

Mental Welfare:
Voluntary Mental Health and Learning Disability Organizations in Britain,
c. 1946–1959

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Abstract

This dissertation traces the trajectories of four British voluntary organizations working in the fields of mental health and learning disability in the late 1940s and 1950s: the National Association for Mental Health; the Mental After Care Association; the Ex-Services Welfare Society; and the National Association for Parents of Backward Children. As the British welfare state was established in these years, voluntary organizations were forced to adjust to a new political landscape, carrying on operations despite increased state responsibility for mental health and learning disability care. First, the dissertation is an institutional history of four distinct organizations, concerned with operations, administration, leadership, and publicity, among a host of other day-to-day affairs. Second, it examines varying responses among voluntarists to the establishment and permeation of the welfare state in British life, asking how these organizations maintained their vitality (and importantly, their sources of support and funding) within a landscape of expanding statutory service provision. That they did survive, and thrive, into the present suggests that the interventionist, “cradle-to-grave” welfare state was not as all-encompassing as originally envisioned—at least in the field of mental health care. Rather than challenge increasing statutory dominance, their persistence confirmed and reinforced several elements of the nascent welfare state. Though voluntarist leaders tended toward political conservatism, and often criticized specific policy directives or statutory services, their organizations generally bolstered three major welfare goals: the regulation of disorder, the maintenance of non-working populations, and the reproduction of labour.

For Sarah, who sees me through.

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List of Abbreviations

AGM	Annual General Meeting
APSW	Association of Psychiatric Social Workers
BCC	Bedfordshire County Council
CAMW	Central Association for Mental Welfare
CGC	Child Guidance Council
CRU	Civil Resettlement Unit
DPEC	Disabled Persons Employment Corporation
DRO	Disablement Rehabilitation Officer
EC	Executive Council
EMS	Emergency Medical Service
ESN	Educationally Sub-Normal
ESWS	Ex-Services Welfare Society
GC	General Committee
GPC	General Purposes Committee
GTC	Government Training Centre
IMC	Industrial Management Committee
LCC	London County Council
LHA	Local Health Authority
MACA	Mental After Care Association
MOH	Ministry of Health
NAB	National Assistance Board
NAMH	National Association for Mental Health

NAMHC	National Association for Mentally Handicapped Children
NAPBC	National Association for Parents of Backward Children
NCC	Norwich City Council
NCMH	National Council for Mental Hygiene
NGO	Non-Governmental Organization
NHS	National Health Service
NI	National Insurance
PNCMH	Provisional National Council for Mental Health
POW	Prisoner of War
PSW	Psychiatric Social Worker
RHB	Regional Hospital Board
WVS	Women's Voluntary Service

Chapter 1

Introduction

Argument and Scope

This dissertation traces the trajectories of four British voluntary organizations working in the fields of mental health and learning disability in the late 1940s and 1950s.¹ Its chronology is roughly bracketed by two major pieces of legislation: the *National Health Service Act 1946*, which gave new administrative shape to the British medical sphere, and the *Mental Health Act 1959*, which abolished outdated mental health treatment structures and signalled a shift to community-based care. In these years, voluntary organizations were forced to adjust to a new political landscape, carrying on operations despite increased state responsibility for mental health care. They approached their work with a variety of strategies, outlooks, and concerns, but shared the goal of remaining operationally viable, publicly visible, and politically and socially influential.

Specifically, the dissertation examines varying responses among voluntarists to the establishment and permeation of the welfare state in British life. It shows how these organizations maintained relevance as welfare policies increasingly encroached on areas that had once been

¹ While not always historically accurate, “mental health,” “mental illness,” and “learning disability” are the terms preferred here, as is person-centred language like “people with mental illness” and “people with learning disabilities.” The use of “learning disability” follows the British example, which tends to eschew the newer term used in North America, “intellectual disability.” In the United Kingdom, “learning disabilities” are usually differentiated from “learning difficulties,” with the latter referring to conditions that do not affect general intelligence, like dyslexia or attention deficit hyperactivity disorder. Learning disabilities vary widely, but are defined by the Department of Health as constituting a “significant reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood.” Outdated terms like “madness,” “lunacy,” “sub-normality,” “retardation,” and “deficiency” are generally avoided—unless contextually appropriate—and appear mainly in quotation marks. It is also important to note that, although mental illness and learning disability were often treated as one set of disorders in the period at hand, they are now understood to be separate sets of conditions. See “Learning difficulties,” [mentalhealth.org.uk](https://www.mentalhealth.org.uk/learning-disabilities/a-to-z/l/learning-difficulties), accessed February 6, 2020, <https://www.mentalhealth.org.uk/learning-disabilities/a-to-z/l/learning-difficulties>; “Learning disabilities,” [mentalhealth.org.uk](https://www.mentalhealth.org.uk/learning-disabilities/a-to-z/l/learning-disabilities), accessed February 6, 2020, <https://www.mentalhealth.org.uk/learning-disabilities/a-to-z/l/learning-disabilities>; James Robinson, “What’s the difference between a learning disability and a mental problem?” May 14, 2016, *Mencap*, accessed December 19, 2018, <https://www.mencap.org.uk/blog/whats-difference-between-learning-disability-and-mental-health-problem>.

dominated by private charity. It tracks distinct yet intertwined narratives, showing that—despite differences in scope—voluntary organizations identified and exploited gaps in statutory service provision, while simultaneously aligning themselves with overarching objectives of welfare capitalism.

The dissertation unites two strands of historiographical work that have largely been treated separately: the first concerns the provision of voluntary care for people with mental illness or learning disabilities; the second concerns the relationship between voluntarism and the state. At a more general level, it explores the delicate balance that modern non-governmental organizations (NGOs) must strike, especially as they gain influence and develop into major players in their respective fields. They often take the form of pressure or advocacy groups, critiquing governmental policy and offering alternative strategic planning. However, NGOs can also derive funding and influence from government, and can be deeply affected by shifting policy directives. Indicating their general success in meeting the challenges posed by the new welfare state, all four groups under study here still exist today (under different names). They form pillars of a united statutory-voluntary approach to mental health and learning disability in the United Kingdom, while also maintaining the balanced approach of the modern NGO: relying on the state for funding and visibility, while simultaneously identifying and critiquing state failures and inefficiencies.

