

MONYHULL COLONY, 1908.

A BRIEF ACCOUNT OF THE ETHOS, AIMS, AND ACHIEVEMENTS OF A SHELTERED COMMUNITY

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LESLIE E. BLENNERHASSETT M. A.

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PREFACE

With the impending demise of Monyhull Hospital, it was suggested I write a brief article on its history, its purpose, and the major events during its near nine decades as a sheltered community for clients with learning disabilities. I have given it the title as "Monyhull Colony", as the Monyhull community was originally established as thus. I write also, as a tribute to its laudable objectives, some misunderstood, some perhaps misconceived, and finally, as an *epitaph*.

INTRODUCTION

Monyhull had the status of a manor.¹ Its owners were affluent and influential over the centuries. They controlled the toll gate of the Alcester Road and held extensive wharves on the adjoining Stratford Canal.² Monyhull Hall, the residence with its Victorian occupants, saw the development of Birmingham as a major city and the industrial heart land of the British Empire. Her owners represented the entrepreneurial class who benefited from the toil and sweat that forged the industrial revolution. The consequent urban upheaval of mass industrialisation was to exacerbate the problems of the improvident, and the feeble minded.

The city fathers were to foresee Monyhull as a sanctuary and a protection for the vulnerable *mental defective*, as people with learning disability were then known. It was "*sufficiently far removed so that no offence was caused to the more 'sensitive' citizens*".² The Poor Law Guardians of Birmingham, Aston and Kings Norton had pre-empted what was recommended in the 1913 and 1927 Mental Deficiency Acts.³ The Mental Deficiency Committee, which the Guardians were empowered to form by the above Act, established Monyhull as a Colony for the feebleminded and epileptics. The Colony became a yardstick, which other Mental Deficiency Committees through out the country tried to emulate.

The Lord Mayor of Birmingham, Alderman H.J.Sayer, J.P., who was Chairman of the Joint Mental Deficiency Committee, opened the Colony in 1908. In the 25th Anniversary commemoration bulletin of its opening in 1933 it stated ; "*It is a source of great happiness, for those responsible for the Colony, to know that right down to the present, he, (i.e. H.J.Sayer above) has been able to keep in touch with the work for which he was largely responsible in placing on a footing which has been copied elsewhere in Britain, and which is well known abroad to students of this particular work.*"

By 1998 this rarefied institution is to be closed. Its clients are to be resettled in the wider community under a competitive process laid down by the Dept. of Health and Social Security. This entails the process of contracts, purchasers and providers copied from the American health system. Many might have preferred to remain in small homes in a multi purpose community in the grounds of Monyhull, with sitting tenants rights for the handicapped in perpetuity, if there had been that choice¹⁸

II

EARLY ETHOS

The provisions for the mental defective was seen as more custodial and preventive rather than egalitarian. Society was less tolerant of those who did not conform and exacted a price. Though it must be accepted that there were charitable altruistic motives. Then, as well as now, well intentioned people sought to protect and rehabilitate those, who because of their disability, were prey to exploitation and deprivation.

A not dissimilar approach applied to young miscreants, who were sent to be trained in industrial and reformatory schools. The prevailing philosophy was that people could be trained and educated in body and mind. Character formation and conforming to society were *de rigour* in all institutions including the home. The rights of the individual were subordinated to the *summum bonum*, i. e. : the greatest good (of society). Individualism and egalitarianism were seen as idealistic rather than pragmatic. They were regarded as impractical and detrimental to the status quo. The rights of women and children were secondary. This was a patriarchal and hierarchical society, with no apologies. Individual expression was in its infancy. Sexual and

and intellectual freedom for the masses was curbed due to the contemporary moral and social climate. This was strengthened by the imagined or real fear that sexual freedom, synonymous with sexual promiscuity would undermine the mores, health and stability of society.

Those who deviated were seen as a threat to the virtues of conventional faith, as well as order in society. They were sent to institutions for their moral and and society's wellbeing. Women and children were classified as particularly vulnerable, and therefore at greater moral risk. The punishment incurred by many single women conceiving children outside wedlock, was rejection and banishment by respectable society. It was thought then that the majority of mental defective persons were prone to deviancy and easily exploited. Also, as many were not capable of autonomy, or self discipline, their custodial protection and rehabilitation was regarded as imperative.

