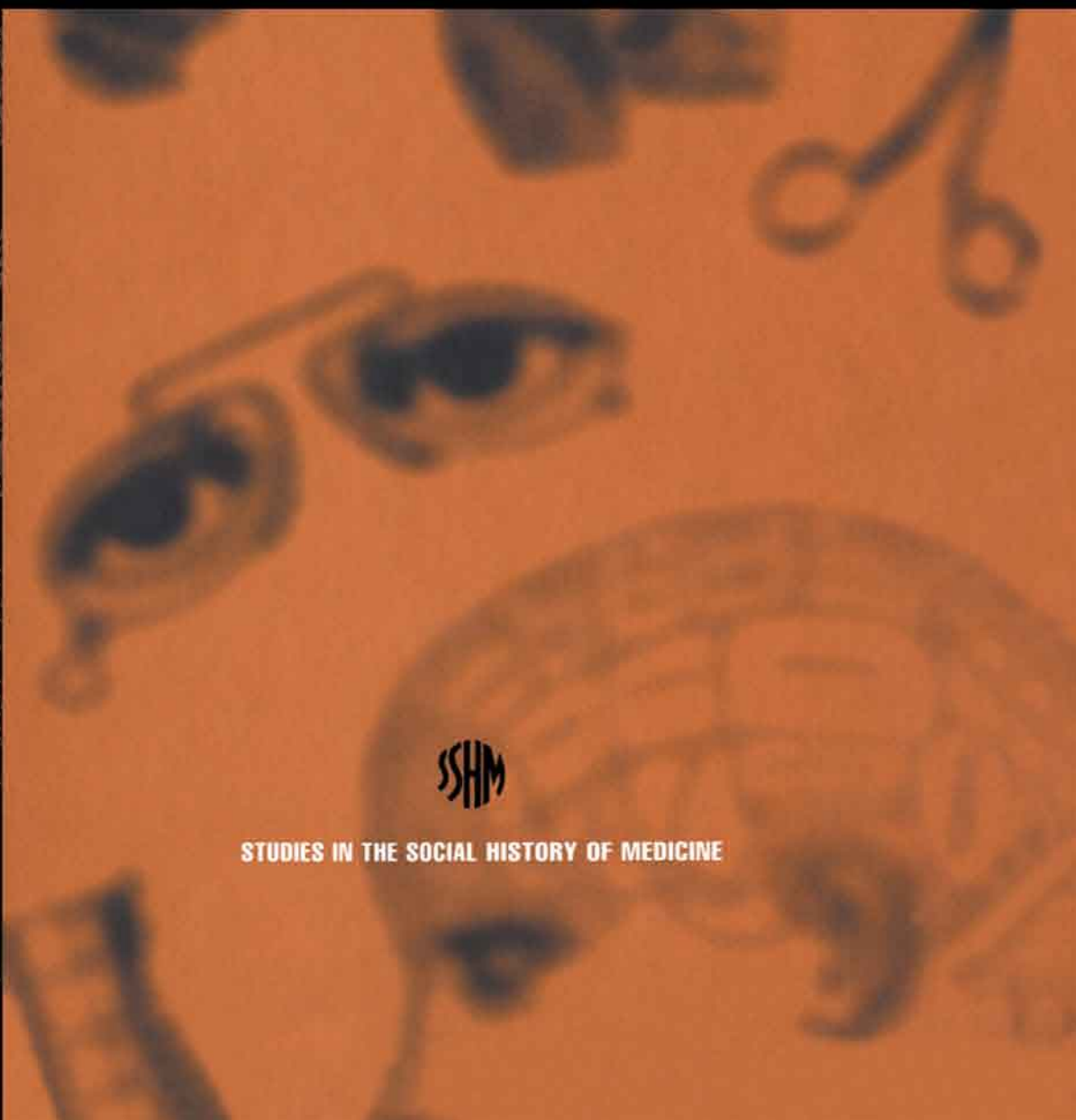


From Idiocy to Mental Deficiency

Historical perspectives on people with learning disabilities

ROUTLEDGE

EDITED BY DAVID WRIGHT & ANNE DIGBY



SSHM

STUDIES IN THE SOCIAL HISTORY OF MEDICINE

FROM IDIOCY TO MENTAL DEFICIENCY

From Idiocy to Mental Deficiency is the first book devoted to the social history of people with learning disabilities in Britain. Approaches to learning difficulties have changed dramatically in recent years. The implementation of 'Care in the Community', the campaign for disabled rights, and the debate over the education of children with special needs have combined to make this one of the most controversial areas in social policy today.

The nine original research essays collected here cover the social history of learning disability from the Middle Ages through to the establishment of the National Health Service. Together with the useful general introduction to the volume, they not only contribute to a neglected field of social and medical history; they also illuminate and inform current debates.

The research presented here will have a profound impact on how professionals in mental health, psychiatric nursing, social work, and disabled rights understand learning disability and society's responses to it over the course of history.

David Wright is Wellcome Lecturer in the History of Medicine at the University of Nottingham. **Anne Digby** is Professor of Social History at Oxford Brookes University.

