

**A GENEALOGY OF 'DUAL DIAGNOSIS'
IN LEARNING DISABILITY**

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ABSTRACT

The dual diagnosis of learning disability and mental illness stigmatises and disenfranchises those subject to it. It silences the structural and material causes of distress, pathologises natural responses to difficult circumstances and legitimises the use of restrictive methods of governance. This study used a Foucauldian genealogical approach to explore the conditions of possibility for the emergence of dual diagnosis in Britain, its attending social practices, and the subjugated discourses that could provide alternative ways of constructing and responding to the distress that people with learning disabilities may experience. Analysis of clinical and social policy documents using Rose's (1999) six perspectival dimensions suggested that dual diagnosis emerged within a historical context of governmental concerns regarding population control, particularly in relation to economy, productivity and social order. Distal conditions of possibility included the establishment of the state's legal and political power over insanity; the medicalisation of idiocy and lunacy; and the emergence of disciplinary and biopolitical apparatuses of the state. The developmental (re)construction of idiocy opened up a possibility for its co-occurrence with insanity and presented a conceptual framework that would be taken up following deinstitutionalisation, when dual diagnosis offered an explanation and potential solution for the social problems caused by those who did not settle into the community as desired. Dual diagnosis is neither fixed nor inevitable; it is a 'truth' produced by power that has been reified and endorsed through clinical and government policy and practice. Implications for clinical practice, research and policy are discussed. It is proposed that a more helpful approach to alleviating distress, poverty and disability is to address the material and social causes and the power-networks that sustain these.

DEDICATIONS

I would like to dedicate this work to my father, Agapito Vidal (1940-2014), a lover of history, politics and current affairs who was my ally during both challenging and mischievous times, and who always had faith that I would succeed.

I would also like to dedicate this research to Professor Mark Rapley (1962-2012), who encouraged me to pursue the topic of 'dual diagnosis' and introduced me to a completely new way of thinking that will shape my personal views and professional practice for years to come.

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CHAPTER 1: INTRODUCTION

My objective . . . has been to sketch out a history of the different ways in our culture that humans develop knowledge about themselves: economics, biology, psychiatry, medicine, and penology. The main point is not to accept this knowledge at face value but to analyze these so-called sciences as very specific "truth games" related to specific techniques that human beings use to understand themselves.

Foucault, 1988, p. 18

1.1 Aims of the research

This research examines and problematizes the ‘dual diagnosis’ of ‘learning disability’ and ‘mental illness’ in Britain using a Foucauldian genealogical approach¹. This involves mapping out how dual diagnosis is understood and acted upon in the present day, followed by an exploration of the historical ‘conditions of possibility’ for its emergence, its associated social practices, and alternative understandings that may have been subjugated. My overall aim is to raise critical discussion and debate and thereby create new possibilities for thought and action.

It is important to note that in problematizing diagnostic categories and their interpellation, my intention is not to deny that people subject to them experience distress, but rather, to question their usefulness as an explanatory framework.

¹ The genealogical approach employed is described in more detail in Chapter 3.

1.2 Definitions and language

'Dual diagnosis' is a medical term used to describe two diagnoses in an individual. Its contemporary use is most commonly associated with the co-occurrence of mental health and substance misuse problems (Department of Health [DoH], 2002), however, in the context of learning disability, the term is used to refer to the co-existence of learning disability and mental health diagnoses (Bernal & Hollins, 1995). 'Learning disability' and 'mental illness' are also medical constructs.

In Britain, within a health and social care context, 'learning disability' is most commonly defined as 'a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development' (DoH, 2001a, p. 14). In some diagnostic systems such as the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10; World Health Organization [WHO], 2016), the historical term 'mental retardation' continues to be used, and in academia, the term 'intellectual disability' is often employed instead. Whilst the exact wording may vary, the three core criteria of impaired intelligence, impaired social functioning, and onset before adulthood are consistent across most definitions (British Psychological Society [BPS], 2000).

'Mental illness' is frequently referred to as a 'mental health problem', 'psychiatric disorder' or 'mental disorder', and definitions across the literature are variable. The WHO (2001) states that 'mental disorders . . . are generally characterized . . . by some combination of disturbed thoughts, emotions, behaviour and relationships with others. Examples are depression, anxiety, conduct disorders in children, bipolar disorders and schizophrenia' (p. 10).

The ways in which particular groups of people are defined and described have significant implications for how they are perceived and responded to by others and themselves. For example, the notion that people diagnosed with a learning disability have reduced cognitive and coping abilities often translates as incompetence, whereas the concept of mental illness carries with it an assumption of irrationality (Foucault, 1961/1988). Both categories lead to the

perception that these are homogeneous groups of people rather than individuals with a range of needs and wishes (BPS, 2011).

It is important to recognise that it is not the individuals subject to these labels who choose to define or understand themselves in this problem-focused way (Ryan & Thomas, 1987). Diagnostic categories are generally imposed on them by others who have been ascribed the authority to do so (usually psychiatrists and psychologists) and who are then granted the power to speak and do things on their behalf (Patel, 2003).

I am mindful that by using these terms (and their historical counterparts) throughout my thesis I risk perpetuating and reinforcing their legitimacy. My hope, however, is that by offering an account that continually questions the origin, validity and reliability of these concepts, the reader will maintain an awareness of their inadequacy.

1.3 Literature review

the question I start off with is: what are we and what are we today? What is this instant that is ours?

Foucault, 1988/2007, pp. 136-137

1.3.1 Introduction to the literature review

In this section I use a Foucauldian-informed approach to offer a critical overview of how dual diagnosis is currently understood within the learning disability literature. 'Isolating the problem' and situating it within a network of practices and power relations to 'diagnose the present' in this way is an important initial step in genealogical research (Tamboukou, 1999; see Chapter 3). As such, the literature review should be considered a part of the overall analytical work in this thesis.

Most of the subheadings used to structure this review are identical to those commonly presented in the literature (epidemiology, policy context, assessment, and intervention). Whilst I am mindful that this risks reproducing the dominant biomedical discourse, my aim in using these constructs is to subsequently problematize them. The literature review ends with some service user and carer perspectives relating to dual diagnosis. This is followed by the

rationale for the current study and the specific research questions that my analysis aims to address.

1.3.2 Search strategy

The information presented in this introduction derives from literature focusing on the mental health of adults with a diagnosis of learning disability from the following sources:

- Up-to-date editions of clinical psychology text books listed in the Learning Disability module reading list for the Professional Doctorate in Clinical Psychology at the University of East London.
- Legislation and guidelines produced by government authorities in the last ten years.
- Policy and guidelines produced by: the British Psychological Society (BPS), the Royal College of Psychiatrists (RCP) and the National Institute for Health and Care Excellence (NICE) in the last five years.
- Clinical and academic research published in English from January 2011 to April 2016 in the form of literature reviews, systematic reviews, and meta-analyses. These were identified through bibliographical database searches (see Appendix A for databases and search terms used) and further refined by reading titles and abstracts to exclude material that was not directly relevant to 'dual diagnosis'. Only studies relating to Great Britain were included. Forensic studies and those that focused predominantly on children, challenging behaviour, autistic spectrum disorders (ASD), attention deficit hyperactivity disorders (ADHD) or dementia were excluded.

The above data sources were chosen because it is predominantly within clinical literature and through policy that the mental health of people with a learning disability is constructed and governed, and because they represent what Foucault termed 'prescriptive' or 'programmatic' texts; documents that describe how people ought to behave and how societies ought to be constructed (O'Farrell, 2005).

1.3.3 The construction of the ‘problem’ of dual diagnosis

1.3.3.1 Epidemiology

Epidemiology is a scientific discipline that has been defined as ‘the study of how often diseases occur in different groups of people and why’ (Coggon, Rose & Barker, 2003, p.1). The ‘knowledge’ collected through epidemiological techniques is subsequently used by authorities to justify the planning of specific services and implementation of strategies that are designed to predict, prevent and manage illness in potentially affected populations (Buckles, Luckasson & Keefe, 2013). This led Detels (2015) to state that epidemiology constitutes ‘the basic science of public health’ (p. 403). It therefore has political value.

The important role played by epidemiology in the differentiation, monitoring, regulation and subjection of particular social groups to governmental interventions is resonant of Foucault’s notion of ‘biopower’². As a technology³ of biopower, epidemiology can present a number of problems for those who are subject to it. For example, the ‘knowledge’ it gathers ignores the rich context of peoples’ lives, reducing them to a set of statistics and probabilities that has a totalising effect and creates an impression of homogeneity. Whilst epidemiology purports to focus on populations rather than individuals (Detels, 2015), its effects can be felt strongly at the individual level. It enables the denomination of particular ‘risk groups’ that are produced by the very process of their identification. This has the potential to create new social identities and realities (Führer & Eichner, 2015), which, for those subject to a dual diagnosis, are often negative.

In the next section I examine recent⁴ epidemiological research relating to dual diagnosis. My aim here is twofold: firstly, to illustrate the lengths to which authorities such as researchers, academics and clinicians have gone to study and differentiate this group of people from the rest of the population; and secondly, to demonstrate the strategic and selective way in which epidemiological data have been used to construct a particular ‘truth’ about dual diagnosis that is then used to justify particular modes of governance.

² ‘Biopower’ refers to the power that is deployed to manage the births, deaths, reproduction and illnesses of populations (O’Farrell, 2005).

³ Foucault used ‘technology’ to refer to the collection of practical and intellectual techniques, devices, and tools used to shape people’s conduct into particular desired ways of being (Rabinow & Rose, 2003).

⁴ In accordance with the search parameters described in Section 1.3.2.

1.3.3.2 Prevalence⁵

'People with intellectual disabilities (...) present with three to four times more common mental disorders than those without' (Zaman & Bouras, 2016, p. 688) – this is the opening line of the chapter on 'dual diagnosis' in the latest edition of the *Handbook of Intellectual Disability and Clinical Psychology Practice*. It is a powerful statement that immediately emphasises and problematizes the mental health of people with learning disabilities.

The statement is representative of the current dominant belief about the increased prevalence of mental illness in people with learning disabilities (DoH, 2001a; DoH, 2009; BPS, 2011). When one looks closely at the evidence used to support this, however, a number of discrepancies emerge that undermine it. These are important to highlight because of the numerous authorities, institutions, policies and social practices that have been produced and legitimised on the basis of the 'truth' of this statement, and the impact of these on those subject to them.

The overall prevalence rates of dual diagnosis reported in published research have varied enormously, from less than 10% to more than 80% (Borthwick-Duffy, 1994; Cooper, Smiley, Morrison, Williamson & Allan, 2007), with the most recent review quoting a range of 13.9% to 75.2% (Buckles et al., 2013). Similarly wide-ranging prevalence rates have been found in research focusing on the diagnosis of specific mental disorders, for example, 6-31% for anxiety symptoms (Bailey & Andrews, 2003), and 1-91% for personality disorders (Alexander & Cooray, 2003). Findings from studies investigating the same mental disorder have been inconsistent, with some studies indicating a higher prevalence amongst people with learning disabilities and others finding no significant difference (Hatton & Taylor, 2010).

The wide variation in reported rates has been attributed to a number of factors, including the use of different sample populations and sizes, the range of diagnoses considered, and the criteria used to define and assess them (Kerker, Owens, Zigler & Horwitz, 2004; Whitaker & Read, 2006; Smiley, 2005; Cooper et al., 2007). The effects of these methodological variations on reported

⁵'Prevalence' refers to the proportion of people in a given population who have been diagnosed with a particular disease or other condition at a specific point in time (Szklo & Nieto, 2007).

prevalence rates are illustrated in Figure 1 and discussed in more detail below. For comparative purposes, I have marked out the mental illness prevalence rate reported for the general population in previous adult psychiatric morbidity surveys undertaken in England (16-25%; Meltzer, Gill, Petticrew & Hinds, 1995; Singleton, Bumpstead, O'Brien, Lee & Meltzer, 2001; McManus, Meltzer, Brugha, Bebbington & Jenkins, 2007).

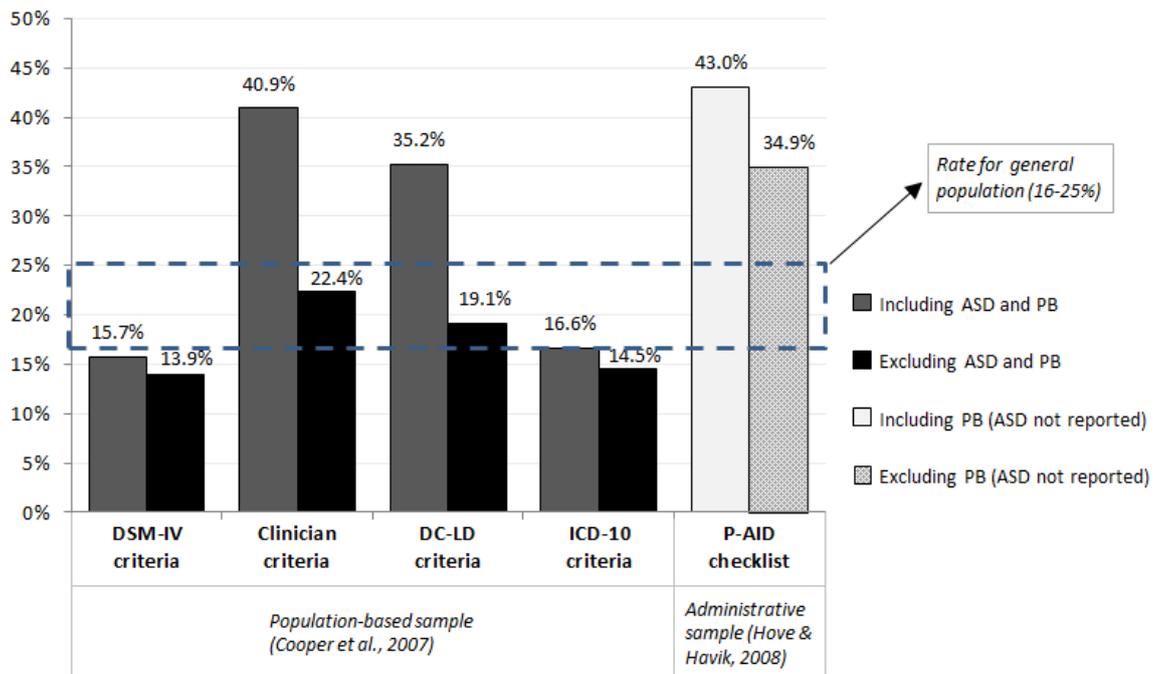


Figure 1: Variation of point-prevalence⁶ of mental disorder in adults with intellectual disabilities: Effect of diagnostic criteria, inclusion/exclusion of autism spectrum disorder (ASD) and/or problem behaviour (PB) and sampling method (adapted from Buckles et al., 2013, p. 202).

Studies undertaken with 'administrative' samples (such as people in psychiatric care settings or individuals known to local authorities) tend to report much higher prevalence rates than those using 'population-based' cohorts (such as a sample of all people with a diagnosis of learning disabilities living in a particular geographical area; Whitaker & Read, 2006). Problems also arise in the inconsistent definition of 'mental illness' in different diagnostic manuals and tools.

The most significant discrepancy arises in the inclusion of 'challenging behaviour' and, to a lesser extent, 'autistic spectrum disorders' within dual diagnosis prevalence figures (Hemmings, Deb, Chaplin, Hardy & Mukherjee,

⁶ 'Point prevalence' refers to a snapshot of the rate present at that particular point in time (Buckles et al., 2013).

2013). In Cooper et al.'s (2007) study, the inclusion of these categories almost doubled the prevalence rate (from 22.4% to 40.9%); a pattern evident in other studies, including Corbett (1979), Lund (1985), and Cooper and Bailey (2001). The classification of 'behaviour problems' as a 'mental disorder' is encouraged by diagnostic manuals that have been produced specifically for the assessment of mental illness in people with a learning disability such as the DC-LD (Diagnostic Criteria for Psychiatric Disorders for Use with Adults with Learning Disabilities/Mental Retardation; RCP, 2001; see section 1.3.4.4.2).

Another problem is the way in which comparisons with the 'general' population are frequently vague or lack validity. For example, Cooper et al. (2007) stated that the 40.9% prevalence rate in their study was 'higher than [that] observed in the UK general population' (p. 32), citing 'Singleton et al (2001) as their evidence, but without specifying the comparison rate. Whilst the rate in question (23%) is indeed much lower, as Singleton et al (2001) did not assess for ASD, ADHD or behavioural disorders, the two figures are not directly comparable. When these diagnoses are excluded from the Cooper et al. (2007) study, the overall prevalence rate is brought down to a more comparable 20.9%.

There are a number of additional problems in how the data are selectively and rhetorically reported. In spite of the variability and sometimes even explicit acknowledgement of a lack of confidence in findings (e.g. NICE, 2016a), most studies go on to conclude that mental health problems are indeed more frequent in people with learning disabilities than in the general population – if not for all diagnoses, then at least for some. When a range of rates is reported that could represent both significant and non-significant findings, it is nearly always the higher figures that are emphasised and cited in subsequent studies and policy. It is also interesting that when findings are non-significant, rather than considering the possibility that they might indicate that people with learning disabilities are not that different from the general population (or indeed that they may be *more* resilient to mental health problems), authorities conclude that this lower rate must be an underestimation of the 'real' prevalence, maintaining that the mental health problems of people with learning disabilities are particularly complex and difficult to detect (Hassiotis & Turk, 2012). Some of the challenges outlined in the 'identification' of mental health problems in people with learning disabilities are discussed below.

It is commonly argued that people with learning disabilities have a reduced ability to self-report thoughts and emotions verbally or reliably, due to a combination of cognitive and communication difficulties, developmental delay, reduced confidence, a tendency to acquiesce, additional neurological, sensory or mental health needs, and/or medication side effects (NICE, 2016a). This constructs and positions them as complex, vulnerable individuals who struggle to express their emotions and whose views about their own lives are unreliable and/or untrustworthy.

Without an insight into an individual's internal world it is not possible to meet the diagnostic criteria for some categories of mental illness (Dagnan & Lindsay, 2012). Consequently, it is argued that there is a need to rely on other people to notice and report changes in presentation (Moss, Prosser, Ibbotson & Goldberg, 1996).

It is also claimed that there is a general lack of awareness about the ways in which mental health problems can manifest differently in people with learning disabilities (particularly those with more severe disabilities) due to the hypothesised effect of developmental level on psychopathology (Sovner, 1986; Sovner & Hurley, 1986; Sturmey, 1995). For example, rather than expressing the 'classic' symptoms associated with depression such as hopelessness or guilt (intellectually complex concepts that researchers argue require a developmental age⁷ of around seven years; Cooper, Melville & Einfeld, 2003; RCP, 2001), someone with a 'severe learning disability' will never reach this 'mental age' and might present with the 'behavioural equivalents' of aggression or social withdrawal instead (Sovner & Hurley, 1982, 1986; Cooper et al., 2003; Hurley, 2008)⁸.

The concept of 'diagnostic overshadowing' (Reiss, Levitan & Szyszko, 1982), whereby the causes for symptoms that might be indicative of a physical or mental health problem are inadvertently attributed to the learning disability itself is also quoted often as a reason for under-reporting. For example, attributing social withdrawal to poor social skills rather than an underlying mental illness

⁷ Developmental age refers to a measure of an individuals' functioning in social, emotional, intellectual or physical domains in comparison to the chronological age at which most individuals demonstrate that level of functioning (Corsini, 2002).

⁸ Another example is the behavioural manifestation of mania as restlessness, insomnia, irritability or agitation (Sturmey, Laud, Cooper, Matson & Fodstad, 2010).

(Taylor, Lindsay & Willner, 2008). Recently, the 'misdiagnosis' of mental illness as 'challenging behaviour' has also been highlighted (see chapter 3).

Other reasons include a lack of well-developed, reliable and valid standardised assessment measures of mental health designed specifically for people with learning disabilities (Deb, Matthews, Holt & Bouras, 2001), and a lack of specialist training for carers and professionals (Quigley, Murray, McKenzie & Elliot, 2001).

There are a number of problems to note here. The 'truths' outlined above position people with learning disabilities as always-already⁹ vulnerable to mental illness, constructing them as complex individuals who struggle to express their emotions, whose views about their own lives are likely to be unreliable (and therefore untrustworthy) and who, because of their 'atypical' presentation, are inherently 'different' from everybody else. These are strong deficit-centric and highly pathologising statements that reinforce the subordination of people with learning disabilities and risk disenfranchising them further (Williams & Heslop, 2005). By positioning people with learning disabilities in this way, authorities construct a complementary identity for themselves as the 'helper' or the 'protector', legitimising their own role and power (Boyle, 2003). By drawing on a discourse of 'complexity', and criticising the knowledge and (in)actions of carers and other professionals, 'specialist' practitioners reinforce their own authority over the dually diagnosed.

1.3.3.3 Aetiology: Causes, associated characteristics and risk factors

There has been considerable interest in identifying possible reasons for the perceived higher prevalence of mental illness in people with learning disabilities. The dominant theory is that it is caused by a combination of three inter-related factors: an increased risk of biological vulnerabilities (NICE, 2016a; O'Brien & Yule, 1995; Zaman & Bouras, 2016); an increased likelihood of adverse life events and circumstances (Cooper et al., 2007; Martorell, Tsakanikos, Pereda, Gutiérrez-Recacha, Bouras & Ayuso-Mateos, 2009); and fewer psychological resources than the general population (van den Hout, Arntz & Merkelbach, 2000). Whilst this biopsychosocial model recognises the influence of people's

⁹ 'Always-already' refers to the idea that the subject positions we take up are already determined by proposed and imposed sociocultural discourses rather than something we can create for ourselves independently of power relations and practices (Foucault, 1984 in Fernet-Betancourt, Becker & Gomez-Müller, 1987).

social and environmental experiences on mental health, these are viewed as triggers rather than causes (which continue to be attributed to underlying biological vulnerabilities; Read, 2005).

A summary table of the specific risk factors highlighted in the literature can be found in Appendix B. Although these have sometimes been presented as 'causes', they generally represent associations rather than causal connections. In general, research findings for aetiological studies have been mixed, with some studies finding an association between dual diagnosis and a particular risk factor and others not. For example, some studies have found an increased prevalence of mental disorders amongst people with more severe learning disabilities (e.g. Cooper et al., 2007; Kerker et al., 2004; Bhaumik, Tyrer, McGrother & Ganghadaran, 2008), whilst others have not (e.g. Whitaker & Read, 2006; Bouras & Drummond, 1992). The lack of consistent findings is perhaps to be expected, particularly when one considers the wide range of factors being considered and the likelihood that causation is multifactorial and complex, and, importantly, unique to each individual. Despite this, as Zaman and Bouras (2016) note, the search for 'a model that can be used in all clinical situations' (p. 689) continues, in the hope that 'with further research a better picture will emerge' (pp. 689-690). Although such universal models may be helpful at a public health level, the problem is their assumption that human beings are homogeneous and that it is possible to capture an objective, universal 'truth' about them. They do not take cultural variations or individual circumstances into account.

The next section looks at the contemporary responses to the 'problem' of dual diagnosis, in terms of policy, service design, case identification (assessment), and strategies to prevent and manage the mental health problems of people with learning disabilities.

1.3.4 The management of dual diagnosis

A number of 'solutions' have been offered in response to the 'problem' of dual diagnosis. These include techniques of surveillance and examination, such as screening for mental health problems at annual physical health checks and undertaking a comprehensive assessment when mental health problems are suspected. They also include the implementation of different types of

pharmacological and psychological interventions to manage the mental health (and behaviour) of people with learning disabilities. These 'solutions' or strategies can be viewed as practices of *governmentality*, which Foucault defined as a form of activity that aims to 'shape, guide or affect the conduct of some person or persons' (Gordon, 1991, p. 2)¹⁰.

Current approaches to assessment and intervention in dual diagnosis are described in sections 1.3.4.4 and 1.3.4.5. First I will offer an overview of the policy context and service delivery models relevant to the mental health of people with learning disabilities. These can be viewed as forming part of the 'solution' because of the important role they play in legitimising the governance of the dually diagnosed.

1.3.4.1 Policy context

Public policy is a technology of power, created to regulate and discipline people's behaviour, and is used to justify and legitimise socio-political practices and institutional arrangements (Colebatch, 2002). It describes not just how the Government is addressing a particular social, economic or political problem, but how it intends to do so in the future (Anderson, 2015). Rather than a simple outcome of scientific, political or legal processes, or originating from a central force such as the 'State', policy is a product of a vast network of power relations. Demands for its creation may arise from a variety of actors: the general public, particular interest groups, service users, public or government officials, or anyone else holding an interest in a particular issue. This wide range of stakeholders has increasingly been directly involved in the process of policy development. Without their support (and that of their affiliated institutions), it is difficult to legitimise or deploy policy (Anderson, 2015), thus power can be seen as emerging and acting from below as well as above. Easy-read versions of policy documents relevant to people with learning disabilities are being increasingly produced, increasing the ability of this group of people to become more informed and involved in the political arena.

Policy and guidelines are productive, creating or redefining roles, identities, authorities and institutions. Through them, and because of the 'specialist

¹⁰ Foucault (1978/1991) also used the term to refer to 'the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power' (p. 102).

knowledge' they have acquired about human behaviour, a variety of 'psy-professionals' such as psychologists, psychiatrists and other health and social care workers have been invested with 'the authority to act as experts in the device of social rule' (Rose, 1993, p. 285). 'Psy-professionals' and their accompanying knowledges therefore constitute important technologies of governmentality. They cannot be seen solely as agents of the State, however. The same 'expert' knowledge and truths that enabled their authority to be granted in the first place ensures the maintenance of their power status.

The involvement of service users in service development is often a policy recommendation for both mental health and learning disability services (NHS Health Advisory Service, 1997; Foundation for People with Learning Disabilities [FPLD], 2004), in recognition that they are 'experts by experience' and thus in a key position to comment on and take on roles within service development (Hoole & Morgan, 2010). Service users with learning disabilities have themselves noted that there should be 'nothing about us without us' (DoH, 2001b).

Such initiatives have the potential to increase feelings of personal agency and enable people with learning disabilities to gain more control over their lives (Dearden-Phillips & Fountain, 2005). However, the focus of consultation and involvement is often set by those in power, who decide what questions to ask and what answers to publish, rather than research being designed by service users themselves. Moving beyond token consultation and delivering the requested outcomes have therefore been challenging tasks.

1.3.4.1.1 Policy relating to dual diagnosis

Underpinning all current learning disability policy in England is the fundamental principle that people with learning disabilities have the same human rights as everyone else (Human Rights Act 1998; United Nations Convention on the rights of persons with disabilities, 2006). The most well-known documents are the *Valuing People* White Papers (DoH, 2001a, 2009). These set out strategies for learning disability services based on the four core principles of legal and civil rights, promoting independence, giving choice to individuals and encouraging social inclusion. Whilst these have provided a helpful focus and supported the implementation of important changes, because White Papers represent

government proposals for future legislation rather than a firm commitment, many saw them as being optional, and there has been a substantial gap between policy and practice (Joint Committee on Human Rights [JCHR], 2008; DoH, 2005).

Although a handful of documents relating specifically to the mental health of people with learning disabilities had been created prior to 2005 (most notably the first Mansell report; DoH, 1993), the last ten years (and five years in particular) have seen a vast increase in the production of reports, guidelines and policy on dual diagnosis. The main driver for this recent proliferation was the 2011 Winterbourne View scandal, where the physical and psychological abuse of people with learning disabilities living at the hospital was exposed by a BBC Panorama investigation (see section 3.3.7). An ensuing review by the DoH (2012) set out a plan of action to review and transform services for people with learning disabilities or autism who also have mental health conditions or 'challenging behaviours'. Key pledges included the development of clinical guidelines on challenging behaviour by Summer 2015, and on dual diagnosis by Summer 2016.

The Mental Capacity Act (MCA) 2005 is particularly relevant to people with a dual diagnosis. Although one of the Act's principles is that capacity is presumed unless demonstrated otherwise, having a 'learning disability' and/or 'mental illness' is sufficient grounds for questioning someone's capacity:

a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain¹¹. . . . It does not matter whether the impairment or disturbance is permanent or temporary. (Mental Capacity Act, 2005, s2)

The NICE (2016a) guidelines state that 'all staff are accountable in ensuring that the person's capacity to make specific decisions is assessed' (p. 32), including consenting to any assessment and treatment offered. People should be supported to make their own decisions wherever possible, and, for those who lack capacity, the best interests process should be followed for any decisions that need to be made on their behalf.

¹¹ Examples listed in the MCA code of practice include 'conditions associated with some forms of mental illness' and 'significant learning disabilities' (Department for Constitutional Affairs [DCA], 2007, p. 44).

The Mental Health Act (MHA) 2007, whilst not specific to people with learning disabilities, is also important, as it allows for the detainment and treatment of individuals against their will should there be significant concerns about their mental health. Through the MHA, the medical psychiatric discourse can be used to control, exclude and impose treatment on those subject to it (Bracken & Thomas, 2001).

1.3.4.2 Clinical and professional practice guidelines

Recommendations regarding clinical interventions for the assessment, prevention and management of specific mental health problems in England are largely provided by NICE in the form of evidence-based 'clinical guidelines'. These are developed by 'independent' committees comprising 'experts' and service user representatives, with draft guidelines open to commentary from interested stakeholder groups. The organisation itself is accountable to the DoH, a power arrangement that may reduce its ability to be truly independent and affect what is prioritised and accepted.

Moncrieff and Timimi (2013) demonstrated how NICE guidelines are formed in the context of power and knowledge relationships, and the significant effect that these and other social and political influences have on the way in which 'evidence' is interpreted and selected. Problems highlighted included the lack of consideration given to critical literature that challenges the validity of psychiatric diagnoses, and the consequent privileging of medicalised understandings and legitimising of biomedical approaches such as treating emotional and behavioural problems with psychotropic medication. They also noted the privileging of particular research designs such as randomised control trials above others (Goldenberg, 2006), which can be particularly problematic in the case of dual diagnosis due to small sample sizes, limited funding for these kinds of studies, and ethical concerns around informed consent that result in the routine exclusion of people with learning disabilities from most research. Another area of concern was the way in which the medicalisation of human distress can benefit particular organisations such as pharmaceutical companies, and the financial conflicts of interest that exist between authors and these companies (Conrad, 2007).

Other problems include the way in which NICE clinical guidelines restrict professional autonomy and choice, implicitly or explicitly discouraging the use of other approaches that have not (yet) met the stringent criteria for evidence. Service user choice is limited for similar reasons.

