Learning Disability
## Contents

**Preface**  vii  
**List of figures**  xi  
**List of tables**  xiii  
**List of contributors**  xv  

### I Learning Disability and Associated Problems that Affect Physical Ability

1  **What is Learning Disability?**  3  
   *Jeanette Rennie*

2  **Learning Disability: Classification and Associated Conditions**  49  
   *Jeanette Rennie, Mark Sterrick and Jane Neil-MacLachlan*

3  **Psychiatric and Behavioural Disorders in People with Learning Disabilities**  64  
   *Tanya Thiagarajah*

4  **Orthopaedic Aspects of Learning Disability**  93  
   *James E. Robb*

### II Assessing Physical Ability and Planning Intervention

5  **The Multiprofessional Learning Disability Team**  111  
   *Patricia Odunmbaku Auty and Jeanette Rennie*

6  **First Steps in Communicating with People Who Have Learning Disabilities**  129  
   *Sue Standing and Sue Smith*

7  **Assessment**  146  
   *Anneliese Barrell*

8  **Interpretation of Assessment Results as a Basis for Intervention and Outcome Measures**  166  
   *Anneliese Barrell*
## CONTENTS

### III Practical Treatment and Management 177

9 **Postural Care** 179  
*John Goldsmith and Liz Goldsmith*

10 **An approach to Treating and Managing Severe Physical Disability** 200  
*Ann Findlay*

11 **Hydrotherapy** 215  
*Patricia Odunmbaku Auty*

12 **Riding for Disabled People** 232  
*Alys Watson*

13 **Rebound Therapy** 249  
*Sally Smith and Debbi Cook*

14 **Group Work** 263  
*Jeanette Rennie, Lucy Clark and Helen Holme*

15 **Sport and Outdoor Pursuits** 279  
*Angela Johnson, Jonathan Gray and Ian Silkstone, updated by Jeanette Rennie*

16 **Developing Opportunities for Health Promotion and Fitness Using Standard Local Facilities** 294  
*Jeanette Rennie, Michael Craven, Amanda Leech and Sybil Williams*

17 **Complementary Therapies** 309  
*Libby Davies, Jane Bruce and Maria Gunstone*

**Appendix A: Further Reading** 325

**Appendix B: Useful Addresses and Web Sites** 331

**Appendix C: Relevant Acts of Parliament** 343

**Index** 345
Preface

Since the first edition of this book there has been a proliferation of surveys, reports, recommendations and Acts of Parliament around the world relating to people who have learning disabilities.

The expansion of post-graduate diploma and higher degree courses in all the therapies and nursing has also continued.

However, literature relevant to the physical treatment and management of people who have learning disabilities is still very limited. Other professionals who are unfamiliar with the UK usage of the term ‘learning disability’ such as general medical practitioners (GPs), generic nurses, therapists and social workers continue to have difficulty finding a comprehensive book that sets the presenting physical disability, whether long-term or acute, in the context of learning disability and conditions associated with learning disability.

The new authors included in this second edition have, like the original authors, based their writing on available research and have many years of practical knowledge in the subject matter of their own chapter.

The book has been written as a resource for health professionals working with people (primarily adults) who have learning disabilities, students, social services staff and carers involved in their day-to-day management. It will provide the necessary background on learning disability and allied conditions for therapists working in general and specialist hospitals who occasionally have people with learning disabilities referred for specific short-term treatment. Also addressed are some of the many questions asked or implied by other health, education or social services professionals who are confused by the multiplicity of terms such as ‘mental retardation’, ‘learning difficulty’, ‘cognitive impairment’, ‘intellectual disability’ and ‘learning disability’. The book cannot answer all the questions nor go into detailed treatment methods; it is hoped that the appendices and reference lists will point readers in the direction of further study. It is also hoped that all who work in this area will be constantly alert for further changes in legislation and their own profession’s guidelines.

The term ‘learning disability’, which is used in the UK, is currently preferred by most learning disabled adults and their families. However, even that can be misunderstood by the general public and some health professionals who tend to assume that it is used only to mean ‘very low intelligence’ and with which
there are no other associated conditions. The place of educationalists, occupational therapists and speech and language therapists to assist their intellectual development can easily be accepted but questions are frequently heard regarding the involvement of doctors, nurses and physiotherapists.

