, known, cured or judged incurable. In this regard, the fact that people with intellectual disabilities are human is, essentially, irrelevant. Discourse has constituted them firstly as items or objects whose humanity is, for most

purposes, irrelevant. This objectification is the root of the power relations between the privileged carers and doctors and the 'others' whom they know and who, through being known, are controlled. It is not caused by *inhumanity* — though inhuman treatment is one of its expressions — as by the *absence* of human subjectivity within the operation of discourse.

However, subjectivity is not completely absent, for discourse also positions its objects as subjects. Wolfensberger approached the issue of individual subjectivity via the idea of social roles; that is, that people play — or are forced to play — numerous 'roles' in society, some of which are more highly valued and more personally fulfilling than others. These roles are not 'natural' but are elicited responses to and engagements with the circumstances in which people find themselves.⁸² He has identified a series of social roles which are imposed upon people with intellectual disabilities. They may be cast as non-human, or children, or holy innocents. Sometimes they may be perceived as the objects of ridicule and pity, or burdens of charity. Often they are seen as sick, or dying, or diseased.⁸³ These roles are the subjectivities which people with intellectual disabilities have when constituted as objects of judicial, medical or moral discourse.

These roles govern the communicative process — the dialogue between people with intellectual disabilities and others in society. Communicative acts by people with intellectual disabilities — be they speech, physical movement, creative expression — are interpreted from the perspective of the role which they are playing. Regardless of the intended meaning of the communicative act, the role expectancies of both parties filter its received meaning so that it is seen as what is *expected* by such a person, rather than being open to various interpretations. For example, if a person with intellectual disabilities throws a chair across a room, it would normally be interpreted as 'violent' or 'aggressive'. Yet the behaviour itself is devoid of meaning; if chair-throwing were a 'normal' feature of society, it would hardly be commented upon. The meaning of the act — its alleged 'violence' — comes from the discursive framework which often positions people with intellectual disabilities as 'aggressive' or, more often, unable to *control* their aggression.

Hence, people with intellectual disabilities are 'allowed' to speak by discourse only from the position set down by the discourse. While everyone in society operates under the similar effects of the many

discourses which constitute their lives, people with intellectual disabilities have far less chance to challenge the speaking positions and object-status to which they are assigned. For example, whereas feminism has emerged as a strong subversive and oppositional discourse to assist women and sometimes men to challenge their socially constructed gender roles, there has been no equivalent generated from within the life experiences of people with intellectual disabilities.

The social roles which people with intellectual disabilities are forced to play are first constructed by the very discourses of disability. In the late nineteenth century, many Social Darwinists saw intellectual development as the reason for the evolution of humans as a superior life form; those unable to show evidence of development acceptable to dominant social conventions were regarded as still developing intellectually, like children. Thus, for white, male, European Social Darwinists, women and non-Europeans were more or less child-like depending on the extent to which they approximated adult male capacities.⁸⁴ Social roles also arose from the *expression* — for example through language, architecture, programmes of control and management — of 'knowledge' about disability and people with intellectual disabilities. Hence, an institutional system in which adults with intellectual disabilities were only allowed to eat with spoons, or were forced to go to bed when told by a carer, or were given only childish toys with which to play, ensured that for much of the time people with intellectual disabilities were playing the role of child. Not surprisingly, through the operation of role circularity, these people often expressed themselves in ways that appeared child-like.

The Devalued Other

In his 1992 summary of social role valorisation theory, one of the roles which Wolfensberger ascribed to people with intellectual disabilities was that of the 'other'.⁸⁵ We would argue that this role is in fact a key one that underpins all other roles. Thus, for example, people with intellectual disabilities can be regarded as objects of pity or inhuman monsters or diseased organisms only if they are first constituted as the 'other'. Now, of course, the 'otherness' of people with intellectual disabilities is not some natural function of their own bodies and minds; rather, the *difference* between them and people without intellectual disabilities generates an *interpretation* of their physical condition which

makes them 'other'. 'Otherness', as many feminist and post-colonial theorists have pointed out, is a state of being 'excluded, shunned, "frozen out", disadvantaged, unprivileged, rejected, unwanted, abandoned, dislocated, marginalised'.⁸⁶ It is a position of lesser power relative to the norms, in contrast to which 'otherness' is constructed. Difference, which does not of itself create inequalities of power, does however lead to the unequal position of the 'other' through the operation of language.

Wolfensberger has argued that human perception is always evaluative. We would argue that, though the effect might be to produce a constant process of evaluation, the origin of this effect is linguistic. Words and ideas do not exist in absolute relation to the things they describe but have meanings only in opposition to other words and ideas. Thus, we can only know what is 'normal' by *also* having a category of 'not-normal'. Moreover, we would argue that rather than knowing what is abnormal by reference to the normal, this definitional process occurs in reverse. For normality to gain its meaning there must exist a people or a place which is not normal: that which is already defined as the 'other'. As Foucault argued, it is a corollary of the construction of objects of knowledge — knowing the 'other' — that arbiters and agents of that knowledge are more powerful than their objects.⁸⁷ Just as a scientist captures, dissects and examines the fixed specimen of their inquiry, so too does the doctor, the ward attendant and so on have the power to fix the object of their care: because 'they know what's best'.

Contemporary Disability Discourses

In 1989, the German philosopher Jurgen Habermas raised a crucial question about the State's 'welfare project' when he contrasted means and ends.⁸⁸ If the proclaimed purpose of the efforts of society through its social institutions is to rehabilitate, develop independence or liberate people who are perceived to be deviant, then the means utilised must be coherent with purpose. Means that contain and control, disempower and regiment lives cannot be successful in those terms. Of course, in raising this issue, as indeed it has been raised over and over again in the context of critiques of the 'welfare' and 'therapeutic' states,⁸⁹ Habermas drew into sharp relief the often latent, unstated purposes to contain, control and punish the 'deviant'. In this view, the 'welfare project', as

it is implemented by the formal human service systems of the late twentieth century, is firmly steered by the requirements of State or 'empire'. So, the spoken expressions of language may detoxify, obscure and distract rather than reflect clearly the 'true' purpose, especially where that purpose is in conflict with values or ethics that do not permit oppression. The rhetoric and polemic of the powerful interests may obscure purpose. Other forms of language contained in discourse, particularly those that represent structure and processes, and those that emanate from the subjects of inquiry themselves, must be critically examined. Discernment of purpose in contemporary disability practice is obviously more difficult without the benefit of hindsight, whereby, from a 'safe' historical distance, we are able plainly to see the rejection of people with intellectual disabilities along with other people made vulnerable by low social valuation. Clarity is also obscured within the post-technological information age in which the sheer volume of available information challenges the human capacity to identify truth and meaning. However, the lesson of history about people with intellectual disabilities is that their experience of rejection, expressed in a multitude of societal practices around congregation and segregation, are universal and age-old. The role of policy and practice still must be critically examined for its imperative to reflect society's implicit desire to put deviance away from it, even while the opposite intent is stated.

Contemporary disability discourses obviously contain the vestiges of historical discourses, not the least because the physical traces of past discourses still take captives; not only bodies, but also minds. In addition, there has been considerable focus in the second half of the twentieth century on attempts to reform the service systems within which people with intellectual disabilities and their families are deeply embedded. This reform process has incorporated consideration of, and debate about, the practices of the past — the medicalisation of disability, the use of large institutions, the removal of people with intellectual disabilities from the mainstream of society — and this has influenced what is perceived to be the nature of needed reform and the limitations of what feasibly can be achieved by the reform project.

The period since World War Two has been marked by a number of influential discourses. The discourse of custodialism, with its assumptions of non-human identity and lack of competence, pervasive in the public conception and in the service systems, has been countered by discourses more favourably disposed towards people with intellectual

disabilities.⁹⁰ The development of the parent advocacy movement in the late 1940s and early 1950s, possibly part of the reaction to the deprivations and inhumanities of the War and Nazism, resulted in service responses that contained positive expectations about people with intellectual disabilities. Throughout the Western world, almost in unison, parent-inspired organisations were established that provided education, work training and accommodation support. In Western Australia, the Slow Learning Children's Group, the Spastic Welfare Association, the Crippled Children's Association and the Mentally Incurable Children's Association were some of the parent bodies which were established between 1948 and 1954 to address the needs of people with intellectual and other disabilities. Each organisation was partly captive of the prevailing custodial and medical discourses regarding disability, and of the perception of the disabled person as an 'eternal child', but, crucially, each advocated for people with intellectual disabilities in a manner that had never occurred before and attempted to reject at least some aspects of custodialism. The fact that many of these parent bodies throughout the Western world have grown to a very large size, have become highly formalised, and have little parent influence is testament to the modern formal human service paradigm of bureaucracy, professionalism and technology that has become dominant over the past 40 years.⁹¹

The British influence on disability discourses and resultant policy and practice was replaced by American influence in the 1960s in Australia. The 'War on Poverty' initiated by President Johnson in the 1960s led to the establishment of the Head Start programme which aimed to stimulate the development and well-being of children from poor families in America. It also stimulated the development of early intervention initiatives for infants with intellectual disabilities. In the 1970s, the Western Australian Division for the Intellectually Handicapped, in unison with similar programmes in Victoria, South Australia and New South Wales, established educational intervention programmes for infants with intellectual disabilities which were based in part on influential programmes in America.⁹² These were a far cry from the discourse of custodialism and reflected more the developmental discourses of the early Enlightenment which had been lost for almost a century. This was also a time of great influence from educational technologies, many of them having their origins in American educational and behavioural psychology, and some involving the re-discov-

ery of positive principles of learning.⁹³ In Western Australia, the adoption of this discourse of development led to the establishment of a social learning model reflected in the adoption of training assistants (later to become social trainers) to replace mental health nurses, and the implementation of programmes based on learning theories.