Today, the welfare state has endeavoured to meet the needs of those with learning disability from a changed perspective with the emphasis on human individuality and freedom. This, however, is not as simple as it appears, as that implies responsibilities and paradoxically, constraints too.

Sir Francis Galton

One has to view the contemporary social problems that the feeble minded posed in the context of the existing knowledge and social mores. The Poor Law Guardians and 'sensitive citizens' were alarmed because of what they perceived as the "criminal tendencies, their drunkenness and prolific breeding"⁴. The local Victorian polymath, pioneer in statistical research, Sir Francis Galton, highlighted the problem in his paper on eugenics, echoing the the Malthusian theory of over population. There was talk of "fear of national degeneracy, of the menace of the feeble minded and of the submerged tenth" Prof. Richard Herrnstein²⁰ most recently, has resurrected a more balanced view in his research findings, where he shows concern among many, about the high significant correlation between those with low intelligence quotients and those residing in places of legal detention, and and its import for society. Contrary, however to the latter view, it was stated that the fears, as expressed by Galton; and those that led to the 1913 Act, had little substance in fact.⁴ It was seen that there was little justification for such a custodial detention policy.

The Poor Law

The Poor Laws and the Workhouses were instituted as national policy during the Elizabethan period. Vagrancy and poverty had become rampant, due in no small part to the dissolution of the much maligned institutions, the monasteries at the behest of Henry VIII. He diverted much of their vast resources to finance his autocratic dynasty. The monasteries were a haven and succour for the improvident section of society. The harsh provisions of the Poor Laws became progressively more acute during the 19th century. Due to industrialisation, the inadequacy of the Poor Law provision imposed itself disproportionately on the the mental defective. Asylums, places of refuge were first opened to relieve the acute plight of the mental defective in the mid 19th century, namely Earlswood Common, Redhill, 1855.

The Midlands Counties Asylum, Knowle, the first of its type in the Midlands was opened in 1870.⁵ It was later known as Middlefield and has had close associations with Monyhull over the decades, with whom it shares the present, Chaplain, Rev. Dr. B. Easter. Colonies for the feeble minded (as the mental defective were later known) and epileptics, a new advanced concept in the care and therapy of mental defectives followed, and were built on a national scale during the early part of the 20th century.

It was then thought by many that the conditions that made people to be feeble minded or epileptic could also be contagious. Feeble mindedness was thought of in terms of a disease, rather than a statistical probability. There was a noted higher risk of infectious disease among the poor, and improvident. Therefore, it was reasoned that they needed protection for themselves, and more important, society needed protection. Shame and embarrassment about diseases of all kinds were prevalent at this time. People feared mental illness, and mental handicap were uniformly inherited. They were sometimes put away in institutions for their protection for the wrong reasons. The Aristocracy were not immune from such

apprehension. At the early part of this century the Bowes-Lyon sisters, cousins of the Queen had learning difficulties. They were admitted to the Asylum at Eariswood. It was then accepted policy for most families, as they were not then inured to cope with severe learning disability. There was not then the susceptibility of the handicapped's right to lead as average a life as possible where that was feasible.

The nursing and care in Asylums had been previously carried out by able bodied paupers in the existing workhouses. A return of 1881 found that only 3% of mental defectives were receiving treatment in the new asylums which were purpose built for them. The situation had improved, thanks to legislation in 1902. A survey in Worcestershire and Wiltshire showed from a nursing care perspective that 34 sane paupers assisted 64 paid attendants in the care of 1124 imbeciles and epileptics.⁴ The majority of attendants had relevant nurse training. These were the inauspicious beginnings of professional care for the mental defective.

