Scandinavian Journal of Disability Research, 2015
Vol. 17, No. 1, 14–25, http://dx.doi.org/10.1080/15017419.2013.868824

Routledge
Taylor & Francis Group

Patients with intellectual disabilities in the forensic asylums 1915–1982: before admission

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(*Received 29 August 2013; accepted 20 November 2013*)

Until 1982, a number of patients with intellectual disabilities (ID) in Norway were hospitalized in the country's two forensic mental health hospitals. The aim of this article was to explore the background of these patients based on the characteristics of their life experiences before admission to the hospital. Data from the period 1895–1982 were retrieved for 272 patients with ID. All patients' records were read and key information from childhood and important life experiences were categorized in terms of both numeric and descriptive variables. Most patients had experienced social and health problems in their family during childhood. A minority had completed primary education. A majority of the patients had some work experience. Offences leading to admission included several types from simple to serious crimes. Three periods were compared in order to study the changes in relation to the changing social and welfare conditions during the century. One main observation was that in spite of better education the trend during the century was that fewer of these patients experienced any labour participation. Historically, the diversity in level of functioning and previous treatment makes patients with ID in the forensic mental health hospitals a more varied group than previously described.

Keywords: intellectual disabilities; history; mental health; forensic; institutions

Introduction

Studies of and interest in offenders with an intellectual disability (ID) have increased rapidly during the last 20–30 years (Holland, Clare, and Mukhopadhyay 2002; Lindsay 2002). However, the focus on this relationship dates back to the early 1900s, when differential psychology, theories of degeneracy and eugenics evolved (McDonagh 2008; Rafter 1997; Scheerenberger 1983). In the beginning of the twentieth century, the association between ID and offending behaviour was perceived as more absolute and ominous than it is at present, against the background of today's welfare-conditioned beliefs. Leading voices such as Walter Fernald and Henry Goddard were pessimistic about the prospects, with statements such as 'the feeble-minded are a parasitic, predatory class, never capable of self-support or of managing their own affairs. They cause unutterable sorrow at home and are a menace and danger to a community' (Fernald 1912). The idea that people with ID were predisposed to criminal activities made such an

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impact on the legislators and policy-makers of the time that special eugenics programmes and legislation were implemented, and special institutions were built to house, protect and train people with ID (Rafter 1997). The view that there was an association between intelligence and crime was dominant until the second half of the twentieth century (Scheerenberger 1983). This relationship is still recognized as robust (Lindsay, Taylor, and Sturmey 2004). However, the causal relationship has been questioned in the studies emphasizing socio-economic status, social deprivation, parental disorders and peer influence (Moffitt et al. 1996; West and Farrington 1973).

Welfare and policies regarding people with ID changed in some respects during the last century. The eugenic institutionalization during the period 1900–1920, as described by Scheerenberger (1983), with a large number of institutional beds for people with ID did not take place in Norway. A few small institutions (500 beds in total) were established until 1952, when the institutional movement began and the number of beds was increased to 5000 in a few years. The neighbouring countries Denmark (in 1911) and Sweden (in 1928) had established forensic hospitals for ID offenders (Kirkebæk 1993). A secure unit for 'restless male patients' was established at one of the Norwegian ID institutions (Emma Hjorts pleiehjem) in 1934, but there seemed to be little political interest in this initiative and consequently insufficient funding to operate this unit (Fjermeros 1998). These national differences have two possible explanations. First, the Norwegian economy was weak, with the result that such services were not prioritized. Second, the highly influential enthusiasts who could raise the issue of such special care on a priority level were absent. In Denmark, Christian Keller dedicated his working life to the forensic ID-services (Kirkebæk 1993) and in the USA, Henry Goddard was among the pioneers (Scheerenberger 1983).

