

**The 'Manufacture' of Mental Defectives in Late Nineteenth and  
Early Twentieth Century Scotland**

**Matt Egan**

**September 2001**

**Thesis submitted to the Faculty of Social Science, University of Glasgow for the  
degree of doctor of philosophy.**

**Research undertaken at  
The Centre for Medical History and the Economic and Social History  
Department, University of Glasgow,  
on behalf of the Economic and Social Research Council**

This thesis has been composed entirely by myself, and the work on which it is based is my own.

A handwritten signature in black ink, appearing to read 'Matt Egan', with a stylized, flowing script.

Matt Egan

## **Abstract**

# **The 'Manufacture' of Mental Defectives in Late Nineteenth and Early Twentieth Century Scotland**

Matt Egan

Glasgow University

2001

Thesis submitted to the Faculty of Social Science, University of Glasgow for the degree of doctor of philosophy.

There has recently been a proliferation of historical studies of mental deficiency in late nineteenth and early twentieth century England, exploring the subject within its administrative, medical, educational and social contexts. This thesis contributes to the history of mental deficiency by describing developments that took place in Scotland. It focuses on the sharp increase in the proportion of the Scottish population labelled mentally defective during the period. This increase can be ascribed to the implementation of state policies geared towards the identification and segregation of mental defectives, but it also reflects a tendency amongst influential professional groups (notably, doctors and teachers) to broaden their definition of mental deficiency to include more people of higher ability. People were labelled mentally defective who would not have been regarded as such in earlier years: as one contemporary put it, 'the present policy tends to manufacture mental defectives'. This broadening of definitions occurred within the context of the Poor Law and lunacy administrations, but an analysis of quantitative and qualitative source material shows that it was within the state education system that most of Scotland's mental defectives were initially identified and segregated from their peers. The thesis also describes how various forms of segregated provision for mental defectives developed and expanded in Scotland over the period, taking into account special education, institutionalisation, boarding-out and other community-based forms of care and supervision. Finally the roles of mental defectives and their families are considered, illustrating how they could influence mental deficiency provision through acts of co-operation and resistance, but also how their influence waned as the state assumed greater powers to intervene in the private lives of its citizens.

## Acknowledgements

My thanks to the ESRC for funding my research and to the University of Glasgow for providing me with a base. I owe a particular debt of thanks to everyone at Centre for the History of Medicine, headed by Prof. Anne Crowther, and the Economic and Social History Department, headed by Dr Mike French, for providing such a supportive environment. I have been extremely well looked-after and I appreciate it greatly. My supervisors, Dr Marguerite Dupree and Prof. Anne Crowther, have been wonderful throughout and I am indebted to them for everything they have done for me.

I have also benefited greatly from the interest, stimuli and hospitality shown to me by other staff, fellows, students and associates who make up the research community in which I have found myself. Thankyou to Dr Malcolm Nicolson for organising the history of medicine reading group, which has helped me broaden my knowledge of this subject area immensely. Everyone who has attended this, and the PhD reading group, has helped me enormously.

Many people have helped me during the course of my research. There is not space to name them all but I would like to express my gratitude to Mike Barfoot, James Bradley, Anne Cameron, Ian Carthy, Jenny Cronin, Roger Davidson, Pamela Dale, Gayle Davis, Rose Elliot, Mark Freeman, Eleanor Gordon, Dan Healy, Andrew Hull, Rae McBain, Krista Maglen, Sandy Macdonald, Lachlan Macmillan, Ann Mulholland, Sibylle Naglis, Irene Ramsay, Lindsay Reid, Sheilla Riddell, Billy Sloan, Graham Smith, Nicola Sneddon, Ian Spencer. I am particularly indebted to Catriona Macdonald and Debbie Nicholson for their ideas, friendship and patience.

I would like to express my gratitude to the archivists at Glasgow City Archives, Glasgow Health Board Archives, the National Archives of Scotland and the Public Record Office. Additional thanks to the staff at Glasgow University Library. I have also received assistance from *Enable*, Glasgow City Council and *The Mental Welfare Foundation*.

*SAM Housing Project* has been invaluable in broadening my perspective and helping me through the last four years. I am grateful for the friendship and support I have received from (my apologies if there are any omissions) Carol Andrews, Maureen Cameron, James Cassidy, Yvonne Cavens, Martin Clark, Michelle Corney, James Dobbie, Bryan Evans, James Ewing, Eve Ferguson, Jackie Fox, Scott Goodall, Paul Guckian, Peter Harkins, Stephen Horsburgh, Brian Keeley, Jo Laird, Frank McCuaig, Fiona MacDonald, Lorraine McGuinness, James McLean, Nicola McMorro, Alan McMurray, Thomas Mack, Jack Marshall, Douglas Mennie, Finley Morrison, Ian Prescott, Gordon Pretsell, Hugh Robson, Jenny Rogers, Robert Sinclair, Elaine Sinfield, William Sharpe, Eugenia Tekpetey, Ian Watson, Glen Williams, Leanne Woolfe.

Special thanks to my parents and to all my family and friends for everything.



# Contents

<b>List of Tables and Figures</b>	<b>5</b>
<b>Abbreviations</b>	<b>6</b>
<b>Regarding Terminology</b>	<b>7</b>
<b>Introduction</b>	<b>8</b>
<b>Chapter 1      Labelling and Segregating Mental Defectives in the Nineteenth Century</b>	<b>26</b>
<b>Chapter 2      Glasgow's Role in the Development of Scotland's Mental Deficiency Administration</b>	<b>50</b>
<b>Chapter 3      Expanding State Provision for Mental Defectives in Scotland</b>	<b>85</b>
<b>Chapter 4      The 'Manufacture' of Mental Defectives (1896-1914)</b>	<b>121</b>
<b>Chapter 5      Scotland's Mental Deficiency Administration (1914-39)</b>	<b>158</b>
<b>Chapter 6      The 'Manufacture' of Mental Defectives (1914-39)</b>	<b>202</b>
<b>Chapter 7      Mental Defectives, Families and the State in Early Twentieth Century Scotland</b>	<b>228</b>
<b>Conclusion</b>	<b>265</b>
<b>Appendix</b>	<b>277</b>
<b>Bibliography</b>	<b>278</b>

## List of Tables and Figures

<b>Table 4.1</b>	<b>Proportion of the Scottish Population Regarded as Mentally Defective by Heads of Household in the Decennial Censuses of Scotland (1871-1911)</b>	<b>128</b>
<b>Table 4.2</b>	<b>Incidence of Mental Deficiency within the Boundaries of the School Board of Glasgow (1896-1914)</b>	<b>136</b>
<b>Table 6.1</b>	<b>Summary of Surveys Showing Incidence of Mental Deficiency within the Scottish Population During the Inter-War Period</b>	<b>207</b>
<b>Table 6.2</b>	<b>Average Number of Household Members per Room in the Homes of Glasgow's School Pupils (1912-36)</b>	<b>225</b>
<b>Table 7.1</b>	<b>The Proportion of Mentally Defective Special School-Leavers Notified by the Education Authorities as Requiring Continued Care (1931-38)</b>	<b>240</b>
<b>Figure 6.1</b>	<b>Number of Mental Defectives in Receipt of Special Education, Institutional Provision or Under Private Guardianship (1920-38)</b>	<b>Between Pages 218-219</b>
<b>Figure 6.2</b>	<b>Number of Mentally Defective Pupils Attending Special Schools and Classes in Scotland (1920-38)</b>	<b>219-220</b>
<b>Figure 6.3</b>	<b>Number of Mental Defectives in Institutions for Adults and Institutions for Juveniles in Scotland (1915-36)</b>	<b>220-221</b>
<b>Figure 6.4</b>	<b>Percentage of Mental Defectives in Institutions and Mental Defectives under Private Guardianship who were Male (1915-36)</b>	<b>221-222</b>
<b>Figure 6.5</b>	<b>Number of Male and Female Mental Defectives Attending Special Schools and Classes (1922-38)</b>	<b>222-223</b>
<b>Figure 6.6</b>	<b>Percentage of Burgh and County School Pupils Receiving Special Education for Mental Defectives (1920-38)</b>	<b>223-224</b>

## Abbreviations

COS	Charity Organisation Society
GBCS	General Board of Control for Scotland
GCA	Glasgow City Archives
GHBA	Glasgow Health Board Archives
NAS	National Archive of Scotland
PRO	Public Record Office
SED	Scotch/Scottish Education Department
SEJ	<i>Scottish Educational Journal</i>

## **Regarding Terminology**

This thesis examines the theories and practices surrounding state provision for people labelled 'mentally defective' in late nineteenth and early twentieth century Scotland. Much of the discussion focuses on the use of various labels associated with the discourse on 'mental deficiency' during that period. Many of the old labels and the ideas that underpin them are now regarded as offensive: 'mental defective', 'idiot', 'imbecile', 'moral imbecile', 'feeble-minded', 'lunatic', 'backward', 'ordinary' and 'normal' are all examples, though some still have currency even today. I personally regard them as offensive, but I also accept them as historical phenomena and have therefore not sought to replace them with terms more acceptable to modern readers. Some readers may feel uncomfortable about this, but I would argue that making people feel comfortable about the past should not be the primary purpose of historical study. In any case, there is no guarantee that currently accepted terms such as 'learning disability' will not suffer similar condemnation at some point in the future.

## Introduction

On the 19<sup>th</sup> December, 1923, the *Glasgow Herald* printed a letter from John Grimmond, a member of Glasgow's local education authority, under the headline 'The "Making" of Defective Children.' In the letter, Grimmond suggested that his own authority had developed an unhealthy enthusiasm for transferring pupils from mainstream into special classes for mental defectives. The school medical officers certified children attending such classes as 'feeble-minded': a sub-category of mental deficiency used to describe individuals with a relatively mild form of defect. According to medical theory and Scottish law, feeble-minded children were defined by their suitability for special education, in contrast to so-called 'idiots' and 'imbeciles' who, being more profoundly defective, were generally regarded as requiring institutional care. Whilst idiocy and imbecility were relatively well-established sub-categories of mental deficiency, doctors, teachers and state administrators had only come to accept 'feeble-mindedness' as a valid medico-legal category during the thirty years or so prior to Grimmond's letter. In doing so, they effectively expanded the boundaries of mental deficiency to include more people of higher abilities.

Grimmond contended that many of the children being transferred to special classes for mental defectives may well have been 'backward' in their studies, but not to such a degree that they should be given a stigmatising label and moved to a separate school away from their classmates. Children were in effect being 'made' into mental defectives through an extensive policy of labelling and exclusion from mainstream education. Grimmond was explicit on this point, claiming that '[f]rom cases which I have investigated it might be urged that the present policy tends to manufacture mental defectives.'<sup>1</sup>

His comments foreshadow some of the arguments found in recent historical studies. In 1994, James W. Trent published *Inventing the Feeble Mind: A History of Mental Retardation in the United States*.<sup>2</sup> Six years later, Mark Jackson published *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in*

---

<sup>1</sup> *Glasgow Herald* (19<sup>th</sup> Dec. 1923).

<sup>2</sup> J.W. Trent, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (California: University of California Press, 1994).



*Late Victorian and Edwardian England*.<sup>3</sup> Both titles echo Grimmond's accusation regarding the 'manufacture' of mental defectives, casting doubt on the validity of mental deficiency (or at least one of its sub-categories) as a *bona fide* medical condition.<sup>4</sup> Both authors argue (to differing degrees) that the condition they describe was socially constituted and developed in association with a growing tendency towards specialised institutional care and education within western society during the nineteenth and early twentieth century. The present study develops these themes within the Scottish context, focusing on the way in which the boundaries of mental deficiency expanded, and examining the relationship between the various agencies responsible for or resistant to that expansion.

If the boundaries of mental deficiency can expand over time, it is clear that the condition cannot simply be understood in terms of biological impairment. Many individuals labelled mentally defective in the 1920s and 1930s would not have been so labelled in the late nineteenth century. Nor can historians use modern medical theories to say which diagnoses were right or wrong. Contemporary notions of learning disability are themselves subject to intense debate and will undoubtedly change in time, just as past theories of mental deficiency did. To avoid an ahistorical approach to the subject, it must be assumed that individuals were mentally defective when they were labelled and treated (in either the medical or more general sense) as such by their contemporaries. This approach is complicated by the fact that contemporaries often disagreed over labelling. However, some were able to dominate the labelling process more than others, and it was their views that tended to have the most decisive influence on the social exclusion of individuals.

Mental deficiency is therefore to be viewed as a historically emergent, social phenomenon rather than an *a priori* medical condition. This is not to suggest that theories of mental deficiency bore no relationship to the genuine difficulty that certain people experience in acquiring socially valued skills. Doctors, teachers and administrators specifically used the label in an attempt to identify, help and/or supervise such people. Nonetheless, the decision to mark one person out as defective and another as normal was problematic, contested and embedded within wider considerations of

---

<sup>3</sup> M. Jackson, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester: Manchester University Press, 2000).

institutional management, efficiency, government policy and accepted standards of behaviour.

Furthermore, although mental deficiency and its various sub-categories were labels, the creation and use of those labels cannot simply be understood in linguistic terms. They were created and deployed in an attempt to identify a group of people who were being marginalised by structural and institutional changes within society. The relationship between labels, individuals, social groups and institutions must be taken into account if a more sophisticated understanding of mental deficiency is to be achieved. This will also enable us to better comprehend how new forms of social exclusion developed over the period.

The impact of these developments has been profound. During the late nineteenth and early twentieth century, the proportion of the Scottish population labelled mentally defective rose dramatically, resulting in large numbers of individuals being segregated from their peers. The extent of this rise can be measured in various ways, but to give some idea of the figures involved it is worth noting that the number of people registered as mentally defective by the Scottish Office and in receipt of some form of special provision rose from several hundred in the late nineteenth century to nearly 10,000 by the eve of the second world war.<sup>5</sup> Many individuals had their lives changed as a result of being labelled and a policy of mass (though not universal) segregation came to be increasingly implemented by the Scottish authorities.

One of the principal aims of this thesis is to explain how the expansion in mental deficiency took place. Its conclusions have a particular relevance to the modern debate surrounding the issue of learning disabilities. In recent years, provision for people with learning disabilities has achieved notoriety. Their social exclusion from mainstream schools and work-places, the policy of institutionalisation and the inadequacies of community care have been used as an indictment against the supposed altruism of the British welfare state and the medical profession.<sup>6</sup> On the assumption that an

---

<sup>4</sup> Note that in the US, feeble-mindedness was generally used as a synonym for mental deficiency, whilst in the UK the term was used more specifically as a sub-category of mental deficiency, Jackson, *Borderland of Imbecility*, 30.

<sup>5</sup> See chs. 4 and 6.

<sup>6</sup> Critical views on the treatment of people with learning disabilities, and the disabled in general within the modern welfare state and education system can be found in J. Ford, D. Mongon and M. Whelan, *Special Education and Social Control: Invisible Disasters* (London: Routledge & Kegan Paul, 1982); R. Sinclair, R. Grimshaw and L. Garnett, 'The Education of Children in Need: the Impact of the Education



understanding of the origins of these exclusionary practices will help inform contemporary policies, this thesis provides insights into the actions of those on the frontline of earlier developments: local administrators, doctors, teachers, mental defectives and their families, as well as central administrators and politicians.

### *Historiography*

From the numerous historical accounts that have been written on the subject, it is apparent that parallels to the developments in Scotland, subject to local variations, can be found across the UK and abroad.<sup>7</sup> In recent years, the historiography of mental deficiency in the UK has expanded and diversified.<sup>8</sup> Most of the work focuses on either the nineteenth or early twentieth century although earlier periods have received some

---

Reform Act 1993 and the Children Act 1989,' *Oxford Review of Education* 20, no. 3 (1994), 281-292; A.L. Chappell, 'From Normalisation to Where?,' L. Barton and M. Oliver (eds.), *Disability Studies* (Leeds: Disability Press, 1997), c. 3; L. Barton, 'The Politics of Special Educational Needs,' L. Barton and M. Oliver (eds.), *Disability Studies* (Leeds: Disability Press, 1997), c. 9; M. Oliver, *Understanding Disability* (London: Macmillan, 1996) chs. 4-6.

<sup>7</sup> For a comparative review of British and American literature on the history of mental deficiency, see Jackson, *Borderland of Imbecility*, 6-8.

<sup>8</sup> For example, N. Anderson and A. Langa, 'The Development of Institutional Care for "Idiots and Imbeciles" in Scotland,' *History of Psychiatry* viii (1997), 243-266; J. Andrews, 'Begging the Question of Idiocy: the Definition and Socio-cultural Meaning of Idiocy in Early Modern Britain: Part 1,' *History of Psychiatry*, 9 (1998), 65-95; D. Barker, 'How to Curb the Fertility of the Unfit: The Feeble-minded in Edwardian Britain,' *Oxford Review of Education*, 9 (1983), 198-9; D. Barker, 'The Biology of Stupidity: Genetics, Eugenics and Mental Deficiency in the Inter-war Years,' *British Journal for the History of Science* 22 (1989), 247-75 G.E. Berrios and R. Porter, *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), c. 9; T. Cole, *Apart of a Part: Integration and the Growth of British Special Education*, (Milton Keynes: Open University Press, 1989); J.S. Hurt, *Outside the Mainstream: A History of Special Education* (London: Batsford, 1988); Jackson, *The Borderland of Imbecility*; E.J. Larson, 'The Rhetoric of Eugenics: Expert Authority and the Mental Deficiency Bill' *British Journal for the History of Science*, 24 (1991), 59; L. Macmillan, 'Origins and Evolution of Special Education for Children with Intellectual Disabilities in Greater Glasgow 1862-1962' (PhD thesis, University of Strathclyde, 1998); P. Potts, 'Medicine, Morals and Mental Deficiency,' *Oxford Review of Education*, vol. 9, no.3 (1983), 181-196; D.G. Pritchard, *Education and the Handicapped 1760-1960* (London: Routledge and Kegan Paul, 1963); G.R. Searle, *Eugenics and Politics in Britain 1900-1914* (Leyden: Noordhoff International Publishing, 1976); G.R. Searle, 'Eugenics and Class', C. Webster (ed) *Biology, Medicine and Society 1840-1940* (Cambridge: Cambridge University Press, 1981), 217-242; H.G. Simmons, 'Explaining Social Policy: the English Mental Deficiency Act of 1913', *Journal of Social History*, 11 (1978); G. Sutherland, *Ability, Merit and Measurement* (Oxford: Clarendon Press, 1984); G.O.B. Thomson, 'Legislation and Provision for the Mentally Handicapped Child in Scotland since 1906', *Oxford Review of Education* 9 (1983), 233-230; M. Thomson, 'The Problem of Mental Deficiency in England and Wales 1913-1946' (D.Phil. thesis, University of Oxford, 1992); M. Thomson, 'Sterilisation, Segregation and Community Care: Ideology and the Problem of Mental Deficiency in Inter-war Britain,' *History of Psychiatry* 3 (1992), 473-98; M. Thomson, ' "Though Ever the Subject of Psychological Medicine": Psychiatrists and the Colony Solution for Mental Defectives,' H. Freeman and G.E. Berrios (eds), *150 Years of British Psychiatry Volume II: The Aftermath* (London: Athlone Press, 1996), 130-143; M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870-1959* (Oxford: Clarendon Press, 1998); M. Thomson, 'Constituting Citizenship: Mental Deficiency, Mental Health and Human Rights in Inter-war Britain,' C. Lawrence and A-K. Mayer, *Regenerated England: Science, Medicine and Culture in Inter-war Britain* (Amsterdam: Rodopi, 2000), c. 9; J. Walmsley, D. Atkinson and S. Rolph, 'Community Care and Mental Deficiency 1913 to 1945,' Peter Bartlett and David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (London: Athlone, 1999), c. 9.

attention.<sup>9</sup> From the mid-nineteenth century onwards, specialised provision for mental defectives expanded significantly: hence, historians have found the late-modern period a particularly fruitful base for their studies. The historiography now boasts a number of specific institutional histories, such as those provided by Michael Barrett, David Wright and Andy Stevens; an account of mental deficiency within the penal administration by Stephen Watson; and a collection of essays focusing on various aspects of the subject throughout the modern period edited by Anne Digby and David Wright.<sup>10</sup> Two monographs have been published viewing mental deficiency from both a policy and medical perspective,<sup>11</sup> whilst other historians have produced relevant work within more general descriptions of the history of special education. There are, however, numerous issues that would still benefit from scholarly attention.

To begin with, historians working in this field traditionally concentrated on one of two areas: *either* special education for defective children in day schools, *or* the workings of the English Mental Deficiency and Lunacy Act, 1913, which established a central body called the General Board of Control to administer, at national level, institutions and community-based services for mental defectives outside the education system.<sup>12</sup> The decision to treat special education as distinct from the other forms of provision for mental defectives was an administrative one, made by state bureaucrats in the late nineteenth and early twentieth century. Historical accounts have frequently remained faithful to the distinction, but this feature of the historiography has serious drawbacks. Many mental defectives routinely passed through the education system into the Board of Control administration: hence, a comprehensive account of this area of social policy must take note of the ways in which the different strands of public provision interacted with one another.

The historiography of special education in the UK is less developed than that of the Mental Deficiency Act. The first monograph on the subject was written by D.G.

---

<sup>9</sup> See contributions by R. Neugebauer, Rushton, J. Andrews and C.F. Goodey in D. Wright and A. Digby, *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London: Routledge, 1996), chs. 2-5.

<sup>10</sup> M.A. Barrett 'From Education to Segregation' (PhD thesis: University of Lancaster, 1987); D. Wright, 'The National Asylum for Idiots, Earlswood, 1847-1886' (D.Phil. thesis: University of Oxford, 1993); A. Stevens, 'The Institutional Care and Treatment of People Categorized as Mentally Defective Before and after the Second World War: the Royal Eastern Counties Institution' (Ph.D. thesis, University of Essex, 1998); S. Watson, ' "The Moral Imbecile": a Study of the Relations Between Penal Practice and Psychiatric Knowledge of the Habitual Offender' (PhD thesis, University of Lancaster, 1988); D. Wright and A. Digby (eds.) *From Idiocy to Mental Deficiency*.

<sup>11</sup> M. Thomson, *Problem of Mental Deficiency*; Jackson, *Borderland of Imbecility*.



Pritchard and published in 1963.<sup>13</sup> Pritchard examines special education for all types of disability (sensory, physical and mental) between 1760-1960, concentrating on central government policies. His account does not question the concept of mental deficiency which underpinned such policies and although he tends to regard education for mental defectives as being inferior to that of other types of special education, his underlying theme is of advancement.<sup>14</sup> Contributions by J.S. Hurt and Ted Cole on the history of special education cover similar ground, though they continue the theme of advancement to more recent attempts to reintegrate special educational needs within mainstream schools.<sup>15</sup>

In 1984, Gillian Sutherland made the first inroads into studying the creation of feeble-mindedness in the early chapters of her monograph *Ability, Merit and Measurement*.<sup>16</sup> Though primarily concerned with the introduction of IQ tests within the English education system, Sutherland also describes how, at the end of the nineteenth century, doctors, teachers and public administrators began to apply the term 'feeble-minded' to children who did not seem to be benefiting from tuition in the state elementary schools. Sutherland's discussion of feeble-mindedness is of particular interest to this study. She presents it as a newly created sub-category of mental deficiency, promoted by doctors with an interest in school medicine and adopted by educational administrators during the 1880s and 90s.<sup>17</sup> In Sutherland's view, these developments ultimately benefited those who were labelled because it facilitated their transfer to special education, the merits of which she assumes without question: 'whatever the continuing uncertainties of classification, it was hardly possible to dispute that the special schools and classes were having a beneficial effect on the children who found their way into them.'<sup>18</sup>

Other commentators have found it possible to dispute the 'beneficial' effects of special education. According to Patricia Potts' polemical account, the practice of labelling pupils mentally defective pathologised their educational failure and sanctioned a 'dehumanising prejudice' toward special school pupils.<sup>19</sup> She argues that medical tracts on mental deficiency from such influential doctors as A.F. Tredgold, C.P. Lapage and

---

<sup>12</sup> Mental Deficiency and Lunacy Act, 1913 (3 & 4 Geo. 5, c. 48).

<sup>13</sup> Pritchard, *Education and Handicapped*.

<sup>14</sup> *Ibid*, c. 14.

<sup>15</sup> Hurt, *Outside the Mainstream*; Cole, *Apart or a Part*.

<sup>16</sup> Sutherland, *Ability, Merit and Measurement*, chs. 1-4.

<sup>17</sup> *Ibid*, c. 1.

<sup>18</sup> *Ibid*, 22.

<sup>19</sup> Potts, 'Medicine, Morals and Mental Deficiency', 195.



G. Shuttleworth reflected the moral and eugenic concerns of the authors. These concerns betray a class and gender bias, which shaped the curriculum and teaching methods in the early special schools, causing pupils to be segregated and stigmatised.

The significance Potts attributes to eugenics is typical of much of the writing on mental deficiency during the 1970s and 1980s. In the wake of the anti-psychiatry movement, scholars began to revise Whigish accounts of the history of psychiatry.<sup>20</sup> Once the treatment of the insane had come under scrutiny, revisionist historians began to turn their attention to mental deficiency, focusing particularly on the links between the Mental Deficiency Act, 1913 and the eugenics movement.<sup>21</sup> The act has played a key role in such histories because it increased the state's powers to certify mental defectives and compel their removal to an institution. It was supported by eugenicists on the grounds that segregated institutional care would prevent feeble-minded women from producing similarly defective offspring.<sup>22</sup>

Historical accounts linking the 1913 act to the eugenics movement have helped challenge the progressive image put forward by earlier historians.<sup>23</sup> However, they have tended to leave readers with a somewhat simplistic view of government policy towards mental defectives. In 1987, E.J. Larson pointed out that politicians, anxious to avoid popular condemnation, made a point of distancing themselves from the eugenics movement. Consequently, they removed those clauses in the original Mental Deficiency Bill that seemed most obviously aimed at preventing defective offspring.

[E]ven though eugenic theories clearly influenced this legislation, its enactment did not reflect a willingness on the part of the British people or parliament to

---

<sup>20</sup> M. Foucault, *Madness and Civilisation* (New York: Pantheon, 1965); D. Rothman, *The Discovery of the Asylum* (Boston: Little, Brown, 1971, revised 1990); A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993). For an extensive historiographical survey of the history of psychiatry see A. Scull, 'Psychiatry and its Historians,' *History of Psychiatry*, 2 (1991), 239-250.

<sup>21</sup> Barker, 'How to Curb Fertility of the Unfit'; Barker, 'Biology of Stupidity'; M. Freeden, *The New Liberalism: An Ideology of Social Reform* (Oxford: Clarendon Press, 1978), M. Freeden, 'Eugenics and Progressive Thought: A Study in Ideological Affinity' *Historical Journal*, 22, 3, (1979), 645-671; M. Freeden, 'Eugenics and Ideology', *Historical Journal* 26, 4 (1983), 959-62; G. Jones, 'Eugenics and Social Policy Between the Wars', *Historical Journal* 25, 3 (1982), 717-728; G. Jones, *Social Hygiene in Twentieth Century Britain* (London: Croom Helm, 1986); D. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (London: Penguin Books, 1986); Searle, *Eugenics and Politics*; Searle, 'Eugenics and Class.'

<sup>22</sup> M. Thompson, *Problem of Mental Deficiency*, 33.

<sup>23</sup> The most commonly cited exponent of this progressive view within the history of psychiatry is K. Jones, *History of Mental Health Services* (London: Routledge, 1972).

conform public policy to those theories. Quite the contrary, parliamentary debate over the bill revealed a profound distrust of both eugenics and eugenicists.<sup>24</sup>

In his recent monograph, Mathew Thomson has stated that eugenics was only one of a number of concerns that influenced the Mental Deficiency Act. Concern over citizenship,<sup>25</sup> Poor Law and penal reform, as well as issues relating to institutional management all had a part to play. He argues that a desire to control female sexuality for both moral and eugenic reasons did lead to the institutionalisation of women. However, he suggests that there were more males than females accommodated in institutions during the period. An analysis of case reviews from the London area leads him to conclude that administrators were at least as keen to control delinquency amongst young men, as to curb female reproduction.<sup>26</sup>

Significantly, Thomson points out that the acts of Parliament governing special education for England and Wales<sup>27</sup> undermined the aims of eugenicists by legislating for a separate system of care for mental defectives of school age, in which attempts were made to give at least some special pupils skills to equip them for life in the community.<sup>28</sup> Thomson does not elaborate on these comments because he generally leaves special education out of his account, electing instead to concentrate on the forms of provision associated with the Board of Control (institutions and, to a lesser degree, community care). This gives him more space to write an extremely insightful and comprehensive history of the Board of Control's administration, but not a comprehensive history of state policy for mental defectives. Because of the focus on institutional provision and community-based care for adults, it is easy to forget when reading Thomson that the state labelled and segregated most mental defectives within the education system.<sup>29</sup>

In his work on the Royal Albert Asylum at Lancaster, Michael Barrett does give an account of how special education impacted upon institutional provision for mental

---

<sup>24</sup> Larson, 'Rhetoric of Eugenics', 59.

<sup>25</sup> Thomson goes on to explore the theme of citizenship in more detail in M. Thomson, 'Constituting Citizenship', *passim*.

<sup>26</sup> M. Thomson, *Problem of Mental Deficiency*, c. 7.

<sup>27</sup> Elementary Education (Defective and Epileptic Children) Act 1899 (62 & 63 Vic., c. 32); Elementary Education (Defective and Epileptic Children) Act, 1914 (4 & 5 Geo. 5, c. 45).

<sup>28</sup> M. Thomson, *Problem of Mental Deficiency*, 39.

<sup>29</sup> See c. 6.

defectives between 1846 and 1918. His thesis describes some of the tensions within the medical profession over the validity of the feeble-minded category.<sup>30</sup> More recently, Mark Jackson has published a study of the Sandlebridge Colony in Cheshire that provides further insights into the different approaches of the various service-providers. In many ways, Jackson's study is more closely related to Barrett's than to Thomson's. Jackson and Barrett focus for the most part on the period before the Mental Deficiency Act, 1913, whilst Thomson concentrates on the post-1913 period. Furthermore, the former two historians examine the medical, political and wider social issues underlying the creation of the feeble-minded category,<sup>31</sup> whilst Thomson has decided that his study 'will not address the evolution of medical theories of mental deficiency ... in any great detail.'<sup>32</sup> Jackson also provides an account of how mental defectives and their families responded to institutional care prior to the Mental Deficiency Act, 1913. In doing so, he builds upon the work of David Wright, who, within his history of the Earlswood Asylum for idiots, has examined the influence of families on both medical discourse and institutionalisation.

All of the historians mentioned above focus on England rather than Scotland, although Thomson misleadingly refers to 'Britain' in the subtitle of his book. Historical accounts of any aspect of mental deficiency in Scotland are something of a rarity. Yet there are distinctions to be made between the mental deficiency administrations that operated north and south of the border. Scotland had a separate education system, separate laws concerning provision for mental defectives and a distinct approach to providing state relief to the poor.<sup>33</sup>

George Thomson has produced a short article outlining Scottish legislation and provision for what he calls the 'mentally handicapped' from the mid-nineteenth century to his time of writing in the early 1980s.<sup>34</sup> Despite acknowledging room for improvement, he believes that the mentally handicapped have benefited from Scotland's historically 'enlightened' approach to education. Harriet Sturdy's work (at times co-authored with William Parry Jones) on the boarding-out system between 1857-1913

---

<sup>30</sup> Barrett, 'From Education to Segregation,' 237-246.

<sup>31</sup> *Ibid*; Jackson, *Borderland of Imbecility*, c. 2.

<sup>32</sup> M. Thompson, *Problem of Mental Deficiency*, 8.

<sup>33</sup> For an account of the treatment of madness (which at that time included idiocy) in early modern Scotland, see R.A. Houston, *Madness and Society in Eighteenth-Century Scotland*, (Oxford: Oxford University Press, 2000), c. 2.

<sup>34</sup> G.O.B. Thomson, 'Legislation and Provision.'



provides a compelling examination of what has often been held to be Scotland's most distinctive contribution to mental health provision during this period.<sup>35</sup> Though Sturdy looks at policy towards the insane in general rather than mental defectives in particular, her work remains relevant to the present study. Scottish institutions for mental defectives have received attention in a jointly-authored article by Neill Anderson and Arturo Langa.<sup>36</sup> Lachlan Macmillan has written a PhD thesis on special education in Glasgow from 1862 to 1962.<sup>37</sup> Following Pritchard's example, Anderson, Langa and Macmillan present optimistic accounts of pioneers and progress.

Such optimism is absent from the present account. The more critical approach adopted here partly stems from my personal experiences of living and working with people labelled as having mild learning disabilities within a community-based setting. Whilst my experiences have led me to strongly favour socially inclusive, user-led models of care and support,<sup>38</sup> I have long suspected that many of the people I have come into contact with would not have been labelled as having a learning disability had they come from a more privileged background. For such people, social circumstances and the stigmatising nature of the label itself constitute more of a disability than any alleged mental impairment.

The critical stance taken in this thesis also reflects the influence of two academic movements: 'anti-psychiatry,'<sup>39</sup> and disability studies. Reference has already been made to the 'anti-psychiatry' literature which, though recently qualified by historians,<sup>40</sup> still demands that modern researchers take a more sophisticated view of mental deficiency provision than the Whig historians of old. Disability studies, referring to the sociological work on disability spearheaded by disabled scholars, is a more recent

---

<sup>35</sup> H. Sturdy, 'Boarding-Out the Insane, 1857-1913' (PhD thesis, University of Glasgow, 1996); H. Sturdy and W. Parry-Jones, 'Boarding-out Insane Patients: the Significance of the Scottish System 1857-1913,' P. Bartlett and D. Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (London: Athlone, 1999), c. 5.

<sup>36</sup> Anderson and Langa, 'Development of Institutional Care.'

<sup>37</sup> Macmillan, 'Origins and Evolution of Special Education for Children with Intellectual Disabilities in Greater Glasgow 1862-1962' (PhD thesis, University of Strathclyde, 1998). Dr Macmillan kindly allowed me to view his thesis before submission, for which I give him my sincere thanks.

<sup>38</sup> Such as that offered by SAM Housing Project, Glasgow.

<sup>39</sup> I place 'anti-psychiatry' in inverted commas as an acknowledgement that some of those whose work has been labelled in this way would not use the term to describe themselves.

<sup>40</sup> G. Grob, 'Marxian Analysis and Mental Illness,' *History of Psychiatry* vol 1 (1990), 223-32; Berrios and Freeman, 'Introduction' in Berrios and Freeman (eds.), *150 Years of British Psychiatry* (London: Gaskell, 1991). Of particular relevance to the history of mental deficiency, see D. Wright, ' "Childlike in his Innocence," ' Wright and Digby (eds.) *From Idiocy to Mental Deficiency* (London: Routledge, 1996), 118-133; Wright 'National Asylum for Idiots,' c. 2; M. Thomson *Problem of Mental Deficiency*, 110-113.

phenomenon. Disability studies emerged from a political struggle in the 1970s in which a number of disabled activists sought to wrest control of the disability civil rights movement away from 'a small number of experts' who 'claim[ed] that they spoke for disabled people while at the same time they did not have to mix with common disabled people.'<sup>41</sup> Since then, disability literature has tended to take an overtly political stance, often drawing on the radical traditions of Marxist and feminist theory.

The most influential achievement of scholarship in this area is the distinction made between the 'individual' and 'social' models of disability, generally accredited to Vic Finkelstein and Michael Oliver.<sup>42</sup> The individual model (sometimes referred to as the 'medical' model) of disability is seen as the old orthodox view of disabled people, sanctified by the medical profession and adhered to by the vast majority of the population including many of those with disabilities. Under this model, disability results from a medical defect or illness 'suffered' by an individual. It is a personal tragedy requiring a combination of individual bravery and expert help to live through it. The individual model is criticised by disability sociologists because, by portraying disability as an unfortunate accident, it conceals (and indeed justifies) the discrimination faced by disabled people in society and allows their lives to be dominated by a plethora of experts and carers.

The social model rejects the view that disability is 'some terrible chance event which occurs at random to unfortunate individuals.'<sup>43</sup> It does so by distinguishing between 'impairment' and 'disability' in much the same way that feminist theory has distinguished between biological sexual difference and gender. Just as gender is seen as constructed through historically contextualised social relationships between people of different sex, disability is seen as constructed through historically contextualised social relationships between people with and without certain impairments. Oliver provides the following summary of what he means by disability under the social model:

[The social model of disability] does not deny the problem of disability but locates it squarely within society. It is not individual limitations, of whatever kind, which are the cause of the problem but society's failure to provide

---

<sup>41</sup> Personal communication from V. Finkelstein to M. Oliver, reproduced in Oliver, *Understanding Disability*, 21.

<sup>42</sup> V. Finkelstein, *Attitudes and Disabled People* (New York: World Rehabilitation Fund, 1980); M. Oliver, *Social Work with Disabled People* (Basingstoke: Macmillan, 1983).



appropriate services and adequately ensure the needs of disabled people are taken into account in its social organisation.

Hence disability, according to the social model, is all things that impose restrictions on disabled people; ranging from individual prejudice to institutional discrimination, from inaccessible public buildings to unusable transport systems, from segregated education to excluding work arrangements, and so on. Further the consequences of this failure do not simply and randomly fall on individuals but systematically upon disabled people as a group who experience this failure as discrimination institutionalised throughout society.<sup>44</sup>

Within British disability studies, the social model has become something of a new orthodoxy. However, there are those within the field who have sought to draw attention to its limitations. Whilst agreeing that social barriers do disable people, Morris argues that ‘to suggest that this is all there is to it is to deny the personal experience of physical or intellectual restrictions, of illness, of the fear of dying.’<sup>45</sup> French questions the view that all limitations imposed by impairment can be removed by ‘social and environmental manipulation’<sup>46</sup>

Historians of mental deficiency have regularly failed to engage with the disability literature. Then again, many disability studies sociologists have been slow to engage with the historical concept of mental deficiency or even its nearest modern equivalent, learning disability. Jan Walmsley has pointed out that the notion of disabled scholars taking a leading role in disability studies is problematic when one considers people with learning disabilities.<sup>47</sup> By definition, people with learning difficulties are generally excluded from gaining access to academic positions through the usual channels. Yet the degree to which physically disabled scholars are willing or able to speak on their behalf is open to question. Anne Louise Chappell argues that in much of the literature ‘[t]he use of the term “disabled people” should include people with learning difficulties but

---

<sup>43</sup> Oliver, *Understanding Disability*, 32.

<sup>44</sup> *Ibid*, 32-3.

<sup>45</sup> J. Morris, *Pride against Prejudice* (London: Women’s Press, 1991), 10.

<sup>46</sup> S. French, ‘Disability, Impairment or Something in Between?’, J. Swain, V. Finkelstein, S. French and M. Oliver (eds.), *Disabling Barriers – Enabling Environments* (London: Sage, 1993), 22.

<sup>47</sup> She has, however, been working to make scholarly work on learning disability more inclusive of people with learning disabilities. J. Walmsley, ‘Including People with Learning Difficulties,’ L. Barton, and M. Oliver (eds.), *Disability Studies: Past, Present and Future* (Leeds: Disability Press, 1997), c. 4..

often it does not and their experiences remain hidden.’<sup>48</sup> It should be noted, however, that the work of Walmsley and Chappell themselves marks an exception to this trend.

One of the problems historians face in drawing upon the ideas put forward within disability studies is that the overtly political stance taken by modern sociologists of disability can be difficult to reconcile with the historicist’s aim of understanding the past in its own terms. Nonetheless, the division between the social and medical models has been useful in showing that disability can be seen as created by discriminatory practices. The present study recognises the importance of discrimination in determining the experience of disability but also recognises the limitations of the social model. As Oliver himself has admitted, ‘models are merely ways to help us to better understand the world, or those bits of it under scrutiny. If we expect models to explain, rather than aid understanding, they are bound to be found wanting.’<sup>49</sup>

### *Themes*

As the literature survey shows, there are a number of large studies dealing with different aspects of mental deficiency in England during the late nineteenth and early twentieth century. Together, they provide a reasonably comprehensive view of the subject taking in educational, medical and governmental perspectives, and including specific institutional histories, the origins of special education, the creation of the feeble-minded category of mental defect, and the workings of the Mental Deficiency Act, 1913.

Histories of mental deficiency in Scotland touch upon some of these themes but there is a lack of detailed analysis, with much of the work framed around an uncritical acceptance of social progress. Harriet Sturdy’s study of the boarding-out of the insane prior to 1913 takes a more sophisticated line, though one that remains more optimistic than the present account.

This thesis gathers together most of the themes dealt with by the various studies of mental deficiency in England and places them into the Scottish context. The advantage of this approach is that it provides a greater opportunity to show the interface between the various strands of mental deficiency provision. The key disadvantage of taking a wide perspective is that the thesis will not be able to cover specific aspects of mental deficiency in as much detail as more specialised studies. Certain themes, most notably

---

<sup>48</sup> Chappell, ‘From Normalisation to Where?’, 53.

<sup>49</sup> Oliver, *Understanding Disability*, 40.

the role of penal reform, are virtually absent from the account, whilst others cannot be explored in quite the same depth that other historians have entered into. For the most detailed account of medical perspectives on mental deficiency one must still refer to Jackson's monograph,<sup>50</sup> whilst Thomson provides the most extensive analysis of the political background to the Mental Deficiency Act for England and Wales.<sup>51</sup> There is no need to repeat their accomplishments. Rather, the aim here is to focus on specific areas of contention within the current literature, whilst using the English accounts to examine the degree to which developments south of the border differed from or corresponded to the Scottish experience.

It is incumbent upon Scottish historians to illustrate the distinct nature of developments north of the border, without attempting to mask the degree to which the various nations within the UK shared a common political and social culture. Whilst there were many differences that require elaboration, it must still be remembered that theories, practices and policies relating to mental deficiency were translated across regional and national boundaries: hence, developments in England and Scotland shaped one another. That said, where mental deficiency provision was concerned, English initiatives usually had a greater influence on Scotland than *vice versa*.

This can be seen in chapter one of the thesis, which traces the history of various medico-legal labels associated with mental deficiency, examining how earlier conceptions of mental deficiency emerged through the interacting agencies of professional groups, philanthropists and state administrators.<sup>52</sup> Early notions of idiocy were reconceptualised during the nineteenth century in association with increased involvement from the medical profession and the development of new forms of provision: most notably specialised institutions for idiots and imbeciles and special day classes for the feeble-minded. The Scottish lunacy administration did gain a reputation for pioneering one particular form of specialised provision: namely the boarding-out of idiots, imbeciles and lunatics to private guardians within the community. The English took the lead in organising specialised institutional care, and special education.

---

<sup>50</sup> Jackson, *Borderland of Imbecility*, especially c. 4.

<sup>51</sup> M. Thomson, *Problem of Mental Deficiency*, Introduction and chs. 1-2.

<sup>52</sup> A similar study (albeit one that focuses particularly on the origins of the feeble-minded category) was published by Mark Jackson whilst this thesis was in its writing-up stage. Despite the risk of overlapping with Jackson's work, I decided that it was necessary to retain my account to ensure that the readers of this thesis had an understanding of the broader historical background within which theories and practices associated with mental deficiency emerged. See Jackson, *Borderland of Imbecility*, c. 2.



Scotland's response to developments south of the border first took the form of local activity centred in and around Glasgow, which later received central backing from the Scottish Office. As chapters two and three illustrate, English initiatives did not simply 'spread' north of the border: rather, they had to be modified and integrated into pre-existing legal and administrative structures by Scottish administrators. During this process, they were shaped by the local political culture within which the administrators operated. Chapter two focuses on the second half of the nineteenth century. It describes how events unfolded in Glasgow leading to the creation of Scotland's first special day classes, and locates these developments within the wider context of Scottish local government, Poor Law policy and institutional care for mental defectives and the insane. The following chapter goes on to show how the Scottish Office became increasingly (though at times, grudgingly) involved in special provision for mental defectives, gradually lending its support to special classes and then drafting the Mental Deficiency and Lunacy (Scotland) Act, 1913. Scottish policy emerged along its own trajectory through the interface between the Scottish Office, local authorities, and Westminster as well as other interested individuals and groups. In the course of the discussion, chapter three provides a detailed comparison of state provision for mental defectives in England and Scotland in the years immediately proceeding 1913, before going on to point out the similarities and differences between the English and Scottish Mental Deficiency Acts.

As important as these legal and political developments are in achieving an understanding of how mental deficiency was conceived and dealt with at this time, it is also necessary to explore the subject beyond the confines of government chambers and local authority committee rooms. The expansion of mental deficiency to include people of higher abilities principally occurred within the education system. It was here that the majority of Scotland's mental defectives became identified as such. Hence, chapter four focuses on theories and practices associated with labelling in Glasgow prior to the passing of the Mental Deficiency Act. It was here that the majority of Scotland's mental defectives were 'manufactured'. Concentrating on those doctors, teachers and administrators situated on the front-line of the local mental deficiency administration, it describes the process by which increasing numbers of pupils came to be labelled and segregated and measures the extent of that increase.

After the Mental Deficiency (Scotland) Act passed through Parliament, all of Scotland's local authorities were obliged to ensure that mental defectives were identified and in receipt of appropriate care. Many local authorities were unenthusiastic and avoided fulfilling their full obligations. At the same time, war, economic depression and unemployment helped push mental deficiency further down the political agenda. The Scottish Office therefore found itself in an unfavourable position as it attempted to implement the truly comprehensive, national system of provision for mental defectives that had been envisaged in 1913. Chapter five provides an account of how the Scottish Office responded to the challenge between 1914 and 1939, focusing on the activities of the two central authorities most closely associated with provision for mental defectives: the General Board of Control for Scotland (GBCS), and the Scottish Education Department (SED). It also examines the role of voluntary organisations in providing community-based support to make up for the perceived shortage of public sector provision.

Despite the many difficulties faced by the GBCS and SED, special provision for mental defectives did expand significantly during the period. As a result, the boundaries of mental deficiency continued to expand to include more people of higher ability. An increasing proportion of the Scottish population came to be labelled mentally defective and administrators began to implement a policy of mass segregation within the school system and through institutionalisation and boarding-out. Chapter six looks at the 'manufacture' of mental defectives during the inter-war period. It considers the role and limitations of mental testing techniques being carried out by psychologists at that time. It also shows how some individuals directly involved in the mental deficiency administration were prepared to publicly question the medical basis upon which many mental defectives were identified.

Having examined the extent to which the boundaries of mental deficiency expanded over the period, there remains the question of which social groups were most likely to be targeted by the mental deficiency administration. To resolve this, an extensive time-series analysis of Scotland's mentally defective population during the inter-war period has been conducted.<sup>53</sup> Correlating data from many disparate sources with the aid of Microsoft Access and Excel, the analysis focuses on the types of people placed in

---

<sup>53</sup> See c. 5.



special classes, institutions, under familial guardianship or boarded-out. From this, it has been possible to make judgements on the kinds of people in receipt of special provision, looking at age, gender, locality and social class. This builds on previous work by Mathew Thomson<sup>54</sup> and is used to demonstrate the inadequacy of viewing policy on mental defectives solely in terms of eugenic theory.

One limitation of viewing the labelling process from a social policy perspective is that it ignores the role of lay discourse in shaping the contemporary understanding of mental deficiency. Mental defectives and their immediate families also influenced the implementation of mental deficiency policies, at times co-operating with administrators but also resisting attempts to label and segregate individuals. David Wright and Mark Jackson have both discussed the role of families in shaping provision for mental defectives before the 1913 act. Wright examines the influence of lay discourse on medical conceptions of idiocy within his nineteenth century study of Earlswood, whilst Jackson has argued that families and patients helped shape institutional life at Sandlebridge through acts of resistance.<sup>55</sup> Chapter seven will apply their arguments to Scotland, looking at the periods both prior to and following the Mental Deficiency (Scotland) Act. It will argue that although mental defectives and their families continued to have a role in shaping policy on mental deficiency provision, that role became increasingly marginalised as the state assumed greater powers of intervention. This first occurred within the special education system but also became a feature of institutionalisation, particularly after 1913. Many of the arguments put forward in this chapter are based on case studies that emerge from the correspondence between family members of patients accommodated at Stoneyetts institution for adult mental defectives and institutional staff.

It is hoped that this thesis will do something to redress the imbalance in the British historiography of mental deficiency by illuminating many of the themes associated with the development of Scotland's mental deficiency administration. It does so at a time when increasing amounts of government money are being channelled towards reversing many of the policies instigated in the late nineteenth and twentieth century. When considering current policies of social inclusion it is important to remember that the decision to label large numbers of the population as mentally defective was a relatively

---

<sup>54</sup> M. Thomson, *Problem of Mental Deficiency*, c. 7.

<sup>55</sup> Wright, ' "Childlike in his Innocence," ' c. 6; Jackson, *Borderland of Imbecility*, c. 6.

recent one, motivated by social and political considerations which became entwined with medical concerns. Many contemporaries of that period, including some of those directly responsible for the expansion, questioned both the validity of changing medico-legal definitions and the ethics of mass segregation. Such questions are as relevant today as they ever were.

## Chapter 1: Labelling and Segregating Mental Defectives in the Nineteenth Century.

In 1913, Parliament passed two Mental Deficiency and Lunacy Acts: one covering England and Wales, the other Scotland.<sup>1</sup> Using identical definitions, both acts divided mental deficiency into four sub-categories: idiocy, imbecility, feeble-mindedness and moral imbecility. All of these labels had featured in medical and political discourse before 1913 but their exact meanings often changed depending upon the time and context in which they were used. Recent historical accounts of mental deficiency in England have highlighted the various ways in which the labels were conceived over time, linking their use to legal changes, changing patterns of institutional care, Poor Law provision, penal administration and special education.<sup>2</sup> The nineteenth century is particularly significant to historians of medicine because it was during this period that the identification and management of mental deficiency became increasingly (though by no means exclusively) dominated by the medical profession. It was within the medical sphere that knowledge of the various forms of mental deficiency was most fluid. Legal labels changed less frequently and occurred largely as a result of medical activity, as doctors sought to consolidate and expand their influence by allying themselves with the state. The aim of this chapter is to bring together the relevant historical accounts of mental deficiency in Britain prior to the twentieth century to provide a broad perspective within which more specific developments in Scotland can then be located.

### *Idiocy and Imbecility*

Of the various labels referred to in the 1913 acts, idiocy had been in existence the longest as a legal and medical category. Linked to the thirteenth century legal distinction between ‘those who were born fools and those who become fools’,<sup>3</sup> English medieval courts applied the label in cases of crown inheritance to describe ‘born fools’. The king was entitled to take charge of and profit from property due to be inherited by

---

<sup>1</sup> Mental Deficiency and Lunacy Act, 1913 (3 & 4 Geo. 5, c. 28), and Mental Deficiency and Lunacy (Scotland) Act, 1913 (3 & 4 Geo. 5, c. 38).

<sup>2</sup> For example, Andrews, ‘Begging Question of Idiocy’; Barrett, ‘From Education to Segregation’; Jackson, *Borderland of Imbecility*, c. 2; Pritchard, *Education and Handicapped*, c. 5; M. Thomson, *Problem of Mental Deficiency*, 10-22; Sutherland, *Ability, Merit and Measurement*, c. 1; Watson, ‘Moral Imbecile’; Wright, ‘“Childlike in his Innocence”’; Wright, ‘National Asylum for Idiots’.

<sup>3</sup> R. Neugebauer, ‘Treatment of the Mentally Ill in Medieval and Early Modern England’, *Journal of History of Behavioural Sciences*, 14 (1978), 158-69; R. Neugebauer, ‘Mental Handicap in Medieval and Early Modern England: Criteria, Measurement and Care’, Wright and Digby (eds.), *From Idiocy to Mental Deficiency*, 22-43.



idiots, on the assumption that they would not be able to manage the estates themselves. The identification of idiots hence provided a source of revenue for the sovereign. Scottish Medieval Law made a similar differentiation in cases of inheritance, indeed Scotland's earliest legislation on the subject may have been adapted from English law.<sup>4</sup>

By the seventeenth century, certain institution managers employed a distinction between idiots and lunatics. In his study of idiocy in early modern Britain, Jonathan Andrews describes how managers of asylums such as Bethlem Hospital attempted to improve their efficiency by focusing resources on curable patients. One strategy they developed from the 1640s was to reject or discharge hopeless cases on the grounds that they were 'idiotts [sic]' from birth. It is doubtful whether the practice was pursued rigorously but it served to reinforce the status of idiocy as an incurable condition in comparison to lunacy, which could be a temporary and treatable affliction. It was not until the next century that certain asylums changed their policy over incurable cases giving idiots greater access to institutional provision. In the 1720s, an incurable ward was opened at Bethlem though not specifically for idiots. Thirty years later, St. Mary Magdalen Hospital in Bath and St. Patrick's in Dublin were providing accommodation specifically for idiots. St. Patrick's in particular devoted an entire hospital floor for the purpose.<sup>5</sup>

During the early modern period, doctors did not regard provision for idiots as necessarily falling within their sphere of activity. Madhouses and asylums were generally run by entrepreneurs and philanthropists who lacked medical training. Although many homes and institutions continued to be run by lay (ie. non-medical) managers well into the nineteenth century, it was during this later period that the medical profession began to extend its reach into the care of lunatics and idiots. Developments on the continent were instrumental in instigating this transition. French psychiatrists (or 'alienists' as they were then known), such as Jean-Marc Itard, Jean-Etienne Esquirol and Edward Seguin have all been associated with the awakening of medical interest in idiocy. Seguin has achieved particular recognition in this regard. He developed a technique for educating idiots, which he practised at various hospital

---

<sup>4</sup> A law barring 'ydiotis and natural fulis, furious and wodmen' from inheritance was issued in 1475 (James III, c. 8). Earlier reference to the king's right to inherit the lands of 'natural fools' (*fatourum naturalium*), can be found in *Regiam Majestatem* (2. Reg. Maj., c. 40), a legal document of uncertain, but possibly English, origin, whose use in Scotland can be traced to 1425 during the reign of James I; see HMSO, *The Acts of the Parliaments of Scotland* I (1844), 40 and 617. For an account of the treatment of idiots in early modern Scottish law see Houston, *Madness and Society*, c. 2.

<sup>5</sup> Andrews, 'Begging question of idiocy', 75-80.

appointments, and began publishing on the subject in 1839 (with Esquirol as co-author) and 1842.<sup>6</sup>

Seguin was not the first doctor to publish the view that idiots could be educated, though according to J.W. Trent Jr., he ‘was obsessed with being known as the discoverer of the first successful system for educating idiots and tolerated no pretenders to that fame’.<sup>7</sup>

Itard had explored the issue in the early 1800s, whilst in 1819, an Edinburgh based doctor named Richard Poole suggested that doctors seeking to treat idiots might circumvent specific brain defects through a ‘principle of substitution’: developing educational techniques that encouraged a wider use of whatever faculties and senses were not defective.<sup>8</sup> Seguin, however, promoted his work more successfully, writing numerous tracts on the subject and regularly inviting prominent figures to visit his training school.

Seguin’s approach did not so much substitute one sense for another, as develop each one in turn. His educational programme came in three parts: muscular or physical education, education of the senses and moral treatment. Physical education was intended to awaken the dormant senses of the idiot. Once activated, Seguin would then educate the senses, beginning with the sense of touch, followed by hearing, which he associated with speech, then taste and smell. In each case, the pupils were encouraged to associate objects, sounds, tastes and smells with appropriate ideas, emotions and responses. The visual sense would be developed throughout all of these processes but would then become the main focus of the educational programme. Pupils were taught to draw and then form the letters of the alphabet. Then they could be taught the educational basics: reading, writing, arithmetic and (Seguin’s innovation) natural history. Throughout, pupils would be disciplined to respect the authority and moral standards of the teacher in order to achieve a level of social functioning comparable to that of the ordinary population. In all matters, Seguin stressed the need to tailor educational techniques to the individual needs of each pupil. He disavowed the practice of learning by rote and stressed the importance of making the learning experience interesting and enjoyable so as to develop the will to learn.<sup>9</sup>

---

<sup>6</sup> Trent, *Inventing the Feeble Mind*, c. 2.

<sup>7</sup> *Ibid*, 40-41.

<sup>8</sup> Originally published in *Encyclopedia Edinensis* in 1819, then reprinted in pamphlet form in 1825. This chapter quotes from the pamphlet: R. Poole, *An Essay on Education* (Edinburgh: Waugh and Innes, 1825).

<sup>9</sup> Trent, *Inventing the Feeble Mind*, 46-52.

His theories were well received and idiocy began to take on a greater appeal amongst psychiatrists. The educational approach to the treatment of idiots meant that their institutional provision no longer had to be limited to the basic custodial functions of feeding, cleaning and restraint. This fitted well with the aims of 'reformist' asylum doctors who advocated the abolition of physical restraints such as bolted chairs and chains.<sup>10</sup> Through education and moral management, doctors could transform seemingly incurable patients into medical successes, and as Seguin had demonstrated, the doctors who affected such transformations could establish their reputations in the process.

Dr John Conolly, the 'reformist' superintendent at Middlesex Lunatic Asylum, was one of a number of prominent British doctors who visited Seguin in the mid 1840s to study his methods. With the assistance of Rev. Dr Andrew Reed, a non-conformist pastor with wealthy connections, Conolly established an 'asylum for idiots' in 1846, accepting both private patients and charitable cases maintained by voluntary subscription. Conolly's success in promoting the new institution was such that within a decade it had moved to larger premises in Surrey and become known as the National Asylum for Idiots, Earlswood.<sup>11</sup>

The managers of Earlswood did not subscribe to the view that all idiots could be 'cured' (ie. have their intelligence developed to the standard of 'ordinary' people) through education. They distinguished between 'improvable' idiot children, who could benefit from Seguin's methods, and 'hopeless' cases whose custodial care could aid poor families unable to support them without recourse to the Poor Law. When similar institutions, such as the Royal Albert in Lancaster and the Western Counties Asylum at Starcross, Devon, were established to provide institutional care for idiots they followed Earlswood's example, taking in both children and adults, mixing education with custodial care.<sup>12</sup>

A two tier categorisation of idiocy was thus used in the institutions to distinguish between educables and incurables. This categorisation became embedded in medical theory and doctors came to employ the label of imbecile to describe educable patients, thereby distinguishing them from incurable idiots. Imbecile came from the Latin word

---

<sup>10</sup> Wright, 'National Asylum for Idiots', 28.

<sup>11</sup> *Ibid*, c. 1.



*imbecillus* and had been used amongst English speakers since at least the early 1800s (and in France for even longer). To begin with, there was little consensus in the way contemporaries employed the term, with many asylum managers simply using the word as a euphemism, employed to spare the feelings of patients' parents or guardians who were worried about the stigmatising effect of the idiot label.<sup>13</sup>

Within Scottish institutions, the term 'imbecile' was frequently used instead of idiot, a practice that may have reflected the fact that the first philanthropists to engage in this kind of institutional care in Scotland had a personal reason for preferring what was then seen as the less stigmatising term. Sir John and Lady Jane Ogilvy opened Scotland's first institution for 'Imbecile Children' in 1855. The Ogilvies had an imbecilic child of their own, whom they had sent to a colony in Abendberg, Switzerland.<sup>14</sup> Established by Dr Johann Jakob Guggenbuhl in the 1840s, Abendberg had achieved international fame on account of its founder's claims to be able to cure cretinism (a form of idiocy considered to be prevalent around that region) through a mixture of clean mountain air, healthy diet, physical exercise and sensory training. The Ogilvies decided to adapt Guggenbuhl's colony model on a smaller scale, initially accommodating 30 children in small huts referred to as villas on their Baldovan estate near Dundee. They initially took in ordinary orphan children as well as imbeciles, but soon began to concentrate on the latter type of inmate.

The Ogilvies' efforts were soon exceeded by those of Dr and Mrs David Brodie, who helped establish the Scottish National Institution for the Education of Imbecile Children.<sup>15</sup> Initially, the Brodies had opened a small home for imbeciles in Edinburgh but after deciding that a converted house in the city square was unsuitable for their needs, they began to plan the opening of a larger institution. With the assistance of Dr John Coldstream, who had been associated with the Edinburgh home, the Brodies established 'The Society for the Education of Imbecile Youth in Scotland', to raise money for a national institution for Scottish imbeciles. The Society began collecting charitable subscriptions in 1859. It took three years to find a suitable site but eventually five acres of land were acquired near Larbert in Stirlingshire for the purpose. In 1863,

---

<sup>12</sup> Pritchard, *Education and Handicapped*, 56-57.

<sup>13</sup> Barrett, 'From Education to Segregation', 162.

<sup>14</sup> D.K. Henderson, *The Evolution of Psychiatry in Scotland*, (Edinburgh: Livingstone, 1964), 74-75; Anderson and Langa, 'Development of Institutional Care', 245-251.

<sup>15</sup> Renamed 'The Royal Scottish National Institution for Mental Defectives' by royal charter in 1917: see Henderson, *Evolution of Psychiatry in Scotland*, 75.

the first part of the institution was opened, Dr Brodie was appointed Physician Superintendent and took charge of 28 patients. Over the next quarter of a century, the inmate population grew to over 250, including private, charitable and 'rate-aided' (ie. pauper) patients.<sup>16</sup>

By the 1860s there existed in Britain a network of philanthropists, asylum managers and doctors involved in providing specialised institutional treatment for idiots and imbeciles. As David Wright has pointed out, the institutions were actively supported by parents and guardians who were willing to place idiot and imbecile offspring into such homes on a voluntary basis.<sup>17</sup> Within the institutions themselves, superintendents had distinguished between two broad types of patient: those who would benefit from the kind of educational programme pioneered by Seguin, and those who would not. The former type were sometimes referred to as imbeciles, the latter as idiots, although many commentators continued to use the two terms interchangeably. As larger numbers of people involved themselves in this area, local and central government authorities were placed under increasing pressure to give state backing to institutions for idiots and imbeciles. Through the state's involvement, medical conceptions of idiocy and imbecility became increasingly tied to legal definitions. This occurred partly as a result of governmental policies aimed at regulating and improving provision for mental defectives, but it also reflects a general desire within the medical profession to strengthen its own position by fostering links with the state.

### *Medicine and the State*

The nineteenth century was a period when rank and file medical practitioners agitated for the state to secure their interests through protectionist legislation that would eventually give those fortunate enough to be recognised as orthodox medical practitioners a monopoly over health care. The licensing of practitioners under the Apothecaries' Act of 1815, the creation of the medical register in 1858 and the statutory requirement that doctors must take examinations in medicine, surgery and midwifery enacted in 1886 all helped to solidify professional boundaries.<sup>18</sup> During the same period, practitioners came to see the state as a potential source of employment. The

---

<sup>16</sup> J. Carswell, 'The Care and Education of Weak-minded and Imbecile Children in Relation to Pauper Lunacy', *Journal of Mental Science* 44 (1898), 482.

<sup>17</sup> Wright, 'National Asylum for Idiots', c. 2.

<sup>18</sup> For an insightful summary of these developments with bibliography see C. Lawrence, *Medicine in the Making of Modern Britain, 1700-1920* (London: Routledge, 1994) chs. 2-3.

government's response to the public health crises and social deprivation associated with industrialisation had led to a proliferation of state funded medical posts such as medical officers of health, medical officers for the poor and factory inspectors.<sup>19</sup> To begin with, these posts were generally part-time and low status, but in a competitive medical market they formed a stable supplement to the general practitioners' incomes.

Doctors who specialised in mental health could also benefit from these developments. Although medicine of the mind was often viewed as something of a backwater by mainstream doctors, psychiatrists were counted amongst the medically orthodox (providing their training and theories met with general approval) and as such enjoyed the protection afforded by the medical acts. In England, psychiatrists were able to capitalise on problems of management within the workhouse system, particularly in the overcrowded urban institutions.<sup>20</sup> They categorised the most troublesome and disturbed inmates as idiots or lunatics, to facilitate their segregation in special lunatic wards and asylums.<sup>21</sup> In Scotland, where able-bodied patients were barred from Poor Law institutions, comparable problems in the management of disruptive inmates also led to separate provision for idiot and lunatic paupers.<sup>22</sup> In this way, Britain's Poor Law administration gradually came to utilise medical expertise in psychiatry, to help create what was hoped would be a rational and efficient system of relief for the poor.<sup>23</sup>

As the century progressed, local and central authorities created new posts within the state apparatus, providing further opportunities for doctors with psychiatric training. At a central level, medical commissioners in lunacy were employed to inspect state licensed institutions for lunatics, idiots and imbeciles. By the later nineteenth century, the larger local authorities around Britain employed certifying officers in lunacy to regulate the admission of pauper patients into institutions. Such measures were intended to prevent wrongful admission and mistreatment of patients. This to some extent restricted the independence of asylum managers (although the inspections were

---

<sup>19</sup> M.W. Dupree and M. and M.A. Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: the *Medical Directory* as a Historical Source' *Bulletin of History of Medicine* 65 (1991), 209-233.

<sup>20</sup> M.A. Crowther, *The Workhouse System 1834-1929: The history of an English social institution* (London: Batsford, 1981), 3.

<sup>21</sup> *Ibid*, 164.

<sup>22</sup> J. Andrews and I. Smith, 'The Evolution of Psychiatry in Glasgow During the Nineteenth and Early Twentieth Centuries', H. Freeman and G.E. Berrios, *150 Years of British Psychiatry Volume II: the Aftermath* (London: Athlone, 1996), 313-4.

<sup>23</sup> Searle, *Quest for National Efficiency*, c. 1.



infrequent), but as a *quid pro quo*, medical inspection and certification created new jobs and served to strengthen the medical profession's hold over state provision for lunatics, idiots and imbeciles.<sup>24</sup>

Those involved in specialised provision for idiots and imbeciles hoped that state recognition would confer legitimacy on the new institutions, consolidate the supply of rate-maintained Poor Law patients and enable institutions to receive Treasury grants or loans. The Society for the Education of Imbecile Youth in Scotland took a leading role in lobbying for the necessary legal changes, and achieved some success with the passing of the Lunacy (Scotland) Act, 1862. The act authorised state Lunacy Commissioners to grant licences to charitable institutions for imbeciles.<sup>25</sup> George Thomson has described the act as a 'unique milestone' because it represents the first statutory recognition in Scotland of the needs of the mentally handicapped as distinct from the mentally ill'.<sup>26</sup> It was also the first piece of British legislation to explicitly refer to the 'training of imbecile children', making it a possible contender for Britain's earliest legislation sanctioning special education for this type of child.<sup>27</sup>

However, such plaudits would have meant little to contemporaries, who had no way of predicting the developments in special education that would follow from the act. In fact, the act's impact at the time was minor. Baldovan opened before 1862 and the construction of the National Institution was well underway by this time, demonstrating that the institutional treatment of imbeciles was not reliant on the legislation. Nor did the act lead to the opening of more charitable institutions for imbecile children: by the early twentieth century, Baldovan and Larbert were still the only two in Scotland (although both had expanded to include more patients).<sup>28</sup> The distinction made between lunacy and imbecility following the act's passage was highly ambiguous. Legally, imbecility remained a subcategory of lunacy and separate provision for imbeciles was authorised but not made compulsory. Patients who did attend institutions for imbeciles could only remain there until the age of 18. After that, they would either be sent back to

---

<sup>24</sup> M. Thomson, *Problem of Mental Deficiency*, 11-12; Scull, *Most Solitary of Afflictions*, 230-231; Jones, *History of Mental Health Services*, 144-181.

<sup>25</sup> Lunacy (Scotland) Act, 1862 (25 & 26 Vic., c. 54) s. 7.

<sup>26</sup> G.O.B. Thomson, 'Legislation and Provision', 234.

<sup>27</sup> Unlike the Idiots Act, 1886, for England and Wales, it did not mention the word 'education' but the distinction between education and training was only beginning to take shape at this time.

<sup>28</sup> Anderson and Langa, 'Development of Institutional Care', 253-256.

their family homes or transferred to lunatic asylums and Poor Law institutions. Some of these developed separate wards for imbeciles but others did not.<sup>29</sup>

In England, the legal status of idiots and imbeciles was also confused. When it came to regulating the asylums, nineteenth century legislators were primarily interested in the management of lunatics. Provision for idiots was generally tagged onto major lunacy legislation as an afterthought. Hence, idiocy was presented as a subcategory of lunacy in the Lunatics Act of 1845. Eager to stress the unique identity of the new idiot asylums, their superintendents lobbied the government for separate legislation. In this, they were greatly assisted by the Charity Organisation Society (C.O.S.), a highly influential organisation established in 1868 to direct charitable efforts of all kind to what was seen as 'deserving' causes, whilst encouraging self-help amongst the able-bodied poor.<sup>30</sup> The C.O.S. formed a special sub-committee in 1876 to consider the problem of mental deficiency and continued to play an active role in lobbying for government policy on this issue well into the twentieth century.<sup>31</sup>

The Idiots Act of 1886 marked the English government's initial response to the growing pressure for legislation in this area in the second half of the twentieth century. The act defined idiocy and imbecility as distinct from lunacy, making it possible for doctors to certify idiots and imbeciles separately. This distinction marked a departure from previous nineteenth century legislation. However, its impact was soon muted by the Lunacy Act, 1890 (applicable to England and Wales), which in contradiction to the act of 1886, continued to treat idiocy as a sub-category of lunacy.<sup>32</sup> The resulting legal inconsistency was not resolved until 1913.

Pressure for state intervention into the institutional care of idiots and imbeciles during the second half of the nineteenth century had consequently yielded unsatisfactory results for the medical profession. Furthermore, the profession's links with the state still did not give doctors a monopoly over care for lunatics, idiots and imbeciles. This was particularly true of Scotland. The same act of 1862 that had permitted the licensing of imbecile institutions also allowed Scotland's Board of Lunacy to grant special licences

---

<sup>29</sup> See W.W. Ireland's comments to J. Carswell in Carswell, 'Care and Education of Weak-minded and Imbecile Children', 488.

<sup>30</sup> J. Lewis, *The Voluntary Sector, the State and Social Work in Britain* (Aldershot: Edward Elgar, 1995), 46-54.

<sup>31</sup> Jones, *History of Mental Health Services*, 184-5.

<sup>32</sup> Lunacy (Consolidation) Act, 1890, (53. Vic., c. 5); see Jones, *History of Mental Health Services*, 185.

to unrelated guardians (referred to as ‘stranger guardians’) to receive up to four insane patients of the same sex, in return for a small allowance paid out of local rates. The practice was referred to as ‘boarding-out’ and, being a form of fostering, the law did not require that guardians appointed to care for insane charges needed to have any special medical training.<sup>33</sup>

To most psychiatrists in Europe and America, boarding-out of the insane referred to the practice of giving asylum patients a chance to live in dwellings located near to an asylum, where they would (in theory) continue to receive some sort of medical supervision from asylum superintendents. This was not always the case in Scotland. Some asylum patients were allowed out on licence to see how they coped in the community but many boarded-out ‘patients’ were paupers who had never set foot in an asylum or imbecile institution in their lives.<sup>34</sup>

Boarding-out developed in Scotland around the end of the eighteenth century, its roots traceable to both the apprenticeship system and the long-standing practice of informally ‘fostering’ orphan children in rural Scottish communities. It was also used to a much lesser degree in England, but the Poor Law Act, 1834 (applicable to England and Wales) prevented Poor Law Unions from boarding children outside the area where each child was deemed to have legal settlement. In contrast, the Poor Law (Scotland) Act, 1845 allowed parish councils, who administered Scottish poor relief, to relocate their charges outside parochial boundaries.<sup>35</sup> This gave urban authorities the freedom to transfer deprived children and insane paupers of all ages from towns and cities into Scotland’s rural communities which, although hardly the healthiest of places at that time, were viewed by administrators with a kind of pastoral romanticism as wholesome environments inhabited by simple but honest country folk.<sup>36</sup>

However, not all paupers referred to as ‘boarded-out’ were fostered by rural guardians. Some insane charges were allowed to remain within their family home, subject to occasional inspection by the district lunacy boards. The natural parents of a lunatic or

---

<sup>33</sup> The 1862 Act built upon earlier the Lunacy (Scotland) Act, 1857. See Sturdy, ‘Boarding-Out the Insane, 1857-1913’ ), 63; Sturdy and Parry-Jones, ‘Boarding-out Insane Patients’, 86.

<sup>34</sup> *Ibid*, 86.

<sup>35</sup> For a comparison of the two Acts see H.J. Macdonald, ‘Children Under the Care of the Scottish Poor Law’ (PhD. thesis, University of Glasgow, 1994), chs. 1-2.

<sup>36</sup> L. Abrams, *The Orphan Country: Children of Scotland's Broken Homes from 1845 to the Present Day* (Edinburgh: John Donald, 1998), 41-53.



imbecile could be registered as official guardians within the boarding-out system and given a weekly aliment to help care for the insane family member, providing the officials were satisfied that appropriate care and supervision were being provided. Owing to an initial shortage of stranger guardians, the majority of 'boarded-out' cases remained under familial guardianship until the mid 1880s. After that period, the percentage of boarded-out cases under stranger guardianship predominated but familial guardianship was still common.<sup>37</sup> Scottish administrators boarded-out insane paupers prior to 1862, but the numbers increased in the years that followed. Many of these were idiots and imbeciles: though statistics are incomplete, it was estimated in 1900 that 47% of the boarded-out 'insane' were in fact congenitally defective.<sup>38</sup>

The boarding-out system therefore provided one means, endorsed and administered by the state, by which people without medical training could maintain a role in caring for lunatics, idiots and imbeciles. It did not appear to cause too much anxiety amongst psychiatrists as they were generally more interested consolidating their role in institutional care at this time. Yet even within the large institutions, state regulation had failed to ensure medical control: a state of affairs that caused the psychiatric community a great deal of concern throughout the nineteenth century. The precarious position of psychiatrists within the institutional system can be exemplified by looking at the career of Scotland's most prominent institution superintendent, Dr William Wotherspoon Ireland. Ireland was an internationally renowned medical theorist. He was to play an influential role in shaping medical conceptions of idiocy and imbecility, but by the end of the nineteenth century he had become disenchanted with the way imbecile asylums were managed in Britain.

Born in Edinburgh in 1832, Ireland was the son of a publisher and a direct descendent of John Knox. He had initially taken a path common amongst Scottish doctors, receiving his medical training at the University at Edinburgh before entering the Indian military service as an assistant surgeon. He left the service after being severely injured at the siege of Delhi and wrote a historical account of the siege in 1861. In later years, he was to publish on a wide range of subjects including nutrition, climate and historical biography, but whilst his intellectual interests were broad, Ireland's medical career became increasingly specialised on his return to Scotland. He became superintendent of

---

<sup>37</sup> Sturdy and Parry-Jones, 'Boarding-out Insane Patients', 101.

<sup>38</sup> Sturdy and Parry-Jones, 'Boarding-out Insane Patients', 96.

Larbert in 1871 and in 1877 he published what has been described as Britain's first comprehensive text book on idiocy and imbecility.<sup>39</sup> This and subsequent publications on the subject established Ireland's reputation. His writings show him to be a committed supporter of educational approaches to institutional care, but this brought him into conflict with Larbert's board of directors. The dispute centred on the function of the institution. Ireland maintained that Larbert should continue to concentrate on education, whilst the directors favoured a more basic, and consequently cheaper, custodial approach to care. The directors had their way, prompting Ireland's resignation in 1881. To his disgust the board replaced him with a superintendent who had no medical background.<sup>40</sup>

That such a well respected figure as Ireland, in charge of an institution as prestigious as Larbert could be replaced by a layman demonstrated that the medicalisation of institutional care had yet to be fully realised, despite the attempts of psychiatrists to obtain state backing. In fact, Ireland viewed state intervention as part of the problem and looked with envy on the medical superintendents of Danish asylums, where 'they had no Lunacy Acts at all, and they had been allowed to work out their views with perfect freedom'.<sup>41</sup> Ireland was, however, a fiercely independent figure and by the late nineteenth and early twentieth century such independence from the state would appear out of step within an institutional system becoming increasingly subject to government regulation. In the late nineteenth century, Ireland's influence would begin to wane, making way for lesser known figures, who were prepared to work more closely with government authorities at both a local and central level.<sup>42</sup>

### *'Curing' Idiocy and Imbecility*

As well as highlighting the still precarious position of the medical profession, the events surrounding Ireland's resignation also illustrate the continuing tensions over the question of curability: whether it was worth attempting to improve the mental ability of idiots and imbeciles through education, or whether the conditions were essentially incurable. For his part, Ireland took a cautiously optimistic approach to the question of

---

<sup>39</sup> Anderson and Langa, 'Development of Institutional Care', 255; K. Day and J. Jancar, 'Mental Handicap and the Royal Medico-Psychological Association: a Historical Association, 1841-1891', G.E. Berrios and H. Freeman, *150 Years of British Psychiatry 1841-1991* (London: Gaskell, 1991), 274.

<sup>40</sup> Henderson, *Evolution of Psychiatry in Scotland*, 75-76.

<sup>41</sup> Ireland's comments to Carswell, Carswell, 'Care and Education of Weak-minded and Imbecile Children', 488.

<sup>42</sup> See c. 2.

cures. Writing in 1898, he criticised some of his patients' parents who would 'never be pleased unless their children are educated to the level of ordinary ones', but went on to say that 'some are patient and reasonable, and grateful for small improvements'.<sup>43</sup> To Ireland, education could improve the mental development of his patients but it could not make them 'normal'. Nonetheless, whilst acknowledging the limitations of his educational approach, Ireland directed his invective at purely custodial approaches to institutional care, challenging those who 'seem to hold that if such creatures [ie. idiot and imbecile patients] are fed and kept clean, and dressed up like dolls and kept confined lest they should dirty their clothes, as much is done as is worth the trouble'.<sup>44</sup>

Although the tension between curative and purely custodial approaches to care had long existed within Britain's asylums and institutions, the late nineteenth century has frequently been portrayed as a period when institution managers increasingly came to favour the custodial approach. This phenomenon is observable in lunatic asylums as well as institutions for idiots and imbeciles. Scull has argued that as asylums grew in size and the numbers of patients increased, conditions inside the institutions became steadily less conducive to promoting mental health. Overcrowding, poor living conditions, excessive regimentation and a lack of therapeutic activities within the asylums made it increasingly unlikely that patients would, if discharged, be able to adjust to life on the outside. The primary function of such asylums consequently became custodial rather than curative.<sup>45</sup>

According to Edgar Miller, a scandal associated with the Abendberg colony in 1858 acted as a catalyst for growing uncertainty about the extent to which idiocy could be cured.<sup>46</sup> During much of the 1840s and 1850s, influential figures such as the Ogilvys and even Charles Dickens had spread word of Guggenbuhl's 'cures' to wide audiences across Europe and America.<sup>47</sup> However, fame turned to notoriety when an official inquiry into conditions at the retreat led two Swiss physicians to deny that any of the idiots at Abendberg had truly recovered. How much of a surprise this caused amongst British institution superintendents is open to scepticism. Institutions like Earlswood

---

<sup>43</sup> W.W. Ireland, *The Mental Affections of Children, Idiocy, Imbecility and Insanity* (London: J. & A. Churchill, 1898), 383.