By the mid-twentieth century, voluntarism was a major force in the field of mental health care. A 1949 survey of the United Kingdom listed nearly 80 organizations “primarily concerned with mental health”—institutes, associations, boards, councils, guilds, centres, and societies.² These groups examined here are: the National Association for Mental Health (NAMH; now called Mind), which has become arguably the nation’s best-known voluntary mental health organization,

² Derek Richter, “British Organizations Concerned with Mental Health,” *British Medical Bulletin* 6, no. 3 (1949): 213–217. See Appendix A for the complete list.

and certainly its most prodigious; the Mental After Care Association (MACA; now called Together), which focused more narrowly on convalescence services for acute and chronic mental hospital patients; the Ex-Services Welfare Society (ESWS; now called Combat Stress), which was established after the First World War to treat and advocate for veterans afflicted with “shell shock”; and the National Association for Parents of Backward Children (NAPBC; renamed the National Association for Mentally Handicapped Children, or NAMHC, in 1955, and now called Mencap), which was formed from regional parents’ groups to advocate for children with learning disabilities.³ These four organizations have been selected for their pre-eminence in the fields of mental health and learning disability voluntarism, and also as a cross-section of the various aspects of those fields—service provision, fundraising, public and professional education, and governmental relations, among others.

By 1948, following the extension of National Insurance and the establishment of National Assistance and the National Health Service (NHS), it seemed to many that the new welfare state had rendered voluntarism obsolete. Voluntary organizations—some which had existed since the Victorian period—were faced with an existential threat, as it seemed that citizens’ needs could be met by all-encompassing governmental programs. In the fields of mental health and learning disability, where charitable ventures dominated the landscape, the potential rupture was especially daunting. Fears of such a rupture would prove to be unfounded, as evidenced by the ongoing presence of voluntary undertakings in British life—however, this was not always clear at the time. Geoffrey Finlayson argues that despite an interwar consensus that statutory welfare provision would and should overtake charity in most areas, by the 1950s voluntary groups were “felt to be

³ *Mind*, *The Mental Health Charity*, accessed February 9, 2020, <https://www.mind.org.uk/>; *Together*, accessed February 9, 2020, <https://www.together-uk.org/>; *Combat Stress*, accessed February 9, 2020, <https://www.combatstress.org.uk/>; *Mencap*, accessed February 9, 2020, <https://www.mencap.org.uk/>.

broadly compatible with the welfare state.”⁴ Voluntarism has gained strength in Britain in the decades since, competing with older associational bonds of party, union, and church as a major arena for political expression.⁵

The shifting and permeable boundary between the worlds of statutory and voluntary service provision has been variously described as “the moving frontier” and “the mixed economy of welfare.”⁶ Whereas many voluntary groups in the nineteenth and early-twentieth centuries complemented scarce statutory provision—independently offering services and facilities which otherwise would not be available—by the 1950s, many voluntarists worked as supplementary providers, bolstering the capacity of the welfare state. This progression was not linear, and several scholars have refuted a narrative that has voluntary provision inexorably giving way to more effective state-controlled measures.⁷ Mental health care was one arena in which oscillating understandings of the “proper” roles of state and volunteer played out—a question that deeply concerned William Beveridge in his famous 1942 report.⁸ Indeed, the groups surveyed here often

⁴ Geoffrey Finlayson, “A Moving Frontier: Voluntarism and the State in British Social Welfare, 1911–49,” *Twentieth Century British History* 1, no. 2 (1990): 205. This assessment has not gone unchallenged, as Rodney Lowe finds that the evolution of the welfare state was hampered by “an ingrained cultural resistance ... to collective action.” Rodney Lowe, *The Welfare State in Britain since 1945*, 2nd ed. (Basingstoke: MacMillan Press, 1999), 102. In response, Arthur Marwick argues that surveys show “a clear development of a welfare-oriented culture since the war.” Marwick, review of *The Welfare State in Britain since 1945*, by Rodney Lowe, *The English Historical Review* 111, no. 441 (1996): 550.

⁵ Matthew Hilton, James McKay, Nicholas Crowson and Jean-François Mouhot, *The Politics of Expertise: How NGOs Shaped Modern Britain* (Oxford: Oxford University Press, 2013), 1–3.

⁶ Finlayson, “A Moving Frontier,” 184 (Finlayson borrows the term “moving frontier” from William Beveridge); Jane Lewis, *The Voluntary Sector, the State and Social Work in Britain: The Charity Organisation Society/Family Welfare Association since 1869* (Aldershot: Edward Elgar, 1995), 3. Lewis notes that family aid and mutual aid are also important components of the mixed economy.

⁷ Geoffrey Finlayson, *Citizen, State, and Social Welfare in Britain 1830–1990* (Oxford: Clarendon Press, 1994); Anne Digby and John Stewart, “Welfare in Context,” in *Gender, Health, and Welfare*, eds. Anne Digby and John Stewart (London: Routledge, 1996).

⁸ Beveridge’s later *Voluntary Action* (1948) would confirm his pessimism regarding government capabilities; he saw voluntary groups as generally more competent. See James McKay, “Voluntary Politics: the sector’s political function from Beveridge to Deakin,” in *Beveridge and Voluntary Action in Britain and the Wider British World*, eds. Melanie Oppenheimer and Nicholas Deakin (Manchester: Manchester University Press, 2010), 82.

zealously emphasized their independence, vitality, and ability to continue providing innovative, complementary services.

This dissertation examines how voluntary groups persevered amidst expanding statutory mental health care provision. Rather than challenge increasing statutory dominance, their persistence confirmed and reinforced several elements of the nascent welfare state. The dissertation shows, for example, that the groups in question maintained their vitality and influence by loosely aligning their objectives with those of the welfare state—whether or not they recognized this at the time. Though voluntarist leaders tended toward political conservatism, and often criticized specific policy directives or statutory services, their organizations generally bolstered three major welfare goals: the regulation of disorder (insofar as people with mental illness or learning disabilities are considered threatening to public order), the maintenance of non-working populations, and the reproduction of labour.

Welfare states do not spring, wholly formed, solely from functionalist or economic need—human empathy and a desire for communal care are crucial elements.⁹ However, a dominant goal is the creation and preservation of commercially productive and self-governing subjects—a goal that mental health voluntarists applied themselves to wholeheartedly. These objectives were rarely referenced directly, suggesting the ways in which political and economic structures, along with social and cultural discourses, can unconsciously shape the parameters of individual and group action. The dissertation’s theoretical underpinnings and approach are further developed below.

⁹ Functionalist theories tend to envision welfare states as the inevitable result of industry-driven urban migration, which in turn created the need for social programs. Critics of this perspective point out that in Britain and Germany, welfare programs came long after the “peak” capitalism of the nineteenth century, and also emerged in mainly agricultural societies like New Zealand. See James Midgley, *Social Welfare in Global Context* (Thousand Oaks: Sage Publications, 1997), 100–102.

