The Role of the Irish Division of the Royal Medico-Psychological Association in the Development of Intellectual Disability Nursing in Ireland

J. F. Sweeney

Abstract. The development of a specialist intellectual disability workforce in independent Ireland by the Royal Medico-Psychological Association was influenced by nursing regulatory bodies and Catholic religious orders, the latter of which provided lay residential education to people with intellectual disabilities. Although the RMPSA shaped curriculum and examinations, practice scope, clinical assessment and practical skills were weighted more heavily towards bedside nursing, psychology and education due to the input of the religious orders and nursing board.

Keywords. Mental handicap nursing, Ireland

Résumé. Le développement d’une main-d’oeuvre spécialisée dans les handicaps intellectuels en Irlande indépendante par l’association Médico-Psychologique royale (AMPR) a été influencé par des organismes de normalisation des soins infirmiers et certains ordres religieux catholiques. Certes, l’AMPR définissait les programmes de formation et contrôlait l’évaluation des candidats à la pratique. Il n’en reste pas moins qu’en raison de ces influences, la portée de la pratique, l’évaluation clinique et les qualifications pratiques ont été plus tournées vers les soins de chevet, la psychologie et l’éducation.

Mots-clés. Soins pour handicapés mentaux, Irlande
INTRODUCTION

In her germinal work, *Health, Medicine and Politics in Ireland 1900-1970*, Ruth Barrington argued that the Catholic Church provided a third pillar to the construction of Irish health policy by the State and medical profession during the 20th century. After a general backdrop to intellectual disability prior to political independence, this paper will explore the ways in which psychiatrists, affiliated to the Irish Division of the Royal Medico-Psychological Association (RMPA), influenced the timing and direction of intellectual disability nursing. In considering this argument, the interplay of the Irish Division of the RMPA with three primary stakeholders—the nursing regulatory bodies, specific Catholic religious orders, and the Irish government will be examined. In particular, consideration will be given to its claim to specialist expertise, its involvement in nurse training in the 1940s, and its consultation by the nursing board from 1958-71 on syllabus development.

This paper contends that the intention of psychiatrists of the Irish Division of the RMPA to develop a specialist intellectual disability workforce in independent Ireland was initially stymied through exclusion and ultimately modified by the influence of the nursing regulatory bodies and specific Catholic religious orders. The latter provided lay residential education to people with intellectual disabilities on behalf of the Irish state during this era. From 1922 to 1950, psychiatrists of the Irish Division of the RMPA unsuccessfully lobbied the General Nursing Council for Ireland (GCNI) to establish what was then called “mental deficiency” nurse training. It was not until January 1959 that the GCNI’s successor, An Bord Altranais (ABA), enacted rules to establish a separate mental handicap division of the nursing register, with its first registrants in September 1960. Although the RMPA shaped the type of syllabus, teaching and examination of the new trainees, the scope of practice, clinical assessment and practical skills were weighted more heavily towards bedside nursing, psychology and education as a result of the combined influence of the religious orders and nursing regulatory board.

IRELAND IN THE PRE-INDEPENDENCE ERA

The development of intellectual disability services in Ireland needs to be understood in the context of the key events leading up to and immediately following political independence from Britain in 1922. Although Ireland had been under colonial rule by the English for several hundred years, it was not until the *Act of Union* in 1801 that it came under direct rule by the British parliament in Westminster. The Irish asylum provision was administered through an Inspector of Prisons reporting
to the Lord Lieutenant. During the mid-19th century persons with an intellectual disability found wandering abroad by the police began to be institutionalized. As there was no separate residential provision for the intellectually disabled, workhouses or the gaols accommodated the rapidly expanding numbers of inmates. The majority were admitted to the workhouse unless deemed to be dangerous to self or others.3

Mental disorder during the 19th century was governed in Ireland by the Criminal Lunatics (Ireland) Act 1838 (1 & 2 Vict. c. 27) which differentiated between “dangerous” and “harmless” lunatics.4 At this juncture, the medico-legal distinction between “lunacy” and “mental deficiency” was imprecise whereby people with intellectual disabilities were admitted to mental asylums. Joseph Robins, an historian and senior Civil Servant,5 argued that, under new rules established in 1843, asylums were authorised to admit “idiots” and “epileptics with imbecility of mind” primarily people who had seizures that were deemed to require greater medical supervision than the workhouse could provide.6 The medical historian Oonagh Walsh7 demonstrated that there was a tradition in Ireland of moving “idiots,” “imbeciles,” and “epileptics” en masse from gaols and workhouses into the newly opened lunatic asylums during the mid-19th century, whereby they filled up rapidly.8 Hanora Henry’s history of the Cork district asylum,9 for example, indicates that persons classified as epileptics, feeble-minded or idiots were cared for within the confines of the mental hospital from 1843 onwards according to the periodic reports of the medical superintendent. In 1862, “imbeciles” and “idiots” made up 11% (491 of 4,506) of lunatic asylum patients, whereas they were 57% (1,268 of 2,225) of workhouse inmates; by 1892, the population in the asylums exceeded 2,000.10

The growing numbers of inmates led the medical superintendents to take an interest in the calibre of the asylum staff to ensure that they carried out medical orders promptly and effectively. From 1841, medical superintendents were able to share experience and ideas through a professional association, the Association of Medical Officers of Asylums and Hospitals for the Insane, which later became the Medico-Psychological Association (MPA).11 The Irish Division of the MPA was one of six regional divisions of psychiatrists who managed district asylums and disseminated their professional ideas through regional meetings from 1870 onwards. Through the association’s magazine, the Journal of Mental Science, and lobbying by their professional association, the Irish Division attempted to influence social attitudes towards care and treatment of the mentally infirm. From the early 1870s, the MPA developed an interest in the education and training of asylum attendants. This began as the dissemination of information among members about the benefits of securing reliable staff and gradually progressed to the provision of lectures, supervision and instruction in a more systematic way. In 1885,
the Association published the first edition of its *Handbook for the Instruction of Attendants on the Insane* and a syllabus which led to an examination of proficiency from 1891 onwards.\(^{12}\)

Medical interest in assuming a lead role in the management of education for “idiots” and “imbeciles,” in contrast, had been tempered by the influx of religious orders after reform of penal laws during the 1830s which saw the Catholic Church emerge as the key provider of education in Ireland.\(^{13}\) It distrusted the motives of philanthropic and reforming Protestants such as the Quaker Jonathan Pim and Dr. Henry Hutchinson Stewart who founded Stewarts Hospital as “an institution for idiots” in 1869. The Catholic primate of Ireland, Cardinal Paul Cullen, opposed the institution on suspicion of proselytizing of vulnerable children in a Protestant school.\(^{14}\) One reason for the Catholic Church’s opposition to medical intervention was a divergent view of the nature of intellectual disability that regarded “idiots” and “imbeciles” as *duine le Dia* or persons of God. It regarded people with an intellectual disability as being in need of protective care and training whose souls had to be safeguarded rather than rather than in need of medical treatment as patients.\(^{15}\) Mental deficiency was deemed to be a matter of education and training in which it held primacy. Elements of the Catholic Church were strongly in favour of the closure of the Poor Law institutions through the use of auxiliary asylums that were staffed by the religious orders without a resident medical officer, on the grounds that care could be provided more cheaply.\(^{16}\)

