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R E P O R T

INTELLECTUALLY HANDICAPPED CHILDREN

REPORT OF THE CONSULTATIVE COMMITTEE SET UP BY THE HON. THE MINISTER OF EDUCATION IN AUGUST 1951

WELLINGTON
DEPARTMENT OF EDUCATION
1953

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Intellectually Handicapped Children

REPORT

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WELLINGTON
DEPARTMENT OF EDUCATION
1953

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The Honourable the Minister of Education,
Parliament Buildings,
Wellington.

SIR,

I have the honour to submit the Report of the Consultative Committee on Intellectually Handicapped Children which you set up in August 1951.

On behalf of the Committee, I am,
Your obedient Servant,
(Signed) R. S. AITKEN,
Chairman.

University of Otago,
Dunedin.
2 December 1952.

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edient Servant,
gned) R. S. AITKEN,
Chairman.

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Introduction

TERMS OF REFERENCE

1. After the presentation to Parliament in August 1950 of a petition from the Intellectually Handicapped Children's Parents' Association, this Committee was set up by the Honourable the Minister of Education in August 1951 with these terms of reference:

(*a*) To consider facilities at present provided in New Zealand for intellectually handicapped children between the ages of 5 and 18;

(*b*) To consider facilities at present provided in New Zealand for intellectually handicapped children over 18 years of age;

(*c*) To make recommendations concerning (*a*) and (*b*);

For the purpose of these terms of reference, the term 'intellectually handicapped children' means 'children who are incapable of deriving instruction from Special Classes in public schools.'

The Committee subsequently received these supplementary terms of reference:

To inquire into and report upon:

(*a*) The number of mentally handicapped children in New Zealand.

(*b*) The places where they reside.

(*c*) The needs of such children as regards education training.

(*d*) The methods that might be employed in their training.

PROCEDURE

2. By newspaper advertisement the Committee invited written submissions from persons or bodies interested in intellectually handicapped children. It received and considered forty-one submissions, from the sources listed in Appendix A.

3. The Committee interviewed and received oral evidence from representatives of the Intellectually Handicapped Children's Parents' Association, and of each of its branches throughout New Zealand, and from a number of educational and medical specialists and representatives of other bodies. A list of those who were interviewed is given in Appendix B. All

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these interviews were conducted in private; they yielded much detailed information about the case histories of intellectually handicapped children and the experiences of their parents which the Committee could not but regard as confidential.

4. The Committee visited five of the larger mental hospitals in the country, Levin Farm and Templeton Farm, the Occupation Centres in the four main cities, some of the Occupation Groups in smaller towns, two Special Classes and two Special Schools, and several other institutions. A list of these is given in Appendix C. At every visit the Committee saw the activities of the institution or centre visited and questioned those in charge on general aspects of the problem of the intellectually handicapped child as well as on the work of their own institution.

5. Apart from these interviews and visits, the Committee held eight formal meetings.

DEFINITIONS

6. In medical terminology, grades of mental defect are classified in this way:

Mentally Subnormal

DULLARD: a person of less than average intelligence, who may yet be regarded as falling in the lowest part of the range of normal intelligence.

MENTAL DEFECTIVE: a person with 'a condition of arrested or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury.'[1]

Mental defectives are subdivided into:

Feeble-minded: 'persons who may be capable of earning a living under favourable circumstances, but are incapable from mental deficiency existing from birth or from an early age of competing on equal terms with their normal fellows, or of managing themselves and their affairs with ordinary prudence.'[2]

Imbeciles: 'persons who though capable of guarding themselves against common physical dangers are incapable, or if of school age will presumably when older be incapable, of earning their own living by reason of mental deficiency existing from birth or an early age.'[2]

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[1]Mental Deficiency Act of the United Kingdom, 1927, section 1 (2).
[2]Mental Defectives Act of New Zealand, 1911.

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Idiots: 'persons so deficient in mind from birth or an early age that they are unable to guard themselves against common physical dangers and therefore require the oversight, care, or control required to be exercised in the care of young children.'[1]

Imbeciles and idiots may be spoken of together as 'lower grade mental defectives.'

7. In educational terminology and for purposes of educational administration, mentally defective children are classified in this way:

Special Class Children: those who are capable of undertaking modified activities and studies at the level of the Primers and Standards 1–4, not, however, in an ordinary School, but in a Special Class, where they are taught by special and protracted methods and given a greater measure of individual attention than is usual in an ordinary school. Their intelligence quotients lie as a rule between 50 and 75.

This group corresponds closely to the feeble-minded.

Occupation Centre Children: those who are incapable of undertaking the activities and studies of Special Classes, but nevertheless can be trained to some extent in social habits and simple tasks. Their intelligence quotients, as far as they can be measured, lie as a rule between 20 and 50.

This group corresponds closely to the imbeciles.

8. The term 'intellectually handicapped child', current in the United States and recently introduced into New Zealand, has no clear definition in medical or educational terminology. The Intellectually Handicapped Children's Parents' Association, in its constitution, has defined it to mean and include 'any child whose mental or educational development is hindered or prevented by reason of physical or mental defect', and the definition is extended to 'adult persons who have suffered from such defect in childhood and continue so to suffer'. This definition would comprise all grades of mental defect as medically and legally defined—namely, feeble-minded, imbecile, and idiot—together with such physical defectives as the deaf, the blind, and the cases of cerebral palsy ('spastics') with normal intelligence. It is therefore much wider than the definition of 'intellectually handicapped children' adopted in the terms of

[1]Mental Defectives Act of New Zealand, 1911.

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reference of this Committee—namely, 'children who are incapable of deriving instruction from special classes in public schools'. It is this last definition, however, that identifies the group of children to be considered in this report. That group comprises the Occupation Centre children or imbeciles, and the idiots. We have taken it to be convenient, and within the spirit of the terms of reference, to exclude the deaf and the blind and the cases of cerebral palsy, who are of normal intelligence, or are feeble-minded; all of these, although not capable of deriving instruction from Special Classes in public schools, are nevertheless provided for in Special Schools.

9. 'Intellectually handicapped' is an unsatisfactory term because it is already being used sometimes in a wider and sometimes in a narrower sense. While it has the advantage that, as yet, it does not carry the derogatory flavour associated with 'imbecile' or 'idiot', yet, as defined in our terms of reference, it has the disadvantage of including the idiot as well as the imbecile, so that it cannot be used as a gentler alternative to the latter. It is with the imbecile that this report is largely concerned, and the term 'imbecile' is therefore unavoidable.

The Number of Intellectually Handicapped Children in New Zealand

10. The Committee finds itself unable to ascertain the number of intellectually handicapped children in New Zealand with any accuracy. The Education Department has no complete record of such children who, although of school age, are not attending school, Occupation Centre, or Occupation Group. The Intellectually Handicapped Children's Parents' Association has compiled lists of children in the areas of its various branches, but on the one hand these are as yet incomplete, and on the other they include numbers of cases which fall outside our terms of reference. The only definite information that is available concerns children in lower grades of mental deficiency who are in the care of the Mental Hygiene Division of the Department of Health, or who are attending Occupation Centres or Groups. This information is set out in the accompanying table, which includes also adult cases:

LOWER GRADE MENTAL DEFECTIVES IN MENTAL HYGIENE INSTITUTIONS OR ATTENDING OCCUPATION CENTRES OR GROUPS

	Imbecile			Idiot		
Age	Under 5	5–18	Over 18	Under 5	5–18	Over 18
Mental Hospitals[1] (see paras. 12–17, 35)	48	233	630	11	36	52
Mental Deficiency Institutions[1] (see paras. 18–22, 36)	8	180	266	9	67	19
Occupation Centres[2]—						
Sunnydene, Auckland		51[3]				
Basin Reserve, Wellington		40[4]				
Wellington After-care Association			22			
Merivale Lane, Christchurch		40				
Moray Place, Dunedin		41				
Occupation Groups[2]		75				
Totals	56	660	918	20	103	71
Totals at all ages		1,634			194	

There are also a large number of imbeciles and a smaller number of idiots, over 18 years of age, being cared for in their own homes. These are entitled to invalid's benefit from the Social Security Fund because they are 'permanently incapacitated from work as a result of an accident or by reason of illness or any congenital defect'. The Social Security records show that on 31 March 1952 invalid's benefit was being paid to 2,519 persons between 18 and 60 years of age suffering from mental defect or allied conditions; this group may include a number of cases of feeble-mindedness, and a few other conditions not within our terms of reference, but it seems likely that up to 2,000 adult idiots and imbeciles are receiving invalid's benefit. A rough estimate of the total number of cases in the country is therefore:

	Imbecile	Idiot	Total
Mental Hygiene institutions and occupation centres and groups	1,634	194	1,828
Receiving invalid's benefit	—	—	2,000
			3,828

11. The total so obtained may be compared with the figures for Britain. There, too, accurate ascertainment has been difficult. After the war of 1914–18 local education authorities made returns to the Board of Education of mentally defective children in their areas, for purposes of the Elementary Educa-

[1]Figures supplied by the Director, Mental Hygiene Division, Department of Health, June 1952.

[2]Figures given to the Committee by the Centres and Groups.

[3]Including 5 on the waiting list.