<sup>44</sup> *Ibid.*

<sup>45</sup> Scull, *Most Solitary of Afflictions*, 277-289.

<sup>46</sup> E. Miller, 'Mental Retardation: Clinical Section – Part I', Berrios and Porter, *History of Clinical Psychiatry*, 218-219.

<sup>47</sup> C. Dickens, 'Idiots', *Household Words* (4<sup>th</sup> June 1853), (<http://www.lang.nagoya-u.ac.jp/~matsuoka/CD-Idiots.html>).



already had a policy of accepting cases they termed ‘hopeless’, which would indicate that superintendents had accepted that there were limitations to the ‘curative’ effects of their education programmes.

Just as it would be unwise to assume that superintendents in earlier years really believed that they could educate all idiots and imbeciles to an ordinary level of intelligence, it would be equally misleading to assume that superintendents in the late nineteenth century uniformly forsook all kinds of teaching. Even in institutions where tuition in reading and writing was abandoned, patients were often encouraged to wash and dress themselves, and taught how to perform menial jobs such as cleaning, tailoring and carpentry. Superintendents would claim these activities had therapeutic value, although the economic benefits to the institution were clearly apparent. Directors could reduce the number of paid staff if the patients themselves worked at the institutions. Many asylums had small farms on their grounds in which patients learned to grow products for home consumption or sale, and again this outdoor work was regarded as therapeutic. As a result of these developments, some commentators began to distinguish between *education* which included the ‘three Rs’, and *training* limited to sensory development, practical skills and manual work.<sup>48</sup> However, this distinction was more commonly made in the twentieth century following the introduction of special education in day schools.<sup>49</sup>

As educational approaches gradually fell out of favour within Britain’s institutions for idiots and imbeciles, superintendents were able to draw upon theories of heredity to explain why their patients could never be fully cured. In 1857, the French alienist, Benedicte Auguste Morel published a theory on the causation of idiocy that could be used to explain the limited successes of institutional education.<sup>50</sup> Morel’s theory of ‘degeneration’ drew on biological studies of evolution that predated Darwin’s *Origin of the Species* (published in 1859). It was commonly used to describe a process of hereditary regression by which social deprivation and moral depravity manifested themselves as physical and mental defects to a greater degree from one generation to the

---

<sup>48</sup> See G.E. Shuttleworth, ‘Industrial Training of Imbeciles’, *Journal of Mental Science* 44 (1898), 531-535; W.W. Ireland, ‘Visits to Danish Asylums for the Feeble-Minded and other Institutions’, *Journal of Mental Science* 44 (1898), 60-61; E.F. Pinsent, ‘Our Provision for the Mentally Defective’, *The Nineteenth Century* 70 (1911), 705-714.

<sup>49</sup> The Education (Scotland) Act, 1945 (8 & 9 Geo. 6, c. 37) distinguished between mentally defective children who were educable, trainable or neither.

<sup>50</sup> B.A. Morel, *Traité des dégénérescences physiques, intellectuelles et morales de l’espèce humaine* (Paris: Bailliere, 1857).

next.<sup>51</sup> As the end products of this process, idiots and imbeciles could be portrayed as being inherently sub-human and consequently incapable of being educated to a 'normal' level of intelligence.

Degeneration theory had its predecessors: notably the writings of the American alienist Samuel Gridley Howe.<sup>52</sup> Hereditary theories of defect were consequently not new to the late nineteenth century, but during that period they seemed to take on a new appeal. Institution managers who wished to cut costs by providing only the basics in custodial care could argue that education was a wasted expenditure on the inherently sub-normal. Medical specialists in idiocy wishing to expand their employment opportunities could invoke hereditary defect in their calls for more institutional accommodation for incurable adult idiots as well as children. Long term custodial care within institutions that segregated patients by gender would prevent idiots and imbeciles from producing defective offspring. Even those who still supported education for idiots and imbeciles could invoke the concept of hereditary disorder when explaining their inability to bring about complete cures.

Discussions on hereditary decline was not simply limited to discourses on institutional care for idiots and imbeciles in the late nineteenth century: in fact the concept came to be regarded in some quarters as the primary cause of many of society's problems. Cesare Lombroso's atavistic explanation of criminal behaviour and Francis Galton's eugenic theory both exemplify this point. Lombroso and Galton were able to apply and adapt Darwinian theory to humans. Lombroso, an Italian criminologist whose work attracted widespread notice in the 1870s, distinguished 'born criminals' from the criminal of habit, passion or occasion. Born criminals were a kind of throwback to a more primitive stage in the evolutionary development of man, and as such possessed physical characteristics such as dark hair and skin, small skull, asymmetrical face, retreating forehead and a predilection for tattoos.<sup>53</sup> The racial element of Lombroso's theory was taken up in Britain by J. Langdon Down: most notably in his identification of the Mongolian idiot, so called because Down saw a facial similarity between certain

---

<sup>51</sup> D. Pick, *Faces of Degeneration: A European Disorder, c.1848 – c.1918* (Cambridge: Cambridge University Press, 1989), 44-59.

<sup>52</sup> Miller, 'Mental Retardation: Clinical Section – Part II', 215-216.

<sup>53</sup> Pick, *Faces of Degeneration*, 109-152; P. Becker, 'The Triumphant Advance of Degeneration: Medical Sciences and Criminal Law in Nineteenth Century Germany' Y. Otsuka & S. Sakai (eds.), *Medicine and the Law*, (Tokyo: Ishiyaku EuroAmerica, 1998), 83-128; W. Norwood East, 'Physical Factors and Criminal Behaviour', L. Radzinowicz and J.W.C. Turner (eds.), *Mental Abnormality and Crime* (London: Macmillan, 1944), 143-146.

idiots and Chinese people. Underlying these accounts was an assumption that white Europeans represented a pinnacle in the evolution of man, whilst other races were depicted as representing an earlier, inferior stage of evolution.<sup>54</sup>

Francis Galton drew on Darwin's Malthusian roots in the development of his eugenic theory. Though he believed in survival of the fittest in nature, Galton was concerned that philanthropy, public health and medical advances had led to the survival of a disproportionately high number of defectives in the human population. He envisaged a new scientific discipline aimed at 'improving the racial qualities of future generations both physically and mentally'.<sup>55</sup> This, he assumed, could be achieved through social planning by encouraging healthy and socially useful members of the population to breed, whilst curbing the fertility of the unfit.<sup>56</sup> Mental defectives were of particular concern because of their alleged sexual promiscuity. Rather than cure mental deficiency, Galton and his supporters aimed to prevent them from bearing similarly defective offspring through strategies such as sterilisation and incarceration in sexually segregated institutions. Although Galton coined the term 'eugenics' in 1884 to describe his new science, his ideas did not gain wider popularity until the early 1900s.<sup>57</sup>

Both the move away from institutional education and the influence of hereditary theories have been cited as evidence of a growing pessimism towards idiocy and imbecility. At times, this pessimism bordered on hostility: Mark Jackson has recently argued that where as idiots and imbeciles were generally portrayed as pitiable and innocent in the early and middle decades of the nineteenth century, late nineteenth century commentators frequently depicted them as 'a dangerous residuum or underclass' whose existence lay at the root of many of society's problems. This general trend towards more pessimistic appraisals should not obscure the variety of attitudes towards mental deficiency that existed throughout the century. However, the image of mental defectives as a threat or a burden helps to explain why, by the end of the century, politicians and administrators within local and central governments began to develop policies that would lead to the increased segregation of individuals on the grounds of mental deficiency.

---

<sup>54</sup> Miller, 'Mental Retardation: Clinical Section – Part II', 217.

<sup>55</sup> Quote taken from Searle, *Eugenics and Politics*, 1.

<sup>56</sup> Paraphrase of the title of D. Barker's article on this subject, Barker, 'How to Curb the Fertility of the Unfit'.

<sup>57</sup> M Thomson, *Problem of Mental Deficiency*, 19.



### *Moral Imbecility and Feeble-mindedness*

Anxiety over the apparently malign influence of mental deficiency on society tended to focus particularly on those defectives whose abilities were on the higher end of the scale (often referred to as 'high grade' defectives). They were depicted as being intelligent enough to be capable of independent action, but lacked the mental development to function properly as citizens, earn their own keep, keep within accepted standards of behaviour and resist the temptations of crime and vice. These concerns over what Jackson has called 'the borderland of imbecility' developed within specific institutional settings such as prisons, workhouses and school.

For example, doctors working within the penal and judicial systems adapted theories of hereditary decline to link mental deficiency with crime and vice. Paralleling the experience of asylums, over-crowding was endemic within late nineteenth century prisons, and the principle of rehabilitation appeared impractical. Concern over repeat offenders, coupled with prison doctors' interest in the fitness of prisoners and their response to discipline provided a context in which doctors could explain criminality in terms of mental deficiency.<sup>58</sup> The term 'moral imbecile' came to be used to describe people alleged to have a hereditary disposition towards crime and vice. However, the concept of moral imbecility caused controversy amongst doctors, particularly over the question of whether moral defects could occur amongst individuals with an otherwise normal level of intelligence. Although moral imbecility became the subject of considerable debate during the late nineteenth and early twentieth century, few individuals were ever certified as having the condition.<sup>59</sup>

The late nineteenth century also witnessed the creation of another sub-category of mental deficiency which, unlike moral imbecility, did come to be widely employed by doctors and state administrators: namely, 'feeble-mindedness'. Feeble-mindedness and moral imbecility were closely related in that both generally applied to individuals whose level of intelligence was higher than that of idiots and imbeciles. To some extent, this overlap of definition made moral imbecility redundant. On the one hand, doctors were generally unwilling to commit themselves to the view that an individual's mental development could be defective from birth in such a way that only the moral faculties

---

<sup>58</sup> Watson, 'Moral Imbecile', 118-127.

<sup>59</sup> *Ibid*, 217-218.

were adversely affected. On the other hand, if the individual in question appeared to have a low level of intelligence, doctors preferred to use the feeble-minded label.<sup>60</sup>

The concept of feeble-mindedness originated in part from the desire of prison and workhouse managers to segregate inmates who posed disciplinary problems within the various institutions, whilst appearing unable to fulfil useful roles in the wider community (in terms of obeying the law and earning a living). However, the vast majority of feeble-minded individuals were initially identified as such whilst at school.<sup>61</sup> It was through the education system that the state first began to seriously recognise the condition and develop its most extensive policy of mass segregation.

The medicalisation of educational failure and the creation of special day classes for feeble-minded children were unintended consequences of the development of universal state education. Traditional historical accounts have viewed the creation of the education system as an attempt by MPs to give the newly enfranchised working-classes the tools to achieve an adequate understanding of the political process.<sup>62</sup> However, J.S. Hurt has revised this view, arguing that compulsory education was considered at the time of its conception to be a ‘matter of social policy’ rather than ‘political necessity’.<sup>63</sup> The Education Acts were not so much aimed at prevailing on Parliament’s ‘future masters to learn their letters’<sup>64</sup> in the wake of the 1867 Reform Act (which only extended the franchise to ‘respectable’ working men). Instead, they were intended as a control mechanism by which ‘correct’ moral standards and discipline could be exerted over the youngest generation of the still disenfranchised pauper class. State schools were created to transform poor children into productive adults in order to prevent, in William Forster’s words, ‘this “residuum” from growing up to be no better than their parents’.<sup>65</sup>

Either way, the separate education of higher grade defectives in day schools did not feature in legislators’ plans. Some members of Parliament did support the notion of special education for blind and deaf-mute children. Several bills dealing with the issue

---

<sup>60</sup> Jackson, *Borderland of Imbecility*, 141.

<sup>61</sup> See c. 6.

<sup>62</sup> S.J. Curtis, *History of Education in Great Britain* (London: University Tutorial Press, 1967), 256.

<sup>63</sup> J.S. Hurt, *Elementary Schooling and the Working Classes 1860-1918* (Routledge and Kegan Paul, London, 1979), 24

<sup>64</sup> *Ibid*, 21

<sup>65</sup> *Ibid*, 24

were put forward throughout the 1870s and 1880s but all failed to gain sufficient support. No contemporaneous attempt was made to provide classes for idiots or imbeciles in the state school system. Indeed, the fear that such a move might follow on from the establishment of special education for the blind and deaf was cited by one M.P. as a reason for opposing the Education of Blind and Deaf Mute Children Bill, 1872.

*Hansard* reports:

If the principle [of special education] with regard to the blind and to deaf-mutes were sound, why should it not be extended to other unfortunate classes of children, such as idiots, cripples, and lunatics, who were quite as much entitled to commiseration? He asked the House, then, to reject the Bill, as being based on a new principle.<sup>66</sup>

Yet by the end of the nineteenth century many towns and cities possessed schools in which special classes for mental defectives were held; Scottish legislators were considering legislation on the issue; and Parliament had passed its first Elementary Education (Defective and Epileptic Children) Act for England and Wales in 1899. The events surrounding the development of special education in Scotland will be described in the next chapter. Historians such as Mark Jackson, Gillian Sutherland and Michael Barrett have looked at different aspects of special education for the feeble-minded in England and it is upon their work that the developments outlined below are based.<sup>67</sup>

No single act of Parliament established a universal state education system in England and Wales but the Education Act of 1880 compelled children to be educated at the state's expense unless parents could afford to pay for their children's schooling themselves. This has led Sutherland to argue that 'only in the last two decades of the century did teachers and school managers begin really to face the full variety of children's needs and conditions'.<sup>68</sup> Educators found themselves confronted with large numbers of children from impoverished backgrounds. Poor nutrition, over-crowded housing and unsanitary conditions had made an impression on the physical health of many pupils. A number of commentators also voiced concern about their mental condition.

---

<sup>66</sup> Mr. Hibbert M.P., *Hansard* 209 (6<sup>th</sup> Feb 1872 - 4<sup>th</sup> Mar 1872), 1502.

<sup>67</sup> Sutherland, *Ability, Merit and Measurement*, c. 1.

<sup>68</sup> *Ibid*, 5.



Until 1890, government grants to elementary schools were based on the number of standard examination passes achieved each year, so schools lost money when pupils failed their exams.<sup>69</sup> This exacerbated anxieties amongst school administrators and teacher's over the relatively high number of pupils who failed to achieve the expected standard. Such failures could have been explained in terms of over-crowded classrooms (50 plus pupils per teacher was not uncommon in large city schools), mechanistic drill-like teaching methods, or unrealistic expectations. However, some doctors began to advocate feeble-mindedness as an alternative explanation and it proved to be popular amongst educationists.

The medical profession's interest in school health occurred initially at a local level, most notably in the capital. Political infighting within London's education authority led to an invitation to Dr James Crichton-Browne, formerly director of West Riding Lunatic Asylum, to examine London school pupils for signs of 'over-pressure'. A Tory faction committed to the voluntarist principle in education had been suggesting that the elementary school curriculum caused too much strain amongst children, resulting in their deteriorating mental and physical health. Brown agreed, though his findings were refuted by the Education Department. His survey was subsequently followed by others from such prominent doctors such as Dr Francis Warner, physician to the London Hospital, and Dr G.E. Shuttleworth, superintendent of the Royal Albert Asylum, as well as the social investigator, Charles Booth.<sup>70</sup>

Though their results differed in detail, all these investigators suggested that large numbers of pupils lacked the mental ability to benefit from teaching at elementary schools. Doctors and teachers used various labels to describe such children, such as dull, backwards, imbecilic and mentally defective, but they eventually came to favour feeble-minded. The term had been used in lay discourse since at least the late seventeenth century. During the nineteenth century, North American asylum superintendents frequently described all mentally defective patients as feeble-minded, which in turn encouraged British doctors to use the term. However, within the English education system, feeble-mindedness was not simply a synonym for mental deficiency, as it was in America. Rather, it was used to describe children whose mental ability was greater

---

<sup>69</sup> G. Sutherland, *Policy-Making in Elementary Education 1870-1895* (Oxford: Oxford University Press, 1973), 266-282.

<sup>70</sup> Sutherland, *Ability, Merit and Measurement*, 5-16.

than that of imbeciles but less than that of even the most backward ordinary child. The elementary school system had introduced a new set of demands on the children of Britain, and those who did not meet the required standard were now to be considered defective.<sup>71</sup>

The theory that failure at school was caused by the defective intelligence of pupils, rather than poor teaching methods or inappropriate curriculum, found support amongst school managers and teachers. It provided additional ammunition in their lobbying efforts to reform the system of payment by results. It also offered a solution to the problem of managing over-crowded classrooms. If the most difficult children could be identified as feeble-minded and taught in separate classes to those pupils considered to be ordinary, the least able would no longer slow the ordinary classes down. Meanwhile, feeble-minded pupils would receive an education more appropriate to their own level of ability. Special classes in day schools would therefore benefit the teachers, the ordinary pupils and the feeble-minded pupils.<sup>72</sup>

Not everyone was convinced. Although Shuttleworth's career clearly benefited from his shift into school health, many of his fellow asylum superintendents feared for their positions. At a time when the curative value of educational institutions for idiots and imbeciles was already in doubt, the prospect of competition from the elementary school system seemed daunting. Some medical superintendents feared that the special day classes would drain the institutions of their most able imbeciles. They consequently refuted the category of feeble-mindedness, arguing that in truth it blended the highest grades of imbeciles with the lowest grade of ordinary child. The results of mixing both types of child in a single special day class would be detrimental to all concerned. Hence, the establishment of special education within the school system developed in the face of resistance from asylum managers.<sup>73</sup>

Despite these objections, the cumulative influence of figures like Brown, Warner, Shuttleworth and Booth was such that the government felt obliged to look into the issue. An opportunity presented itself in the form of a Royal Commission set up in response to constant lobbying for legislation on state special classes for blind and deaf-mute

---

<sup>71</sup> Jackson, *Borderland of Imbecility*, 29-30.

<sup>72</sup> Jackson, *Borderland of Imbecility*, 25-7; Pritchard, *Education and Handicapped*, 115.

<sup>73</sup> Barrett, 'From Education to Segregation', 237-246.

children. In 1886 the Commission, chaired by Lord Egerton, widened its remit to cover feeble-minded children. Warner and Shuttleworth were called as witnesses but education of blind and deaf mute children remained Egerton's chief concern. The Commission supported state-financed special day schools for the latter, but limited its recommendations on feeble-minded children to institutional treatment at the education authorities' expense.<sup>74</sup>

In the 1890s, a number of education authorities decided to go beyond the Egerton Commission's recommendations. The school boards of London and Leicester were the first to establish special classes for the feeble-minded in 1892. The opening of such classes posed a financial problem to the education authorities. Payment by results was largely abolished by 1890, but elementary schools were still required to teach the standard curriculum if they wanted to receive a government grant. To avoid this problem, London's school board, through its connections with the Education Department, had managed to secure for itself a special clause in the funding regulations allowing feeble-minded children in special classes to be regarded as infants. This only partially appeased board-members, who argued that special school pupils cost more to teach than infants because they needed extra equipment and smaller classes. By 1897, school boards in Nottingham, Birmingham, Bradford, Brighton, Bristol and Plymouth were also experimenting with special education and pressure for additional government funding and legal recognition consequently increased.<sup>75</sup>

The government responded to calls for action by appointing a Departmental Committee on Defective and Epileptic Children. Shuttleworth was on the committee and the final report, published in 1898, came out in favour of special day classes (somewhat belatedly as many already existed by that time).<sup>76</sup> Despite opposition from institution superintendents, the report referred to 'feeble-mindedness'. Nonetheless, the use of the term proved so controversial that when, in the following year, Parliament passed an Education Act recognising the school boards' powers to establish special classes, the Board of Education decided to use the term 'mental defective' as a euphemism for 'feeble-minded'.<sup>77</sup> This caused some difficulty as the term 'mental deficiency' was

---

<sup>74</sup> HMSO *Report of Royal Commission on the Blind, the Deaf, and the Dumb* (C 5781, 1889). See Pritchard, *Education and Handicapped*, 95-114; Hurt, *Outside the Mainstream*, 125-6; Sutherland, *Ability, Merit and Measurement*, 17-18; Jackson, *Borderland of Imbecility*, 26.

<sup>75</sup> Sutherland, *Ability, Merit and Measurement*, 18-19.

<sup>76</sup> HMSO, *Report of Departmental Committee on Defective and Epileptic Children I-II* (C 8746-7, 1898).

<sup>77</sup> Elementary Education (Defective and Epileptic Children) Act, 1899 (62 & 63 Vic., c. 32).



already being used as an umbrella term for idiocy, imbecility, moral imbecility and feeble-mindedness. To avoid confusion, educational administrators distinguished between educable mental defectives (ie. the feeble-minded) who could benefit from education in special day classes, and uneducable mental defectives (ie. idiots and imbeciles) who required institutional care.

### *Conclusion*

By the end of the nineteenth century, the four categories that would make up mental deficiency under the terms of the 1913 acts were well known. None of the categories were stable and their definitions were the focus of controversy between rival interests within the medical profession. During the early part of the century, idiocy had come to be associated with institutional education. Later, the efficacy of this educational approach was challenged and as new categories of defect were devised, the idiot label was defined far more narrowly to describe people with a very low grade of ability, for whom educational treatment was generally not provided. In contrast, the term imbecile came to refer to mental defectives who might benefit from training (and possibly education) within an institutional setting.

As institution managers gradually began to favour more custodial models of care, theories of hereditary decline became a useful way of explaining why asylum-based educational treatment had failed to live up to its early promise. Within the prison system, hereditary deficiency was also used to explain how attempts at rehabilitation had failed to prevent numerous prisoners from re-offending. The sub-category of moral imbecility emerged from the work of prison medical officers and criminologists, who pathologised deviant behaviour and associated mental deficiency with crime.

Whilst contemporaries increasingly came to see institutionalised mental defectives as ineducable (though not necessarily untrainable), doctors working within the school system began to establish a new sub-category of defective, for whom special education in day schools was considered entirely appropriate. The development of universal state education had the unintended effect of raising the lower limits of what people conceived as normal intelligence. To be useful within the context of the education system, children had to be able to learn the school curriculum, stay well-behaved and pass exams. Educational failure became a medical issue through the creation of the feeble-minded category, and special day classes were offered as a solution to the schools' problems.

However, many institution superintendents viewed special day classes as a dangerous source of competition. They rejected the term feeble-minded arguing that in reality it combined the most able imbeciles with the most backward ordinary children. Despite their objections, the state gave its backing to the establishment of more special day classes, whilst institutions continued to shift their emphasis to custodial care rather than education.

By the end of the nineteenth century, mental deficiency was beginning to be regarded as a major social problem. Through the creation of the feeble-minded category, the definition of mental deficiency expanded to include a larger section of the population in possession of higher levels of ability. Mental defectives, particularly high grade imbeciles and feeble-minded defectives, were associated with racial degeneration, crime and immoral behaviour, educational failure and unemployment. Pressure groups such as the Charity Organisation Society. were campaigning for state action to ensure they received greater supervision. Doctors claimed that their understanding of the condition gave them the authority to provide such supervision. State administrators, at the end of a century in which they had attempted to develop a scientific approach towards the management of social problem groups, were beginning to take notice. Mental deficiency was about to take a more prominent position on the British political agenda.

## Chapter 2. Glasgow's Role in the Development of Scotland's Mental Deficiency Administration.

In the late nineteenth century two of Glasgow's local authorities instigated a series of initiatives that proved pivotal in the development of Scotland's mental deficiency administration. Those involved took a liberal interpretation of the permissive powers given to them in Scottish legislation on poor relief, lunacy provision and education, by engaging their authorities in activities that had not previously been considered part of their remit. The Poor Law authority for Glasgow's Barony parish increased its expenditure on separate institutional provision for mentally defective children and established its own institution for defectives considered to be untrainable. Meanwhile, the School Board of Glasgow conducted a survey to identify defective pupils on the school roll and experimented with special education in day classes. The adoption of these new methods for dealing with the mentally defective poor resulted from initiatives taken by a network of ambitious local officials seeking to expand their individual roles within Glasgow's local government scene. This network co-ordinated the activities of different local authorities and strengthened the ties between local government, charitable bodies and the medical and teaching professions. As a result, local officials increased their powers to intervene in the lives of private citizens, particularly where the well-being of children was concerned. This was to have a profound effect on labelling and provision for mental defectives.

To understand how Glasgow's public provision for mental defectives developed differently to that of other Scottish local authorities it is necessary to examine how the city's economy, its social problems and political culture influenced the way local officials shaped social policy.<sup>1</sup> Local authorities associated the segregation of mental defectives with their attempts to deal efficiently with social problems caused by large

---

<sup>1</sup> For recent work on Scottish social history and the history of Glasgow see W.W. Knox, *Industrial Nation: Work, Culture and Society in Scotland 1800-Present* (Edinburgh: Edinburgh University Press, 1999); W.H. Fraser and I. Maver (eds), *Glasgow Volume II: 1830 to 1912* (Manchester: Manchester University Press 1996); T.M. Devine and Gordon Jackson (eds), *Glasgow Volume I* (Manchester : Manchester University Press, 1995); R. Williams, 'Medical, Economic and Population Factors in Areas of High Mortality: the Case of Glasgow', *Sociology of Health and Illness* 16 (1994), 143-179; I. Levitt, *Poverty and Welfare in Scotland 1890-1948* (Edinburgh: Edinburgh University Press, 1988); R.A. Cage (ed), *The Working Class in Glasgow 1750-1914* (London: Croom Helm, 1987); T.C. Smout, *A Century of the Scottish People 1830-1950* (London: Collins, 1986); G. Gordon (ed), *Perspectives of the Scottish City* (Aberdeen: Aberdeen University Press, 1985); S.G. Checkland, *The Upas Tree: Glasgow 1875-1975...and After 1975-1980*, (Glasgow: University of Glasgow Press, 1981); T.C. Smout (ed), *The Search for Wealth and Stability: Essays in Economic and Social History Presented to M.W. Flinn* (London: Macmillan, 1979).



scale poverty in the city. Their approach emphasised the need to distinguish between a 'deserving' and 'undeserving' poor, with mental defectives falling into the former group on account of their supposed inability, rather than unwillingness, to find work. This distinction between deserving and undeserving was characteristic of social policy in both Britain and Scotland at that time. However, it was particularly prevalent in Glasgow as a result of the influence of Thomas Chalmers, an evangelical preacher who worked in Glasgow during the early decades of the nineteenth century and inspired a generation of social reformers in the city.<sup>2</sup>

### *Glasgow in the Nineteenth Century*

Charles Withers, has recently claimed that there is 'no doubt that Glasgow was Scotland's "shock city" ' during the nineteenth and early twentieth century, in terms of living conditions and the poor health of many of its population.<sup>3</sup> These social problems were closely tied to the city's rapid growth. In the nineteenth century Glasgow became Scotland's foremost commercial and manufacturing centre, based on its status as a major port and its textiles, metallurgical and shipbuilding industries.<sup>4</sup> As such, it attracted large numbers of migrants, mostly from neighbouring lowland areas of Scotland, but also from the Highlands and Islands. Irish immigration also featured strongly in Glasgow's demography, particularly around the time of the potato famine of the mid-nineteenth century when the average weekly inflow of Irish into the city peaked at an estimated 1,000 a week.<sup>5</sup> The constant influx of surplus labour helped to keep Glasgow a low-wage city, which promoted further growth in manufacturing but made living conditions harsh for many of its residents.<sup>6</sup>

Glasgow suffered crises of poverty and disease characteristic of all industrial areas during the period. W.H. Fraser and Irene Maver have recently questioned whether its social problems were really any worse than those experienced in the smaller Scottish

---

<sup>2</sup> M.A. Crowther, 'Poverty, Health and Welfare', W.H. Fraser and R.J. Morris, *People and Society in Scotland II 1830-1914* (Edinburgh: Donald, 1990), 267-268; O. Checkland, *Philanthropy in Victorian Scotland: Social Welfare and the Voluntary Principle* (Edinburgh: Donald, 1980), 298ff.; Lewis, *The Voluntary Sector, the State*, 46-54.

<sup>3</sup> C. Withers, 'The Demographic History of the City, 1813-1911', Fraser and Maver, *Glasgow Volume II*, 158.

<sup>4</sup> For the most recent surveys of Glasgow's economic development in the nineteenth century see G. Jackson and C. Munn, 'Trade, Commerce and Finance', Fraser and Maver, *Glasgow Volume II*, 52-95; J. Butt, 'The Industries of Glasgow', Fraser and Maver, *Glasgow Volume II*, 96-140.

<sup>5</sup> Withers, 'Demographic History of the City', 150.

<sup>6</sup> R. Rodger, 'Employment, wages and poverty in the Scottish cities 1841-1914', G. Gordon, *Perspectives of the Scottish City*, 54-5.

towns or English industrial cities.<sup>7</sup> Nonetheless, the assumption commonly expressed in the nineteenth century was that conditions in Glasgow were particularly scandalous. In 1842, Edwin Chadwick, chief architect of the English Victorian Poor Law administration, reported that ‘the condition of the population in Glasgow was the worst of any part of Great Britain’.<sup>8</sup> Decades after he published his report, numerous commentators continued to testify to the city’s squalor.<sup>9</sup>

Between 1841 and 1891, Glasgow’s population more than doubled to 565,839. Ten years later it exceeded three quarters of a million and finally passed the million mark after an expansion of the city boundaries in 1912. The city spread out as the population grew, especially after improvements in transport gave affluent residents an opportunity to commute into the centre from suburban districts like Hillhead and Partick, which lay to the west of the city. However, it was to the extreme concentration of poverty in the city centre that Glasgow owed its reputation for urban malaise.<sup>10</sup>

Like many Scottish cities, Glasgow was, and still is, dominated by tenement blocks, usually three or four stories high. In the nineteenth century there would typically have been around twenty homes in each tenement block, although there were cases where the number extended to 60 or even 70. Each home might have up to five or more rooms, but Glasgow became particularly notorious for its many ‘single-end’ apartments in which entire households crammed themselves into one, often tiny, room.<sup>11</sup> Overcrowding and poor sanitation encouraged illness and disease, as did poor nutrition associated with low wages and a cost of living that was comparatively higher than that found in English cities.<sup>12</sup>

Even if many of its social problems were shared by other Scottish towns and cities, the scale of poverty in Glasgow was greater than that of other Scottish urban areas. To

---

<sup>7</sup> W.H. Fraser and I. Maver, ‘Social Problems of the City’, Fraser and Maver, *Glasgow Volume II*, 387.

<sup>8</sup> M.W. Flinn (ed), *Report on Sanitary Condition of the Labouring Population of Gt. Britain by Edwin Chadwick 1842* (Edinburgh: Edinburgh University Press, 1965), 99.

<sup>9</sup> Examples can be found in Crowther, ‘Poverty, Health and Welfare’, 266; Checkland, *Upas Tree*, 20; Smout, *Century of the Scottish People*, 32-35.

<sup>10</sup> Checkland calculates that by 1914, 700,000 people lived in three square miles of central Glasgow ‘thus creating the most heavily populated central area in Europe’, Checkland, *Upas Tree*, 18.

<sup>11</sup> Fraser and Maver, ‘Social Problems of the City’, 363.

<sup>12</sup> *Ibid*, 373; R. Rodger, ‘The invisible hand: market forces, housing and the urban form in Victorian cities’, D. Fraser and A. Sutcliffe, *The Pursuit of Urban History* (London: E. Arnold, 1983), 190-211; M.J. Daunton, *House and Home in the Victorian City: Working-Class Housing, 1850-1914* (London: Arnold, 1983), 169.

tackle its problems, the city authorities instigated large scale civic improvement schemes in the second half of the nineteenth century. At first they concentrated on public health reforms in sanitation and the supply of drinking water. The city's first municipal fever hospital was built in 1869. The late 1870s and early 1880s, saw the opening of public baths, wash-houses and even the establishment of a municipal laundry service. Slum clearance took place in the 1860s, although the city authority's commitment to building new homes was somewhat half-hearted and sporadic.<sup>13</sup> Other civic developments included the municipilisation of the gas supply in 1867 and the creation of a tramline system in the 1870s.<sup>14</sup> With the exception of municipal housing, the above mentioned enterprises were not specifically for the benefit of the poor. All residents of Glasgow stood to gain from clean water, improved fuel supply, transport and the control of infectious disease. Even City housing tended to accommodate the more affluent working-class families, rents being generally too high for the poorest slum-dwellers.<sup>15</sup> Glasgow's municipal government was not responsible for providing relief for its poorest citizens: the unemployed, the infirm, the sick, the insane or the mentally defective. To understand how these groups were dealt with by the state it is necessary to examine the workings of the Scottish Poor Law administration.

### *Relief for the Poor, the Insane and the Mentally Defective in Scotland*

In the early nineteenth century, relief for the poor was organised by local churches under the Old Scottish Poor Law. By the early 1840s, church collections were proving insufficient to deal with the sheer scale of deprivation in urban parishes, and the Kirk-session that oversaw the administration was suffering from financial difficulties exacerbated by its own internal splits. The Poor Law (Scotland) Act, 1845 relieved the church of its role in poor relief by establishing new local authorities to raise money through the rates. Central control of the Poor Law administration was made the responsibility of a newly established government agency: the Board of Supervision (which was replaced by the Local Government Board for Scotland in 1894). However, reformers did not radically overhaul the established system of poor relief along the lines of Chadwick's remodelling of the English Poor Law in 1834.<sup>16</sup> Two key features of the Scottish Poor Law tradition survived the 1845 act: firstly, access to relief depended on the so-called 'disability qualification', and secondly, the act retained the principle of

---

<sup>13</sup> Fraser and Maver, 'Tackling the Problems', 422-3.

<sup>14</sup> Smout, *Century of the Scottish People*, 45.

<sup>15</sup> Fraser and Maver, 'Tackling the Problems', 421.

<sup>16</sup> Crowther, 'Poverty, Health and Welfare', 266-8.



parochial administration instead of adopting the English model by which numerous parishes were grouped together into Poor Law Unions.

As provision for lunatics and mental defectives became closely associated with the New Poor Law administration, it is worth considering these two features in detail. Regarding the disability qualification, church organised charity had traditionally stressed the need to care for the sick but in the earliest decades of the nineteenth century a new generation of Whig lawyers attempted to restrict relief to this section of the poor. In doing so, they were influenced by the prominent evangelical preacher, Thomas Chalmers. Chalmers held that charity, be it public or private (and in early nineteenth century Scotland the distinction between the two was blurred), undermined the Christian virtues of self-reliance and familial responsibility. In a series of court decisions and authoritative legal texts, Chalmers' sympathisers within the legal community created the so-called 'disability qualification' for poor relief.<sup>17</sup> Always controversial and inconsistently applied, this qualification barred the able-bodied unemployed from obtaining relief under the Old Scottish Poor Law. As it matched, indeed exceeded, the Chadwickian view that able-bodied adults should be discouraged from applying for relief, reformers influenced by Chadwick chose not to tinker with this aspect of the Scottish Poor Law tradition. A legal decision of 1852 confirmed that the rule remained valid within the New Scottish Poor Law system and should be applied to the unemployed.<sup>18</sup>

The disability qualification remained, but according to M.A. Crowther, its effects were blunted by an unwillingness amongst Poor Law medical officers to test applicants' eligibility 'to the limits of starvation'.<sup>19</sup> Hence, able-bodied paupers could often obtain the medical certificate they needed to gain out-door relief or entry into the poorhouse (significantly not called a workhouse because its inmates were regarded as unable to work owing to disability). This indicated a very basic level of altruism within the Poor Law administration, but it was also an expedient way of managing the poor. Early intervention in the relief of poverty could prevent later public expense being incurred if the unaided destitute population became ill or turned to crime. Officially, poor relief to able-bodied adults, except in the case of women bringing up children, was regarded as

---

<sup>17</sup> R. Mitchison, 'The Creation of the Disablement Rule', Smout, *Search for Wealth and Stability*, 199-217.

<sup>18</sup> Crowther, 'Poverty, Health and Welfare', 270.

<sup>19</sup> *Ibid*; see also Levitt, *Poverty and Welfare in Scotland*, 11-12; I. Levitt, 'The Scottish Poor Law and Unemployment, 1890-1929', Smout (ed), *Search for Wealth and Stability*, 263-282.

an abuse of the system. In practice, doctors often employed less stringent criteria in their diagnosis of disability to give more paupers access to state subsidised subsistence. This point is worth noting, bearing in mind that over the next century Poor Law authorities widened their definition of mental deficiency to include more people of higher ability. Although the following chapter will argue that the broadening of the mental deficiency definition occurred chiefly within the education system, parish authorities did show a willingness to maintain defectives possessing a high grade of ability at the expense of the rate-payer.

In its own way the creation of parochial boards, like the relatively loose application of the disability qualification, demonstrated a limited degree of altruism within a general spirit of parsimony. The 1845 act aimed to increase poor relief to disabled paupers by ensuring that local authorities had the power to levy compulsory rates rather than rely on voluntary church donations. Nonetheless, the decision to base local administration around the parish contributed greatly to the paucity of Scottish public provision for the poor. To administer state aid in England, the act of 1834 had created Poor Law unions, each one typically consisting of around 30 neighbouring parishes. In contrast to Scotland's parochial boards, the unions were more likely to include both affluent and poor areas, thereby giving administrators the opportunity to tax the well-off in order to provide for the destitute. They could afford to build larger workhouses and provide institutional treatment for lunatics, idiots and imbeciles, either in specially designated workhouse wards or asylums.

Scotland's 886 parochial boards were generally too small to afford institutions of their own. As the century progressed, many combined to share the cost of a poorhouse, but the resulting combination authorities never approached the size of the English unions and consequently lacked their resources.<sup>20</sup> Despite this, the parish remained the bedrock of Scottish poor relief for decades to come. In 1894, parochial boards were replaced by the more democratic parish councils, but it was not until the Local Government (Scotland) Act, 1929, that administration of the Poor Law was transferred to larger local authorities. For this reason, the Scottish Poor Law system relied heavily on cheaper, non-institutional measures including outdoor relief within the parish and boarding-out

---

<sup>20</sup> Crowther, 'Poverty, Health and Welfare', 270-272.

to unrelated guardians in other areas.<sup>21</sup> These types of provision were offered to lunatics, idiots and imbeciles but when institutional care was deemed appropriate and affordable, parochial boards could also transfer their mentally disabled paupers to the charitable or private asylums that were scattered around Scotland. Many, however, remained in unsegregated poorhouses, the inadequacies of which prompted recurring criticisms throughout the century.

To encourage and regulate separate institutional treatment for the insane (including idiots etc.), the Lunacy (Scotland) Act, 1857, divided Scotland into 19 lunacy districts, each managed by a district lunacy board.<sup>22</sup> District boards were answerable to the newly created General Board of Commissioners in Lunacy for Scotland. The Board's commissioners were obliged to inspect asylums and force asylum managers to maintain a basic level of quality through a system of licensing. The loss of a license would lead to an asylum's closure.

The newly created General Board of Lunacy and its accompanying district boards were separate authorities from those administering the poor relief but the lunacy and Poor Law administrations were, nonetheless, linked in many ways. Although the district boards of lunacy were to build their own asylums through locally levied rates and loans approved by the General Board, parochial boards administering the Poor Law still had to pay for the maintenance of pauper patients accommodated in those district asylums. Hence, the act of 1857 did not transfer responsibility for maintaining the pauper insane away from the Poor Law system.<sup>23</sup> It did largely transfer responsibility for building and maintaining the public asylums themselves to the district boards of lunacy. However, even then it was possible for a Scottish parochial board to build and manage its own asylum if it could afford to do so, and providing its parochial asylum met with the approval of General Board of Commissioners in Lunacy for Scotland.<sup>24</sup>

Only the parochial boards based in Scotland's cities were large enough to establish asylums of their own but they too could be restricted by parish boundaries that divided

---

<sup>21</sup> J.R. Motion, Glasgow's Inspector of the Poor, claimed in 1906 that Glasgow Parish Council saved between £2,500-£3000 a year by boarding many of its insane paupers out rather than accommodating them in asylums, HMSO, *Royal Commission on the Care and Control of the Feeble-Minded* III (Cd. 4217, 1908), 60.

<sup>22</sup> Lunacy (Scotland) Act, 1857 (20 & 21 Vic., c. 71).

<sup>23</sup> It did, however, allow families to place lunatics and imbeciles in asylums at the Poor Law authorities' expense without themselves being pauperised in the process, I. Levitt, *Poverty and Welfare*, 13.

<sup>24</sup> T. Walmsley, 'Psychiatry in Scotland', Berrios and Freeman, *150 Years of British Psychiatry*, 294-305; J. Andrews and I. Smith, 'Evolution of Psychiatry in Glasgow', 312-314.



the rateable population. Under the Poor Law Act, 1845, Glasgow was split into four parishes. The City Parish covered the densely populated central area north of the Clyde. It included the rich commercial centre of the city but also contained areas of extreme poverty. City Parish had inherited the old Town Hospital, which made it the only parochial board in Glasgow to have its own poorhouse when the New Poor Law came into operation. Lunatics, idiots and imbeciles made up a significant proportion of its inmates. Following the Lunacy (Scotland) Act, 1857, poorhouses were required to establish separate institutional space for lunatic inmates (which included idiots and imbeciles under the terms of the act). The City purchased one of Scotland's few private lunatic asylums, which became Glasgow District Asylum in 1881. This was replaced by Gartloch Hospital in 1897.

In contrast to the City, Gorbals parish, covering the poorest area south of the Clyde, had no pre-existing institution in which to house the poor and lacked the money to build one. In 1872, it amalgamated with the parish of Govan, which contained pockets of both poverty and affluence. Most of its population lay south of the Clyde but the parochial boundaries crossed the river in the west to take in the wealthy suburb of Partick. Contemporaneously to its merger with Gorbals, Govan began to provide separate institutional care for lunatics in a ward of its recently built Merryflats poorhouse. Govan's first district asylum opened at Hawkhead in 1895.

The fourth Glasgow parish was Barony, which surrounded City Parish in a giant horseshoe north of the Clyde. It included the wealthy suburban district of Blythswood from which the parochial board acquired sizeable rates to fund ambitious projects. The parish quickly established its own poorhouse with in-house medical provision at Barnhill hospital. It also pioneered the building of large parochial asylums with the opening of Woodilee Hospital in 1875.<sup>25</sup> Following the contemporary preference for out of town institutions, Woodilee was situated on a large country estate outside Glasgow. By the end of the century it accommodated some 600 patients and seemed to enjoy a fairly wide-spread reputation.<sup>26</sup> The Barony Parish employed a part-time Certifying Physician in Lunacy to oversee the admission of lunatic paupers into Woodilee Asylum. In the last two decades of the century, the post was taken by Dr John Carswell.

---

<sup>25</sup> Andrews and Smith, 'Evolution of Psychiatry in Glasgow', 312-314; S. Blackden, 'The Poor Law and Health: A Survey of Parochial Medical Aid in Glasgow, 1845-1900', Smout (ed), *Search for Wealth and Stability*, 243-262.

<sup>26</sup> Blackden, 'Poor Law and Health', 252.

Carswell was to have an influential role in shaping services for mental defectives in Scotland. He was born in Glasgow in 1856 and educated in his home city, graduating from Anderson College in 1877 before taking the post of assistant physician at Woodilee Asylum. As a boy, Carswell had seen his father and two of his siblings die of typhoid. He was later to claim that these tragedies had helped strengthen his commitment to public health. This commitment was to make him resistant towards eugenic theories propagated around the turn of the century, as Carswell believed that eugenicists blamed improvements in public health for the growing numbers of mental and physical defectives (by providing an environment in which the least fit members of society were able to survive and reproduce).<sup>27</sup> Carswell's psychiatric career was more of a gradual climb than a spectacular rise. He published some short articles on subjects such as insanity, mental deficiency and alcoholism, and favoured an approach to mental illness that emphasised the importance of early intervention and treatment. In later years, as school medical officer specialising in mental deficiency for Glasgow's school board, Carswell would extend the principle of early intervention to his role within the special education system. However, his earliest achievements in this area took place whilst he was certifying officer for the Barony. In 1887, he established one of Britain's first observation units at Barnhill hospital to identify people in the initial stages of mental illness and facilitate their treatment.<sup>28</sup>

Besides the parochial and district asylums, Scotland possessed two other types of institution for the insane. The least important of the two were the private asylums. Unlike England, private, profit-led, madhouses had not flourished in Scotland. Having said this, the boarding-out system allowed private guardians to profit from keeping small numbers of mentally disabled paupers in their homes.<sup>29</sup> After 1862, up to four lunatics or idiots could be maintained by a private guardian. Guardians received a weekly payment for each boarded-out case from the Poor Law authority that sent them. This aliment was mainly intended for the maintenance of the boarded-out pauper(s), but there was no effort made to prevent guardians from taking an over-generous share for

---

<sup>27</sup> NAS MC 14/6 John Carswell, 'The Fifth Maudslay Lecture: Some Sociological Considerations Bearing Upon the Occurrence, Prevention and Treatment of Mental Disorders' reprinted from the *Journal of Mental Science* (1924).

<sup>28</sup> A.B. Sclaire, 'John Carswell: A Pioneer in Scottish Psychiatry', *Scottish Medical Journal* 26 (1981), 265-270; J. Andrews, 'A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry', *History of Psychiatry* 8 (1997), 196-197.

<sup>29</sup> Sturdy and Parry-Jones, *Boarding-out Insane Patients*, 86-114.

themselves if they so desired.<sup>30</sup> Outside the boarding-out system, there were also a few larger private madhouses similar to those found in England. They did not fare well in Scotland. By the early twentieth century there were only three left, the others having been closed by the General Board of Lunacy on account of poor conditions or taken over by local authorities.<sup>31</sup> The remaining three were all very small and only accommodated patients from wealthier families.<sup>32</sup>

More significant than the private madhouses were the 'Royal or Chartered Asylums'. These were large charitable institutions, established by act of Parliament or royal charter. Under the Lunacy (Scotland) Act, 1857, the General Board of Lunacy had powers to inspect and report on such institutions, but only an advisory role in their administration. By the turn of the century, there were seven asylums of this kind in Scotland. Three received only private patients, whilst four also took in rate-aided paupers maintained at the expense of the parochial authorities who sent them there. Glasgow's Royal Asylum opened in 1814 and was intended to take lunatics out of the Town Hospital. Overcrowding prompted a move in 1843 to a larger building in the city's western hinterland where the asylum took on the new name of Gartnavel. It received private, charitable and rate-aided patients, though in the later part of the century, its superintendent, Dr David Yellowlees, pursued a policy of transferring pauper lunatics to the district asylums.<sup>33</sup>

The national institutions for imbecile children were licensed under the terms of the Lunacy (Scotland) Act, 1862 and were broadly similar in status to the royal or chartered lunatic asylums. By the end of the century, there were still only two in existence: the Scottish National Institution for the Education of Imbecile Children at Larbert, Stirlingshire and the Baldovan Asylum for the Treatment of Imbecile Children near Dundee. Both contained rate-aided patients from Glasgow, although the city authorities tended to favour Larbert because it was nearer.<sup>34</sup> Larbert and Baldovan received private, charitable and rate-aided patients, who could remain there until the age of 18.<sup>35</sup> In this

---

<sup>30</sup> Abrams, *Orphan Country*, c. 2; Sturdy, 'Boarding-Out the Insane', 95.

<sup>31</sup> Andrews and Smith, 'Evolution of Psychiatry in Glasgow', 313-315.

<sup>32</sup> HMSO, *Royal Commission on Feeble-Minded* III, 9.

<sup>33</sup> Andrews and Smith, 'Evolution of Psychiatry in Glasgow', 309-314.

<sup>34</sup> In 1906, Glasgow Parish Council (formed out of the Barony and City parishes after their merger in 1898) had 68 pauper imbeciles at Larbert and 19 at Baldovan, HMSO, *Royal Commission on Care and Control of Feeble-Minded* VIII (Cd. 4202, 1908), 396.

<sup>35</sup> The decision to bar adult defectives over the age of 18 from residing at Larbert or Baldovan was taken by the General Board of Lunacy in Scotland in 1876, see Ireland, *Mental Affections of Children*, 410.



respect, the Scottish institutions differed from the English idiot asylums, which generally received adult chronic cases as well as children. On reaching their majority, Scottish patients could be discharged into the community, boarded-out or returned to their legal guardians. However, any patient considered by the authorities to require further institutional treatment on reaching adulthood could be transferred to asylums or lunatic wards in poorhouses, despite the fact that this appeared to blur the distinction between mental imbecility and lunacy.

Under the 1862 act, imbecility was classed as a kind of lunacy, and the practice of transferring adult imbeciles to lunatic asylums demonstrates how the two conditions could be conflated in practice. Nonetheless, medical opinion at the time tended to distinguish between the two types of mental disability and this medical distinction found its way into a number of administrative and legal procedures associated with state-regulated institutional care. Children accommodated at one of the two imbecile institutions were registered separately from lunatics in the General Board of Lunacy's statistical records.<sup>36</sup> More importantly the state had fewer powers of intervention when dealing with imbecile children. Whilst it was possible for the authorities to apply to the courts for a sheriff's order compelling the committal of a lunatic to an asylum, children could only be sent to one of the institutions for imbeciles with the consent of their legal guardians. For most patients, the legal guardian was a parent or other family member, although in the case of abandoned, neglected or orphan children guardianship would be passed to whichever Poor Law authority was responsible for paying their maintenance. The voluntary principle governing entry into imbecile institutions ceased to apply if the authorities later chose to transfer an imbecile patient to a lunatic asylum. If a patient's guardian refused to consent to such a transfer, the authorities could compel such a move on successful application for a sheriff's order.<sup>37</sup>

The linking of imbecility and lunacy in Scottish law therefore obscured administrative distinctions as well as separate institutional provision. This was recognised by contemporary administrators. For instance, John Carswell claimed to be unconcerned about the legal confusion because in practice imbeciles were treated separately from lunatics. In 1898 he was reported as telling the Scottish Division of the Royal Medico-Psychological Association:

---

<sup>36</sup> Carswell, 'Care and Education of Weak-minded and Imbecile Children', 476.

<sup>37</sup> HMSO, *Royal Commission on Feeble-Minded* III, 11.

in Scotland they had the knack of being able to say half a dozen when it did not suit them to say six, and he [ie. Carswell] thought they could get round about difficulties in this way: that here was a method in which imbecile and idiot children had been dealt with as lunatics on the initiation or application of the Inspector of Poor, and in the proceedings of the parish council... they had been considered as lunatics, but had never been treated like an ordinary lunatic in the asylum. They had been separately provided for, just as if there was a special Act providing for them.<sup>38</sup>

However, Carswell's view was based on his experience at the Barony parish, which provided more asylum accommodation than any other Poor Law authority in the country. He also astutely limited his remarks to idiot and imbecile *children*. Adults were less likely to receive separate treatment. In 1906, he admitted to a Royal Commission investigating provision for mental defectives that some Scottish asylums continued to accommodate adult imbeciles and lunatics in the same wards. When asked by a Commission appointee to state any objections he had with 'the current procedure for dealing with imbeciles as lunatics in Scotland', Carswell replied:

I would prefer personally ... to see the imbeciles kept together in an imbecile institution instead of being sent into the wards of asylums where there are chronic, maniacal and epileptic persons... I am always sorry when I see adult imbeciles in the ordinary wards of the asylum.<sup>39</sup>

Furthermore, in some poorhouses, lunatics and imbeciles were placed in the same wards as ordinary inmates. In his evidence to the same Royal Commission, the Scottish Local Government Board's General Superintendent of Poor Houses, R.B. Barclay, stated that before his appointment in 1892, it was regular practice for lunatics and idiots/imbeciles to be admitted to the ordinary wards of poorhouses even though this was forbidden by the Lunacy (Scotland) Act, 1857. Medical officers attempted to circumvent the law by avoiding direct reference to lunacy or idiocy in their medical certificates for mentally disabled paupers entering ordinary poorhouse wards. Barclay told the commission:

---

<sup>38</sup> Carswell, 'Care and Education of Weak-minded and Imbecile Children', 491.

<sup>39</sup> HMSO, *Royal Commission on Feeble-Minded* III, 66.

[a]dmission to the poorhouse is obtained on an order from the poor of the parish where the applicant applies. The order must be accompanied by a medical certificate in a form prescribed by the Board.

In this certificate the medical officer has to give a categorical reply to the question:-

“Is applicant or any dependent ‘Lunatic, insane, idiot, or of unsound mind’, ” and it is pointed out on the certificate that “No person so described can be legally sent to, or received in a poorhouse, unless it possesses licensed lunatic wards, and then only with the sanction of the General Board of Lunacy.”

Previous to my appointment, it was found that the answer to the above question was frequently evaded either by an omission to answer the question altogether or by making some such remark as “weak-minded” or “formerly in asylum” etc.<sup>40</sup>

Barclay immodestly maintained that he had stamped out such abuses and virtually cleared the ordinary poorhouse wards of mentally disabled paupers. However, the Royal Commission found other witnesses who suggested this was not so. One Commissioner in Lunacy, Dr John Macpherson, conducted a personal investigation of two Scottish poorhouses and found a number of imbeciles and other mentally disabled paupers in each. He also confirmed that parish authorities ‘bargained about imbeciles before acting on certificates or obtaining certificates for them’.<sup>41</sup> The Royal Commission found that even in the larger poorhouses of Glasgow, ‘mentally abnormal inmates’ were only said to have been segregated ‘[w]here structural arrangements render it possible’.<sup>42</sup>

There was a financial incentive to break Poor Law regulations by placing lunatics and imbeciles in ordinary wards. As they were not licensed to receive mentally disabled patients, such wards evaded inspection by lunacy commissioners and did not need to meet the General Board of Lunacy’s standards. Staff ratios were generally less favourable in the ordinary wards, and the cost of maintaining inmates was well below those of the asylums. The figures for 1898 are fairly typical for the late nineteenth century. In that year, the average annual cost of maintaining a pauper in the ordinary

---

<sup>40</sup> *Ibid*, 163

<sup>41</sup> HMSO, *Royal Commission on Feeble-Minded* VIII, 372-373.



wards of Scotland's poorhouses came to £10.5.4¼.<sup>43</sup> In contrast, it cost an average of £18.1.9. to maintain a pauper in a lunatic ward of a poorhouse and an average of £25.14.7. to maintain a pauper in an asylum during the same year.<sup>44</sup> The maintenance charge for pauper imbeciles attending Baldovan Institution was £25 a year, whilst Larbert charged £30.<sup>45</sup> Most of the expenditure was born by the parish. Parochial authorities could ask for contributions from family members if they were considered able to afford it, but most pauper lunatics and imbeciles came from poor backgrounds making familial contributions small or none existent.

Parishes also received Treasury contributions for the maintenance of lunatics and imbeciles after 1874. During most of the 1890s the Treasury contribution was fixed at £115,000. This was distributed to the parochial authorities, the maximum Treasury contribution to the maintenance of any one pauper lunatic or imbecile being set each year at around 4s. per week (the figure fluctuated slightly from one year to the next). This maximum contribution applied to any lunatic or imbecile whose maintenance in an institution came to 8s. a week. If the patient's maintenance was more than 8s., the parish would be penalised, as no additional Treasury contribution would be provided to subsidise the extra cost.<sup>46</sup> In fact, the average cost of keeping a pauper in a lunatic asylum or institution for imbeciles came to around 10s. a week. Despite the Treasury contribution, it would cost a Poor Law authority at least 50% more of its own rate-levied income to send a pauper to a lunatic asylum or institution for imbeciles than it would to send the pauper to an ordinary ward in a poorhouse.

Despite the additional costs, some parishes, particularly the larger urban authorities, did begin to make a serious attempt at segregating their mentally disabled paupers. For those who could afford to do so, removing disruptive inmates from the ordinary wards aided poorhouse management.<sup>47</sup> Furthermore, central government increasingly pressurised local authorities to provide special accommodation for the mentally disabled. The Scottish General Board of Lunacy existed to enforce the Lunacy (Scotland) Act, 1857. Although it lacked effective powers to do so, its role in

---

<sup>42</sup> HMSO, *Royal Commission on Feeble-Minded* III, 376.

<sup>43</sup> HMSO, *4<sup>th</sup> Annual Report of Local Government Board for Scotland 1898* (C. 9273, 1899), xv.

<sup>44</sup> HMSO, *42<sup>nd</sup> Annual Report, General Board of Lunacy for Scotland 1900* (Cd. 368, 1900), liii-liv.

<sup>45</sup> Carswell, 'Care and Education of Weak Minded and Imbecile Children', 482.

<sup>46</sup> HMSO, *42<sup>nd</sup> Annual Report, General Board of Lunacy for Scotland 1900*, pp. liii-liv.

<sup>47</sup> Andrews and Smith, 'Evolution of Psychiatry in Glasgow', 309-311; M. Thomson, *Problem of Mental Deficiency*, 34.

distributing Treasury contributions after 1874 aided its case in persuading local authorities to provide asylum accommodation. During the 1890s, Scotland's Local Government Board also attempted to prevent the wrongful committal of lunatics and imbeciles to ordinary wards, even if its efforts did not meet with the level of success claimed by Barclay in 1906.

High profile organisations within the voluntary sector also took up the cause of institutional care for mental defectives in the second half of the nineteenth century. The Charity Organisation Society and Scotland's Society for the Education of Imbecile Children have been alluded to in the previous chapter. The COS followed the tradition of Thomas Chalmers, whom members acknowledged as an inspiration, believing that an indiscriminating use of charity had a detrimental effect on society.<sup>48</sup> Much of the Society's work centred on encouraging the able-bodied poor to become self-reliant (ie. find a job), whilst focusing genuine charitable assistance on those considered to be deserving of it. Hence, the COS worked along similar principles as the Poor Law and adopted its view of the 'deserving poor': that is, children, the old and the infirm.<sup>49</sup>

Mental deficiency had been a campaigning issue for the COS since the mid-1870s. Around that time, the COS also began to branch into Scotland.<sup>50</sup> In 1896 it stepped up its activities on the issue of institutional care for mental defectives by forming the National Association for Promoting the Welfare of the Feeble-Minded. The Association's work was well publicised. Many of its leading figures were highly placed within governmental circles.<sup>51</sup> They also gained support from certain doctors involved in institutional provision for mental defectives. For example, whilst making his own calls for separate institutional provision for idiots and imbeciles W.W. Ireland made the following remark:

[t]o sum up in the words of the Special Committee of the Charity Organisation Society, who carefully examined the question – 'In Scotland there is the same mixing together of lunatics and idiots [as in England], to the serious injury of both, and the same absence of any legal provision for training juvenile idiots and imbeciles, all of which has arisen from the laws having been passed when the

---

<sup>48</sup> Crowther, 'Poverty, Health and Welfare', 268.

<sup>49</sup> Lewis, *Voluntary Sector, and the State*, 46-54.

<sup>50</sup> Crowther, 'Poverty, Health and Welfare', 268.

<sup>51</sup> M. Thompson, *Problem of Mental Deficiency*, 14-15.

essential differences between lunatics and idiots were not understood or acknowledged'.<sup>52</sup>

The pressure on local authorities to create more institutional provision of this kind was therefore increasing. In terms of institutions for lunatic paupers, Barony became Scotland's most active parish with its asylum at Woodilee (notable as one of the few parochial asylums) and observation wards at Barnhill Poorhouse. In 1898, Barony merged with City Parish and with their combined resources (and social problems) the resulting Glasgow Parish Council became Scotland's largest single supplier of patients to the Scottish asylum system. Yet even Glasgow Parish Council repeatedly experienced difficulties finding suitable accommodation for all the paupers certified by its medical officers as lunatic or imbecile. Glasgow's continuing housing shortage, encouraged by large-scale migration into the city and periodic trade depressions meant that even whilst the city economy was buoyant (in comparison to present day standards), the poorhouses continued to fill. It seems reasonable to assume that the stresses of poverty could have a malign effect on the mental health of the destitute, and as the population of Glasgow grew, so did the perceived need for additional asylum space.

This provides one reason for why Glasgow's local authorities continually felt it necessary to increase the amount of institutional accommodation available to pauper lunatics and imbeciles.<sup>53</sup> There is, however, a second reason not necessarily exclusive of the first. Namely, that the increasing demand for asylum accommodation was as much a consequence as it was a cause of Glasgow's extensive public sector provision for lunatics and imbeciles. Carswell believed that public provision tended to subsume philanthropic effort, an opinion he had formed from observing how public asylum provision had led to rate-aided lunatics largely replacing charitable patients during the second half of the nineteenth century. In 1898, he foresaw a similar pattern emerging as a result of Barony's willingness to pay the maintenance of imbecile children at Larbert and Baldovan, claiming that '[t]his method of providing for pauper imbecile children tends towards an increase of the number so maintained, because voluntary charity ceases when legal provision is found ready at hand to take its place.'<sup>54</sup>

---

<sup>52</sup> Ireland, *Mental Afflictions of Children*, 411.

<sup>53</sup> HMSO, *Royal Commission on Feeble-Minded* III, 64.



Whilst voluntary organisations like the COS were pushing for more institutional provision for mental defectives, they expected the Poor Law authorities to pay for the maintenance of their poor patients.<sup>55</sup> The trend away from charity, towards state financed provision for mental defectives would continue in the years that followed. By the early twentieth century, the overwhelming majority of institutionalised mental defectives were rate-maintained, whilst charitable work concentrated more on new forms of community-based care for mentally defective adults.<sup>56</sup> As the public sector possessed considerably greater resources than the charitable sector it was able to finance an expansion in institutional accommodation. Looking back in 1924 on the increase in institutionalised patients that occurred in Glasgow during the period he held his post as Certifying Officer in Lunacy, Carswell asserted that, 'we very soon found, what all experience teaches, that when public provision is made for any purpose, the demand increases with supply'.<sup>57</sup>

Carswell believed that the increased demand for publicly maintained asylum accommodation was linked to a growing awareness amongst the public that such institutions could be of use in caring for mentally abnormal family members. This particularly applied to Barnhill's observation wards and the imbecile institutions where all the patients were admitted on a voluntary basis.<sup>58</sup> However, in the 1890s, one of Glasgow's local authorities was to embark on a policy that would have a more direct impact on the growing demand for specialised provision for mental defectives. The School Board of Glasgow introduced the concept of feeble-mindedness into its public education system, thereby extending the boundaries of mental deficiency to include a greater proportion of the city's population. This was to have significant repercussions in encouraging the expansion of institutional care for mental defectives, besides introducing a new form of segregation within the school system. To understand how these developments occurred, it is necessary to examine the origins of special education for the feeble-minded in Scotland.

### *Special Education in Day Classes and Institutional Care*

Scotland's school boards were established by the Education (Scotland) Act, 1872. The School Board of Glasgow's boundaries broadly followed those of the municipality,

---

<sup>54</sup> Carswell, 'Care and Education of Weak Minded and Imbecile Children', 477.

<sup>55</sup> Jones, *History of Mental Health Services*, 184-5.

<sup>56</sup> See c. 5.

<sup>57</sup> NAS MC 14/6 Carswell, 'Fifth Maudlsey Lecture', 7-8.

taking in City and Barony Parishes, as well as a few districts south of the Clyde such as Gorbals and Tradeston. Govan Parish School Board followed, as the name suggests, the parish boundaries of Govan (which included Partick on the north bank of the river). The 1872 act nationalised an education system formerly administered by religious denominations, but the transition from church to state was far from complete. The act allowed schools that drew their pupils from minority religions to occupy a middle-ground between the public and private sector. These ‘denominational’ or ‘voluntary’ schools continued to maintain their links to their local churches. They were not owned by the state but were able to receive state grants. Representatives of denominational schools were permitted to take seats on local school boards, which usually contained a high proportion of churchmen and produced policies that affected both public (ie. state owned<sup>59</sup>) schools and denominational schools. This feature of Scottish education particularly encouraged the development of Catholic schools. By 1914, an eighth of Scotland’s pupils were being educated in Catholic schools, whilst in Glasgow the figure was closer to a fifth. Other denominations such as the Episcopalian church maintained similar educational establishments but lacking the cohesiveness and numbers of the Catholic community, the other kinds of voluntary schools declined in number in the decades following 1872.<sup>60</sup>

Scotland also had a smaller number of private schools, recognised by the state but not maintained by school boards. Using statistics which he admits ‘are not very reliable’, R.D. Anderson has estimated that 8% of Scottish pupils attended private schools in 1880, whilst by 1897 the figure had decreased to 1.5%.<sup>61</sup> The private schools were fee paying, but then the act of 1872 had not legislated for free education even in the public sector. Instead, school boards were only obliged to pay for the education of a pupil, if the child’s legal guardians lacked the money to pay for it themselves. Many educationists appreciated the additional income brought in by parental contributions, but free education became something of a political issue amongst working-men’s organisations. In 1885 the populist English liberal, Joseph Chamberlain, included free education in his ‘unauthorised programme’ although it was the Tories who finally passed the necessary Scottish legislation in 1890. Free education was made mandatory

---

<sup>58</sup> HMSO, *Royal Commission on Feeble-Minded* III, 64-6.

<sup>59</sup> In this thesis, the term ‘public school’ will always refer to state-owned schools, rather than private schools of the Eton and Harrow variety.

<sup>60</sup> R.D. Anderson, *Education and the Scottish People 1750-1918* (Oxford: Clarendon Press, 1995), 180.

<sup>61</sup> *Ibid*, 225-6.

for pupils between the age of 5 and 14. This affected the public and denominational schools but not fee-paying private schools.<sup>62</sup>

The Education (Scotland) Act, 1872, moved the Scottish education system closer to the principle of universal state education than its English equivalent had two years earlier. Nonetheless, private school pupils were not the only children outside the new system. It was recognised from the start that the new elementary schools would not be designed to cater for the needs of children with sensory, mental or physical defects.<sup>63</sup> There were, in the 1870s, Members of Parliament prepared to advance the cause of special day classes for blind and deaf-mute children, although it was not until 1890 that Parliament passed legislation giving Scottish school boards the option of establishing such classes. Parliament seemed more willing to provide special education for pupils with sensory defects in comparison to mental defectives. Given the appropriate teaching methods it was possible for the blind and deaf to perform well within the school curriculum. Imbeciles, on the other hand, could be characterised as inherently unable to succeed at school, particularly at a time when their ability to make sufficient educational progress in the teaching institutions was in doubt. There were also relatively few pupils possessing sensory defects, which helped to limit the expense of providing them with special classes. Mental defectives were more of an unknown quantity (literally). As the previous chapter described, pressure for special day classes for mental defectives (and, for that matter, physical defectives<sup>64</sup>) did not begin to gain ground until the late 1880s.

In the 1870s and 1880s, idiots and imbeciles were excluded from the state education systems of both England and Scotland. In Scotland, the legal basis for this exclusion was unclear until 1883. In that year, Parliament passed a vaguely worded Education (Scotland) Act, which stated that 'sickness or any other unavoidable cause' could be cited as a 'reasonable excuse' for exempting children from elementary schools.<sup>65</sup>

Responsibility for exempting mental defectives was left to headmasters and attendance officers rather than qualified medical practitioners, school medical officers being virtually unheard of at this time.

---

<sup>62</sup> *Ibid*, 190.

<sup>63</sup> Mr. Hibbert M.P., *Hansard* 209 (6<sup>th</sup> Feb 1872 - 4<sup>th</sup> Mar 1872), 1502.

<sup>64</sup> For an account of what he calls the 'discovery' of the crippled child in the late nineteenth and early twentieth century, see R. Cooter, *Surgery and Society in Peace and War* (London: Macmillan, 1993), c. 4.

<sup>65</sup> Education (Scotland) Act, 1883 (46 & 47 Vic., c. 56).



The legislators behind the Education (Scotland) Act, 1872 had not considered the issue of idiocy, no doubt assuming that such children were best left to the asylum authorities. When headmasters decided that certain children were unable to receive an education owing to mental or bodily defect, there was no real procedure to guide their actions. The simplest response was to bar such children from school and leave it to the parents to provide the necessary care. There was no obligation on the school boards to inform any other local authority, such as the parish or district boards, if a child was excluded on grounds of mental deficiency. The decision to apply for poor relief, boarding-out or institutional provision was left to the parents. At least, this was generally the case. Members of the School Board of Glasgow came to adopt a different policy by taking it upon themselves to inform other authorities of pupils they excluded.

When this policy was first suggested is unclear but W.W. Ireland recollected that during his period at Larbert (between 1871 and 1881) a member of Glasgow school board approached Barony parish to discuss the provision of institutional accommodation for around 70 of the Board's pupils.<sup>66</sup> The school board member was William Mitchell. Like most school boards, Glasgow's was dominated by clerics of one denomination or another. Mitchell, on the other hand, though a member of the free church, ran a modest calico printing business. He was elected to the Board in 1873 with fewer votes than any other successful candidate and served for the next twenty-seven years, gaining a reputation as its most active member.<sup>67</sup> Taking a special interest in infirm children, he made a point of contacting all the local institutions that could provide accommodation for the various types of defective children on the school roll. According to Ireland, Mitchell's attempt to persuade Barony to establish an institution for imbecile children was thwarted by the directors of Larbert. They stepped in to dissuade the parochial board from taking this course of action and set about accommodating the children themselves. Ireland claims to have opposed his directors' actions on the grounds that Larbert only had space for about a third of those pupils on Mitchell's list but his objections were ignored.

How far this view of events can be treated as reliable, bearing in mind Ireland's long-running grievance against his previous employers, is open to doubt. Speaking in the late

---

<sup>66</sup> Ireland's comments to Carswell in Carswell, 'Care and Education of Weak Minded and Imbecile Children', 488.

<sup>67</sup> J.M. Roxburgh, *The School Board of Glasgow 1873-1919* (London: University of London Press, 1971), 174-5.

1890s, he used the tale as an excuse to work up some fresh invective against his old tormentors, telling an audience of local notaries that he ‘did not think it was proper for men called philanthropists to vote against providing accommodation’ for all the children concerned.<sup>68</sup> Ireland’s inference seemed to be that the directors of Larbert were prepared to let two thirds of Mitchell’s pupils go unaccommodated rather than give their support to the opening of a rival institution. If Mitchell shared Ireland’s resentment, he refrained from making a public issue of it. Writing in 1886, the school board member singled out Larbert by name when he praised local institutions that had accommodated pupils excluded by his school board:

[i]t only needed representations by the School Board regarding the circumstances of such children to call forth active and sympathetic co-operation on the part of the respective managers, and the most pressing cases were at once admitted to the institutions suitable to their circumstances. The institutions for the Deaf and Dumb, the Blind, and, at Larbert, for the Imbecile, all received an accession to their numbers, and soon a very perceptible inroad was made on this numerous band of infirm and suffering children.<sup>69</sup>

In any case, the Barony parish did not act on Mitchell’s suggestion; at least, not in the short term.

In the years that followed, the school board of Glasgow began to expand its role beyond the classroom, extending its gaze into the homes of pupils and forming closer ties with Poor Law authorities and local charitable organisations such as the Scottish Society for the Prevention of Cruelty to Children (SSPCC). Mitchell instigated many of these initiatives. In his publication of 1886, titled (in characteristically missionary language) *Rescue the Children*, he promoted the school board’s interest in defective and neglected children in terms of Christian charity, social stability, patriotism and education.

Like clay in the hands of the potter, they [the pupils] are waiting to be moulded. The material there for goodly vessels, honest, honourable citizens of the future. Great the danger that, left in their present condition, they will grow up to swell

---

<sup>68</sup> Ireland’s comments to Carswell in Carswell, ‘Care and Education of Weak Minded and Imbecile Children’, 488.

<sup>69</sup> W. Mitchell, *Rescue the Children: or Twelve Years’ Dealing with Neglected Girls and Boys*, (London: Wm. Isbister Ltd., 1886), 80-81.

the already too numerous class who bring disgrace on themselves and shame and discredit on their country. Ah! you say, are they not being educated? That will bring them round all right. Will it? I fear not, or at least only partially. Education is the leading spirit of the age, but education is not food, education is not clothing; education cannot take the place of home comforts, home training, home influences. Children must have the natural and material wants of the body supplied ere the benefits and blessings of education can be either received or valued. The Education Act lays upon the parent the duty of educating his child, but makes no corresponding demand in respect to his physical wellbeing.<sup>70</sup>

Mitchell's justification for his school board's interests in the health and welfare of its children echoed the stated aim of W.E. Forster, that the state should intervene to prevent the children of the lowest class growing up to be 'no better than their parents'.<sup>71</sup> Schools ensured that parents were no longer solely responsible for bringing up their children, thus mollifying that strand of middle-class opinion that suspected many working-class households to be unsuitable environments for the development of healthy young bodies and minds. Forster placed his trust in the power of education to instil morality and productive habits into the children of the poor, but the Education Acts of the 1870s still left responsibility for the general welfare of the child to the parents. Mitchell sought to go beyond this original remit, as his personal experience of dealing with the parents of his most difficult children left him doubtful of their ability to safeguard their physical or moral well-being. His attitude towards them mixed pathos with condemnation:

there are stories of heroic fortitude and endurance, pictures of moral grandeur and beauty, scenes of harrowing distress and misery, which would tax his utmost powers. Combined with these, and of still more frequent occurrence, tales of wicked, foolish, misspent lives, where the demon of intemperance has held sway, and where the poor suffering children have been the sad victims of their parents' sin and shame.<sup>72</sup>

When Glasgow's school board was first established, there were institutions at hand to accommodate blind, deaf mute and imbecile pupils but no such institution existed for

---

<sup>70</sup> *Ibid*, 16.

<sup>71</sup> Quoted by Hurt, *Elementary Schooling*, 24.

<sup>72</sup> Mitchell, *Rescue the Children*, 20.



physically defective or sick children. Yet it was the poor physical condition of pupils, exacerbated by low standards in housing and nutrition, that made the biggest impression on educationists at that time. Glasgow's school board operated in similar conditions to the city's Poor Law authorities, in the sense that it had to deal with the problems of poverty on a large scale but had a large enough rateable income to pay for more ambitious projects than the smaller Scottish school boards. Glasgow was also home to a number of wealthy philanthropists, including the industrialist Alexander Whitelaw, who became the first chairman of Glasgow's school board in 1873.<sup>73</sup> Perhaps because they shared a similar background in business, Whitelaw and Mitchell were able to form a close working relationship at the Board. Together, they helped found East Park Home for physically defective children in 1874.

The money to build the home came from local philanthropists but although the institution was a charitable endeavour, it was founded by school board members in response to the large numbers of unhealthy children made visible to the authorities following the Education Act of 1872. The link between the school board and the institution was strengthened by the fact that Whitelaw became chairman of the Home's board of managers. In this role, he employed a part time medical officer who visited patients at East Park, many of whom had been notified to the home by the school board. Thus, Glasgow's education system had at an early stage informally developed a school health service with its own treatment centre and doctor.<sup>74</sup> Initially this school health service initially focused on physically defective children, mental defectives soon came under its gaze.

Glasgow school board's access to medical resources placed it in an ideal position to respond to the developments in special education that were taking place in England during the last decade of the century. The Egerton Commission published its report in 1889, with its tentative recommendations that mentally defective pupils be educated separately from ordinary pupils. Since 1892, several urban-based education authorities south of the border had established their own special day classes for feeble-minded children within the state school system.<sup>75</sup> Four years after London's education authority took this initiative, Glasgow's school board embarked on an investigation that would

---

<sup>73</sup> Roxburgh, *School Board of Glasgow*, 20-22.

<sup>74</sup> Mitchell, *Rescue the Children*, 84-6.

<sup>75</sup> See c. 1.

lead to the establishment of Scotland's first special day classes for mental and physical defectives. Following the example of London, Glasgow's school board employed the services of a medical practitioner from the outset.

In 1896, the board conducted a survey to determine the number of mental and physical defectives on Glasgow's school roll. Little documentation of the event has survived but it is possible to piece together some of the circumstances in which the survey was conducted. At that time, the school board's links to the medical profession had developed to the point that it employed its own part time medical officer to examine pupils with a view to arranging treatment in East Park Home or one of the other institutions. The medical officer was Dr Wilson Bruce, who was also a member of Barony Parish Council. Barony, it will be remembered, had been running Woodilee, Scotland's largest parochial asylum, since 1875.<sup>76</sup> Hence, the school board's survey was conducted by a member of a well resourced Poor Law authority (relative to the rest of Scotland) with a proven record in providing specialised institutional treatment for lunatics.

The survey had three purposes: to find out the number of defective children on Glasgow's school roll, to categorise those children by type and degree of defect and to assess whether or not their parents could afford to pay maintenance for those children deemed to require institutional provision. The board invited headmasters and attendance officers under its authority to give notice of any child of school age, who 'after a trial in an ordinary public elementary school, has been found, owing to mental or physical disability, to be capable of receiving instruction in only a proportion of elementary education'.<sup>77</sup> The medical officer then examined those pupils whose names were put forward, whilst the board looked into the financial position of the parents.

The survey was not published, but in 1906, R.S. Allan, who chaired the school board at that time, summarised the results to the Royal Commission. Of the children currently attending elementary schools, 184 were identified by headmasters as defective. Of these, the medical officers classed 79 as mental defectives, 41 as both mentally and physically defective, whilst 40 were considered to be physically defective only. This made a total of 160 pupils diagnosed by Bruce as having some form of deficiency,

---

<sup>76</sup> Carswell, 'Care and Education of Weak Minded and Imbecile Children', 478.

<sup>77</sup> HMSO, *Royal Commission on Feeble-Minded* III, 268.

leaving 24 not diagnosed as defective. The attendance officers also alerted Bruce to a number of pupils exempted from school on the grounds of imbecility. As a result, Bruce diagnosed 47 children as suitable for placing in an institution such as Larbert. The board's inquiries into the financial position of the parents led them to notify the relevant Poor Law Authorities of 67 'imbecile children of poor parents' residing in their areas.<sup>78</sup> The school board expected these children to be accommodated at the parishes' expense, rather than the school board's.

In notifying imbecile children to the Poor Law authorities, Glasgow's school board had taken upon itself a role that had traditionally been left to the children's parents. Admissions to imbecile institutions were supposed to be voluntary, so it was usually up to the parents, as the legal guardians, to apply for their children to be accommodated therein. There was a way in which this voluntary principle could be circumvented. During the second half of the nineteenth century, Glasgow's Poor Law authorities had assumed greater powers to compel the removal of children from their family homes by transferring their guardianship to the parish. Despite the questionable legality of such actions, parishes were prepared to take custody of children whose parents were in jail. In addition, Glasgow's Poor Law authorities adopted the more interventionist policy of removing children deemed to be subject to cruelty or neglect by responding to information passed to them by voluntary organisations. For example, voluntary inspectors working for the Scottish Society for the Prevention of Cruelty to Children (SSPCC), whose first branch opened in Glasgow in 1884, actively sought out children believed to be at risk and notified them to parochial authorities.<sup>79</sup> Mitchell became a director of the SSPCC, thereby creating a channel of communication between the school board, voluntary inspectors and Poor Law authorities on this issue.<sup>80</sup>

Improved communication between the various local authorities and the SSPCC facilitated a more comprehensive approach to state intervention into the family home. State legislation also increased the local authorities' powers in this regard. In 1889, Parliament passed an 'Act for the Prevention of Cruelty to and Better Protection of Children', which gave a firmer legal basis to the Poor Law Authorities' practice of removing children.<sup>81</sup> An amendment act in 1894 listed injury to a child's mental health

---

<sup>78</sup> *Ibid.*

<sup>79</sup> Macdonald, 'Children Under the Care of the Scottish Poor Law', 73-88.