Sources consulted include annual reports, meeting minutes, newspaper and journal articles, correspondence, policy circulars, parliamentary and ministerial records, and various other memoranda and documents held in several archives. The National Archives holds material on all four organizations, as well as documentation deriving from relevant governmental ministries—mainly the Ministries of Health, Labour, and Pensions.¹⁰ The Wellcome Library’s Mind and MACA collections are the most complete and well-organized of the groupings at hand. Substantial portions of both collections have been digitized and are available via the Library’s website.¹¹ Additional documents on the ESWs are held in an institutional archive at the Combat Stress offices in Leatherhead, Surrey. Finally, the NAPBC/NAMHC offered the least in historical documentation (much of which has apparently been disposed of by Mencap since the early 2000s). As a result, the chapter on that organization relies more heavily on secondary accounts and the available archives of local and regional affiliate branches.

In any project on mental health or learning disability, it is desirable to understand the experiences and testimony of those most affected: the people experiencing an illness or disability.¹² While this dissertation makes an effort to convey such testimony wherever possible, it is limited in this effort both by its scope and by the available sources. The second chapter, on the NAMH, presents the most top-down narrative, and while client experience is briefly covered in the other chapters, it is not a primary focus. Instead, the goal here is determine how voluntarists themselves situated their organizations—rhetorically and practically—within a landscape of shifting considerations around policy, funding, public awareness, staffing, treatment, and community.

¹⁰ *The National Archives*, accessed February 9, 2020, <https://www.nationalarchives.gov.uk/>.

¹¹ *Wellcome Library*, accessed February 9, 2020, <https://wellcomelibrary.org/>.

¹² For works that deal more explicitly with client/patient experience, see Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrews Hospital c. 1810–1998* (Woodbridge: The Boydell Press, 2003); Diana Gittins, *Madness in Its Place: Narratives of Severalls Hospital, 1913–1997* (London: Routledge, 1998); Duncan Mitchell et al., eds. *Exploring Experiences of Advocacy by People with Learning Disabilities: Testimonies of Resistance* (London: Jessica Kingsley Publishers, 2006).

Medical Care in the Welfare State

In the first half of the twentieth century, Britain experienced a series of unprecedented upheavals and dislocations—an influenza pandemic, the Depression, two World Wars, and the beginning of the end for one of the World’s most powerful colonial empires.¹³ However, John Stevenson argues that these upheavals underlie a central paradox: despite a “catalogue of disruption and deprivation,” the nation saw major economic growth and a significant rise in living standards.¹⁴ For example, in 1951 Seebom Rowntree and G.R. Lavers conducted a survey showing that 1.5 percent of the population lived in poverty, while fifteen years earlier the number had been 18 percent. Stevenson writes, “[f]ull employment, higher wages, and the Welfare State had virtually eliminated the major causes of poverty found before 1939.”¹⁵

The creation of the welfare state—and its subsequent survival amidst attacks and spending cuts—is perhaps the crowning achievement of the British political establishment in the twentieth century. The story of mid-twentieth century British collectivization has received a great deal of attention, and need not be repeated too extensively.¹⁶ Following their 1906 electoral victory, the

¹³ For general works of British history in the interwar and postwar periods, see Paul Addison, *No Turning Back: The Peacetime Revolutions of Postwar Britain* (Oxford: Oxford University Press, 2010); Lawrence Black and Hugh Pemberton, eds., *An Affluent Society? Britain’s Post-War ‘Golden Age’ Revisited* (London: Routledge, 2014); Stephen Constantine, *Social Conditions in Britain, 1918–1939* (London: Routledge, 1983); Peter Dewey, *War and Progress: Britain 1914–1945* (London: Routledge, 2014); Peter Hennessy, *Having it So Good: Britain in the Fifties* (London: Penguin, 2007); Arthur Marwick, *British Society Since 1945* (London: Penguin, 1996); Ross McKibbin, *Classes and Cultures: England 1918–1951* (Oxford: Oxford University Press, 2000); Kenneth O. Morgan, *Britain Since 1945: The People’s Peace* (Oxford: Oxford University Press, 2001); John Stevenson, *British Society 1914–45* (Harmondsworth: Penguin, 1984)

¹⁴ Stevenson, *British Society*, 103.

¹⁵ *Ibid.*, 142. Poverty was never eliminated entirely, and the 1960s would see a “rediscovery of poverty,” characterized by social science inquiries into persistent inequality and the insufficiency of National Assistance payments. See John Veit-Wilson, “The National Assistance Board and the ‘Rediscovery of Poverty,’” in *Welfare Policy in Britain: The Road from 1945*, eds. Helen Fawcett and Rodney Lowe (London: Palgrave MacMillan, 1999).

¹⁶ See, for example, Derek Fraser, *The Evolution of the British Welfare State: A History of Social Policy since the Industrial Revolution* (London: The MacMillan Press, 1973); Pat Thane, *The Foundations of the Welfare State* (London: Longman, 1982); Susan Pedersen, *Family, Dependence, and the Origins of the Welfare State: Britain and France, 1914–1945* (Cambridge: Cambridge University Press, 1993); Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London: Harper Collins, 1995); Lowe, *The Welfare State in Britain since 1945*; Bernard Harris, *The Origins of the British Welfare State: Society, State and Social Welfare in England and Wales, 1800–1945* (Basingstoke: Palgrave MacMillan, 2004).

Liberal Party introduced a series of welfare reforms in response to the social problems of poverty.¹⁷ Fears sparked by the apparently poor physical condition of Boer War recruits were compounded by industrial decline—itsself thrown into stark relief by the booming economies of the United States and Germany. A hastily struck governmental committee pegged urban overcrowding and rampant poverty as the culprits, and recommended several social and environmental measures. Ensuing social legislation centred mainly around pensions and child welfare.¹⁸

Again, the path of the welfare state over ensuing decades has been well-trod: the influence of investigative and polemical writing like Maud Pember Reeves's *Round About a Pound a Week* (1913) and Eleanor Rathbone's *The Disinherited Family* (1924); direct actions like the 1936 Jarrow March; William Beveridge's 1942 *Report* and resultant debate within the wartime coalition government; post-1945 improvements in health care, education, employment, and social security; and the emergence of political consensus (to some degree) by the 1950s.¹⁹ Most important for the study at hand is the development of the nation's comprehensive medical service, and its implications for mental health care.

The first significant legislative step came with the *National Insurance Act 1911*, which involved significant concessions to both insurance companies and a protectionist medical profession. By the mid-1940s, approximately half the population was covered under the Act's

¹⁷ These measures were also meant to stave off the challenge of an increasingly popular Labour Party. See Fraser, *The Evolution of the British Welfare State*, 136–137.