[4]Including 14 on the waiting list.

tion (Defective and Epileptic Children) Act 1914. According to these returns the incidence varied from 0·73 per thousand children in average attendance at school in one area through a complete range up to 16·14 per thousand in another area, figures which were fantastic and incredible. Local mental deficiency authorities could provide no better information. A Joint Committee of the Board of Education and the Board of Control then undertook a careful inquiry[1] into the numbers of mentally deficient children and adults in England and Wales. The Committee appointed an Investigator who was qualified and experienced as school teacher, administrator and doctor. With the assistance of trained social workers, he made a survey of six representative areas in England and Wales, each containing a population of 100,000; all mental defectives that could be discovered were sought out, identified, and classified in schools, institutions, and private houses. The task occupied upwards of two years. The incidence of mental defect, so arrived at, is shown in this table:

INCIDENCE OF MENTAL DEFECT IN SIX AREAS IN ENGLAND AND WALES, 1927

(Rate per 1,000 of population in age-group indicated)

	POPULATION	FEEBLE-MINDED	IMBECILE	IDIOT	ALL GRADES
Under 16—					
Urban areas .	96,620	9·05	2·04	0·46	11·54
Rural areas .	78,518	15·51	2·83	0·64	18·98
Over 16—					
Urban areas .	221,069	3·52	0·87	0·22	4·60
Rural areas .	226,673	5·76	1·47	0·32	7·55
All ages—					
Urban areas .	317,689	5·20	**1·22**	**0·30**	6·71
Rural areas .	305,191	8·27	**1·82**	**0·40**	10·49

If it be assumed that the incidence of the lower grades of mental defect in New Zealand is intermediate between the incidence in the urban areas and that in the rural areas of England and Wales, then New Zealand may expect to have, in a population of 2,000,000:

Imbeciles .	Between 1·22 and 1·82 per 1,000 =	2,440 to 3,640
Idiots .	Between 0·30 and 0·40 per 1,000 =	600 to 800
Total		Between 3,040 and 4,440

This conforms with our own rough estimate of 3,836, and leads us to conclude that the number of imbeciles and idiots in New Zealand probably approximates 4,000. The number of imbeciles between the ages of 5 and 18 is at least 660, and more probably 700 to 800.

[1]Report of the Mental Deficiency Committee, London: H.M.S.O., 1929.

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Facilities at Present Provided in New Zealand for Intellectually Handicapped Children between the Ages of 5 and 18

MENTAL HOSPITALS

12. Up till 1922 the only State provision for lower grade mentally defective children was the mental hospitals, within which those admitted were cared for among the adult patients, with no discrimination of handling or accommodation.

13. In 1922 the old Nelson Mental Hospital building was vacated by adult patients, who were transferred to the new villa hospital at Stoke (Ngawhatu), and set aside for the accommodation of mentally defective children. Many of the lowest grades from all over New Zealand have subsequently been concentrated there.

14. In 1929 a mental deficiency institution was opened at Templeton, near Christchurch, and in 1945 another at Levin. These will be referred to below. Today they provide for the majority of the mental defectives for whom the Department of Health is responsible. A few are to be found in each of the mental hospitals, as shown in the following table:

LOWER GRADE MENTALLY DEFECTIVE CHILDREN BETWEEN THE AGES OF 5 AND 18 IN NEW ZEALAND MENTAL HOSPITALS[1]

	IDIOTS		IMBECILES		TOTAL		
	M	F	M	F	M	F	M + F
Sunnyside	0	3	6	2	6	5	11
Seacliff	1	0	6	2	7	2	9
Nelson and Ngawhatu	7	9	101	62	108	71	179
Kingseat	1	0	12	3	13	3	16
Raventhorpe	0	0	0	0	0	0	0
Tokanui	1	3	10	16	11	19	30
Hokitika	1	0	1	3	2	3	5
Auckland	2	1	4	3	6	4	10
Lake Alice	0	0	0	0	0	0	0
Porirua	0	7	0	2	0	9	9
	13	23	140	93	153	116	269

[1]Figures supplied by the Director of the Mental Hygiene Division as at 27 June 1952.

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15. Admission to a mental hospital is governed by the Mental Defectives Act 1911 and its amendments, which require a Reception Order from a Magistrate and certificates from two medical practitioners; in the case of a minor an order for admission can be given by the Mental Hygiene Division of the Department of Health, in which case parents are at liberty to withdraw their children, temporarily or permanently, except in cases involving danger to the children or to others.

16. In the old mental hospital at Nelson the buildings are out of date and unsuitable, and overcrowding is extreme, but at least segregation from adult patients is achieved and, as far as limitations of space and staff allow, there is opportunity for some kind of activity for children who are capable of it.

17. In the other mental hospitals the small numbers of lower grade mental defectives are occasionally separately housed (as at Tokanui and Porirua, where, however, idiots and imbeciles are placed together), but more often they are accommodated with older patients of various types. There is some provision for games and useful activities, but staff is not available for much separate attention to children or groups of children. This state of affairs is unsatisfactory: mentally defective children should not be in the same wards with numbers of adult defectives and demented patients. The Mental Hygiene Division of the Health Department is well aware that it is undesirable to place mentally defective children in mental hospitals, but is forced to do so for lack of accommodation elsewhere. In the case of idiots and the lowest grade of imbeciles the children do not suffer, for they receive physical care, and physical care is all they need; but for imbeciles of other than the lowest grade the mental hospital can rarely give the opportunity of all the development that is possible for the child.

MENTAL DEFICIENCY INSTITUTIONS

18. These are under the control of the Mental Hygiene Division of the Department of Health. Admission usually follows the procedure laid down for minors in the Mental Defectives Act 1911, and parents have the same liberty of withdrawal of minors as in the case of the mental hospitals.

19. In 1929, Templeton Farm was established on a site of 900 acres near Christchurch. It is under the administration of Sunnyside Mental Hospital, but is geographically separate. It now accommodates (June 1952):

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	IDIOTS			IMBECILES			
	M	F	M + F	M	F	M + F	TOTAL
Under 5 years . .	1	4	5	1	3	4	9
Ages 5–18 . .	12	17	29	59	29	88	117
Over 18 years . .	5	9	14	114	68	182	196
	18	30	48	174	100	274	322

In addition, there are slightly over 100 feeble-minded young people who, for one reason or another, require institutional care.

20. The institution has nine villas, each accommodating about fifty children. This allows a considerable amount of classification and grouping. Each villa has four dormitories, with twelve beds in each; every child has a bedside locker and a larger one in an adjacent room. The villa has a day-room, a dining-room with small tables (six at a table), kitchen, staff quarters, and bathrooms, &c. There are outdoor playing areas with some equipment, and a number of indoor games. Children do simple housework in the villas and various kinds of handwork (the opportunities for which are somewhat limited): they help in the kitchens and work in the sewing-room, the laundry, the small boot-repairing and upholstery shops, and in the garden and on the farm. They have folk-dancing, and a mouth-organ band, and take some part in institutional concerts. Parents are allowed to visit their children, and, if there is no special danger involved, to take them home for short periods; parents contemplating placing their children in Templeton Farm are encouraged to inspect it beforehand.

The staff establishment at Templeton Farm is 86 nurses (of whom 50 are male nurses) and 22 other staff; in 1952 the actual staff is 28 below establishment.

21. Levin Farm is an institution of similar kind, opened in 1945. It is administratively independent. It now accommodates (June 1952):

	IDIOTS			IMBECILES			
	M	F	M + F	M	F	M + F	TOTAL
Under 5 years . .	1	3	4	2	2	4	8
Aged 5–18 . .	27	11	38	70	22	92	130
Over 18 years . .	5	0	5	55	29	84	89
	33	14	47	127	53	180	227

In addition, there are 41 feeble-minded young people who, for one reason or another, require institutional care.

22. The Levin Farm buildings were formerly those of an air-force establishment, and are consequently less well suited than

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those of Templeton Farm for their present purpose. However, their adaptation and furnishing have been successful and even imaginative. The site is 50 acres, with a further 120 acres available. The children's activities are similar to those of Templeton Farm, but more varied and extensive, and assisted by much more equipment. There is a gymnasium with an interested and enthusiastic instructor, a sense training room, and an occupational therapy department under a trained therapist; also—a lucky luxury—a swimming bath. Parents have the same facilities as at Templeton Farm. Communication with parents is maintained; the staff write letters to parents on behalf of some of their children. The institution gives the impression of cheerfulness, enterprise, and steady development; its facilities are being improved and many of its staff seem well chosen and genuinely keen in their work. Arrangements are in train for the purchase of a seaside cottage at a local beach.

The staff establishment at Levin Farm is 50 nurses (of whom 22 are male nurses) and 34 other staff; in 1952 the actual staff is 12 below establishment.

HOMES OF COMPASSION

23. In Wellington, at Island Bay and Silverstream, are two Homes of Compassion belonging to the Roman Catholic Church. They are hospitals admitting both acute and chronic sick, and homeless persons. At Silverstream we found one idiot and one imbecile child; at Island Bay about eight imbecile children over five, together with a number of imbecile babies. The children are well cared for, and given a limited range of simple occupations, in rather cramped quarters. They are admitted on application from the parents, with medical recommendation.

OCCUPATION CENTRES

24. During the last twenty years the Education Boards, under the general direction of the Education Department, have developed Occupation Centres in each of the four main cities. Their purpose is:

1. To develop the children mentally, physically, and socially, within the limitations imposed by their handicaps, so that both at the Centre and in their own homes they may lead happy, interesting lives. The curriculum should therefore include such activities as habit training, sense training, physical training, speech training, handwork, music and movement, story telling, gardening, training in simple domestic tasks, table manners, &c., provision for periods of free play and of rest and relaxation. For the less handicapped children in the group there can be some training, within the limits of their comprehension, on simple word recognition, counting, and making change.

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2. With this end in view, to help the children to form good habits, to acquire self-control, and to develop a social sense as they learn to work and play with others.