1.3.4.2.1 *Clinical guidelines relating to dual diagnosis*

NICE guidelines relating to dual diagnosis were published in September 2016. These state that they pre-existing NICE guidelines should continue to be used to guide the support offered to people with learning disabilities and that their aim is to highlight adjustments that might be needed to ensure equality of care and support for them (NICE, 2016a). The BPS (2016) has recently produced a publication outlining the range and effectiveness of psychological therapies available to people with learning disabilities, and the RCP (2016) has produced guidelines on the prescription of psychotropic drugs for mental health or challenging behaviour.

1.3.4.3 Service delivery models

‘Services’ are the sites within which technologies of power are deployed, wherein conduct becomes officially constituted as ‘problematic’ and as requiring intervention, and where ‘expert’ authorities act upon it to improve it (Rose & Miller, 1994).

Government policy has set a clear expectation that wherever possible and appropriate, people with learning disabilities should access mainstream services for their physical and mental health needs. It has also emphasised the importance of having ‘specialist’ services for those with more complex needs (Association of Directors of Adult Social Services [ADASS], Local Government Association [LGA] & NHS England [NHSE], 2015). Mental health services provided by the NHS are delivered in a stepped-care model as follows:

1.3.4.3.1 Primary care

The general practitioner (GP) is usually the first point of contact when there are physical or mental health concerns (NICE, 2016a). These are usually raised by those who deem the person’s behaviour ‘problematic’, rather than the person with a learning disability themselves (Beail & Jahoda, 2012); it is those who deem their behaviour to be ‘problematic’ who typically raise concerns. Concerns

might also be identified at the annual health checks offered to people on the 'Learning Disability Register'¹². When a mental health problem is suspected, the GP initiates treatment or refers to a secondary mental health or learning disability service if the presentation appears complex (NICE, 2016a). One of the problems with this regular monitoring and the site within which it takes place is that it inevitably leads to higher numbers of people being identified. It always-already involves a medicalised construction of and response to distress, and may result in the unnecessary medicating of people who might have responded to other approaches.

1.3.4.3.2 Secondary care

Community mental health teams (CMHTs)

CMHTs support people with a moderate degree of mental health need (Joint Commissioning Panel for Mental Health [JCPMH], 2013). They are usually Psychiatry-led and tend to privilege a medical understanding of mental health difficulties. The inclusion of people with learning disabilities in this mainstream service has been challenging, with users reporting access difficulties (BPS, 2011; Michael, 2008), poorer support and, in many cases, negative experiences (Bouras & Holt, 2004). CMHT staff often express not feeling appropriately skilled to meet their needs (Naylor & Clifton, 1993); a feeling that may be reinforced by dual diagnosis specialists' own emphasis on the 'expert' knowledge that may be required.

Community learning disability teams (CLDTs)

CLDTs comprise health and social care professionals with specific 'learning disability' expertise, including nurses, social workers, psychiatrists, clinical psychologists, occupational therapists, physiotherapists and speech therapists (Cooper & Bonham, 1987; NICE, 2016a). There is some overlap between professions, which can enable a more flexible and holistic approach but can also lead to lack of role clarity, 'territoriality' and discipline elitism (Hanley, 2000). As well as delivering direct interventions, CLDTs may provide support to enable people with learning disabilities to access mainstream services (ADASS, LGA & NHSE, 2015).

¹² In the UK, GP practices are financially rewarded for keeping a register of patients with learning disabilities through the 'Quality and Outcomes Framework' scheme.

Mental health in learning disability (MHiLD) teams

In some areas of the country, psychologists, psychiatrists and community psychiatric nurses have moved away from CLDTs to form specialist MHiLD 'hubs'. These support people with learning disabilities who have more severe and/or complex mental health needs, and link into CLDTs, CMHTs and other more specialist services (such as forensic). One of the dangers in the formation of these separate teams is the reinforcement of the notion that people with learning disabilities have needs that are different and more complex than those without this label. There is also a risk of interventions becoming increasingly medicalised in the absence of close working relationships with other disciplines. Another disadvantage is that MHiLD teams are unable to offer the wider range of expertise and approaches available in mainstream mental health services (such as trauma or substance misuse; RCP, 1996). Moreover, specialist services do not provide the same level of crisis and out-of-hours support as mainstream services.

1.3.4.3.3 Tertiary / Inpatient care

As a last resort, those with acute and severe mental health needs may be detained or admitted to hospitals specialising in forensic, psychiatric, learning disability, and/or neuropsychiatric conditions (RCP, 2013). Medication is the predominant treatment here, although there are usually opportunities for occupational, psychological or creative therapies. Locked wards, and chemical and physical restraint are common, and within these environments people with learning disabilities have very little power. Research indicates that many hospital admissions could be prevented with better community support, and that many people are remaining in hospital for long periods of time despite being fit for discharge (ADASS, LGA & NHSE, 2015).

Whilst having such a wide range of options to meet the mental health needs of people with learning disabilities may be helpful, it can also be extremely confusing for users, referrers and service providers alike. Each will have their own eligibility criteria, and inappropriate referral may result in a delayed service. People are frequently passed from service to service and may 'fall through the gaps' (FPLD, 2002).

Having described the policies guiding the governance of people with a dual diagnosis and sites within which this occurs, I now examine the assessment processes through which the behaviours and emotions of people with learning disabilities come to be constructed as problematic, followed by the ways in which these are governed through particular 'interventions'.

1.3.4.4 Assessment

Mental health assessment is an important technology of power; a dividing practice that separates the 'mad' from the 'sane' and that secures a legitimate authority over the government of those who come under the medical, psychiatric or psychological gaze. The focus on diagnosis positions assessment firmly within a medical model, subjugating alternative understandings of distress.

1.3.4.4.1 General principles for assessment

NICE (2016a) guidelines recommend coordination of mental health assessments in people with learning disabilities by professionals with specific expertise in dual diagnosis (typically Psychiatrists), recognising and reinforcing their authority of in this field. The guidelines also encourage the involvement of family, carers and other professionals, thus extending the gaze and authority to other people in the individual's life. They promote an in-depth and comprehensive assessment, not just of the primary complaint, but of all potential psychiatric and physical pathology, social circumstances, level of learning disability, and risk. In this way, authorities gain power and control over the entirety of a person's life; not just of the mind but also the body. Whilst the word 'strengths' is included amongst the list of areas to explore, the emphasis of assessment is very much on deficit, which could further stigmatise individuals already disempowered by their learning disability diagnosis.

1.3.4.4.2 Assessment tools: Technologies of diagnosis

Diagnostic classification systems are the main tools of the psychiatric profession. These both construct and are constructed by psychiatric knowledge, and through them, the application of psychiatric power is authorised. Diagnostic systems continue to be regarded as accurate reflections of objective diseases or disorders (Reich, 2000), despite the lack of evidence for any specific biological or genetic causal markers for mental illness (Bentall, 2004).

Numerous criticisms about the validity of such classifications, and evidence that their construction has been politically and socially driven have not significantly undermined the scientific status accorded to diagnosis and the tools for their 'identification'.

In Britain, the most frequently used tool for the classification and diagnosis of mental illness is the ICD-10¹³ (WHO, 2016). Whilst this can be used with people with a mild learning disability and good communication skills (Clarke et al., 1994), for those with moderate to severe learning disabilities, the DC-LD¹⁴ (RCP, 2001) is recommended. The DC-LD is based on the premise that mental illness in people with learning disabilities presents atypically (because of delays to their emotional and cognitive development), and uses behavioural manifestations of mental illness to aid its identification in people with more severe impairments who are unable to verbally report on their internal world (RCP, 2001).

The DC-LD is considered a valid and reliable assessment tool because it matches the diagnostic prevalence rates generated by the 'gold standard' of clinical judgement (Cooper et al., 2003). However, as noted in section 1.3.3.2, this is likely to be a consequence of both these methods categorising 'problem behaviours' as 'mental disorders', unlike other diagnostic systems. Only a handful of researchers have highlighted the controversial nature of this practice, and the potentially damaging effects that this lowering of diagnostic thresholds might have (McBrien, 2003; Tsiouris, Mann, Patti & Sturmey, 2003). So much emphasis has been placed on the superiority of the DC-LD over conventional diagnostic systems that its validity has not been thoroughly questioned. It has become somewhat of a 'bible' for learning disability psychiatrists, dominating much of the current thinking about dual diagnosis in clinical practice and research and, like its 'mainstream' counterparts, playing a significant role in the reification of mental disorders (and of dual diagnosis itself).

1.3.4.4.3 Implications of diagnosis

The use of diagnostic systems may give a sense of legitimacy, confidence and predictability to individuals, carers and professionals (Gergen, Hoffman, &

¹³ In the US, the DSM-V (Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association [APA], 2013) is used instead.

¹⁴ In the US, the DM-ID (Diagnostic Manual – Intellectual Disability; Fletcher, Loschen, Stavrakaki & First, 2007) is used instead.

Anderson, 1996). However, they locate the problem within the individual, and ignore the role played by socio-political, economic and historical contexts, such as the higher deprivation, health inequalities and physical and attitudinal barriers that people with learning disabilities often experience (Emerson & Hatton, 1994; Gillman, Heyman, & Swain, 2000; Williams, 1996). Whilst diagnoses may enable access to health and social support, in the case of dual diagnosis, this often leads to people being excluded from or falling between services.

Diagnosing someone is far from a neutral endeavour and has a significant impact on people's subjectivities. Diagnoses 'bring forth pathology, create problem saturated identities, and construct careers as patients and cases' (Gillman et al., 2000, p. 403), limiting and delimiting how a person understands themselves and are understood by others (Roberts, 2005). They characterise people as unable to govern themselves and encourage dependency on 'rational' others to govern them (Roberts, 2005). The 'dual diagnosis' label is particularly problematic because it carries with it stigma associated with both learning disability and mental illness diagnoses. It could create a social status of a 'double pariah' (Szymanski & Grossman, 1984, p. 156), and result in the further disempowerment of people with learning disabilities (Williams, 1999).

The predominantly biomedical way in which the problem of dual diagnosis is constructed sets up particular ways of responding to it that are necessarily consistent with its medical conceptualisation. It is to these forms of government, or 'interventions' that I now turn.

1.3.4.5 Interventions

1.3.4.5.1 Pharmacological interventions

Pharmacological interventions refer to the prescription of psychotropic drugs, including antipsychotics, antidepressants, anxiolytics and mood stabilisers. It is the primary mode of treatment in the management of dual diagnosis, despite little evidence for its effectiveness. It has been argued that people with learning disabilities are the most overmedicated group in society (Matson & Mahan, 2010), and that medication is used as a form of chemical restraint for challenging behaviour, rather than treatment of an underlying mental illness (PHE, 2015). Polypharmacy is common (McGillivray & McCabe, 2004), and

there is substantial evidence that medication is used for long periods of time without a clear justification or adequate review (Public Health England [PHE], 2015).

One of the main problems with psychotropic medication, and antipsychotics in particular, is their significant side effects, which can range from dry mouth, weight gain and sedation to more serious and sometimes permanent metabolic, neurological and physiological damage (Matson & Mahan, 2010; Jenkins, 2000). Medication can also produce the very behavioural symptoms that are considered indicators of mental illness, and could thus lead to new or extended diagnoses (McBrien, 2003). Another problem with pharmacological approaches is that they tend to be used in isolation, and do not address the psychosocial factors that might be influencing a person's distress. Whilst the RCP (2016) recommends that antipsychotics only be used in combination with psychological (or other) interventions, this is not particularly emphasised, and in the NICE (2016a) guidelines, this recommendation is entirely absent.

1.3.4.5.2 Psychological interventions

From a Foucauldian perspective, psychological therapies are a manifestation of 'confession' (Foucault, 1998, p. 58), a power-knowledge relation where a client is encouraged to disclose their inner thoughts and feelings to a therapist who judges and acts upon them in accordance with what their body of knowledge or theoretical framework deems to be 'normal' (Roberts, 2005). Clients are invited to internalise this framework and inscribe within themselves this power-knowledge relation to become self-governing individuals (Foucault, 1998; Roberts, 2005).

Historically, emotional and behavioural difficulties expressed by people with learning disabilities were assumed to be environmentally contingent or organically mediated (BPS, 2016). It was not believed that they possessed the intellectual ability or emotional understanding to benefit from talking therapies and consequently, behavioural therapies were the psychological treatment of choice. Whilst these remain popular, particularly for 'challenging behaviour', over the past decade the range of psychological therapies available to people with learning disabilities has expanded considerably to include those that had been available to the general population for some time. These include cognitive

behavioural therapy, psychodynamic approaches, narrative therapy, systemic therapy and 'third-wave' approaches such as mindfulness and acceptance and commitment therapy.

The evidence-base for psychological therapies for people with learning disabilities is limited compared to the general population (Gustafsson et al., 2009; Prout & Browning, 2011), largely due to the methodological constraints noted in section 1.3.3.2. 'Knowledge' about what 'works' comes primarily from practice-based research originating in specialist services (BPS, 2016). However, because practice-based research is not perceived to be sufficiently 'scientific', it has not been included in the NICE (2016a) guidelines.

In order to make these approaches more accessible to individuals with learning disabilities (and presumably increase compliance), NICE (2016a) a variety of personalised adaptations are recommended, for example, shorter sessions, simplified manuals and protocols, and the use of visual materials (NICE, 2016a). Carers are encouraged to be involved, not just to provide additional support within or between sessions but also to develop and agree intervention goals (NICE, 2016a), thus ensuring an extended gaze and surveillance of individual's behaviours, thoughts and feelings outside the clinic.

1.3.5 Service user and carer views

The biomedical discourse is not only dominant amongst professionals, it is also entrenched in the culture and belief systems of society at large (Gillman et al., 2000). Many carers seek diagnosis to explain their relative's experiences and anticipate the outcomes to be generally beneficial (for example access to social and medical support). Whilst this may be the case for some people, the negative consequences of receiving a diagnosis (see section 1.3.4.4.3) have prompted alternative conceptualisations of disability and distress.

The social model of disabilities is a civil rights approach that was developed by people with physical disabilities in the 1970s and 80s. The model argues that disability is created through the political, social, economic, cultural and psychological exclusion of people with 'impairments' rather than by the impairment itself (Oliver, 1990; Barnes, 1991). Whilst people with a learning disability were largely absent from its original conceptualisation, authors such as Chappell (1998) argue that it can and should be extended to this group. It is

argued that with the right support, people with learning disabilities should be able to achieve the same things as everybody else.

Other authors have argued that the impairment-disability dichotomy does not adequately recognise the historical social-political construction of 'learning disability' (Goodley, 2001; Rapley, 2004) and that embodied notions of 'impairment' are not appropriate for people with learning disabilities for whom this impairment is inferred (Goodley & Rapley, 2001). The social model has been criticised by others for its lack of recognition of the 'realities' of impairment (Crow, 1996; Shakespeare, 2006) and recent trends argue for a medical and social continuum of disability that recognises that everyone is impaired in some way, not just disabled people (Shakespeare, 2006).

Duggan (2002) advocates a social model of mental distress, which draws on the social model of disability in terms of its emphasis on service user expertise, power, exclusion and oppression, but which engages with individuals' inner worlds more fully and links their experiences with external factors more explicitly. The model views mental distress as a response to intolerable life experiences and focuses on people's needs rather than their diagnosis (Williams & Heslop, 2005).

Alongside these social models, people with learning disabilities are increasingly finding a voice through self-advocacy groups, particularly People First (Goodley, 1998). These have provided a public forum for the views and actions of people with learning disabilities to become known. They recognise people's competence and resilience and can offer a framework for resistance (Chappell, Goodley & Lawthom, 2001). The subjectivities portrayed by this strengths-based movement contrast sharply with the vulnerable and unreliable individual that is constructed by the psy-professions and other authorities.

1.4 Rationale for study and research questions

In this introduction, I have presented some of the problems with dual diagnosis and the ways in which certain truth claims have been used to promote social practices and legitimise authorities that are not always helpful to those who are subject to them.

If we are to critically analyse the ongoing influence, applications and implications of the dual diagnosis label for people's subjectivities, it is necessary

to capture the underlying 'conditions of possibility' (the 'preconditions') for its emergence, and the 'dimensions of materiality, history and institutional practice in which it is embedded' (Hook, 2005, p.26).

References to the historical emergence of the dual diagnosis concept (e.g. Bongiorno, 1996; Bouras & Holt, 2004) tend to adopt a grand, progressive narrative emphasising the long overdue empirical discovery and recognition of the 'truth' about the mental health of people with learning disabilities. Alternative discourses have been marginalised and silenced, and the influence of power on these truth claims has rarely been acknowledged.

The aims of this study, as stated in section 1.1, are to create new possibilities for thought and action by mapping out and exploring the conditions of possibility for the emergence of the dual diagnosis concept in Britain, its associated social practices, and alternative understandings that may have been subjugated.

In order to do this, I will focus on the following research questions:

1. How was dual diagnosis 'made' possible?
2. What has held it in place?
3. What have been the dominant discourses and their implications?
4. What have been the subjugated discourses and how might these allow alternative understandings of the distress experienced by people diagnosed with a learning disability?

CHAPTER 2: METHODOLOGY

2.1 Epistemology

This thesis is undertaken from a critical realist ontological position within a postmodernist social constructionist epistemological framework.

In contrast with Western traditional 'realist' approaches (which assume there is a single reality that is fixed, measurable and observable), social constructionist approaches argue that numerous constructions of the world are possible, and that what becomes regarded as 'truth' is dependent on specific social, cultural and historical factors (Burr, 2003). Adopting a social constructionist perspective enabled me to take a critical stance toward 'taken-for-granted' knowledge about 'dual diagnosis', and explore the different ways in which the mental health of people with 'learning disabilities' have and could be understood.

In order to adequately address issues of embodiment¹⁵, materiality¹⁶ and power¹⁷, I adopted a weaker version of social constructionism that allows for the existence of a world external to discourse (Willig, 2013). This enabled me to acknowledge the influence of extra-discursive social and material realities that structure and constrain our subjectivities and actions, such as the broader economic, political, institutional, legal and professional contexts (Willig, 2013). Harper (2011) has described this version of social constructionism as 'critical realist social constructionism' (p. 8), which is epistemologically relativist but ontologically realist. This position 'acknowledges that our knowledge of the world is necessarily mediated by, and therefore also constructed through,

¹⁵ By 'embodiment' I am referring to the ways in which peoples' subjectivities and actions are constituted by and through their biological/physiological body, and the discourses, cultural practices and person-social histories inscribed therein (Cromby & Nightingale, 1999).

¹⁶ 'Materiality' refers to the physical nature of the world, and the tangible aspects and qualities of the 'things' within it, including the distribution of resources, the arrangement of space, and the positioning of bodies (Cromby & Nightingale, 1999).

¹⁷ Please see section 2.2.3 for a detailed description of how I am conceptualising 'power' in this thesis.

language . . . while maintaining that there are underlying structures and mechanisms that generate phenomena' (Parker, 1992, p. 141).

2.2 Genealogy

'Genealogy' is a Nietzschean conception and term that was adopted by the French philosopher Michel Foucault to describe the historical mode of inquiry he used in his work from the 1970s onwards. Foucault did not attempt to theorise or describe a universal methodology of genealogy, revising and customising his approach to the particular 'problem' he was trying to address at the time (Garland, 2014). He famously stated: 'I would like my books to be a kind of tool box which others can rummage through to find a tool which they can use however they wish in their own area' (Foucault, 1974/1994, p. 523).

Consequently, genealogy has been understood and interpreted in different ways by different people, and it can be challenging to grasp and apply it. My own understanding has been shaped by the reading of a range of theoretical texts, genealogical studies and Foucault's own work, as well as discussions with supervisors, colleagues and peers. A number of themes and key features have emerged from this process, namely: the ways in which genealogy differs from traditional historiography; the analysis of 'emergence' and 'descent', and the centrality of power in Foucault's work. These are explained below.

2.2.1 Genealogy vs traditional historiography

Genealogies do not search for 'origins' (Foucault, 1977); they are not concerned with finding out what 'truly happened', to unearth something that was already there to be discovered, or to 'capture the exact essence of things' (p. 142).

Rather than attempting to capture a precise object of knowledge, genealogy focuses on the processes and practices within which the object came to be seen as 'truth', to demonstrate that 'there is no truth but truths, no reason but rationalities, no knowledge but knowledges of the ways people have come to understand themselves and the world' (Tamboukou, 1999, pp. 210-211).

Conventional historical analyses tend to present teleological accounts, describing history as a progressive linear development from a single point of origin towards an inevitable and meaningful end point (Burr, 2003). In contrast, genealogy documents the discontinuous process by which the past became the present – one that is haphazard, contingent and accidental (Sembou, 2011;

Hook, 2005; McNay, 1994). Whilst simultaneously retaining sensitivity to the recurrence of events and indeed to those occasions when they are absent (Foucault, 1977), genealogy focuses on identifying instances of events that are an exception to what is assumed as self-evident. This attentiveness to 'buried' or delegitimised knowledges enables the development of a counter-memory that can destabilise taken-for-granted truths and thus free up space for alternative ways of thinking and acting.

Traditional histories use present-day concepts and meanings to understand and interpret past events when these may have been constituted quite differently and thus not be commensurate with the way in which they are experienced today (Tamboukou, 1999; Sembou, 2011). One example of this would be to claim that what was termed 'idiocy' in the nineteenth century is the same as what is defined as 'learning disability' today.

Finally, whereas traditional history tends to place self-reflective subjects at the centre of events, genealogies view social and political practices as strategies without strategists rather than resulting from individual or collective psychological motivations: 'no one is responsible for an emergence; no one can glory in it, since it always occurs in the interstice' (Foucault, 1971, p. 150).

2.2.2 Analysis of 'emergence' and 'descent'

Instead of a search for origins or truth, Foucault elaborates genealogy as an analysis of 'emergence' and 'descent' (Tamboukou, 1999). Together, these principles aim to 'fragment that which is presented as unitary and ahistorical on the one hand, and to destabilize assumptions of origin and continuity on the other' (Hook, 2005, p. 23).

- **Emergence:** The analysis of emergence attempts to grasp the very 'moment of arising'. This is not a case of locating the 'birth' of a metaphysical object that had been awaiting discovery, but of unearthing the field of action within which it was brought into being. Analysis of this 'surface of emergence' involves plotting the multiple and complex processes that constitute it (Foucault, 1981), delineating the force relations in the diverse systems of subjection within which things appeared as events (Tamboukou, 1999).
- **Descent:** Analysis of descent refers to the process of exploring the 'lineage' of objects or social types (Hook, 2005). However, rather than attempting to

identify a single ‘ancestor’, or point of origin, it aims to trace the numberless beginnings and historical transformations of people’s practices (Tamboukou, 1999). Descent also explores the regimes that have enabled concepts to become ‘formalized objects of knowledge and targets for intervention’ (Butchart, 1998, p. 9, cited in Hook, 2005). By exposing the heterogeneity of what had been conceived as consistent, the analysis of descent disturbs and fragments what was previously thought immobile and unified (Foucault, 1977).

2.2.3 Emphasis on Power

Foucault outlines a number of methodological considerations in the analysis of power that distinguish it from more traditional liberal and Marxist theories¹⁸:

- *Power is a relation, not a ‘thing’ owned by the State or anybody else:* Power is a complex network of relations between individuals and groups that involves the whole social body, operating at the most micro-levels of social relationships (O’Farrell, 2005). Power is the *result* of these relations rather than their *cause* (McHoul & Grace, 1993). It should be analysed as something that circulates, a system within which individuals are merely vehicles who simultaneously experience and transfer power rather than being the points of its application (Foucault, 1977/1980). Power can only exist when it is being exercised, so for example, a king can only be a king if he has subjects (O’Farrell, 2005).
- *Power is productive as well as constraining:* It generates particular types of behaviours, knowledges, institutions and subjectivities. It serves not just to dominate or repress, but also to make individuals ‘more intelligent, wise, happy, virtuous, healthy, productive, docile, enterprising, fulfilled, self-esteeming, [and] empowered’ (Rose, 1996a, p. 12). Foucault argued that it is always possible to react and behave in different ways, noting that ‘there is no power without potential refusal or revolt’ (Foucault, 1986/2000, p. 325). Foucault also argued that power and knowledge are inseparable, building on each other so that specific types of knowledge are produced through the exercise of power and used to reinforce it further (Foucault, 1975/1991).

¹⁸ Liberal and Marxist theories characterise power as something that can be acquired, and that is usually deployed by a higher authority (such as the State) to control or oppress others.

2.3 Rationale for Genealogy

I opted for genealogy because I felt that it would be the most suitable methodology to address my aims and research questions. A traditional discourse analysis would not have allowed for the analysis of power or the historical dimension enabled by a genealogy. I considered interviewing those involved in the promotion and development of the dual diagnosis concept in 1980s Britain, and perhaps this might have helped me identify some of its more beneficial and productive aspects. However, I was conscious that this might resemble the progressive medical histories that are already available and miss out the distal conditions of possibility for its emergence. Another alternative would have been to interview individuals subject to dual diagnosis. This would have given me a good understanding of its current impact on people's subjectivities and lived experiences but neglected the historical dimensions pertaining to the dual diagnosis itself.

Psychological knowledge is produced in and through history, yet Psychology as a discipline has tended to search for empirical, 'ahistorical', universalising, internal and depoliticising explanations (Hook, 2005; Pilgrim, 2008). The psy-complex has actively contributed to the ongoing medicalisation of people described as having learning disabilities and mental health problems, whether through their role and power in defining and diagnosing them, formulating understandings of experiences of distress within particular conceptual frameworks, or determining what (if any) treatment or support is given (Goble, 1998).

Genealogy can be a helpful way of thinking more critically about our present practices, including the deconstruction of the authority that the 'psy' disciplines have been accorded to pronounce on the 'truth' of this group of people. If clinical psychologists are to achieve their profession's aim of promoting 'valued, inclusive lives for people with learning disabilities' (BPS, 2011, p. 1), it is important for them to be aware of what has led to the emergence of contemporary understandings of mental health issues in learning disability, the role that they play within these, and the alternative ways in which they may wish to think and practice.

2.4 Reflexivity and Ethical Considerations

In this section I describe the models and ideas relating to reflexivity and ethical considerations adopted in my research, giving a more personal, contextualised account in section 2.4.3.

2.4.1 Reflexivity

Qualitative research explicitly acknowledges the influence that researchers' own perspectives and experiences may have had in the research process, and explores these through the practice of 'reflexivity' (Burr, 2003). This is in contrast to positivist research, which strives to present authors and researchers as 'neutral observers' who are detached, objective and impartial (Silverman, 1997).

Willig (2013) distinguishes between two types of reflexivity:

- *Personal reflexivity* involves a consideration of how the research may have been shaped by the researcher as a person, by their own 'values, experiences, interests, beliefs, political commitments, wider aims in life and social identities' (p. 10). It also involves reflecting on how undertaking the research may have affected and possibly changed the researcher, personally and professionally.
- *Epistemological reflexivity* relates to theoretical stance, and considers how the research has been shaped by the researcher as a theorist or thinker adopting particular assumptions about knowledge and the world. It looks at the implications (and possible limitations) of these assumptions for the research and its findings.

Researchers' subjectivities are often viewed as 'biases' that may compromise the rigour of research, however, as Willig (2013) asserts, researchers' motivations should not be constructed in this way; they are an important factor in making research possible, and their responses to it may even allow for particular insights and understandings that would not otherwise be conceivable.

Foucault (1977) moves beyond researcher subjectivity, advocating an awareness of and accounting for one's own 'entry into knowledge' – not as an individual, but as a participant of a particular discipline (as a 'Psychologist', for example) and an attention to the formation of the discipline itself (Hook, 2005).

Foucault also recognises the role played by the researcher in the production of knowledge (Rose, 1999), and in the next section I consider some of the ethical considerations regarding the production and application of the knowledge produced herein.

2.4.2 Ethical Considerations

Notwithstanding the perspectival nature of the genealogical study I produce here, it still contains moral and political dimensions that can have 'material effects' (Jóhannesson, 2010). For example, it could 'disrupt longstanding notions of selfhood, gender, autonomy, identity and choice' (Morgan, 2010, p. 4) of the subjects implicated in the analysis. Whilst not an aspect that is within my control, it is also important to consider how findings may be used by others (Lee, 2000), for example to justify or legitimise particular courses of action or non-action.

Ethical approval was not required as there were no participants in my research. Documents used are available in the public domain.

2.4.3 Personal account

The idea for this thesis was borne out of my previous experience working in an adult learning disability psychology service that was in the process of moving away from the CLDT to form one of the specialist MHiLD teams described in section 1.3.4.3. This shift had a number of potentially negative implications for the subjectivities of service users, and it raised some questions for me about the political, economic and professional motivations for such a move. My prior training had privileged scientific knowledge and deficit-focused models of understanding difference, and although I did not yet have an awareness of the critical literature, on a personal and professional level I had also become frustrated with the limitations that biomedical frameworks had on the subjectivities of those I worked with and on my own ability to work creatively with them. My thinking was shaped further by my experience of being a trainee clinical psychologist on a course that promotes a critical approach (Harper, Patel, Davidson & Byrne, 2007), particularly through the attendance of lectures that highlighted the fragility of the concept of mental illness, and the historical contingency of psychological knowledges and practices.

These experiences and reflections led me to opt for a methodology that enables me to question the naïve realist assumptions that are dominant within contemporary practices generally and those relating to dual diagnosis more specifically. However, I am aware that this is a difficult position to maintain for a number of reasons, including my own long-term socialisation into the scientist-practitioner model within Psychology, the fact that I myself belong to the social apparatus and act as an ‘authority’ within it (Deleuze, 1992), my lack of experience with dual diagnosis at a personal level, and my inexperience with post-structuralist qualitative methodologies. In line with my epistemological positioning, it is also important to acknowledge that my research findings will represent an alternative perspective or interpretation, rather than the ultimate ‘truth’ about dual diagnosis.

I have taken a number of measures to help me address some of these tensions and challenges, including exploring them at supervision, with other peers undertaking Foucauldian-informed analyses, and keeping a reflective research journal (see Appendix C). Further reflections about these aspects following the completion of my research are discussed in Chapter 4.

2.5 Procedure

This section describes how I operationalised the principles of genealogy outlined in section 2.2 to enable a genealogically-informed analysis of dual diagnosis.