The Catholic Church’s direct intervention in provision of care and education for “feeble-minded” children took a decisive turn in the last decade of the 19th century. This occurred during an era of major social engagement by the Catholic Church on behalf of the poor for social justice in housing, health care, and education regardless of social standing epitomized by a papal encyclical “Rerum Novarum” by Pope Leo XIII.\(^{17}\) In 1890, the Daughters of Charity had been encouraged by Cardinal Paul Cullen to undertake work in the pauper school of the auxiliary workhouse of the North Dublin Union at Cabra. Although they taught in the school, they remained accountable to the workhouse overseer until 1925 when the poor law institutions were disbanded.\(^{18}\)

Through the MPA, psychiatrists staked a claim to the possession of specialist expertise and knowledge for their management, care and treatment, a claim that in pre- and post-independence Ireland set them at odds at times with the workhouse authorities, Church and religious orders, government and nursing bodies. Crucial to their credibility as experts on mental deficiency, psychiatrists in Britain relied upon the recruitment, training, and retention of a skilled and dedicated workforce.\(^{19}\) Nolan traces the development of training for asylum attendants to the introduction of specialist nurse training in the form of the Certifi-
cate in Psychological Medicine in 1885 by the MPA. With it emerged a call from members to establish a register of “good attendants,” the development of good practice through an instructional handbook and the testing of training through examination. The push for systematic training thus emanated from medicine through enlightened self-interest. Despite the popularity of training from 1881, its inherent requirement for after hour’s study, professional subordination to medical superintendents and lack of impact on workforce advancement, terms or conditions led to disenchantment among the attendants in the 1920s. Nolan concludes that the introduction of nurse training succeeded in refuting allegations of amateurism towards the fledgling speciality of psychiatry among the medical fraternity while simultaneously consolidating control over a necessary workforce.

This provided the impetus for the expenditure of great energy, time, and commitment to establish syllabuses and handbooks for training, to give courses of instruction, set and administer written and practical examinations, and to maintain a register of suitable attendants. This workforce emanated from the asylums and was established within the discipline of nursing in Britain as mental nursing and mental deficiency nursing after World War I and under the Nurses’ Registration Act 1919. The newly established regulatory bodies for nursing, the General Nursing Council (GNC) and the GNC for Ireland offered their own certificates under supplementary parts of the nurses’ register from the early 1920s. However, in Ireland the RMPA continued to offer a cheaper alternative training certificate for mental nurses until 1935 and in Britain a certificate of mental deficiency nursing until 1951.

The major legislative change in the UK at this period was the Mental Deficiency Act of 1913. One of the principal recommendations of the report of Royal Commission on the Care and Control of the Feeble-Minded in 1908 was for legislation, which resulted in two mental Deficiency Bills of 1912 and 1913. The 1913 Act legitimized the incarceration and control of persons deemed mentally deficient who had come to the attention of medical, educational, legal, psychiatric, and workhouse officials. It established a Board of Control to oversee the identification, care, and control by institutional confinement or use of community supervision of those deemed mentally deficient. The Board of Control provided for the detention of a person in a mental deficiency colony for five-year, renewable periods or for community supervision through guardianship orders that could be revoked if the person absconded or became sexually active. Jan Walmsley and Sheena Rolph note that while the UK began later than other North American states or provinces in attempting to seek a judicial response to mental deficiency, it was the first to enact countrywide legislation. Harvey Simmons argues that influential lobby groups, notably the Eugenics Society and the Charity...
Organisation Society, campaigned through the UK parliament, print media, medical organizations, and public addresses to convince the government to act.\textsuperscript{29} Poverty, inebriety, illegitimacy, immorality, sexual promiscuity, and venereal disease were attributed to the social danger of permitting unmarried women of low intelligence to breed.

During the period June 1912 to June 1913, intensive lobbying took place in Parliament for an extension of proposed mental deficiency legislation to Ireland. Opposition from the politicians and members of religious groups to medical control of care for people with intellectual disabilities prevented the passing of the Mental Deficiency Bill (Extension to Ireland) in 1912-13. In 1912, the Irish Division of the Medico Psychological Association lobbied for extension of the bill to all parts of Great Britain and Ireland\textsuperscript{30} but the proposal was rejected on the grounds that Irish law necessitated separate legislation.\textsuperscript{31} It was clear that both the members of parliament and the superintendents of the district asylums, through the Irish Division of the MPA, lobbied for extension of the bill to Ireland.\textsuperscript{32}

Throughout 1912 and 1913, the government had been lobbied to extend the provisions of the bill to Ireland or to draft a separate bill as in the case of Scotland.\textsuperscript{33} The government had responded to these petitions in respect of Scotland, since the Poor Law and asylum legislation differed, as was the case for Ireland.\textsuperscript{34} By July 1912, the government spokesman conceded that the proposal to extend the provisions of the bill to Ireland was under consideration “provided such extension is in accordance with the wishes of the Irish representatives.”\textsuperscript{35} This was a key opt out clause indicative of both support and opposition to the bill in Ireland. Despite resolutions in support of extending the bill to Ireland, Mr. Russell noted objections to the proposal when asked to commit to funding an annual grant for mental deficiency care.\textsuperscript{36}

In June 1913, Augustine Birrell,\textsuperscript{37} the Chief Secretary for Ireland, commented that “it would be impossible to introduce a Mental Deficiency Bill for Ireland during the present session.”\textsuperscript{38} The identity of those opposing either the extension of the bill or the introduction of a separate bill for Ireland were not disclosed nor were their reasons for this stance explained to the House. Earlier claims that the bill was pagan in nature suggest that the detractors were either individual Christians or members of established churches. Nonetheless, support for the bill, came from clergy of the Church of England and Free Church, Justices of the Peace, Mayors, Women’s Co-operative Guild and representatives of Friendly Societies.\textsuperscript{39} Though the position of the Catholic Church was unclear, its absence from the signatories suggests it dissented. The government’s proposal under legislation to provide religious instruction to those detained in the institutions was especially feared and would have been anathema to the Catholic authorities that feared conversion of a detained and vulnerable population.\textsuperscript{40}
The cost of implementing mental deficiency legislation provided a further reason for the bill’s non-extension to Ireland in 1913. The Mental Deficiency Act 1913 had established state machinery to carry out this function in the form of the Board of Control, at considerable expense to UK government. The costs were reduced from 1916 through reliance on charitable women who acted as Local Visitors to support and monitor mental defectives in their community to assist the Board of Control in its function. However, neither the Board of Control nor the voluntary associations extended their remit to Ireland, despite the finding of the Radnor Commission (1908) that 66% of the 14,136 mentally defectives were living outside the asylums in Ireland. This was a much higher percentage than for England and Wales (44%) or for Scotland (35%). In the absence of extension of the Act to Ireland, the British government accepted no liability to fund the employment of officials to identify mentally defective persons in Ireland or to provide specialist residential care. As a result and although World War I interrupted its full implementation until 1919, the duty of each Local Authority to identify and provide care for persons with an intellectual disability did not extend to Ireland. Arguably, on the eve of World War I and with prevention of sedition as his greatest priority, Birrell had more pressing duties than to see through legislation that had already proved to be contentious for England and Wales.