¹⁸ Thane, *The Foundations of the Welfare State*, 58–59; Vanessa Heggie, “Lies, Damn Lies, and Manchester's Recruiting Statistics: Degeneration as an ‘Urban Legend’ in Victorian and Edwardian Britain,” *Journal of the History of Medicine and Allied Sciences* 63, no. 2 (2008): 179–180, 191; Fraser, *The Evolution of the British Welfare State*, 137–139, 142–143. Both Thane and Heggie argue that anxieties centred around the poor military performance against the Boers, but Heggie shows that recruitment statistics supposedly showing widespread ill-health were heavily flawed. Either way, the resulting outcry provided justification for a more interventionist state. Despite a prior historiographical emphasis on this military explanation, Heggie (215) finds that a “feminized” discourse of degeneration concerned with women's supposed “ignorance, fecklessness, and emancipation” likely did more to spur statutory action.

¹⁹ See Kathleen Jones, *Social Policy in Britain: From the Poor Law to New Labour*, 3rd ed. (London: The Athlone Press, 2000), chs. 7–11.

contributory healthcare scheme, which was largely administered by state-subsidized friendly societies and commercial insurance companies. However, there were several significant limitations: generally only the male family breadwinner was covered, and so working-class families still bore the cost of medical services for wives, mothers and children. Furthermore, only general practitioner services were covered, not hospital services.²⁰

In the interwar years, there were several attempts to develop a replacement for the incomplete insurance scheme, and to improve the nation's antiquated and diffuse hospital system. Various measures were proposed by the 1920 Dawson Report, the 1926 Commission on National Health Insurance, the Sankey Commission and the policy institute Political and Economic Planning in 1937, and British Medical Association committees in 1930 and 1938. These proposals included the extension of governmental health insurance across the entire population, and better coordination of voluntary and public hospitals.²¹ During the Second World War, health services came under the administration of the Emergency Medical Service (EMS), which demonstrated that administration could be centralized, and that the state was capable of running a comprehensive medical scheme. As a result, there were calls for an immediate postwar conversion into a nationalized hospital service.²²

Following extensive negotiations with the medical profession by both Coalition and Labour governments, the NHS Act passed into law in 1946, and came into effect in 1948. The Act mandated a "tripartite" system, with hospital services, primary care, and public health governed under separate authorities. Hospital administration experienced the greatest shift, as the existing

²⁰ Harris, *Origins of the British Welfare State*, 211–213; Thane, *Foundations of the Welfare State*, 84–87; Christopher Ham, *Health Policy in Britain: The Politics and Organisation of the National Health Service*, 5th ed. (Basingstoke: Palgrave MacMillan, 2004), 10.

²¹ Ham, *Health Policy in Britain*, 13; Harris, *Origins of the British Welfare State*, 211–212; Anne Rogers and David Pilgrim, *Mental Health Policy in Britain*, 2nd ed. (Houndmills: Palgrave, 2001), 59.

²² Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 1998), 7.

system of divided voluntary and public governance was abandoned in favour of nationalization. Regional Hospital Boards (RHBs) based on fourteen geographic “natural regions” across England and Wales were responsible for policy, planning, and budget control (Northern Ireland and Scotland would be governed separately). Pre-existing Local Health Authorities (LHAs)—generally attached to borough, county, or city councils—remained under the direction of local Medical Officers of Health. These were responsible for public health activities including maternity care, home nursing, and immunization.²³ Crucially, LHAs also bore responsibility for non-hospital mental health and learning disability services.

Despite fanfare around the 1948 inauguration of the NHS, the tax-funded, “free at the point of use” service quickly encountered entrenched opposition and financial difficulties. Inaccurate cost projections provided ammunition for Conservative opponents, and their critiques would colour perceptions of the NHS as wasteful and ill-conceived into the 1950s.²⁴ In 1952, amidst Conservative calls for a reduction of the NHS tax base and a reintroduction of contributory principles, a committee of enquiry was established under economist C.W. Guillebaud to determine the Service’s real costs. In a frustrating turn for the Conservatives, the Committee’s report found little evidence of wasteful spending, and argued that additional resources should be freed up for hospitals and community care.²⁵

Charles Webster situates the first phase of NHS development between 1948 and 1964, and by the end of that period, the Service had seen mixed outcomes. In some areas—particularly consultant specializations like anaesthetics, radiology, and neurosurgery—services had been extended and improved nationwide. However, crumbling infrastructure and wartime damage

²³ Webster, *The National Health Service*, 8–20.

²⁴ See Tony Cutler, “A double irony? The politics of National Health Service expenditure in the 1950s,” in *Financing Medicine: The British Experience Since 1750*, eds. Martin Gorsky and Sally Sheard (Abingdon: Routledge, 2006).

²⁵ Webster, *The National Health Service*, 32.

continued to present problems, as few resources were set aside for capital projects and hospitals were largely excluded from the postwar construction boom.²⁶ The NHS also did little to address ongoing regional inequalities—southern metropolitan areas enjoyed “the greater concentration of general practitioners, group practices, and dentists, as well as the lion’s share of younger and more innovative practitioners,” while Wales, the Midlands, and the North had fewer teaching hospitals, GPs, and consultants.²⁷

Mental Health, Learning Disability, and State Medicine

Mathew Thomson argues that over the course of the twentieth century, medicine became imbued with psychological ideals, and ordinary Britons came to understand themselves in psychological terms. “Psychological subjectivity” spread in two ways: it was either “imposed on the individual through the discipline’s increasing influence as a tool of governance within the modern welfare complex”; or it was “internalised in the individual through the growing influence of experts and their advice within private life.”²⁸ One of the most significant ideological and intellectual influences in this shift was the mental hygiene movement—expressed in the interwar years through groups like the National Council for Mental Hygiene, the Child Guidance Council (both groups would later be amalgamated into the NAMH), and the MACA.²⁹

The mental hygiene movement was predicated on several ideas: shifting mental health care from the asylum to the community; extending provision to borderline and relatively benign conditions; employing early treatment and after care; and supplementing medical treatment with social work.³⁰ Though originally preoccupied with medical understandings of mental illness and

²⁶ Ibid., 39–40. Under-resourced mental institutions would suffer greatly from infrastructure problems.

²⁷ Webster, *The National Health Service*, 57–58.

²⁸ Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006), 5.

²⁹ Ibid., 192.

³⁰ Ibid.

learning disability, mental hygienists increasingly looked to social services as “the key arena” for their campaigns.³¹ They emphasized social and developmental processes in diagnosing mental disorder, thereby justifying increased scrutiny and surveillance of lower-class familial and working environments.³² While eugenic ideas initially permeated hygienist ideology, Thomson argues that in the interwar years eugenics became “too illiberal for the politico-legal climate,” and as a result, “mental hygiene fell back on aspiration, education, and exhortation: a suitably liberal route, but one with little real power.”³³ The establishment and eventual dominance of a group like the NAMH can be read as an attempt to regain some of that lost power.