2.5.1 Doing a Genealogy

As stated earlier, Foucault did not provide a detailed description or step-by-step approach of how to undertake a genealogy. In developing my own ‘steps’ for doing a genealogy I was guided in particular by: Tamboukou (1999), Sembou (2011), and Garland (2014) for the preliminary stages of ‘diagnosing’ and problematizing the present, as well as the development of a *dispositif* (see below); Hook (2005) and Sembou (2011) for the analysis of ‘emergence’ and ‘descent’; Carabine (2001) for the application of Foucauldian analysis to historical social policy documents; Rose (1999) for the analytical lenses; and Hawksley (2013) and Prescott (2013) for examples of how to adapt the above to a clinical psychology doctoral thesis. Whilst I present what appears to be a linear procedure, it is important to note that in a genealogical investigation, the

processes of collecting, analysing and interpreting data are entwined and dynamic, informing each other and often taking the researcher in unexpected directions (Carabine, 2001; Foucault, 1984/1988).

The 'first' step was to *isolate the 'problem'* of 'dual diagnosis' (Tamboukou, 1999). This involved capturing how it is understood and experienced 'in the terms current today' (Foucault, 1984/1988, p. 262), and 'diagnosing' the present through the interrogation and disturbance of what has become accepted as the 'truth' (Sembou, 2011; Tamboukou, 1999; Garland, 2014). This is what my 'Introduction' chapter aimed to achieve.

The next step involved formulating a *dispositif*¹⁹ (Tamboukou, 1999), outlining the network of power relations between the 'procedures, practices, apparatus and institutions' (Carabine, 2001, p. 276) that might relate to the problem of dual diagnosis: 'what was and is being said and done, by whom to whom, and to what effects' (Dreyfus & Rabinow, 1982, p. 200). I attempted to do this visually (see Appendix D), to help me establish more readily what may be holding 'dual diagnosis' in place and hence what the analytical points might be for the next stage of my enquiry; for example, how did Psychiatry and Psychology become the main authorities in the governance of people with a dual diagnosis?

I then looked at the surface of emergence within which dual diagnosis was brought into being, mapping the various force relations, systems and events that made it possible to emerge when and how it did. Alongside, I traced its historical descent, identifying the regimes that enabled it to become an object of knowledge as it is understood today, and tracking the ways in which events and practices involved in its history have changed or stayed the same (see section 2.2.2).

The above 'steps' were informed by Rose's (1999) 'perspectival dimensions' (described in detail in section 2.5.3). I also made a chronology of events relating to the emergence of dual diagnosis to help me navigate through its complex history (see Appendix E).

¹⁹ *Dispositif* is the term Foucault used to describe 'a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions' (Foucault, 1977/1980, p. 194).

2.5.2 Selecting a corpus of statements

The process of selection of my *corpus of statements*²⁰ for analysis was guided by my research aims. I was also mindful of Arribas-Ayllon and Walkerdine's (2008) advice on this subject, such as including historically-variable samples that reflect the diversity of discursive practices, and that identify their transformation over time and across different institutional spaces.

2.5.2.1 Sources of data

Data sources for analysis comprised legislation, official reports, policy documents and guidance published by the government or professional organisations; and academic and clinical research published in psychological or psychiatric journals or books. As outlined in chapter 1, my decision to focus on these types of documents was influenced by Foucault's own interest in 'prescriptive' or 'programmatic' texts. It was also driven by the suggestion that the object of 'dual diagnosis' first emerged within the psychiatric literature (RCP, 2003) and the authority that has been ascribed to the psy-professions within the fields of mental health and learning disability.

Wider reading was undertaken to help me contextualise the analysis within a broader social, political, legal, economic and professional framework. This included Foucault's own work²¹, critical disability literature (e.g. Tremain, 2005; Rapley, 2004), and existing historical studies relating to learning disability, mental illness and dual diagnosis (e.g. Wright & Digby, 1996; Borsay, 2005; Dale & Melling, 2006; McDonagh, 2008; Pilgrim & Rogers, 2014; Menolascino, 1970; Turner, 1989; Berrios, 1994), as well as the professions of Psychiatry and Clinical Psychology (e.g. Bewley, 2008; Hall et al., 2015).

2.5.2.2 Search Strategy

Foucault (1977) stated that genealogy 'requires patience and a knowledge of details and it depends on a vast accumulation of source material' (p. 140). However, within the time constraints and confines of this thesis it was necessary to impose some pragmatic restrictions in relation to the type and

²⁰ A *corpus of statements* (Foucault, 1969/2002) refers to a collection of discursive facts or formations; a text or social institution that reflects the 'gaze' of those who produced it and thus articulates the power relations of those involved (Letherby, Scott & Williams, 2013).

²¹ In particular: *Madness and Civilization; The Birth of the Clinic; Psychiatric Power; Discipline and Punish; The History of Sexuality; and Nietzsche, Genealogy, History.*

quantity of material analysed, as outlined below. Carabine (2001) notes that these kinds of restrictions do not necessarily limit the value of the analysis, as genealogy need not trace the full history of particular moments in order to yield useful information about the imbrication of power and knowledge, or indeed about the construction of the problem. The final corpus of statements that this study was based on is listed in Appendix F.

- *Legislation, official reports, policy documents and guidance:* documents relating specifically to the mental health of people with learning disabilities in Britain were identified through online searches of the BPS (www.bps.org.uk), the RCP (www.rcpsych.ac.uk), NICE (www.nice.org.uk) and the National Archives (<http://webarchive.nationalarchives.gov.uk>). In order to trace how the construction and government of people with a dual diagnosis may have changed over time, I also used my reading, reference lists and archives to identify reports, policy and guidance that are now considered 'out-of-date'. Searches were not limited to a particular time-frame, as I was interested in tracing the first time categories historically associated with learning disability and mental illness had been differentiated and legislated for. Once I had identified this as being 1324, and because there Official documents formed the bulk of my corpus of statements.
- *Academic and clinical research:* For the analysis of emergence I used Menolascino (1970) as my point of departure, as this publication is frequently cited as being the 'origin' of the 'dual diagnosis' term itself. By undertaking a search of the 'dual diagnosis' term in academic publications²² from 1800-2015, I discovered that it had in fact emerged in the 1980s. From the search results and through my reading I identified that the first books published about, and referring specifically to 'dual diagnosis' were Menolascino and McCann (1983) in the US, and Bouras (1994) in the UK. I added these publications to my corpus of statements as they offered a comprehensive representation of how dual diagnosis was being constructed at the time and could help me highlight potential conditions of possibility for its emergence.

When I became aware that classifications historically associated with mental illness and learning disability had previously come together as co-occurring diagnoses, I decided to use this earlier iteration of dual diagnosis as the

²² See Appendix A for databases and search terms used.

starting point of the 'emergence' part of my analysis. I undertook a further literature search²³, this time using historical terms and limiting my search to the period up to and including 1919. I knew from my reading that by then there had been a number of publications referring to the possibility of dual diagnosis, and that after the Mental Deficiency Act 1913, the population being studied had changed significantly. I complemented this literature with publications cited in contemporary histories of dual diagnosis, selecting those that appeared to be particularly relevant to how dual diagnosis is understood and practiced today.

The documents identified for the introduction (see section 1.3.2) were also used to help trace emergence and descent.

2.5.3 Tools and process of analysis

2.5.3.1 Perspectival dimensions

My analysis was guided by the six 'perspectival dimensions' that Nikolas Rose (1999) outlined in the preface to the second edition of his book *Governing the Soul*, namely: Problematizations, Explanations, Technologies, Authorities, Subjectivities and Strategies. Rose (1999) suggested that considering these interlinked dimensions can help uncover the various elements and relations that have contributed to the emergence of how we think, judge and act today.

Rose's 'perspectival dimensions' are described below, followed by examples of questions pertinent to 'dual diagnosis' that I used in the analysis of my corpus of statements.

- **Problematizations:** This is a concept fundamental to Foucauldian theory that looks at the processes by which particular things have come to be seen as 'problems' or 'problematic' and in need of intervention (Foucault, 1985; Dean, 1999; Rose, 1999). According to Rose (1999), this dimension looks at the different concerns (e.g. moral, political, economic), institutional sites (e.g. courts, schools, asylums), authorities (e.g. medical, legal, religious), criteria (e.g. norms, requirements, regulations) and 'dividing practices' (e.g. normality from pathology, madness from rationality) that have contributed to the emergence, definition and management of 'problems'.

²³ See Appendix A for databases and search terms used.

- **Explanations:** These refer to the ways in which something has been described and constructed that have enabled it to acquire a status of 'truth', for example, through the use of particular language or concepts, the employment of particular domains of evidence, criteria of demonstration or proof, and the forms of visibility, remarkability and calculability bestowed (Rose, 1999).
- **Technologies:** This dimension focuses on how what has been deemed as 'true' happens at a technical or material level. 'Technologies' encompass the various knowledges, instruments, techniques, persons, systems of judgement, buildings and spaces that have been devised to shape human conduct in directions that are in accordance with wider political, economic and moral strategies (Rose, 1996b). These assemblages of procedures, practices and tactics enable government to work at a distance (Miller & Rose, 2008). They establish not only how people come to be known and acted upon, but how they come to know and act upon themselves (see 'subjectivities' below).
- **Authorities:** Within this dimension, Rose (1999) draws our attention to those who have sought, claimed or been given the authority or ability to 'speak truthfully about humans, their nature and their problems' (p. 27). It looks at who those persons are, what types of authority they exert, and where. It investigates how their authority came to be sanctioned (through which apparatuses, using what techniques), the conflicts and alliances between different claims to authority, and how authorities themselves are governed. It also examines the relation between authorities and those who are subject to them (e.g. doctor and patients, manager and employee, priest and parishioner).
- **Subjectivities:** When analysing subjectivities, Rose (1999) emphasises four main areas:
 - i) *ontology* (how human beings have come to be known, for example, as spirit, as soul, or as beings who possess consciousness, will, feelings, beliefs, and desires; as individualised or collectivised);
 - ii) *epistemology* (how it is possible to 'know' human beings, for example through practices of observation, examination, or confession);

- iii) *ethics* (the type of 'selves' that people should aim to be, for example, honourable, wise, self-controlled, autonomous and content;
- iv) *technical* (the practices and procedures people must apply to themselves if they are to achieve their ethical goals of autonomy, freedom and self-fulfilment.

As noted earlier, subjectivities are constituted through the effects of various technologies of power and of the self that are in keeping with wider socio-political, moral and economic strategies.

- **Strategies:** These relate to the ways in which regulatory practices link in with the wider moral, social and political objectives for the governance of populations (for example, maximising its fitness through eugenics, or using mental hygiene to minimise the cost of social maladjustment; Rose, 1999). This dimension looks closely at the relations and divisions between ways of governing conduct that have been accorded the status of 'political', and those authorities and apparatuses that are deemed 'non-political' (such as the 'expert' knowledge of psychiatrists, or the 'natural' knowledges of the family; Rose, 1996). It includes a consideration of the role played by the psy-practitioners within the broader governmental framework.

2.5.3.2 Questions to guide analysis

Problematizations: How, where, why and by whom are the emotions and behaviours of people with learning disabilities being rendered problematic? According to what systems of judgement and in relation to what concerns do they become characterised and treated as a mental illness?

Explanations: How is 'dual diagnosis' being described and constructed? What concepts and explanatory systems are used to evidence it as truth? What is prioritised and emphasised? What alternative meanings and explanations are silenced or ignored?

Technologies: What are the procedures and practices used to judge, classify and categorise people as 'dually diagnosed'? What techniques are used to guide the conduct of people who are subject to this classification?

Within which institutions do practices associated with 'dual diagnosis' take place and how are these institutions organised?

Authorities: Who is accorded the authority to speak of and/or act upon dual diagnosis and how did this come to be? What supports or legitimises this authority? What governs it? What is the relation between authorities and those who are subject to it? Where is there resistance to the dominant authority/ies and what impact does this have? Is there any space for people with 'dual diagnoses' to be authorities or experts of their own lives?

Subjectivities: What types of subjectivities are presumed and produced through the discourses and practices associated with 'dual diagnosis'? What are the effects of these? What subjectivities are being constrained and what alternative ways of thinking and being might these subjectivities allow?

Strategies: What are the wider moral, social and political aspirations for the governance of people with a 'dual diagnosis'? How are the regulatory practices associated with 'dual diagnosis' linked with these aims? What roles do political and non-political authorities and apparatuses play in the government of people with a 'dual diagnosis', and what are the relations and divisions between them?

CHAPTER 3: ANALYSIS AND DISCUSSION

How have we become what we are and what are the possibilities of becoming 'other'?

Tamboukou, 1999, p. 215

3.1 Introduction

This chapter maps out and explores a number of historical, cultural, political and socio-economic 'conditions of possibility' for the emergence of dual diagnosis in Britain and its associated social practices, as well as alternative understandings of distress that may have been subjugated.

I have chosen to present my analysis in the form of a broad chronological account to facilitate the reader's experience of the narrative. Consistent with Foucault's principle of non-linearity, however, a 'discontinuous history' is emphasised throughout by exposing multiple contingencies and shifts in power/knowledge networks that have influenced the present state of affairs. This includes the examination of a number of events that challenge the dominant discourse or that have been subjugated in mainstream accounts.

The analysis is divided into two main sections:

- Section 3.2 focuses on the analysis of 'descent' as outlined in section 2.2.2. It examines the historical 'lineage' of the dual diagnosis of learning disability and mental illness, exploring the different systems of thoughts that enabled particular ideas associated with these two diagnoses to emerge, and tracing the multiple beginnings and transformations in people's practices throughout history. In other words, it looks at how the surface of emergence was made possible.

- Section 3.3 focuses more explicitly on dual diagnosis itself, offering a more detailed analysis of the ‘surface of emergence’ into which it was brought into being. As explained in section 2.2.2, this involves mapping out diverse events and force relations that made it possible for dual diagnosis to emerge when it did, and the multiple and complex processes that constitute and maintain both its constructed nature and the attendant practices it supports.

The sections above comprise a number of subsections, each incorporating a constellation of events or ‘conditions of possibility’ within a particular time period that can be traced back from the ways in which dual diagnosis has come to be constructed and governed in the present day. The precise content of each subsection varies, however, in general, most contain: an exploration of how particular individuals and populations came to be considered ‘problematic’ and in need of intervention in relation to broader social, political, economic or moral contemporaneous concerns; an analysis of the strategies and practices linked with the governance of such individuals or groups; and the implications of this deployment of power for those subject to it. Within each subsection I consider how these events and power networks may have contributed to how we think about, judge and act upon dual diagnosis today. I also identify subjugated discourses, and consider how these might enable alternative ways of thinking and acting in relation to the distress that people diagnosed with a learning disability may experience.

It is important to note that it would not be possible (nor is it my intention) to undertake a comprehensive analysis of all the events that are implicated in, or could have contributed to, the emergence of dual diagnosis. Rather, my analysis is driven by the research questions I am aiming to answer (see section 1.4), the selection of ‘prescriptive texts’ as my data source (such as policy documents and clinical research), and the attention to discontinuities outlined above, all within the context of the constraints inherent in a doctoral thesis that I described in section 2.5.2.2.

3.2 Analysis of descent

In this section, I analyse the historical lineage and transformations of a number of events that constitute various conditions of possibility for the emergence of

dual diagnosis and its associated social practices. In the analysis of descent I will be focusing on the more distal conditions of possibility for the emergence of dual diagnosis (research question 1), as well as examining the dominant and subjugated discourses associated with them (research questions 3 and 4). The aims here are to demonstrate the constructed nature of the two diagnoses that constitute dual diagnosis, namely learning disability and mental illness; and to identify some of the historical antecedents that have been picked up and circulated in the understanding and practice of dual diagnosis in the present day.

In section 3.2.1 below I examine how the power networks implicated in the legal creation and differentiation of ‘idiocy’ and ‘lunacy’ in the beginning of the fourteenth century shaped how learning disability and mental illness – the two diagnoses that constitute dual diagnosis today – came to be constructed, differentiated and governed in later years.

3.2.1 The creation, differentiation and governance of ‘idiocy’ and ‘lunacy’ in early English Law: *De Praerogativa Regis* 1324

Although references to both idiocy and lunacy can be traced back to Greek and Roman societies in the fourth and fifth century B.C.E. (Ryan & Thomas, 1987), the first time these terms were codified and differentiated in English Law is thought to have been in the 1324 statute of King Edward II known as *De Praerogativa Regis*²⁴ (McGlynn, 2005). This statute gave the monarch jurisdiction over the persons and property of those (usually men) who were deemed incapable of looking after their own affairs, including those who had not yet come of age and those of ‘unsound mind’ (Wright & Digby, 1996)²⁵.

In late medieval England, the feudal system of land tenure and ownership represented an important source of royal revenue. Therefore, those who might struggle or feel disinclined to maintain their lands or pay rent posed an economic problem for the King (McDonagh, 2008). To protect this income and

²⁴ This translates as ‘On the King’s Prerogative’.

²⁵ Berkson (2006) notes that many of the items in the *Praerogativa Regis* can be traced back to the *Digest of Justinian* – an extensive codification of Roman laws from the 6th century C.E. that specified the legal requirements and rights of those deemed as lacking understanding due to a variety of sensory or mental disorders (including those who were deaf [*surdus*], blind [*caecus*], mute [*mutism*], cognitively impaired [*demens* or *fatuus*], insane or lunatic [*furiosus* or *insanus*], and exceptionally disreputable [*turpitudine notabilis*]), such as owning and managing property, making a will, or getting married.

preserve the patrimony of land ownership, a system was needed that facilitated the governance of these ‘problem’ individuals. One of the ways in which this was enabled was through the development of ‘statutes’– written enactments of a legislative authority (in this case, the King) – that problematized particular behaviours or kinds of people, and stipulated how they should be governed (in much the same way as laws and policy do today). In Foucauldian terms, statutes constituted a technology of power that enabled the enactment of ‘sovereign power²⁶’ (Foucault, 1975/1991).

The *De Praerogativa Regis* created a number of legal entities that those who were not looking after their own affairs could be subjected to, and that explicitly or implicitly questioned their competency or capacity to do so. Of particular relevance to dual diagnosis were the categories of ‘Idiot’ and ‘Lunatick’:

Section 11, relating to ‘The Custody of Lands of Idiots’, dictated that:

The King shall have the Custody of the Lands of natural Fools, taking the Profits of them without Waste or Destruction, and shall find them their Necessaries, of whose Fee soever the Lands be holden ; and after the Death of such Idiots he shall render [it (the same)] to the right Heirs, so that such Idiots shall not aliene, nor their Heirs shall be disinherited.
(Record Commission, 1810/1963, p. 226)

This meant that when people were identified as ‘idiots’ or ‘natural fools’ (fools from birth), the King took custody of their lands and kept all profits generated therein, using a small portion of these to meet the idiot’s basic needs (Neugebauer, 1996). Upon the idiot’s death, his heirs would be able to assume control of the estate by purchasing their claim to the lands from the King (McDonagh, 2008).

‘Of Lands of Lunaticks’ (section 12), stated that:

Also the King shall provide, when any, that beforetime hath had his Wit and Memory happen to fail of his Wit, as there are many [per lucida intervalla (with lucid Intervals)] that their Lands and Tenements shall be safely kept without Waste and Destruction, and that they and their

²⁶ ‘Sovereign power’ is a system of government that operated in feudal societies based on the power of the king as the representative of God on earth, to whom allegiance was owed and whose laws required compliance with (O’Farrell, 2005).

Household shall live and be maintained competently with the Profits of the same, and the Residue besides their Sustentation shall be kept to their Use, to be delivered unto them when they come to right Mind; so that such Lands and Tenements shall in no wise (within the aforesaid time) be aliened; and the King shall take nothing (of the profits) to his own Use. And if the Party die in such Estate, then the Residue shall be distributed for his Soul by the Advice of the Ordinary. (Record Commission, 1810/1963, p. 226)

This meant that the King would assume custody of the lands of those who were judged as having lost their 'wit' or reason later in life (referred to as '*non compos mentis*' and later 'lunatic'), that the revenue generated from those lands would be used for the upkeep of both the individual and their household, and that the lands and any profits made would be returned to the individual when (and if) he regained his wits or, if he did not recover, to his heirs upon his death (McDonagh, 2008).

In order to deploy this statute, a system was needed that enabled the identification and differentiation between those who were (likely to be) able to meet their land-owning duties and those who could not – a 'dividing practice' (Foucault, 1982) that separated the 'competent' from the 'incompetent'. This was achieved through the establishment of 'inquisitions' – examinations undertaken before a jury by local government officials (known as 'escheators') that judged whether or not someone was an 'idiot' or a 'lunatic' (McGlynn, 2005). If the Crown became aware of a potential 'idiot' or 'lunatic' with personal wealth or assets (usually through a relative or government official), writs were issued that commanded a king's representative to

...diligently inquire, if the same I. be a Fool or Idiot, as aforesaid is, or not; and if he be, then whether from his birth or from another time; and if from another time, then from what time, and in what manner, and how (Fitzherbert, 1534/1718, p. 519)

The evidence gathered was presented before the jury, and the person in question was examined against a set of criteria broadly relating to the government of financial affairs and other qualities desirable in the maintenance

of patrimony and patrilineage (McDonagh, 2008). To assess and establish idiocy, a fairly rudimentary form of assessment was used:

And he who shall be said to be a Sot and Idiot from his Birth, is such a Person who cannot acopt or number Twenty-pence, nor can tell who was his Father, or Mother, nor how old he is, etc. so as it may appear that he hath no understanding of Reason what shall be for his Profit, or what for his Loss: But if he have such Understanding that he know, and understand his Letters, and do read by Teaching or Information of another Man, then it seemeth he is not a Sot, nor a natural Idiot.
(Fitzherbert, 1534/1718, p. 519)

Bearing a resemblance with the process of assessment for learning disability in the present day, if the person was able to demonstrate good orientation, intellect and memory through the pragmatic tests above, idiocy was ruled out. The examination then proceeded to an evaluation of reasoning and judgement in everyday life to help determine whether the person had lost their 'Wit'. Possibly disturbed thoughts or behaviour were noted and used to support conclusions of lunacy (Neugebauer, 1996), much like the psychiatric assessment of mental illness today. Towards the end of the sixteenth century, individuals' physical appearance, health, daily life and habits were also incorporated into examinations (Neugebauer, 1996); areas (amongst many others added since) that continue to be assessed by authorities in dual diagnosis today (see section 1.3.4.4) and that reflect the ever-increasing penetration of power and surveillance into everyday life for the purposes of identifying those who might struggle to meet particular socio-political and economic aspirations.

The specific causes for the 'unsound mind' were not a concern, although they were recorded during inquisitions. Whilst contemporary authors writing about dual diagnosis (such as Szymanski & Crocker, 1989; and Scheerenberger, 1987) have emphasised a dominance of supernatural or theological explanations for idiocy and lunacy until the eighteenth century, in his analysis of parish records relating to the application of the *De Praerogativa Regis* statute, Neugebauer (1979) demonstrated that most royal officials and private individuals actually proposed physical and psychological aetiologies. Rushton's

(1988) examination of poor law records from 1600 to 1800 found a similar dominance of causal references to physical injury and grief.

Whatever the probable cause, individuals subject to the *De Praerogativa Regis* statute were constructed as having little or no control over the onset or outcome of their 'problem'. There is no sense of them being expected to or even able to manage any aspect of their financial affairs, or indeed of looking after themselves in any way, as suggested by the King's commitment in *De Praerogativa Regis* to find Idiots their 'Necessaries', and for 'Lunaticks' to be 'maintained competently'.

If the jury determined that someone was an 'idiot' or a 'lunatick', the provisions of *De Praerogativa Regis* would come into force and the individual would lose all authority. For all intents and purposes, his legal rights would be relegated to those held by children (McDonagh, 2008) and he would become a ward of the sovereign, governed in accordance with the King's *parens patriae*²⁷ legal power to act as his guardian and thus manage his property and earnings on his behalf. It is this same legal doctrine that continues to authorise the present-day government to intervene in someone's 'best interests' when they are judged as unable to look after their affairs due to a 'mental disorder' (Gooding, 2014; BPS, 2008).

Guardianship for those subject to the *De Praerogativa Regis* statute was generally contracted out to private individuals (usually kin), rather than executed by the King himself or his administration – an example of how power can be deployed through a network of subsidiary authorities to govern people's behaviours in accordance with the state's aims and concerns. Idiots were either cared for by their family or confined in public houses, whilst lunaticks were typically cared for by friends or relatives, who might have hired servants for this purpose (Melton, Petril, Poythress & Slobogin, 2007; Neugebauer, 1996).

No treatment or cure was offered or suggested, although people with the means to do so may well have resorted to the different religious, astrological and physical approaches that were available at the time (Jarrett, 2012), and the notion that 'lunaticks' could recover (see below) would become increasingly relevant (particularly to the medical profession) in later years. Whilst an appeals

²⁷ This translates at 'the state as parent'.

process was available to those who believed they had been judged incorrectly, they needed to prove that they were sane, rational and competent before they could be 'trusted' to govern their own affairs in a desirable manner (McDonagh, 2008), much like those who are subject to the Mental Health Act must do today.

Implicit in the excerpts outlined above is a suggestion that whilst 'Lunatics' may have lost their 'Wit' (ability to reason), this could be temporary, and they generally retained their 'Memory' (Melton et al., 2007). An idiot, on the other hand, lacked both 'Wit' and 'Memory', and theirs was a more permanent affliction – they were 'natural fools' (fools from birth) and they did not improve. These three dimensions: the lack or loss of ability to understand and/or reason; the degree of chronicity; and the age of onset – set up, defined and differentiated lunacy from idiocy within a broader concept of an 'unsound mind' (Berkson, 2006), which in turn was inextricably linked to a notion of mental (in)competency. This construction is remarkably similar to modern-day definitions and differentiations of mental illness and learning disability (see section 1.2) – both categorised within a broader concept of a 'mental disorder' (Mental Health Act 2007; APA, 2013; WHO, 2016), and explicitly associated with the notion of mental (in)capacity.

With respect to dominant and subjugated discourses (research questions 3 and 4), the construction of incompetence owing to an 'unsound mind' for people who are struggling to manage their affairs is a formulation that silences the strong economic discourse underpinning the creation of the 'idiot' and the 'lunatic' suggested in the excerpts and analysis above. Whilst some authors have proposed that the main purpose of the *De Praerogativa Regis* statute was a protective one, to ensure that people subject to it were not exploited (e.g. Ramsay, Gerada, Mars & Szmukler, 2011), it was clearly linked with profit and productivity, with little regard for the safeguarding or provision of those who were not landowners. The latter group of people, for now, were not of concern to the King; they were a problem for the family, the lord of the manor, the church or some other social institution to address if required. Further evidence for the financial and political motivations concerning this statute can be found in the ways in which the categories of 'idiot' and 'lunatic' were redefined or reinterpreted at different times for the benefit of particular authorities (Neugebauer, 1996). They offer an additional indication of the power that

authorities can have in determining the classification, administration and governance of people who might present a challenge to the status quo.

3.2.2 The political power of the state over insanity

In this subsection I examine the historical, socioeconomic and political factors that contributed to the extension of the Sovereign's gaze from the problems represented by 'incompetent' land-owners to the problems posed by the non-working poor, and that provided the conditions of possibility for the emergence of a public system of welfare for those who came to be labelled the 'impotent poor'. I identify that it was within this 'impotent poor' category that pauper 'Ideots' and 'Lunatickes' would emerge as a separate group of people, and for whom legislation and state provision would become increasingly targeted and refined in the eighteenth and nineteenth centuries because of the problems they posed to the economy and social order. I then examine how the conflation of risk with lunacy enabled the emergence of the state's 'police power'; a power that in combination with the state's power over the destitute and its medieval *parens patriae* power justified (and continues to justify) the state's political authority over the 'insane' (including 'lunatics', 'idiots', and now people with a dual diagnosis; Mellett, 1981; Foucault, 1961/1988).

3.2.2.1 The rising problem of the non-working poor: *Labour Laws and Vagabonds Acts*

Following the demise of 30-40% of the population during the 'Black Death' plague pandemic in 1348, a number of labour laws (such as the Ordinance of Labourers 1349) were introduced to enforce those under the age of 60 to work and prevent them fleeing employers or demanding high wages at a time of labour shortage. This emphasis on productivity and its importance for the state's economy was all the more urgent given the need to continue funding ongoing royal military activities such as the 100 years war (1337-1453) and the ensuing War of the Roses (1455-1487). It can also be construed as a sovereign attempt to limit the power that labourers and servants were gaining.

The poor who did not work were increasingly constructed as 'idle by choice', with Vagabonds Acts introduced to criminalise and, characteristic of sovereign approaches, confine and punish anyone found, or even suspected of, begging: 'vagabonds, idle and suspected persons shall be set in the stocks for three days

and three nights and have none other sustenance but bread and water' (Vagabonds and Beggars Act 1494). They would then be rendered invisible by being 'put out of Town' (Vagabonds and Beggars Act 1494). This legislation did not acknowledge or address the problem or causes of poverty and unemployment. Neither did it distinguish those who were physically unable to work or those who were struggling to find employment despite trying. When faced with the choice of starving or breaking the law, many opted for survival, which meant that legislation was largely ineffective in reducing the numbers of beggars.

3.2.2.2 The emergence of a public system of welfare for the 'impotent poor': *Old Poor Laws*

The Punishment of Beggars and Vagabonds Statute of 1531 created the 'impotent poor' subject, a category that comprised the disabled, the sick and the elderly (Beier, 1985). This enabled the discrimination of those who were 'unable' to work (and consequently deserving of charity), from those perceived as 'unwilling' to work (and consequently deserving of punishment). It authorised the 'impotent poor' to apply for a licence to beg in an allocated area – the first time that outdoor relief was officially permitted for this group of people. In so doing, it also became possible to 'enclose' and 'contain' them, techniques of power that enabled more effective surveillance and thus governance (and that would become increasingly important in later times – see section 3.2.3). The statute also ordered the public flogging of able-bodied 'beggars' and 'vagrants' before returning them to their parish under the imperative that they put themselves to labour (Slack, 1990); a public display of sovereign power designed to deter the 'idleness' of others.