3. To relieve the strain caused by the presence of an untrained intellectually handicapped child in a family, and to help the parents of handicapped children by demonstrating methods of training and care.[1]

25. The minimum number of children for an Occupation Centre is 16, the normal maximum 40. Selection is made, after full medical examination, by an Advisory Committee consisting of

Representative of the Education Board,

Senior Inspector of Schools, or his representative,

Representative of the Department of Health (Psychiatrist if available),

Co-opted member or members (*e.g.*, a representative from the Education or Psychology Departments of the University College, or a Visiting Teacher),

Psychological Officer of Education Department.

Children selected must be incapable of benefiting from instruction at a Special School or Special Class, and must have attained a reasonable level of personal hygiene. The more amenable tend to be preferred, and mongols are found in the Occupation Centres in relatively large numbers. Epileptics are seldom accepted. The intelligence quotients are 50 or lower.

Each Centre has an Occupation Centre Committee of up to seven members elected by the parents of the children attending. This Committee, analogous to a School Committee, is responsible for keeping the building in good order and repair, the provision of heating, cleaning, and sanitation, and the care of grounds, fences, and gates.

The staff establishment is in the ratio one member of staff to every ten pupils, with a minimum of two; it includes certificated teachers and uncertificated assistants.

Children attend five days a week, from 10 a.m. or a little earlier till 2.30 p.m. or a little later. The Education Board is responsible for transporting them to and from their homes.

26. The Auckland Centre (Sunnydene) is in an adapted old school building; playing space around it is limited, unless the adjacent cemetery is invaded. The maximum number of children has been exceeded, for 46 children attend; there are 5 on the waiting list. Of these, 34, from more or less distant parts of Auckland, are brought and taken home in taxis. Three

[1]Education Department Circular B. 50/65, 24 October 1950.

come alone by public transport; the rest are escorted by their parents. In the Centre they are grouped according to age and attainment. They learn to dress themselves, after long practice with buttons and laces; to feed themselves, with reasonably good table manners; to play with dolls and prams; to knit straight strips, paint in outline drawings, weave, and use jig-saws; to sweep and wash and mix things in kitchen bowls, under supervision. Attempts at teaching reading achieved so little worth while that they were given up; continued pressure in this direction made some children cross and cruel. Rhythmic exercises and a percussion band were successful.

The running costs of this Centre are £80 per child per year.

27. The Wellington Occupation Centre is temporarily housed (early 1952) in the basement of the grandstand at Basin Reserve, with an equipped playground and ample grass space adjacent. It can take only 26 children, all of whom come and go by taxi. Their well-organized activities include stringing, colour and form distinction; building with blocks; cutting with scissors and painting; use of coloured paper and pasting; modelling with dough and plasticine; sewing, knitting, simple weaving; rhythmic exercises. A little writing and word-recognition is attempted, not as a step towards serious reading, but as a means to improve concentration, and to bring familiarity with street signs and directions.

The recent costs of the Wellington Centre are:

	£
Salaries (two teachers, one domestic) . .	1,810
Transport	1,453
Capitation (Centre Committee expenses) .	23
	£3,286
Annual cost per child (26 children) . .	£126

A new brick building is in course of construction* for the Wellington Centre at Coromandel Street. The estimated cost, including furniture and ground developments, is £14,224. A large main classroom is provided; infant bay, kitchen, lunch-room, crafts bay, general store, and cloakroom open off it, and there is further crafts accommodation in the basement.

28. The Wellington After-care Association has for twenty-five years conducted an Occupation Centre, now at 111 Brougham Street (see para. 37). For most of that time children of school age attended, but when the Education Board's Centre at the Basin Reserve was established parents were invited by the

*It was opened on 11 October 1952.

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Board to transfer their children there; taxis, which had been frowned on by the After-care Association, were provided, and the children were transferred.

29. The Christchurch Occupation Centre (Merivale Lane) has an adapted private house in a small pleasant garden. Forty children attend, of whom 16 have taxi transport. Activities resemble those in the Centres already described, with first an attempt to improve posture, dress, balance, and muscular co-ordination; second, a training in good behaviour, including personal habits and behaviour towards others; third, some teaching of knitting, sewing, woodwork, and other manual exercises. A minimum of reading is tried with a few of the highest grade children. The head teacher originally began with a scheme of work modelled on a primary school programme, but was gradually forced to reduce the academic side of it almost to nothing, replacing it with manual occupations and habit training. A man assistant helps with the workshop.

The recent costs of the Christchurch Centre are:

	£
Salaries (staff of four)	2,100
Transport of children	950
Caretaking, incidentals, materials	335
Maintenance	150
	£3,535
Annual cost per child (40 children)	£88

30. The Dunedin Occupation Centre (Moray Place) carries on its work in part of an old school, otherwise converted into Education Board and High Schools Board offices. There is no outdoor playing space at all. The Centre was opened in 1938 under a teacher who had been trained in work with mental defectives in England. Forty-one children attend, including 13 who come by train under supervision from Hunterville Hostel, 6 who come in buses, and 22 by taxi. The equipment is good and the activities cover a fairly wide range, including a successful percussion band. Training in tidiness, good habits, and table manners is emphasized. The parents' organization provides a cook, who prepares a hot meal. Inspectors have noted remarkable progress among the children in individual self-control, combined and group activities, respect for order and authority, sense of rhythm, and manual skill. Indifferent premises have not hindered successful work.

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The recent costs of the Dunedin centre are:

	£
Salaries (staff of four)	1,946
Transport of children	700
Preparation of meals	68
Cleaning	287
Incidentals	50
	£3,051
Annual cost per child (41 children)	£74

31. Also under the Otago Education Board is a residential hostel for children attending the Occupation Centre whose homes are outside Dunedin. The building is a former residence of thirteen rooms, in a garden of $1\frac{3}{4}$ acres. It accommodates up to 13 children, between the ages of 8 and 15. They sleep up to five in a bedroom; there is a dining-room, a playroom, and staff accommodation. The atmosphere and environment are completely domestic. The staff establishment is a matron, an assistant matron, and two assistants.

Latest figures for the running costs of this hostel are:

	£
Salaries (staff of up to four)	1,235
Other costs	580
	1,815
Less boarding fees	695
Cost to Education Board	£1,120
Total annual cost per child (average of 8 children)	£227

The capital cost of the hostel was £4,880 in 1945.

OCCUPATION GROUPS

32. The Education Department has facilitated the establishment in the smaller towns of Occupation Groups with the same general objects as those of Occupation Centres (Education Department Circular B. 51/48, 6 December 1951). These are inaugurated and managed by local branches of the Intellectually Handicapped Children's Parents' Association, which secure accommodation and equipment, arrange transport, engage staff, and largely meet the costs. A Group caters for 6 to 15 children, who attend on one or two days a week. It is visited by Education Department officers, and if approved by the Department receives a setting-up grant of £20 and an annual grant of £60.

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Groups exist in Otahuhu, Hamilton, Gisborne, Hastings, Palmerston North, Wanganui, New Plymouth, and Invercargill, and have a total enrolment of approximately 75 children.

SPECIAL CLASSES AND SPECIAL SCHOOLS

33. Although they are outside our terms of reference, we visited the residential Special Schools at Otekaike (North Otago, for boys) and Richmond (Nelson, for girls), and two Special Classes in public schools (Grafton and Petone). The children attending them are feeble-minded, and since the boundary between feeble-mindedness and imbecility is not a sharp one, it is not surprising that an imbecile child has occasionally found his way into a Special Class—his lack of progress there usually leads to his transfer to an Occupation Centre or to Levin Farm, Templeton Farm, or Nelson Mental Hospital. Administrative arrangements are such that transfer of a child in the opposite direction is not difficult to arrange, but cases justifying it seem rarely to have occurred.

CORRESPONDENCE SCHOOL

34. Five or six years ago the Correspondence School in Wellington encountered one or two imbecile children and attempted by correspondence methods to help their mothers to occupy and train them in their own homes. Initial success encouraged the School to make a special study of them, and in the last three years, under a teacher specially interested, an experimental two-year course of monthly assignments is being developed and used. Twenty-two children are on the roll. The 'lessons' and material supplied cover habit training, helping in house and garden, play, safety training, drawing and handcrafts, speech training, rhythmic music games and stories; kindergarten school broadcasts are used; a pre-reading scheme is included. The teacher and the mothers exchange letters frequently, and through these the mothers' interest, patience, and ingenuity are greatly supported. In the congested Correspondence School building the teachers are handicapped through sheer lack of space for their work and their materials.

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Facilities at Present Provided in New Zealand for Intellectually Handicapped Children over 18 Years of Age

MENTAL HOSPITALS

35. The mental hospitals accommodate lower grade mentally defective adults in the numbers shown in this table:

LOWER GRADE MENTALLY DEFECTIVE PERSONS OVER 18 YEARS OF AGE IN NEW ZEALAND MENTAL HOSPITALS[1]

	IDIOTS		IMBECILES		TOTAL		
	M	F	M	F	M	F	M + F
Sunnyside	4	2	73	32	77	34	111
Seacliff	1	6	22	12	23	18	41
Nelson and Ngawhatu	2	5	142	27	144	32	176
Kingseat	0	3	38	23	38	26	64
Raventhorpe	0	0	2	23	2	23	25
Tokanui	6	1	23	23	29	24	53
Hokitika	0	3	44	30	44	33	77
Auckland	6	1	39	27	45	28	73
Lake Alice	0	0	9	0	9	0	9
Porirua	3	9	19	22	22	31	53
	22	30	411	219	433	249	682

They are usually scattered through a number of chronic wards or villas, associated with patients suffering from various mental disorders; there is grouping in these wards or villas according to standards of social conduct and physical health. A proportion of the mental defectives are occupied in minor useful capacities in the buildings, garden, and farms; the remainder get exercise where possible in walking parties. All are cared for under medical and nursing supervision. In some of the hospitals their activities are limited by crowding in the buildings and by shortage of staff.