The civil rights movement of the 1950s and 1960s formed a foundation for the disability rights movement which gathered pace through the late 1970s and 1980s in Australia. Yet even so, the development of advocacy — both the advocacy of others and the ‘self-advocacy’ of people with intellectual disabilities themselves — developed slowly, reflecting the low social status and power of this group, and was influenced to a great extent by formal service systems and government funders. Nevertheless, during the 1980s, there were self-advocacy groups established in Australia, including Western Australia, and for the first time, the voices and stories of people with intellectual disabilities began to be heard directly with less ‘filtering’ by the formal systems that contained them. However, these voices have continued to be dependent upon the support of formal service systems and government, and thus are precarious and particularly vulnerable, as they always have been, to the ‘rational’ economic discourse that discounts their value. In both Victoria and Western Australia, self-advocacy groups and other forms of advocacy in Victoria were ‘de-funded’ in 1994 and 1995, and Australia awaits the result of deliberations in Canberra to discover the policy of government towards advocacy. Even the nature of the bureaucratic deliberations strongly echoes the rationalist discourse, and advocacy is at risk of being cast as yet another expression of the formal service system. Whether it will survive may depend upon the capacity of advocacy efforts to truly gain independence from the dictates of State, since freedom from conflicts of interest with the formal system in being able to stand beside people who are powerless and vulnerable is the *sine qua non* of advocacy.⁹⁴

Although the normalisation principle emerged from Scandinavia in the late 1950s and early 1960s,⁹⁵ it was developed and promulgated in the English-speaking world by Wolfensberger, who worked in Canada and America. Wolfensberger recast the normalisation principle as social role valorisation, widening its application to the phenomena of social devaluation and systematising the body of knowledge into a social theory.⁹⁶ Normalisation and social role valorisation have had an enormous influence on contemporary disability discourses.⁹⁷ From the

late 1960s to the present, these principles, along with others such as the 'least restrictive alternative'⁹⁸ and the 'dignity of risk'⁹⁹ have gained expression in virtually all disability related policy, legislation and practice in the Australian disability field. The principles are intrinsically positive about people with intellectual disabilities and also contain a discourse that generates critical knowledge of, and insights into, the universal aspects of the societal and systemic responses to people with intellectual disabilities which contribute to their devaluation and oppression.

The relatively positive influences of the parent movement, the early rights discourse, the application of the developmental model, and the inspiration and energy provided by the powerful ideas contained in normalisation and social role valorisation in particular were very strong until overtaken by the rationalist discourse of economics from the mid 1980s: another set of ideas partly imported from the economic and social policies of Thatcher in the UK and Reagan in the USA¹⁰⁰ but having their origins in Enlightenment values and the abandonment of higher order values and principles of the early Christian era.¹⁰¹ The discourse has shifted away from concern for the subject arising from an understanding of their lives and needs, to a broader debate about the economic and political needs of society that may be as threatening to vulnerable people as was the period of indictment in the late nineteenth and early twentieth centuries.

Although the meaning of 'economic rationalism' is debated, particularly by economists who, like true technocrats absolving themselves of moral responsibility for their products, argue that neo-classical economics makes no *policy* recommendations at all,¹⁰² the term is generally considered to encompass social policies that argue for minimal government involvement in service provision, the relocation of services into the private sector, and a strong reliance on 'market' forces to deliver 'efficient' outcomes. These policies are dominating human services in Australia and there is now an extensive literature debating the pros and cons.¹⁰³ This discourse, with its broader political connections and purposes, has coloured policy, legislation and practice, and altered the pattern of reform and initiative to the extent that it is possible to discern a re-emergence of custodialism and enlargement in formal service systems, and also to perceive that this discourse is compatible with a contemporary eugenics discourse through the economic imperatives that arise from the cost of care and treatment. The relatively brief

ascendancy of ideologies rooted in the knowledge of people in the twenty-year period to the mid 1980s and their replacement by economic rationalism has parallels with the nineteenth century, when positive ideologies associated with the Enlightenment were replaced by the period of indictment¹⁰⁴ and the genetic alarm. Both processes have been well aided by economic, commercial and professional discourses.

In the context of human services, one view of these developments is that they represent the high point of the adoption of materialistic science — not just for people with intellectual disabilities, but more broadly for other groups such as elderly people — in the context of 'high modernism'.¹⁰⁵ Deviant people have always presented problems to society, but the adoption of cultural values of materialism, rationalism, utilitarianism and individualism in the Enlightenment period accelerated the adoption of bureaucratic, professional and technological structures and practices that constitute a paradigm of 'modern formal human services'.¹⁰⁶ The economic discourse has always been present and influenced disability discourses, but never before with such apparent scientific rectitude and legitimacy.

The characteristics of this discourse have special relevance for people who are vulnerable and powerless, including people with intellectual disabilities. For example, the anti-communal nature of the value of individualism which underpins the economic discourse has implications for movements that are based on inclusion, integration and assimilation. The replacement of public by private interests, so powerfully illustrated in policies of 'outsourcing' and 'privatisation', and so equivocal in their outcomes when applied to non-human service activities,¹⁰⁷ more starkly 'commodifies' and objectifies devalued people. The economics of heightened vulnerability, illustrated by the use of 'unit costs', 'standard costs' and 'case mix', mean that people with high support needs who exceed the 'average' cost are likely to be further disadvantaged or at least remain relegated to an 'underclass' or an 'object of charity' role. Alternatively, they may die if they do not meet the required birthweight for ameliorative service, if they pass the age at which certain life-sustaining treatment is mandated, or require care that is 'unaffordable'.¹⁰⁸

How do vulnerable and powerless people fare in the brave world of markets? The confusion of this discourse is reflected in the notion of 'quasi markets' that do not, in fact, behave like 'true' markets to the extent that even though tantalised by the rhetoric of choice, vulnerable

people lack the means to exercise that choice.¹⁰⁹ Distinctions between service 'providers' and service 'purchasers' still exclude the subjects from the transactions as they continue to rely on one element or other of the formal system to represent their needs. Most pertinently, what are the lessons of history when human services are reduced to technology and are delivered rationally, objectively and with detachment; that is, when the humanity is taken out? This discourse of economic rationality clearly has enormous implications for social policies that aim to break down large institutions and have vulnerable people living in the community. In fact, it is possible in some places in Australia to discern that the underpinning purpose of these policies is no longer (if indeed it ever was) primarily to benefit people with disabilities. In Victoria, for example, large institutions have been closed in very short time periods, residents have been relocated to previously decommissioned wards in other institutions and to nursing homes, and in the case of one institution, a village of more than 200 residents is to be constructed on the site of the old institution. 'Downscaling', along with 'outsourcing', 'purchaser-provider splits', 'quasi-markets' and 'case mix' have been added to the lexicon of modern formal human services technology-speak in the 1990s.

The history of people with intellectual disabilities has always reflected the social imperative of containment and control, most clearly perceived in systemic responses that have rejected them through congregation and segregation. The contemporary discourse offers commodification of people through focus on outputs rather than outcomes, representing a shift of emphasis from input process to the other end, but still missing the point. The next period of time will likely see the real outcomes of this discourse, although the age of information, rhetoric and polemic and the sheer volume of information will make discernment difficult indeed. Yet there may be an emerging disability discourse concerned with liberation ideologies that essentially conceptualises people with intellectual disabilities as people who are oppressed and the societal response through its systems of formal services, essentially as 'empire'. Associated with this is the discourse of advocacy wherein the responsibilities of citizens for each other, and the vulnerability and powerlessness of some is recognised. This concept of an essentially communal society is associated with democratic principles, but both are under threat by the contemporary discourse of rationality.

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Index

- Aborigines 301-302
- activity centres *see* people with intellectual disabilities and education
- Activ Foundation ix, 128
- Acts Amendment (Imprisonment and Parole) Act 1987* *see* legislation
- Acts Amendment (Sexual Offences) Act 1992* *see* legislation
- Acts of Parliament *see* legislation
- Administrative Co-ordinating Team 269
see also service provision, multi-disciplinary approach
- advocacy 8, 92, 124, 142, 157, 161, 310-311
see also Citizen Advocacy; parent groups
- aetiology 15-24, 57, 58, 210 *see also* people with intellectual disabilities, classifications systems for, labelling of
- AIMS 114, 118
- Albany Prison 188
- Alder, Amy 211
- Alice 100
- alienists 15, 17, 18, 209, 210 *see also* Esquirol, Jean-Etienne; Itard, Jean-Marc; Pinel, Phillipe; Seguin, Edouarde
- American Association for Mental Deficiency 241
- Angwin Committee *see* Claremont Hospital for the Insane
- Anhalt, Prince of 283
- animality *see* people with intellectual disabilities, labelling of
- Ann H. 61
- Arthur H. 60
- assessment *see* people with intellectual disabilities, assessment of
- Association of Heads of Special Schools 237
- Association of Social Trainers Western Australia 277
- asylums 63, 292
in Europe 41, 65
in Great Britain 45, 145-146, 208
purpose 127, 179
rise of 33, 209, 303
and social change 3, 25, 251
in USA 33, 65
see also Fremantle Asylum, The Knowle
- Attfield, Dr George 30, 36, 37, 41, 42
- audiologists 230
- Australian Association of Psychology and Philosophy 214-215
- Australian Association of Special Education 237, 239, 241
- Australian Council of Education Research in Western Australia 224
- Australian Disability Strategy 160
- Australian Group for the Scientific Study of Mental Deficiency (AGSSMD) 98
- Authority for Intellectually Handicapped Persons (AIH) 2, 109, 122, 123, 126-130, 158, 161, 196
- Authority for Intellectually Handicapped Persons Act 1985* *see* legislation
- Aveyron, Wild Boy of 19, 297-299
- Balga Special School 237
- Bank-Mikkelsen, Neils 93
- Barnett, Dr 43, 45, 47, 210
- Barr, Dr 23 *see also* Elwyn School
- Barrett, Dr 39
- Bartnik, Eddie 129
- Barton's Mill 190-191
- Baxter, Norman 107, 108, 109
- Beacham Report 126, 158
- Bear, Don 230

