UNIVERSITY OF CANTERBURY

To be Made Disabled

A Discourse Analysis of Intellectual Disability in New Zealand, 1900 – 1960

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Abstract

The New Zealand historiography on intellectual disability has been expanded in the twenty years by histories of the residential institution and the foundation of advocacy groups. However, there is still a limited field of history regarding how the intellectually disabled were discussed in twentieth century New Zealand. This thesis will discuss how the identity of the intellectually disabled was constructed as a social category, through different discourses, in twentieth century New Zealand. It shall be argued that from 1900 to at least 1960 those who created medical, government and public discourse also maintained the power to create the identity of the intellectually disabled. This argument will take the form of a discourse analysis and will draw on both primary and secondary sources. The primary sources will include government documents, medical literature and newspaper content. The secondary sources will cover material which provides context, and / or which has discussed the construction of intellectual disability. It will be argued that discourses centred on an idea of a 'problem' within the intellectually disabled individual. Also, the medical discourse and 'medicalized' understandings of intellectual disability will be seen to influence public and government discourse. Further, a tension will be shown in these discourses between the desire to assist the intellectually disabled and their families, as well as to protect the New Zealand community from these people.

Contents

Introduction

Through-out New Zealand's history, a range of labels such as these have been applied to the intellectually disabled. Each was imbued with certain attitudes. Each was mobilized for a specific social purpose. None were terms chosen by those to whom they were applied.

These shifting terms and labels show that the position the intellectually disabled have occupied in New Zealand society has by no means been a static one. This thesis will examine how intellectual disability was constructed as a social category, through different discourses, in the context of early twentieth century New Zealand. More specifically, the analysis will focus on government, medical and public discourses of intellectual disability in the period from 1900 to 1960. Having set out a theoretical framework, a working definition of intellectual disability and methodology, each of these three discourses shall be discussed individually. Particular attention shall be paid to the ideology, inherent in these discourses, of intellectual disability as a problem located within individuals, as opposed to within their social environments. This 'individual' model will be seen to operate in the push for residential institutions as an answer to how those deemed morally and or mentally 'defective' should be cared for or contained. A 'medical model' will also be discussed which draws on and reinforces this 'individual' approach. Further, this early twentieth century discourse will be shown to reflect and in many cases be based on international policy on intellectual disability. Overall, this paper attempts to discuss whether discourses influenced, dominated or informed one another, and how they were subject to change over a sixty year period. Moreover, this discussion aims to bring attention to the power of discourse to create and control the intellectually disabled as a social category.

Definitions

While an emphasis has already been placed on the term 'intellectual disability', it is necessary to offer a more comprehensive definition of this term, and the people to whom this term is applied. The term 'intellectual disability' is a relatively new one, and it has been argued that there are other terms which are more comprehensive or sensitive to the individual/s in question. However, for the purposes of clarity and consistency in the

argument, this discussion shall use the term 'intellectually disabled'. The decision to add 'intellectual' also creates a distinction from, and thereby avoids a confusion with the mentally ill – those who experience discrimination as a result of their psychiatric state.

Also integral to this discussion is the distinction between 'impairment' and 'disability' within the term 'intellectually disabled'. To be impaired and to be disabled are not one in the same. An 'intellectual impairment' relates to any disruption which effects normative biological or 'intellectual' functioning, namely during pregnancy, or in early childhood. Such impairments may in cases be linked to physical factors, for example oxygen deprivation or brain injury. Disability may be taken, on the other hand, to be not found within but visited on the individual. It may be discussed as an active and shifting process wherein biological conditions are imbued with social values or meanings, often as a means of 'controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms'.[1] Impairment may therefore be understood in this discussion as a biological state, and disability, emphasized by Lennard J. Davis, as the forms of discrimination experienced as a consequence of the social reception and construction of this impairment.[2]

Certain models of intellectual disability must also be defined. Between 1900 and 1960, the focus of this discussion, the 'medical' model dominated understandings of disability. The dominance of this model was not exclusive to New Zealand. The medical model was an approach to intellectual disability which emerged in line with the rise of modern medicine.[3] Intellectual disability was approached through this model as a personal characteristic or condition.[4] This model gave medical practitioners power to define roles for

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[1] Riessman, Catherine Kohler, 'Women and Medicalization: A New Perspective', in Kirkup, Gill and Keller, Laurie S., *Inventing Women: Science, Technology and Gender,* Malden, Blackwell Publishers, 1998, p. 124, in Withers, A.J., *Disability Politics and Theory,* Winnipeg, Fernwood Publishing, 2012, p. 5,7,33; Braddock, David. L., and Parish, Susan L., 'An Institutional History of History', in Albrecht, Gary L., Katherine D. Seelman and Michael Bury, *The Handbook of Disability Studies,* (Thousand Oaks: Sage Publications, 2001), p. 11

[2] Braddock and Parish, 'An Institutional History of Disability', in Albrecht, p. 12

[3] Withers, p. 31

[4] Linton, Simi, *Claiming Disability – Knowledge and Identity,* (New York: New York University Press), 1998, p. 13; Withers, p. 4

intellectually disabled people, and therefore this model was used as a form of social control.[5] In contrast, the social model of intellectual disability approaches intellectual disability not as a condition of individuals but as a social category.[6] This model emphasizes institutional and social structures and responses which shape the roles of the intellectually disabled.[7]

Theoretical framework

The creation and function of intellectual disability as a separate social category has been analysed and debated by theorists including Michael Oliver, Lennard J. Davis, Thomas S. Szasz, Michel Foucault, Ivan Illich, Erving Goffman and Irving Zola. In regard to my own discussion, the most significant contributing theory is that the experience of intellectual disability is externally constructed and driven; that people are not born disabled, they are *made* disabled. Such a process is taken by Ivan Illich to be reliant foremost on the transformation of an individual's challenge with impairment into a perceived problem of society.[8] Further, as posited by Szasz, Davis and Illich, an understanding of the role of the intellectually disabled in modern society may be derived from an understanding of the roles of legislators and medical practitioners *in relation to* the intellectually disabled.[9] Expanding on Foucault's theory of the power which may be exercised through the possession of knowledge, these theorists have attempted to explain how the privileging of modern medical and professional discourse has allowed the intellectually disabled to be discriminated against,

[5]Illich, Ivan, *Limits to Medicine: Medical Nemesis – The Expropriation of Health,* (New York: Penguin, 1977), p. 97; Zola, Irving Kenneth, 'Medicine as an Institution of Social Control: The Medicalizing of Society', in Tuckett, David, Kaufert, Joseph, *Basic Readings in Medical Sociology,* (London: Tavistock Publications, 1978), p. 168; Gooding, Caroline, *Disabling Laws, Enabling Acts – Disability Rights in Britain and America,* (Boulder: Pluto Press, 1994), p. 17

[6] Kudlick, Catherine J., 'Disability History: Why We Need Another Other', *The American Historical Review,* Vol.108, No.3, (June 2003), 765; Corker, Mirian, French, Sally, *Disability Discourse,* (Buckingham,:Open University Press, 1999; Race, David, *Intellectual Disability – Social Approaches,* New York, Open University Press, 2007, Rapely, Mark, *The Social Construction of Intellectual Disability,* Cambridge, Cambridge University Press, 2004

[7] Marks, Deborah, *Disability: Controversial Debates and Psychosocial Perspectives,* London, Routledge, 1999, p. 3

[8] Illich, p. 17

[9] Szasz, Thomas S., *The Second Sin,*. (London: Routledge and Keagan Paul), 1974, p. 21; Szasz, Thomas S., *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement,* (New York: Dell Publishing), 1970, p. 208; Albrecht, p. 11; Illich, p. 17

denied rights to self-determination or at very least relegated to a status through definition, classification and labelling.[10] In deciding who is normal and who is not, who or is or is not able to participate in society, discourse establishes and reinforces a binary which at once determines the right of the 'able' to classify, and 'expropriates the power of the individual to . . . shape his or her environment'.[11] 'Disability' becomes the inability to define the self; the 'ability' or power of discourse in relation to the intellectually disabled, therefore to shape and determine experience through the demonstration of knowledge.[12]

However, as recognized by Michael Oliver, there are a multitude of models used to discuss how the identity of the intellectually disabled is invented as a social category.[13] Oliver argues that this multiplicity is logical, because intellectual 'disability is not a fixed category. Rather it is a fluid definition that depends not only on the context in which it is defined, but also who defines it'.[14] Oliver's own theory draws on an 'individual' model of intellectual disability. This model finds a common ideology apparent in medical, professional and other discourses of intellectual disability; the belief of disability as an individual's problem which requires external intervention, either for the good of the afflicted, or, more significantly, to protect society *from* the individual.[15] While this model proves useful for this discussion, it is necessary to use such a model in conjunction with A.J. Wither's assertion that even within this model there exists 'different conceptualizations of disability, different actors and different effects . . . distinct approaches to disability [which] warrant separate discussions'[16]. The use of Oliver's individual model, tempered by Withers' analysis, may be applied to a discussion of discourses which locate intellectual disability within the individual yet remain distinct from one another.

