International Journal of Law in Context, 1,4 pp. 315–334 (2005) Cambridge University Press
DOI: 10.1017/S1744552305004015 Printed in the United Kingdom

# Risk, modernity and history

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## Abstract

*A current trend in sociology characterises the end of the twentieth century as obsessed with risk. Ulrich Beck and Anthony Giddens are perhaps the leading expositors of this theme. Both emphasise a break with the past as the last millennium approached its conclusion, whereby changes in patterns of work, technological developments and the demise of traditional social forms have ushered in a new modernity. In their view, social organisations became more reflexive in their assessments of the circumstances of daily life, at a time when new technologies created the possibility of damage on a global scale. The result in the new social world is a society focused on risk. Some aspects of this assessment are uncontroversial. New technologies have emerged, whilst the role of the nation state has changed since its apogee in the nineteenth century. Other aspects of this new vision are, however, empirically more problematic. Furthermore, the degree to which social changes actually had the effects identified by Beck and Giddens remains an open question. Using the early twentieth-century regulation of mental defectives as a case study, this paper will interrogate this 'discontinuist' vision, exploring whether and how our understanding of risk has changed.*

## The risk society

One of the current views in sociology is that we live in the age of risk. Perhaps the leading expositors of this theme are Ulrich Beck and Anthony Giddens.[1] In their view technological developments, changes in patterns of work, and the demise of other social forms – including class, family, gender, marriage and parenthood in the shapes that we have known them (Dingwall, 1999) – have resulted in both new social concerns and new forms of governance. Social organisations have become more reflexive in their assessments of the circumstances of daily life, at a time when new technologies create the possibility of damage on a global scale. According to Beck, we are thus no longer merely a 'wealth-distributing' society, but a 'risk-distributing' one as well (1992, p. 20). This conjunction creates a tension or instability in developed capitalism. Environmental catastrophe serves as a useful illustration in this regard. In the past such risks were understood to be evident to the senses, to be local in effect and, generally, to be conveniently located among the poor. Today, however, such distancing from risk is no longer possible. As evidenced by events such as the Chernobyl disaster, environmental catastrophe may be global in scale and it risks affecting us all.

Neither Beck nor Giddens suggests that concerns about risk were absent in the past. Indeed, risk constitutes a basic phenomenon of human action. As such it both pre-dates, and is characteristic of, modern industrial society (Beck, 1992). At issue is thus a new *placement* of risk in the social fabric. In effect it lies in a new place within the social structure, and has assumed a new importance as a result of new social arrangements and technological possibilities. It is this combination of factors which

* The work on this article was supported by the Leverhulme Trust programme grant 'Biorisks and Society'. I would like to thank Peter Bartlett for his extremely helpful comments on an earlier draft of this paper.

1 See, e.g., Beck (1992); Giddens (1990), (1991).

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has given risk its prominence, ushering in a period of what Beck calls 'advanced' or 'late modernity', and Giddens refers to as 'high modernity'.

This analysis does, however, raise some interesting questions for historians. It is initially important to acknowledge, although not to overstate, the difference that exists between the sociological and historical projects. Where the sociologist arguably seeks to understand the present, the historian seeks to understand the past – or indeed to understand the present in terms of the past. Yet insofar as the Beck-Giddens thesis purports to be defining the boundaries of high modernity, it does, by implication, make claims about the past – the territory located on the other side of that boundary. Indeed, having noted the limited empirical support for certain aspects of Beck's argument, Dingwall (1999) suggests that closer scrutiny of the contrast between modern and pre-modern societies should be encouraged. It is thus appropriate for the historian to investigate those implied historical claims.

This inevitably prompts the question as to the nature of the claims advanced by Beck. Rather helpfully, he summarises his argument in the form of five points (1992, p. 22–4). The first of these five claims is that risk is different from wealth. The nature of risk in high modernity is such that we cannot necessarily identify it with our own eyes – for example, we cannot recognise the presence of harmful toxins in our food simply by looking at it. The result is that in order to identify such potential risks to our health, we become dependent upon the judgment and knowledge of experts. The pivotal players in the sociology of risk are thus the experts, and it is these people who thereby gain both social and political power.

Beck's second claim is that risks affect people differently – in essence, '*social risk positions* spring up' (1992, p. 23). This is partly reflected in the politics of globalisation, which has treated the Third World very differently from the First. The transfer of hazardous industries to the low-wage countries of the Third World – the 'systematic attraction' between extreme poverty and extreme risk (1992, p. 41) – is a familiar one. However, if our perspective is reoriented to the local level, these risk positions do not map precisely onto class divisions. Environmental disaster makes no distinction, for example, between the sink estate and the affluent suburb.

The third claim advanced by Beck is that the diffusion and commercialisation of risks raise capitalist development to a new state. Capitalism responds by developing a new generation of professionals defining risk. The economy becomes 'self-referential' – in the sense that it becomes independent of the surrounding satisfaction of human needs – and insurance and similar industries boom. Thus, while risk inevitably involves losers, at the same time there are also winners. The economic exploitation of risks becomes big business.

Beck's fourth claim is that whilst one possesses wealth, one is, by comparison, affected by risk. Furthermore, the way in which people are affected by class and risk is very different. In class, being determines consciousness. However, in risk, consciousness determines being. By way of illustration, Beck refers to the potential threat residing within the determinants of the class situation, such as the loss of a job. This 'affliction' is evident to all those affected, no special surveys or measurements are required. In that sense it is therefore independent of knowledge (1992, p. 53). By comparison, the situation of those who find that their food is contaminated – for example, as with the recent Sudan 1 scare[2] – is very different. Here one cannot know either the extent of contamination, or the affect of such. In this instance the affliction is far from clear. Rather, the nature and extent of endangerment – in essence our 'risk positions' – are dependent upon external knowledge. Knowledge thus attains a new political significance.

Beck finally goes on to claim that risks, once socially recognised, become politically explosive. To re-deploy the earlier example of environmental risk, those activities that were previously believed to

2 In February 2005, the presence of Sudan dyes were discovered in a large number of U.K. food products. The dyes are used for colouring solvents, oils, waxes, petrol and polishes, and their inclusion in food is prohibited within the European Union – according to the Food Standards Agency, such inclusion 'may' contribute to the development of cancer.

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lie beyond the legitimate scope of politics – such as product planning, technical equipment and waste disposal – become drawn into the political realm. In essence, the elimination of the causes of environmental damage within the industrial process is no longer a matter purely for industry and industry management. The issue becomes a political one, resulting in the expansion of politics into new domains that lie beyond its traditional purview.

Many of the themes articulated by Beck appear equally in Giddens' work. Giddens (1991) does, however, expound his theory less in the economic context of late capitalism, than in modern perceptual and organisational structures. Indeed, for him, modernity is characterised primarily in terms of three main elements, the first of which is the separation of time and space. Such a separation represents the condition for articulating social relationships across time and space. In addition, it is crucial for what is identified as the second key characteristic of modernity, namely the disembedding of social institutions. The 'disembedding mechanisms', which lift social activity and relationships out of localised contexts, take two forms. The first is symbolic tokens, the prime example of which is money, whilst the second comprises expert systems and technical knowledge and trust. The standardised value of money enables transactions to take place between individuals who need never physically meet. Expert systems – or 'systems of technical accomplishment or expertise' that organise substantial aspects of our material and social environments – similarly provide guarantees of expectations across time and space. For example, upon boarding an aeroplane the majority of us enter an expert system of which we have no technical knowledge. We do, nevertheless, have faith that it will convey us safely to our chosen destination (Giddens 1990, pp. 27–8).