STUDIES IN THE SOCIAL HISTORY OF MEDICINE

Edited by Jonathan Barry and Bernard Harris

In recent years, the social history of medicine has become recognised as a major field of historical enquiry. Aspects of health, disease, and medical care now attract the attention not only of social historians but also of researchers in a broad spectrum of historical and social science disciplines. The Society for the Social History of Medicine, founded in 1969, is an interdisciplinary body, based in Great Britain but international in membership. It exists to forward a wide-ranging view of the history of medicine, concerned equally with biological aspects of normal life, experience of and attitudes to illness, medical thought and treatment, and systems of medical care. Although frequently bearing on current issues, this interpretation of the subject makes primary reference to historical context and contemporary priorities. The intention is not to promote a sub-specialism but to conduct research according to the standards and intelligibility required of history in general. The Society publishes a journal, *Social History of Medicine*, and holds at least three conferences a year. Its series, Studies in the Social History of Medicine, does not represent publication of its proceedings, but comprises volumes on selected themes, often arising out of conferences but subsequently developed by the editors.

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FROM IDIOCY TO MENTAL DEFICIENCY

Historical perspectives on people with
learning disabilities

*Edited by David Wright and
Anne Digby*



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Anne Digby

Historically, the social marginality of people with learning disabilities has been mirrored by their academic marginality. Even when the 'new social history' of the 1960s and 1970s had focused on 'history from below' and made visible a number of social groups previously neglected by historians, people with learning disabilities at first did not come into view. More recently some excellent, but as yet unpublished, doctoral theses have taken this group of people as their subject.¹ A Society for the Social History of Medicine conference entitled 'From "Idiocy" to "Mental Deficiency": Historical Perspectives on People with Learning Disabilities' attracted considerable interest at home and abroad when it was held in London in 1992.² This book is the outcome of papers given at that conference and will, it is hoped, stimulate further studies in the history of these individuals.

This introductory chapter provides a broad contextualisation and period perspective which aims to enhance an appreciation of the more detailed case studies in the volume. The chapter begins by looking at the language of difference, and earlier attempts to locate the nature of that difference. A discussion of the institutional response to learning disabilities from the eighteenth century to the twentieth century, of the social and intellectual climate in which this developed, and of alternatives in the form of familial or community care then follows. The chapter also highlights some human rights issues.

Pragmatic tests for idiocy (notably those in relation to property), were based on establishing orientation, intellect, judgement and memory. *Ad hoc* questioning ascertained whether individuals were aware of knowing where they were, what age they were, what day of the week it was, if there was an ability to count to twenty pence or do a simple literacy test, as well as determining whether there was an orderly weekly religious attendance at church.³ As Richard Neugebauer

indicates in Chapter 2, during both the medieval and early modern periods it is interesting to discover that naturalistic tests rather than demonological criteria were used to evaluate mental impairment in English court hearings that involved the Crown's incompetency jurisdiction over property. From the thirteenth century onwards there had been a legal dichotomy between idiocy and lunacy. Idiots (for a time also termed natural fools) were seen as having a disability that was permanent, a condition involving absence of understanding from birth. This was distinct from lunacy which was a postnatal event. By the seventeenth and eighteenth centuries, as Peter Rushton points out in Chapter 3, intermediate categories had been introduced. Legal decisions often effectively validated the viewpoint of families or endorsed the popular reputation of the individual as an idiot. A common-sense familiarity or lack of embarrassment towards eccentricity, lunacy or idiocy was indicated by the richly nuanced language describing them.⁴

Social negativity grew stronger as more widespread institutional care resulted in a distancing of idiots and imbeciles from the community. Closer social, medical, or educational attention was also focused upon these institutionalised individuals. At first this specialist focus was not necessarily associated with any great precision since, for example, those born deaf and dumb continued to be legally presumed to be idiots.⁵ Idiots were seen as less able to reason than imbeciles, and an additional term, the feeble-minded, was borrowed from American writings in the 1860s. The fluidity of the latter enabled a variety of social problems to be conflated with it; late nineteenth-century fears of miscegenation and degeneration in Britain associated the feeble-minded with class and, in the Empire, with race.⁶ In medico-legal terms the states of idiocy and imbecility were only gradually distinguished from lunacy. The Report of the Metropolitan Commissioners in Lunacy in 1844 recognised congenital idiots and congenital imbeciles as two of its nine categories of lunacy. Under the Lunacy Act of 1890 an insane person was defined as either an idiot, a lunatic or a person of unsound mind. Legally, however, it was not until the twentieth century that lunacy excluded mental disability. Twentieth-century legislation was interesting linguistically since successive mental health and education acts referred to feeble-mindedness, idiocy and imbecility (1913), mental sub-normality (1944 and 1959), and mental impairment (1983). In Britain, as in the United States, however, lay confusion of mental illness and idiocy/imbecility continued.⁷

Historically, therefore, the subject is confused by a multiplicity of terms, while current notions of political correctness and enablement

