DEVELOPMENT OF LEARNING DISABILITY SERVICES 
IN THE WEST YORKSHIRE REGION

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Introduction

This account represents a general background to the development and evolution of hospital care services and rehabilitation of people with mental handicap in the West Yorkshire hospitals during the 20th century.

A number of periods were recognisable during this era. There was a philosophy to which a particular ethos and ethic was the main theme. These periods broadly speaking can be divided into the following:

The self help, ethos period from 1920s to 1940s.

This was the period between the wars and the 40s up to the introduction of the National Health Service (NHS) in 1948. One significant event nationally during this period was the opening of the Maudsley Hospital in 1923, which was delayed because of the war (Gelder et al., 1996). The Mental Deficiency Act of 1913 (Wormald and Wormald, 1914; Potts and Fido, 1991) legalised the detention of individuals with varying degrees of mental defect namely ‘idiots’, ‘imbeciles’, ‘feeble-minded’ and the ‘morally defective’ and empowered local authorities to provide for their confinement. The Mental Deficiency Act 1927 however imposed a responsibility upon them to provide for training and occupation. Partly as a result of the legislation this period saw an increase in the number of institutional places for “Mentally Defective”. The total number of inpatients rose from about 6,000 in 1916 to about 50,000 in 1939 nationally (Gelder et al., 1996). New, purpose built, colonies were created in Leeds at Meanwood Park Hospital and in Bradford at West Wood Hospital. In other parts of West Yorkshire, a variety of buildings, workhouses, sanatoria, mansions and an inebriate’s retreat were used for accommodation.

Admission to the institution was under compulsion and required magistrate’s order. There was virtually no expert psy-
chiatric input. In West Yorkshire, the large Meanwood Park colony did not have a medical superintendent until 1939.

The institutions were run by lay superintendents, secretaries and nurses. This debunks a popular myth that the institutions were dominated by doctors. Medical cover was provided by local visiting doctors.

The urban background in the inner city was one of social deprivation, economic depression and industrial recession with much poverty, ignorance and poor health and housing. For example, to look after an overactive or incontinent severely mentally backward child in an overcrowded back-to-back scullery house with a shared lavatory at the end of the street posed serious difficulties. To take the defective children from appalling slums into an institution surrounded by green grass offering clean beds, warm uniform clothes, regular meals and an organised life was seen at the time as humane, helpful and a protective measure, even if this appears to have been regimented to later generations.

Many of the admissions were from the socially deprived areas and social classes III and IV in the Registrar-General’s classification (Office of National Statistics 2001; Race, 1995). Often those admitted were homeless, without relatives, unemployed, illiterate, guilty of petty crime and included women who had illegitimate pregnancies and were regarded as needing care and protection (Potts and Fido, 1991). There was little community provision and seriously mentally defective children were excluded from ordinary schools.

The psychiatry of mental handicap was in its infancy and the range of effective remedies available in medical practice was limited. Epilepsy was difficult to control. During the war time many institutions for the mentally defective were commandeered in the national emergency for use as emergency hospitals. This led to a shortage of available accommodation which in turn resulted in over-crowding of the mentally defective population into the remaining accommodation or their evacuations to make-shift accommodation.

The industrial work ethic period 1950s-1970s

In the period after the Second World War, there was full employment and a recovering national economy. The United Kingdom was still one of the world’s wealthiest nations. The West Yorkshire industrial areas had a great demand for labour. Hence many of the more able patients in the hospitals (as they had become in 1943) could be placed out to work in generally unskilled jobs. At the same time, the hospitals found it hard to recruit staff as they were in the competitive market for labour. Nurses were recruited from abroad, from Mauritius, for example. Obtaining nurses was particularly difficult in West Yorkshire.

Hostels were set up for patients providing a step towards their living in lodgings or more independently. Before the Mental Health Act of 1959, patients went out to work and live out under ‘licence’. They could be returned to hospital if necessary. Meanwood Park had ‘Crooked Acres’ as a Hospital Hostel, Westwood had Green Lane Hall, Todmorden had Stoodley Lodge, Oulton Hall had Cardigan, Castleberg had its “cottage” and Whixley had Tadcaster and Bubwith Hostels. The more able patients were discharged from hospitals and their places were taken up by many more severely physically and mentally disabled patients including children who were surviving in infancy and childhood in greater numbers than previously
through improved obstetrical and paediatric practices in the NHS, better standards of hygiene and housing in a better off community. Additional single story villas and hospital schools and special care units for spastic children were created at the hospitals. New villas were built in Westwood and Meanwood Park hospital. Westwood had a new school.