The inclusion of mental health and learning disability care as components of the NHS was never assured, and there is a complex history behind their eventual incorporation. In the late nineteenth century, the *Lunacy Act 1890* mandated the certification and institutionalization of “lunatics.” By the 1948 inauguration of the NHS, appreciation for comprehensive mental health care reform had developed gradually, although this should not be overstated. The 1926 *Report of the Royal Commission on Lunacy and Mental Disorder* (MacMillan Report) affirmed the importance of viewing mental disorder as an organic illness rather than a moral failing, and advocated for medical treatment rather than social intervention.³⁴ The *Mental Treatment Act 1930* put several of the Report’s recommendations into practice, by directing LHAs to establish outpatient clinics and preventive programs, and simplifying and encouraging the practice of

³¹ Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870–1959* (Oxford: Clarendon Press, 1998), 274.

³² Nick Crossley, “Transforming the mental health field: the early history of the National Association for Mental Health,” *Sociology of Health and Illness* 20, no. 4 (1998): 465.

³³ Thomson, *Psychological Subjects*, 193.

³⁴ Joan Busfield, “Class and Gender in Twentieth-Century British Psychiatry: Shell-Shock and Psychopathic Disorder,” in *Sex and Seclusion, Class, and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodopi, 2004), 299. While Webster’s periodization focuses on the entire NHS, Busfield divides the chronology of mental health care and policy into “Integration and Medical Innovation, 1930–1953,” and “Community Care and Public Sector Expansion, 1954–1973” (297).

voluntary, uncertified institutional admission. It also allowed hospitals to fund and engage more constructively with mental health research.³⁵ Sixteen years later, the NHS Act transferred responsibility for hospitals (including mental institutions) from local authorities to RHBs. While mental health services nominally existed under the same purview as other medical services, Thomson argues that “in reality [they] remained apart,” and suggests that they may have benefited more if they had been kept out of the NHS.³⁶

The new changes made it difficult to establish continuity of care across regions, institutions, and programs—a particular concern in the treatment of mental illness or learning disability. The Minister of Health was made the “central authority” for all health services, while the RHBs supplanted the existing mix of county and borough authorities governing individual mental hospitals.³⁷ However, there was often little relation between local authority boundaries and hospital catchment areas, making administrative integration a challenge.³⁸ Long-term care, short-term care, and social services—all key components of holistic mental health treatment—were administered separately.³⁹ LHAs were meant to appoint Mental Health Sub-Committees, and while some did develop “positive programmes,” others performed their duties only perfunctorily during meetings of the main Health Committees.⁴⁰ The MacMillan Report had advocated for the inclusion of psychiatry in general practice, but instead it remained subordinate to other services—a process Kathleen Jones notes was “accelerated by the introduction of psychotropic drugs.”⁴¹

³⁵ Ibid., 300; Madeline Roof, *Voluntary Societies and Social Policy* (London: Routledge, 1957), 112–113.

³⁶ Thomson, *The Problem of Mental Deficiency*, 285–287.

³⁷ Kathleen Jones, *Mental Health and Social Policy 1845–1959* (London: Routledge & Kegan Paul, 1960), 144.

³⁸ Ibid., 148–149; Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London: Athlone Press, 1993), 145.

³⁹ Hugh Freeman, “The General Hospital and Mental Health Care: A British Perspective,” *The Millbank Quarterly* 73, no. 4 (1995): 656.

⁴⁰ Jones, *Asylums and After*, 145. The operations of specific Mental Health Sub-Committees are discussed further in chapters 2 and 5.

⁴¹ Ibid., 182.

Administrative disarray thus prevented statutory mental health and learning disability services from expanding and succeeding to the degree they otherwise could have, but it also constituted a boon for voluntary organizations. The NHS Act mandated that LHAs should “make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons.” To this was added the proviso that “reasonable” charges could be recovered for services provided, and crucially, that contributions could be made to voluntary organizations involved in the same work.⁴² LHAs were expected to submit proposals to the Minister of Health detailing how they would carry out their duties in accordance with existing mental health legislation, and many LHAs would rely heavily either on existing voluntary services and facilities, or newly formed agreements.⁴³

In terms of policy and practice, mental health care faced numerous challenges. Writing in 1957, sociologist Madeline Roofff contended, “while progress has been considerable, the mental health services are still struggling to free themselves from a legislative and social pattern worked out in the 19th century.” The Lunacy Act remained in effect until 1959, when it was abolished by the Mental Health Act, and certification (and consequent stigmatization) continued to “haunt” patients. Furthermore, there were deep divisions among different specializations: between mental health care and general care, and between the different branches and schools of thought in mental health care. Mental institutions were experiencing severe overcrowding, and mental health nursing was generally seen as an unattractive career choice. Finally, there was a shortage of social workers, who were needed to facilitate an ongoing shift from institutional care to community care.⁴⁴

⁴² *National Health Service Act 1946*, 9 & 10 Geo. 6, c. 81, § 28.

⁴³ *Ibid.*, § 51.

⁴⁴ Roofff, *Voluntary Societies and Social Policy*, 79–80.

In 1954, the government established the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission) to address problems in mental health care. The Percy Report, delivered in 1957, counteracted the tendency—evident in prior legislation—toward enforced certification, institutionalization, and stigmatization. Emerging from the Report, the Mental Health Act consequently abolished the Board of Control, which had been the central body overseeing mental treatment since 1913. LHAs were empowered to conduct inspections and reviews, to provide accommodation, guardianship, and occupational training, and to appoint mental welfare officers. In terms of patients’ rights, regulations for compulsory admission to mental hospitals were tightened and placed under the purview of medical professionals, rather than magistrates.⁴⁵

As Rooff noted, mental health treatment had seen a great deal of progress in a relatively short period, largely thanks to techniques pioneered during the Second World War and an increased awareness of psychological disorders in general practice—in 1952, the newly established Royal College of General Practitioners included “the development of psychological awareness” in its programme.⁴⁶ While in many quarters it was feared that the War would produce a shell shock crisis similar to that seen two decades earlier, Kathleen Jones finds that the expected “mass hysteria” never materialized. Instead, the Second World War produced “remarkable new initiatives in mental health provision,” influenced largely by the appointment of Tavistock Clinic Director Dr. J.R. Rees as Director of Army Psychiatric Services. Rees, along with psychoanalytically-inclined colleagues including Ronald Hargreaves, John Bowlby, Thomas Main, and Wilfred Bion, would be integral to the proliferation of social psychiatry in the 1950s and 1960s.⁴⁷

⁴⁵ Kathleen Jones, *Mental Health and Social Policy*, 156–157.

⁴⁶ Rhodri Hayward, *The Transformation of Psyche in British Primary Care, 1880–1970* (London: Bloomsbury Academic, 2014), 57.

⁴⁷ Kathleen Jones, *Asylums and After*, 142–143.