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have helped fuel an increasingly rapid change in nomenclature. For example, after forty years of existence as the 'Spastics Society' the organisation felt it necessary in 1994 to be renamed as 'Scope', with the subtitle 'for those with cerebral palsy', because it considered that the original name, 'spastics', had become a term of abuse.⁸ With present-day equal opportunities policies, and with a more widespread adoption of a human rights culture, the stigmatising of people with learning disabilities – in which yesterday's definition becomes today's term of abuse – as in 'fool', 'idiot', 'moron', 'cretin', or 'imbecile' – may become harder. Today, it is society that the impaired themselves now perceive as disabling for the individual, and human potential will, it is thought, be achieved through anti-discrimination legislation. This may offer a better way forward than concern directed at stigmatised labelling. All too often debates over linguistic political correctness have produced semantic ingenuities – 'intellectually challenged', 'developmentally retarded', or 'differently abled' – which have done little to improve the actual civil rights of the disabled. It is this perspective which has informed the decision to use the terminology of the period under discussion in different parts of this chapter, as well as a belief that the language used historically helps us to understand past values and social attitudes.

Implicit in the language describing these individuals was, and is, the notion of the Other. 'The changing definitions of difference constitute the history of the mentally handicapped. These definitions have always been conceived of by others, never are they the expression of a group of people finding their own identity, their own history.'⁹ The issue of their relative humanity or animality was the subject of discussion by early psychologists and philosophers.¹⁰ Thomas Willis in a chapter on mental deficiency listed the physical insults to the body that predisposed parents to have imbecilic children.¹¹ Changelings, as the handicapped children of normal parents were called, aroused particular interest from Paracelsus onwards. Locke, in a famous and apparently unproblematic distinction between lunatics and idiots, argued that 'Idiots make very few or no propositions, and reason scarce at all.' But Locke's view of the idiot was far from unproblematic since this was based on a circular identification of idiots and changelings. In reviewing what it was to be human, it has been suggested that Locke provided a much more comprehensive exclusion of the idiot than the earlier one based on particular schema (such as the historical tests discussed above).¹² In Chapter 5 of this volume, Chris Goodey analyses the antecedents of Locke's thought in seventeenth-century theological

debates that developed distinctions between natural and moral disability, probed the reasons why God should have created idiots, and pondered whether they could ever achieve salvation. Goodey demonstrates how Locke extended the discussion into the secular realm of the political nature of consent in a civil society, and so suggests the relevance – both past and present – of the relationship of disability to consent and civil liberty.

Idiocy was seen mainly as a domestic or family problem so that institutional remedies were thought largely inappropriate in the early modern period. The situation became a matter of public concern – and thus of Poor Law applications – only when care broke down, the burden of care resulted in family poverty, or if male adults (often the main productive members of the family), were concerned.¹³ Peter Rushton argues in Chapter 3 that so far from indicating a pre-industrial golden age of social integration this situation suggests that the family was ‘at the centre of the state-enforced system of care’. Thus the English parish only looked after a minority of individuals by subsidising care in neighbours’ homes. And some parishes were so reluctant to shoulder the financial burden for this that payment had to be enforced by the magistracy. In contrast, in Chapter 4, Jonathan Andrews prefers to stress the compassionate nature of these kinds of parochial relief on the basis of his research into a sample of metropolitan parishes during the seventeenth and early eighteenth centuries. Whilst also emphasising the predominantly family-based and domiciliary locus of care he also finds that some idiots were sent out to surrounding counties for nursing or lodging. Boarding out with ‘kindly guardians’ was later employed in nineteenth-century Scotland for the mentally deficient. The official – and probably over-optimistic view – of these community-based strategies was that ‘Being dressed like ordinary people ... the old village fools seemed at once to disappear from the villages without having really left them.’¹⁴

Only a minority of idiots were placed in institutions. In Chapter 4 Jonathan Andrews suggests that whilst Bethlem Hospital was putting more effort into excluding the incurable, amongst whom were numbered the idiotic, from the late seventeenth century onwards workhouses privileged idiots above lunatics because of the utility of their labour. A process of institutionalisation gradually accelerated within an industrialising and urbanising society. This transition from life in the family or community (which was an almost invisible presence as far as the historical record was concerned), to that in institutions has led to more documentation and hence – for historians – to greater social visibility. But even in workhouses, asylums and prisons idiotic inmates

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were for some time outside the main focus of concern, not least because it was perceived only belatedly that they were a separate category. From the documentation it appears as if idiots and imbeciles had only 'walk-on parts' as criminals, paupers, or lunatics because they were not on the historical stage for long enough to be within the vision of eighteenth-century and nineteenth-century administrators and policy-makers. Ironically, in reality, they might be the longest-stay inmates. This failure to come 'under the spotlight' also derived from the circumstances surrounding institutional development. A burst of therapeutic and social optimism had created such establishments. But imbeciles and idiots were not the easiest people for whom to claim recovery or rapid discharge rates, and hence to publicise a 'successful' establishment which could then gain additional funding from a credulous public. A lack of understanding of their needs, and of a suitable typology in relation to those seen as idiots and imbeciles, led to them being housed in a variety of institutions. In this spectrum there was a hierarchy of cost as well as of social, educational or medical suitability; general workhouses were cheaper than any of the alternatives. The growth of Georgian and Victorian institutions was driven as much by the desire to safeguard the interests of society as to care for particular groups. Revealingly, the Quaker expert on psychological medicine, D.H. Tuke, stated in 1882 that:

There may be times when, desiring to see the 'survival of the fittest', we may be tempted to wish that idiots and imbeciles were stamped out of society. But ... there is a compensation for the continued existence of so pitiable a population in our midst in ... that our sympathies are called forth on their behalf ... those who are strong should help the weak.¹⁵

Once created, for whatever combination of altruistic and self-regarding motives, institutions both highlighted and themselves created problem populations. By the mid- and late nineteenth century the optimism of early reformers had been succeeded by a pessimism in which feeble-minded inmates were seen as inherently problematic. As long-stay, 'chronic' inmates they assisted in the silting up of the asylum through impeding its curative potential. At the same time, as recidivists in prison populations, they contributed to what was perceived as an alarming growth of Victorian criminality. In these circumstances it was predictable that the prevalence of the feeble-minded should become an important strand in contemporary debates on social degeneracy, and

hence on eugenics. Henry Maudsley characteristically referred to hereditary degeneracy as culminating 'in the extreme degeneracy of idiocy'.¹⁶ Within a wider focus of concern about the unregenerate poor 'who had turned their backs on progress, or had been rejected by it', there were groups who aroused particular anxiety; earlier this was the weak-minded criminal and later on, the feeble-minded fecund woman. A fear of the degenerate residuum or underclass, and of contamination arising from it, was part of a wider discussion of national efficiency, and of the coercive, disciplinary, or segregative social policies that might be involved in order to achieve it.¹⁷ Although early Victorian asylum superintendents had discharged the weak-minded, without apparently seeing them as a threat to society, from the late 1860s by contrast there were demands for the certification and institutional isolation of the mentally retarded. And, during the late nineteenth century, rising statistics of 'feeble-mindedness' seemed to have attested more to increased social sensitivity than to any real growth in their numbers.

What were the English institutional policies or practices that had led up to this situation? Under the New Poor Law of 1834 it was only the practicalities of early workhouse administration that led to those of unsound mind becoming recognised as a distinct class of pauper: Poor Law orders between 1834 and 1847 referred variously to idiots, persons of weak intellect, mental imbeciles, and the mentally infirm. Other categories of disability were conflated with them, as were the deaf, or deaf and dumb, in Warwickshire workhouses.¹⁸ Under later Poor Law orders of 1844 and 1852 idiots and imbeciles were allowed outdoor relief, but many found their way into the workhouses, some as short-stay inmates called 'ins and outs', and others as very long-stay ones.¹⁹ A survey of long-standing inmates of workhouses in 1861 found that the idiotic and epileptic formed a principal category. In Norfolk, for instance, amongst indoor paupers who had been in the workhouse for over five years one-third were imbecilic or idiotic, including Rachel Dixon, 'an idiot' of King's Lynn, who had entered sixty-six years before.²⁰ Inside the workhouse there were no orders for the separation of lunatics and imbeciles from other inmates, nor any general provision of specialist accommodation. Indeed, the Webbs correctly referred to a 'paralysis' of Poor Law policy in regard to this group of people since circulars referred in passing to them, but not as a matter of central concern. For example, in 1868 the same diet was to be given to imbeciles as to the aged, whilst in 1895 there was a prohibition on care to workhouse children from weak-minded inmates. Otherwise, only an occasional inspectorial anxiety was raised about imbeciles and also

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about the group of senile imbeciles, with whom they were conflated. Concern was expressed about idiots' or imbeciles' impact on the sane in an institution rather than about any such individuals in their own right. In these circumstances few Poor Law unions built imbecile wards.²¹ London was exceptional in that the Metropolitan Poor Act of 1867 led to specialist Poor Law accommodation being provided for idiots and imbeciles in large-scale institutions at Leavesden, Caterham, and later at a school for 1,000 pupils at Darenth.²²

Until the late nineteenth century there existed at best only a blunted perception of difference between the imbecilic and the harmless or chronic lunatic, or between the congenitally handicapped and the senile demented. The English workhouse was the likeliest location for the imbecile, and local guardians found such imbecilic inmates useful – more especially as numbers of other able-bodied inmates soon declined to a point where they were insufficient in numbers for labour in the laundry or the kitchen. In many such cases the establishment gained more from the inmate in work, than did the individual from the institution through care. From 1845 the newly appointed Lunacy Commissioners were compliant with this situation, although they placed some pressure on the Poor Law authorities to improve facilities. But, at local level, little action was taken in response.²³ The cheapness of the workhouse in comparison to the asylum meant that Poor Law authorities preferred retention of all save violently disturbed lunatics whose troublesomeness outweighed the costs of sending them to an asylum. In Ireland, in contrast, certification at petty sessions meant that the law, and not the Poor Law administrator, was the primary determinant of the composition of asylum populations: here there was a clear distinction made between workhouses as the destination of idiots and imbeciles, and asylums as that of lunatics.²⁴