Kirkebæk (1993) based her studies on the Kellerske institutions in Denmark, where people with ID were separated into two groups: those with intellectual and those with moral disabilities. The latter group was associated with insanity, but was treated separately in the forensic mental health care. The Norwegian historian Svein Skålvåg (2003, 317–318) argues that in Norway a different explanation was given for people with ID. The differences were mainly that ID was not classified separately but was categorized under mental disorders in Norway unlike the situation in Denmark with two scientific classes as described by Kirkebæk (1993). Skålvåg (2003) argues that different perspectives and professional positions on ID during the first decades of the twentieth century may reflect major conceptual differences in the Nordic countries. The consequence was that the ID-services were subordinated to mental health services in Norway, in contrast to several other countries.

Offenders with an ID in Norway

Although the Norwegian services were influenced by these international trends, very few institutional places were adapted for people with ID and none was specially adapted for offenders with ID. A significant proportion of the patients in the Norwegian forensic asylum Reitgjerdet (1923–1987) and its predecessor Kriminalasylet (1895–1963) were however characterized as mentally disabled. A large proportion of these patients were admitted from prisons or other local asylums because of problematic or dangerous behaviour. A significant number of patients were also admitted directly from their own homes, apparently as a consequence of social crisis. The background information on most of the patients was described in the medical journals. Inadequate welfare services seemed to have contributed to the large number of ID patients. A number of comments on this

'welfare gap', describing these patients as unfit for treatment in this forensic hospital (Andresen 1926), seemed not to influence the admission policy during the entire century.

The Reitgjerdet asylum then had to provide for ID offenders, although the hospital was intended for other forensic services. The chief physician at Reitgjerdet, Karl Andresen wrote in 1926 that issues of ID were outside the scope and competence of the Norwegian psychiatrists; however, they had to admit such patients in the absence of other options (Andresen 1926). When institutionalization was introduced in 1952, some ID offenders may have been placed in such non-forensic services, but the admission of ID offenders to Reitgjerdet was continued until the Norwegian parliament decided to phase it out in 1982.

A selected historical scope

The number of pupils in special schools for people with ID, introduced by law in 1881, declined significantly from 1900 to the 1930s and the age of entrance to the schools increased from 7–8 years to 10–12 years. High costs and low priority from the government were the subject of some of the complaints from the special school administrators (Grennes 1933). Professionals in the field were disappointed about the political disregard of the needs of people with ID. After Second World War, this social problem seemed to be overdue for inclusion in a developing welfare system. The introduction of the modern welfare system was associated with the central financial responsibility for care of people with ID in 1949 and later with the establishment of the national health care for people with ID in 1952 (Sandvin 1995).

The insufficient services and neglect of the needs of people with ID during the first half of the twentieth century led to placements and care from services and staff in other sectors and professions. One such recipient of these people was the forensic services.

Aims of the study

This study has aimed to explore the characteristics of patients with an ID in the forensic services in Norway in the period 1895–1982, as these patients has previously not been recognized. The emphasis was on their family background, school experiences, health, adulthood, offending behaviour and the reason for admission to the forensic hospital. One objective of this study was to question the Norwegian policy of incarceration of people with ID and to compare it with previous and recent international practice. In the search for literature, we did not find any other descriptive studies of a comparable sample.

Methods

Material

The patient archives of the forensic hospital Reitgjerdet and its predecessor Kriminalasylet cover 1810 individual patients who were admitted one or several times during the period 1895–1982. All patients were admitted with medical reports and diagnoses, and most of the patients were diagnosed with severe mental disorders such as dementia praecox (schizophrenia). Among the minority of patients, 272 (15%) were diagnosed with ID, labelled debility, imbecility or idiocy. Several patients with other diagnoses such as epilepsy, *insania ex constitutione* and *insania degenerativa* also had considerable intellectual problems, but without an ID diagnosis.

The background information varied in quality, content and structure, and reflected the traditions and the formulations of the chief physician. However, the patient information made it possible to make useful comparisons and descriptions.

The study has attempted to describe the magnitude of lives amongst patients with ID in the forensic psychiatric hospitals in Norway through shifting periods in the twentieth century. The unique aspect of the sample is that all patients with an ID have been included on a national basis.