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[10] Szasz, *The Second Sin* , p. 21, 114,115

[11] Foucault, Michel, trans. Sheridan, Alan, *Discipline and Punish – The Birth of the Prison System,* (London: Penguin), 1977, p. 23; Illich, p. 16

[12] Gooding, p. 9

[13] Withers, p. 3

[14] Withers, p. 5,3

[15] Withers, p. 5; Linton, p. 13; Ballard, Keith, *Disability, Family, Whanau and Society,* (Palmerston North: Dunmore Press), 1994, p. 18

[16] Withers, p. 5

A further influence on this research which must also be acknowledged is the body of theory concerning 'medicalization' or the 'medical model' of intellectual disability. Following in the tradition of Foucault, theorists, including Ivan Illich and Irving Zola, have sought to explain how the privileging of modern scientific medicine has enacted a change in how we conceptualize and approach intellectual disability.[17] To Zola and Illich, this new 'medicalized' knowledge relates to the power of psychiatrists, psychologists and medical practitioners to diagnose, label and treat intellectual disability as an individual affliction. Of the dominant social discourses of intellectual disability, the medical discourse is problematic in that it both reinforces the individual model of disability but obscures this process through claims of scientific neutrality.[18] As put by Illich, the medical discipline was able not only to provide but to expropriate health, and more seriously, to provide the 'power of an individual to heal himself or shape his or her environment.'[19]

While New Zealand historians have previously focused on mental illness and the role of the residential institution, intellectual disability has been a relatively new area of analysis. A greater concern with intellectual disability has been in part linked to the emergence in New Zealand of disability studies as a discipline. Peter Beatson's *The Disability Revolution in New Zealand,* for example, is positioned as an 'analysis of the relationship between impairment and society through which disability is constructed'.[20] Recent histories of intellectual disability in New Zealand have also examined the role of the residential institution.[21] The Intellectually Handicapped Committee (IHC) has also played a role in the development of historiography on intellectual disability, authorizing texts such as Julia Millen's history of the first fifty years of the IHC.[22] It should also be noted that these studies maintain a Pakeha focus. As suggested by David Race, in Maori culture intellectual disability is often seen differently.[23] It is not to say that Maori New Zealanders have not been excluded and

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[17] Braddock and Parish, 'An Institutional History of Disability', in Albrecht, p. 52

[18] Gooding, p. 19

[19] Illich, p. 16

[20] Beatson, Peter, *The Disability Revolution in New Zealand – A Social Model, Third Edition,* (Palmerston North: Massey University, 2004), p. ii

[21] Hunt, Lynn, *The Lost Years,* (Christchurch: Nationwide Book Distributors, 2000)

[22] Millen, Julia *Breaking Barriers: IHC's First Fifty Years,* (Wellington: IHC New Zealand, 1999)

[23] Race, p. 84

discriminated against, but that they have a different cultural approach to intellectual disability.[24]

Methodological Considerations

This theoretical framework informs my own methodology and research approach. While this research could be undertaken as a social or medical history, my discussion of intellectual disability will take the form of a discourse analysis. The focus will not be not so much what was being said about intellectually disabled New Zealanders during this period, but what attitudes and assumptions underpinned these discourses. Understanding the ideologies of those who defined intellectual disability as an identity is essential in understanding how the identity of the intellectually disabled was a product of discourse in the period 1910 to 1960.

To approach this analysis, I have drawn on three differing discourses: – government, medical and public. Each of these discourses emerged from the same cultural and historical context, and tended both to locate intellectual disability within the individual and to subsequently emphasize the role of the residential institution. Yet, each maintained different views of and approaches to intellectual disability. Each discourse shall be examined through the sources particular to it. In order to assess government perspectives on the intellectually disabled, I have focused on parliamentary legislation and debate in addition to reports from departments and commissions of inquiry. The medical perspective has been examined through medical literature, namely psychiatric and psychological journals and medical dictionaries. Finally, newspapers are the main source of assessing the public perspective. It is acknowledged that the newspaper content is selective, and does not represent a total range of public opinion. By evaluating three discourses, which each involve different actors and distinct conceptions of disability, this discussion seeks to understand how discourses relate to and influence one another, and whether or not a dominant discourse was operating to define the identity and experience of intellectual disability in early twentieth century New Zealand.

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[24] Ballard, p. 17; Heron, Alastair, Myers, Mary, *Intellectual Impairment – the Battle Against Handicap,* (London:, Academic Press, 1983), p. 8

<u>Overview</u>

The discussion will begin with the medical discourse of intellectual disability. This section will outline the role of medicine in determining disabled identity in the 1900 to 1960 period. It will be argued that the presentation of medicine as a modern scientific body of knowledge effectively allowed doctors to identify, classify and treat intellectual disability as though it were pathological or physiological condition. This trend will be shown to have been largely informed by international discussions of intellectual disability, and by the direct contribution of English practitioners and diagnostic criteria. The general trend in the first half of the century was for doctors to argue their methods were neutral and objective, yet it shall be shown that in the cases of Doctor Theodore Gray and Doctor Clarence Beeby, social biases motivated their approaches to intellectual disability. While elements of benevolence characterized their policies, doctors such as Gray and Beeby shall be discussed as examples of how segregation was promoted as a result of fundamental beliefs in the negative social value of the intellectually disabled. However, Ernest Beaglehole and Charles Burns will be used to show a shift in medical understandings of intellectual disability. Both Beaglehole and Burns highlight a new medical focus on intellectual disability as socially conditioned rather than as a condition in individuals.

Following this discussion, the government discourse will be introduced. This discussion begins by examining the emergence of a new government perception, at the turn of the century, of both the state's role in protecting those rendered vulnerable by intellectual impairment, and of the social problem presented by the intellectual disabled living among the general population of New Zealand. A discussion of the 1911 Mental Defectives Act will then be employed to demonstrate a continuation of the state's role as a benevolent 'protector', and a growing emphasis on social segregation. The reinforcement of these two factors will be discussed in relation to the establishment of 'defective colonies' through the Mental Defectives Amendment Act (1928). Lastly, the Aitken Report will be outlined as emerging government recognition of alternate methods of approaching intellectual disability, yet a recognition which was outweighed by a continuing emphasis of the role of the state in defining and determining policy.

Having examined government and medical discourses, the discussion will turn to the relationship between public discourse and intellectual disability. This analysis of public

discourses will include voluntary and charitable bodies, the views of the general public, and those of the parents and families of the intellectually disabled. This section of the discussion will highlight the general public's position on the intellectually disabled which endorsed the government's emphasis on segregation by means of the residential institution. While this view was often a product of genuine kindness or at least couched in the language of benevolence, the analysis of this discourse will show that most often segregation was promoted by the public as a perceived means of removing those deemed dangerous to society by the nature of their mental and moral defects. Beginning in the 1930s and characterizing much of the 1950s though, a tension was evident between these beliefs and the ideology of the right of the intellectually disabled to social inclusion. This tension will be explored through the debates between the general public and the IHCPA over the establishment of occupation centres.

Finally, tensions between these three discourses over a sixty year period will be examined, emphasising the relationship between these three shifting discourse and the role of the intellectually disabled in twentieth century New Zealand. Moreover, this conclusion will highlight the absence in public, government and medical discourses – a discourse of the intellectually disabled themselves. The absence of such a discourse will be shown to be fundamental in the lack of self-determination among the intellectually disabled. Finishing the discussion with such a discourse, it is hoped, will emphasize that the ability of the intellectually disabled to contribute to the debate as to how they should be identified, and what roles they should be entitled to occupy within New Zealand society, is in many ways dependent on discourse.