Medical interest was much greater in lunacy than in idiocy and imbecility. Jonathan Andrews indicates in Chapter 4, that it was highly unusual to find references to medical treatment in seventeenth-century parochial records. And David Wright argues in Chapter 6 on the basis of an analysis of certification for the first Idiot Asylum in England, Earlswood, that so far from the Victorian medical practitioner having much expertise in the process of medical certification of idiocy, it was the family – who had had the experience of caring for the idiot child – who took the lead in specifying the 'indications' of the disability. Lay attitudes on what constituted idiocy, he suggests, involved a sense of difference in that the child was perceived as more dependent, and relatively backward because lacking meaningful speech, and being deficient

in social skills. In Chapter 7 David Gladstone refers more briefly to the nature of initial assessments (by an honorary medical officer to the Western Counties Idiot Asylum in 1880), as being based very much on common-sense criteria. These indicated strong continuity with those which Richard Neugebauer and Peter Rushton suggested were used by lay people several centuries earlier. In linking the ‘origins’ of the children’s idiocy to physical conditions such as epilepsy or physiological abnormalities, however, David Wright argues that certifying doctors did find medical models more useful.

It is important to recognise that advances in medical knowledge occurred only very gradually and episodically, and then often as the result of an individual doctor’s interest. From the sixteenth to the nineteenth centuries there had been some discussion of cretinism, but it was during the late nineteenth century that the condition was discovered to have been the result of thyroid deficiency.²⁵ In 1866 John Langdon Down formulated his classic description of mongolism, and this led to it being renamed as Down’s syndrome. It was not until the turn of the twentieth century, as Mark Jackson indicates in Chapter 8, that doctors constituted themselves as ‘experts’ in mental deficiency and wrote papers, articles and books discussing feeble-mindedness as a state which was likened to an organic disease. The diagnostic significance of physical aspects of mental defect, revealingly termed the ‘stigmata of degeneration’, was discussed by doctors in relation to what they saw as the distinctively pathological nature of the feeble-minded. This biological/medical model of mental deficiency as disease, in which clinical observations were coloured by moral judgements, influenced later social policies of segregation.²⁶ Differentiation in legal certification also derived from medical advances in knowledge. The Lunatics Act of 1845 had required two medical certificates for entry to a lunatic asylum, whereas there was medical discretion as to the certification of idiots. Under the Idiots Act of 1886 one medical certificate was required to send a child to a special school.

Creation of specialist accommodation for idiots, particularly for children, had come with five English provincial licensed houses for idiots; Earlswood, Surrey (1853), Eastern Counties (1859), Western Counties (1864), Northern Counties (1864), and Midland Counties (1868) which were registered under the Idiots Act of 1886.²⁷ The 1886 Act led to more children coming under institutional care, so that treatment and care of the idiot child assumed a new importance. David Gladstone discusses in Chapter 7 the interplay between broad national policy-making and local factors in the development of English institutions. More specifically, in

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the case of the Western Counties Asylum, he suggests that policy was directed increasingly at the industrial training of inmates, and at achieving economic viability through the recruitment of pauper inmates whose stay would be financed by the Poor Law. Institutionalisation also grew apace elsewhere. Scottish foundations included an Idiot Asylum in Edinburgh (1855), a Scottish National Institution for the Education of Imbecile Children at Larbert (1863), and a Special School for Mental Defectives at Paisley (1912).²⁸ In the USA there was provision in New York (1852), Massachusetts (1853), Philadelphia (1858), Ohio (1872), and Illinois (1872). Systematic training was developed from the 1840s by Edouard Séguin, first at the School for Idiots at the Bicêtre in Paris, and later at the Massachusetts School for Idiots and Feeble-minded Youths, while some further work was done by the medical psychologist, G.E. Shuttleworth, at the Royal Albert Asylum.²⁹

Therapeutic optimism about the training of young idiots contrasted with much lower levels of concern about the adult with mental disabilities. In consequence relatively little is known about the lives of adult idiots and imbeciles in early asylums. During the Georgian period private madhouses had admitted imbeciles although they comprised only a very small group of patients. At the Bethel in Norwich two individuals were discharged in the late eighteenth century as 'unfit' because of being 'in a state of idiocy' or 'suffering from idiotism'.³⁰ At Witney and Hook Norton in Oxfordshire from 3 to 4 per cent of total admissions were those of imbecilic patients between 1725 and 1854. Their imbecility was only a part of a wider spectrum of presenting symptoms, including physical illness, and their duration of stay was short. In contrast, at the York Retreat, half of those termed imbecilic had treatment of ten years or more. Numbers of these patients declined from 10 to 1 per cent of the total patient population between 1796 and 1914, mainly as a result of a better knowledge of the clinical distinction between idiocy and lunacy which gradually led to a more discriminating admissions policy. As with Poor Law establishments, the work of imbecilic patients was useful to the asylum. One female imbecile demanded her release, stating that 'nothing ailed her mind' but that she had 'worked like a slave for seven years' in order – unsuccessfully – to earn her freedom.³¹