Sample

All patients with an explicit ID diagnosis (n = 262) were identified from the patient archive. Further study covering related diagnosis groups such as epilepsy, *insania ex constitutione* and *insania degenerativa* indicated that 10 more had a co-morbid ID diagnosis, so the sample was adjusted to 272 patients. The forensic hospital was established in 1895, but the first identified patient with an ID was retrieved in 1915, and the study sample in this matter dated back to 1915.

Procedure

All data were coded from the records and structured in categories of numeric information. The study was approved by the Regional Ethics Committee for medical research (REK), reference number 2010/2206-10.

Data management

Because the focus of this study was on the time before admission to the forensic hospital, the key aspects explored included information on demographics, family relationships, illness in the family, behaviour in childhood, education, residential care, health information, crime and mental health before admission, employment and mental functioning (IQ and/or mental age). We also looked at differences in the patients admitted during three periods: 1915–1939, 1940–1959 and after 1960.

Through several consultations within the project group, the variables and target objectives were defined. All patient records were studied and the key information was registered electronically. The Statistical Package for Social Sciences (SPSS) version 16 was used to conduct the analysis. In describing crucial childhood, schooling, relational or offending episodes we used string variables as supportive to the quantitative measures. These variables were systematized and served as supporting information.

Results

The mean age on first admission to the forensic psychiatric hospital was 31.0 years (SD = 10.2). All patients were male. The admission age ranged from 14 to 60 years. Most patients (n = 196, 72%) had a previous history of forced labour (n = 40, 11%), prison (n = 122, 45%) or psychiatric institutionalization (n = 136, 50%). However, 76 (28%) had no previous institutionalization. Only 9 patients (3.3%) were admitted from institutions for individuals with ID and 34 patients (12.5%) were admitted directly from their homes.

Descriptions of mental disorders, intellectual disabilities, alcohol problems or offending behaviour in the family of the admitted patient were retrieved (see Table 1).

Severe Illness and Injuries

Severe illness and injuries during childhood were reported for a small proportion of the sample. Illness (n = 46, 17.2%) was mainly associated with epilepsy and encephalitis, and

Table 1. Problems described in the proximate family (parents and siblings) of the admitted patients (n = 272). A combination of several problems in the family was found for some of the patients.

Problem in the proximate family	Number of proximate family members affected (%)
Mental disorder	61 (22.3)
Intellectual defect	60 (22.0)
Alcohol (substance) problem	81 (29.7)
Criminality	26 (9.5)
Supported by the poor relief	52 (19.0)
Parental death during childhood	72 (26.4)
No such family problems	20 (7.3)

injuries (n = 23, 8.6%) were mainly due to accidental falls. Numerous patients seemed to be admitted to the forensic services in the absence of more appropriate services or because of maladjustment in the services, often based on practical more than medical grounds:

> Torstein aged 14 was diagnosed with Spielmeyer-Vogt disease (characterized by blindness, ID and early death) when admitted in 1945. He had previously been treated at home, but as he became older and his condition grew worse, with more severe seizures and impaired mental functioning, his parents applied for professional health services. In an unusual letter to the forensic services, the father appealed to the director of the hospital: 'When we now hand over our dear son to you, you will hopefully share the heavy burden that we were given'. Scant knowledge of the disease in the health services combined with the absence of suitable services led to this admission. Torstein was later described in a case report. (Löken and Cyvin 1954).

Educational history

A large proportion of the admitted patients had entered regular school (n = 181, 66.5%), but only a small proportion had completed primary school (n = 57, 21.0%). For 32 patients (11.8%), there was no information about school history.

A considerable number had been transferred to approved schools (n = 49, 18.0%) or special schools for children with ID (n = 65, 23.9%). Behaviour problems in school (including approved and special schools) were described in the records of 159 (58.5%) patients.

Employment experiences

A large proportion had no previous work experience (n = 119, 43.8%), and most of those with work experience were unskilled or casual workers (n = 120, 44.1%). The occupations ranged from seamen and construction workers to farm-workers. Only 29 patients (10.6%) had experience as skilled workers, independent farmers or fishermen.