Innovative social and community therapies developed during the war represented a conscious effort to abandon the “disease model” of mental illness. At Mill Hill EMS Hospital and Belmont Hospital, Dr. Maxwell Jones introduced pioneering group psychotherapy techniques, helping to address problems of “inflexibility and monotony of routine, regimentation, depersonalisation and a wide ‘social distance’ between the staff and the patients.”⁴⁸ Indicating the perceived importance of workplace reintegration, Jones also established an “Industrial Neurosis Unit” at Belmont. Largely funded by the Ministry of Labour, the Unit employed Disablement Resettlement Officers (DROs) to assist with employment, and ran workshops on vocational skills. Dr. Aubrey Lewis pursued a similar program at the Institute of Psychiatry, reflecting “the general acceptance ... of the objective of resettlement in employment.” By 1959, 58 psychiatric hospitals were engaged in industrial therapy, and as will be seen in this dissertation, voluntary groups acted in tandem.⁴⁹

The introduction of psychotropic drugs like barbiturates, antidepressants, and antipsychotics also helped practitioners immensely. In particular, they allowed for more patients to be treated outside of long-stay mental hospitals.⁵⁰ The first psychiatric day hospital in England was opened in 1948, offering social clubs, group therapy, electro-shock therapy, and insulin coma treatment. A decade later, there were 38 day hospitals across England, offering an alternative to long-term institutional care.⁵¹ These developments meant that greater attention and resources could be directed to chronic and long-term cases, rather than acute cases—as a result, some voluntary groups would largely re-orient their services towards chronic cases, beginning in the 1950s.

⁴⁸ Kevin Gournay, Jim Birley, and Douglas Bennett, “Therapeutic interventions and milieu in psychiatry in the NHS between 1948 and 1998,” *Journal of Mental Health* 7, no. 3 (1998): 264–265.

⁴⁹ Gournay, Birley, and Douglas, “Therapeutic interventions and milieu in psychiatry,” 266–267.

⁵⁰ Freeman, “The General Hospital and Mental Health Care,” 659.

⁵¹ Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), 235–236.

In the field of learning disability—“mental deficiency” in the language of the time—Thomson argues that available services reflected reforms in health care more generally, with “movement ... towards the nationally organized, rationalized, and medically dominated NHS.” However, there were a number of areas where learning disability policy showed a continuation of the “moving frontier,” with responsibilities shared between central and local authorities, the voluntary sector, and individual families. Wartime labour shortages resulted in improved employment prospects for people with learning disabilities, and those who remained institutionalized received *ad hoc* employment training to make up for staff shortages. As Thomson puts it, “the challenge of war had stimulated the development of mental health services and encouraged institutions to release high-grade defectives for work in the community.”⁵²

However, much of this progress was reversed after 1945, as the Ministry of Health stopped directly employing psychiatric social workers (PSWs), and there were insinuations that the mental health services had overstated their indispensability in wartime. Learning disability services suffered as mental welfare workers moved into psychiatric clinics where they could nurture interests in psychological and psychoanalytic theory.⁵³ Despite being relatively ignored, “mental deficiency” did remain a crucial field for voluntary-statutory partnership. Roofff noted that “experiments in community care by voluntary organisations have been considerable, and ... the combination of public and private enterprise in the face of repeated setbacks affords an excellent illustration of a partnership in social service.”⁵⁴

The Percy Report recommended eliminating the legal and social distinctions between mental and physical illness, and also noted that patients not requiring inpatient care should receive

⁵² Thomson, *The Problem of Mental Deficiency*, 271–272, 275.

⁵³ *Ibid.*, 275.

⁵⁴ Roofff, *Voluntary Societies and Social Policy*, xii.

community-based treatment. The resultant Mental Health Act represented a culmination of the postwar debate over community care, to which voluntary groups—as major providers of residential services—were implicitly tied. Institutional care had produced a host of difficulties—among them, “institutional neurosis, with apathy, withdrawal, resignation and loss of individuality.”⁵⁵

Throughout the 1940s and 1950s, many asylums built in the Victorian era continued to operate as mental hospitals, with the number of large institution beds peaking at 150,000 in 1954.⁵⁶ As in general hospitals, infrastructure problems persisted, and minor improvements were commissioned by some RHBs—mostly replacing equipment and furniture. However, the old buildings remained overcrowded, drafty, run-down, expensive to maintain, and “manifestly unsuitable for the post-war era.”⁵⁷ Calls for an increase in community care became more urgent, and patients’ rights were increasingly considered in crafting policy. Perhaps the most significant public endorsement of community care came in 1961, when Minister of Health Enoch Powell announced the shuttering and demolition of the old asylums in his famed “water towers” speech—so called for his evocation of the institutions’ towers as a symbol of decay and social isolation.⁵⁸

By the 1960s, then, the practice and understanding of mental health care had undergone several shifts. Innovative therapies, new drugs, and policy decisions all helped to lessen the burden on long-stay institutions, and to (gradually) increase the quantity and quality of outpatient and community options, for both mental health patients and people with learning disabilities. This is

⁵⁵ Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS* (London: King’s Fund Publishing, 1998), 231.

⁵⁶ Rogers and Pilgrim, *Mental Health Policy in Britain*, 61.

⁵⁷ Jones, *Asylums and After*, 147–148.

⁵⁸ Powell’s speech was delivered at the NAMH’s annual medical conference, indicating that organization’s elevated stature in medical and policy circles. Despite Powell’s rhetoric, the transition to community care would largely flounder in the 1960s. John Welshman argues that the government’s plan for a ten-year reduction of hospital beds “did not provide adequate costings, and therefore failed to provide a credible framework for community care.” As for Powell, in 1968 his work as Minister of Health would be largely eclipsed by his even more famous anti-immigration “Rivers of Blood” speech. See John Welshman, “Rhetoric and reality: community care in England and Wales, 1948–74,” in *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000*, eds. Peter Bartlett and David Wright (London: Bloomsbury Academic, 2001), 212.

not to say that these options were ideal, and there was still plenty of space for voluntary groups to act as service providers and advocates for both individuals and policy—roles they had occupied for decades.

The Development of Voluntarism

In the nineteenth century, charitable organizations were often the sole source of welfare services, working amidst Poor Laws focused on deterrence and punishment, instead of relief. The Charity Organisation Society sought to address poverty within the framework of the Poor Laws, by emphasizing “good habits,” “self-maintenance,” and integration into civil society.⁵⁹ Its main critics, Alfred Marshall and Samuel Barnett, attacked the rigidity of its methods and eschewal of state cooperation, and Jane Lewis argues that early-twentieth-century Liberal reforms were part of a broader “indictment” of existing philanthropic methods. This indictment arose for a variety of reasons: the financial cost of decentralized social provision; the growth of specialized bureaucratic departments; and “changes in the content of liberalism,” emphasizing “positive” liberty and individual fulfillment. Whereas nineteenth-century statutory services tended to complement the more robust voluntary sector—especially in the field of mental health care—by the mid-twentieth century these positions had reversed, and voluntarists were largely supplementing statutory provision.⁶⁰

As noted in this chapter’s opening section, Finlayson’s application of the “moving frontier” helps to understand the back-and-forth nature of statutory and voluntary provision in the period. Finlayson offers another metaphor, arguing that prior work on the welfare state presented a teleological “welfare state escalator”—one gets on in the late nineteenth century, and the natural

⁵⁹ Lewis, *The Voluntary Sector, the State and Social Work in Britain*, 11.