The proceeding years (1536-1541) saw the destitution of a large number of sick and poor people as a direct result of the dissolution of the monasteries and the accompanying destruction of the religious institutions that had hitherto been their primary source of health and social support (Slack, 1990). This caused public concern, not just for the welfare of those affected, but for the physical dangers that these 'bands of sturdy beggars' might represent to the rest of society (Alaszewski & Brown, 2012). There were several appeals from local magistrates for the Crown to address this problem, and the ensuing 1536 Act for Punishment of Sturdy Vagabonds and Beggars, in addition to reinforcing the

punitive and labour imperatives of the earlier 1531 Statute, advocated voluntary weekly collections by the parish specifically for the care of the 'impotent poor', in the hope that this would eliminate their need to beg and thus help restore public order (Slack, 1990). It was a move that represented the first official state provision for this broad group of people, signifying a shift from religious to civic support, and strengthening the power of the state over destitute persons that had already begun to emerge (Mellett, 1981).

The state's power over the destitute was further reinforced through the Act for the Relief of the Poor 1601, which consolidated the provisions of previous Acts and made the levying of tax from rate payers compulsory (Alaszewski & Brown, 2012). Assistance under this Act had two forms: 'outdoor' relief (such as food, fuel, clothing or money); and the less common (and more expensive) 'indoor' relief, largely provided by the institutions that began to emerge in the space opened up by the destruction of the religious establishments. Outdoor relief varied according to how an individual was classified: the 'impotent' poor could be cared for in 'houses of dwelling' (poorhouses or charitable almshouses); the sick could be admitted to hospital; the 'able-bodied' poor could be set to work in a House of Industry; and the 'idle poor' could be sent to a House of Correction or prison (Slack, 1990). In practice, such classifications and dividing practices were not so precise, however they did set up a way of thinking about what is now termed 'service provision' for particular 'categories' of people that would be taken up more methodically from the eighteenth and nineteenth centuries (Scull, 1989), and that is embodied in today's 'specialist' learning disability, mental illness and dual diagnosis services (see Chapter 1). Indeed, some of the institutions listed above were the forerunners to the workhouses and asylums that would become central to the disciplinary apparatus of the state in later years – and that continue to exist in modified form for those with a dual diagnosis today.

Whilst traces of Britain's modern welfare state can be recognised in the poor law system described above, it is important to note that at this stage, and up until the nineteenth century, social and economic assistance from the state was highly localised and reserved for those who were truly destitute. As before, 'idiocy' and 'lunacy' continued to be viewed predominantly as a domestic or family problem, becoming subject to poor law applications only when care

arrangements broke down (usually due to illness or for financial reasons; Digby, 1996; Rushton, 1988). Rushton (1996) argues that this was not because such individuals were well-integrated within society but because the family was placed 'at the centre of a state-enforced system of care' (Digby, 1996, p. 4). Indeed, the 1601 Poor Law stipulated that:

the Father and Grandfather, and the Mother and Grandmother, and the Children of every poor, old, blind, lame, and impotent Person or other poor Person not able to work, being of a sufficient Ability, shall, at their own Charges, relieve and maintain every such poor Person in that Manner. (Cited in Higginbotham, 2017a)

Hence, when the state intervened, and in line with current practice, it was to support the family rather than replace it (Rushton, 1988).

The 'old' 1601 Poor Law was largely perceived as an equitable system that, with some amendments, formed the basis of poor relief for the next two centuries. However, it had been designed for a pre-industrial society, when 90% of the population lived in rural areas, and where overseers of the poor knew their parishioners and could distinguish the 'deserving' from the 'undeserving' poor. In section 3.2.3 I will examine how the state's reliance on private domiciliary support for the 'impotent poor' became unsustainable in the context of a capitalist society and rapid population growth, and how the management of 'lunacy' (and later 'idiocy') was shifted to publically-funded institutions from the more traditional family or community spheres. First, it is important to highlight another concern that emerged in relation to subcategories of the 'impotent poor' that is relevant to the governance and subjectivities of people with a dual diagnosis today: that of pauper 'lunatics' and 'idiots' and the dangers that they might (re)present to society.

3.2.2.3 The conflation of risk with 'lunacy' and 'idiocy': *Vagrancy Acts and Lunacy Laws*

Having previously been amalgamated with those who had physical and sensory disabilities, it was in the 1601 Poor Act that those 'naturally disabled. . . . in wit, . . . as the Ideot, Lunaticke, . . . etc., not being able to work' (Dalton, 1618, p. 76) were explicitly highlighted as a separate subtype of the 'impotent poor'. At this stage, however, the extensive administrative and legal efforts that had been

made in *De Praerogativa Regis* to distinguish land-owning ‘lunaticks’ from ‘idiots’ (see section 3.2.1) were not translated to their pauper counterparts, presumably because there was no financial gain in doing so, inquisitions were an expensive process (Neugebauer, 1996), both groups were considered ‘deserving’ of charity, and neither was viewed as particularly problematic to the state (beyond their lack of productivity).

The perception of the pauper lunatic as ‘impotent’ and deserving of charity would change significantly over the course of the next two centuries. This shift is apparent in the Vagrancy Act 1714, which authorised the detention of ‘persons of little or no estates, who, by lunacy, or otherwise, are *furiously mad, and dangerous* [emphasis added]’, for the duration of their ‘madness’. The discourse of risk, already used to legitimise the governance of the ‘sturdy beggars’ in the sixteenth century, is evident here, explicitly linking lunacy with the potential for violence and crime, and thus enabling the state to detain a group of people that had previously been protected under the ‘impotent poor’ label. In so doing, the status of the ‘dangerous’ pauper lunatic becomes similar to that of a ‘vagrant’, inviting the same custodial and punishing methods of governance associated with the latter.

The Vagrancy Act marked the emergence of the state’s ‘police power’, a type of power that authorises it to act as protector of the public through the detention of people judged as posing a risk of physical harm to others (Gooding, 2014). It is a power that has been, and continues to be, used to justify legislation intended to safeguard the physical, social and moral well-being of the population, and that, in combination with the state’s *parens patriae* powers (see section 3.2.1) constitutes much of modern mental health law (Melton et al., 2007). Its application in contemporary British law has been widened from the use of detention to the application of non-consensual treatment for people with a diagnosis of mental illness (and by extension, those with a dual diagnosis), as well as those diagnosed with a learning disability who display ‘abnormally aggressive or seriously irresponsible conduct’ (Mental Health Act 2007). It has equally been broadened out to include not just those who may be at risk of harming others but also those who may harm themselves (Gooding, 2014).

In authorising the detention of the ‘furiously mad and dangerous’, the Vagrancy Act 1714 supported the expansion of the small institutions specialising in the

care of lunatics that had already begun to emerge in the context of the *De Praerogativa Regis*, such as the private madhouses. The 'trade in lunacy' was a lucrative one, and represented an economic way to restrain those who threatened public order (Scull, 1977). From 1760 onwards, specialist institutions became the preferred (albeit last resort) choice for the confinement of dangerous lunatics (Rushton, 1988). By 1801, charitable asylums for pauper lunatics had opened up in nine different English towns. Whilst only housing a relative minority, these 'specialist' institutions served to promote the notion that they might be the best place to confine those who were troublesome or different (Jarrett, 2012).

The concern over the 'dangerousness' that 'lunatics' may present increased substantially following a failed attempt on King George III's life in 1800 by James Hadfield, who was found to be insane and thus acquitted from criminal charges²⁸. The Criminal Lunatics Act 1800 was hastily introduced to prevent his release, instructing the indefinite detention of anyone who committed a crime during an episode of insanity. Argent (1978) argues that this reform was also a counter-revolutionary measure, motivated by the general fear amongst the English aristocracy that there would be a rebellion uprising to kill the King and overthrow the government like the one that had taken place in France.

During the next four decades, 'pauper lunatics' and 'criminal lunatics' became increasingly conflated. They began to be legislated for together, initially in the Act for the better Care and Maintenance of Lunatics, being Paupers or Criminals in England 1808, which dictated that all those detained under vagrancy laws be sent to a county asylum in the first instance or, in its absence, to a licensed madhouse. A few years later, the criterion of 'dangerousness' for the detention of lunatics was diluted and, in some cases, became entirely absent. For example, whereas the Madhouses Act 1828 had defined 'insanity' to include any *dangerous* 'lunatic' or 'idiot', the Madhouses Law Amendment Act 1829 changed this to mean *all* 'lunatics', 'idiots' and those of 'unsound mind' (Roberts, 1981). This omission legitimised the confinement of all 'lunatic' paupers – whether they were dangerous or not. It was an initiative that was

²⁸ Insanity was (and continues to be) a defence to criminal charges, but at the time of Hadfield's assassination attempt, if a jury agreed that he understood the crime 'no more than a wild beast or a brut, or an infant' (Rex v Arnold, 1724), he would have been released into the care of his family, leaving him free to make another attempt on the Monarch.

closely linked with the state's efforts to rid workhouses of these individuals, who could be troublesome and unproductive, and who thus posed a threat to the order and discipline that the workhouse was designed to instil.

The (potential) risks posed by 'lunatics' to society were reinforced further when, like other paupers, their morality was highlighted as a major concern. In combination with the medical construction of 'lunacy' as an illness and the associated discourses of chronicity and cure, the discourses of morality (and moral treatment) were used to justify the mandate for the compulsory construction of public lunatic asylums in the County Asylums Act 1845. Importantly, it was at this time that 'idiots' (who had not generally been considered a social threat and thus had avoided much of the confinement that 'lunatics' were being subjected to)²⁹, were also highlighted as potentially 'dangerous, not only in the ordinary but in a moral acceptance of the term' (Metropolitan Commissioners in Lunacy [MCL], 1844, p. 97). The implication then, was that 'idiots' too needed to be closely monitored and confined, something that would indeed begin to happen as a matter of course towards the end of the nineteenth century, when concerns about morality, criminality and degeneration intensified.

The construction of 'idiots' and 'lunatics' as potentially 'risky' continues to penetrate and, arguably, dominate the construction and subjectivities of those who are 'dually diagnosed' today. For example, 'challenging behaviour' is often interpreted as a symptom of mental illness, and frequently cited as the main reason individuals who end up being given a dual diagnosis come to the attention of services. The NICE (2016a) guidelines encourage a 'risk assessment' of those who are dually diagnosed, explicitly identifying 'risk to self' (p. 18) and 'risk to others (including sexual offending)' (p. 19) as areas to be assessed. Given the relatively low prevalence of 'sexually inappropriate behaviour' amongst even clinical populations of people with learning disabilities (1.6%; NICE, 2016b, p. 64), the fact that this is the only area to be explicitly highlighted under 'risk to others' suggests that moral danger continues to be a major concern. Similarly, social practices such as marriage and parenting continue to be areas of contention and state regulation today.

²⁹ This decision was also a financial one, as domiciliary care was cheaper for the state to support than institutional options (Rushton, 1988).

Having explained how the state achieved its political authority over 'insanity', I now return to the narrative of the 1601 Poor Law, the historical events that led to its reform, and the concurrent establishment of a vast disciplinary apparatus of the state within which 'specialist' institutions for 'lunacy' and 'idiocy' would emerge, and where 'knowledge' and 'truth' about 'dual diagnosis' could, and would, be created.

3.2.3 The emergence of a disciplinary apparatus of the state

3.2.3.1 From private to public burdens: *Poor Law Amendment Act 1834*

After the English civil war (1642-1651), Parliament replaced the Monarchy as the ruling power, and over the next century, the breakdown of feudalism gave rise to a capitalist social and economic system that stimulated new methods of production and the emergence of agricultural and industrial 'revolutions'. These significantly boosted the economy, and population numbers in England alone rose from approximately 8.3 million in 1801 to 16.7 million in 1851 (Census of Great Britain, 1801, 1851). As manufacturing processes became increasingly mechanised and unaffordable to previously self-sustained farmers, people were forced to migrate to towns and cities in search of employment within capitalist-owned factories. By 1850, more than half the British population lived in urban areas, working in factories and mines.

The new capitalist society privileged able-bodied workers who could keep up with the speed of factory work (Ryan & Thomas, 1987). This meant that 'unproductive' family members were increasingly viewed as being a burden – not just for the state, but for families, who could no longer afford to stay at home to protect and support them (Scull, 1989). Family responsibility for lunatics and idiots thus became increasingly difficult for magistrates and parishes to enforce (Rushton, 1988).

By the end of the eighteenth century, the number of people seeking poor relief had increased dramatically. Circumstances became even more challenging following the subsequent industrial and agricultural depressions, high unemployment rates, and soaring national debt caused by the Napoleonic wars. The rising cost of poor relief caused significant concern to the state (Scull, 1977), as did the increase in civil unrest amongst the poor, and the seemingly limited effect that existing legal frameworks were having in imposing social

order. An alternative approach to addressing this myriad of problems was therefore needed.

To this end, in 1832, the government appointed an 'expert' Royal Commission to undertake a thorough review of the poor relief system and make recommendations for alternative, more effective and economic ways of addressing the problem of poverty. This method of reviewing policy was markedly different from the government's former ad hoc, incremental and pragmatic responses to challenges relating to poverty and labour (Alaszewski & Brown, 2012). In this 'new' approach, government action was to be shaped by recommendations made by expert reviews; a process that closely resembles the development of 'evidence-based' legislation, policy and guidance today (including that which is made for people with dual diagnosis). Whilst this shift may have reflected both the increasing power ascribed to such experts, and the privileging of a more methodical, 'scientific approach', there is also evidence to suggest that the Royal Commission was established to substantiate the changes that the government had planned already (Bloy, 2002).

The Commission drew on a combination of social, moral, political and economic theories and concerns to justify and support their review: Thomas Malthus's forecasts that population growth would outstrip food supplies; David Ricardo's concern that an 'iron law of wages' was detrimental to independent labourers; and Jeremy Bentham's theory of utilitarianism, which argued for the greatest good for the greatest number of people. The rationalisation for reform was no longer one that focused on the authority and glory of the sovereign, but one that emphasised the creation of a society that promoted the well-being and happiness of its citizens (Alaszewski & Brown, 2012). Some argued that the move was also a political one: an attempt by the Whig government to win the votes of the people who had been enfranchised by Great Reform Act 1832 by reducing the amount of tax they needed to pay.

In their 1834 report, the Royal Commission concluded that poverty was caused by the idleness of morally weak individuals rather than socioeconomic factors, and that the existing system supported this 'indolence and vice' (p. 228). The rapidly ensuing Poor Law Amendment Act 1834 took forward most of the Royal Commission's recommendations. It significantly modified the system of poor relief for the able-bodied so that it could only be obtained through well-

regulated, centralised public workhouses (where individuals could be closely monitored and contribute to their own upkeep by working), rather than administered arbitrarily at the parish level. Unlike its predecessor³⁰, the 'new' workhouse was not about relieving destitution; it was about deterring idleness (Higginbotham, 2017b). The directive was for conditions to be so dire that only the truly desperate would seek relief; a mandate that was described as a message that 'whosoever will not work ought not to live' (Carlyle, 1839, cited in Bloy, 2016`).

3.2.3.2 Disciplinary power and its deployment in new workhouse

The 'new' workhouse was to be a place of strict discipline and order. To this end, the newly established Poor Law Commission was empowered to 'make and Issue all such Rules, Orders, and Regulations for the Management of the Poor, [and] for the Government of Workhouses' (Poor Law Amendment Act 1834, section 15). They developed a standardised template of rules that all workhouses could adopt, stipulating in great detail everything from the admission procedure, to how space should be organised, to how paupers should spend their day. For example, on admission, individuals would be 'carefully examined, washed and cleaned', issued with a workhouse uniform, and their own clothes and possessions stored until their discharge. The workhouses space was highly compartmentalised to enable strict segregation by sex and age, with no contact between them except at mealtimes (which had to be taken in silence). A regimented routine that involved set hours for activities such as mealtimes, work and rest structured each day, with a bell in operation to ensure good time-keeping. There were rules for when windows could be opened, how many hot meals per week should be served, when people should bathe, and when prayers should be read. 'Disorderly' or the more serious 'refractory' conduct was punished, and a list of rules and penalties was in prominent display to remind inmates of the potential cost of such behaviours. 'Inmates' were technically free to leave, but permission from the Governor or Matron was needed, and there were strict rules around this.

³⁰ Parochial workhouses were well-established in England and Wales, with nearly two thousand in operation by the end of the eighteenth century that together housed approximately one hundred thousand paupers (Slack, 1990). Their original aim had been to provide work for unemployed able-bodied paupers and they had not been designed to be particularly punitive or unpleasant. However, the majority of those who took up residence were the 'impotent poor,' resulting in workhouses taking on much more of a social institution function.

This highly structured system had been inspired by the rhythms of monastic and military life and was already being deployed in other institutions such as factories and prisons (Foucault, 1975/1991). It represented the operation of a new form of power that Foucault (1975/1991) termed 'disciplinary power'; a power that enabled the mass control of bodies and movement by both 'increas[ing] the forces of the body (in economic terms of utility) and diminish[ing] these same forces (in political terms of obedience)' (Foucault, 1975/1991, p. 138).

As illustrated in the above account, the operation of this 'disciplinary power' was facilitated by a number of techniques (such as the regulation and organisation of space, time and behaviour according to precise 'norms'), and further aided and enforced by complex systems of surveillance (such as examination, hierarchical observation and normalising judgements; Foucault, 1975/1991; O'Farrell, 2005). Any deviant behaviour was immediately 'corrected', enabling individuals to learn how to behave in the ways that were expected of them and, ultimately, to internalise the regulations so that they could discipline themselves. Together, these strategies enabled the creation of compliant, or 'docile bodies', improved and reformed rather than simply punished (Foucault, 1975/1991). They therefore represented a shift from (though not complete displacement of) a 'sovereign' power 'that drives out, excludes, banishes, marginalizes, and represses, to a fundamentally positive power that fashions, observes, knows, and multiplies itself on the basis of its own effects' (Foucault, 1975/2003, p. 48).

Disciplinary techniques and technologies would later be adopted in asylums and mental health hospitals (Foucault, 1975/1991), and continue to be exercised in existing services for people with a dual diagnosis. In fact, the mechanisms of discipline have since permeated the entire social body, and form a key component of the governance of society today (Foucault, 1975/1991).

3.2.3.3 The separate governance of the insane

As discussed earlier, the idea that 'dangerous' and land-owning lunatics could be managed in dedicated institutions (such as madhouses and charitable asylums) had already become fairly well-established in the eighteenth century. In 1808, the County Asylums Act demonstrated the government's commitment to extend this segregation to *all* lunatics. It highlighted that 'the practice of

confining such lunatics and other insane persons . . . in Gaols, Houses of Correction, Poor Houses and Houses of Industry, is highly dangerous and inconvenient' (County Asylums Act 1808), presumably because 'even by threats and punishment, [they] could neither be persuaded nor induced to conform to the regulations' (Scull, 1977, p. 343) and were thus more difficult and expensive to manage. In the hope that these institutions could return to their original functions, the 1808 Act had authorised and encouraged magistrates and Justices of the Peace to build publically funded lunatic asylums in every county (Jarrett, 2012). Due to the financial implications of this, however, only a few were built and most people who might have come under the rubric of 'insanity' continued to receive alternative means of support.

3.2.3.3.1 *The emergence of dedicated 'insane wards' in the workhouse*

The separate governance of the insane was reiterated in the Royal Commissioners' 1834 poor law report:

The principle of separate and appropriate management has been carried into imperfect execution, in the cases of lunatics, by the means of lunatic asylums; and . . . it might be carried into more complete execution under extended incorporations acting with the aid of the Central Board. (Poor Law Commissioners [PLC], 1834, p. 307)

The succeeding Poor Law Amendment Act 1834 did not make provisions for 'a more complete execution', however, and one theory is that commissioners were unable to develop a consistent and comprehensive policy for this complex and elusive group of people (Green, 1983). In actual fact, the new Poor Law made no reference to the management of lunacy or idiocy at all, except to prohibit the 'detention in any workhouse of any dangerous lunatic, insane person, or idiot for any longer period than fourteen days' (section XLV). Of significance was the way in which this was almost immediately interpreted as meaning that 'non-dangerous' lunatics, 'insane' persons or 'idiots' could stay in workhouses indefinitely, even though this had not been the Royal Commission's intention (Myers, 1998). This alternative reading was likely to have been inspired by the reduced expense of keeping 'insane' paupers in poor law institutions (Ayers, 1971) and, as expected, it resulted in a considerable rise in the number of these individuals within workhouses.

In many cases, workhouses began to establish their own dedicated 'insane wards', and by 1865 almost one in seven workhouses in England and Wales had one. A system of judgement to facilitate the classification and isolation of pauper 'idiots' and 'lunatics' was introduced early on:

As soon as a pauper is admitted, he or she shall be placed in the probationary ward . . . until examined by the medical officer of the workhouse. If . . . labouring under any disease of body or mind, the pauper shall be placed either in the sick ward, or the ward for lunatics and idiots, not dangerous, as the medical officer shall direct. (Poor Law Commission Office [PLCO], 1836, p. 89)

In Foucault's words, this examination was

a normalizing gaze, a surveillance that makes it possible to qualify, to classify, and to punish. It establishes over individuals a visibility through which one differentiates them and judges them . . . The superimposition of the power relations and knowledge relations (Foucault, 1975/1991, p. 184).

Medical examination was thus a technique that had the power to produce a pauper 'lunatic' or 'idiot', just like medical and psychiatric examination can produce someone who is 'dually diagnosed' today. Insanity and idiocy become 'truths' about a person; additional subjectivities that may not have existed until the deployment of the systems of judgement in question, and that had implications for how they were managed.

The Poor Law excerpt above highlights an important discursive shift that began to take place towards the end of the eighteenth century: that of the construction of lunacy and idiocy as a 'disease of the body or mind', the associated potential for treatment and cure, and the ascendancy of the medical profession as the dominant authority in these matters. The medicalisation of lunacy and idiocy and its relevance to dual diagnosis will be examined in more detail in section 3.2.4. For the purposes of this section relating to the emergence of a disciplinary apparatus of the state, I will focus on how discourses of chronicity and cure enabled the proliferation of the public asylums that had been espoused by the government for so long, and the application of disciplinary technologies of power therein (research questions 1 and 3).

3.2.3.3.2 *Discourses of chronicity and cure: County Asylums Act 1845 and Lunacy Act 1845*

The notion that lunacy could be temporary (and that recovery was therefore possible for many) had already been clear in law as early as the fourteenth century. Whilst possible causes and treatments had been debated since ancient times, these had not been a particular focus of legislation. This is perhaps not surprising given that legislation relating to insanity had initially developed from a need to administer property and, later, from a need to impose social, political and economic order amongst the poor. The main purpose of early institutions was therefore to contain populations of people who were unproductive or undesirable in society. They had little or no therapeutic input, and punishment was common, particularly in asylums and madhouses where mechanical restraint and physical coercion was the rule (Scull, 1981).

The construction of lunacy and idiocy as biological illnesses in the nineteenth century enabled the emergence of novel treatments, and with them, the possibility of a cure. At a time when the insane were increasingly perceived as inconvenient, and custodial approaches were having a limited (or even negative) impact, such auspicious new approaches were gratefully embraced.

In 1842, Metropolitan Commissioners in Lunacy were tasked with undertaking an in-depth national inquiry and census of the 'insane', which included the classification, treatment regime and conditions of paupers on admission to county asylums and licenced madhouses. Their 1844 report focused mainly on 'lunatics', although there were a few references to 'idiots' that were significant to their later construction and government that I will refer to further when discussing the emergence of idiot asylums in section 3.2.3.3.4. In relation to 'lunatics', the Commissioners advised that:

the first object ought to be their cure, by means of proper medical treatment. This can only be obtained in a well-regulated Asylum; and therefore the detention of any curable lunatic in a Workhouse is highly objectionable, on the score both of humanity and economy. (MCL, 1844, pp. 95-96)

These assertions had several implications. Firstly, that lunacy was curable in a large proportion of cases – but only if treated early – so lunatics should be sent

to the asylum as soon as possible. Secondly, that treatment needed to be 'proper' and 'medical'. This involved a combination of physical and moral management, reflecting not only the perceived causes of insanity and tried and tested methods, but also the growing authority of the medical profession (see section 3.2.4). Thirdly, that treatment needed to take place in a properly constructed and resourced asylum, highlighting the view that the building was an integral part of the treatment, and in itself therapeutic. Fourthly, that it was not only inhumane but expensive to keep lunatics in workhouses. It was argued that existing asylums were filling up with incurable lunatics because they had been initially sent to workhouses, where their condition had deteriorated and medical relief would no longer be effective. It had also been claimed that, once an asylum was built, the cost of curing a pauper lunatic could be as little as £5 (versus the £200 to £400 cost of holding him indefinitely), and that up to 70% of cases could be cured (Ashley, 1843, in Roberts, 1981). Curing the lunatic could, of course, have the additional economic advantage of rendering him productive again.

The promise of treatment and cure provided the final thrust and justification for the propagation of public lunatic asylums (Scull, 1977). In 1845, Parliament simultaneously approved two complementary Acts. The County Asylums Act 1845 commanded the compulsory construction of public lunatic asylums and, whereas in 1832 there had only been thirteen such county asylums, by 1858 that number had trebled (Bartlett, 1999), and by the end of the century there were 120 new public asylums housing more than one hundred thousand people in total (Jarrett, 2012). Alongside, the Lunacy Act 1845 mandated that asylums be headed by a live-in medical superintendent, officially recognising and contributing to the dominant position of the medical profession in the governance of lunacy. It also created a 'Lunacy Commission' tasked with licensing public and private asylums, as well as monitoring all admissions, treatments and discharges therein. In conjunction with the powers that had already been ascribed to Poor Law Commissioners, this enabled the establishment of a vast network of surveillance and examination of the insane across a number of institutional sites.

Lunatic asylums were thus no longer constructed as sites for the confinement of troublesome individuals (Foucault, 1961/1988), or as 'a permanent refuge for

the insane, . . . [but as] hospitals for their relief and cure' (MCL, 1844, p. 7), much like acute mental health wards and 'dual diagnosis' inpatient units continue to be constructed today. Correspondingly, lunatics were no longer constructed as prisoners but as 'patients' who could be rendered docile by being treated, disciplined and even cured by the medical profession; a medical construction that continues today for those who are diagnosed with a mental illness (and by extension those with a dual diagnosis).

3.2.3.3.3 *The deployment of disciplinary power in lunatic asylums*

As mentioned above, the asylum building itself was considered an essential component for the treatment of insanity. It was not uncommon for medical superintendents to collaborate with architects to design buildings that could achieve its dual safeguarding and rehabilitative functions. In 1847, physician John Conolly, who was also superintendent at Hanwell Lunatic Asylum, published *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, a book that would become the standard for asylums in England and Wales. Its wide-ranging influence illustrates the intimate relationship between power and knowledge; how they build on each other so that specific types of knowledge are produced through the exercise of power and used to reinforce it further (Foucault, 1975/1991).

Using Derby Lunatic Asylum as his prototype (see Figure 2), Conolly (1847) advised on every detail, including: architecture, construction materials, layout of sleeping rooms and galleries, furniture and internal decoration; classification and arrangement of patients; clothing and diet; recreation, employment and education; and staff numbers, qualifications and duties. He recommended that for optimum governance, asylums should house no more than four hundred individuals, that men and women should be segregated, and that there should be 'separate wards and bed-rooms for the tranquil, for the sick, for the helpless, for the noisy, the unruly, or violent, and the dirty' (p. 8).

Lunatic asylums were typically built in semi-rural locations within large grounds, surrounded by high walls to prevent people escaping. Many had looming water towers, around which were arranged the kitchens, laundries, workshops, recreation hall, medical surgery and administration block (Jarrett, 2012). They were self-contained, 'total' institutions, requiring minimal contact (or

interference) from the outside world. Their layout was reminiscent of the power relation embodied in Foucault's concept of the *Panopticon*, where a central observation tower enables the continuous surveillance of 'inmates' who assume they are being monitored at all times, and thus regulate their own conduct to avoid punishment (Foucault, 1975/1991). The architecture of institutions thus becomes an apparatus for creating and sustaining power relations independent of those who manage it (Foucault, 1975/1991). Indeed, the ability to govern from a distance and constant visual monitoring were key aspects of the new non-restrictive regime of treatment and cure:

by this plan every advantage is secured, including that constant superintendence which is indispensable to preserving order and comfort, and without which the prevention of mischief – which is an important element of the non-restraint treatment – is quite impracticable. (Conolly, 1847, p. 17).

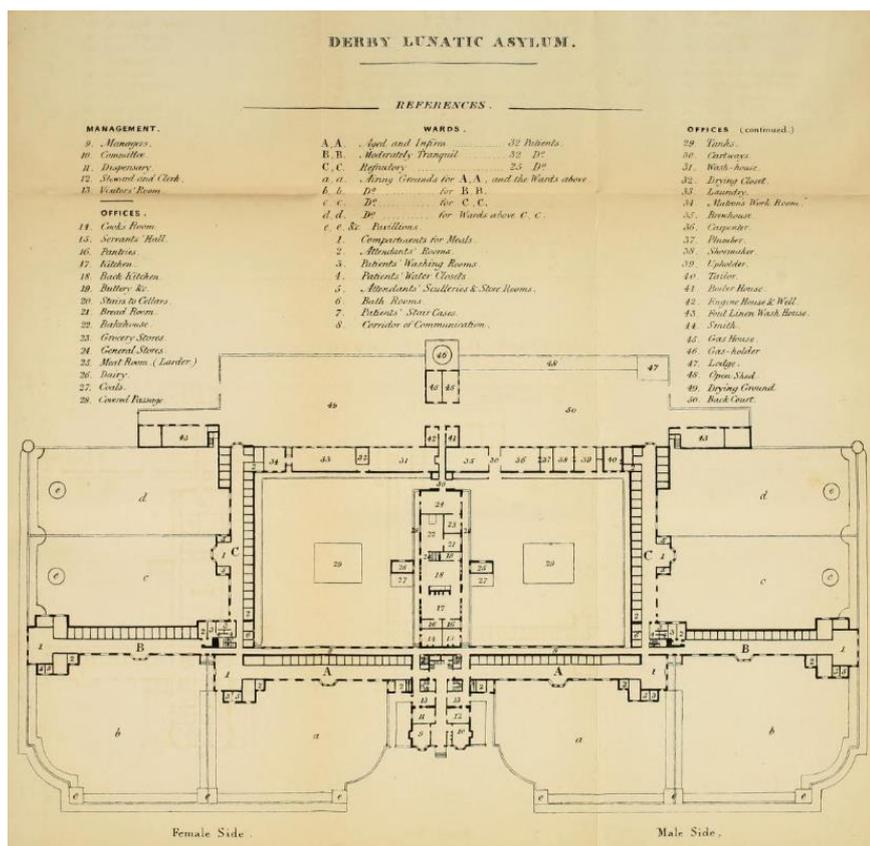


Figure 2: Plan of Derby lunatic asylum (Conolly, 1847, p. 184).