Offending behaviour

Most of the patients (n = 268, 98.1%) were admitted to the forensic hospital because of behaviour described by the referring instance as problematic or dangerous. A variety of offending behaviour were described and some of the patients had been associated with a large number of criminal activities; however, 52 (19.0%) had no record of offences. One

Table 2. Offending behaviour described in the patient records. Some patients had several previous and different criminal offences.

Offence	*N* (%)	*N* (%)
Theft and robbery	94 (34.4)	
Petty theft		83 (30.5)
Robbery/ organized crime		11 (4.0)
Sexual offences[a]	82 (30.1)	
Rape		17 (6.3)
Attempted rape		36 (13.2)
Indecency or exposure		42 (15.5)
Violent offences[b]	94 (34.4)	
Homicide		12 (4.4)
Serious violence offence		41 (15.1)
Less serious violence offence		49 (18.0)
Property damage	39 (14.3)	
Arson	26 (9.6)	
Other offending behaviour[c]	104 (38.1)	
illegal begging		17 (6.3)
threats		50 (18.4)
public order offences		68 (25.0)

[a]A few patients were convicted for several types of sexual offences.
[b]A few patients were convicted for both serious and less serious violent offences.
[c]Some patients had been convicted for more than one other type of offending behaviour.

or more serious crimes (sexual offences, harmful violence including homicide or arson) were described in 162 people (59.3%) in the sample. Theft/robbery and violence were the most frequent offending behaviours (see Table 2).

Mental health

Although the forensic mental health hospital was intended for treatment of patients with psychiatric disorders, many of the patients in this sample only had an ID (n = 120, 44.1%). Psychosis (n = 56, 20.6%) and other psychiatric disorders with less-specific descriptions (n = 39, 14.3%) were reported in these patients. Such psychiatric disorders specified in less detail could be reframed in terms of neurosis, sociopathy, sexual perversions or deviant emotional personality.

The intellectually disabled patients were mainly diagnosed with the label ‘imbecile’ (n = 171, 62.9%). A considerable proportion was labelled as ‘idiots’ (n = 46, 16.9%), and some as ‘debile’ (n = 40, 14.7%). Information about intellectual function was obtained in only 63 cases (23.2%) and ranged from IQ 30 to 94 (mean 59.7, SD = 13.7).

Pragmatic arguments of convenience sometimes overruled the more restrictive criteria of admitting patients to Reitgjerdet, exemplified by the case below:

> Harry, admitted in 1954 from prison, was described as a ‘difficult psychopath’ since childhood with alcohol consumption and severe threats towards his own family. Forensic examinations had been conducted twice, both concluding with no insanity but delayed moral development, debility, mendacious, emotionally unstable, undisciplined and contentious psychopathic. In previous institutions, he had had a history of suicidal and self-injurious behaviour. The prison medical officer describes relief in transferring him and ‘in the present situation I find no other solution than declaring him insane for practical reasons to get him admitted to Reitgjerdet’.

Time periods

The changing characteristics of the patients admitted to Reitgjerdet and Kriminalasylet were studied in three groups, those admitted before 1940, between 1940 and 1959 and after 1960. In total, 122 people were admitted in the first period, 101 in the second and 49 in the third. Childhood, education, employment and institutional past were the target objectives of the analysis. Figures 1–3 illustrates the differences found in the periods.

The changes in welfare services over time are exemplified by two cases in which the described problems were addressed differently:

> Otto, admitted in 1926 at the age of 23, had left school after two years, at the age of nine, and subsequently lived in a dysfunctional home taking part in farming work. Throughout his childhood he was described as stubborn with bursts of anger. When he was an adult, after he had tried to set fire to the local grocery, his threatening behaviour towards his father was discovered by the district medical officer and the police. The behaviour problems had developed and increased, with suicidal threats and severe knife attacks on his father.

> Arne (age 23) was admitted in 1968, and was from early childhood described as 'mentally unable to manage an independent life'. However, he was educated until the age of 16, in both normal and special schools. Besides the learning disabilities, he displayed oppositional and sadistic behaviour to his teachers and schoolmates. In the special schools, his misbehaviour was described as even worse, terrifying and almost killing weaker schoolmates. Later, he did not succeed in the labour market; he lived as a tramp, and he was treated by social services and care services for alcoholism. He was convicted for an attempted homicide.