<sup>80</sup> Roxburgh, *School Board of Glasgow*, 175.

<sup>81</sup> Prevention of Cruelty to, and Better Protection of Children Act, 1889 (52 & 53 Vic., c. 44).



and failure to notify a doctor about a child's medical complaint amongst the offences covered by the legislation.<sup>82</sup> This meant that the various parishes of Glasgow did have a means of compelling the institutionalisation of imbecile children in certain cases. An inspector of the poor could arrange for his parish to assume guardianship of neglected mentally defective children, which would then give the parish the authority to have such children certified and institutionalised.

How frequently this course of action was actually taken is unknown. It would partly depend on the degree to which administrators supported either the voluntary principle or compulsion when it came to admissions to imbecile institutions. In Glasgow, opinion was divided. Carswell tended to prefer voluntary admissions. In 1898, he stated that 'the parents themselves are the proper parties to make the necessary applications'.<sup>83</sup> Eight years later he told the Royal Commission for the Care and Control of the Feeble-minded that, 'we have no power of compulsory detention'. When asked if he wanted such powers, he replied, 'I do not know that we feel the want of it. I should not like to have it.'<sup>84</sup>

Nonetheless, even Carswell felt obliged to admit that he had 'seen cases, not a great many, where compulsion on the parents would be a wise thing in the interests of the child.'<sup>85</sup> More significantly, Glasgow Parish Council's chief inspector of poor, James Russell Motion, told the same Royal Commission that he strongly supported compulsory detention for mentally defective paupers.<sup>86</sup> Helen Macdonald has recently argued that during the late nineteenth century, Glasgow's Poor Law inspectors placed an increasing number of children under the guardianship of the parish, and, considering Motion's views on the subject, it seems likely that a proportion of these would have been mentally defective. However, it was not until the Mental Deficiency (Scotland) Act, 1913 that local authorities received extensive powers to compel the removal of mental defectives from the family home. It is likely that when Glasgow's school board first notified the parishes of those imbecile children deemed to be in need of institutional care, they would have actively sought the consent of parents.

---

<sup>82</sup> Prevention of Cruelty to, and Better Protection of Children Act, 1894 (57 & 58 Vic., c. 27).

<sup>83</sup> Carswell, 'Care and Education of Weak Minded and Imbecile Children', 482.

<sup>84</sup> HMSO, *Royal Commission on Feeble-Minded* III, 66.

<sup>85</sup> *Ibid.*

<sup>86</sup> *Ibid.*, 57.

As a result of the school board's survey of 1896, the parish councils were faced with a sudden influx of imbeciles notified as requiring institutional treatment. Whilst the other Glasgow parishes made little attempt to respond, Barony parish council quickly set up an inquiry to consider the existing system with a view to accommodating the 18 imbecile children notified to it by the school board. The inquiry was headed by John Carswell and Dr. Hamilton Marr, the assistant superintendent of Woodilee Asylum. Dr. Bruce was also regularly consulted, as was James Russell Motion, who was inspector of poor for Barony before it amalgamated with Glasgow City Parish to form Glasgow Parish Council in 1898.

With its superior financial and institutional resources and personal links to the school board it is not surprising that Barony should have taken the lead in responding to the school board's initiative. However, the main purpose of the inquiry was to find the cheapest acceptable method of accommodating the extra imbecile children. As Carswell put it, he and his fellow doctors made their recommendations 'with the object of advising the Council upon all the facts relating thereto, so that an intelligent policy might be adopted in view of the considerable increase in public burdens contemplated'.<sup>87</sup>

In 1898, Carswell made a public statement of their recommendations. Barony should establish its own institution for low grade mental defectives in a separate building to be constructed on the grounds of Woodilee asylum. It was not an entirely novel suggestion. Mitchell had put forward a similar idea some years earlier. There had also been longstanding support for an initiative of this kind amongst some of the other members of Barony Parish. In 1881, its asylum committee had considered establishing a home for imbeciles at another location in Fauldhead, but the parochial board had rejected the suggestion (it seems likely that this occurred at the time that Mitchell produced his original list of 70 imbeciles). In 1889 the committee raised the issue of purchasing some cottages for the reception of imbeciles but again the idea was rejected. The school board's actions in 1896 finally gave those like Carswell, who supported the building of a new institution, the extra ammunition they needed to persuade Barony's councillors. As the school survey was conducted by one of Carswell's medical colleagues on the Council, there are grounds for suggesting that it was planned by interested members of

---

<sup>87</sup> Carswell, 'Care and Education of Weak Minded and Imbecile Children', 479.

the medical profession as a means of putting pressure on Barony to fund the construction of separate institutional accommodation for imbeciles. Carswell, however, was emphatic that the school board's actions were purely humanitarian, claiming that the 'School Board has no motive in this matter upon the notice of the different parishes but the necessity of having the children properly cared for'.<sup>88</sup>

The institution proposed by Carswell and Marr following the survey of 1896 was intended to be different in character to those of Larbert and Baldovan. The Woodilee home was not intended to be a training centre. Carswell explained this decision on the grounds that the results of training at Larbert had not, in his opinion, been sufficiently successful to justify the relatively high cost of maintaining its patients:

[t]he feeling we had was that as regards care in management and nursing, and well-directed successful efforts to secure the comfort, happiness, and general well-being of the children in Larbert and Baldovan Training Schools, nothing was left to be desired. But we were bound to go further, and ask, What has the parish gained by its expenditure in training those children? Has it been relieved to any extent of the ultimate burden of maintaining those children when they reached adult life?<sup>89</sup>

To answer this question, Carswell examined the case histories of fourteen former patients who had left Larbert since 1887, after being maintained there at the Barony's expense. Eight were still chargeable to the parish (four were in asylums, four under private guardianship), five had died before being discharged and one was living with parents without the aid of poor relief. This led Carswell to make the following conclusion.

That fully 50 per cent. of the children chargeable to the parish under training in imbecile schools were deriving no benefit from those specially equipped schools that could not be equally well secured in a custodial asylum, under the management of the parish council, as a department of their lunatic asylum, but separate as regards building.<sup>90</sup>

---

<sup>88</sup> *Ibid*, 482.

<sup>89</sup> *Ibid*, 479.

<sup>90</sup> *Ibid*, 480.



The home at Woodilee was therefore recommended to Barony's councillors on the grounds that they could save money, by providing cheap custodial care for imbeciles incapable of benefiting from training. The home would accommodate children, but Carswell hinted that he also had in mind provision for adults considered to be in need of continued care. Training in sensory development and practical skills would still be provided for higher grade imbecile children at Larbert. Meanwhile, the school board would deal with mentally defective pupils capable of receiving some degree of education in the more academic sense of the word. Carswell used the terms 'weak-minded' and 'feeble-minded' synonymously to describe this latter group.<sup>91</sup> Carswell and Marr had therefore, for the first time in Scotland, developed a policy for dealing with mental defectives based on the three grades of ability (untrainable idiots, trainable imbeciles and educable feeble-minded) suggested by Shuttleworth to the Committee on the Education of Epileptic and Defective Children.<sup>92</sup> Indeed, Carswell cited that committee's report, also published in 1898, as his model, thus illustrating how political developments in England could be accommodated into local government initiatives in Scotland.

Before Carswell gave public notice of this scheme, Glasgow school board had already made some initial steps to establishing special day classes in their public schools. It advised headmasters to place defective pupils in each school into the same class 'under teachers who would be in sympathy with their deficiencies'.<sup>93</sup> Initially, physical and mental defectives were grouped together. In 1898, the School Board took a further step by establishing a special class at Oatlands school that would accommodate defective children currently attending the various schools around the area. This came to be regarded as the first special day class of its kind in Scotland. As the *Glasgow Herald* later reported, it was:

opened in a lavatory attached to one of the large public schools in Glasgow. The class was put under the charge of Miss Aitken, a teacher of wide experience, who had charge of a large centre school in London for the training of feeble

---

<sup>91</sup> *Ibid*, 475.

<sup>92</sup> See c. 1.

<sup>93</sup> HMSO, *Royal Commission on Feeble-Minded* III, 268.

children. And here in this primitive class were gathered both cripple and mentally feeble children from the surrounding district.<sup>94</sup>

The 'lavatory' may well have been a cloakroom rather than the toilets, but either way it is clear that the school board's experiment in special education hardly received prestigious treatment. As the future school board chairman, R.S. Allan recalled, the class 'was simply tentative and was carried on by the Board without any extra grant'.<sup>95</sup> By 1901, the school board members were sufficiently impressed by the results to open more classes in different schools and adopted the policy of educating physical defectives and feeble-minded pupils separately.

Not everyone was pleased about the new arrangements. Special classes in day schools were designed to accommodate the most able mental defectives, some of whom would previously have been placed in institutions. To those involved in special education, this was an advantage. The first teacher, Catherine Aitken, justified special classes in a letter to the English Education Department on the grounds that they prevented defective and epileptic children 'being placed in asylums, to their great detriment'.<sup>96</sup> However, such an argument would not have much appeal amongst those who worked in the institutions. Special schools were an unwelcome source of competition for many institution superintendents. They opposed the new classification of feeble-mindedness and argued that special classes unwisely mixed the highest grade imbeciles with the lowest grade of ordinary child (the so-called dull and backward children).<sup>97</sup>

In Scotland, W.W. Ireland was characteristically outspoken in his opposition to the new arrangements. His support of educational models of institutional care clearly ran counter to Carswell and Marr's proposal that Woodilee would fulfil a purely custodial function. Furthermore, the category of feeble-mindedness sat uneasily with his 'scientific' understanding of mental deficiency. Ireland had established his reputation as a medical theorist by devising the following nosology of mental deficiency, which classified

---

<sup>94</sup> *Glasgow Herald*, (13th Feb, 1904).

<sup>95</sup> HMSO, *Royal Commission on Feeble-Minded* III (Cd. 4217, 1908), 268.

<sup>96</sup> Although Aitken uses the word 'asylum', her criticism refers not only to lunatic asylums but also to institutions where '[e]ducational appliances of a kind, may be supplied'. This is clearly a reference to the training institutions for imbeciles at Larbert and Baldovan: NAS ED 7/7/1, letter from Aitken to Duke of Devonshire, Lord President of English Education Department (1<sup>st</sup> Aug 1899).

<sup>97</sup> Barrett, 'From Education to Segregation', 237-246.

‘idiocy’ (which he uses here as a shorthand for both idiots and imbeciles) in terms of specific ‘diseases’ rather than grading them by intelligence:

1. Genetous Idiocy.
2. Microcephalic Idiocy.
3. Hydrocephalic Idiocy.
4. Eclampsic Idiocy.
5. Epileptic Idiocy.
6. Paralytic Idiocy.
7. Traumatic Idiocy.
8. Inflammatory Idiocy (the result of Encephalitis).
9. Sclerotic Idiocy.
10. Syphilitic Idiocy.
11. Cretinism (including the Endemic and Sporadic or Myxoedematous Forms).
12. Idiocy by Deprivation.<sup>98</sup>

For the purposes of this discussion there is no need to describe these categories in detail, save to say that they were based on a combination of physical and mental symptoms. Ireland argued that this ‘pathological classification’ (his term) allowed doctors to gain a more accurate understanding of their patients’ long-term capabilities. Two patients may have similar levels of intelligence (they may both, for example, be high grade imbeciles), but if they belonged to different medical categories of disease they would require a different prognosis:

for example, it would be incorrect to give the same prognosis for an epileptic as for a traumatic idiot, from the degree of intelligence left. In the one case we have an existing disease still likely to cause further mischief; in the other we have a lesion come and gone, whose unfortunate effects may be expected to diminish over time.’<sup>99</sup>

Although Ireland saw some value in grading defectives by their level of intelligence, his pathological classification emphasised that idiots and imbeciles were fundamentally

---

<sup>98</sup> Ireland, *Mental Affections of Children*, 41. For an earlier version of this classification system see W.W. Ireland, ‘On Idiocy, especially in its Physical Aspects’, *Edinburgh Medical Journal*, vol. 19, part 2 (Jan. to Jun. 1874), 596.

<sup>99</sup> Ireland, *Mental Affections of Children*, 39-40.



different from the ordinary population: they were diseased. Consequently, he spoke out against what he saw as an attempt to blur the distinction between mental defectives and backward children. He attended the meeting where Carswell first outlined his and Marr's proposals and raised a number of objections, which were reported in the *Journal of Mental Science*. Regarding special education, Ireland made his preference for residential schools plain, whilst casting doubt on the wisdom of labelling children who were backward in their studies as mentally defective. He told Carswell of his 'considerable suspicion' regarding special education in day schools and claimed that 'it would be an outrage to those backward children if they were sent in among imbecile children. Many children were bright enough in the playground, although they were stupid at their lessons'.<sup>100</sup>

He believed that the education and training of imbeciles could best be achieved within an institutional setting rather than in day schools. The disappointing results of Larbert's and Baldovan's training programs were in his view due to a mixture of unrealistically high expectations and the parsimonious attitude of institution directors, who had reduced training facilities to a minimum in recent years. To Ireland, these institutions had already lowered their standards to an unacceptable level.<sup>101</sup> To propose a new institution at Woodilee that would limit itself to an even cheaper form of custodial care was anathema. Writing in 1898, he argued that, 'an asylum for idiots where there were no teaching and no progress would be like a marsh which takes in and accumulates everything noisome and gives out nothing'.<sup>102</sup>

Ireland could boast an international reputation as a medical expert on mental deficiency, but in Glasgow he lacked the networking skills of Mitchell, Bruce, Carswell, Marr and Motion. These relatively unknown local officials were more in tune with political developments in London and they could implement their initiatives within Glasgow's local government scene. For this reason, they succeeded in establishing Scotland's first special classes within the school system and as the special education system grew, Ireland's objections came to seem increasingly irrelevant. At the end of the nineteenth century, Ireland's professional reputation could not grant him the same degree of influence achieved by Carswell *et al* through their association with the state.

---

<sup>100</sup> Ireland's comments to Carswell in Carswell, 'Care and Education of Weak Minded and Imbecile Children', 484.

<sup>101</sup> Ireland, 'Visits to Danish Asylums', 60.

<sup>102</sup> Ireland, *Mental Affections of Children*, 383.

As for the proposed institution at Woodilee, it was opened in 1900 by the recently amalgamated Glasgow Parish Council. By 1906 it housed 32 pauper children, each of whom cost the council an average of 6s. 4d. a week. The cost of maintaining children in Larbert or Baldovan at that time was a little over 10s. a week. Untrainable mental defectives therefore cost the rate-payer less than the trainable variety. Unfortunately for the parish, the savings proved to be something of a false economy, as the cost of building the institution had spiralled beyond original projections. According to Motion, this was due to 'the extravagant ideas of the architect', who 'manages somehow or other to get these plans passed'. The final cost of the building was £11,000, which Motion described as 'very excessive'.<sup>103</sup> Based on the savings in maintenance they were making in 1906, it would have taken Glasgow's Poor Law authority around 35 years to recoup the cost of building the institution. In fact, this was roughly how long the institution continued to accommodate mental defectives, its last patients being moved out in 1937.<sup>104</sup> Nonetheless, it was on the promise of cheaper institutional accommodation at Woodilee, that Carswell and Marr originally sold the idea to Barony Parish. The potential savings that council members thought might be made in 1898 provides one explanation as to why they officially recognised the existence of untrainable mental defectives, despite Ireland's assertion that even the lowest grade of idiot could respond to some training.

### *Conclusion*

The late-nineteenth century was a period when the state increased its powers to intervene in the family home. Despite Carswell's enduring support for voluntary admissions to institutions, the Cruelty Acts provided a legal basis to an already established practice by which parochial authorities could remove children from homes deemed to be unsuitable. Glasgow's school board took it upon itself to promote the institutionalisation of defective children. With its own attendance officers and through voluntary inspectors working for organisations like the SSPCC, the school board was able to extend its gaze into the home of pupils. It could actively seek to persuade parents to apply for institutional accommodation for their children, whilst Poor Law inspectors had some legal authority to compel such action if necessary. The school board also

---

<sup>103</sup> HMSO, *Royal Commission on Feeble-Minded* III, 56.

<sup>104</sup> GHBA HB 30 8/23, List and notes of imbecile patients transferred from Woodilee to Lennox Castle or Caldwell House (1937).

developed its school health service to intervene in the health and welfare of children who were deemed to be inadequately cared for at home, whilst the initial decision to separate children in special classes does not seem to have been taken with any regard to parental feeling on the matter.

State intervention generally targeted the poorest sections of society. Mathew Thomson has suggested that ‘the segregation of mental defectives cannot be dismissed as a simple “class issue” ’ because members of all social classes came to support the policy.<sup>105</sup>

Reducing developments to a single cause such as class would indeed obscure the variety of factors that came to influence the increased adoption of exclusionary practices in the later nineteenth century. However, during that period, local authorities in Glasgow began to make institutional provision for mental defectives a public sector activity rather than a private or charitable endeavour. As this transition centred around the local Poor Law administration, it is clear that state policy towards the management of the poor did have a crucial bearing on the increased tendency towards the social exclusion of mental defectives at that time. In this sense, provision for Glasgow’s mental defectives was more of a class issue at the end of the nineteenth century than it had been fifty years earlier. Baldovan and Larbert took on private and charitable cases but in the later part of the century, increasing numbers of patients at the two national institutions were maintained at the rate-payers’ expense. In 1898, John Carswell correctly predicted that his and Marr’s recommendations would lead to an expansion of state-financed provision for mental defectives. By 1900, Glasgow Parish had built its own institution for untrainable idiots at Woodilee. Around the same time, the school board of Glasgow established special day classes in which feeble-minded defectives would receive a basic education. In both cases, the moves were principally intended for children of the poor.

Carswell and Marr’s proposal demonstrates how special education within the state school system could impact upon the institutional treatment of mental defectives.

Michael Barrett has argued within the English context that the establishment of special education in day schools helped encourage the switch from educational to custodial approaches to institutional care in the late nineteenth and early twentieth century. A number of institution superintendents objected to special education for the feeble-minded but they were unable to prevent special day classes from taking over the role of

---

<sup>105</sup> M. Thomson, *Problem of Mental Deficiency*, 76.



educating high grade defectives. This dealt a blow to residential education for idiots and imbeciles, although the educational model had already begun to fall out of favour amongst English institution directors before the first special day classes opened.<sup>106</sup> Developments in Glasgow broadly support this argument. Ireland's objections to special day classes mirror those of the superintendents in Barrett's account. The plan to establish a purely custodial institution at Woodilee was occasioned by Glasgow school board's initial forays into special day classes. However, the decision to limit the form of care offered at Woodilee was also influenced by economic considerations and a feeling that education and training at Larbert had failed to turn patients into productive and self-sufficient members of society. That said, the directors of Larbert had been moving away from the educational model since the 1880s.

The policies developed in Glasgow in the late nineteenth century occurred as a result of a number of personal initiatives taken by various influential figures networking within the city's local government scene. They marked a departure from an earlier view of mental deficiency and its treatment personified by the internationally respected but politically impotent W.W. Ireland. In the years to come, mental deficiency would be shaped by politicians, state-employed doctors, educationists and local administrators. In many ways, the first fifteen years following the public pronouncement of Carswell's and Marr's plan were to be the most influential of all in determining how mental deficiency would be defined and treated in the twentieth century. During this period, central government would become increasingly involved in the issue, culminating in the passing of the Mental Deficiency and Lunacy (Scotland) Act of 1913.

---

<sup>106</sup> Barrett, 'From Education to Segregation', 352.

### Chapter 3: Expanding State Provision for Mental Defectives in Scotland

By the end of the nineteenth century, Glasgow's local authorities had developed a new administrative model for dealing with mental defectives. The school board identified mentally defective children on the school roll and provided special classes for feeble-minded pupils. Parish councils paid the maintenance for adult mental defectives, as well as idiot and imbecile children deemed to require state provision outside the education system. Parishes co-operated with the district board of lunacy in arranging for defectives to be institutionalised, boarded-out or left with familial guardians in receipt of financial assistance from the state. When the government reformulated state policy on mental deficiency in 1913, officials included most of the key features of this administrative model.<sup>1</sup> Local administrators in Glasgow might, therefore, be considered primarily responsible for devising the framework upon which Scotland's national mental deficiency administration came to be based.

However, the circumstances in which the government decided to translate the Glasgow model into a national administration for the care and supervision of mental defectives still needs to be explained. It might be tempting to assume that the Glasgow model diffused to the rest of Scotland as a result of its own inherent value. This view takes the development of special services for mental defectives to be an example of social progress, assuming that these services spread because they were necessary and superior to previous arrangements.<sup>2</sup> Conversely, one might view wider economic developments as in some way determining the nature of the mental deficiency administration.<sup>3</sup> Neither explanation is adequate because both ignore the unpredictable and transformative nature of human agency. Scottish policy on mental deficiency emerged from a complex and at times heated series of negotiations. Glasgow's role was significant but so were political developments taking place in England and within the Scottish office at that time. At no point was the outcome of these negotiations certain. Even when the Scottish office reinforced its policy directives with legislation it was impossible to predict how local authorities would respond, either in Glasgow or across Scotland as a whole.<sup>4</sup>

---

<sup>1</sup> Mental Deficiency and Lunacy Act, 1913 (3 & 4 Geo. 5, c. 28); Mental Deficiency and Lunacy (Scotland) Act, 1913 (3 & 4 Geo. 5, c. 38).

<sup>2</sup> Lachlan Macmillan and George Thomson take this approach; Macmillan, 'Origins and Evolution of Special Education', 152-193; G.O.B. Thomson, 'Legislation and Provision', 233-240.

<sup>3</sup> See Oliver and Barnes, *Disabled People and Social Policy*, 32-35.

<sup>4</sup> John Pickstone has discussed the relationship between national policy and local psychiatric services in Manchester during the early years of the national health service in J.V. Pickstone, 'Psychiatry in District General Hospitals: History, Contingency and Local Innovation in the Early Years of the National Health

In order to understand how Scotland's mental deficiency administration came into being, it is necessary to look at the interface between the British government, the Scottish Office and local authorities, as well as influential voluntary organisations and professional groups. The activities of individuals operating across this network require scrutiny, as their attempts to find the best way of dealing with mental defectives became entwined with their own interests and those of the government bodies and professions they belonged to.

The history behind the Scottish Office's endorsement of special education for defective children exemplifies how local initiatives in Glasgow and English political developments influenced national policy in Scotland. In 1899, the school board of Glasgow opened its first special day class for mental defectives in the lavatory of Oatlands Elementary School. From this inauspicious beginning, Scotland's education system developed its extensive practise of educating defective pupils in separate classes, which was to reach its zenith in the second half of the twentieth century. However, the local administrators involved in the events of 1898 did not regard the creation of a national special education system as either inevitable or necessarily desirable. To them, their class was an experiment, the success of which was by no means guaranteed.<sup>5</sup> It received a modest degree of local funding and no additional assistance from central government. It had little publicity outside Glasgow, yet it roused the opposition of W.W. Ireland, the most respected medical theorist on mental deficiency in Scotland. The experiment could have failed. Some would have been glad if it did, whilst most would have been none the wiser.

Instead, officials came to regard the experiment as a success. Doubtless, it succeeded beyond the expectations of its chief architects, Bruce, Mitchell, Carswell and Marr. Scotland's central government eventually gave its backing to the principle of separate

---

Service', J.V. Pickstone (ed), *Medical Innovations in Historical Perspective* (London: Macmillan, 1992), c. 10.

<sup>5</sup> Pritchard's account of the early experience of England's first special class in Leicester illustrates the precarious position of special education at this time. He quotes one observer who wrote, 'Leicester was the first town to establish special provision for M.D. Children, but its interest appears to have been arrested as soon as it was aroused'. The education authority did not forsake special day education, but kept its investment in special classes at a minimum. Consequently, the number of children attending such classes 'increased very slowly' and by 1911 its special education system was much less developed than Glasgow's. Hence, early interest did not necessarily lead to a serious long term commitment if local administrators began to take an unfavourable view of the policy. Pritchard, *Education and Handicapped*, 123-4.



day classes for mental and physical defectives. The Treasury provided extra grants to assist and encourage the development of such classes. Parliament passed legislation to empower other Scottish education authorities to follow Glasgow's example, even though Glasgow's school board had assumed such powers before any legislation was passed.<sup>6</sup> Later, Parliament compelled Scottish education authorities to provide special education of this kind. Doctors and psychologists devised new theories and techniques to assist school medical officers in their role of selecting pupils for special classes.<sup>7</sup> Education authorities across Scotland gradually, and to varying degrees, came to accept the principle.

The special education system grew because its supporters found a way of making special classes appeal to those who had access to the resources necessary to establish and maintain them: politicians, central and local administrators, school medical officers and teachers. Even then, there were those within the state apparatus who voiced their objections. Opposition was stronger in some areas of Scotland than others, resulting in a large degree of local variation in the way special education was administered and the proportion of the local school-aged population taught in such classes.<sup>8</sup> From parents, too, came a mixture of support and opposition. As for the children, inspectors' reports uniformly described special school pupils as contented and making progress in their segregated surroundings.<sup>9</sup> However, in a recent English oral history study of ex-special school pupils, S. Humphries and P. Gordon present a different picture of isolation, humiliation and tedium.<sup>10</sup> Their work has an avowedly inclusionist agenda. This also applies to criticisms of segregated special education from sociologists of disability. For example, Oliver condemns special education as one part of a wider trend of exclusion experienced by disabled people in society.<sup>11</sup>

It is therefore necessary to take care when applying the word 'success' to the Oatlands' experiment. Many of those who passed through the special education system have come to question its supposed benefits. However, during the earliest years of special

---

<sup>6</sup> Education of Defective Children (Scotland) Act, 1906 (6 Edw. 7, c. 10); Education (Scotland) Act, 1908 (8 Edw. 7, c. 63).

<sup>7</sup> See c. 4.

<sup>8</sup> See c. 6.

<sup>9</sup> Macmillan, 'Origins and Evolution of Special Education', 159-169.

<sup>10</sup> S. Humphries and P. Gordon, *Out of Sight: the Experience of Disability 1900-1950* (Plymouth: Northcote House, 1992), especially chs. 2 and 3.

<sup>11</sup> Oliver provides a useful summary of how sociologists of disability have recently developed the 'integration/segregation debate' in Oliver, *Understanding Disability*, c. 6.

education, administrators had no means of obtaining this kind of retrospective opinion. At times they showed an awareness that some parents objected to their children being labelled and educated separately, but parents generally lacked direct access to Whitehall. They were able to exert some influence at a local level, during face to face encounters with officials, but the vast majority lacked the education, the political connections and the organisation to compete with the lobbying efforts of professionals, local administrators and voluntary organisations that supported segregation. Instead, officials at the Scottish Office relied on the views of fellow administrators, doctors and teachers, local and national politicians, and interested pressure groups. For this reason, any attempt to describe the circumstances in which the Scottish Office came to endorse special education must concentrate on the activities of government officials and the people who came into direct contact with them.

### *The Scottish Office and Special Education*

Scotland's central government was an untidy collection of *ad hoc* boards, some of which were based in London and some in Edinburgh. The office of Secretary for Scotland was established as late as 1885. Its core function was to transfer from the Home Office the duty of maintaining public order and regulating the police. However, as G.S. Pryde has described, the Secretary came to be seen as 'Scotland's minister', and took on numerous additional roles 'ranging from the application of the lunacy laws to oversight of education'. Pryde suggests that the Secretary's 'Scottish Office' became 'the real heart of executive government in Scotland' from the late nineteenth century onwards.<sup>12</sup> However, the secretary belonged to a cabinet and legislature based in England. English influence on Scottish policy came to be a recurring source of rancour amongst many Scottish local administrators and nationalists.

The Scotch Education Department (SED)<sup>13</sup> became one of the responsibilities of the Secretary for Scotland, but those who held the post tended to give the Department's administrative head (the SED secretary) the freedom to take policy initiatives. The SED was created by the Education (Scotland) Act, 1872. It had little independence to begin with. During the Parliamentary debates concerning the 1872 act, the Duke of Richmond opposed the establishment of a separate education department for Scotland, claiming

---

<sup>12</sup> G.S. Pryde, 'Central and Local Government in Scotland Since 1707', *Historical Association General Series* 45 (London: Routledge, 1960), 19-20.

<sup>13</sup> The Scotch Education Department was renamed the Scottish Education Department in 1918: in this thesis both variations of the title will be abbreviated to SED.

that the only feature that would distinguish it from the English department would be ‘a room in Whitehall, and the name “Scotland” painted over it’.<sup>14</sup> The SED was answerable to the same Parliament as its English counterpart and there were numerous similarities between the Scottish and English education codes.

Anderson argues that the creation of the Scottish Office in 1885 was crucial in giving the SED the chance to assert itself as ‘a small but powerful and creative department’.<sup>15</sup> Though its officials were still situated in London, they relocated themselves across Whitehall to Dover House and became the responsibility of the Secretary for Scotland. In 1884, the first SED secretary, Francis Sandford, was replaced by Henry Craik, the son of a Glasgow minister, who retained this position until 1905. Craik was a Unionist in his sympathies and enjoyed a high profile amongst civil servants. He was able to operate with relatively little interference from Parliament. According to Anderson, alterations to the Scotch code ‘were laid before Parliament annually, but they were often of a technical character which only experts could grasp, and Craik was able to carry out important changes incrementally’.<sup>16</sup> His influence was at its height during the Unionist tenure of the Scottish Office, when Lord Balfour of Burleigh was Secretary for Scotland. Balfour held office between 1895 to 1903 and during this time was prepared to work closely with Craik, sharing his interest in education. It was during Balfour’s period of office that the issue of special education for defective children at public day schools surfaced.

There is no evidence to show that either the SED or the Scottish Office had any involvement in the events leading up to the establishment of the Oatlands class. This is not so surprising given the large degree of autonomy possessed by local authorities in a political culture characterised by its permissive approach to social legislation. The ‘tentative’<sup>17</sup> nature of Glasgow’s experiment and the geographical remoteness of the London-based Scottish Office explain why SED officials were not given prior notice of developments. What is more surprising is that Glasgow’s school board members did not appear to have approached the SED for an additional grant to help fund the new class. Perhaps they were waiting to see the results of their experiment before committing themselves formally to the principle of special education for defective pupils.

---

<sup>14</sup> Quoted from *Hansard* by Anderson, *Education and the Scottish People*, 66.

<sup>15</sup> Anderson, *Education and the Scottish People*, 173.

<sup>16</sup> *Ibid*, 174.

<sup>17</sup> HMSO, *Royal Commission on Feeble-Minded* III, 268.



In contrast, Oatlands' first special education teacher, Catherine K. Aitken, made a major commitment from the start. Aitken had been amongst the UK's first special class teachers, having taught feeble-minded children in London before taking the post in Glasgow.<sup>18</sup> As was common amongst teachers at that time, she was unmarried, giving her the freedom and perhaps the motivation to move up to Glasgow and stay with her brother, Patrick, who had recently been appointed assistant minister at a Presbyterian church in the city.<sup>19</sup> Her decision to take the Oatlands post involved a certain degree of risk, considering that Glasgow school board regarded the original special class as an experiment, and it also carried the indignity of having to work in the school lavatory. Judging by the tone of her letters, mental deficiency was a highly emotive issue for her. She was clearly anxious to see her class at Oatlands succeed and become better resourced, so on her own initiative Aitken appealed to the Scottish Office for support.<sup>20</sup>

As far as the Scottish Office was concerned, Aitken was an outsider. She was a rather low-ranking employee of Glasgow's school board, and she appeared to act on her own authority rather than that of the board members. However, she was able to mobilise some resources in her attempts to influence decision-making at the Scottish office. These resources were somewhat limited but included a knowledge of relevant political developments in London, a rather tenuous personal connection with one of the SED's high ranking officials and her status as an educated professional with direct experience of special education in London and Glasgow.

The earliest surviving record from the Scottish Office to mention Glasgow's special class is a hand written letter to Lord Balfour, signed by 'C. K. Aitken' and dated 15<sup>th</sup> November 1898. The letter was politically naïve in its content, making it unlikely that Glasgow's school board-members had a hand in its composition. It was forwarded to Craik and became the first item to be placed into a special file headed 'Defective and Epileptic Children'. Balfour's reply to Aitken gave no indication that he was familiar with her recent appointment. In fact, until they received a second letter signed 'Catherine Aitken', the officials assumed she was a man. If this did indeed mark the

---

<sup>18</sup> NAS ED 7/7/1, letter from C. Aitken to Duke of Devonshire (1<sup>st</sup> Aug. 1899).

<sup>19</sup> NAS ED 7/7/1, letter from P. Aitken to J. Struthers (30<sup>th</sup> Oct. 1900); NAS ED 7/7/1, letter from J. Struthers to H. Craik (31<sup>st</sup> Oct. 1900).

<sup>20</sup> Certain details regarding C. Aitken's correspondence with the Scottish Office can also be found in Macmillan, 'Origins of Evolution of Special Education', 152-156.

Scottish Office's introduction to the issue of special day classes, the initial impressions were not favourable. Aitken asked Balfour for a 'Special Grant for the teaching of Defective Children' in order to buy equipment, allow for smaller classes and pay for experienced teachers. She referred to the development of special education in day schools as a 'movement' and was clearly hoping to see more special classes opened in Scotland with the Scottish Office's support. Aitken justified her request on paternalistic and religious grounds, ending the letter with the following appeal:

[f]or the sake of the afflicted little ones, so sadly handicapped, will you be so kind as to bring their needs, before the notice of Her Most Gracious Majesty Queen Victoria, who has such Queenly sympathy for the sorrows and needs of all her subjects, so that She may see fit to direct that a Grant may be applied for the betterment of the weaklings of the Great Shepherds flock.<sup>21</sup>

Such language serves as a reminder of the philanthropic and religious traditions upon which charitable provision for the infirm had long depended. It also appears noticeably out of place amongst the memos, minutes and correspondence of the Scottish Office.

Balfour's reply is quoted in full:

Sir,

I have to acknowledge receipt of your letter of the 15<sup>th</sup> in regard to children whom you describe "suffering from mental or physical defect but who are neither imbecile nor lunatic" and in which you suggest that this class should be made the subject of special grants in respect of their defect. I will consider the suggestion in the light of such official experience as we can bear upon it, but it occurs to me to say that I think you will have to define much more accurately the class of children to whom you refer, because under the words which I have quoted it would be open to suggest that the exceptionally stupid child should be a subject in respect of whom an especially high grant is given. He suffers from "mental defect" but I think this can hardly be your real intention.<sup>22</sup>

Balfour's objection was similar to that previously advanced by W.W. Ireland in 1898, and by the asylum superintendents who criticised special day classes during the

---

<sup>21</sup> NAS ED 7/7/1, letter from C. Aitken to Balfour (15<sup>th</sup> Nov. 1898).

<sup>22</sup> NAS ED 7/7/1, letter from Balfour to C. Aitken (17<sup>th</sup> Nov 1898).

hearings of the Royal Commission on the Blind, Deaf and Dumb *etc.* (1889) and the Departmental Committee on Defective and Epileptic Children (1898). From their perspective, special day classes for the feeble-minded grouped genuine mental defectives with dull and backward children. Both Balfour and the superintendents focussed their arguments on the problem of defining mental deficiency, but their opposition to the category of feeble-minded (or 'educable') mental defective was influenced by additional considerations such as finance, professional interests and the nature of institutional care. Superintendents feared that special education in day schools would make educational institutions redundant. Balfour's stated concern was that if the borderline between normality and feeble-mindedness was not defined carefully, the SED might find itself paying higher grants to large numbers of children who were falling behind in their studies.

Balfour's request that Aitken define her terms more accurately seems highly disingenuous considering that two successive English government committees, taking evidence from acknowledged authorities on mental deficiency, had failed to settle the controversy over definitions. However, Aitken had worked previously within London's burgeoning special education system and kept herself informed about developments south of the border. The Treasury agreed to give London's education authority extra financial assistance for its special classes in 1892. Furthermore, although the Departmental Committee hearings revealed continued disagreement over the validity of the feeble-minded category, the final report of 1898 did support special day classes. The following year saw the passing of the Elementary Education (Defective and Epileptic Children) Act for England and Wales. Before drafting the Bill, the Lord President of the Education Department, the eighth Duke of Devonshire, had been careful to square the measure with M.E. Hicks Beach, Chancellor of the Exchequer. Treasury support was finally secured for special classes throughout England and Wales on the understanding that the act would be permissive and would specify that children who were 'merely dull and backward' were not to attend special classes.<sup>23</sup>

These events were not lost on Aitken. On 1<sup>st</sup> August, 1899, she wrote to the Duke of Devonshire, asking him to extend the provisions of his bill to cover Scotland.<sup>24</sup> Devonshire merely forwarded the letter to Craik. Shortly after receiving the letter, Craik

---

<sup>23</sup> Sutherland, *Ability, Merit and Measurement*, 13-24.

<sup>24</sup> NAS ED 7/7/1, letter from C. Aitken to Devonshire (1<sup>st</sup> Aug 1899).



began drafting a similar bill of his own for Scotland.<sup>25</sup> The extent to which Aitken's lobbying influenced the SED secretary is difficult to gauge. The evidence suggests that her efforts irritated the SED officials, but this does at least mean that she made some kind of impact. Craik did not inform her of his plans to draft a special education bill when he wrote to her in response to the letter sent to Devonshire. He also avoided seeing her in person. In November 1900, Aitken attempted to engineer a meeting with Craik. She asked her brother to call a 'personal favour' from his old student acquaintance, John Struthers, who was at that time a senior member of the SED.<sup>26</sup> Patrick Aitken wrote to Struthers, asking him if he would introduce Craik to his sister whilst the SED secretary was on an official visit to Glasgow. Struthers duly informed Craik of the Aitkens' request but referred to Catherine in his letter to the secretary as 'the lady who during the past session was stirring the waters in connection with the bill for the Education of defective children'.<sup>27</sup> Craik declined to find the necessary time in his schedule for the meeting.

Aitken's lobbying placed special day classes for defective pupils on the SED's agenda, but the occupants of Dover House only began to act on the issue once the financial and legal issues had already been worked out between the Treasury and the English Education Department. From the correspondence of the SED, it is clear that those involved with the drafting of the bill used the English act of 1899 as a guide. The definition of 'defective children' in the draft 'Defective and Epileptic Children [Scotland] Bill' of 1900 closely reflected the terms of the English act by stressing that the merely dull and backward were not to be included.<sup>28</sup>

However, whereas the English legislation granted permissive powers to local education authorities, the Scottish Bill made it a duty for school boards to pay for the special education of those children deemed capable of benefiting from it, unless the parents could afford to pay the fees themselves. In carrying out this duty, Scottish school boards would have had the option of establishing classes of their own, paying for each defective child to attend a residential institution, or boarding-children out to areas where special classes were provided. School boards would be compelled to ensure defective

---

<sup>25</sup> NAS ED 7/7/1, draft 'Bill to Amend the Law in regard to the Education of Defective and Epileptic Children in Scotland' (26<sup>th</sup> Feb 1900).

<sup>26</sup> NAS ED 7/7/1, letter from P. Aitken to Struthers (3<sup>rd</sup> Oct 1900).

<sup>27</sup> NAS ED 7/7/1, letter from Struthers to Craik (31<sup>st</sup> Oct 1900).

<sup>28</sup> NAS ED 7/7/1, letter from J.H. Millar to Craik (27<sup>th</sup> Feb 1900).

children received some form of special education, making the Scottish bill more far-reaching than the permissive English legislation. Craik was at this time also planning an amendment to the Education of Blind and Deaf-Mute Children (Scotland) Act, 1890. This act imposed similar compulsory obligations on school boards in Scotland and it seems as though Craik intended to extend its provisions to include all 'educable' defective children.<sup>29</sup>

The Scottish 'Defective and Epileptic Children Bill' never made it to a first reading in Parliament. Craik presented the draft to Struthers for comment in early March 1900. In a confidential memo to the secretary, Struthers opposed the bill because it gave parents the power to force school boards into providing special education for their defective offspring. School boards, however, could not compel parents to send their children to a special school. The bill also neglected to mention the role of a doctor in identifying mental defectives. In short, it seemed that the final decision as to whether a child was to be treated as a defective or not was to be made by the parents or guardians. Struthers found this unacceptable. In fact, he was not convinced that legislation on education for defective children should be passed at all, telling Craik 'I have never felt that there was any urgent need for this bill in Scotland'.<sup>30</sup>

Despite the opposition of an influential member of his department, Craik pressed on with the bill for a short time. In a letter dated 12<sup>th</sup> April 1900, the secretary gave his view that the Treasury would be unlikely to agree to a direct grant to finance the special classes. He therefore considered alternative ways in which additional central funds could be secured. This letter marks the last time any mention of the Education for Defective Children Bill can be found in the secretariat file. Whether the measure was dropped as a result of Struther's objection, shortcomings of the bill itself, or problems securing financial support is unknown.<sup>31</sup>

Although the legislation was dropped for the time being, the question of funding was not. During a comprehensive overhaul of the Scotch Code that took place between 1901-1902, Craik was able to make a special provision regarding classes for defective children. From 1902, a class of 20 defective pupils could receive the same grant as a

---

<sup>29</sup> Education of Blind and Deaf-Mute Children (Scotland) Act, 1890 (53 & 54 Vic., c. 43).

<sup>30</sup> NAS ED 7/7/1, private memo from Struthers to Craik (1<sup>st</sup> Mar 1900).

<sup>31</sup> NAS ED 7/7/1, Letter from Craik (recipient's name illegible), (12<sup>th</sup> April 1900).

class containing 50 ordinary pupils. Even without this extra money, the School Board of Glasgow had opened two more special classes in 1901.<sup>32</sup> The change to the Scotch Code led to a marked growth in the number of special classes for defectives, although Glasgow still remained the focus of activity. By 1906, Glasgow's school board administered six schools in which mentally defective children were taught. Five of these were based in classrooms belonging to ordinary schools, whilst Bridgeton Special School was exclusively 'set apart for mentally and physically defective children only'.<sup>33</sup> The Board also employed John Carswell in the post of part-time school medical officer for mentally defective children, which he held along with his position at Glasgow Parish Council as Certifying Officer in Lunacy. In the same year, there were two schools belonging to the neighbouring Govan Parish School Board holding classes for mental defectives. In 1907, Govan's board also opened a special school, similar to that of Bridgeton.<sup>34</sup>

As special education began to expand in and around Glasgow, the SED finally conceded the need for legislation. In 1906 Parliament passed the Education of Defective Children (Scotland) Act. Unlike the earlier Scottish bill, the 1906 act gave school boards the power rather than the duty to establish special classes for mental defectives, physical defectives and epileptics. Parents did not have the right to compel Boards to do so. The legislation also conferred on School Boards the authority to employ medical inspectors. The Bill of 1900 had therefore been rewritten along the lines of the suggestions made by Struthers in his confidential memo, but this was hardly surprising as in 1905 Struthers had replaced Craik as Secretary. Of course, even before the act was passed, Glasgow and Govan had assumed such permissive powers existed and had even been given additional financial assistance from the Treasury. Nonetheless, as Balfour said in his speech during the bill's second reading in the Lords, the legislation was 'anxiously looked for, especially by some of the larger school boards'.<sup>35</sup>

In 1908 Parliament passed the Education (Scotland) Act, which raised the leaving-age of pupils attending special classes from 14 to 16 years and emphasised that school boards had the power to compel pupils to attend regardless of parental wishes.<sup>36</sup>

---

<sup>32</sup> HMSO, *Royal Commission on Feeble-Minded* III, 268.

<sup>33</sup> HMSO, *Report of Committee of Council of Education in Scotland with Appendix, 1907-1908* (Cd. 4085), 443-446.

<sup>34</sup> J.T.G. Ewan, *The School Health Service* (Glasgow: Glasgow Corporation, 1956), 10-11.

<sup>35</sup> Balfour of Burleigh, *Hansard*, 4<sup>th</sup> series, vol. 153 (14<sup>th</sup> June 1906), 1095-1096.

<sup>36</sup> Education (Scotland) Act, 1908, s. 5.



Glasgow's school board had been calling for this measure for a number of years on the grounds that many special school-leavers were finding themselves unsupervised at a time when they were most likely to engage in delinquent behaviour.<sup>37</sup> Struthers had also been aware that the English act of 1899 raised the leaving age for special class pupils to 16.<sup>38</sup>

The special education clause constituted a relatively minor part of the 1908 act, which was primarily concerned with giving school boards the power to provide school meals and a school health service. The Scottish Office's endorsement of school health occurred in similar circumstances to its eventual backing of special education for defectives, in that the act was preceded both by local initiatives in Glasgow and Govan and by similar legislation passed for England and Wales. School health services, like special day classes, had a dual role. They were promoted as a means of ensuring that children developed into more productive, or at least less 'burdensome', adults, whilst assisting teachers in their attempts to educate pupils. As school health developed in association with special education the policy requires some discussion.

According to B.B. Gilbert, school health became a prominent political issue throughout Britain following concern over the poor physique of recruits during the Boer War of 1899-1902. In an argument later developed by Searle, Gilbert points to a series of government reports, including the Royal Commission of Physical Training (Scotland) 1903, the Interdepartmental Committee on Physical Deterioration (England) 1904, and the Interdepartmental Committee on Medical Inspection and the Feeding of Children (England) 1906.<sup>39</sup> These reports recommended routine medical inspection of pupils together with physical training and school meals to ensure the health of the new generation of workers and soldiers. Legislation empowering local authorities in England and Scotland to carry out these recommendations followed as a consequence. The Education (Provision of School Meals) Act, 1906 and the Education (Administrative Provisions) Act, 1907 established school meals and a school health service respectively for England and Wales. The Scottish Office followed England's lead in 1908.<sup>40</sup>

---

<sup>37</sup> HMSO, *Royal Commission on Feeble-Minded* VIII, 271.

<sup>38</sup> NAS ED 7/7/1, private memo from Struthers to Craik (1<sup>st</sup> Mar 1900).

<sup>39</sup> HMSO, *Royal Commission of Physical Training* (Cd. 1508, 1903); HMSO, *Interdepartmental Committee on Physical Deterioration* (Cd. 2032, 1904); HMSO, *Interdepartmental Committee on Medical Inspection and the Feeding of Children* (Cd. 2784, 1906). The first report centred on Scotland, whilst the latter two focused on England.

<sup>40</sup> B.B. Gilbert, *The Evolution of National Insurance in Great Britain: the Origins of the Welfare State* (London: Michael Joseph, 1966), 117-131.

Gilbert's view of events has since been revised: Hurt argues that school health found favour as a means of providing relief for children without having to make recourse to the Poor Law. It should therefore be seen within the context of Poor Law reform.<sup>41</sup> Harris suggests that undue emphasis has been placed on the role of the Boer War, pointing out that school health had been an issue of public debate and local government policy long before the war started. Education authorities operating special classes employed school medical officers in the 1890s. Before then, medical officers of public health routinely inspected schools, viewing them as a breeding ground for infectious diseases. Concern about the alleged physical and mental problems caused by 'over-pressure' had sparked a series of surveys into the health of school children in the 1880s and 1890s.<sup>42</sup> It would be unwise to omit the Boer War entirely from the history of Britain's school health service, as recruitment problems did contribute to the contemporary debate on the health of the population.<sup>43</sup> It was, however, only a single factor amongst many influential developments.<sup>44</sup>

The Parliamentary enquiries into school health took evidence from local officials, including those based in Glasgow and Govan. This in turn seemed to prompt local authorities into intensifying their own activities in this area of policy. After being called as a witness to the Committee on Deterioration in 1904, Dr A.K. Chalmers, the medical officer in charge of Glasgow's Public Health Department, conducted a survey into the health of 750 children attending schools in the city.<sup>45</sup> This led Glasgow school board to produce a report on the physical measurements of Glasgow's school population in 1905. Two years later, Govan's school board established the kind of comprehensive school medical service envisaged in the English Act of 1907. The board appointed ten part-time school medical officers to examine the mental and physical condition of all its pupils, supervise special schools and classes and advise on school hygiene. This has

---

<sup>41</sup> J.S. Hurt, 'Feeding the Hungry Schoolchild in the First Half of the Twentieth Century', D. Oddy and D.S. Miller (ed), *Diet and Health in Modern Britain* (London: Croom Hill, 1985), 178-206.

<sup>42</sup> B. Harris, *The Health of the Schoolchild: a History of the School Medical Service in England and Wales* (Buckingham: Open University Press, 1995), c. 3.

<sup>43</sup> Searle gives examples of how contemporary commentators discussed army recruitment in the debate on the 'national physique', Searle, *Quest for National Efficiency*, 60-61.

<sup>44</sup> For a discussion of English school health policy during the inter-war period see Webster, C., 'The Health of the School Child During the Depression', N. Parry, and D. McNair,, *The Fitness of the Nation : Physical and Health Education in the Nineteenth and Twentieth Centuries: Proceedings of the 1982 Annual Conference of the History of Education Society of Great Britain* (Leicester : History of Education Society, 1983), 70-85.

<sup>45</sup> HMSO, *Interdepartmental Committee on Physical Deterioration*, 239.



since come to be described as Scotland's first school health service.<sup>46</sup> Such an accolade ignores the activities of Glasgow's school board in the late nineteenth century, but whereas Glasgow's work had focused on defective children, Govan's school health service routinely examined its entire school population in order to detect less obvious health problems.<sup>47</sup>

It is no coincidence that Struthers conceded the need for legislation to support special education at the same time that the SED was looking into school health. The issues were interconnected. As Struthers subscribed to what was by then a commonly held opinion that school medical officers should control access to special classes, any school board wishing to establish special classes therefore required a school medical officer.<sup>48</sup> In the early years of the school health service, the role of medical officers was generally limited to diagnosing pupils' ailments. Parents were supposed to arrange and pay for treatment themselves, once the school board had alerted them of any problem. Many workers within the growing school health service were dissatisfied with these arrangements and special classes were seen as one way in which a limited form of 'treatment' could be administered. For mental defectives this entailed providing the pupils with appropriate education which aimed to develop their mental ability. For physical defectives it could include health-promoting measures such as greater use of physical exercise, special meals and 'open air' classes designed to give pupils plenty of fresh air (this latter strategy was attempted in Glasgow despite the questionable health benefits of prolonged exposure to the Scottish climate).<sup>49</sup>

The SED's endorsement of special classes can be partly attributed to pressure for legislation from local authorities already developing special education in their own areas. It also reflects a growing national (ie. UK-wide) interest in school health, promoted by school medical officers, teachers and charitable organisations both as a way of raising educational standards and a means of ensuring that the future British

---

<sup>46</sup> Ewan, *School Health Service Glasgow*, c. 2.

<sup>47</sup> See. c. 2.

<sup>48</sup> The Departmental Committee on Defective and Epileptic Children learned that medical officers did not control access to special classes in two of the earliest English education authorities to open special classes: Leicester and Birmingham. The committee recommended that a medical examination was necessary and this became incorporated in the Education Act of 1899: see HMSO, *Report of Departmental Committee on Defective and Epileptic Children* I, 11; Elementary Education (Defective and Epileptic Children) Act, 1899, s. 3.

<sup>49</sup> Anon, 'The Bernard Street Open-air School in Glasgow', *School Hygiene* VIII (1917), 53-58; Glasgow Education Authority, *Report of Educational Requirements of Glasgow* (Glasgow: McCorquodale, 1920), 50-58. For a more general perspective on the treatment of physically defective children, see Pritchard,



workforce and armed forces would be healthy, productive and efficient. However, there was another political initiative taking place in the early years of the twentieth century that would help push mental deficiency closer to the forefront of the Scottish Office's agenda. Whilst education authorities in the Glasgow area stepped up their commitment to special education, the British government began to consider the need for a more comprehensive policy to segregate and care for mental defectives of all ages. It did so by appointing a 'Royal Commission on the Care and Control of the Feeble-Minded' in 1904.

### *The Royal Commission on the Care and Control of the Feeble-Minded*

As Mathew Thomson points out, there is no detailed account available describing the events leading up to the Royal Commission's appointment.<sup>50</sup> However, Pritchard and Sutherland state that in 1903, the National Association for Promoting the Welfare of the Feeble-Minded presented the Home Secretary, Akers Douglas, with a petition signed by 140 influential persons calling for such action. When the Commission was finally appointed, its membership included numerous high-ranking figures from the National Association and its parent organisation, the Charity Organisation Society.<sup>51</sup> They published their final report and recommendations in 1908 after a comprehensive investigation of all aspects of care and supervision for mental defectives in Britain. Many of the witnesses giving evidence in both England and Scotland emphasised the need for more custodial care for adult mental defectives. The report recommended new legislation and administrative reforms to ensure that mentally defective children and adults deemed to be at risk from or a risk to the community received adequate provision. Five years later, Parliament passed its Mental Deficiency Acts for England and Scotland. The acts carried through many of the recommendation put forward by the Royal Commission.

The work of the Royal Commission and events leading to the passage of the Mental Deficiency Act for England and Wales have been well documented by historians.<sup>52</sup> In many ways, historical accounts dealing with the subject have outlined similar themes to those that can be found in the historiography of school health: the development of local

---

*Education and Handicapped*, c. 12; Cooter, *Surgery and Society*, ch.4.

<sup>50</sup> M. Thomson, *Problem of Mental Deficiency*, 23.

<sup>51</sup> Pritchard, *Education and Handicapped*, 183; Sutherland, *Ability, Merit and Measurement*, 183.

<sup>52</sup> Most notably, M. Thomson, *Problem of Mental Deficiency*, 23-76; E. J. Larson, 'Rhetoric of Eugenics', 45-60; Sutherland, *Ability, Merit and Measurement*, 39-52; Searle, *Eugenics and Politics*, c. 9; Jones, *A History of Mental Health Services*, 191-215.

initiatives in the nineteenth century, the role of the Boer War, and the search for alternative forms of relief from the workhouse. Most of the historians pay scant attention to Scotland but their work is still relevant to the following study because of the influence that English dominated Parliamentary politics had on the Scottish Office.

Searle's work on mental deficiency links with his wider study into what he calls the 'national efficiency' debate in Edwardian Britain.<sup>53</sup> According to his thesis, British government officials had, since Victorian times, attempted to rationalise their administration of social policy along scientific lines by identifying various problem groups requiring distinct forms of provision to be managed by professionally trained 'experts'. According to Searle, this trend reached a kind of apotheosis as a result of the Boer War. He points to the Interdepartmental Committee on Physical Deterioration and the Royal Commission on the Feeble-Minded, as well as the Liberal Government's legislative programme between 1905-13. During this period, Parliament passed legislation on old age pensions, national insurance and school health care, each aiming to give specialist assistance to different sections of the population and minimise recourse to the Poor Law.<sup>54</sup> Within this political climate, mental defectives became identified as a key threat to national efficiency. Eugenic theories began to attract wider notice, particularly after the formation of the Eugenics Education Society in 1907. Searle argues that the appointment of Royal Commission on the Feeble-Minded in 1904, and the Mental Deficiency Act of 1913, constituted further attempts to segregate people viewed by the government to be a threat to national efficiency on account of their supposed unproductivity and tendency towards deviant behaviour.<sup>55</sup>

Thomson's account constitutes a partial re-appraisal of Searle. He states that '[i]t has become something of a historical cliché to argue that... anxiety turned into panic over 'national efficiency' in reaction to the reported poor condition of British recruits for the Boer War.'<sup>56</sup> Rather than relying on the concept of 'national efficiency', Thomson holds that the origins of the Mental Deficiency Act can only be fully understood by taking into consideration nineteenth century developments such as the creation of idiot asylums, changes in medical theory and the development of special education. His work

---

<sup>53</sup> Searle, *Eugenics and Politics*, 2. For Searle's major work on national efficiency see Searle, *Quest for National Efficiency*, *passim*.

<sup>54</sup> Searle, *Quest for National Efficiency*, 236.

<sup>55</sup> Searle, *Eugenics and Politics*, 106-115.

<sup>56</sup> M. Thomson, *Problem of Mental Deficiency*, 21.

also qualifies the influence of eugenics. Thompson acknowledges that eugenic ideas did influence the trend towards greater segregation of mental defectives, but challenges historians such as Searle over the extent to which social policy towards mental defectives following the 1913 act marked an endorsement by the state of the eugenics programme.

Nonetheless, Thomson still accepts many of the key themes put forward by Searle. He concedes that the physical deterioration debate helped create a climate of opinion amenable to the lobbying efforts of pressure groups looking for legislation on mental deficiency. He also states that mental deficiency became a focus for 'overlapping anxieties about moral, demographic and racial decline', and that the Royal Commission was primarily established to find 'a more rational and efficient' administrative solution for dealing with mental defectives.<sup>57</sup> Thomson's main objection seems to be that by invoking the phrase 'national efficiency', historians might seek a lazy explanation for the government's interest in this issue without looking into the specific medical, institutional and political developments that lay behind the formulation of state policy on mental deficiency.<sup>58</sup>

Searle's work on the rationalisation of the state administration, together with Thomson's reminder that individual policies have their own distinct set of causes, provide us with a means of understanding both the general context and specific developments that encouraged politicians to give mental deficiency their attention. It is not the intention of this thesis to substantially revise these accounts in so far as they pertain to English politics, except to argue that Searle has exaggerated the role of eugenics.<sup>59</sup> It is also necessary to point out, as Thomson does, the limits to which

---

<sup>57</sup> *Ibid*, 23-5.

<sup>58</sup> It should be noted that Searle himself did not attempt to explain Liberal welfare policy entirely in terms of national efficiency. He claims that 'other influences were obviously at work in shaping the Liberal Government's social legislation' such as 'humanitarian impulse, ...calculations of electoral advantage and...the ambition of particular ministers', Searle, *Quest for National Efficiency*, 236. Likewise, he claims that when Reginald McKenna introduced the second Mental Deficiency Bill in 1913, the Home Secretary 'went out of his way to play down any connections it might have had with the E.E.S. [Eugenics Education Society]', Searle, *Eugenics and Politics*, 110.

<sup>59</sup> Although Searle qualifies the role of eugenics at various points in his book (see previous footnote), he still locates the passing of the Mental Deficiency Act firmly within his account of the growth of the eugenics movement. The influence and nature of the eugenics movement has received a great deal of historical attention with the effect that its impact on early nineteenth century social policy appears greater than the evidence warrants. Some key texts on the historical debate include, Barker, 'How to Curb the Fertility of the Unfit'; Barker, 'Biology of Stupidity'; Freeden, *New Liberalism*; Freeden, 'Eugenics and Progressive Thought', 645-671; Freeden, 'Eugenics and Ideology', 959-62; Jones, 'Eugenics and Social Policy Between the Wars', 717-728; Jones, *Social Hygiene in Twentieth Century Britain*; Kevles, *In the*



central government was able to influence the administration of state provision for mental defectives.<sup>60</sup> Central government officials often translated local initiatives into national schemes, which were then re-translated or simply ignored by the various local authorities carrying out the day to day administration.<sup>61</sup> In Scotland, this process was further complicated by the Scottish Office's ambiguous position as a semi-autonomous central authority for Scotland tied to a London-based legislature, the political agenda of which was generally dominated by English concerns.

In 1906, the commissioners took their inquiry to Scotland. They heard witnesses representing all aspects of provision for mental defectives: lunacy commissioners, poor law inspectors, prison administrators, educationalists and asylum superintendents. The Commission's inquiry into Scotland paid special attention to Glasgow, which, according to the report, 'in its arrangements for the care of mentally defective persons stands apart from the rest of Scotland'. Witnesses included the Chairman of Glasgow's school board, Robert S. Allan; the head teacher of Bridgeton Special School, Lily Monteagel; and two of the architects of Glasgow's mental deficiency administration: Inspector of the Poor, James Russell Motion, and John Carswell. All of those involved in special education used the opportunity to stress its importance, which could only have reinforced the feeling within the Scottish office that Scotland's central government needed to respond to the issue.<sup>62</sup>

The Royal Commission itself was keen to produce a set of recommendations that could be implemented across the UK. For this reason, Commissioners made a point of identifying similarities and differences between the English and Scottish administrations. Mental defectives had a different legal status north and south of the border, as there was no Scottish equivalent to the Idiots Act, 1886, which allowed

---

*Name of Eugenics*; Searle, *Eugenics and Politics*; Searle, 'Eugenics and Class.'

<sup>60</sup> M. Thomson, *Problem of Mental Deficiency*, c. 6.

<sup>61</sup> Bruno Latour provides some useful insights into the dissemination of ideas and practices. Particularly informative is his contrast between 'models of translation' and 'models of diffusion.' Latour rejects the diffusion model whereby (put crudely) someone has an idea, and if that idea works it spreads throughout society. Instead he draws attention to the multiplicity of actors involved in the creation of new knowledge, practices etc, and to the way ideas are continually modified (or 'translated') at different stages of their development. Latour argues that this process extends beyond what is normally regarded as the moment of discovery or invention, as end-users also modify objects to suit their own purposes. This chapter does not tie itself strictly to Latour's views (Latour's principal interest is science, technology and the combination of human and material agencies) but his work has been an aid in conceptualising how ideas and practices associated with mental deficiency changed over time and space. See B. Latour, *Science in Action*, (Massachusetts: Harvard University Press, 1987), 132-144.

<sup>62</sup> HMSO, *Royal Commission on Feeble-Minded VIII*, 65, 263-265, 270.

English idiots to be certified separately from lunatics. However, this legal distinction was of little significance. In both Scotland and England, some idiots and imbeciles were segregated from lunatics either in special asylum wards or institutions for mental defectives, whilst others were placed in lunatic wards or even the ordinary wards of Poor Law institutions. Much depended on the availability of segregated institutional accommodation, which varied from one local authority to the next in both countries.<sup>63</sup> Age was also a factor. Scotland's adult mental defectives were much less likely to be placed in mental deficiency institutions than their English counterparts. The institutions for imbeciles at Larbert and Baldovan were obliged to discharge patients once they reached the age of 18, whereas English institutions such as Earlswood and the Royal Albert had no such age limit.

On the other hand, although Scotland's Board of Lunacy prevented adult patients from staying at Larbert or Baldovan, it did not place a permanent bar on charitable organisations establishing their own institutions for adult mental defectives. As Glasgow's special education system developed, many of those involved began to feel that a large proportion of feeble-minded pupils required continued care and supervision after they left school. R.S. Allan, A.K. Chalmers and a number of other prominent local officials and voluntary workers joined forces in 1906 to establish the Glasgow Association for the Care of Defective and Feeble-minded Children. The title was misleading because although the Association promoted the welfare of mentally defective children, its most practical work centred around the establishment and management of a home for female mentally defective school-leavers at Waverley Park, Kirkintilloch.<sup>64</sup> Similar homes already existed in England and represent an early attempt to prevent sexual activity amongst mentally defective women.<sup>65</sup> These attempts could be linked to a eugenics ideology, but the Glasgow Association's annual reports steered clear of eugenics terminology. Instead they promoted the home as a place where vulnerable young women could receive 'protection and elementary education, and industrial training'.<sup>66</sup> By the time the Royal Commission published its report, Waverley Park was the only institution in Scotland for adult mental defectives. Its accommodation was limited to 30 young women, most of whom were maintained from charitable

---

<sup>63</sup> *Ibid*, 25-6; HMSO, *Royal Commission on Feeble-Minded* VIII, 3-8 and 372-373; HMSO, *Royal Commission on Feeble-Minded* III, 66.

<sup>64</sup> GCA T-PAR 1.10, *Annual Reports of Glasgow Association for the Care of Defective and Feeble Minded Children*, 37-56; HMSO, *Royal Commission on Feeble-Minded* III, 270-271.

<sup>65</sup> M. Thomson, *Problem of Mental Deficiency*, 16; Barrett, 'From Education to Segregation', 266.

<sup>66</sup> GCA T-PAR 1.10, *Report of Glasgow Association for Feeble-minded Children* 1908, 53.

subscription. There were no specialised institutions for mental defectives in Scotland that accommodated adult males.

In terms of institutional provision for adults, Scotland's mental deficiency administration was therefore much less developed than England's. However, the Scottish administration had an alternative form of provision largely unavailable south of the border. Through its boarding-out system, Scottish Poor Law authorities could relocate mental defectives of all ages and place them in the care of foster parents in rural areas. In England, this practice was much less prevalent, partly because there was no long-standing tradition of boarding-out, as there was in Scotland, and partly because English Poor Law unions lacked the legal power to relocate charges to private guardians located outside local authority boundaries. On the other hand, small private madhouses were much more common in England.

Besides these differences in provision, there were also administrative distinctions between England and Scotland.<sup>67</sup> In England, county and borough councils were the local authorities in charge of regulating asylums. These authorities established 'visiting committees' to inspect asylums and create new rules governing how they were to be managed. In Scotland, district boards of lunacy administered district asylums, whilst parish councils administered parochial asylums. Most district boards of lunacy took their representatives from county councils and from burgh magistrates. In the case of the largest burghs where the district boards of control occupied the same area as a single parish, the board's membership was identical to that of the parish council. There were seven such 'single-parish district boards' at that time: Glasgow, Govan, Edinburgh, Paisley, Aberdeen, Dundee, and Leith.

Regarding special education, Scottish school boards possessed similar permissive powers to the English education authorities by 1908. In both cases, classes were intended to cater for feeble-minded pupils although the legislation used the term 'educable mental defectives'. Scotland's special classes could accommodate children between the ages of 5 and 16, whilst in England the age range was 7 to 16. The earlier starting age for Scottish pupils had been a feature of the Scottish education system since the Education (Scotland) Act of 1872. It was therefore not a special measure for

---

<sup>67</sup> For a list of most of the administrative differences between mental deficiency provision in England and Scotland see, HMSO, *Royal Commission on Feeble-Minded VIII*, pp 210-211.



defective pupils and few children under the age of seven were placed in special classes.<sup>68</sup> The main difference between special education north and south of the border was simply the extent to which local authorities had made use of their permissive powers. In England and Wales, eighty-seven education authorities had established special classes by 1906,<sup>69</sup> whilst in Scotland, Glasgow and Govan were still the only authorities providing special education for defective children.

The Royal Commission acknowledged differences between state provision north and south of the border and produced separate recommendations for both England and Wales on the one hand and Scotland on the other.<sup>70</sup> However, the main points of these recommendations were constant for the whole of Britain. The final report proposed new legislation to reorganise and extend specialised provision for mental defectives. Mental defectives of all ages should come under the remit of two central bodies (one for England and Wales, the other for Scotland) known as General Boards of Control. These General Boards of Control would be reconstituted from the current General Boards of Lunacy. Controversially, the Commission recommended that special education for educable mental defectives in day schools should also come within the remit of the General Boards of Control rather than the English Education Department and the SED. The aim was to make it easier for the authorities to transfer pupils between special day schools and institutions if such a move was felt to be necessary. Local administration was similarly to be placed in the hands of those local authorities currently answerable to the General Boards of Lunacy: the district boards in Scotland, and committees of the county and county borough councils in England. Commissioners favoured the removal of the word 'Lunacy' from the titles of government bodies because they found it derogatory (they preferred the word 'insane') and inaccurate. The report took the view that idiocy, imbecility, feeble-mindedness and moral imbecility should not be regarded as types of lunacy.

The recommendations steered clear of proposing a comprehensive system of provision for all mental defectives. They emphasised that the state should not intervene in cases where defectives could be maintained at their own expense or at the expense of 'relatives or friends'.<sup>71</sup> Following the ambivalent attitude to mental defectives illustrated

---

<sup>68</sup> GCA D-ED 9/1/33, *School Board of Glasgow: Report on Medical Inspection of Children* 1910, 10-11.

<sup>69</sup> HMSO, *Royal Commission on Feeble-Minded* VIII, 88.

<sup>70</sup> *Ibid*, 322-360 and 401-409.

<sup>71</sup> *Ibid*, 322 and 401.

by the title of the Royal Commission, this meant that the Boards of Control would focus their activities on the provision of specialised care for those unable to afford it themselves, and target the poor for additional state control. The report proposed that authorities should be given greater powers to compel detention but did not intend all mental defectives to be detained. Instead, Commissioners recommended a flexible approach whereby individuals could be dealt with in a number of ways depending on their circumstances. The report made it clear that familial guardianship, boarding-out to foster guardians, special education in day or residential schools and institutionalisation were all viable methods of dealing with mental defectives, providing care was taken regarding who received the various forms of provision.

Influential members of the government, notably Winston Churchill and John Burns, sympathised with the Commission's call for new legislation on mental deficiency, but a bill on the issue was slow to materialise. Progress may have been hampered by a busy legislative schedule, but there were also points of controversy regarding the Royal Commission's recommendations that required settling.<sup>72</sup> Most notably, the suggestion that the General Boards of Control should administer special education in day schools roused the opposition of the English Board of Education. Officials from the Board successfully mounted a sustained campaign within Whitehall to ensure that special education remained within their remit.<sup>73</sup>

In the absence of government legislation, pressure for action continued to mount. The Majority and Minority Poor Law Reports of 1909 both argued that provision for mental defectives should be extended and clearly separated from lunacy provision. In 1911, the Eugenics Society and the National Association for Promoting the Welfare of the Feeble-Minded drafted their own 'Feeble-Minded Control Bill' to legalise the certification and detention of the feeble-minded. The Charity Organisation Society also drafted a 'Mental Defect Bill'. Unlike the Feeble-Minded Control Bill, the COS's proposed legislation entailed additional Treasury expenditure. This made it unsuitable for private members legislation and the bill was abandoned at an early stage.

In the same year, the Secretary for Scotland, Lord Pentland, introduced a 'Lunacy Amendment (Scotland) Bill' into the House of Lords. This bill empowered parish

---

<sup>72</sup> M. Thompson, *Problem of Mental Deficiency*, 33.

<sup>73</sup> Sutherland, *Ability, Merit and Measurement*, 44-52.

councils, under the supervision of the district boards of lunacy, to provide for feeble-minded children. The bill failed to pass further than a first reading in the House of Lords. As with the Feeble-Minded Control Bill, Pentland's proposals did not include an additional Treasury grant to help local authorities fund the expanding service. It was consequently eclipsed when the government finally announced the drafting of its own legislation on the issue.<sup>74</sup>

### ***The Mental Deficiency and Lunacy (Scotland) Act, 1913***

The British government introduced its first Mental Deficiency and Lunacy Bill in February 1912. It provided the blue print for an overhaul of the mental deficiency and lunacy administration and was to apply to both England and Scotland. It also included an annual Treasury grant, which though generally considered to be insufficient, was enough to persuade most supporters of the previous bills to switch allegiances. The legislation was rushed through Parliament, as one commentator put it, 'at the fag-end of an overcrowded session'.<sup>75</sup> Critics condemned the government's handling of the bill as undemocratic. The Liberal radical, Josiah Wedgwood, was particularly outspoken. Wedgwood objected to the bill itself: particularly those clauses granting greater powers for the compulsory detention of mental defectives, which he viewed as an infringement of civil liberties. In an attempt to block the bill's passage through Parliament, Wedgwood accused the government of ignoring proper Parliamentary procedure by cutting short debate in the House of Commons and relying on unelected appointees to redraft the bill at committee stage.

The committee stage dragged on too long for the bill to reach the statute book by the end of the Parliamentary session. In an recent article challenging the role of eugenics in Edwardian politics, Edward Larson has argued that the committee was preoccupied with removing the more overtly eugenic clauses from the bill, such as the proposal to segregate all those 'in whose case it is desirable in the interests of the community that they should be deprived of the opportunity of procreating children'.<sup>76</sup> Thomson states that the revisions made at committee stage were prompted by weakness in the bill itself, which, he asserts, 'contained some very clumsy and contentious phrasing'.<sup>77</sup> Whilst it is

---

<sup>74</sup> J. Macpherson, 'The Administration By Parish Councils of their Powers and Duties Under the Mental Deficiency and Lunacy Amendment Act, 1913', *Poor Law Magazine*, 23 (1913), 342.

<sup>75</sup> *Ibid*, 343.

<sup>76</sup> Larson, 'Rhetoric of Eugenics', 45-60.

<sup>77</sup> M. Thompson, *Problem of Mental Deficiency*, 39.



clear that the committee did direct its energies towards tightening the language and removing eugenic terminology from the proposed legislation, historians have missed another reason why the first Mental Deficiency Bill failed to pass through Parliament. It met with vigorous opposition from Scotland.

The Scottish Office dropped Pentland's proposals when the government bill was announced. The promise of additional Treasury funding proved too tempting to resist. As John Macpherson, Commissioner for the Scottish Board of Lunacy, put it, the government 'dangled in front of us the bribe of a grant of about £20,000'.<sup>78</sup> However, whilst the Scottish Office may have been placated, the new proposals caused consternation within Scotland's parish councils.

Scotland's parochial authorities saw the Mental Deficiency Bill as an opportunity to redress a long standing grievance they held regarding the membership of district boards of lunacy. Since their creation in 1857, the majority of Scotland's district boards did not contain representatives from the parish councils.<sup>79</sup> A minority, the seven single-parish district boards for Scotland's largest urban areas, were formed entirely from parish councillors. Parish councils notified the district boards of pauper lunatics and mental defectives requiring provision, then paid the maintenance fees of those pauper patients accommodated in district asylums. They also managed and financed the boarding-out system and the provision of relief to familial guardians. However, despite their key role in financing and administering provision, most parish councils were denied representation on the district boards of lunacy. Under the Mental Deficiency Bill, parish councillors would continue to be left out of the newly proposed district boards of control. Instead, the local authorities administering institutional care and private guardianship of adult defectives in the community would be appointed by county or county-burgh authorities.

To Scotland's parish councillors, the proposals illustrated Westminster's ignorance of the political situation north of the border. In November 1912, a special 'Conference of Parish Councils of Scotland on the Mental Deficiency Bill' was held in Glasgow. There was a distinctly nationalist mood to the meeting. Chairing the conference was James

---

<sup>78</sup> Macpherson, 'Administration by Parish Councils', 342.

<sup>79</sup> Blackden, 'Poor Law and Health', 252.

Cunningham, Chairman of Glasgow Parish Council, who spoke of his frustration at the influx of legislation emanating from London.

We had hardly mastered the Children's act of 1908 with its wide ramifications and claims on Poor Law administration, until we had the Old Age Pension in its original and amended form; then the various Lunacy Bills in different stages of vitality; Education Act; then the House Letting Bill, the National Insurance Act, the Inebriates' Bill and others touching more or less on Poor Law work; and now the Mental Deficiency Bill, which is apparently intended to take the place in Scotland of the Bill for the amendment of Lunacy Administration, which was specially prepared by the Scottish Office with a full knowledge of Scottish needs - while the Mental Deficiency Bill is primarily an English Bill considered by a committee of 83, of whom only 9 are Scotchmen. We have, I think, a distinct grievance in Scotland, that legislation intended to this section of the kingdom where conditions of life and administration of laws for the moral and social well-doing of the people, differ much from those in England, and are devised and carried by a mass of legislators who know nothing of the circumstances of the people they are legislating for.<sup>80</sup>

The delegates resolved to lobby the government for a separate Mental Deficiency Bill for Scotland, which would 'recognise that as Parish Councils deal with all other classes of poor, the care of the feeble-minded should also be under their jurisdiction'. To emphasise the links between the parochial Poor Law administration and provision for mental defectives, conference members voted in favour of lobbying the government to insert a clause into the bill that would 'bring under proper control such poorhouse "ins and outs" as may be proved to be mentally defective'.<sup>81</sup> Glasgow's chief Poor Law inspector, James Motion, is likely to have been behind the proposed amendment. He had strongly advocated such a measure to the Royal Commission on the Feeble-Minded in 1906, as a means of tackling the problem, as he saw it, of paupers who repeatedly entered the poorhouse for relatively short periods of time. Motion wished to see such 'ins and outs' detained in separate institutions to other inmates and felt that certifying

---

<sup>80</sup> GCA T-PAR 1.19, 'Conference of Parish Councils of Scotland on Mental Deficiency Bill' (1912), 388.

<sup>81</sup> *Ibid*, 394.

them as mentally defective (he believed most ins and outs to be feeble-minded) would facilitate such a policy.<sup>82</sup>

The conference resolved to press for a revision of the bill that would give half the seats on the district boards to parish councillors, except in the case of the seven large urban areas where parish councils already formed the entire district boards. This represented a major change to the existing system and even conference members seemed to think that their proposal was possibly too ambitious to succeed. As one speaker is reported to have put it, '[i]f it did not receive assent from a majority of the House of Commons, let them take one third, but make application for a half'.<sup>83</sup>

In the months that followed, deputations of parish council representatives visited London to lobby the Secretary for Scotland and the Commissioners on the General Board of Lunacy, as well as MPs directly.<sup>84</sup> Assurance was quickly given in Parliament that a separate Bill would be brought in for Scotland, and in July 1913, the newly formed Parish Councils Association were invited to send representatives for consultation by government officials during the committee stage of the Bill.<sup>85</sup>

They were joined by the Executive of the Scottish School Boards Association, who had their own list of alterations that they wished to see made to the bill. The school boards were concerned that the English Board of Education had been too successful in ensuring that mental defectives of school age would be the responsibility of education authorities, whether they were educable or not. On viewing the initial bill, the School Board of Glasgow decided to lobby Parliament for an amendment to the proposed legislation, guaranteeing the 'relief of School Boards from the responsibility and expense of dealing with and supporting children and young people incapable of being educated'. Board members wished to see a continuation of the local practice whereby educable mental defectives were accommodated in special day classes at the school board's expense, whilst ineducable idiots and imbeciles came within the remit of parish councils. They successfully secured the support of the Scottish School Boards Association. School boards outside Glasgow and Govan had shown little interest in providing for mental

---

<sup>82</sup> HMSO, *Royal Commission on Feeble-Minded* III, 58.

<sup>83</sup> *Ibid*, 398.

<sup>84</sup> Anon., *Poor Law Magazine* 23 (1913), 19.

<sup>85</sup> There had been an earlier abortive attempt to establish a 'Parish Councils Association' in Scotland in 1895: anon, 'Notes of the Month', *Poor Law Magazine* 23 (1913), 190-191.



defectives and doubtless preferred their current permissive powers under the Education (Scotland) Acts of 1906 and 1908 (which they could ignore) to any proposal compelling them to provide for educable and uneducable children alike.

The Association also wanted to ‘simplify’ the procedure by which children could be removed from unsuitable home conditions without the consent of parents; and felt that the General Board of Control should put in place a more rigorous system of checks on the way parish councils dealt with defectives whose names had been passed onto them by the school boards as requiring further provision. Both measures were geared towards emphasising the role of the parish councils in dealing with defectives outside the education system. Finally, like the parish council members, school board members sought representation on the district boards of control.<sup>86</sup>

In early July, the various local representatives travelled to Westminster to meet the Scottish Grand Committee reviewing the new bill. Before attending the Committee, they were granted an unexpected audience with a number of key figures from the Scottish Office who were involved with the Scottish bill: these included Pentland, John Macpherson, and Ewan Macpherson of the Local Government Board. Not satisfied with the Scottish Office’s non-committal response to their proposals, parish council representatives decided to approach individual MPs, a number of whom agreed to table their amendments to the Grand Committee.