Categorisation

Alarm about the social problems and vulnerability of the continued presence in the community of the many defectives led to the Mental Deficiency Act, 1913 Act. This formulated different levels of learning disability known then as *mental defectiveness*. They were now to be categorised as *idiots*, *imbecile* and the *feeble minded*. The idiot was the most severe grade of those who were classified under this nomenclature. This categorisation was to acquire notoriety in a short time for its pejorative overtones. Categorisation in the field of learning disability was to become controversial. It was often abused as a labelling device with disadvantageous consequences for the person thus classified. The feeble minded were to be later categorised as *subnormal*, with mild, moderate and severe grades, statistical nomenclatures, under the Mental Health Act, 1959. This again assumed pejorative overtones. Today, the term used for people with learning disability is people with *learning difficulty*, or by some, as people with a *mental handicap*. This latter term can be misleading, as it can cause confusion with the classification of people who are mentally ill. The characteristics of those who have learning disability is that the underlying aetiology can not be reversed, though its effects can be ameliorated, unlike many who are mentally ill, where the condition may be temporary or spasmodic, and not necessarily permanent.

Normalisation

Those with learning disability, were to suffer from labelling systems which highlighted the negative rather than positive aspects of their abilities. A reaction to negative labelling systems and the institutionalisation of those with a learning disability was later to lead to what may be regarded as a '*progressive movement*' with singularly uniform views called *normalisation*. Over institutionalisation was a problem as the nurse was trained to carry out orders, which were carried down the line in an often ritualistic fashion. This had adverse consequences on imagination and initiative, essential characteristics in meeting the *therapeutic* needs as opposed to *functional* needs of clients with learning difficulties. Hierarchy, it is said, had little place in a therapeutic community.⁴ Of course there is an element of hierarchical practice in all human organisations. It was the manner in how the hierarchical practice was carried out that was under scrutiny.

*Normalisation*²³ is a sociological concept that became common in the 70's. It emphasised values and needs, which all people share with each other, regardless of disability. It encouraged the integration of clients with disabilities in to the wider community. This was to have an enlightening effect on the attitude on the general public. Its message was further strengthened by the mass media, and increasing client contact with the community outside.

To return to contemporaneous policy, as result of the 1913 Act, the policy towards the mental defective changed from ineffective *laissez-faire* supervision to supervised custodial detention. The mould of the attitude of contemporary Colony staff reflected this custodial policy.⁴ Later sociologists were to state that paradoxically, the handicapped were more '*handicapped*' by people's attitudes, and some of the institutions in which they lived, as much as the perceived handicap.

Monyhull was listed in the Domesday Book as Monyhull Hall and was owned by a religious order, probably the Cistercians.² There are still traces of the moat which surrounded the Hall in those days,¹ presumably for defensive purposes. Also there are remnants of the pond which was important for supplying fish for the manor house. This pond, with its own rowing boat, was used for leisure purposes by the staff and clients of Monyhull, up to the 1960s when it was eventually filled in.⁶

In the lay subsidy roll of 1275 here was mentioned a Richard De Monyhull. The term "hull" is middle English, meaning hill.¹ The site of the present Hall is on a hill with fine open views to the South which includes the relatively recent suburbs of the Maypole, and Druids Heath. This was rural country, side prior to the characterless municipal development with its high rise blocks post 1960, surely the nadir of architectural and civil development. Monyhull Hall is in the parish of Kings Norton, which was a chapelry of Bromsgrove in the past.⁷ It was part of the County of Worcester along with Kings Norton until 1911 when it became part of the City of Birmingham.

At the time of the dissolution of the monasteries in the 16th century, Monyhull belonged to the College of Westbury, a monastic foundation near Bristol. The manor house of Monyhull was built in the 16th century and possibly there was an older building before that time as in the reign of Henry III, (13th century) there was a "Ketel de Monyhull" who was listed as a tenant in Kings Norton.⁸ The present mass closure of hospitals has an analogy in some respects to the 16th century dissolution of the monasteries. Monyhull Hospital is planned for closure and eventual demolition as stated. Its expansive acreage will be sold to developers subject to planning permission.

The main Hall which is known colloquially as the 'White House', is a Grade II listed building was built in 1864 and not 1750 as stated in Lock's History of Old Kings Norton. The description of an earlier building is mentioned in the 1825 advertisement of the public auction of Monyhull Hall and its estate.⁹ The 1750 house was built by John Pountney whose family have a memorial in Kings Norton church. It was more modest in specification than the present building, built for Mr. E. Millward, the gun manufacturer in 1864.