Notwithstanding the failure to extend legislation to Ireland, the 1913 Mental Deficiency Act was very important in shaping medical attitudes among psychiatrists towards the care of people with an intellectual disability. The MPA decided to differentiate mental deficiency nursing from psychiatric nursing in 1917 when the work of Board of Control identified the need for specialist workers. Central to the notion of such a nurse was the attitude of psychiatrists who sought a specialist workforce to bolster their claim to be experts in mental deficiency. The Irish psychiatrists were, however, less numerous than their counterparts in Britain and did not have access to a nation-wide network of mental deficiency colonies during a period of public clamour for something to be done about the “menace of the feeble-minded.” Instead, the psychiatrists sought to influence wider Irish society on the value of it providing specialist care through the regular meetings of their professional association.

Despite its perceived primacy of specialist knowledge, the Irish Division lobbied the Minister for Local Government and Public Health unsuccessfully for several years to secure representation on both the Irish Public Health Council (IPHC) and the GNCI. The non-extension of mental deficiency legislation to Ireland proved a major cause for concern for provision of medically led services among psychiatrists. In its Report on Mental Deficiency of October 1919, the MPA argued that the costs to
the local authorities would spiral if no action were taken to combat the threat to society posed by the mentally defectives.48

Such rhetoric both reflected and fuelled the moral panic among the middle classes in North America and Britain, fearing a chaotic decline at the hands of an amoral underclass that would subvert social and class distinctions in the postwar era. The need to address the “problem” of the mentally deficient by expert identification, diagnosis, classification, and institutionalization applied also to Ireland where the lack of legislative change was singled out for criticism.49 In April 1919, the Irish Division objected50 to its omission as an expert group from representation on the IPHC.51 This memorandum did not result in an invitation to join the IPHC. This prompted the Division to send another letter the following year, arguing that psychiatrists alone were competent to address issues of caring for patients, running institutions and training staff. It insisted “That an act on the lines of the Mental Deficiency Act 1913, be extended to Ireland.”52

1922-1958 INDEPENDENT IRELAND

After the Irish parliament, Dáil Éireann approved the Anglo-Irish Treaty on 7 January 1922, Ireland became independent from Britain and the Irish Free State was established. Arguably, a specialist “mental deficiency nurse” qualification in Ireland was not introduced into Ireland after independence from Britain in 1922 due to opposition primarily from the Catholic Church, which became the official church through the constitution. After the partition of island of Ireland, Catholics formed 95% of the population Free State53 and Catholic religious orders provided a low-cost option for education and health care at a time of crippling reparations to Britain.54 The government also delayed it on cost grounds, lack of a legislative imperative and by the matter of timing. The lack of specific legislation coincided with the struggle for political autonomy during World War I (1914-18), the War of Independence (1920-21) and Civil War (1922-23). This meant that the care of Irish people with intellectual disabilities was given low priority by the British and Irish governments.

Unlike Britain, where psychiatrists needed a workforce to run burgeoning mental deficiency colonies and organized training through their professional organisation,55 Ireland had only one medically led, specialist facility for people with an intellectual disability, Stewarts Hospital. The GNCI established in 1920 “a separate division containing the names of nurses trained in the nursing and care of feeble minded or mentally defective persons.”56 However, this part of the professional register closed in 1923 without a single registrant since Stewarts Hospital did not put forward any applicants. Moreover, despite an agreement to recognize registrations granted by nursing bodies in other jurisdictions,57
the GNCI did not extend reciprocity to recognition of the British Registered Nurse Mental Deficiency (RNMD) qualification under statutory rule changes.\textsuperscript{58} This would have been an important means of enabling the movement of Mental Deficiency Nurses between jurisdictions.\textsuperscript{59} At a time of economic stagnation and ongoing strikes among psychiatric nurses with their employers over pay, the possibility for nurses to work in England, Wales, and Scotland would have provided a tangible benefit to registration for an Irish Mental Deficiency Nurse.\textsuperscript{60}

The Irish Free State had inherited a legacy of diffuse institutional care based on the British workhouse and mental asylum model and faced an immediate economic crisis.\textsuperscript{61} It lacked a legislative imperative to ascertain and detain persons with an intellectual disability within a network of specialist mental deficiency colonies led by medical superintendents. Resistance from the Boards of Guardians, which had divided on pro- or anti-Treaty lines at the outbreak of hostilities during the War of Independence and the Civil War, dogged plans to abolish the workhouses. It was almost impossible for local authorities to fulfil their statutory obligations when hospitals and workhouses were occupied or destroyed through military action.\textsuperscript{62} The state’s major priorities were to combat high infant mortality and infectious diseases such as tuberculosis and to sever links between medical care and treatment of the sick from the Poor Law provision by abolition or amalgamation of the workhouses.\textsuperscript{63}

After cessation of hostilities in July 1923, the Free State government abolished the Poor Law workhouse system.\textsuperscript{64} Those who had been residing in workhouses and were classified as “epileptics,” “idiots” or “imbeciles” were moved into the County Homes or District Mental Hospitals under the care of general or psychiatric nurses.\textsuperscript{65} Those in care included also the poor, unmarried mothers, children, the mentally ill, the elderly, and people with chronic conditions such as epilepsy. All represented diverse socially disadvantaged and disenfranchised groups who were contained within the District Mental Hospitals and County Homes.

In January 1926, the Daughters of Charity were encouraged by the then Archbishop of Dublin to manage the former Cabra auxiliary workhouse as a residential school for children with an intellectual disability.\textsuperscript{66} This residential day school was renamed as St. Vincent’s Centre, Navan Road. The sisters managed care so cheaply and effectively throughout the austerity of the interwar years that this approach was much emulated by other Catholic religious orders throughout Ireland over the next 30 years.\textsuperscript{67} The rapid expansion of the Catholic Church’s involvement in care and education of people with an intellectual disability occurred in the context of the health and social policy of successive Irish governments from 1922-60.

Faced with a broad range of health and social challenges, Ernest Blyth, the first Minister for Local Government initiated the idea of
supplementing health spending by use of lottery funds raised by the Irish Hospitals Sweepstake. The Hospitals Commission was established by the Public Hospitals Act, 1933 to oversee government spending through the administration of the sweepstake surplus through the Hospitals Trust Fund. Its statutory function was to advise the Minister for Local Government on all issues related to nursing or hospital provision and to review, authorize and monitor hospital building projects through inspection of schemes of work.

This proved to be both a popular and effective initiative but in its early years the Hospitals Commission concentrated grants on general and mental hospital building projects. Provision of specialist care to people with an intellectual disability became a greater priority for the Irish government from 1935. In its second report, the Commission made a brief reference to “mental deficiency and sane epilepsy.” A significant expansion of services by the Catholic religious congregations between 1945 and 1955 was partly in response to the findings of a survey of incidence of “mental deficiency and sane epilepsy.” Dr. Louis Clifford conducted the survey on behalf of the Hospitals Commission but his final report over-estimated the incidence by a threefold figure according to Joseph Robins.

With the establishment of the Department of Health and the 1947 Health Act, the government began to review the care of the mentally ill and persons with an intellectual disability. By 1955, the Commission and the Department of Health had dispensed IR£1.25 million for the funding of a major transfer of residential places from the County Homes to specialist residential schools provided by religious orders. The decision to permit the religious orders and psychiatrists to manage care was an important factor in the growth of services primarily in the voluntary sector.