Chapter 2 - Medical Discourse

The medical profession had a privileged place in twentieth century New Zealand society, as was the case through-out the British speaking world. Included in this rise was the introduction of the supposedly neutral medical model, in which intellectually disabled people were diagnosed, classified and 'treated' as abnormal bodies rather than as members of the community, giving medical practitioners, such as Dr Theodore Gray, the ability to define disabled identity. In particular, Grey's contributions to the 1924 Mental Defectives and Sexual Offenders, and the 1928 Mental Defective Amendment Act highlight the use of medical knowledge to define intellectually disabled as a condition to be 'treated' through segregation. The views expressed by Gray will be correlated with those of Clarence Beeby to show the monopoly and power of medical professionals over definitions of disabled identity. Finally, the views of Ernest Beaglehole and Charles Burns will be discussed to show an emergent medical emphasis on the role of environment, against the dominant medical model, in the formation of disabled identity.

Medicine in the early twentieth century – the power of the practitioner over the intellectually disabled

As was true in many developed countries by the twentieth century, medicine and its practitioners had achieved a privileged space in New Zealand society. This rise of medicine as a modern scientific discipline was largely related to advancements in the fields of anatomy, physiology and pathology throughout the nineteenth century. As Gary Albrecht argues, this vastly increased medical knowledge of the body greatly increased the 'physician's abilities to intervene to address difference and dysfunction'.[25] This ability was also facilitated by construction of hospitals and development of medical education in the national university system, including the introduction of an equivalent to the British 'moral and mental' psychology, first taught in Otago under philosophy.[26] In New Zealand, this

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[25] Braddock and Parish, 'An Institutional history of Disability', in Albrecht, p. 21

[26] Haig, Brian D., and Dannette, Marie, 'New Zealand', in Baker, David B., *The Oxford Handbook of the History of Psychology: Global Perspectives,* (Oxford: Oxford University Press, 2012), p. 378, 382

meant that primary health care came to be dominated by doctors.[27] By the early twentieth century, greater medical knowledge had allowed doctors to become the dominant authority on the body. This authority extended to the knowledge of the bodies of those designated intellectually disabled.

Medical policy on the intellectually disabled in twentieth century New Zealand paralleled (and was largely informed by) British policies, especially the 'medical model'.[28] Just as the British legislation exerted influence over New Zealand's stance on intellectual disability, New Zealand followed British medicine's 'solution' to the perceived problems these people presented to society. This process of defining and exerting power over the intellectually disabled through medical knowledge is now often referred to as the 'medicalization' or 'medical model' of disability services.[29] As AJ Withers suggests, this medical 'approach . . . focused on the use of diagnostic tools (namely, IQ testing) to identify pathology and make interventions'.[30] In New Zealand, deviation from an officially measured standard norm of intelligence allowed doctors to diagnose and classify individuals as mentally defective or 'abnormal'.[31] Argued as value natural, objective science, this process of diagnosis and classification effectively created a distinct category of people distinct from 'normal' society, their disability represented as a characteristic rather than a product of their environment.[32] Despite claims to objectivity and scientific neutrality, medicine was effectively used as a means of classification, control and justification of social order through discursive practice.[33]

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[27] Belgrave, Michael, 'Primary Health Care', 5 August 2013, http://www.teara.govt.nz/en/primary-health-care

[28] Race, p. 82

[29] Race, p. 82, Braddock and Parish, 'An Institutional history of Disability', in Albrecht, p. 51

[30] Withers, p. 31, Ballard, p. 14

[31] Ballard, p. 14, Withers, p. 31

[32] Ballard, p. 24, Linton, p. 13, Braddock and Parish, 'An Institutional history of Disability', in Albrecht, p. 51, Race, p. 82

[33] Gooding, p. 17, 18, Rapely, p. 15

Power over policy – medical professionals and the ability to influence the politics of disabled identity

Medical knowledge gave New Zealand doctors the power to define identity and 'treat' the intellectually disabled. Medical ideology on intellectual disability was promoted through the *New Zealand Medical Journal.* Established in 1887, a year after the New Zealand Medical Association, this journal not only published research, but acted as both a site of professional debate and as a political platform.[34] This journal was largely informed by its British counterpart, the *British Medical Association.[35]* Medical ideologies on intellectual disability were also largely informed by other British publications such as the *Black's Medical Dictionary*. Black's provided a list of symptoms, diagnosis and treatments for various cases, and was used as the primary diagnostic manual by New Zealand general practitioners. The language of signs and symptoms, usually taken to identify and treat physical conditions was extended to 'mental defection', marking the belief that intellectual disability was a problem inherent within the individual which could be identified, classified and 'treated' by medical authorities. Disability was not represented as socially produced but as the logical consequence of an impairment.[36]

Not only British publications, but British practitioners exerted a direct influence over how intellectual disability was conceived of in twentieth century New Zealand. Men like Dr Theodore Gray, a Scottish emigrant, sought to implement international medical trends and policies on intellectual disability. In the view of David Race, Gray 'provides an interesting case study in the import of both ideas and people that fitted well with the confident and well-established Anglo-centric' medical profession.[37] From 1911, Gray worked under the Mental Hospitals Department. One of Gray's first most significant contributions to how intellectual disability was understood in New Zealand was the 1924 Commission of Inquiry on Mental Defectives and Sexual Offenders. The views expressed by Gray were supported by the 92

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[34] Belgrave, 'Primary Health Care'

[35] The New Zealand Medical Association was, from 1896 to 1967, referred to as The New Zealand Branch of the British Medical Association

[36] Ballard, p. 20

[37] Race, p. 82

witnesses who contributed to the report, the vast majority being professors of psychology, representatives of the British Medical Association, and general practitioners.[38] Following a nation-wide survey of the evidence of a 'problem' of caring for and treating the 'menace' presented by the 'feeble minded and subnormal', Gray reported back to the Minister of Health his findings and recommendations.[39] Gray's recommended 'method' of addressing intellectual disability, drawing on international examples for support, was a policy of segregation, with a suggested implementation of a Eugenics Board and program of 'sterilization' of mental defectives as a preventative measure.[40]

These recommendations included a benevolent element. The report presented sterilization as an act of kindness, both removing the intellectually disabled from suffering in normal society, or preventing more even being born into such suffering at all.[41] However, the focus on prevention reflected eugenic belief that intellectual disability was a threat to the future national population.[42] The use of medical jargon and the evidence of medical authorities allowed Gray to advance his report as a scientific answer to a problem inherent not in society, but within individuals. Moreover, it may be argued that the motivation for Gray's report was a negative view of the social value of the intellectually disabled population of New Zealand.[43] This is particularly apparent in his emphasis on 'institutional care as necessary for mentally defective persons whose helplessness or anti-social traits would render them either the victims of the unscrupulous or a menace to society'.[44] Further, Gray proposed a register of the intellectually disabled, effectively allowing them to be tracked. Here, medical discourse functioned not to treat or care, but to discriminate and to effectively nullify the right of the intellectually disabled to self determination.

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[38] 'Mental Defectives and Sexual Offenders', *Report of the Committee of Inquiry Appointed by the Honourable Sir Maui Pomare, Minister of Health,* Wellington, 1925, 3,4,5

[39] Ibid, 5

[40] Ibid, 14, 17, 18, 19

[41] Ibid, 21

[42] Race, p. 83; Withers, p. 4; Davis, Lennard J., *Bending Over Backwards: Disability, Dismodernism, and Other Difficult Positions,* (New York: New York University Press, 2002), p. 14

[43] Race, p. 83

[44] Mental Defectives and Sexual Offenders, 11

These views were reinforced within Gray's report to New Zealand parliament on 'Mental Deficiency and its Treatment'. Presented to the House of Representatives in October 1927, this report was informed by Gray's engagement with international practitioners in, and viewings of the institutions of, Canada, America, Europe and Britain. Having surveyed treatment methods of intellectual disability abroad, Gray arrived at the conclusion that there was no 'cure' for intellectual disability, once again depicted as a permanent condition to be diagnosed within the individual.[45] Following on from this, Gray pronounced his belief that 'we can gradually assume control of its incidence and diminish the burden it imposes on the community'.[46] Drawing on the language of pathology and deficiency allowed Gray to depict intellectual disability as a medical or eugenic problem to be bred out rather than as New Zealand society's responsibility. However, while promoting a process of classification, diagnosis, identification, treatment, Gray acknowledged that such a process could draw on subjective methods to negatively alter the perceived value of a person. While continuing to outline intellectual disability as a problem located within the body of the individual, Gray also acknowledged the power of medical discourse to incorrectly label people as 'sick', or 'pigeon hol[e] them'.[47] This signals an early medical awareness that intellectual disability was a socially constructed category. However, Gray's main emphasis remained, as with the Report on Mental Defectives and Sexual Offenders, the establishment of a register and a Eugenics Board which would control the social movement and civil liberties of the intellectually disabled.[48]