MENTAL DEFICIENCY INSTITUTIONS

36. Templeton Farm (see para. 19) has 14 idiots and 182 imbeciles over 18 years of age; Levin Farm (see para. 21) has 5 idiots and 84 imbeciles over 18 years of age. Their accommodation and facilities have been described above. The adult patients are segregated from the children, and in both institutions they can be given more space and more supervised activities, both useful and recreational, than in the mental hospitals.

[1]Figures supplied by the Director of the Mental Hygiene Division as at 27 June 1952.

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37. This voluntary body was organized in 1925 to provide after-care for children leaving Special Classes on reaching the age of 18. A year or two later it extended its activities to include the care of mental defectives of imbecile grade, who were from that time excluded from Special Classes. It conducted an Occupation Centre for them, and allowed them to continue attendance after the age of 18. It worked under the general guidance of the Mental Hospitals Department or the Mental Hygiene Division, and over the years its work attracted favourable comment from a number of Cabinet Ministers as well as some Government financial support. It is managed by a Committee of twelve, and employs one trained member of staff and one domestic; other help necessary is voluntarily given by members of the Association, two or three of whom are present every day. The aim is general training in behaviour and good habits, and occupation in such things as handwork, woodwork, weaving, and sewing: any attempt at formal education or bookwork has been eschewed. Until recently 32 'children' attended, of whom 22 were between 19 and 28 years of age. The hours are 9.30 a.m. to 2 p.m. on Tuesdays and Wednesdays, and 12.30 p.m. to 4 p.m. on Mondays and Thursdays. The present house is an attractively furnished dwellinghouse, with a garden, in Brougham Street; the upper story is let as a flat. All children come on foot, in public transport, or in private cars, at their parents' expense. When the Basin Reserve Occupation Centre was opened, the 10 children who were under 18 were summarily transferred by their parents from Brougham Street to Basin Reserve: according to the Committee of the After-care Association the parents were attracted to the Basin Reserve by the provision of taxi transport and by the promise of educational in addition to occupational training. The After-care Association continues to maintain Brougham Street on its present lines as a Senior Occupation Centre for defectives over 18. It has considered using the upper part of the house as a short-term residential home for a few of them from families in temporary difficulty.

SENIOR OCCUPATION GROUPS

38. An Occupation Group for lower grade mental defectives over 18 is conducted in Napier by the Hawke's Bay Branch of the Intellectually Handicapped Children's Parents' Association; it takes the form of a workroom for girls and has 5 on its roll. Another group has been mooted in Auckland.

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39. The lowest grade of mental defective is the idiot, a being in human shape who lacks the power, and often the instinctive desire, to protect himself against common physical dangers. He cannot learn to clothe or feed or clean himself, or to control his excretions, or at most he can acquire these habits only very imperfectly. He may learn to walk, but often cannot. He makes meaningless sounds and purposeless movements. He responds to only the simplest commands or to none at all. He may be apathetic, or he may be restless, excitable, or destructive. Many idiots are physically deformed, sometimes grotesquely.

40. Most idiots are readily yielded by their parents to the custody of an institution, where they are nourished and cared for. The task of doing so is extremely laborious, and the great majority of people would reject it as too distasteful; it is possible, fortunately, to find men and women who are willing to do it, but it is always difficult, for it can bring little emotional satisfaction.

41. The imbecile group at its lower limit shades into the idiot, at its upper limit into the feeble-minded. At neither extreme is the boundary sharply defined, and between the extremes there is a considerable range of capability. Most imbeciles can learn to avoid the dangers of fire, water, and moving objects. They can be trained to wash, dress, and feed themselves more or less efficiently, and to control their excretions. Many can be taught to carry out simple manual tasks, like mopping floors, sweeping and dusting, laundry work, mowing lawns, digging gardens, and general fetching and carrying. They acquire speech to varying degrees, short of the normal. The best endowed of them can learn to read and spell the simplest words, and to do the most elementary calculations with small numbers. The most of any reading they may achieve is mechanical recognition and repetition of words; it may extend to the useful recognition of street signs and names, but rarely to the grasp of the meaning of sentences and paragraphs. Many of them are incapable of any dealing with written words or with numbers. The lowest of the imbecile group cannot learn to play, unless the apparently purposeless handling of objects be called play; those better endowed can kick and handle balls, perform on swings and chutes, join in simple marching games, co-operate in percussion bands, and even take effective part in football, with evident satisfaction.

42. In nearly all he does the imbecile's span of attention is short and his concentration ill-sustained. For the continuance

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or completion of a task supervision is therefore necessary; without constant and largely individual supervision he does not develop what limited powers he has.

43. Some imbeciles are temperamentally stable, placid, stolid, and inoffensive. Others are unstable or excitable, restless, and unpredictable in their activity, even aggressive and destructive. These characteristics are held to be innate, although there is some evidence that supervision and training of the excitable ones, in occupation that interests them, can direct their energy into more acceptable channels.

44. In physical characters some imbeciles are entirely normal. Others are odd and ungainly in appearance and movement, and some have developmental abnormalities of head or trunk or limbs. Up to 40 per cent of them have at some time or other epileptic fits, which if frequent call for drug treatment and special management.

45. Medically, imbeciles are classified according to associated clinical features or evidence of causation: examples are the 'simple congenital', the microcephalic, those with specific developmental abnormalities of the brain, those suffering the after effects of meningitis or encephalitis, congenital syphilitics, and cretins. Of cases of cerebral palsy ('spastics'), about 30 per cent have mental defect amounting to imbecility. An interesting and fairly numerous group are the 'mongols'. Mongolism is attributed, for want of greater knowledge, to an obscure defect of the germ cells from which the mongol child originated. The mongol has easily recognized physical features, such as a small rounded head, narrow sloping eye-slits, a large rough tongue, broad flabby hands, coarse dry skin, a typical cast of feature, and a short squat body-build; the resemblance to the Mongolian races of Asia, which gave rise to the name, is only superficial, and of no significance. Most mongols are imbeciles; a few are idiots, and a few at the other extreme lie above the range of imbeciles, in the lower reaches of the feeble-minded. The mongol is characteristically docile and cheerful, fond of attention, a good mimic, interested in rhythmic movement and in music. He readily engages affection and responds to patient training. An epileptic mongol is rare.

46. From the above description it is clear that imbeciles are not 'educable' in the sense of being able to learn to read, write, and calculate usefully. On the other hand, they have, in greater or less degree, the capacity to acquire socially desirable habits, to communicate with other people, and to do simple things which are entertaining to themselves or useful to others. How much

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they achieve in these directions will depend on the opportunity and training they receive. The training process is always very much slower than with a normal child; long and patient effort produces but a small result, for the mental defect remains unchanged, and, in the present state of our knowledge, unchangeable. All that training can do is to develop the limited capacities that are there; it cannot add to the child's originally defective equipment. This is the generally accepted view of medical and educational authorities, and we saw nothing in our visits to mental hospitals, mental deficiency institutions, or Occupation Centres that would lead us to doubt it. We emphasize this, because it is tempting to a parent to believe that his child's defect lies in the slowness of his learning rather than in the limited amount he can learn; that if only he is taught long enough and patiently enough he will eventually catch up on the feeble-minded or even the normal child, and be able to stand on his own in the world. This is not the case, and it is peculiarly unkind to let parents believe that it is. Indirectly they may have been encouraged to do so by the use of the term 'intellectually handicapped', which, as we have seen, can be taken to cover both feeble-minded children and defectives of lower grades, and therefore to imply that if one intellectually handicapped child (feeble-minded) can be trained to partial economic independence the same should be possible with others. We are glad to add that the majority of those parents of imbecile children whom we interviewed realized and accepted the limitations imposed by that degree of mental defect, and did not cherish hopes of the impossible.

HOME LIFE WITH AN INTELLECTUALLY HANDICAPPED CHILD IN THE FAMILY

47. We have had no opportunity, officially, of visiting the homes of lower grade mentally defective children, but from many interviews with the parents and from the evidence of doctors, teachers, and others who have been in the homes we have formed a fairly clear picture of what home life is like when there is a defective child in the family. The child in question is usually within the imbecile range, for idiots, as we have already indicated, are nearly always placed in institutions under the Mental Hygiene Division. Imbecility may in some cases be recognizable at birth, for example when the physical features of mongolism are present; or it may be suspected and gradually confirmed during the first two or three years of life. The imbecile baby is either abnormally placid or abnormally fretful; he is unobservant and unresponsive and very late in

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sitting up, standing, walking, and speaking. During those first three years, however, the attention he requires differs little from that needed by the normal baby, and except when he is unduly restless, especially at night, his defect does not disturb the normal pattern of domestic activity. From three or four years onwards, however, he continues to require the same close and constant supervision as a child of two, and the burden on his mother grows. He is found incapable of attending school, and remains all day at home. He continues to need help in dressing, feeding, and attending to himself. His mother can scarcely ever let him out of her sight, for he will wander into mischief or into danger. She has to take him with her on shopping expeditions, and deny herself social and recreational outings, except when she can find some one else to take charge of him. Often he engages her affection and indulgence in an almost excessive degree, and she spends long hours amusing him or trying to teach him simple games and the rudiments of reading and writing. When he appears outside the house, other children are quick to mock and tease him, and the mother, hurt and unhappy, tries to shield him. Inevitably, the other children in her own family get less than their fair share of her attention. Family holidays are difficult or impossible to arrange. Year in and year out the burden is unremitting. Sometimes the father and the older children learn to treat the defective one with gentleness and will help in looking after him. At other times he is an embarrassment: the father rejects him; the older brothers and sisters are ashamed of his presence and hesitate to bring their friends into the house; tension and distress develop in the family. If the mother suffers a temporary illness, there is a major crisis in the home, and as time goes on there is for both parents an increasing anxiety about what will eventually happen to the defective child when they are no longer there to provide for him. Many mothers bear this heavy burden with wonderful patience and devotion, and will say after years that they are better people for having had to bear it; a few are pushed under the protracted strain to the point of physical or nervous breakdown; nearly all are forced into a narrow and restricted pattern of life.