- Beazley Report 234-235, 238
 behaviourism 4, 113, 229-231, 232, 242 *see also* people with intellectual disabilities, methods of control
 Belmont Hostel 100
 Belmont Shire 107
 Benn, Bernard 84-86, 95
 Benn case 84-86, 99
 Bennet Brook 123
 Benn, Maurice 84-86
 Bennetts, George 81
 Bentham 291
 Bentley, James 69, 210
 Bicêtre 293
 Binet, Alfred 218 *see also* intelligence testing
 Binet test 219 *see also* intelligence testing
 Birmingham, Dr 7, 65-66, 77, 149, 172-174, 175, 176, 212, 213, 227
 Birmingham Report 65-67, 69, 86, 172-174, 198, 227
 Birnbrauer, Dr Jay 113, 230
 Black, Dr 44, 45
 Blakers, Maud 212
 Blue Books 25, 27
 Board of Visitors *see* Claremont Hospital for the Insane
 Boston Hostel 116
 Boulder Special Education Centre 226
 Brady, John 82
 Brahe, Tycho 16
 Brand, David 85
 British Associationists 18
British Lunacy Act 1845 see legislation
 British Medical Society 207
 British Psychological Society 214
 Brooklands Study 97, 249-250, 260
 Brooks, Elaine 106
 Brown, Ellis 259
 Burdekin Report 130
 bureaucratic model *see* service provision, models of
 capitalism 3, 4, 32, 64, 206, 207, 263, 271, 305 *see also* service provision, market model
 capital punishment *see* intellectual disability and the law
 Cardell-Oliver, Mrs 74, 76
 Careers Research Branch 225, 226
 Carramar 111, 118
 Casey, Annie 13, 14, 29, 30, 36, 38, 41, 42
 Castledare 59, 224
 certification *see* people with intellectual disabilities, certification
 changeling *see* people with intellectual disabilities, labelling of
Chester v. The Queen 194-195
 Children's Ward, Perth Hospital 59
 children with intellectual disabilities *see* people with intellectual disabilities, children
 Child Welfare Department 110, 222
 Church of England Girls' Orphanage 59
 Citizen Advocacy 124
 civil rights movement 5, 93, 156, 305, 311
 Civil Service Commission 34, 272-273
 Claremont Hospital for the Insane 5, 53-87, 94, 205, 210, 229, 291-292
 admission procedures 81, 149, 155, 156
 Angwin Committee 67, 149
 attitudes of public towards 81, 86, 87, 95, 100
 Board of Commissioners 149
 children in 2, 74, 98, 112, 213, 227, 228, 250, 251, 254, 260, 262, 265
 closing of 96
 comparisons with Fremantle Asylum 61-62
 conditions in 61, 62, 73, 74-76, 78, 79, 83, 87, 94, 95, 131, 149, 251
 criticisms of 61-62, 74-76, 78-79, 82, 154
 day hospital at *see* Graylands Hospital
 design of 61-62, 74
 establishment of 55-59, 86
 financing of 56, 96
 J Ward 250-251
 inquiries and reports into 61-62, 76, 78-79, 252, 253 *see also* Royal Commissions, Lunacy; Stoller Report
 life in 75-76, 151, 252, 295
 media interest in 74-76, 95
 mistreatment of patients 62, 75-76, 78, 101, 253
 overcrowding 61-62, 78, 79, 80, 83, 87
 patients at 59-61, 100, 124, 221, 224
 people with intellectual disabilities in 1, 2, 39, 40, 53, 58, 74, 75, 76, 78, 81, 92, 161, 182, 258, 291
 population of 58, 78, 100, 295
 relocation 99, 100
 reorganisation of 100

- role of government 55, 56, 62-63, 95
- selection of site 56, 57, 58, 292
- separation of the sexes 58, 74, 95
- staff at 64, 76, 78, 94, 230, 251-255
- standard of care 249, 251-254, 260, 262, 295
- transferrals from Fremantle Asylum 39, 40, 56, 59
- transferrals out of Claremont 79, 255, 262, 265
- work farm 56-57, 63, 71
- Claremont Hospital Open Day 86, 95
- Clarke, Delia 167-170, 177
- classification systems *see* people with intellectual disabilities, classification systems
- Clontarf Roman Catholic Orphanage 59
- Clubb, Wallace 220
- Cocks, Errol 98, 129, 230
- Cohen, Dr Harry 106
- Colanda 291
- Collier, Philip 175
- Colonial Hospital 27
- Commonwealth Rehabilitation Service 157
- Commonwealth State Disability Agreement 160
- community living *see* people with intellectual disabilities and community living
- Community Residential Support Service 102
- Condillac, Abbé de 18, 19
- congregation *see* people with intellectual disabilities, congregation of
- Connell, Inspector 168
- convict system 33, 36, 44, 45, 291 *see also* Fremantle Asylum
- Cornell, James 71
- Court of Chancery 145
- Court, Sir Charles 106, 107, 108, 109
- cretinism *see* people with intellectual disabilities, labelling of
- Criminal Code *see* legislation
- Crippled Children's Association 310
- Cromane Hostel 125
- Croyden Hostel 100-101
- Cullen, William 294
- Cummings, Ann 39
- curable/incurable *see* service provision, medical model
- custodialism *see* services provision, models of
- Dale, Dr 39-40
- Darwinism 4, 212, 227, 301, 302, 304, 307
- Davies, Mrs J. 221-222
- Dax, Dr Eric 96
- day hospital 77, 80, 82, 83 *see also* Graylands Hospital; Irrabeena
- day placement centre 101, 264
- deaf and hearing impaired *see* people with sensory disabilities
- deinstitutionalisation 4, 79, 83, 118, 127, 131, 227, 228, 230
- Department of Corrections 185, 186, 187, 188, 189, 198
- Depo Provera 121-122
- deviancy *see* intellectual disability and deviancy
- Devonleigh 109, 110
- Diane Y 118-120
- Disability Advisory Council of Australia 157
- Disability Discrimination Act 1992* *see* legislation
- Disability Services Act 1986* *see* legislation
- Disability Services Act 1993* *see* legislation
- Disability Services Commission 130, 159, 161, 233
- Disabled People's International 157
- discourse *see also* ideology; intellectual disability and discourse
- District Co-ordinators 129
- Division for Intellectually Handicapped Persons (DIH) 101, 102, 103, 104, 123, 126, 190, 191, 310
- Dixon, Thomas 33
- doctors *see* medical professions
- Dorset Hostel 100, 105
- Down, Dr Langdon 22
- Down syndrome 22, 76, 120, 125
- Dunne, Peter 129
- Earlsferry 110
- early intervention 5, 310
- economics *see* ideology; intellectual disability and economics
- education *see* people with intellectual disabilities and education
- Education Act Amendment Act 1976* 235
- Education Department 78, 211, 213, 215, 217, 220, 221, 222, 224, 225, 226, 230, 233-234, 235, 236, 237, 238, 240, 257
- Education Support *see* people with intellectual disabilities and education
- educators and teachers