In 1543 Henry VIII gave to Sir Ralph Sadler "*the manor of Monihills*" and some of the manor lands went to a Thomas Grevis.¹ The manor was then sold to the Sparry family whose first owner was William Sparry, grandfather of Francis Sparry²¹, scholar, and assistant to Sir Walter Raleigh in his quest for Eldorado. They were Roman Catholics.. They were proscribed, and virtually under house arrest, as they were regarded as recusants due to their assumed political beliefs. In 1610, after considerable debts, this family relinquished the manor to William Child, with whose family it remained until the mid 18th century. It eventually passed to John Pountney and his heirs. They sold it to the Millward family in 1864.⁸ It was eventually transferred with 128 acres for the sum £13,500 in 1905 to the Joint Poor Law Committee and Guardians of the poor for Birmingham, Aston and Kings Norton.³

IV

MONYHULL COLONY

In 1901 at the West Midland Poor Law conference, Mr. R. J Curtis, clerk to the Poor Law Joint Committee (later Sir James Curtis, K.B.E.) delivered a paper recommending the "*removal of mentally defective persons from the workhouse where they could not receive suitable treatment and where they were a source of inconvenience and often danger to other inmates*". The first section of six Homes for 216 patients was completed at Monyhull Hall in 1908. A further extension was added in 1913 and was opened by the Home Secretary, Rt. Hon. R. McKenna, M.P. The children's section was not finished, and was taken over by the War Office, as a military hospital until 1919.

It was known officially as Monyhull Colony for feebleminded and epileptics after the 1913 Mental

Deficiency Act. Later there were added two adjacent farms, Kingswood and Bell's farm. The latter is being restored as an architectural historic moat house with Saxon and Tudor origins. It won the Sunday Times restoration award in 1989. This was largely financed by grants from the the City council. It had close links with the manor of Monyhull and its recusant owners in the 16th and 17th centuries. It was reputed to have a secret staircase and tunnel which were useful during that period of religious persecution, and the paranoia arising out of the misconceived Gunpowder Plot. The would be perpetrators were from local midland gentry stock who were recusants. Draconian measures were passed, to the economic detriment of Catholic recusant families, of which the Sparrys above were no exception. The Ferrers of Baddesley Clinton were similarly affected. Bell's Farm was the residence of the bailiff of the manor of Kings Norton, John Field, in 1706.⁸ It was to resume a similar occupancy by being the residence of the farm bailiff of Monyhull Colony in 1909.

By 1925, the total land acreage of Monyhull Colony was 320 acres. Of this 270 were acres were farm and vegetable gardens. The remainder was occupied by buildings, ornamental gardens and playing fields. Electricity installation was a later addition in its modernization after the First World War.¹⁰

St Francis School

In 1913 the children's section, later to be known as St. Francis school, was built. It was opened as a special residential school in 1920.¹⁰ A chapel was opened in 1917 to cater for the Colony, whose patron saint was St. Francis. - In deference to cultural modernity, the school's name was changed to Lindsworth, after a local farm, now long since forgotten. In addition to the usual subjects, the curriculum included physical training, music and gardening.

Colony Life

On the adult side there was emphasis on trades and occupations including agriculture. There were organised games, dancing, sports, cinema, walks and shopping expeditions. There were special leave facilities, at the behest of the medical staff, in keeping with the *"the Committee's legal and moral obligations"*. It was stated that there were *"many dangerous and troublesome patients"*¹⁰ The patients had the right to address their grievances to the Committee. *"Discipline was harsh and the diet was not calculated to lead to overweight, although sufficient not to lead to underweight."*⁸ The scarcity of food during World War I was of great health concern to the first Matron of the colony, Miss Mary J Carse.⁹

Miss Carse retired after 14 years of service with a glowing tribute : *"The occasion of your retirement as Matron.....the Committee recall the fact that you were elected as the first matron of the Colony in November 1907 and assisted to establish the Colony and begin the pioneer work of specialising in the treatment and training of the mentally deficient. The subsequent extensions to the Colony, their furnishings and equipment, the setting up of various training departments and the opening of the Residential School have emphasised the possession of administrative qualities of a high order which you have unsparingly given during a period of years rendered more difficult by the stress of a great war....."*.