Moreover, the medical discourse within this report exerted power over not only the intellectually disabled but over other discourses. Gray's recommendations, though not whole sale, were incorporated into the 1928 Mental Defectives Amendment Act, namely, the legislative seal on the establishment of 'mental defective colonies'. Here, the medical discourse was working with and in many ways influencing the direction of government

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[45]'Mental Deficiency and its Treatment', *Report on Visits of Inspection to Various Institutions in Great Britain, America, and the Continents, by Dr Theo G. Gray, Inspector General of Mental Hospitals in the Dominion of New Zealand,* Wellington, 1927, 2

[46] Ibid, 2

[47] O'Brien and Thesing in Lemon, David J., *The Closure of the Templeton Centre – A Study of the Social and Economic Discourses that led to the Closure of a State Institution,* (Saarbrucken: VDM Verlag, 2008), p. 21

[48] Mental Deficiency and its Treatment, 4,5,7

discourse. This relationship between the two discourses highlights the opinion of Dr Hugh Douglas, the chairman of the New Zealand branch of the British Medical Association in 1928, of the power of the medical practitioner allied with the government official to influence social policy.[49]

Continuity and change in medical ideas of intellectual disability

The ideas of Dr Clarence Beeby were closely related to those of Gray, especially in terms of the social value of 'mental defective colonies'. As a medical practitioner and the assistant Director of Education from 1939, Dr Beeby was in a position to influence policy on the intellectually disabled, and did so namely though his recommendations for the establishment of Levin Farm as a counterpart to Templeton.[50] Like Gray, Beeby was an English emigrant who sought to incorporate international trends into New Zealand's approach to intellectual disability. Beeby subscribed to the ideology of intellectual disability as a permanent condition which could be at best treated but not cured. This belief manifested in his stance against education programs, perceiving the mentally defective to be unable to derive any benefit from common schooling. Further, in July 1939, Beeby recommended that intellectually disabled children should be trained within institutions, 'in simple habits and in some degree of self control'.[51] The belief that removing a child from their family to be safely contained within an institutional setting made two things clear. Firstly, Beeby conformed to the general inclination of medical professionals of the time to discourage parents from bringing up their 'defective' children within the family.[52] Further, Beeby perceived intellectual disability as a permanent condition for which there was no hope of recovery and which marked people as different from and a burden to society. Like Gray, Beeby presented the institution as a form of kindness: kindness for the afflicted individual, their family, and society.

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[49] Belgrave, Michael, in Bryder, Linda, *A Healthy Country: Essays on the Social History of Medicine in New Zealand,* (Wellington: Bridget Williams Books, 1991), p. 8

[50] Hunt, p. 2

[51] Gousmett, Sharyn Louise, 'Families of children with developmental disabilities: family environment, social support and sibling well-being', MA Thesis, University of Canterbury, 2006, 5; Hunt, p. 2

[52] Gousmett, p. 4

In addition to Beeby, Dr Ernest Beaglehole, (appointed as New Zealand's first Professor of Psychology in1948) was also influential in determining the identity of the intellectually disabled.[53] Beaglehole's 1958 text *Mental Health in New Zealand* followed a general trend of medical belief in asserting that intellectual disability was an individual condition which could be identified, diagnosed and treated by medical methods. Beaglehole argued that the intelligence test could be employed as an objective measure in classifying people as abnormal or normal.[54] However, another theory also characterized Beaglehole's text. While claiming that medical knowledge of the intellectually disabled was based in empirical research, Beaglehole acknowledged that in many cases it was the 'social relations that (were) disordered or abnormal – not the individual himself or by himself'.[55] While a believer in the neutral truths of medical science, Beaglehole demonstrated awareness that the experience of being 'mentally defective' was in many cases an environmentally and socially conditioned one. *Mental Health in New Zealand* is indicative of an emergent awareness of the problem of medical paradigms of intellectual disability.

Dr Charles Burns (later Sir) also embodied new ideologies within the New Zealand medical discourse on intellectual disability. A graduate of Otago Medical School, Burns practised modern scientific medicine yet has been remembered in terms of his service to people, notable his work with Our Lady's Home of Compassion from 1940 and a patron for the Wellington Association for Deaf Children.[56] This involvement with the community and the ability to think in terms of people and their interests rather than as patients was apparent in his involvement with the Intellectually Handicapped Children's Parents Association's (IHCPA). Beyond sympathy for the aims of securing education and employment opportunities and occupational facilities for the intellectually disabled, Burns proved willing to work against the general medical opinions of the time.[57] Whereas Gray and Beeby had argued that residential institutions were in keeping with international trends regarding

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[53] Haig in Baker, p. 381

[54] Beaglehole, Ernest, *Mental Health in New Zealand,* (Wellington: Price Milburn, 1958), p. 5

[55] Beaglehole, p. 9

[56] Beasley, A.W., 'Charles Ritchie Burns', 8 August 2013, http://www.teara.govt.nz/en/biographies/5b50/burns-charles-ritchie

[57] Burns, Charles, *The Mental Deficiency Services: An Analysis of Existing Policy and the Community's Requirements,* New Zealand Branch of the British Medical Association, 1959, p. 24: Millen, p. 44

intellectual disability, Burns proposed that places such as Levin and Templeton were out of step with developments elsewhere in the world. This proposal led Burns, within a report published in 1958, to reject the Aitken Report and its findings for a general failure to recognize the significance of environment in the state of intellectual disability.[58] Advocating instead small scale facilities and services within the community, the Burns Report suggested, in line with the IHCPA, that 'separation from the family at an early age' rather than benefitting the family and the individual 'often retarded intellectual development because the child missed the stimulation of the family environment'.[59] Commissioned by the New Zealand branch of the British Medical Association, this report may be seen to reflect a new vein of thought rather than those of Burns alone, especially where paired with the views of Dr Jack J Tizard, a New Zealander practising in London, who also argued against the Aitken report on the grounds that affection and attention of the home were paramount to segregation within institutions.[60]

Conclusion

The views of Tizard and Burns were deemed by some medical practitioners as 'overly optimistic', yet marked a departure from the dominant medical ideologies of intellectual disability in New Zealand which had marked the first half of the twentieth century.[61] While Burns and Tizard did not argue against the involvement of the medicine in the lives of the intellectually disabled, they displayed an emergent awareness that medicine was constructing intellectual disability as a category rather than treating it. This contrasted the traditional view of modern scientific medicine's usefulness in the definition and treatment intellectual disability as a disorder, a process reliant on claims to neutrality but motivated by social bias. As with the government, the medical discourse by 1960 maintained a tension between those who continued to advocate this view, and those who had come to promote the importance of environment in the experience of intellectual disability.

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[58] Burns, p. 24; Millen, p. 45

[59] Burns, p. 24

[60] Millen, p. 27

[61] *Evening Post*, 3 March, 1959

Chapter 2 - Government Discourse

In contrast to emphasis on family-based care during the colonial period, intellectual disability was perceived by the New Zealand government in the early twentieth century as a state responsibility and concern. Legislation such at the 1911 Mental Defectives Act was perceived as a means of protecting the interests of those intellectually disabled deemed unable to protect themselves. Moreover, the legislation was enacted as a means to contain and control what was perceived as a threat to the normal social order. Conflated with mental illness in government policy, by 1920 intellectual disability was included in a homogenous category of those who should be legally separated from 'normal' society, evident in the title of the 1924 Commission of Inquiry into Mental Defectives and Sexual Offenders. While the 1928 Mental Defectives Amendment was to define the mentally defective as constituting a category of people distinct from the psychiatrically unwell, this legislation also reinforced the government's desire to separate the 'defective' from New Zealand communities by way of the residential institution. An interest in establishing community-based care for the intellectual disabled acted as an early recognition of the impact on social inclusion on the intellectually disabled. Yet while the Aitken Report reflected this recognition, the findings of this report, in conjunction with the Mental Defectives Amendment of 1954, worked to reinforce the government perception of the intellectually disabled as a social problem.