- rise of 237-238, 240
- role of 20, 46, 205, 78, 210-214, 217, 220, 222, 222-226, 235, 239, 240, 302
- training of 77, 225, 236-237
- in USA 238
- see also* professionals
- Edwards, Elizabeth 38
- Edwards, Mary 167
- Ellis, A. S. 80, 95-96, 99, 105, 106, 107, 108, 109, 250, 255, 258
- Elwyn School 23 *see also* Barr, Dr
- Emily R. 60-61
- employment *see* people with intellectual disabilities and employment
- empowerment *see* people with intellectual disabilities, empowerment of
- Enlightenment 296-298, 300, 310, 312, 313
- epileptic *see* people with intellectual disabilities, labelling of
- Eppe, Abbé de 297
- Epsom Hostel 100, 110
- Equal Opportunity Act 1984* *see* legislation
- Esquirol, Jean-Etienne 15, 18, 21, 293, 295
- see also* alienists
- Ethel M. 60
- eugenics 4, 6, 64-72, 76, 86, 87, 92, 142, 172-173, 176, 177, 179, 194, 198, 209, 212, 213, 215, 216, 219, 221, 223, 289, 295, 300-305, 312 *see also* darwinism; intellectual disability and morality
- euthanasia 289
- Exceptional Child in WA* 238
- Fairholme Hostel 123
- families
 - concerns of 103, 104, 119, 122-123, 125
 - difficulties faced by 108, 118, 119, 121-123, 125-126, 181, 309
 - and government 99, 122, 152, 229, 235, 240
 - in NSW 116
 - and professionals 95, 115, 122, 125, 128, 221-222, 226, 239, 240-241
 - respite for 129
 - role of 38, 70, 85, 105, 114, 140-141, 144, 146, 162, 227
 - support for 6, 116, 126, 127, 129-130, 132-133, 181, 227, 229, 299
 - see also* parent groups; service provision, home care
- farm colony 56, 57, 77, 78, 79, 80, 151, 176, 221, 222, 223, 303 *see also* Hawkevale; Whitby Falls
- feeble-minded *see* people with intellectual disabilities, classification systems, labelling of
- Female Register *see* Fremantle Asylum
- Ferguson, Dr John 27
- Fernald, Walter 176
- Flynn, Charles 211-212
- Flynn, Dr 40
- Formentin, Trish 241
- Forrest Government 55, 63
- Foucault, Michel 285-287, 288, 296
- Frankleton, William 30-31, 36, 40, 42
- Franklin, Benjamin 298
- Frazer, Constable 168
- Freedom of Information Act 1992* *see* legislation
- Fremantle Asylum 5, 13, 26, 28-49, 92, 210, 252
 - admission to 32, 41
 - Case Book records 24, 29-31, 35-40, 59, 60
 - conditions in 45, 55, 81
 - and the convict system 32, 33, 39, 42, 44, 45, 47 *see also* convict system
 - economic function of 34, 35, 40
 - establishment of 28, 29, 32, 33
 - Female Register 36
 - financing of 55
 - inmates of 29-31, 34-43, 46, 53
 - alcoholics 26
 - Asian 34, 35
 - children 32
 - people with intellectual disabilities in 29-31, 34-43, 46, 53
 - poor 26, 34, 35
 - inquiries into 44, 45, 48, 55, 148, 253 *see also* Vosper Inquiry
 - labels attached to inmates 26, 31 *see also* people with intellectual disabilities, labelling of
 - Medical Board findings 30, 31, 36, 37
 - moral function of 34, 35, 40
 - overcrowding 43, 44, 45, 55
 - public opinion 81, 55
 - quality of life 37, 41, 42, 43, 45, 46
 - role of Government 43, 44, 45, 55
 - staff at 55, 43, 251-252
 - standard of care 42, 249
 - suitability for people with intellectual disabilities 31, 40, 41, 47
 - Surgeon's Daily Journal 37
- Fremantle Gaol *see* people with intellectual disabilities in Fremantle Gaol

- Freud, Sigmund 217
 Friendly Societies 207
 Friends of Tresillian 106, 108
- Galton, Francis 4, 213
 Galvani, Luigi 298
 genetics 64, 65, 132, 175, 198, 212, 228, 301, 302, 304, 313 *see also* darwinism; eugenics
 Gladys Newton School 235-236, 239
 Glenys 134
 Goddard, H. H. 173, 176, 210
 Government Industrial School 59
 Government Mental Health Legislation Review 158
 Gray, Edmund 70
 Gray, Dr W. B. C. 80, 210
 Grayden, Bill 108
 Graylands Hospital 82, 100, 183, 184, 185, 196
 Great Britain
 legislation 26, 153
 social conditions in 4, 32, 33, 291
 see also asylums; British Associationists; convict system; intellectual disability; legislation; service provision
 Great Depression 71, 72, 219, 220, 222, 305
 Green, Keith 237
 group homes 110, 117, 120, 123-124, 129, 130, 132
 guardianship 138-139, 145, 146, 148, 158
Guardianship and Administration Act 1965
 see legislation
 Guhl, Jenny 106, 129
 guidance officers 238, 239
- habilitation programmes 59 *see also* people with intellectual disabilities, training
 Halliday, Alice 37-38
 Hamilton, Guy 6, 78, 96-99, 105-111, 114, 116, 126, 210, 228-231, 237, 257-261, 263, 264, 265, 266, 267, 275
Handicapped Persons Assistance Act 1974 *see* legislation
 Handicapped Programs Review 157
 Harmer, Henry 212
 Harper, Nathaniel 76, 154
 Harris, Sue 115-116
 Havelock psychiatric clinic 80
 Hawkevale 77
 Hawkins, G. 85
 Head Start 310
- Health Department 105, 126
 Heathcote Reception Hospital 68, 69, 81, 86, 150
 Heathcote Reception Hospital, Royal Commission *see* Royal Commissions
 Highgate Senior School 226
 Hill, Thomas 216, 218, 220
 Hing, Jua Ah 34, 35
 hippotherapy 294
 Hislop, James 82
 Hockey, Athol 228
 Hodgkinson, Lorna 211
 home care *see* service provision, models of
 homelessness *see* intellectual disability and homelessness
 Homeswest 130
 homoeopaths *see* medical profession
 Hope, Dr J. W. 34, 47, 210
 Hospital Employees Union 108
 Hospital and Kindred Industries Union 256
 hospitals for the insane 57, 63, 64, 68, 86, 149, 209, 251, 276 *see also* Claremont Hospital for the Insane; Fremantle Asylum
 Hospital Workers Union 273
 hostels 8, 99-110, 121
 for children with intellectual disabilities 99, 128 *see also* Croyden
 comparisons with other accommodation 123
 conditions in 110, 123, 124
 cost of 104, 129
 councils, influence of 105, 106
 devolution of 123, 130
 establishment of 105, 107, 109, 132, 264
 grading system 102, 103
 placement in 121, 122-123, 125, 128, 190, 191, 268
 problems with 102-104, 121, 122, 123, 124, 125
 rationale for 107
 special care hostels 99
 staffing of 100, 103-104, 109, 110, 121, 122, 264-265, 267
 see also progression model; Pyrtton
 Hough, Isobell 39-40, 47
 Hough, Joseph 39
 Hounscome, David 129
 House of Mercy 59
 Huelin, F 73

- Hull, Clark 229
- Human Rights and Equal Opportunities Commission 160
- Hunt, Charles 168
- Hutchinson, Ross 82, 83
- Hutchinson, Ruby 79
- Hutt, Governor 27
- hydrotherapy 294
- iatrogenesis 232
- Ideologues 18
- ideology
 and discourse 4, 284
 and economics 4, 7, 313
 and environment 292
 and management viii, 232
 and markets 9
 and notion of progress 9, 229
 and service provision 4-5, 8, 132, 284
- idiot *see* people with intellectual disabilities, classification systems, labelling of
- Illich, David 181-191, 192, 193, 194, 195, 196, 197
- Illich, Ivan 248
- imbecile *see* people with intellectual disabilities, classification systems, labelling of
- Imperial Act Adoption Act 1834 see* legislation
- Indeterminate Sentencing Board 180 *see also* intellectual disability and the law
- infanticide 289
- insanity *see* intellectual disability and mental illness
- Institute for Deaf Mutes 19
- institutionalisation 24, 66, 73, 81, 84, 94, 102, 117, 121, 131, 156, 196, 208, 218, 219, 227, 289
- institutions 97, 99, 105, 110, 123, 144, 231, 258, 300, 307 *see also* service provision, custodial model
 architecture of 289-293, 295, 300, 307
 in Australia 62, 291
 cost and funding 4, 55, 81, 86, 95, 96, 149, 300
 downscaling of 79, 314
 growth of viii, 23, 309
 placement in 128, 187
 staffing of 99
 stigma of 5, 73, 95, 100, 149
 in USA 289-290
- integration *see* people with intellectual disabilities and community living, education
- intellectual disability
 and alcoholism 26, 148, 155, 173, 302
 and the church 123, 224, 283, 293 *see also* Castledare
 community attitudes 28, 44, 45, 55, 70, 71, 72, 73, 74, 79, 84, 87, 93, 103, 106-110, 123, 125, 126, 130, 131, 132, 142, 144, 156, 177, 193, 198, 282-290, 292, 309
 comparisons with UK and USA 46, 47, 172, 249, 310
 and convict system *see* Fremantle Asylum; convict system
 and criminality 24, 26, 27, 29, 63, 65, 66, 146, 147, 148, 153, 154, 162, 172-173, 175, 176, 179, 193, 198, 213, 223, 288, 291, 292, 293, 294, 305 *see also* intellectual disability and the law
 definitions of 17, 21-22, 26, 64, 83, 127, 137-140, 142, 143, 155, 156, 158, 160, 161, 177, 209, 225, 250 *see also* people with intellectual disabilities, classification of
 and deviancy 5, 26, 33, 35, 48, 94, 109, 131, 153, 175, 179, 209, 285, 288, 290, 293, 294, 300, 308, 313 *see also* Foucault, Michel
 and discourse ix, 92, 219, 242, 283-314
 and economics 4, 33, 34, 35, 40, 55, 62, 63, 67, 70, 71, 74, 77, 86, 87, 93, 101, 103, 123, 125, 129, 131, 143, 156, 162, 179, 208, 300, 302, 305, 311-314
 in Europe 15, 17, 46, 48, 288-289, 297-299, 301
 and government policy viii, ix, 44, 55, 62, 70, 72, 84, 87, 92, 93, 96, 99, 103, 107, 118, 122, 126, 131, 132, 156, 157, 160, 171-172, 205, 212, 219, 220, 222, 225, 229, 234, 235, 296, 301, 302-303, 305, 309, 312, 314 *see also* intellectual disability and the law
 and homelessness 153, 293
 and immigrants 26, 34, 35, 73, 287
 and the law ix, 6, 43, 68, 126, 137-162, 166-200, 222, 312
 British colonial 145-146
 capital punishment 177, 179
 children 152-154, 240-241
 concepts in 138
 criminal law 137, 139-140, 143,