For Giddens (1991), the third key element of modernity can be located in the reflexivity of organisations. In modernity, reflexivity is introduced into the very basis of system reproduction. This constitutes much more than simple 'reflection', with social practices constantly examined and reformed in light of the acquisition of new knowledge and information about them. Such knowledge and information thus has the capacity to alter constitutively the character of those practices (Giddens, 1990, p. 37). The end result is that our experience in late modern society is mediated in a barrage of commentary to which we are exposed. The reflexivity of organisations has penetrated society as a whole. Distant events invade our daily lives, as the world becomes literally a collage in the news media (Giddens, 1991, p. 26). Modernity has thus become a theme in its own development (Beck, 1992, p. 19). This, in turn, has an existential effect, a vision of a world changing without our control. In Giddens' phrase, we see ourselves as riding the 'careering juggernaut' (1990, p. 53).

## When is modernity?

Of course there is much to be said about whether the picture painted by Beck and Giddens provides an appropriate view of how we see our current lives. That, however, is beyond the scope of this paper. Of interest to the present discussion is that, for historians, an obvious first question is 'when' in these theories modernity actually starts. In historical terms, what is the subject of Beck and Giddens? Perhaps because their project is not that of the historian, the theorists do not appear to be overly concerned by this question. At times, however, they do seem to suggest that modernity is co-extensive with industrial society. As Giddens explains:

> 'I use the term "modernity" in a very general sense, to refer to the institutions and modes of behaviour established first of all in post-feudal Europe, but which in the twentieth century increasingly have become world-historical in impact. "Modernity" can be understood as roughly equivalent to "the industrialised world", so long as it be recognised that industrialisation is not its only institutional dimension.' (Giddens, 1991, pp. 14–15)

Historians can deal with such a view – after all, they are used to the idea that modernity begins somewhere around the early seventeenth century. Yet there is some 'slippage' within the Beck-Giddens

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thesis. For example, at other times the discussion appears to be largely about the period after the Second World War, post-Hiroshima. Indeed, the post-nuclear world and globalisation would seem to play a significant part in the mentality of the risk society. Furthermore, the pre-modern world is frequently left ambiguous. Thus when Giddens says that, 'there were experts in pre-modern societies, but few technical systems' (1991, p. 30), is this a reference to a Hobbesian state of nature, reflected rightly or wrongly in a naïve view of 'primitive' tribal cultures, or is it a reference to Rome? Presumably it relates to the former, since the statement is qualified as being particularly true of small societies. Yet these tribal societies have not existed in this simplistic way in the West since at least the beginning of feudalism.

Even if a wide view of periodisation is adopted, then there remains some cause for pause. For example, Giddens refers to the development of symbolic tokens as a particularly clear example of the disembedding of institutions in society. However, by any stretch of the concept, money pre-dates modernity. In a similar vein, Beck asserts that the nuclear family is indicative of modern industrial societies. However, the so-called modern nuclear industrial family is evident well before dominance of that particular mode of production (Dingwall, 1999).[3] It should be noted that the purpose of these observations is not to make cheap shots at the theorists, but rather to suggest that insofar as these markers are indicative of modernity, they are indicative because of their *social placement* in modernity. They were not new in the modern period, and the question is how their usage has changed over time. Indeed, as Giddens goes on to note, whilst the larger pre-modern social systems had developed forms of monetary exchange, the money economy became vastly more sophisticated with the emergence of modernity (1991, p. 18).

The same argument can be advanced in relation to risk. Both Beck and Giddens acknowledge that it is not a new concept, and that its relevance for their theories is its social placement in the modern world. As Giddens argues, life has always been 'a risky business' (1991, p. 29), yet the concept of risk has become more fundamental to the way in which the social world is organised. From the end of the twentieth century, government and society are said to have become risk obsessed – both creating new risks through technological innovation, and according the minimisation of risk a predominant place in the formulation of law and social policy. However, neither Beck nor Giddens are historians, and perhaps for that reason do not examine how we arrive at this 'late modern' risk.

This paper derives from a project that is examining this question within the context of mental disorder. Mental health law has a prominent contemporary profile, as the existing framework is currently undergoing a lengthy reform process. The rhetoric of 'risk' has featured prominently in that process thus far.[4] Yet even a cursory look at history reveals an ongoing set of concerns about risk in the formulation of mental health law and policy. Issues relating to the protection of society are central to legal discourse, whilst the law of madness provides an insight into the way in which society conceives mental disorder during a particular period (Bartlett, 2001). Law within this context thus provides fertile ground for exploring the construction and social placement of risk over time.

3 See also Laslett and Wall (eds.) (1972); Wrigley and Schofield (1981); Stone (1977); Hareven (1987); Stone (1990).

4 Mental health law is currently contained in the Mental Health Act 1983. In 1998 the Richardson Committee was appointed to advise on the shape of future legislation. The publication of its report in July 1999 was followed by a Government Green Paper, and then subsequently by a White Paper in December 2000. In June 2002 the Government produced a Draft Mental Health Bill, together with a consultation document. Following a period of consultation the original Bill was refined, with a revised draft Mental Health Bill published in September 2004. This Bill then underwent pre-legislative scrutiny by Joint Parliamentary Committee, whose report on the proposals was published in March 2005.

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## Mental deficiency

The present discussion focuses on one particular development in early twentieth-century mental health law, namely the Mental Deficiency Act 1913.[5] The arrival of the twentieth century heralded the emergence of a class of what were termed 'mentally defective' people – namely those who were situated somewhere on the continuum between idiocy and normalcy (Sutherland, 1984). Several broader societal concerns and debates converged around this particular group, resulting in a growing sense of anxiety that a whole range of social problems could all be laid at the door of mental deficiency. These problems included children who were unable to cope in schools, mentally disordered prisoners who appeared not to be amenable either to traditional forms of punishment and regulation or attempts at rehabilitation, and the demoralised poor.[6]

The Mental Deficiency Act represented the government's response to this genesis of mental deficiency into a major social issue. The Act legally defined 'mental defectives' as a distinct category, and placed a duty upon all local authorities to ascertain, certify and make provision for those defectives living in their area. It was envisaged that a substantial aspect of this provision would take the form of building special institutions in which to house such individuals – thereby separating them from the population at large.[7] Indeed, Thomson (1992) suggests that it was this segregative nature of the approach endorsed by the Act that dramatically set it apart from its predecessors. This, in turn, raises questions as to the nature of those factors contributing to the adoption of such a different approach.

### The 'subjects'

The starting point for investigation lies with those individuals falling within the scope of the Mental Deficiency Act. The definition of 'defectives' can be found in s. 1, where it is divided into four categories: (1) 'idiots', namely those so defective in mind from birth or an early age, 'as to be unable to guard themselves against common physical dangers'; (2) 'imbeciles', whose deficiency is such that they are 'incapable of managing their own affairs'; (3) 'feeble-minded persons', whose defect, though not amounting to imbecility, means that they require 'care, supervision and control for their protection or for the protection of others'; and (4) 'moral imbeciles', whose mental defect is 'coupled with strong vicious or criminal propensities on which punishment has little or no deterrent effect'.[8] Section 2 of the Act then goes on to detail the circumstances in which those falling within such definitions actually become 'subject to be dealt with' under the legislation. These circumstances include where the defective individual is found, 'neglected, abandoned or without visible means of support'; is found guilty of any criminal offence; is an 'habitual drunkard';

5 3 & 4 Geo. V, c. 28.