The Colony relied on the farm for vegetable, meat and dairy produce though it was not entirely adequate.

The 35 gallons of milk produced daily in 1921 was not sufficient for its needs and was supplemented by condensed milk.⁹ Modern farming methods would not have necessitated such supplements thanks, to extra milk yields that a large farm of this size would obtain today. It had its own bakery run largely by the inmates. Clothing and shoes were made by the Colony's own craftsmen² who included osiers⁹ who made baskets from the osier willow grown on the Colony's adjacent marsh land.

In 1927, a second Mental Deficiency Act laid upon the Mental Deficiency Committees the duty of providing training for those who were otherwise considered *ineducable*. The two main principles of the Mental Deficiency Act were that *"the comfort, convenience, and well being of the general community require that those defectives who offend, in any way, against the community, or are them selves ill treated or neglected or in any other danger, be removed from amongst the general public, or placed in other suitable care"*. One of the main aims was to rehabilitate suitable patients to live useful productive lives. During

the period of training and care, the patient was encouraged to make a contribution towards the cost of their maintenance. *"The defective is equally regarded with any other class of afflicted persons as deserving of practical sympathy. The help given by the placing of orders for surplus goods that be supplied by the patients is gratefully acknowledged. There remain however, many ways in which understanding help, not charity, can be given in this way"*¹⁰

Medical Supervision

In 1922 Monyhull had its first Medical Superintendent, Dr. Bert Jordan with experience in psychological medicine. It was to become an institution for Mental Research, established jointly by the City and University of Birmingham.¹⁰ Female patients were to later join, and were firstly, housed in large hostels outside, namely the Haunch. The Laurels and Trostreay are still extant as the Psychology Department, South Birmingham Mental Health Trust. Many female patients were under Colony supervision as they were regarded as, being at moral risk. It would be regarded as patronising by some today. It showed concern for the welfare of clients who would otherwise have been abused by their circumstances. Such supervision may have been regarded as an unwarranted intrusion in the life of people who could not conform to a conventional lifestyle. However, the social issues involved made their temporary admission necessary in most instances. The concerns now are that many people, with learning disability and mental illness, of both sexes, end up in inadequate institutions, often jails, which aggravate their difficulties. These concerns have not been seriously addressed following recent legislation. It by default or negligence undermines much of the pioneer work carried out previously under the traditional ethos

The medical superintendent used to be the sole administrator, judge and arbiter of all decisions affecting the feeble minded. The social structure in most mental defective hospitals was acutely hierarchical. At the top was the medical superintendent. To quote J. O' Hara, a Monyhull male nurse of the 1960's, *"There was built round him a fence of sanctity and he occupied a demeanour of majesty that he was well nigh unapproachable"*⁴

Pioneering approach

Nevertheless, Monyhull was fortunate in having medical superintendents with broad perspectives, some of whom were pioneers in the therapy and education of adults with learning disability, namely the distinguished medical directors and psychiatrists, Drs. C.J. Earl, and R.J. Stanley, respectively, along with the noted educationalist/psychologist, Dr. H.C. Gunsberg. They gave Monyhull a national reputation in the education, occupation and therapy of the mentally handicapped.¹¹ Dr. Earl diagnosed the difficulty appertaining to the education and care of the handicapped: *"It is a bitter paradox that all concerned educationalists, psychologists, sociologists, psychiatrists find it easier to deal with complex intelligent patients than with simple subnormals"*¹² was a perspicacious comment in his book on the *subnormal* personality.

Education

One of the great difficulties inherent in hospitals for the mentally handicapped was the inbuilt rigid hierarchy emanating from the medical director and allied medical nursing structure, as stated by J.O' Hara in his perceptive essay.⁴ As far back as 1929 the Wood Committee had thrown down the gauntlet. *"The mental deficiency institution should not be a stagnant pool but a flowing lake, it should be equipped with a school workshops, playing fields...."* i.e. closer to a boarding school than a hospital.⁴ The nurse should be seen more as a teacher or a houseparent. Discipline is necessary in any well run community. It should be tempered by a caring imaginative ethos, not by impersonal hierarchies which did stifle measured sensitivity, necessary in a community run for the benefit of handicapped clients.