- 145, 146, 148, 152, 158-159, 166-200, 303
- criminal responsibility 170-171, 172, 177, 191-193
- development of special rules and conditions 141-142, 143-147, 152, 182, 185, 194, 196, 197, 189, 199
- fitness to plead 167, 169, 182, 193, 198
- function of 137
- juvenile offenders 180-181, 187
- legal incapacity 141
- parole 184, 185, 187, 188, 189, 190, 191, 195, 197
- and professionals 141-142, 147, 150
- and protection of property 43, 145, 146, 147, 148, 150, 155
- role of legislation 137
- sentencing 166, 171, 174-176, 180-181, 182-183, 184, 185, 187, 193-194, 195, 198, 199
- statutory definitions 64, 137-144, 155, 156, 158, 160, 161, 162
- and support provision 154, 188, 198
- women 146, 151, 152-153, 303
- see also* guardianship; legislation; people with intellectual disabilities, rights of
- and the media 45, 67, 74-76, 95, 107, 108, 109, 124, 169, 170, 179, 224, 225, 253, 301
- and mental illness viii, 15, 17, 21, 22, 26, 29, 31, 34, 46, 53, 56, 64, 71, 75, 79, 81, 82, 83, 87, 92, 96, 140, 147, 148, 154, 156, 158, 159, 161, 177, 213, 227, 257, 291, 295, 304
- and morality 21, 22, 23, 24, 26, 34, 35, 41, 58, 65, 66, 151, 152, 153, 173, 176, 193, 210, 213, 223, 293, 299, 301
- see also* eugenics
- and poverty 26, 29, 33, 34, 35, 65, 147, 173, 208, 213, 288, 293
- and reform 79
- and sexuality 24, 58, 69, 141, 151, 152, 153, 159
- and social change 7-8, 14
- in USA 46, 48, 2990
- intelligence testing 4, 65, 97, 143, 214, 215, 216-219, 221, 223, 224, 225, 226, 230, 232, 233, 239, 241-242, 286, 287, 301
- International Year of Disabled Persons 126, 156, 157
- Invalid Depot 36
- Irrabeena 77, 80, 85, 96, 98, 101, 102, 115, 116, 120, 124, 126, 127, 128, 129, 130, 154, 228, 230-231, 233, 241, 258, 262-263, 264, 268
- Itard, Jean-Marc 18, 19, 20, 22, 293, 297, 298, 299
- Jackson, Robert 114-117
- James, Walter 63
- Johnson, Lyndon B. 310
- Jones, Dr William 61
- Juke family 301
- Jull, Roberta 221
- Jung, Carl 113
- Justices' Association 180
- Kallikak family 173, 301
- Kareeba 107
- Karmel Report 237
- Kellum, John 27-29
- Kennedy, Governor 27
- Kennedy, John F. 93
- Kentucky Hostel 100
- Kew Idiot Ward 150, 252
- Kitson, W. H. 71
- Klein, Peter 124
- Klinefelter's Syndrome 189
- Knowle, The 44
- labelling *see* people with intellectual disabilities, labelling of
- Lake, Bill 111, 113, 230
- Lavery, Frederick 82
- Lavoisier, Antoine-Laurent 298
- law
 - British colonial 144-146
 - and children 141
 - and juveniles 151
 - purpose of 140
 - and women 151
 - see also* intellectual disability and the law
- Law of Progressivity 301
- lazaretto 290
- least restrictive alternative *see* service provision, developmental model
- legislation
 - Acts Amendment (Sexual Offences) Act* 1992 139
 - Acts Amendment (Imprisonment and Pa-*

- role) Act 1987 195
Authority for Intellectually Handicapped Persons Act 1985 2, 6, 126-127, 139, 158, 161
British Lunacy Act 1845 26
Criminal Code 139, 148, 152, 155, 158, 159, 170-171, 174-175, 176-180, 184, 187, 191-195, 198
Disability Discrimination Act 1992 160-161
Disability Services Act 1986 157, 160
Disability Services Act 1993 139, 161
Education Act Amendment Act 1976 235, 240
Equal Opportunity Act 1984 159
Freedom of Information Act 1992 139
Guardianship and Administration Act 1965 138
Handicapped Persons Assistance Act 1974 157
Imperial Act Adoption Act 1834 146
Lunacy Act 1871 26, 29, 35, 42-44, 147, 253, 254, 256
Lunacy Act 1903 45, 56, 63-64, 80, 148, 154, 155, 253, 254, 256
Lunacy Act Amendment Act 1950 154
Mental Deficiency Bill 1929 6, 59, 62, 69, 71, 142, 151-152, 155, 179-180, 219-220
Mental Health Act 1962 6, 80-84, 87, 147, 155-156, 159, 189
Mental Health Act 1981 138, 158
Mental Health Act Amendment Act 1964 138, 156
Mental Health Act Amendment Act 1965 138, 156
Mental Treatment Act 1917 149
Mental Treatment Act 1927 68, 80, 149-150
Mental Treatment Amendment Act 1940 154
Offenders Probation and Parole Act 1963 181, 195
State Children's Act 1907 152-153
State Grants (Mental Health Institutions) Act 1955 79
Statute de Praerogative Regis 145
Western Australian Equal Opportunity Act 1984 140
Western Australian Police Act 1892 153
 see also intellectual disability and the law
 leprosaria 288, 290, 292
 leprosy 15, 288, 290, 292
 Little, Murray 220, 225
 Local Area Co-ordination 6, 129-130, 132
 Locke, John 18, 19
 Logan, Leslie 81
 Lombroso, Cesare 173
Lotus 27
 Louis, S. 60
 Louis XIV 293
 Love, Dr 221
 Lovegrove, Dr 39, 210
 Lovekin, Arthur 70, 71
Lunacy Act 1871 see legislation
Lunacy Act 1903 see legislation
Lunacy Act Amendment Act 1950 see legislation
 Lunacy Department 62
 lunacy reform 63, 67 see also *Lunacy Act 1903*
 Lunacy, Royal Commission on see Royal Commissions
 lunatic see people with intellectual disabilities, labelling of
 lunatic asylum see asylum; Claremont Hospital for the Insane; Fremantle Asylum
 Luther, Martin 16, 283-284, 289
 Lyell, Charles 212
 Macartney, Helen 103
 MacCall, James 225, 226, 227
 MacKinnon, Graham 99, 112, 259, 264
 McKnight, John 248, 263-264
 McMillan, Justice 192
 mainstreaming see people with intellectual disabilities and education
 Malson, Lucien 297
 managerialism 5, 232-233 see service provision, market model
 Mann, Henry 168, 169, 176-178
 market model see ideology; service provision, models of
Marquis of Anglesey 291
 Massachusetts School for the Feeble-Minded 176
 Maudsley Hospital 249
 Medical Board see Fremantle Asylum
 medical model see service provision, models of
 medical professions 141-142, 206-210, 221
 alternative medicine 207
 paediatricians 228
 psychiatrists 77, 209, 210, 228-229,

- 230, 231, 252, 287, 303
 rise of 206-207, 228
 role of 19, 29, 30, 41, 43, 46, 47, 55, 57,
 63, 64, 67, 72, 82, 84, 86, 87, 121, 147,
 148-149, 150, 154, 155, 162, 192,
 205, 211, 215, 217, 223, 232, 239,
 241, 242, 249, 250, 253, 254, 268,
 285, 286, 287, 295, 302, 303, 304,
 305, 306, 308
see also nurses; professionals
 Medicare 207
 medicine *see* medical profession; service
 provision, medical model
 Melville City Council 107
 Mendel, Gregor 212
 mental defective *see* people with intellec-
 tual disabilities, labelling of
 Mental Deficiency Bill 1929 *see* legislation
 Mental Deficiency Bill, Select Committee
 on 59, 69-71, 153
 Mental Deficiency Division (MDD) 96, 98,
 99, 101, 105, 123, 210, 228, 257, 264, 268
 mental deficient *see* people with intellec-
 tual disabilities, labelling of
 Mental Health Act 1962 *see* legislation
 Mental Health Act 1981 *see* legislation
 Mental Health Act Amendment Act 1964 *see*
 legislation
 Mental Health Act Amendment Act 1965 *see*
 legislation
 Mental Health Department 77, 95
 Mental Health Services 79, 94, 96, 105, 107,
 109, 110, 131, 157, 182, 183, 184, 185,
 186, 187, 188, 189, 190, 194, 210, 227,
 228, 237, 257, 258, 259
 Mental Hygiene Department 77
 mental illness *see* intellectual disability
 and mental illness
 Mentally Incurable Children's Association
 (MICA) 99, 310
 Mental Treatment Act 1917 *see* legislation
 Mental Treatment Act 1927 *see* legislation
 Mental Treatment Amendment Act 1940 *see*
 legislation
 Mental Welfare Committee 73-74
 Metropolitan Mental Hospital Employees
 Union 256
 midwives 207
 Miles, J. A. 212
 Milford Hostel 100, 110
 Minbalup 77
 Mist Chloral 39
 Mitchell, James 220
 mongol *see* people with intellectual dis-
 abilities, labelling of
 Mongolism *see* Down syndrome
 Montalto, Felipe 15-16
 Montesquieu, Charles-Louis 298
 Montessori, Maria 298
 Montessori School 213
 Montgomery, Dr Sydney 55-58, 169-172,
 210, 252
 Moon, Jack 167-172, 177, 192, 193
 Moynagh, Dr Digby 80
 Munsie, S. W. 69, 179
 Murdoch, Walter 220, 224
 Murray, Michael QC 158
 Myoora 111, 118
 Nairn, Frederick 167
 Nathaniel Harper Homes 76-78, 83, 87,
 100, 111, 154, 234
 natural fool *see* people with intellectual
 disabilities, labelling of
 Nazism 72, 289, 302, 310
 Nedlands Council 106-107, 109
 Newton, Isaac 300
 Nicholson, John 177-178
 Nirje, Bengt 93
 Nordic 301
 normalisation *see* service provision, de-
 velopmental model
 North, F. D. 171-172
 North Fremantle Infants' School 221
 North Perth Infants' School 226
 Nulsen Haven 234, 255
 nurses
 asylum attendants 251-255, 257, 308
 in Australia 2, 255
 in Britain 2, 249, 256, 257
 psychiatric nurses 94-95, 228, 251,
 252, 254-256, 257, 258, 311
 registered nurses 260, 262, 265-267
 role of 2, 57-58, 69, 94, 95, 105, 110, 111,
 115, 207, 213, 242, 249, 250, 252,
 253, 254, 265, 276, 304
 sexual division of labour 255, 257
 training of 252, 256, 257, 258-259, 275
 unionisation 256, 257
 Nurses Registration Board 252
 O'Brien, Dr 39
 occupational therapists 77, 111, 230, 255,
 264, 267, 268, 269, 276
 O'Connor, Ray 108
 Offenders Probation and Parole Act 1963 *see*