THE ROLE OF PSYCHIATRISTS OF THE IRISH DIVISION OF THE RMPA

To develop its claim of specialist expertise, the psychiatrists needed a mental deficiency nursing workforce along lines established in Britain. Key to this idea was the creation of a training school and examiners. The MPA developed a distinct mental deficiency syllabus of training for mental deficiency nurses in 1919 despite difficulties in separating out content from mental nursing. This former section included reference to characteristics of the nurse, educational principles, speech and sensory-motor development, habit training and community care and treatment. Training of Irish nurses was central to claims by the Division in 1920 for its primacy in mental deficiency as a specialized area of medicine, part of the Irish Division’s attempt to force local authorities to establish institutions for persons with an intellectual disability and to staff them. “Too
much importance cannot be placed on methods to secure efficient attendant staffs, consequently the Commissioners should lay down such rules as to training and examination as would be calculated to secure men and women well-fitted to their responsible task.”

Evidently the type of staff the Irish Division had in mind were “nurses attending on the feeble-minded,” since the Irish Division was active then in nurse training and research into mental deficiency. At that time Stewarts Resident Medical Superintendent, Dr. Frederick Rainsford, was one of two Irish examiners for the mental deficiency nurse examinations in Britain and travelled regularly to London for meetings of the MPA Examination and Handbook Committees. In 1924, the Irish Division reached an accommodation with the GNCI to permit the MPA psychiatric nursing examinations to continue to be recognized in return for the appointment of nurses to its panel of examiners.

After reaching an accommodation with the GNCI over psychiatric nursing in 1925, the Irish Division appointed Nurse Examiners for the practical final examinations in Britain. A revised syllabus, published 1927, introduced four distinct routes to registration as RMND. This consisted of (a) bedside nursing, (b) special methods for teaching mentally defective children, (c) the teaching of mentally defective adults or (d) physical training, drill, dancing, indoor and outdoor amusements. The flexibility of the new syllabus meant that diverse types of residential colony or educational institution for adults or children could train nurses to suit its needs. This syllabus also gave detailed schedules for practical instruction for examination under one of the four sections. Of these bedside nursing was most detailed, reflecting the influence of the nursing board. This aspect was consolidated by the appointment in July 1928 of Miss Delaney, Matron of Mullingar District Mental Hospital, as nurse examiner for mental deficiency finals in England and psychiatric nursing final examinations in Ireland. The syllabus now stipulated instruction on (i) general duties of nurses in a mental deficiency colony or home; (ii) elementary anatomy and physiology; (iii) first aid; (iv) hygiene; (v) theory and practice of nursing; and (vi) bodily diseases and disorders and their nursing requirements.

It was not just over training that psychiatrists felt aggrieved; the Division resented the continuous lack of consultation by government on matters relating to its scope and expertise. In 1928, it submitted a memorandum to the Irish government, objecting to its exclusion from the Commission on the Relief of the Sick and Destitute Poor, including the Insane Poor established by the Department of Local Government. Commenting two years later on the report at a meeting in Ballinasloe, Dr. Moran suggested that the district asylums had become “the Cinderella of the Public Health Services.”
Our service came under review by the recent Commission on the relief of the sick and destitute poor, including the insane poor. Owing to the personnel on the Commission—no member had any experience of this branch and only one was a medical man—the Commission could hardly be considered well qualified to report on our needs. As far as essential reforms are concerned the report was most disappointing. To relieve our overcrowding they suggested the extension of the system of auxiliary mental hospitals, and have recommended the utilization of some of the disused (and dilapidated) workhouses as auxiliaries. This I contend would be a most retrograde step.... We have fallen very much below the standards prevailing in similar institutions in England and Scotland.87

To the charge that the Commission lacked expertise to comment on matters of insanity, Moran went on to advocate the importance of a well-trained nursing workforce noting “Ideally, a higher state of intelligence and capability is necessary for the mental nurse than for the general nurse.” In 1930, the new Resident Medical Superintendent at Stewarts Hospital, Dr. Keene, hosted the Irish Division meeting and gave a clinical paper on the subject of Down syndrome.88

In 1931, the MPA published a separate handbook for mental deficiency nursing89 which became the “Manual for Mental Deficiency Nurses” (1931), more commonly known as the “Green Handbook.” Although a new syllabus and a revised handbook of instruction were published in 1932, the content of most sections remained the same with minor additions. However, there were changes to the “hygiene,” “mind in health,” “mental deficiency” and “principles of nursing” sections and new sections on “legal relations,” “community care,” and required a nurse to “show a working knowledge of modern theory and practice of education.”90

A stronger nursing influence could be detected from the restructuring of section (a) bedside nursing, which included cleaning of furniture, bed making, linen changing, lifting, washing and bathing patients, and prevention of bedsores. This ethos was reflected in the Final Examination paper91 of November 1932. This marked a departure from the notion of active ambulant patients to the care at the bedside with emphasis on use of aides to prevent pressure sore development in long-term bed rest. This is consistent with Mitchell’s finding that the General Nursing Council for England and Wales (GNC) argued for a greater focus on nursing the sick to be included in the “mental deficiency” nursing curriculum during the interwar years.92 The Division’s concern to lead intellectual disability services for was reaffirmed in 1935 when Dr. Fitzgerald presented a paper entitled “Mental Deficiency in the Saorstát93: A Medico-Legal and Educational Problem.”

Dr. Fitzgerald pleaded for the tackling of the Mental Deficiency Problem in the Irish Free State, on broader and more modern lines, and showed, by careful
reasoning, that expenditure on this question would ultimately result in an economy to the State. He also pleaded for the modernization of legislation with regard to mental defectives, and also for the modernization of the present lunacy laws.94

At this time, the Irish Division had three members involved in mental deficiency examinations in England, but their numbers were small among Irish psychiatrists. Behind the financial and legal imperatives, Fitzgerald was sending a message to the Irish government that the fledgling specialist mental deficiency services should not be left to the care of the religious and necessitated medical leadership.

A key requirement for the introduction of mental deficiency nurse training in Ireland would have been the availability of specialist approved training institutions. For such approval, institutions were required to meet the standards of the examination body and to have the capacity in terms of training experience, expert tuition and approved examiners.95 The MPA Education Committee96 ruled that there must be a minimum of 100 beds and the institution had to be approved by visit and recommendation of the association. This proved to be a difficult criterion to meet in Ireland where the model of large colonies did not apply and numbers of beds in individual institutions did not grow until the 1950s. Training rules were revised in 1933; the RMPA relaxed the stipulation for a resident medical officer and reduced the minimum patient level to 50. These provided the Irish Division with a further impetus to train mental deficiency nurses since a nursing tutor had to hold a certificate of proficiency from either the MPA or the GNC.97

In July 1931, the St. John of God order founded St. Augustine’s Colony’s one of three institutions in the Irish Free State catering for children and young people with an intellectual disability.98 It provided specialist residential care and training for young men over 16 years of age who could not be sent home or placed in employment. Its significance was as a residential centre administered by a religious order consisting of a large house on a 30-acre plot of arable land suitable for agriculture and workshops.99 The brothers taught a variety of manual trades including boot repairs, tailoring, upholstery and carpentry; other skills taught included household tasks, kitchen work, moral, religious, and physical training. The Hospitals Commission identified the urgent need to extend provision by funding extra residential provision at St. Augustine’s colony since mental defective children were being transferred to County Homes if they could not be discharged home or found employment. The Local Government Department was keen to develop such facilities100 noting that the Order of St. John of God provided a better standard of physical and developmental care, than for those in district mental hospitals or County Homes.101
The Hospitals Commission approved a grant of £38,600 to the Order to increase its existing accommodation from 80 to 200 places. The rising number of admissions from local authorities across Ireland, between 1931 and mid-1936, illustrated in Table 1 below, probably influenced the Commission to recommend expansion of St. Augustine’s services to meet what it saw as a growing need. Nonetheless, to increase provision to 200 places at what was at the time a huge capital cost during a period of tight fiscal control over government spending was remarkable for this era.