The negative custodial relationship, often through no fault of the nurse, was to change, very slowly, to a new multi-faceted, multi-disciplined approach based on a socio-educational model. Monyhull was foremost in many areas not least the importance of the educational role in learning disability, with its

implied learning deficit, which is the *raison d'etre* of the education and rehabilitation facilities which were built. It was the first mental deficiency hospital to appoint an educationalist of graduate status under the auspices of the *avant-garde* Dr. H.C. Gunsberg.¹⁹ He was to achieve international recognition in the field of rehabilitation, education and assessment.¹³ Emphasis was now placed on the role of continuing education which up to then had been neglected.

The implementation of the new approach was the building of new education, training and therapy workshops, which were the first of their kind in the country.¹³ There was a revolving door policy with an accent on the new approach, with a view to eventual discharge, where practical. It had already established the precedence of *individual care in the community*. The Colony's hostels, mentioned, were used for this purpose from the late 1920' onwards. The necessity of munition factory workers during the Second World War expedited the discharge of able clients, who remained outside as independent citizens.²²

V

^a MONYHULL HOSPITAL,

In 1930 the Colony was transferred to the City Council and in 1931 to the Mental Deficiency Act Committee, thus ending 23 years of work under the Poor Law Acts. Monyhull was transferred to the National Health Service in 1948 and was joined as a Group Hospital with Middlefield, Knowle. It ceased officially as Monyhull Colony. This was to eventually see the termination of the large acreage and farming activity which many regarded as a retrograde step. It removed one possibility of meaningful occupation. Access to occupation, preferably paid, is important for most people and those with learning disability are no exception.

The number of clients of both sexes resident in Monyhull reached a maximum of over 1000 by the beginning of 1960 which was beyond the capacity of the original plan. However with the exodus which had begun after this peak of admission, the number of clients was reduced to 399 by 1985 and is now down to 135 residents approximately. The most able have been discharged. The remaining clients are the most severe in terms of disability. They require the most intensive support be it care or therapy. These will, by government policy, be provided for by a competitive process when the hospital closes.

VI

COMMUNITY CARE

The hospital doors began to open widely in the 1960's and what was a trickle soon became a deluge. The community outside was ill equipped to deal with the influx. The progressive cut backs in national and local funding has made 'community care' for many a 'glib phrase' rather than a viable therapeutic policy to quote a recent prominent local politician. Community care is a controversial concept. In 1975 the White Paper on mental health called it "a catch phrase", and recognised the problems of the wider community not being able to meet the needs of individuals with severe mental impairment. The community care policy instigated in 1961 was introduced with out prior research and with out special funding and "with out any attempt to find out what the community was prepared to accept."¹⁴ Many clients suffer deprivation in the community due the haste in which they were discharged, repeating the cycle of deprivation, and in some instances, exploitation, from which they they had been protected while resident at Monyhull.

Constraints

An other dilemma is that minimal 'unfettered space', and a lack of a *community ethos* is constraining the ability of those, with severe mental impairment, to adjust or be accepted in a *laissez-faire* society.¹⁸ A movement in favour of the positive aspects of sheltered communities for some, is now come to the fore with an emphasis on a eclectic approach. Charities such as *Rescare*, with the blessing of Lord Renton ex president of Mencap gives credence to this alternative view.¹⁵ Political correctness or uniform thinking, in all matters affecting mental welfare does not have wide scale parental approval.¹⁶ Much recent legislation with intention to improve the rights of the handicapped, has ironically not achieved its

purpose of ensuring adequate treatment for those with learning difficulties. It has made those with severe impairment, conform to a particular sociological view of society which in many cases, ill suits their needs. Laws, without proper financial support, for the vulnerable section, to which they apply, may pay only lip service to their real needs.¹⁴ Wide choice, and diversity of provision with proper funding, should be an aim in meeting the individual needs of client within the continuum of learning difficulty.