6 See, e.g., Simmons (1978); Zedner (1991); Digby (1996); Thomson (1998); Jackson (2000).

7 The reality of the Mental Deficiency Act did ultimately prove to be somewhat different from that originally envisaged by legislators. Although the primary thrust of the legislation was to promote the establishment of institutions, it also enabled the authorities to regulate and control defectives within the community. In addition to institutionalisation, the Act provided that defectives could be placed 'under guardianship' – i.e. in the control of a suitable person as guardian, with such powers, 'as would have been exercisable if he had been the father of the defective and the defective had been under the age of fourteen' (s. 10(2)). The construction of specialist institutions for the defective proved to be an expensive option for local authorities, with the result that large numbers were ultimately catered for outside institutions throughout the inter-war period. See, e.g., Walmsley, Atkinson and Rolph (1999).

8 Imbecile children are those who are 'incapable' of being taught to manage their own affairs. Feeble-minded children are defined as those who appear to be 'permanently incapable' of receiving proper benefit from teaching in ordinary schools.

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and is receiving poor relief at the time of giving birth to an illegitimate child, or whilst pregnant with such a child.[9]

The Mental Deficiency Act thus adopts what might be termed a two-stage approach towards the construction of the 'mentally defective'. The definitions of mental deficiency were based upon those originally offered by the Royal Commission on the Care and Control of the Feeble-Minded, which had been appointed by the Government in 1904 to examine the whole issue of deficiency and feeble-mindedness.[10] The Commission, in turn, described itself as 'chiefly indebted' to the Royal College of Physicians for providing the various definitions (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. viii, para. 559). The legislation thus established a framework based, first, upon a 'medical' definition of deficiency. That framework was, however, implemented only in certain, specified social circumstances. In essence, the Act thus takes effect only where the individual is vested with defective intellect, and is in need of care or control for social reasons (Thomson, 1992).

When investigating the presence of risk within the policy equation, it is notable that the framework established by the 1913 Act did not include those individuals who are physically dangerous to others. One reason for this omission may have been a general consensus that such individuals were properly dealt with under the lunacy legislation. Although the work done by historians on nineteenth-century lunacy asylums does suggest that simplistic views of admissions policy are not convincing,[11] it would seem that people were sent to asylums when there was a cogent reason to do so, and that dangerousness constituted such a reason. Indeed, admission to county asylums was discretionary on the part of the Justices of the Peace, but from 1846 that discretion had been limited by a requirement to send lunatics to the asylum if they were dangerous. This requirement remained in lunacy legislation until the Mental Health Act of 1959.

The proposition that lunacy legislation constituted the correct forum for dangerous individuals also appears to derive support from the Royal Commission. Indeed, in its report, the Commission made specific reference to Reception Orders under the Lunacy Act of 1890.[12] Here individuals could be admitted to a lunatic asylum by private application made on petition, accompanied by two medical certificates and a 'statement of particulars', and presented to a judicial authority.[13] The Commission noted that the statement of particulars was specific on four key points, including

9 Mental Deficiency Act 1913, s. 2(1)(b). The full list of circumstances rendering defectives subject to be dealt with under the Act can be found in s. 2.

10 The Royal Commission on the Care and Control of the Feeble-Minded was appointed in September 1904, and charged with the task of examining the existing methods of dealing with the mentally disordered, and suggesting possible ways forward in the future. This included investigating the existing system for dealing with lunacy, in order to see whether it could be somehow adapted in order to deal with mental defectives. During the course of its investigations the Commission examined 248 witnesses – including medical officers and inspectors of special schools, prisons, workhouses, lunatic and idiot asylums and inebriate homes, as well as teachers, doctors, charity workers and other central and local government officials – set up its own medical survey in order to estimate the numbers of defectives who required provision, and visited various American institutions in order to see the range and efficacy of provision for defectives within the United States. The Commission's eight-volume report was subsequently published in 1908: *Report of the Royal Commission on the Care and Control of the Feeble-Minded* (1908) Cd. 4215–4221, vols. i–vii, Cd. 4202, vol. viii.

11 See, e.g., Bartlett (1999).

12 53 Vict. c. 5.

13 Lunacy Act 1890, s. 4. The form of the petition, statement of particulars and medical certificates are contained in Sch. 2 to the Act. The Lunacy Act differentiated between private and 'pauper' patients, and contained different procedures for each category. The Royal Commission had particular regard to the situation relating to private patients.

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whether the subject of the petition was dangerous to others.[14] Indeed, they observed that the principle underlying the whole approach employed by the Lunacy Act was as follows:

> 'to ascertain the nature of the defect with especial reference to its being a cause of danger to the man himself or to others; and this defines the state of mind that involves detention or exclusion from society.' (1908, vol. viii, para. 441)

The Mental Deficiency Act does not, therefore, appear to be particularly concerned with individually dangerous people. Does it thus follow that the legislation provides a straightforward endorsement of the Beck-Giddens thesis in the sense that the Act was not actually about risk at all? A brief examination of its genesis does suggest that the spectre of economic risk was not far away from policy considerations, particularly during the early stages. Certainly, the Royal Commission was keen to highlight the 'gravity' of a situation which failed to deal adequately with large numbers of defectives, whose irresponsible lifestyles involved substantial and ongoing expenditure that was 'wasteful' both to the community, and to individual families (1908, vol. viii, para. 9).[15] Furthermore, when defining mental defect, the Commission took what it described as the 'distinctive phrase' of the Lunacy Act – 'unable to manage themselves or their affairs' – as the determining words in the various definitions. In their opinion, the evidence demonstrated that the ability to earn a living was often the 'critical question', at least on what was described as the 'social side' (1908, vol. viii, paras. 559–60).[16]

The importance accorded to this 'critical question' is evident in the Commission's definition of the higher grades of deficiency. For example, 'imbeciles' were defined as those incapable of earning their own living by reason of mental defect. In a similar vein, the 'feeble-minded' were those who might be capable of earning a living under what were termed 'favourable' circumstances, but whose mental defect rendered them incapable of either 'competing on equal terms with their normal fellows', or 'managing themselves and their affairs with ordinary prudence' (1908, vol. viii, para 559). The social inefficiency of defective individuals was thus regarded as posing a threat to the wider community (Thomson, 1998, p. 118).

Evidence of 'social' risk in the sense of the mentally defective posing a potential threat to the state of the nation, is also clearly present within the Mental Deficiency Act itself. Once again, the definition section is an informative one in this regard. As noted previously, the definition of feeble-mindedness that was ultimately incorporated into the Act, included those requiring care, supervision and control *for the protection of others*. In Parliament, the Liberal MP Josiah Wedgwood asserted that the true meaning of this clause was actually protection 'against the breeding of persons undesirable in the interests of the race' (Parliamentary Debates (HC) (1913) 56, col. 84). A vehement opponent of the legislation, Wedgwood argued that an 'ordinary' interpretation of the words would involve protection against actual physical abuse – an interpretation that he would apparently have been prepared to accept. However, he argued that, rather than protecting people from violence, the clause was actually concerned with 'the segregation of people so that they shall not have children'. As such, it contained what he described as 'the most dangerous words' in the Bill (Parliamentary Debates (HC) (1913) 56, col. 110). In reply, Secretary of State for the Home Department, Reginald McKenna, argued that the clause simply constituted a 'useful guide' in the definition of defective

14 The other three key points were: (1) the nature of the 'attack'; (2) whether the mental defect had shown itself in the past and was recurrent; and (3) whether the subject was suicidal.

15 The Royal Commission Report has been described as confirming the medical convention of defining and categorising defectives according to their 'social and economic capabilities' (Jackson, 2000, p. 207).