48. There are, of course, exceptions. Especially in the country, where the pressure of social life is less exacting and where a defective child can find harmless diversion about the farm, there are well-knit families which carry the burden without undue distortion of their own life; but from doctors as well as from parents we gathered that these are in the minority.

More often than not the presence of a lower grade mental defective in a family is a serious handicap to the home life of the other members, and even to the physical and mental health of the mother.

RESIDENTIAL INSTITUTIONS

49. Those considerations incline us to the view that the State should provide residential care for all imbecile children whose parents will agree to part with them. There are arguments both for and against this view. Those for it may be stated thus:

(i) Relieved of the care of the defective child, a family will be free to develop its own life in a fuller and more normal fashion; in some cases the mother will be able to contemplate having further children.

(ii) A well-equipped and well-run institution can offer to the child advantages and opportunities of development which are lacking in many homes. Constant contact of the defective child with brothers and sisters and other people of normal mentality, with whom he is forced to compete but cannot compare, causes him strain and frustration; but among a group of his equals, kindly treated, he can be happier and more confident, and under the gentler stimulus of more limited competition he can develop more fully those capabilities which he has. An institution, too, if well and wisely staffed, can give him the right amount of encouragement and discipline from those in charge, whereas some parents will inevitably be neglectful, while others, with the best of intention, will be over-solicitous and by too ambitious demands on his powers make him restless, tense, and unhappy.

(iii) For some types of imbecile there is no practicable alternative to a residential institution. These are the severe epileptics, the unstable, and others who require continuing expert care and treatment.

(iv) Nearly all imbecile children who survive into adult life will eventually have to be cared for in institutions, when their parents are no longer able to look after them. In general, they will spend happier and more active lives in an institution if they have been accustomed to institutional life from childhood than if they are transferred to an institution after reaching adult years.

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50. The arguments against placing a defective child in a residential institution are these:

(i) No staff, however wisely chosen, can give the child just the same love and care as that of a good parent. Parents therefore, very understandably and naturally, struggle to do all they can, while they can, for their defective child, and shrink from parting with him. They cherish him, whether wisely, excessively, or imperfectly. Both a sense of duty and a genuine affection contribute to this attitude.

(ii) Residential institutions are costly. The approximate annual cost of a patient in a mental hospital is £260; that of a child in Levin institution is £275 (1951–52 figures); that of a child in a residential Special School with a teaching staff is £278 (Richmond) or £313 (Otekaike).

The capital cost of new or extended institutions may be roughly estimated at £1,500 per child; fifty-bed villas planned at Levin Farm are estimated by the Mental Hygiene Division to cost £58,000 each, exclusive of staff quarters and other facilities.

(iii) The residential institutions now available in New Zealand are not, in the opinion of many parents, satisfactory institutions. The mental hospitals, despite their change of name, still create in some people's minds the aversion that used to be associated with the 'asylum'. Parents believe that their children in these hospitals are treated harshly and impersonally, 'herded' with the insane, given little in the way of amenities and individual attention. Some parents bring charges of a like kind against the institutions at Levin and Templeton, though others speak very appreciatively of them.

The beliefs just referred to, however well- or ill-founded, are an argument in the parents' minds against institutional care. They are not, we think, a valid argument, because the parents' picture of the mental hospital or the mental deficiency institution may be distorted. On the other hand, it cannot be said that at present these institutions are all they might be. The mental hospitals are seriously over-crowded and under-staffed, and lack the equipment and the supervision necessary to keep defective children diversely occupied. Indeed, they accept children of the imbecile group only, as it were, under pressure, when there is

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nowhere else for them to go, and they are not able to segregate them as they would wish within the hospital organization. In the mental deficiency institutions the conditions are very much better, and are in process of improvement, but they too have had great difficulty in securing enough staff, and staff of the right kind. It is sound to argue that, although a really good institution may be better than most homes, yet many homes are better than an indifferent institution.

51. After weighing these arguments and considering what we have learned from parents, teachers, doctors, and social workers, as well as from our own observations, we conclude that the only satisfactory policy is the provision of good residential institutions, well equipped and well staffed, for the great majority of imbecile children, and the encouragement of parents to place their children therein at about the age of 5. In this way more will be done to liberate the parents, and to develop the powers of activity and enjoyment in the children, than can be achieved in any other way. Admittedly this sacrifices the peculiar advantages that the child may have from being in his own home; but while no one would doubt that a normal child gains from a good home upbringing something of great value that cannot be provided in any institution, it remains open to question whether much of that nature can be gained by a lower grade defective child, for his intellectual and emotional powers are greatly limited and he is never going to face the complicated adult world unprotected and relying on his own resources. We have been touched to hear intelligent parents, who with the greatest devotion have done their utmost for a defective child at home, concede in the end that it would have been better for both parents and child if he had been placed early in the care of a good institution. Their experience is typified in this extract from Pearl Buck's account of her own defective child[1]:

> There I planned my child's days and my own, so much time each day devoted to finding out what she could learn. I willed myself to patience and submission to her capacities. Impatience was a sin. So the long year began, work interspersed with exercise and play.
>
> The detail of those months is unimportant now, but I will simply say that I found that the child could learn to read simple sentences, that she was able, with much effort, to write her name, and that she loved songs and was able to sing simple ones. What she was able to achieve was of no significance in itself. I think she might have been able to proceed further, but one day, when, pressing her always very gently but still steadily and perhaps in my anxiety rather relentlessly, I happened to take

[1] *The Child Who Never Grew,* Pearl S. Buck, The John Day Co., New York, 1950.

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her little right hand to guide it in writing a word. It was wet with perspiration. I took both her hands and opened them and saw they were wet. I realized then that the child was under intense strain, that she was trying her very best for my sake, submitting to something she did not in the least understand, with an angelic wish to please me. She was not really learning anything.

It seemed my heart broke all over again. When I could control myself I got up and put away the books forever. Of what use was it to push this mind beyond where it could function? She might after much effort be able to read a little, but she could never enjoy books. She might learn to write her name, but she would never find in writing a means of communication. Music she could hear with joy, but she could not make it. Yet the child was human. She had a right to happiness, and her happiness was to be able to live where she could function.

'Let's go outside and play with the kitties,' I said. Her little face took on a look of incredulous joy, and that was my reward.

Happiness, I now determined, was to be her atmosphere. I gave up all ambition for her, all pride, and accepted her exactly as she was, expecting nothing, grateful if some flash came through the dimness of her mind. Wherever she could be most happy would be her home. I kept her with me until she was nine years old, and then I set out in search of her final home.

52. From our conclusion in favour of residential institutions we would except stable defective Maori children living in relatively primitive communities. There is evidence that they fit into that social environment, and are accepted and cared for with little difficulty. Some *ad hoc* provision in Maori schools for those of school age, and some supervision by field officers, may be desirable, but in most cases their removal to institutions would not be justified.

53. We now discuss what we should regard as a satisfactory residential institution. Many representatives of the parents urged on us the desirability of 'cottage homes'. They were sometimes vague about the details of what they had in mind, but they usually contemplated 12 to 25 children, in a large house and garden, situated near their own homes, living a domestic life like that of a big family. From the experience of the Otago Education Board with Hunterville Hostel we judge this to be the most expensive form of residential institution and the most difficult to staff; Hunterville Hostel employs four staff to care for up to thirteen children, and the annual cost is £227 per child; this applies to a residential year of forty weeks, and since the children attend the Dunedin Occupation Centre, the Hostel does not feed or look after them through the day on five days a week. Full care throughout the year would be much more expensive. General provision of such hostels by the State, even if staff were assured, would be too costly, and staff with special kinds of experience would be practically out of the question.

The State, however, might reasonably subsidize any cottage homes of this type that might be provided and run by voluntary effort, subject to inspection by the Department of Health.

54. Considerations of cost and staffing make a large institution the only practicable one. It should be an aggregation of units or villas, each housing about thirty children and each approaching towards the cottage home ideal. Small dormitories are appropriate, provided that each child has his own locker and wardrobe in which he can keep and care for his own possessions. Each villa has its own kitchen, dining-room, and living rooms, and a reasonable supply of equipment for games and simple normal occupation. Ample outdoor space is necessary for play, exercise, and garden work; a seaside cottage is a valuable amenity. A major advantage of the large institution is that it allows grouping of the children in separate villas according to age, sex, and mental condition, and the organization of appropriate activities for each group. There is also advantage in including a limited number of older feeble-minded children and adults requiring institutional care; they can give valuable help in the domestic and outdoor work of the institution, and even in the supervision of the imbecile groups, thereby lightening the burden of cost and the difficulty of staffing. The institution should admit the epileptics, and those with combined physical and mental defect, such as cerebral palsy cases with severe mental impairment. For this reason, and for the general medical care of its large numbers, it requires a resident medical and nursing staff, and therefore should be placed under the management of the Mental Hygiene Division of the Department of Health.