Professionals working with people who have learning disabilities are also guilty of using ‘verbal shorthand’ and failing to mention that clients have one or more disabilities associated with the learning disability, for example physical, psychiatric or behavioural problems, epilepsy, autistic spectrum disorders or speech disorders.

It is worth repeating the following frequently asked questions that were listed in the first edition:

- Why do people with learning disabilities have physical disabilities?
- How do the various problems associated with learning disability affect each other?
- Why do physiotherapists work with people who have learning disabilities?
- How can I talk to a person with learning disability – will they understand me?
- Where does a physiotherapist new to learning disability start?
- How do you encourage learning disabled people to get fit and stay fit?
- Why do fully grown adults need to use special seating and equipment?
- What’s the point of surgery for people with learning disabilities?

The once frequently asked question ‘Why is it important that a range of professionals and care staff work in conjunction with each other?’ is heard less often since flexible working practices were proposed in the 1999 Health Act and followed by the report ‘Working Differently’ (published by the Department of Health in 2005). It is an area in which learning disability has been one of the leaders of the field.

Since the 1950s when therapists began to work with people who had a combination of physical and learning disabilities four points have emerged. First, there have never been sufficient staff to meet the need; second, consistency of treatment is essential; third, individual therapy sessions cannot succeed without ongoing involvement from day care staff and family or carers; and fourth, people with learning disabilities need to find out for themselves that therapy is fun, creates a sense of achievement and makes them feel better. Now that fewer people with learning disabilities live in NHS long-term accommodation in the UK and most live in family-sized houses therapists have to be capable of delivering treatment and management in a wide range of settings.

No book relating to learning disability can ever be written for one single profession neither can it refer to only one profession’s or one country’s literature. Although physiotherapists have written many of these chapters each includes involvement by other professionals and agencies.
The book is divided into three sections. Part I describes the theory underlying learning disability and conditions associated with learning disability. This begins with worldwide social policy developments that have influenced attitudes towards learning disability and therefore subsequently affected treatment and management of physical disabilities. It has been extended to include rapidly developing policies emanating from the United Nations, the European Assembly and devolved UK government. Further revised and expanded chapters describe the following: the causes and classification of learning disability, medical treatment of associated conditions, side-effects of medication and their impact on physical ability and orthopaedic procedures. Additional information includes an introduction to Autistic Spectrum Disorder. Part II focuses on assessment. It outlines the multi-professional structure within which assessments are undertaken and describes communication skills, which are a prerequisite of their success. Chapters 7 and 8 in this section are physiotherapy assessments but are applicable to other professions; they include a résumé of the International Classification of Functioning, Disability and Health (ICF) (WHO 2001). Part III describes nine different methods of managing and treating physical disability and improving physical fitness and general health of learning disabled people. Additional sections have been added to two chapters and the importance of health promotion and use of standard facilities are reflected in a completely new chapter.

Apart from the main chapter authors there are many other people I would like to thank in addition to those whose names appear in the first edition. It should be noted that the tables in the revised Chapter 3 are almost entirely the work of Dr Mohamed Megahed MB ChB MRCPsych, formerly a Specialist Registrar in Psychiatry, The Royal London and St. Bartholomew’s Scheme, who wrote Chapter 3 for the first edition.

Thanks to the following people are recorded:

- Members of the ACPPLD who responded to the original questionnaire and participated in discussions on assessment.
- Dr Walter Muir, Department of Psychiatry, University of Edinburgh and NHS Lothian, Primary and Community Division Learning Disability Services, who read and discussed sections of Part I.
- Daniel Mold, YOU and ME trainer, lecturer Orchard Hill College of Further Education; Pat Pickering, Casteleigh Day Services Officer, Cheshire YOU and ME practitioner; Lynn Bhania, teacher and YOU and ME practitioner who all contributed case studies in Chapter 17; Karen Leslie, senior 1 Paediatric Physiotherapist and External Moderator for the Students’ YOU and ME Foundation Program.
- Stella Giblin and Helen Baggs of the Office of National Statistics Library, for finding and checking references.
- Staff of the library of the Scottish Executive, for finding and checking references.
• Margaret Owens, Senior Physiotherapist and Fiona Wilkie, Community Nurse NHS Lothian, Primary and Community Division Learning Disability Services, who have continued to be a support.