Early Twentieth Century Legislation in New Zealand and the 'Idiot'

By the onset of the twentieth century, a new ideology was apparent in New Zealand government policy regarding the appropriate environment for and approach to the intellectually disabled. [62] In the last decades of the nineteenth century intellectual disability had been viewed and therefore treated by parliament as a private problem. A personal problem, intellectual disability was to be 'taken care of' through the programs of community aid accorded to other socially dependant citizens, namely orphans or the ill, infirm or

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[62] Grant, John Robert, 'De-institutionalization: community living and quality of life for ex-Templeton Centre residents', MA Thesis, University of Canterbury, 2002, p. 8,9

destitute.[63] Where institutional care was not an option, the care of the intellectually disabled was primarily the responsibility of their family. However, such a government perception had been subject to change by the turn of the century, with a new approach to the intellectually disabled manifest in the Hospital and Charitable Boards Act of 1908. Within this legislation, the 'idiot' was both depicted as unable to fully protect him or herself and yet different to the wider institutionalized population of New Zealand.[64] Though lacking (and never enacting) an equivalent of the British Poor Law, by 1900 New Zealand government policies concerning the disabled reflected the paternalistic and benevolent British concept of the intellectually disabled as 'deserving poor', or worthy recipients of public / state relief within the context of the residential institution.[65] Arguably, in the first decade of the century the New Zealand government was moving towards a legislative recognition of a newly perceived role as a paternalistic protector of the intellectually disabled.

However, while the Hospital and Charitable Boards Act differentiated the intellectually disabled from other New Zealand citizens dependent on the aid of the state, there remained an absence of legislation setting out how, or even whether these people should be received and treated within separate residential institutions. More significantly, there remained a legislative failure to distinguish the 'idiot' (intellectually disabled from birth) from the mentally ill (having developed a psychiatric impairment over the course of their life). As such, the intellectually disabled and the mentally unwell tended to be conflated in New Zealand government discourse, as apparent in the 1908 Lunacy Act, which discussed 'idiocy' interchangeably with 'lunacy' in the criteria for institutionalizing an individual.[66] One impetus underlined the incarceration of this homogenous category: the government desire to utilize the residential institution as a form of social control or containment.[67]

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[63] Drake, Robert F., 'Welfare States and Disabled People', in Albrecht, p. 414,16, *Hospitals and Charitable Boards Act, Part 1*, Section 2, 681

[64] *Hospital and Charitable Boards Act*, Part 1, Section 104, 704

[65] Race, p. 82; Brookbanks, Warren, 'Mental Health Law', in Skegg, Peter and Ron Paterson, *Medical Law in New Zealand,* (Wellington: Brookers Ltd, 2006), p. 360; Blaxter, Mildred, *The Meaning of Disability – A Sociological Study of Impairment,* (London: Heinemann Education Books Limited, 1976), p. 2

[66] *Lunacy Act,* 1908

[67] Grant, p. 9

The inclusion of the intellectually disabled in a generic classification of 'mentally unsound' or mentally unfit' within government legislation therefore had overwhelmingly negative ramifications for people identified by the government as 'idiots'. Foremost, the social stigmas and labels applied to the mentally unwell patient, namely, charges of moral deviancy and degeneracy, were also extended through the Lunacy Act to the intellectually disabled. Secondly, the conflation of the ill and the disabled saw those judged as 'idiots' residing in institutions among 'lunatics', often accorded similar care irrespective of their selective needs. Thus, while 'protection' could be seen to operate as a benevolent concept, where custody protected individuals rendered socially vulnerable by their mental state, the term 'protection' could also be taken to characterize a government desire to exclude this same group as a means of protecting normal society.

Defining the 'Defective' and Continued Segregation

In 1911, the government of New Zealand established the term 'mental defective' as distinct from 'lunatic'. Replacing the Lunacy Act of 1908, The Mental Defectives Act of 1911 saw New Zealand parliament offer an official definition of 'mentally defective'. This legislation provided seven categories of classification, ranging from 'persons of unsound mind' to 'feeble-minded' on a scale of perceived ability to function intellectually and socially.[68] Moreover, the Mental Defectives Act established that the logical outcome of any individual being defined defective, in accordance with such legislative criteria, was incarceration. 'Commitment' to institutionalized care from the age of five, as a means of ensuring 'oversight, care or control for his [the patient's] own good', effectively allowed the disabled to reside in institutions previously reserved specifically for the psychiatrically unwell.[69] The legislative emphasis on 'oversight' and 'care' of the 'mentally defective' characterized the assumption that intellectual disability was a permanent state of dependence from which the residential institution provided respite or benevolent protection. In this light, the Mental Defectives Act may be interpreted as an effort on behalf of the government to fulfil the role of protector, emanating from a belief that the intellectually disabled could be assigned to a status of permanently socially vulnerable and dependent.

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[68] Millen, p. 7

[69] *Mental Defectives Act,* 1911, section 2, 14; Millen, p. 4; Lemon, David, 'The Closure of the Templeton Centre', 5

However, a reading of the Mental Defectives Act shows that protection of the individual was promoted alongside, and perhaps overshadowed by a governmental emphasis on protecting society *from* the 'mentally defective' individual. Any interpretation of the act as benevolent, or as focused on the intellectually disabled, is limited by a lack of emphasis on the rights of the individual in a commitment process designed to enforce social segregation. Though maintaining a section on the 'Care and Treatment of Mentally Defective Persons', reinforcing the obligation of the institution staff to attend to the needs of their patients, the Mental Defectives Act was characterized by the belief that the disabled were to have no influence over their own incarceration.[70] Further, paired with the recurring use of terms including 'detention' 'custody' and 'containment', a government belief manifested in this document that to remove the rights of the disabled via institutionalization served the rights of society.[71] Therefore, Mental Defectives Act saw the New Zealand government construct or label disability, through language and terminology, as a social problem to be resolved through incarceration. The Mental Defectives Act may be represented as advocating a form of exclusion which took the physical form of the residential institution.

That the intellectually disabled were viewed by the New Zealand government not as a distinct group with rights as individuals, but rather as part of a wider problem of social hygiene, may be supported by the continuing legislative conflation of the psychiatrically unwell and the intellectually disabled in policy regarding residential institutions. The population of New Zealand mental hospitals in the years directly following the issue of the Mental Defectives Act, including Sunnyside, have been seen by Sharyn Gousmett as reinforcing such an argument.[72] That Sunnyside remained primarily a hospital for the mentally ill yet maintained intellectually disabled residents (including children) in the wake of the Mental Defectives Act, including children, shows that the government could distinguish between the two groups, yet continued to include both in an officially sanctioned program of exclusion made possible by the residential institution.[73]

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[70] *Mental Defectives Act*, part 7, 34

[71] *Mental Defectives Act*, part 3, section 24, subsection1, 23

[72] Gousmett, p. 6

[73] Gousmett, p. 5; Grant, p. 9; Millen, p. 5; Bell, and Brookbanks, p. 64

Such a claim finds greater credibility when discussed in relation to the 1924 Committee of Inquiry into Mental Defectives and Sexual Offenders. Appointed by the Minister of Health, the committee's choice of title for their report reflected the tendency to relegate the intellectually disabled to a category of degenerates or morally dangerous people including sexual offenders. This was realized in the statement for the origin and scope of the inquiry. The committee commented that 'for a considerable time, there has been a growing feeling of anxiety among the public owing to the number of mental defectives becoming a charge upon the state, and the alarming increase upon the state'.[74] While this reflects monetary concerns, the problem was again located within the individual, making their containment socially expedient. Referred to in terms of 'revulsion' and 'menace', the intellectually disabled were labelled as a source of society's problems rather than as a group worthy of the philanthropy of the New Zealand government.[75]

Amended Acts and the Rise of the 'Colony'

Towards the end of the First World War, an effort was made on behalf of the New Zealand government to create residential institutions specifically focused on the intellectually disabled. This effort was represented in the 1928 Amendment to the Mental Defectives Act. While the 1911 Mental Defectives Act had facilitated the ability for the intellectually disabled to live in mental hospitals, the Mental Defectives Amendment Act of 1928 acknowledged that, within these institutions, care remained orientated towards the psychiatrically unwell at the expense of the 'mentally defective'.[76] The 1928 Amendment allowed parliament to set aside specific residential institutions for the intellectually disabled, a development which facilitated the establishment of facilities such as the Templeton Farm Colony. Templeton's establishment allowed intellectually disabled patients (solely male, at first) to be relocated from mental hospitals into a condition specific environment. The amendment also, as has been argued by both John F. Grant and Lynn Hunt, provided a source of hope to parents who previously had no alternative than to deal with disability within the

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[74]'Mental Defectives and Sexual Offenders', *Report of the Committee of Inquiry Appointed by the Honourable Sir Maui Pomare, Minister of Health,* Wellington, 1925, section 1, p. 2

[75] Ibid, 5

[76] Millen, p. 5

context of the home.[77] In this, the 1928 Amendment may be viewed as a legislative attempt to promote specific forms of institutional care as based on the experiences of the disabled individual and the family unit.[78]

However, the legislative designation of residential institutions such as Templeton Farm may be seen to have reinforced rather than to have diluted the negative social stigma attached to intellectually disabled New Zealanders. In large part product of a British influence on government policy, the 1928 Amendment to the Mental Defectives Act positioned the institution as an answer to a social problem, namely through geographical isolation. [79] As noted by David Race, the developments in institution building in New Zealand, prompted by the 1928 Amendment, paralleled the program of facility building in Britain following the 1913 Mental Deficiency Act.[80] As in England, the principle impetus for the expansion in residential facilities in New Zealand was to ensure the containment of the intellectually disabled, achieved at Templeton, where the rural surrounds cut its residents off from wider society to achieving the incarceration or segregation in the name of the 'public interest' advocated within the Amendment.[81] In this, the 1928 amendment may be viewed not as a benevolent effort to protect disabled individuals but to segregate them based on the entrenched assumption that the residential institution could be used as a means of social control.[82] Though the disabled may have, from the 1930s onwards, been housed in environments specifically designed for their needs, the ideology behind the establishment of such facilities was centred on a model of society that these individuals were viewed by the government as separate from the rest of the New Zealand population.