Generic Service

From the 1960's onwards, Social Services, slowly, if somewhat fitfully, became the approved agency for providing a service for clients with learning disability. The needs of clients demanded an independent client lead service, which is not constrained by the philosophy of any monopoly provider. Health and Social services, as providers, may have other major priorities within their own specific structures. A learning disability service is uniquely generic. It demands an independent inter-disciplinary approach. This would help prevent such a service being relegated to an under funded, cinderella service, with history repeating itself. It should be ideally an independent funded, multi-disciplinary body drawing on the expertise of all services with parental, advocate, and consumer input. The role of *Voluntary* and *Private agencies*, as recommended by government policy, will not necessarily resolve the difficulty. It could hinder improvements, due to lack of a professional care ethic, inadequate resources, and the dependency on profit as opposed to regulated dependability and national therapeutic standards of care.

Due to fate of history, asylums for the feeble minded adopted a medical model rather than a generic one, On the Continent the approach was more multi-disciplinary, particularly in institutions which emphasised the role of education in learning disability.¹⁷ Dr. I. Freedman, recent Chairman of the Medical Staff Committee, at Monyhull, encouraged the multi-disciplinary concept both in theory and practice.

Resettlement

The purpose built villa type accommodation, for which Monyhull was renowned, was a great advance at the time. It was however oversubscribed with up to 70 clients per villa. The villas were designed for less than half the numbers who lived in them. This minimised the comfort aspect they were originally designed to fulfil. Such villas type accommodation became overcrowded and impersonal. This was due more to under funding rather than any intention to cause depersonalisation *per se*. Hence the need to resettle clients in small homely living units became a priority under the resettlement process.

Parents and Relatives

The parents, relatives and others fought to retain the the grounds and amenities of Monyhull for the use of the clients. A small part of of Monyhull grounds, after the villas are demolished, were recommended by Social Services, to be used for small domestic homes with 4-5 clients to each homes. The villa type accommodation will be laid to rest and replaced with small personal units outside. It is hoped that the positive aspects of Monyhull with its caring ambience will not be entirely lost. The longevity of clients in the hospital speaks for itself.¹⁸ It is hoped that the client's community of friends will continue to be viable in modified and improved facilities outside. The outside *community*, however, will not exist for the majority¹⁴ who have grown to know each other. Their need for non hazardous, familiar, therapeutic, open surroundings is necessary, humane and civilised. and is essential for the most vulnerable.¹⁸

Closure

The fate of the purpose built day and recreational amenities is still in doubt, hopefully to be replaced by adequate recreational and occupational facilities outside. The Year 1997, which is the planned year for final closure. Evolution rather than the undue haste may affect the future provision for the handicapped. It suggests the retention of the positive aspects of communities for people with learning difficulties. These, at their best, can be on par with the best of what an eclectic and caring society will willingly accept for its most improvident. Any community or institution, small or big, which has inadequate care or meagre funding will repeat the same mistakes. This is particularly so in the complex and dependent area of

learning disability. Only by constant vigilance, and critical re appraisal of old and new policies of care, can one hope to avoid the ignominies of the past. The crux of the present difficulties, is that in the quest for rapid change, i.e the forced implementation of *community care*, before the end of this millennium, the government, may be motivated by financial reasons, rather than the genuine attainments of the client's optimum interests.

September 1995.

-Leslie E. Blennerhassett.