The Committee meeting took place on the 8<sup>th</sup> July. Relations between the General Board of Lunacy and the parish councils were strained, with John Macpherson accusing parish councillors of being hostile towards the bill: a charge that the councillors denied. Provision for mental defective children of school age emerged as a major cause of disagreement between the government and the parishes. The government had been converted to the principle that all defective children should be dealt with by the school boards, whilst parish council representatives wanted authority over pauper mental defectives of all ages. However, the parishes did not present a united front on this issue. Council members from Edinburgh, Glasgow and Govan suggested a compromise in line with the School Boards Association’s proposal: namely that school boards should deal with educable defectives of school age, whilst ineducable children, along with mentally

---

<sup>86</sup> GCA D-ED 1/1/1/17, *Minutes of School Board of Glasgow* (10<sup>th</sup> June 1913), 203.

defective adults, should to be notified to the parish councils. In other words, the *ad hoc* scheme developed by Glasgow in the late nineteenth century should be extended to the rest of Scotland. The recommendation was accepted. The Scottish Grand Committee arrived at its decision on the 10th July and the Government issued its amendments two days later.

The other key issues debated by the local authorities during the committee stage centred around definitions of mental deficiency, representation on the district boards of control, finance and the introduction of a clause that would obligate maintenance of pauper defectives to be paid by the parish of settlement. The government did not allow arguments over definitions to take up too much time. The Grand Committee informed local representatives that the first section of the bill, in which the different grades of mental deficiency were defined, would be based on that of the English bill.<sup>87</sup> Henceforth, the Scottish Grand Committee's attention focused on administration and finance.

The county and burgh councils fought to safeguard their domination of the district boards of control. However, parish council representatives argued that they had a right to representation on the district boards. As the *Glasgow Herald* reported:

They [ie. the parish councils] have represented that they supply either all or most of the patients that fill these asylums; that they pay the whole or nearly the whole cost of maintenance out of the poor rate; that they know intimately the class of people from whom the patients are drawn, and that therefore they should be represented on the Boards that erect and manage the institutions, and that this representation should be one-half.<sup>88</sup>

The parish councils also sought to convince the government that offering their nominees a place on the district boards would allow for the introduction of a settlement clause into the Bill, and so bring mental defectives into line with other classes chargeable on the rates.<sup>89</sup> The law of settlement in Scotland was particularly important for the mental deficiency and lunacy administrators because it allowed parishes to relocate paupers to other parts of the country at the expense of the local authority that sent each pauper,

---

<sup>87</sup> Anon., 'Mental Deficiency and Lunacy (Scotland) Bill', *Poor Law Magazine*, 23 (1913), 285-286.

<sup>88</sup> *Glasgow Herald* (7<sup>th</sup> Jun. 1913), 11.

rather than the local authority that received them. This enabled urban parishes to board-out pauper lunatics and mental defectives to rural areas, and ensured that parishes running their own asylums would not have to pay the maintenance fees of patients sent from outlying areas.

The government gave its qualified support to the parishes. They were given a third of the places on the District Boards of Control (except in the seven largest areas already referred to) and a settlement clause was introduced. These concessions to the parishes were to constitute a significant distinction between the English and the Scottish administration of the mental deficiency system. South of the border, the county or county-borough councils appointed committees to deal with adult defectives and uneducable children. In Scotland, the work was to be done by the parish councils, who formed a part of the district boards of control. Furthermore, Scotland's mental deficiency administration was to be particularly geared towards relocating mental defectives, either in outlying institutions, or through the boarding-out system.

In contrast to the parish councils, Scotland's school boards were not successful in their attempts to gain representation on the district boards of control. The Grand Committee informed the Scottish School Board Association that by avoiding responsibility for uneducable mental defectives, they must also forfeit their place on the new authorities. This decision was viewed by the Association as an injustice, as they believed that the activities of the district boards would still have a considerable bearing on the work of the school boards. Two months after the act had been passed, David M. Wilson, the School Board of Glasgow's leading representative on the Association, commented in a report on the proceedings that '[i]t will be for the School Boards to see that when an amending act is called for (and the call will probably come very soon), their just claims to representation are not over looked.'<sup>90</sup>

In fact, no evidence of school boards calling for such an amendment (apart from the above quote) has been discovered, and government legislation on the issue did not materialise. In the years that followed the passage of the 1913 act, Scotland's mental deficiency administration was hindered by a lack of communication between education authorities and parish councils that could have been avoided if both bodies had

---

<sup>89</sup> *Ibid.*

<sup>90</sup> GCA D-ED 1/1/17, *Minutes of School Board of Glasgow* (15<sup>th</sup> October 1913), 347.



representatives on the district boards. As a result, many mental-defectives disappeared from the state's view on leaving school, although it would be unwise to assume that this was always detrimental from the school-leavers' point of view.

There were other aspects of the final act that caused dissatisfaction within the school boards. The Association had hoped the legislation would make it easier to remove children from their homes without the consent of parents or guardians. Compulsory powers of detention formed the focal point of opposition to the act from liberal radicals like Wedgwood. However, school boards had experience of compelling school attendance in the face of parental resistance and representatives were keen to ensure that similar powers extended to all forms of provision for mentally defective children. The Association capitalised on the alleged inadequacies of the 'unrespectable' poor by portraying the issue as a humanitarian policy aimed at saving children from abusive or neglectful parents. School board members consequently lobbied Parliament for a 'simplification of the procedure prescribed for the rescue of children and young persons from unsuitable surroundings and for retaining them under control and protection'.<sup>91</sup>

In his report to the School Board of Glasgow, Wilson declared himself unimpressed by the final settlement on this matter. He complained that the procedure under the new act for removing young mental defectives from their homes was 'even more cumbrous than that which was prescribed in the original bill'. He went on to imply that the government had put children at risk by placing too much emphasis on individual liberty.

The liberty of the subject, it was said, is of supreme importance, and any procedure by which that may be curtailed must be such as to exclude the possibility of mistake or abuse. Experience will show whether this caution has not been carried to an unreasonable extent.<sup>92</sup>

In terms of the financial provisions of the bill, the Association was relieved that school boards were not obliged to take on the 'heavy burden'<sup>93</sup> of paying for the care and control of uneducable defectives. Under the terms of the legislation, school boards and parish councils were obliged to pay half the cost of maintenance for each defective

---

<sup>91</sup> *Ibid*, 345.

<sup>92</sup> *Ibid*, 346.

<sup>93</sup> *Ibid*.

under their charge (unless money could be obtained from a parent or guardian), whilst the Treasury was committed to paying the other half. If the Treasury could not afford to pay its share, then the local authorities did not have to pay theirs, in which case the defective would not be provided for. The various local authorities were generally appeased by the prospect of receiving Treasury assistance. Indeed, this was arguably the most attractive feature of the Government's bill. There was, however, widespread criticism of the size of the initial Treasury grant, which was set at £20,000. The Scottish School Board Association appealed for a larger sum, but was informed that the grant had been calculated proportionally to the £150,000 that had been allocated to England and Wales. According to Wilson, '[i]t was not pretended that the sums would be adequate when the scheme came into full operation, but it was thought that they would be sufficient for a start.'<sup>94</sup>

The Mental Deficiency and Lunacy (Scotland) Act, 1913 was finally passed on the 15th August. Like the legislation for England and Wales, it received cross-party support and was voted in by a large majority. In fact, unlike the English act, support in the House of Commons was so strong that the speaker allowed the act to pass its third reading on a show of hands. For this reason, the exact number of MPs voting for and against the legislation was not recorded.<sup>95</sup>

The act defined four classes of mental defectives, identical to the definitions in the English act.

- (a) Idiots; that is to say, persons so deeply defective in mind from birth or from an early age as to be unable to guard themselves against common physical dangers;
- (b) Imbeciles; that is to say, persons in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy, yet so pronounced that they are incapable of managing themselves or their affairs, or, in the case of children, of being taught to do so;
- (c) Feeble-minded persons; that is to say, persons in whose case there exists from an early age mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision, and control for their own

---

<sup>94</sup> *Ibid.*

<sup>95</sup> Information gratefully received from House of Commons Information (HCINFO@parliament.uk).

protection or for the protection of others, or, in the case of children, that they by reason of such defectiveness appear to be permanently incapable of receiving proper benefit from the instruction in ordinary schools.

(d) Moral imbeciles; that is to say, persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect.<sup>96</sup>

The definitions were vague. The difficulty of bringing precision to the categorisation of mental deficiency had been recognised by the government since the late nineteenth century, if not earlier. The 1913 legislation graded defectives in terms of educability, social adaptability and behaviour, rather than using a disease-based classification system such as that advocated by W.W. Ireland, or using intelligence quotients, which were still relatively novel at this time.<sup>97</sup> In any case, there was and is no reason to think that the ‘pathological’ or psychological means of classification would have been any more accurate.<sup>98</sup> The focus on defectives’ performance in the classrooms and in society at large better reflected the government’s motives for introducing the act. It was primarily intended to provide care and control for people who were judged to be a risk to themselves and a ‘burden’ on the community.

Whilst the ‘lower grade’ classes of idiots and imbeciles were defined only in terms of being unable to protect themselves, the more intelligent, ‘higher grade’ defectives were also depicted as being a danger to others. This was particularly true of the moral imbeciles, who were defined exclusively in terms of their potential threat to the rest of society. It was common amongst medical authorities at this time to view moral imbeciles as possessing a level of intelligence ‘very little below the average child’,<sup>99</sup> which made their certification contentious. Few individuals were ever certified under this category of mental defect: for example, Glasgow Education Authority’s surviving records on mentally defective pupils show only two pupils labelled in this way between 1909 and 1936 (one was diagnosed in 1913, the other in 1915).<sup>100</sup> As early as 1914,

---

<sup>96</sup> Mental Deficiency and Lunacy (Scotland) Act, 1913, s. 1.

<sup>97</sup> See chs. 2 and 4.

<sup>98</sup> See c. 6.

<sup>99</sup> C. P. Lapage, *Feeble-mindedness in Children of School-Age* (Manchester: Manchester University Press, 1911), 76.

<sup>100</sup> GCA D-ED 9/1/30, School Board of Glasgow’s (later Glasgow Education Authority) Records of Mentally Defective Children (1909-1936).



John Macpherson was aware that the term would present problems when he made the following claim:

[t]he certification of moral imbeciles is likely to present more difficulty, for the vicious or criminal propensities and even the incorrigibility which form essential parts of the statutory definition may merely represent the results of bad upbringing and a stubborn disposition in the case of a child of normal intelligence.<sup>101</sup>

The definitions given in the act did not, by themselves, determine who was to be dealt with by the local authorities concerned. A parish council could provide for mental defectives if they were brought to its attention by parents, guardians or school boards. They could also deal with any defective who was neglected, had committed a crime, was a habitual drunkard, or was an unmarried mother receiving poor relief at any time during pregnancy or birth. Following petitioning by the parish councils, the Scottish act also specifically listed poorhouse 'ins and outs' as 'subject to be dealt with' if they have been in receipt of poor relief on three or more occasions within six months.<sup>102</sup> The English legislation contained no such clause: hence the Scottish act was particularly geared towards targeting the poor. If the consent of parents or guardians could not be obtained, mental defectives could be removed from home by a sheriff's order after being certified by two doctors.<sup>103</sup> Overseeing the actions of the parish councils (as well as the school boards), the district boards of control would keep a register of all mental defectives in their area who had been removed to certified institutions or maintained by the state under private guardianship (whether it be a familial guardian or a 'stranger' guardian through the boarding-out system).

The act added to the statutory duties of school boards in Scotland. They were now obliged to employ appropriately qualified doctors to identify which pupils on the school role were mentally defective. Those pupils judged to be ineducable would be notified to the parish. School boards also had a duty to 'make provision for the education or for the proper care and supervision' of educable mental defectives of school age. Although it may have seemed as though the act compelled school boards to establish their own

---

<sup>101</sup> J. Macpherson, 'Paper Read to the Meeting of the Association of Parish Councils on 12th June, 1914' *Poor Law Magazine* 24 (1914), 267.

<sup>102</sup> Mental Deficiency and Lunacy (Scotland) Act, 1913, s. 3.

<sup>103</sup> *Ibid*, s. 2-10.

special classes, the SED made clear in a circular in 1914 that this was not the case.<sup>104</sup> School boards could avoid establishing special classes of their own by relocating defectives to other areas, where special classes already existed under the management of another authority, or to training institutions. In this way, the Scottish legislation differed significantly from English law. In England, the Elementary Education (Defective and Epileptic Children) Act, 1914, compelled school boards to provide special education within their own area. Scotland had no such legislation to accompany its Mental Deficiency Act.<sup>105</sup> As a result, Scottish school boards retained some degree of permissive powers when it came to special education: a reflection of the lack of interest which still characterised the attitude of most Scottish school boards towards special education for mental defectives at that time.

### *Conclusion*

The Mental Deficiency and Lunacy (Scotland) Act, 1913, emerged from a process of negotiation between the British government, Scottish Office, local authorities and voluntary organisations. Not only did it expand Glasgow's mental deficiency administration geographically to cover the rest of Scotland, the legislation also extended the range of services offered by obliging authorities to direct more resources into identifying and providing for mental defective adults as well as children. It did so because, despite the lobbying efforts of local authorities, much of the final act still resembled the English legislation on which it had previously been based. The definitions of mental deficiency were identical to the English act. The powers of compulsory detention were broadly similar, apart from technical modifications made to take into account differences between the legal systems north and south of the border. The criteria by which a defective was judged 'subject to be dealt with' under the English and Scottish acts were, for the most part, in line with one another. Both gave local authorities greater powers to institutionalise adults and children in certified institutions for mental defectives.

The main differences between the two acts resulted from the lobbying efforts of Scottish local authorities. The Scottish legislation gave parish councils a prominent role in the local administration as well as membership on the district boards of control. The act specified that mentally defective poorhouse 'ins and outs' would be 'subject to be dealt

---

<sup>104</sup> SED Circular no. 459, reprinted in *Poor Law Magazine* 24 (1914), 193-6.

<sup>105</sup> M. Thomson, *Problem of Mental Deficiency*, 38.

with', and facilitated the boarding-out of defectives to other areas of Scotland. Finally, Scotland had no equivalent to the Elementary Education (Defective and Epileptic Children) Act, 1914. Hence, whilst education authorities in England and Wales were compelled to establish special classes within their own areas, Scotland's school boards were not.

Both the English and the Scottish acts targeted mental defectives of school age, and adult mental defectives in trouble with the law, whilst the Scottish act also aimed to deal with poorhouse inmates. The legislation was therefore primarily a reform of the Poor Law, education, and penal administrations, exemplifying the contemporary penchant for specialised services managed by trained experts (in this case, the medical and teaching professions). Neither act can be seen to illustrate a genuine commitment by the state to the eugenics programme. As Thomson points out, the English Education Act of 1914, worked against eugenic principles because it encouraged special classes to attempt to teach feeble-minded children skills that would equip at least some of them for life in the community. Although Scotland's special education legislation was permissive, the same argument still applies. Furthermore, Scotland's boarding-out system encouraged mental defectives of all ages to receive care and supervision within a community setting, rather than in a more controlled institutional environment where male and female patients were segregated and constantly supervised.

Women could be (and indeed were) institutionalised for being sexually active, but the 1913 Acts did not legislate for the compulsory institutionalisation of all mental defectives. Such a policy was judged to be too controversial in view of its disregard of civil liberties, and too expensive for the Treasury to countenance. Furthermore, relatively little attention was paid to the issue of male defectives parenting children. Sexual control, when it occurred, was much more likely to be directed against women. This makes little sense from a eugenic point of view. Rather, it points to legislators and officials following conventional moral mores, viewing female sexuality outside marriage as less acceptable than male sexuality. It can also be seen as an attempt by Poor Law authorities to avoid the cost of childcare.

In any case, pregnancy was only one concern that legislators intended to address: others included crime, poverty, educational failure, disruptive behaviour in the classroom and neglect or cruel treatment at home. Although the eugenics movement briefly helped



bring mental deficiency to the forefront of British politics, the resulting legislation was geared more towards dealing with problems legislators associated with the current generation of mental defectives, rather than any threat to society that might be posed by their descendants.

## Chapter 4: The 'Manufacture' of Mental Defectives (1896-1914)

One of the most remarkable features of the mental deficiency administration was its tendency to 'manufacture' mental defectives.<sup>1</sup> The majority of these were 'manufactured' within the education system. In the early years of special education, ideas about what constituted and caused educational failure shifted in such a way that it became more likely that a pupil struggling to meet the demands of the education system would be labelled mentally defective. The feeble-minded sub-category allowed doctors and teachers to prescribe segregated education to pupils who were considered to possess higher levels of ability than those more typically sent to institutions for idiots and imbeciles. The creation of this sub-category marks only one milestone in a continuing trend towards the expansion of mental deficiency. Even after feeble-mindedness came to be accepted, the number of individuals labelled in this way continued to rise. It proved to be a highly elastic term, capable of being stretched by doctors, teachers and administrators to cover an increasing proportion of the population. As the special education system grew, the boundaries of mental deficiency expanded in conjunction with it.

This 'stretching' of the feeble-minded category is a subject that rewards more detailed analysis. There already exists a body of academic work tackling similar issues within the broader field of disability. Stone has looked more generally at the expansion of disability as an administrative/welfare category in Britain, Germany and America.<sup>2</sup> Albrecht, in his American-based study, argues that people with disabilities have become consumers in an expanding market of goods and services, which he refers to as the 'Disability Business'.<sup>3</sup> In his work on psychiatry, Scull argues that insanity increased during the nineteenth century and ascribes this phenomena to 'an expansion of the boundaries of what constituted mental illness'.<sup>4</sup> Scull explains this expansion in terms of both the professional self-interest and humanitarian motives of asylum doctors, and their success in persuading members of the public to view institutions as appropriate places to send mentally incapacitated family members.

---

<sup>1</sup> *Glasgow Herald* (19<sup>th</sup> Dec. 1923).

<sup>2</sup> D. Stone, *The Disabled State* (Philadelphia: Temple University Press, 1984), *passim*.

<sup>3</sup> G.L. Albrecht, *The Disability Business: Rehabilitation in America* (Newbury Park: Calif Sage, 1992), *passim*.

<sup>4</sup> A. Scull, 'Was Insanity Increasing', A. Scull, *Social Order / Mental Disorder* (London: Routledge, 1989), 243. See also, Scull, *Most Solitary of Afflictions*, c. 7.

Historical accounts of mental deficiency vary in the degree to which the increase in feeble-mindedness has been acknowledged or tackled. Sutherland links the creation of the feeble-minded category with developments in special education. In this sense, her account recognises that social processes informed and changed medical knowledge associated with mental deficiency. However, Sutherland views these developments in a progressive light. She does not question the supposedly beneficial effect that special classes had on feeble-minded pupils. Likewise, she regards changes in the methods by which mental defectives were identified as a mark of progress: Sutherland describes the introduction of IQ tests following the establishment of special education as ‘a great improvement on the methods of diagnosis and assessment that had gone before’.<sup>5</sup>

For Sutherland, new knowledge regarding mental deficiency is viewed simultaneously as the product of social circumstances (particularly educational policy) and an example of scientific advance. Hence the reader is left wondering whether feeble-mindedness really was a category invented to solve problems within the education system, or whether it was an *a priori* condition revealed to the medical profession once their diagnostic techniques had achieved a sufficient level of sophistication. In contrast, Barrett stresses only the social factors that led to the creation of both special education and the feeble-minded category, and he avoids the assumption that these developments were necessarily beneficial.<sup>6</sup>

Mark Jackson has provided the most sophisticated account of the origins of feeble-mindedness. He argues that the sub-category was ‘the product not only of diverse cognitive developments in the emerging fields of psychiatry, anthropology, criminology, and education, but also of shifting administrative practices and experiences in asylums, schools, prisons, workhouses, and courtrooms’.<sup>7</sup> Jackson then provides insights into how these shifts occurred, paying particular attention to special education and institutional care. Taking a qualitative approach, he chooses to focus on changing ideas and practices rather than attempting to measure the extent to which the ‘borderland’ of mental deficiency was extended in terms of the number of people labelled. In doing so, he has prepared the ground for an approach that combines qualitative and quantitative analyses. This will allow us to better understand the impact

---

<sup>5</sup> Sutherland, *Ability, Merit and Measurement*, 3.

<sup>6</sup> Barrett, ‘From Education to Segregation’, 237-247.

<sup>7</sup> Jackson, *Borderland of Imbecility*, 22.



of the shifts described by Jackson, and pinpoint more accurately where and when the expansion of mental deficiency took place.

Unlike Jackson, Mathew Thomson has tried to stay clear of the debate on the origins and nature of mental deficiency. He does state that mental deficiency was 'socially, politically, ideologically, and linguistically constituted' and also refers to the 'social reality of individuals within society who have special needs and different abilities'.<sup>8</sup> However, these comments do not form the basis of a more detailed exploration of labelling, as Thompson explicitly seeks to avoid involving himself in what he dismisses as a 'sterile battle over the reality of mental illness'.<sup>9</sup>

Others besides Thomson have suggested that the debate surrounding mental illness has at times yielded unsatisfying results. Whilst maintaining a critical stance against 'psychiatry's self-proclaimed rationality',<sup>10</sup> Scull has been troubled by the willingness of those who take a purely constructionist view of mental illness 'to ignore the enormity of the human suffering and the devastating character of the losses sustained by this form of communicative breakdown or to lay the blame for whatever pathology they do acknowledge squarely and solely on the shoulders of a misguided or actively harmful profession'.<sup>11</sup> More general criticisms of social constructionism have pointed to a tendency within this kind of approach to make claims about the inherently social nature of both physical and mental pathologies that are irrefutable to the point of being facile. For instance, Bury complains that 'allegations that diseases are reifications, fetishised commodities and the like, are often expressed in such abstract terms that the possibility of refutation is avoided'.<sup>12</sup>

It is, however, possible to conduct a detailed study into the social constitution of mental deficiency that is neither facile nor sterile. To suggest that the development of theories of mental deficiency, or the practice of labelling individuals in this way were social acts is to make no great claim in itself. Clearly, neither activity could have taken place outside society. However, there are important points to make about how contemporary

---

<sup>8</sup> M. Thompson, *Problem of Mental Deficiency*, 9.

<sup>9</sup> *Ibid.*

<sup>10</sup> Scull, *Most Solitary of Afflictions*, 5.

<sup>11</sup> A. Scull, 'Reflections on the Historical Sociology of Psychiatry', Scull, *Social Order/Mental Disorder*, 9.

<sup>12</sup> M.R. Bury, 'Social Constructionism and the Development of Medical Sociology', *Sociology of Health and Illness* 8 (1986), 137-169.

knowledge of mental deficiency came to take its particular form and how that form changed over time. Whose interests did it serve? What can developments tell us about the way different professional groups, administrative bodies and the wider public inter-related? The question of who was and who was not labelled is also of no small importance, particularly as the labelling of individuals was likely to have a profound impact on their lives.<sup>13</sup>

The following account will demonstrate the fluid nature of contemporaries' understanding of mental deficiency and explain this fluidity in social terms. Within Scotland, Glasgow provided the initial locus around which most of changes in labelling practice took place. In particular, activity centred around the creation of Scotland's first special day classes in that city. It is here that one must look to discover how the introduction of special education provided an arena where ideas about who should be given which label shifted in the late nineteenth and early twentieth century. However, to place developments in Glasgow into perspective, it is useful to begin with a general survey of how the incidence of mental deficiency was estimated in the late nineteenth and early twentieth century.

### *Estimates of Incidence*

The chief difficulty involved in estimating the incidence of mental deficiency within a given population was the lack of agreement over the criteria that marked one person out as mentally defective and another person out as ordinary. From the writings of doctors specialising in mental deficiency in the nineteenth century, the criteria that occurred most frequently included: specific intellectual characteristics of the patient, such as attention, imagination and abstract thought; the age at which a child learned to sit up, walk and speak; ability to communicate; mobility; the degree to which the patient could protect him/herself from external dangers; knowledge of every day facts such as family names, days of the week and currency; moral behaviour and hygiene.<sup>14</sup> By the late nineteenth century, physical signs of deficiency (referred to as 'stigmata') were also assuming a greater importance in diagnoses, as medical practitioners applied the theories of criminal anthropologists and alienists (such as Lombroso and Morel) who catalogued a variety of physical defects associated with various types of 'degenerates'.<sup>15</sup>

---

<sup>13</sup> See c. 7.

<sup>14</sup> G.E. Berrios, 'Mental Retardation: Clinical Section – Part II', Berrios and Porter, *A History of Clinical Psychiatry*, 225-238; Jackson, *Borderland of Imbecility*, 112.

<sup>15</sup> Pick, *Faces of Degeneration*, 44-59; Jackson, *Borderland of Imbecility*, c. 4.

Drawing upon all this work, doctors identified mental defectives on the basis of a mixed bag of symptoms and characteristics, evaluated and prioritised largely at the discretion of each individual examiner. Hence, even amongst the medical profession, personal judgements played a significant role in identifying mental defectives. For this reason, nineteenth century doctors lacked a commonly agreed, rigorously standardised approach to diagnostics in this area. The problems of standardising criteria became even more pronounced when it came to conducting large scale surveys into mental deficiency, because such surveys generally relied on the judgement of a number of people, not all of whom were necessarily doctors.

Looking at government reports, census data and the writings of medical specialists from the mid-nineteenth century onwards, it becomes clear that those who attempted to put a figure on the number of mental defectives in Scotland generally sought to insure themselves against criticism by emphasising the difficulty of this task. Even before the creation of the feeble-minded category, attempts to estimate the incidence of mental defectives were hampered by confusion over definitions that blurred the distinction between idiots, imbeciles, the insane and the ordinary. As the Scottish Lunacy Commission's *Report on Lunatic Asylums in Scotland* put it in 1857, statistics on this issue 'can only be regarded as a vague approximation of the truth'.<sup>16</sup> This did not prevent the Commission from presenting the results of its own inquiry into the incidence of lunacy, idiocy and imbecility within the Scottish population. According to the report, there were 768 'curable lunatics' in Scotland (0.3 per 1,000 of the population), 4032 'incurable lunatics' (1.3 per 1,000) and 2603 'congenital idiots and imbeciles' (0.9 per 1,000).<sup>17</sup> These statistics were not based entirely on medical examinations. Whilst the Commission took into account institutionalised and boarded-out people considered by the authorities to be insane, the figures also include the results of a survey in which police constables, sheriff-officers and clergymen were asked to send details of insane people living in their local communities. When the Commission received the returns, it found that figures varied widely from one locality to the next, leading the report to conclude that there had been no standardisation in the way information had been collected.<sup>18</sup>

---

<sup>16</sup> HMSO, *Scottish Lunacy Commission Report on Lunatic Asylums in Scotland I*, 1857 (2148), 37.

<sup>17</sup> *Ibid.*

<sup>18</sup> *Ibid.*, 36.



The problems caused by varying standards applied by respondents were magnified in the case of decennial census returns. The census enumerators did attempt to find out the number of idiots and imbeciles (and in later years feeble-minded persons) in Scotland, but their results were dependent on designated heads of household being willing to describe household members in this way. W.W. Ireland believed that the results of such enquiries underestimated what he considered to be the true incidence of idiocy and imbecility, as heads of household would often be unwilling to admit that family members fell into these categories. Writing of census returns in 1898 he states, presumably for the benefit of his Scottish readership, that:

[i]n no other country is this difficulty of getting at the whole truth about the prevalence of idiocy greater than in Scotland, from the proud, cautious, and reserved character of the people.<sup>19</sup>

The census returns also shared a similar problem to that referred to by the Lunacy Commission in 1857: namely the lack of standardisation in the distinctions made by respondents between various types of mental illness, such as lunacy, imbecility and feeble-mindedness. The census commissioners were partly to blame for this. The first census to tackle the issue was that of 1871, which included the words ‘whether imbecile or idiot’ within the enumerator’s form. The schedules given to enumerators did not include a definition of imbecility and idiocy that would distinguish the conditions from dementia. When the following census of 1881 also failed to make the distinction, W.W. Ireland wrote a letter to the *Scotsman* criticising what he saw as a ‘want of proper definition’.<sup>20</sup>

Before the census of 1891 was issued, Ireland and Dr David Yellowlees, then president of the Scottish Medico-Psychological Association, persuaded the census commissioners to ensure that enumerators were made aware from the census schedules that idiocy and imbecility applied to people whose mental incapacity was visible from birth or an early age, whilst mental incapacity developed later in life should be listed under lunacy (dementia, at that time, being regarded as a form of lunacy). As a result, fewer cases of dementia were listed under idiocy or imbecility that year, and the overall number of

---

<sup>19</sup> Ireland, *Mental Affections*, 4.

<sup>20</sup> Ireland recounts these events in W.W. Ireland, ‘Observations on Mental Affections in Children and Allied Neuroses’, *Edinburgh Medical Journal* XLI (1895), 97-105. Whilst Ireland does not give an exact

idiots and imbeciles recorded in the census dropped by nearly a thousand. In the census of 1901, the figures rose again, but on this occasion the sub-category 'feeble-minded' was included alongside 'idiot' and 'imbecile'. As the wording of the census changed from one decade to the next, attempts to compare different census returns are bound to be flawed.

Furthermore, although Ireland and Yellowlees succeeded in clarifying the enumerator's definitions of idiocy and imbecility, many heads of households still failed (or chose not) to grasp official distinctions between idiocy, imbecility, feeble-mindedness and lunacy. The census report of 1911 states that '[a]n examination of the returns... provides ample evidence that these distinctions have not been uniformly applied'. The report points out that from the information given by heads of households, the age-distribution of imbeciles and feeble-minded people contained a disproportionately high number of elderly defectives. This contradicted prevailing medical opinion, which generally held that mental defectives were more likely to die young than ordinary people. The census commissioners ascribed this anomaly to respondents applying the labels to 'cases in which the mental infirmity has arisen, not at an early age, but in middle and advanced life'.<sup>21</sup>

A study of the former occupations of those returned as imbeciles and feeble-minded reinforced this point:

while it is reasonable to assume that those who are mentally infirm from childhood are incapable of qualifying for a learned profession, or for a skilled trade, the returns include many examples of these infirm being reported to have had such occupations. For instance, the list of those returned as 'imbecile' or 'feeble-minded' includes an officer of the Royal Navy, two ministers of the Established Church of Scotland, an advocate, two sick nurses, a school mistress, and a very considerable number with other occupations requiring skill and technical knowledge.<sup>22</sup>

---

reference for his letter to the Scotsman, it was reprinted ten years later in *Journal of Mental Science* (1891), 289.

<sup>21</sup> *Census of Scotland I*, 1911, xviii.

<sup>22</sup> *Ibid.*

Looking back to data in census reports from the late nineteenth century, similarly anomalous statistics on age and occupations occur.<sup>23</sup> Such findings illustrate the tensions between popular and medical understandings of mental deficiency. This makes Ireland’s belief that the census returns under-represented the number of mental defectives problematic. As noted above, he observed that statistics fell short of his own estimate because of a reluctance amongst heads of households to label family members as mentally defective. Considering the stigma attached to mental deficiency, it is likely that many householders were reluctant to use the label, but the census returns also included many individuals who would not have been regarded as mentally defective by the medical profession because they did not develop their symptoms until later in life. Once he had succeeded in prompting a change to the schedules in 1891, Ireland chose to focus only on those factors that would help him argue that mental deficiency was more, rather than less, widespread than was generally supposed.

**Table 4.1: PROPORTION OF THE SCOTTISH POPULATION REGARDED AS MENTALLY DEFECTIVE<sup>24</sup> BY HEADS OF HOUSEHOLD IN THE DECENNIAL CENSUSES OF SCOTLAND, 1871-1911**

Date	Total Population of Scotland	Number of people labelled mentally defective	Per 1,000 of Scottish population labelled mentally defective
1871	3360018	4621	1.4
1881	3735573	5991	1.6
1891	4033103	5017	1.2
1901	4472000	6623	1.5
1911	4759445	7911	1.7

Sources: Census of Scotland, 1871-1911.

Although the Scottish census commissioners persisted in collecting returns on imbecility, it is clear that state officials and medical specialists were not prepared to accept the results as being in any way definitive. On the other hand, the returns do give some indication of lay opinion in Scotland: they tell us the number of people described to the enumerators as mental defectives by heads of households. Between 1871 and

<sup>23</sup> *Census of Scotland*, 1871, 75 and 541-542; *Census of Scotland*, 1881, 75; *Census of Scotland II*, 1891, 58; *Census of Scotland III*, 1901, 735-739.  
<sup>24</sup> The censuses of 1871, 1881 and 1891 refer only to ‘imbeciles’ and ‘idiots’, whilst the censuses of 1901 and 1911 also refer to the ‘feeble-minded’.



1911, the census returns showed an average of 1.5 per 1,000 (6033) of the Scottish population were described as imbecile to census enumerators (see Table 4.1). This is lower than the figure of 2 per 1,000 suggested by W.W. Ireland in 1898.<sup>25</sup>

Unlike their Scottish counterparts, the English Commissioners decided that returns on mental deficiency were too unreliable to warrant inclusion in the census after 1891. As in Scotland, the general feeling amongst specialists was that the decennial returns underrepresented the true incidence of the condition. An investigation carried out by the Charity Organisation Society's special committee in 1876-7 suggested that the number of mental defectives in England and Wales was around 25% more than the 1871 census estimate of 29,452. Once more, this alleged under-representation was ascribed to 'the prevailing ignorance on the subject and the natural desire to conceal the existence of idiocy in families'.<sup>26</sup>

However, the Charity Organisation Society's estimate was made before the establishment of special education for the feeble-minded. By the 1890s, doctors and educationists involved in special education argued that figures for the incidence of mental deficiency would vastly under-estimate the proportion of mental defectives in the community unless feeble-mindedness was taken into account. It is for this reason that the Scottish Census commissioners included the term in 1901 and 1911. In the late nineteenth century, estimates made by medical specialists involved in special education also began to take account of the new sub-category. In 1898, the Departmental Committee on Defective and Epileptic Children took a rough average of the estimates made by witnesses with a background in special education and reported that approximately 10 per 1,000 of the school aged population was feeble-minded.<sup>27</sup> The Committee did not concern itself as to whether this figure could also be applied to the adult population, but then, from the start feeble-mindedness was primarily bound to the issue of education.

Even when doctors and state officials eventually began to consider feeble-mindedness amongst the wider population, the condition was not considered to be as prevalent amongst adults as it was with children. Hence, whilst the Royal Commission of 1908

---

<sup>25</sup> Ireland, *Mental Affections*, 7.

<sup>26</sup> Quoted in Jackson, *Borderland of Imbecility*, 34.

<sup>27</sup> HMSO, *Departmental Committee on Defective and Epileptic Children I*, 5.

suggested that 4.6 per 1,000 of the total population of England and Wales was mentally defective (idiots, imbeciles, feeble-minded and moral imbeciles), the report suggested that the proportion of mentally defective children amongst the school-age population was higher.<sup>28</sup> In its discussion of feeble-mindedness amongst school children, the Commission's final report initially made reference to the lack of consensus on the subject, particularly with regard to the regional disparities: '[w]e have thus variations in estimate from .25 per cent., .5, .8 to 1 per cent., and even 2 per cent'.<sup>29</sup> It did, however, report that some 35,662 mentally defective children were currently denied the special education they needed. Adding these to the 9,082 pupils already accommodated in special classes at that time would indicate that 7.4 per 1,000 of the pupils on school registers in England and Wales should, according to the Royal Commission, be placed in special classes for the feeble-minded.<sup>30</sup>

The figures offered in the 1908 report indicate that estimates for the incidence of mental deficiency amongst the overall population (across all age-groups) of England and Wales had generally increased since the 1870s. Although the proportion of school pupils deemed to be in need of special provision in 1908 was less than that estimated in 1898, both the Departmental Committee and the Royal Commission gave figures suggesting a significant expansion in mental deficiency amongst school children when compared to the earlier statistics that only recognised idiocy and imbecility.

However, these national estimates provide only the barest of outlines in showing how the mental deficiency label came to be applied to an increasing proportion of the population. National averages belie regional variations in the extent to which mental deficiency was regarded as a 'problem', and (a related point) in the number of individuals segregated to receive special provision. Furthermore, estimates and surveys had limited direct impact on people's lives. No individual became regarded as a mental defective as a result of a general estimate. This is not quite the case with surveys: for example, individuals were identified as being mentally defective when medical professionals conducted large scale examinations of school pupils. However, these medical examinations did not necessarily lead to certification or the provision of special services for the pupils involved. A child labelled mentally defective for the purposes of

---

<sup>28</sup> HMSO *Royal Commission on Feeble-minded*, VIII, 6.

<sup>29</sup> *Ibid*, 90.

<sup>30</sup> *Ibid*, 88 and 91.

a specific investigation could continue being treated as ordinary, albeit backward, once the examination was completed. This situation was made more likely by the fact that the number of pupils identified as being mentally defective in surveys tended to substantially outweigh the number of places available in special classes.<sup>31</sup>

### *Glasgow*

A more detailed understanding of how mental defectives came to be 'manufactured' can be achieved by examining the activities of those directly involved in the labelling of individuals in a specific locality. For a Scottish study, the obvious choice of area is Glasgow: the first locality in Scotland where feeble-mindedness was officially recognised and the first to provide special education in day schools. Throughout the period covered in this thesis (and beyond), more individuals were labelled mentally defective and given segregated special provision in this city than in any other burgh or county north of the border, both in terms of raw figures and as a percentage of local populations.<sup>32</sup> A study of the identification and segregation of mental defectives in Glasgow reveals who was directly involved in increasing the use of the label, the methods they employed and how different professional groups responded to the issue. Furthermore, by considering all these issues over the first twenty or so years of Glasgow's special education administration, it is possible to show how medical theories and practices associated with mental deficiency changed in the period immediately following the local authorities' initial recognition of feeble-mindedness amongst school children.

To gain a sense of how mental deficiency in Glasgow increased between 1896 and 1918, it is worth examining some of the statistics available on the subject and placing them within the social context within which they were created. The earliest figures relating to mental deficiency within Glasgow's education system come from Bruce's survey of 1896. In 1905, another survey was carried out at the request of the Royal Commission on the Care and Control of the Feeble-Minded. This time, the examinations were organised by John Carswell, who had succeeded Bruce as Glasgow School Board's medical officer specialising in mental defectives. He was assisted by A.

---

<sup>31</sup> For examples see, Carswell's, Chalmers and Oswald's 1905 survey of school children in HMSO, *Royal Commission on Feeble-Minded III*, 369-373; Scottish Council for Research in Education, *The Intelligence of Scottish School Children* (London: University of London Press, 1933), 123; A.M. MacMeeken, *The Intelligence of a Representative Group of Scottish Children* (London: University of London Press, 1939), 138.

<sup>32</sup> See c. 6.



K Chalmers, Glasgow's Medical Officer of Health, and Landel Rose Oswald, Physician Superintendent at Gartnavel Asylum. The final set of figures for the period come from the School Board of Glasgow's Annual Reports, which from 1910, gave details of the work of the school medical officer for mental defectives. Carswell occupied this post until 1914.

Going back to the examinations conducted by Dr Bruce at the behest of Glasgow School Board in 1896, the various headmasters gave notice of 184 pupils, most of whom were confirmed as having some kind of deficiency by Bruce. According to R.S. Allan's (Chairman of Glasgow School Board) later testimony to the Royal Commission on the Care and Control of the Feeble-minded, 79 were diagnosed as mentally defective, 41 were diagnosed as mentally and physically defective and 40 as physically defective. A further 47 children were identified by attendance officers as not attending school on the grounds of imbecility. This makes 167 children on the school roll identified as possessing some form of mental deficiency. Of these, 120 seem to have been attending ordinary classes up to that point, although their teachers must have suspected them of being mentally defective, otherwise the children would not have been referred to Dr Bruce for an examination.<sup>33</sup> As Bruce dealt only with board schools, his survey does not take account of the pupils attending voluntary and private schools. There were nearly 23,000 such pupils outwith the board's inquiry, the vast majority of whom went to Roman Catholic schools. However, out of the 76,237 pupils stated to have been on the roll for Glasgow's Protestant board schools in 1896-7, Bruce identified 2.1 per 1,000 as being mentally defective, three quarters of whom were attending ordinary classes.<sup>34</sup>

This does not quite cover all the children who were officially recognised as being mentally defective in 1896, as the survey omits those children who had already been certified and sent to either of the two residential training institutions for mental defectives at Larbert and Baldovan. According to Glasgow School Board's Attendance Officer's Report for 1896-7, there were 112 such inmates from the Glasgow area, but the report states that 30 of these were accommodated as a direct result of representations from the school board following the survey.<sup>35</sup> Hence, at the time Bruce began his investigation, there were 82 children from Glasgow identified as imbeciles and residing

---

<sup>33</sup> HMSO, *Royal Commission on Feeble-Minded* III, 268.

<sup>34</sup> GCA D-ED 9/1/3/17, School Board of Glasgow, *Annual Report of School Attendance by School Attendance Committee* 1896-7, 13.

<sup>35</sup> *Ibid*, A4.

in Larbert or Baldovan. Most of these were maintained by the parish and, unlike the school children examined in the survey, could have been Protestant *or* Catholic. For this reason it would be problematic to include them in statistics based on children attending the Protestant board schools. However, as a percentage of the **total** school-aged population of Glasgow (as stated in the school board's report for 1896-7<sup>36</sup>) the proportion of children officially recognised as being mentally defective in Glasgow in 1896 comes to 2.3 per 1,000. This figure includes those identified in the survey and those residing in the two institutions.

These figures roughly match Ireland's view that 2 per 1,000 of the population was mentally defective. This raises questions about the immediate impact of the feeble-minded category in changing perceptions about the incidence of mental deficiency within the population. Ireland based his estimates on idiots and imbeciles only. Bruce, on the other hand, recognised idiocy, imbecility and feeble-mindedness. Yet his inclusion of the extra category did not cause him to identify a significantly higher proportion of mental defectives compared to Ireland's estimate. It did, however, result in many individuals being labelled and segregated for the first time. Following the survey, pupils identified as feeble-minded were grouped together in the same classes, whilst those identified as being imbeciles were, if the parents were judged incapable of paying for private care, notified to parish councils as being in need of institutional care.<sup>37</sup> Thus, whilst the overall findings of the survey would not have been startling to observers, the impact on individuals and on the provision of special services in Glasgow was profound.

The most startling developments in the expansion of mental deficiency occurred in the years that followed the acceptance of the feeble-minded category. Hence, the survey of 1905, conducted for the Royal Commission for the Care and Control of the Feeble-Minded, identified a much larger number of mental defectives than Bruce's earlier inquiry. The Royal Commission was appointed to assess the true extent of the mental deficiency 'problem' in the UK. Commissioners used Glasgow as one of their case studies because provision for mental defectives in that city was much more extensive than in any other area in Scotland. Following the specifications laid down by the Commission, Carswell, Chalmers and Oswald conducted a survey that included both

---

<sup>36</sup> *Ibid*, 13.

<sup>37</sup> HMSO, *Royal Commission on Feeble-Minded* III, 268.

voluntary and board schools, in addition to children kept at home or placed in institutions.

They identified 634 mentally defective children in schools. They also identified 90 at home, of whom just over a third were deemed educable. Finally, from their report, at least another 109 can be identified, as coming under the Poor Law or attending charitable institutions. This last figure includes 66 inmates of Larbert institution, but does not include inmates of Baldovan (Carswell *et al* do not explain why Baldovan was not included in the enquiry).<sup>38</sup>

At that time, the number of children on Glasgow's school role, including board schools and voluntary schools, was 108,184. Meanwhile, the estimated school-aged population of Glasgow was 114,586 (not everyone of school-age was on the school role: some started school late, some finished early, whilst institutional cases were registered elsewhere). Hence, whilst in 1896 there were 2.1 mental defectives attending school or being cared for at home after being exempted from day school for every 1,000 children on that years' school roll, by 1905, the figure had risen to 6.7. In 1896 there were 2.3 mental defectives at school, at home or in specialist institutions for every 1,000 children of school age in Glasgow. In 1905, the figure had risen to 6.9 despite the fact that mentally defective children at Baldovan were not included in the later survey.<sup>39</sup>

It is also worth noting that Carswell *et al* went on to extend their investigation to the adult population of Glasgow, tracking down suspected mental defectives with the assistance of Poor Law inspectors, charitable workers, institutional staff, and general practitioners. From these enquiries, they reported that the 2.5 per 1,000 of Scotland's total population (of all age-groups) was mentally defective. The survey consequently failed to find anywhere near as many adult mental defectives as it had children: the feeble-minded label proved less applicable to adults, partly because it was largely understood within an educational context, and partly because adult's living in the

---

<sup>38</sup> *Ibid*, 369-405.

<sup>39</sup> Note that Carswell *et al*, state that there are 724 mentally defective children of school age who fall within the purview of the School Board (an incidence of 6.3 per 1,000 of the school age population). I have added to this number the 66 mentally defective children attending Larbert institution. There were a further 43 mental defective children identified in the report as being dealt with by non-specialist institutions or simply coming under the Poor Law. Adding these to the total would give a figure of 7.2 mental defectives per 1,000 of the school-aged population. *Ibid*.



community were often able to avoid the kind of medical surveillance children experienced at school.<sup>40</sup>

The rise in the number of school-aged defectives between 1896 and 1905 can be explained at least partly in terms of increased surveillance within each school. It can be argued that this allowed the medical officers to 'discover' more pupils who fit their criteria for feeble-mindedness. In conducting the survey, Carswell *et al* did not simply rely on headmasters' notifications, as Bruce did in 1896. Carswell's report states that:

In many instances the head masters had, by request, prepared lists of those whom they considered to be mentally defective; but these were only accepted as a guide in the examination of the school, each class in every school being reviewed by the investigator for himself... and pupils were selected by him for examination in addition to those submitted by the teachers.<sup>41</sup>

The investigators identified 634 mental defectives on the school roll, of whom only 272 attended special classes. The rest were still being taught in the ordinary classes. Hence, it could be argued that the doctors 'discovered' 362 mental defectives in the ordinary classrooms (although some of these defectives would also have been on the headmasters lists referred to above). However, it should be noted that virtually all of those included in these figures would not have been identified as mentally defective had the 'feeble-minded' category not been created, as all but 14 of the pupils listed belonged to this category.

Furthermore, within 10 years of the survey, Glasgow School Board was providing special classes for over 1,000 educable mental defectives.<sup>42</sup> This later increase cannot simply be ascribed to more extensive surveillance by the medical officers, because the procedure used by the school board when selecting candidates for special classes was not as extensive or as thorough as that employed by Carswell *et al* in the survey of 1905. Once his work for the Royal Commission was completed, Carswell returned to his regular duties as school medical officer for mental defectives. It was a part-time position, so he conducted examinations only on those children specially notified to him.

---

<sup>40</sup> HMSO, *Royal Commission on Feeble-Minded* III, 398.

<sup>41</sup> *Ibid*, 371.

<sup>42</sup> GCA D-ED 9/1/33, *Annual Report of School Board of Glasgow* 1914-15, 6.

In other words, apart from in 1905, the Board’s medical officer specialising in mental deficiency did not have access to the entire school population, but rather examined only those pupils who had been selected for him. The rise in the number of mental defectives on Glasgow’s school rolls was not a simple reflection of the greater access to the student population obtained by medical officers for mental deficiency over the period: the greatest access was achieved in 1905, but higher numbers of mental defective were recorded from 1910, when access was more restricted.

**Table 4.2: INCIDENCE OF MENTAL DEFICIENCY WITHIN THE BOUNDARIES OF THE SCHOOL BOARD OF GLASGOW**

Year	Mental defectives in special institutions <sup>43</sup>	Mental defectives on the school roll <sup>44</sup>	Total no. of mentally defective children in Glasgow	No. of mentally defective children living at home and/or attending special classes, per 1,000 children on school roll in Glasgow. <sup>45</sup>	No. of mentally defective children at home, attending special classes or accommodated in special institutions per 1,000 children of school-age in Glasgow. <sup>46</sup>
1896	82	167	249	2.1	2.3
1905	66	724	790	6.7	6.9
1910	168	833	1001	7.3	9.0
1914	123	1082	1205	8.5	9.1

Sources: GCA D-ED 9/1/3/16 and 17, School Board of Glasgow, *Annual Reports on School Attendance by the School Attendance Committee*, 1896 and 1897; HMSO, *Report of The Royal Commission on the Feeble-minded III*, 1908, pp. 369-405; GCA D-ED 9/1/33 *Annual Report of the School Board of Glasgow*, 1909-10, pp. 11 and 31; *Annual Report of the School Board of Glasgow*, 1913-14, pp. 6-7.

Table 4.2 illustrates how the number of children labelled mentally defective continued to rise between 1896 and 1914. It should be noted that the table is only intended to indicate a general trend, rather than give an exact representation of who was being labelled. The statistics gathered from Glasgow School Board reports between 1910-14 include only those children attending special day classes (in voluntary and board

<sup>43</sup> Larbert and Baldovan (except for 1905, in which only Larbert is listed).  
<sup>44</sup> 1896 and 1905 figures include mental defectives exempt from school and living at home, as well as pupils labelled mentally defective attending ordinary classes or (in 1905) special classes; 1910-14 figures only include pupils in special classes.  
<sup>45</sup> See footnote 42.  
<sup>46</sup> See footnote 42. School-age was not a constant throughout the period studied. In fact, children as young as 3 attended schools on occasion, though the legal entry age was 5. The school leaving age for elementary pupils was raised to 14 in 1901, whilst the Education Act, 1908 raised the leaving age of defective children to 16. There were also higher schools and continuation classes that catered for older children. Before the changes in 1901, the School Board of Glasgow estimated the childhood population within the age group of 5-13. Afterwards, its estimations were based on the age group 5-14.

schools) or specialist institutions for imbeciles. They do not include pupils in ordinary classes considered to be mentally defective, or children excluded from the education system and living at home.

Despite the fact that the statistics for 1910-14 limit themselves to those children actually in receipt of segregated provision (in either special classes or institutions), they still exceed the figures given in the survey of 1905. Therefore, despite inconsistencies in the way the various statistics were obtained over the years, it must be concluded that a child in Glasgow was considerably more likely to be labelled a mental defective in 1914 than he or she would have been in 1896. In 1896, 2.3 per 1,000 of the school aged population of Glasgow were either already in receipt, or considered to be in need of some form of special provision on the grounds of mental deficiency. By 1914 the number of mental defectives already receiving some form of special provision had risen to 9.1 per 1,000. As this continuing rise cannot be explained solely in terms of increased surveillance, it is necessary to look for other factors that could account for the trend. Specifically, the rise in the number of mental defectives can be said to have resulted from changes in the way those involved in the special education system defined the condition.

### *Identifying Mental Defectives*

As stated earlier, doctors seeking to identify mental defectives could draw on a mixed bag of medical criteria, taking into account mental, physical and social attributes. The chief disadvantage of this approach was the lack of standardisation, which to some extent undermined the doctors' claim that their means of identifying mental defectives were firmly grounded in scientific criteria (though this did not stop them from making the claim). It left them open to the criticism that ordinary people could at times be misdiagnosed as mentally defective. This was a particular problem for advocates of special education for the feeble-minded: for example, the English government committees that considered special education in the late nineteenth century (the Royal Commission of 1886 and Departmental Committee of 1898) found themselves continually mired on the issue of finding a fool-proof way to distinguish feeble-minded pupils from pupils who were ordinary, albeit dull and backward.<sup>47</sup>

Other countries embarking on special education faced similar difficulties distinguishing

---

<sup>47</sup> Sutherland, *Ability, Merit and Measurement*, 14-24.



mental defectives from ordinary pupils. The French government enlisted the services of the psychologists Alfred Binet and Theodore Simon, who devised a series of mental tests that aimed to standardise the criteria by which mental defectives were identified. They ignored physical and behavioural symptoms, opting instead to 'measure' a range of intellectual abilities such as comprehension, judgement, attention, reasoning and invention through a series of set questions to be administered on an individual basis by a trained psychologist.

Binet and Simon first published their work in 1905, but it was not until around 1910 that British authorities began to take notice.<sup>48</sup> Even then, the tests did not immediately transform the diagnostics of mental deficiency. Rather, they became an appendage to the more established mixture of *ad hoc* criteria. Hence, in the early twentieth century, influential textbooks on mental deficiency, such as those written by R.E. Tredgold and C.P. Lapage, continued to refer to physical stigmata and the need for experienced doctors to make subjective appraisals of their patients' intellectual ability, social competency and behaviour based on simple questioning, observation and an investigation into the patients' home and school lives.<sup>49</sup>

Doctors involved in Glasgow's burgeoning special education system were therefore operating in a field in which personal discretion played a prominent role in determining who was to be labelled and upon which criteria. Unfortunately, the Glasgow doctors provide us with little information as to how they carried out their examinations. However, the school medical officers working for the neighbouring school board of Govan were more forthcoming. Govan Parish School Board opened its first special classes for mental defectives at Pollokshields Public School and Broomloan Road School in February 1904, whilst in 1909 the Board opened Summerton Special School, which catered specifically for physical and mentally defective pupils (with the two types of defectives being taught in separate classes).<sup>50</sup> Statistics for the earliest years of special education are not available, but it is clear that Govan's special education system

---

<sup>48</sup> *Ibid*, 52-6.

<sup>49</sup> Lapage, *Feeble-mindedness in Children*; AF Tredgold, *Mental Deficiency (Amentia)* (London: Bailliere, Tindall & Cox, 1908), 324-326.

<sup>50</sup> GCA D-ED 9/1/33, Govan Parish School Board, *Annual Report of Medical Inspection of School Children* 1910, 41-42.

did not expand as rapidly as Glasgow's. During the school year 1913-14 there were only 145 mental defectives on the school roll.<sup>51</sup>

Nonetheless, with the exception of Glasgow, Govan's commitment to special education outstripped any other school board in Scotland in the early years, and Govan's annual reports on *The Medical Inspection of School Children* devoted a considerable amount of space to discussing mental deficiency. Both George Arbuckle Brown, Govan School Board's Chief Medical Officer since 1909, and Kate Fraser, who had been appointed by the Board as a school medical officer in 1908, took a special interest in the subject. Brown administered Govan's school medical service along similar lines to Glasgow and in 1918, the two services were amalgamated into Glasgow Education Authority with little disruption on either side.

Though born in Ayrshire in 1873, Brown grew up in Glasgow and graduated with an MB at the university at the age of 23. After a short spell working in a fever hospital in England, he returned to Glasgow to study public health under A.K. Chalmers. Eight years prior to his appointment at Govan Parish School Board, he was appointed medical officer for Partick.<sup>52</sup> This would have brought him into contact with many of Govan's schools and helped him establish personal connections with key figures from Govan's local authorities. Hence, when the post of school medical officer became available, Brown's application was personally backed by both the local Provost and the chairman of the school board: indeed, when it looked as though the majority of board members preferred another candidate, it was their support that secured Brown's appointment.<sup>53</sup> Up to the point where he took the job, there was nothing in Brown's background to indicate that he had many dealings with mental deficiency. His subsequent interest in the issue, following his appointment at Govan, may well have been encouraged by Fraser.

Fraser had studied mental deficiency as a postgraduate and would come to devote her entire career to mental health. She was four years Brown's junior, the daughter of a successful general practitioner in Paisley, and the niece of Glasgow's renowned

---

<sup>51</sup> GCA D-ED 9/1/33, Govan Parish School Board, *Annual Report of Medical Inspection of School Children* 1914, 33.

<sup>52</sup> GGHBA HB 38/2/3, School Board of Glasgow's, press cuttings related to child welfare, *Glasgow Herald* (Nov 1909), book 1, 1.

<sup>53</sup> GGHBA HB 38/2/3, School Board of Glasgow's, press cuttings related to child welfare, *Daily Record* (Nov 1909), book 1, 1.

Professor of Pathology, Joseph Coats. Following the family tradition (though initially against the wishes of her father), Fraser studied medicine at Glasgow University. Her academic career was not distinguished (her own niece's generally eulogistic biography concedes that Fraser 'referred to herself as a "plodder," a tortoise rather than a hare...if she failed an examination she sat it again').<sup>54</sup> However, she was determined and, once she had overcome the initial opposition of her father towards her becoming a doctor, well-resourced. Having obtained her medical qualifications in 1903, she embarked on a period of post graduate study in both Vienna and Paris. It was in Paris, at the Sorbonne, that she became familiar with Binet's and Simon's work. Binet was Director of Psychology there, and Fraser made her own translation of his tests.<sup>55</sup> In Govan, she continued her research into mental deficiency, submitting an MD thesis to Glasgow University in 1913 on the subject of 'Feeble-minded children – an inquiry into Mental Deficiency in School Children with Special Reference to Syphilis as a Causative Factor'.<sup>56</sup>

The research required Fraser to conduct numerous types of medical examinations of her subjects. As her frequent references make clear, Fraser based her approach to these examinations on the work of established authorities on mental deficiency such as Tredgold, Ireland, Shuttleworth and Lapage. She employed a number of different techniques and looked for a correlation of different 'symptoms', any one of which would not be sufficient to signify mental defect, but in conjunction with others, would be used to confirm that the child under examination was indeed mentally defective.

Hence, when looking for physical stigmata, Fraser followed what was by then a commonly held assumption that whilst many children with a normal level of intelligence possessed a single stigmata, children with multiple stigmata were much more likely to be mentally defective. These stigmata could include a small or asymmetrically shaped head, defects of the ear, epicanthal folds (folds of skin coming from the upper eye), obliquity of orbit (having one eye lower than the other), cleft or otherwise deformed palate, receding jaws, small bodily stature and 'rough and scaly'.<sup>57</sup>

---

<sup>54</sup> M. Mayes, *The Stormy Petrel: A Life of Dr. Kate Fraser* (Glasgow: Wellcome Unit for the History of Medicine, 1995), 49.

<sup>55</sup> *Ibid*, 55-73.

<sup>56</sup> K. Fraser 'Feeble-minded Children - an Inquiry into Mental Deficiency in School Children with Special Reference to Syphilis as a Causative Factor as Determined by the Wassermann Reaction' (MD. thesis, Glasgow University, 1913).

<sup>57</sup> *Ibid*, 22.



skin. Whilst Fraser believed that the link between stigmata and low intelligence was not always apparent, there were certain observations she made about her patients' physical appearance that made explicit the connection. Examining facial expressions, Fraser looked for 'a dull, puzzled expression', or an expression that 'may be dull, vacant, heavy, anxious or wanting'.<sup>58</sup> She looked for an ill-balanced body, 'with one shoulder higher than the other in a loose and slouching attitude',<sup>59</sup> and defective speech caused by 'thick and clumsy action of the lip and tongue muscles'.<sup>60</sup> According to her findings, the correlation between mental deficiency and the possession of three or more physical defects was 'so great as to be of some diagnostic value'.<sup>61</sup>

Besides physical characteristics, Fraser interviewed the children's guardians to obtain etiological information about previous family history of deficiency, as well as obtaining information about the age children began to walk and talk. Cross-referencing parental interviews with school records, Fraser looked for evidence of a family history of diseases of the nervous system, alcoholism, tuberculosis, syphilis, consanguinity, as well as unusually large age-differences between the parents. Her own findings suggested that such indicators of a hereditary deficiency occurred less frequently than writers such as Tredgold, Shuttleworth, Lapage and Potts had suggested.

She then looked at extrinsic causes such as accident or illness during pregnancy or labour, as well as malnutrition or trauma experienced by the mother or child. These seemed to occur more frequently than many of the established writers suggested. However, Fraser was cautious about her findings as she considered parental evidence to be unreliable. In her view few parents would 'care to admit (particularly to school authorities) the occurrence of Insanity, Alcoholism, Syphilis, or Consumption in their family'.<sup>62</sup> On the other hand, attributing mentally defective offspring to ill health, accidents or shocks to the mother tended to present a more palatable explanation for parents wishing to avoid the stigma implied by hereditary disorder.

After describing physical and etiological characteristics of mental deficiency, the thesis then goes on to discuss mental characteristics. To the modern observer, this section is of

---

<sup>58</sup> *Ibid*, 30.

<sup>59</sup> *Ibid*, 31.

<sup>60</sup> *Ibid*, 25.

<sup>61</sup> *Ibid*, 7.

<sup>62</sup> *Ibid*, 60.

particular interest because of Fraser's early use of the Binet Simon Tests.<sup>63</sup> Indeed, it is conceivable that she may have been the first School Medical Officer in Britain to examine children in this way. The tests asked examinees to describe pictures, define well known objects, compare the length of lines, compare objects from memory, frame sentences that used certain key words; she also tested colour recognition and ability to follow multiple instructions. The tests were of increasing difficulty and Binet and Simon had prepared detailed accounts of how they would expect the average child of each age-group to respond. In this way, the psychologists claimed to be able to measure the mental age of patients. An examinee was considered to be mentally defective if their test results indicated that his or her mental age was two or more years below their actual age.

Fraser did not view psychometric testing as capable of providing any definitive answers in the identification of mental defectives. She used her own translation of the tests on the children of Govan, but only as a supplement to the other methods of examination and she did not present any quantifiable data on mental age or mental levels in her thesis. The tests were, after all, something of novelty: in Fraser's words, 'a future possibility'. Within the medical profession, the debate as to their value was only beginning, so Fraser was in no position to dispense with more established methods of gauging mental ability. In any case, she believed that less formalised methods of mental assessment still played a valuable diagnostic role, stating that:

much can be learned...by conversation, by careful and skilled observation of his [the examinee's] manner, behaviour, general conduct and natural scholastic ability.<sup>64</sup>

During her examinations she observed and spoke with the children, making subjective appraisals of their temperament and intelligence, weighing her personal impressions against information provided by teachers regarding pupils' academic performance. She looked for children who seemed irresponsive and lacking in initiative, or conversely, seemed impulsive, emotional and restless. They might be 'weak-willed', 'timid', 'affectionate', 'dependent' or 'cruel'.<sup>65</sup> These appraisals did not seem as 'scientific' as

---

<sup>63</sup> K. Fraser, 'The Use of the Binet-Simon Tests in Determining the Suitability of a Child for Admission to a Special School', *School Hygiene* 2, IV (1913), 77-88.

<sup>64</sup> Fraser 'Feeble-minded Children', 37.

<sup>65</sup> *Ibid*, 56-57.

the standardised, quantifiable assessments gained from Binet and Simon's tests, which perhaps explains why Fraser was unwilling to go into much detail about this aspect of her examinations. Nonetheless, they remained an essential part of her examination procedure. As Brown pointed out when he gave an account of Fraser's use of the Binet Simon tests in his report for Govan Parish School Board, only a 'small number' of mental defectives had their mental age included on the school records by 1914. Hence, the doctor's more impressionistic appraisals of a child's mental state would remain an essential part of the diagnosis:

[d]uring the year good progress has been made in compiling a medical register of all the mentally defective children in our schools; but much remains to be done. It is proposed to provide a complete medical record for each child along with the approximate mental age. It should be possible to classify the children for school purposes by means of the Binet-Simon tests. An attempt to do so has been initiated, but only a small number of the children in the schools have so far been classified. When the arrears of work in this direction have been overtaken, a more reliable method of estimating the mental progress of the children will probably be established. Instead of the present rough and ready method of judging a child's progress we hope to be able, at regular intervals to estimate the mental progress of the child.<sup>66</sup>

It is important to recognise that the examinations conducted by Fraser in the course of her academic research would have differed in certain respects from the examinations carried out by her for the School Board. The 'rough and ready' approach to diagnostics referred to by Brown in his annual report for Govan Parish School Board better characterised the latter type of examination, not least because of the time constraints involved that prevented Fraser from conducting her examinations for the school board with the same degree of thoroughness as she had for her thesis. The aims of the examinations also differed. As Fraser's thesis focused on the supposed links between syphilis and mental deficiency, each child underwent a Wassermann test for the disease: a procedure that was not generally used in school medical examinations. Equally significant, Fraser sampled children for her research who had already been placed in special classes. In her research, unlike her work as school medical officer, Fraser's task

---

<sup>66</sup> GCA D-ED 9/1/33, Govan Parish School Board, *Annual Report of the Medical Inspection of School Children* 1915, 30



was to employ the full variety of examination techniques on pupils already certified as mentally defective, rather than identify mental defectives for the first time.

One diagnostic criterion that received relatively little attention in Fraser's thesis is educational ability. This results from her decision to sample children already known to be mentally defective. The poor educational ability of her sample of special school pupils was not in question, as under the Education of Defective Children (Scotland) Act, 1906, mental defectives could only be placed in special classes if they were judged 'incapable of receiving proper benefit from the instruction in Ordinary Schools'. It is important to note that in Fraser's more routine examinations of school pupils, educational ability had a much more prominent role. This was partly because of the legal requirement stated above and partly because of the way pupils were selected for examination with a view to entry into special education.

Regarding selection procedure, it is worth summarising how Govan's school medical system operated. Before 1907, medical examinations were not performed routinely, but rather in exceptional circumstances called upon by the headmaster. This changed following the establishment of Govan's school medical service in that year, after which, all school pupils would expect to have at least two routine medical examinations during their school career. However, these routine examinations were conducted by medical officers who lacked psychiatric or psychological training, and were geared towards identifying physical complaints such as rickets, tuberculosis, malnutrition and sensory impairments. Examinations to determine whether or not a child was mentally defective were conducted separately by Fraser: they were not routine and only a minority of pupils underwent them. In a description of how pupils were selected for these special examinations, Fraser writes:

[t]he general practice in actual operation is that a child who is found by the teacher to make no progress by the methods of instruction used in an ordinary class, is presented to the medical officer in order that a diagnosis of the child's physical and mental condition may be made, and his suitability or otherwise for special tuition be determined.<sup>67</sup>

---

<sup>67</sup> Fraser, 'Use of Binet-Simon Tests', 77.

Fraser would therefore be called in to perform special examinations when notified to do so by headmasters. The headmasters made such notifications when teachers informed them that a particular child was making insufficient progress in the ordinary classes. Fraser therefore only examined children who had been selected by teachers as potential special pupils on the grounds of poor education performance.

The medical examination was in many ways a process of elimination. If physical defects were found that might have impeded a child's education independently of his or her mental ability, Fraser wanted to see these remedied before going on to assess the child's mental ability. On the other hand, Fraser was also aware that certain physical abnormalities often existed alongside mental defects, hence the physical examination could both rule out or give evidence to support mental deficiency. Likewise, Fraser drew upon school records, visiting school nurses and attendance officers to assess conditions in the child's home, in order to find evidence of ill treatment that could have adversely affected the child's education, or to see if there was a family history of mental abnormality that may indicate congenital defect. The children Fraser identified as potential special class pupils were therefore regarded as educational failures, whose poor performance in the classroom could not, according to Fraser, be attributed solely to physical defects or environmental disadvantages.<sup>68</sup>

Members of two different professions, doctors and teachers, consequently worked in conjunction to identify mental defectives within the education system. Whilst the law made it clear that the school medical officers had the final say, the relative influence of teachers and doctors appears less clear when the process of selection is examined in practice. Contemporaries involved in the process had difficulty clarifying who had what role, for the simple reason that the roles were never clear to begin with. The legal definitions that school medical officers were obliged to adhere to referred to educational ability, but this left doctors in a somewhat ambiguous position. It was not immediately obvious that school medical officers would make better judges than teachers in assessing how a child performed at school. Even Shuttleworth, the UK's foremost proponent of special education, found himself having to defend the authority of the school medical officer when he was called as a witness to the English Departmental

---

<sup>68</sup> *Ibid*, 78.

Committee on Defective and Epileptic Children (1899), as the following exchange illustrates:

Q. Do you not think that an ordinary person could detect a feeble-minded child?

A. [Shuttleworth] I think an ordinary person might suspect it but I do not think he or she could be sure of it with the same degree of certainty as a trained and scientific observer could be sure of it.

Q. What I wanted to get at was this: would a teacher in a school, after three or four months experience in a school, be able to point to a child as unable to keep pace with other children?

A. I think so. Of course, that would be the result of experience with the child after three or four months, but there are many conditions on which feeble-mindedness depends that I think it is a matter for scientific and physical discrimination after that as to whether the child is to be denominated feeble-minded.

Q. In all cases a medical certificate would be necessary to discriminate?

A. That is my opinion. I mean that the conditions of the feeble-minded are so mixed up with physical conditions that it is important that a person who has been trained to discriminate between various abnormal physical conditions should have the decision as to the state of the child.<sup>69</sup>

The difficulty in determining the roles of teachers and doctors is at times noticeable in the historiography of mental deficiency. Mark Jackson has referred to the way doctors were 'paradoxically prepared to accept definitions of feeble-mindedness that focused primarily on educational and social capacity', but goes on to say that 'medical acquiescence to the role of teachers was more apparent than real'.<sup>70</sup> However, during his later analysis of Manchester's special education system, Jackson concludes that school medical officers were prepared to 'suspend inter-professional differences and

---

<sup>69</sup> HMSO, *Report of Departmental Committee on Defective and Epileptic Children II*, 3

<sup>70</sup> Jackson, *Borderland of Imbecility*, 111.



collaborate with teachers' as part of a 'pragmatic approach to diagnosis and selection'.<sup>71</sup> The willingness of doctors to work in partnership with the teaching profession when identifying mental defectives was in practice more real than apparent.

In Glasgow, the collaborative approach that Brown described as 'rough and ready', and Jackson as 'pragmatic', seems to have been accepted from the start. Regarding the initial survey of 1896, relatively little can be said about how Bruce arrived at his diagnoses but it is clear that teachers had a significant role. Two things are known about the way Bruce's survey was conducted, both of which converge with Fraser's later approach to her work as School Medical Officer at Govan. Firstly, he only examined those children who had already been notified to him by headmasters and attendance officers. In other words, the primary diagnoses were made by people without medical training. The Medical Officer's role was to validate or reject these diagnoses and state whether he believed the deficiency was mental and/or physical. Secondly, whilst the definition of imbecility had been established in medico-legal terms since the Lunacy (Scotland) Act of 1862, the concept of feeble-minded or educable defectives was still novel at this time. Hence the Board, presumably on consultation with Bruce, provided the following definition of 'defective' upon which headmasters were to base their judgements:

The expression 'defective' means a child who, after a trial in an ordinary public elementary school, has been found, owing to mental or physical disability, to be capable of receiving instruction in only a proportion of elementary education.<sup>72</sup>

Both mental and physical deficiency was, therefore, described in relation to educational performance, although it is notable that the term includes children who are capable of receiving some (ie. 'a proportion') of elementary education. In the years that followed, educational performance remained central to the identification of mental defectives within the school system. When Carswell *et al* conducted their survey in 1905, their definition of mental deficiency was based on that provided in the Elementary Education (Defective and Epileptic) Act, 1899, for England and Wales. The 1899 act referred to children who, 'are by reason of mental or physical defect incapable of receiving proper benefit from the instruction in the ordinary public elementary schools, but are not

---

<sup>71</sup> *Ibid*, 114.

<sup>72</sup> *Royal Commission on Feeble-minded* III, 268.

incapable, by reason of such defect, of receiving benefit from instruction in such special classes or schools as are in this Act mentioned'.<sup>73</sup> The wording was therefore slightly different from that used in 1896, but in practice the terms 'proportion of elementary education' and 'proper benefit from...instruction' were equally vague as to be indistinguishable. As the English definition was then incorporated into the Education of Defective Children (Scotland) Act, 1906, it became the legal basis upon which Scotland's mental defectives were defined within the education system until 1946 (bearing in mind that even after the Mental Deficiency and Lunacy (Scotland) Act, 1913, was passed, special education was still legally founded on the 1906 act).

The centrality of educational performance to the identification of mental defectives within the school system was further born out by Carswell. In his contribution to the School Board of Glasgow's *First Annual Report on the Medical Inspection of Children* in 1910, Carswell states that he classified children ear-marked for special education in the following way: '(1) educable; (2) doubtful as to educability; and (3) doubtful as to whether imbecile.'<sup>74</sup>

Carswell seems to have been using a similar classification system since at least 1905, as one of Glasgow's special school mistresses, Lilly Monteagle, offered the Royal Commission on the Feeble-Minded the following explanation of what the expected prognosis was for each of these types:

[c]hildren are admitted to these classes direct from the ordinary schools, on the recommendation of ordinary class teachers. These children are then medically examined and classified by the doctor as Class I. - hopeful; Class II. - less hopeful; or Class III. - not hopeful. Those in Class I. seem to me to make great progress in the special classes, and are often able, after one or two years' training, to rejoin an ordinary class. Those in class II. also made marked progress, but will most likely require to remain all their school lives in a special class. Those in Class III. make little or no progress in ordinary school work, but benefit largely by the school discipline, teacher's influence, and in the centres

---

<sup>73</sup> Elementary Education (Defective and Epileptic Children) Act, 1899.

<sup>74</sup> GCA D-ED 9/1/33, School Board of Glasgow, *Annual Report on Medical Inspection of Children* 1910, 51.

where dinners are provided, by the wholesome food which they receive. They become like rational beings and more fit to associate with society in general.<sup>75</sup>

Besides emphasising how the classification of mental defectives was intricately bound to the question of educability, Monteagle also points to the continuing importance of teachers in making the primary diagnosis. Teachers and headmasters therefore played a crucial role in determining where the dividing line lay between the feeble-minded pupil and the ordinary but backward pupil. It was they who continued to make the initial selection of children they considered to be unsuitable for ordinary elementary education, and, as the years went by, the number of children they selected rapidly increased.

In 1906, Robert S. Allan, explained why the Board's special classes currently accommodated so many more mental defectives than had originally been revealed in the survey of 1896 by arguing that it took time for his teaching staff to gain the medical knowledge and motivation to identify higher grade mental defectives. He told the Royal Commission on the Care and Control of the Feeble-Minded that:

the head-masters have been taking more interest in the matter lately, and they understand better what was wanted, I believe that in the earlier investigation there were probably a large number who were really defective and were not included.<sup>76</sup>

Through continued co-operation with the medical officers, educators began to find deficiencies in children where they had never seen them before. Educationists justified this development on the grounds that special education provided a more responsive and humane form of education for difficult pupils, whilst simultaneously improving the efficiency of teaching in ordinary classes. According to R.S. Allan, Glasgow's school board had, following the initial survey of 1896, asked headmasters to select pupils who were 'becoming a hindrance or an offence to other scholars'.<sup>77</sup> Children did not necessarily have to misbehave to be regarded as a problem: rather, transfer to special classes could occur simply as a result of 'arrested development in regard to some

---

<sup>75</sup> HMSO, *Royal Commission on Feeble-minded* III, 263.

<sup>76</sup> *Ibid*, 269.

<sup>77</sup> *Ibid*, 268.



subject of instruction'. In Allan's view, it was 'a great relief to the ordinary schools to have these children dealt with separately'.<sup>78</sup>

The majority of pupils referred to Carswell were diagnosed mentally defective and placed into special classes. For example, during the school year 1909-1910, the medical officer was called upon to examine 302 pupils suspected by teachers of being mentally defective. Of this number, 215 were certified by the medical officer as being mentally defective, 62 were certified 'doubtful mental defect' and 25 as 'not mental defective'. Regarding these figures, Carswell wrote that:

[t]he children certified as not mentally defective were all very backward. The small number of merely backward children submitted for examination is proof of the care exercised by teachers in estimating the capacity of those children who might be considered to be mentally defective.<sup>79</sup>

For the most part, the school medical officer concurred with the opinions of the teachers who notified children to him. Even when he was undecided, Carswell had a policy of certifying children as 'of doubtful mental defect, and placing them in a Special School for a specified probationary period of a year'.<sup>80</sup> He justified this action with the following argument:

I think probationary care, training and observation which those children require are best secured in a Special School; indeed, it would be a useless proceeding to leave them in the ordinary schools, because it is on account of their absolute failure to profit by training there that they are brought forward for medical inspection.<sup>81</sup>

Carswell therefore believed that if a teacher notified a child to him, this in itself indicated that the pupil should be removed from the ordinary classroom. However, in order to continue placing the majority of pupils notified by teachers in special classes, Carswell found it necessary to broaden the meaning of mental deficiency to cover

---

<sup>78</sup> *Ibid*, 269.

<sup>79</sup> GCA D-ED 9/1/33, School Board of Glasgow, *Annual Report on Medical Inspection of Children* 1910, 50.

<sup>80</sup> *Ibid*, 51.

<sup>81</sup> *Ibid*.

children with higher levels of ability:

it would be wrong to limit our conception of the function of Special Schools to providing for children whose deficiency is essentially similar to that of the imbecile child, though less in degree. The mental defect which renders a child incapable of receiving proper benefit from instruction in the ordinary public elementary schools may be limited to letter or word blindness, or to delayed development of the speech centre in the brain, or to a condition of mental bewilderment caused by bad physical conditions, all which need not entail permanent mental deficiency. These cases are urgently in need of the kind of care which the Special School provides. As already indicated, the distinction between mere backwardness on the one hand and imbecility on the other can be made, but the term mental defect should be *elastic* [my italics] enough to include many cases of children who will recover from their disability.<sup>82</sup>

Responding to pressure from teachers to remove struggling children from the ordinary classes, Carswell developed an increasingly 'elastic' definition of mental deficiency. This was how mental defectives were 'manufactured' in Glasgow. The special education system was consequently able to expand: ordinary teachers were able to remove difficult pupils, and the medical officer maintained his official position in charge of referrals to special classes despite the fact that his decisions were largely prompted by the educational concerns of teachers. The special class teachers, the ordinary teachers and the school doctors all benefited and in their opinion the pupils benefited too. They neglected, however, to document the opinions of the pupils themselves on this matter.

The broadening of mental deficiency was achieved with the approval of the school board, even though there was no direct financial incentive for the board to back the corresponding expansion of special education. Even with additional government assistance to special classes, the cost incurred by ratepayers for the special education of a mentally defective pupil averaged £1 12s in 1906, as opposed to £1 6s 9d for a pupil in an ordinary class.<sup>83</sup> However, when the Royal Commission asked Carswell to justify the additional expense, he replied, 'I think it is a humane and proper thing to do and a

---

<sup>82</sup> *Ibid.*

<sup>83</sup> HMSO, *Royal Commission on Feeble-minded* III, 269.

scientific thing to do, and I do not think the expense is so very great that the ratepayers need complain of it.’<sup>84</sup>

Carswell’s appeal to humanity and science ties neatly with Mark Jackson’s recent use of the term ‘scientific morality’.<sup>85</sup> Jackson uses the term to describe how contemporaries provided a rationale for the segregation of mental defectives that conflated two widely held beliefs: that society should be founded on moral principles, and that science could make society more efficient. Special education was a relatively inexpensive way of introducing scientific morality into the education system in order to solve some practical problems caused by children who appeared unable to benefit from ordinary teaching methods. Even though pupils tended in practice to be labelled on educational grounds, Carswell and his fellow school medical officers were able to lend the authority of science to this policy of segregation by referring to the medical theories that underpinned conceptions of mental deficiency.