As the number of residents grew (see Table 1) expansion of the workforce became necessary to cater for the needs of its young adults for longer-term care. It would appear from correspondence with the RMPA that the Order had staffed the mental deficiency centre with members of the religious who had trained as mental nurses at the Order’s “large private Mental Hospital adjoining Obelisk Park.” Evidently, it occurred to Brother Benedict Tobin, a member of the St. John of God’s nursing staff, that the mental nurses might be able to register as mental deficiency nurses after taking the final examination set by the RMPA in Britain. The idea prompted communication between Brother Tobin and the RMPA’s Education Committee in 1943. At its March 1943 meeting, the Educational Committee compared the regulations of the GNCI’s final examination and judged these to be practically identical. The RMPA to decide to permit candidates to sit the final examination for its Mental Deficiency Certificate after one year’s training and approved St. Augustine’s Colony training school in July. St. Augustine’s Colony was approved in 1943 as one of two RMPA institutions for training for the Mental Deficiency Certificate in Ireland. The “inmates” were provided with medical supervision from two medical officers, one a member of the Order, attached to the adjacent psychiatric hospital. From the perspective of the RMPA, it was highly suitable as a training institution, with on-site medical supervision for training, a variety of specialist skilled trades and a dedicated workforce of religious who had completed mental nurse training either through the RMPA or GNCI schemes.

The RMPA register of registered mental deficiency nurses indicated earlier training of mental deficiency nurses than recorded by Scanlan’s study and official histories. The records showed that 37 nurses employed at St. Augustine’s Colony had passed the mental deficiency examination between November 1944 and November 1951, making these the first qualified mental deficiency nurses in the Irish Free State. There were no entries for any of the other establishments, which were providing care at the time—Stewarts Hospital, St. Vincent’s Centre, the Brothers of Charity in Cork, St. Joseph’s, Clonsilla, St. Teresa’s, Stamullen or St. Mary’s, Drumcar (see Table 1). The mental deficiency nurses
### Table 1

**Numbers of Persons with an Intellectual Disability in Residential Care 1926-56**

from Annual Reports of the Inspector of Mental Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>Stewart’s Holy Kilkonnan</th>
<th>County</th>
<th>Homes</th>
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<tr>
<td></td>
<td>Hospital Palmerstown</td>
<td>St. Vincent’s St. Augustine’s St. Aug.</td>
<td>St. Teresa’s St. Joseph’s Our Lady of Good Counsel</td>
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<tr>
<td>1927</td>
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trained at St. Augustine’s had all qualified initially as psychiatric nurses and had been entered onto the GNCl register of mental nurses from 1935 onwards. They had completed a one-year post-registration course in mental deficiency nursing at St. Augustine’s Colony.

On successful completion of the final examination, they registered with the RMPA, since there was no Irish nursing register created until 1959. Between 1944 and 1951, 14 of the Brothers went on to achieve the Section B certificate (“Special Method of Teaching Mentally Defective Children”) subsequent to passing the “Certificate in Proficiency in the Nursing of Mental Defectives.”\textsuperscript{113} This required an additional six-months training and another examination reflecting the growing importance attached to education by the order. The current Provincial confirmed that Brother Benedict Tobin, a nurse administrator, had negotiated recognition of St. Augustine’s as an approved mental deficiency training school in 1943. Though St. Augustine’s had a medical officer, Dr. Devlin, for the preliminary examinations,\textsuperscript{114} Dr. Louis Clifford,\textsuperscript{115} the Medical Superintendent for Dundrum Mental Hospital, undertook the oral and practical examinations, assisted by “Ms. Delaney, Mullingar, and the Sister Tutor of Mercer’s Hospital, Dublin.”\textsuperscript{116}

The significance of the Irish Division RMPA’s training programme with St. Augustine’s was having a medical superintendent working in an organization run by the St. John of God order. This signalled a small but important change in the relationship between the religious orders and psychiatry which was to bear fruit in the following decades. During the 1950s and 1960s, relationships between the psychiatrists of the Irish Division and the religious service providers improved steadily. In 1948, two members of the St. John of God Hospitaller Order at St. Augustine’s were elected as mental deficiency examiners, Dr. A. J. Devlin and Brother Benedict Tobin as a Nurse Examiner.\textsuperscript{117} In January 1951, the Irish Division visited St. Augustine’s Colony, where a paper entitled “Mental Deficiency and St. Augustine’s” was presented by Dr. P. O’Brien. At the meeting, hosted by the Brothers of St. John of God, the minutes record the absence of Dr. Noel Brown, Minister for Health, on grounds of ill health.\textsuperscript{118} This suggests governmental support the Irish Division and the religious organizations in the planning of services.\textsuperscript{119}

In May 1951, an Irish Divisional meeting was held at Stewarts Hospital. Its medical superintendent, Dr. H. St. George Smith, presented a paper entitled “Some Aspects in the Education of Mentally Handicapped Children” in which he stressed three factors—religious principles, family relationships, and understanding speech.\textsuperscript{120} By 1952, the Department of Health had superseded the Department of Local Government and Public Health and ABA had replaced the GNCl. The Irish Division was invited to nominate a representative to the National Health Council; Dr. Dunne served from 1952 to 1962.\textsuperscript{121} By 1962, when the division met at
the Mater Hospital by invitation of the Reverend Mother Superior and Dr. O'Malley, Professor Dunne was again nominated to continue to act as the division’s representative to the National Health Council. Despite this, psychiatrists specializing in mental deficiency were few.

1959-1971: THE ERA OF MENTAL HANDICAP NURSING

In 1958, ABA established a committee to prepare a syllabus of training of nurses in the care of the mentally handicapped. The nursing body had approved a draft syllabus as early as 1956, suggesting that consultation with the RMPA had taken place on its content. Dr. H. St. George Smith, the Medical Superintendent of Stewarts Hospital, chaired the committee, which held its first meeting in mid-February. In 1961, the Department of Health refused Stewarts Hospital a place on the newly established Commission of Inquiry in Mental Handicap, which sat from 1961-64. However, ABA recognized it as a source of medical expertise on which it could draw for syllabus development. In attendance were the Chief Executive, Mr. J. Keogh, and an Education Officer, indicating the priority accorded by the Board to this initiative. The committee initially consisted of three members of the religious orders, one brother and two sisters, who were both general nurses, three doctors, one psychiatric nurse and two general nurses and one other, Mr. T. Condon. There were relatively few medical officers in Ireland during the 1950s and 60s, as many of services administered by the religious orders were without permanent medical superintendents. Although one leading psychiatrist of the era, Dr. Dolphin, declined to serve in view of his “official duties,” it was agreed to co-opt Dr. Ryan, the Medical Officer of St. John of God. As a member of this committee, Dr. Ryan served both the psychiatric and religious interests in formation of a secular workforce.