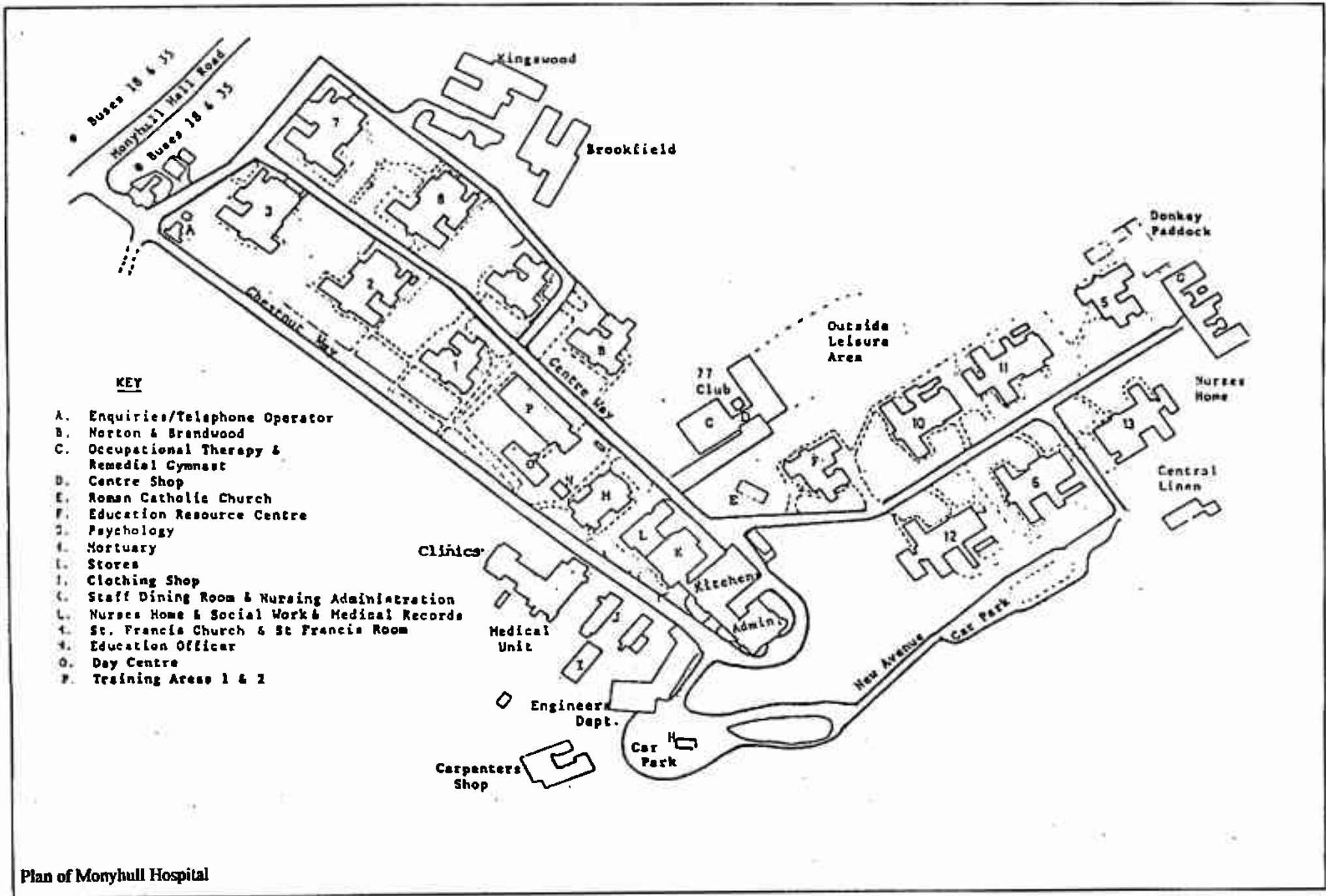
[Born in Dublin. Read Psychology and Philosophy at Trinity College, Dublin and completed Post Graduate Education Studies at Shenstone College, Bromsgrove. Ex Chairman, Harborne History Group, Committee member of the Harborne Society. Education Officer at Monyhull since 1976.]

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KEY

- A. Enquiries/Telephone Operator
- B. Norton & Brandwood
- C. Occupational Therapy & Remedial Gymnast
- D. Centre Shop
- E. Roman Catholic Church
- F. Education Resource Centre
- G. Psychology
- H. Mortuary
- I. Stores
- J. Clothing Shop
- K. Staff Dining Room & Nursing Administration
- L. Nurses Home & Social Work & Medical Records
- M. St. Francis Church & St Francis Room
- N. Education Officer
- O. Day Centre
- P. Training Areas 1 & 2

Plan of Monyhull Hospital