Recognition and Resistance – The Aitken Report

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[77] Hunt, p. 22, Grant p. 5,6

[78] Gousmett, p. 6

[79] Race, p. 82

[80] Ibid

[81] *Mental Defectives Amendment Act*, 1928, section 7, 401

[82] Grant, p. 9

Arguably, it was only in the second half of the twentieth century that the New Zealand government came to acknowledge alternatives to the residential institution as the appropriate environment for intellectually disabled.[83] The government by this point had begun to consider the possibility that needs of the intellectually disabled were not best served within the confines of the institution. Such a consideration was expressed by the Minister of Education's establishment of a Committee of Inquiry to report back on the state of New Zealand's 'mental defective colonies' in August 1951. In the process of constructing its report, the committee invited public submissions, consulted medical professionals and toured institutional facilities housing intellectually disabled people.[84] More commonly referred to as the Aitken Report, (after one of its principle members) the findings were released in February 1953 under the title of *Report of the Consultative Committee on Intellectually Handicapped Children.* In the discussion and recommendation section of the document, the committee concluded that the facilities offered often failed to provide appropriate care for the disabled, being 'seriously over-crowded and understaffed, and [devoid of] . . . the supervision necessary to keep defective children diversely occupied'.[85] The Aitken Report thus gave government recognition of the right of the disabled to be cared for, or the state responsibility to provide for these people.

However, despite this recognition, the Aitken Report's main recommendation was the continuing segregation of the intellectually disabled. An indication of the report's direction was provided in the definitions, 'intellectually handicapped' being rejected in favour of 'mentally subnormal'.[86] The report was characterized by the belief that there was 'nothing essentially wrong with the concept of mental deficiency colonies' the role of which subsequently being reinforced by the committee.[87] Rather than offering an alternate model of care, the Aitken Report returned its findings in the form of a renewed support for the institution, encouraging parents to 'liberate' themselves by committing their children, who

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[83] Ibid

[84] 'Intellectually Handicapped Children Report', *Report of the Consultative Committee Set up by the Honourable Minister of Education in August 1951*, Wellington, 1953, p. 1,2

[85] 'Intellectually Handicapped Children Report', p. 23

[86] Ibid, 2

[87] Gousmett, p. 6

were termed as embarrassments, and as burden on the family unit.[88] Further, rather than subjecting the role of centres such as Templeton Farm to questioning or critique, the Aitken Report advocated an expansion of the residential institutional model embodied by these centres. In concluding, the report stated that 'after weighing these arguments and considering what we have learned . . . the only satisfactory policy is the provision of good residential institutions . . . for the great majority of imbecile children'.[89] In short, the Aitken Report allowed the government to put a seal on the forms of social segregation entailed by incarcerating the intellectually disabled in residential facilities. It may therefore be argued that by the middle of the twentieth century the government continued to perceive the intellectual disabled not as members of society, but individuals outside of, and to be kept outside of, society.

Conclusion

By 1960, a discernible shift was evident in New Zealand government policy on intellectual disability when contrasted with those policies of 1900. The intellectually disabled were not longer conflated within legislation with the mentally ill. However, while distinct from the mentally ill, the 'mentally defective' were still regarded by government as different from, and to remain separate from, general New Zealand society. This view was not the view of all members of parliament, evident with the Department of Education's backing of occupational centres. However, the continuing government sanction on residential institutions marked how entrenched the belief in the socially defective nature of these people was. In 1960, the opinion that the intellectually disabled individual was to be protected and protected from was still the dominant government opinion, counter to a view towards social inclusion of the intellectually disabled.

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[88] 'Intellectually Handicapped Children Report', p. 22, 24

[89] Ibid, p. 24

Chapter 3 - Public Discourse

Arguably, it was the public discourse which was characterized by the greatest degree of change over a sixty year period. Charitable bodies and the general public formed the dominant general public discourse on intellectual disability between 1900 and 1960. The ideology behind this discourse contained two key ideals; firstly, that it was the benevolent act to incarcerate vulnerable defective individuals. Secondly, and perhaps more significantly, public discourse maintained that the protection of 'normal' society was ensured by the segregation of people deemed defective and therefore dangerous and deviant. However, those with a familial or emotional connection to the intellectually disabled did not always conform to the ideology inherent in the dominant public discourse. From the 1930s onwards, public advocacy and activism highlighted a desire for, and willingness to push for, the inclusion of the intellectually disabled into the community. The tension between these voices and entrenched public beliefs in the benefits of segregation may be examined in the debates over the establishment of occupation centres during the 1940s and 1950s. By 1960, the public was divided between those focusing on rights of the intellectually disabled, namely the Intellectually Handicapped Children's Parents Association (IHCPA) and those pushing society's responsibility to contain them.

Early twentieth century New Zealand and the public perception of the 'backward'

At the beginning of the twentieth century, there was a general tendency in the New Zealand charitable aid sector to view intellectual disability as an issue to be dealt with by the government. While charity continued to be accorded to the disabled, such charity, in the general sense, was directed at the 'deserving' or 'sentimentally appealing' disabled cases among the New Zealand population.[90] Such 'deserving' disabled included the physically handicapped, who could be perceived as warranting hope, able to be both physically and socially rehabilitated.[91] However, there remained exceptions in the provision of charitable aid

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[90] Tennant, Margaret, *The Fabric of Welfare – Voluntary Organizations, Government and Welfare in New Zealand, 1840 – 2005,* (Wellington: Bridget Williams Books, 2007), p. 102; Office for Disability Issues, *Disability in New Zealand: A Changing Perspective,* 2 June 2013, http://www.odi.govt.nz/resources/guides-and-toolkits/disability-perspective/disability-nz.html

[91] Tennant, *The Fabric of Welfare – Voluntary Organizations, Government and Welfare in New Zealand, 1840 – 2005,* p. 102

to those deemed as 'backward'. For example, the establishment of the St Joseph Home for Incurables (1900) and the Home of Compassion (1906) allowed Mother Mary Joseph Aubert and her Sisters of Compassion to provide residential care to children identified as either physically or intellectually disabled, or both.[92] Yet, these establishments remained exceptional, and the very choice of the title 'Incurables' reflected a stigma which was to adversely affect the wider provision of charitable aid to the intellectually disabled. Whereas the physically disabled could potentially be treated, cured and returned to the community, and deserved support to do so, this potential was not identified within the intellectually disabled. Reflecting dominant government and medical discourse, in particular, the medical model, by 1900 bodies of charitable aid had come to view intellectual disability as a problem located within the afflicted individual. This view was reflected in the general stance that the aim for the 'backward' was not reintegration into the community supported by the charitable sector. Rather, voluntary and charitable bodies focused their attention elsewhere, maintaining the reliance of the intellectually disabled on the aid of the state to sustain their permanent state.

Beyond the view of charitable aid bodies that intellectual disability was the responsibility of the state rather than society, popular consensus at the start of the twentieth century was that the 'backward' were a social problem. Linked to a popular confusion with the mentally ill was the pervasive view of the intellectually disabled as representing a 'moral problem' in society. this moral problem was linked to the eugenic belief that the intellectually disabled could negatively alter the make-up of future populations.[93] The idea then followed that the identification, classification and segregation of these people was the necessary means of protecting the moral fabric of society, a view inherent in popular responses to the 1911 Mental Defectives Act. This legislation was met with general approval, and New Zealanders at large supported the state process of removing from the community those 'deemed likely to [both] be a danger to others, and to transmit their weakness [of morals and intellect] to future generations'.[94] In following with the medical model, intellectually disability was viewed by the general public not as an issue of responsibility but a problem warranting socially expedient containment.