Discussion

Most of the admitted patients with ID grew up in families with social and/or medical problems, and the impact of these problems continued during childhood, education, adolescence and adulthood. A small proportion (7.3%) had no associated family

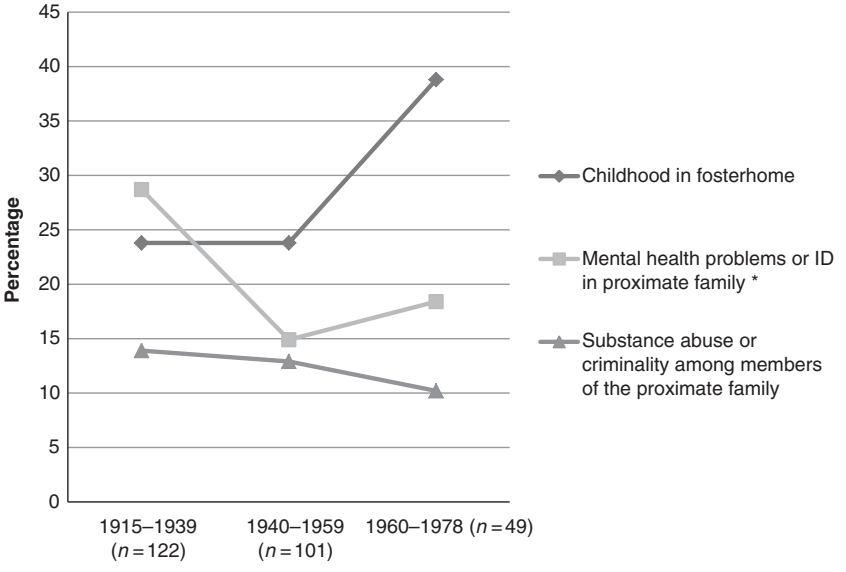

Figure 1. Childhood experiences in patients with an ID. (*) indicates that the difference were found significant below the level of 0.05 using a Chi square-test.

Figure 2. Education and employment before admitting in the hospital. (**) indicates that the difference were found significant below the level of 0.01 using a Chi square-test.

problems. Recent studies have emphasized the social factors common in offenders with and without ID. Characteristics include severe psychological disadvantage with a history of offending by other family members (Day 1988; Simpson and Hogg 2001; Winter, Holland, and Colling 1997), behavioural and mental health problems dating back to childhood (Farrington 2000; Noble and Conley 1992) and high levels of unemployment (Murphy, Harnett, and Holland 1995).

For many patients, admission to Reitgjerdet was their first hospitalization. Patients with ID had no institutional affiliation elsewhere, and probably the lack of defined responsibility for care and treatment placed them outside the realm of most welfare services. The chief physician between 1923 and 1938, Karl Andresen wrote an article in 'Tidsskrift for Abnormvæsnet' in 1926 where he expressed '*The forensic hospital was*

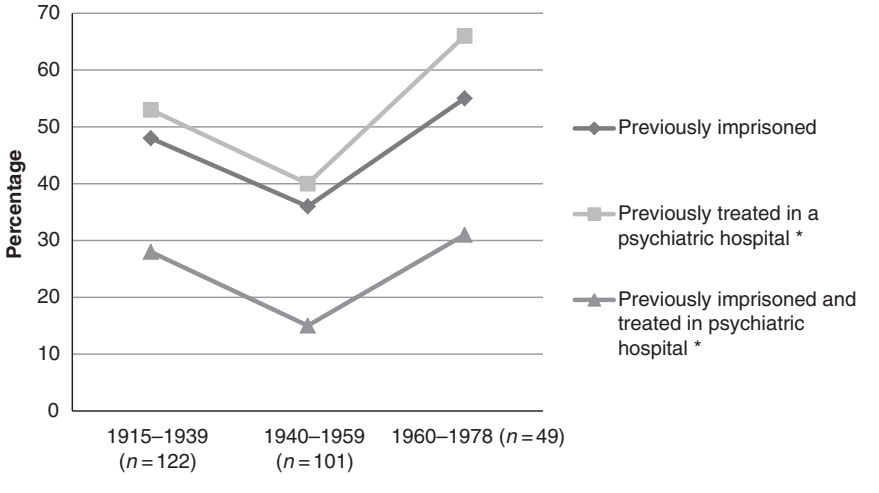

Figure 3. Institutional past amongst patients with an ID. (*) indicates that the difference were found significant below the level of 0.05 using a Chi square-test.