16 The centrality accorded to the ability to earn one's own living is arguably, in part, a vestige of the placement of mental disability law in the framework of the Victorian poor law.

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persons – as part of the definition clause, the words were not actually operative in any real sense (Parliamentary Debates (HC) (1913) 56, col. 111). However, he failed to respond to repeated questioning as to the nature of the correct interpretation to be placed upon the provision.

Whatever the apparent status of the definition section, s. 2 of the Act is undoubtedly operative in that it prescribes the particular social circumstances in which the Act takes effect. Here, risk in the sense of social degeneracy is most explicitly present within s. 2(b)(vi) – which includes those feeble-minded women either pregnant with, or having given birth to an illegitimate child whilst receiving poor relief. Originally suggested by the campaigner and pioneer in the development of provision for the defective, Mary Dendy – who argued that such women should be regarded as having shown themselves to be feeble-minded by the very irresponsibility of their actions – this provision is vested with clear financial overtones.[17] It is not just a woman's impropriety, but also her poverty that renders her the legitimate subject of public judgment and ultimately control (Zedner, 1991). In addition, however, the subsection reflects the fact that an increased awareness of mental deficiency coincided with growing fears as to the fitness of the population. Indeed, one such example of this can be located in the more 'demoralised' view of poverty which emerged during this period – namely that beneath the class of 'self-respecting' poor, was a group whose poverty was attributable to the members' 'feeble and tainted' constitutions. The social problem of the unfit thus became linked with the emerging problem of the mentally defective (Simmons, 1978, p. 390).

The problem of mental deficiency also emerged against the backdrop of expanding biological explanation, which was dominated by the popularisation of Darwinian evolution (Soloway, 1982). Ideas about evolution and inheritance were being added to the burgeoning science of genetics – and indeed this is a period which has been described as witnessing the birth of genetics (Barker, 1989). These 'new' ideas increasingly permeated medical thinking, thus fuelling debate about the relative impact of heredity on mental health.[18] Certainly, the balance of evidence heard by the Royal Commission on the Feeble-Minded did favour hereditary explanations of deficiency – of the 35 witnesses who specifically addressed the matter, 25 attached great importance to heredity as a factor in its causation (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. viii, para. 547).[19]

The Royal Commission report expressed the view that there was the 'highest degree of probability' that feeble-mindedness was usually spontaneous in origin, and that it tended 'strongly to be inherited'. The evidence was also felt to reveal the likelihood of a higher than normal birth rate amongst the feeble-minded. These findings supported the implementation of measures allowing for defectives to be institutionalised, or placed under supervision for as long as it might prove necessary (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. viii, para. 553). The focus of such measures was directed very firmly towards women, with Gladstone describing the 'faces of degeneration' during this period as 'inescapably female' (1996, p. 157). Fuelled by a section of contemporary literature that warned of the need to curb defective women, the prospect of leaving

17 Mary Dendy was Secretary of the Lancashire and Cheshire Association for the Permanent Care of the Feeble-Minded, and a member of the Manchester Education Committee. She was key both to the establishment, in 1902 of Sandlebridge Boarding Schools and Colony for defectives, and also to its subsequent management. For a full discussion, see Jackson (2000).

18 Heredity had been perceived as a 'predisposing' cause of mental disorder since the mid-nineteenth century. That thinking was, however, infused by contemporary developments in science and genetics.

19 Examples of such witnesses include Henry Ashby MD, Medical Officer to the Manchester Special Schools and physician to a children's hospital, who stated that heredity was the key factor in deficiency, whilst anything else was 'of very little importance' (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. i: para. 583). In a similar vein, A. F. Tredgold, physician to the Littleton Home for defective children, and formerly London City Council research scholar in insanity and neuropathology, gave evidence to the effect that his research had revealed that 'hereditary influences' were responsible for mental defect in 90% of cases (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. i: para. 396).

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such individuals at large was surrounded by a very real sense of eugenic danger (Zedner, 1991).[20] Constructed as both the biological source of mental deficiency, and as posing a threat to 'respectable' notions of sexuality and family morality (Simmons, 1978), mentally defective women thus became the object of social control. As Sir James Crichton-Browne MD stated in his evidence to the Commission, 'imbecile women seem to breed freely, and with all but the certainty of transmitting their own defect' (Royal Commission on the Care and Control of the Feeble-Minded, 1908, vol. i, para. 309).[21]

Yet whilst feeble-minded women became high-profile targets for legislative control, risk in the sense of degeneracy was constructed as involving more than just this particular group. For example, the 'criminal offence' criterion contained in s. 2 – which brings those defectives found guilty of an offence within the scope of the Act – also appears to reflect the apparent 'threat' posed to society by an undisciplined and irresponsible residuum. During the latter part of the nineteenth century, ideas of criminality had begun to change, with explanations for criminal behaviour increasingly sought in biology rather than morals (Thomson, 1992). One result was thus an amplification of the dangers associated with deficiency, as feeble-mindedness came to be seen as the causal link in a range of deviant behaviour (Zedner, 1991).

The background to this shift in thinking can perhaps be located in the fact that model prisons were failing to reform criminals, whilst punishment and deterrence also appeared to lack the power to cut crime. As Saunders notes, the suggestion that certain offenders were inherently 'irreclaimable' must therefore have been an attractive one (1988, p. 277). This 'reformulation' of criminality resulted in a campaign amongst a section of penal professionals for the segregation of weak-minded criminals into specialised institutions. In 1881 a Departmental Committee was established to look into criminal lunacy, including whether special provision should be made for those imbeciles who were 'habitually criminal.' Although unable to reach any firm conclusions, the Committee agreed both that a serious problem existed, and that further investigation was required (Report of the Departmental Commission on Criminal Lunacy 1882, p. 19). This question of the weak-minded criminal was ultimately subsumed within the broader debate surrounding the degenerate poor towards the end of the nineteenth century (Saunders, 1988), but the link between deficiency and crime had been made. Indeed, its existence was subsequently advocated in evidence given to the Royal Commission – for example, Dr Parker Wilson, medical officer at Pentonville prison, made very strong links between the 'defective juvenile', 'the feebleminded adult' and the 'habitual criminal' (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. viii, para. 385).

The Royal Commission itself certainly viewed the 'weak-minded' criminal as socially problematic – not only at an administrative 'level' within penal institutions, but also upon their release. Relatives were frequently left unable to cope, resulting in a number of defectives being left to wander within the community, without any definite system of control (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. viii, para. 413). A large proportion of these individuals were believed to be dangerous, both 'morally and physically', and inherently criminal. The Commission therefore concluded that this group should be subject both to 'systematic notification' – if necessary by fingerprints – and to 'some authoritative control, by which they could be detained' (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. viii, para. 414).

20 Zedner suggests that factors contributing to this focus on women included: the general perception that women were inherently less responsible and naturally predisposed to mental illness; the fact that a number of pioneers and activists in the feeble-minded sphere were women, who tended to concentrate on (and thus raise the profile of) the problem of wayward and feeble-minded young women; and that feeble-minded women unavoidably came to the notice of those in positions of authority through their repeated reappearance in reformatories, rescue homes, workhouses and prisons.