In modern day, the 'all seeing eye' subsists at the centre of inpatient wards in the form of a 'nursing station', sometimes surrounded by large viewing windows.

In addition to the extensive regulation of space, disciplinary power was deployed in the day-to-day running of the asylum through techniques that resembled those exercised in the workhouse (see section 3.2.3.2), and that are recognisable in how those with a dual diagnosis are governed today in both inpatient and community contexts. These included the regulation of time (strict schedules and routines), people's conduct (marching drills for exercise; manual work), physical examinations, and normalising judgements (correcting undesired behaviour) (Jarrett, 2012; Foucault, 1975/1991). Disciplinary power was also implemented through a variety of medical and psychosocial treatments that aimed to produce not just docile bodies, but docile minds (Carlson, 2005). For example, work was used as a 'means of occupying the restless, diverting the thoughts of the melancholy, relieving the vacuity of the imbecile . . . in short, of contributing to the cure of all descriptions of patients' (Conolly, 1847, p. 106). Importantly, and similar to those sectioned under the Mental Health Act today, individuals were not free to leave when they wished; their release was dependent on medical examination and approval.

3.2.3.3.4 *The emergence of idiot asylums*

Although the County Asylums Act 1845 had authorised the admission of all forms of 'insanity'³¹ into lunatic asylums, because 'idiots' were largely 'regarded as being beyond the means of cure' (MCL, 1844, p. 97), in practice, many specifically excluded them due for fear that they would 'silt up' the system (Rushton, 1996). Consequently, idiots formed a minority of the asylum population (MCL, 1844)³². With the renewed efforts to relocate the insane from workhouses to asylums, and the emergence of a risk discourse associated with idiocy, there was increased pressure to provide some sort of care for these individuals – whether in lunatic asylums or (preferably) elsewhere.

The success of Séguin's work with idiot children at the Bicêtre Hospital in Paris in the 1840s highlighted a new approach that could be used with them: that of education and training. This incorporated elements of the 'moral treatment' used

³¹ The principal forms of insanity were described as: mania, dementia, melancholia, monomania, moral insanity, congenital idiocy, congenital imbecility, general paralysis of the insane, epilepsy and delirium tremens (MCL, 1844).

³² In 1844 only 518 (approximately 5%) of the 11,272 'insane' persons confined in asylums in England and Wales were classified as 'idiots' (MCL, 1844, p. 184). This was in contrast with the workhouse population, estimated by the Poor Law Commission as comprising an almost equal proportion of 6451 lunatics to 6261 idiots in 1842 (although a broader definition of the term 'idiot'; MCL, 1844, p. 96).

in lunatic asylums and involved a systematic (and disciplinary) programme of muscular, sensorial, moral and intellectual stimulation and training. It was designed to improve idiocy and, importantly, to create more useful, self-sufficient, and productive individuals that could potentially return to society (Coulter, 2009). It was perceived as so effective that, just three years after stating that not much could be done for them, the Lunacy Commissioners declared that idiots 'are in general capable of being greatly improved, both intellectually and morally, by a judicious system of training and instruction' (Commissioners in Lunacy, 1847, p. 275).

Despite ostensible support for such approaches, the government did little to support their introduction because lunatics presented a more urgent management problem, and the number of idiots of concern to the state and other authorities were comparatively few (Wright, 2001). The establishment of dedicated 'idiot asylums' was ultimately instigated by Mrs Ann Serena Plumbe, a parent who was dissatisfied with the lack of suitable education and training options available to idiot children like her son (Wright, 2001). As an arrow-root merchant she had a number of medical acquaintances whom she contacted for advice and interest in founding an institution for idiots that could provide education and training. These included Dr Samuel Gaskell (medical superintendent of the Lancaster lunatic asylum, and Dr John Conolly (Ayers, 1971), who had both personally observed and written about Séguin's work (Conolly, 1847). With their support and that of philanthropist and family friend Rev Andrew Reed³³, Mrs Plumbe founded the *Charity for Asylum of Idiots* and, in 1848, the first 'Hospital for Idiots' was built in Highgate, London.

Despite being a charitable organisation it was clear that charity did not extend to everyone. People were rejected 'on the grounds of age, hopelessness, unfitness, too unfavourable, epileptic, badness, [or being] on parish relief' (Langdon Down Museum of Learning Disability [LDMLD], 2014), with admission restricted to private patients and individuals who had been 'voted in' and whose fees were partially or fully paid for by charity subscribers (Wright, 2001). Demand was high: after opening with eight patients, this had risen to 33 just two months later, and doubled to 66 by the following year, significantly exceeding

³³ Reed had been involved in the establishment of a number of charitable foundations, including the London Orphan Asylum and the Royal Hospital for Incurables.

the hospital's capacity (LDMLD, 2014). In 1850 a public petition was made to raise funds for the construction of a purpose-built 'Asylum for Idiots' with a capacity for 400 residents. By 1855, 'Earlwood Asylum' had opened its doors, and over the next fifteen years the charity promoted and supported the establishment of a further four large-scale voluntary 'idiot asylums' (Bewley, 2008).

These purpose-built 'idiot asylums' adopted the characteristic architecture of lunatic asylums, enabling the same disciplinary deployment of space and techniques of examination, normalising judgement and strict regulation of time and conduct. They too were registered as 'hospitals' (even though they were more like 'schools'), overseen by medical superintendents and bound by the Lunacy Commission's regulations and inspectorate, which brought them under government authority despite the lack of state funding (LDMLD, 2014). In 1886, the Idiots Act made specific provision for 'idiots' and 'imbeciles', explicitly defining them as a separate group of people from those with 'lunacy'. It authorised local authorities to build 'facilities for the care, education, and training of Idiots and Imbeciles' and empowered poor law officials to detain such individuals in existing charitable institutions (Bewley, 2008). For individuals to be admitted, their parent or guardian had to agree for them to be certified as 'idiots' or 'imbeciles'.

However, it clearly dictated that they could not be institutionalised 'unless, in the opinion of a medical practitioner, he is capable of receiving benefit from the institution' (Lushington, 1895, p. 812). McDonagh (2008) argues that the introduction of this Act was mainly driven by the professional and economic motivations of medical superintendents of existing 'idiot asylums' to have 'idiocy', their area of expertise and authority, legally recognised as an entity distinct from 'lunacy'. It was also influenced by the growing concerns about degeneration of the population that had been highlighted by the lack of moral and intellectual improvement of pauper children in statutory education facilities, and the need to identify those who were most likely to benefit from education and training (McDonagh, 2008).

In summary, this section examined the emergence of a vast disciplinary apparatus of the state as a condition of possibility for the emergence of dual diagnosis. The initial adoption of a standardised institutional approach for the

growing number of paupers who struggled to meet the capitalist and industrialist aspirations of productivity was necessarily limited, and required clearer demarcations of 'deviance' to distinguish and isolate those who could not, or would not, conform to the new disciplinary regime. This differentiation was made possible through processes of examination that produced pauper 'lunatics' and 'idiots'. The construction of their 'affliction' as a biological illness provided a strong justification for specialist institutions for these populations that could serve the safeguarding and rehabilitative functions that continue to drive dual diagnostic services in the present day. Indeed, many of the techniques and technologies of disciplinary power that were deployed and refined by medical superintendents and other staff to produce 'docile bodies' and 'docile minds' in these institutions can be recognised in the approaches used to govern dual diagnosis today. Importantly, 'lunatic' and 'idiot' asylums provided sites where knowledge and 'truth' about particular groups of people could be gathered and used to assist in the identification and governance of 'deviants' both within and without the confines of the institution. It was within these institutions that knowledge and 'truth' about 'dual diagnosis' would be created.

The next section examines the shifts in discursive regimes, the knowledge-power links and the social practices that enabled the medical profession to become the main authority and producer of knowledge about 'idiocy' and 'lunacy' as additional conditions of possibility for the emergence of 'dual diagnosis'.

3.2.4 The medicalisation of 'lunacy' and 'idiocy'

In this section I explore some of the events that, in combination with the institutional context outlined above, facilitated the gradual medicalisation of 'lunacy' and 'idiocy', the associated ascendancy of medical authority in these areas, and the emergence of the Psychiatric profession; a profession that was inextricably linked with the emergence of 'dual diagnosis' and that continues to be its main proponent, authority and producer of knowledge in the present day. I also highlight some of the psychiatric technologies and techniques that were taken up in the later governance of dual diagnosis.

3.2.4.1 The rise of science as 'truth'

In the sixteenth and seventeenth centuries, beliefs that 'insanity' was caused by excess, possession of the soul or divine retribution were challenged by philosophical explanations that emphasised the lack or loss of 'reason'. Resembling the concept of 'Wit' in *De Praerogativa Regis*, the ability to 'reason' was now situated in a person's immaterial mind or soul, which in turn was perceived as being separate from the material body (Descartes, 1649/1989). Informed by this Cartesian mind-body dualism (that continues to shape our thinking today), the English philosopher John Locke (1690/1825) argued that the mind was a *tabula rasa*, a blank slate, and that reason could therefore be stimulated and restored through corrective experiences. In relation to insanity, he argued that

there are degrees of madness, as of folly : the disorderly jumbling of ideas together, is in some more, some less. In short, herein seems to lie the difference between idiots and madmen, that madmen put wrong ideas together, and so make wrong propositions, but argue and reason right from them : but idiots make very few or no propositions, and reason scarce at all. (Locke, 1690/1825, p. 94)

This emphasis on 'rationality' and new interest in the subject and object of 'Man' represented a sharp departure from the prior focus on 'God' and the divine. Rather than an approximation to the 'truth' about 'idiocy' or 'lunacy', however, this shift was produced by what it was possible to think within contemporaneous discursive regimes, power relations and legitimations of authority (Alcoff, 2005). In this case, it reflected (at least in part) the decline in the power of the Church and concurrent secularisation of the state, and the shift towards the scientific discourse of the 'Enlightenment' or 'Age of Reason'. Within this intellectual and philosophical movement, science became a privileged way of uncovering truth and, for knowledge to acquire value as 'truth' it had to organise itself in accordance with scientific criteria (O'Farrell, 2005). In this way, science became a field of power/knowledge relations: 'There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations' (Foucault, 1975/1991, p. 27). Medicine, and later psychiatry, psychology, criminology, and sociology constituted the 'human sciences'; bodies of

knowledge that describe and govern human bodies and behaviour in accordance with 'norms' that they themselves produce.

3.2.4.2 The production of medical knowledge about lunacy and idiocy

Although some physicians had been involved in the 'trade in lunacy', most of the care in madhouses had been provided by people with no medical background, whose interests and motivations were largely economic (Scull, 1977). Medical interest in 'lunacy' was scarce until the end of the eighteenth century, when legislation supported (and mandated) greater involvement of physicians in its administration (Scull, 1989). It was only in the second half of the nineteenth century, when specialist 'idiot asylums' collected large numbers of people together, that systematic medical attention to the problem of 'idiocy' emerged (Ryan & Thomas, 1987). Indeed, the assemblage of such 'populations' in facilities where physicians were placed in charge, was one of the ways in which the exponential production of medical knowledge about 'insanity' became possible.

Drawing on the empirical language and methodologies of observation and experimentation of the new scientific discourse, physicians began to collect, create and disseminate 'knowledge' about 'lunacy' and 'idiocy' in the numerous medical and scientific journals and publications that emerged in the beginning of the eighteenth century. Initially drawing on single case studies, physicians debated the causes of 'insanity' and whether these originated in the mind or in the body, with important implications for how they were treated or managed. Cases such as Victor, the 'wild boy of Aveyron', provided opportunities for physicians such as Jean Itard (1802) to test Locke's *tabula rasa* theory of mind, and experiment with the application of educational and sensory-training and stimulation methods that had been used successfully with deaf students (and that would later be taken up by Séguin with 'idiot' children; Donaldson & Menolascino, 1977). French alienists Pinel and his pupil Esquirol argued that insanity was primarily an emotional (psychological) disease rather than spiritual or physical, and that it could therefore be cured through the stabilisation of the person's emotional life (an important component of the emergent 'moral treatment' and current psychotherapies for people with a 'dual diagnosis').

Physical theories of insanity that challenged such Lockean views developed contiguously. For example, in his 1758 *Treatise on Madness*, English physician William Battie argued that mental disorders were caused by a dysfunction of the body rather than the mind and that they were therefore amenable to physical treatments. Neuroscientific theories of mind provided further somatic accounts of 'lunacy' and 'idiocy' (Desjardins, 2016). For example, Gall's (1810/1835) theory of organology (later re-named 'phrenology') viewed 'idiocy' as primarily physical in origin, hypothesising an aetiology of brain lesions, absent brain 'organs' or small brain size. These medico-philosophical conceptualisations of insanity and neuroscientific theories about brain physiology and pathology significantly shaped the subsequent study of 'idiocy' and 'lunacy' (Desjardins, 2016), and their influence is noticeable in current psychological and biomedical theories relating to the 'functional' and 'organic' aetiologies of 'dual diagnosis'. By constructing insanity as a disease, physicians were (and continue to be) able to profess an expertise in its management, and thus make a claim to knowledge and power (Scull, 1977). Physicians reinforced and embraced this proficiency, frequently commenting on the unique positioning of 'medical men who have lived in asylums, and among the insane, and who alone know what the insane require' (Conolly, 1847, p. 6); a sentiment echoed by Psychiatrists in relation to 'dual diagnosis' in later years. In so doing, any expertise that others might have been relegated, including the self-knowledge and expertise of the subject in question.

Medical knowledge and interest in the co-occurrence of 'idiocy' and 'lunacy' did not begin to emerge until the end of the nineteenth century (Parsons, May & Menolascino, 1984). From an administrative point of view, the imperative was (and had been since at least the fourteenth century) on their distinction, so that each social group could be governed in the most efficient and effective way. This emphasis had inevitably shaped the dominant nineteenth-century conceptualisations of 'idiocy' and 'lunacy' that viewed them as illnesses on a continuum of 'insanity', and thus mutually exclusive (see below).

3.2.4.2.1 *The emergence of technologies of classification*

Partly inspired by the hierarchical Linnaean classification system (Linnaeus, 1735), physicians began to develop their own taxonomy and nomenclature in

the eighteenth century, often drawing on existing or past medical, legal and lay terminology to describe various forms and degrees of 'insanity'. For example, Pinel (1798/1806) categorised 'insanity' into four basic types: 'melancholia', 'mania' with or without 'delirium', 'dementia', and, at its lowest level, 'idiocy'. By the 1840s these had increased to ten principle forms of 'insanity', acquiring a medico-legal status through their iteration in Lunacy Commissioner reports and subsequent legislation. A new category called 'moral insanity' was introduced to describe those whose emotions, affections and habits were 'disordered', 'violent' or 'morally perverse' but who did not have hallucinations or problems with their intellectual or reasoning abilities (MCL, 1844). In other words, those who presented a threat to the social order but whose governance had perhaps not been so well-defined under previous 'insanity' legislation. This emphasis reflected a growing concern about morality that would eventually give rise to the extension and modification of insanity laws to enable the incorporation of this new group under the broader category of 'mental defectives'.

In his *Compendium of Psychiatry*, Kraepelin (1883/1919) argued that as a medical science, Psychiatry should research the biological causes of mental illness using methodologies employed by the natural sciences. In order to do this, he devised a classification system that grouped diseases according to patterns of clinical symptoms over time rather than the previously-used taxonomy based on similarity of major symptoms. Present-day diagnostic systems such as the DSM-5 and the ICD-10 can be traced back to Kraepelin's nosological system. Their constant modification and expansion to reflect contemporaneous societal concerns are another illustration of how science and politics have interacted so that problems of knowledge become aligned with solutions to problems of social order (Pickersgill, 2012). Indeed, classification systems are powerfully constitutive of pathology and normality, and are one of the primary means through which psychiatric power operates (Pickersgill, 2012; see Chapter 1). As a technology of power, they represent an important condition of possibility for the creation and maintenance of dual diagnosis.

3.2.4.2.2 Techniques of treatment and cure: Moral Treatment and Education

As noted earlier, the 'new' conceptualisations of 'lunacy' and 'idiocy' made it possible for novel treatments and cures to emerge at a time when existing frameworks and approaches were having a limited impact. One of the main approaches popular in the nineteenth century was moral treatment, a psychosocial approach to madness that emerged towards the end of the eighteenth century that was promoted by Pinel at the Bicêtre Asylum in France and by Tuke at the York Retreat in Britain. A large component of moral treatment was dedicating to addressing the environmental causes of distress by providing optimal moral and environmental conditions, and a regimentation of daily life. Scull notes that as an alternative response to insanity, moral treatment represented 'an epistemological break in the history of Western responses to madness' (Scull, 1981, p. 9).

Moral treatment was not offered to those with idiocy as they were constructed as lacking in emotions and thus not able to benefit from it. However, as discussed in section 3.2.3.3.4, in the 1840s Séguin, a French physician who had worked with both Itard and Esquirol, developed an educational training programme that challenged the perceived futility of treatments for idiots (Bewley, 2008). This built on approaches that had been used successfully with the deaf:

In this application the master has to educate the muscular system and the sensorial apparatus, as well as the intellectual faculties . . . through them . . . doing, in fact, for them by art, by Instruction, by rousing imitation, what Nature does for healthier infant organizations.

Séguin's ideas were employed in British asylums, for example by Shuttleworth at the Royal Albert, who went on to publish his own book about the treatment and training of mentally-deficient children (Shuttleworth, 1895).

Despite some success, the therapeutic optimism elicited by moral treatment and educational approaches was relatively short-lived. By the end of the nineteenth century it had become unworkable due to a variety of factors including cost, overpopulation of asylums and, importantly, changes in discourses about

insanity and its management (Benjamin & Baker, 2004; Pilgrim & Rogers, 2014).

3.2.4.3 The birth of Psychiatry

Derived from the Greek *psyche* ('soul' or 'mind') and *iatros* ('physician'), Psychiatry as a profession dates back to 1841, when the *Association of Medical Officers of Asylums and Hospitals for the Insane* (now *Royal College of Psychiatrists*) was formed (Shorter, 1997). As a medical 'specialty', however, its origins can be traced back to the eighteenth century. The medical profession had been involved in the administration of lunacy for some time, with medical practitioners (physicians, surgeons and apothecaries) increasingly being called upon by royal and parish officials to help with the assessment of thought to be insane (Stebbing, 2012). A number of doctor-led hospitals for the insane had also opened in the second half of the eighteenth century (Bartlett & Sandland, 2004) that had helped establish their involvement and develop their expertise. Their powers to certify, detain and inspect were legally vested in the Madhouses Act 1774, and strengthened further by future legislation. The Madhouses Act 1828 required institutions with over 100 inmates to have a resident medical officer, a mandate that was extended to all asylums in the Lunacy Act 1845. The latter also authorised non-consensual treatment of those who had been certified (Gooding, 2014). In the words of Scull (2015), 'madness was increasingly seen as something that could be authoritatively diagnosed, certified and treated only by a group of legally recognized experts. . . . "medical men" – increasingly an organized and self-conscious specialism within the profession of medicine' (p. 6).

In conclusion, the authority that physicians gained within the field of 'idiocy' and 'lunacy' was made possible by a combination of inter-related factors, including: the growing influence and importance of medicine in maintaining the physical health of the nation; the presence of physicians within asylums; their adoption of the scientific discourse and the 'expert' scientific knowledge they were able to produce from the individualised disciplinary procedures adopted within these sites; the perceived success of moral treatment and other approaches in rehabilitating and reintegrating the 'insane' as productive members of society; and an increased legitimisation of their powers through legislation. It was this complex network of power-knowledge that enabled the emergence and

establishment of the medical speciality of 'Psychiatry'; a profession that would become the main authority and producer of knowledge in 'dual diagnosis'.

In the final section of the analysis of descent, I examine the moral, political and socioeconomic concerns and explanations that led to the demise of 'therapeutic optimism' and a return to a model of care for the 'insane' that focused on confinement and protection rather than rehabilitation or cure. I highlight how such governmental concerns were concomitantly informed by and incorporated into changing discourses that emphasised a biomedical aetiology of 'insanity'; a construction that continues to dominate our understanding of 'dual diagnosis' today. I note how discourses of heredity and degeneracy enabled the attribution of social problems such as poverty, illness and crime to individuals' biology, and how this supported the development of new 'preventative' biological technologies of power designed to act at the level of the 'population'. I also look at how the associated creation of the 'mental defective' as a new class of social deviance in the Mental Deficiency Act 1913 legitimised the detention and supervision of a much greater number of individuals whose behaviours were perceived to pose an irremediable threat to the social order.

I then analyse the confluence of knowledge and power in the creation and administration of the intelligence test, highlighting the ways in which the inscription of psychological concepts such as 'mental age' and 'developmental delay' onto the bodies and minds of 'idiots' and 'imbeciles' would pave the way for the emergence of 'dual diagnosis', and create a role for the emerging discipline of Psychology that would later support its ongoing involvement with the dually diagnosed.

3.2.5 The emergence of a biopolitical apparatus of the state

As the rates of admissions accelerated, hospitals become overcrowded, with a growing number of 'chronic' and 'dangerous' cases (Digby, 1996). In the context of these larger asylum populations and the associated growth in the administrative responsibilities of medical superintendents, it became increasingly difficult to appropriately promote and implement the cost- and resource-intensive approaches that moral treatment and systematic training programmes represented (Bradoch & Parish, 2001). Cure rates for lunacy, which had never been as high as predicted, dwindled, and although 'idiots'

could learn skills and many had become 'productive workers', they did not achieve 'normality' (Myers, 1998; Harbour & Maulik, 2010). Coulter (2009) highlights also a deterioration in global economic conditions in the last quarter of the nineteenth century (the 'Long Depression'), when such individuals were unable to compete with more 'able' others for the scarce employment available, and were thus maintained in the devalued subjectivities of non-productive, social and moral deviants (Manion & Bersani, 1987). The result was that institutions once again became custodial warehouses, whose success was redefined as meeting basic needs rather than 'cure' (Scull, 1981).

Notions of curability and associated practices were also challenged by the emerging discourses about heredity and degeneration as the main causes of not only insanity, but of a myriad of other physical, moral and social 'evils' that were particularly rife amongst the poor (Pilgrim & Rogers, 2014). As an inherited genetic disorder of the brain, located firmly within the body of the patient, insanity was not likely to be amenable to environmental or educational reform. More alarmingly, there was a danger that this condition would be passed on to the children of affected individuals, and, because they were breeding faster than the 'elite' bourgeoisie, it would ultimately result in the degeneration of the entire population. On the basis of these assumptions, such individuals posed a risk to both current and future social order, and a solution that addressed both these axes was needed. This was enabled through the science and practice of 'eugenics'.

3.2.5.1 Eugenics, biopower and the emergence of the 'mental defective':

Mental Deficiency Act 1913

'Eugenics' was the name given by Francis Galton (1883) to describe the science of improving the population's genetic stock. In combination with other racist theories, such as Bénédict Morel's (1857) degeneration theory and Cesare Lombroso's (1876/2006) theory of anthropological criminology, Galton's research gave strength to the eugenics socio-political movement of the late nineteenth century that 'sought to improve the body politic and to relieve it of the economic and social burdens of disease and degeneracy in the future by acting upon the reproductive decisions and capacities of individuals in the present' (Rose, 2001a, p. 3).

Eugenics embodied a regime of power that Foucault (1976/1998) named 'biopower': a type of power over life that aimed to achieve the 'subjugation of bodies and the control of populations' (p. 140) via the interrelated 'anatomopolitics' of the individual body (through techniques of discipline), and the 'biopolitics' of the population (through a range of regulatory controls over biological processes that included 'propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary'; p. 139).

In the twentieth century, these aims were made possible through the formulation and enactment of a number of state policies and programmes that included both 'positive' eugenic measures (such as encouraging the reproduction of 'fit' individuals who had 'desirable' traits), and 'negative' measures (such as segregation or institutionalisation, sterilisation, prevention of marriage, forced abortion or genocide of those individuals and families identified and classified as 'degenerate' or 'unfit'; Rose, 2001b). Such reprobates included people who were poor, disabled, or of 'unsound mind', as well as criminals, 'moral deviants' (such as unmarried mothers and homosexuals), and particular racial and cultural groups (such as Roma gypsies and Jews in Nazi Germany).

In Britain, concerns about the problems that these kinds of individuals posed to the moral, physical and economic welfare of society were long-standing. They were reinforced further by the lack of moral and intellectual improvement of pauper children in statutory education facilities, where, following the implementation of the Education Act 1870, they had become visible for the first time (McDonagh, 2008). In the context of the 'crisis' of the asylums, a downturn in the economy, and the availability of new discourses about 'insanity' and its management, a Royal Commission on the Care and Control of the Feeble-Minded in 1904 was established to review 'the existing methods of dealing with idiots and epileptics, and with imbecile, feeble-minded, or defective persons not certified under the Lunacy Law' and advise on 'the amendments in the law or other measures which should be adopted in the matter, due regard being had to the expense involved in any such proposals' (Commission for the Care and Control of the Feeble-Minded [CCCFM], 1908, p. xvi). Their findings, published as the Radnor Report four years later, concluded that:

there are numbers of mentally defective persons whose training is neglected, over whom no sufficient control is exercised, and whose wayward and irresponsible lives are productive of crime and misery, of much injury and mischief to themselves and to others, and of much continuous expenditure wasteful to the community and individual families.

We find a local and “permissive” system of public education which . . . even if it be useful during the years of training, is supplemented by no subsequent supervision and control. . . . We find large numbers of persons who are committed to prisons for repeated offences, which, being the manifestations of a permanent defect of mind, there is no hope of repressing, much less of stopping, by short punitive sentences. We find lunatic asylums crowded with patients who do not require the careful hospital treatment that well-equipped asylums now afford, and who might be treated in many other ways more economically, and as efficiently. We find, also, at large in the population many mentally defective persons, adults, young persons, and children, who are . . . incapable of self-control, and who are therefore exposed to constant moral danger themselves, and become the source of lasting injury to the community. (CCCFM, 1908, p. 3).

Constructed as a burden on the economy, the community, the family and the state, the logical solutions to be advocated by the Commission for these ‘irresponsible’, ‘wayward’ individuals who were ‘incapable of self-control’ or of defending themselves against ‘constant moral danger’ due to an irrepressible and ‘permanent defect of mind’, were more efficient and effective methods of identification, surveillance and control. Recommendations included sheltering and protecting them from society in segregated, self-sustained ‘colonies’, preventing their reproduction ‘to diminish the number of such persons in the population’ (CCCFM, 1908, p. 185) and improving surveillance across a number of statutory and community sites to identify and govern those who were ‘at large’.

The ensuing Mental Deficiency Act (MDA) 1913 created a new kind of person – the ‘mental defective’, who came in four different forms of ‘social inefficiency’ (Burt, 1920, p. 52): the ‘idiot’, the ‘imbecile’, the ‘feeble-minded’ and the ‘moral

defective'. Each of these was operationalised to 'facilitate the introduction of better and more discriminating methods of help and control in regards to those whom the terms represent[ed]' (CCCFM, 1908, p. 7), with an emphasis on social competency and adaptation that illustrates the social rather than medical concern for their creation, and that remains an integral part of the definition of 'learning disability' today (Race, 2002). The latter two 'higher grade' categories were new and legitimised the institutionalisation of 'moral deviants', such as unmarried mothers and young men with minor offending behaviours who were arguably the main focus and drive for this new Act. In fact, many of the changes that were implemented involved an extension of existing lunacy legislation to these new 'classes' and, by utilising existing administrative and institutional frameworks and designs, the implementation of the Act was a fairly economic and straightforward one.

In line with recommendations, the Mental Deficiency Act 1913 mandated the compulsory segregation of the 'mentally deficient' in the 'large farm colonies'. Using existing asylum buildings, or constructing new ones that followed the same architectural layout enabling the disciplinary regulation of space, such 'colonies' were designed to be self-sufficient, with onsite amenities and schools where children who were able to could learn useful practical skills for their adult life – not in society, but for use in the colony itself (Jarrett, 2012; Bradoch & Parish, 2001). There was to be a clear division of labour dependent on the 'grade' of defectiveness:

the high-grade patients are the skilled workmen of the colony, those who do all the higher processes of manufacture, those on whom there is a considerable measure of responsibility; the medium grade patients are the labourers, who do the more simple routine work in the training shops and about the institution; the best of the lower-grade patients fetch and carry or do the very simple work. (Mental Deficiency Committee [MDC], 1929, p. 33)

It was felt that 'an institution that takes all types and ages is economical because the high-grade patients do the work and make everything necessary, not only for themselves, but also for the lower grade' (MDC, 1929, p. 33). Rehabilitation and reintegration into society were thus no longer central aims. Instead, individuals were 'employed and detained; and . . . kept under effectual

supervision so long as may be necessary' (CCCFM, 1908, p. 185) – a decision that invariably fell to the medical superintendents that would continue to administer such facilities. In fact, as in previous legislation, medical power was widely supported by the MDA 1913; by mandating the submission of two medical certificates for the purposes of admission, the power to diagnose and dictate the site and mode of governance was firmly placed in doctors' hands (Race, 2002), where it has remained for those deemed 'mentally ill' today.

As recommended by the report, the Act also introduced careful surveillance and control of all potential deviants in the community to enable their identification and governance. This detection was aided by the systematic examination of children in statutory education using 'scientific' tools such as the intelligence test, and with assistance from voluntary organisations such as the 'Central Association for the Care of the Mentally Defective' that visited people on behalf of the government's Board of Control³⁴ (Hall, 2008). These measures enabled the operation of biopower through dispersed networks and across a number of different sites, especially in schools, where local education authorities were legally required to notify the local authority of any 'defective' children within their area (Mental Deficiency Act 1913); a mandate that continues today under the 'Special Educational Needs' framework.