Finally I would again like to thank the children and staff of Oslo Observasjonshjem og Poliklinikk for Åndssvake, Norway who started me on this journey in 1964 and my husband who has patiently continued to encourage me.

Jeanette Rennie
Figures

1.1 Links between government and service users with learning disabilities in England in 2002.

4.1 Preoperative appearances of the wrist.

4.2 Postoperative appearances of the wrist.

4.3 Postoperative radiological appearances; the wrist has fused and the plate has been used to align the third metacarpal to the radius and has been contoured to give some dorsiflexion.

4.4 Preoperative radiograph of the pelvis. The right hip is in severe adduction and the hips are dislocated.

4.5 Appearances following the abduction osteotomy.

4.6 Clinical appearances before and after hip surgery.

5.1 Example of transfer from paediatric to adult services.

5.2 Case study 1: J.A.

5.3 Case study 2: B.H.

5.4 Case study 3: K.T.

6.1 Communicating the concept of ‘tree’.

6.2 How do I ‘do’ intensive interaction?

7.1 Physiotherapy assessment, sociodemographic information (form 1).

7.2 Physiotherapy assessment, sociodemographic information (form 2).

7.3 Physiotherapy assessment, sociodemographic information (form 3).

7.4 Functional ability.

7.5 Problem list.

7.6 Initial plan and goals.

7.7 Assessment of deformities, range of movement and muscle tone.

9.1 Lying squint can cause problems.
10.1 I’m wearing my jacket.
10.2 Sitting in my Symmetrikit chair.
10.3 This is my Edinburgh harness.
10.4 Here I am sitting in my wheelchair.
10.5 My spinal jacket is about to be taken off for my physiotherapy exercises.
10.6 Lying quietly on the mat.
10.7 My prone lyer.
10.8 I do smile in this position.
10.9 Me standing in my ‘EasyStand’ standing frame – from the side.
10.10 Me in my ‘EasyStand’ standing frame – from the front.
10.11 This is just a diagram of my ARROW Walker.

11.1 Example of hydrotherapy information sheet developed by Lewisham and Southwark ALD physiotherapy services.
11.2 Example of letter to GPs developed by Lewisham and Southwark ALD Physiotherapy Services.
11.3 Example of hydrotherapy aims, plan and outcome developed by Lewisham and Southwark ALD Physiotherapy Services.
11.4 Example of hydrotherapy evaluation developed by Lewisham and Southwark ALD Physiotherapy Services.
11.5 Example of discharge summary developed by Lewisham and Southwark ALD Physiotherapy Services.

12.1a Optimum posture.
12.1b Sacral sitting.
12.2 Hippotherapy assessment.
12.3 Assessment of body tilt reactions using vestibular board and tiltmeter.
12.4 Timed walking test.

14.1 Mobility/fitness group – weekly record.
14.2 Physiotherapy mobility/fitness group – six monthly progress.

16.1 Example of risk assessment form.
16.2 Example of standard operating procedure.
Tables

1.1 Key developments worldwide
1.2 UK, key reports and legislation
1.3 Development of terminology
1.4 Development of definitions
1.5 Normalisation and beyond
2.1 Causes of epileptic seizures from a learning disability perspective
3.1 Prevalence of psychiatric disorders in people with learning disabilities
3.2 Syndromes of learning disability, their associated intellectual impairment, behavioural phenotypes and psychiatric vulnerabilities
3.3 IQ ranges and associated behavioural patterns
3.4 The 10 most frequent symptoms of acute schizophrenia in the general population
3.5 Symptoms and signs of anxiety
3.6 Classification of psychiatric medications used in the field of learning disabilities
3.7 Behavioural and psychiatric side effects of psychotropic medications used in learning disability
4.1 Associated conditions seen at Gogarburn Hospital
4.2 Problems of walking in patients with cerebral palsy
4.3 Problems of nonwalking in patients with cerebral palsy
4.4 Foot problems among patients
5.1 System of Papathanasiou and Lyon-Maris
5.2 An example of staffing level requirements for physiotherapists for one year
5.3 Models of physiotherapy case management
6.1 Development of normal intentional communication
9.1 Breakdown of time spent during a year
9.2 Benefits from the Mansfield study
11.1 A simplified rating system
12.1 Rider response to walking horse
12.2 Variations in stride and direction
13.1 Positioning equipment
13.2 Sensory equipment
13.3 Coordination equipment
13.4 Handling and moving equipment
15.1 Benefits and development through sport and outdoor pursuits
16.1 Examples of UK discussion papers and initiatives
17.1 Oils used in case study 1
17.2 Oils used in case study 2
17.3 Oils used in case study 3
17.4 Oils used in case study 4
17.5 Colours for the body areas, looseners and related postures arranged into a sequence of the whole-body-movement leading to the CAT as the main posture
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I Learning Disability and Associated Problems that Affect Physical Ability
1 What is Learning Disability?