21 Sir James was a Doctor of Medicine, Doctor of Laws, Fellow of the Royal Society, and the Lord Chancellor's Visitor in Lunacy.

https://doi.org/10.1017/S1744552305004015 Published online by Cambridge University Press

One further example of a more specific concern about the risk of degeneracy can be located in the criteria of habitual drunkenness, that is also contained in s. 2. In view of the evidence submitted to it, the Royal Commission had felt compelled to conclude that habitual drunkenness was frequently indicative of mental defect. Alcohol in the parent was also believed to have both a 'distinct influence' in the production of feeble-mindedness in children and, by reducing their 'normal resistive power', to render them liable to breakdown and insanity in later life (Royal Commission on the Care and Control of the Feeble-Minded 1908, vol. viii, para 421). As existing legislation was insufficient to deal with the issue, the Commission concluded that defective inebriates should be brought within the scope of any new legislative framework. It was recognised that many such inebriates were in need of sympathy and care, but that action was also required in order to safeguard society (Savage, 1909).[22]

## Risk and rights

This necessarily brief discussion does reveal the presence of a set of concerns about risk within mental deficiency policy. The 'nature' of that risk is constructed primarily in terms of the apparent social danger posed by mental deficiency both to the community and, more widely, to the state of the nation. However, in order to interrogate the Beck-Giddens claim that risk has assumed a new importance today, it is necessary to go on to explore the exact 'placement' of risk within the policy equation. In other words, how central was risk (and risk management) to the formulation of the 1913 Act? Certainly, Thomson has argued that humanitarian notions of assisting the defective were just as important as concerns about their 'social incompetence' (1998, pp. 297–8) – the care-control paradox. Allied to that is the nature of the relationship or 'balance' between risk and rights. At its most basic level law determines the rights of the mentally disordered person (Bartlett, 2001). How were the rights of mentally defective individuals thus juxtaposed with issues of risk and the protection of society?

In addressing these questions it is first useful to have regard to the way in which certain aspects of the legislation evolved as the policy process progressed. The publication of the Royal Commission's report in 1908 generated calls for legislative action from a variety of quarters, both inside and outside Parliament.[23] The government's failure to bring forward legislation did, however, ultimately prompt the two main pressure groups active in this area – the Eugenics Education Society and the National Association for Promoting the Welfare of the Feeble Minded – to produce their own Feeble-Minded Persons (Control) Bill.[24] This provided for the compulsory detention of the feeble-minded, and was introduced into Parliament on 19 February 1912 (Parliamentary Debates (HC) (1912) 34, col. 307).[25] The Bill reached its second reading, but was eventually dropped in favour of the government's own Mental Deficiency Bill, which was presented to the House of Commons on 16 May 1912 (Parliamentary Debates (HC) (1912) 38, col. 1292). This Bill was debated over the course of the summer, but was ultimately lost due to lack of parliamentary time. However, on 28 May 1913, the Secretary of State introduced a second Mental Deficiency Bill. On this occasion the parliamentary process was successfully negotiated, with the Bill finally receiving Royal Assent in August of 1913.

22 The Habitual Drunkards Act 1897 permitted voluntary detention in a 'retreat'. The failure of the Act to reform a large number of inebriates was, however, believed by the Commission to demonstrate 'the necessity of compulsion' (para. 415). The Inebriates Act 1898 did empower a court to commit the habitual drunkard to an inebriate reformatory for special treatment or control, but only for a maximum period not exceeding three years.

23 For a discussion of both pre-Parliamentary and Parliamentary developments see, e.g., Thomson (1998); Jackson (2000).

24 The National Association for Promoting the Welfare of the Feeble-Minded was established 1896, with the Eugenics Education Society subsequently founded in 1907. The aim of both groups was essentially that of identifying the mentally defective, and inhibiting their numerical growth: Walmsley et al. (1999).

25 The Bill was introduced by the Conservative MP, Gershom Stewart.

https://doi.org/10.1017/S1744552305004015 Published online by Cambridge University Press

The first government Bill adopted those definitions of mental deficiency initially advanced by the Royal Commission. Particular concern was, however, expressed about the possibility of segregating those found to be feeble-minded by virtue of an inability to compete with their 'normal' counterparts (see, for example, Parliamentary Debates (HC) (1912) 38, col. 709). Indeed one MP, Mr Hume-Williams, even suggested that due to the 'much greater brain power' with which a number of his fellow professionals were endowed, he was unable to compete with his 'normal fellows' within a professional context. As such he could technically be caught by the legislation (Parliamentary Debates (HC) (1912) 38, col. 746). The Bill also contained a clause threatening segregation for those defectives, 'in whose case it is desirable in the interests of the community that they should be deprived of procreating children' (Parliamentary Debates (HC) (1912) 38, col. 710). This provision is described by Larson as 'blatantly eugenic' (1991, p. 54), and was criticised by Wedgwood as 'about the most abominable thing ever suggested' (Parliamentary Debates (HC) (1912) 38, col. 710). Furthermore, and despite the Royal Commission's view that it would be 'unwise' to modify existing marriage law (Royal Commission on the Care and Control of the Feeble-Minded (1908) vol. viii, para. 553), this first Bill also criminalised marriages with defectives (Parliamentary Debates (HC) (1912) 38, col. 739).

Thomson (1998) argues that at the level of what he terms 'high politics', issues of social danger did ultimately yield to the civil rights of the individual. Certainly, by the time the second government Bill was published, much of the language which might have been described as eugenic was missing from the text. The Bill itself was presented as a primarily humanitarian measure – as the Home Secretary stated, its purpose was now 'the protection of individual sufferers' (Parliamentary Debates (HC) (1913) 53, col. 22). This latter point was further reiterated with reference to the revised list of 'subjects' which, it was argued, endeavoured to deal with those cases of deficiency where there was 'tangible proof' that some degree of care from the state was needed (Parliamentary Debates (HC) (1913) 53, col. 222). Within this revised framework, the marriage of defectives was no longer prohibited, whilst the Bill also excluded the idea that individuals could be segregated purely in the interests of the community.

Risk thus featured less explicitly as the legislative process progressed – both in the sense of the language that surrounded the legislation, and the various changes made to certain provisions. However, if we follow the Secretary of State's advice and have regard to the list of subjects contained in the 1913 Act then, as the discussion has already demonstrated, issues of risk and control are still clearly present. For example, whilst individuals may no longer be explicitly segregated purely in community interests, the incorporation of feeble-minded women receiving poor relief whilst pregnant with or having given birth to an illegitimate child, would seem to constitute an effective re-working of that controversial provision.

Turning to the actual mechanics of the framework established by the Mental Deficiency Act, a judicial order was generally required before any defective individual could be 'dealt with'.[26] This order could be obtained by any relative or friend of the alleged defective (or by an authorised officer of the relevant local authority), upon a private application by petition. Such a petition should be accompanied by two medical certificates, one of which had to be signed by an approved medical practitioner.[27] By virtue of s. 6, the judicial authority could then make the requisite order only if satisfied that the individual concerned was defective, that he was subject to be dealt with under the

26 Mental Deficiency Act 1913, s. 4(a). Those found guilty of a criminal offence, or already in detention, could be dealt with under an order of the court (s. 4(b)) and an order of the Secretary of State (s. 4(c)) respectively.