Much of the early meetings focused on how a proposed change of Preliminary Examination for Mental Nurses would also affect RNMMH syllabus and what recognition to grant to “existing nurses.” This was a clear reference to those who had trained earlier or elsewhere as mental deficiency nurses or had qualified as general or psychiatric nurses and had worked for several years in mental handicap services. The minutes record that there was disagreement between Brother Fidelis of Drumcar and Miss Young, a general nurse, as to the minimum length of experience required to register as an existing nurse once the register were open. After much discussion, it was agreed to admit nurses to the Division of the RMHN register by one of three means (i) by examination (ii) by reciprocity and (iii) for a period of three years only from date of the first examination for the register as “existing nurses.” The committee proceeded to draft rules that were published as the Nurses for Mentally Handicapped Persons Rules (1958) and that required an applicant
for registration as an “existing nurse” to meet strict criteria under one of seven conditions.

The system of examining adopted was very similar to the former RMPA final examinations for mental nurses since 1919. This strategy proved to have been successful. Members were informed that 18 of the 21 students entered had passed their final examination in November 1963 and that the examiners who were used to marking and conducting final examinations for the RNMD qualification, considered that the standard compared more favourably than that in England. The committee noted that there was no shortage of applicants for training or for future employment prospects, but did express concern at lack of opportunity for RMHNs to progress their career by taking general nurse training in Ireland.

The ABA archives contain a copy of the booklet used to chart a mental handicap student nurse’s record of practical instruction that provided an insight into the nature of the training and practice experience. It consisted of 13 printed pages with instructions for completion by Nurse Tutors, Ward and Departmental Sisters or Charge Nurses and how these were to signify evidence of proficiency gained in each skill. It is apparent that the same record chart could be equally applied to general bedside nursing in hospitals save for the addition of columns headed mild, moderately, and severely mentally handicapped patients. There was one specific two-page section (7-8) entitled training procedures that reflected the nursing care and management of the specific client group. This included practical instruction in habit-, toilet-, social-, sense- and speech training, discipline, feeding, dressing, training procedures, special difficulties in management, investigatory procedures, psychiatric and paediatric nursing. The training procedures listed recreational activities, occupational therapy, domestic training, farm and garden training, hobbies and handicrafts, group entertainment, and simple formal education. This in itself was suggestive of nursing skills required to care for the mentally handicapped across the life span but did not at that time embrace the concepts of employment other than as “training.”

One area of serious discord and compromise across the 12-year period from 1958-70 was around the structure and content of the syllabus of instruction. The syllabus, reflecting its time, was heavily influenced by the medical underpinnings of the RMPA training syllabus for mental deficiency nurses in England and Wales. The influence of psychiatrists too was revealed in an early revision to specific parts of the new syllabus of training. One such area for revision was Section IX of the Final Syllabus entitled Clinical Entities and Types strengthening its biomedical emphasis on aetiology, treatment and nursing care of types on primary and secondary mental handicaps and childhood disorders.
The first syllabus was developed through the deliberations of nurses, psychiatrists, and the religious orders of nurses providing care. During the next decade it was subject to minor changes, possibly a reflection of the very few training centres and small intake cohorts from 1959-65. The psychiatric nurses, both lay and religious on the working group, generally supported the proposals of the psychiatrists. General nurses and ABA education officers, by contrast, largely opposed any perceived dilution of the bedside nursing elements of the preliminary training year in particular. The committee reduced the hours from 40 to 20 in Occupational Therapy, but it could not agree on a minimum of three months in a general or sick children’s hospital and three months in a psychiatric hospital proposed by the ABA officers. Both the representatives of the employers—the three nurses from the religious orders, the psychiatric nurse, and a psychiatrist Dr. Fitzgerald dismissed Miss Young’s suggestion as idealistic and impractical. The members could not agree and deferred the item was to a later meeting; it was redolent of the attempt by the General Nursing Council to increase the bedside nursing element of mental deficiency nursing in Britain during the interwar period.138

Medical influence on the syllabus revealed a change in both behavioural and cognitive approaches at the expense of bedside nursing, reflecting social and psychological paradigm changes to psychiatry. That the committee received a request from the New South Wales Nursing Board seeking a copy of the ABA Syllabus as a special course in Mental Handicap Nursing had been approved in New South Wales suggests that internationally, the Irish nursing program was considered to be progressive. Notwithstanding interest abroad, the syllabus was considered by many of the employer’s representatives to be outmoded within a decade of its introduction, with too little emphasis on social, educational, and behavioural trends.

CONCLUSIONS

The Role of the RMPA in Intellectual Disability Care in Independent Ireland

David Thomson argued that medical superintendents and assistant medical officers active in the mental deficiency work or research in Britain constituted only 11% of the RMPA’s membership139 and that “psychiatrists involved in the care of mental defectives continued to form a backwater within the medical profession …”.140 Since less than one-third possessed specialist psychiatric qualifications, their administration of asylums for the incurable gave them low status within the field of psychiatry.141 This meant that within the organization they lacked influence over policy formulation. The prevalent view of incurability, even if
partly tempered by optimism grown through scientific research, led the medical superintendents to an over dependence on long-term institutional care in the colony.\textsuperscript{142} There they fulfilled a warehousing function by managing overcrowded and under-resourced institutions that interfered with a therapeutic, research or caring function.\textsuperscript{143}

If psychiatrists caring for mental defectives in Britain were marginalized within the RMPA,\textsuperscript{144} those within the Irish Division were doubly disadvantaged because of the scarcity of medically led colonies or institutions within Ireland. Like their counterparts in Britain, who were not consulted directly over the \textit{National Health Service Act},\textsuperscript{145} the Irish Division of the RMPA was denied representation by the Department of Local Government and Public Health on the General Nursing Council for Ireland from 1921-51. It was to require the emergence of the Department of Health and the new nursing regulatory body in 1951 before the Irish Division was recognized as a competent authority on psychiatric and intellectual disability practice and education.

ABA showed itself to be more flexible than its predecessor to new ideas and to susceptibility to pressure from the Department of Health and employers to work more closely with psychiatrist to develop a new syllabus. During its first decade of office it took the lead to co-ordinate the development of novel branches of training and co-opted psychiatrists to work with it on syllabus development. It was possibly made aware that psychiatric nurses had qualified as mental deficiency nurses but had been unable to register as such in Ireland during the 1940s. The psychiatrists, now working closely with the religious orders in the voluntary sector that employed nurses, influenced the Commission of Inquiry in Mental Handicap (1961-64).