⁶⁰ *Ibid.*, 13.

and inevitable end point is expanded social provision in the late 1940s. As Finlayson puts it, voluntarism can be seen as:

...élitist rather than egalitarian, unreliable, patchy and moralizing, ameliorative rather than curative, amateur rather than professional, overlapping and wasteful rather than properly planned, dependent on suspect goodwill or objectionable ability to pay rather than centred on needs and entitlements.⁶¹

From this perspective, voluntarism becomes marginal and even obstructive to social and economic progress.

In a similar vein, Frank Prochaska argues that prior historians of nationalized health care tended to exaggerate public support for state intervention, as well as suspicion of voluntary organizations. He notes that Labour officials including Attlee and Bevan were not wholly opposed to voluntarism—Attlee asserted that voluntary services “humanize our national life and bring it down from the general to the particular.”⁶² The Second World War disrupted most charities to some degree, causing some to wane or disappear entirely. However, Prochaska finds, “[f]ar fewer cashed it in than is sometimes imagined. Government absorbed many of philanthropy’s health and welfare functions, but institutions soldiered on, as did neighbours and families.” The establishment of the welfare state was another blow, but some (particularly in the health sector) recognized that improved statutory provision could free many charities of “thankless tasks.”⁶³

By abandoning the usual insistence on the inevitability of welfare, Finlayson arrives at a similarly nuanced understanding of how statutory and voluntary bodies worked to mutual benefit. The voluntary sector provided a ready pool of labour and knowledge, while association with the state afforded financial benefits that left many volunteers “more free to experiment and

⁶¹ Finlayson, *Citizen, State, and Social Welfare*, 3, 11.

⁶² F.K. Prochaska, *Philanthropy and the Hospitals of London: The King’s Fund, 1897–1990* (Oxford: Clarendon, 1992), 160, 163.

⁶³ F.K. Prochaska, *The Voluntary Impulse: Philanthropy in Modern Britain* (London: Faber & Faber, 1988), 81–82, 84.

innovate.”⁶⁴ This arrangement was not universal, however—by 1960 it was clear that some voluntary groups were experiencing financial strain, as improvements in state provision made their efforts redundant, and made potential donors more reluctant. In many cases, voluntary groups survived on government subsidies, rather than the more traditional sources of charity.⁶⁵

Finlayson also notes that voluntary groups were able to act as vehicles of democratization and political participation—a suggestion echoed by Matthew Hilton, James McKay, Nicholas Crowson and Jean-François Mouhot.⁶⁶ They argue that since the Second World War, NGOs have largely replaced the mass political party as the nation’s primary vehicle of political action. They suggest that these groups contradict any notion that the population has become disengaged from the political establishment—engagement has simply taken on different forms.⁶⁷ While their work emphasizes groups dedicated to medicine, social welfare, international aid, environmentalism, and human rights, this dissertation shows that mental health and learning disability organizations also acted as social and political pressure groups.

Voluntarists as Professionals

Studies of professionalism and expertise tend to ignore the role of voluntarism, but several authors have developed useful concepts for situating groups not traditionally viewed as “professionals” within the professional realm. Mental health and learning disability policy were influenced in the 1940s and 1950s by a host of political and medical interests, but also by lay pressure groups. Anne Rogers and David Pilgrim have termed members of these groups “paraprofessionals”: GPs, clergy, teachers, probation officers, police, and others whose work

⁶⁴ Finlayson, *Citizen, State, and Social Welfare*, 293. As evidenced in chapter 2, some mental health voluntarists leaned heavily on the notion of “pioneering” new services as a form of self-justification.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*, 402.

⁶⁷ Hilton et al., *The Politics of Expertise*, 1–4.

brought them into contact with people with mental illnesses or learning disabilities.⁶⁸ The concept of the paraprofessional is echoed by Pamela Dale’s work on “lay professionals” in the mental health field: “teachers, social workers, local government officers, charity workers, probation officers and institution managers, together with councillors and lay members of governing bodies and visiting committees.”⁶⁹

Finally, Chris Nottingham has offered the concept of the “insecure professional,” referring specifically to social workers, health workers, and teachers, as opposed to lawyers and doctors—all groups struggling to maintain a middle class wage while establishing monopolies of knowledge in their particular fields.⁷⁰ Vicky Long has extended Nottingham’s analysis to include paid PSWs and psychiatric nurses, and this dissertation extends it further still, to the voluntary sphere.⁷¹ The question of maintaining a middle class salary is not as applicable—it usually took a certain amount of pre-existing wealth to be able to establish oneself as a voluntarist leader—but the same concerns existed around the maintenance of influence and the protection of knowledge.

Andrew Abbott sees this protection as one of the primary functions of professional structures. Abbott argues that prior studies of professionalization focused too heavily on external structures like ethics codes, association, and licensing, and did not adequately explain how abstract knowledge is developed, guarded, and disseminated. For Abbott, the dominant aspect of professional life is “interprofessional competition”—the ways in which professionals vie for control over jurisdictions of knowledge.⁷² He describes the conflict using an ecological metaphor:

⁶⁸ Rogers and Pilgrim, *Mental Health Policy in Britain*, 20–25.

⁶⁹ Pamela Dale, “Tension in the voluntary-statutory alliance: ‘lay professionals’ and the planning and delivery of mental deficiency services, 1917–45,” in *Mental Illness and Learning Disability since 1850: Finding a place for mental disorder in the United Kingdom*, eds. Pamela Dale and Joseph Melling (London: Routledge, 2006), 156.

⁷⁰ Chris Nottingham, “The Rise of the Insecure Professionals,” *International Review of Social History* 52 (2007): 473.

⁷¹ Vicky Long, *Destigmatising mental illness? Professional politics and public education in Britain, 1870–1970* (Manchester: Manchester University Press, 2014), 12, 65–66.

⁷² Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (Chicago: University of Chicago Press, 1988), 2.

intellectual and practical niches are vacated by one profession (or segment of a profession), only to be filled by another. As Abbott puts it, “thus events propagate backwards in some sense, with jurisdictional vacancies, rather than professions themselves, having much of the initiative.”⁷³ Knowledge is not produced in a vacuum, and professional groups do not simply leap teleologically from one venture to the next—rather, they recognize vacant or vulnerable jurisdictions of knowledge and activity, and adjust strategically.