The allocation of an institution for the imbecilic adult was something of a lottery. Arbitrary decisions during the mid-nineteenth century showed that the police and magistracy were not particularly concerned to make a correct diagnosis of weak-mindedness, so that individuals might find themselves in prison, rather than an asylum. Sometimes a

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weak-minded person having been sent to prison was then transferred to an asylum.³² The experience of male and female feeble-minded offenders was a differentiated one; the petty offences of feeble-minded women tended to get lesser punishments than the offences of mentally defective men, whose charges included more serious ones of sexual assault. Whilst the short sentences of the women often meant that their mental state was not detected by prison medical officers, those in prison for longer spells were more likely than men to be certified as insane and sent to an asylum.³³

Prisons were the focus for the worst kind of stereotyping of imbecility, since here individual misfortune appeared most clearly as a social threat. The driving force for segregation from the 1860s to the 1880s came from prison surgeons, whose stereotypical view of the criminality and recidivism of the weak-minded arose from the small minority of mentally deficient prisoners with whom they came into contact. In 1870, an influential paper by J.B. Thomson, a Scottish prison surgeon, estimated that one in eight prisoners in Scotland were mentally weak, whilst in the previous year William Guy, Superintendent of Millbank, had highlighted the 'dark figure' of criminal imbecility and proposed transfer to lunatic asylums. This view was echoed in the Report of the Penal Servitude Acts Commission of 1878.³⁴ In any case a take-over of English local prisons by a central authority three years earlier had exposed large numbers of weak-minded individuals in prisons. This contributed to a widespread pessimism in penal and asylum circles about the ineffectiveness of institutional solutions for social problems and also fed into the contemporary debates about degeneracy. The numbers of weak-minded people in prisons thus caused concern, although the cost of implementing any system of segregation inhibited action, as it had done with Poor Law inmates. Only belatedly did a drive to provide segregated accommodation lead some prisons to specialise in this category of prisoner, notably Parkhurst for men and Aylesbury for women.

By the 1890s the focus of concern had moved from the weak-minded criminal to degeneracy more generally. In Chapter 8 Mark Jackson analyses the changed nature of the rhetoric that had fuelled such anxiety, and the influential role that Mary Dendy played in attempting to alter social perceptions of the feeble-minded. Depicting feeble-mindedness as a permanent, hereditarian condition that was essentially pathological, Dendy argued that it required permanent segregation, if it was not to result in degeneracy through pauperism and criminality. The Sandlebridge Schools and Colony were the practical outcome of

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this rhetoric, although Mark Jackson shows that – in its actual mix of educational and custodial methods, and in its failure to enforce permanent care – Sandlebridge was similar to earlier idiot asylums. At the beginning of the twentieth century, feeble-minded women in particular were seen as the source of a biological perpetuation of mental deficiency, and as a sexual threat to respectability and normal family life.³⁵ Traditional views on the animality of the idiot thus resurfaced in an interpretation of the unbridled sexuality of the subnormal woman. This gendered anxiety centred as much on moral as physical issues. A philanthropic concentration of female activists and their interest in women in asylums, workhouses, inebriate reformatories, magdalens and rescue homes, and lying-in hospitals also meant that institutional provision for feeble-minded women came to exceed that for men during the early twentieth century. Since its formation in 1897 the National Association for Promoting the Welfare of the Feeble-Minded had encouraged small voluntary homes for girls and women, but the Royal Commission on the Care and Control of the Feeble-Minded of 1904–8 was influenced by the contrasting American model of large state institutions for feeble-minded women. There, instead of conviction and prison, those on a criminal charge were given life-long care that effectively prevented breeding by those perceived as unfit.³⁶

The gendered implications of social policy on mental deficiency during the early twentieth century are analysed in two chapters. Pamela Cox suggests in Chapter 9 that girls who were committed to mental-deficiency institutions were designated delinquent not only in terms of their perceived unbridled sexuality, but also in relation to their violent or disruptive behaviour, and their unemployability. And in Chapter 10 Mathew Thomson argues that the Mental Deficiency Act of 1913 was deployed by the London County Council as a ‘tool of sexual control’, so that long-stay institutional care was most likely to be given to females, whereas for males the legislation was useful at first in controlling delinquency through shorter periods of supervision and parole.

The construction of the feeble-minded as a social problem, and hence the appointment of the Royal Commission in 1904, had followed from a convergence of several debates. These discussions centred on not only the fecundity of the feeble-minded woman (and her threat both to morality and to the healthiness of the race), but on other issues, notably the educability of children with special needs, and the threat that a residuum of casual poor was seen as posing to the moral and physical welfare of society.³⁷ The resulting Mental Deficiency Act of 1913 provided for a division of those with congenital defects or impairment

from a very early age, into idiots, imbeciles, and the feeble-minded. It proposed an institutional separation so that mental defectives should be taken out of Poor Law institutions and prisons into newly established colonies. While England accepted this principle, Scotland preferred a system of overlap between the Poor Law and lunacy authorities, and Ireland backed a transfer of mental defectives from all other institutions to the Poor Law.³⁸ That women were seen as a prime focus of the Act's provisions is suggested by a conspicuous presence of women (including Mary Dendy) on the Board of Control that succeeded the Lunacy Commission, as well as on the inspectorate.³⁹ But a lack of preventative powers, and still more of resources, meant that the Act's impact was blunted. At the local level Medical Officers of Health at first refused to accept such defectives because of the cost to local authorities, although more comprehensive provisions in the Mental Deficiency Act of 1927 aimed to expedite its implementation.⁴⁰ In Chapter 10 Mathew Thomson emphasises that the impact of mental-deficiency legislation should not be viewed in isolation, but should be placed instead within the context of an expanding welfare complex of penal, medical and educational provision, in which individuals might be shifted from one type of institution to another.