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[92] Sullivan, Martin, 'Disability and Disability Organizations', 22 July, 2013, http://www.teara.govt.nz/en/disability-and-disability-organisations Tennant, *The Fabric of Welfare – Voluntary Organizations, Government and Welfare in New Zealand, 1840 – 2005,* p. 97

[93] Withers, p. 3

[94] 'The Mental Defectives Act, 1911', *Kia Tiaki: The Nursing Journal of New Zealand,* Vol.5, No.1, 1912, 20

However, benevolent intentions were also manifest in the popular desire to segregate the intellectually disabled. A widely held conviction in New Zealand at the start of the twentieth century was that residential care was a form of relief for both the afflicted individual and their family. In this view, state institutions were not a means of segregating so much as providing support to those who would otherwise suffer emotionally and financially under the 'burden' of an intellectually enfeebled family member.[95] This view was applied to both Oamaru's Otekaike School for feeble-minded boys, established in 1908, and Salisbury School, established near Nelson in 1916 for feeble-minded girls.[96] In many respects, this view was justified. For example, Janet Frame's recollection of her brother's epilepsy places emphasis on the stress both on the finances and dynamics of a family attempting to cope with a disability within the home.[97] It is true that in many cases residential care offered appropriate care for 'defectives' whose families could not support them and who the voluntary sector had neglected.[98] However, the depiction of reprieve did not always mirror the reality for parents faced with institutionalizing their children. Between this 'benevolent' pressure and the negative stigma attached to intellectual disability, the process often amounted to removing the right to self determination, and was often recounted as a traumatic one, with the emotional attachment to a child often in contrast to the tide of social opinion.[99]

The 1930s and a challenge to the dominant (the rise of the IHC)

During the 1920s and 1930s, the state continued as the main provider of services for the intellectually disabled, and as a general rule, the New Zealand public continued to support policies of segregation. This assimilation of medical and government discourse into the general public view of intellectual disability was represented in the response to the 1928 Mental Defectives Amendment Act. Conforming to medical and legislative opinion, comments on the Act in the *Evening Post* showed a continuing public belief in the residential institution as protecting vulnerable individuals.[100] However, the emphasis on protection was

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[95] Sullivan, 'Disability and Disability Organizations'; 'Backward Children – the Otekaike School', *The New Zealand Herald,* Vol.45, No.13699, 16 march 1908, 8

[96] Millen, p. 6

[97] Frame, Janet, *To the Is-land,* Auckland, Vintage, 1991

[98] Gousmett, p. 4,7

[99] Gousmett, p. 8

[100] 'Social problem', *Evening Post,* Vol.106, No.34, 13 August 1928, 9

namely made in regard to the concept of 'public good'. A focus on perceived abnormality and moral questionability inherent in 'defective' people underlined the belief that legislation was dealing with a 'social problem'.[101] While acknowledging evidence of divided opinion in both parliamentary and medical camps, the general support of the Mental Defectives Amendment may be read as an expression of the public belief that the current 'normal' social order was to be preserved by the segregation of those designated 'abnormal'.[102]

Yet in this period, a new ideology became apparent within the public discourse. This new view on intellectual disabled people and their role in society was pushed not by the voluntary sector but those with a first-hand experience of living with the 'defective'. While by no means representing the general trend, such a challenge was apparent in the case of parents such as Hal and Margaret Anyon.[103] By the standards of the 1930s, the decision to raise son Keith, born a 'Mongoloid' (with Down's Syndrome) worked against both the public desire to segregate and the perceived obligation of many charitable bodies to 'curb' the inclination of families to bring up intellectually disabled children within the home. Beyond the decision to resist segregation, the Anyon's were among the first parents to insist on the right for their intellectually disabled children to live out their lives within the community. The call for education and employment opportunities for people such as Keith, let alone the ability to be raised within the community, was significant in marking a departure from the dominant ideology of intellectual disability as a problem located within the individual. Keith's case shows a belief in, and call for recognition of, the role of environment as the most significant factor in the experience of intellectual disability. While cases such as the Anyons' proved in many ways isolated, and 'although there was still a great deal of stigma attached to people with an intellectual disability . . . for the first time it was beginning to be argued that people with learning difficulties should receive the rights accorded to other members of (New Zealand) society.'[104]

The struggle to influence the establishment and policy of occupational centres, however, highlighted the entrenched views of the general public which effectively limited the

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[101] 'Mental defectives', *Evening Post,* Vol.106, No.19, 25 July 1928, 10; 'Social problem', *Evening Post,* Vol.106, No.34, 13 August 1928, 9

[102] 'Social problem', *Evening Post,* Vol.106, No.34, 13 August 1928, 9

[103] Millen, p. 7

[104] Ibid

potential of parents to offer their children lives within the community. The impetus behind the parental push for occupational centres was their desire to offer their children an alternative to long term residential institutional care. In February 1933, Auckland parents met with other members of the public to discuss the possible establishment of a occupational facility for intellectually disabled children. However, the subsequent formation of the *Auckland After Care Association* (a public group with an interest in occupational care) both excluded parents and eventually succumbed to the tide of public opinion, rebranded the Institution for the *Care of Backward Children* within a year.[105] The very title of this new organization reflected a deep vein of public opinion regarding the proper environment for the intellectually disabled. With its emphasis on 'care', the institution reflected the general belief that incarceration was both benevolent, and the necessary social answer to the problem embodied by the 'backward'. Therefore, despite the existence of a parent voice, the public at large continued to back residential institutions as a 'remedy' both for the burden on the family and a problem in society.[106]

To hold up 'backward' policies or to move onward – tension within the public discourse

A divergent public ideology of intellectual disability, pushed largely by parents, benefitted indirectly from the formation of charity groups organizing on behalf of the disabled. These groups included the likes of the Crippled Children's Society (CSS)(1935) and the New Zealand Foundation for the Blind (1955). While advocating on behalf of the physically disabled, elderly and their families, these rights-based groups maintained an emphasis on impairments.[107] Further, the CSS and other consumer groups combined advocacy with activism, bringing pressure on both the state and charitable bodies, and attempting to influence public opinions on marginalized members of the community.[108] The organizational frameworks, campaign methods and ideologies provided by these consumer groups would later be drawn on by advocates for intellectual disability.[109] Essentially, these groups provided a model which the IHCPA could draw upon. Established in 1949, the pace of

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[105] Millen, p. 8

[106] Gousmett, p. 4

[107] Sullivan, 'Disability and Disability Organizations'

[108] Office for Disability Issues, 'Disability in NZ – A Changing Perspective'; Tennant, *The Fabric of Welfare – Voluntary Organizations, Government and Welfare in New Zealand, 1840 – 2005,* p. 153

[109] Office for Disability Issues 'Disability in NZ – A Changing Perspective'

development and rate of member admission to the IHCPA served to emphasis a new ideological standpoint on intellectual disability. Parents did not conform to the dominant popular argument that 'institutions (such as Levin) *care* for children who are mentally deficient . . . (who) require protection from the hazards of *normal* life'.[110] The IHCPA set an ideological precedent in their argument that what was relevant was not the concept of normality, but the rights and needs of their children. This argument marks the shift, at least by one consumer group, away from the individual model of disability to one focused on social environment.

However, the struggle to establish rights for the intellectually disabled in the community served to emphasize that the IHCPA was working against general public opinion. The tone of debate suggested that the general public interpreted the policies and campaigns of the IHCPA as an affront to deeply held ideas of the nature of the intellectually disabled and their role in New Zealand social life. This was no more apparent in 1950 than with the debates over the establishment of an Oriental Bay Occupation Centre in Wellington. In response to the IHCPA's campaign for residential community care, residents of Oriental Bay organized in opposition to the proposed centre.[111] This public resistance took the form of a petition. Placing emphasis on the 'interests of the children', the petition argued that occupational centres were best established in geographically isolated areas.[112] However, the focus on the 'interests of the children' veiled a deep seated ideology about the intellectually disabled, which became apparent in public submissions on the issue to the *Dominion Post*. Introducing an occupational centre in a residential area would equate, as put by one submission, to 'the deterioration of our locality'.[113] Rather than the interests of the children, the interests of society, in the minds of the petitioners, were those to be respected and protected. While other members of the public supported the IHCPA and their campaign, in the minds of those behind the submission, community was a concept to be maintained by the exclusion of the intellectually disabled, rather than their inclusion. The National government's eventual rejection of the proposed centre in March 1950 functioned to show that this belief was maintained not only at public, but at a government level.