There were, however, checks on the rate at which the boundaries of mental deficiency could be extended. One was the existence of special classes for physical defectives. These were created contemporaneously with special classes for mental defectives, and were used to accommodate children whose education was believed to be hindered by physical ailments rather than mental inability. Teaching in special classes for physical defectives more closely resembled the ordinary school curriculum. The vast majority of pupils accommodated in such classes had rickets, whilst a substantial number were diagnosed with tuberculosis.<sup>86</sup> The existence of this branch of the special education system meant that even whilst the boundaries of mental deficiency continued to expand, educational failure did not necessarily lead to an individual being labelled mentally defective. It remained a medical issue, but if the school medical officer decided the problem was physical rather than mental, the label used and the educational arrangements associated with the label differed.

A second check on the expansion of mental deficiency related to the accusation put forward by institution superintendents such as W.W. Ireland, that children who were ordinary, albeit educationally backward, were being misdiagnosed as mentally

---

<sup>84</sup> *Ibid*, 65.

<sup>85</sup> Jackson, *Borderland of Imbecility*, 64-69.

<sup>86</sup> GCA D-ED 9/1/33, School Board of Glasgow, *Annual Report on Medical Inspection of Children* 1910, 47-48.



defective. Each year, Carswell decided that a small number of pupils brought to him should not be transferred to special classes for mental defectives. Nonetheless, he did not believe such pupils should attend ordinary classes either. Rather, he suggested in 1910 that there could be

separate teaching of backward children, not mentally defective and yet not capable of profiting by the methods used for other children.<sup>87</sup>

Similar circumstances existed in Govan, prompting Brown to make the following remark in his Medical Report for Govan Parish School Board in 1916.

During the early period of medical inspection almost all the children nominated as mentally defective were on examination found to be true mental defectives, but during the past two years it has been noticeable that more children who are merely dull and backward are now nominated.

On careful consideration of these facts, it seems to have been the case that during the earlier years of medical inspection, and the period of initiation of special classes for mentally defective children, only low-grade types were nominated.<sup>88</sup>

Like Carswell, Brown's proposed solution was 'the institution of special classes in the ordinary schools for "dull and backward" children'. Classes of this kind were established by the School Board of Glasgow in 1912,<sup>89</sup> whilst similar efforts were made in Govan after 1916.<sup>90</sup> However, financial and staff shortages brought on by the war frustrated the efforts of both school boards. It was not until after the Education (Scotland) Act of 1918, which amalgamated both boards into a single authority, that classes for backward children resumed.<sup>91</sup> In effect, the medical officers, in conjunction with the school boards and the teachers, had stretched the concept of mental deficiency as far as they could at that time. Then, wishing to exclude children of an even higher

---

<sup>87</sup> *Ibid*, 50.

<sup>88</sup> GCA D-ED 9/1/33, Govan Parish School Board, *Annual Report on Medical Inspection of School Children* 1916, 25.

<sup>89</sup> GCA D-ED 9/1/33, School Board of Glasgow, *Annual Report on Medical Inspection of Children* 1914-15, 14.

<sup>90</sup> GCA D-ED 9/1/33, Govan Parish School Board, *Annual Report on Medical Inspection of School Children* 1916, 26.

<sup>91</sup> Education Authority of Glasgow, *Report on Educational Requirements of Glasgow*, 50.

level of ability from the mainstream classrooms, they side-stepped mental deficiency altogether and began to provide separate provision for the lowest grades of ordinary children. Nonetheless, in the years that followed, the number of pupils labelled mentally defective would continue to grow, and as these pupils moved into adulthood, a similar, though less pronounced increase in adult mental defectives would follow.

### *Conclusion*

In the late nineteenth and early twentieth century, doctors and teachers working in and around Glasgow extended the boundaries of mental deficiency to include more people of higher ability. They did so to facilitate an expansion in segregated special education in day schools. Their actions reflected similar developments occurring in urban centres south of the border and would eventually lead to a policy of educational segregation that would be implemented across the UK. As a result, many individuals were labelled mentally defective who would not have been regarded as such in earlier years.

In demonstrating the ‘manufacture’ of mental defectives, a number of potential objections need to be either refuted or incorporated into the argument. Firstly, it could be argued that any attempt to show a definite rise in the number of people labelled mentally defective relies on the mistaken assumption that at any one time, experts agreed on a single set of figures (which rose over time) estimating the incidence of the condition. In fact, disagreements on this point regularly occurred.<sup>92</sup> For this reason, there can be no simple comparison of estimates for the incidence of mental deficiency between one time period and another: in each period it is possible to find many different estimates and a variety of ways in which the condition was conceived and identified.

Responding to this criticism, it has been demonstrated that *in general*, estimates of the number of mental defectives within the population tended to rise during the late nineteenth and early twentieth century. This was because influential figures within the state administration, medical and teaching professions broadened their definitions of mental deficiency to include more people possessing higher level of abilities.

A second possible criticism of the claim would be that the increase in specialised state

---

<sup>92</sup> Besides the evidence presented in this chapter, accounts of disagreements within the medical profession over the number of mental defectives can be found in Sutherland, *Ability, Merit and Measurement*, c. 1. See also, Ireland, *Mental Affections*, 3-10.

provision for mental defectives did not create mental defectives but rather gave officials the means and the motive to extend their gaze further into the community. They then ‘discovered’ a hidden sub-population of mental defectives, which had always existed but had so far evaded detection by the authorities.<sup>93</sup> This criticism is particularly persuasive in relation to attempts to identify mental defectives amongst the school-aged population. The education system provided an arena whereby virtually an entire generation came under the state’s gaze, and it was in schools that most individuals labelled mentally defective were initially identified as such.

This objection does not quite tally with the evidence presented above. Statistics from Glasgow’s school board show a greater number of mental defectives in the years 1910-14, than Carswell *et al* were able to identify in 1905. This is despite the fact that the 1905 figure results from by far the most thorough investigation into mental deficiency. It is reasonable to say that local officials were generally making greater efforts to identify mental defectives who had previously evaded their attention. However, medical officers and teachers were also applying the label to children who, even if they had come under the observation of professionals associated with mental deficiency, would previously have been regarded as normal. Whilst this *was* a period of increased surveillance, it was *also* a period in which doctors and teachers broadened the criteria by which they identified mental defectives.

Thirdly, the notion that mental defectives were ‘manufactured’ could be criticised for failing to give proper recognition to the experience of people with mental impairments. It can be seen to imply that mental deficiency was simply a label with no direct bearing on an individuals’ physiology (with reference to the medical model of disability), or (in terms of the social model) on the way people with mental impairments experienced exclusion in society prior to being officially recognised as defective by the state.<sup>94</sup>

This third criticism relies on a simplistic interpretation of what is meant by labelling. Although numerous actors involved in labelling were prepared to comment on the arbitrary nature of divisions between normality and mental deficiency, doctors and teachers did not apply the label at random. They used it in an attempt to describe individuals who had already become the object of concern in the classroom, on account

---

<sup>93</sup> M.Thomson, *Problem of Mental Deficiency*, 13-14.

<sup>94</sup> Oliver, *Understanding Disability*, 30-42.,



of persistently low marks in school work, misbehaviour or detrimental influence on other pupils. Educational success, behaviour and influence on others are all socially constituted criteria: the values placed on them emerge from a complex series of intersecting relations between different individuals and different social groups. Nonetheless, some pupils showed themselves to be less able or willing to meet these criteria than others. Doctors and teachers attempted to identify pupils who were not fulfilling certain basic expectations: they then decided whether individual pupils were wilfully failing to comply with the demands of the education system, whether such failure was caused by environmental or physical factors (eg. poor parenting, malnutrition, physical disease etc.) or whether the pupils' mental development was 'defective' for biological reasons. Over time, they became increasingly willing to use the latter explanation.

A final objection might be that the argument so far has focused on labelling by professionals. The views of individuals labelled mentally defective, their families, friends and other members of the community might be regarded as being at least as important as the opinions of state officials in determining whether an individual was to be considered as a mental defective or not.<sup>95</sup>

This last point will be dealt with in more detail in the final chapter of this thesis. Suffice it to say that the period under examination witnessed an increase in state powers to examine children (through the school medical service) and segregate them into special classes without the consent of parents. By segregating pupils, officials facilitated their exclusion from mainstream society from an early age. Children labelled mentally defective grew up in an environment where their supposed difference from the normal population was emphasised both to themselves and the people around them. A pupil regarded as a high grade mental defective in one school may have had a similar level of ability to a child considered to be ordinary, albeit dull and backward, in another. The former child would be earmarked for special education, whilst the latter would be allowed to remain in ordinary classes. Neither child was likely to perform well academically but the difference in their social status and formative experiences would be marked. In the late nineteenth and early twentieth century, local officials working

---

<sup>95</sup> David Wright has sought to emphasise the role of families in the construction of idiocy and in the provision of institutional care: Wright, 'Childlike in his Innocence', 118-133.

within Glasgow's education system did have the power to 'manufacture' mental defectives. Over time they became increasingly prepared to use that power.

## Chapter 5: Scotland's Mental Deficiency Administration (1914-39)

The Mental Deficiency and Lunacy (Scotland) Act, 1913, came into operation in April 1914. By the eve of the Second World War, the state's administration for mental defectives had grown significantly. After the first year of the act's enforcement, the newly created General Board of Control for Scotland (GBCS) had 295 mental defectives on its register, accommodated in certified institutions for mental defectives or living in private dwellings under the care of either familial or non-familial guardians. By 1938, the number had risen to 4982.<sup>1</sup> These figures include all adult mental defectives in receipt of specialised state provision and children who were considered too defective to benefit from special education in day schools. The Scottish Education Department (SED) kept separate records on mentally defective children receiving special education in day schools. Unfortunately, the SED's statistics did not initially distinguish between pupils attending special classes for mental defectives and pupils attending special classes for physical defectives. This source of confusion was rectified in 1919. In that year there were 2482 mentally defective pupils receiving special education, whilst by 1938 the number had risen to 4800.<sup>2</sup> These rises occurred within a Scottish population that was undergoing a slight decline at the time.

Although the state administration expanded, the issue of mental deficiency did not continue to maintain its position at the forefront of British political debate after 1914. War, unemployment and economic depression re-focused the attention of successive governments at Westminster and within the Scottish Office. In any case, the 1913 act itself settled the issue to some degree, though there remained areas of controversy and conflict within the administration.<sup>3</sup> Neither the GBCS, nor the SED were satisfied with the extent to which state provision for mental defectives had developed by the end of the inter-war period. Despite the rise in the number of mental defectives receiving state provision, officials from both government bodies believed that many defectives remained at large in the community without adequate care or supervision. Disruptions caused by the Great War, financial shortages that continued after the war and a lack of enthusiasm shown by many of Scotland's local authorities all served to limit the rate to which the administration expanded.

---

<sup>1</sup> HMSO, *GBCS Annual Report 1938* (Cmd. 5970, 1939), 41.

<sup>2</sup> See appendix 1.

<sup>3</sup> For an account of limitations of the post-1913 consensus within the English context, see M. Thomson, *Problem of Mental Deficiency*, 54.



The challenges faced by Scotland's central administration and the strategies developed to deal with those challenges helped shape the way Scotland's mental defectives were dealt with by the state over the period. On the other hand, Scotland's mental deficiency administration cannot simply be understood by looking at the policies developed at national level. At times, it was the local authorities that took the initiative in creating or modifying services. On other occasions, they were unwilling to carry out central directives. Hence, whilst this chapter refers in the singular to Scotland's mental deficiency *administration*, it should be noted that this administration was translated differently from one area to the next and across different levels of government.

### *The Early Years of the Mental Deficiency Act and the Impact of War*

Implementing the 1913 act entailed some changes to Scotland's lunacy administration but there was no wholesale restructuring. The district boards of lunacy became known as district boards of control, with a third of their membership now being drawn from parish councillors. The district boards oversaw the work of local institutions, whilst parish councils arranged for the maintenance of mental defectives accommodated in those institutions or under private guardianship. Whilst institution superintendents were answerable at a local level to the district boards of control, the system of private guardianship was administered by Poor Law officers answerable to parish councils. However, both institutions and private dwellings were routinely inspected by deputy commissioners of the GBCS.<sup>4</sup>

At a national level, the General Board of Commissioners in Lunacy for Scotland became the GBCS and took on some extra personnel. The act directed the new Board to appoint an additional medical commissioner and two deputy medical commissioners (one of whom had to be a woman) to deal with the extra responsibilities of providing specialised provision for mental defectives. Two of the new appointees had direct experience of working in special education in Glasgow: John Carswell left Glasgow to become medical commissioner, whilst Kate Fraser resigned her post in Govan to be the female deputy medical commissioner. Besides these new appointments, the make-up of the board did not fundamentally change. It remained under the authority of the Secretary for Scotland; the chairman of the old Lunacy Board, Thomas Mason retained his role in

---

<sup>4</sup> See c. 3.

the GBCS, as did the legal commissioners, John Cowan and John Wilson, and the senior medical commissioner, Dr John Mcpherson.<sup>5</sup>

Where provision for mental defectives was concerned, John Mcpherson was the most influential figure on the board until his retirement in 1922. Mcpherson was the son of a Free Church Minister in Inverness-shire. He graduated in medicine at Edinburgh and worked as an asylum superintendent in Stirlingshire before being appointed to the Board of Lunacy in 1899 when he was 41 years of age. He had played a leading role in the creation Scotland's Mental Deficiency Act, negotiated with local authorities and given public lectures on the subject. In these lectures he advocated a mixture of increased specialised care and supervision for mental defectives together with more general social reforms that would aid the mental (and physical) development of the population: greater use of institutionalised care on the one hand, and improving conditions in the slums on the other. Of course, as a senior commissioner for the GBCS, Macpherson had the power to apply the first remedy but could only talk about the need for the second.<sup>6</sup>

In contrast to the limited changes that occurred within the GBCS, the administrative structure of the education system was virtually untouched by the 1913 act save for the requirement of school boards to set up mental deficiency sub-committees. These sub-committees took over the procedure by which parish councils were notified of mental defectives deemed incapable of benefiting from special education. However, the selection of mental defectives remained the duty of school medical officers in consultation with teaching staff. The act did not make it compulsory for school boards to establish their own special classes, providing the boards with a loophole through which they could avoid fulfilling their obligation to ensure that high grade mentally defective children received special education.<sup>7</sup>

At national level, the SED did not undergo any changes in personnel, nor did it put a great deal of effort into ensuring that school boards were fulfilling their requirements under the act. At the time it came into force, the department was busy considering the need for reforming the school board system, promoting secondary education and

---

<sup>5</sup> HMSO, *GBCS Annual Report 1914* (Cd. 7944, 1914-16), viii-ix.

<sup>6</sup> Anon, 'Dr John Macpherson', *Poor Law Magazine* 23 (1913), 385-388.

<sup>7</sup> See c. 3.

removing the quasi-independent status of voluntary schools. The issue of special education barely featured within these debates. Nonetheless, John Struthers, who still occupied the post of Principal Secretary during the early years of the act's enforcement, had dealt personally with the issue in the past and would continue to show some interest in mental deficiency during his remaining years at the department.

Mental deficiency was a lower priority to the SED than it was to the GBCS, whilst even within the GBCS, it was less of a priority than provision for the insane (around 85% of individuals receiving some form of provision from the GBCS in the inter-war period were lunatics rather than mental defectives<sup>8</sup>). Within the country as a whole, the issue soon lost any claim to priority status when Britain declared war on Germany in August 1914. Mathew Thomson has argued that the war led to an increase in demand for unskilled manpower both in the armed forces and within the war-time economy in which high grade mental defectives could find a role for themselves. As a result, 'mental deficiency was hardly recognised as a problem; indeed, many high-grade defectives contributed to the war effort in the forces or on the home front'.<sup>9</sup> The additional demand for unskilled labour ended when hostilities ceased and long term unemployment became a more prominent feature of British life. In Thomson's view, mental defectives were then considered a problem again, and the policy of segregation began in earnest during the inter-war period. For this reason, Thomson argues that '[i]n Britain, the war marked a brief interlude and delay, but not a volte-face, to the plans for mass segregation'.<sup>10</sup>

A study of the mental deficiency system in Scotland necessitates that some of Thomson's conclusions be qualified. Whilst it is likely that war-time demand did allow many adults to avoid the Poor Law system, where they were most likely to be identified as being mentally defective, moves towards mass segregation were none-the-less well underway by 1918. Thomson does not take into account that most high-grade defectives identified by the state were children, whose segregation took the form of special education within the education system. War-time recruitment did not provide a new, more valued role for those who were too young to join the army or gain employment in war production. Hence, the expansion of the special education system continued during

---

<sup>8</sup> HMSO, *GBCS Annual Report* 1938, 1 and, 41.

<sup>9</sup> M. Thomson, 'Status, Manpower and Mental Fitness', 161.

<sup>10</sup> *Ibid.*



the war, albeit it at a fairly modest rate. Between 1914-1918, the number of mental and physical defectives receiving special education in day schools rose from 4425 to 5549. From the statistics of the 1920s, when mental and physical defectives were recorded separately, there were approximately 9 mental defectives for every 10 physical defectives receiving special education. Applying these figures back to the war period, one would expect the number of mental defectives in special schools and classes to have risen from around 2000 to 2,500 between 1914-18.<sup>11</sup>

The segregation of mental defectives outside the education system increased at a much more significant rate during the war. In particular, the number of patients accommodated in certified institutions for mental defectives rose dramatically. The first *Annual Report* of the GBCS stated that there were 295 mental defectives on its register in 1915 (207 of which were accommodated in certified institutions and 88 under private guardianship).<sup>12</sup> By 1918 the number had risen to 1,594 (1,091 in institutions and 503 under private guardianship).<sup>13</sup> As most of the pre-war mental deficiency institutions accommodated children, it is not surprising that the majority of mental defectives institutionalised during the war were under 18. However, the GBCS also began to make ground with their policy of segregating adults. During the war, the number of adults in mental deficiency institutions rose from 51 to 356.<sup>14</sup>

These statistics do not fit well with Thomson's claim that mental deficiency was hardly recognised as a problem during the war. Even though high grade mental defectives living in the community may have found more opportunities to gain employment or join the armed forces, the authorities still followed a policy of increased segregation in institutions. This apparent paradox can be explained by noting that many of the inmates placed into institutions for mental defectives at that time were transferred from other institutions such as poor houses and lunatic asylums.<sup>15</sup> As the Royal Commission of 1908 had discovered, many Scottish officials believed that Poor Law institutions were rendered less efficient and less humane by the practice of placing mental defectives in the same wards as ordinary patients and lunatics.<sup>16</sup> The war did not provide any

---

<sup>11</sup> See appendix 1.

<sup>12</sup> HMSO, *GBCS Annual Report* 1914, xv; HMSO, *GBCS Annual Report* 1918 (Cmd. 143, 1919), xxxv.

<sup>13</sup> HMSO, *GBCS Annual Report* 1938, 41.

<sup>14</sup> *Ibid.*

<sup>15</sup> GHBA HB 19/1/2, Glasgow District Board of Control, 'Report on Accommodation for Mental Defectives' in GDBC Minutes of the Chairman's Committee (9<sup>th</sup> Nov. 1914).

<sup>16</sup> See c. 2.

temporary solutions to this problem, and so the GBCS implemented its policy of transferring inmates believed to be mentally defective into their own specialist wards and institutions.<sup>17</sup>

Despite these significant increases, the war did impose some limits on the rate at which both the GBCS and the SED were able to expand their respective parts of the mental deficiency administration. This was not because officials stopped seeing mental defectives as a problem: rather, the war caused financial restrictions and led to shortages of other resources such as teaching and medical staff and building materials. Even then, the short-term impact of the war remains difficult to measure. The policy of mass segregation could only be implemented at the rate at which new institutions and special schools could be built. There is no exact way of determining the extent to which the delay in obtaining sufficient accommodation was caused by war-time shortages, and the extent to which there was a 'natural delay' in building and opening new institutions and special schools.

The GBCS achieved much of its early expansion of specialised institutional accommodation for mental defectives by certifying a number of pre-existing wards in asylums, institutions for epileptics and poorhouses as suitable for mentally defective patients. The original inmates of the wards would then be transferred out to other locations whilst inmates identified as mentally defective would be transferred in. Glasgow's district board of control conducted this policy on the largest scale. In 1914, the board secured the approval of the GBCS to convert its entire colony for epileptics at Stoneyetts into a certified institution, which by the end of the war accommodated 345 adult mental defectives.<sup>18</sup> On a smaller scale, Edinburgh's district board, converted four wards of the City Poorhouse into Craiglockhart Institution for mental defectives in 1915, housing 30 inmates by 1918.<sup>19</sup>

Whilst these developments took place, superintendents squeezed increasing numbers of mental defectives into existing certified institutions such as Baldovan and Larbert, utilising whatever building space was available. This naturally compromised living standards in the institutions. In his report on Baldovan for 1916, one GBCS inspector

---

<sup>17</sup> HMSO, *Royal Commission on Feeble-Minded* III, 66, 163 and 372-6.

<sup>18</sup> HMSO, *GBCS Annual Report* 1914, li.; HMSO, *GBCS Annual Report* 1918, xxxv.

<sup>19</sup> HMSO, *GBCS Annual Report* 1915 (Cd. 8313, 1916), xxvii; HMSO, *GBCS Annual Report* 1918, xxxv.

wrote, '[e]xception is again taken to the accommodation of the old buildings, but in present circumstances it is said to be impossible to bring this part of the institution up to the high structural standard of the main building'.<sup>20</sup>

The directors of Larbert were able to fund some additional building work to cope with the increase in numbers, although the prime beneficiaries were staff rather than inmates. The new accommodation was built for the nurses who could then move out of their current inferior accommodation, making it available for the patients. The GBCS's *Annual Report* for 1917 commented:

[t]he Nurses Home is now nearly ready for occupation, and it is expected that the staff will soon be in residence. The new home will not only secure greater comfort for the nurses, but will set free much-needed accommodation for additional inmates.<sup>21</sup>

According to the GBCS reports, the main constraint on mental deficiency provision caused by the war was lack of financial assistance from the Treasury. Under the 1913 act, the Treasury was to pay half the cost of maintaining mental defectives outside the education system in institutions or under private guardianship, the other half being paid by parish councils out of the rates. However, the act also placed a ceiling of £20,000 on annual Treasury contributions to the GBCS for the maintenance of mental defectives. Once that ceiling was reached, parish councils would either have to pay the full cost of maintaining additional defectives, or could simply refrain from arranging special provision for any newly notified mental defectives until the following year's budget could be accessed. Some local authorities (notably from the large urban centres such as Glasgow) took the former option, whilst others (typically those representing small towns or rural communities) took the latter.

The British government had taken the figure of £20,000 for Scotland to be proportional (in terms of population size) to the £150,000 set aside for England and Wales but there was a widely held view that both grants were too small to pay for the level of mass segregation envisaged in 1913. As *The Glasgow Herald* noted at the time, it was 'obvious that neither the £150,000 named in the English Bill or the £20,000 named in

---

<sup>20</sup> HMSO, *GBCS Annual Report* 1916 (Cd. 8565, 1917-18), xxx.

<sup>21</sup> HMSO, *GBCS Annual Report* 1917 (Cd. 9068, 1918), xxxii.



the Scotch Bill will be adequate as Treasury grants when the acts are in full working order'.<sup>22</sup> Looking back in 1924, Dr Ivy Mackenzie, the consulting physician to the Glasgow's district board of control, stated that 'the Treasury grant of £20,000 was ridiculously inadequate'.<sup>23</sup>

The GBCS had hoped to see the Treasury grant increase but the war made the chances of this happening remote. In 1916, A. D. Wood, Secretary to the General Board of Control for Scotland issued a circular to clerks of the district boards of control, parish councils and school boards with the following news:

I am directed by the Secretary for Scotland to state for the information of your Board (or Council) that the Lords Commissioners of His Majesty's Treasury have intimated that, in view of the financial circumstances arising out of the War, no increase in the Annual Grant can be contemplated, either now or for many years to come, beyond the amount (£20,000) mentioned [in the Mental Deficiency Act].<sup>24</sup>

However, restrictions on spending imposed by the Treasury grant only became noticeable towards the end of 1917. In the first three years following the 1913 act, the GBCS did not appear to need the £20,000 grant. It was expanding Scotland's mental deficiency administration from a small base at a time when the war was causing a disruption in staffing and a scarcity of building material. The GBCS consequently lacked institutional accommodation in which to place additional, publicly maintained defectives. This kept expenditure low until the accommodation shortage could be redressed.

During the first full year of the act's implementation (1915), only £4,078 of the Treasury grant was needed to match local authority contributions. In the following year the figure had grown to £17,441 and it was only in 1917 that the expenditure ceiling was reached. During that year, the local authorities spent £20,743 on provision for mental defectives, whilst the Treasury spent £19,963 (inexplicably falling £37 short of the promised £20,000). In January 1918, the GBCS informed the Treasury that an

---

<sup>22</sup> *Glasgow Herald* (3<sup>rd</sup> Jun. 1913), 11.

<sup>23</sup> Anon, 'Problems of the Mentally Defective', *Scottish Educational Journal* (17th Oct. 1924).

<sup>24</sup> GBCS, 'Circular 174', HMSO, 3<sup>rd</sup> *GBCS Annual Report* 1916, xxxix.

estimated £30,761 would be required from the central grant for the coming year's expenditure.<sup>25</sup> This attempt to persuade the Treasury to increase its contribution was unsuccessful. The local authorities went on to spend £29,921 that year against the Treasury's £19,978. However, in 1919, the post-war Parliament passed an amendment to the Mental Deficiency Act, repealing the £20,000 limit. Future grants were to be negotiated annually between the Treasury and the GBCS. From then on, Treasury contributions increased at an uneven rate, slowly at first, but more noticeably after 1926. On average they rose by just under £4,400 a year during the 1920s.<sup>26</sup> The Local Government (Scotland) Act, 1929, then introduced the block grant with the effect that Exchequer and local contributions ceased to be recorded separately.

One might expect financial shortages during the war to have impeded the expansion of institutionalisation more than that of special education. Institutional accommodation was much more expensive, not least because it involved maintenance fees for 24 hour care. In addition, special education for 'educable' mental defectives was not affected by the £20,000 ceiling. School boards received Treasury funding for special education in day schools through an educational grant detailed in article 20 II of the Scotch Code. This had been in operation since 1902 and was revised in 1913 to allow for 'a material increase of the sums hitherto allowed in aid of the education of this class of children'.<sup>27</sup>

However, institutionalisation expanded at a faster rate than special education between 1914-18. One explanation for this is that special education was growing from a larger base: there were already more mental defectives attending special classes at the start of the war than were accommodated in institutions by the end of the war. In addition, the Scotch Code made it relatively simple to secure funding for the teaching of individual mental and physical defective pupils in special schools and classes, but before the children could be taught new classrooms and schools needed to be built. This was where the shortages associated with the war caused the most problems.

For instance, the *Annual Report* of the School Board of Glasgow for 1915-16 noted that the war had limited building construction.<sup>28</sup> The report for the following school year

---

<sup>25</sup> NAS MC 8/2, 'Minutes of General Board of Control for Scotland' (23<sup>rd</sup> Jan. 1918).

<sup>26</sup> HMSO, *GBCS Annual Reports* 1914-1929.

<sup>27</sup> HMSO, *Scottish Education Department Report of the Committee of Council on Education in Scotland* (henceforth referred to as *Annual Report of SED*) 1913 (cd. 7392, 1913-14), 18.

<sup>28</sup> GCA D-ED 9/1/33, *Annual Report of School Board of Glasgow* 1915-16, 5.

was more forthright, stating that. '[o]wing to the war, the board were unable to proceed with the erection of any school buildings'.<sup>29</sup> Special classes took up considerably more room space per pupil than ordinary classes, as the SED imposed a maximum of twenty pupils per special class (whilst ordinary classes could regularly accommodate 50 or more pupils). The board found additional space by suspending its practice of teaching dull and backward children in separate classes to other ordinary pupils and by leasing temporary accommodation outside school grounds for special pupils. This second strategy predated the war, but increasingly became a feature of the war-time administration. By the time hostilities abroad ceased, the school board had numerous special classes placed in temporary annexes and two entire special schools located in temporary buildings. Glasgow's education authority (the term 'school board' ceased to be used after the Education (Scotland) Act, 1918) viewed the use of temporary accommodation as necessary but 'not satisfactory'.<sup>30</sup>

At a national level, the SED seemed largely resigned to the fact that the expansion of special education had 'naturally been adversely affected by the war'.<sup>31</sup> By the school year of 1917-18, only 16 of Scotland's 947 school boards were operating special classes for mental or physical defectives. The increase in the number of pupils receiving special education was limited almost exclusively to schools located in the larger burghs and cities. The other school boards deferred establishing special classes of their own, which they were entitled to do under the 1913 act. However, many that did so also refrained from identifying mentally defective pupils or arranging for their education in special schools run by other school boards. This was a violation of the legislation but in view of the overall shortage of accommodation in special schools and classes, exacerbated by the war, there was little the SED would do about it.

The only direct initiative that Struthers took during the period to encourage special education was to make an informal arrangement with the English Board of Education in the summer of 1918 to have more Scottish teachers sent to England to receive training in the teaching of mental defectives. Even this step was taken as an alternative to the SED funding a similar course in Scotland, Struthers arguing that 'the number of

---

<sup>29</sup> GCA D-ED 9/1/33, *Annual Report of School Board of Glasgow 1916-17*, 5.

<sup>30</sup> Glasgow Education Authority, *Report on Educational Requirements of Glasgow*, 52.

<sup>31</sup> HMSO, *SED Annual Report 1919-20* (cmd. 782, 1920), 23.



teachers of mentally defective chr. [ie. children] in Scotland is as yet so small as to make it inexpedient to conduct separate courses for Scottish teachers'.<sup>32</sup>

The SED secretary may have also indirectly influenced special education during the period. Glasgow's earliest special classes tended to limit tuition to the traditional skills of reading, writing, arithmetic, religious instruction and physical exercise, with additional emphasis on speech training, and singing 'as a relaxation'.<sup>33</sup> Gradually, the schools began to introduce more manual training into their timetables, beginning with drawing, modelling and cooking, but then, during the war years, employing carpenters, tailors and cobblers to teach vocational crafts to older mentally defective pupils on a part-time basis.<sup>34</sup> Struthers emphasised the value of manual training in the elementary school curriculum,<sup>35</sup> and his support may have influenced the Glasgow board's decision to introduce more of these vocational classes (whilst continuing to teach the more traditional school subjects). This was one innovation in special education that flourished during the war, no doubt encouraged by the fact that the employment of craftsmen for teaching purposes could help redress the shortage of school staff caused by teachers serving on the front. Referring to the success of its vocational classes, the school board's *Annual Report* of 1915-16 felt able to claim that despite the war restricting the opening of new classes, the work of existing special schools 'was carried on with little or no dislocation'.<sup>36</sup>

Educationalists found this manual training useful in a number of ways. Speaking in 1906, the headmistress of Bridgeton Special School, Lily Monteagle, emphasised the therapeutic value of the early lessons in manual work: '[t]he children are taught these occupations with various ends in view, of which the most important is so to train the hand, eye, and brain as to lead them to intelligent observation.'<sup>37</sup> By the end of the war, Glasgow's Education Authority could cite other uses for its vocational classes. Shoes made or repaired by mental defectives in their cobbling classes were distributed to necessitous children by the authority. The education authority was also pleased to announce that vocational training had, in some cases, allowed mentally defective pupils

---

<sup>32</sup> PRO ED 50/117, events described in a memo to Sir H. Orange, (21<sup>st</sup> Apr. 1920).

<sup>33</sup> HMSO, *Royal Commission on Feeble-Minded* III, 263.

<sup>34</sup> Glasgow Education Authority, *Report on Educational Requirements of Glasgow*, 52.

<sup>35</sup> J. Scotland, *The History of Scottish Education, Volume Two* (London: University of London Press, 1969), 27.

<sup>36</sup> GCA D-ED 9/1/33, *Annual Report of School Board of Glasgow 1915-16*, 16.

<sup>37</sup> HMSO, *Royal Commission on Feeble-Minded* III, 263.

to find employment on leaving school: 'Tailoring and Shoemaking are taught to mentally defective boys, a number of whom, after leaving school, have followed up the trade.'<sup>38</sup>

The authority was not prepared to state how many mentally defective school leavers had found work, and the number may well have been small. Nonetheless, the use of vocational training does demonstrate that teachers attempted to prepare at least some of their special pupils for life in the community. Hence, whilst moves towards mass segregation of mental defectives were underway in the years immediately following the 1913 act, the special school system could be used to achieve limited integrationist goals for a proportion of its pupils, albeit within a general policy of exclusion. This should come as no surprise, as there is no evidence of either the SED or the GBCS advocating a policy of universal institutionalisation for mental defectives.

The first four years of the Mental Deficiency Act's implementation were something of an anti-climax in comparison to the high level of political activity devoted to the issue before the war. This should not obscure the significant expansion of state provision that did take place during the war, particularly in terms of specialised institutional accommodation for mental defectives. The practice of segregating mental defectives during the period can be seen in hindsight as problematic during a period when increasing numbers of individuals were being labelled as defective, who would previously have been regarded as ordinary. From a modern perspective, policies of institutionalisation and special education would be criticised for promoting social exclusion. However, those involved with the implementation of the 1913 saw the policy of large-scale segregation as both necessary and beneficial to those segregated. The war did nothing to persuade them otherwise but it did impose some practical constraints on the extent to which the policy could be pursued.

### *The GBCS in the Inter-war Period*

The long term impact of the war on Scotland's mental deficiency system is, if anything, even more difficult to evaluate than its immediate effect. In general terms, some commentators have suggested a link between modern warfare and increased public expenditure on social services such as the mental deficiency system. Writing in the 1950s, Andrzejewski and Titmuss hypothesised that higher levels of working-class

---

<sup>38</sup> Glasgow Education Authority, *Report on Educational Requirements of Glasgow*, 52.

participation in modern warfare tended to lead to a greater degree of social equality in the post-war settlement. Titmuss argued that mass mobilisation made the quality of lower-class recruits a matter of national importance (exemplified by the Boer war and the national efficiency debate, or the second world war and Beveridge).<sup>39</sup> These views, embedded in an optimistic appraisal of the post-1945 welfare state, do not seem immediately applicable to the politically incoherent post-first world war settlement. Conservative dominance of Lloyd George's national government, concern over the £1,150 million war debt to the U.S. and the boom-bust period of 1918-22 curtailed the 'land fit for heroes' programme of social reforms even before the Geddes cuts on social expenditure were announced in 1921-2.<sup>40</sup> In Middleton's words,

[t]here is general agreement amongst historians – though less so amongst political scientists... that, in the short run, the war had little impact upon the British state and in particular upon its economic [including social policy] functions. In part, this conclusion will be dependent upon what expectations are entertained about the potential impact of total war... and perhaps by an unfavourable comparison with the Second World War which, via Keynes and Beveridge, appeared to produce something both more durable and significant – something identifiable as a durable post-war settlement'.<sup>41</sup>

However, economists and historians (including Middleton) have sought to revise the view that the First World War did not have a significant impact on public expenditure for social services. Peacock and Wiseman argued in 1967 that social upheavals such as war produce a 'displacement effect' in public expenditure by making higher levels of taxation politically acceptable. They calculated that public expenditure on social services never fell below 8% of the gross national product in the inter-war years: double the pre-war figure.<sup>42</sup> Furthermore, Lowe points out that 'the First World War... was the occasion, if not necessarily the cause of the effective democratisation of Britain'.<sup>43</sup> By

---

<sup>39</sup> Referred to in G.C. Peden, *British Economic and Social Policy: Lloyd George to Margaret Thatcher* Second Edition (Oxford: Philip Allan Publishers Ltd., 1985), 53.

<sup>40</sup> R. Middleton, *Government versus the Market: The Growth of the Public Sector, Economic Management and British Economic Performance, c. 1890-1979* (Cheltenham: Edward Elgar Publishing Ltd., 1996), 311.

<sup>41</sup> Middleton, *Government versus Market*, 310.

<sup>42</sup> A.T. Peacock and J. Wisman, *The Growth of Public Expenditure in the United Kingdom* Second Edition (London: George Allen and Unwin, 1967), 91; Peden, *British Economic and Social Policy*, 53.

<sup>43</sup> R. Lowe, *Adjusting to Democracy: The Role of the Ministry of Labour in British politics, 1916-1939* (Oxford: Oxford University Press, 1986), 2.



trebling the electorate at both local and national levels, the 1918 Reform Act made social policy for the lower classes a matter of more immediate concern for parties wishing to retain or achieve power. The war also occasioned revolutions in Russia and Germany. Fear of bolshevism invoked a double-edged response from the British government, encouraging successive cabinets to increase public expenditure on social services in times of crisis, whilst maintaining a conservative persona characterised, for example, by Baldwin's speeches and Treasury orthodoxy.<sup>44</sup>

The long term effect of the war appears to be an increase in total public expenditure on social services. According to figures quoted by Middleton, this increase continued during the inter-war period: rising from 4.9% of GDP in 1920 to 9.2% in 1929 and 10.5% in 1937.<sup>45</sup> These figures belie both rises and falls in central government expenditure on social services from one year to the next as depression led to government cuts in the 1920s and extra expenditure on crisis management in the 1930s.<sup>46</sup> Scotland's mental deficiency system appears to have been cushioned from short term decreases in social expenditure. Total expenditure of central and local authorities on the maintenance of Scotland's mental defectives always increased from one year to the next, although the size of that increase varied yearly.<sup>47</sup> The rate of increase in the 1930s was noticeably higher than that of the 1920s.<sup>48</sup>

It has already been mentioned above that Scotland's mental deficiency system was developing from a small base during this period. The relatively small expenditure it incurred might explain why it escaped the worst excesses of economic stringency during the inter-war period. A second explanation (not exclusive of the first) centres around the mental deficiency system's relationship with the British government's piecemeal attempts at Poor Law reform. Ian Levitt has described how the Scottish Poor Law came under criticism for its failure to cope with the social problems caused by

---

<sup>44</sup> Middleton, *Government versus Market*, 304-324.

<sup>45</sup> *Ibid.*, 91.

<sup>46</sup> Peden, *British Economic and Social Policy*, 72 and 106.

<sup>47</sup> At first sight the expenditure for 1923 appears to show a decrease from the previous year. In fact this was caused by a decision in 1922 to alter the method by which the Treasury contribution was to be paid. Instead of covering actual expenditure of the preceding year, the grant was now to be based on an estimate for the following year. The change-over to the new method of payment was carried out in such a way as to give a false impression that expenditure rose sharply in 1922 and then fell in 1923. In fact, both years witnessed an increase in expenditure. See GBCS Circular No. 194, HMSO, 8<sup>th</sup> GBCS Annual Report 1921 (Cmd. 1723, 1922), 47.

<sup>48</sup> HMSO, *GBCS Annual Reports* 1920-1938.

relative economic decline and depression between 1890 and 1948.<sup>49</sup> To help relieve the strain, the authorities expanded provision for mental defectives as an alternative system of care and supervision for a growing number of people identified as being incapable of maintaining themselves through wage labour. The expansion of provision for mental defectives was thus linked to rising unemployment and urban malaise, giving the UK's economic problems a causal role in the development of the mental deficiency administration. Although short term financial crises prompted the government to impose stricter limits on expenditure for mental defectives, greater increases in funding were always agreed upon whenever the Treasury felt the money was available.

Despite the rises in public expenditure, the GBCS claimed throughout the inter-war years that provision for mental defectives was hampered by a lack of institutional accommodation. However, as the years progressed its reports increasingly sought to shift responsibility for this problem away from the Treasury and towards those local authorities that had been slow to respond to the Mental Deficiency Act. During the 1920s, the Treasury was the GBCS's over-riding concern. At the time of the Geddes cuts, Treasury commissioners sought not only to restrict expenditure but also to impose its will on the GBCS over the forms of provision that would be offered to mental defectives. In 1921 the Treasury issued instructions to the GBCS which 'limited to 1,477 the numbers of defectives in institutions who would be entitled to participate in the Imperial [ie. Treasury] Grant'.<sup>50</sup> No similar restriction was placed on the number of defectives who could be placed under guardianship in private dwellings: guardianship being a more cost effective form of provision than institutional accommodation. This policy of capping institutional accommodation continued until 1925.

The GBCS responded to the Treasury's dictum by instructing local authorities to limit provision to those cases considered to be 'urgent'. A circular issued by the GBCS in 1922 to the district boards of control, education authorities and inspectors of the poor defined 'urgent' in the following terms:

- 1) Defectives who are found neglected, abandoned, or without visible means of support.

---

<sup>49</sup> Levitt, *Poverty and Welfare in Scotland*, *passim*.

<sup>50</sup> HMSO, *GBCS Annual Report 1925*, (Cmd. 2737, 1926), lxi.

- 2) Women...if they are likely to take their discharge from Poor Law institutions.  
The urgency is increased if they have venereal disease.
- 3) Young women now at large or about to leave institutions (Poor Law or other) who have no homes, or bad homes, and are in danger of corruption.
- 4) Children about to leave special schools with no decent homes to go to, and unable to protect themselves.
- 5) Youths who are a source of local corruption.
- 6) Industrial and Reformatory school children who are found to be defective and to need control, and any other cases subject to be dealt with under sections 9 or 10 of the Act.
- 7) Children of very low mentality who, on account of faulty or pernicious habits, are an intolerable burden in their own homes, or are unfit to associate with the other children there, and who would not be appropriately placed in a Poor Law institution.
- 8) Defectives, the subjects of epilepsy, whose fits are so frequent or severe, or whose habits are so faulty, or otherwise such as to render them unfit to associate with normal children, and who would not be appropriately placed in a Poor Law institution.<sup>51</sup>

Between 1921 and 1925, the number of mental defectives under private guardianship rose from 635 to 1,003, whilst institutional accommodation remained limited by the Treasury's stipulations quoted above.<sup>52</sup> The GBCS was content to allow local authorities to provide for its 'urgent' cases in this way until another financial crisis appeared to loom. Each year, certifying officers entered a much higher number of people onto the GBCS's register for mental defectives, then were removed through either death or discharge. Whilst this situation remained (as it did throughout the inter-war period) the mental deficiency system was locked into a continual process of expansion, which in the early 1920s was occurring at a faster rate than the increases in public expenditure on the system. In its report for 1925, the GBCS announced that 'the total amount of Grant provided for in the estimates of the Board is now fully used up'.<sup>53</sup> As a result, the local authorities were sent a circular with the following warning:

---

<sup>51</sup> NAS MC 9/1, GBCS, *Circular 194*.

<sup>52</sup> HMSO, *GBCS Annual Report 1938*, 41.

<sup>53</sup> HMSO, *GBCS Annual Report 1925*, lxi.



In the circular referred to [ie. that of 1922, quoted above] attention was drawn to the necessity of Local Authorities limiting their activities under the Mental Deficiency Act to the certification of urgent cases only, and it was suggested that as far as possible new cases should be certified only when vacancies on the Register of certified mental defectives were created by death or discharge of patients already certified. So far as institution cases are concerned, the Board are satisfied that their suggestion has received the utmost consideration by Local Authorities, but they feel that the shortage of institutional accommodation has led to a much greater number of mental defectives being placed under guardianship than would have been so placed under normal conditions, and accordingly the Government Grant in respect of such boarded-out cases has been taxed to the utmost.

During the past year the Treasury have sanctioned an increase in the Grant for mental defectives in institutions and the Board intend to apply at the end of the current year for a larger Grant towards the cost of certified mental defectives who may be placed under guardianship in private dwellings.

There is still a great need for economy, and the Board cannot yet depart from the instruction that only urgent cases should be dealt with by Local Authorities under the Mental Deficiency Act.

In the circumstances it was considered to be of primary importance that greater provision should be made for the institutional accommodation of mental defectives requiring to be urgently dealt with either in their own interests or in the interests of the lieges and accordingly the Board applied for and obtained an increase in the Grant for institutional cases. It is felt that patients who are suitable for residence in a private dwelling cannot generally be regarded as urgent cases.<sup>54</sup>

The circular went on to say that apart from 'very exceptional cases' local authorities would have to bear the full cost of any new cases placed under guardianship. Furthermore the Board 'suggested' that all such cases should be submitted to the GBCS,

---

<sup>54</sup> GBCS, *Circular 201*, HMSO, *GBCS Annual Report 1925*, 47.

who would then make the decision as to their urgency.

Whilst the circular attempted to deter Poor Law inspectors from placing all but their most urgent cases of mental defectives living in the community under private guardianship, the GBCS seemed to be more supportive of institution superintendents boarding patients out to private guardians. As deputy commissioner, George Gibson, explained in an article published in the *Journal of Mental Science* in 1925, the need to free accommodation space for urgent cases was at a premium. Making his comments in the journal that was most likely to be read by the psychiatric profession, Gibson criticised institution superintendents and Poor Law inspectors for their reluctance to board-out suitable patients from asylums and institutions. With a strong note of sarcasm, he suggested that they were simply seeking to avoid extra work:

[b]efore a patient is boarded out satisfactory guardians must be found; arrangements for medical visitation must be made and the patient must be transported to the new home. There, after all this trouble, he or she may prove to be an entirely unsuitable case, and have to be removed somewhere else after a few days. Then if the patient be successfully domiciled, he or she must be visited twice a year by inspectors - rather a cumbersome procedure in each individual case. How much easier to avoid all this trouble by allowing the patient to remain quietly in the asylum!<sup>55</sup>

He even went as far as to explain superintendents' reluctance to board-out in economic terms:

with shorter hours of work and increased wages, the cost of providing male and female staffs for asylums has gone up very greatly. As a result the good working patient has acquired an enhanced value, especially as a farm-worker.<sup>56</sup>

From 1925, institutional provision for mental defectives grew at a faster rate than guardianship and this trend continued to the end of the inter-war period. Nonetheless, the shortage of institutional accommodation in the 1920s had forced administrators to re-evaluate their position on community-based care. Although the ratio of defectives

---

<sup>55</sup> G. Gibson, 'The Boarding-out System in Scotland', *Journal of Mental Science* 71 (1925), 259-260.

<sup>56</sup> *Ibid*, 260.

under guardianship to defectives in institutions, never rose above 2:3,<sup>57</sup> GBCS officials became increasingly prepared to advocate guardianship as the preferred option for certain high-grade mental defectives. In particular, they favoured boarding-out defectives from towns and cities to non-familial guardians in rural areas. In the GBCS report for 1934, Kate Fraser gave the following account of the shift in attitude towards boarding-out:

When the Mental Deficiency Act was framed I do not think it was contemplated that boarding-out would be utilised to any great extent, particularly for the higher-grade cases. It was found, however, that there was not sufficient accommodation for all such cases in our certified institutions, and owing to national and economic conditions it was recognised that there would be a shortage of institutional accommodation for many years to come. So, very tentatively at first, the boarding-out of the higher-grade defectives was tried. There were naturally some failures, owing partly to the fact that some doubtfully suitable cases had to be given a trial while waiting for institutional accommodation, and partly to the fact that during the war years it was difficult to get the right type of guardian for that kind of case. But the failures were relatively few, and it was soon recognised that here was a very valuable method of disposal and care. Now the boarding-out of defectives has become a definitely organised scheme, especially within the large Town and County councils.<sup>58</sup>

Despite the fact that boarding-out seemed to find new favour with administrators, increased expansion of institutional accommodation after 1925 meant that by the end of the inter-war period, the proportion of mental defectives under guardianship against those in institutions had changed to 3:7.<sup>59</sup>

Whilst the GBCS was therefore making some headway in overseeing a general increase in institutional accommodation for mental defectives, it still had problems ensuring that every Scottish local authority was fulfilling its obligations under the 1913 act. This was made more difficult by the role of the parish councils in identifying and paying for half the maintenance of mental defectives under the GBCS's jurisdiction. Parochial

---

<sup>57</sup> HMSO, *GBCS Annual Report* 1938, 41.

<sup>58</sup> HMSO, *GBCS Annual Report* 1934 (Cmd. 4838, 1935), xxxi.

<sup>59</sup> HMSO, *GBCS Annual Report* 1938, 41.



involvement meant that the mental deficiency administration suffered from a similar disadvantage to the Poor Law system, of which it was an offshoot. Small parishes were ill-equipped to pay for provision for mental defectives out of the rates and many local officials were inexperienced in dealing with such matters. In Gibson's words, which apply as much to mental deficiency as they do to lunacy:

[r]emember there are 875 parishes in Scotland, running from Glasgow with over half a million parishioners, to Lyne, with 78. A host of the smaller parishes have either very few patients or none at all. To them the occurrence or certification of a case is a rare happening...they have little practice in the working of the lunacy laws<sup>60</sup>

Plans to abolish parochial administration of poor relief had been available to the Scottish Office since 1917,<sup>61</sup> but it was Neville Chamberlain's reform of local government in England, culminating in the Local Government Act, 1929, which finally prompted the Scottish Secretary, John Gilmore, to take action on the issue. Gilmore produced his own bill for Scotland, which passed through Parliament in the same year as Chamberlain's.<sup>62</sup>

The Local Government (Scotland) Act, 1929 created a series of new local authorities, the most important of which were the 31 county councils,<sup>63</sup> and the four largest town councils: namely, Glasgow, Edinburgh, Dundee and Aberdeen (sometimes referred to as 'counties of cities'). The aim was to ensure that each of these authorities had a population of over 20,000 so that they could carry out the range of public services entrusted to them. However, the act also created 'large burghs' out of towns situated within rural counties. They were given a degree of local autonomy in the administration of certain services, which included institutionalisation and private guardianship but not education. Services that the large burghs were prevented by the act from administering themselves were to be administered on their behalf by the county councils. The act abolished parish councils, *ad hoc* education authorities and district boards of control,

---

<sup>60</sup> Gibson, 'The Boarding-out System', 260.

<sup>61</sup> Levitt, *Poverty and Welfare*, 104.

<sup>62</sup> *Ibid*, 160. For a discussion of 'regionalism' within the early health service see C. Webster, 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History* 1 (1990), 115-151.

<sup>63</sup> These 31 councils administered for 33 counties: for all major services the Act united Perth with Kinross and Moray with Nairn, see Pryde, 'Central and Local Government in Scotland Since 1707', p. 24.

and instructed the new local authorities to submit schemes to the Secretary of Scotland outlining how they planned to carry out the old authorities' administrative functions.

To those involved in special provision for mental defectives, the act raised some important issues as to whether the condition should be regarded as primarily a medical or a welfare issue. Not surprisingly, those with a vested interest in keeping mental deficiency within the authority of specialist medical practitioners argued against amalgamating the mental deficiency administration with any non-specialist authorities. In 1929, the Royal Medical-Psychological Association sent a deputation to meet the commissioners of the GBCS (at that time, chaired by Sir Arthur Rose), to express their concern to the Board. The deputation feared that the imminent restructuring of local government would mean that lunatic asylums and institutions for mental defectives would be managed by local health committees and in some areas even by public assistance committees. They stressed that the care of the insane and mental defectives was very much a specialist activity. Superintendents and nurses had to undergo special training and dealt with different issues from other medical workers. Consequently, they argued that local authorities should establish separate mental health committees and appoint experienced members of the old district boards of control to manage them.<sup>64</sup>

The commissioners had no desire themselves to see the local administrations for lunatics and mental defectives lose their independence. They consequently assured the deputation that they were drawing up a circular aimed at persuading the new authorities to establish separate mental health committees. The circular was distributed in December, 1929, but most of the new authorities ignored the GBCS's advice and seconded various aspects of mental deficiency administration to different committees within county and town councils. In 39 cases, new local authorities maintained a similar sort of division as had previously existed between parish councils and district boards of control, by sharing mental deficiency administration between public health committees and public assistance committees. In 10 cases they were administrated by a joint public health and public assistance committee. Five of the new authorities transferred the whole responsibility for mental defectives to their public assistance committees. One created a 'joint public health and lunacy and mental deficiency committee'. In addition

---

<sup>64</sup> GHBA HB 20/4/8, Report By Deputation Of Royal Medico-Psychological Association (1929).

to the committees mentioned above, all of the county councils, including 'counties of cities', had education committees which dealt with special education in day schools.<sup>65</sup>

The GBCS Commissioners consoled themselves by pointing out in their 1930 *Annual Report* that in 'a number of cases a Mental Diseases Sub-Committee of the Public Health Committee has been appointed'.<sup>66</sup> However, the Medico-Psychological Association were not as easily mollified. In 1935 its representatives made a further attempt at lobbying local authorities to establish mental health committees.<sup>67</sup> Their efforts met with little success and after the second world war, mental hospitals became subsumed within general hospital management to an even greater degree under the NHS.

The local government reforms of 1929 therefore compromised the administrative independence of public sector mental health care provision. The act also weakened the position of the GBCS through its reorganisation of Treasury funding. The legislation combined a number of separate grants paid annually by the Treasury to help fund for specific services (such as mental deficiency provision). Each local authority was now to receive its own 'block grant' from the Treasury to pay for a range of services, including education and health care. This meant the Treasury negotiated directly with each local authority over the size of the block grant, and local authorities decided upon the level to which they were prepared to finance mental deficiency provision. The GBCS consequently lost its role in distributing central funds for the maintenance of mental defectives and it could no longer negotiate with the Treasury for increased contributions to the mental deficiency administration. Instead, the Board had to persuade each local authority to increase its funding for mental defectives: a task made more difficult by the fact that many local authorities lacked committees dealing specifically with mental health.

However, these blows to the GBCS do not seem to have exerted a negative impact on the mental deficiency administration as a whole, suggesting that commissioners and psychiatrists had over-estimated the importance of continued autonomy within the mental health-care administration. During the 1930s, the number of mental defectives in

---

<sup>65</sup> HMSO, *GBCS Annual Report* 1930, (Cmd. 3976, 1931), viii.

<sup>66</sup> *Ibid.*

<sup>67</sup> GHBA HB 20/4/8, Report by Royal Medico-Psychological Association (1935).



institutions or guardianship increased at roughly twice the rate of that in the 1920s. The average expenditure over the 1930s also doubled that of the 1920s.<sup>68</sup> Still, the GBCS was concerned that certain local authorities were not fulfilling their duties to ascertain all mental defectives and ensure suitable provision was received by those considered to be in need of it. As the Local Government Act had removed the GBCS's role of negotiating with the Treasury for larger grants, the Board was obliged in the 1930s to focus its efforts on persuading local authorities to institutionalise greater numbers of mental defectives. Authorities were encouraged to combine for the purpose of financing more institutional accommodation, or at least make contracts with existing institutions to guarantee that a specified number of beds would be laid aside for people from their area.

Although there was a marked increase in institutional accommodation over the 1930s, this was not, for the most part, a result of the GBCS's efforts to encourage greater regional uniformity of provision. The number of mental defectives in institutions rose from 1,965 in 1930 to 3,709 in 1939 but a large proportion of this increase can be accounted for by the opening of Lennox Castle in 1936.<sup>69</sup> Lennox Castle accommodated 1,200 adult mental defectives, but these came mainly from Glasgow, an area that had already invested heavily in mental deficiency provision. Hence, the institution widened the gap in provision between Glasgow and the rest of the country.

Institutional provision for mental defectives was very much a Lowlands phenomenon. In its report for 1937, the GBCS asserted that increased provision was 'particularly necessary in the North of Scotland as there is no existing institution convenient enough for the Local Authorities in that region'.<sup>70</sup> In the late 1930s, the Board attempted to increase the pressure on the less active local authorities by issuing two circulars. The first, in 1937, was sent to all local authorities. The GBCS informed them that:

[i]t is now 23 years since the Mental Deficiency and Lunacy (Scotland) Act came into operation and over 18 years since the termination of the Great war, and the Board consider that the time has now arrived when each Local Authority should be required to comply strictly with the Statute by making institutional

---

<sup>68</sup> HMSO, *GBCS Annual Report 1938*, 41.

<sup>69</sup> Anderson and Langa, 'The Development of Institutional Care', 258.

<sup>70</sup> HMSO, *GBCS Annual Report 1937* (Cmd. 5715, 1938), xl.

provision for its mental defectives:

1. by the establishment of an institution either alone or in combination with other Local Authorities, or
2. by contracting with the Managers of an existing Certified Institution.<sup>71</sup>

One of the few means possessed by the GBCS for imposing its will on local authorities was its powers to control access to institutions. Following the circular of 1937, the GBCS insisted that authorities entered into formal contracts if they 'have more than 4 defectives boarded in institutions in which they have no claim to accommodation'.<sup>72</sup> Having made such a contract, it was hoped that the local authorities would feel obliged to fill the beds that had been reserved for them.

In 1938 the GBCS sent a second circular, this time addressed specifically to its least active local authorities situated in the 'East Central' part of Scotland. These included counties, cities and towns in the areas of Aberdeen, Dundee, Perth, Kincardine, Banff, Moray and Arbroath. In this circular, the Board set out a more detailed plan of action to redress the lack of provision, but its general strategy of encouraging combinations and contracts were similar to those issued the previous year.<sup>73</sup> The extent to which local councillors took these circulars seriously is open to debate. In its annual report for 1938, the GBCS stated that a number of authorities had recently made contracts with institutions but none of the authorities mentioned were within the 'East Central' area. However, the General Board's offensive against lack lustre local authorities was soon to be overtaken by events beyond its control. In 1939, Britain declared war on Germany and this time expansion of provision for mental defectives really was put on hold, whilst national resources were directed to the prosecution of total war.

The inter-war period had, then, been a frustrating time for the GBCS. Although the Board had overseen a considerable expansion in its provision for mental defectives, this expansion had not kept pace with the increasingly large numbers of people regarded as mentally defective. The GBCS had also seen its authority challenged by both local and

---

<sup>71</sup> *Ibid*, 45-6.

<sup>72</sup> *Ibid*.

<sup>73</sup> *Ibid*, 46-7.

central government. Uncooperative local authorities, particularly many of those representing rural areas, had done little to fulfil their obligations under the Mental Deficiency Act. The Treasury frequently placed restrictions on expenditure; the Local Government (Scotland) Act, 1929, reduced the authority of the Board still further. The GBCS saw its role in negotiating Treasury contributions removed and its local authorities, the district boards of control, abolished. Although mental deficiency provision expanded at the end of the period there was a large degree of regional disparity regarding institutional provision. This prevented the mental deficiency administration from being a truly nation-wide system. It also encouraged GBCS administrators to place a greater emphasis than they had originally intended on the community-based approach of placing mental defectives under private guardianship.

### *The SED in the Inter-war Period*

The SED faced similar problems to those experienced by the GBCS in the inter-war period, namely Treasury restrictions and a lack of co-operation from many local authorities when it came to provision for mental defectives. Nevertheless, the period witnessed an expansion in special education for high grade mentally defective children in day schools. In the school year 1919-20, 2.8 per 1000 of Scottish pupils attended special classes for mental defectives. By 1937-8 the figure had more than doubled to 6.2 per 1,000.<sup>74</sup>

Numerically speaking, mental deficiency was a marginal concern within the education system. The vast majority of Scotland's pupils were taught in ordinary classes and it was to these ordinary pupils that the SED looked for its educational 'successes', who would gain qualifications, employment, and perhaps even social advancement. Even amongst 'special' pupils, 'educable' mental defectives were only a minority, with physically defective pupils outnumbering them up until the second world war.<sup>75</sup> Of course, the importance of special education cannot simply be measured in numerical terms and there is evidence that SED officials did periodically consider taking a more active role in encouraging an increase in special schools and classes for mental defectives. However, there remained a basic reluctance to allocate resources to this area of education, with the result that the occasional flurries of activity within the department failed to lead to many concrete initiatives on mental deficiency. Once more, the

---

<sup>74</sup> See appendix 1.

<sup>75</sup> *Ibid.*



majority of innovations came from local rather than central authorities with Glasgow continuing to take the leading role.

From the start of the inter-war period, the SED could rely upon a more efficient and coherent local government structure than the GBCS. Whilst the GBCS saw the local administration of institutional provision and private guardianship divided between district boards of control and parish councils in the 1920s, the SED had managed to reform its local authorities with the Education (Scotland) Act, 1918. The act replaced Scotland's 947 school boards with 38 education authorities. They represented 33 Scottish counties and five cities: Glasgow, Edinburgh, Aberdeen, Dundee and Leith (although Leith and Edinburgh quickly combined to form a single authority). The education system was therefore administered locally by authorities large enough, in theory, to provide a variety of educational services, including school health, secondary education and special education, with greater efficiency.<sup>76</sup>

Like the school boards, the new education authorities were run independently from other local authorities such as parish councils etc. (hence, they were commonly known as '*ad hoc* education authorities') until the Local Government Act (Scotland), 1929 turned them into 'Education Committees' answerable to county or city councils. With the approval of the SED, two or more education authorities could also work in combination, thus widening the administrative area still further. The *ad hoc* education authorities also possessed wider powers within each authority, as the Education (Scotland) Act of 1918 successfully encouraged the transfer of the majority of voluntary schools into the public sector (these became known as 'transferred schools').

The act may have given the SED a more efficient local government but geographical differences still influenced the degree to which special education became established across Scotland. As with the GBCS, the SED found many of its rural authorities to be particularly uncooperative. The school medical service was generally less developed in the thinly populated areas of rural Scotland. This hampered the ascertainment process, as did the knowledge that even if certain children in a rural area were identified as being mentally defective, they were likely to be living a considerable distance from one another. Many rural authorities refrained from developing a comprehensive scheme of

---

<sup>76</sup> Scotland, *History of Scottish Education*, 20.

ascertainment because of the logistical difficulties involved in transferring children identified as being mentally defective into special classes. As special classes catered for a relatively small minority of the school-aged population, they tended to require a much greater degree of centralisation than the ordinary school system: pupils attending special classes in the counties would either have to travel long distances to and from school or be boarded-out to foster guardians who lived nearer to the school in question. The former option led to problems of transportation, whilst the latter was likely to incur parental resistance.<sup>77</sup>

As with special provision under the GBCS, most special schools and classes were established in the southern, more densely populated parts of Scotland. There was little the SED could do to stir its less active education authorities out of dormancy, not least because for most of the period there was no legal obligation for education authorities to establish special classes. Scotland lacked an equivalent to the Education Act of 1914, which compelled authorities in England and Wales to provide special education in their own area. The Scottish authorities did have a duty to ensure that all 'high grade' defectives received special education but could fulfil this duty by sending the defectives elsewhere to receive their education. By refraining from identifying mentally defective pupils in the first place, education authorities could avoid even this latter obligation.

Still, the overall number of mental defectives on the rolls of special schools and classes rose at a slow but reasonably steady pace throughout the inter-war period. Although most of these classes were located in Scotland's burghs, the rate of expansion was higher in the counties, albeit starting from a smaller base. Between the school years 1919-20 and 1927-8, the number of mental defectives on the roll for special schools and classes in Scotland's burghs rose from 2,074 to 2,393. Despite a decline in numbers during the later 1920s, the figures give an average rise of 46 pupils a year. The corresponding figures for the counties rose steadily from 408 to 1,099: an average of 99 per year, which comes close to the actual rise for each year.

The Local Government (Scotland) Act, 1929, placed schools in small and large burghs (ie. all but the five largest cities) under the jurisdiction of the counties, which skews the figures for the 1930s to a certain degree. Despite this weighting in favour of the counties, the cities continued to provide special education for the majority of Scotland's

---

<sup>77</sup> See c. 7.

‘educable’ mental defectives. In 1931-2 they had 2,608 on the roll and by 1937-8 the figure had risen to 3,221: an average rise of 102 per year. The rate of increase for the counties during this period was smaller than it had been in the 1920s. In 1931-2, there were 1,390 pupils on the counties’ roll and in 1937-8 there were 1,579: an average yearly increase of 32. These figures occurred within the context of an overall school population (ie. including ordinary pupils) that fell slightly in both burghs and counties during the inter-war period.<sup>78</sup>

The large urban centres, particularly Glasgow, had always dominated provision for mental defectives. Following the Local Government (Scotland) Act, 1929, they expanded their special education system at an increased rate, whilst the counties began to flag. The cities were in a stronger position, financially and administratively after the 1929 Act and this no doubt accounts for their increased activity. However, unlike provision under the GBCS, the education system still received direct Treasury contributions after 1929. This meant that counties could still rely on financial backing from central government if they established their own special schools and classes. The fact that the extension of special education outside the cities began to slow down in the 1930s can be attributed to lack of political will, perhaps exacerbated by flaws in the post-1929 administrative infrastructure.

The Local Government Act gave large burghs responsibility over many of their own services, but insisted that their schools must be administered by county councils. The county councils requisitioned money from the burghs to pay for the burghs’ schools. Consequently, the burghs had no way of controlling how money they had raised through the rates for education was actually spent. Reviewing this system in 1969, the report of *The Royal Commission on Local Government in Scotland*, under Lord Wheatley, criticised the 1929 act for encouraging financial mismanagement and an unhealthy dependency between one authority and another.<sup>79</sup> There was clearly a danger that county councils would spend money raised by the burghs on services in the rural hinterland. As a result, the towns’ lower priority educational services, such as special education, would suffer. In a review of the mental deficiency administration, published in the GBCS report for 1934, Kate Fraser singled out the large burghs as being the locus for the recent problems in ascertainment:

---

<sup>78</sup> See appendix 1.

<sup>79</sup> HMSO, *Royal Commission on Local Government in Scotland 1966-69* (Cmnd. 4150, 1968-69).



When the [Mental Deficiency] Act was passed it was hoped that in the larger towns where there were special schools and classes, knowledge of all defectives of school age would be obtained. This hope has not been fully realised.

Particularly within recent years there has been a tendency to retain the higher-grade cases in the ordinary school.<sup>80</sup>

The extension of mental deficiency to include 'high-grade' cases was not practised by many of Scotland's medical officers, for reasons that can be attributed to the local situation in which they operated. By the mid-1930s, around a third of Scotland's education authorities had made no provision for mental defectives.<sup>81</sup>

From the beginning, the SED showed signs of wanting to tackle the lack of uniformity amongst different local education authorities in their approaches to special education. In 1921, the Department instigated a special census of mental defectives of school age and found 'wide variations as between different education areas both in the standards adopted by the certifying officers and in the thoroughness of their investigations'.<sup>82</sup> For the next few years, the new Department Secretary, W.W. McKechnie, repeatedly turned to the subject. McKechnie had risen through the ranks of the school inspectorate and had shown some interest in special education prior to his appointment in 1921.<sup>83</sup> Between 1922-23, he gave a number of public addresses to women's groups in various towns and cities, in which he emphasised the need for more special classes, institutions and voluntary after-care for mental defectives.<sup>84</sup>

In a draft memo written by McKechnie in 1923, he commented on how the proportion of school pupils educated in special classes for mental defectives differed widely depending upon the education authority. Rural education authorities were singled out as being particularly tardy in their provision of special education for this group: '[i]t is clear from [the] statistics that while the Burghs show 63.6 per 10,000 the Counties show only 7.6 and if Paisley and Greenock are deducted, their position is still worse. 21 Counties have done nothing.'<sup>85</sup>

---

<sup>80</sup> HMSO, *GBCS Annual Report 1934*, xxxii.

<sup>81</sup> NAS ED 28/231, *SED Circular No. 105* (1<sup>st</sup> Sep. 1937).

<sup>82</sup> *Ibid.*

<sup>83</sup> Macmillan, 'Origins and Evolution', 203.

<sup>84</sup> *Ibid.*, 210-213.

<sup>85</sup> NAS ED 28/230, W.W. McKechnie, draft memo (16<sup>th</sup> Feb. 1923).

The cuts in public spending following the Geddes Report prevented the department from providing additional money to help rectify this situation.<sup>86</sup> However, even when the Treasury began to relax spending restrictions, the SED could not force its local authorities to establish their own special classes (which were still permissive under the 1906 act). Hence in 1926, McKechnie had to content himself with drafting a lengthy circular designed to persuade authorities to take the issue more seriously. The circular stressed that it was a duty of all education authorities to notify idiots and imbeciles to parish councils. Once notified, they could then receive the training and supervision they needed to 'make them less of a burden to themselves and for others'. McKechnie then went on to advocate special classes for the feeble-minded:

[i]t has a double advantage. The defective child is a serious drag on the ordinary class, he is apt to take up much of the teacher's time and attention, and not infrequently makes discipline difficult. In the interests of the normal pupils, therefore, he should be removed. But his own gain will still be great. He can derive but little pleasure or profit from the normal curriculum, he must weary for something within his powers and comprehension, and, unless he is of the placid, stable type, his dissatisfaction will tend to issue in over rebellion.<sup>87</sup>

Wishing to give the matter a greater sense of urgency, McKechnie emphasised the 'very great national importance' of special education:

the Special School is our first line of attack on the insidious enemy to our civilisation whose official name is Mental Defect, but whose real meaning is Social Inefficiency, with its long train of poverty, misery, crime, alcoholism and prostitution.<sup>88</sup>

The circular was never completed or distributed. The urgency that McKechnie sought to instil in his local authorities ultimately seemed lacking within his own department, and more particularly within the Treasury. The SED turned its attention to mental deficiency once more in 1931 when the GBCS submitted a memorandum suggesting that the

---

<sup>86</sup> NAS ED 28/230, memo from H.S.H. to Langford, (25<sup>th</sup> Sep. 1931).

<sup>87</sup> NAS ED 28/230, draft SED circular (6<sup>th</sup> Dec. 1926).

<sup>88</sup> *Ibid.*

definitions provided by the 1913 act should be changed to include not only those who had shown signs of their deficiency 'from birth or from an early age' but also individuals who became defective at any time up to the age of 18. The memo was prompted by the English Mental Deficiency Amendment Act, 1927, which was designed to allow sufferers of a recent encephalitis lethargica epidemic to be dealt with as mental defectives.<sup>89</sup> Despite there being general sympathy towards the proposal within the Department, McKechnie was not prepared to formally give the SED's support to the GBCS and the matter was dropped.<sup>90</sup>

The following year, the Department considered tackling once more the problem of the local authorities, mindful that after successive abortive ventures it 'would be unfortunate to continue the series of inopportunities'. However, plans for a new circular were postponed again when officials received word that the Treasury was 'unfavourably impressed' with their plans to encourage an increase in local spending on special education during a period of economic depression.<sup>91</sup> It was not until 1937 that the department finally distributed a circular to its local authorities informing them of the need to ensure that all mentally defective pupils were identified and given appropriate provision, either in special classes or through notification to local committees administering institutionalisation and private guardianship.<sup>92</sup>

The fact that it took the SED virtually the whole of the inter-war period to send its circular indicates that however much personal importance individual officials may have liked to attach to special education, within the government as a whole, it was viewed as an issue that could be readily put aside whilst more urgent concerns were being dealt with. Throughout the 1920s, the Department was generally content to let the GBCS assume greater responsibility when it came to paying for special provision. When certain education authorities proved unwilling to open special day classes of their own, the Department suggested that district boards of control should resolve the situation by building institutions for 'educable' defectives and paying for them out of the Treasury grant to the GBCS. For instance, the SED report for 1919-20 states:

---

<sup>89</sup> M.Thomson, *Problem of Mental Deficiency*, 55.

<sup>90</sup> NAS ED 28/228, Scottish Education Department, memorandum on the education and care of mentally defective children for Departmental Committee on the Scottish Lunacy and Mental Deficiency Laws (1938).

<sup>91</sup> NAS ED 28/230, SED memo (9<sup>th</sup> Sep. 1932).

<sup>92</sup> NAS ED 28/231, *SED Circular No. 105* (1<sup>st</sup> Sep. 1937).



the solution of the problem depends very largely upon the possibility of obtaining an adequate supply of residential institutions. The condition of the children, it is true, admits of their being educated at special day schools and classes while residing at home or with guardians appointed under the Mental Deficiency and Lunacy (Scotland) Act, 1913. But there remains a large class who, though educable, and therefore coming under the care of the Education Authority, can only be suitably educated under the conditions obtainable in residential institutions.

The report goes on to remind its readers that:

provision of sufficient accommodation in residential institutions, both for educable defectives under the age of 16, whom the Education Authority send to such institutions, and also for all other mental defectives, is the duty of the District Boards of Control.<sup>93</sup>

The SED was also prepared to use the lack of institutional accommodation for ‘ineducable’ children and adult mental defectives as an excuse for those Education Authorities who lacked the motivation to expand their special day schools and classes. Such authorities had ‘small encouragement...to extend provision’ because:

the training which is given by the Education Authorities to the children who can be taught in day schools and classes provided by themselves is practically thrown away if, on the children reaching the age of 16, when they automatically pass out of the hands of the Education Authority, or if on their arriving, before that age at a stage of development when they can no longer be retained in the day school or class, no institution is ready for their reception where they can lead a life suitable to their condition and so benefit by the earlier training they have received.<sup>94</sup>

The calls for institutional accommodation were repeated in subsequent reports.<sup>95</sup> This could be interpreted as an attempt by the SED to back up the GBCS in its lobbying

---

<sup>93</sup> HMSO, *SED Annual Report 1919-20* (Cmd. 782, 1920), 23.

<sup>94</sup> *Ibid.*

<sup>95</sup> HMSO, *SED Annual Report 1921-2* (Cmd. 1666, 1922), 20; HMSO, *SED Annual Report 1922-3* (Cmd. 1885, 1923), 16-17; HMSO, *SED Annual Report 1925-6* (Cmd. 2676, 1926), 25.

efforts to raise Treasury contributions, or it could simply have been an attempt to advocate more institutions as a means of transferring the cost of providing for certain 'educable' defectives away from the SED. Neither interpretation is exclusive of the other. In 1925, the SED persuaded Parliament to pass an Education Act in 1925, which widened the power of education authorities to send children to institutions within or outside their own areas.<sup>96</sup> The measure was intended to encourage rural authorities to find residential accommodation for their mentally defective pupils. There were no plans for the SED to finance its own residential schools for 'educable' mental defectives, so any institutional space used for this purpose would have to be provided by the GBCS. Local education authorities would be responsible for the cost of education, and half the cost of transport and maintenance of any institutionalised children receiving special education, whilst the institutions themselves were financed and administered by the district boards of control.

Although the SED tended to pass responsibility to the GBCS whenever possible, it would be wrong to say that the department took no initiatives of its own during the period. Meckechne may have found it difficult to produce a circular to encourage more action amongst his local authorities, but he did provide the following message in the *Annual Report* for 1925-6:

[f]or many years it was mainly in the large urban areas that Special schools and classes were to be found, but since 1919 there has been a growing tendency for the counties to rise to their responsibilities in the matter, and most gratifying progress is being, or will soon be, made in Ayr, Fife, Lanark, Dumbarton and West Lothian. Renfrewshire has been well to the front for many years, with large and increasing centres at Paisley and Greenock. Considering the difficulties that have had to be overcome, the achievement is very creditable and there is clear evidence that a number of the Authorities are taking a serious view of their responsibilities in regard to defective children. But the advance is far from being general and there are still many areas where little or nothing has been done.<sup>97</sup>

---

<sup>96</sup> *Education (Scotland) Act 1925* (15 & 16 Geo. 5., c. 89), section 5.

<sup>97</sup> HMSO, *Annual Report of SED 1925-6*, 25-6.

More significantly, towards the end of the inter-war period, the SED was able to remove the legal loophole through which local authorities could avoid establishing special classes: namely the permissive nature of the 1906 act. Once the Education (Scotland) Act, 1936, became law, education authorities were compelled to provide adequate facilities for special education within their own area, rather than attempt to send their 'educable' mental defectives elsewhere. It was this act that prompted the SED Circular of 1937, drawing attention to the regional variations in special education and outlining how authorities should go about fulfilling their new obligations.

The short term impact of these developments was muted. The rate at which enrolment in special schools and classes for mental defectives increased was only slightly higher between 1935-6 and 1937-8 than in the earlier part of the 1930s. The second world war then intervened to frustrate the SED's plans. The number of mental defectives enrolled fell sharply, from 4,800 in 1937-8 to 3,751 in 1941-2. It was not until the end of the war that the figure passed its pre-war level.<sup>98</sup>

Although special education expanded significantly during the inter-war years, the SED's experiences mirrored those of the GBCS in many ways. Both central authorities had been given the role of establishing a state-wide system of provision. Both had been frustrated by unenthusiastic local authorities, located for the most part in the poorer, less populated areas in the north. Towards the end of the 1930s, the central authorities had taken measures to stir their local authorities into action, but the war denied these measures any immediate opportunity to make any impact.

### *Community-based Voluntary Organisations*

Another strategy employed by the GBCS to help deal with the perceived shortage of accommodation was the funding of community-based voluntary organisations.<sup>99</sup> In the early years of the twentieth century, Glasgow's local authorities had encouraged voluntary organisations to provide food and clothing for poor children. One such organisation, the Glasgow Infant Health Visitors Association, became especially prominent. Apart from its Honorary President, the Lord Provost of Glasgow, its fifty plus members were all female and appear to have been drawn from the middle-classes.

---

<sup>98</sup> See appendix 1.

<sup>99</sup> For a collection of articles examining different aspects of community care for lunatics and mental defectives, see P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999).



The Association included such notable figures as the wife of Glasgow's Medical Officer of Health, A.K. Chalmers; Mrs Bannatyne, a school board member with a particular interest in mental deficiency; four titled 'Ladies' and two female doctors. The Association worked with the Medical Officer of Health, visiting people's homes and supplying infants with milk, parents with advice and the Medical Officer of Health with information about families in the form of written reports. In return for this service, they received an annual grant of £75 from Glasgow Corporation.<sup>100</sup>

The Glasgow Infant Health Visitors Association was one of a number of organisations in Britain fulfilling similar functions. Many used quasi-professional techniques such as card indexed records for case notes and grouped themselves under the umbrella of the Charity Organisation Society, which since the 1870s had demonstrated a particular interest in mental deficiency. One of the features of the pre-first world war Liberal welfare reforms, was the Liberal government's willingness to draw on voluntary organisations to help administer its services: the incorporation of friendly societies into the National Health Insurance scheme is perhaps the best known example of this strategy. Voluntary organisations provided a ready made administrative infrastructure that, being at least partly financed by donations or subscriptions, was cheap to run and could be portrayed as a means of limiting direct state intervention into the private lives of individuals. It comes as no surprise, therefore, to find in section 38 of the Mental Deficiency and Lunacy (Scotland) Act, 1913, the following clause:

[w]here a society has undertaken the duty of assisting or supervising defectives whilst not in institutions under this Act, there may be paid to the society out of money provided by Parliament towards the expenses of the society in connection with such persons such sums and on such conditions as the Secretary for Scotland, with the approval of the Treasury, may recommend.<sup>101</sup>

During the war years, this particular aspect of the Mental Deficiency Act seems to have gone unnoticed in Scotland, but in 1920 the GBCS's attention was directed to a newly formed organisation called the Paisley After-care Committee. In his unpublished thesis, Lachlan Macmillan has described how Mary Naismith Russell had become involved in the voluntary provision of after-care for former pupils of the Special Classes Public

---

<sup>100</sup> GCA DTC. 7/7/13, *Annual Report of Glasgow Infant Health Visitor's Association* 1911-12.