Matching the individual to an institution preoccupied policy-makers concerned with children, whether they were involved primarily with education or with health. Since the late nineteenth century the logic of the law requiring compulsory attendance for all children at elementary school had meant that great difficulty was experienced in determining those seen as educable and capable of attendance at ordinary schools, and those who required special schooling.⁴¹ Special schools were first opened in London in 1892 and seven English School Boards soon followed this example. Legislation in 1899 permitted, and that in 1914 required, local educational authorities to provide special schools. From 1907 school medical inspections included a review of possible medical defect, and medical certification was then required before entry to special schools. But, despite concern over mental deficiency and feeble-mindedness there was no adequate measurement of the severity of mental defect. For example, in 1908 the Committee on Defective and Epileptic Children commented that, 'none of the witnesses were (*sic*) able to offer any verbal definition of the degree of want of intelligence which constitutes a defective child'.⁴²

Intelligence testing appeared to answer that need. It was introduced within a historical social context of discussion about degeneracy, segregation and eugenics, so that it was predictable that a theoretical

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continuum in IQ became, in practice, a means to segregate and separate the 'subnormal' from the 'normal'. In 1905 Alfred Binet and Victor Simon had published the first set of French tests linking mental and chronological age, and the German psychologist, William Stern, then developed this work into the concept of intelligence quotient or IQ. Under Newman, its Chief Medical Officer, the Board of Education's early twentieth-century policies were informed by the concept of mental measurement. In 1924 the board's *Report on Psychological Tests of Educable Capacity* in part justified IQ testing as the 'sifting out of defectives and dull children by special educational methods'.⁴³ In practice, however, this approach was severely constrained by the financial strait-jacket which restrained government activity during the interwar years; the Mental Deficiency Committee found in 1926, for example, that more than three-quarters of these children were in ordinary rather than special schools.⁴⁴ Also inhibiting children going to special schools or mental-handicap hospitals were social and familial pressures. Families might see disability as a taboo area, deny its existence as far as possible, and be profoundly suspicious of any specialist institutional care because it was perceived to be stigmatising.⁴⁵ Within the climate of opinion created by the eugenics movement such suspicion was understandable.

In early twentieth-century Britain the eugenics movement's aims included voluntary sterilisation of mental defectives and birth control for unemployed workers. These objectives were impeded both by a lack of consensus (notably over whether mental defect was hereditary), and by a weak constituency of support. The movement attracted more support for its birth control policies,⁴⁶ but a policy that was perceived to be anti-working class was opposed by the Labour movement,⁴⁷ while any scientific legitimisation of eugenics was much less apparent than in America.⁴⁸ In the USA between 1900 and 1940 the mental hygiene movement, backed by welfare officials and psychiatrists, and in the face of public apathy, succeeded for a short time in using state authority to back eugenic ideas on heredity. Indiana was the first state to pass a law for mandatory sterilisation of a group including idiots and imbeciles in 1907, and fifteen others emulated this in relation to those perceived as biologically undesirable.⁴⁹ There was sufficient ambivalence about sterilisation for such laws later to be overthrown by the courts, for state governors to veto the law, or to decline to release funds to institutions performing sterilisations. By the 1920s many superintendents of institutions for the mentally deficient were also having second thoughts about eugenics as a basis for sterilisation. Instead, they perceived a

continued rationale for the practice in the mental hygiene movement's emphasis on social adjustment, and thus supported sterilisations for both men and women as a prelude to an inmate's parole and release into society.⁵⁰

During the earliest years of the National Health Service, policy-making by default characterised the mentally handicapped in Britain since (as with earlier radical legislative changes in social policy), a restructuring of services was focused on the needs of other groups. Thereafter the relationship between institutions for the mentally subnormal and society came under greater critical scrutiny in the second half of the century. By the 1950s institutions were beginning to be perceived not as solutions as had been the case formerly, but as problems involving stigmatisation and depersonalisation. Within this context it gradually became clear that the institutionalisation of the mentally handicapped had helped exaggerate difference, and that this in itself then provided a self-sustaining rationale for institutional confinement.⁵¹ A number of sociological studies exposed the negative features of mental handicap hospitals. These included professional seclusion leading to a 'corruption of care' (such that administrative convenience superseded social rehabilitation), obsolete training opportunities, and geographical remoteness which exacerbated the problem of maintaining contact between families and inmates.⁵² Even in a late twentieth-century mental handicap hospital it was found that one in three patients was never visited within a year, and three out of four never left hospital to visit their families.⁵³ Hospitalisation thus might imply a profound isolation from normal life within society.