Government policy, espoused by the 1965 recommendations of the Commission of Inquiry into Mental Handicap,\textsuperscript{146} championed a rapid expansion of training of nurses to care for people with an intellectual disability and worked to the advantage of employers and psychiatrists. This was key to the securing of a viable workforce at a time that the religious orders were experiencing falling numbers of entrants to vocations while their services were expanding rapidly. Coincidentally, in securing a reliable supply of new recruits to manage services provided and managed by the religious, psychiatrists contributed indirectly to a gradual process of secularisation of the frontline workforce. Although the RMPA shaped the type of syllabus, training and examination, the influence of the religious orders and nursing regulatory board deflected practice towards bedside nursing, psychology, and education.
ACKNOWLEDGMENTS

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NOTES

2 Later Inspector of Lunatic Asylums.
4 The period of the 20th century has seen consistent changes in terminology applied to the person with an intellectual disability. This poses a dilemma for the historiographical researcher reliant on primary archival sources. Terms employed reflecting erstwhile correct legal definitions have over the century acquired meanings that are at least derogatory and at worst terms of abuse, power or humiliation. The danger of applying labels is recognized as a negative consequence of institutionalized power or abuse. Earlier applied terms deriving from the *Mental Deficiency Acts* (1913, 1927) such as “mentally deficient,” “feeble-minded,” “idiot,” “imbecile” or “moral defective” fall clearly into this category. They were, however, accurate terminology of an earlier era and were in turn superseded with “mental subnormality,” “mental retardation” or “mental handicap.” All such terms have fallen into relative disuse and have become tainted with pejorative meanings.
6 Robins, *Fools and Mad*, p. 158.
9 Hanora Henry, *Our Lady’s Hospital, Cork: A History of the Mental Hospital in Cork Spanning 200 Years* (Cork: Haven Books, 1989). Miss Henry was the former Senior Nursing Tutor at Our Lady’s Hospital Cork.

11 The Royal College of Psychiatrists was founded in 1841 under its original title as the Association of Medical Officers of Asylums and Hospitals for the Insane. It underwent four name changes becoming the Medico-Psychological Association in 1865 and was then known as the Medico-Psychological Association for Britain and Ireland from 1887. In 1926, it acquired a royal charter and in 1974 was accorded status as a royal college of medicine. It was under the name of the (Royal) Medico-Psychological Association (RMPA) that it was known as a source of primary materials for this study.


14 Robins, *Fools and Mad*, p. 120.

15 Robins, *Fools and Mad*, p. 158.


18 Robins, *From Rejection to Integration*.


22 Nolan, “Trained for What?”


25 This was known as The Radnor Commission (Report of the Royal Commission on the Care and Control of the Feeble-Minded, Cd 4202 of 1908), which heard evidence from 1904-08. The Commission visited 35 schools, 32 workhouses, 10 asylums and diverse prisons and reformatories and concluded that two-thirds of those ascertained needed urgent residential provision. The figure later reported in Hansard as part of the parliamentary debate to seek enactment of the mental deficiency legislation for Ireland reported a higher figure that was closer to the census figures; U. K., H. C., *Parliamentary Debates*, 5th ser., vol. 55, col. 2199-2200 (24 June 1913), Oral Answers: Mental Deficiency Bill (Ireland).


37 Augustine Birrell (1859-1933), a member of the Liberal government and Chief Secretary for Ireland from 1906 to 1916, forged links with an ally in the Irish party, John Dillon. Opinion differs as to Birrell’s intentions. Seamus Collins, a journalist writing in the *Irish Times* (“Narrow view of 1916 may prove an obstacle to peace,” 4 February 2006, p. 15) considers Birrell’s agenda as being to prepare the country for Home Rule. Roy Foster, however, suggests that Birrell was “hardly involved in the Home Rule question” and that to him was attributed the failure to stem the rise of Sinn Fein. This culminated in the Easter Rising of 1916, after which Birrell resigned as an “ill-fated … chancellor.” See his *Modern Ireland* (London: Allen Lane, The Penguin Press, 1988), p. 432.


43 Persons with an intellectual disability in Ireland were not subject to ascertainment, identification, segregation, and institutionalization by a Board of Control as in Britain until much later. Under sections of the 1947 Health Act (Ireland, Acts of the Oireachtas, No. 28/1947, *Health Act*, 1947), a duty was imposed upon a health authority to ascertain cases of mental deficiency among children in attendance at (Section 22) or not attending schools (Section 23) who were resident in its area.


48 MPA, “Part IV,” p. 309.

49 MPA, “Part IV,” p. 309.


51 The IPPHC had been established under section 10(2) of the *Ministry of Health Act 1919* c 21 with a specific remit for “treatment of physical and mental defects” to regulate both mental illness and mental deficiency under section 3(2b) of the act.

56 Irish Centre for Nursing & Midwifery History, University College Dublin, ABA Archives, General Nursing Council for Ireland, Minutes of Council Meeting 22 September 1920 Vol. 1, File 1, Part II Rules Section 1.2 (c) made by the GNC for Ireland under Section 3.1 (a) of the Nurses Registration (Ireland) Act, 1919 for the Formation, Maintenance, and Publication Existing Nurses of the Register (1920).
57 Scanlan, *The Irish Nurse*.
59 Once the GNCI’s successor, An Bord Altranais established a Register for Mental Handicap Nurses in 1959, there is evidence of inter-country movement of nurses between Scotland, England, and Ireland through reciprocity arrangements. Between 1962 and 1970, 22 nurses from St. Joseph’s Rosewall, Midlothian in Scotland, Darent Park, Calderstones, Coleshill Hall Birmingham, St. Ockenden’s, the Manor, Epsom, and Brockhall in England were registered to work as mental handicap nurses: ABA Archives, Professional Registers, Vol. 18 *Register of Mental Handicap Nurses’ Division of the Register 1960-1983*, Vol. 1 (1960), Dublin.
61 Nolan and Sheridan, “In Search of the History.”
63 Barrington, *Health, Medicine and Politics*.
64 With the enactment of the Local Government (Temporary Provisions) Act No. 9/1923, County Homes, District Hospitals and Mental Hospitals were established for each County Board in 1925. Ireland had no community worker such as the Local Visitors in Britain for persons with an intellectual disability. Individuals already in residential care remained in care. Those deemed harmless were discharged home or boarded out to other institutions. All County Councils dismissed the Boards of Guardians, re-employed the staff, closed or amalgamated the workhouses and designated them as County Homes or District Hospitals. Those deemed as “harmless idiots” and “healthy epileptics” were transferred into these County Schemes.
66 Robins, *From Rejection to Integration*.
67 Robins, *From Rejection to Integration*.
72 Robins, “*Fools and Mad*, p. 190.
75 The content of this preliminary syllabus at barely two pages is short on detail but included three sections “Diseases and Disorders,” “The Nervous System” and “The Mind.” The fourth section “Conduct and its Disorders” was replaced by two new sections entitled “Types of mental disorder” which set out under headings (b) to (d)


79 MPA, “Obituary—Frederick, Edward Rainsford, M. D. Dubl,” *Journal of Mental Science*, clxvii (1923): 268. The spring 1917 meeting of the Irish Division had been held at the Stewarts Hospital, hosted by Rainsford who gave a paper entitled “A Review of the Admissions of Imbeciles of the Mongolian Type during the Last Twenty Years”; MPA, “Minutes of the Irish Division,” *Journal of Mental Science*, lxiv (1917): 238-41. Rainsford, in reviewing the 30 patients admitted from a total of 385 over the same period, described their clinical features, and drew on Langdon Down’s “theory of retrogression of ethnic type.” He noted that “Mongolian imbecility” did not accurately describe the type of disorder since striking differences were to be observed with the Kalmuck people of Mongolia but described them as “essentially ‘unfinished’ children.” In the subsequent discussion of the paper, members highlighted the unique nature of the Stewart Institution in Ireland. By 1922, Rainsford was recorded as one of three medical examiners for the “Mental Defectives” nursing final examination indicating that expertise for training and examining mental deficiency nurses existed within the Irish Free State.