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[110] 'Home at Levin', *Evening Post,* Vol.140, No.50, 28th August 1945, 6

[111] Millen, p. 16

[112] Ibid, p. 16

[113] Ibid, p. 19

In addition to the Oriental Bay dispute, the Aitken report highlighted a major tension between the IHCPA's ideologies of intellectual disability, and those not only of the New Zealand public, but government and medical profession at large.[114] The Commission of Inquiry itself was a first for New Zealand, given the public involvement, putting pressure on the government to initiate a discussion of the alternatives to residential institutional care. Public calls for education, occupation and communal integration were considered by the government and the February 1953 verdict emphasized instead continuation of segregation, endorsed the residential institution and encouraged the public to do the same.[115] Developments in IHC policy from February 1953 onwards, however, show an almost total rejection of this ideology. In total, 13 occupational centres had been established by branches of the IHCPA by the close of July 1953, providing community based care for over 100 children.[116] In essence, the IHCPA had reacted to the Aitken report by positioning itself as national welfare service provider.[117]

Conclusion

While the public discourse was divided by 1960, this discourse was also characterized by development. A rights based ideology, generally pushed by families of the intellectually disabled, had emerged and was being acted on. Those denied an alternative to institutionalisation turned to activism and advocacy. However, with the advent of the IHCPA and in the face of resistance, these dissenters established themselves as a national service provider. The persistence of the IHCPA highlights foremost the members' deeply held belief that the intellectually disabled were people first, and deserved to live within the community. Yet, their persistence also highlights the limitations of such a campaign in the face of the more wide spread belief that the intellectually disabled were more a danger to, or endangered in, New Zealand society, as opposed to possible participants in it.

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[114] Aitken report is the short title for the Commission of Inquiry

[115] Gousmett, p. 8

[116] Millen, p. 28

[117] Millen, p. 42

Conclusion

The medical, government and the public discourse regarding intellectual disability influenced, informed and in many ways related to one another. Was any one discourse dominant by 1960? Did tensions within and between discourses eventuate in new policies or the consolidation of the standard ones? More significantly, how did these discourses impact on the role of the intellectually disabled in New Zealand society by 1960? What do developments up to and beyond 1960 have to tell us about the relationship between discourse and identity in the case of intellectually disabled New Zealanders?

Dominance, Influence, Emergence and Change

In early twentieth century New Zealand, intellectual disability was predominantly a social category determined by government officials and medical practitioners, rather than the general public. The possession of 'professional' knowledge gave doctors and legislators power to define and address intellectual disability in line with the dominant social attitudes and prejudices of the period, both domestic and international. Moreover, as a general rule, the New Zealand government and the medical professional body maintained similar, and therefore mutually reinforcing, views about the social position of the intellectually disabled. Significantly, both within medical practice and government legislation, intellectual disability was presented as a problem inherent within individuals, not within their social environment. The two bodies of knowledge therefore saw the body and not the environment of 'the mental defective' as the site of action. Such action namely referred to the promotion of a 'medical model', and policies of social segregation taking the form of the residential institution. The same underlying motivation for these policies was held by doctors and legislators. With various exceptions, both medical discourse and government discourse emphasized social segregation. Whether on benevolent or 'socially expedient' grounds, it was assumed that removing the right to self-determination would benefit both the intellectually disabled and normative society. Significantly, while the 'mentally defective' were discussed and policy applied to them, they were not participants in these discussions, but subordinate to their consequences. Whether in the perceived interests of the disabled or general society, in these discourses, the intellectually disabled themselves almost entirely absent as actors, identity constructed for them not by their own volition.

The absence of a discourse of the intellectually disabled was also apparent in public discourses on the topic. Government and medical views tended to be assimilated into the general popular conceptions of disability, in particular, the problem presented by those deemed mentally and or morally 'abnormal' or 'defective'. Further, the New Zealand public followed government and medical policies on segregation, adhering to the view that the intellectually disabled could be cared for or contained. However, not all members of New Zealand adhered to this belief that disability was a individual condition, but rather, a form of social discrimination. Those with a direct experience of intellectual disability were the earliest adopters of a discourse which emphasized environment and rights, and further, to exert pressure on government and the medical establishment to recognize these factors in policy and practice. In essence, the push for the intellectually disabled to become members of the community, accorded the same education, employment and living rights as other citizens, was pushed from below. Yet, it should be emphasized that parents and families were behind this push. Though their rights were being advocated, the intellectually disabled were, as in government and medical discourse, not the driving force behind this discourse. While by 1960 a new identity was being defined, reflective of new beliefs, discourse continued to define the intellectually disabled, rather than the other way around.

A discourse of the intellectually disabled

Beyond 1960, discourse continued to define intellectual disability in New Zealand. Moreover, discourse continued to be influenced by international trends. However, a new set of discourses emerged which in turn created a new definition of intellectual disability. Foremost was the discourse of normalization, influenced by the American disability rights movement of 1970. This discourse emphasized the right of the intellectually disabled to live among and in the same way as other members of society.[118] In Britain, theorists and advocates went beyond calling for an end to discrimination to questioning its ideological origins. The discourse of this new 'social model' centred on disability as a construct of an individual's social environment, as opposed to being a product of their intellectual impairment.[119] David Lemon's history of the Templeton Centre shows how both such discourses influenced New

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[118] Withers, p. 8; Barnes, Colin, Mike Oliver, and Len Barton, *Disability Studies Today,* Cambridge, Polity Press in association with Blackwell Publishers, 2002, p. 9

[119] Marks, p. 3; Barnes, p. 7

Zealand's policy on intellectual disability.[120] Deinstitutionalization in favour of community-based care is taken by Lemon to reflect the discourse of normalization, and the impact of the social model.[121] Historian Keith Ballard has followed Lemon, citing a new emphasis on the disabled being 'people first' to evidence the influence of British theorists, namely Mike Oliver.[122] Further, Ballard notes that labels are now often pushed by the intellectually disabled themselves.[123] Ballard and Lemon both bring attention to how discourse, once only a tool of discriminating against the intellectually disabled, was from the 1970s onwards used to the benefit of the intellectually disabled.[124] Where groups such as the IHCPA had spoken on behalf of the interests intellectually disabled, the formation of groups such as People's First gave these people a voice of their own. A discourse owned by the intellectually disabled themselves gives a previously marginalized group a greater say in how there group identity should be defined. While the intellectually disabled are still subject to discrimination, such change in discourse has seen a shift from ideologies of social exclusion to those of inclusion.[125]

Why a discourse analysis?

A discourses analysis brings light to the nature of intellectual disability as a constructed category of identity, dependent on both social and historical context. This discussion of medical, government and public discourse from 1900 to 1960 emphasizes that intellectual disability was not a fixed state, but rather existed as a fluid social category dependent on who defined it, in what context it was being defined, and for what purposes. This analysis also emphasizes that the production of identity is a process in which the intellectually disabled themselves have traditionally been absent or barred from, possessing their own discourse

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[120] Lemon, *The Closure of the Templeton Centre – A Study of the Social and Economic Discourses that led to the Closure of a State Institution*

[121] Lemon, *The Closure of the Templeton Centre – A Study of the Social and Economic Discourses that led to the Closure of a State Institution,* p. 7, 13

[122] Ballard, p. 13; Oliver, Mike, 'Intellectual Masturbation – A Rejoinder to Soder and Booth', *European Journal of Special Needs Education* Vol.7, No.1 (1992), 21

[123] Ballard, p. 11; Linton, p. 15

[124] Lemon, *The Closure of the Templeton Centre – A Study of the Social and Economic Discourses that led to the Closure of a State Institution* , p. 14

[125] Beatson,p. iv

only the 1960s onwards.[126] The examination and understanding of three discourses of intellectual disability therefore has two overriding purposes. Foremost, to examine discourse is to gain an insight into dominant social attitudes in early twentieth century New Zealand social policy. In addition an understanding of these discourses, and the power of discourse to define experience, is also a prerequisite to understanding life for intellectually disabled New Zealanders in the period spanning 1910 to 1960. It reminds us that discourse is a powerful tool of defining identity, and without a discourse of their own, the intellectually disabled are in danger of being identified not so much in terms of their own needs and desires but those of society.

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[126] Barnes, p. 3-4; Withers, p. 81

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