The measures introduced by the Mental Deficiency Act 1913 were perceived as progressive and humane alternatives to workhouses, prisons and lunatic asylums and, because 'mental defectives' were deemed incapable of responsible citizenship, both conservative and liberal politicians agreed that their welfare and control had to be taken over by the state (Thomson, 1999). However, they clearly embodied ideas that 'mental deficiency' was responsible for the poverty, illness and crime that accompanied urbanisation (Harbour & Maulik, 2010), and eugenic fears that these permanent hereditary and pathological conditions would result in the degeneracy of the general population. Like earlier legislation (such as the Poor Law 1834), the Mental Deficiency Act ignored the fact that thousands of people had physical and sensory impairments caused by the poor housing, sanitary conditions, healthcare, lack of immunisations and diet associated with poverty and disease,

³⁴ The 'Board of Control' replaced the 'Lunacy Commission', maintaining the strong medical and legal presence and authority that had been characteristic of the latter.

and no provisions were made to improve these. It had support from the majority of professionals involved in the administration of the mentally deficient, the 'experts' who carried out the policy which, under the Act, continued to be Psychiatrists. Under this new regime, however, Psychiatrists were reconstructed as experts in heredity and social behaviour whose role was to differentiate the 'normal' from the 'deficient', and to govern rather than cure.

3.2.5.2 The 'Intelligence Quotient' (IQ) apparatus of knowledge-power

Initially intended as an aid for the appropriate educational placement of children in France, the intelligence test that was developed at the beginning of the twentieth century by Binet and Simon (1904) was quickly adopted and adapted by supporters of the eugenics movement across the Western world to support the identification and categorisation of the 'mentally deficient'. Facilitating the ready comparison and quantification of individuals against a set of 'norms' (Rose, 1999), the intelligence test represented a far more efficient and effective 'scientific' technology of power for the differentiation of 'normality' and 'pathology' than the more qualitative psychiatric examination had done (Menolascino & McCann, 1983). Its deployment led to the 'discovery' of many more 'mentally deficient' people in the community than previously thought existed, although a more Foucauldian perspective would argue that it *created* more 'mentally deficient' subjects. In combination with the association of feeble-mindedness with heredity (Goddard, 1913), these 'findings' further endorsed eugenic fears and demands for the identification and permanent segregation of all such individuals (Hall, 2008).

The intelligence test placed 'idiots' and 'imbeciles' on a continuum with 'normal' people, which represented a shift from a categorical conceptualisation of 'insanity' to a more quantitative one (Berrios, 1994). This challenged the conceptualisation of 'idiocy' as an 'illness' or form of 'insanity', favouring the 'developmental' framework that continues to dominate constructions of learning disability today (Berrios, 1994). This discursive shift was aided by the concept of 'mental age', which matched the performance of children who were struggling with school with that of younger children on intelligence tests. German psychologist William Stern (1912/1914) would later divide mental age by chronological age to yield an intelligence quotient (IQ); a measure of the rate of intellectual growth that would produce the concept of 'developmental delay'

(Berkson, 1993). Notwithstanding this new discourse, intelligence as a learning 'potential', was viewed as a relatively stable, heritable, biological trait. This view has endured despite opposing evidence that it is predominantly environmentally determined, and that IQ tests are educationally and culturally biased (Manion & Bersani, 1987; Ryan & Thomas, 1987).

Whilst it was not novel to conflate the competences of 'idiots' with those of children, the notion that their intellectual ability could be equated to typically-developing children influenced later ideas that the emotional development in these two groups is also comparable; a key premise for the emergence and maintenance of 'dual diagnosis' and its attending social practices. The association of 'idiocy' with children also served to reinforce and justify the infantilising and paternalistic approaches that had been and, in many ways, continue to be afforded to these individuals.

In combination with psychologists' responsibility for the assessment of the evolving concepts of 'personality' and 'temperament', 'intelligence' and its measurement helped to create a role for the emerging discipline of Psychology, enabling psychologists to become 'experts' in establishing the 'degree of mental inadequacy' (Burt, 1920, p. 53). Largely due to this historical involvement, psychologists would later become one of the main authorities in learning disability and dual diagnosis alongside Psychiatry. Intelligence tests continue to be used as a dividing practice between the 'normal' and the 'learning disabled' in the present day (Barnes, 1991), and are one of the main determinants in peoples' ability to access learning disability (and consequently dual diagnosis) services (Berkson, 1993).

Together, the deployment of the IQ test and the prerogatives and philosophies of the Mental Deficiency Act 1913 resulted in an exponential increase in the number of admissions to the existing and newly-built colony asylums. Whereas in 1914 there had been just over 2,000 'mental defectives' in institutions in England and Wales, by the mid-1950s this number had risen to nearly 61,000 (Jones, 1972), with a further 43,000 under statutory supervision in the community (Race, 2002).

3.3 Analysis of the surface of emergence

In this part of my analysis, I focus more explicitly on dual diagnosis. I map out and examine the more proximal conditions of possibility for its emergence, the implications of associated discourses on subjectivities and practice, and the subjugated understandings that might help identify alternative ways of acting (research questions 1, 3 and 4). As I lead up to the present, I will also examine some of the power-knowledge networks that sustain dual diagnosis (research question 2).

I start by examining how classifications associated with learning disability and mental illness first began to be considered as a co-occurrence, and identify some of the historical explanations and practices that have been carried into contemporary understandings of dual diagnosis. I then consider the conditions of possibility for the re-emergence of this co-occurrence in the last quarter of the twentieth century, and examine some of the ways in which understandings and practices are changing.

3.3.1 Emerging medical research in the co-occurrence of ‘idiocy’ and ‘insanity’: Late 1800s-1950

The early to mid-nineteenth century conceptualisation of ‘idiocy’ and ‘lunacy’ as illnesses on a continuum of ‘insanity’ meant that they were largely perceived to be mutually exclusive. Within this dominant theoretical framework and, given the imperatives of efficient and effective administration and governance of the insane, most studies had focused on their distinction. Notable exceptions included Esquirol (1845), who stated that ‘imbeciles are not always deprived of moral sensibility, and are capable of becoming melancholics’ (p. 453), and Ireland (1877), who in his book chapter ‘insanity in children and insane idiots and imbeciles’ noted he had ‘seen imbeciles affected with mania, melancholia and delusions’ (p. 249). The title of Ireland’s (1877) chapter illustrates the concomitant efforts to investigate and understand instances of ‘childhood psychosis’, the often conflated ‘infantile autism’, and their relation to ‘mental deficiency’ (Donaldson & Menolascino, 1977). These interests were partly driven by observations that some forms of ‘insanity’ led to a (sometimes permanent) loss of intellectual and social functioning, sometimes at a very early age, and associated degenerative discourses and concerns that these were caused by a pre-existing ‘mental deficiency’ that eluded detection. Another

motivation was the growing preoccupation with the 'dangerous age of childhood' and the threats posed by the 'maladjusted child' to themselves, their family and wider society (Stewart, 2011).

With the reconceptualization of 'idiocy' as a developmental delay on a continuum of 'normality' rather than an 'illness' or form of 'insanity', studies in the late nineteenth and early twentieth centuries began to consider the possibility that the two could co-exist in a more focused and systematic fashion (Parsons, May & Menolascino, 1984). In their investigations, psychiatrists and psychologists were able to make use of the more 'sophisticated' technologies and techniques of classification and examination that emerging nosological systems, IQ tests and concepts such as 'mental age' had enabled, to define, refine and theorise about particular clinical 'subgroups'. Their professional involvement across a number of disciplinary sites, including asylums, schools, and the child guidance clinics that began to appear in Britain in the 1920s ensured a readily accessible population of individuals upon which such technologies could be deployed, and about whom knowledge could be created.

Initially, the possibility of 'insanity' co-occurring with 'mental deficiency' was considered for the 'higher grades', as they not only represented the group 'of greatest sociological importance' (Earl, 1934, p. 230), but also because the largely non-verbal behaviour of 'idiots' made it inherently difficult to reliably identify 'psychotic' symptoms such as 'delusions' and 'hallucinations'. Early researchers were particularly interested in whether presentation and aetiology of 'insanity' in those classified as 'mentally deficient' resembled that of 'ordinary' people. By and large, researchers concluded that in higher grades of 'imbecility', 'actual insanity in the form of 'impulsive acts, morbid propensities. . . . mania . . . melancholia, and . . . delusions . . . run about the same course as in persons who possess a normal brain' (Hurd, 1888, p. 269). Using detailed case studies, researchers provided numerous examples to support their conclusions. Many tested their theories by assessing peoples' responses to painful stimuli or persistent provocation and, rather than interpreting subsequent aggression as a natural response, it was taken as evidence of 'mania' or 'emotional dissociation' (Ireland, 1877; Barr, 1904; Earl, 1934).

Whereas initially it had been believed that 'the lowest grade of imbeciles . . . do not have delusions nor can they properly be considered insane' (Hurd, 1888, p.

269), as knowledge about 'childhood psychosis' was constructed alongside that of 'insanity' in 'mental deficiency', researchers increasingly concluded that 'a primitive catatonic schizophrenia occurs in idiots and in very young normal children' (Earl, 1934, pp. 250-251). To assist with the differentiation of insanity affecting 'normal' children, Kraepelin (1896/1919) introduced the classification of 'pfpopfhebephrenie'³⁵ to describe 'hebephrenia' engrafted or superimposed on 'idiocy' or 'imbecility'.

In terms of presentation, and in contrast with the relatively normalised construction of 'insanity' in 'imbecility', it was largely believed that 'insanity' in 'idiocy' presented 'atypically', in two main forms: 'dull/melancholic' or 'excitable/manic'. Barr (1904) claimed that behavioural and physiological signs of 'insanity' were detectable as early as the first year: 'The torpid thumb-sucking baby, thin, anaemic, constipated, whose attention can seldom be attracted and never held' (pp. 231-232) represented the 'melancholic' type; and 'the screaming, restless, sleepless infant with variable temperature, quick pulse, flushed face, wild eyes and furred tongue, kicking and beating continually with hands or head' (p. 232) typified the 'manic' variety. Earlier theorists had noted the difficulty in demonstrating that such behaviours in infants were not due to physical pain (Maudsley, 1876; Ireland, 1877), but this alternative explanation (which could be applied to those with limited verbal communication today) has been systematically silenced or subjugated by the power-knowledge 'truth' statements produced by the biomedical psychiatric discourse.

By the 1930s, the delineation and interpretation of 'behaviour' as indicative of 'mental illness' had become a central focus of research. As illustrated by Earl (1934), this shift was largely pragmatic: 'as the idiot is incapable of conversation, you have to rely on objective study of behaviour and psychomotor phenomena' (p. 230) 'not because the remaining features are unimportant, but merely because such active and positive phenomena as movements form better material for investigation' (p. 250). In other words, they were a more tangible, convenient and acceptable target for the deployment of the positivist empirical technologies associated with the dominant scientific regime. In so doing, it became possible to claim the creation of 'new' knowledge, one that supported the notion of an 'atypical' behavioural presentation of 'psychosis' that was

³⁵ Renamed 'propfschizophrenia' by Bleuler in 1911 (Kratzer, 1959).

unique to 'idiocy' and which in turn facilitated its diagnosis. This notion of 'atypical' presentation would be carried forward into Sovner and Hurley's (1986) concept of 'behavioural equivalents', and into the production of the DC-LD (RCP, 2001). It continues to provide the justification for the diagnosis of 'mental illness' in those assessed as having a lower level of intellectual functioning.

It was at this time that emotions also became a focus of research. In line with current conceptualisations of people with a learning disability as having delayed or compromised emotional development, Earl (1934) stated that 'the emotional life of idiots deviates from the normal almost as widely as their intelligence' (p. 230). Despite noting that 'it is incredibly difficult at the lowest level to determine which feature is 'normal' and which is not' (p.248), he went on to say that he believed that 'in the great majority of cases, the earliest signs [of psychosis] are those of emotional abnormality' (p. 242), highlighting 'causeless weeping. . . [or] laughter' (p. 242) as behavioural expressions of this anomaly. It is evident here that the judgement of causality, proportionality and appropriateness of emotional expression was (and continues to be) made by an 'examiner' always-already in a position of power. 'Idiots' were constructed as lacking an internal world that they could be responding to, such as memories of past or current traumas (including the experience of institutionalisation itself), or physical pain or illness. In his report of patients who would 'talk to themselves or even to a nurse, but remain obstinately mute in front of the psychiatrist' (p. 235), and the subsequent attribution of this response to 'negativity' and thus further evidence of 'insanity', Earl (1934) highlights how such power relations were (and continue to be) difficult to resist.

Environmental, social, economic and psychological aetiological discourses were not entirely absent at this time. However, they were typically silenced or subjugated in favour of moral and biomedical discourses. For example, whereas Hurd (1888) outlined multiple examples of 'untoward events', 'overwhelming calamities' and 'severe mental shock' in individuals' personal histories, he concluded that 'such causation seems rare' (p. 268) and highlighted instead that:

the determining causes of the development of insanity among imbeciles are generally physiological epochs or crises, or vicious practices or indulgences acting upon a neurotic organization

which has been directly inherited from an insane or dissolute parent. (p. 269)

Earl (1934) too concluded that 'the present evidence would appear to indicate the causal importance of physical rather than of experiential factors' (p. 251). To support aetiological theories of brain injury or pathology, researchers increasingly drew on experimental animal studies demonstrating that damage to particular areas of the brain could cause symptoms of hypo- or hyperkinaesia. These reinforced discourses of 'idiocy' representing an almost sub-human ontological state that lay somewhere between 'animal' and 'man': 'the idiot forms . . . a connecting link [between] the experimental animal . . . and the normal man of psychopathologists' (Earl, 1934, p. 231). Constructed as such, any thoughts, feelings or pain such individuals might experience were more easily dismissed. There were a few attempts to formulate the internal world of 'idiots' within emergent psychodynamic theories, however, researchers typically concluded that their 'emotional life . . . has never been sufficiently developed to allow one to talk of conflict or repression in the analytical sense' (Earl, 1934, p. 249). The view that their psyche was 'insufficiently organized to possess a super-ego' (Earl, 1934, p. 248) persisted for decades, thwarting the proffering of psychological therapies to people with a learning disability and contributing to the view that such individuals were not sentient beings.

Reflecting the ongoing influence of biological and degenerative discourses, by the 1940s it was generally agreed that 'mental illness' was more common in the 'mentally deficient', and it was even stated that 'the rate of mental disease declines as the degree of intelligence advances [and] if we were intelligent enough we might escape mental disease altogether' (Pollock, 1945, p. 362). Research cited to support these conclusions included a survey undertaken by Duncan, Penrose and Turnbull (1935) in a British lunatic asylum that concluded one fifth of its patients could have been certified as 'mentally deficient'. This inference assumed 'insanity' was a primary and accurate diagnosis, when in fact individuals' cognition sometimes declined following episodes of 'insanity', physical illness, or seizures, and those who were too difficult to manage in other settings were routinely sent to lunatic asylums even when they were not thought to be 'insane' (Barr, 1904). Rather than highlighting or reflecting on the administrative and diagnostic inconsistencies that might have contributed to this

higher rate of 'mental disease' among the 'mentally deficient', a number of pathologising explanations were offered to explain this apparent link. Pollock (1945) listed these as follows:

1. The mentally defective are poorly equipped to withstand stresses of unusual character.
2. They have great difficulty in resolving their mental conflicts.
3. Due to their lack of social competency and their susceptibility to suggestion they get into all sorts of difficulties.
4. Many . . . are emotionally unstable and easily become so excited or depressed that they lose control of themselves.

(Pollock, 1945, p. 362)

These explanations are almost identical to those used today to justify why people with a 'learning disability' have an increased risk of developing a 'mental illness'.

Consistent with the biomedical discourses they were founded upon, treatments during this time became increasingly medicalised – fever therapy, insulin-coma therapy, prefrontal lobotomy, electroconvulsive therapy; procedures that carried serious medical risks and that only doctors could administer (Grob, 1983).

Sedatives were also used as a form of chemical restraint: 'trional or tetronal are excellent hypnotics, especially in cases of destructive proclivity' (Barr, 1904, p. 232). Alongside these however, were regimes reminiscent of aspects of moral therapy, including the avoidance of 'undue excitement or fatigue; simple food, sleep, exercise and periods of rest, occupation and recreation alternating' (Barr, 1904, p. 232).

The studies examined above illustrate the emergence of a discourse around the co-occurrence of 'mental deficiency' and 'insanity' towards the end of the nineteenth century that introduced a number of explanations and practices that continue to underpin and have relevance for contemporary understandings of dual diagnosis. It was accompanied by a shift from the evaluation of intellectual aspects to the increasingly technical and detailed assessment of social, emotional and behavioural dimensions. These initial efforts to explore the co-occurrence of mental deficiency and insanity were relatively short-lived however, and would not be revisited in earnest again until the 1970s.

3.3.2 The 'tragic interlude'

There were a number of events that contributed to what modern dual diagnosis psychiatric historians refer to as the 'tragic interlude' (Donaldson & Menolascino, 1977). The introduction of the Mental Deficiency Act 1913 had provided a permanent institutional solution to the problem of idiocy and imbecility, making them less of a concern or focus (Turner, 1989), particularly in the context of war and economic disarray. Governmental concerns became increasingly about the 'borderlands' – the troublesome feebleminded boys and the promiscuous feebleminded girls on the borderline with imbecility (Jackson, 2000) – particularly as they approached adolescence, which was perceived as a particularly risky and unmanageable time. The study and governance of juvenile delinquency thus received more attention and, in an effort to prevent the degradation of the children 'at large', community education and parenting programmes were introduced, deployed through emergent 'Child Guidance clinics' led by child psychiatrists, psychologists and psychiatric social workers.

Psychoanalysis, which offered a new role for community psychiatrists, was ruled out for people with mental deficiency as it was believed that 'normal' intellectual and language abilities were necessary for its success (Szymanski, 1994). In combination with the increased reliance on 'mental tests' to diagnose mental deficiency, the assessment and therapeutic services of Psychiatrists were rendered expendable, and their role became much more about administration of those perceived to be chronically and incurably ill. The need for further study into the co-occurrence of insanity in idiocy and imbecility was also reduced substantially following Kanner's (1943) demarcation of 'autism', which offered the explanatory framework for childhood psychosis that researchers had been searching for some time (Eaton & Menolascino, 1982).

As a consequence of the above events and the privileging of the 'new' approaches and patient groups, psychiatrists in mental deficiency hospitals were increasingly seen as the poor relation, or 'Cinderella' of Psychiatry (Donaldson & Menolascino, 1977) and the specialty was considered by many as a narrow and fruitless area for professional involvement (Menolascino & McCann, 1983). It was not until the last quarter of the twentieth century that it would once again rise in prominence and power as an important solution to governmental problems.

3.3.3 The emergence of the welfare state: *National Health Service Act 1946*

The period following the Second World War saw a number of political and organisational reforms led by the newly-elected Labour Party. This included the creation of a new National Health Service, as part of the State's efforts to abolish the 'five giants' identified in the Beveridge Report (Inter-departmental Committee on Social Insurance and Allied Services, 1942): want, disease, squalor, ignorance and idleness³⁶.

The NHS offered free medical care to the whole population that was not based on the principle of insurance (where people would only be entitled if they had contributed). As such, and of interest to my research question number four, it represented a significant departure from most of the historical approaches to health and social care; the first system of its kind in any Western society (Hall et al., 2015). Under the NHS Act, responsibility for colonies and other certified institutions was transferred from Local Authorities to the Minister of Health. Colonies and asylums became 'mental handicap' and 'mental illness' hospitals, defined as institutions for 'the reception of treatment of persons suffering from illness or mental defectiveness' (NHS Act 1946, s79).

They were incorporated into the newly-formed Regional Hospital Boards under their own Hospital Management Committee; a structure that would remain unchanged until 1974. Race (2002) notes how this shift in provision would considerably strengthen the medical power and authority over learning disability (and it is a power that continues to govern dual diagnosis today):

Despite all the hospital closures, government reports, incentives and even legislation to try and get either joint working with others, or others as 'lead authorities', power over the learning disability agenda (even the 'official' adoption of that classification) has remained in the hands of the Department of Health' (p. 34).

Initially, however, they continued to be run as before. There was 'limited public and political awareness of the parlous state of these hospitals, which were massively underfunded and with overwhelming staffing problems' (Hall, 2008, pp. 1006-1007). The lack of action or interest is also likely to have reflected

³⁶ Other measures included the reform of social security, housing, education and unemployment (Hall et al., 2015).

ongoing economic, social, moral, degenerative and eugenic concerns, despite events and studies challenging the heritability of 'mental disorders', their higher prevalence amongst the lower classes, and the dominance of genetic aetiology as the sole explanation (for example, 'combat stress' in soldiers, and the impact of the environment on development; Berkson, 1993). This is demonstrated in the following entry by Alfred Tredgold (1952), whose *Textbook on Mental Deficiency* was considered the most authoritative in the field of mental deficiency for training doctors and nurses (Hall, 2008) wrote that:

The 80,000 or more idiots and imbeciles in the country . . . are not only incapable of being employed to any economic advantage, but their care and support, whether in their own homes or in institutions, absorbs a large amount of time, energy and money of the normal population which could be utilised to better purpose. Moreover, many of these defectives are utterly helpless, repulsive in appearance, and revolting in manners. Their existence is a perpetual source of sorrow and unhappiness to their parents, and those who live at home have a most disturbing influence upon other children and family life . . . In my opinion it would be an economical and humane procedure were their existence to be painlessly terminated. (p. 92)

Public policy continued to promote the confinement of mental defectives (Coulter, 2009; Harbour & Maulik, 2010). The conditions of institutions would not begin to be reviewed until the mid-1950s, with changes to practice taking a substantially longer period of time.

3.3.3.1 The rise of the psy-professions

As noted above, outside the institutions, mental hygiene and psychodynamic approaches had emerged and gained popularity in the inter-war period as more attention was placed on those more therapeutically promising than the mentally handicapped (Thomson, 1999). This new focus had enabled the formation of new disciplinary authorities – psy-professions such as psychoanalysts, child psychiatrists and educational psychologists who, when the new NHS was formed, competed with the institutional authorities for a claim to both resources and a role in the post-war welfare state (Thomson, 1999).

3.3.3.2 The emergence of Clinical Psychology

The emergence of Clinical Psychology is closely linked with the formation of the NHS; a 'symbiotic' power-relation that is ongoing (Hall et al., 2015). As the chief employer and funder of the profession and its training today, the NHS has shaped where and how clinical psychologists practice. The formation and subsequent involvement of the Clinical Psychology profession with dual diagnosis was made possible by Psychology's earlier (and ongoing) roles in psychometry and in the deployment of behavioural technologies of power. This authority was aided by an appeal to the ruling scientific discourse in what was a medically dominated environment (Pilgrim, 2010), and significantly extended when the BPS was granted a royal charter in 1965 (which conferred it the right to be consulted on a range of government issues; Hall et al., 2015). Smail (1995) adds that part of the reason for the success of the clinical profession is the fact that it has not significantly challenged the more powerful authority of Psychiatry by attempting to obtain the statutory powers that underlie their existence.

In the first two decades following the inception of the NHS, only a minority of mental illness or handicap hospitals employed psychologists. Earlswood Asylum, for example, appointed its first psychologist in 1959, with a remit of supporting patients with difficult behaviour. Behaviour increasingly became the focus of interventions, and in the 1960s, an outpatients department for children with emotional and behavioural difficulties was opened.

3.3.3.2.1 Technologies of behavioural control

Behaviourism is a psychological approach founded on the premise that all behaviour is learned from the environment through processes that became known as 'classical' or 'operant conditioning'. Watson (1913) explained it as follows:

Psychology as the behaviorist views it is a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behaviour. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness. The behaviorist, in his efforts to get a unitary scheme of

animal response recognizes no dividing line between man and brute. The behaviour of man, with all of its refinement and complexity, forms only a part of the behaviorist's total scheme of investigation. (p. 158)

Behaviourism has long been considered one of the most scientific psychological approaches and was key in helping the establishment of the Clinical Psychology profession. A disciplinary technology of power, it is typically deployed by more powerful persons to shape the conduct of those who are less powerful into more acceptable, desirable forms (Kipnis, 1990).

Within institutions, behaviourists employed a wide variety of aversive techniques in an attempt to change peoples' 'maladaptive' behaviours. This became increasingly unacceptable with the advent of normalisation principles, and more 'positive' behaviour support strategies were developed that interpreted behaviour as functional (LaVigna & Donnellan, 1986) and communicative (Carr & Duran, 1985) rather than maladaptive. By the 1970s, behaviour therapy had become the main psychological treatment for mental disorders (Stenfert Kroese, Dagnan & Loumidis, 1997) and, it continues to be extremely popular in the construction and governance of dual diagnosis today.

Of interest to my final research question, Smail (1990) has argued that behavioural approaches offered an alternative to medical focus on internal biology, but that the *environmentalism*³⁷ they advocated was 'lost in the power politics of scientific legitimation' (p. 2). However, they still represent an individual solution to the problem, and their construction of internal states and emotions as irrelevant because they are not observable or measurable has contributed to their neglect.

3.3.4 Challenges to institutional practices

3.3.4.1 Human and civil rights discourses of abuse

In 1951, the National Council for Civil Liberties (NCCL) published a called *50,000 Outside the Law* highlighting the breach to civil liberties represented by the detention of people in institutions and drawing attention to the inadequacies and abusive conditions of the existing system (NCCL, 1951). The need for

³⁷ Smail (1990) uses this term to describe 'the view that people's 'inner worlds', their psychology and indeed their emotional distress, are the products of and directly traceable to the influences of material structures of the 'outer world''

reform was supported by a wide variety of pressure groups, including parents, politicians, doctors, psychologists and patients themselves (Unsworth, 1987), a collective power that forced a governmental review of the existing system.

This took the form of the 1954 *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency*. The ensuing report (commonly known as the *Percy Report*) was published in 1957. It proposed the abolition of compulsory detention for people who were mentally distressed to hospital (unless they were a danger to themselves or others) and a review of legal classifications to remove associations with criminality (Wooldridge, 1994). It recommended the integration of health and social welfare services, with mental health services integrated into existing local authority health and welfare departments to enable a continuum of care similar to that already provided to older people and those with physical disabilities (Concannon, 2005). It also recommended that mental hospitals be run in a similar way to general hospitals, with the development of supplementary outpatient and domiciliary care services in the community (Concannon, 2005).

Most of these recommendations were welcomed by The Ministry of Health (Colcannon, 2005) and incorporated into the 1959 Mental Health Act (MHA; Wooldridge, 1994). The 1959 MHA reviewed the existing nomenclature, replacing 'mental deficiency' with 'mental disorder' that comprised four categories: 'mental disorder', 'severe subnormality', 'subnormality' and 'psychopathic disorder'. It ended compulsory certification, enabling the discharge of people with learning disabilities into the community but still retaining the power to 'section' people into hospital. The authority of Psychiatry was extended, for example compulsory detention became primarily a medical decision with the removal of routine court involvement.

In the late 1960s the abusive conditions in the Ely and South Ockendon mental handicap hospitals were exposed in the national newspapers, with allegations of verbal and physical cruelty, neglect, lack of medical care and the wide-spread use of sedation. Both hospitals had been poor law institutions in the nineteenth century. These incidents and the subsequent inquiries prompted further policy review, resulting in the 1971 White Paper *Better Services for the Mentally Handicapped* (Department of Health and Social Security [DHSS], 1971), which recommended the closure of long-stay hospitals and set national targets for the

discharge of half the British hospital population into the community by 1990. It also recommended that people with a mental handicap should have equal access to mainstream health and social care services, including mental health services (DoH, 1993).

Between 1968 and 1980 there were 18 published inquiries investigating allegations of mistreatment of patients at mental illness and mental handicap hospitals, which were found to be characteristic rather than exceptional (Mansell, 1997). Service users' voices were either absent from reports or their testimony was given little weight (Butler & Drakeford, 2003), an indication of the way in which power networks operated to silence them, not just at the local level but also at a wider governmental one. Notwithstanding, the power that the public gaze can have is evidenced by the fact that most scandals were exposed by pressures groups, the media, strike action or police investigation of malpractice, rather than official complaints procedures (Butler & Drakeford, 2003). This continues to be the case today, as evidenced by the serious case review of the Winterbourne Hospital scandal (see section 3.3.7).

Institutionalised practices and abuse persist both within hospitals and in community services, and are especially evident in 'specialist' residential services that were designed to support people with severe and complex needs such dual diagnosis (Mansell & Ericsson, 1996).

The challenges to institutional conditions and practices were driven by philosophies of human and civil rights, normalisation and citizenship that began to take shape in the late 1960s and 1970s. These also helped to promote the social acceptability of people with a 'mental handicap' in the community and, crucially for the emergence of dual diagnosis, the notion that they should have access to the same services, including mental health services, as everybody else. Normalisation principles also helped to think about people with mental handicap as having the same needs as everyone else, including emotional needs.

Whilst exposure of abusive practice and principles of human and civil rights drove policy debates and led to some policy changes, there was again a gap between policy and practice. Institutional costs were lower than the proposed alternatives (Mansell & Ericsson, 1996), additional funding was not forthcoming and, with their restricted budgets, local authorities prioritised other areas

(Concannon, 2005). For changes to take place they needed to be consistent with government aspirations and agendas, which would not happen until the 1980s and 1990s (Mansell & Ericsson, 1996), as discussed below.

3.3.5 Deinstitutionalisation and community care

The growth in the implementation of deinstitutionalisation in the 1980s became possible through a number of different but inter-related events, including: the neoliberal Thatcherite reforms, the growing evidence for the feasibility of community-based services, and philosophies of normalisation and civil rights (Mansell & Ericsson, 1996).

Reforms by the Thatcher's conservative government in the beginning of the 1980s represented a shift from social democracy to neoliberal approaches to policy focused on reducing public expenditure. This included reorganising the NHS along more commercial lines and privatizing public goods and services (which included a greater emphasis on the family's caring responsibilities). The high costs that care in the community would have represented were neutralised through transferring responsibility to local authorities and the potential income that the closure of large institutional estates represented (Mansell & Ericsson, 1996). It was supported by 'dowries' available to those leaving institutions (Mansell & Ericsson, 1996).

The Audit Commission's (1986) *Making a Reality of Community Care* report criticised the lack of progress with the community care programme and made recommendations on how changes could be carried out that. A number of reports following, including the Griffiths Report (DHSS, 1988) and subsequent White Paper (1989), culminating in the NHS & Community Care Act of 1990. This Act signified a radical reorganisation of both health and social care services. It introduced a 'purchaser-provider' split; an internal market whereby Health Authorities commissioned services provided by NHS Trusts, GPs, private and voluntary services.