- legislation
- O'Sullivan, Joseph 72-73, 84, 85
- overcrowding 23, 100 *see also* Claremont Hospital for the Insane; Fremantle Asylum
- Panopticon 291
- Paracelsus, Philippus 14
- parent groups 2, 6, 8, 23, 77, 87, 92, 96, 109, 131, 156, 234, 305, 310, 312 *see also* families; MICA; SLCG
- parents *see* families
- Parkerville Children's Home 117
- PASS (Programme Analysis of Service Systems) 114
- Paul, Sir George 145-146
- pauper lunatic *see* intellectual disability and poverty; people with intellectual disabilities, labelling of
- Pennefather, C. E. D. F. 174-176
- Penny, Clifton 169, 170
- people with intellectual disabilities
 - accommodation for 27, 29, 61-62, 68, 83, 96, 99, 101, 104, 107, 109, 110-126, 127-130, 142, 154, 155, 159, 160, 172, 175-176, 220, 221, 223, 224, 231, 289-293, 296, 310 *see also* group homes; hostels
 - aged 69, 79, 82, 99, 148, 155
 - assessment of 96, 99, 100, 128, 130, 145, 150, 178, 226, 287, 302
 - certification of 40, 63-64, 68, 69, 81, 149, 150
 - children with intellectual disabilities
 - accommodation for 2, 59, 70, 73, 74, 76-77, 79, 82, 97, 98-99, 104, 105, 110, 146, 150, 154, 155, 222, 234, 250, 255, 257, 296 *see also* hostels; Nathaniel Harper Homes; Pyrtton
 - guardianship 145, 152
 - parents with 72-73, 84-85, 95, 96, 102, 104, 108, 114, 116, 108, 118, 119, 121-123, 125-128, 181, 221-222, 226, 235, 240-241
 - training of 20, 59, 111-116, 222, 224-225, 227, 233-234, 250, 259, 297
 - treatment of 283, 289
 - see also* Claremont Hospital for the Insane; early intervention; Fremantle Asylum; people with intellectual disabilities and
- education
 - classification systems for 210
 - at Claremont Hospital for the Insane 55, 58, 74, 94
 - Education Department 226, 233-234, 305
 - at Fremantle Asylum 146-147, 148
 - idiocy, feeble-mindedness, imbecility 21-22, 65, 177
 - mental disorder 83, 155, 156, 158
 - in *Mental Health Act 1962* 82
 - by 1968 Ministerial Committee 104
 - removal of 81
 - at Salpêtrière 293
 - classification of 14, 15, 16, 17, 45, 46, 48, 53, 54, 58, 59, 60, 61, 62, 64, 81, 121, 122, 123, 124, 143, 150, 162, 170, 211-212, 216, 220, 221, 224, 225-227, 241, 282, 287, 302, 303
 - and community living 8, 9, 22, 23, 94, 96, 97, 99, 101, 102, 103, 104, 106, 109, 117, 118, 120, 123, 124, 125, 127, 131, 132, 143, 156, 181, 186, 205, 227, 231, 234, 264, 276, 305 *see also* deinstitutionalisation; service provision, developmental model
 - congregation of 3, 53, 73, 75, 82, 83, 94, 110, 111, 114, 115, 123, 132, 146, 148, 156, 289-290, 292, 299, 309, 314
 - in country areas 128-129
 - deregistration of 130
 - detention of 14, 25, 29, 63, 145, 146, 147, 148, 153, 156, 158, 159, 166, 174-176, 177, 179, 180, 182, 183, 186, 187-188, 189, 190, 191, 193, 194, 195, 196, 198, 227, 286, 290, 291, 303, 304
 - devaluation of 3, 58, 94, 176, 282-284, 288, 289, 290, 292, 300, 309, 311, 312
 - diagnosis of 15, 17, 26, 34, 35, 36-39, 42, 58, 59, 60, 61, 72, 84, 170, 186, 209, 211-212, 217, 227, 228, 287
 - discrimination against 140, 157, 159, 160-161, 235
 - education 99, 179, 181-182, 210-214, 215-218, 222-228, 233-242, 287, 296-299, 305, 310
 - access to 122, 152-153, 159
 - benefits of 18
 - day activity centres 99, 116, 117, 234

- Education Support Centre 236, 238
 Education Support School 235, 237
 Education Support Units 236
 establishment of residential schools 17, 20, 22, 23, 46, 47, 76, 77, 78, 151, 216, 222, 297, 299
 maindumping 235
 mainstreaming 234-238, 241, 242
 rationale 24, 66, 94
 remedial classes 211, 212
 segregation in schools 215, 216, 221, 224, 234, 238, 240, 241, 242, 302
 special classes 226, 227, 230, 233, 234, 238
 special education ix, 76, 77, 211, 213, 216-217, 220, 226, 234, 236-242
 special schools 128, 154, 230, 233, 235, 238
 and employment ix, 66, 118, 144, 159, 160
 sheltered workshops 66, 99, 101, 120, 121, 157, 262, 263
 work experience 111, 122
 exploitation and abuse of 3, 75, 82, 100, 120, 121, 125-126, 142, 152-153, 154, 188, 197, 198, 227, 243, 253
 see also Claremont Hospital for the Insane
 empowerment of 9, 93
 in Fremantle Gaol 169, 171, 172, 175, 176, 183, 184, 185, 186, 188, 189, 190, 191
 identification of 142, 196, 197, 211, 215, 303
 isolation of 3, 22, 24, 28, 82, 111, 290-292
 labelling of
 animality 16, 19, 24, 60, 106, 295, 297
 changeling 16, 283
 child-like 170, 296, 305, 306, 307, 310
 cretin 15, 211
 criminal lunatic 29, 75, 146 *see also* intellectual disability and criminality
 epileptic 16, 60, 66, 69, 172, 173, 226, 302
 feeble-minded ix, 17, 21, 59, 65, 66, 67, 69, 148, 172, 173, 176, 217, 219, 284, 297, 301, 302, 303
 handicapped 79, 98
 idiot ix, 6, 7, 13, 14, 16, 17, 18, 19, 20, 21, 23, 24, 26, 30, 36, 37, 38, 39, 43, 44, 59, 60, 62, 65, 84, 145, 146, 147, 148, 152, 159, 177, 286, 287, 293, 297, 300
 imbecile ix, 7, 13, 14, 17, 21, 23, 30, 36, 37, 38, 40, 41, 53, 58, 59, 60, 61, 62, 65, 148, 152, 159, 177, 213, 225, 286
 innocents 15, 306
 insane 17, 25, 26, 31, 33, 37, 41, 53, 55, 62, 64, 68, 147, 148, 172, 193, 299, 303 *see also* intellectual disability and mental illness
 lunatic 25, 26, 27, 28, 30, 31, 33, 41, 46, 57, 71, 145, 146, 147, 148
 mental defective viii, 20, 53, 62, 64, 65, 66, 67, 69, 70, 71, 79, 83, 84, 111, 118, 153, 170, 172, 174, 177, 179, 186, 192, 213, 215, 218, 219, 220, 221, 222, 224, 302, 303, 304
 mental deficient ix, 17, 57, 58, 62, 65, 69, 70, 71, 72, 81, 86, 172, 173, 175-176, 177, 178, 179, 194, 198, 213, 217, 219, 223, 224, 284, 295, 302
 mongol 22, 60, 284
 natural fool 14, 15, 16, 145, 285, 286
 pauper lunatic 13, 35, 147 *see also* intellectual disability and poverty
 retarded 16, 79, 85, 226, 287, 305
 simple-minded 30, 31
 slow learner 287, 305
 spastic 226
 subnormal 14, 16, 18, 21, 40, 85, 177, 212, 249, 250
 unsound mind 26, 30, 36, 43, 64, 145, 146, 147, 148, 192, 193
 weak-minded 47, 53, 58, 170, 192
 methods of control 289, 307, 308
 aversion therapy 113, 119, 229, 230
 punishment 113, 172, 252, 294-295, 308
 restraint 28, 29, 37, 39, 41, 42, 60, 62, 75, 119, 146, 149, 150, 161,