Within the hospitals, the strong work ethic resulted in more emphasis on industrial therapy and occupation for patients. Simple contract work was introduced. Packing for central sterile supply departments was done at some of the hospitals. With the departure from the hospitals of the more able patients, tailoring, furniture repairing, joinery, shoe making, mattress making, wood chopping and jobs done by men to help the internal economy of the institutions ceased. The women patients could no longer do all the laundry and cleaning and additional staff had to be recruited to do these tasks. After the inception of the NHS, the number of “consultant psychiatric specialists” in mental handicap began to increase and new appointments were made in the 60s and 70s. This resulted in the more dynamic policies in the hospital with changes which were not always readily accepted by non-medical staff. Later, when the staff were converted to new ideas, they would act as though they had invented them, for example, doors were no longer kept locked as this removed the challenges to the patients to try to escape. The development of the hospitals by the medical directors and superintendent was along the following lines:

- Outpatient clinics became established.
- More interest was taken in medical diagnosis, patients were classified according to the classification of the American Association of Mental Deficiency and the World Health Organisation (WHO) international classification of diseases ICD (American Psychiatric Association 1994; World Health Organisation 1992).
- The psychiatry of mental handicap began to develop as a specialty.
- The rehabilitation and occupation and training of patients expanded.
- Emphasis turned to staff education and nurse training. Many hospitals were approved for Nurse Training by General Nursing Council.
- Whenever possible, able patients were discharged into lodgings, hostels and their own flats or other accommodation. Relatively few could go home.
- Voluntary help in the hospitals expanded. League of Friends were founded.
- Role of carers and other support workers continue to assume prominence.
- Hospital used further education services introduced in the evening classes.
- Excursions, trips and holidays for patients were expanded so that minibuses were needed.
- Teaching, research and instructions were developed with lectures, staff and laboratories and training schemes in mental handicap for doctors.

The period of post industrial occupation in hospital in 1970s:

In contrast to the self help ethos period when the institution supported and took a pride in being run as economically as possible with their residents doing the work, in the 70s, hospitals were criticised for not spending money. There was criticism of the employment of the patients in the internal economy of the hospitals. Over the years, the able patients had been used to help the staff look after less able patients (Potts and
The hospitals recruited more nursing, domestic and other staff to do work such as cleaning and laundry which had previously been done by the patients. Farming and gardening were run down and farms were closed and land sold or leased.

With loss of more capable patients and the admission of the more severely handicapped cases, the hospital population became relatively more disabled so that occupation, educational and rehabilitation were an increasing challenge and the number of wheelchair patients increased. To meet this change, the occupational therapy activities “play” and “diversional” therapy expanded. Industrial therapy became less important. Social education rehabilitation and training received more attention. The philosophy of normalisation became the fashion (Nirje, 1976; Wolfensberger, 1972; O’Brien and Tyne, 1981). The emphasis moved to preparation for fuller life and social independence. Excursions, holidays and recreational activities aimed to widen the horizons and experience of the patients. Patient allowances, non-contributory invalidity pension, and mobility allowance, gave patients more money to spend. Suitable cases were placed out of hospital usually to live in social services department hostels. Some patients were able to attend adult training centres daily from hospital and gateway clubs flourished. This was the trend in the West Yorkshire region as a whole at the time.

The patients who had been admitted to hospitals in pre-war years were ageing and hospitals began to feel an increasing need for ground floor accommodation for the elderly, infirm and disabled patients. The changing environment became less acceptable for milder mentally retarded patients with disturbed behaviour, mental illness and psychopathic disorder and they became part of the so-called difficult to place patients group.

**The period of post-hospital alternative living in 1980s:**

The hospital “mass living” with alleged “regimentation”, “segregation” and “conglomeration” and “institutionalisation” was claimed to be inimical to the objectives the hospital was aiming to achieve (Goffman 1961; Department of Health and Social Security, 1971; Howe Report: 1969). As such, Community Mental Health Teams (CMHT) (Department of Health; 1989) were set up to advise and support families and facilities in the community and to prevent admission to hospital especially in the case of mentally handicapped children under the age of 16. A “spectrum” offering a choice of alternative living models began to develop with a range of supporting services. This spectrum ranged through:

a) The parental home  
b) Another persons home, lodgings, fostering, family placement  
c) A staffed home / house  
d) An unstaffed house  
e) A group home  
f) Hostel  
g) Hospital for mental handicapped

A combination of some of this was the “core and cluster arrangement” in which a core staff central resource supported a cluster of other types of accommodation.

From a peak of 60,000 in the mid-sixties, the number of NHS hospital beds for mental handicap across the country had fallen to 40,000 in the early 80s, with less than 45,000 places in adult training centres. The deaths of the long-stay patients together
with fewer new long stay admissions accounted for the reduction. With fewer inpatients, the hospitals became relatively more expensive to operate. Philosophical and economic pressures to run them down and to close them emerged.

As a consequence, the outlined strategic objective for the future planning was to re-shape the mental handicap services to provide comprehensive community oriented district based services where this did not exist or were inadequate and by so doing to replace the services that were hitherto provided by the mental handicap hospitals leading to their eventual closure.

**Summary**

This is a historical summary of the development of learning disability services in the West Yorkshire region of the United Kingdom. It focuses mainly on the evolution of hospital services as well as the rehabilitation of people with mental handicap in the region during the 20th century. The different periods were broadly subdivided into four i.e., the Self Help ethos period from 1920s to 1940s, the industrial work ethic period 1950s – 1970s, the period of post industrial occupation in hospital in 1970s and the period of post hospital alternative living in the 1980s. Understanding the history of services is quite useful and valuable in shaping future trends.

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