JEANETTE RENNIE

INTRODUCTION

In the UK the term ‘learning disability’ is used to mean mental retardation or intellectual disability (see Table 1.4 and Chapter 2). It is used throughout this book except where it is important to record terminology of a particular period.

A number of writers have described the history of the concept of mental retardation – for example Morris (1969), Scheerenberger (1987), Trent (1994) and Harris (2006). This chapter examines the way in which history has influenced treatment and management of associated physical disabilities. It does not deal in depth with social and educational developments or specify the work of individual voluntary agencies, nor does it detail all legislation that impinges upon learning disability.

The chapter is divided into sections describing:

• the events and attitudes leading to the establishment of institutions and organisational developments within them
• the concept of community care for people with learning disabilities and its development
• the present legal aspects in the UK and recent changes in health and social care

Tables are used to show international influence on policymaking, UK legislation, development of definitions and terminology and evolution of the definition of ‘normalisation’.

A MIX OF POLITICS, EDUCATION, SOCIAL POLICIES AND MEDICINE

• Have ideologies, theories and practices benefited or deprived people with learning disabilities with regard to facilities that would assist them to lead a fulfilled life?
 WHAT IS LEARNING DISABILITY?

- Have neurological and sensory impairments present in people with mild mental retardation (Fryers 1997) been considered worthy of treatment or ignored as a nonspecific associated clumsiness?
- Does the term ‘learning disability’, used in the UK to assist integration into normal society, promote misunderstanding amongst generic healthcare professionals who associate ‘learning’ with ‘education’?
- Does the term ‘learning disability’ hinder research between countries? For example, in the US the term was introduced in 1962 to mean: ‘A disorder in one or more of the basic psychological processes involved in the understanding or in using language, spoken or written, which may manifest itself in an incomplete ability to listen, think, speak, read, write or spell, or to do mathematical calculations . . .’ It includes ‘perceptual handicaps, dyslexia, developmental aphasia, brain injury, mid brain dysfunction’. It does not include motor handicaps or mental retardation (Education for All Handicapped Children Act. Public Law 94–42, 34 C.F.R. 300.5 [b] [9], in Brown and Aylward 1996).

People with learning disabilities have produced many and varied reactions in those around them. They have also caused philanthropists, educationalists, health professionals and sociologists to consider deeply how their needs may be met. The social and economic climate of the time has influenced thinking, which in turn has informed political decision making, sometimes clashing with isolated progressive thought and sometimes reinforcing it. Many caring and progressive attitudes of previous years, interpreted today as selfish and condescending, were the building blocks for present policies. Key developments and interaction between countries in the developed world are listed in Tables 1.1, 1.2 and 1.3.

Before the development of modern medicine the majority of profoundly learning-disabled children died in infancy. In general, therefore, the literature refers to people who would now be regarded as having mild to moderate learning disability.

Writings such as Arthurian legends and Shakespearean plays refer to people ‘possessed’ or with ‘second sight’ who influenced everyday occurrences or major battles. Such people were either venerated or locked up and maltreated (Morris 1969, Scheerenberger 1987, Trent 1994). In the early fourteenth century in England, differentiation was made between learning disability (people who were born ‘fools’) and mental illness (people who became ‘mad’) on the basis that the former could never become ‘normal’ but the latter might regain their sanity: ‘born fools could not inherit property, the King as parens patriae assumed rights over the fool and his property as if he were an infant’ (O’Connor and Tizard 1956).