<sup>101</sup> Mental Deficiency and Lunacy (Scotland) Act, 1913, s. 38.

School Paisley, in which she taught. In 1919, she established an occupation centre and the following year formed the Paisley After-care Committee, with the objectives of finding employment or providing training and care for mentally and physically defective school-leavers in the community. It liaised with parents and promoted community-based care in newspapers and official circles.<sup>102</sup> Russell wrote to the GBCS in 1920 applying for Treasury funds. The GBCS agreed to give her organisation an annual grant of £3 and advised Russell that the Committee should merge with other local care committees to form a larger and more co-ordinated after-care service, as was the case in England.<sup>103</sup>

The Paisley committee acted upon this advice. The following year, it asked for and received a small grant of £23 from the GBCS,<sup>104</sup> whilst an organisation calling itself the Central Association for Local Care Committees obtained a £20 grant from the Board.<sup>105</sup> This Central Association achieved greater prominence by organising a conference in 1922, attended by representatives of various local authorities. The main speaker was Sir Leslie Scott, Solicitor General in England and President of the Central Association for Mental Welfare: the London based organisation that the GBCS had suggested Russell look to as a model. After a period of deliberation, many of the local authorities, including those of Glasgow, gave their backing to the principle of voluntary after-care. In 1923, the voluntary organisations formed the Scottish Association of Care Committees, which included representatives from local authorities, but during its first annual meeting members decided that they should broaden their remit to encompass other aspects of mental health in the community. As a result, they changed the organisation's name again to the Scottish Association for Mental Welfare.

As Treasury restrictions on expenditure took their toll in the early 1920s, the GBCS became increasingly concerned about those mental defectives whom it considered were not receiving adequate supervision. In its annual report for 1925, the GBCS gave details of a recent survey it had carried out to determine the number of 'all mental defectives throughout the country',<sup>106</sup> using the definitions given in the Mental Deficiency Act. The survey was conducted by officers working for the parish councils, education

---

<sup>102</sup> Macmillan, *'Origins and Evolution'*, 176-177.

<sup>103</sup> NAS MC 8/2, *Minutes of GBCS* (3<sup>rd</sup> Nov. 1920).

<sup>104</sup> NAS MC 8/2, *Minutes of GBCS* (25<sup>th</sup> May 1921).

<sup>105</sup> NAS MC 8/2, *Minutes of GBCS* (2<sup>nd</sup> Nov. 1921).

<sup>106</sup> HMSO, *GBCS Annual Report 1925*, lvii.

authorities and district boards of control. The returns stated that there were 1,341 mental defectives known to the education authorities but not receiving special education. There were a further 742 children who had been notified to the parish councils by education authorities as being 'ineducable' but were not under guardianship or in institutions. The parish councils stated that 250 of these were on a waiting list for institutional accommodation, whilst the others could 'safely be left under the care of their relations'.<sup>107</sup> In addition to the children of school age, parish councils and district boards of control stated that there were 1,460 adult mental defectives not receiving provision in institutions or under private guardianship. The survey also indicated that there were 1,709 mental defectives (adults or children), who had been certified under the Lunacy Acts and placed in asylums or lunatic wards of poor houses. To summarise, the authorities were of the opinion that there were 2,083 mental defectives of school age, and 1,460 adult defectives living in the community who were not receiving any form of special provision.

The GBCS produced these figures at the end of a period of financial shortages, and they can be seen as a persuasive device to secure more funds from the Treasury. That said, the Board was concerned enough about the lack of provision to raise its annual grant to the Scottish Association for Mental Welfare to £700. The GBCS justified this move on the grounds that voluntary sector community work could make up for deficiencies in familial care, protect defectives from being exploited and prevent them from engaging in deviant behaviour. Furthermore, the GBCS maintained that voluntary organisations could achieve this without infringing on the liberty of the individual. The report argued that:

While the Board have no desire to limit the freedom of any of these defectives, they view with concern the fact that owing to deaths of parents and relatives, and sometimes unfortunately because of careless and inconsiderate parents and relatives who seem to be unfitted to have the care of their mentally defective offspring or relations, the defectives concerned may be taken advantage of or embark on criminal habits and subsequently require to be dealt with by the Local Authority and placed in institutions.<sup>108</sup>

---

<sup>107</sup> *Ibid.*

<sup>108</sup> *Ibid.*



The report implied that community-based care would not only help counter the shortage of accommodation in institutions, but also appeal to the interests of the mental defectives involved by allowing them to stay out of those institutions. This recognition that institutionalisation was not always in the interests of mentally defective people did not mark a change in direction for government policy. Special education in day classes and schools had long since aimed to equip at least a proportion of its pupils for a life in the community. However, through its backing of the Scottish Association for Mental Welfare, the GBCS was able to extend its ethos of care and control to a greater number of people than could be reached through the state's own administrative machinery. More mental defectives were given support in terms of clothing, occupation and social networks but in return, these same mental defectives and their families faced a greater degree of supervision from voluntary workers who possessed direct channels of communication with the state authorities..

By the early 1930s, local care committees affiliated to the Scottish Association for Mental Welfare dealt with thousands of defectives at a fraction of the cost of institutionalisation. Community-based care and supervision of this kind could also be used to complement the system of guardianship, by providing what the GBCS regarded as meaningful day time occupation, particularly in urban communities where the labour market for people labelled mentally defective was extremely limited. The GBCS was able to exercise a large degree of control over the care committees<sup>109</sup> (a price the Scottish Association had to pay for the £700 grant) and could therefore tailor the voluntary services to meet its requirements. During the inter-war period numerous local care committees were established around Scotland to visit mental defectives in their homes, provide occupational centres for 'uneducable defectives' and employment centres for ex-pupils of special schools in the community.

The Local Government (Scotland) Act caused financial problems for the Scottish Association by transferring responsibility for funding away from the GBCS and into the hands of the local authorities. In its circular of December 1929, the GBCS reminded the new authorities that it had the power under section 64 of the Local Government Act to impose a scheme on local authorities to fund the voluntary organisations at the same rate as had occurred before 1929. The GBCS 'hoped, however, that Local Authorities

---

<sup>109</sup> NAS MC 9/1, *GBCS Circular 218* (28<sup>th</sup> Apr. 1931).

and voluntary Associations may be able mutually to agree as to the amounts of contributions, so as to render it unnecessary for the Board to make any scheme under Section 64'.<sup>110</sup> In its report for the following year, the GBCS stated that the local authorities' response to this appeal 'was not satisfactory'.<sup>111</sup> The GBCS then carried out its promise and drew up a funding scheme for each local authority in which a recognised voluntary organisation was operating. As with the other forms of provision administered by the GBCS, voluntary care was concentrated in the more populated southern half of Scotland. Glasgow's voluntary organisations were to receive just over £164, by far the largest allocation of the £700 sum. Edinburgh came second with around £65, whilst the two counties that received the highest allocation were Lanark (£48.16.) and Ayr (£33.5).<sup>112</sup>

The new authorities paid little attention to the GBCS's scheme, just as they had paid little attention to the Board's requests for the establishment of special local committees to deal with provision for mental defectives (see above). In its annual report for 1933, the GBCS showed its frustration at being ignored by the local authorities:

the financial support given by the Local Authorities cannot be regarded as in any way commensurate with the importance and value of the work performed by these Societies and their affiliated local Committees. The absence of direct statutory authority may have accounted for the smallness of the Local Authority support in the past, but that is no longer a valid reason in view of the special provision under [section 64 of] the Local Government (Scotland) act, 1929<sup>113</sup>

Despite the GBCS's claim that the Scottish Association for Mental Welfare suffered from 'serious financial difficulties',<sup>114</sup> it appears to have undergone a considerable expansion since the early days of the Paisley After-care Committee. By 1933, there were voluntary organisation affiliated to the Scottish Association in Ayr, Argyllshire, Cambusland, Clydebank, Dumbarton, Dundee, Dunfermline, Eastwood, Edinburgh, Glasgow, Greenock, Hamilton, Inverness, Kilmarnock, Kircaldy, Motherwell and Winshaw, Paisley, Perthshire and West Lothian. Most of these were in the south of

---

<sup>110</sup> NAS MC 9/1, *GBCS Circular 211* (2<sup>nd</sup> Dec. 1929).

<sup>111</sup> HMSO, *GBCS Annual Report 1930*, xi.

<sup>112</sup> NAS MC 9/1, *GBCS Circular 218* (28<sup>th</sup> April 1931).

<sup>113</sup> HMSO, *GBCS Annual Report 1933* (Cmd. 4712, 1934), xxxiv.

<sup>114</sup> *Ibid*, xxx.

Scotland. The report records over 3,000 defectives in total being catered for by the affiliated organisations, an unknown number of which were also were also receiving provision from the GBCS under the guardianship system. Again, the largest proportion of defectives receiving voluntary provision was located in Glasgow. There were 1,705, mental defectives on Glasgow's voluntary care association's visiting roll.

In some areas at least, the links between the public mental deficiency administration and voluntary sector care were strengthened over the period. In terms of numbers and public funding, Glasgow's local authorities were particularly prominent. Edinburgh Corporation went as far as to take over the running of its local occupation centre, though it continued to draw on the support of the voluntary care committee. The Scottish Association for Mental Welfare attempted to consolidate its links with the state administration still further by providing training for local medical officers in dealing with mental deficiency. Twenty-two medical officers attended the course. The Association also aimed to raise the professional status of its volunteers by running a course for 'Social Workers', which had an attendance of 70.<sup>115</sup>

From a modern perspective, these moves can be seen as early developments in the state's involvement in community care for people with disabilities. Their origins can be traced to the charitable community work carried out by women who possessed time and resources to spare for such activities. In particular, the after-care movement appears to have been born out of the frustration experienced by special educationalists such as Mary Russell at seeing the training and supervision they offered in the classroom being withdrawn as soon as many of their pupils left school. The SED and the GBCS shared this frustration and saw in the work of voluntary committees a cost-effective means to redress problems caused by the shortage of institutional accommodation.<sup>116</sup>

Voluntary care and supervision took three major forms: visiting committees, occupational centres and employment centres. The visiting committees involved the largest number of defectives and can be seen as an extension of the proto-social work activities carried out before the war by organisations like the Glasgow Infant Health Visitors Association. Visitors would 'supervise defectives in their own homes' and

---

<sup>115</sup> *Ibid.*

<sup>116</sup> NAS ED 28/228, Departmental Committee On Scottish Lunacy And Mental Deficiency Laws. Memorandum by C.W. (13<sup>th</sup> Apr. 1938).



attempt to secure institutional accommodation if they thought it necessary. At times, they also attempted to find 'suitable employment' for certain defectives, or recommend attendance at an occupation or employment centre.<sup>117</sup>

Occupation centres were established for children excluded from the education system on grounds of being 'ineducable'. In fact, the age of these 'children' ranged from 6 to 30. The older defectives were separated from the younger, but all were referred to as 'boys' or 'girls'. Using the occupation centre in Paisley as an example, the GBCS listed numerous activities offered there. The centre was open for 3 hours a day and its itinerary reflected the concerns of its mostly female, middle class volunteers. Religion and the work ethic were two of the strongest themes. 'Children' sang hymns, prayed, threaded beads, laced cards, made woolly balls, knitted, and crocheted. Traditional gender roles did not seem to apply as both 'boys' and 'girls' engaged in activities that would generally be seen by contemporaries as female occupations. Likewise, all the 'children' learned skills designed to make them more independent around the house, such as dressing themselves, 'elementary housewifery' and personal hygiene. The volunteers also devoted time to speech therapy and physical exercises as well as more recreational training in speech and muscle co-ordination such as singing and dancing.

The employment centres were for ex-pupils of special schools and classes. Again, using Paisley as an example, its employment centre opened twice a week between 10.00am and 3.00pm. Activities included the making of rugs, toys, wax flowers, painting on glass and wood, wood-carving and gardening. The ages of mental defectives attending the centre ranged from 16 to 36, and again the GBCS report referred to them as 'boys' and 'girls'. Though these higher grade mental defectives would have been segregated by gender if they were accommodated in institutions, they do not appear to have been segregated in the employment centre. Other voluntary committees, such as the one in Dundee, did have separate employment centres for 'boys' and 'girls'. Furthermore, many local committees, including those of Paisley and Glasgow, created special social clubs for mental defectives, frequently modelled on those of the Scout, Guides and Boys Brigade movement. These social clubs did generally separate by gender, but this was no different to the way ordinary children were treated.<sup>118</sup>

---

<sup>117</sup> HMSO, *GBCS Annual Report 1933*, xxix.

<sup>118</sup> *Ibid.*

A common theme running through both the occupation and employment centres was a belief in the redemptive powers of work. The GBCS was particularly keen on highlighting this aspect of the centres' activities. In two short case studies, deputy commissioner Kate Fraser charted the progress of mental defectives attending local centres by referring to their 'usefulness' and ability to earn money. She even linked the happiness of mental defectives to their ability to work:

A little imbecile girl, certified, living in her own home was restless and difficult and so causing overstrain and irritability at home. I got her admitted to an Occupation Centre, which she attends most regularly, has learned to knit, and can now help to wash up dishes and do simple housework. Consequently, she feels she is useful and is bright and happy.

A feeble-minded young man, certified, and under guardianship in his own home, had meningitis in infancy, and was very deaf. He was admitted to an Employment Centre where he has become one of the most skilful basket-makers, and gets quite a good return for his work.<sup>119</sup>

There were economic advantages in this work-centred approach to community care. Care committees were able to sell the produce of defectives attending the centres. In 1933, the Paisley employment centre made over £13 during a sale of its handicrafts. However, the volunteers and GBCS commissioners were influenced by more deep rooted concerns. Mental deficiency had long been linked to unemployment through notions of social inefficiency.<sup>120</sup> The form of training offered to mental defectives in voluntary centres was shaped by the common association of 'normality' with employment and social 'respectability'. Even when the mental defectives were considered too 'low grade' to ever earn their own living, training was work-related because it aimed to enable defectives to become closer to what the voluntary staff conceived to be 'normality'.

Despite the GBCS's concern in the 1930s that local authorities were not giving enough support to voluntary organisations, the inter-war period saw the birth and rapid expansion of a new form of voluntary sector provision for mental defectives. Visiting

---

<sup>119</sup> *Ibid*, xxxii.

<sup>120</sup> For example, this association is made throughout the *Royal Commission on Feeble-Minded*, 1908.

committees, occupational centres and employment centres all flourished in response to the perceived shortage of public sector provision, particularly with regards to institutional accommodation. The GBCS encouraged and partly financed their expansion to compensate for its own inability to establish services for mental defectives that were comprehensive and universal. As a result, the number of people receiving specialised care and supervision on the grounds of mental deficiency in Scotland was also able to grow at a much faster rate than would have been achieved if the only forms of provision available had been those located wholly within the public sector. Furthermore, through the links established between the GBCS and the Scottish Association for Mental Welfare, a line of communication existed between commissioners, voluntary workers, and ultimately the mental defectives they supervised. Thanks to the voluntary sector, a greater number of those mental defectives created by the education system could remain within the state's gaze throughout their lives.

### *Conclusion*

The Mental Deficiency Act had not been fully implemented on a truly national scale by the end of the inter-war period. It had, however, expanded significantly and developed in ways that had not been envisaged in 1913. National crises brought on by war and economic depression helped push mental deficiency to the background of political debate, yet some administrators at least continued to devote time and resources to fulfilling the duties laid out in the act. In doing so, they had to develop strategies to overcome potential obstacles to increased special provision, such as financial restrictions, legal loopholes, uncooperative local authorities and inefficient local administrative structures.

The most important strategy was to rely more heavily on community-based services: notably private guardianship and voluntary committees. Through its policy of boarding-out, the Scottish Office had a long tradition of utilising community-based provision for mental defectives, whilst voluntary organisations had been visiting the homes of the poor since at least the nineteenth century, so developments in the inter-war period were not entirely novel. However, as commissioners themselves were prepared to comment upon, the degree to which private guardianship and voluntary sector care were utilised in the 1920s and 30s came as something of a surprise. Furthermore, what began as something of an expediency brought on by financial restrictions and a shortage of



asylum accommodation, led to a shift in attitude by which officials began to value community services more favourably.

That said, the inter-war period cannot be portrayed as a time when officials began to favour community-based care above institutional provision. Both the GBCS and the SED devoted considerable energy to directing the attention of Treasury officials and local authorities towards what they considered to be a critical shortage of institutional accommodation for mental defectives. Their efforts met with some degree of success, as institutional provision expanded considerably. By the start of the second world war, people labelled mentally defective were being incarcerated in large numbers, whilst many who were able to avoid institutionalisation found themselves segregated within the community in separate special classes, employment centres and occupation centres. The state had succeeded in implementing a policy of mass segregation. It had not succeeded in implementing a policy of universal segregation, but such a policy had never been part of the government's agenda.

## Chapter 6: The 'Manufacture' of Mental Defectives (1914-39)

Just as the expansion of local provision for mental defectives in Glasgow had led to an increase in the number of individuals labelled mentally defective in that city, so the attempts to implement the Mental Deficiency (Scotland) Act, 1913, on a national scale corresponded with an increase in labelling within the Scottish population as a whole. An individual in Scotland was therefore more likely to be labelled mentally defective in 1939 than in 1914. Of course, some people were more likely to be labelled than others. Those doctors, teachers and administrators involved in the labelling process looked for individuals who seemed to match the definitions of mental deficiency provided in the 1913 act (and the earlier Education Act of 1906): children who did not appear to be benefiting from education in the ordinary classrooms, people who could not manage their own affairs, and people requiring additional care and supervision for their own protection or the protection of others, as a result of apparently sub-normal mental ability.<sup>1</sup>

An analysis of labelling by age, gender, locality and class reveals that certain demographic groups contained disproportionately high numbers of people regarded as mentally defective. One possible explanation for this put forward at the time by doctors and psychologists was that low intelligence was more widespread amongst some groups than others. However, historians of mental deficiency have argued that doctors and administrators 'targeted' certain groups.<sup>2</sup> The uneven distribution of mental deficiency amongst different sections of society reflected an unevenly developing mental deficiency administration, whose gaze penetrated some areas of society to a greater degree than others. Furthermore, the Mental Deficiency Act itself was framed in such a way as to direct the attention of those involved in the labelling process to particular social groups.

These social and administrative factors need not constitute an outright refutation of the earlier medical explanation: indeed, contemporary doctors and administrators could argue that mental deficiency was more prevalent amongst certain social groups, whilst conceding that the obligations to identify mental defectives under the 1913 act were

---

<sup>1</sup> The Mental Deficiency and Lunacy (Scotland) Act, 1913, s. 1.

<sup>2</sup> M. Thomson, *Problem of Mental Deficiency*, 241.

interpreted and implemented in different ways across the country.<sup>3</sup> Although doctors and administrators achieved a certain level of agreement over the kinds of criteria by which a person could be judged to be mentally defective, practices continued to vary and change, not least because the condition was constantly being re-constituted to include an increasing proportion of the population.

### *The Continuing Increase in Mental Deficiency*

Following the rationale set out in chapter 4, the increase in mental deficiency can be measured by referring to various large scale surveys conducted at different times over the period. Alternatively, it can be measured by looking at the number of certified individuals in receipt of special education, institutional care or private guardianship for mental defectives. The former method has the advantage of extending beyond the confines of state provision, but includes some individuals who, whilst identified as mentally defective by those conducting the survey, may not have been regarded as such in the course of their everyday lives (eg. at school, home or work). The chief advantage of the latter method is that by taking into account every certified individual in receipt of some form of special provision, the historian is able to focus on people who regularly experienced the effects of being labelled mentally defective: through their segregation within the education system, or their removal from the family home to institutions or non-familial guardians, or through the additional state assistance and supervision given to familial guardians of registered defectives.

After 1911, the decennial censuses for Scotland no longer took into account mental deficiency or its various sub-categories: a reflection of the growing dissatisfaction amongst medical specialists and census commissioners regarding the reliability of census returns on this issue.<sup>4</sup> The large scale surveys conducted during the inter-war period used doctors or psychologists to identify mental defectives rather than relying on the word of lay members of the public (as the decennial censuses used to do). The inter-war surveys usually concentrated on children of school age because the education system provided an ideal arena for medical officers and psychologists to examine large numbers of the population.

---

<sup>3</sup> See for example, NAS ED 28/231, *SED Circular No. 105* (1<sup>st</sup> Sep. 1937).

<sup>4</sup> See c. 4.



In 1921, the SED conducted a national survey based on returns from school medical officers and found that around 5,000 (approximately 5 per 1000) of the school population of Scotland was mentally defective. According to a circular drafted (though never distributed) by the department in 1926, this figure was regarded as an underestimate. The draft circular referred to the estimate made by Sir George Newman, Chief Medical Officer for the English Board of Education and Board of Health, that 8.6 per 1,000 of the school population of England was mentally defective. If this figure was applied to Scotland, the incidence of mental deficiency amongst 5-16-year-olds would have come closer to 8,000.<sup>5</sup>

The GBCS's *Annual Report* for 1925 gave details of the only major survey of the period to include all age groups. It presented figures from the SED census alongside the results of its own inquiry conducted by medical officers working for parish councils and district boards of control. Although the report admitted that there 'may have been slight overlapping in some cases', the various returns suggested that there were 12,969 defectives throughout Scotland.<sup>6</sup> From the total population of Scotland given in the census of 1921, this would give a figure of 2.6 per 1000 of the population. Of these, there were 6,398 mental defectives of school age (between 5 and 16 years inclusive) in Scotland including those accommodated in special classes, ordinary classes, institutions, under private guardianship or not receiving any form of special provision. These mentally defective children represented 6.6 per 1000 of the school-aged population.

The two major surveys of the 1930s both focused entirely on children and were both conducted by psychologists, whereas the SED and GBCS enquiries in the 1920s were conducted by local medical officers, many of whom still relied on traditional diagnostic methods instead of, or in conjunction with, psychological tests.<sup>7</sup> Since 1917, psychologists had made considerable inroads into Scottish education, with several universities instituting Bachelor of Education degrees containing substantial psychology components.<sup>8</sup> The first world war had helped to raise the profile of psychology, but the most notable developments had occurred in America rather than the UK. Mental testing became a standard feature in the recruitment of US soldiers following a wartime testing programme led by the psychologist Robert Yerkes, adapted from the group tests devised

---

<sup>5</sup> NAS ED 28/230, draft SED circular (6<sup>th</sup> Dec. 1926).

<sup>6</sup> HMSO, *GBCS Annual Report* 1925, lvii.

<sup>7</sup> For an account of what is meant by traditional diagnostic methods, see c. 4.

<sup>8</sup> Sutherland, *Ability, Merit and Measurement*, 128-9.

by his colleague (and rival) Lewis Terman.<sup>9</sup> Terman's group tests were a variation on those developed by Binet and Simon, but whilst the French psychologists had intended them to be administered orally on an individual basis, Terman experimented with written tests that could be administered to large numbers of people simultaneously. Psychological mental testing did not become a prominent feature of recruitment in the UK army, but the notion of group testing did attract the interest of British psychologists such as Cyril Burt and Godfrey Thomson. Burt became the most well known (indeed notorious) of the two, owing to his role in shaping the English education system and his alleged falsification of data intended to substantiate some of his theories. Thomson features more prominently in Scottish developments.

Thomson was appointed from the Chair of Education in Newcastle to the Chair of Education at Edinburgh University in 1925 and became a key figure in the Scottish Council for Research in Education, founded five years later. It was largely as a result of Thomson's influence that the Council chose as its first major undertaking a comprehensive survey aiming to measure the intelligence of every single eleven year old child in Scotland in 1932. Approximately 90,000 children were examined using a group test developed by Thomson which became known as the Moray House Test. Ineducable children and children residing in institutions were included in the inquiry. A sample of 1,000 children were also tested individually: Thomson believed individual tests to be the most accurate method of assessing mental ability and could therefore be compared to the group tests, with the results from the latter being calculated to correspond more closely with those of the former.<sup>10</sup>

The test consisted of two pages of pictorial questions and five pages of verbal questions, but owing to faulty instructions, the results of one of the pictorial pages had to be abandoned. The pictorial tests asked pupils to identify similar pictures of objects or symbols belonging to the same group: for example, pupils were shown pictures of a horse, a cow and a sheep and were then asked to pick one more object that belonged most obviously with the others, out of a small bird, a fish, a man, a parrot and a goat. The verbal tests made pupils think about the relationships between words; asking them to identify words with similar or opposite meanings, as well as presenting them with puzzles, sentences and arguments requiring completion. The aim was to measure the

---

<sup>9</sup> M. Thomson, 'Status, Manpower and Mental Fitness', 158.

<sup>10</sup> Sutherland, *Ability, Merit and Measurement*, 128-144.

pupils' intelligence, rather than the knowledge they had acquired during the course of their education.<sup>11</sup>

The survey was the first in its kind in Scotland to attempt to measure national intelligence on a single numeric scale (I.Q.) rather than grade pupils' intelligence by grouping them into categories such as idiot, imbecile, feeble-minded, dull and backward, ordinary etc. The Council's final report drew some general conclusions about the incidence of mental deficiency, which it defined in terms of the rule of thumb commonly used by psychologists that anyone with an I.Q. below 70 was likely to be mentally defective (an IQ of 100 was considered representative of average intelligence). The Council found that, '[i]f 70 I.Q. be taken as the boundary line separating the dull from the "mentally defective," it appears that not fewer than 1½ and not more than 3 per cent. of children born in 1921 fall within this category'.<sup>12</sup>

This noticeably vague estimate reflected the Council's uncertainty regarding the test's accuracy in measuring intelligence at the lower end of the scale. The Council had been particularly interested in using the survey to measure children with high levels of intelligence, with the result that the tests used were deemed less suitable for mental defectives. The vast majority of the questions in the test were verbal and the Council believed that this would make it difficult to accurately distribute children whose reading ability was less developed. With this reservation, the report adopted a cautious approach to its finding on mental defectives, stating that 'it would be rash in the extreme to assume that the "mental defectives" in Scotland represent as many as 2 per cent. of the school population'.<sup>13</sup>

As stated earlier, the results of the group tests were calibrated in line with the findings of the individual tests conducted on 1,000 children. However, the Council came to regard this as a weakness. The method by which the 1,000 children had been originally sampled came under criticism for failing to accurately represent the spread of intelligence across the population. To rectify this apparent problem, the Council resolved to obtain a new sample of children, testing every child in Scotland born on the first day of February, May, August and November in 1926. The tests were conducted by

---

<sup>11</sup> The tests are printed in full in the appendix to Scottish Council for Research in Education, *Intelligence of Scottish Children*, 125-157.

<sup>12</sup> *Ibid*, 123.

<sup>13</sup> *Ibid*.



A.M. Macmeeken, from the psychology department of Edinburgh University, between 1935 and 1937. In line with the earlier individual tests used in the earlier survey, the Macmeeken adopted Terman’s 1916 Stanford Revision of the Binet-Simon Tests with certain modifications introduced to suit Scottish rather than American children (translating occasional usage of American terminology, etc).<sup>14</sup> The results of the new inquiry were published in 1939 and concluded that 1.26% of the children were mentally defective, having an IQ below 70.<sup>15</sup>

**Table 6.1: SUMMARY OF SURVEYS SHOWING INCIDENCE OF MENTAL DEFICIENCY WITHIN THE SCOTTISH POPULATION DURING THE INTER-WAR PERIOD.**

Date	Survey by	Population	No. of Mental Defectives per 1000 of Scottish Population
1921	SED	School-aged population	5 (actual found) 8.6 (estimated figure)
1925	GBCS	School-aged population	6.6
1925	GBCS	Total Population (children and adults)	2.6
1932	Scottish Council for Research in Education	Every 11-year-old in Scotland	15-30 (but probably less than 20)
1939	Scottish Council for Research in Education	Recalibration of 1932 survey based on approx. 1,000 new tests	12.6

Sources: NAS ED 28/230, draft SED circular (6<sup>th</sup> Dec. 1926); HMSO, *Annual Report of GBCS 1925*, p. lvii; Scottish Council for Research in Education, *The Intelligence of Scottish Children*, p. 123; A.M. Macmeeken, *The Intelligence of a Representative Group of Scottish Children*, p. 138.

Between 1921 and 1939, Scotland’s large scale surveys showed a distinct rise in the proportion of the population regarded as mentally defective, although the picture was complicated by doubts expressed by those who conducted the surveys. In 1921, the SED found that 5 per 1000 of its school population was mentally defective but was prepared to accept that the real figure could be as high as 8.6 per 1000. In 1925, the GBCS offered figures to suggest that 6.6 per 1000 of the school-aged population was mentally defective but also showed that amongst the entire population (adults and children) only 2.6 per 1000 were identified as such. In the report on the 1932 survey of every 11-year-

<sup>14</sup> A.M. Macmeeken, *Intelligence of a Representative Group of Scottish Children* (London: University of London Press, 1939), 2-13.  
<sup>15</sup> *Ibid*, 138.

old child in Scotland, the Scottish Council for Research in Education suggested that between 15 and 30 per 1000 of those tested were mentally defective but then went on to say that the real figure was not likely to be as high as 20 per 1000. The recalibration of those results published in 1939 put the figure at 12.6 per 1000. Despite the complexities of these statistics, it is clear that the figures presented in the 1930s were significantly higher than those presented in the 1920s (see table 6.1).

Likewise, the number of individuals in receipt of segregated state provision for mental defectives rose in Scotland during the inter-war period. SED statistics show that the proportion of Scottish pupils on the school roll in receipt of special education more than doubled from 2.8 per 1000 in the school year 1919-20 to 6.2 per 1000 in 1937-8 (2482 pupils in 1929-30 to 4800 in 1937-8, against a slight overall decline in Scotland's school-aged population).<sup>16</sup> The total number of people in Scotland (combining SED and GBCS statistics) receiving special education, institutional care or state-supervised private guardianship also doubled from 4259 in 1919, to 9,782 in 1938.<sup>17</sup>

Approximately 0.9 per 1,000 of Scotland's population were being treated as mentally defective by the authorities in 1919 (assuming the total population of Scotland to be 4,882,288, in accordance with the census of 1921). Approximately 2.0 per 1,000 of Scotland's population were receiving segregated provision for mental defectives in 1938 (assuming the total population of Scotland to be 4,842,980, in accordance with the census of 1931).

This rise can partly be explained on administrative grounds. As more local authorities began to fulfil their obligations under the Mental Deficiency Act, more people came to be certified as mentally defective. For instance, in the school year 1919-20 only a third of Scotland's education authorities had their own special schools and classes for mental defectives. By 1937-8 the figure was close to two thirds.<sup>18</sup> Not surprisingly, the number of mental defective pupils in Scotland nearly doubled during the same period that the proportion of local education authorities holding special classes similarly expanded.

But the increase in the number of people labelled mentally defective was not simply caused by new local authorities taking an interest in this kind of provision. Rather,

---

<sup>16</sup> See appendix 1.

<sup>17</sup> GBCS figures taken from HMSO, *GBCS Annual Report* 1938, 41.

<sup>18</sup> NAS ED 28/231, *SED Circular No. 105* (1<sup>st</sup> Sep. 1937).

throughout the inter-war period, different influential groups continued to expand the boundaries of mental deficiency: in effect, broadening its definition to include people with higher grades of ability. For this reason, the proportion of the population labelled mentally defective grew even in those areas that already had well-established special services. For instance, Glasgow's education authority had been administering its special education system since the late nineteenth century. Yet, the proportion of the city's school children labelled defective during the inter-war period still rose dramatically from 8 per 1000 pupils on the city's school roll in 1919-20 to 14 per 1000 in 1937-8.<sup>19</sup>

Contemporaries were aware that the criteria by which individuals were identified as being mentally defective were continuing to broaden during this period. For instance, Dr. R. D. Clarkson, then Medical Superintendent of Larbert, told a government Committee on Scottish health services in 1935 that 'the number of mental defectives is increasing very largely' but 'this is due to different diagnosis. Forty years ago almost half of the cases that are now being certified as mentally defective would not have been so certified'.<sup>20</sup>

Not every local authority encouraged this expansion in labelling. Certain school medical officers, particularly those working in the Highlands, felt that the feeble-minded label unnecessarily stigmatised children with low educational attainment. The problem was discussed within the SED when the Department came to consider a report it was due to present to a government Committee on the Scottish Lunacy and Mental Deficiency Laws in 1938 (the report itself was not published until 1946, its work being delayed by the war). One SED inspector, Allan L. Rodger, described the situation as follows:

[a]nother obstacle to progress in matters relating to the care and educ[ation] of MD children is the stigma which many people, unfortunately attach to the condition. Because of this attitude (not confined entirely to the man-in-the-street), some doctors are reluctant to say that a child is MD and many teachers refrain from directing the doctors attention to possible cases and a few parents resist the verdict.<sup>21</sup>

---

<sup>19</sup> See appendix 1.

<sup>20</sup> HMSO, *Report of Department of Health for Scotland's Committee on Scottish Health Services* 1936 (Cmd. 5204, 1935-6), 60.

<sup>21</sup> NAS ED 28/228, Departmental Committee on the Scottish Lunacy and Mental Deficiency Laws: private memo by A.L. Rodger (2<sup>nd</sup> May 1938).



Even within Glasgow's education authority, Scotland's flagship authority where special education was concerned, there was contention. John Grimmond's letter to the *Glasgow Herald* in 1921, illustrates how some contemporaries involved in educational policy contested the increased use of the mental deficiency label. Grimmond, it will be recalled, was himself a member of the education authority and his letter provides the accusation upon which the title of this thesis is based: namely that, 'the present policy tends to manufacture mental defectives'.<sup>22</sup>

Surprisingly, Grimmond's verdict was to be substantiated by the education authority's own school medical officer responsible for mental deficiency. Dr Robert Marshall was appointed to the post after Carswell became a medical commissioner for the GBCS in 1914. Marshall had been assistant superintendent at Gartnavel Asylum and his appointment to the school board was made on the recommendation of Gartnavel's chief medical superintendent, Landel Rose Oswald (who had been offered the job himself, but declined).<sup>23</sup> Judging from his journal publications, Marshall's real interest lay in insanity rather than mental deficiency<sup>24</sup> but as 'Consulting Neurologist' to Glasgow Education Authority it is extremely probable that he diagnosed more mentally defective children in the first twenty years following the Mental Deficiency Act than any other individual doctor in Scotland. The majority of these were feeble-minded children, destined for special education, which makes it all the more remarkable that in 1931 the *Scottish Educational Journal* reported a speech delivered by Marshall to the Scottish Association for Mental Welfare, in which the Consulting Neurologist claimed that '[f]eeble-mindedness was a legal fiction, and not a disease'.<sup>25</sup> Marshall viewed the medical diagnosis and certification of feeble-minded children as little more than bureaucratic procedures made necessary by law for transferring pupils with poor educational ability into special classes. The *SEJ*'s reporter described his speech as 'interesting' and little else was said on the matter, suggesting that neither the journal's editorial staff, nor its readership found Marshall's comments particularly controversial.

---

<sup>22</sup> *Glasgow Herald* (19<sup>th</sup> Dec. 1923), 7.

<sup>23</sup> GCA D-ED 1/1/1/17 *Minutes of School Board of Glasgow* (4<sup>th</sup> Mar. 1914), 645-646.

<sup>24</sup> Marshall's publications included: 'Intra-Cranial tumour with Mental Symptoms', *Journal of Mental Science* (1909); 'Periodic Attacks of Excitement and Depression in the Chronic Insane', *Journal of Mental Science* (1911); 'Differential Diagnosis of Manic Depressive Insanity and Dementia', *Glasgow Medical Journal* (1913).

<sup>25</sup> *Scottish Educational Journal* 14 (1931), 606.

Continuing a trend begun in Glasgow in the late nineteenth century, the expansion of special provision in Scotland occurred alongside an increase in the number of people labelled mentally defective. The increase in the number of mental defectives occurred partly because more local authorities were fulfilling their legal obligations but also because the borderline between defective and ordinary intelligence continued to be raised, with the result that people with higher level of abilities were now being regarded as mentally defective. Some contemporaries publicly questioned the assumption that all of those labelled actually had a medical disorder. However, scepticism regarding the medical basis of certification did not necessarily constitute an attack on segregated provision *per se*: as Marshall demonstrates, it was possible to view feeble-mindedness as a purely legal category yet still actively support special education.

### *Psychology and Mental Testing*

The increase in mental deficiency began in Glasgow before the Binet Simon tests could make an impact on diagnostics (although Kate Fraser had pioneered the tests in Govan, the neighbouring school board of Glasgow had already expanded its concept of mental deficiency to include children who seemed to possess higher levels of ability).<sup>26</sup>

However, if mental testing was not responsible for the initial increase, it is at least possible that the tests helped enable the rise to continue into the inter-war years. This seems to have been what R.D. Clarkson meant when he said that the rise in the number of mental defectives was due to 'different diagnosis'. However, it would be a mistake to assume that mental testing exerted a profound impact on the way defectives were identified before World War II, despite the fact that psychologists successfully carved out a more prominent role for their sub-profession during the period. Certainly, mental testing dominated the large scale surveys of the 1930s but their influence on the day-to-day diagnoses of mental defectives is less striking.

Psychologists did extend their role within the special education system. In 1922, Jordanhill College (a teacher training college located on the western outskirts of Glasgow) began Scotland's first course for teachers working with mental defectives. The National Committee for the Training of Teachers, a body made up of representatives of Scotland's Education Authorities, invited Cyril Burt to run the course but finally settled on the Scottish psychologist, Dr D. Kennedy Fraser after Burt

---

<sup>26</sup> See c. 4.

declined the offer. The course touched on practical and theoretical issues associated with the teaching of mental defectives, as well as tuition on making 'accurate diagnosis through testing'.<sup>27</sup> It enabled an increasing number of Scottish special teachers to gain an understanding of mental testing: the figures available indicate that around 250 teachers had attended the classes by 1937.<sup>28</sup> However, the level of understanding they could achieve is open to question, particularly as the course was drastically shortened from one year to a single term in 1923.

Whilst psychologists made some significant inroads within the special education system, they did not replace the more established school medical officers. When Kennedy Fraser was appointed to Jordanhill, Glasgow education authority took the opportunity to employ him as Scotland's first school psychologist. His role was purely advisory and although he quickly instigated a programme of mental testing, the results confirmed rather than challenged the diagnoses already made by Marshall.<sup>29</sup> The final decision as to whether a child was mentally defective or not remained the prerogative of the Consulting Neurologist. Furthermore, Marshall treated IQ tests with a polite scepticism, maintaining that educational ability rather than an abstract notion of intelligence should be the primary consideration in determining the category of mental deficiency. During his address in 1931, he described the criteria he used to categorise mental defectives. His thoughts on distinguishing an imbecile from a feeble-minded child were reported as follows;

[t]he psychologist...had come to the physician's aid by laying it down as a working rule that if an individual had not a mental ratio of 50 per cent. he was probably an imbecile.

Experience, however, had shown that it was always a matter of chance to exclude from the special schools any child with a mental ratio round 50 per cent. on the ground of imbecility.

---

<sup>27</sup> Macmillan, 'Origins and Evolution', 203-204.

<sup>28</sup> NAS ED 28/228, SED Scottish Education Department, memorandum on the education and care of mentally defective children for Departmental Committee on the Scottish Lunacy and Mental Deficiency Laws (1938).

<sup>29</sup> GCA D-ED 9/1/35 Glasgow Education Authority, *Annual Report on Medical Inspection of School Children* 1923-4, 11.



The wisest thing to do in such circumstances was to submit the child to the crucial test of attendance at the special classes for at least a year. If at the end of that time he had not benefited by the instruction, he could then be excluded with confidence as uneducable...<sup>30</sup>

When distinguishing a normal from a feeble-minded child, Marshall did not even mention IQ testing. Instead, he argued 'the criterion should be purely a scholastic one – incapacity to receive proper benefit from instruction in the ordinary classes'.<sup>31</sup> In other words, his decision would be reached in consultation with the child's teachers and based on the pupil's performance at school.

It should not be surprising that school medical officers were reluctant to commit themselves wholeheartedly to mental testing, considering that those doctors who traditionally controlled access to the special classes could easily view psychologists as potential rivals. In its 1937 circular, the SED attempted to persuade local authorities to make greater use of mental tests whilst reassuring school medical officers that their own positions would not be undermined as a result:

[w]hile the services of a psychologist or a teacher trained in mental testing are of great value in the preliminary selection of cases, the position of the school medical officer in any adequate scheme of ascertainment is of the first importance. It is essential that he should have knowledge and experience of testing mental capacity. Mental tests have passed beyond the stage of experiment. If applied with skill, tact and judgement and with due regard to the limitations of the intelligence quotient as an absolute diagnosis, they are very useful instruments and should form an integral part of every examination of suspected mental defect.<sup>32</sup>

That this appeal came at the end of the inter-war period rather than the start, indicates that the new techniques took some time to gain widespread acceptance. It should also be noted that the SED's confidence in the tests were not without reservation. The circular referred to the tests' 'limitations': the SED intended them to supplement and improve

---

<sup>30</sup> *Scottish Educational Journal* 14 (1931), 606.

<sup>31</sup> *Ibid.*

<sup>32</sup> NAS ED 28/231, *SED Circular No. 105* (1<sup>st</sup> Sep. 1937).

upon more established diagnostic methods, rather than replace them.

It is important to bear in mind that contemporaries did hold reservations about mental testing, particularly considering that such techniques have, in recent times, come under extensive criticism. Whilst drawing attention to the modern perception of mental tests as ‘instruments of bias, primarily designed to justify social inequality’, Mathew Thomson has sought to show that those involved with their development and application in the inter-war period frequently acknowledged at least some of their shortcomings.<sup>33</sup>

Thomson’s argument seems to be corroborated by the research undertaken for this study: take, for example, the willingness with which the Scottish Council for Research in Education criticised and revised its 1932 survey. Even the recalibrated results of 1939 were expressed in the most cautious terms: after stating that 1.26 per cent of the population was mentally defective, the Council qualified itself by stating that ‘there are 68 chances in 100 that the “best” percentage of our data will lie between .92 per cent. and 1.63 per cent (ie. 1.26)’.<sup>34</sup>

To add to the uncertainty, it should be born in mind that the results of IQ tests could be influenced by issues such as sampling, the degree to which the tests focused on arithmetic as well as verbal skills, and the degree to which literacy was a necessary precondition to scoring highly. Furthermore, the tests could be criticised for assuming that intelligence was capable of being accurately quantified on a unitary scale (ie. that each child had a single level of intelligence, instead of a variety of different aptitudes across numerous forms of intellectual activities), and they assumed that intelligence could be identified and measured separately from acquired knowledge. From the literature at the time it is apparent that psychologists acknowledged and debated these points, but as Gillian Sutherland has pointed out, psychologists at this time were also engaged in a media campaign to convince the public of the ‘respectability’ and ‘social utility’ of their techniques.<sup>35</sup> Despite the many flaws underlying its calculations, the Scottish Council still advanced the figure of 1.26% as a serious estimate of the incidence of mental deficiency.

There was, however, a more serious problem that psychologists were less prepared to

---

<sup>33</sup> M. Thomson, *Problem of Mental Deficiency*, 242.

<sup>34</sup> Macmeeken, *Intelligence of a Representative Group of Scottish Children*, 138.

<sup>35</sup> Sutherland, *Ability, Merit and Measurement*, 145.

discuss: namely that the tests were not designed to provide the kind of information that the authorities were looking for. Within the special school system, school medical officers did not simply seek to identify individuals who could be considered defective in terms of the rather abstract notion of intelligence implicit in the intelligence quotient. Rather, they attempted to discern whether a child was capable of being educated in an ordinary class, a special class, or whether the child was ineducable within the day school system. According to the definitions provided in the Mental Deficiency Acts and Education Acts, these criteria determined the category of mental defect that a child should be placed into. For this reason, Marshall believed that the only sure way to determine whether or not a child was ordinary, feeble-minded or imbecile was to assess the pupil's educational performance (in consultation with the teacher) and if necessary prescribe trial periods in special classes for further observation.

Within the mental deficiency institutions, where the teaching of school subjects featured less prominently in comparison to Scotland's special day schools and classes, educational ability was less of a concern. Nonetheless, as institution superintendents gradually began to use mental tests, the limitations of testing continued to reveal themselves. This can be illustrated with reference to some case histories from Lennox Castle's correspondence files, all of which were produced at the end of the period examined here. In 1939, the GBCS asked the institution's superintendent, Dr Chislett, to send the General Board details of certain patients being considered for boarding-out. Chislett's communication referred to the mental age of patients but also provided information on their physical condition, behaviour and ability to perform domestic labour: information that could not have been revealed through mental testing, but was highly relevant to the authorities in determining whether or not the patient should be boarded-out. Examples include:

T.H. [male]<sup>36</sup>, aged 46 years...is feeble-minded, his mental age being equal to that of a person of 7 years of age. Is simple, facile and well-behaved. Physical condition is good.

C.E. [female], aged 46 years...is feeble-minded, her mental age being equal to that of a person of 8 years. Is very childish, and occasionally emotional. Physical condition is good.



A.F. [female], aged 36 years... is a feeble-minded person, her mental age being equal to that of a person 9 to 10 years. She is childish in manner and behaviour, but has given no trouble since admission, and is a good house worker. Physical condition is fairly good.<sup>37</sup>

A more detailed comparison between test results, and the more impressionistic evaluations made by doctors can be made with the following case study. In 1940, the GBCS asked Chislett to provide information on a female patient, V.F., who had been offered employment as a domestic servant to a Dunfermline family, providing she could be released from Lennox Castle on licence. V.F. had already undergone an individual psychometric test, the results of which have been preserved in some detail. Contrasting the psychometric test results to the superintendent's final evaluation further demonstrates the limited value of the tests in making the practical choice as to whether to release the patient on placement. The test results gave details of her score in attention tests, her ability to correctly associate various pictures of objects, remember sentences of various length, and identify nonsensical associations of words and pictures. As a result of her performance, the report stated that she had a mental age of 12 years and an IQ of 84.

She also underwent a paper folding test, and the psychologist recorded his impression of her emotional state, stating that '[s]he is slightly suggestible. Emotionally she seems placid and throughout the test seemed at ease'.<sup>38</sup> This shows that the psychological evaluation did involve some attempt to measure V.F.'s suitability for work outside the institution, in terms of emotional behaviour and manual dexterity. However, the final decision as to whether she was suitable for boarding-out still involved an assessment of additional qualities. Chislett's final verdict was as follows.

She is a feeble-minded person with a mental age of 12 years. She is suggestible and I am inclined to believe emotional. I have formed the opinion that her capacity for practical work is probably good. She is a fairly good looking girl

---

<sup>36</sup> Original names have been replaced with initials and indication of gender to preserve anonymity.

<sup>37</sup> GHBA HB 20/1/44 Lennox Castle correspondence file, letter from Chislett to Secretary GBCS (20<sup>th</sup> Dec. 1939).

<sup>38</sup> GHBA HB 20/1/44 Lennox Castle correspondence file, letter from George GN Douglas, Public Assistance Officer for City and Royal Burgh of Dunfermline to Secretary GBCS (2<sup>nd</sup> Sep. 1940).

and because of her suggestibility will require very strict observation. If the Board is satisfied that such could be provided in the home of [details removed to preserve anonymity], I would be inclined to give this patient a chance.<sup>39</sup>

There are a number of points to make about this assessment. Firstly, Chislett describes V.F. as feeble-minded despite having an I.Q. of 84 (well above the 70 mark, accepted by psychologists as being the borderline between mental defectives and people who were merely dull or backwards). Secondly, Chislett contradicts the tester's view that V.F. was emotionally 'placid'. Thirdly, V.F.'s suitability for boarding-out was compromised by the fact that she was considered to be 'fairly good looking'. For this reason, she could only enter her post as a domestic servant if 'very strict observation' could be provided by the family intending to employ her. The I.Q. test did not assess V.F.'s likelihood of becoming sexually active, but the authorities considered this to be a prime concern. The label of feeble-mindedness and the form of provision arranged for V.F. were administered on criteria that went beyond abstract measurements of intelligence and embraced considerations of behaviour and social adaptability.

One final example relates to W.B., a thirty-four-year-old male mental defective. W.B. was boarded-out to a farm in Perthshire when he found himself in trouble with the law (the exact nature of his offences are not made clear). In preparation for his hearing at the local sheriff court, W.B. was given a pictorial I.Q. test (known as the 'Cattell Intelligence Tests') which resulted in him being given a mental age of 8½ and an IQ. of 47. However, when Dr James Curran (who had by then replaced Chislett as superintendent of Lennox Castle) came to give his statement for the Sheriff Court, he made a point of asserting that the intelligence tests only served to confirm opinions about W.B. that he had already formed in conversation with the man.

In conversation I found him to be simple with a paucity of ideas. His power of concentration and understanding is much below normal. I formed the opinion that he is unduly suggestible but when he has accepted a suggestion he is impervious to ordinary reasoning.

---

<sup>39</sup> GHBA HB 20/1/44 Lennox Castle correspondence file, letter from Superintendent of Lennox Castle to Secretary of GBCS (7<sup>th</sup> Sep. 1940).

He lacks foresight, judgement, and reasoning ability and would be unable to plan the expenditure of his earnings with ordinary care. His comprehension is insufficient to enable him to do other than routine labour under supervision and he would in my opinion be unable to adapt himself to conditions outside his routine.

Following my conversation with him, I assessed his intelligence by the Cattell Intelligence Tests, which are entirely non-scholastic. The result of these tests bore out the opinions I had formed during our conversation. His response to the tests showed poor comprehension, preservation of ideas, and rapid exhaustion of mental function. His intelligence is about 50% of normal.<sup>40</sup>

Although there are limits to the generalisations that can be made from a handful of examples of this kind, the evidence suggests that attempts to precisely measure individual intelligence were of secondary importance for people working in the mental deficiency system. Of more importance was the need to gauge the form of care and supervision that seemed most appropriate for each individual. Whilst the large scale surveys of national intelligence in the 1930s relied exclusively on various types of mental tests, the concepts of mental age and IQ were merely supplemental to the assessments conducted by workers within the mental deficiency administration. Amongst such workers, scholastic attainment, ability to engage in various forms of manual work and willingness or ability to conform to prescribed standards of behaviour were the criteria upon which mental defectives were assessed.

### *Who were the mental defectives?*

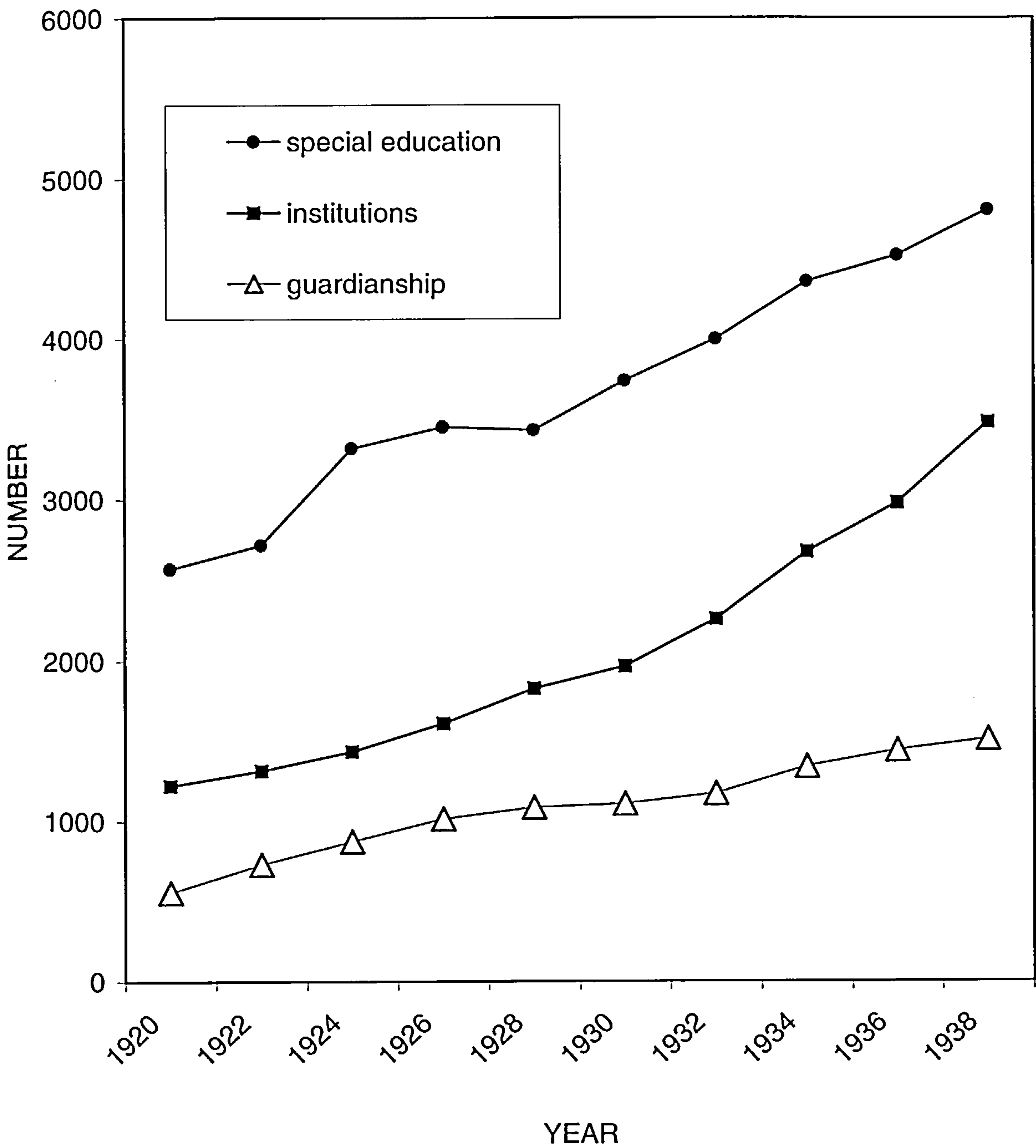
With this in mind, it is worth considering which kinds of people were more likely to be labelled mentally defective during the period. This is not the first study of this kind. Mathew Thomson's work on mental deficiency in England and Wales includes an analysis of institutionalised mental defectives, using figures compiled by the Registrar General's Office in 1949, followed by more qualitative analysis of case histories sampled from 55 adult mental defectives from London in the inter-war period. Thomson paid particular attention to age and gender. From his sample, men were more likely to be institutionalised when they were between the ages of 16-25. Women tended to stay in

---

<sup>40</sup> GHBA HB 20/1/44 Lennox Castle correspondence file, J. Curran, draft statement to sheriff court (26/11/43).



Figure 6.1: NUMBER OF MENTAL DEFECTIVES IN RECEIPT OF SPECIAL EDUCATION, INSTITUTIONAL PROVISION OR UNDER PRIVATE GUARDIANSHIP IN SCOTLAND (ALL AGES)



Sources: *Annual Reports of GBCS 1920-38*; NAS ED 55, SED Annual Statistics 1919-20 to 1937-8.

institutions longer than men, so institutionalised mental defectives over 25-years-old were more likely to be women. Thomson explains his results in terms of beliefs held by certifying officers and asylum superintendents. Males were most likely to be viewed as threatening when linked to discourses on crime and delinquency: 'social problems' generally associated with young men. Females were more likely to be seen as posing a sexual threat (described in both moral and eugenic terms), which led contemporaries to advocate greater levels of control throughout female adulthood to prevent them becoming sexually active.<sup>41</sup>

These arguments are compelling and warrant further investigation within the Scottish context. Expanding on Thomson's approach, the following survey will take into account every mental defective placed into Scotland's special classes, institutions or under private guardianship during the inter-war period. There has not been time to back up the statistical analysis with qualitative case studies (indeed, no equivalent to the 55 detailed case histories discovered by Thomson has been unearthed during research for the present study). Thomson's qualitative study has the advantage of illustrating how mental defectives could move in and out of various institutions over the course of their lives. The statistics used here obscure this aspect of institutional provision but it was common amongst those caught up in the mental deficiency systems north and south of the border. On the other hand, the present survey is more comprehensive in terms of the types of provision under examination and the geographical area covered.

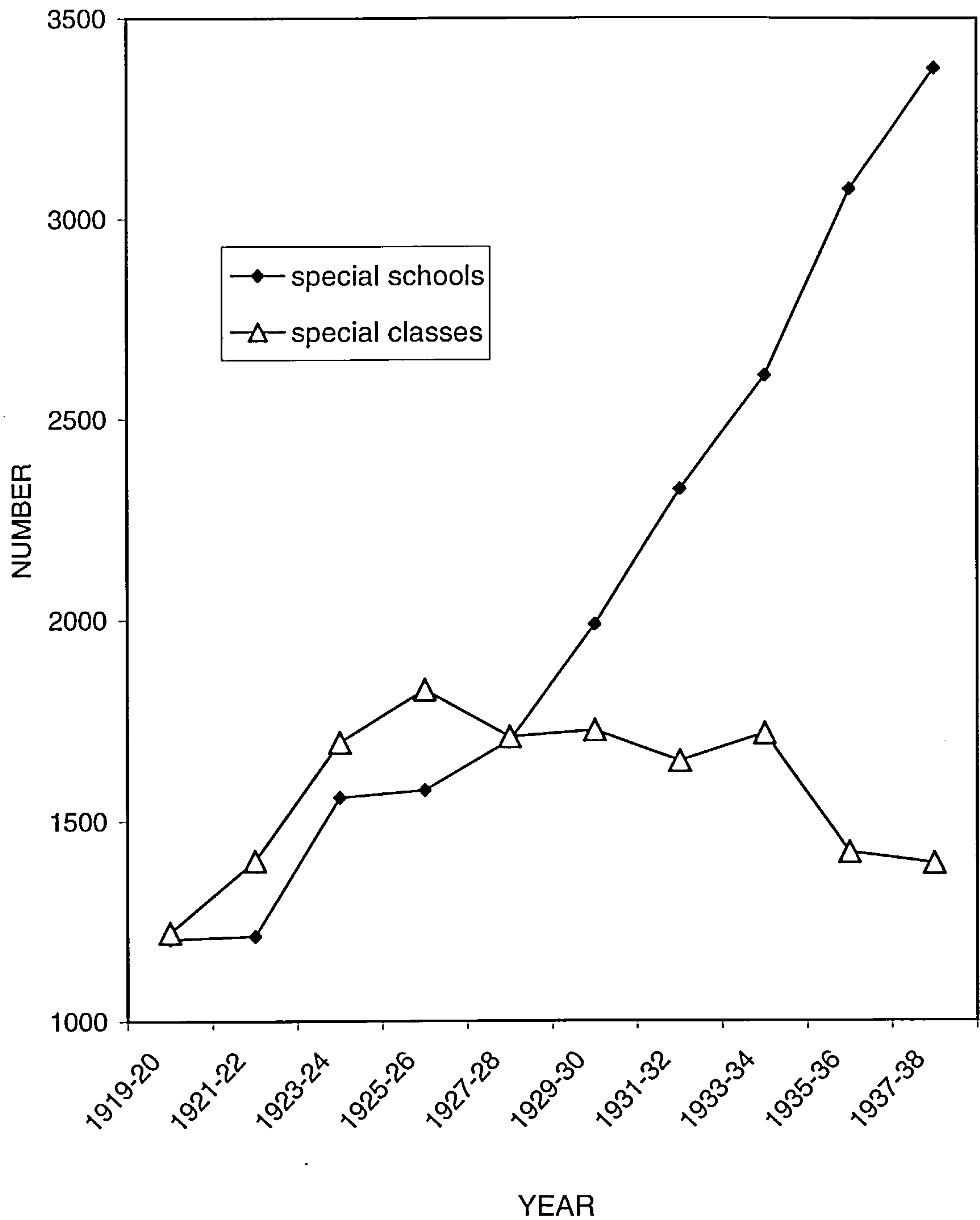
By correlating statistics from the SED and the GBCS it is immediately apparent that special education was by far the most common form of special provision for mental defectives (see figure 6.1<sup>42</sup>). Apart from the final year, the figures for special education were higher than those of institutionalisation and private guardianship combined. There are several reasons why special education in day schools and classes was the most common form of special provision. Special classes were cheaper to establish and maintain than institutions, and they were less disruptive in that special pupils did not have to move away from their family home to attend them. They also accommodated a demographic group (ie. children of school age) who were constantly subject to

---

<sup>41</sup> M. Thomson, *Problem of Mental Deficiency*, c. 7.

<sup>42</sup> Note that most of the charts presented here give raw figures rather than percentages of the population, in order to give the reader a picture of the actual numbers involved. The percentage of figures have also been calculated and the results correspond with the trends illustrated in this chapter.

Figure 6.2: NUMBER OF MENTALLY DEFECTIVE PUPILS  
ATTENDING SPECIAL SCHOOLS AND CLASSES IN SCOTLAND



NAS ED 55, SED annual statistics 1919-20 to 1937-38



numerous kinds of assessments and medical examinations, increasing their chances of being brought to the attention of the authorities.

The chart supplies an interesting corrective to much of the historiography of mental deficiency, which tends to emphasise institutionalisation and the influence of eugenics on the mental deficiency administration.<sup>43</sup> In numerical terms, special education was by far the most important of the various types of provision: it was in schools that most mental defectives were initially labelled and segregated. The chart shows that the vast majority of mental defectives in receipt of state provision were allowed to remain within the community, either attending special day classes or placed under private guardianship.

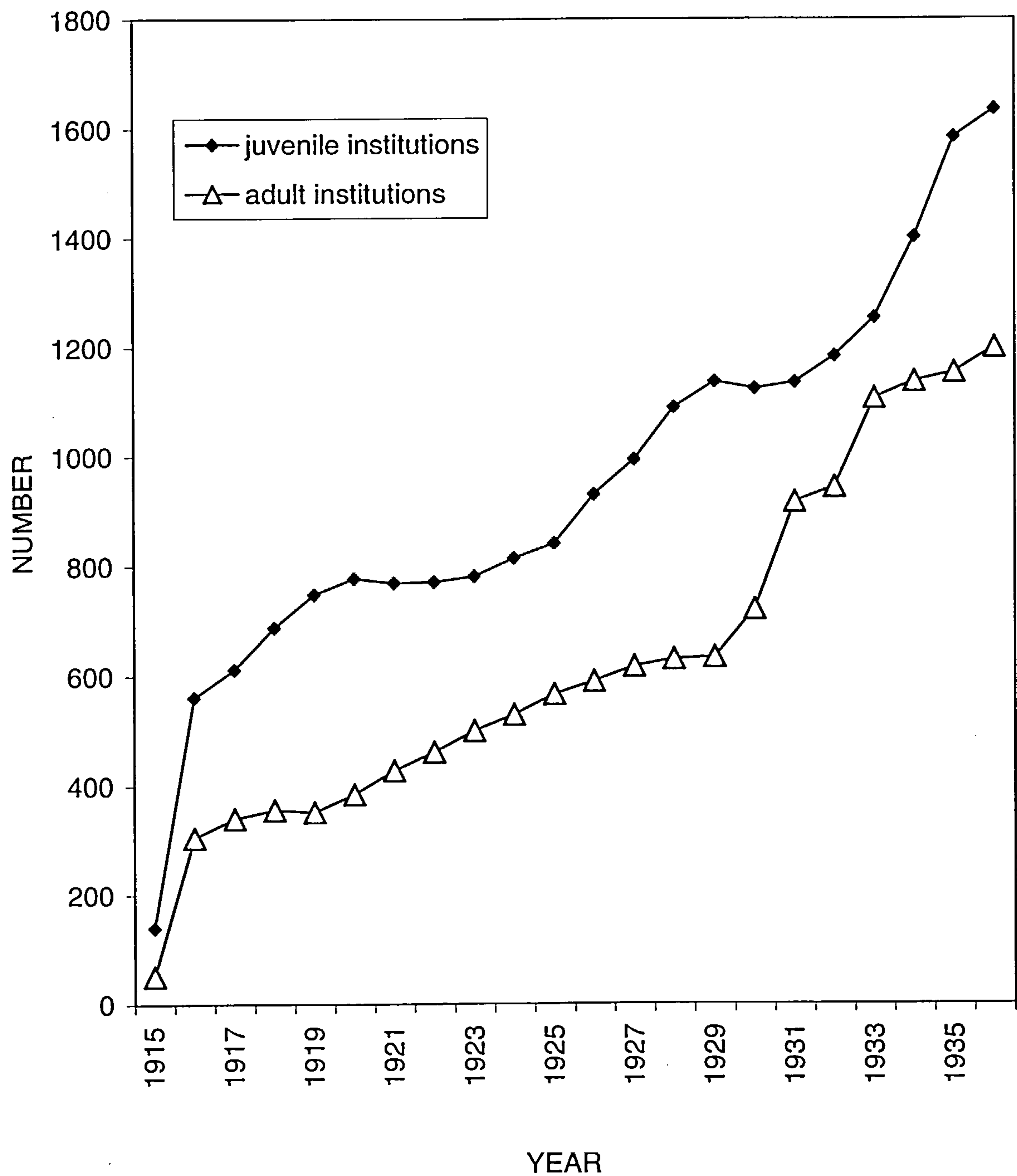
Despite this, mental defectives were increasingly segregated from mainstream society during the period. Special education removed children from the ordinary classroom, often to an entirely separate site from the other pupils, such as a special school or annexe. Throughout most of the 1920s, the majority of educable mental defectives were accommodated in special classes within ordinary schools. However, in the 1930s education authorities representing urban areas began to concentrate on special schools. Consequently, the majority of mental defectives in the latter decade were prevented from coming into any contact with ordinary pupils during school hours (see figure 6.2). Private guardianship did not necessarily mean segregation, as many officially recognised guardians were actually the parents of mental defectives or other family members. Nonetheless, the authorities generally preferred to use non-familial guardians, ideally located in rural areas.<sup>44</sup> This meant that many defectives under guardianship had been removed from their family home. Finally, although only a minority of mental defectives were accommodated in institutions, institutionalisation did increase at a faster rate than either of the other forms of provision (particularly in the 1930s, largely as a result of the opening of the large institution at Lennox Castle). Whilst it would be wrong to suggest that the mental deficiency administration was particularly geared

---

<sup>43</sup> Searle, *Eugenics and Politics in Britain 1900-1914*; Searle, 'Eugenics and Class'; G. Jones, 'Eugenics and Social Policy Between the Wars', 717-728, Freedon, 'Eugenics and Progressive Thought: A Study in Ideological Affinity', *Historical Journal* 22, 3, (1979), 645-671, Freedon 'Eugenics and Ideology', *Historical Journal* 26, 4 (1983) pp. 959-62. Whilst Mathew Thomson does not over-emphasise the role of eugenics, his account of English social policy on mental deficiency in England and Wales gives little consideration of special education despite the school system's crucial role in the identification and segregation of mental defectives: M. Thomson, *Problem of Mental Deficiency*.

<sup>44</sup> HMSO, *GBCS Annual Report 1928* (Cmd. 3413, 1929-30), 1-li; HMSO, *GBCS Annual Report 1936* (Cmd. 5408, 1937), xxx-xxxi.

Figure 6.3: NUMBER OF MENTAL DEFECTIVES IN INSTITUTIONS FOR ADULTS AND INSTITUTIONS FOR JUVENILES IN SCOTLAND



Sources: *GBCS Annual Reports 1915-1936*

towards incarcerating defectives, there was certainly a policy of mass segregation taking place.

Having introduced the various types of provision, it is now possible to look at the kinds of people who were targeted by the administration. The first point to make is that children were more likely to be segregated than adults. Figure 6.1 has already gone a long way to illustrating this point, as it is evident that the majority of mental defectives received special education in day schools, which was only available for children of school age. This is despite the fact that according to the 1931 census, less than 20% of the Scottish population were between the ages of 5-16.

GBCS statistics show that Scotland's institutions were also geared towards accommodating younger patients (see figure 6.3).<sup>45</sup> The statistics do not give inmates' exact ages, but the GBCS placed juveniles in separate institutions from adult defectives and the numbers accommodated in each type were recorded on an annual basis. There is a slight discrepancy in comparing the GBCS figures with those on special education because juvenile institutions housed defectives up to the age of 18, whilst the leaving-age for special school pupils was 16. Nonetheless, figure 6.3 still shows that most of Scotland's institutional accommodation was reserved for juveniles rather than older defectives and it should again be borne in mind that this was counter to the general demographic trend. Private guardianship was the only form of provision that, judging from the annual rate of admissions, was more geared to adult defectives.<sup>46</sup> Children capable of living at home were ideally to receive professional training and supervision through the education system, rather than from private guardians.

Having established that Scotland's mental deficiency administrators were primarily concerned with young people, it is now time to consider gender. Taking juvenile and adult institutions together, the proportion of male and female inmates remained roughly equal, though the males had a slight majority throughout most of the period. The gender difference becomes more noticeable when adult and juvenile institutions are compared. Male inmates were in a slight minority within the population accommodated in adult institutions, but had a more significant majority within the juvenile institutions (see

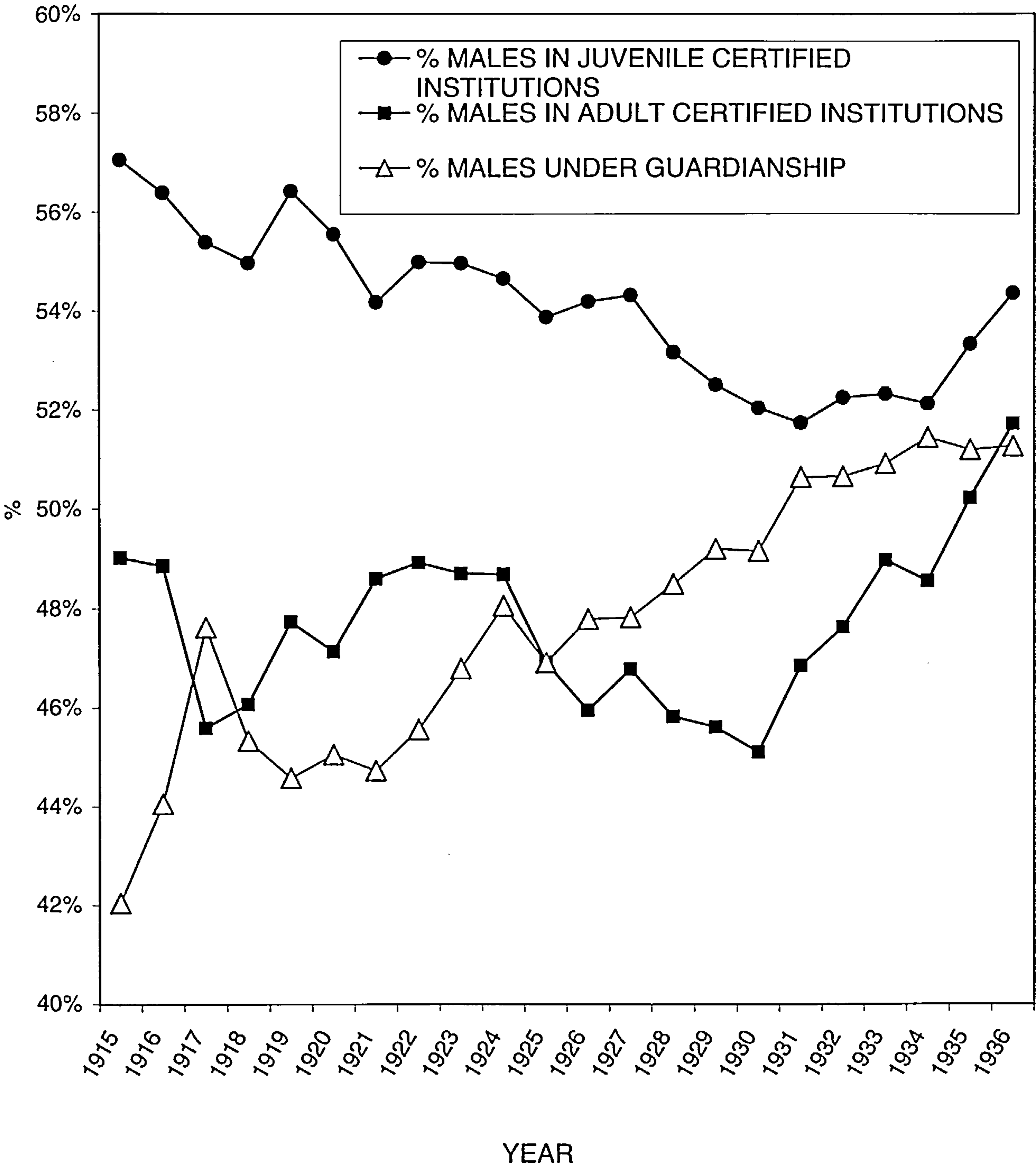
---

<sup>45</sup> Note that whilst the SED statistics on mental defectives are only available from the school year 1919-20, the GBCS statistics start from 1915. For this reason, charts using only GBCS statistics begin from the earlier date (ie. figures 6.3 and 6.4).

<sup>46</sup> HMSO, *GBCS Annual Reports* 1920-39.



Figure 6.4: PERCENTAGE OF MENTAL DEFECTIVES IN INSTITUTIONS AND MENTAL DEFECTIVES UNDER PRIVATE GUARDIANSHIP WHO WERE MALE



Sources: *GBCS Annual Reports 1920-38*

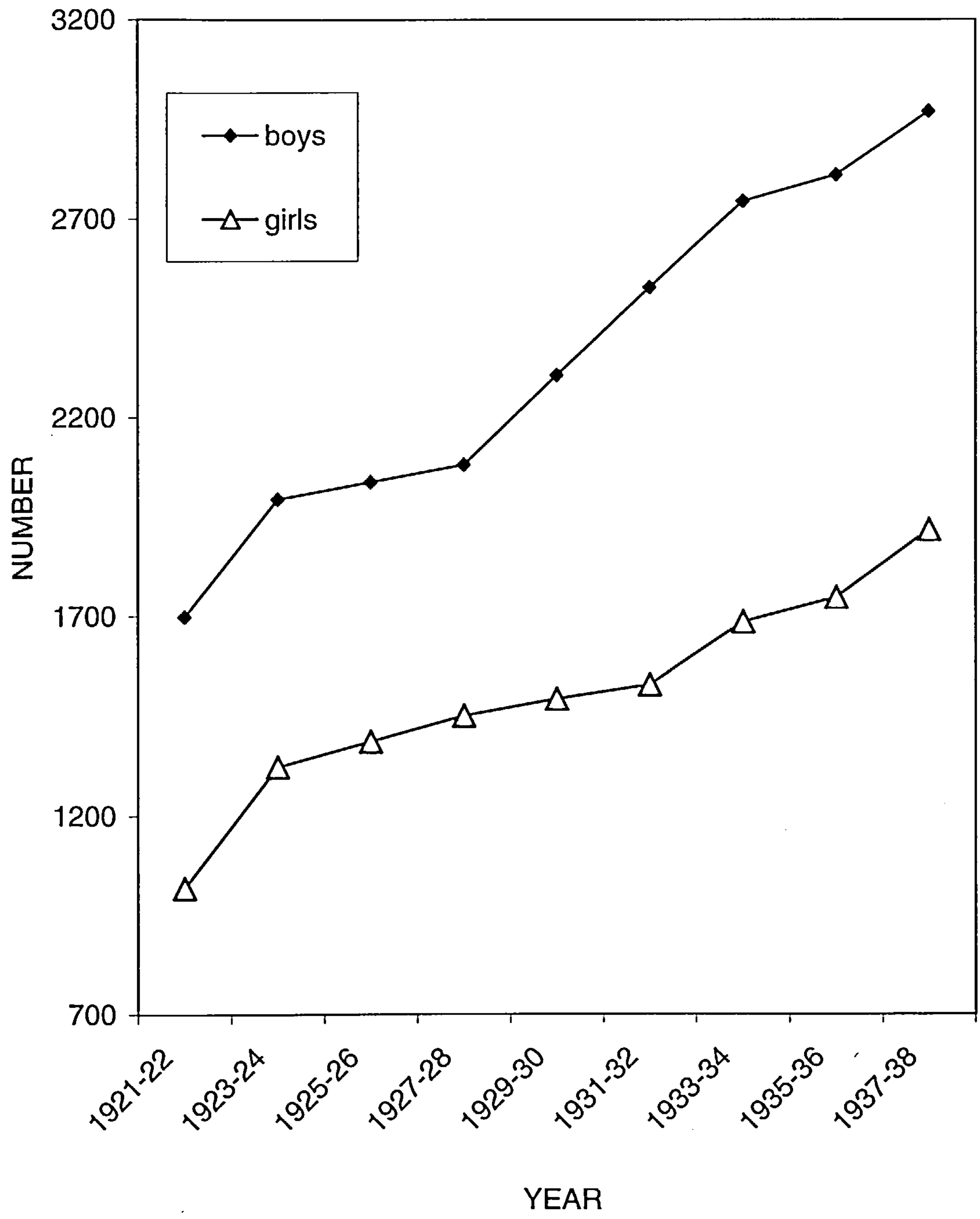
figure 6.4). These results generally support Mathew Thomson's argument that the authorities sought to control males while they were young, whilst females were more likely to remain a concern throughout their adult life, (reflecting contemporary anxiety over criminality amongst male youths and sexual activity amongst adult females).

The gender analysis of private guardianship seems to fit less easily with Thomson's arguments. Throughout the 1920s and early 1930s, there were more females than males receiving this type of provision. The majority of these were adults, which indicates that the authorities were reasonably tolerant about adult females receiving state provision in a community setting, away from the controlled, sexually segregated environment of the institutions. However, on further inquiry it becomes evident that Thomson's argument still has some explanatory value. At a time when the GBCS believed institutional accommodation to be scarce, guardianship provided a means of ensuring that defectives living in the community received some form of supervision. It also appears that many administrators believed that women could be sufficiently controlled in the family setting. Unlike male mental defectives, women were generally not allowed out of the house unsupervised, at least that was the impression that many administrators had gained: for example, Board of Control Inspector, Francis Sutherland made the following remarks on the subject in 1938:

the disadvantageous effects [of defectives living in the community] may not be as conspicuous in the case of female mental defectives, for in the case of most of these domestic occupation is found for them in their homes, and the great majority of them are more or less adequately supervised out of doors. In the case of male mental defectives, however, it is very frequently found that they are out, and their whereabouts are unknown.<sup>47</sup>

Within the special education system a gender ratio of 3 boys for every 2 girls remained fairly constant throughout the period (see figure 6.5). Again, this corroborates Thomson's arguments that where youths were concerned, the authorities were more interested in males than females. However, it would be problematic to assume that this simply reflected the view that young males were more likely to engage in criminal activity. Within the school system, educational ability was the most important factor in determining whether a child should attend a special school or not. Why boys should be

Figure 6.5: NUMBER OF MALE AND FEMALE MENTAL DEFECTIVES ATTENDING SPECIAL SCHOOLS AND CLASSES



Sources: NAS ED 55, SED annual statistics 1921-2 to 1937-8 (note, figures for 1925-6 are an average of figures for 1923-4 and 1927-8, as original data is missing from NAS archives).



more likely to under-perform in their school work than girls poses something of a problem.