intended to house the most difficult and dangerous patients with severe mental health disorders, and patients with ID were generally and explicitly regarded as outsiders that did not belong to Reitgjerdet' (Andresen 1926).

In general, the patients with ID at Reitgjerdet did not seem to have had higher levels of physical disabilities or morbidity than the patients without ID had. They were possibly more affected by neglect and social circumstances than by biological disorders/conditions. Most of the ID patients had not had an education adapted to the ID, with only 23.8% attending special schools for people with ID.

Most studies in the twentieth century identified several aspects of an impoverished childhood environment in relation to intellectually disabled offenders. These included immorality in the family, alcoholic parents, child abuse, parental emotional problems, parental criminal activity, poverty, illiteracy, inadequate physical living conditions and poor physical health (Scheerenberger 1983). Although most of the studies in the first half of the twentieth century estimated that 13–40% of juvenile delinquents had an ID, influential criminologists such as Herman Adler and Eleanor Glueck claimed that no correlation existed between crime and intelligence (Scheerenberger 1983). A Norwegian study based on forensic assessments in 1952 and 1953 (Dalgard 1966) concluded that 15% had 'oligophrenia' as a diagnosis. The proportion of people with ID in the patient sample from 1915–1982 in the present study was 15%, but admission to the forensic mental health hospital seemed not to be exclusively associated with offending behaviour. Although most of the patients had offended previously, they seemed to represent professional challenges to other institutions or services and were then referred for admission to Reitgjerdet. Prisons did not have the competency to treat mental health disorders, mental health hospitals did not have the competency to treat intellectual disabilities, and ID institutions had limitations in treating challenging behaviour. According to annual national statistics of 1920, 1965 and 2010, the proportion of patients with ID with a hospital admission in the mental health services is estimated at 1–4% (Nasjonalt folkehelseinstitutt 2003–2006; Statistisk Sentralbyrå 1965; Statistisk Centralbyrå 1920). With a proportion of 15% in the forensic psychiatric hospital, the difference is obvious, but there may be several explanations. (1) The regular mental health services failed to treat these patients, (2) People with ID did not respond adequately in prison settings and (3) These people exposed themselves and others to danger in ways that no other institutional services could handle.

The Norwegian legislation on special schools was introduced in 1881 and entitled all children to primary education. Since the first special schools in 1882 (Skålvåg 2003), the expansion in the first decade was followed by a decline until the 1930s (Grennes 1933). The result was a high proportion of children with ID who did not finish school (which was mandatory for seven years), and who were not transferred to a special school. Several of these pupils were handed over to the care of their families, sometimes with employment, but also in some form of protective care. Some were evaluated as exhibiting risky behaviour, and leaving the family to handle and react to dangerous behaviour sometimes resulting in severe offences.

Time periods

In relation to childhood, education, employment and institutional past, some interesting differences may reflect the shifts over time. Problems within the family seem to have been solved more extensively by welfare services in the later period, possibly as a consequence of child protective services that functioned better. The first Norwegian law

on child protection was adopted in 1953. Better integration in normal school contrasting with lower participation in working life was also found in the later period. These findings probably reflect the changes in school policy and welfare services. Uniform educational facilities became statutory in 1936 and progressed in a revision in 1959. In parallel with the educational developments, legislation on social welfare services including financial support to disabled people was introduced in 1936, and revised in 1961 (Seip 1994). The decrease in the working force participation may also be explained by the general shifts from primary to secondary industries, with more emphasis on skilled work and rationalization. Previous employment such as farm hands and unskilled labourers decreased, to be replaced by a more skilled workforce. The establishment of health care for people with ID in 1952 with financial guarantees and a nationwide professionalizing of care probably relieved several of the ill-adapted services that had been used previously. Estimates based on the number of people with ID placed in psychiatric hospitals and poor relief care indicated a need for 5200 beds in health care institutions for people with ID (Sandvin 1995). The patients of the forensic asylum seemed to have been included in this institutional care to a limited degree. One explanation may be that the criminal justice and health care services for people with ID were too divergent.