Comparison with infants led to a protective and humane attitude towards the more severely learning disabled. It was also possible, however, for anyone to sue for the guardianship and administration of a ‘fool’s estate’ – ‘to beg for
| France | 1806 | Pinel published his paper ‘Treatise on Alienism’. ‘Defectives’ had the ability to be trained to their level of intelligence but no further (Trent 1994). |
| France | 1846 | Seguin published ‘The psychological treatment, hygiene and education of idiots’ a handbook for institutional care (Kanner 1964). |
| US | 1820–60 | The Depression, ideas from Europe and Britain and the Civil War led to end of ‘outdoor relief’ and development of ‘indoor relief’. |
| US | 1848 | Seguin moved to US. |
| US | 1856 | Schools for feebleminded children became residential asylums for training feebleminded adults and idiots. Medically trained superintendents replaced headteachers. |
| Late 1800s | 1958 | Anthony Dexter conceived a ‘social system concept’ and ‘labelling’ |
| Late 1800s | 1961 | President Kennedy appointed a President’s Panel on mental retardation. |
| Late 1800s | 1969 | Concept of normalisation introduced by Bank Mikkelsen and Bengt Nirje (Table 1.5) |
| Late 1800s | 1970 | The Developmental Disabilities Services and Facilities Construction Act. |
| Late 1800s | 1971 | International League of Societies for the Mentally Handicapped endorsed philosophy of normalisation |
| Late 1800s | 1973 | The Rehabilitation Act |
| Switzerland | 1839 | Guggenbuhl established a ‘colony’ on the Abendberg |
| Italy | 1870s | Lombroso suggested that inherited factors caused criminal tendencies. |
| Italy | 1978 | Law passed to replace all institutions with community care |
| Denmark | 1959 | The Government passed an Act concerning Care of the Mentally Retarded and other Exceptionally Retarded Persons (Table 1.5) |
| Canada | Early 1970s | Responsibility for people with mental handicap transferred from health to social welfare and educational ministries. |
| Australia | 1970s | Several states acted upon reports recommending mentally handicapped people transfer to the community |
| Australia | 1998 | The state of Western Australia proposed ‘local area coordination’. |
### Table 1.1. Continued

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN</td>
<td>Declaration on the Rights of Mentally Retarded Persons</td>
</tr>
<tr>
<td>1971</td>
<td>Declaration on the Rights of Disabled People</td>
</tr>
<tr>
<td>1975</td>
<td>Reported that disability was beginning to be treated as a broad human rights issue</td>
</tr>
<tr>
<td>WHO</td>
<td>International Classification of Impairments, Disabilities and Handicaps (Table 1.4)</td>
</tr>
<tr>
<td>1980</td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>Recommended that all institutions close</td>
</tr>
<tr>
<td>1990</td>
<td></td>
</tr>
<tr>
<td>European Assembly</td>
<td>European Social Charter (revised) Article 15: the right of persons with disabilities to independence, social integration and participation in the life of the community</td>
</tr>
<tr>
<td>2002</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>European Year of People with Disabilities</td>
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</tbody>
</table>

(Compiled in part from Morris 1969, Scheerenberger 1987, Trent 1994)