Contemporaries believed that whilst average intelligence was roughly equal for males and females, males were more likely to dominate the extreme ends of the scale: there were more highly intelligent boys than girls and there were more mentally defective boys than girls.<sup>48</sup> An alternative explanation might be found in the different ways children were brought up. If, as Francis Sutherland suggested, girls really were generally subject to greater levels of supervision within the family home, this may have influenced their approach to school. They may have been more likely to pay attention in class and gain higher marks. Boys on the other hand, may have been more likely to have been disruptive in class and allow their work to suffer. The evidence at hand can do little to confirm either theory, so for now the explanations offered must remain at the level of conjecture.

The figures presented so far give national trends, in that the statistics include every individual receiving state provision within a given year. However, the likelihood of being labelled mentally defective and segregated by the state varied from region to region. The previous chapter has already discussed how both the SED and the GBCS were aware that small towns and rural areas lagged behind the large urban conurbations, when it came to carrying out their duties under the Mental Deficiency Act.<sup>49</sup> A city-dweller was much more likely to be placed in a special class, an institution or under guardianship than his or her country counter-part. Presenting statistics to illustrate this point is problematic because local boundaries and populations changed over the period. However, the changes were less drastic for education authorities: their boundaries underwent their most significant revisions at the start of the inter-war period, as a result of the Education (Scotland) Act, 1918 (in contrast to institutions and private guardianship, whose local administration was radically reconfigured midway through the period, following the Local Government (Scotland) Act, 1929).

Figure 6.6 shows that a much smaller percentage of pupils belonging to county education authorities were placed in special schools or classes for mental defectives,

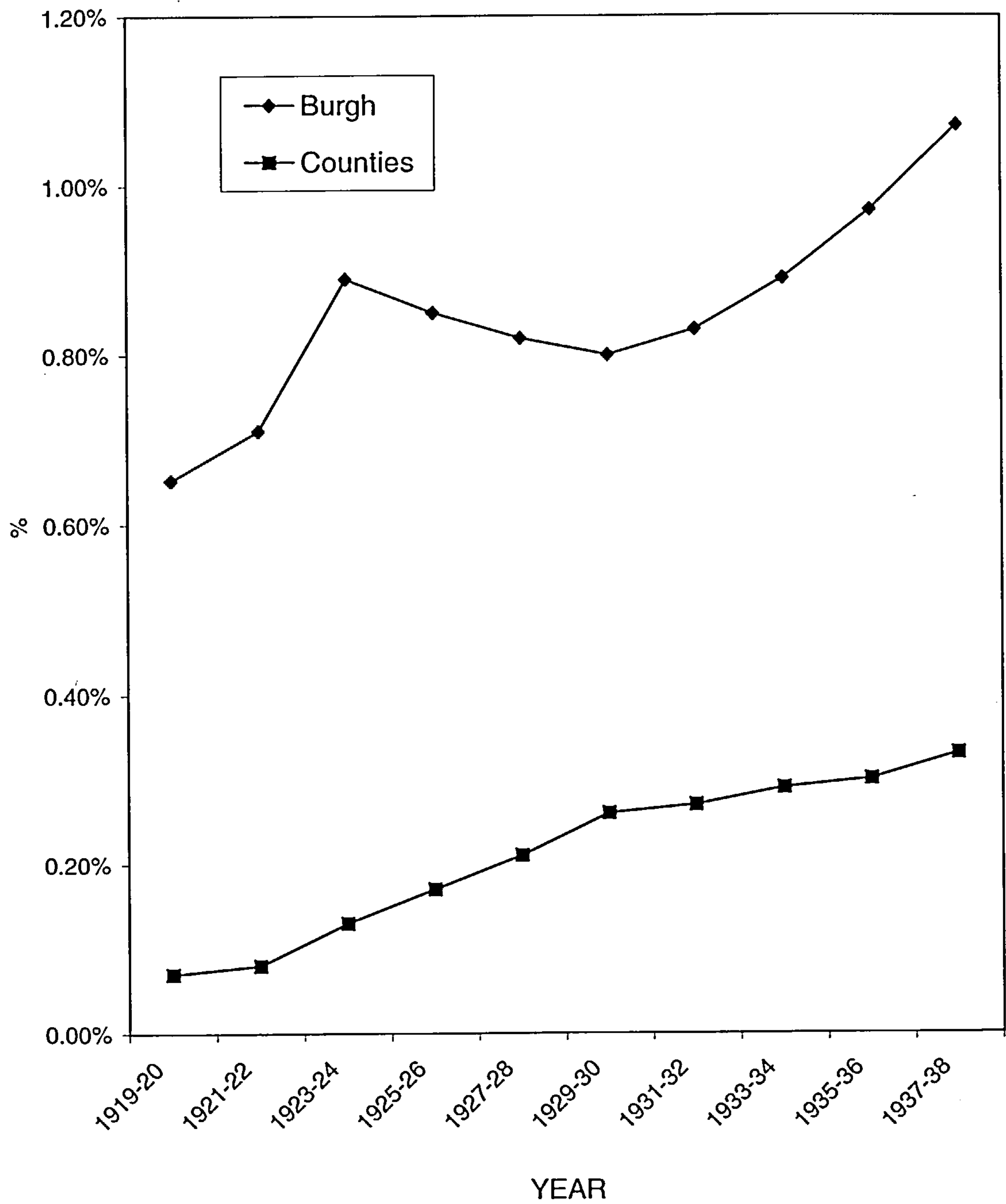
---

<sup>47</sup> HMSO, *GBCS Annual Report* 1938, xxx-xxxii. For further discussion on this point see c. 7.

<sup>48</sup> Scottish Council for Research in Education, *Intelligence of Scottish Children*, 122.

<sup>49</sup> See c. 5.

Figure 6.6: PERCENTAGE OF BURGH AND COUNTY SCHOOL PUPILS RECEIVING SPECIAL EDUCATION FOR MENTAL DEFECTIVES



Sources: NAS ED 55, SED annual statistics 1919-20 to 1937-38

compared to pupils belonging to burgh authorities. At the start of the inter-war period there were roughly five mentally defective pupils receiving special education in burgh schools for every one mentally defective pupil receiving special education in a county school (2074 burgh special pupils, compared to 408 county special pupils in 1919-20). By 1937-8 the ratio had shifted to 2:1 (3221 burgh special pupils to 1579 county special pupils). The counties had therefore begun to make ground, but it should be borne in mind that throughout the period the overall school population in the counties (ordinary and defective pupils) was over 50% greater than that of the burghs.<sup>50</sup> Burgh authorities were therefore segregating a significantly higher proportion of their school population than county authorities. GBCS statistics on institutions and guardianship demonstrate a similar bias towards burgh authorities.<sup>51</sup>

The annual statistics of the SED and GBCS give information about age, gender and locality, but they are less forthcoming on the subject of social class, doubtless because of the difficulties involved with obtaining statistics on this subject. GBCS statistics show that the proportion of rate-aided mental defectives accommodated in institutions remained close to 100% throughout the period.<sup>52</sup> This indicates that wealthier families generally used their own resources to look after family members in need of care and supervision. As a result, their children could avoid the stigma of being labelled a mental defective by the authorities and remain with their family (although there are a hand full of guardians who were prepared to place family members in institutions at their own expense).

An alternative means of approaching the subject of social class can be found in the annual reports for Glasgow's school health service. Glasgow's school medical officers periodically looked at the housing conditions of its pupils, taking into account the number of residents and the number of rooms in each household: the results are summarised in table 6.2.

The table indicates that mentally defective pupils lived in more crowded households than the average school pupil. However, their homes are not as crowded as the homes of pupils from transferred schools (who were predominantly Roman Catholic) or physical defectives, many of whom had deficiencies such as rickets that were directly related to

---

<sup>50</sup> See appendix 1.

<sup>51</sup> HMSO, *GBCS Annual Reports* 1920-39.



poor living standards. There are problems in assuming that household size and family size can give an accurate representation of social class. A small home in an affluent area may cost more than a larger home in a poorer district; families with cheaper houses may be able to spend a larger proportion of their income on goods that will improve their living standards in other ways, such as food, fuel and clothing, and some homes have larger rooms than others. Meanwhile, a high income level could facilitate a larger family, but then a large family could impoverish a household with an average income level.<sup>53</sup> Nonetheless, if one assumes that these factors played on the various groups cited in the table in roughly equal measure than there are grounds for assuming that mental defectives did tend to come from poorer households than the average ordinary pupil, although Catholics and physical defectives were poorer still.

**Table 6.2: AVERAGE NUMBER OF HOUSEHOLD MEMBERS PER ROOM IN THE HOMES OF GLASGOW’S SCHOOL PUPILS**

Year	1912	1924	1931	1936
Average no. of householders per room for all school pupils (including ordinary and defective pupils)	2.8	2.8	2.5	2.3
Average no. of householders per room for transferred pupils	3.2	3.2	3	2.7
Average no. of householders per room for mentally defective pupils	2.9	3.3	3	2.6
Average no. of householders per room for physically defective pupils	3.3	3.5	2.9	2.7

Sources: GCA D-ED 9/1/36/1-20, Glasgow Corporation Public Health Department, Education Health Service Report on the Medical Inspection and Treatment of School Children 1936, p. 67.

The most persuasive evidence to support the argument that mental deficiency administrators targeted the poorer sections of society can be found not from statistical evidence but within the Mental Deficiency Act itself. The ‘subject to be dealt with clauses’ specifically directed officials to provide for neglected or abandoned children, criminals and adults claiming poor relief.<sup>54</sup> Individuals from these groups were the most susceptible to being segregated under the terms of the act.

<sup>52</sup> *Ibid.*  
<sup>53</sup> My thanks to Mark Freeman for pointing these difficulties out to me.  
<sup>54</sup> See c. 3.

## *Conclusion*

Following the passage of the Mental Deficiency and Lunacy (Scotland) Act, professionals involved in Scotland's mental deficiency administration continued to raise the conceptual border-line that divided 'ordinary' people from 'mental defectives'. As a result, more people considered to have higher levels of ability were labelled mentally defective and received special state provision. The mental deficiency administration was particularly developed in large towns and cities, where the local population was large enough to pay for additional services out of the rates and supply the authorities with relatively large numbers of people who could be certified mentally defective. State provision for mental defectives focused primarily on children, especially boys, but was also geared towards identifying mental defectives of all ages within the Poor Law system.

Female sexuality was not, in numerical terms, the prime concern of the mental deficiency administration. This may come as a surprise considering that much of the early historical work on the Mental Deficiency Act for England and Wales portrayed it as a primarily eugenic piece of legislation. Thomson has since gone some way to revising this view, by stressing that the English authorities were at least as concerned about criminality amongst male youths as they were about sexual activity amongst women. If one takes into account the fact that most mental defectives were initially labelled and segregated at school, both the eugenic-centred account and Thomson's revision become problematic. Although older special school pupils were generally sexually segregated, the initial reason for their entry into special classes had more to do with their performance in the classroom than the potential threat that their future offspring might pose to the nation. Likewise, whilst male mental defectives were certainly associated with criminality, it is questionable as to how much this influenced the daily decisions of teachers and school medical officers.

Thomson's arguments are based on his study of institutionalised defectives and it is within this context that they carry the most persuasive force. One of the central issues surrounding institutional care was the question of whether or not a patient was fit to live in the community. As the cases of V.F. and W.B. illustrated, institution superintendents did consider sexuality and criminality when deciding whether or not a mental defective was fit to live outside the institution walls. Within the school system, however, such considerations did not appear to have carried the same weight. Teachers came to work

in order to teach the school curriculum. Those pupils who seemed incapable of making what the teachers regarded as being satisfactory progress were considered a problem: a medical examination was arranged and the child was given a trial in a special class. If a child's behaviour was disruptive, this no doubt added an extra incentive to arrange the transfer, but children who were too disruptive were removed from the education system altogether and recommended for institutional care and supervision.<sup>55</sup>

The creation of the feeble-minded category allowed teachers to become increasingly intolerant of educational failure by facilitating the removal of children whose school work was believed to be sub-standard from the ordinary classes. As the special education system developed, more children could be removed. Educational failure was therefore sufficient grounds in itself to have most of Scotland's mental defectives labelled and segregated from their peers. As an explanation, this may seem more prosaic than theories on national efficiency, social control or eugenics, but the day-to-day practice of labelling within the education system was conducted by local doctors and teachers, not politicians or social theorists, and the work itself was prosaic.

---

<sup>55</sup> *Scottish Educational Journal* 14 (1931), 606.



## chapter 7: Mental Defectives, Families and the State in Early Twentieth Century Scotland

So far, this thesis has focused on the role of the state in labelling and providing specialist services for mental defectives. It has argued that medical officers and teachers dominated the labelling process, broadening the definition of mental deficiency to include greater numbers of the population. Officials working at various levels of local and national government also decided which forms of provision were most appropriate for each individual coming under the administration's jurisdiction. Yet to be considered is the issue of whether or not families of mental defectives were able to influence these developments. The following account assesses the role of parents and guardians in the labelling process, the degree to which they could help shape the implementation of state provision for mental defectives, and the ways in which they could challenge the state when disputes arose.<sup>1</sup> The chapter will also look at the role that mental defectives themselves played in proceedings, so far as the evidence permits.<sup>2</sup>

Family-based studies of this kind pose an immediate methodological problem: once the historian directs his or her attention away from social elites and towards the wider public, the quality and quantity of surviving primary source material often declines sharply. One way of redressing the shortage of evidence would be to conduct an oral study. Time constraints have made this option impractical within the context of this thesis, moreover it would be difficult to find respondents who have had experience of bringing up mentally defective family members in the early part of the twentieth century. Hence, the evidence surveyed for this study is limited to written sources: primarily official papers and correspondence from parents of patients accommodated in the Stoneyetts Institution, which housed adult mental defectives, generally from the

---

<sup>1</sup> See Jackson, *Borderland of Imbecility*, c. 6; M. Kelm, 'Women, Families and the Provincial Hospital for the Insane, British Columbia 1905-1915', *Journal of Family History* 19 (1994), 177-93; A. Pernice, 'Family Care and Asylum Psychiatry in the Nineteenth Century: the Controversy in the *Allgemeine Zeitschrift für Psychiatrie* Between 1844 and 1902', *History of Psychiatry* 6 (1995), 55-68; P.E. Prestwich, 'Family Strategies and Medical Power: "Voluntary" Committal in a Parisian Asylum, 1876-1914', *Journal of Social History*, 27 (1994), 799-818; M. Thomson, *The Problem of Mental Deficiency*, 258-269; M. Thomson, 'Family, Community and State', 207-230; Wright, ' "Childlike in his Innocence" ', 118-133; D. Wright, 'Family Strategies and the Institutional Confinement of "idiot" Children in Victorian England', *Journal of Family History*, 23 (1998), 190-208; D. Wright, 'Familial Care of "idiot" Children in Victorian Britain', P. Horden and R. Smith (eds), *The Locus of Care: Families, Communities, Institutions, and the Provision of Welfare Since Antiquity* (London: Routledge, 1998), 176-197; Wright, 'The National Asylum for Idiots, Earlswood', 48-73. For a collection of articles examining mental illness and mental deficiency within a domestic/community setting see Bartlett and Wright (eds), *Outside the Walls of the Asylum*.

<sup>2</sup> Jackson, *Borderland of Imbecility*, 181-186.

Glasgow area. Both types of source have their pitfalls: official papers present the authority's view of the role of parents, rather than first-person accounts by the parents themselves. The letters to Stoneyetts were written by parents and guardians themselves, but the information they were prepared to give to institutional staff may not necessarily correspond with opinions expressed privately amongst family members. Despite these problems, some observations can still be made about the way parents and guardians interacted with officials: how they could co-operate with or resist state intervention, and the results such interactions could have on individuals being dealt with by Scotland's mental deficiency administration.

In his work on the English National Asylum for Idiots at Earlswood between the years 1847 and 1886, David Wright has argued that families of patients actively involved themselves in the labelling and institutionalisation of idiots and imbeciles. Wright suggests that parents (or guardians) were prepared to categorise particularly needy or unproductive members of their family as 'idiots' and 'imbeciles'. Frequently, they attempted to provide care and supervision for such children within the family home for as long as they felt the household economy could support them. However, if the parents felt that they could not afford to provide for their whole family, they would send the 'idiot' or 'imbecile' to be examined and institutionalised at Earlswood. This typically happened during a period in the family life-cycle when the household contained a number of children who were too young to contribute to the household economy, but still required to be clothed and fed from the income of the wage-earner(s). Later on in the cycle, when some of the other children had reached an age when they could find employment and contribute to the household economy themselves, families often took advantage of the increased income by having the institutionalised family member discharged and returned to the household. Parents therefore had their children admitted and discharged from the institution on a voluntary basis (voluntary from the parents' point of view, rather than the children's).

Wright's arguments raise issues that are relevant to this study. He suggests that knowledge of idiocy and imbecility and the practice of institutionalising family members emerged from a process of negotiation between familial guardians and institution superintendents. Idiots or imbeciles were initially singled out by family members before they were examined by the asylum's medical superintendent. Indeed, the superintendent's 'medical' assessments of the patients seem to have been influenced

by the comments made to them by parents: a point that Wright illustrates by quoting from medical reports that refer to observations from parents.<sup>3</sup>

Families therefore played a key role in selecting children to be put forward for institutionalisation at Earlswood but it would be unwise to assume that labelling within the lay community occurred in isolation from medical theory. The very fact that they chose to take their children to be examined for entry into the idiot asylum indicates that parents believed that a medical examination geared towards identifying symptoms of idiocy would be appropriate for their child. To recognise this, the parents must have had some prior knowledge of the medical understanding of idiocy, otherwise it could never have occurred to them to send their children to Earlswood in the first place. Wright presents a persuasive case for arguing that lay conceptions of idiocy influenced medical discourse, but the phrase ‘and *visa versa*’ should be added to his argument. Despite this objection, Wright leaves us with an appreciation that the labelling and institutionalisation of idiots and imbeciles involved some degree of active participation from family members: it was not simply imposed on the lay community by the medical profession.

Another attempt to revise the view that the treatment of mental defectives was a ‘top-down’ process, imposed upon families by the medical profession and the state has recently been made by Mark Jackson. Jackson concentrates on acts of resistance against the authorities. In his study of the Sandlebridge Colony in Cheshire, he describes how parents could register their dissent by attempting to remove their children from the colony, either by formal application, legal challenges or by assisting absconding patients. Comparing Wright’s account of Earlswood with Jackson’s study of Sandlebridge, it would appear that the parents of Sandlebridge patients had to fight harder to impose their will on the institution authorities, particularly when it came to securing the discharge of patients. Furthermore, their efforts did not always meet with success. This is understandable considering that the colony’s management, led by Mary Dendy, was committed to the principle of life-long institutional care for mental defectives. However, the personal beliefs of Dendy and her associates form part of a wider trend. Jackson’s account focuses on the early twentieth century, a period when the

---

<sup>3</sup> Wright, ‘ “Childlike in his Innocence” ’, 118-133.



state assumed greater powers to compel segregated provision for mental defectives, with or without the consent of parents.<sup>4</sup>

In his study of institutionalisation and community care in London, Mathew Thomson briefly considers how Wright's arguments could apply to England's mental deficiency administration following the Mental Deficiency Act, 1913. He emphasises that specialised care and supervision continued to be shaped by a process of negotiation between families and the state. There were 'tensions and misunderstandings which divided providers and recipients of care' but officials also exhibited 'a significant degree of flexibility and a willingness to moderate policy in response to the complaints of the family.' Thomson argues that parents had a certain amount of leverage over the authorities because officials were 'keen for policies to satisfy their clients'. He also states that 'instilling discipline into defectives was a response to parental desire, as much as local authorities'. However, he also argues that parents had difficulty making an impact on institutional care, as their attempts to do so were frequently frustrated by a 'bewildering maze of bureaucracy' and a 'rapid growth of state medico-legal power'.<sup>5</sup>

All of these commentators make a strong case for claiming that family members helped shape provision for mental defectives, but as Thomson's work shows, there is a need to assess how the process of negotiation between state and family changed as state power increased. It seems reasonable to assume that if state officials did obtain greater powers to intervene and enforce their decisions within the family sphere, the influence of family members must have waned to some degree. The present discussion tests this hypothesis within the context of Scotland's twentieth century mental deficiency administration, taking into account the role of families within each of the three major forms of state provision: special education, boarding-out and institutionalisation.

### *Familial Response to the SED*

Scotland's school medical service, first established in Glasgow and Govan in the late nineteenth and early twentieth century, allowed medical officers working for the school boards to examine children routinely without having to wait for parents to bring the child to a doctor for an examination. This development marks a shift from earlier arrangements, such as those described by Wright (though applicable to Scotland as well

---

<sup>4</sup> Jackson, *Borderland of Imbecility*, 21-22 and 181-188.

<sup>5</sup> M. Thomson, *Problem of Mental Deficiency*, 264-269.

as England), in which parents wishing to have their children institutionalised made the initial decision to take them to the idiot asylum for a medical examination. In the years before local school medical services were established, local authorities could only compel examinations of this kind if they assumed guardianship of the child: a course of action reserved for urgent cases of cruelty, neglect or parental absence. Within the school health service, medical officers could examine children who were still under their parents' guardianship without having to wait for the parents to decide for themselves that their children should see a doctor. This made it easier for doctors to diagnose more children as being mentally defective without the active involvement of parents.

The school boards also excluded pupils from mainstream education regardless of whether or not parents consented. The Education of Defective Children (Scotland) Act, 1906, legitimised the school boards' powers to establish special schools and classes. The act did not specify whether or not a school board could force children to attend special classes against the will of parents, but John Struthers, then secretary of the SED, almost certainly intended the legislation to be interpreted this way. As an under secretary, he had opposed an earlier bill on special education in 1900, on the grounds that it gave parents the authority to dictate the form of education their children should receive.<sup>6</sup> One of Glasgow's first special school teachers, Lilly Monteagle, indicated that children were sometimes placed into her school against the wishes of their parents (although she claimed that perceived successes in special education tended to win the parents over eventually). Speaking to the Royal Commission on the Care and Control of the Feeble-Minded in 1906, Monteagle commented that:

[m]any parents do not like the idea of their children attending the special classes at first, but they soon become reconciled to this when they see the progress made. I am of the opinion that, for the good of the children, it should be made compulsory to send all children, certified to be mentally defective, to special classes.<sup>7</sup>

---

<sup>6</sup> See c. 3.

<sup>7</sup> HMSO, *Royal Commission on Feeble-minded* III, 263

The Education (Scotland) Act, 1908 cleared up any confusion by explicitly compelling parents to accept special education for defective children when it was offered.<sup>8</sup> In practice, however, some parents were able to exert some influence regardless of the legislation. In its circular of 1937, the SED complained that:

[t]horoughness of ascertainment and classification has been impaired by a feeling among parents and occasionally even among teachers and medical officers that an injury is done to a child by marking him as mentally defective and in need of a special type of education.<sup>9</sup>

In certain rural areas, where scattered populations made special day schools impractical, parents were in a better position to dissuade school medical officers from fulfilling the education authority's duty to identify all mentally defective pupils, particularly if there were no special classes in the area to place such children. In December 1936, W.A. Robertson, a member of Angus Education Authority sent a letter to the SED, outlining the predicament of authorities seeking to provide special education within a rural setting.

When the list of 'defective' children is finally made up, what should be done with them? There is no 'defectives' school, or class in Angus, and, although there might be 50 defectives on the list, they will be found to be scattered over the County. Further, the parents make centralisation impossible in a majority of cases. There are, I think, very serious objections to having such pupils in the ordinary school, even if they are 'well behaved'. In many cases they could not well be taught at home, especially if the home is poor. A solution is very difficult.<sup>10</sup>

Even in a large urban area such as Glasgow, parents still attempted to influence school policy through acts of resistance. Despite being in breach of the law, they sometimes refused to send children who had been certified mentally defective to school until they were reinstated in the 'ordinary' classes. This extreme course of action occurred most frequently when pupils were transferred to special classes in the later years of their

---

<sup>8</sup> *Education (Scotland) Act* 1908, s. 5.

<sup>9</sup> NAS ED 28/231, *SED Circular No. 105* (1<sup>st</sup> Sep. 1937).

<sup>10</sup> NAS ED 28/231, Letter from W.A. Robertson to SED (23<sup>rd</sup> Dec. 1936).



school career after being diagnosed as feeble-minded. In his letter to the *Glasgow Herald* (the same one in which he accused his own authority of ‘manufacturing’ mental defectives), Glasgow Education Authority member, John Grimmond, provided the following account.

In one case where a Government inspector visited Wolseley Street School and asked that a few backward children should be sent to him for examination 12 out of 13 were certified mentally defective. The exempted child had 67 marks [ie. an IQ of 67], and the mother of one of the 12 certified pupils, the latter of whom had 71 marks, refused to send her girl to a special school. After this girl had been out of school for 15 months the case for her transference to a special school was withdrawn and she was readmitted to her old school. In connection with this case I asked at a meeting of the Authority if it were the case that this girl – regarding whose work, despite her long absence from school, the reports were generally satisfactory – had been twice examined and certified a feeble-minded each time, and the answer by the Director of Education was “That, I am informed, is correct.”

A group of cases of similar kind could be quoted. In these cases the parents admit that their children are backward, but do not admit that they are mentally defective. Their argument is that their children have been at school from five to seven years, and during that time they were not informed that the children were not progressing.<sup>11</sup>

As a form of parental resistance, keeping a child at home rather than allowing him or her to attend a special class was not without its risks. Even if the child was eventually reinstated in ordinary classes, this would be at the expense of having been denied an education for a lengthy period of time. Furthermore, successful resistance was by no means certain. Education authorities could and did apply to the courts for attendance orders, forcing the pupils to attend special classes. However, judging by the length of time it generally took for education authorities to take such action, the decision to apply for a court order appears to be one they made with some reluctance.

---

<sup>11</sup> *Glasgow Herald* (19<sup>th</sup> Dec. 1923), 7.

In the late 1920s, *The Scottish Educational Journal (SEJ)* reported that a number of parents from Dumbartonshire kept their supposedly defective children away from school for over a year before the local education authority felt moved to serve them with attendance orders. During that time, one of the parents was able to afford a private tutor to educate his child ‘normally’, but this would be an option denied to poorer families.<sup>12</sup> In all cases, resistance to labelling still meant the children were being excluded from the ‘ordinary’ school population: for most, it also entailed a more general exclusion from education.

The events in Dunbartonshire provide a rare example of collective parental resistance against certification and special education. According to the *SEJ*, one of the main sources of contention with parents was the fact that the children were certified late on in their school career. Having spent most of their school life in ‘ordinary’ classes, certification appeared to them to be an unnecessary stigma that would result in the pupils being forced to remain in school for at least an additional year. During that additional year the child would not be able to look for work and contribute to the household economy.

The objection of parents has been that their children were not certified as unsuitable for tuition in the ordinary day school until near the close of their normal school life. The parents plead that it is a distinct hardship that belated certification should thus compel the attendance of the children at the special school until attaining the age of 16 years – the statutory requirement in such cases.<sup>13</sup>

The parents had numerous conferences with members of the local education authority, which from the authority’s point of view ‘proved ineffective’.<sup>14</sup> However, the parents were not entirely without support from education authority members. Just as John Grimmond questioned the special education policy of his education authority, Dunfermline’s education authority also experienced dissension from within: in this case from a member of the authority by the name of James Paul. Paul took it upon himself to advocate on behalf of the family of the boy who received private tutoring at home. The

---

<sup>12</sup> *Scottish Educational Journal* 11 (28<sup>th</sup> Dec. 1928), 1382.

<sup>13</sup> *Scottish Educational Journal* 12 (4<sup>th</sup> Jan. 1929), 1-2.

<sup>14</sup> *Ibid.*

*SEJ* reported on the education authority committee meeting at which the boy was discussed:

Mr James Paul ... declared that the boy was not mentally defective. If they sent the boy there [ie. the special school] they had a chance of making him mentally defective. It was, he maintained, a case of the Authority wanting to boost up their special school.<sup>15</sup>

Following Paul's intervention, the education authority voted nine to three against serving an attendance order to the boy's parents. The other children's parents received their orders.<sup>16</sup> Whilst the *SEJ* did not comment on why one child was treated differently from the rest, it seems apparent that the wealthier family received more favourable treatment, partly because a member of the authority supported their case and partly because the parents could afford to educate their child outside the state school system.

An alternative strategy for parents looking to dispute the certification of their children was to bring in a second medical opinion. There are few examples of this in the sources examined. This could be because family doctors were unwilling to contradict school medical officers in a branch of medicine with which they were probably unfamiliar. There was also a financial barrier, as dependants of working family members were not initially covered by the National Health Insurance Act, 1911. Although some local contributory schemes for dependants were established, the poorest sectors of society would have generally found it difficult to obtain a second opinion from doctors outside the Poor Law and School Health Services.<sup>17</sup> In any case, the school medical officers responsible for selecting mental defectives had, since the beginnings of special education, been used to carrying out their practice in the face of opposition from other branches of the medical profession (notably, certain institution superintendents such as W.W. Ireland). They were unlikely to look favourably upon a GP contradicting their diagnosis.

Again, the difficulties experienced by Dunbartonshire's education authority can be used to illustrate the point. In 1932, just less than four years after the first dispute came

---

<sup>15</sup> *Scottish Educational Journal* 11 (28<sup>th</sup> Dec. 1928), 1382.

<sup>16</sup> *Scottish Educational Journal* 12 (4<sup>th</sup> Jan. 1929), 1-2.

<sup>17</sup> P. Thane, *Foundations of the Welfare State* (London: Longmans, 1996), 178-9.



to light, the *SEJ* ran another story about parental resistance to special education in the area. On this occasion, a parent whose child had recently been certified mentally defective by the school medical officer, produced a certificate from his GP reversing the previous diagnosis. Once more, a member of education authority, this time a Mr M'Intyre, took up the cause of the parent. M'Intyre argued that the committee should provide funds for parents to seek a second medical opinion in cases of disputed certification. However, his suggestion met with hostility from other committee members. One argued that there would be little point spending money on special schools and a school health service, if decisions made by officials were then 'passed over by an outside doctor'. In addition to the cost, the acceptance of second opinions from GPs would challenge the committee's claim to expert authority in this field. There was, according to another member, 'less chance of mistake in Dumbartonshire than in any county in Scotland. There was not only the opinion of the doctor, but of psychologist, and the teachers'. According to the *SEJ*, the matter was subsequently 'allowed to drop'.<sup>18</sup>

Whilst it seems reasonable to assume that many parents did not resist special education, the examples above show that parents could and did express dissent towards the special education system. Parental resistance could help deter county education authorities from establishing special classes, although logistical problems (for example, transport difficulties) also contributed to the lack of special education within Scotland's sparsely populated areas. In more densely populated areas, education authorities were more willing to arrange medical examinations and transfers to special classes irrespective of parental consent. In such cases, parents could still resist the decisions by voluntarily removing their child from school, or enlisting the support of a doctor or education authority member to challenge the diagnosis of their child. However, such support could be difficult to obtain and in no way guaranteed success. It proved difficult for parents to contest the labelling of children who had already been officially certified mentally defective at school. Attempts to reverse a diagnosis and have a child uncertified often met with intransigent opposition: from school medical officers whose claim to authority lay in their being able to make 'correct' diagnoses, and from education authorities who could apply for court orders compelling parents to allow their children to attend special classes.

---

<sup>18</sup> *Scottish Educational Journal* 15 (4<sup>th</sup> Nov. 1932), 1344.

### *Familial Response to the GBCS*

Whilst the Education (Scotland) Act, 1908 made special education in day schools the first form of segregated provision to be legally imposed on Scotland's mental defectives against the wishes of familial guardians, the trend towards compulsory segregation soon extended beyond the school walls. Before 1913, admission to the Scottish institutions for idiots and imbeciles at Baldovan and Larbert worked on a similar voluntary principle to that described by Wright in his account of Earlswood. Children were admitted with the consent of parents. The only exceptions to this rule were children for whom the state (usually the parish) assumed guardianship in a response to parental neglect, illness or death etc. The boarding-out system operated in a similar vein. The 1913 act increased the powers of local authorities to compel institutionalisation and boarding-out. Local administrators were given the legal authority to seek a court order to place mental defectives in institutions or under guardianship against the wishes of parents. The knowledge that such action could be taken may have influenced some parents to accept the verdicts of certifying officers and administrators more readily. However, the authorities remained concerned about parental resistance.

Institutionalisation and boarding-out to non-familial guardians involved the removal of mentally defective offspring from the family home. Not surprisingly, parents often objected to any attempt by the state to compel such a move. The SED had long recognised that, in contrast, special education in day schools could often prove to be a more palatable form of segregation on the grounds that children attending special day classes could generally continue to live with their families. Hence the Department instructed its local authorities to emphasise to parents that certification within the education system did not necessarily mean the child would be 'separated from his home or segregated from other children except in so far as is necessary to give a special type of education'.<sup>19</sup>

The GBCS did not have the same advantage when it came to securing parental support for institutionalisation or boarding-out. GBCS officials recognised that relocation could place a strain on familial bonds, especially, it was claimed, the bond between the mother and child. They also interpreted parental resistance in terms of hurt pride, arguing that parents saw the removal of children from their home as an indictment on their own

---

<sup>19</sup> NAS ED 28/231, *SED Circular No. 105* (1<sup>st</sup> Sep. 1937).

ability to provide for family members. Dr Gibson, an inspector for the Board, reported in 1924 that:

[i]t should not be forgotten that in the majority of instances the defective child is the mother's favourite ... Any suggestion of removal naturally meets with the strongest opposition, and criticism of the living conditions is apt to arouse a warm resentment.<sup>20</sup>

According to GBCS reports, this was especially true of 'high-grade cases' (ie. the feeble-minded). For instance, when Lennox Castle opened in 1936, most of its patients were 'low grade' (ie. idiots and imbeciles) mental defectives. 'High-grade' cases were generally only admitted when they were considered to have behavioural problems, a poor physical condition or seemed to the authorities to be uncared for or unsupervised at home. Another GBCS inspector, Dr Laura Mill, made the following comments on the lack of 'high-grade' patients at Lennox Castle in the report for 1937:

a large number of high-grade feeble-minded patients would benefit greatly by a period of training there. In such cases parents or guardians feel that there is very little wrong with the patient, and it is often difficult to convince them that special training would be most helpful and might result in the patient achieving independence and being discharged.<sup>21</sup>

In the GBCS report for 1938, Dr Francis Sutherland discusses the problems faced by those local authorities seeking to accommodate more high-grade defectives in institutions:

the difficulty would appear to arise, not from any reluctance on their [ie. the local authorities'] part to provide educational and training facilities for suitable high-grade defectives, but from an uninformed aversion on the part of related guardians towards any contemplation of transference even temporarily to an institution or school for the benefits to which I have made reference. On making the suggestion that such a course of action would be advantageous, one may often hear the opinion expressed that the patient "is not as bad as all that". It is

---

<sup>20</sup> HMSO, *GBCS Annual Report 1924* (Cmd. 2487, 1924-5), xliii.

<sup>21</sup> HMSO, *GBCS Annual Report 1937* (Cmd. 5715, 1938), xxvi-xxvii.



evident that too generally the certified institutions or special school is quite unreasonably regarded as a place of custody or of correction; and it is clear that much more enlightened conceptions on the part of related guardians as to the true nature and beneficial purpose of these agencies are greatly to be desired.<sup>22</sup>

Under the Mental Deficiency Act, authorities could apply for a detention order from the sheriff to force parents to accept special provision, but the act did not give the authorities *carte blanche* in this regard. Orders could only be given when a mental defective was considered ‘subject to be dealt with’ under the terms of section 3 of the 1913 act. Mental defectives fell into this category if they were maltreated or abandoned, had committed a crime, were habitual drunkards, unmarried mothers in receipt of poor relief, poor law ‘ins and outs’, or if they had been notified by the education authorities as requiring further care. In practice, the majority of ‘high-grade’ mental defectives were likely to be ‘subject to be dealt with’ on reaching adulthood because the education authorities tended to notify most of their mentally defective special school-leavers. Table 7.1 illustrates this point, although the statistics are only available for the 1930s.

**Table 7.1: THE PROPORTION OF MENTALLY DEFECTIVE SPECIAL SCHOOL-LEAVERS NOTIFIED BY THE EDUCATION AUTHORITIES AS REQUIRING CONTINUED CARE.**

YEAR	NO. OF MENTAL DEFECTIVES LEAVING SCHOOL AT 16	NO. OF THESE SCHOOL LEAVERS NOTIFIED AS REQUIRING FURTHER CARE	% OF THESE SCHOOL LEAVERS NOTIFIED AS REQUIRING FURTHER CARE
1931	370	310	84%
1932	325	283	87%
1933	318	280	88%
1934	331	292	88%
1935	363	321	88%
1936	500	425	85%
1937	409	341	83%
1938	398	344	86%

Sources: NAS, ED 28/288, SED papers on special education (1938); HMSO, *SED Annual Report 1938* (1938-9, Cmd. 6007), p. 40.

Between 83% and 88% of ‘educable’ defectives leaving special schools could be taken away from their family homes with a court order, regardless of the standard of care

<sup>22</sup> HMSO, *GBCS Annual Report 1938* (Cmd. 5970, 1939), xxxi.

offered in the home, or the behaviour of the defective. According to the GBCS, it was the parents of these 'high-grade' defectives that tended to offer the most resistance when it came to institutionalisation or boarding out. In such cases, the law would be on the side of the authorities.

Still, there were other obstacles to the authorities' use of court orders. Frequent recourse to the courts could be time-consuming and involve legal fees. It would also often prove pointless in view of the shortage of accommodation in institutions and the difficulty of finding sufficient non-familial guardians to house every defective who might, in the opinion of the authorities, benefit from relocation. Consequently, many of the school-leavers notified by education authorities did not receive after-care (a source of continuing dissatisfaction for the SED). The sheriff's order was treated as a last resort, though uncooperative parents could easily be made aware of the fact that an order *could* be sought if the authorities thought it necessary. That said, there is evidence that the GBCS administrators would at times go to considerable lengths to obtain parental co-operation through persuasion rather than legal compulsion. Inspectors could enlist other family members and local figures in the community to help them. They would also seek to assure parents that the relocation of a defective need not entail permanent separation. In the GBCS report for 1934, Kate Fraser illustrated the strategies that she and her officials could employ with a case history describing efforts to persuade a mother living in a Lanarkshire town to consent to her mentally defective daughter being boarded out in the country:

[a]t earlier interviews the mother refused point-blank to let the daughter away, although she admitted that it was very hard on the daughter to keep her in such a crowded house. She said that if only they could get a new house, everything would be all right. This led the question back to the Public Assistance authorities, who were able to confirm not only that the present house was condemned, but also, and more important, that the family would be moving into a new house, if not immediately, at least within a reasonable time.

A further interview at last brought hope. The patient's grandfather was present, and with his support the mother of the girl admitted, first, that she would be glad if the patient were away for a holiday; and then – and this was where the old gentleman was so helpful – that the usual kind of convalescent home would not

be willing to take a defective girl. That was not all. The mother finally admitted that she was afraid to let her daughter away in case she was not allowed home again. The secret was out. It was that fear which had barred every approach; and once it was known, it was possible to assuage it, and so get something done. Further interviews followed with the Public Assistance authorities and the local clergyman; the assistance of the Board was called in on certain technical points; and the parents allowed the patient to go to the country on the clear understanding that the separation was a temporary one, that is, until such time as the family was rehoused.<sup>23</sup>

The case study could be used to demonstrate the care and effort made by the authorities to ensure familial co-operation in the interests of both parent and child. It may, of course, be an exceptional example deliberately included in the Board of Control report to give this very impression. In any case, an alternative interpretation (not entirely exclusive of the first) would be that by repeated interviews and the enlistment of the grandfather, the clergyman and the public assistance authorities, Fraser and her colleagues pressured the parents into accepting the relocation. For their part, the parents bear some resemblance to those described by Wright, in that they finally seemed to have accepted relocation as a temporary measure to help them through a time of hardship: in this case, whilst they waited to be re-housed in more suitable accommodation. What sets them apart from Wright's subjects is the extent to which the mother was cajoled by the authorities into making her decision.

According to the GBCS reports, parents appeared to be most co-operative when provision did not involve relocation. This appears particularly evident when it came to guardianship. Guardianship did not have to mean boarding mental defectives out to live with other families: a defective could be placed under the guardianship of his or her own parents. The parents would then receive a weekly aliment or a clothing allowance or both, half of which was paid by whichever local authority was dealing with the defective, whilst the other half came from the GBCS.<sup>24</sup> In return, the parents would have to accept periodic visits by Poor Law or public assistance officers and GBCS inspectors. As they might expect these visits anyway, particularly if the mental defective was a child, it is little wonder that parents decided to take the money. GBCS

---

<sup>23</sup> HMSO, *GBCS Annual Report 1934* (Cmd. 4838, 1935), xxxvii.



administrators at times accused the parents of a certain cynicism when it came to familial guardianship. One inspector, Dr Sturrock, voiced the following opinion in the GBCS report for 1920: '[i]n a great many cases the only interest manifested in the [Mental Deficiency] Act by the parents is the possibility of obtaining financial aid'.<sup>25</sup>

According to Kate Fraser, in 1933, the majority of defectives under familial guardianship in Glasgow and Govan were 'high-grade' cases who had recently left special school. Typically, she suggests, the parents applied for assistance when the defective 'on leaving school cannot obtain employment'.<sup>26</sup> This substantiates the argument that parents actively sought to utilise provision for mental defectives to help them support family members who did not contribute financially to the household.

The GBCS reports show an ambivalent attitude on the part of the administrators towards familial guardianship. Though they frequently praised parents for coping in difficult circumstances, inspectors often expressed the view that over-reliance on familial care left many defectives living in an unsuitable environment with inadequate care and supervision. In particular, the inspectors distrusted the influence of the urban environment on high-grade defectives living with their families. Most defectives under the GBCS-sanctioned guardianship of family members lived in towns or cities. Most non-familial guardians enlisted by the GBCS to provide for relocated defectives lived in the country, where 'boarded-out' defectives frequently helped out on farms or with the housework. Annual reports of the GBCS frequently discussed the relative disadvantages and advantages of the two types of environment. The accounts always demonstrated distinct pastoral leanings on the part of the administrators. In the report for 1928, Dr Gibson ventures these opinions about urban based male mental defectives:

[f]requently, male defectives have been observed in slum dwellings, leading empty, purposeless lives with no occupation beyond standing about in the crowded streets or loafing around the entrance of a close. Living amid distinctly poor surroundings they are liable or even certain to meet and mix with associates who will do them little or no good and from whom they may learn all manner of bad habits. So obvious are the advantages of boarding-out in instances such as

---

<sup>24</sup> Until the Local Government (Scotland) Act, 1929, removed the Treasury grant from the GBCS. In the 1930s, all the aliment would come from the local authority concerned. See c. 5.

<sup>25</sup> HMSO, *GBCS Annual Report 1920* (Cmd. 1396, 1921), xxxiii.

<sup>26</sup> HMSO, *GBCS Annual Report 1933* (Cmd. 4712, 1934), xx.

these, that the refusal of parents to consider it, is difficult to understand. Nothing can be better for the high grade male defective than to board him out on a small farm or croft, where with a certain amount of work, in addition to good food and fresh air, his outlook is enlarged, his mind occupied and his physique improved. In spite of painstaking attempts to enable the parents to realise the advantages of such a life, they are not easy to convince. They prefer to keep their defective children with them in the slum conditions mentioned above, whether from motives of affection, because of the advantages accruing to the receipt of an aliment or the benefits of having someone at home to help in the work of the house.<sup>27</sup>

In 1936, Dr Laura Mill made these remarks about Glasgow, indicating that even when urban conditions improved, the GBCS were less than satisfied:

Glasgow, with over 450 mentally defective patients living under guardianship, almost all in their own homes, presents special problems. Family unemployment, bad housing, and lack of suitable outlets and occupation are the great difficulties in the way of satisfactory conditions for mental defectives in Glasgow. Many patients, however, are now living in new housing areas, and several of them are taking a healthy interest in the gardens. As far as occupation is concerned, there is too often a tendency to let the patients drift. This is especially the case with male patients, as women and girls usually help in the house. Parental discipline and control are too often lax, and many of the lads would be much better doing farm work in the country under good guardians. Unfortunately, many of the parents are not agreeable to this.<sup>28</sup>

Parents of mental defectives seemed to have been prepared to co-operate with the mental deficiency administration when they considered it to be in their interest to do so. In particular, they looked to administrators for additional financial support. When it came to breaking familial bonds and relocating the defective, parents were more likely to offer resistance. For their part, the authorities attempted to gain the consent of parents as much as possible, and if this consent was not given, administrators were at times prepared to rethink their strategy, albeit reluctantly. Medical officers in certain areas

---

<sup>27</sup> HMSO, *GBCS Annual Report 1928* (Cmd. 3413, 1929-30), 1-li.

<sup>28</sup> HMSO, *GBCS Annual Report 1936* (Cmd. 5408, 1937), xxx-xxxi.

refrained from ascertaining defectives, and administrators in urban areas settled for familial guardianship when they would have preferred relocation. Although the authorities voiced their frustration at the way many parents insisted that their mentally defective offspring remained at home, it should also be noted that there was a shortage of accommodation in institutions and with non-familial guardians during the period. In fact, it is difficult to tell how far the authorities' tolerance of familial guardianship was influenced by the parents, and how far they simply lacked the resources to place the defective elsewhere.

Nonetheless, a large number of individuals were relocated by the GBCS. Furthermore, many parents did not resent the removal of their child from the family home. For instance, the mother of a mental defective accommodated in Stoneyetts shared the view commonly held by GBCS Commissioners, that a change to a rural environment would do her son 'a world of good'.<sup>29</sup> A few months after venturing this opinion, she wrote, 'I was always thinking he would be perhaps sent to a farm to learn to do something but perhaps time is needed for that. I really believe it would suit him.'<sup>30</sup>

Although exact figures are unavailable, it is clear from the surviving correspondence of Stoneyetts Institution for adult mental defectives that many parents actively co-operated in moves to have their offspring institutionalised. Some appeared to be unreservedly convinced of the benefits of institutionalisation, such as Mrs. C., who wrote to Miss Stewart, Matron of Stoneyetts, in 1915 saying of her son's treatment at the institution, 'I can never forget the kindness which has been done for him since going to Stoneyetts'.<sup>31</sup>

Others simply seemed relieved to see the defective offspring removed from the family home and less than anxious to secure their return. When one Stoneyetts patient, W.R., told his father that some of the institutional staff had mentioned the possibility of a discharge from the institution, his father wrote to the Matron, Miss Stewart, with the following inquiries:

I am quite ready to give him another chance, but if he misbehaves again what will be the result? When he was at home he was too easy[sic] led into evil

---

<sup>29</sup> GHBA HB 20/1/3, Stoneyetts correspondence, A.A. to Matron Stewart (8<sup>th</sup> Aug. 1918).

<sup>30</sup> GHBA HB 20/1/3, Stoneyetts correspondence, A.A. to Matron Stewart (19<sup>th</sup> Dec. 1918).

<sup>31</sup> GHBA HB 20/1/2, Stoneyetts correspondence, Mrs C. to Matron Stewart (19<sup>th</sup> Mar, 1915).



company, and being a bit soft he was always the culprit. Perhaps he may have changed from all that. If you see your way to set him at liberty, I believe a good smart warning from you would serve the purpose. I would be delighted to have your opinion of him, he is nearly three years with you so I cannot say how much he has changed. Also I don't think he is as strong as he looks. Perhaps you could say what class of employment he is best suited for?<sup>32</sup>

Other families experienced internal disagreements over institutionalisation. Such was the case of the family of HB, another patient at Stoneyetts. Whilst H.B's mother was anxious for him to return home, at least for a short period, his sister expressed her reservations to the matron:

he has got so big and stout I was saying we would never manage him as we used to do and then going back only makes them think of home too much and perhaps would just make him have a bad week with the fits but my Mother would like to have him home... please do not let him no [ie. know] that I have written to you not asking him out as I put him off by saying I would ask him to get out if time permits you to let us know<sup>33</sup>

However, the correspondence files also show how some parents resisted the institutionalisation of a family member. In 1917, Miss Stewart wrote to AD Wood, secretary to the GBCS, giving details of an incident when the parents of one patient refused to allow their son to return to Stoneyetts at the end of four day period of leave, granted to allow the patient to visit her apparently sick mother. The account describes what happened when the matron sent one of her nurses to the parents' home to retrieve the patient:

[w]hen Nurse... arrived the Parents (including the Mother who was in quite good health) were so abusive and threatening to her that before she could remove the Patient the Police had to lock the Parents up until she got away – they were both however very much the worse of liquor.<sup>34</sup>

---

<sup>32</sup> GHBA HB 20/1/3, Stoneyetts correspondence, Mr J.R. to Matron Stewart (24<sup>th</sup> Apr. 1927).

<sup>33</sup> GHBA HB 20/1/5, Stoneyetts correspondence, Mrs B. to Matron Stewart (7<sup>th</sup> Aug. 1918).

<sup>34</sup> GHBA HB 20/1/37, Stoneyetts correspondence, Matron Stewart to AD Wood (10<sup>th</sup> Jan. 1917).

This was the only example of parental resistance bordering on violence found in the sample of letters viewed for this study. There are, however, numerous examples of parents writing to Stoneyetts questioning the need to have family members institutionalised and challenging the mental deficiency diagnosis that led to the removal. For instance, Mrs S. wrote the following letter to the GBCS regarding her daughter, who was apparently notified by her education authority as in need of institutional care after performing poorly at school. In the letter, Mrs .S. appears unable to accept that her daughter is mentally defective and hence questions the rationale behind her continued incarceration:

[m]y daughter was sent away for being slow to pick up lessons at school. She was to get home when she was sixteen. When I make an application to get her home they tell me I have not got sufficient room. Now [she] has an aunt who is both able and willing to take her and I would be very much obliged if you would use your authority in trying to get her out. She is now 23 years of age and her letters are heart-breaking. She is very unhappy and as there is no reason for keeping her a prisoner I think if matters are properly looked into she will be released. She is a fine healthy big girl and works very hard in the home; she is willing to go into service.

Sir, Her father and I would be very glad to see her out of the home. She is the only single girl we have left and would be a big help to us. If there was anything wrong with her we would not fight so hard for release but she was not sent away for violence or anything like that. Now her education is complete I do not know what they are keeping her for. I will await your reply.<sup>35</sup>

When another patient, J.C., was transferred from Stoneyetts institution to Gartloch lunatic asylum following a violent incident in the wards, the patient's father wrote to the GBCS suggesting that his daughter had been abused by staff members. Like Mrs S., the father of J.C. did not believe that his daughter was mentally defective.

I now take the opportunity of writing to you as regards [J.C.] and her mental condition, and I think that it is not fair sending her to Gartloch Hospital for there

---

<sup>35</sup> GHBA HB 20/1/41, Stoneyetts correspondence, Mrs .S. to GBCS (6<sup>th</sup> Sep. 1922).

is really nothing wrong with her, for if she had a chance of her freedom she would be all right as she is cowered down at present. Dear Sir, I may inform you that on May, the 8th, she was beat by two nurses at Stoneyetts and their names are Nurse...and Nurse...and if you doubt my statement then you are at liberty to call me to question and I will procure my witnesses for you for this is not the first time that it has happened. Now they have shifted her to Gartloch because she would not let them do as they liked and I would like to know if there is not a possible chance of me claiming her or even having her for a day or two at home for she has not seen the outside world in her life and as regards her crime she never did anything in her life for to be imprisoned all her days and I am willing to look after her if there is a chance of me having her home for, Sir, I may tell you that all the Medical Travelling Boards that was at Stoneyetts she never was at one so it is hard to tell if there is anything the matter with her, so I would like if you would look into her case as soon as possible and let me know for I would like to see her fairly done to [sic]<sup>36</sup>

On occasion, parents of patients enlisted professional allies to support their claim that a family member had been misdiagnosed and wrongfully institutionalised. The father of the patient E.L. attempted such a strategy when his daughter was granted a licence of leave from Stoneyetts. Unbeknownst to the institution's superintendent, the father used the opportunity to have E.L. examined by the local GP. The GP refuted the diagnosis of mental deficiency, and the father voiced his unwillingness to send his daughter back to the institution once the period of leave had ended. When the superintendent, Dr Chislett, inquired as to her whereabouts, the father replied as follows:

[i]s it not possible having a medical report from her town doctor stating that she is not a mental case to have her free from further action of the Board of Control a further period of Licence is surely not necessary, when I am in the position to inform you that Her own doctor and two of His assistants consider that she is not mentally unsound [sic]<sup>37</sup>

Chislett was far from impressed by this challenge to his medical authority:

---

<sup>36</sup> GHBA HB 20/1/41, Stoneyetts correspondence, Mr P.C. to GBCS (3<sup>rd</sup> Jun. 1925).

<sup>37</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Mr H.L. to Chislett (29<sup>th</sup> Sep. 1927).



Dear Sir,

Apparently you do not appreciate the circumstances attending ... [E.L]. These are as follows:-

Whilst she is on licence, she is still under our jurisdiction. If she is not reported to me by the day her licence expires, which is Wednesday, 5<sup>th</sup> October, she will require to be treated as if she has absconded, and I shall be compelled to take steps to have her apprehended, and possibly returned to the Institution, also anyone knowing her circumstances, who has helped her escape is liable to prosecution.<sup>38</sup>

Hence, it is clear that whilst Wright's model of parental co-operation can be applied to some cases of labelling and institutionalisation in twentieth century Scotland, the overall context was different to that which Earlswood operated under in the mid-nineteenth century. Scotland's mental deficiency administration progressively marginalised the role of parents, replacing voluntary provision with compulsion. As a result, a substantial number of parents did dispute the labelling of their offspring and resented state provision for mental defectives, particularly when it involved the removal of the alleged defective from the family home.

### *Securing a Discharge*

The case of E.L. also demonstrates the risks faced by any parent who (following the argument put forward by David Wright) wanted to use institutionalisation as a temporary means of providing for a defective family member, to help them through hard times. Once parental consent had been given for a mental defective to be relocated by the GBCS, the parents had little power to compel the defective's return. The Mental Deficiency Act stated that parental consent could be withdrawn at any time by a written statement to the GBCS requesting that the child be discharged from an institution or from private guardianship. The Board then had 14 days in which to respond to the request. If the officials felt that it was 'in the interest of the defective'<sup>39</sup> to continue provision, discharge would not be granted. The parents would then have to wait a year before they could repeat their request.

---

<sup>38</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Chislett to Mr H.L. (1<sup>st</sup> Oct. 1927).

<sup>39</sup> Mental Deficiency and Lunacy (Scotland) Act, 1913, s. 13 (1).

The GBCS based its decision as to whether or not it was in the interest of a patient to be discharged from an institution upon the verdict of the institution's medical superintendent. From the various cases found within the Stoneyetts correspondence files, the criteria upon which the superintendent delivered his verdict varied from case to case but generally took into account considerations of both the patient's progress and behaviour at the institution, but also the ability or willingness of the parents to provide an appropriate level of care and supervision at home. For example, Mrs P wrote to the GBCS in 1919 to give notice of her intention to secure the discharge of her son, also using the opportunity to make some critical comments regarding what she saw as the paucity of training at the institution:

I am going to take my boy home from Stoneyetts. I put him in there thinking he was going to be learned a trade, but I don't see anything to learn there. I will find him something to do where he will be a little help to me, instead of paying for him. He has a good home to come to and thats the main thing. [sic]<sup>40</sup>

Mrs P's letter is not a request: having voluntarily admitted her son to Stoneyetts, she assumed that his discharge would be granted to her on demand. In this, she was mistaken. The GBCS followed its usual course of action by passing the letter on to Chislett so that he could give his opinion on the case. Hence, the fate of Mrs P's son was to be decided by the superintendent who ran the institution that Mrs P had criticised in her note. Dr Chislett prevented the discharge, informing the GBCS that the patient's lack of progress in learning a trade indicated his unsuitability for life outside the institution:

[h]e shows some improvement since admission. Many bad habits have been corrected, and he is brighter and takes more interest in his surroundings... I do not consider, however, that the improvement is such that he should be discharged to his home, as he is still incapable of learning a trade, and still requires much supervision.<sup>41</sup>

Although parents were generally at the mercy of the authorities when it came to securing the return of relocated defective offspring, there were numerous occasions

---

<sup>40</sup> GHBA HB 20/1/39, Stoneyetts correspondence, Mrs P to GBCS (17<sup>th</sup> Nov. 1919).

<sup>41</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Chislett to GBCS (26<sup>th</sup> Nov. 1919).

when the institution superintendents were prepared to concur with parents' wishes. Whilst accommodation was short and waiting-lists long, administrators were under a certain amount of pressure to create space within the institutions for 'urgent' cases.<sup>42</sup> Discharging the less 'urgent' cases would achieve this. Nonetheless, despite the general conditions that might encourage the authorities to grant discharges, cases were decided upon at an individual level. Hence, the Stoneyetts correspondence files include many successful applications for discharge as well as many unsuccessful ones, with Chislett basing his decisions on the unique circumstances attending each case. For example, Mr. K. made the following appeal to the GBCS in 1922:

I wish to apply for the purpose of getting home...my son, who is an inmate of Stoneyetts institution, Chryston. My reason for doing so is his mother is on the verge of a nervous breakdown through him being confined in the above Institution so the only way is to have [him] home. Hoping you will see your way to grant my application.<sup>43</sup>

On being asked to give his verdict, Chislett made the following comments to the GBCS, resulting in the patient's release a week later:

[m]entally he is feeble-minded, his mentality being equal to that of a child of 10 years. He is quite well-behaved, and able to do light work under supervision. His physical condition is fairly good, but he has occasionally disordered action of the heart.

In my opinion he is suitable for discharge to a good home.<sup>44</sup>

Chislett's caveat regarding the patient's suitability for discharge 'to a good home' was significant. In deciding upon a discharge application, the superintendent assessed not only the patient but also the parents and the parental home, which was open to inspection from Board of Control inspectors and Poor Law officers (often the same individual). Parents seeking to secure the release of a family member could therefore assist their case by demonstrating to the authorities that they were 'respectable' and that

---

<sup>42</sup> See c. 5.

<sup>43</sup> GHBA HB 20/1/41, Stoneyetts correspondence Mr K. to GBCS (10<sup>th</sup> Jun. 1922).

<sup>44</sup> GHBA HB 20/1/41, Stoneyetts correspondence, Chislett to GBCS (14<sup>th</sup> Jun. 1922).



conditions in the home were suitable for the patient. At times, parents went to some lengths to win the superintendent's approval, as in the case of Mr and Mrs G, who claimed to have made alterations to their home in preparation for their re-application for their daughter's discharge. They made the following appeal to the GBCS in 1922.

I again make an appeal to get my daughter...home. On my last visit to Stoneyetts I was interviewed by Dr Chislets[sic] and when I asked him to let her home for a holiday he said He would not let her have a holiday as she is quite qualified to be discharged and that I was to appeal to you. I have had my house renovated and prepared for her to come home and if convenient please send your inspector to see the house so that you may be satisfied as to the improvements. Hoping this will meet with your full attention as soon as possible.<sup>45</sup>

Whatever renovations Mr and Mrs G. had made to their house, they proved inconsequential. In Chislett's account to the GBCS, the parents themselves were in his view inadequate to the task of ensuring the patient received a suitable level of supervision at home:

Mrs G. has applied to me on several occasions to have her daughter...home on pass, but on the advice of the Inspector...Glasgow District Board of Control, who knows the home conditions, I have always refused her application, also she does not appear to me to be a suitable guardian.

The patient's mental condition is that of feeble-mindedness, she is simple, easily led, and in my opinion would easily drift into immorality. Her physical condition is good.<sup>46</sup>

There were however, occasions when parents or guardians could obtain the support of the superintendent, even after initially falling out of favour with the authorities. In a series of letters between Mr L. and Chislett, written between June 1927 and February 1928, the following details can be recounted. Mr L. wrote to Chislett to request that his brother, R.L., be released into his care for a day (requests for short periods of leave were made directly to the superintendent rather than through the GBCS), but Chislett refused

---

<sup>45</sup> GHBA HB 20/1/41, Stoneyetts correspondence, Mr and Mrs G to GBCS (21<sup>st</sup> Jul. 1922).

<sup>46</sup> GHBA HB 20/1/41, Stoneyetts correspondence, Chislett to GBCS (27<sup>th</sup> Aug. 1922).

on the grounds that on a day-out two years earlier, Mr L. had failed to return his brother to the institution at the agreed time. An infringement of this kind was guaranteed to give the superintendent a low opinion of a parent's or guardian's ability to adequately supervise a patient. However, Mr. L. not only persisted in his request for a day release, he also made it clear that he wanted his brother permanently discharged from the institution. In a letter dated 16<sup>th</sup> June 1927, he told Chislett that he did not realise R.L. had failed to return to Stoneyetts at the correct time two years ago, though he admitted responsibility for the mistake. He also pointed out he had no intention of repeating the error, not least because his landlady objected strongly to the police turning up the last time in search of the missing patient. Mr L. ended the letter with the following appeal:

I wrote to Edinburgh [ie. the GBCS] to try and get him his discharge, he was interviewed by an commissioner, any chance he had of getting away for to work for himself you put the bar up for him by using the same complaint against him. If I could not do anybody a good turn I would not do him a bad one. Until I can get his discharge out of that place which I am trying hard for to get through every possible source I am asking you to reconsider your decision by doing so help me to help him in his best behaviour and from causing trouble to anyone.  
[sic]<sup>47</sup>

Chislett seems to have been moved sufficiently by the letter to arrange an interview with Mr L., following which, R.L. was allowed a day's leave.<sup>48</sup> As this passed without incident, Mr L. applied for another in September, this time with the purpose of taking R.L. to meet a potential employer, who had offered to take him on.<sup>49</sup> The superintendent agreed and the meeting seems to have been a success.<sup>50</sup> This encouraged Mr L. to re-apply to the GBCS for his brother's discharge, but the application was rejected when an inspector judged Mr L's home to be unsuitable. This prompted a further letter to Chislett in which Mr L. stated that the inspector had visited his home before he had got round to preparing his brother's room. Furthermore, the inspector had actively tried to dissuade his wife from taking M.L. into the home:

---

<sup>47</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Mr L. to Chislett (16<sup>th</sup> Jun. 1927).

<sup>48</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Chislett to Mr L. (18<sup>th</sup> Jun. 1927).

<sup>49</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Mr L. to Chislett (18<sup>th</sup> Sep. 1927).

<sup>50</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Chislett to Mr L. (20<sup>th</sup> Sep. 1927).

regarding my home investigation I can say very little for I was not in when the man called and my wife was quite at a loss what to say to him and by what she told me he seemed set on persuading her not to take [the brother] out just now that it would be too big an undertaking. We had quite a comfortable kitchen he admits but we had not the room ready then, but it is quite ready for inspection now and should you care to send down some one to see it I am quite sure it will meet with your approval. I will be at home on Tuesday afternoon from 2.30 should any one call they will be sure to find me in. failing that I will take it that you are quite prepared to take my word for it. I will in any case await your advice as to what course to take regarding [the brother's] discharge. I am anxious to have him out soon will I leave it to you or will I write to the board again will await your reply. [sic]<sup>51</sup>

By then, Mr L. appears to have secured the superintendent's trust. Chislett told him that his brother had been 'doing very well' and that he would recommend his discharge once suitable accommodation could be found.<sup>52</sup> The issue must have been settled because in a letter dated 22<sup>nd</sup> February 1928, the superintendent informed Mr L. that he had now given his recommendation to the GBCS and the discharge would be granted as soon as the board finished processing the application.<sup>53</sup>

The above example illustrates how parents and guardians could at times take positive action to influence the form of provision offered to family members within the mental deficiency system, whilst giving an indication of some of the difficulties they faced in securing their objectives. Mr L. had to win the favour of the superintendent, find a job for his brother (a task doubtless made more difficult by the brother being institutionalised at the time) and ensure that his own home met with the approval of the inspector.

The example can also be used to show how a particular feature of institutional care, namely the granting of temporary leave from the institution, developed over the period in response to the needs of parents, patients and the authorities. Besides giving patients the chance to spend time with their families, temporary leave offered parents and

---

<sup>51</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Mr L. to Chislett (undated).

<sup>52</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Chislett to Mr L. (23<sup>rd</sup> Dec. 1927).

<sup>53</sup> GHBA HB 20/1/13, Stoneyetts correspondence, Chislett to Mr L. (22<sup>nd</sup> Feb. 1928).



guardians a chance to demonstrate that they could be trusted to provide sufficient care and supervision; or conversely, it gave the authorities the chance to reach a conclusion as to how trustworthy the parents or guardians were.

Temporary leaves of absence granted by the institution superintendent had long been a feature of institutional management but during the inter-war period, the GBCS increasingly promoted the granting of longer periods of leave through a system of licensing. Such licences were issued by the GBCS for a trial period of between 3-12 months to see how defectives behaved and coped in less supervised surroundings, under either familial or non-familial guardianship. They were designed to assist in the transition from institutional to community living. According to Fraser, a trial period at home could placate parents anxious for their children to be returned from the institutions, even if it was decided at the end of the period of leave that the mental defective required further institutional provision:

[i]t is often impossible to say whether a defective who has been for some years in an institution will adapt himself to home life when discharged, or whether the parents or guardians will be able to carry out the supervision required. By liberating the patient on licence for a period of 3 or more months one can determine more accurately whether or not discharge is advisable. Sometimes the Licence has to be renewed for a further period. In a few instances it has had the indirect benefit of proving to the parent that a particular patient is much safer and happier in an institution.<sup>54</sup>

Licensed periods of leave may have helped make institutional care appear more palatable to parents, but there were still many who had opposed the institutionalisation of a family member in the first place. When it came to securing a discharge, parents of patients who had been placed into an institution by order of the sheriff were in a less favourable negotiating position than the parents who had given consent. The authorities petitioned for a sheriff's detention order when they disagreed with the parents over the parents' ability to provide adequate care or supervision within the family setting. It seems unlikely that administrators would agree to a discharge unless they were satisfied that the perceived inadequacies that had prompted the original order were remedied.

---

<sup>54</sup> HMSO, *GBCS Annual Report* 1934, xxxi.

Parents who disputed the continued institutionalisation of their children could appeal against detention orders,<sup>55</sup> but there were numerous bureaucratic, not to mention financial, obstacles to this strategy.

The 1913 act obligated District Boards of Control to renew each mental defectives' detention order at periodic intervals: one year after the first order was made, and every three years following that. In addition, a new order was required if the defective reached the age of 21 whilst in an institution or under guardianship. Again, the fate of defectives in institutions was left largely in the hands of the medical superintendents, who after examining the patient, would give their report to the GBCS. Boarded-out defectives were evaluated by Board of Control inspectors. The GBCS used these reports to decide whether or not to renew each order. Parents did not participate in this process but they could dispute a renewed order by taking the matter to court. The defectives themselves were present during the renewal proceedings, but again they could only appeal against the decision through the sheriff courts (providing they were adults). There are few figures available as to the proportion of appeals that were upheld, but the impression is that the superintendents' decisions were generally not overturned. In 1937, seven appeals were made: four at the instance of mental defectives and three at the instance of parents or guardians. Only one was upheld.<sup>56</sup>

An additional obstacle for parents seeking to overturn a renewal of the detention order was that many may not have been unaware that they could make an appeal. Most parents of mental defectives came from the poorer, less educated classes so it seems plausible that many would not have a detailed knowledge of their legal position. The GBCS seemed to be aware of this problem and made attempts to redress it in the 1930s: hence the GBCS's *Annual Report* for 1937 states that in 'recent years the Board, in making their intimations, have directed the attention of the defective and of the parent or guardian to this right of appeal',<sup>57</sup>

---

<sup>55</sup> Mental Deficiency and Lunacy (Scotland) Act, 1913, s. 12 (3).

<sup>56</sup> HMSO, *GBCS Annual Report* 1938, xliii. Although four appeals were made at the instance of patients, rather than their parents or guardians, this does not necessarily mean that the patients instigated the legal proceedings themselves. It is unlikely that mentally defective patients had access to legal advice or sufficient knowledge of the law to take legal action on their own volition: they may simply have been named by the parents or guardians when the action was first taken. Evidence on this issue is scarce but in 1908, the Moulin School Board found itself defending its decision to exclude a feeble-minded pupil from school at the Sheriff Court in Perthshire. When the grandfather of the child instigated legal proceedings against the school board he named his grandchild as plaintiff. See, *Scots Law Times – Reports* 15 (28<sup>th</sup> Mar. 1905), 1032-1037.

<sup>57</sup> HMSO, *GBCS Annual Report* 1938, xliii.

In fact, some parents were not even informed that the detention order on their child had been renewed at all. The wording of the Mental Deficiency Act was vague as to whether the authorities needed to pass on this information to the parents.<sup>58</sup> In cases where a local authority had presented the original petition for a detention order, the GBCS could interpret the law as meaning that they could choose between informing *either* the parent or guardian *or* the local authority about the order's renewal. Although the GBCS usually attempted to contact both, the law did not state specifically that failure to inform the parents or guardians would nullify the renewed detention order. As the Mental Deficiency Act gave interested parties only 14 days to lodge an appeal, any parent who failed to receive news of the renewal, for whatever reason, would effectively be denied the chance to contest the authorities' decisions.

In 1938, Mrs Isabella Pearson Page of Kirkcaldy took the GBCS to court for its failure to inform her of the renewal of the detention order for her son, James. James Bruce Innes (the mother had remarried: hence the different surnames) had been sent to Baldovan Certified Institution, Dundee, in 1932 after being issued a detention order, petitioned for by the local authority. After a year, the detention order was renewed and a letter of intimation was sent to Mrs Page's address. Unbeknownst to the Board, Mrs Page had moved house but was still living in Kirkcaldy. When the postal service returned the letter to the GBCS marked 'gone', administrators made no attempt to find out Mrs Page's new address and did not send any other letters of intimation on the subsequent occasions when her son's detention order came to be renewed. Mrs Page contended that her right to appeal had been denied. The GBCS argued that the law did not require its administrators to inform her that the detention order had been renewed, and even if it did, the letter they sent in 1933 should be regarded as sufficient.

The court found in favour of Mrs Page. In his report, the sheriff-substitute for Fife and Kinross, Dudley Stuart, stated that:

I am unable to accept the defenders' [ie. the GBCS] argument that it is sufficient if intimation is given, as in fact it was, to the local authority, as alternative to intimation to the parent or guardian. On the contrary, it seems to me clear that

---

<sup>58</sup> Mental Deficiency and Lunacy (Scotland) Act, 1913, s. 12 (2).



the parent or guardian, if there be one, he or she who has the vital interest in the defective must receive intimation of the Board's decision; otherwise the right of appeal to the Sheriff against that decision is nugatory.<sup>59</sup>

Stuart also criticised the GBCS for not attempting to find Mrs Page's new address, which, he suggests, could have been obtained from her son James had he been asked. He emphasised the 'necessity for the strict observance of the conditions prescribed by the statute in such a case where the liberty of the subject was at issue',<sup>60</sup> and, as he believed that these conditions had been breached, the court ordered James Bruce Innes to be discharged from Baldovan. The GBCS made two unsuccessful appeals against the verdict and the discharge was eventually granted in 1939.<sup>61</sup>

The judgement placed the onus of intimation onto the GBCS: even when parents had failed to inform the Board that they had changed address. This exposed other detention orders to the risk of being similarly overturned by the courts. Consequently, the Board's commissioners drafted an amendment to the Mental Deficiency Act, that would safeguard them against claims that they had infringed the liberty of the subject. The Mental Deficiency and Lunacy Amendment (Scotland) Act was passed in 1940.

Hansard only gives details of the Amendment's second reading in the House of Lords. Introducing the Bill, the Marquess of Zetland emphasised that its primary purpose was to safeguard additional detention orders from being invalidated. Under the amended law, it would not be necessary for the intimation of a renewed order to reach the parents. This effectively overturned the verdict of the Page v. GBCS case. However, the legislation also offered what Zetland termed a '*quid pro quo*'<sup>62</sup> to the parents or guardians. Namely that the 14 day window in which they had to lodge their appeal following a renewed order was abolished. Parents and guardians could now appeal at any time, with the proviso that if the sheriff judged against them they would have to wait another two years before they could appeal again.<sup>63</sup>

---

<sup>59</sup> *Scots Law Times – Reports* (18<sup>th</sup> Mar., 1939), 135.

<sup>60</sup> *Ibid.*

<sup>61</sup> HMSO, *GBCS Annual Report* 1938, xliii.

<sup>62</sup> Marquess of Zetland, *Parliamentary Debates: House of Lords* 115, Official Report, 5<sup>th</sup> Series (1939-40), 459.

<sup>63</sup> Mental Deficiency and Lunacy Amendment (Scotland) Act, 1940, s. 2.

Various judges involved with Page v. GBCS had criticised the Board for compromising the 'liberty of the subject'. With this in mind, it is not surprising that the 1940 act offered certain concessions to the parents. Nonetheless, the principal aim of the act was to ensure that the Board's renewed detention orders were secure. The Board did not have to ensure that parents were informed about renewals. Parents or defectives making an appeal against a renewed order would have to convince the judges that the 'expert' medical and legal opinions of the GBCS administrators were somehow at fault. If the appeal failed, no subsequent appeal could be made for another two years. After 1940, parents or guardians choosing to use institutionalisation or boarding-out as a temporary solution to a short term problem were still taking a risk. The decision to discharge mental defectives remained overwhelmingly the prerogative of the administrators.

### *Resistance from Patients*

The above discussion has examined the relationship between state and citizen during the implementation of mental deficiency policy by focusing on the interface between officials and state-employed medical professionals on the one hand, and family members of mental defectives on the other. The influence that mental defectives themselves could exert on proceedings has not been directly discussed. A detailed analysis on this topic is difficult to conduct because of the acute shortage of evidence.<sup>64</sup> Nonetheless, in his study of Sandlebridge, Jackson has used records compiled by Mary Dendy and her associates to show that patients, like their parents, could express 'dissension and resistance to the regime...in a number of ways'.<sup>65</sup> Some were rude or lazy, others violent and abusive; patients could directly challenge staff members, subvert authority by lying and stealing, indulge in 'erotic' behaviour that flouted attempts by staff to repress patients' sexuality, or abscond from the colony altogether. According to Jackson, such behaviour influenced management strategies at Sandlebridge in that it prompted the staff to introduce and refine various types of disciplinary measures. Staff interpreted deviant behaviour as a symptom of mental deficiency. However, Jackson points out that acquiescence to the colony's regime also marked a patient out as mentally defective: as Dendy put it, 'the fact that they are so contented shews [sic] that they are Feeble-minded.'<sup>66</sup>

---

<sup>64</sup> Oral histories could help redress this shortage: see, D. Atkinson, 'Autobiography and Learning Disability', *Oral History* 26 (1998), 73-80; Humphries and Gordon, *Out of Sight*, 99-116; Walmsley, 'Including People with Learning Difficulties', 62-77.

<sup>65</sup> Jackson, *Borderland of Imbecility*, 182.

<sup>66</sup> *Ibid*, 186.

As with Dendy's patients, the inmates of Scottish institutions for mental defectives could express numerous forms of dissent: these ranged from fairly common examples of mildly challenging behaviour to less frequent but more extreme forms of resistance. In the Stoneyetts correspondence files, superintendents' descriptions of 'troublesome' inmates include such phrases as 'lazy and apathetic', 'lacking powers of self control', 'emotional', 'untruthful', 'erotic' (generally used to describe female patients), and 'restless and impatient at being kept in hospital.'<sup>67</sup> On occasion, the correspondence focuses on more disturbing cases. Within a few months of being placed in Woodilee, F.M. was '[v]ery depressed and was caught trying to jump out of a window with suicidal intentions.' R.B.'s case notes stated that he 'lies in bed with his head under clothes and refuses to get up'.<sup>68</sup> The superintendents regarded all these forms of misbehaviour as indicative of mental deficiency, thereby justifying the patients' continued institutionalisation.

Less frequently, patients' behaviour proved intolerable to the institutional staff. In such cases, superintendents had the offending patients transferred to a lunatic asylum, where discipline was more stringent. B.W. was sent from Stoneyetts to Gartloch Asylum because '[s]he requires constant observation on account of impulsive actions, in which she destroys things, and attacks those near her without reason.'<sup>69</sup> J.M. received similar treatment because '[h]e has outbursts of religious fervour, and has on more than one occasion attacked without apparent provocation those working beside him.'<sup>70</sup> H.D. was transferred to an unnamed lunatic asylum because she was 'very homicidal', had 'hallucinations of sight and hearing' and 'delusions of persecution.'<sup>71</sup> It seems reasonable to assume (unless one takes the view that the case notes were deliberately misleading) that these patients were genuinely disturbed, although one could speculate that institutional life itself may have contributed to their problems. What is notable is that the dividing line between mental deficiency and insanity seemed to depend in part on the extent to which the staff of Stoneyetts felt able to cope with the patients' behaviour. Those patients who proved uncontrollable within the mental deficiency

---

<sup>67</sup> GHBA HB 20/1/43, Stoneyetts correspondence, case notes of patients transferred to Stoneyetts from Woodilee (1930); GHBA HB 20/1/41, Stoneyetts correspondence, Chislett to GBCS (20<sup>th</sup> Nov. 1924); GHBA HB 20/1/37, Stoneyetts correspondence, Chislett to Wood (10<sup>th</sup> Sep. 1916); GHBA HB 20/1/2, Stoneyetts correspondence, draft letter from Chislett regarding C.T. (undated: circa 1919).

<sup>68</sup> GHBA HB 20/1/43, Stoneyetts correspondence, case notes of patients transferred to Stoneyetts from Woodilee (1930).

<sup>69</sup> GHBA HB 20/1/42, Stoneyetts correspondence, Chislett to GBCS (26<sup>th</sup> May 1925),

<sup>70</sup> GHBA HB 20/1/37, Stoneyetts correspondence, Medical Officer to GBCS (22<sup>nd</sup> Nov. 1916).

<sup>71</sup> GHBA HB 20/1/37, Stoneyetts correspondence, Medical Officer to GBCS (7<sup>th</sup> Nov. 1916).



institution's disciplinary regime (usually because of violent behaviour) were rediagnosed as insane, illustrating how the medical distinction between mental deficiency and insanity was closely bound to the practice of institutional discipline.