27 Section 5(2). If a medical examination proved to be 'impracticable', then the petition had to instead be accompanied by a certificate to that effect. Petitions also had to be accompanied by a statutory declaration made by the petitioner and at least one other person stating: that the subject of the petition was a defective, and the class of defectives to which he was alleged to belong; that the person was subject to be dealt with under the Act, together with the circumstances rendering him so subject; whether or not a petition had previously been made under either the Act or the lunacy legislation and, if so the details thereof; and if a medical examination had proved to be impracticable, the circumstances which rendered it such.

https://doi.org/10.1017/S1744552305004015 Published online by Cambridge University Press

Act, and that institutionalisation was 'desirable' in his interests.[28] The judicial authority was both required to see the alleged defective before making his decision,[29] and accorded the power to determine the appropriate destination for him.[30]

Question marks do, however, surround the exact nature of the judicial role within this process – to what extent was it envisaged that judges would actually scrutinise the medical assessment of patients? This 1913 framework was modelled on that already in place with regards to lunatics.[31] This reflected the original view of the Royal Commission – namely that the certification system employed by the Lunacy Act 1890 should be extended to the mentally defective (Royal Commission on the Care and Control of the Feeble-Minded (1908) vol. viii, para. 720). In its report, the Commission noted that the function of the sheriff – the judicial authority dealing with lunatics in Scotland – was actually 'administrative' rather than judicial. Essentially, his role was to ensure there were no grounds for objecting to the petition; that the prescribed forms had been correctly complied with; and that the two medical certificates accompanying the petition afforded reasonable evidence that the subject was insane. It was only in the event that any of these points were not satisfied that the order could be refused. This was contrasted with the situation in England. Rather than simply judging the reasonableness of evidence contained in the medical certificates, the English magistrate acted 'practically as supervising medical examiner'. As part of the process, he would see the individual involved 'with the object of judging the reality of the alleged lunacy' (Royal Commission on the Care and Control of the Feeble-Minded (1908) vol. viii, para. 725).[32]

The Commission's view was that such a process both enabled the public to have confidence in the justice of the transaction, and ensured that the patient's interests were fully considered. They also felt that if the magistrate was to assume a judicial position, then he should generally see the subject: 'We believe that it accords best with the English feeling that the judicial authority should make the order judicially' (Royal Commission on the Care and Control of the Feeble-Minded (1908) vol. viii, para. 726). This view derives support from the 1899 case of *Hodson v. Pare*,[33] in which it was held that judges operating under the Lunacy Act 1890 were acting in a genuinely judicial role. In reaching its decision the Court of Appeal had regard both to the definition of 'judicial authority' contained in the legislation, and the jurisdiction and powers that it accorded to him. These provisions were mirrored in the Mental Deficiency Act.[34]

28 Section 6(3).

29 Section 6(1).

30 By virtue of s. 6(3) the judicial authority could either order the defective individual to be sent to an institution, or appoint a suitable person to act as his guardian.

31 See above n. 13. Under the Lunacy Act 1890, an individual could be detained as a private patient in an institution for lunatics by private application on petition and presented to a judicial authority. The judicial authority was required to consider both the allegations contained in the petition and accompanying statement of particulars, and the evidence of lunacy contained in the supporting medical certificates. It was also within his discretion to see the alleged lunatic.

32 Of course, the situation on the ground was not as simple as the picture painted by the Commission. Bartlett's work in Leicester (1999) indicates that, at least when it suited them, the Justices of the Peace did engage in a certain amount of real consideration of the evidence. In a similar vein, Akihito Suzuki (1995) suggests that JPs were quite active in nineteenth-century asylum administration. By contrast, Forsythe et al. (1999) found that, by the early twentieth century, JPs in Devon were signing sheafs of blank certificates without any attempt to examine the individual subjects involved.

33 [1899] 1 QB 455 (CA).

34 The court stated that s. 9 of the Lunacy Act 1890 defined the judicial authority. Particular reference was made to s. 9(2), which provided that: 'Every judicial authority shall, in the exercise of the jurisdiction conferred by this Act, have the same jurisdiction and power as regards the summoning and examination of witnesses, the administration of oaths, and otherwise, as if he were acting in the exercise of his ordinary jurisdiction.' A similar provision can also be found in the Mental Deficiency Act 1913, s. 19.

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The Royal Commission thus viewed the judicial authority as constituting something more than a simple stamp of approval to the medical assessment. Within Parliament, some concerns were also expressed regarding the power that might potentially be accorded to doctors within any new scheme. For example, during debates on the private Feeble-Minded Persons (Control) Bill, Wedgwood worried about entrusting powers to a group of specialists 'whose absolute remedies for disease change every year' (Parliamentary Debates (HC) (1912) 38, col. 1471). In a related vein, Sir Frederick Banbury criticised the ease with which it was often possible to obtain medical certificates from a doctor (Parliamentary Debates (HC) (1912) 38, col. 1489). However, William Chapple countered with the assertion that power was not actually vested in doctors: 'They are simply witnesses. The power rests with magistrates' (Parliamentary Debates (HC) (1912) 38, col. 1515). Wedgwood did continue to articulate his concerns during various subsequent debates, but they do not appear to have been widely shared amongst his parliamentary colleagues.

It should also be noted that the Mental Deficiency Act did not require a judicial authority in every instance. Indeed, a parent or guardian could place an idiot or imbecile in an institution (or under guardianship) upon the simple production of two medical certificates.[35] This exception appears to reflect a recommendation originally made by the Royal Commission, who had examined the mechanism by which idiots were admitted to asylums under the Idiots Act 1886.[36] Here, an idiot or imbecile aged under 21, could be institutionalised by his parent or guardian upon the simple certificate in writing of a duly qualified medical practitioner. This certificate was required to state that the subject was an idiot, and that he was capable of benefiting from institutionalisation. The subject could then be detained until he reached full age, and indeed beyond with the consent of the Commissioners in Lunacy (Parliamentary Debates (HC) (1912) 38, para. 476). The Royal Commission was impressed by what it regarded as this 'very simple' scheme,[37] and recommended that such a single medical certificate form of certification should be applicable to mentally defective individuals under the age of 21.[38]

In addition to requiring two medical certificates, the 1913 Act did ultimately incorporate a judicial authority when dealing with higher grades of mental deficiency in children. Where the subject was neither an idiot nor an imbecile, the decision to admit him to an institution had to be supported by a judge.[39] This particular provision was inserted at a relatively late stage in the parliamentary proceedings. Following the return of the second government Bill from Standing Committee, the Home Secretary reported to the Commons that he had promised to change the relevant provision, 'to ensure that a judicial authority should have cognisance of the [medical] certificate'. His initial proposal was the medical certificate should be 'countersigned' by a judicial authority, but this met with criticism from a number of MPs (Parliamentary Debates (HC) (1913) 56, col. 158). For example, Mr Ellis Davies questioned whether it would give the judicial authority any power to inquire as to either the conditions of the application, or the nature of the evidence. In a similar vein, Mr John Rawlinson labelled it an 'illusory' safeguard – the magistrate would simply have to satisfy himself that the medical certificates were in proper order. There was no power to, for

35 Mental Deficiency Act 1913, s. 3(1).

36 49 Vict. c. 25.

37 The simplicity of the scheme could be located in the fact that the 'single issue' was whether or not the subject was an idiot or imbecile, and the 'single condition' for admission was that it would be beneficial (para. 477).

38 Such individuals could thus be placed by their parent or guardian (or indeed by the local authority) in suitable institutions upon the certificate in writing of a qualified medical practitioner, and without the intervention of any judicial authority (para. 531). It was also recommended that supervision could continue after the age of 21, with the consent of the Board of Control (Recommendation LII).

39 Mental Deficiency Act 1913, s. 3(1).

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example, send for or cross-examine the doctors involved. The proposal was thus described as, 'merely the ministerial office of countersigning by a judicial authority' (Parliamentary Debates (HC) (1913) 56, cols. 187–8).