- 252, 294-295 *see also* strait-jacket
- seclusion 41, 42, 60, 119, 146, 150, 161, 294
- and participation 127
- people with severe and profound disabilities
- accommodation for 99, 104, 106, 132, 234, 265
- classification of 104, 121, 122, 123
- services for 99, 120, 235
- placement of 99, 125, 129, 182, 183, 188, 190, 239 *see also* hostels; institutions
- and professionals ix, 8, 93, 95, 117, 131, 142, 162, 205, 213, 218, 219, 227, 231-232, 232-233, 237, 238-243, 248, 249, 250, 255, 264, 267, 268, 269-271, 275, 276, 277, 286-287, 297, 300, 302, 313 *see also* educators; psychologists; medical professions; social trainers; service provision, multi-disciplinary approach; social workers
- quality of life 97, 117, 131, 132, 161, 277, 283, 289 *see also* Fremantle Asylum; Pyrton
- registration of 98, 101, 130, 142, 151, 153, 263
- rights of 5, 6, 68, 82, 92, 96, 106, 107, 122, 126, 127, 131, 132, 141, 143, 154, 156, 157, 158, 180, 195, 198, 199, 200, 234-235, 243, 311, 312 *see also* advocacy
- segregation of 3, 44, 48, 53, 57, 66, 68, 69, 70, 71, 72, 74, 76, 86, 94, 110, 111, 114, 156, 171, 172, 173, 175-176, 179, 194, 208, 209, 213, 219, 220, 223, 224, 250, 303, 304, 305, 309, 314 *see also* education
- sterilisation of 66, 67, 69, 70, 71, 153, 209, 289, 303 *see also* eugenics
- training 9, 20, 39, 46, 77, 92, 94, 96, 99, 100, 103, 114, 117, 132, 151, 222, 225, 233, 265, 268, 298, 300, 305, 310 at Claremont Hospital for the Insane 95
- general skills 102, 120, 154, 213, 216
- industrial skills 66, 76, 94, 149, 222, 224
- life skills 19, 79, 99, 111, 112, 234 at Pyrton 111-117, 119-120
- rationale 41, 42
- self-care 37, 38, 102, 119-120, 218
- skill evaluation 102 *see also* hostels
- training centres 227, 233-234 *see also* people with intellectual disabilities and employment; social trainers
- treatment of 14, 20, 27, 28, 45, 48, 53, 60-61, 68, 81, 83, 121-122, 148, 149, 150, 158, 161, 175, 182, 185, 186, 189, 209, 210, 221, 223, 228, 229, 286, 289, 294-295, 299, 300, 303 *see also* hippotherapy; hydrotherapy; Rush chair; service provision, medical model; whirling
- women with intellectual disabilities 41, 66, 70, 95, 122, 123, 151, 152, 153, 219-220, 222, 224, 251, 255, 302-303 *see also* intellectual disability and sexuality; women
- people with sensory disabilities 16, 19, 29, 297, 298
- Pereirie, Jacob-Rodriguez 19
- Perth Infants' School 76, 210-212, 222
- Perth Technical College 110, 259
- Pestalozzi, Johann 297
- pesthouses 290
- physiological method 20 *see also* Seguin, Edouard
- physiotherapists 20, 111, 112, 230, 276
- Pindarra 111, 118
- Pinel, Phillipe 17, 19, 293, 297, 298
- podiatrists 230
- poor houses 33, 39, 40, 146, 208
- Primary Responsibility Teams 269 *see also* service provision, multi-disciplinary approach
- Princess Margaret Hospital 84, 99, 104, 105, 109, 228
- Princess May Infants' School 222
- professionals *see* people with intellectual disabilities and professionals
- progression model 100, 102, 111, 114, 117, 123, 132
- Psychiatric Nurses' Association 256
- psychiatrists *see* medical professions
- psychologists
- clinical psychology 230, 259
- and management 231-233
- rise of 214-215, 225, 230, 232
- role of 20, 29, 55, 57, 77, 78, 87, 113, 114, 117, 119, 120, 122, 131, 155, 205,

- 214-221, 222-224, 225-226, 228, 229,
230-232, 238, 239, 240, 241, 242,
255, 264, 268, 305, 310
training of 225, 229
see also behaviourism; intelligence test-
ing; professionals
psychology clinic 75, 151, 219-220, 222,
225 *see also* Ethel Stoneman
psychometrics 4, 229 *see also* intelligence
testing
Pulley, Pamela 225
Pyrton Training Centre 110-121, 124, 132
children in 110, 112-117, 234, 257, 262
community attitudes towards 114,
115
comparisons with Claremont 111,
115
controlling behaviour in 112, 113,
114, 119, 120
design of 111, 112, 120, 258
and economics 86
establishment of 83, 98, 99, 110, 261,
262, 305
expansion of 2, 99, 264
involvement of families 114-116, 119-
121
and Mental Deficiency Division 100
professionals 117-120, 265-267, 270
progression model 117
quality of life at 117
rationale 111, 114
residents at 113, 118-121
restructuring of 114, 118
specialised service provision at 6
staff 110, 111, 112, 113, 116, 117, 119,
120, 258-260-263, 265-267 *see also*
social trainers
training 110-115, 117, 119, 120, 258
see also children with intellectual
disabilities, training of
Randall, George 13
Randell, Emily 38, 40
Reagan, Ronald 312
reception house 68, 69 *see also* Heathcote
Reception Hospital
Red Hill Industrial School 59
Regional Advisory Councils 127
registered nurses *see* nurses
registration *see* people with intellectual
disabilities, registration of
Rennie, Dr D. F. 30, 41
residential care 92-133 *see also* group
homes; hostels
residential schools *see* people with intel-
lectual disabilities and education
retardation *see* people with intellectual
disabilities, labelling of
Rigg, Dorothy 100
Rischbieth, Bessie 73
Robertson, Sue 193
Robinson, Robert 174-175
Rooth, Justice 170, 171, 193
Ross Memorial Hospital 107-109
Round House 291, 293
Rousseau, Jean-Jacques 297, 298
Royal College of Surgeons 207
Royal Commissions
Heathcote Reception Hospital 254
Lunacy 61, 62, 68, 150, 154, 253-254
Rush, Benjamin 294
Rush chair 294
Salpêtrière 293
Salvation Army Industrial School for Boys
and Girls 59, 221
Salvation Army Seaforth Boys Home 59,
218, 220, 222, 224
Sarah A 120-123
Saw, Dr Athelstan 68, 70, 178
Scarboro Hostel 100
segregation *see* people with intellectual
disabilities, segregation of
Seguin, Edouard 18, 20, 21, 22, 23, 293, 298
Select Committee on Mental Deficiency
Bill *see* Royal Commissions, Mental
Deficiency Bill
service provision
assessment for 142, 143, 268-269, 271
see also Irrabeena
cost and funding of 55, 127, 129, 130,
160, 161, 179, 224, 236, 260, 276,
305, 311, 312
in country areas 99, 101, 127-130
development of viii-ix, 6, 99, 127, 130,
131, 132, 144, 257
features of 2, 154
in Great Britain 57
models of
bureaucratic model 1, 5, 6, 9, 126,
130, 144, 233, 310-311, 313
see also managerialism
custodial model 5, 9, 22, 23, 43, 44,
46, 61, 62, 66, 69, 75, 76, 79, 83,
86, 92, 131, 140-141, 142, 150,
152, 155, 156, 159, 162, 212,

- 249, 250, 252, 258, 260, 262,
276, 304, 305, 309, 310, 312
- developmental model 205, 228,
242, 276, 277, 312
- least restrictive alternative 5,
123-124, 305, 312
- normalisation 5, 92, 93-94, 96,
97, 98, 101, 104, 105, 107,
117, 124, 127, 131, 132, 156,
205, 230, 231, 234, 264,
274, 276, 284, 305, 308, 311,
312
- social role valorisation 93-94,
131, 276, 284, 306, 307, 311,
312
- see also* deinstitutionalisation;
people with intellectual
disabilities and commu-
nity living
- educational model 23, 92, 287
- families/home care 95, 101-102,
111, 118, 120, 122-124, 125, 127,
128, 129, 130, 152, 228, 231, 249
- market model 1, 3, 4, 5, 9, 208, 263-
264, 312, 313-314
- managerialism 232-233
- see also* capitalism; intellectual
disability and economics
- medical model 2, 53, 57, 79, 86, 92,
94, 149, 205, 209, 210, 212, 228,
239, 249, 250, 251, 256, 257,
258, 276, 277, 287, 303-304, 309,
310
- curable/incurable 15, 16, 18,
27, 44, 46, 47, 53, 65, 68, 72,
87, 94, 95, 142, 149, 150,
151, 161, 209, 217, 241, 242,
251, 293, 294, 296, 297, 298,
299, 304, 305
- multi-disciplinary approach 268-
271, 276
- in North America 129, 218
- in prisons 179, 181
- problems with 85, 122-123, 128
- quality of 98
- role of community 6, 8, 76, 78, 85, 92,
103, 125, 127, 128-129, 131, 157,
162, 264, 305
- role of State Government 6, 8, 77, 79,
81, 95, 99, 126-127, 128, 129, 130,
131, 155, 156, 157, 160, 162, 257,
258, 311, 312
- trends in vii, 1-10, 77, 157, 257
- see also* families; ideology
- services, disability
 - access to 138, 142, 143, 160, 162
 - demand for 101, 104, 127, 128, 131, 221
 - eligibility for 142-143
 - establishment of 77, 83, 144, 264
 - evaluation of 114
 - features of 2, 292
 - mainstreaming of 130
 - specialised 2, 6, 94, 98, 99 *see also*
Pyrton
 - in New South Wales 3
 - in USA 5
 - in Victoria 7
 - see also* residential services
- Shean Report 236, 237, 238, 240-241
- sheltered workshops *see* people with
intellectual disabilities and employ-
ment
- ship of fools 286
- Sholl, Colonial Surgeon 27, 28
- Shuttleworth, George 17
- Simon, Theophile 218
- simple-minded *see* people with intellec-
tual disabilities, labelling of
- Skinner, B. F. 229
- Slayford, David 221
- Slee, Pat 112
- slow learner *see* people with intellectual
disabilities, labelling of
- Slow Learning Children's Group (SLCG)
77, 80, 85, 87, 96, 98, 99, 102, 123, 126,
128, 154, 155, 227, 234, 310 *see also*
parent groups
- Social Darwinism *see* Darwinism
- social role valorisation *see* service provi-
sion, developmental model
- social trainers 248-278
 - experiences of 112, 230, 262
 - initial problems of 111
 - and parents 115, 120
 - professionalisation of 2, 100, 228, 249,
268, 271, 277
 - and professionals 256, 257, 264-268,
269, 270, 271, 275, 277
 - recruitment of 110, 260-261
 - role of 20, 111, 112, 117-118, 122, 128,
260, 262, 265-267, 268-271, 275, 311
 - and service delivery 102, 231-232,
264-271, 273, 274-277
 - sexual division of labour 260-261,
272, 274, 276
 - training of 110, 259, 262, 263, 268, 274-