### Table 1.2. UK, key reports and legislation

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1713–14</td>
<td>Vagrancy Acts: ‘apprehension of those who might be dangerous’</td>
</tr>
<tr>
<td>1774</td>
<td>Madhouses Act: ‘provision of minimum standards of care and for the control of private madhouses’</td>
</tr>
<tr>
<td>1808</td>
<td>County Asylums Act: public asylums in England replaced private madhouses.</td>
</tr>
<tr>
<td>1908</td>
<td>Report of Royal Commission on Care and Control of the Feebleminded.</td>
</tr>
<tr>
<td>1913</td>
<td>Mental Deficiency Act: people with mental deficiency dealt with as a specific group. Segregation introduced. Mental defectives classified</td>
</tr>
<tr>
<td>1914</td>
<td>Mental Deficiency Act: Local authorities to protect mentally defective patients by providing accommodation.</td>
</tr>
<tr>
<td>1927</td>
<td>Mental Deficiency Act: Creation of separate institutions for the mentally ill and mentally handicapped.</td>
</tr>
<tr>
<td>1946</td>
<td>National Health Service Act: minimum standard of care available for all who needed it.</td>
</tr>
<tr>
<td>1948</td>
<td>The National Health Service Act (as amended) standardised mental subnormality hospitals in accordance with general hospitals.</td>
</tr>
<tr>
<td>1959</td>
<td>Mental Health Act repealed all previous legislation. Emphasis placed on voluntary instead of compulsory admission to hospital. Civil rights of patients recognised, including access to a Health Service Commissioner.</td>
</tr>
<tr>
<td>1961</td>
<td>Minister of Health proposed start of ‘running down’ mental hospitals.</td>
</tr>
<tr>
<td>1971</td>
<td>Better Services for the Mentally Handicapped</td>
</tr>
<tr>
<td>1975</td>
<td>The National Development Group and National Development Team for the Mentally Handicapped established</td>
</tr>
<tr>
<td>1978</td>
<td>Helping Mentally Handicapped People in Hospital</td>
</tr>
<tr>
<td>1978</td>
<td>Warnock Committee Report on special educational needs</td>
</tr>
<tr>
<td>1979</td>
<td>Jay Report. Policy based on principles of normalisation. Special help would be required from their communities and the professional services. Advocacy recommended</td>
</tr>
<tr>
<td>1979</td>
<td>‘A Better Life’ (Scotland). Concept of community care endorsed, gradual progress recommended</td>
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</tbody>
</table>
Table 1.2.  Continued

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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</thead>
<tbody>
<tr>
<td>1980</td>
<td>SHAPE (Scottish Health Authorities Priorities for the Eighties)</td>
</tr>
<tr>
<td>1981</td>
<td>Education Act for Children with Special Education Needs and Education (Scotland) Act. Education should be fitted to the child’s requirements as far as possible. Statement of needs and needs assessments proposed.</td>
</tr>
<tr>
<td>1983</td>
<td>The All Wales Strategy</td>
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<tr>
<td>1983</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>1984</td>
<td>The Mental Health (Scotland) Act</td>
</tr>
<tr>
<td>1986</td>
<td>The Disabled Persons Act (Tom Clarke Bill). Right to representation, assessment, information, consultation. Carers right to ask for assessment of disabled persons’ needs and carers’ ability to care taken into account.</td>
</tr>
<tr>
<td>1988</td>
<td>Community Care: Agenda for Action (Griffiths Report)</td>
</tr>
<tr>
<td>1988</td>
<td>SHARPEN (Scottish Health Authorities Review of Priorities for the Eighties and Nineties)</td>
</tr>
<tr>
<td>1989</td>
<td>White Paper <em>Caring for People: Community Care in the next Decade and Beyond.</em></td>
</tr>
<tr>
<td>1995</td>
<td>The Health of the Nation including ‘A strategy for people with learning disabilities and their carers’</td>
</tr>
<tr>
<td>1998</td>
<td>‘Signposts for success’</td>
</tr>
<tr>
<td>1998</td>
<td>Health laws for Northern Ireland devolved to Northern Ireland Assembly</td>
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<tr>
<td>1999</td>
<td>Health laws for Scotland devolved to The Scottish Executive</td>
</tr>
<tr>
<td>1999</td>
<td>The Health Act to improve coordination of services for everyone</td>
</tr>
<tr>
<td>1999</td>
<td>National Assembly for Wales established The Learning Disability Advisory Group</td>
</tr>
<tr>
<td>2000</td>
<td>The Same as You? A Review of Services for People with Learning Disabilities encouraged use of generic services with appropriate support</td>
</tr>
<tr>
<td>2000</td>
<td>The Adults with Incapacity (Scotland) Act</td>
</tr>
<tr>
<td>2001</td>
<td>The Learning Disability Advisory Group reported to the Welsh Assembly ‘Fulfilling the Promise’</td>
</tr>
<tr>
<td>2001</td>
<td>Seeking consent: working with people with learning disabilities</td>
</tr>
<tr>
<td>2003</td>
<td>Partnership for Care, Scotland’s Health White Paper</td>
</tr>
<tr>
<td>2003</td>
<td>The Mental Health (Care and Treatment) (Scotland Act) had relevance to people with a dual diagnosis of learning disability and mental disorder by making new arrangements for detention, care and treatment</td>
</tr>
<tr>
<td>2004</td>
<td>Improving Mental Health law: towards a New Mental Health Act</td>
</tr>
<tr>
<td>2005</td>
<td>The Mental Capacity Act</td>
</tr>
<tr>
<td>2006</td>
<td>White Paper, Our health, Our care, Our say; A New Direction for Community Services</td>
</tr>
<tr>
<td>2006</td>
<td>Start of three-year strategic plan for assessing and encouraging improvement in the healthcare of adults with learning disabilities</td>
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</table>
WHAT IS LEARNING DISABILITY?