The ensuing debate resulted in the incorporation of a judicial power of 'inquiry'[40] which would, once again, appear to support the view that risk did ultimately yield to rights. Certainly the debate does illustrate a political unease at the prospect of leaving the decision to institutionalise individuals entirely in the hands of family and doctors, and without some kind of external 'check'; although the nature of that check with regards to children is somewhat limited. However, there are questions as to how the judicial authorities might exercise those powers in the future. For example, would they ultimately prove willing to challenge the position of parents and doctors? A further note of caution is also sounded by the findings of the Royal Commission on Lunacy and Mental Disorder. Appointed to examine existing law and practice, the Commission's 1926 report revealed that the methods adopted by magistrates when deciding whether to make an order under the Lunacy Acts, actually varied 'considerably'. Although some did endeavour to exercise independent judgment, a number indicated that they rarely or never had occasion to differ from the conclusions contained in the medical certificate. Indeed, one magistrate gave evidence to the effect that he felt 'bound' to rely on the medical certificates placed before him (Report of the Royal Commission on Lunacy and Mental Disorder 1926, para. 83).

The 'role' of medical expertise in the management of mental deficiency under the 1913 Act also requires some consideration. Commentators such as Monahan et al. (2001) have observed that risk assessment is assumed (by both policy makers and the public) to be a core skill for mental health professionals today. Indeed, the government is now engaged in the task of reforming mental health law, one objective of which is to incorporate an effective system of risk management and public protection (Report of the Joint Committee on the Draft Mental Health Bill 2005, vol. 1, para. 33). Under current proposals, the role of assessing the risks posed by patients falls largely to the clinicians. However, much doubt has been cast on the medical profession's ability accurately to predict such risks,[41] whilst doctors themselves do not necessarily feel that this is an appropriate role for them to undertake. Indeed, a number of witnesses appearing before the recent Joint Parliamentary Committee on the Draft Mental Health Bill questioned both the efficacy of risk assessment techniques, and their competence in applying them. As Dr Zigmond from the Royal College of Psychiatrists observed:

> 'the notion of predicting that somebody is a clear danger either to themselves or, indeed, anybody else, I have to say is rather a fallacious one. My colleagues and I are not good at it.' (Report of the Joint Committee on the Draft Mental Health Bill 2005 vol. 1, para. 125)

But whatever the expectations placed upon doctors today, what exactly was their role in the early twentieth century? Indeed, an initial question might be to ask why doctors were involved in mental deficiency at all. This may appear strange, yet whilst the Act entrusted the diagnosis of mental deficiency to doctors, question marks do surround the extent to which those definitions were actually 'medical'. For example, Zedner (1991) argues that, at least with regards to women, the definition of deficiency was frequently informed by considerations other than the finding of psychiatric diagnosis. These considerations might include a woman's poverty, or the general failure

40 Where the defective (aged under 21) is not an idiot or an imbecile, certificates in the 'prescribed form' and signed by two qualified medical practitioners are required. The certificates must also be signed 'after such inquiry as he shall think fit' by a judicial authority, and must state that the signatories of the certificate are severally satisfied that the subject is a defective and the class of defectives to which he belongs (s. 3(1)).

41 See, e.g., Greenland (1980); Geddes (1999); Munro and Rumgay (2000).

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of penal or welfare institutions to deal adequately with her.[42] In a related vein, Potts suggests that all four categories of deficiency were actually defined in terms of a social threat, 'particularly in terms of a lack of self-control' (1983, p. 186). Furthermore, any judgment regarding the diagnosis of mental deficiency necessarily incorporated a high degree of subjectivity.

The question is particularly interesting in light of earlier developments within the educational sphere. The issue of mentally defective children had appeared on the policy radar at a relatively early stage, following the introduction of universal elementary education in 1870. This revealed a significant section of the school population who were unable to cope with mainstream education, and has been described as a major factor in the development of the wider social problem of mental deficiency.[43] In 1885 the government established a Royal Commission to look into the matter, which recommended that such children be provided with special education (Report of the Royal Commission on the Blind, the Deaf and the Dumb 1889).[44] Although no action was taken centrally, a number of special schools and classes were opened through various local initiatives.[45] Pressure was gradually placed upon the state to provide these establishments with regulation and aid, and in 1896 a Departmental Committee was appointed to investigate.[46] The Committee's 1898 report recommended that local authorities should be obliged to provide special education (Report of the Departmental Committee on Defective and Epileptic Children 1898), although this recommendation was not to receive legislative force until 1914.[47]

Within the various local initiatives, medical expertise had not always been sought when diagnosing mental deficiency. For example, in its (written) evidence to the Departmental Committee, the Nottingham School Board stated its opinion that children could be satisfactorily selected for special education through a combination of teachers and School Board Inspectors (Report of the Departmental Committee on Defective and Epileptic Children 1898, vol. ii, p. 199). This non-medical approach was echoed in evidence given on behalf of the Leicester School Board. Mr H. Major, the School Board Inspector, explained that those children requiring special provision were initially identified by teachers. If the children were not attending school, then the task was carried out by lay visitors. Following this initial identification, the children were sent to Mr Major who, after conducting various tests, reached a judgment as to their mental state.[48] Cases were only referred on

42 Zedner also suggests that 'feeble-mindedness' was employed as 'a generic term encompassing all those who appeared to be blighted by a mental incapacity for making correct moral judgements' (1991, p. 7).

43 See, e.g., Simmons (1978); (Thomson, 1998).

44 The Commission was appointed in 1885 to look at education for the blind. In 1886 the terms of reference were changed to include the deaf and dumb, as well as 'such other cases as from special circumstances would seem to require exceptional methods of education'. The Commission considered that this included idiots, imbeciles and the feeble-minded.

45 Leicester opened the first special class in April 1892. They were followed by several other local education authorities – namely Birmingham, Bradford, Brighton, Bristol, London and Nottingham.

46 The Departmental Committee on Defective and Epileptic Children was charged with the task of enquiring into, and advising upon any changes to the existing system of, educating those feeble-minded and defective children who were not under charge of the Guardians, and who were not idiots or imbeciles; to report upon the means of discriminating between educable and non-educable children, and between those who could be taught in an ordinary schools and those requiring special classes; and to enquire into the provision of elementary education for children suffering from epilepsy.

47 Elementary Education (Defective and Epileptic Children) Act 1914 (4 & 5 Geo. V, c. 45). The Elementary Education (Defective and Epileptic Children) Act 1899 (62 & 63 Vict. c. 32.), which was passed in the wake of the Departmental Committee report, merely enabled local authorities to provide special education.

48 Mr Major stated that children were examined from a reading book, in order to see whether 'they have a certain amount of intelligence in the interpretation of pictures and in the answering of social questions limited to their own surroundings' (Report of the Departmental Committee on Defective and Epileptic Children 1898, vol. ii, p. 133).

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to the Medical Officer if there was any doubt, but such instances were described as 'rare'. When asked about the desirability of all children being medically examined, Mr Major answered firmly in the negative – despite being medically qualified himself. As he remarked in his evidence: 'I can only say that I ascended the honours list in physiology in the London University, but I do not think it helps me very much' (Report of the Departmental Committee on Defective and Epileptic Children 1898, vol. ii, p. 138).