55. Some witnesses have urged us to recommend that the care of imbecile children be detached from the Mental Hygiene Division and placed under a separate authority, combining medical and educational direction. We do not think this administrative elaboration is necessary, nor its added cost justifiable. On the other hand, we favour administrative separation of individual mental defective institutions from mental hospitals. One advantage of this is that free visiting by parents and others legitimately interested in the institution can be encouraged, to an extent that is not possible in a general mental hospital; this would go far to establish confidence in the institution in the eyes of parents. Another advantage is that staff recruitment need not be tied to any professional requirements. While a skeleton staff of trained nurses is required, it is not necessary nor advisable that all the staff be

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nurses. The only essential qualifications for a member of staff are that he or she be temperamentally stable, interested in and kindly disposed towards defective children, and able to feel satisfaction in working with them. We have met many such people, some with a nursing background, some with a teaching background, but we feel that the personal attitude is more important than the professional training, and we think that a well-run, well-equipped institution could attract many suitable untrained persons to its staff, whether men, women, or married couples, and train them 'on the job' to satisfactory and satisfying work. With this in view we would add to the skeleton nursing staff some specialists of other kinds, either as visiting advisers or as residents seconded from their own services, for example, teachers, an educational psychologist, an occupational therapist, a speech therapist, and a physical educationist. The introduction of teachers is important as a means of marrying educational experience with medical and nursing experience in the same field.

56. The aim of such an institution should go well beyond custodial care of the imbecile. His limited abilities to play, to enjoy games and music, to employ his hands and body usefully, and to make personal friendships, should all be developed. It is possible that that development may go further than is now thought likely, if the children are handled in small carefully chosen groups by people who combine some expert knowledge with personal interest. A field of study is open, as well as a field of work, and this kind of practical study of methods of handling is, in our view, the most appropriate 'research' in mental deficiency that can be undertaken in New Zealand at the present time. The deep-lying causes of most cases of mental defect have long eluded able investigators with large resources. They are not likely to be uncovered by any frontal attack that could be organized in New Zealand. Somewhere, some time, a chance observation or an original idea may give a clue, but these things do not come to order. When they do come, however, they can be turned quickly to advantage if the care and training, the routine observation and case-recording, of defectives are already well organized.

57. The optimal size of the community we contemplate is 400 to 600 inmates, or a maximum of twenty villas, providing for 400 to 500 defectives of the imbecile group, children and adults, together with 100 to 200 selected feeble-minded. We agree with one of our experienced psychiatric witnesses in not favouring expansion of Levin Farm or Templeton Farm beyond this limit; we should prefer to see a third institution established

in the Auckland Province, and this indeed is already urgently required.

58. Once the institution has accepted responsibility for an imbecile child, it should be prepared to look after him for the rest of his life, keeping him generally in a group of roughly his own age and attainment. On the other hand, he need not be permanently cut off from his own home; if his parents wish it, where his condition allows it, they should be free to take him home for short or long periods at any time. When provision is adequate in amount and quality, we think that the majority of parents will be willing to place their severely defective children in these institutions. For those, however, who prefer to keep a defective child mainly at home, the institution should still be willing to accept him for short periods, as when there is illness in the family or when the mother is in need of rest and respite. It should also be prepared to take new cases for a few weeks temporarily, and that for either of two purposes: to allow a period of close observation in cases which are medically complicated or where assessment or classification is in doubt, and to give both parents and child a period of trial, after which parents can decide what permanent arrangement they wish.

59. We have said that institutions of this kind are the only satisfactory way of dealing with severe mental defect in the community. Whether New Zealand can afford them, or rather how soon they can be provided, is a question beyond our terms of reference. On the basis of present experience at Levin we estimate their capital cost to be of the order of £1,500 per child, and their running cost £275 per child per annum. Against these costs must be set the sums already payable under Social Security to or on behalf of lower grade mental defectives not in institutions: namely, family allowance up to the age of 16, £26 per annum; invalidity benefit, from 16 to 20, £117 per annum, and from 20 to 60, £149 10s. per annum. Even within the field of mental health, the added cost of accommodating the majority of mental defectives, together with expenditure on Occupation Centres and Groups for many of the rest, must be considered against the claims of other, more economically useful, persons: there are, for example, the mentally ill, treated, often successfully, in mental hospitals; the feeble-minded, who may be helped to achieve at least partial economic independence; and the maladjusted child or the delinquent child, who may be assisted to recover his health by the efforts of child guidance clinics. The motive for providing good mental defective institutions is partly economic (since they liberate the energies of parents) but largely humanitarian.

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60. The existing Occupation Centres do valuable work. The children in them receive a better training in habits and manual occupations, and better exercise for their mental faculties, than many of them would in their homes; under constant skilled supervision, occupied in various ways, among their equals, they are happy. Parents report improvement in their home behaviour after they have attended the Centre. The mothers are set free for a few hours each day from the exacting task of looking after them.

The average cost is £92 per year for a child attending for twenty to twenty-five hours during school terms. This may be compared with the cost of £275 per year for a child wholly looked after in an institution.

61. While we regard good institutional provision for nearly all lower grade mentally defective children as the only satisfactory policy, there is yet need for day Centres (*a*) because some parents will prefer to keep their children at home and are the better for some assistance in the task of training them, and (*b*) because good institutional provision is likely to lag behind the demand for it and Occupation Centres are a helpful stopgap. We therefore recommend their continuance, and we offer these comments on their conduct:

(*a*) The staffing ratio of one member of staff to ten children with a minimum of two staff, is satisfactory. The member in charge should be a trained teacher, with experience in handling lower grade mentally defective children, and with a special personal interest in work of this kind. The assistants can be younger teachers similarly interested, but if such are not available, untrained assistants who are attracted to the work and willing to learn under direction should not be excluded.

There is room, too, for voluntary workers as assistants. The desire of many parents and associations of parents to be of direct service is apparent. By assisting in a Centre for a day a week or a day a fortnight they could both help the Centre and themselves gain useful experience. Though, admittedly, some Centres have tried parent co-operation and found it unsatisfactory, we feel that there must be many parents whose services would be of value, and who would learn more from participating in the work of the Centre than they would from talks and lectures or from social meetings.

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(*b*) The method of training of staff, especially those to take charge of Centres, has exercised a number of those who made submissions to us. Special courses, in either Training Colleges or University College Departments of Education, have been suggested. We cannot agree that these are justified. Three of the present four heads of Occupation Centres have trained themselves, by trial and error, in the work itself. Future heads, we think, being teachers with kindergarten experience, should learn to deal with mentally defective children by working as assistants in one of the Centres; some specified study at a University College would be a useful addition, but the bulk of the training should be an apprenticeship. Training College students and kindergarten trainees should gain acquaintance with the work of Occupation Centres by making short visits for observation.

The head of each Centre should be given an occasional opportunity to visit one or more of the other Centres, to compare methods and results. One selected head could with advantage be sent to study methods in use overseas.

(*c*) The remuneration of teachers in Occupation Centres, especially those in charge, should be so graded as to afford them reasonable prospects of advance in salary; lack of country service should not be a bar to their promotion. While a teacher's main motive for undertaking this work should be his or her personal interest in it, he or she should not be discouraged from attempting it by the limited chance of advancement in a small field, nor should successful teachers be forced out of this work for economic reasons.

(*d*) A Centre requires premises, equipment, and amenities, but they need not be too elaborate. The personal qualities of the staff determine its success. Excellent work, for example, is done in the Dunedin Centre, whose facilities are the most limited.

(*e*) We are concerned over the high costs incurred in providing taxi transport at public expense for children attending Occupation Centres (Auckland, £975; Wellington, £1,453; Christchurch, £950; Dunedin, £700; annually). We think that more children could be trained to use public transport, that tram and bus conductors could be encouraged to recognize and help them, and that the public generally would learn to treat them kindly; this would be of advantage to the children themselves and their social training. In other cases,

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parents may be able to provide or arrange transport. For the remainder, taxis may be necessary; but if the use of a school bus should prove feasible and less expensive, it should be preferred, even if that should involve more spreading out in the times of arrival and departure of the children.

OCCUPATION GROUPS

62. Our remarks about the value of Occupation Centres, and their relation to institutional provision, apply equally to Occupation Groups. The experiment of developing Occupation Groups on a voluntary basis, with a little financial help from the Education Department, has justified itself. However, the beginning made with only one day a week is not enough. We recommend that Groups should be encouraged to operate two, three, or four days a week and that the grant provided should be at least £60 per annum for each day of operation in the week.

63. Since Groups are under the management of Committees appointed by the local branches of the Intellectually Handicapped Children's Parents' Association, and since one function of these Committees will be to raise money and engage the interest of voluntary helpers, it is desirable that each Committee should contain a proportion of members, say two or three out of five, who are not parents of intellectually handicapped children. If this stipulation is not made, the parents are placed in the awkward position of appealing to the public for voluntary contributions and help for the sake of their own children, a position not far removed from that of asking directly for charity. We believe that the public is interested and willing to assist, but the appeal should be made indirectly through disinterested people, not directly by the parents of the recipients.

64. It is desirable that a teacher in charge of an Occupation Group should have an occasional opportunity of working for a few weeks as assistant in an Occupation Centre, to gain wider experience.

SENIOR OCCUPATION CENTRES AND GROUPS

65. The Wellington After-care Association has shown the value of an Occupation Centre for lower grade defectives over 18. Little if any work of economic value can be expected from them, but they can be kept occupied and interested, their behaviour training maintained, and their homes relieved from some of the task of supervision. Provision and management of

similar Centres in cities and towns where there is demand for them is, in our view, an appropriate field of service for voluntary bodies.