83 As a competitor for mental nurse training, the MPA’s certificate remained a source of tension to the General Nursing Council in Ireland until 1935 when it was relinquished; Scanlan, *The Irish Nurse*, p. 18.


88 RMPA “Minutes of Irish Division, 1930.”


90 Royal College of Psychiatrists Archives (London) Nursing Records Box 1, Folder 3, RMPA, “Syllabus for the Examinations for the Certificate of Proficiency in the Nursing of Mental Defectives (1932).”

91 Candidates had to answer six from eight questions on topics of bedsores, admission of a patient, bathing, temperature recording, skin disorders, haematemesis and haemoptysis, “bad habits,” and music therapy.

93 The Irish Free State.
95 MPA, “Regulations for the Training and Examination of Candidates for the Certificate of Proficiency in Nursing and Attending on the Mentally Deficient,” Journal of Mental Science, clix (1917): 621.
96 Royal College of Psychiatrists Archives (London), Nursing Records Box 1, Pamphlet 1, MPA, “Report on the Revision of the List of Recognized Institutions,” 1924.
98 Namely St. Vincent’s Home and the Stewarts Hospital.
102 The Hospitals Commission, Second General Report, p. 46.
105 Pseudonym.
106 Royal College of Psychiatrists Archives (London), Nursing Files, Minute Book Box 2, 1937-71, RMPA, “Minutes of the Education Committee Meeting 28 July 1943.”
107 Royal College of Psychiatrists Archives (London), Nursing Files, Minute Book Box 2, 1937-71, RMPA, “Minutes of the Education Committee Meeting 28 July 1943.”
109 The other was Stewarts Hospital, which had been approved by the MPA as a training institution for psychiatric and mental deficiency nurses in 1917.
110 Royal College of Psychiatrists Archives (London), Nursing Files, Register Box 2, Vol. 2, (1939-51), RMPA, “Register of Persons who have obtained the Certificate of Proficiency in Nursing Mental Defectives, Vol. II.”
111 Scanlan, The Irish Nurse.
113 RMPA “Register of Certificate of Proficiency: Vol. II.”
115 This would have been good practice to seek a medical superintendent from another institution to act as medical examiner.
116 In 1924, the MPA had reached an accommodation with the GNCI to permit the MPA psychiatric nursing examinations to continue in return for the appointment of nurses to its panel of examiners. Miss Delaney, the former matron of Mullingar District Mental Hospital, had been a nurse examiner for mental deficiency final examinations in England since 1928.
119 Though the minister may have given his apologies routinely for meetings he was unable or unwilling to attend, it is more likely that the controversy with the John Charles McQuaid, Catholic Archbishop of Dublin Church and other political leaders over his proposed mother and baby scheme accounted for his absence. The political outfall from this crisis lead to his resignation on 11 April 1951 as Minister for Health,
his expulsion from his political party, Clann na Poblachta, and to the fall of the inter-
party government of John A. Costello.
121 RMPA, “Minutes of the Irish Division,” Journal of Mental Science (1954): 11-12, July
Supplement.
123 ABA Archives Box 1, Folder 4, Annual Report: RMPA Certificate (1956), p. 2
124 ABA Archives, Minutes of the Mentally Handicapped Nursing Committee: 1958-
1983, Box 1, Vol. 1, “Minutes of Meeting held on 14 February, 1958 of the Committee
set up to draft a Syllabus for the training of nurses in the care of the mentally hand-
icapped.”
125 He was in at this time Inspector of Mental Hospitals.
126 St. John of God’s Order.
127 ABA Archives, Minutes of the Mentally Handicapped Nursing Committee, Box 1,
Folder 4, Nurses for Mentally Handicapped Persons Rules (1958): Section 21 of Nurses
Act, 1950.
128 The final examination was to consist of two written papers each of 8 questions from
which five must be answered covering Sections 8-14 of the MH Syllabus. The written
paper was to be set and marked by Medical Examiners, an oral examination, con-
ducted by two Medical Examiners and a practical examination, conducted jointly by
a Nurse Examiner and a Medical Examiner.
129 ABA Archives, Minutes of the Mentally Handicapped Nursing Committee: 1958-
1983, Box 1, Vol. 1, “Minutes of Mentally Handicapped Nursing Committee Meeting
held on 8 October 1964.”
130 The marking system for the final oral and written examinations was amended to
place greater weighting on Mentally Handicapped Diseases, sections that were con-
ducted and marked by Medical Examiners.
131 ABA Archives, Minutes of the Mentally Handicapped Nursing Committee: 1958-
1983, Box 1, Folder 6, “Record Charts of Practical Nursing Instruction and Experi-
ence for the Certificate of the Nursing of the Mentally Handicapped (1959).”
132 The document followed the format of the RMHN syllabus and Part 1 comprised the
following headings—hospital economy, technique of ward cleaning, general nursing
care of the patient, bed making and accessories, record keeping, administration of
medicines. Part 2 of the syllabus included special treatments, serving of food to
patients, ward dressings and bandaging, special nursing procedures, general nursing
procedures, preparation and care of the patient and apparatus, and examination of
eye, nose, and throat. In all, 11 of the 13 pages of the record charts were dedicated to
general nursing skills such as pre- and post-operative care, amputation beds, surgical
techniques, rectal lavage, eye syringing, and intravenous infusions to name but a few.
133 These consisted of violence, delinquency, absence without leave, epileptic behav-
iour disturbance, and emotional maladjustment; ABA Archives, “Record Charts of
Practical Nursing Instruction and Experience for the Certificate of the Nursing of
the Mentally Handicapped (1959),” p. 8.
134 Intelligence, scholastic and social aptitude testing.
135 Since the 1930s in Ireland this was the type of experience that had been developed for
adult clients by the religious orders such as the Brothers of St. John of God and
Daughters of Charity in their residential homes.
136 ABA Archives, Minutes of the Mentally Handicapped Nursing Committee: 1958-
1983, Box 1 Vol. 1, “Minutes of Mentally Handicapped Nursing Course Committee
Meeting held on 12 February 1959.”
137 “(a) Primary Mental Handicap: Subcultural type-extreme variation of normal–Clinico
pathological types; mongolism, cretinism, epiloia, microcephaly, macrocephaly,
phenylketonuria, hypertelorism, amaurosis, metabolic disorders and mutant genetic variations. (b) **Secondary Mental Handicap**: Rhesus incompatibility, virus infections during pregnancy, spirochaetal infection, birth injuries, prematurity and asphyxia, traumatic, meningitic and encephalitic varieties. (c) **Pseudo Mental Handicap**: Childhood psychosis, gross emotional maladjustment, environmental deprivation, deafness, aphasia, the spastic child”**: ABA Archives, “Minutes of Mentally Handicapped Nursing Course Committee Meeting held on 12 February 1959.”


142 Thomson, *The Problem of Mental Deficiency*, p. 128.

143 Thomson, *The Problem of Mental Deficiency*, p. 128.

144 Thomson, *The Problem of Mental Deficiency*, p. 291.