- 276
 unionisation 271-273, 274
see also professionals
 social workers 77, 122, 124, 131, 229, 238, 239, 255, 263, 268, 269, 276
 Sophia 13
 Sparrow, Neville 114
 spastic *see* people with intellectual disabilities, labelling of
 Spastic Welfare Association 310
 Special Domestic Class 222
 special education *see* people with intellectual disabilities and education
 speech therapists 77, 230, 264, 276
 Stanford-Binet Test 219 *see also* intelligence tests
 State Children's Act 1907 *see* legislation
 State Grants (Mental Health Institutions) Act 1955 *see* legislation
 State Psychological Clinic *see* psychology clinic; Stoneman, Ethel
 State School Teachers' Union 223, 225
 sterilisation *see* people with intellectual disabilities, sterilisation of
 Stirling, James 146
 St Joseph's Roman Catholic Orphanage 59
 St Kevin's Industrial School 224
Statute de Praerogative Regis *see* legislation
 Stoller, Allan 77-79
 Stoller Report 78-79, 154
 Stone, G. F. 28
 Stone, Philip 212
 Stoneman, Ethel 7, 151-152, 153, 216-224, 225, 226, 227, 302
 straitjacket 37, 39, 42, 75, 294 *see also* people with intellectual disabilities, methods of restraint
 subnormal *see* people with intellectual disabilities, labelling of
 Sussex Hostel 109
 Swanbourne Hospital 100, 101, 102, 104, 109, 119, 121, 182, 183, 184, 186
 Swan Boys' Orphanage 59
 Symmons, Thomas 36
 Syracuse University 93
 Tann, Di 114
 teachers *see* educators and teachers
 Temperley, William 40
 Terman, Lewis 216
 Thatcher, Margaret 312
 Thompson, Dr Ernest 59, 69, 86, 210
 Tizard, Jack 97, 105, 249-250, 258
 training *see* people with intellectual disabilities, training, children
 treatment *see* people with intellectual disabilities, treatment of
 Tredgold, Alfred 22, 210
 Tresillian 104, 105-109, 131
 alternatives to 107-108, 109 *see also* Ross Memorial Hospital
 community concerns about 106, 107
 function of 107
 and government 106, 107, 108
 media coverage of 107, 108, 109
 Nedland's council's objection to 105-106, 107
 Open Day 108
 relocation to 104
 staff 108
 support for 106, 108, 109
 transfer of residents from 105-106, 108
 Troy, M. F. 73
 Turner, Lawrence 74-76, 253
 United Nations 156, 160, 234
 unsound mind *see* people with intellectual disabilities, labelling of
 Victor *see* Aveyron, Wild Boy of
 Victorian Office of the Public Advocate 199
 Volta, Alessandro 298
 Voltaire 298
 Vosper Inquiry 45, 55, 148, 251-252, 253
 Waifs' Home 59
 Walker, Thomas 175
 Walter C. 59-60
 Walton, Chief Inspector 211, 212
 Watchdog 105, 108, 126
 weak-minded *see* people with intellectual disabilities, labelling of
 Weihsan, Dr 211, 212
 Western Australian Equal Opportunity Act 1984 *see* legislation
 Western Australian Male and Female Mental Nurses Union 256
 Western Australian Police Act 1892 *see* legislation
 whirling 294
 Whitby Falls 44, 56, 57, 62, 83, 210, 223
 White Palace 100
 Wild Boy of Aveyron *see* Aveyron, Wild

- Boy of
Willcock, John 177
Wolfensberger, Wolf 93, 97, 110, 111, 125,
282, 284-285, 289, 306, 307, 311
women
 discrimination against 3, 151, 305
 and the law 146, 151, 152, 153
 and society 3, 151, 152, 307, 308
 see also people with intellectual dis-
 abilities, women; social trainers
Women's Service Guild 73
work experience *see* people with intellec-
 tual disabilities and employment
work houses 3, 290
Working Party 158
Workpower 111

Young, P. C. 167
Young, Ray 109, 157

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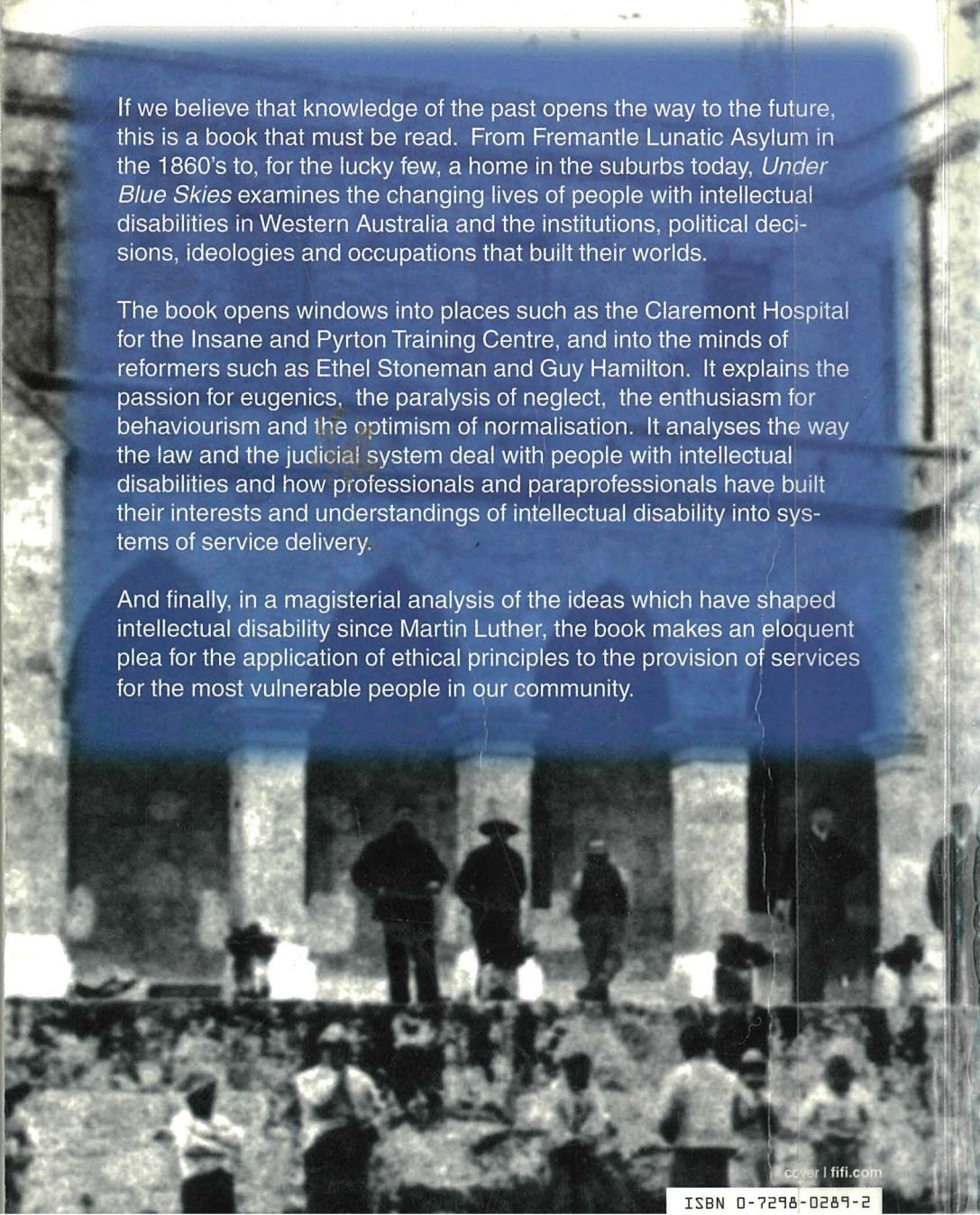
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If we believe that knowledge of the past opens the way to the future, this is a book that must be read. From Fremantle Lunatic Asylum in the 1860's to, for the lucky few, a home in the suburbs today, *Under Blue Skies* examines the changing lives of people with intellectual disabilities in Western Australia and the institutions, political decisions, ideologies and occupations that built their worlds.

The book opens windows into places such as the Claremont Hospital for the Insane and Pyrtton Training Centre, and into the minds of reformers such as Ethel Stoneman and Guy Hamilton. It explains the passion for eugenics, the paralysis of neglect, the enthusiasm for behaviourism and the optimism of normalisation. It analyses the way the law and the judicial system deal with people with intellectual disabilities and how professionals and paraprofessionals have built their interests and understandings of intellectual disability into systems of service delivery.

And finally, in a magisterial analysis of the ideas which have shaped intellectual disability since Martin Luther, the book makes an eloquent plea for the application of ethical principles to the provision of services for the most vulnerable people in our community.