CORRESPONDENCE SCHOOL

66. There is ample evidence in the letters of parents to the Correspondence School that the School's assignments and advice are of great help and comfort to the parents in handling their defective children in remote places. This work could with advantage be expanded. It would be improved if the teachers conducting it could themselves have direct experience of children of the kind with which they are dealing. For this reason, and also because the Correspondence School building is seriously over-crowded, we suggest that accommodation for the Correspondence School teachers specializing in intellectually handicapped children should be made available in the new Wellington Occupation Centre at Coromandel Street.

67. There is need for a booklet of information and advice for the parents of intellectually handicapped children similar to those entitled *Children Who Can Never Go to School,* published in London by the National Association for Mental Health, and *The Backward Child,* published by the Mental Health Division, Department of National Health and Welfare, Canada. This could best be prepared by the Correspondence School in conjunction with Occupation Centre teachers and the Mental Hygiene Division of the Department of Health.

RADIO PROGRAMMES

68. The N.Z.B.S. programmes *Rhythm for Juniors* and *Kindergarten of the Air* are used by Occupation Centres and by parents in their homes, especially in the country. These are adequate, and we see no justification for an attempt at designing programmes specifically for lower grade mental defective children.

HEALTH CAMPS

69. It has been suggested to us that the facilities of Health Camps should be made available to intellectually handicapped children, presumably to those who are physically in poor health, alternatively as a means of giving parents temporary relief from responsibility. There are Health Camps available at Whangarei (Maunu, 24 cots), Nelson (50 cots), and

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Invercargill (Omaiu, 56 cots). Their running expenses in 1950–51 were up to £2 14s. 4d. per child per week. For intellectually handicapped children the expense would be higher, since it is doubtful whether they would be filled to capacity. Suitably experienced staff would be difficult to obtain. The transition to strange surroundings, especially if the staff were inexperienced, might be disturbing to the children, whose rate of adaptation is slow, and the problems and cost of transporting them from widely scattered homes would be considerable. The suggestion perhaps warrants an experiment, but we are doubtful if sufficient benefit would accrue to justify the expenditure of time and money. We see greater advantage in making temporary accommodation available in institutions like Levin Farm, not for a prearranged period of so many weeks, but for individual children at any time required, when family illness or stress calls for it.

CONTRIBUTION OF SPECIALISTS

70. Speech therapy experts have assured us that their special techniques have little or nothing to contribute to the development of speech in lower grade mental defectives. They quote their own experience, and this is borne out by the experience of one Occupation Centre, which employed a speech therapist working an hour a week for a year with six children, but saw no greater improvement than that which occurred in other children as part of the general response to Occupation Centre training. Speech therapists are therefore justifiably unwilling to devote time to further regular work with lower grade mental defectives, at least so long as their services are in urgent demand elsewhere; but they should be available for occasional consultation.

71. Occupational therapists, handcraft teachers, physical educationists, and teachers of art all have some contribution to make to the training of lower grade mental defectives, but for each kind of specialist the task, within his field, is a limited one. Except possibly for occupational therapists in large mental deficiency institutions, we would not recommend permanent attachment of these specialists to institutions or Occupation Centres. On the other hand, they should make from time to time short visits of a few days or weeks, in which they can study the opportunities, introduce new methods, and instruct the staffs of institutions or Centres in the use of their techniques with defective children.

OPPORTUNITY FOR VOLUNTARY WORK

72. Since, as we have already remarked, the motive for community care of lower grade mental defectives is largely humanitarian, it is not surprising that voluntary bodies have shown considerable interest and willingness to help, when their attention has been drawn to the problem. This is true not only of the Intellectually Handicapped Children's Parents' Association, whose position is a special one because its members are themselves ready to accept help as well as give it, but also of some of the churches, Rotary, student bodies, and others. The problem is so large that, however responsive the State may be, there will still be room for voluntary assistance as well. We suggest that it might take any of these forms:

Provision of private cottage homes, on any scale desired. They should be subject to inspection by the Mental Hygiene Division, to ensure adequate standards. They should receive from the State the family allowance or social security payments to which those admitted would have been entitled had they remained in their own homes.

Provision and management of Senior Occupation Centres for defectives over 18.

Voluntary assistance at Occupation Centres.

Provision and management of Occupation Groups, with some Government subvention.

Assistance in spreading accurate information about mental defect and encouraging friendliness and kindness towards defectives and their parents.

EDUCATION OF PARENTS AND PROPAGANDA

73. Until recently the parents of an imbecile child have more often than not been ashamed of their misfortune and prone to conceal their child from public attention; they have suffered from a confused feeling of guilt and sometimes from a fear of having more children, lest they too should prove to be defectives. The public in general has tended to regard the presence of an imbecile child as a stigma on a family. These attitudes are in process of changing, and the propaganda of the Intellectually Handicapped Children's Parents' Association has contributed to the change. Newspaper and other publicity is teaching people that lower grade mental defect is apparently a chance occurrence in families of all kinds; it does not, like feeble-mindedness, ' run in families '. The personal approach of branches of the

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Association to individual parents has helped them to face their problem openly, and from collaboration with other parents they have gained knowledge and support. All this is to the good. Propaganda can, however, be harmful, chiefly when it encourages parents to expect or demand more than is possible for lower grade defective children. In the present state of knowledge, any suggestion that these children can be trained to be self-supporting, even in part, is pernicious. Any display of claims for new forms of treatment, before they have been adequately tested, raises false hopes cruelly; for example, five years ago, an American periodical reported a thesis in which an 'enriched education' was said to raise intelligence quotients from 51-52 up to 85, but it did not publish the subsequent demonstration that the measurements were faulty and the claim unfounded.

ASSESSMENT

74. The present arrangements for diagnosis and assessment of the lower grades of mental defect, as outlined above in paragraphs 15, 18, and 25, are incomplete. The ideal is that each child should initially be examined by a group of experts able among them to assess as accurately as possible his physical condition, the cause of his defect, his intellectual and emotional state, and the social background of his family; this means a group including a paediatrician, a neurologist, a psychiatrist, an educational psychologist, and, if possible, a social worker. Such groups can and should be organized in the main centres, either independently, or preferably in association with an existing child health clinic or with a hospital out-patient department. They should have adequate time for thorough examination, discussion among themselves, and the giving of authoritative advice to parents. Except where distance makes it impossible, they should be the channel of admission to mental defective institutions and Occupation Centres, which should receive copies of their records and recommendations. They should have the opportunity of re-examining cases after an interval, for accurate assessment at a single session can be difficult, and the rate of development of defective children in different environments is worth recording. In addition to furnishing more complete documentation, and promoting the sharing of experience between medical and educational workers, these groups would do much to settle the minds of anxious parents, who often consult doctor after doctor in search of clear information and convincing advice about a possibly defective

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child. Parents also from smaller centres and from the country should be encouraged to bring their children to them once for initial thorough assessment. Where this is not possible, local medical and educational expert advice should be made available, through the Medical Officer of Health.

ASCERTAINMENT OF NUMBERS

75. We have referred in paragraphs 10 and 11 to the difficulty of ascertaining the numbers of lower grade mental defectives in the population. Under the Education Act 1914 the notification of all mentally defective children was made compulsory, but in 1925 it was found by a Committee of Inquiry to be not sufficiently effective; the Committee recommended[1] that registration be undertaken along with other functions by a proposed Eugenics Board, but the Board which was established had a short existence. In spite of these failures, the ascertainment of lower grade defectives is desirable; it is pre-requisite to adequate provision of institutions and Occupation Centres and Groups; and it should be feasible. The method adopted need not be applied to the feeble-minded, who already are ascertained with considerable accuracy by the Education authorities; if it comes to be associated in the public mind with possibilities of assistance it is not likely to meet with resistance from parents. We suggest for consideration two possible methods:

(*a*) Mental defect of idiot or imbecile grade could be made notifiable by medical practitioners in the same way as certain infectious diseases are notifiable. This would secure notification of most cases in early childhood, but would not furnish information of their subsequent history and whereabouts.

(*b*) The Social Security machinery could be used to obtain:

(i) The names of all children between 5 and 16, outside mental hygiene institutions, who are not attending school. On all claims for family benefit, parents or guardians would be required to name the school attended, or state 'not attending school'. Individual visits by Medical Officers of Health, or other officers, would follow, to establish the cause of non-attendance, and in the case of mental defectives to encourage the parents to obtain full assessment and advice.

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[1]*Mental Defective and Sexual Offenders.* Report of a Committee appointed by the Minister of Health, 1925.

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(ii) The names of all lower grade mental defectives between 16 and 60, outside mental hygiene institutions, who are receiving Social Security invalidity benefit on account of total incapacity for work.

This information, taken with returns from the Mental Hygiene Department, would be more nearly complete and up to date, within the age range 5 to 60, than any other information that is readily obtainable.

We recommend method (*b*), supplemented perhaps by method (*a*) applied only to children under 5.

RESEARCH

76. We have indicated our general views on fundamental research in paragraph 56. It is doubtful whether the offer of money in this field will secure either good research workers or good research. On the other hand, if a good research worker offers, money should be secured to give him his opportunity. Full ascertainment and assessment of cases, and accurate clinical records, are themselves a first step towards research, and additionally desirable for that reason; they would, for example, establish the number of cases of mental defect attributable to German measles in the pregnant mother, and therefore preventable. 'Research', but not 'fundamental research', may include the process of experiment in methods of handling and training mental defectives that should go on all the time in mental deficiency institutions and occupation centres. In this connection we are glad to note that trials have been made in Levin Farm of the effects of the recently advocated administration of glutamic acid to mental defectives; unfortunately, the results have merely confirmed the conclusions of the majority of observers abroad[1], namely that the oral administration of this expensive substance, which in any event is already an ingredient in food, manufactured in the body and present in large amounts in the brain, has no beneficial effect.