The decrease in institutionalization experiences among the patients during the period 1940–1959 is mainly explained by the fact that during Second World War Reitgjerdet became the only asylum in operation in the northern and central regions of Norway. During Second World War, the German armed forces changed the use of the regular asylums to serve military purposes. Because of this, the patients admitted to Reitgjerdet mainly became patients with acute mental diseases and without any criminal or asylum record (Thomassen 2013).

A shift in the prevalence and nature of offenders with an ID, resulting from changes in the welfare services rather than from individual differences, has been studied in Denmark. The study concluded that the decrease in offenders with an ID during deinstitutionalization was explained by an allocation of offenders with mild and borderline ID to ordinary penal sanctions instead of institutions for offenders with an ID (Lund 1990).

The completion of primary school was higher in the second part of the century compared with the first part, and reports of school behavioural problems seemed to increase after 1945. This is probably a consequence of more resources being allocated to the schools and high ambitions for inclusion of all children.

The inclusive school, established under Norwegian law in 1936, is the most probable explanation of why patients such as Arne completed the primary classes. However, there was less emphasis on efforts to enable an inclusive transition to adult life. This is reflected in the results, where we find more patients who had completed primary classes and at the same time fewer patients with work experience after 1945.

The idea that people with intellectual disabilities were predisposed to criminal activities had such an impact on the legislators and policy-makers of the time that special eugenics programmes and legislation were developed, and special institutions were built to house, protect and train people with intellectual disabilities (Rafter 1997). The view that there was an association between intelligence and crime was dominant until the second half of the twentieth century (Scheerenberger 1983). Many western countries effected some segregation between people with ID and mental health disorders within the forensic mental health services, exemplified by Denmark and the Kellerske anstalter (Kirkebæk 1993). During the last 30–40 years, the western countries have seen a process of deinstitutionalization of care for people with ID. In Norway, the decision to establish a

forensic institution for patients with ID in 2002 was controversial (Søndenaa, Linaker, and Nøttestad 2009) because this was claimed to be in conflict with the concept of deinstitutionalization. The criminal law, therefore, sets a narrow limit for sentencing people with ID to segregated forensic services. Denmark and many other countries were better prepared for such needs in the criminal justice services because they had the knowledge based on a history of forensic incarceration of people with ID. In the recent climate of more forensic services applied in services to people with ID (Doudes and Bantwal 2011), the total of 300 people with ID within the Danish forensic criminal system (Mikkelsen, Klausen, and Sandberg 2007) compared with the significant lower figure of 10 people in Norway (Søndenaa, Linaker, and Nøttestad 2009) may have a historical explanation.

There are several limitations to this study based on the differences in the given information. The medical emphasis of the chief physician and the social context from which the information is retrieved may colour some of the findings. Some of the patient information was insufficient and even missing and there was some inconsistency in diagnostic practice. This study was based on and limited to a national sample, so that some reservations must be made regarding generalization.

Conclusion

A previously unrecognized proportion (15%) of the patients of the Norwegian forensic psychiatric hospital Reitgjerdet had an ID. The background characteristics of these patients showed a range of problematic conditions during childhood, education and adjusting to the expectations of adulthood. A wide range of offending behaviour and mental disturbance influenced admission to the forensic asylum. The decreasing participation in the labour force corresponded with an increase in educational level, which may reflect the developing welfare services and a general shift from primary to secondary industries throughout the century. Comparable international studies on similar samples may illustrate the pathways and decisions in the context of modern welfare of these vulnerable patients. Further studies on treatment, the period of stay, readmissions and outcomes are planned from the present sample.

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