Fletcher (1988) argued that deinstitutionalisation highlighted the mental health needs of people with learning disabilities, which Szymansky (1994) stated was because 'disturbed behaviours are one of the main (if not the main) reasons of the failure of their integration into the community' (p. 20). The distress experienced by people with learning disabilities was constructed as a pathology

rather than as a response to chronically under-developed and under-resourced community care system. Concerns about their behaviours enabled the justification for the creation of specialist health and social services to ‘manage’ them.

3.3.5.1 Crises in the legitimacy of Psychiatry

With the move to community care, psychiatrists who had worked in the institutions had to carve out a new role for themselves as the continuing need for their specialist services was questioned from both within and outside the profession (Day, 1994; Bewley, 2008; Godber, 1973). Within the profession and medicine more generally, mental handicap had a very low status, with poor resources, therapeutic nihilism and no prospects for more lucrative private practice endeavours making the recruitment to the specialty very poor (Ryan & Thomas, 1987; Bewley, 2008).

The reputation of Psychiatry as a whole had been scrutinised by both the anti-psychiatry movement’s publications such as Goffman’s (1961) *Asylums*, and the hospital inquiries that often implicated medical superintendents (Bewley, 2008), calling into question not just the field of knowledge it was based on but also its power-knowledge functions (Foucault, 2006). Other professions such as mental handicap nursing were also under threat, with recommendations for it to be replaced by a new social work profession in community-based services adopting a philosophy based on the principles of normalisation (Jay Committee, 1979).

The Mental Deficiency Section of the RCP responded to concerns by publishing a series of memorandums and reports that emphasised the mental health needs of people with a mental handicap and promoted the formation of specialist services in the community that should be led by Psychiatrists with specialist skills (RCP, 1974, 1978, 1983, 1986).

The Jay Committee (1979) recommendations were not implemented, not necessarily because of these responses but due to the much wider changes that were taking place with the introduction of Thatcher’s ‘New Public Management’.

The role of psychiatry in the governance of ‘dual diagnosis’ was secured following a DoH (1989) review of mental handicap services that led the Minister

of State for Health to reaffirm the long-term need for specialist psychiatric provision for people with learning disabilities (DoH, 1991; Day, 1994).

The Mansell Report (DoH, 1993) threatened to shift the focus to 'challenging behaviour' rather than general mental health needs, prompting the RCP to publish an update to their earlier report to re-emphasise them (RCP, 1997).

3.3.6 The 'dual diagnosis' term

In the context of learning disabilities, the 'dual diagnosis' term has been consistently attributed to Frank Menolascino, an American Psychiatrist who published extensively about the mental health needs of children and adults with 'mental retardation'. It appears to emerge for the first time in *Mental Health and Mental Retardation: Bridging the Gap* (Menolascino & McCann, 1983), and subsequently 'imported' to Britain via *Mental health in mental retardation: Recent advances and practices* (Bouras, 1994).

3.3.6.1 Increase in the 'dual diagnosis' documentary apparatus

The growth in professional interest in dual diagnosis is reflected in the increase in academic publications employing this term from the 1980s onwards (Fletcher, 1988). A search of the term 'dual diagnosis' in academic publications³⁸ suggests that up until the 1980s it was used infrequently, referring predominantly to the co-existence of two physical health diagnoses. The earliest use of the term was traced to 1929, in the text of a paper titled 'Conditions simulating pulmonary tuberculosis' by Chandler, a doctor working at Charing Cross Hospital. Honig's (1955) paper 'Psychosis and peptic ulcer' was the first time 'dual diagnosis' included a mental health diagnosis. The remaining papers identified as containing the term 'dual diagnosis' between 1950 and the 1970s almost all relate to physical health diagnoses. Its first use in relation to learning disability appears in 1978, in a paper titled 'The elderly retarded: A little-known group' by DiGiovanni, and refers to a dual diagnosis of 'mental retardation' and 'emotional or behaviour problems' (p. 265).

From 1980 onwards, two significant things happen. Firstly, there is an exponential rise in the number of documents adopting the term 'dual diagnosis' (see Figure 3). Secondly, it begins to be used strategically.

³⁸ See Appendix A for databases and search terms used.

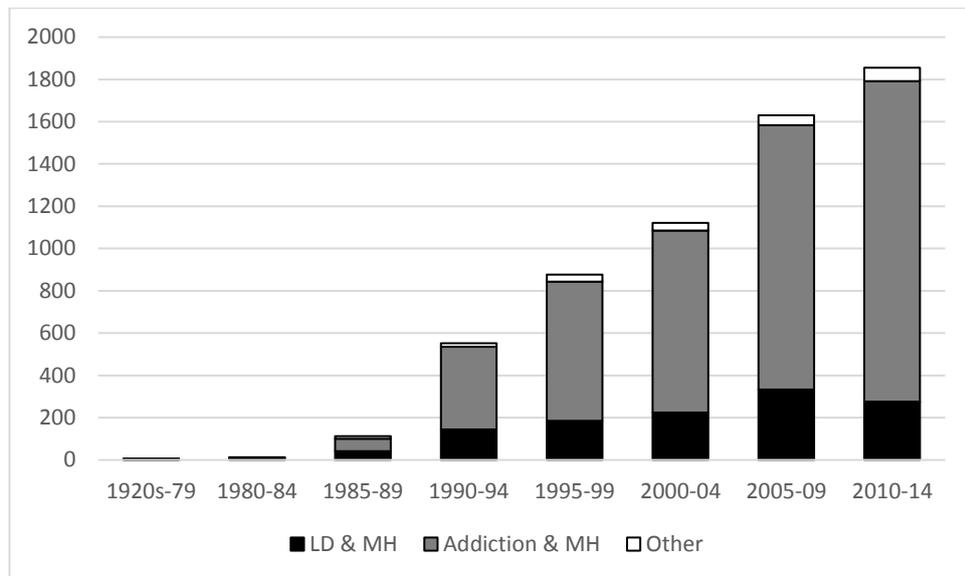


Figure 3: Number of publications employing the 'dual diagnosis' term³⁹.

From the 1980s, there is a significant rise in the number of publications using the term, and, from 1980-1984, it is predominantly adopted in reference to the dual diagnosis of i) mental retardation, and ii) mental illness, emotional disorders or behavioural disorders. In 1983, the *National Association for the Dually Diagnosed* was formed in the US to promote the concept and assisted in the further production of knowledge in the form of national and international conferences with associated proceedings (e.g. Menolascino, 1984). In Britain, the Mental Handicap Section of the World Psychiatric Association held an International Conference at the University of Kent in 1994, leading to the publication of a book called *Mental Health in Mental Retardation: Recent Advances and Practices* (Bouras, 1994).

Despite the initial success of the 'dual diagnosis' term, its dominance in the field of mental retardation was relatively short-lived. Within five years, its use was overtaken by literature focusing on addiction, possibly reflecting the greater threat to social order that this problem was perceived to present. Although the number of publications relating to learning disability continued to rise in the subsequent decades, the term began to fall out of fashion in the beginning of the twenty-first century. In Britain, this decline is likely to have been influenced by the DoH's (2002) *Dual Diagnosis Good Practice Guide*, which clearly placed 'dual diagnosis' within the remit of the substance misuse arena.

³⁹ Derived from literature search as outlined in section 1.3.2, with the subsequent exclusion of the following search string: NOT ("cannabis" OR "tobacco" OR "chemical dependency" OR "substance abuse" OR "substance misuse" OR "substance use" OR "alcohol*" OR "addict*" OR "drug abuse" OR "drug rehabilitation" OR "cocaine")

Regardless of its adoption by a different speciality, the 'dual diagnosis' term continued to be used in both American and British publications. It also appeared in the Royal College of Psychiatry's guidelines for *Meeting the Mental Health Needs of People with Learning Disability* in 1997, and its 2003 update (but not in the 2012 update nor in the NICE (2016a) guidelines).

Although the use of the term itself has declined, the concept and practice that it embodies – that of the diagnosis of both learning disability and mental health – has become common-place (see Chapter 1).

3.3.6.2 The strategic use of 'dual diagnosis'

The second aspect to note is that the term began to be used strategically – instead of referring to a dual diagnosis, it became *the* dual diagnosis.

Szymanski and Grossman (1984) note that it had 'been expected by some that the implication of this term would be an increase in the professionals' attention to the problem of mental disorders among persons with mental retardation through designating them as having a special condition, or rather a combination of two conditions'.

Reiss (1994) highlights the links between the use of the term and service provision: 'The concept of dual diagnosis provides an alternative to the concepts of primary and secondary handicaps. Instead of trying to guess whether the primary problem is emotional or intellectual, both disorders are diagnosed and (...) the person is given services for both mental retardation and mental illness.' (p. 68).

The production of knowledge through psychiatric and psychological literature relating to the mental health of people with learning disabilities helped to give credence to the notion of dual diagnosis whilst simultaneously constructing it as something that only a minority (of professionals) were sufficiently skilled to identify. Researchers and clinicians (re)developed or (re)colonised theories that supported a construction of people with learning disabilities as 'atypical' and 'complex', for example regarding the effect of developmental level on emotional expression, the notion of 'behavioural equivalents' and the concept of 'diagnostic overshadowing' (Reiss et al, 1982); explanations that continue to be widely cited in British research and policy relating to dual diagnosis today.

3.3.6.3 Refining technologies of diagnosis: *The DC-LD*

There were a number of modifications to the DSM in the second half of the twentieth century that supported the production of dual diagnosis. In particular, the DSM-II (APA, 1968) encouraged the use of multiple mental health diagnoses for a single patient, and in the DSM-III-R (APA, 1987) the diagnosis of mental retardation was transferred to Axis II (personality and developmental disorders), which compelled clinicians to make a separate statement about Axis I diagnosis (mental illness; Szymanski, 1994). Notwithstanding these shifts, Psychiatrists and researchers frequently argued that ‘mainstream’ classification systems such as the DSM and the ICD were not valid for people with learning disabilities. The rationale was twofold. Firstly, it was reasoned that diagnostic criteria required a degree of self-report to enable access to individuals’ internal world, which was difficult for people with significant cognitive and communication impairments. Secondly, it was argued that manuals did not take into account the effects that developmental level can have on psychopathology (see section 1.3.3.2). In an attempt to address these challenges, the RCP produced the DC-LD (RCP, 2001) a psychiatric diagnostic manual for use with adults with moderate to profound learning disabilities. With its publication, Psychiatry achieved the reification of mental illness in people with a learning disability, further reinforcing the notion of dual diagnosis, and their authority within it. What is interesting about the DC-LD is that ‘the criteria derived essentially reflect current practice within the UK and Republic of Ireland’ (RCP, 2001, p. 3). It is therefore a measure of current practice rather than of ‘mental illness’; a logical fallacy much like the notion of ‘behavioural equivalents’.

3.3.7 Transforming care?

In 2011 the BBC exposed the systematic physical and psychological abuse of people with learning disability living at Winterbourne View hospital. A serious case review identified hundreds of previous incidents and numerous failures to act on former warnings, as well as multiple examples of poor practice across the UK (South Gloucestershire Safeguarding Adults Board, 2012). In its response, the Government vowed to ‘transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging’ (DoH, 2012, p. 2). It set out a *Transforming Care* programme of action to improve existing services, reduce the number and duration of hospital

admissions and delayed discharges, out-of-area placements, and the use of physical and chemical restraint; measures highlighted as necessary almost twenty years earlier in the Mansell report (DoH, 1993). Amongst their time-tabled pledges were the better inspection and regulation of dual diagnosis services, publication of clinical guidelines for managing the mental health of people with learning disabilities and/or autism (NICE, 2016a), and a recommendation that the BPS take a lead on promoting positive behaviour support training (DoH, 2012).

Progress reviews in 2014 and 2015 found that people continued to be inappropriately placed in long-term institutional care, and that limited progress had been achieved in relation to discharging people to the community and closing inpatient units (Transforming Care and Commissioning Steering Group, 2014; 2015). It was noted that 'some commissioners have failed to grasp and act on the urgency of putting in place suitable community provision' (Parkin, 2016, p. 11), and the Government pledged to intervene (through legislation if necessary) if policy did not translate into practice (Parkin, 2016). *Building the Right Support* (ADASS, LGA & NHSE, 2015) introduced a 'national service model' (see Appendix G), setting out the range of support required to reduce the need for institutional care and achieve the 35-50% decrease in the number of inpatient beds by the new target date of 2019.

In the latest progress update, the National Audit Office (NAO; 2017) found that whilst the numbers of admissions had begun to decline, the duration of inpatient stays had increased. The community infrastructure was still inadequate, and the *Transforming Care* programme partners were not confident that the 2019 target would be achieved. The majority of people in hospital were not being reviewed within the specified time-frame, and there was a lack of funding available for the additional community support needed. The NAO (2017) reiterated that 'moving people out of mental health services is a considerable challenge. . . . [that] cannot be done quickly or cheaply' (p. 25), and that 'efforts to do so date back to the 1980s, and is a difficult task which defies simple solutions' (p. 25). Indeed there are numerous parallels between the current drivers and measures for the closure of inpatient units and those associated with the deinstitutionalisation (and earlier) movements. For example, the recent reform was prompted by the exposure of abusive and restrictive practices, once again illustrating the power

of the media in effecting policy change. In the case of Winterbourne View this has involved the production of documentation relating to dual diagnosis that is so extensive that it defies peoples' ability to become familiar with it all, and that consequently may result in its poor or patchy deployment. Policy once again promotes hospital closures and the development of community services and, as before, there is a significant gap between recommendations and practice, as well as a lack of commitment to ongoing funding. Costs are being shifted to local authorities already struggling to meet local residents' needs with their much reduced budgets so it is difficult to imagine how the *Transforming Care* programme will be sustainable. In combination with the severe and ongoing cuts to peoples' benefits, support and self-advocacy services (National Forum of People with Learning Disabilities & National Valuing Families Forum, 2016)⁴⁰, the structural and material causes of poverty, disability and distress are unlikely to be adequately addressed.

3.3.7.1 The 'new' dual diagnoses

Government policy since the Winterbourne scandal has consistently addressed 'people with learning disabilities and/or autism' together (as though they are homogenous groups with similar needs), particularly when discussing those who 'display challenging behaviour, including those with a mental health condition'. The perceived association between these diagnoses and presentations has been increasingly emphasised in both policy and clinical research, where it has been illustrated as follows:

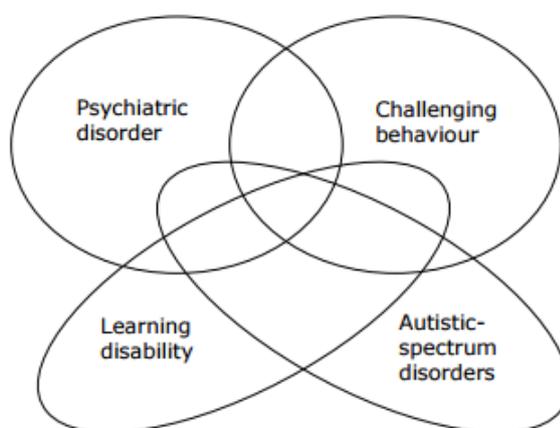


Figure 4: The relationship between learning disability, ASD, psychiatric disorder and challenging behaviour (RCP, BPS & RCLST, 2007, p. 30)

⁴⁰ The DoH funding for the organisations that produced this report has also been discontinued.

This figure was originally intended to demonstrate the association between challenging behaviour and psychiatric disorder across the spectrum of intellectual ability, and to illustrate that whilst there are overlaps between diagnoses, not everyone who has a learning disability or ASD will have a mental illness or display challenging behaviour (Xenitidis, Russell & Murphy, 2001).

Whilst the recent change in policy focus may reflect pre-existing administrative practices, and policy has recognised that this 'highly heterogenous group' needs an approach to service development that reflects its diversity (ADASS, LGA & NHSE, 2015), grouping them together in this way is likely to impede the person-centred focus advocated. It is not a coincidence that the 'new' dual diagnoses of (i) learning disability and/or autism; and (ii) mental illness and/or challenging behaviour encompasses those who most struggle to conform to extant socioeconomic norms and values. It is but the most recent example of the long-standing practice of redefining classifications and categorisations to facilitate the governance of those problematized as unproductive, undesirable or as threatening to the capitalist social order.

3.3.7.2 Challenging behaviour

The term 'challenging behaviour' emerged within the 'mental retardation' field in alongside 'dual diagnosis' in the 1980s (Xenitidis et al., 2001). It came to be defined as

culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities. (Emerson, 1995, cited in Emerson, 2001, p. 3)

The emergence of the challenging behaviour concept enabled the development of a variety of psychosocial approaches that focused not only on the reduction of challenging behaviour itself but also on the improvement in people's skills and quality of life, including 'person-centred active support' (Beadle-Brown, Hutchinson & Whelton, 2012) and the positive behavioural support (LaVigna & Willis, 2005) that is promoted in the *Transforming Care* programme. Despite evidence for the efficacy of these approaches for people with challenging behaviour (e.g. LaVigna & Willis, 2012), they have not been routinely offered to

people diagnosed with a mental illness because guidelines for the latter favour a more psychopharmacological approach. Yet the causal factors associated with challenging behaviours are remarkably similar to those associated with mental illness – physical discomfort or illness, psychological trauma, communication difficulties, neuropsychiatric disorders and mental illness itself (RCP, BPS & Royal College of Speech and Language Therapists (RCSLT), 2007).

As noted above, challenging behaviour and mental illness are consistently associated in both research and policy, with authors arguing that challenging behaviour may be unrelated to psychiatric disorder, but can also be a primary or secondary manifestation of it' (Xenithidis et al., 2001), a theorisation has developed in association with the explanatory concept of 'behavioural equivalents'. The incorporation of 'mental illness' within the broader category of 'challenging behaviour' has enabled both concepts to coexist without significantly competing with each other, although efforts to demarcate the two concepts does suggest a tension between them (e.g. RCP, BPS & RCSLT, 2007; RCP & BPS, 2016). One of the solutions has been to highlight the social construction of 'challenging behaviour' whilst maintaining the perception of 'mental illness' as an unquestionable scientific 'truth': 'Challenging behaviour . . . is a socially constructed, descriptive concept that has no diagnostic significance and makes no inferences about the aetiology of the behaviour' (NICE, 2016a, p. 176). However, as argued in this thesis and demonstrated by other critical researchers (e.g. Szasz, 1960; Boyle, 2014), mental illness could be considered a social construction too, and whilst it can provide a 'diagnosis', the aetiology of behaviour remains unclear. Nevertheless, this delineation between challenging behaviour and mental illness has enabled psychologists and psychiatrists to continue to claim a stake in the governance of people with learning disabilities that is consistent with their respective conceptual frameworks, with psychologists typically managing 'challenging behaviours' and psychiatrists managing them under the guise of 'mental illness'. It will be interesting to see what happens to these roles and remits now that these two categories are being catered for in combination.

Although intended to highlight that the problems caused by people's behaviours were a function of both the ways in which a person was supported and of their

personal characteristics (DoH, 1993), recent publications have highlighted the increased tendency of its use as a diagnostic label, which locates the problem solely within the individual (RCP & BPS, 2016). Its construction means that when faced with a variety of distressing circumstances, people with learning disabilities are not described as 'sad' or 'worried' or 'angry'; they display 'challenging behaviour' that at times is interpreted as a mental health problem or illness, shaping not just their identities but the kinds of responses that are possible. Whilst challenging behaviour may offer an alternative, less medicalised construction of the expression of distress, this is not always the case, and it still elicits individualised approaches that may subjugate the person's emotional life.

CHAPTER 4: SUMMARY AND CONCLUSIONS

This thesis examined and problematized the dual diagnosis of learning disability and mental illness using a Foucauldian genealogical approach. It aimed to map out and explore the conditions of possibility for its historical emergence in Britain, its associated social practices, and the alternative understandings that may have been subjugated in order to raise critical discussion and debate, and thereby create new possibilities for thought and action. In this final chapter I provide a summary of the findings in the context of my research questions. This is followed by a consideration of potential implications for clinical psychology practice, research and policy, and a critical and reflective evaluation of the research undertaken.

4.1 Summary of findings

4.1.1 How was dual diagnosis ‘made’ possible?

The conditions of possibility for the emergence of dual diagnosis that were identified and examined in this thesis are summarised in Figure 5.

Dual diagnosis emerged within a historical context of enduring governmental concerns about population control, particularly in relation to economy, productivity and social order. Legal and conceptual frameworks shaping how the two classifications constituting dual diagnosis came to be constructed, differentiated and governed in the present can be traced back to fourteenth century English law. The state’s ongoing political power over mental disorders (and thus those with a dual diagnosis) was established through the introduction of *patriae parens* powers to act on behalf of those deemed ‘incompetent’ to look after their own affairs, and ‘police powers’ to detain those perceived as posing a ‘risk’ to self or others. It was strengthened further through the vast disciplinary apparatuses of the state that developed in the context of a rising capitalist and industrial society to assist in the governance of a growing pauper population.

The knowledge and technologies produced in and by the scientisation and medicalisation of idiocy and lunacy within these apparatuses enabled the medical profession to become a dominant authority in their governance and thus shape how they were understood. When idiocy was reconceptualised as a developmental delay (rather than an illness), it enabled its disaggregation from insanity and opened up the possibility for their co-occurrence. It also provided a framework for many of the concepts that underpin current understandings of how people with a learning disability (and dual diagnosis) express their distress.

Following the Second World War, the emergence of the NHS, challenges to institutional practices, and the advent of civil and human rights movements, in combination, opened up a space for alternative models and professions to compete with the dominance of the psychiatric framework. The dual diagnosis concept offered a solution to the social problem caused by those who did not settle into the community as desired, and legitimised the ongoing involvement of the Psychiatric profession with people with learning disabilities.

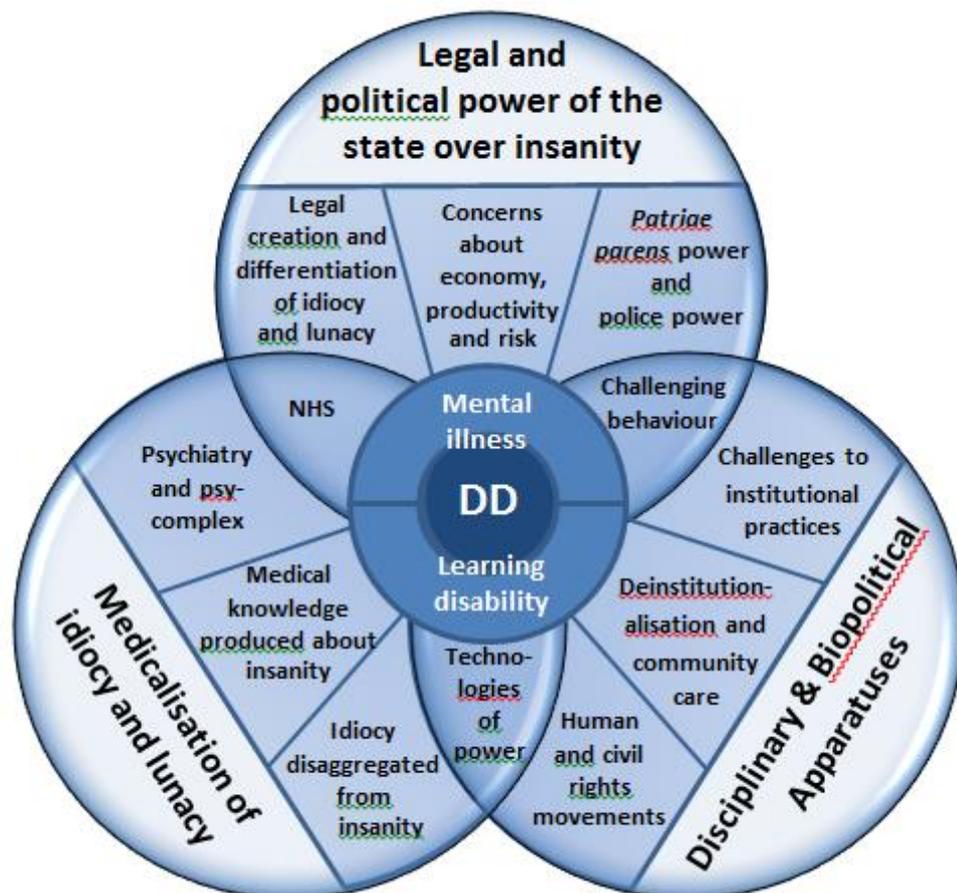


Figure 5: Summary of the conditions of possibility for the emergence of dual diagnosis

4.1.2 What has held it in place?

Dual diagnosis has been maintained by the production of an ever-increasing array of power-knowledge networks encompassing numerous authorities, technologies and techniques (see Appendix D). These have largely been endorsed by (or created through) government policy and strategy due to the potential solutions they present to the governance of undesirable behaviours. Through the use of the privileged scientific discourse and the rhetorical deployment of knowledge, the psy-complex in particular has contributed to the production of ‘truths’ about dual diagnosis and how people with learning disabilities express their distress that are difficult for those who are subject to them to question or challenge. The (re)production of these truths in legal and medical publications has played a key role in their reification, and they appear to be accepted by professionals, carers and services users alike. Paradoxically, the ‘scandals’ highlighting the inadequacy of governmental strategies have reinforced the very power-networks that they seek to challenge, as further governmental policy reiterating the need for specialist provision for this ‘complex’ group of people is (re)created in response. With the ongoing cuts to social supports and a lack of readily-available (and economic) alternatives, the state has continued to rely on historical systems of government for the management of dual diagnosis.

4.1.3 What have been the dominant discourses and their implications?

Broadly, the discourses underpinning dual diagnosis have been predominantly economic, social, legal and biomedical, often working in concert through the power-knowledge networks outlined above.

Economic discourses and associated governmental imperatives of productivity have problematized those who do not work as socioeconomic burdens – both to their families and to society. Social and moral discourses about how people should conduct themselves have contributed to the development of medicolegal and psychological ‘norms’ against which the behaviours (and thoughts) of people with a dual diagnosis are judged and acted upon. Legal discourses have positioned them as incompetent, irrational, vulnerable and risky, leaving little space for them to be authorities or experts in their own lives. Legislation has empowered competent, rational others with ‘specialist’ knowledge to govern

people with a dual diagnosis under discourses of care and protection. It has also legitimised the non-consensual detention and management of those exhibiting undesirable behaviours, particularly when justified by social discourses of risk and medical discourses of treatment and cure. The medicalisation of distress locates its cause within individuals, silencing the role played by peoples' socio-political, economic and historical material and personal contexts, and pathologising what could be construed as a natural response to difficult circumstances. Associated developmental discourses and assumptions that people with learning disabilities are atypical and always-already vulnerable to mental illness contribute to deficit-centric subjectivities that only serve to stigmatise and disenfranchise them further. The privileging of such discourses may subjugate alternative understandings and responses that could be more helpful for both service users and clinicians. They also silence the economic and political motivations for the creation of dual diagnosis and its historic counterparts.

4.1.4 What have been the subjugated discourses and what alternative understandings might these allow?

In the history of dual diagnosis, there has been a consistent subjugation of the emotions and voices of the dually diagnosed themselves and of the material and historical causes of distress. This has taken different forms, ranging from being silenced or altogether absent to being acknowledged as relevant but secondary to a biological construction of and predisposition to mental illness. Amelioration of peoples' social and material environments has sometimes been part of psychosocial interventions (such as moral and behavioural therapies), however, these have largely been enacted at the level of the individual, and do not target the wider society structural causes giving rise to inequalities and damaging experiences or the power relations that sustain them. Where the latter have been acknowledged, there has been a significant discrepancy between policy and practice, and a lack of financial commitment to undertake change. Whilst there may be no point at which human beings are free from all power-relations, resistance is always possible (Foucault, 1976/1998), and in the next section I draw on the discourses outlined above to suggest some of the ways in which it may be possible to think, judge and act differently in relation to dual diagnosis.

4.2 Implications for Clinical Psychology

It is important to note that in his work, Foucault aimed to raise questions and debate, rather than offer solutions or 'implications' for future research or practice (Foucault, 1984/1988). In the context of the demands of a clinical psychology doctoral thesis, and reflecting my own critical realist positioning, however, potential implications and possibilities for action within clinical psychology practice, research and policy are considered below.

4.2.1 Clinical practice: *Resistance at the local level*

As one of the main authorities in dual diagnosis, clinical psychologists must recognise their own role in creating and maintaining discourses about distress that might not be helpful to service users, and aim to use this authority to facilitate meaningful change. It is important not to collude with totalising formulations that pathologise the individual and conceal structural and historical causes of distress. Crucially, we must listen to, believe and validate the narratives of individuals and their families, use their own language and understandings to formulate their experiences, and help restore the power imbalance by treating them as 'experts' in their own lives (Pickersgill, 2012). For those who are non-verbal, we must view their behaviour not as an expression or confirmation of pathology, but as communication, and support their right to protest or resist what are often intolerable circumstances

Instead of individualising approaches aiming to create docile bodies and minds that risk denying or silencing peoples' voices, we should promote empowering social formulations and approaches that focus on a contextualised understanding of peoples' needs and wishes. This includes challenging notions of 'recovery' and 'strengths-based' approaches that implicitly suggest a need to compensate for some kind of personal 'deficit' (Harper & Speed, 2012). It may be helpful to draw on social justice tools and approaches from 'mainstream' mental health service user and critical psychology movements, such as the 'UnRecovery Star' (Recovery in the Bin, 2015) and Hagan and Smail's (1997) 'power mapping', to highlight the political nature of mental health, the 'impress of power' (Smail, 1999) upon peoples' lives, and resources and powers that may be available for the alleviation of distress (see Appendix H).

Notwithstanding their potential value, it is vital that we move beyond reactive individual therapies to preventative approaches that reduce socioeconomic deprivation and inequality, perhaps drawing on community psychology and public health traditions as suggested by Harper (2016). The challenge is how to do so in the context of austerity and existing neoliberal structures and approaches to health care.

4.2.2 Research: *The creation and dissemination of subjugated 'knowledge'*

Future research should aim to talk to those who are dually diagnosed and their families about their experiences of being positioned in this way, and implications for their subjectivities and their ability to access support that is (or is not) helpful to them. Moving beyond the traditional 'satisfaction questionnaire', this should aim to capture their rich, lived experiences, and allow for a consideration of both the productive and domination effects of power. Exploring how people diagnosed with a learning disability and their families have coped successfully with distress outside of the psychiatric framework could also help to develop a counter-memory promoting subjectivities of strength and resilience, as opposed to vulnerability and risk. This could open up alternative understandings and practices relating to distress and its prevention that could be more helpful to both service users and clinicians. Ultimately, research agendas should be determined by those subject to dual diagnosis themselves.