Summary of Recommendations

77. We now summarize our main recommendations, with references to the paragraphs in which discussion and more detailed suggestions have been given:

[1]*Nutrition Reviews*, 1951, 9, 113.

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(1) That the Government adopt the policy of providing good residential institutions, under the Mental Hygiene Division of the Department of Health but independent of mental hospitals, for the majority of intellectually handicapped children and adults in the community (paras. 50, 51, 54, 57).

(2) That each institution accommodate 400 to 500 mental defectives, in separate residential units taking about 30 each (paras. 52, 53, 56).

(3) That each institution provide for the intellectually handicapped (*a*) the essential requirements of physical health, (*b*) opportunity for physical and mental activity up to the limits of his powers, (*c*) social life among his equals in a friendly and sympathetic atmosphere, and (*d*) medical and nursing care (paras. 53, 54, 55).

(4) That parents be encouraged to place intellectually handicapped children in these institutions at about the age of 5 (para. 51).

(5) That the Education Department continue to provide Occupation Centres and to subsidize Occupation Groups for intellectually handicapped children whose parents prefer to keep them at home and for those for whom institutional provision is not yet available (paras. 59, 60, where detailed suggestions concerning the management of Occupation Centres and Groups are made, and paras. 61, 62, 63, 64).

(6) That the work of the Correspondence School, for intellectually handicapped children who remain at home in isolated places, be continued and developed (paras. 65, 66).

(7) That voluntary bodies be encouraged to provide cottage homes (with Government subsidy equivalent to family allowance or invalidity benefit), Senior Occupation Centres, Occupation Groups, voluntary assistance at Occupation Centres, and assistance in interesting parents and public in the humane handling of intellectually handicapped children (para. 71).

(8) That more accurate diagnosis and assessment of lower grade mental defect be attempted by means of specialist clinics in the main centres, comprising each a paediatrician, a neurologist, a psychiatrist, an educational psychologist, and a social worker (para. 73).

(9) That more accurate ascertainment of the number of intellectually handicapped children and adults in the country be attempted through the Social Security Department and the Medical Officers of Health (para. 74).

(10) That research be directed in the first place to the establishment of full clinical and personal records, and to the improvement of methods of handling and training intellectually handicapped children in institutions and Occupation Centres (paras. 55, 75).

Acknowledgments

78. We should like to put on record our appreciation of the large amount of information and opinion frankly and freely given by members of the Intellectually Handicapped Children's Parents' Association and its branches, and by numerous other witnesses, and we wish to acknowledge the efficient and considerate services of our secretary, Mr D. N. Hull.

R. S. AITKEN, *Chairman*
J. G. CAUGHLEY
F. C. LOPDELL
G. L. MCLEOD
JEAN M. ROBERTSON
G. M. TOTHILL

Appendix A

List of Organizations and Persons Submitting Written Statements to the Committee

Correspondence School, Education Department, Wellington.
Education Boards: Auckland, Wellington, Otago.

Intellectually Handicapped Children's Parents' Association:

New Zealand Committee,
Northland Branch,
Auckland Branch,
South Auckland Branch,
Gisborne and East Coast Branch,
Taranaki Branch,
Wanganui Branch,
Manawatu Branch,
Hawke's Bay Branch,
Wellington Branch,
Christchurch Branch,
South Canterbury Branch,
Otago Branch,
Southland Branch.

New Zealand Educational Institute.
New Zealand Federation of University Women.
New Zealand Society for the Protection of Women and Children.
New Zealand Speech Therapists' Association.
Sunnydene Occupation Centre (I.H.C.) Committee, Auckland.
Wellington After-care Association.
Mrs H. S. Anyon, Wellington.
Miss D. Barnitt, Teacher, New Plymouth.
Dr N. C. Begg, Paediatrician, Dunedin.
Dr E. D. Burnard, Paediatrician, Wellington.
Miss M. C. Clachan, Wellington.
Mr W. W. Gordon, Auckland.
Dr Theo G. Gray, former Director-General, Mental Hospitals Department.
Miss M. Johnson, Teacher of Intellectually Handicapped Children, Dunedin.
Mrs C. L. James, Hamilton East.
Mr Fred T. Jones, Hastings.
Mrs A. B. Pownall, Wellington.
Mr G. C. Smith, Child Welfare Officer, Auckland.
Mr P. A. Smithells, Director, School of Physical Education, University of Otago.
Mrs H. C. D. Somerset, Wellington.
Mr Thos. Taylor, Occupation Centre Head Teacher, Wellington.
Professor F. W. Mitchell and Dr R. Seddon, Department of Education, University of Otago.
Mr R. M. Zeller, Christchurch.

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Appendix B

List of Persons Interviewed by the Committee

Representing the Intellectually Handicapped Children's Parents' Association:

New Zealand Committee: Mrs H. S. Anyon, Mr D. Laurenson.
Northland Branch: Mr Arthur Cates.
Auckland Branch: Mrs W. W. Gordon; Mr S. Luker.
South Auckland Branch: Mrs A. B. Ranby.
Gisborne and East Coast Branch: Mrs J. Hacche; Mrs G. Smith.
Taranaki Branch: Mrs L. R. Ivill; Mrs M. A. McRae; Rev. Mr E. Hill.
Wanganui Branch: Mrs G. Y. Rowe; Mrs J. D. Summervell; Mr H. Delves.
Manawatu Branch: Mrs B. M. Masters; Rev. Mr V. Mead.
Hawke's Bay Branch: Mrs G. Fischer; Mr A. A. Helleur; Mr W. J. Lennon.
Wellington Branch: Mrs J. Clark; Mr H. S. Anyon.
Nelson Branch: Mr and Mrs J. Lusty; Mr and Mrs E. T. Taylor; Mr and Mrs W. Whaley; Mr A. J. Bennington.
Christchurch Branch: Mrs W. Townsend; Mr L. Armstrong; Mr S. M. Tucker.
South Canterbury Branch: Mrs L. G. Fyfe.
Otago Branch: Mr R. W. S. Botting; Mr K. A. North.
Southland Branch: Mr B. Clearwater.

Representing New Zealand Speech Therapists' Association:
Mrs J. Gordon.

Representing Sunnydene Occupation Centre (I.H.C.) Committee:
Mr W. W. Gordon.

Representing Paediatric Society of New Zealand:
Dr Elizabeth Hughes.

Representing Wellington After-care Association:
Mrs D. Coutts; Mrs E. Dobbs; Mrs H. O. Logie.

Representing Family Guidance Council, Wellington:
Mrs P. Macaskill.

Representing New Zealand Educational Institute:
Mr G. Ashbridge; Mr E. G. Smith.

Representing New Zealand Federation of University Women:
Miss V. Barron; Miss M. Fyfe.

Departments of Education, University Colleges:

Victoria: Professor C. L. Bailey.
Canterbury: Professor H. E. Field; Dr R. Winterbourn.
Otago: Professor F. W. Mitchell; Dr R. Seddon.

School of Physical Education, University of Otago:
Mr P. A. Smithells, Director.

Education Department:

Supervisor of Special Classes, Auckland: Miss A. A. Sheat.

Superintendent of Physical Education, Auckland: Mr K. Reid.

Supervisor of Art and Crafts, Wellington: Mr A. G. Tovey.

Correspondence School, Wellington: Mr E. N. Le Petit; Mrs D. E. Burton.

Visiting Teachers:
Hutt Valley: Miss R. K. Reilly.
Wellington: Miss F. B. Nutting.

Principals of Special Schools:

Richmond: Miss C. A. McRae.
Otekaike: Mr D. O'Connor.

Principals, Occupation Centres:

Sunnydene, Auckland: Mrs M. L. Newman.
Basin Reserve, Wellington: Mr Thos. Taylor.
Merivale Lane, Christchurch: Mrs P. J. Fletcher.
Moray Place, Dunedin: Miss J. C. Green.

New Zealand Broadcasting Service:

Miss J. Combs, Broadcasts to Schools Section.

Medical Practitioners:

Dr N. C. Begg, Paediatrician, Dunedin.
Dr E. D. Burnard, Paediatrician, Wellington.
Dr Theo G. Gray, former Director-General, Mental Hospitals Department, Wellington.

Others:

Mr W. W. Gordon, Auckland.
Mr G. C. Smith, Child Welfare Officer, Auckland.
Mrs A. B. Pownall, Wellington.
Mrs H. C. D. Somerset, Dominion Adviser to the Federation of Nursery Play Centres, Wellington.

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Colleges:

Dr R. Winterbourn.
Dr R. Seddon.

ity of Otago:

and: Miss A. A. Sheat.
ion, Auckland: Mr K.

gton: Mr A. G. Tovey.
: Mr E. N. Le Petit;

Newman.
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Adviser to the Federation
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Appendix C

List of Institutions Visited by Committee

Mental Deficiency Institutions:

- Levin Farm.
- Templeton Farm.

Mental Hospitals:

- Avondale.
- Kingseat.
- Tokanui.
- Porirua.
- Nelson and Ngawhatu.

Homes of Compassion:

- Silverstream, Upper Hutt.
- Island Bay, Wellington.

Special Schools:

- Richmond.
- Otekaike.

Special Classes:

- Grafton School, Auckland.
- Petone Central School, Petone.

Occupation Centres:

- Sunnydene, Auckland.
- Basin Reserve, Wellington.
- Wellington After-care Association.
- Merivale Lane, Christchurch.
- Moray Place, Dunedin.

Hunterville Hostel, Abbotsford, Dunedin.

Occupation Groups:

- *New Plymouth.
- *Wanganui.
- *Palmerston North.
- *Hastings.
- *Invercargill.

Correspondence School, Education Department, Wellington.

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*Visited by one or two members on behalf of Committee.

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