Table 1.3. Development of terminology

<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
<th>Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late 1890</td>
<td>US</td>
<td>Wilbur’s categories of mental defectives (Table 1.4)</td>
</tr>
<tr>
<td>Late 1890</td>
<td>UK</td>
<td>Feeble minded, imbecile, idiot</td>
</tr>
<tr>
<td>1913</td>
<td>UK</td>
<td>Moral imbecile, feeble minded, imbecile, idiot</td>
</tr>
<tr>
<td>1921</td>
<td>US</td>
<td>Mental Retardition</td>
</tr>
<tr>
<td>1927</td>
<td>UK</td>
<td>England, moral defective replaced moral imbecile</td>
</tr>
<tr>
<td>1959</td>
<td>UK</td>
<td>Legal terminology England and Wales: subnormal, severe subnormal. (Also used ‘mental handicap’ and ‘severe mental handicap’)</td>
</tr>
<tr>
<td>1968</td>
<td>WHO</td>
<td>Mental Retardation: mild, moderate, severe, profound</td>
</tr>
<tr>
<td>1978</td>
<td>UK</td>
<td>Education terminology England and Wales moderate and severe learning difficulties replaced moderate and severe educationally subnormal</td>
</tr>
<tr>
<td>1980</td>
<td>WHO</td>
<td>Mental Retardation – all people with IQ of &lt;70</td>
</tr>
<tr>
<td>1981</td>
<td>UK</td>
<td>Education terminology: one category – learning difficulty</td>
</tr>
<tr>
<td>1983</td>
<td>UK</td>
<td>England and Wales mental impairment. Scotland mental handicap, severe mental handicap</td>
</tr>
<tr>
<td>1995</td>
<td>UK</td>
<td>Learning disability accepted terminology. Medically, used in conjunction with more specific definition (Chapter 2 and Table 1.4)</td>
</tr>
<tr>
<td>2000</td>
<td>US</td>
<td>Began to use intellectual disability in documents and referred to a wide range of terms used world wide</td>
</tr>
<tr>
<td>2003</td>
<td>US</td>
<td>Federal Advisory Committee replaced Mental Retardation with Intellectual Disability – the ‘President’s Committee for People with Intellectual Disabilities’</td>
</tr>
<tr>
<td>2003</td>
<td>US</td>
<td>Continued the use of mental retardation, ‘American Association on Mental Retardation’</td>
</tr>
<tr>
<td>2005</td>
<td>Scotland</td>
<td>Learning disability confirmed as legal terminology</td>
</tr>
<tr>
<td>2006</td>
<td>WHO</td>
<td>The 2006 version continued the use of Mental Retardation</td>
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</tbody>
</table>

a fool’ (see The Chambers Dictionary, 1994 edition). In the sixteenth and seventeenth centuries various tests were devised to verify ‘fools’, both to protect them and to gain their property rights.

Before the Industrial Revolution, however, local people with learning disabilities were an accepted part of life. This probably contributed to the success of outdoor relief given as direct aid to ‘worthy’ dependants in the US before 1820 (Trent 1994).

Until France produced pioneers such as Itard, Pinel and Seguin in the early nineteenth century, positive treatment or teaching had been deemed impossible. The first steps towards enabling ‘defectives’ to learn and to grow in
self-esteem were Itard’s use of warm baths as sensory stimulation to train ‘defectives’, Pinel’s humanitarian, psychological approach and Seguin’s ‘physiological and moral training’ with 10 ‘idiots’ in Paris (Kanner 1964).