Patients seeking to avoid the institutional regime altogether could attempt to escape. Between 1925 and 1938, an average of 25 patients absconded from Scotland's mental deficiency institutions each year (an average of 0.7% of the institutionalised population for each year). From the GBCS statistics, just over 70% of escapees were recaptured, usually within a few days of their disappearance.<sup>72</sup> That leaves a small number of inmates who succeeded in unofficially discharging themselves from their institutional captivity. This form of resistance influenced institutional policy in terms of leading to tighter security and necessitating links between institutional managers and local police forces who were given the task of finding escapees. One strategy employed by male mental defectives for avoiding recapture was to join the army whilst on licence or after escape from a certified institution.<sup>73</sup> This prompted the GBCS to make special arrangements with the Army Council in 1931 to exchange information on mental defectives found to have enlisted (though the Army Council reserved the right to retain known defectives in the forces if they were able to perform their duties).<sup>74</sup>

Attempts to escape carried the risk of considerable punitive action. If caught, patients would frequently find their visiting rights suspended and any chance of discharge severely diminished. Such was the case of A.G. who escaped from Stoneyetts in 1920. Prior to the escape, Chislett had successfully arranged her discharge on the grounds that she 'appeared to be doing well' at the institution and her parents' home conditions were good. However, on hearing that A.G. had absconded, the GBCS immediately wrote to Chislett requesting that her notice of discharge be returned.<sup>75</sup>

Some patients engaged in solitary acts of defiance, whilst others resisted in collusion with others. T.M. for example, caused consternation amongst the staff at Waverley Park certified institution (where she was an inmate), for trying to induce fellow patients to

---

<sup>72</sup> HMSO, *GBCS Annual Reports* 1925-38.

<sup>73</sup> HMSO, *GBCS Annual Report* 1931 (Cmd. 4163, 1932), 45.

<sup>74</sup> GHBA HB 20/1/37, Stoneyetts correspondence, GBCS Circular no. 222 (30<sup>th</sup> Dec. 1931).

<sup>75</sup> GHBA HB20/1/39, Stoneyetts correspondence, Chislett to GBCS (17<sup>th</sup> Jan. 1920); GHBA HB20/1/39, Stoneyetts correspondence, GBCS to Chislett (29<sup>th</sup> Jan. 1920).

‘run away by giving them the addresses in Glasgow to which they can go.’<sup>76</sup> More commonly, patients attempted to persuade their parents or other family members to apply for leaves of absence or permanent discharge. Mrs S. explained to the GBCS that her request for her daughter’s discharge was prompted by the ‘heart-breaking’ letters she had received from her.<sup>77</sup> However, parents varied to the degree to which they sympathised with such requests from institutionalised offspring. For example, W.R.’s pleas to be allowed home met with an unenthusiastic response from his father, who was concerned about what would happen when his son ‘misbehaves again’.<sup>78</sup>

The conclusions that can be formed from such limited evidence must be treated with caution, but there are grounds for arguing that mental defectives did find ways to express dissent, despite the apparent powerlessness of their position. When considering the position of patients, distinctions between the roles of family and state can become blurred: whilst some patients succeeded in enlisting the support of family members in their attempts to secure a return home, other patients had parents and guardians who had colluded in their institutionalisation in the first place. In such cases, parents and guardians aligned themselves with the state. It should also be noted that resistance did not characterise the behaviour of all mentally defective patients. Correspondence from Stoneyetts’ staff contain frequent references to the good behaviour of many of the inmates.<sup>79</sup> Good behaviour was, of course, a useful strategy for patients hoping to be discharged, but it could also simply reflect acquiescence to the disciplinary regime in which people found themselves captive.

## *Conclusion*

During the first half of the twentieth century, parents were increasingly marginalised in the process by which mental defectives were labelled and excluded from mainstream society. This did not mean that parents always opposed state policy in this area, nor that they lacked any power at all to influence the process by which the various forms of

---

<sup>76</sup> GHBA HB 20/1/44, Lennox Castle correspondence, report on T.M. by Waverly Park Home, Visiting Medical Inspector Isobel C. Armstrong (23<sup>rd</sup> Aug. 1939), enclosed in letter from GBSC to Chislett (26<sup>th</sup> Oct. 1939).

<sup>77</sup> GHBA HB 20/1/41, Stoneyetts correspondence, Mrs .S. to GBCS (6<sup>th</sup> Sep. 1922).

<sup>78</sup> GHBA HB 20/1/3, Stoneyetts correspondence, Mr J.R. to Matron Stewart (24<sup>th</sup> Apr. 1927).

<sup>79</sup> Eg. patients are described as ‘no trouble’ or ‘well behaved’ in each of the following: GHBA HB 20/1/3, Stoneyetts correspondence, Matron to Mrs R. (12<sup>th</sup> Jun. 1916); GHBA HB 20/1/44, Stoneyetts Correspondence, K. Fraser, notes on progress of Lennox Castle patients on licence (16<sup>th</sup> Mar. 1939); GHBA HB 20/1/44 Lennox Castle correspondence, letter from Chislett to Secretary GBCS (20/12/39); GHBA HB 20/1/43, Stoneyetts correspondence, case notes of patients transferred to Stoneyetts from Woodilee (1930).

special provision were allocated. However, they rarely instigated the diagnosis of their child as mentally defective because the school health service took the decision to have children medically examined out of the parents' hands. Furthermore, parents had little chance of reversing the decision of a school medical officer once it had been made. Teachers, medical officers and administrators took over the labelling role. These professionals consulted with parents and could be influenced by their acts of resistance, but resistance caused additional problems for the families concerned. These problems were sometimes financial, as with parents seeking take the authorities to court or pay for a private tutor to provide a 'normal' education for children outside the school system. Resistance could also deny pupils their education if parents refused to send children to special classes but lacked the money to provide private tuition at home. It could also lead to defectives being compelled to leave the family home if administrators responded to uncooperative parents by applying to the sheriff for a detention order.

It should also be noted that during a period when the number of people in Scotland labelled mentally defective grew dramatically, parents seemed unwilling to make use of the official terminology by which the authorities categorised their children. One notable feature of all the letters viewed from the Stoneyetts correspondence files is that parents overwhelmingly chose to avoid using terms like 'mental defective', 'feeble-minded', 'idiot' or 'imbecile' when describing the patients. This characteristic is common to both parents who supported the institutionalisation of a family member and parents looking for a discharge. Some used terms like 'soft', 'too easy led' or 'dazed', whilst others referred to the patients' 'trouble'.<sup>80</sup> Some concentrated on educational problems: 'my daughter was sent away for being slow to pick up her lessons at school', or '[h]e didn't do bad at school only the arithmetic puzzled him'.<sup>81</sup> More frequently, parents commented upon the patients' propensity to take fits or inquired as to the state of their child's physical health.<sup>82</sup> Many letters avoid all reference to medical matters.

---

<sup>80</sup> GHBA HB 20/1/3, Stoneyetts correspondence, Mr J.R. to Matron Stewart (24<sup>th</sup> Apr 1927); GHBA HB 20/1/5, Stoneyetts correspondence, Mrs A. to Matron Stewart (19<sup>th</sup> Dec. 1928); GHBA HB 20/1/28, Stoneyetts correspondence, Mrs J. to GBCS (26<sup>th</sup> Aug. 1917).

<sup>81</sup> GHBA HB 20/1/41, Stoneyetts correspondence, Mrs .S. to GBCS (6<sup>th</sup> Sep. 1922); GHBA HB 20/1/5, Stoneyetts correspondence, Mrs A. to Matron Stewart (19<sup>th</sup> Dec. 1928).

<sup>82</sup> 'He was a lad who never had a fit till eighteen months ago', GHBA HB 20/1/41, Stoneyetts correspondence, Mr J.M. to GBCS (1<sup>st</sup> May 1922); 'he will be bad enough with the fits', GHBA HB 20/1/5, Stoneyetts correspondence, Mrs B. to Matron Stewart (7<sup>th</sup> Aug. 1918); 'he had the flu, would you please let me know if he is any better or any worse since he had it, as his trouble started from the time he had influenza when he was about 14', GHBA HB 20/1/5, Stoneyetts correspondence, Mrs C. to Matron



On the other hand, if parents tended to recoil from official labels, they did not always resist official policies. Familial guardianship was popular because it allowed families to receive additional financial support from the state. Parents seemed to view this as an acceptable trade off for the increased level of state surveillance that could be directed towards familial guardians. Institutionalisation and boarding out also continued to be used, much as Wright described, as a means by which parents could temporarily relocate defective offspring during a period of hardship. The only problem here was that parents frequently experienced difficulty claiming their children back. In short, though parents were by no means passive in their relationship with the mental deficiency administrators, their influence seems severely restricted when compared to their mid-nineteenth century counter-parts.

---

Stewart (27<sup>th</sup> Nov. 1918); 'she was so poorly when I was visiting her on Saturday last', GHBA HB 20/1/3 Stoneyetts correspondence, Mrs R. to Matron Stewart (4<sup>th</sup> Oct. 1916).

## Conclusion

In the year 2000, the Scottish Executive published its new proposals on services for people with learning disabilities following a wide-ranging and thorough review of the issue. The resulting report, entitled *The Same as You? A Review of Services for People with Learning Disabilities*, does much to demonstrate the Executive's genuine interest in seeking to improve the quality of life for people with learning disabilities in Scotland, as part of the government's overall aim of encouraging greater social inclusion.<sup>1</sup> The review involved consultations with service providers, service-users and carers, and the report recommends that policy in this area should be guided by seven general principles. These principles stress the importance of people with learning difficulties being valued and having the same rights as everyone else, being seen as individuals, having their ideas heard (with assistance if necessary), being involved in choosing the services they want, having services that allow users to have 'as much freedom as possible', having services which take account of their age, using mainstream services 'wherever possible', and special services 'if they need them as well as, and not instead of, general services'.<sup>2</sup>

It is currently too early to assess the impact of the review and its recommendations, but they clearly mark another step in the attempt by the government to distance itself from those policies of segregation that characterised the period covered in this thesis. The report condemns the practice of institutionalisation saying '[h]ospitals are not places where people with learning disabilities can live full lives'.<sup>3</sup> It also recommends a 'major shift in the balance of care and support services', with more children with special educational needs being educated in mainstream schools and more people with learning disabilities having access to mainstream health, social care, education and employment services. The recommendations reflect a trend in government policy that extends at least as far back as the 1970s, when the *Report of the Committee of Enquiry into the Education of Handicapped Children and Young People* (commonly referred to as the 'Warnock Report') called for more integrated services for people with learning

---

<sup>1</sup> Scottish Executive, *The Same as You? A Review of Services for People with Learning Disabilities* (2000), <http://www.scotland.gov.uk/>. The following year, a similar document was produced by the English government: HMSO, Department of Health, *Valuing People: A New Strategy for Learning Disability for the 21<sup>st</sup> Century* (Cm 5086, 2001).

<sup>2</sup> *Ibid*, 10-11.

<sup>3</sup> *Ibid*, 39.

disabilities across the UK.<sup>4</sup> The view that pupils with special educational needs should have those needs met wherever possible in mainstream settings finally received legislative backing in 1981; whilst the imminent closure of Lennox Castle marks a landmark in the ongoing shift from institutional to community-based services. *The Same as You?* has not transformed the debate on social inclusion but it does restate the Scottish Executive's apparent commitment to speeding up the rate of change and ensuring that people with learning disabilities and their carers have a greater say in determining the types of services offered to them.

Such policies have the potential to benefit many people who would in earlier years have found themselves removed from their local community but it needs to be remembered that institutions have never had a monopoly over discriminatory practices, poor quality services and social exclusion: these problems can also occur within a community setting.<sup>5</sup> The government's good intentions can only be realised if community services are well-resourced and genuinely framed around the needs, choices and goals of individuals who require extra assistance from the state. The government must also find a way of delivering services without stigmatising service-users: on this point one must question the degree to which the practice of labelling increasing numbers of people as having a learning disability is a help or a hindrance.

To all appearances, Scottish policy on people with learning disabilities at the start of the twenty-first century differs greatly from policies on mental deficiency instigated during the late nineteenth and early twentieth centuries. The terminology has also undergone a series of transformations: 'mental deficiency' having been replaced by 'learning disability', and the sub-categories 'feeble-minded', 'idiot', and 'imbecile' are now abandoned in favour of less pejorative adjectives like 'mild', 'moderate', 'profound' and 'multiple'. Between 'mental deficiency' and 'learning disability', a number of other labels have moved in and out of fashion: these include 'mental sub-normality', 'mental retardation' and 'mental handicap'. More recently, 'intellectual disability' has begun to find favour in some quarters.<sup>6</sup>

---

<sup>4</sup> HMSO, *Committee of Enquiry into Education of Handicapped Children and Young People* (Cmnd 7212, 1977-78).

<sup>5</sup> A. Scull, 'Decarceration Reconsidered', J. Lowman, R.J. Menzies and T.S. Palys (eds.), *Transcarceration: Essays in the Sociology of Social Control* (Aldershot: Gover, 1987), c. 16.

<sup>6</sup> Scottish Executive, *The Same as You?*, 101.



Despite the change in labels and the moves towards more socially inclusive policies, some characteristics of the old mental deficiency administration have proved resilient. The term 'mental defective' may now be something of a relic, but the process by which they were 'manufactured' in increasing number has continued through the succession of different labels. *The Same as You?* states that '20 people for every 1000 have a mild or moderate learning disability', and a further '3 to 4 people for every 1000 have a profound or multiple disability'.<sup>7</sup> This brings the current total for the number of people in Scotland with learning disabilities to approximately 120,000. In arriving at this estimate, the Scottish Executive has defined learning disability using 'traditional descriptions from medicine and education along with details of the support that people need to be able to do the things they would like.'<sup>8</sup> It does not include people who developed their disability after the age of 18, nor does it include 'people with specific learning difficulties such as dyslexia'.<sup>9</sup>

In 1898, W.W. Ireland estimated that 2 per 1000 of Scotland's total population was mentally defective. The survey of Glasgow conducted by Carswell, Chalmers and Oswald in 1905 stated that mental defectives constituted 2.5 per 1000 of the city's total population (all age-groups), and 6.7 per 1000 children on the school roll.<sup>10</sup> In 1921, the SED counted 5 per 1000 mental defectives amongst the school-aged population of Scotland, but suggested that the figure might in reality be as high as 8.6 per 1000. In 1925, the GBCS suggested that 6.6 per 1000 of Scotland's school-aged population was mentally defective, whilst only 2.6 per 1000 of the total population of Scotland could be regarded as such. In 1933, the Scottish Council for Research in Education claimed that 'it would be rash in the extreme' to assume that 20 per 1000 of Scotland's school-aged population was mentally defective. Six years later, the Council opted for a figure of 12.6 per 1000 children.<sup>11</sup> The Scottish Executive currently believes that 23 or 24 per 1000 of the population has either a mild, moderate, profound or multiple learning disability.<sup>12</sup>

According to these statistics, the chances of having a learning disability in 2000 are over ten times greater than the chances of being labelled mentally defective a century earlier.

---

<sup>7</sup> *Ibid*, 5.

<sup>8</sup> *Ibid*, 3.

<sup>9</sup> *Ibid*, 102.

<sup>10</sup> See c. 4.

<sup>11</sup> See c. 5.

<sup>12</sup> The estimate for England is closer to 30 per 1000: HMSO, Department of Health, *Valuing People*, 14-16.

Labels have come and gone and some of the meanings associated with those labels have changed, but they have always changed in a way that results in an ever-increasing proportion of the population being identified as ‘different’ or ‘special’ on account of apparently low levels of intelligence. The government’s policies may have become more inclusive but so have the labels.

The number of people regarded as mentally defective in large scale surveys and estimates has always been significantly higher than the number of people actually in receipt of specialised state provision. In 1938, just under 9,800 mental defectives were included in either the SED’s or GBCS’s annual statistical returns for mental defectives accommodated in special classes, institutions or under private guardianship. Even if mental defectives in contact with state-subsidised voluntary organisation were added to these figures, the proportion of Scotland’s population involved prior to the Second World War would not come to more than 3 per 1000.<sup>13</sup> It should be born in mind that according to the Scottish Council for Research in Education, the actual incidence of mental deficiency within Scotland’s population in 1939 was supposed to be 12.6 per 1000.<sup>14</sup>

Despite the fact that the mental deficiency administration could never keep up with the inflated estimates of the large scale surveys, the number of mental defectives receiving special provision grew significantly as the administration extended its activities. This extension of services has continued up to the present day. According to *The Same as You?*:

[u]sing information from three local areas which appears to be reasonably thorough we estimate that only 30,000 people [with learning disabilities] are in regular contact with local authorities or the health service in Scotland. Others may have occasional or short-term contacts.<sup>15</sup>

Out of the 120,000 people with learning disabilities estimated to be living in Scotland, a quarter are believed to have regular contact with the state. They constitute approximately 6 per 1000 of the entire Scottish population.

---

<sup>13</sup> GBCS Annual Report 1937, ; GBCS Annual Report 1933, xxvi-xxxiv; see appendix.

<sup>14</sup> Macmeeken, *Intelligence of a Representative Group of Scottish Children*, 138.

The conclusions that can be drawn from these statistics present difficulties for policy-makers and service providers. If the current figures are viewed in isolation, they would give the impression that the majority of people with learning disabilities are not receiving state services. If those state services are seen to be beneficial (and there are common sense reasons for supposing that the quality of life for people with learning disabilities can be improved by some services, such as day-care home support, supported-employment services, supplementary benefits, etc.) then there is a good case for arguing that the state is failing in its duty to implement a welfare policy for people with learning disabilities that is both comprehensive and equitable.

Nonetheless, if one compares all the figures from the past 100 or so years it becomes clear that current estimates are problematic. From the late nineteenth century, state administrators, doctors and teachers began raising the conceptual borderline between mental deficiency and 'ordinary' intelligence, so that more people with higher levels of ability could be labelled mentally defective. The creation of the feeble-minded sub-category began this trend but decades after feeble-mindedness had achieved widespread (though never universal) acceptance, the number of mental defectives continued to grow.

Many of those involved in the process were prepared to admit that the rise in mental deficiency occurred as a result of changing definitions. Nowhere was this more true than in Glasgow, where the largest expansion of Scotland's mentally defective population took place. Dr John Carswell, the School Board of Glasgow's medical specialist on mental deficiency, talked in 1910 of the need to make the term 'mental defect' more 'elastic'.<sup>15</sup> His successor to the post, Dr Robert Marshall, who was responsible for certifying more feeble-minded mental defectives than probably anyone else in Scotland during the twenty years that followed the passing of the Mental Deficiency Act, claimed that feeble-mindedness was nothing more than 'a legal fiction'.<sup>17</sup> Glasgow Education Authority member, John Grimmond, claimed that Glasgow's special education policy was responsible for the 'manufacture' of mental defectives, whilst Dr. R. D. Clarkson, Medical Superintendent of Larbert, said in 1935 that the increase in mental deficiency

---

<sup>15</sup> Scottish Executive, *Same as You?*, 6.

<sup>16</sup> GCA D-ED 9/1/33, School Board of Glasgow, *Annual Report on Medical Inspection of Children* 1910, 51.

<sup>17</sup> *Scottish Educational Journal* 14 (1931), 606.



was 'due to different diagnosis. Forty years ago almost half of the cases that are now being certified as mentally defective would not have been so certified'.<sup>18</sup>

To understand why people consciously chose to label more individuals mentally defective it is necessary to consider a number of factors. From a broad perspective, the phenomenon fits in with the general trends towards the specialisation and expansion of bureaucracy in western society during the nineteenth and twentieth century. It provides an example of how social policy became increasingly shaped by professional 'experts': in this case, the medical profession and (though it had a lower status) the teaching profession. It also illustrates how the state was increasingly prepared to intervene in the lives of private citizens in response to some of the problems associated with advanced industrial society: notably, urbanisation, population growth, concentrations of poverty and unemployment. In particular, social reformers constructed a distinction between the 'undeserving poor' (able-bodied adults capable of work) and the 'deserving poor' (the young, the old, those with mental disabilities and those with physical disabilities) when deciding how charitable and state relief ought to be distributed.

These general explanations are useful in placing Scottish policy on mental deficiency within a broader context but more specific developments also need to be considered. In the mid-nineteenth century, idiocy and imbecility attracted people's attention as a result of highly publicised work being carried out on the continent, which purported to challenge the long-standing belief that idiots and imbeciles were incurable. Certain doctors and philanthropists (in Scotland, the Ogilvys and the Brodies stand out as early examples) established specialised institutions for idiots and imbeciles and lobbied the government for interventions that would legitimise their efforts and supply them with additional resources.

Local authorities saw in these new institutions a means of removing some of the more unmanageable inmates from mainstream poorhouses and hospitals. This was particularly evident in the large urban areas, where social problems existed on a grand scale and where the local population was capable of generating a rateable income large enough for local authorities to engage in ambitious and innovative projects. In Scotland, Glasgow was the locus for most of the local innovations. Poor Law authorities already had experience of utilising mental health services in their attempts to make the relief

---

<sup>18</sup> *Glasgow Herald* (19<sup>th</sup> December 1923), 7; HMSO, *Report on Scottish Health Services* 1936, 60.

system more efficient and, supposedly, more humane, by developing a policy of placing paupers judged to be insane in asylums and lunatic wards or boarding them out to private guardians. As specialised care for idiots and imbeciles became more established and better promoted through organisations like the Charity Organisation Society and the Society for the Education of Imbecile Youth in Scotland, the practice of placing idiots and imbeciles in the same wards as lunatics became the subject of increasing criticism. Asylums, like ordinary Poor Law institutions, experienced management and disciplinary problems exacerbated by over-crowding and once again, the removal of difficult patients to a separate specialist ward or institution appeared to be a widely accepted solution to the problem. Initially, Scottish institutional care for idiots and imbeciles was limited to juveniles under the age of eighteen but the Mental Deficiency Act also made adult institutions obligatory.

The growth of specialised institutional care for idiots and imbeciles encouraged local authorities to identify and segregate mental defectives. However, it was the establishment of a universal state education system that proved to be the most significant factor in encouraging officials to expand their conception of the condition to include more people of higher abilities. Again, Glasgow's local authorities took the initiative in Scotland. To understand why, one must consider not only the superior resources available to them, but also the role of individuals and the ideological and social contexts in which they operated.

William Mitchell was the first member of Glasgow School Board to take an active interest in mental deficiency by arranging for imbecile pupils to be transferred to Larbert institution during the 1880s. As the title of his book, *Rescue the Children*, suggests, Mitchell saw education as one part of a more general attempt to save the children of the poor from the evil influences of ignorance, poverty, ill health and immorality, in order to transform the youngest generation into better and more productive citizens than their predecessors.<sup>19</sup> For this reason, he and others who shared his general beliefs, turned their attention to the health of school children, which in turn led to their attention being drawn to pupils excluded from school on account of mental deficiency.

---

<sup>19</sup> Mitchell, *Rescue the Children*, 16.

When a number of English school boards began to experiment in special day classes, Glasgow's educational reformers were shown a way to deal more directly with its most difficult pupils. Following the English model, they adopted the concept of feeble-mindedness and applied it to children who were not responding positively enough to the discipline and the learn-by-rote teaching methods that characterised Glasgow's overcrowded classrooms. Paralleling the experience of Scotland's poorhouses and asylums, the school board attempted to improve the efficiency of its education system by certifying and segregating its most difficult pupils.

To create the special education system, school medical officers and teachers had to learn to work closely with one another. The transfer of children to special classes was arranged tentatively at first, but within a relatively short space of time, the identification and special education of feeble-minded pupils stopped being a novel experiment in educational reform and started to become routine. Teachers became increasingly familiar with the routine and consequently more willing to send pupils who were struggling in their studies to the school medical officer. The school medical officer in turn became more willing to certify educational failures and have them transferred to special classes. Educationalists could justify such actions in terms of the supposed educational benefits to both feeble-minded and ordinary children, whilst some teachers, such as Catherine Aitken could also invoke the notion of Christian charity towards the weak. School medical officers might prefer to view special education as a means of applying scientific principles to the state school system (this was John Carswell's view). All involved agreed that the most important criterion for transferring pupils to special classes was the pupil's educational performance.

Whilst Mitchell, a self-styled 'pioneer', chose to portray his school board's activities as a means of bringing about far-reaching changes in society, the everyday work of selecting pupils for special education tended to focus on the more immediate concerns of educationalists: namely school management and teaching. Mitchell's grand pronouncements appear better suited to the early days of innovation and experiment, but there are limits to the explanatory value of such rhetoric. In the 1880s, Mitchell identified seventy or so imbecile pupils in need of institutional treatment, whilst the survey of 1896 revealed only 167 pupils considered by school board members to represent the entire number of mentally defective children on the school roll. With these figures in mind, it seems unfeasible to believe those early pioneers in special education



could possibly have expected that by 1910 there would be over 1000 such pupils attending special classes in the city. For all that pioneers like Mitchell talked of transforming society, the most far-reaching expansion in the labelling and segregation of mentally defective children was achieved quietly, within the more limited aims of those doctors and teachers involved in the day-to-day routine. Most mentally defective children were labelled and segregated because they performed poorly in the classroom and because they were judged to be a hindrance to teachers and other pupils in the ordinary classrooms.<sup>20</sup>

A similar distinction between early rhetoric, and the more prosaic, but ultimately more significant workings of the routine that followed can be made when considering national policy on mental deficiency. During the late nineteenth century and the early twentieth century, mental deficiency became embedded in discourses of national efficiency and eugenics. This helped push the issue to the forefront of the political agenda, which in turn led to the appointment of the Royal Commission on the Care and Control of the Feeble-Minded and the passing of the English and Scottish Mental Deficiency Acts of 1913. The influence of this rhetoric was not negligible. As Mark Jackson has pointed out, it resulted in the ‘pathologising’ of mental defectives: hardening attitudes towards them and providing a justification for increasingly interventionist policies of mass segregation.<sup>21</sup> During the inter-war period, the negative rhetoric associated with mental deficiency continued to some degree, particularly within the institutional system where the most extreme form of segregated care and control was practised. However, even when the impetus towards institutional care was at its height, most mental defectives continued to be identified and segregated when they were young as a result of their supposed inability to benefit from teaching in mainstream classrooms.

Policy on mental deficiency in the early twentieth century has frequently been associated with the aims of the eugenics movement but the case has been over-stated. Whilst eugenicists tended to emphasise the need for life-long institutional care, Scottish policy was particularly geared towards allowing mental defectives to remain in the community. The policy of boarding-out mental defectives to strangers demonstrates that community-based care is not a modern phenomenon. In fact, whilst boarding-out is

---

<sup>20</sup> See c. 4.

<sup>21</sup> Jackson, *Borderland of Imbecility*, 33-40.

noteworthy in its status as a particularly Scottish policy (although boarding-out was practised to a limited degree south of the border), it was only one of a number of community-based services available in the first half of the twentieth century. In 1938, around 1,500 mental defectives were listed by the GBCS as being under private guardianship, but for many this merely meant being monitored and financially assisted whilst living with their families rather than being boarded-out to strangers. In the same year 4,800 children attended special day classes for mental defectives and the vast majority of these lived at home with their parents. There were also in excess of 3,000 mental defectives on the visiting lists of state-subsidised voluntary organisation, or attending voluntary sector occupation and employment centres. Some of the local voluntary organisations worked with institutionalised defectives but the majority served the local community. Around 3,700 mental defectives were accommodated in institutions at that time: institutionalised mental defectives therefore constituted a significant minority, but community-based forms of provision were more common.<sup>22</sup>

In view of the modern preference for community care, it might be tempting to argue from the above statistics that Scotland's mental deficiency administration was surprisingly progressive. However, as Mathew Thomson has argued, many community services worked in tandem with the institutional system by giving institution superintendents a chance to see how patients could respond to life in the community in a relatively controlled setting.<sup>23</sup> Policy makers did not really have to choose between community care and institutionalisation: both forms of care constituted different parts of the same general policy of segregated care and supervision. Mental defectives did not have to be institutionalised in order to be segregated and stigmatised: for instance, special education allowed mentally defective children to live with their families but they were still excluded from mainstream services and separated from many of their peers.

It is also worth noting that all the community-based services also existed in England, so Scotland has little grounds for claiming to have a particularly pioneering role in community care. Scotland's mental deficiency administration was generally quite similar to England's, which is not surprising when one considers that Scottish legislation on special education and the Mental Deficiency (Scotland) Act, 1913 was largely based on English models. The chief difference between the Scottish and English

---

<sup>22</sup> *GBCS Annual Report 1937*, ; *GBCS Annual Report 1933*, xxvi-xxxiv; see appendix.

<sup>23</sup> M. Thomson, *Problem of Mental Deficiency*, 179.

administrations (besides the greater use of boarding-out in Scotland) relate to the role of local authorities. Scotland's parish councils succeeded in securing a greater role for themselves within the local administration, thereby forging a stronger link between the mental deficiency system and the Poor Law administration. However many parishes lacked the resources to execute their duties to the satisfaction of the central authorities. Meanwhile, Scotland's education authorities retained the prerogative to decide for themselves whether or not they should open special classes in their own areas. Whilst English education authorities had a statutory duty to establish their own special classes after 1914, Scotland had to wait until the Education (Scotland) Act, 1936 for the provision of special education to be made mandatory. As a result, many education authorities, particularly those representing rural areas, were slow to develop their own special education systems. This exacerbated regional disparities in the implementation of policy, though again, such disparities also existed in England.<sup>24</sup>

On account of the regional disparities, it is more accurate to say that Scotland had a number of local mental deficiency administrations, rather than a single comprehensive system that spanned the country. There were also other ways in which the implementation of Scotland's mental deficiency policy lacked cohesiveness. As with England, Scotland's central administration continued to be split between two different authorities, with the SED regulating special education and the GBCS regulating institutionalisation and private guardianship. This split also existed at a local level, with the local administration divided between education authorities, parish councils and district boards of control. The Local Government (Scotland) Act, 1929 weakened the central administration further by removing the GBCS's role in negotiating Treasury contributions to local services for mental defectives, and giving local authorities more autonomy to devise their own administrative schemes.

Despite these administrative inefficiencies, the power of the state to intervene in the lives of mental defectives and their families grew considerably during the period. The school medical service took away the parents' right to decide whether or not their children should have their mental ability examined by a doctor. The Education (Scotland) Act of 1908 compelled parents to accept the school board's decision to transfer pupils into special classes. The Mental Deficiency (Scotland) Act increased the power of state officials to compel the institutionalisation of mental defectives with or

---

<sup>24</sup> *Ibid*, c. 6.



without the permission of the defectives themselves or their guardians. As the state became more willing to certify people as mentally defective, officials were able to exercise their powers over an increasing proportion of the Scottish population. Parents, guardians and mental defectives were able to influence the implementation of state policy through acts of resistance but resistance became more difficult over time.

After 1913, the public debate over mental deficiency lost much of its sense of urgency as more pressing concerns such as war, economic depression and unemployment dominated the political agenda. Still, the mental deficiency administration continued to gain momentum, with the result that the number of defectives labelled and segregated from their peers went on rising. Policy-makers seem to have allowed this rise to take place without much comment. Even now, the Scottish Executive seems to accept the view that 'the number of people with learning disabilities will continue to grow by over 1% a year over the next 10 years'.<sup>25</sup> The state uses labels as a means of identifying people believed to be in need of specialised support or supervision. Depending on the policies followed and the ways they are implemented this can be beneficial to those labelled but it can also lead to social exclusion and stigma. As the issue of learning disabilities has returned to the political agenda, it is now time to consider the implications of increased labelling more carefully. Unless its long term goal is to label the entire population of Scotland as having a learning disability, the Scottish Executive needs to face up to the fact that at some point the labelling is going to have to stop.

---

<sup>25</sup> Scottish Executive, *Same as You?*, 7. The English government expects a 1% rise for the next 15 years: HMSO, Department of Health, *Valuing People*, 14-16.

## Appendix

### Statistics from the SED

The Scottish Education Department's statistics for the period covered in this thesis can be found at the National Archive of Scotland (ED 55/108-955). Each year, the SED compiled various lists of figures onto hand-written ledgers. The Department published some of this information in their annual reports. The earliest set of ledgers retained by the archive date from the school-year 1912-13, and the series continues unbroken from that point. The archive does not have a complete set of records for the years before 1912-13. It does, however, have some printed statistical reports that cover most years in the first three decades of the twentieth century. Though they contain much the same information, the printed reports have a different format to the ledgers, which at times makes them easier to refer to but can also cause some confusion.

From time to time, the SED made small changes in the way it's officials calculated and formatted their statistics and I have found that these changes are generally easier to identify in the ledgers than they are in the printed reports. For this reason, I collated information from the ledgers by creating a relational database using Microsoft Access. Because the quality of the statistical evidence improved greatly after 1918, most of the information on the database relates to the inter-war years and to save time I have collected data on alternate years only. I have taken considerable steps to ensure that changes in the way the SED calculated and formatted its statistics has not led to inaccurate or misleading results on my database. I have also made clear to the reader in the text of the thesis points where the statistics are problematic. Additional information about the database can be provided on request.

## Select Bibliography

### Archival Sources

#### Glasgow City Archives:

D-ED 1/1/1/17	<i>Minutes of the School Board of Glasgow.</i>
D-ED 1/1/30	School Board of Glasgow, (later Glasgow Education Authority), Records of Mentally Defective Children (1909-1936).
D-ED 9/1/5/7	Education Committee, 'Glasgow Scheme of Education for the Glasgow Area' (1936).
D-ED 9/1/3/17	School Board of Glasgow, <i>Annual Reports of School Attendance by the School Attendance Committee.</i>
D-ED 9/1/33	School Board of Glasgow, <i>Annual Reports; Annual Report on the Medical Inspection of Children</i> ; Govan Parish School Board, <i>Annual Report of the Medical Inspection of School Children.</i>
D-ED 9/1/36	Glasgow Education Authority, <i>Annual Reports on the Medical Inspection of School Children.</i>
D-ED 11/1/186	Glasgow Education Authority, correspondence for tutorial classes. (1930-69).
D-HE 1/2/3	Staffing Instructions And Organisation Of Glasgow's Health Service (1930-48).
D-HEW 2/2	Barony Parochial Board, Minutes.
D-HEW 7/1	Glasgow District Lunacy Board, Minutes.
D-HEW 7/2	Printed Minutes Of Parochial Board And Committees Relating To District Lunacy Board.
D-HEW 7/4	Boarding Out Of Mental Patients Register (1886-1923).
D-HEW 7/5	Lunatic Asylum Record Of Petitions - After 1923 This Comes Under Public Assistance Committee (1921-43).
D-HEW 7/6	Register Of Notified Cases (1932-7)
D-TC 6/606/6/17	Scheme For Constitution Of Education Committee Under Local Government Act, 1929.
D-TC 7/7/13	<i>Annual Report of the Glasgow Infant Health Visitor's Association 1911-12.</i>
D-TC 14/2/21	Scheme for constitution of education committee under Local Government (Scotland) Act, 1929 (1932).
T-PAR 1.10	<i>Annual Reports of the Glasgow Association for the Care of Defective and Feeble Minded Children.</i>
T-PAR 1.19	Glasgow Parish Council Association, 'Conference of Parish Councils of Scotland on Mental Deficiency Bill', (1912).

#### Glasgow Health Board Archives:

HB 19/1/2	Glasgow District Board of Control, 'Minutes of the Chairman's Committee'.
HB 19/2/2	Reports relating to pressure on accommodation in Glasgow's mental institutions (1930-1).
HB 19/2/14	Statement to be submitted to Departmental Committee on Scottish Lunacy and Mental Deficiency Laws.
HB 20/1/1-50	Correspondence from Stoneyetts Certified Institution (1913-36) and Lennox Castle Institution (1936-48).
HB 20/2/1-10	Register of mental defectives in institutions.
HB 20/3/1	Case notes on patients at Stoneyetts (1914-19).
HB 20/4/8	Minutes and examination papers for the Royal Medico-Psychological Association; minutes of Scottish Association for Mental Welfare, brochures of Mental After-care Association; notes on Lennox castle (1927-36).
HB 30/8/23	List and notes of imbecile patients transferred from Woodilee to Lennox castle or Caldwell house (1937).
HB 38/2/3	School Board of Glasgow/Glasgow Education Authority, press cuttings relating to child welfare (1909-1939).



### **National Archive of Scotland:**

ED 7/7/1	SED, 'Special Education file' (1898-1901).
ED 28/228	SED, memorandum on special education and care of mentally defective children (1938).
ED 28/229	SED, suggested amendments to Mental Deficiency Acts (1931).
ED 28/230-231	SED, education and care of mentally and physically defective children; ascertainment and provision before and after age of 16; draft and issue of circular (1932-7 ).
ED 55/108-955	SED, annual statistics.
MC 8/2	GBCS, minutes.
MC 9/1	GBCS, circulars.
MC 13/3-5	General Board of Lunacy for Scotland/GBCS, legislation on lunatics and mental defectives with additional notes and newspaper cuttings (1857-1940).
MC 14/6	GBCS, miscellaneous, including J. Carswell, 'The Fifth Maudlsey Lecture: Some Sociological Considerations Bearing Upon the Occurrence, Prevention and Treatment of Mental Disorders', reprinted from the <i>Journal of Mental Science</i> (1924).

### **Public Record Office:**

ED 50/117	Correspondence related to training of special school teachers (c. 1920).
-----------	--

### ***Acts of Parliament***

- Lunacy (Scotland) Act, 1857 (20 & 21 Vic., c. 71).
- Lunacy (Scotland) Act, 1862 (25 & 26 Vic., c. 54).
- Lunacy (Scotland) Act, 1866 (29 & 30 Vic., c. 51).
- Elementary Education Act, 1870, (33 and 34 Vic., c. 75).
- Education (Scotland) Act, 1872 (35 & 36 Vic., c. 62).
- Education (Scotland) Act, 1878 (41 & 42 Vic., c. 78).
- Education (Scotland) Act, 1883 (46 & 47 Vic., c. 56).
- Idiots Act, 1886 (49 & 50 Vic., c. 25).
- Prevention of Cruelty to, and Better Protection of Children Act, 1889 (52 & 53 Vic., c. 44).
- Lunacy (Consolidation) Act, 1890, (53. Vic., c. 5).
- Education of Blind and Deaf-mute Children (Scotland) Act, 1890 (53 & 54 Vic., c. 43).
- Elementary Education (Blind and Deaf Children) Act, 1893 (56 & 57 Vic. c. 42).
- Prevention of Cruelty to, and Better Protection of Children Act, 1894 (57 & 58 Vic., c. 27).
- Elementary Education (Defective and Epileptic Children) Act, 1899 (62 & 63 Vic., c. 32).
- Education (Scotland) Act, 1901 (1 Edw. 7, c. 9).
- Education of Defective Children (Scotland) Act, 1906 (6 Edw. 7, c. 10).
- Education (Provision of Meals) Act, 1906, (6 Edw. 7, c. 57).
- Education (Scotland) Act, 1908 (8 Edw. 7, c. 63).

Children Act, 1908 (8 Edw. 7, c. 67).

Mental Deficiency and Lunacy Act, 1913 (3 & 4 Geo. 5, c. 28).

Mental Deficiency and Lunacy (Scotland) Act, 1913 (3 & 4 Geo. 5, c. 38).

Elementary Education (Defective and Epileptic Children) Act, 1914 (4 & 5 Geo. 5, c. 45).

Education (Scotland) Act, 1925 (15 & 16 Geo. 5, c. 89).

Education (Scotland) Act, 1936 (26 Geo. 5 & 1 Edw. 8, c. 42).

Mental Deficiency (Scotland) Act, 1940 (3 & 4 Geo. 6, ch. 8).

Education (Scotland) Act, 1945 (8 & 9 Geo. 6, c. 37).

Education (Scotland) Act, 1946 (9 & 10 Geo. 6, c. 72).

### *Official Publications*

HMSO, *Report of the Committee of Council of Education in Scotland with Appendix*, 1907-1908.

HMSO, *Annual Reports of the Local Government Board for Scotland* 1894-1919.

HMSO, *Annual Reports of the General Board of Commissioners in Lunacy for Scotland* 1859-1913.

HMSO, *Annual Reports of the General Board of Control for Scotland* 1914-1938.

HMSO, *Census of Scotland* 1861-1931, and 1991.

HMSO, *The Acts of the Parliaments of Scotland* I (London: 1844).

HMSO, *Scottish Lunacy Commission Report on Lunatic Asylums in Scotland* I, 1857 (2148).

HMSO *Report of the Royal Commission on the Blind, the Deaf, and the Dumb* (C 5781, 1889).

HMSO, *Report of the Departmental Committee on Defective and Epileptic Children* I-II (C 8746-7, 1898).

HMSO, *Royal Commission of Physical Training in Scotland* (Cd. 1508, 1903).

HMSO, *Interdepartmental Committee on Physical Deterioration*, (Cd. 2032, 1904).

HMSO, *Interdepartmental Committee on Medical Inspection and the Feeding of Children*, (Cd. 2784, 1906).

HMSO, *Royal Commission on the Care and Control of the Feeble-Minded* III (Cd. 4217, 1908).

HMSO, *Royal Commission on the Care and Control of the Feeble-Minded* VIII (Cd. 4202, 1908).

HMSO, *Report of the Royal Commission on the Poor Laws and Relief of Distress* (Cd. 4499, 1909).

HMSO, *Feeble-Minded Persons Under the Poor Law (Scotland)* (539, 1913).

HMSO, *Regulations made by the Scotch Education Department under Sections 3 (2) and 78 of the Mental Deficiency and Lunacy (Scotland) Act, 1913* (Cmd. 7420, 1914).

HMSO, *Departmental Committee on Sexual Offences Against Children and Young Persons in Scotland* (Cmd. 2592, 1926).

HMSO, *Report of the Interdepartmental Committee on Mental Deficiency* (London: 1929).

HMSO, *Report of the Department of Health for Scotland's Committee on Scottish Health Services* (Cmd. 5204, 1935-6).

HMSO, *Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws* (Cmd. 6834, 1946).

HMSO, *Royal Commission on Local Government in Scotland 1966-69* (Cmnd. 4150, 1968-69).

HMSO, *Committee of Enquiry into the Education of Handicapped Children and Young People* (Cmnd 7212, 1977-78).

Scottish Executive, *The Same as You? A Review of Services for People with Learning Disabilities* (2000) ([www.scotland.gov.uk](http://www.scotland.gov.uk)).

HMSO, Department of Health, *Valuing People: A New Strategy for Learning Disability for the 21<sup>st</sup> Century* (Cm 5086, 2001).

### ***Serials***

*British Medical Journal*

*Glasgow Herald*

*Edinburgh Medical Journal*

*Educational News*

*Glasgow Medical Journal*

*Hansard*

*Journal of Mental Science*

*Journal of State Medicine*

*Medical Directory*

*Lancet*

*Poor Law Magazine*

*Public Health Magazine*

*School Hygiene*

*Scots Law Times*

*Scottish Educational Journal 1918-1956.*

*Scottish Medical and Surgical Journal*

*Transactions of the Royal Philosophical Society of Glasgow*

### ***Published Primary Sources***

Anon. 'Medical Inspection in Ayrshire', *School Hygiene* 2 (1911), 638-640.

Anon., 'Mental Deficiency and Lunacy (Scotland) Bill', *The Poor Law Magazine*, 23 (1913), 285-286.

Anon, 'Dr John Macpherson', *Poor Law Magazine* 23 (1913), 385-388.

Anon, 'The Bernard Street Open-air School in Glasgow', *School Hygiene* VIII (1917), 53-58.

Anon, 'Problems of the Mentally Defective', *Scottish Educational Journal* (1924).

Binet, A, and Simon, T. (translated by Town, C.H.), *A Method of Measuring the Development of Intelligence of Young Children* (Illinois: Courier-Herald, 1913).

Brown, G.A., 'The Method of Investigation and Selection of Necessitous School Children in Govan Parish, Glasgow', *School Hygiene* 5 (1914), 156-165.

Butterworth, J.J., 'The Diagnosis of Feeble-mindedness in School Children', *Public Health* 24 (1910-1911), 425-428.

Carswell, J., 'Lunacy in Relation to Public Health Administration', *Transactions of the Royal Philosophical Society of Glasgow*, (1911), 137-148.

Carswell, J., 'The Legal Control of Inmates', *Transactions of the Royal Philosophical Society of Glasgow*, (1910), 101-113.



- Carswell, J., 'Insanity and Alcoholic Excess', *Scottish Medical and Surgical Journal* 13 (1903), 385-390.
- Carswell, J., 'The Working of the Inebriates Act', *Journal of Mental Science* (1901), 658-666.
- Carswell, J., 'The Care and Education of Weak-minded and Imbecile Children in Relation to Pauper Lunacy', *Journal of Mental Science* 44 (1898), 474-491.
- Carswell, J., 'Dangerous Lunatics Charged with Crime', *Journal of Mental Science* (1896), 517-525.
- Davies, A.M., 'The Presence of the Parent at Medical Inspection', *School Hygiene* 2 (1911), 89-93.
- Dickens, C., 'Idiots', *Household Words* (1853).
- Down, J.L.H., *Mental Affections of Children and Youth* (London: Churchill, 1887).
- Fraser, K., 'Feeble-minded Children - an Inquiry into Mental Deficiency in School Children with Special Reference to Syphilis as a Causative Factor as Determined by the Wassermann Reaction' (MD. thesis, Glasgow University, 1913).
- Fraser, K., 'The Use of the Binet-Simon Tests in Determining the Suitability of a Child for Admission to a Special School', *School Hygiene* 2, IV (1913), 77-88.
- Fraser, K., and Watson, H.F., 'The Role of Syphilis in Mental Deficiency and Epilepsy', *Journal of Mental Science* 59 (1913), 641-651.
- Glasgow Education Authority, *Report of the Educational Requirements of Glasgow* (Glasgow: McCorquodale, 1920).
- Gibson, G., 'The Boarding-out System in Scotland', *Journal of Mental Science* 71 (1925), 253-264.
- Graham, E.J., *The Mental Deficiency and Lunacy (Scotland) Act, 1913 : (3 & 4 Geo. V., Cap. 38) with Introduction, Notes and Appendices* (Edinburgh: William Hodge, 1914).
- Henderson, D.K., 'Mental Hygiene', *Glasgow Medical Journal* 6 (1923), 337-360.
- Ireland, W.W., *The Mental Affections of Children, Idiocy, Imbecility and Insanity* (London: J. & A. Churchill, 1898).
- Ireland, W.W., 'Visits to Danish Asylums for the Feeble-Minded and other Institutions', *Journal of Mental Science* 44 (1898), 45-65.
- Ireland, W.W., 'Observations on Mental Affections in Children and Allied Neuroses', *Edinburgh Medical Journal* XLI (1895), 97-105.
- Ireland, W.W., 'On the Diagnosis and Prognosis of Idiocy and Imbecility', *Edinburgh Medical Journal* (1882), 1072-1085.
- Ireland, W.W., 'On Idiocy, especially in its Physical Aspects', *Edinburgh Medical Journal*, vol. 19, part 2 (Jan. to Jun. 1874), 593-610 and 689-702.
- Kelynack, T.N. (ed.), *Defective Children* (London: P.S. King and Son, 1915).
- Kelynack, T.N. (ed.), *Medical Examination of Schools and Scholars* (London: P.S. King and Son, 1910).
- Lapage, C.P., *Feeble-mindedness in Children of School-Age, with appendix by Mary Dendy* (Manchester: Manchester University Press, 1911).
- Mackenzie, H.L., 'Child Welfare in Scotland', *School Hygiene* 7 (1916), 97-109.
- MacMeeken, A.M., *The Intelligence of a Representative Group of Scottish Children* (London: University of London Press, 1939).

- Macpherson, J., 'The Duties of Parish Councils as Laid Down in the Regulations Under the Mental Deficiency and Lunacy (Scotland) Act' *Poor Law Magazine* 24 (1914), 255-268.
- Macpherson, J., 'The Administration By Parish Councils of their Powers and Duties Under the Mental Deficiency and Lunacy Amendment Act, 1913', *Poor Law Magazine*, 23 (1913), 341-360.
- R.M. Marshall, 'Differential Diagnosis of Manic Depressive Insanity and Dementia', *Glasgow Medical Journal* (1913).
- Marshall, R.M., 'Periodic Attacks of Excitement and Depression in the Chronic Insane', *Journal of Mental Science* (1911), 74-85.
- Marshall, R.M., 'Intra-Cranial tumour with Mental Symptoms', *Journal of Mental Science* (1909), 310-321.
- Mackenzie, L., 'Scotch Education Department: Memorandum on Systems of Physical Training and their Relation to the Personal Hygiene of School Life', *Public Health* 20 (1907-8), 268-272.
- Mitchell, W., *Rescue the Children: or Twelve Years' Dealing with Neglected Girls and Boys*, (London: Wm. Isbister Ltd., 1886)
- Morel, B.A., *Traité des dégénérescences physiques, intellectuelles et morales de l'espèce humaine* (Paris: Bailliere, 1857).
- Nicholls, W.A., 'The Doctor in the School', *School Hygiene* 1 (1910), 37-40.
- Pinsent, E.F., 'Our Provision for the Mentally Defective', *The Nineteenth Century* 70 (1911), 705-714.
- Poole, R., *An Essay on Education* (Edinburgh: Waugh and Innes, 1825).
- Richards, H.M., 'The Methods and Aims of the Medical Inspection of School Children', *Public Health* 21 (1908-9), 31-34.
- Roberts, E.T., 'Medical Inspection in Relation to Special Schools', *Journal of State Medicine* 22 (1914), 594-601.
- Seguin, E., *Idiocy: and its Treatment by the Physiological Method* (New York: William Wood & Co, 1866).
- Shrubsall, F.C., 'The Ascertainment of Mental Deficiency', *School Hygiene* 12 (1921), 115-137.
- Scottish Council for Research in Education, *The Intelligence of Scottish School Children* (London: University of London Press, 1933).
- Shuttleworth, G.E., 'On some Slighter Forms of Mental Defect in Children and their Treatment', *BMJ* (1903), 828-830.
- Shuttleworth, G.E., 'The Industrial Training of Imbeciles', *Journal of Mental Science* 44 (1898), 531-535.
- Shuttleworth, G.E., *Mentally Defective Children: Their Treatment and Training* (London: H.K. Lewis, 1895).
- Tredgold, A.F., *Mental Deficiency (Amentia)* (London: Bailliere, Tindall & Cox, 1908), and subsequent editions.

### *Published and Unpublished Secondary Sources*

- Abrams, L., *The Orphan Country: Children of Scotland's Broken Homes from 1845 to the Present Day* (Edinburgh: John Donald, 1998).
- Albrecht, G.L., *The Disability Business: Rehabilitation in America* (Newbury Park: Calif Sage, 1992).
- Anderson, N., and Langa, A., 'The Development of Institutional Care for 'Idiots and Imbeciles' in Scotland, *History of Psychiatry* 8 (1997), 243-266.
- Anderson, R.D., *Education and the Scottish People 1750-1918* (Oxford: Clarendon Press, 1995).
- Andrews, J., 'Begging the question of idiocy: the definition and socio-cultural meaning of idiocy in early modern Britain: Part 1', *History of Psychiatry* 9 (1998), 65-95.
- Andrews, J., 'A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry', *History of Psychiatry* 8 (1997), 177-212.
- Andrews, J., 'Identifying and Providing for the Mentally Disabled in Early Modern England', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 4.
- Andrews, J., and Smith, I., 'The Evolution of Psychiatry in Glasgow During the Nineteenth and Early Twentieth Centuries', Freeman, H., and Berrios, G.E., *150 Years of British Psychiatry Volume II: the Aftermath* (London: Athlone, 1996), 313-4.
- Atkinson, D., Jackson, M., Walmsley, J. (eds.), *Forgotten Lives: Exploring the History of Learning Disability* (Kidderminster, BILD Publications, 1997).
- Bailey, V., *Delinquency and Citizenship* (Oxford: Clarendon Press, 1987).
- Barclay, J., *Langho Colony/Langho Centre. 1906-1984: A Contextual Study of Manchester's Public Institution for People with Epilepsy* (Manchester: Manchester Social Services, publication date not given).
- Barfoot, M., and Morrison-Low, A.D., 'W.C. M'Intosh and A.J. Macfarlan: Early Clinical Photography in Scotland', *History of Photography* 23 (1999), 199-210.
- Barker, D., 'The Biology of Stupidity: Genetics, Eugenics and Mental Deficiency in the Inter-War Years', *British Journal for the History of Science* 22 (1989), 347-375.
- Barker, D., 'How to Curb the Fertility of the Unfit: The Feeble-minded in Edwardian Britain'. *Oxford Review of Education*, 9 (1983), 197-211.
- Barnes, C., 'A Legacy of Oppression', Barton, L., and Oliver, M. (eds.), *Disability Studies: Past, Present and Future* (Leeds: Disability Press, 1997), c. 1.
- Barrett, M.A., 'From Education to Segregation' (PhD thesis: University of Lancaster, 1987).
- Barton, L., and Oliver, M. (eds.), *Disability Studies* (Leeds: Disability Press, 1997).
- Barton, L., 'The Politics of Special Educational Needs', L. Barton and Oliver, M. (eds.), *Disability Studies* (Leeds: Disability Press, 1997), c. 9.
- Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999).
- Bartlett, P., and Wright, D., 'Community Care and its Antecedents', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 1.



- Becker, P., 'The Triumphant Advance of Degeneration: Medical Sciences and Criminal Law in Nineteenth Century Germany' Otsuka, Y. and Sakai, S. (eds.), *Medicine and the Law*, (Tokyo: Ishiyaku EuroAmerica, 1998), 83-128.
- Berrios, G.E., 'Mental Retardation: Clinical Section – Part II', Berrios, G.E. and Porter, R., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), 225-238.
- Berrios, G.E., and Freeman, H. (eds.), *150 Years of British Psychiatry* (London: Gaskell, 1991).
- Berrios, G.E., and Porter, R., *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995).
- Blackden, S., 'The Poor Law and Health: A Survey of Parochial Medical Aid in Glasgow, 1845-1900', Smout, T.C., (ed.), *The Search for Wealth and Stability : Essays in Economic and Social History Presented to M.W. Flinn* (London: Macmillan, 1979), 243-262.
- Bury, M.R., 'Social Constructionism and the Development of Medical Sociology', *Sociology of Health and Illness* 8 (1986), 137-169.
- Butt, J., 'The Industries of Glasgow', Fraser, W.H., and Maver, I., *Glasgow Volume II: 1830 to 1912* (Manchester: Manchester University Press 1996), 96-140.
- Butterfield, P.H., 'The Evolution of Special Education 1893-1939' (PhD. thesis, University of London, 1970).
- Bynum, W.F., Porter, R., and Shepherd, M. (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry Vol. 3* (London: Routledge, 1988).
- Bynum, W.F., Porter, R., and Shepherd, M. (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry Vol. 2* (London: Tavistock Publications, 1985).
- Bynum, W.F., Porter, R., and Shepherd, M. (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry Vol. 1* (London: Tavistock Publications, 1985).
- Cage, R.A. (ed.), *The Working Class in Glasgow 1750-1914* (London: Croom Helm, 1987).
- Campbell, J., 'Mental Health Policy, Care in the Community and Political Conflict: The Case of the Integrated Service in Northern Ireland', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 11.
- Chappell, A.L., 'From Normalisation to Where?', Barton, L., and Oliver, M. (eds.), *Disability Studies* (Leeds: Disability Press, 1997), c. 3.
- Checkland, S.G., *The Upas Tree: Glasgow 1875-1975...and After 1975-1980*, (Glasgow: University of Glasgow Press, 1981).
- Checkland, O., *Philanthropy in Victorian Scotland: Social Welfare and the Voluntary Principle* (Edinburgh: Donald, 1980).
- Cole, T., *Apart of a Part: integration and the growth of British Special Education*, (Milton Keynes: Open University Press, 1989).
- Cole, T., 'The History of Special Education: Social Control or Humanitarian Progress?', *British Journal of Special Education* 17 (1990), 101-7.
- Cooter, R., *Surgery and Society in Peace and War* (London: Macmillan, 1993).
- Cox, P., 'Girls, Deficiency and Delinquency', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 9.
- Crowther, M.A., 'Poverty, Health and Welfare', Fraser, W.H., and Morris, R.J., *People and Society in Scotland II 1830-1914* (Edinburgh: Donald, 1990), c. 9.

Crowther, M.A., 'Family Responsibility and State Responsibility in Britain Before the Welfare State', *Historical Journal* 25 (1982), 131-145.

Crowther, M.A., *The Workhouse System 1834-1929: The history of an English social institution* (London: Batsford, 1981).

Cruickshank, M., *A History of the Training of Teachers in Scotland* (London: University of London Press, 1970).

Curtis, S.J., *History of Education in Great Britain* (London: University Tutorial Press, 1967).

Day, K., and Jancar, J., 'Mental Handicap and the Royal Medico-Psychological Association: a Historical Association, 1841-1891', Berrios, G.E., and Freeman, H., *150 Years of British Psychiatry 1841-1991* (London: Gaskell, 1991), 268-278.

Daunton, M.J., *House and Home in the Victorian City: Working-Class Housing, 1850-1914* London: Arnold, 1983).

Devine, T.M., and Jackson, G., (eds.), *Glasgow Volume I* (Manchester : Manchester University Press, 1995).

Dowbiggin, I., ' "An Exodus of Enthusiasm": G. Alder Blumer, Eugenics, and US Psychiatry', *Medical History* 36 (1992), 379-402.

Downs, A., *Inside Bureaucracy* (Boston: Little, Brown and Company, 1967).

Dupree, M.W., and Crowther, M.A., 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: the *Medical Directory* as a Historical Source' *Bulletin of the History of Medicine* 65 (1991), 209-233.

Dwyer, E., 'Stories of Epilepsy, 1880-1930', Rosenberg, C.E., and Golden, J. (eds.), *Framing Disease: Studies in Cultural History* (New Brunswick: Rutgers University Press, 1992), c. 12.

Ewan, J.T.G., *The School Health Service* (Glasgow: Glasgow Corporation, 1956).

Fennell, P., *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People Since 1845* (London: Routledge, 1996).

Finkelstein, V., *Attitudes and Disabled People* (New York: World Rehabilitation Fund, 1980).

Flinn, M.W. (ed.), *Report on the Sanitary Condition of the Labouring Population of Gt. Britain by Edwin Chadwick 1842* (Edinburgh: Edinburgh University Press, 1965).

Ford, J., Mongon, D., and Whelan, M., *Special Education and Social Control: invisible disasters* (London: Routledge & Kegan Paul, 1982).

Foucault, M., *Madness and Civilisation* (New York: Pantheon, 1965).

Fraser, D., *The Evolution of the British Welfare State* (London: Macmillan, 1984).

Fraser, W.H., and Maver, I. (eds.), *Glasgow Volume II: 1830 to 1912* (Manchester: Manchester University Press 1996).

Fraser, W.H., and Maver, I., 'The Social Problems of the City', Fraser, W.H., and Maver, I. (eds.), *Glasgow Volume II: 1830 to 1912* (Manchester: Manchester University Press 1996), 352-393.

Freedon, M., 'Eugenics and Ideology', *Historical Journal* 26 (1983), 959-62.

Freedon, M., 'Eugenics and Progressive Thought: A Study in Ideological Affinity', *Historical Journal* 22 (1979), 645-671.

Freedon, M., *The New Liberalism: An Ideology of Social Reform* (Oxford: Clarendon Press, 1978).

Freeman, H., and Berrios, G.E., *150 Years of British Psychiatry Volume II: the Aftermath* (London: Athlone, 1996).

French, S., 'Disability, Impairment or Something in Between?', Swain, J., Finkelstein, V., French, S., and Oliver, M. (eds.), *Disabling Barriers – Enabling Environments* (London: Sage, 1993), p. 22.

Gabbay, J., and Webster, C., 'General Introduction. Changing Educational Provision for the Mentally Handicapped: from the 1890s to the 1980s', *Oxford Review of Education* 9 (1983), 169-175.

Gilbert, B.B., *The Evolution of National Insurance in Great Britain: the Origins of the Welfare State* (London: Michael Joseph, 1966).

Gladstone, D., 'The Changing Dynamic of Institutional Care: The Western Counties Idiots Asylum, 1864-1914', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 7.

Goodey, C.F., 'The Psychopolitics of Learning and Disability in Seventeenth Century Thought', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 5.

Gordon, G. (ed.), *Perspectives of the Scottish City* (Aberdeen: Aberdeen University Press, 1985).

Grob, G., 'Marxian Analysis and mental Illness', *History of Psychiatry* 1 (1990), 223-32.

Grob, G., *Mental Illness and American Society 1875-1940* (Princeton: Princeton University Press, 1983).

Gould, S.J., *The Mismeasure of Man* (London: Penguin Books, 1984).

Hamlin, C., *Public Health and Social Justice in the Age of Chadwick: Britain, 1800-1854* (Cambridge: Cambridge University Press, 1998).

Harris, B., *The Health of the Schoolchild: a History of the School Medical Service in England and Wales* (Buckingham: Open University Press, 1995).

Henderson, D.K., *The Evolution of Psychiatry in Scotland*, (Edinburgh: Livingstone, 1964).

Hirst, D., Michael, P., 'Family, Community and the Lunatic in Mid-nineteenth-Century North Wales', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 4.

Houston, R.A., *Madness and Society in Eighteenth-Century Scotland*, (Oxford: Oxford University Press, 2000).

Houston, R.A., '“Not Simple Boarding”: Care of the Mentally Incapacitated in Scotland During the Long Eighteenth Century', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 2.

Humphries, S., and Gordon, P., *Out of Sight: the Experience of Disability 1900-1950* (Plymouth: Northcote House, 1992).

Hurt, J.S., *Outside the Mainstream: A History of Special Education* (London: Batsford, 1988).

Hurt, J.S., 'Feeding the Hungry Schoolchild in the First Half of the Twentieth Century', Oddy, D., and Miller, D.S. (ed.), *Diet and Health in Modern Britain* (London: Croom Hill, 1985).

Hurt, J.S., *Elementary Schooling and the Working Classes 1860-1918* (Routledge and Kegan Paul, London, 1979).

Jackson, G., and Munn, C., 'Trade, Commerce and Finance', Fraser, W.H., and Maver, I., *Glasgow Volume II: 1830 to 1912* (Manchester: Manchester University Press 1996), 52-95.

Jackson, M., *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester: Manchester University Press, 2000).



- Jackson, M., 'Changing Depictions of Disease: Race, Representation and the History of "Mongolism"', Ernst, W., and Harris, B. (eds), *Race, Society and Medicine 1700-1960* (London: Routledge, 1999), 167-188.
- Jackson, M., 'It Begins with the Goose and Ends with the Goose: Medical, Legal, and Lay Understanding of Imbecility in *Ingram v. Wyatt*, 1824-32', *Social History of Medicine* 11 (1998), 361-380.
- Jackson, M., 'Institutional Provision for the Feeble-Minded in Edwardian England: Sandlebridge and the Scientific Morality of Permanent Care', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 8.
- Jackson, M., 'Images of Deviance: Visual Representations of Mental Defectives in Early Twentieth-century Medical Texts', *British Journal of the History of Science* 28 (1995), 319-337.
- James, F.E., 'Some Observations on the Writings of Felix Platter (1539-1614) in Relation to Mental Handicap', *History of Psychiatry* 2 (1991), 103-108.
- Jones, G., *Social Hygiene in Twentieth Century Britain* (London: Croom Helm, 1986).
- Jones, G., 'Eugenics and Social Policy Between the Wars', *The Historical Journal*, 25, 3 (1982), 717-728.
- Jones, K., *A History of Mental Health Services* (London: Routledge, 1972).
- Kelm, M., 'Women, Families and the Provincial Hospital for the Insane, British Columbia 1905-1915', *Journal of Family History* 19 (1994), 177-93.
- Kevles, D., *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (London: Penguin Books, 1986).
- Knox, H.M., *Two Hundred and Fifty Years of Scottish Education 1696-1946* (Edinburgh: Oliver and Boyd, 1953).
- Knox, W.W., *Industrial Nation: Work, Culture and Society in Scotland 1800-Present* (Edinburgh: Edinburgh University Press, 1999).
- Larson, E.J., 'The Rhetoric of Eugenics: Expert Authority and the Mental Deficiency Bill' *British Journal for the History of Science*, 24 (1991) p. 45-60.
- Latour, B., *Science in Action: How to Follow Scientists and Engineers Through Society* (Massachusetts: Harvard University Press, 1987).
- Lawrence, C., *Medicine in the Making of Modern Britain, 1700-1920* (London: Routledge, 1994).
- Levitt, I., *Poverty and Welfare in Scotland 1890-1948* (Edinburgh: Edinburgh University Press, 1988).
- Levitt, I., 'The Scottish Poor Law and Unemployment, 1890-1929', Smout, T.C. (ed.), *The Search for Wealth and Stability: Essays in Economic and Social History Presented to M.W. Flinn* (London: Macmillan, 1979), 263-282.
- Lewis, J., *The Voluntary Sector, the State and Social Work in Britain* (Aldershot: Edward Elgar, 1995).
- Lowe, R., *Adjusting to Democracy: The Role of the Ministry of Labour in British politics, 1916-1939* (Oxford: Oxford University Press, 1986).
- Macdonald, H., 'Children Under the Care of the Scottish Poor Law' (PhD. thesis, University of Glasgow, 1994).
- Macmillan, L., 'Origins and Evolution of Special Education for Children with Intellectual Disabilities in Greater Glasgow 1862-1962' (PhD thesis, University of Strathclyde, 1998).

Marland, H., 'At Home with Puerperal Mania: the Domestic Treatment of the Insanity of Childbirth in the Nineteenth Century', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 3.

Mayes, M., *The Stormy Petrel: A Life of Dr. Kate Fraser* (Glasgow: Wellcome Unit for the History of Medicine, 1995).

Melling, J., Forsythe, B., and Adair, R., 'Families, Communities, and the Legal Regulation of Lunacy in Victorian England: Assessments of Crime, Violence and Welfare in Admissions to the Devon Asylum, 1845-1914', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 8.

Middleton, R., *Government versus the Market: The Growth of the Public Sector, Economic Management and British Economic Performance, c. 1890-1979* (Cheltenham: Edward Elgar Publishing Ltd., 1996).

Miller, E., 'Idiocy in the Nineteenth Century', *History of Psychiatry* 7 (1996), 361-374.

Miller, E., 'Mental Retardation: Clinical Section – Part I', G.E. Berrios and R. Porter, *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), 212-224.

Mitchison, R., 'The Creation of the Disablement Rule', Smout, T.C. (ed.), *The Search for Wealth and Stability: Essays in Economic and Social History Presented to M.W. Flinn* (London: Macmillan, 1979), 199-217.

Morris, J., *Pride against Prejudice* (London: Women's Press, 1991).

Neugebauer, R., 'Mental Handicap in Medieval and Early Modern England: Criteria, Measurement and Care', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 2.

Neugebauer, R., 'Treatment of the Mentally Ill in Medieval and Early Modern England', *Journal of the History of the Behavioural Sciences*, 14 (1978), 158-69.

Niskanen, Jr., W.A., *Bureaucracy and Representative Government* (Chicago: Aldine Atherton, 1971).

Norwood East, W., 'Physical Factors and Criminal Behaviour', Radzinowicz, L., and Turner, J.W.C. (eds.), *Mental Abnormality and Crime* (London: Macmillan, 1944), 143-146.

Oliver, M., *Understanding Disability* (London: Macmillan, 1996).

Oliver, M., *Social Work with Disabled People* (Basingstoke: Macmillan, 1983).

Oliver, M., and Barnes, C., *Disabled People and Social Policy* (London: Longman, 1998).

Parry-Jones, W., *The Trade in Lunacy: a Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London: Routledge and Kegan Paul, 1971).

Payne, S., 'Outside the Walls of the Asylum? Psychiatric Treatment in the 1980s and 1990s', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 12.

Peacock, A.T., and Wisman, J., *The Growth of Public Expenditure in the United Kingdom* Second Edition (London: George Allen and Unwin, 1967).

Peden, G.C., *British Economic and Social Policy: Lloyd George to Margaret Thatcher* Second Edition (Oxford: Philip Allan Publishers Ltd., 1985).

Perkin, H., *The Rise of Professional Society: England Since 1880* (London: Routledge, 1989).

Pernice, A., 'Family Care and Asylum Psychiatry in the Nineteenth Century: the Controversy in the Allgemeine Zeitschrift für Pyschiatric Between 1844 and 1902', *History of Psychiatry* 6 (1995), 55-68.

Pick, D., *Faces of Degeneration: A European Disorder, c.1848 – c.1918* (Cambridge: Cambridge University Press, 1989).

Pickering, A., *The Mangle of Practice: Time, Agency, and Science* (Chicago: University of Chicago Press, 1995).

Pickstone, J.V., 'Psychiatry in District General Hospitals: History, Contingency and Local Innovation in the Early Years of the National Health Service', Pickstone, J.V., *Medical Innovations in Historical Perspective* (London: Macmillan, 1992), c. 10.

Porter, R., 'History of Psychiatry in Britain', *History of Psychiatry* 2 (1991), 271-279.

Potts, P., 'What's the Use of History? Understanding Educational Provisions for Disabled Students and those who Experience Difficulties in Learning', *British Journal of Educational Studies* 43 (1995), 398-411.

Potts, P., 'Medicine, Morals and Mental Deficiency', *Oxford Review of Education*, vol. 9, no.3 (1983), 181-196.

Prestwich, P.E., 'Family Strategies and Medical Power: "Voluntary" Committal in a Parisian Asylum, 1876-1914', *Journal of Social History*, 27 (1994), 799-818.

Primrose, D.A., 'Changing Sociological and Clinical Patterns in Mental Handicap', *British Journal of Psychiatry* 144 (1984), 1-8.

Primrose, D.A., 'The Development of Mental Deficiency Hospitals in Scotland', *Health Bulletin* 35 (1977), 63-65.

Pritchard, D.G., *Education and the Handicapped 1760-1960* (London: Routledge and Kegan Paul, 1963).

Pryde, G.S., 'Central and Local Government in Scotland Since 1707', *Historical Association General Series* 45 (London: Routledge, 1960), 1-26.

Radford, J.P., 'Sterilization Versus Segregation: Control of the "Feeble-minded", 1900-1938', *Social Science and Medicine* 33 (1991), 449-458.

Ray, L.J., 'Eugenics, Mental Deficiency and Fabian Socialism between the Wars', *Oxford Review of Education* 9 (1983), 213-222.

Rodger, R., 'Employment, wages and poverty in the Scottish cities 1841-1914', Gordon, G. (ed.), *Perspectives of the Scottish City* (Aberdeen: Aberdeen University Press, 1985), 25-64.

Rodger, R., 'The invisible hand: market forces, housing and the urban form in Victorian cities', Fraser, W.H., and Sutcliffe, A., *The Pursuit of Urban History* (London: E. Arnold, 1983), 190-211.

Rosenberg, C.E., and Golden, J. (eds.), *Framing Disease: Studies in Cultural History* (New Brunswick: Rutgers University Press, 1992).

Rothman, D., *The Discovery of the Asylum* (Boston: Little, Brown, 1971, revised 1990).

Roxburgh, J.M., *The School Board of Glasgow 1873-1919* (London: University of London Press, 1971).

Rushton, P., 'Idiocy, the Family and the Community in Early Modern North East England', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 3.

Sclare, A.B., 'John Carswell: A Pioneer in Scottish Psychiatry', *Scottish Medical Journal* 26 (1981), 265-270.

Scotland, J., *The History of Scottish Education, Volume Two* (London: University of London Press, 1969).

Scull, A., *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993).



- Scull, A., 'Psychiatry and its historians', *History of Psychiatry*, ii (1991), 239-250.
- Scull, A., *Social Order / Mental Disorder* (London: Routledge, 1989).
- Scull, A., 'Decarceration Reconsidered', Lowman, J., Menzies, R.J., Palys, T.S. (eds.), *Transcarceration: Essays in the Sociology of Social Control* (Aldershot: Gover, 1987), c. 16.
- Scull, A., *Madhouses, Mad-Doctors and Madmen* (London: Althone, 1981).
- Scull, A., *Museums of Madness* (London: Allen Lane, 1979).
- Searle, G.R., 'Eugenics and Class', Webster, C. (ed.), *Biology, Medicine and Society 1840-1940* (Cambridge: Cambridge University Press, 1981), c. 6.
- Searle, G.R., *Eugenics and Politics in Britain 1900-1914* (Leyden: Noordhoff International Publishing, 1976).
- Searle, G.R., *The Quest for National Efficiency: A Study in British Politics and Political Thought, 1899-1914* (Oxford: Basil Blackwell, 1971).
- Simmons, H.G., 'Explaining Social Policy: the English Mental Deficiency Act of 1913', *Journal of Social History*, 11 (1978), 387-403.
- Sinclair, R., Grimshaw, R., and Garnett, L., 'The Education of Children in Need: the Impact of the Education Reform Act 1993 and the Children Act 1989', *Oxford Review of Education* 20, no. 3 (1994), 281-292.
- Smout, T.C., *A Century of the Scottish People 1830-1950* (London: Collins, 1986).
- Smout, T.C. (ed.), *The Search for Wealth and Stability: Essays in Economic and Social History Presented to M.W. Flinn* (London: Macmillan, 1979).
- Stone, D., *The Disabled State* (Philadelphia: Temple University Press, 1984).
- Sturdy, H., and Parry-Jones, W., 'Boarding-out Insane Patients: the Significance of the Scottish System 1857-1913', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 5.
- Sturdy, H., 'Boarding-Out the Insane, 1857-1913' (PhD thesis, University of Glasgow, 1996).
- Sutherland, G., *Ability, Merit and Measurement* (Oxford: Clarendon Press, 1984), chs. 1-4.
- Sutherland, G., 'Endpiece. Intergrating Historical and Contemporary Studies on Special Education Policy', *Oxford Review of Education* 9 (1983), 277-279.
- Sutherland, G., 'Measuring Intelligence: English Local Education Authorities and Mental Testing 1919-1939', Webster, C. (ed.), *Biology, Medicine and Society 1840-1940* (Cambridge: Cambridge University Press, 1981), c. 9.
- Sutherland, G., *Policy-Making in Elementary Education 1870-1895* (Oxford: Oxford University Press, 1973).
- Suzuki, A., 'Enclosing and Disclosing Lunatics within the Family Walls: Domestic and Psychiatric Regime and the Public Sphere in Early Nineteenth-century England', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 6.
- Temkin, O., *The Falling Sickness: A History of Epilepsy from the Greeks to the Beginnings of Modern Neurology* (3<sup>rd</sup> edition, Baltimore: John Hopkins Press, 1994).
- Thane, P., *Foundations of the Welfare State* (London: Longmans, 1996).

G.O.B. Thomson, 'Legislation and Provision for the Mentally Handicapped Child in Scotland since 1906', *Oxford Review of Education*, vol. 9, no. 3 (1983), 233-240.

Thomson, G.O.B., Riddell, S.I., and Dyer, S., 'The Placement of Pupils Recorded as Having Special Educational Needs: an Analysis of Scottish Data, 1986-1998', *Oxford Review of Education* 16 (1990), 159-177.

Thomson, M., 'Constituting Citizenship: Mental Deficiency, Mental Health and Human Rights in Inter-war Britain', Lawrence, C., and Mayer, A.K., *Regenerated England: Science, Medicine and Culture in Inter-war Britain* (Amsterdam: Rodopi, 2000).

Thomson, M., *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870-1959* (Oxford: Clarendon Press, 1998).

Thomson, M., 'Family, Community, and State: The Micro-Politics of Mental Deficiency', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 10.

Thomson, M., '“Though Ever the Subject of Psychological Medicine”: Psychiatrists and the Colony Solution for Mental Defectives', Freeman, H., and Berrios, G.E. (eds.), *150 Years of British Psychiatry Volume II: The Aftermath* (London: Athlone Press, 1996), 130-143.

Thomson, M., 'Sterilisation, Segregation and Community Care: Ideology and the Problem of Mental Deficiency in Inter-war Britain', *History of Psychiatry* 3 (1992), 473-498.

Thomson, M., 'The Problem of Mental Deficiency in England and Wales 1913-1946' (D.Phil thesis, University of Oxford, 1992).

Tighe, J.A., 'The Legal Art of Psychiatric Diagnosis: Searching for Reliability', Rosenberg, C.E., and Golden, J. (eds.), *Framing Disease: Studies in Cultural History* (New Brunswick: Rutgers University Press, 1992) c. 10.

Trent Jr., J.W., *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (California: University of California Press, 1994).

Unsworth, C., *The Politics of Mental Health Legislation* (Oxford: Clarendon, 1987).

Walmsley, J., Atkinson, D., Rolph, S., 'Community Care and Mental Deficiency 1913-1945', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 9.

Walmsley, J., 'Including People with Learning Difficulties', Barton, L., and Oliver, M. (eds.), *Disability Studies: Past, Present and Future* (Leeds: Disability Press, 1997), c. 4.

Walmsley, T., 'Psychiatry in Scotland', Berrios, G.E., and Freeman, H. (eds.), *150 Years of British Psychiatry* (London: Gaskell, 1991), 294-305.

Walsh, O., 'Lunatics and Criminal Alliances in Nineteenth-century Ireland', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 7.

Watson, S., 'The Moral Imbecile: a Study of the Relations Between Penal Practice and Psychiatric Knowledge of the Habitual Offender' (PhD thesis, University of Lancaster, 1988).

Weber, M. (translated by Gerth, H.H., and Mills, C.W.), *From Max Weber: Essays in Sociology* (London: Routledge, 1991).

Webster, C., 'Conflict and Consensus: Explaining the British Health Service', *Twentieth Century British History* 1 (1990), 115-151.

Webster, C., 'The Health of the School Child During the Depression', Parry, N., and McNair, D., *The Fitness of the Nation : Physical and Health Education in the Nineteenth and Twentieth Centuries: Proceedings of the 1982 Annual Conference of the History of Education Society of Great Britain* (Leicester : History of Education Society, 1983), 70-85.

Webster, C. (ed.), *Biology, Medicine and Society 1840-1940* (Cambridge: Cambridge University Press, 1981).

Welshman, J., 'Rhetoric and Reality: Community Care in England and Wales', Bartlett, P., and Wright, D. (eds.), *Outside the Walls of the Asylum: The History of Community Care 1750-2000* (London: Athlone, 1999), c. 10.

Wildavsky, A., *Budgeting: a Comparative Theory of Budgetary Processing* (Boston: Little, Brown and Company, 1975).

Williams, R., 'Medical, Economic and Population Factors in Areas of High Mortality: the Case of Glasgow', *Sociology of Health and Illness* 16 (1994), 143-179.

Withers, C., 'The Demographic History of the City, 1813-1911', Fraser and Maver, *Glasgow Volume II: 1830 to 1912* (Manchester: Manchester University Press 1996), 141-162.

Wooldridge, A., *Measuring the Mind: Education and Psychology in England, c. 1860-1990* (Cambridge: Cambridge University Press, 1994).

Wright, D., 'Familial Care of "idiot" Children in Victorian Britain', Hordern, P., and Smith, R. (eds.), *The Locus of Care: Families, Communities, Institutions, and the Provision of Welfare Since Antiquity* (London: Routledge, 1998), 176-197.

Wright, D., 'Family Strategies and the Institutional Confinement of "idiot" Children in Victorian England', *Journal of Family History*, 23 (1998), 190-208.

Wright, D., ' "Childlike in his Innocence" ', Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996), c. 6.

Wright, D., 'The National Asylum for Idiots, Earlswood, 1847-1886' (D.Phil. thesis: University of Oxford, 1993).

Wright, D., and Digby, A. (eds.), *From Idiocy to Mental Deficiency* (London: Routledge, 1996).