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1954–7) suggested that parallel services for community care should be developed by local authorities. In 1961 the Minister of Health, Enoch Powell, announced that mental hospital accommodation should be halved within fifteen years. But little practical action ensued so that the White Paper of 1971, *Better Services for the Mentally Handicapped*, found that only one in four English and Welsh authorities had so far developed this kind of residential provision.⁵⁴ Scandals in mental handicap hospitals, notably those at Ely and at South Ockendon,⁵⁵ caused further heart searching on the fundamental rationale and objectives of services for people with learning disabilities. Central to a rethinking of policy were two committees. The Warnock Committee into Special Educational Needs (1978) resulted in the Education Act (1981), which initiated a system of identifying, assessing and reviewing all children with special needs, and involving parents to

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a greater extent than hitherto. The Jay Committee into Mental Handicap and Care (1979) emphasised the human rights of the mentally handicapped to be treated as individuals and to live normally within the community.⁵⁶ The ensuing Care in the Community initiative of 1981 resulted in some transfer of resources to local authorities in order to effect the transfer of residents from hospitals into community care,⁵⁷ and this process found its logical culmination in the NHS and Community Care Act (1990), which transferred the entire responsibility for community care to local authorities.

Community care initiatives are often seen as a distinctive feature of the 1970s but more accurately should be perceived as the most common historical response to those with learning disabilities – as in parochial arrangements under the Old Poor Law in England, or in boarding-out arrangements in nineteenth-century Scotland. Mathew Thomson shows in Chapter 10 how the implementation of the Mental Deficiency Act of 1913 in London led to negotiation between families and the state to enable community- or family-based strategies to be worked out for the care of adolescents. (Significantly, he also indicates that families might be coerced into accepting medically or bureaucratically derived solutions.) In addition, prototypes for a different form of community may perhaps be found in the interwar English colony for mental defectives, which has been interpreted as ‘a microcosm of the outside community’, and one which embodied the fundamental work ethic of a wider society.⁵⁸ And James Trent argues that the farm colonies linked to institutions in the USA during the 1920s, and (to a lesser extent) the 1930s, aimed to provide an environment in which mental defectives could be prepared for work, and then for release on parole. Interestingly, in this case, the driving force was the urgent need to provide an economical mechanism so that inmates could be released into society, while grossly overcrowded institutions could be enabled to admit yet another cohort of inmates.

Later, during the 1970s, an unlikely alliance – between officials wanting to cut costs and humanitarians wishing to close down inhumane public institutions – resulted in a programme of de-institutionalisation in the USA. Drawing on Erving Goffman’s ideas on deviance and labelling the psychologist, Wolf Wolfensberger, argued in an influential book, *The Principle of Normalization in Human Services* (1972) that existing state facilities had merely drawn attention to the negative or devalued qualities of mentally retarded individuals so that a new initiative was needed to provide an appropriate framework for human dignity. Publicity on early initiatives in Nebraska that implemented this kind of programme was

particularly persuasive in helping shape English thinking at this time. Nebraska implemented a process of normalisation (sometimes called mainstreaming), through which the mentally handicapped lived in community housing. More generally an institutional bias remained sufficiently strong in the USA to ensure that the majority of mentally retarded people in 1988 were housed in community care units with more than sixteen beds, whilst a concomitant run-down of state facilities meant that these were predominantly private (often private for profit) establishments.⁵⁹

In late twentieth-century Britain community care is a term whose apparent 'feelgood' resonance has helped conceal both its conceptual complexity and its parsimonious funding. A tension between optimistic labelling and harsh underlying economy then compounds practical problems involved in its implementation – such as moving resources from one sector to another, retraining staff, or co-ordinating educational, medical and social agencies. The Audit Commission discovered that in practice 'the care that people receive is as much dependent on where they live as on what they need'.⁶⁰ Integration posed problems, including those of financial costs, which were higher not lower than those of institutional care. It was significant that in 1976 a government consultative paper foresaw a 'continued development of community care with particular emphasis on low cost solutions'.⁶¹ The Griffiths Report on Community Care of 1988 aptly referred to community care as 'a poor relation, everybody's distant relative, but nobody's baby'.⁶²

Also relevant in the context of community care is the extent to which those with learning disabilities are/were perceived to be 'socially acceptable'. For adults with learning disabilities community care may involve varied mixes of life in the family alternating with professional care in day hospitals, or day care centres. When no longer distanced and invisible within an institution the presence within a neighbourhood of individuals with learning disabilities may make prejudice overt: 'All of us ... have complex reactions when confronted by handicapped people. They arouse in us fears of our own possible abnormalities and dependencies. What if I were like that? How would I feel about myself? Would anyone like me?'⁶³

In addition, there were important issues involved in de-institutionalisation which concerned the nature of familial care. An empirical survey of the locus of community care for the mentally and physically impaired found that it had important gender implications, since 'the major burden of care falls on women – whether wives, mothers, spouses, siblings, or friends'.⁶⁴ As far as the mentally impaired