Clinical psychologists' proficiency in research (Health and Care Profession's Council, 2015) means that they are well-positioned to challenge the rhetorical deployment of scientific 'truth', and emphasise the potential consequences of power, inequality, socioeconomic and political factors on peoples' well-being generally, and for people diagnosed with a learning disability in particular. There is an urgent need for more critical psychological work in dual diagnosis (and learning disability) that contextualises these historically, socially and politically and, crucially, that questions assumptions and implications of current understandings and practices instead of glorifying them as 'progressive'. It would be helpful for this interrogation to begin much earlier in psychologists' careers, for it to play a central rather than 'alternative' focus in teaching and, indeed, for these views to be discussed at a wider societal level rather than amongst a relatively small number of people.

It is important to find ways of disseminating these subjugated understandings, and making these (and the associated critical methodologies) more accessible and comprehensible for all. This involves moving away from complex academic terminology and sharing views in a wider range of formats (such as video, oral history and social media).

4.2.3 Policy: *Political action*

Foucault (1963/2003) stated that ‘the first task of the doctor is . . . political’ (p. 33), and I would argue that this applies to clinical psychologists too. We are already involved in a number of clinical, academic, and partnership committees and boards where they can advocate for change and help shape strategy and action. We might achieve greater impact by forging strategic alliances and coalitions of interest with other agencies and service user groups (such as ‘Psychologists Against Austerity’ and ‘Learning Disability England’), drawing on corresponding political agendas and commissioning priorities to promote desired change. In this process it will be vital to abide by service users’ mandate that there should be ‘nothing about us without us’ (DoH, 2001b) and ensure that they empowered to be ‘leaders’ and ‘co-producers’ rather than ‘passive recipients’ (Crowther, 2007).

I would encourage trainee psychology programmes to include more assignments geared towards political change, for example, completing a project with a self-advocacy group, attending an MP drop-in session to improve the local community and/or discuss alternative approaches to distress, or preparing a written response to proposed policy or clinical guideline changes.

What we really need is a social transformation approach that looks at and addresses the root causes of and associations between distress, disability and poverty (Department for International Development, 2000). This will ultimately require a redistribution of social, economic and political resources, power and control, and substantial investment, reform and cultural change in governmental policy and services (Harper & Speed, 2012; Crowther, 2007).

4.3 Critical evaluation and reflection

Genealogy represents an interpretational form of qualitative research and, as such, it would not be appropriate to apply ‘positivist’ criteria such as ‘validity’, ‘reliability’ and ‘generalisability’ to its evaluation (Guba & Lincoln, 1981). In the

appraisal of the quality of my research, I have chosen the guiding principles outlined by Spencer and Ritchie (2012) to reflectively assess its 'contribution', 'credibility' and 'rigour'.

4.3.1 Contribution

Although there are numerous publications regarding the mental health of people with learning disabilities, these are written almost exclusively from an empirical and realist epistemological position. My research offered an analysis that was substantially different. By adopting a genealogical approach I was able to problematize dual diagnosis, destabilise 'taken-for-granted' knowledge associated with its medicolegal construction, and demonstrate the power/knowledge networks that limit and delimit what can be said and done in relation to the distress that people with a learning disability may experience.

This included challenging specific 'truth' statements (such as the perceived increased prevalence of mental illness and its 'atypical' presentation in people with learning disabilities), drawing attention to how 'knowledge' has been used rhetorically throughout history to support particular political or socioeconomic aspirations, emphasising the role that the psy-complex has played in its construction and production, and highlighting how the dually diagnosed themselves have been systematically subjugated. By revealing some of the historical contingencies, continuities and discontinuities associated with dual diagnosis, I aimed to demonstrate that things do not have to be as they are, and suggested some possibilities for action that may not have been explored before.

4.3.2 Credibility

Foucault (1977) emphasised the perspectival nature of genealogy. It is 'an *interpretation*, which itself is neither true nor false' (Sembou, 2011, p. 3). Hence, in my research, I was not attempting to create a more accurate, exhaustive or 'true' representation of dual diagnosis, but to illustrate how 'truth' is a socially produced power, that present day understandings are not fixed or inevitable, and to highlight some of the subjugated discourses that may be helpful to consider. Notwithstanding, I strived to be precise in the sense of thoroughly researching the historical events analysed, accessing original documents wherever possible, and using extracts from these as well as secondary sources to support my arguments. I also consulted texts that were not limited to clinical

or policy arenas to ensure a broader contextualised account and enable the identification of discourses and events that might be important to highlight in the history of dual diagnosis.

One obvious limitation of my thesis was that the views and experiences of those who are dually diagnosed are largely speculative, and this limited the extent to which I was able to explore and adequately address my final research question about 'subjugated discourses' and 'alternative understandings'. This omission reflects the significant absence of literature focusing on service users' perspectives, recommendations for further research to capture this subjugated yet central view are made in section 4.2.

4.3.3 Rigour

During the development of my thesis I was often reminded of Foucault's (1977) statement that 'genealogy demands relentless erudition' (p. 77), particularly given my limited pre-existing knowledge of history, philosophy, politics and economics, and complete unfamiliarity with Foucault's work. Whilst I understood the potential value of his ideas, Foucault's complex terminology, regular modifications to the meaning of theoretical concepts, and the lack of a clear methodology for genealogy (Mills, 2013; O'Farrell, 2015) made it challenging to put his ideas into practice. It also required me to step outside the 'positivist' epistemology favoured by my previous training and experience (see section 2.4.3), and to be mindful not to be drawn towards writing a 'continuous' history or undertaking an overly-Marxist examination of power that risked disregarding its productive aspects.

To help me address and explore some of these tensions and challenges, I read and regularly referred back to Foucault's own work and others' genealogies as outlined in section 2.5.2.1. I also discussed them frequently with my supervisor and other clinical psychology trainees undertaking Foucauldian-informed research, keeping a reflective research journal to help me develop my thinking (see Appendix C). These measures were also beneficial for resolving analytical dilemmas, as the history of dual diagnosis turned out to be much more complex than I had been aware, and my analysis ended up taking a path and focus that were rather different from the ones I had set out. For example, I had not intended to go as far back as the fourteenth century, or to focus so much on the

histories of learning disability or mental illness themselves. However, as I traced the emergence and descent of dual diagnosis, it became increasingly evident that not doing so would have missed important governmental concerns, strategies, and power-knowledge networks that continue to have relevance to present day practices and subjectivities. Attempts to restrict what I focused on were continually challenged, and I had to be more inclusive than I had originally intended. For example, I had to extend my analytical gaze to literature on children and 'mental illness' (including children without a mental deficiency diagnosis), because they represented a key condition of possibility for the emergence of dual diagnosis and the concepts that underpin its construction today.

On reflection, my aims and research questions were somewhat ambitious for a clinical psychology doctorate, and as a novice researcher I am conscious that there are numerous aspects of dual diagnosis that remain unexamined and unexplored. Notwithstanding, my hope is that this research will encourage readers to be more critical about the value and meaning of not only dual diagnosis and its associated social practices, but of the diagnoses of learning disability and mental illness more broadly, and of the historical socioeconomic, political and professional contexts that continue to shape the present. I hope that it inspires others to investigate, develop, and indeed challenge my thesis further, and that in so doing, we can continue to create new possibilities for thought and action.

4.4 Conclusion

In this research I have argued that the creations of dual diagnosis and its historical counterparts have been responses to social, political, moral and economic governmental concerns and problematizations, particularly (although not exclusively) in relation to the poor, and those unable or unwilling to contribute to the economy or conform to social or behavioural norms. As such, present day understandings are neither fixed nor inevitable; they are 'truths' produced by power. Dual diagnosis stigmatises and disenfranchises people with learning disabilities further by conceptualising them as atypical, irrational and always-already vulnerable to mental illness. Its biomedical construction locates problems within individuals, pathologising natural responses to difficult circumstances and legitimising restrictive and potentially damaging

interventions. A social transformation approach is needed that addresses the material and social causes of distress, disability and poverty, and the power-networks sustaining these. This will require a redistribution of social, economic and political resources, power and control, and substantial investment, reform and cultural change in governmental policy and services.

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APPENDICES

APPENDIX A

Bibliographical databases and search strings used

The bibliographical databases used for all searches were:

- Academic Search Complete, CINAHL Plus, Education Research Complete, ERIC and PsycINFO.

1. Introduction chapter

Search string:

"intellectual* disab*" OR "learning disab*" OR "mental* retard*" OR
"developmental* disab*" OR "developmental* disorder*"

AND

"mental health" OR "mental* ill*" OR "mental* disorder*" OR "psychiatric* ill*" OR
"psychiatric disorder*" OR "psychological problem*" OR "psychological* disturb*" OR "spsychopathology"

2. Analysis and discussion chapter

i) 'Dual diagnosis' term

Search string: "dual* diagnos*"

(In order to identify other early papers, additional searches were undertaken using: *the BPS Discovery service, Google Scholar and the British Medical Journal*).

ii) Historical co-occurrence of diagnoses

Search string:

mental* retard*" OR "mental* handicap*" OR "mental* impair*" OR "mental* defect*" OR "mental* deficienc*" OR "mental* disab*" OR "Mental* subnormal*" OR "learning disab*" OR "developmental* disab*" OR "developmental* disorder*" OR "developmental* impair*" OR "intellectual* disab*" OR "intellectual* disord*" OR "intellectual* impair*" OR "intellectual development disorder*" OR "idiot*" OR "idiocy" OR "imbecil*" OR "feeble minded" OR "oligophren*"

AND

"emotional* disturb*" OR "emotional* disorder*" OR "behavior* disturb*" OR "behavior* disorder*" OR "behaviour* disturb*" OR "behaviour* disorder*" OR "psychopathology" OR "mental* ill*" OR "mental health" OR "mental* disorder*" OR "psychiatr*" OR "schizophreni*" OR "psychosis" OR "psychotic" OR "insan*" OR "lunatic" OR "lunacy" OR "hebephreni*"

Biopsychosocial factors associated with an increased risk of mental health problems in people with learning disabilities.

Biological	Genetic links (including ‘behavioural phenotypes’ associated with particular genetic conditions ⁴¹ , or the heritability of particular mental health disorders such as schizophrenia); Increased risk of comorbid neurological conditions (such as epilepsy), biochemical and structural abnormalities ⁴² , medical problems (such as abnormal thyroid functioning), physical disabilities, and sensory impairments (such as visual or hearing loss); Medication side effects associated with polypharmacy; Increasing severity of learning disability; Particular demographic factors (such as increasing age, female gender, and belonging to an ethnic minority).
Psychological	Limited coping strategies due to poorer communication, problem-solving and planning skills (van den Hout et al., 2000), poor emotional awareness, perceived powerlessness and external locus of control, low self-esteem, lack of confidence, attachment difficulties (Hollins & Sinason, 2000) and the effects of labelling, stigmatisation and trauma (Schuengel, de Schipper, Sterkenburg & Kef, 2013).
Social	Increased likelihood of stigma, physical and sexual abuse; increased exposure to negative life events such as bullying and loss; restricted access to employment, marriage and parenting; low income; impoverished support systems; poor quality of life; lack of meaningful leisure opportunities (BPS, 2016).

⁴¹ A behavioural phenotype is ‘a characteristic pattern of motor, cognitive, linguistic and social abnormalities which is consistently associated with a biological disorder. In some cases, the behavioural phenotype may constitute a psychiatric disorder’ (O’Brien & Yule, 1995, p.2). For example, affective psychosis has been associated with Prader-Willi syndrome (Beardsmore, Dorman, Cooper & Webb, 1998) and social anxiety with Fragile X syndrome (Paschos, Bass & Strydom, 2014).

⁴² For example, structural abnormalities in the frontal lobe are thought to cause apathy, social withdrawal and disinhibition

Example pages from research journal

Journal entry - 15/02/12

Lisa Blackman's PhD.

how is it possible for this to be talked about in this way?

I am still finding it difficult to capture the nature + process of my thesis - what am I trying to do + how? I am trying to trace the history? ~~and~~ ^{not searching for the 'origin' - this is not the purpose of genealogy} origin of the term 'clinical diagnosis' in LD - what made it possible (conditions of possibility) at this time (1970s) onwards, what effects has it had - on individuals, professionals, gen. public, + what enables it to remain in place? And what are the alternatives - maybe subjugated discourses?

In order to do this I will need to:

- Look @ the history of: 'dd' as a term in itself - outside LD + its ^{intro/} application in LD. Its use in the medical sciences + adoption by Ψ .
- The Hx of Ψ + psychiatry as professions ^{in + outside of LD} + struggles between them
- The Hx of LD + the Hx of MH - the separation + joining of the 2. - the under sociopolitical + economic environment.

This will give me a history of these but I am struggling to separate out my introduction (to set the scene) ^{outline - this is what I know - what don't we know - which lead up to research etc.} + my analysis. What texts will I look @? How can I be methodical?

One option is to use the intro to look @ the conditions of possibility + the analysis to look @ the effects + what holds this concept in place. So the intro as a historical overview, ^{(context).} and the analysis looking specifically @ ~~the~~ practices enabled, linking back to particular discourses. If so, perhaps I could focus my analysis on biomedical texts + social policy documents - RCP circulars, BPS docs, NICE guidelines, that specifically mention 'DD' in the context of LD but also those that talk about MH + pwtD together, what using the term 'DD'.

But how can I capture the historical element? + non-biomedical perspectives?

Q: Is ~~an~~ ^{the} text analysis an FDA + setting it in its historical context looking @ knowledge ~~power~~ ^{power} / discourse what makes it a genealogy? → go back to Arbas - Aylon -

Journal entry - 19/01/13 - Reflections on ^{DISCOURSE} MIND/BODY DIVIDE.

Mind/body divide ?Cartesian

Read about how/when this came about.

lots of focus on the body + biology + medicine but increased focus on the mind - as ?more powerful, ie able to ^{cause} create ~~medical~~ (physical problems (Psychosomatic))

→ interest in 'the power of the "mind"'

?contributing discourses - 'Intellect' + its imp. for productivity, 'the Brain'

is this an old word?

Industrialization
Capitalism
Neoliberalism

still a medical discourse inherent/around but is the mind taking on a life of its own? or did it nearly for a while eg psychic, UFT, genital etc + now scientific

irrational + undervalued

So what do 'mind' what are you?

Q: Am I identifying discourses in the analysis + then using them in the Discussion?

check Carabine's 'Genealogy' chap.

→ or do I explain some/any of these in the intis?

- may be useful to make a list of discourses

I expect to find - not just to look out for them (NB dangers of doing this) ^{may miss others subjugated} but to id what I need to know about/read about (eg neoliberalism) - But is this a "discourse"?

My lack of clarity re: what

What is a discourse
What isn't a discourse
How do I identify it

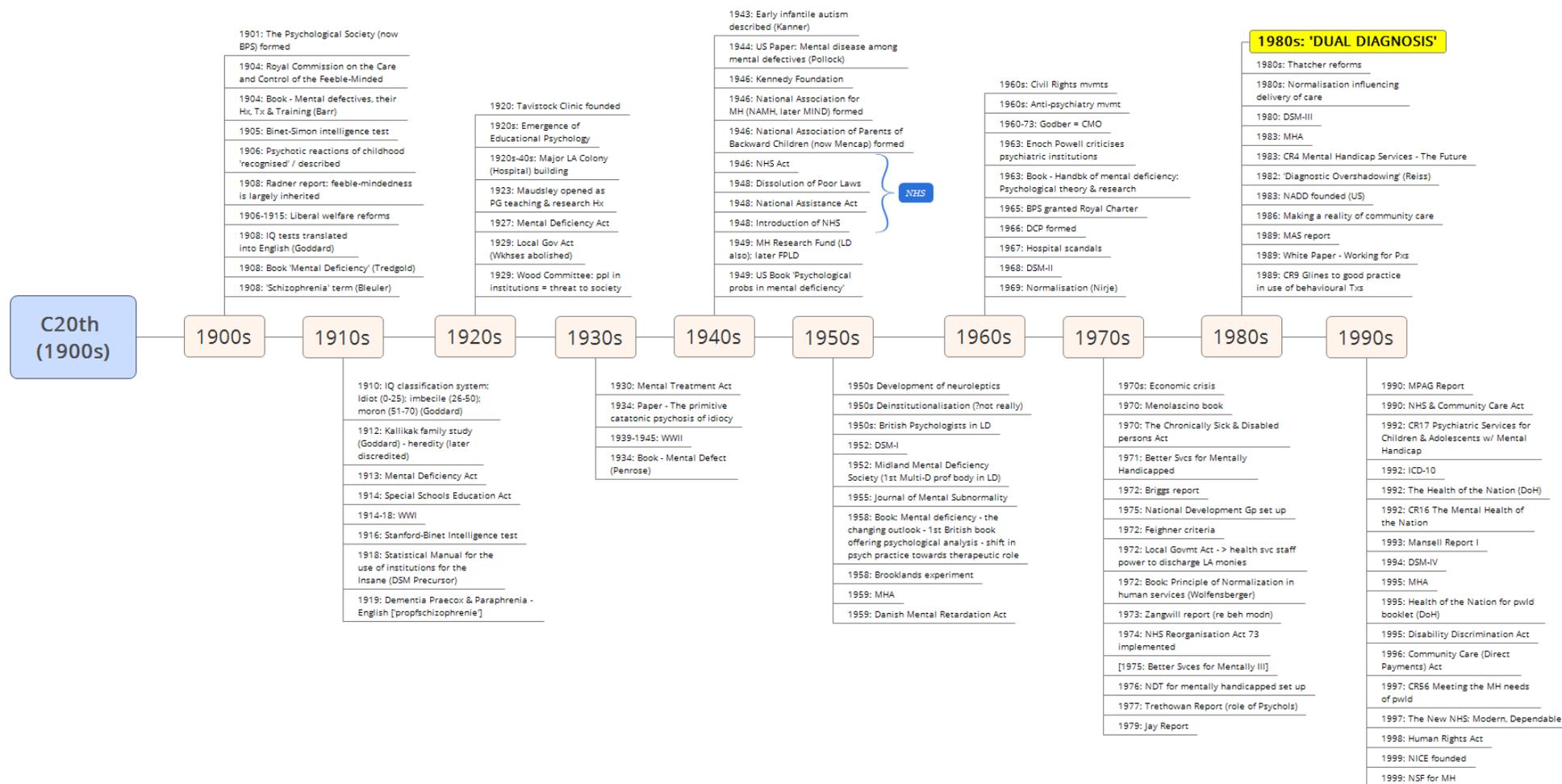
but also: what my understanding of it is

How do I do it?

How will I identify them in practice?

Try it out + describe what I'm doing (id my discourses in text) how come to that decision, that it's a 'discourse'

Chronology extract



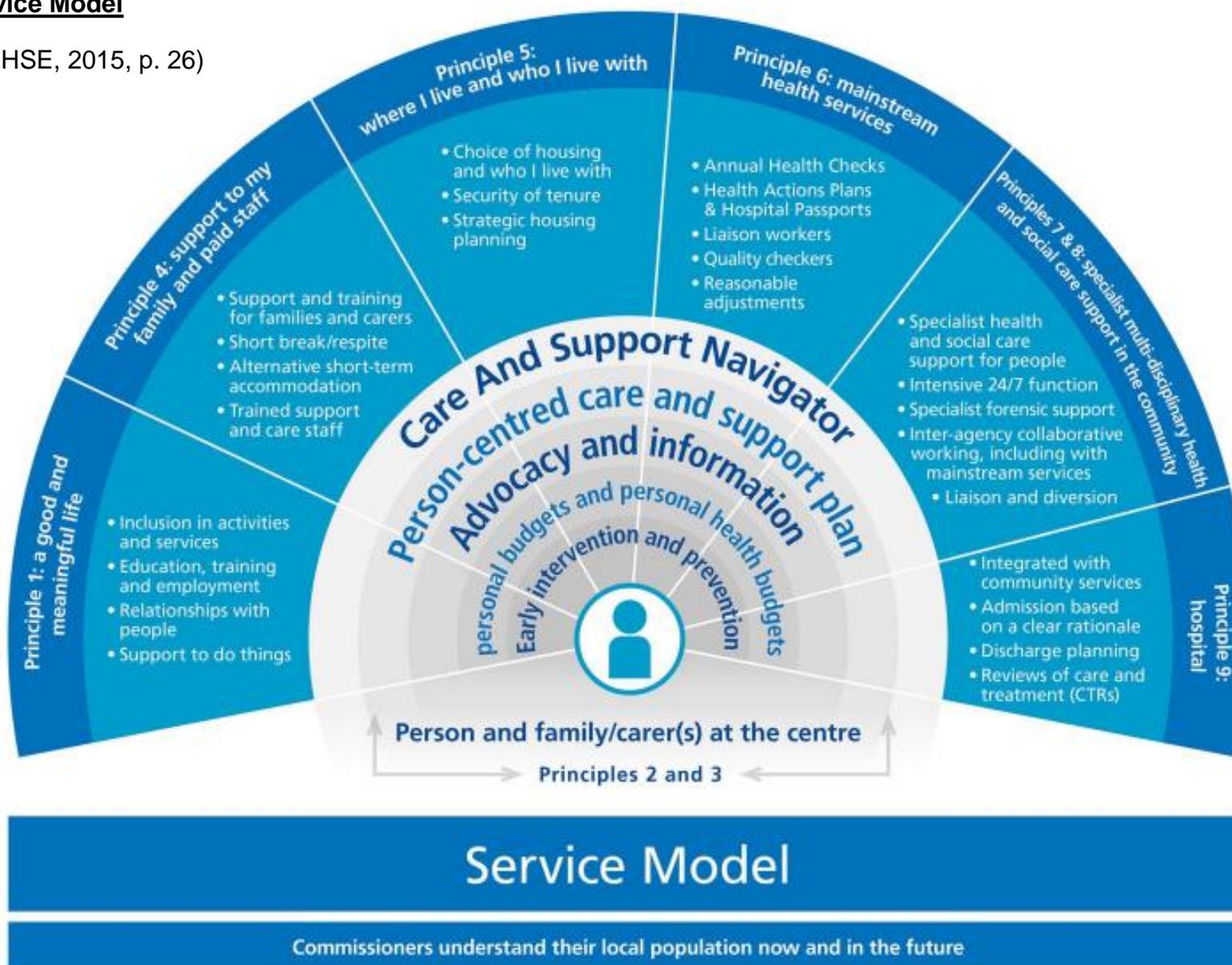
Corpus of statements genealogy was based on

Section of Analysis	Official Legislation, Policy and Guidance	Clinical Literature
DD in the present	<ul style="list-style-type: none"> • Mental health problems in people with learning disabilities: Prevention, assessment and management (NICE, 2016a) • Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines (RCP, 2016) • Psychological therapies and people who have intellectual disabilities (BPS, 2016) • ICD-10 (WHO, 2016) • Building the right support: a national plan to develop community services and close inpatient facilities for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition (ADASS, LGA & NHSE, 2015) • Guidance for commissioners of mental health services for people with learning disabilities (JCPMH, 2013) • People with learning disability and mental health, behavioural or forensic problems: The role of in-patient services (RCP, 2013) • Enabling people with mild intellectual disability and mental health problems to access healthcare services (RCP, 2012) • Transforming Care: A national response to Winterbourne View Hospital (DoH, 2012) • Future role of psychiatrists working with people with learning disabilities (RCP, 2011) • Commissioning clinical psychology services for adults with learning disabilities (BPS, 2011) 	<ul style="list-style-type: none"> • Managing mental health problems in people with intellectual disabilities (Zaman & Bouras, 2016). • A systematic review of the prevalence of psychiatric disorders in adults with intellectual disability, 2003-2010 (Buckles et al., 2013) • Review of research for people with ID and mental health problems: A view from the United Kingdom (Hemmings et al., 2013) • People with intellectual disabilities and mental ill-health (Dagnan & Lindsay, 2012) • Psychotherapy with persons with intellectual disabilities: A review of effectiveness research (Prout & Browning, 2011). • Mental health support needs of people with a learning difficulty: a medical or a social model (Williams & Heslop, 2005).
Emergence	<ul style="list-style-type: none"> • Services for people with learning disabilities and challenging behaviour or mental health needs (DoH, 2007) • Valuing people now: A new three-year strategy for learning disabilities (DoH, 2009) • Mental Health Act 2007 • Mental Capacity Act: Code of practice (DCA, 2007) • Mental Capacity Act 2005 • Meeting the mental health needs of adults with a mild learning disability (RCP, 2003) • DC-LD: Diagnostic criteria for psychiatric disorders for use with adults with learning disabilities/ mental retardation (RCP, 2001) • Valuing people: A new strategy for learning disability for the 21st century (DoH, 2001a) • Nothing about us without us: The service users advisory group report (DoH, 2001b) • Meeting the mental health needs of people with learning disability (RCP, 1997) 	<ul style="list-style-type: none"> • Mental health in mental retardation: Recent advances and practices (Bouras, 1994) • Bridging the gap (Menolascino & McCann, 1983) • Psychiatric approaches to mental retardation (Menolascino, 1970) • Mental disease among mental defectives (Pollock, 1944) • The primitive catatonic psychosis of idiocy (Earl, 1934) • Mental defectives, their history, treatment and training (Barr, 1904) • Imbecility with insanity (Hurd, 1888) • On idiocy and imbecility (Ireland, 1877) • Mental maladies: Treatise on insanity (Esquirol, 1845)

Section of Analysis	Official Legislation, Policy and Guidance	Clinical Literature
	<ul style="list-style-type: none"> • Services for people with learning disabilities and challenging behaviour or mental health needs (DoH, 1993) • Mental handicap services: The future (RCP, 1983) • Better services for the mentally handicapped (DHSS, 1971) • Mental Health Act 1959 	
Descent	<ul style="list-style-type: none"> • Report of the Mental Deficiency Committee (MDC, 1929) • Mental Deficiency Act 1913 • Report of the Royal Commission on the care and control of the feeble-minded (CCCFM, 1908) • Lunacy Act 1890 • Idiots Act 1886 • Commissioners in Lunacy (1847) • County Asylums Act 1845 • Report of the Metropolitan Commissioners in Lunacy (1844) • Second annual report of the poor law commissioners (PLCO, 1836) • Poor Law Amendment Act 1834 • Report from His Majesty's commissioners for inquiring into the administration and practical operation of the poor laws (PLC, 1834) • County Asylums Act 1808 • Vagrancy Act 1714 • Poor Relief Act 1601 • Act for Punishment of Sturdy Vagabonds and Beggars 1536 • Punishment of Beggars and Vagabonds Statute 1531 • Vagabonds and Beggars Act 1494 • De Praerogativa Regis 1324 	<ul style="list-style-type: none"> • The definition and diagnosis of mental deficiency. Part I: Amentia as distinguished from dementia (Burt, 1920) • The construction and government of lunatic asylums and hospitals for the insane (Conolly, 1847) • An essay concerning human understanding (Locke, 1690) • The New Natura Brevium (Fitzherbert, 1534)

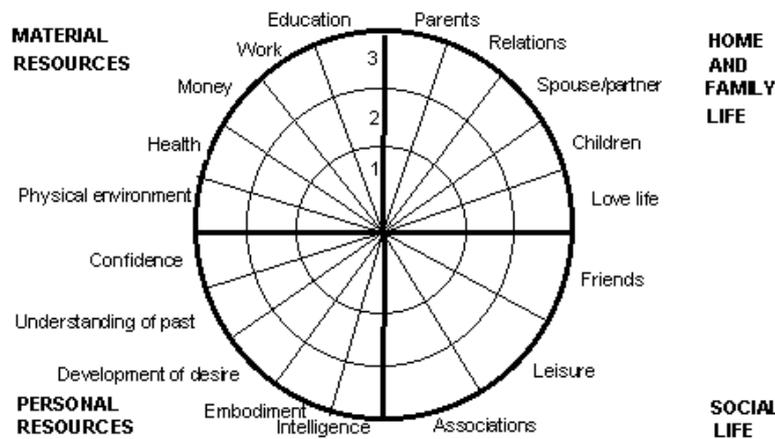
The National Service Model

(ADASS, LGA & NHSE, 2015, p. 26)



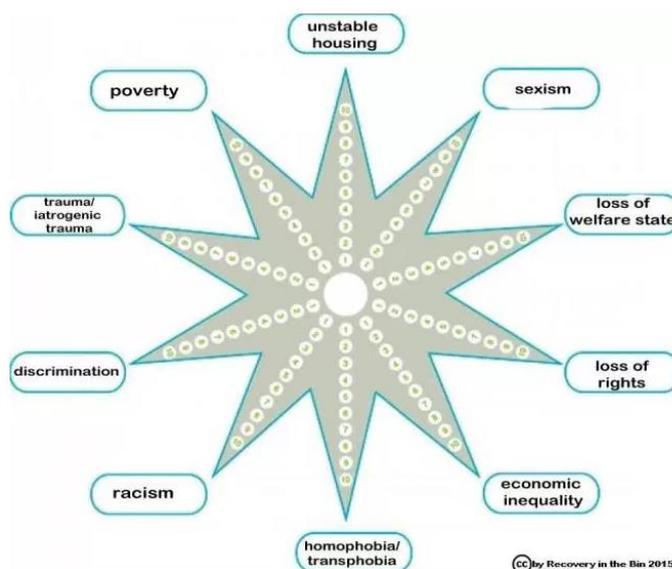
Power-based formulations and tools

1. Power-mapping (Hagan & Smail, 1997)



To acknowledge the importance of power in context(s), Hagan and Smail (1997) developed ‘Power Mapping’, which moves away from individual ‘pathology’ and considers supportive and destructive influences (or *powers*) in a person’s life. The authors suggest four quadrants (Home and Family Life, Social Life, Personal Resources and Material Resources), which are rated in relation to their supportiveness/destructiveness for the individual. The clinical focus, then, becomes less about individual change and more about consideration for the extent to which the individual can modify negative influence(r)s and develop positive powers within their context. Acknowledging power thus allows for a more realistic, contextually situated (and therefore more humanistic) view of the individual in distress.

2. The ‘UnRecovery Star’ (Recovery in the Bin, 2015)



The UnRecovery star highlights existing social inequalities that can hinder ‘recovery’. It can be used as a teaching tool to help people consider wider community/society/family problems as factors that may lead to an individual’s distress. It can also be used to campaign for greater social equality by identifying social and political solutions for social problems.