Spa treatment was being used throughout Europe for a variety of medical conditions and the term ‘hydrotherapy’ was an accepted description for specifically medical treatment in England. However, Itard appears to have used baths for training purposes only and not to improve physical abilities in ‘mental defectives’.

DEVELOPMENT OF INSTITUTIONS

During the mid-nineteenth century two parallel strands developed:

- an awareness that ‘defectives’ had an ability to learn and that it was society’s duty to provide education and security for them
- the proposal that low intellectual ability was an entirely inherited factor – the ‘degeneration’ theory, which later gave rise to eugenics

In 1839, Guggenbuhl established a colony for the cure of cretinism on the Abendberg in Switzerland. It was closed 20 years later due to failure to discover a ‘cure’. However, the principle of ‘colonies’ and Guggenbuhl’s treatment theories of a sensible diet, massage and physical exercise, spread to other countries in Europe, the UK and the US.

In the UK, philanthropic reformers began to found institutions to replace the asylums where mentally ill and learning-disabled people were kept together, a problem only solved in the early twentieth century. For example Dr and Mrs Brodie (Henderson 1964) founded the Edinburgh Idiot Asylum in 1855. It transferred to Stirlingshire and became The Scottish National Institution for the Education of Imbecile Children and subsequently the Royal Scottish National Institution for Mental Defectives, the first purely for ‘mental defectives’.

In the Republic of Ireland, Stewarts Hospital in Dublin was opened in 1869. This was a private charitable institution administered on a voluntary basis by a committee of management, supported by the state through revenue allocations and capital grants.

The US responded to pressure from local officials, parents and superintendents by ending outdoor relief and following the UK’s government-driven programme of building large centralised hospitals for ‘idiots’ and ‘feebleminded’ individuals.

Gradually medically trained superintendents and medical terminology became normal practice in the residential institutions and an increasing number of physicians was employed. Dr John Haydon Langdon-Down, who had been Superintendent of the Asylum for Idiots, Earlswood, since 1858,
opened a private home for ‘mental defectives’ in 1868. There, he recognised and described ‘Mongolism’ (Down syndrome). The home developed into a community where residents learned life skills and sports and enjoyed various excursions.

Despite this development, all study and research appears to have been directed towards assessing and categorising ‘idiots’ into different levels by intellectual ability.

CATEGORISATION

Galton (in 1869) and McKeen Cattell (in 1890) were amongst the earliest individuals to attempt categorisation and measurements using new tests of IQ (intelligence quotient). The most notable tests, however, were devised by Binet and Simon. (Savage 1970). The tests were revolutionary but assumed that intelligence could be tested in isolation, without reference to an individual’s social and environmental conditions or physical disabilities. They therefore reinforced the theory of hereditary transmission, which inadvertently fostered fear of a further increase in the number of people with learning disability. In the late nineteenth century this fear led to the development of the eugenics movement and custodial care of people with learning disability.

SEGREGATION

In 1908, the first edition of Tredgold’s renowned book, *Textbook on Mental Deficiency*, was published. In 1909, in an article in the *Eugenics Review*, he referred to the high inheritance factor in mental deficiency and a relatively high birth rate amongst the poor and the handicapped. It has been suggested that this influenced the addition of a statutory instrument to the Mental Deficiency Act of 1913 in 1927. The 1913 Act had originally been introduced to separate people with learning disabilities from those with mental health problems. The statutory instrument that was added to become part of the 1927 Act introduced the category of ‘moral defective’, which segregated ‘mentally deficient’ people from the general population and from the opposite sex to prevent an increase in ‘mental deficiency . . . as a protection of society as a whole’.

One of the effects of segregation was to retain children and adults who had a combination of physical disabilities and learning disability in hospitals specialising in learning disability. Staff were not equipped to treat their physical disabilities and were, on the whole, unable to recognise the impact that such disabilities made upon communication, mobility and daily living skills and subsequently to frustration and resulting in aggressive behaviour.

Photographs from large UK and US hospitals, however, showed that active exercise was provided for physically able people with learning disabilities, in