Amongst certain Local Education Authorities, medical expertise was thus subordinate to that of education.[49] However, at the national level, policy actors did look very firmly towards doctors – indeed a recurring theme within national policy documents during this period was that medical knowledge was 'indispensable' when it came to judging the mental state of children.[50] This was ultimately reflected in the Elementary Education (Defective and Epileptic Children) Act 1899, which handed control over selection and assessment procedures to doctors – the certificate of a duly qualified practitioner approved by the Education Department being required in the case of every child admitted to a special school or class.[51] This medical colonisation of mental deficiency was further cemented by the assertion of the Royal Commission on the Care and Control of the Feeble-Minded, that the medical inspection of schools constituted a condition precedent to any progress in the care and treatment of mental defectives.[52]

The perception that the definition, care and treatment of mental illness and those affected by it lies within the province of medicine, has been described as constituting a late modern perspective (Bartlett, 1999). However, as this discussion has demonstrated, a similar perception was present in earlier twentieth-century policy towards the mentally defective. Policy actors positively sought out medical opinion – indeed, the Royal Commission on the Feeble-Minded even established its own medical survey directed by two doctors[53] – whilst the diagnosis and management of deficiency was largely handed over to the medical profession. It is true that this legislative faith in doctors was not unlimited. There was an unwillingness, at least at the political level, unequivocally to endorse medical and scientific opinion in the sense of giving it free rein. Evident within national policy is a negotiation between social risk and individual rights. The end result was the use of law to protect individual rights – through, for example, the imposition of judicial checks on medical decision-making. However, as Thomson (1998) notes, the nature of those protected rights was limited, with the defective constructed as too irresponsible either to exert their own civil rights, or to be accorded the right of liberty.

Moving from diagnosis to the management of mental deficiency, it was notable how the optimism that characterised earlier views of the defective as potentially improvable dissipated with the arrival of the twentieth century. For example, Rose refers to the emergence of a 'second discourse' on idiocy in which the idiot 'was not so much a challenge for a scientific and philanthropic pedagogy, as a burden on the nation' (1985, p. 95). Indeed, the medical profession was virtually unanimous in its belief that mental deficiency was incurable (Gladstone, 1996). Mental

49 Some Local Education Authorities did, however, take a somewhat different approach. For example, in its evidence to the Departmental Committee, the London School Board suggested that although teachers should assist the Medical Officers, deficiency could not be properly diagnosed without formal medical training. In a similar vein, Bradford deemed the medical inspection of children to be essential.

50 See, e.g., Report of the Departmental Committee on Defective and Epileptic Children (1898).

51 Section 1(3).

52 The Royal Commission advocated the establishment of registration system for mental defectives. This was not felt to be possible without first putting in place a system providing for the medical inspection of school children (1908 vol. viii, para. 305).

53 The survey was directed by W. Potts, Medical Officer of Birmingham and A. F. Tredgold, a leading expert in mental deficiency.

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deficiency thus represents something of a challenge to the medical profession – if a condition is by definition incurable, then it is not altogether clear that medical care is needed. Thomson (1998) notes that most of the institutions established under the 1913 Act did remain under medical management, despite the fact that their regimes tended to reflect widely held ideas about work and discipline as opposed to any new medical therapies. Did their prominent position within the system thus reflect an ongoing 'fetishisation' that doctors could actually do something about mental disorder – in effect did they derive power from a 'constructed truth' as to the nature of their expertise? Alternatively, did the institutional solution constitute a tool in the legitimation of the medical profession's control over the new system of care? With regards to lunacy, Scull (1993) argues that a similar loss of optimism surrounding the curability of sufferers in the mid 1850s had the effect of turning attention towards more administrative matters. Indeed, the Lunacy Commission began to encourage the adoption of an 'efficient custodialism' as the primary good of the asylum system, whilst the performance of medical superintendents was increasingly assessed not in terms of their success in treating or curing patients but rather their efficient performance of administrative tasks and their efforts to provide for the comforts of their charges. In effect, doctors thus came to be seen as experts in the warehousing of patients. Indeed, it might even be suggested that doctors were key to the legitimation of the institutional solution – by sustaining the illusion that the institutions were medical, the removal of troublesome individuals from the community whose confinement might otherwise have been difficult to justify was effectively accorded a legitimacy.[54]

## Conclusion

Implicit within the Beck-Giddens thesis is the suggestion that risk was somehow of less importance to society and government during the modern period when compared to the present day. It is certainly true that the rhetoric of risk has featured strongly throughout the current mental health reforms. That risk has been constructed principally in terms of individually dangerous people – for example, long-standing concerns surround those individuals said to suffer from dangerous and severe personality disorder. A high profile example of this is provided by the case of Michael Stone, who killed Lin Russell and her six-year-old daughter Megan in 1996. Stone's condition was considered to be untreatable, with the result that it had not been possible to detain him under existing legislation.[55] The reform process has thus been accompanied by the fear – widely articulated by both government and the media – that the public is being placed at undue risk of harm from such 'untreatable' individuals.

This paper has, however, demonstrated that whilst the way in which risk is constructed might change, risk considerations were an important factor in mental deficiency policy at the turn of the nineteenth century. The 2005 Report of the Joint Parliamentary Committee on the draft Mental Health Bill noted that legislation which focuses on risk has the effect of circumscribing patient autonomy and favouring containment over treatability. The Mental Deficiency Act of 1913 can be said to possess both of these features. What is, however, notable about this period is the way in which the rhetoric of risk and social danger – at its strongest in the 1908 Royal Commission report – was gradually toned down as the legislative process progressed through the political arena. Thomson (1998) suggests that the Commission's approach constituted a shock tactic designed to secure

54 According to Scull: 'The asylum's ability to keep crazy people out of harms way, and to provide them with more humane care than they would otherwise receive, increasingly became the justification for its continued existence' (1993, p. 306).

55 Under the Mental Health Act 1983, treatment for those with a mental impairment of psychopathic disorder must be likely to alleviate or prevent a deterioration of the patient's condition.

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legislative action.[56] Thus, while the rhetoric of risk and social danger may have proved useful in getting legislation onto the political agenda, it was apparently not believed to be helpful thereafter. Indeed, the Act's proponents increasingly turned to humanitarian arguments and language in order to advance their support for legislation.

Yet despite the changes surrounding its presentation, the Mental Deficiency Act did retain the central eugenic concept of compulsory segregation for the mentally defective (Larson, 1991).[57] The end product can therefore be seen as an endorsement of the Royal Commission's strategy of policing the boundary between those within society, and those who were perceived to represent at threat to it (Rose, 1985). Although not ultimately regarded as a potentially winning argument for legislative action, concerns about risk and risk management were thus clearly important within the policy equation. This raises the question as to whether, in this context at least the risk literature is actually noting a phenomenon that has become more explicit, rather than one that has necessarily become more important to the task of policy-making.

It must also be noted that the brief nature of the present discussion has necessarily focused on the 'production' of the 1913 Act. As such it represents only a partial snapshot of the situation. Legal frameworks inevitably provide 'space' for those charged with delivering policy to engage in a process of negotiation, and to exercise discretion – policy is not 'made' only by the centre, but also in the daily activities of those working on the ground.[58] Some of the work that has been done on the implementation of the Mental Deficiency Act certainly suggests that control did ultimately prove to be more important than care. For example, Walmsley's (2000) investigation of the Act's implementation in Bedfordshire reveals that it was used to target women for sexual regulation. This is supported by Thomson's (1996) London study, which also suggests that the Act was used to control the delinquent behaviour of boys – boys were certified defective as an alternative to imposing a penal solution. However, as Dale (2003) notes, the impact of the Mental Deficiency Act requires further assessment – particularly with regards to the classification and management of deficiency. Some additional work will therefore be required before a complete picture of risk within mental deficiency policy can be truly uncovered.

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56 This observation is made with specific reference to the Commission's support of the view that heredity was central to the production of mental deficiency, and that the fertility of defectives was abnormally high – both of which Thomson feels went beyond what could 'reasonably' be concluded from the evidence.

57 In addition, the gender-related eugenic provision – bringing those feeble-minded women who gave birth to or were pregnant with an illegitimate child whilst receiving poor relief within the scope of the legislation – was incorporated in s. 2(1)(b)(vi).

58 See, e.g., Davis (1969); Lipsky (1990).

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