In a call for further study, Abbott declares “[w]e need histories of jurisdictions—who served them, where they came from, how the market was created, how conflict shaped participants.”⁷⁴ This dissertation is a history of that creation and conflict in mental health and learning disability care, and is informed by Abbott’s conception of interprofessional competition. Voluntary groups maintained influence by identifying and occupying jurisdictions either overlooked or abandoned by statutory authorities. Nottingham writes that Abbott’s work:

...suggests a clear difference between established and insecure professions. The latter simply have no secure working jurisdiction, no zone of exclusive responsibility. Some work under bureaucratic control, some operate in confused jurisdictions, which others must pursue their occupations in the area where the supremacy of another profession is firmly established ... Professions with secure jurisdictions will exhibit a political style which is, in most circumstances, defensive and precise, whereas the politics of insecure professions will tend, of necessity, to be promotional and diffuse.⁷⁵

Voluntarists, as insecure professionals, were by their very nature “promotional and diffuse”—to varying degrees—and were closely involved in the charting, development, occupation, and maintenance of jurisdictions within mental health care. As will be seen, voluntary mental health groups could collaborate just as often as compete—the major jurisdictional competitor in the post-war period was the State.

⁷³ *Ibid.*, 3

⁷⁴ *Ibid.*, 325.

⁷⁵ Nottingham, “The Rise of the Insecure Professionals,” 465.

Theoretical Influences

At one level, this dissertation is a structural account of four organizations, concerned with occasionally mundane topics like fundraising, property ownership, professional licensing, staffing, public outreach, and education. At another level, the research questions it poses—concerning the degree of voluntary organizations’ subordination to the state, those organizations’ contributions to essential welfare objectives, and the social and cultural importance of commercial productivity—are informed by several bodies of theoretical work. These bodies constitute wholly different approaches to historical explanation, and the goal here is not to reconcile them. However, they do help to arrive at a similar place: an understanding of the strategies of bureaucratic, capitalist welfare states, and in the context of this dissertation, the ways in which voluntary groups served to reinforce those strategies.

Concerning welfare states, analyses that root our understanding in political economy include Gøsta Esping-Andersen’s influential *The Three Worlds of Welfare Capitalism* (1990), which categorizes the British postwar state as a “liberal,” relatively non-interventionist welfare regime. Esping-Andersen offers a “reconceptualization” of what is important about those regimes: in particular, the degree to which they act to “de-commodify” a given labour market (to make it easier to choose not to work).⁷⁶ Also within the sphere of political economy, Marxist critiques of the welfare state argue that welfare forms a contradictory solution to the ingrained problems of market capitalism, particularly with regard to systemic inequality. By extension, voluntary organizations that reinforce welfare structures can serve to shore up the subjugatory relations they nominally hope to abolish—lest they become victims of their own success.

⁷⁶ Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton: Princeton University Press, 1990), 2–3.

Next, “governmentality” studies inspired by the work of Michel Foucault suggest a historical process of development for both the bureaucratic state and the (ideally) self-governing democratic subject, and an analytic strategy for understanding multifaceted power relations. This approach is relevant to both welfare institutions and the treatment of populations widely understood to be incapable of self-governance—in this case, people with mental illness or learning disabilities. Voluntary organizations occupy a liminal position between state and subject, working to both guide subjects into behaviour that is compliant with statutory dictates and sociocultural norms, and to ultimately promote self-imposition of the same.⁷⁷

The Political Economy of the Welfare State

De-commodification, as Esping-Andersen uses it, refers to “the degree to which [social rights] permit people to make their living standards independent of pure market forces.”⁷⁸ He argues that de-commodifying welfare states are a relatively recent development—these are regimes in which, ideally, “citizens can freely, and without potential loss of job, income, or general welfare, opt out of work when they themselves consider it necessary.” Britain’s welfare regime is categorized as “liberal,” meaning it is characterized by low de-commodification and high economic stratification. In particular, Esping-Andersen argues that in liberal regimes, “the progress of social reform has been severely circumscribed by traditional, liberal work-ethic norms ... Entitlement rules are therefore strict and often association with stigma; benefits are typically modest.”⁷⁹

⁷⁷ On the similarities and differences between political economy—Marxist or otherwise—and Foucauldian theory, see Mark Olssen, “Foucault and Marxism: rewriting the theory of historical materialism,” *Policy Futures in Education* 2, nos. 3–4 (2004): 454–482; Gary Browning and Andrew Kilmister, *Critical and Post-critical Political Economy* (London: Palgrave Macmillan, 2006), 61–83.

⁷⁸ Esping-Andersen, *The Three Worlds of Welfare Capitalism*, 3.

⁷⁹ *Ibid.*, 26–28. “Liberal” regimes mainly exist in what Esping-Andersen calls the “Anglo-Saxon” countries—the UK, the US, Canada, and Australia. His other types are “Corporatist” regimes, which share a “historical corporatist-statist legacy” emphasizing “the preservation of status differentials” (Austria, Germany, France, Italy); and “Social Democratic” regimes, in which universalism and de-commodification are high, and have been extended to the middle classes (Scandinavian countries).

A goal of this dissertation is to understand how voluntarism can contribute to the relatively arrested de-commodification of Britain's welfare system. Even voluntary efforts that serve to maintain non-working populations—like residential programs—can have the effect of re-commodifying the labour of former caregivers (usually family members). More obviously, a heavy emphasis on occupational skills and workplace “reintegration” in mental illness and learning disability care meant that a main (and perhaps incidental) voluntarist goal was to ease the burden on the liberal welfare state. As argued here, this formed a major component of voluntarists' ongoing indispensability within the welfare order.

In his introduction to Ian Gough's *The Political Economy of the Welfare State* (1979), Peter Leonard notes that Marxist analysis “has to walk a tightrope between crude functionalism and starry-eyed voluntarism—at its extreme, between seeing the welfare state as wholly oppressive and seeing it as a bastion of socialism within a capitalist economy.”⁸⁰ This is what Gough seeks to accomplish (as does this dissertation). Gough views the welfare state as “a constituent feature of modern capitalist societies,” which provides services, but also regulates private activity.⁸¹

In applying Marxist political economy, Gough addresses oversights in both functionalist and pluralist theories of welfare development: functionalism ignores the welfare state's “controlling, repressive” nature; pluralism fails to explain the need for welfare policies in the first place, as well as the ever-growing expansion of welfare expenditure.⁸² Gough argues that through

⁸⁰ Peter Leonard, “Introduction,” in Gough, *The Political Economy of the Welfare State*, ix.

⁸¹ Gough, *The Political Economy of the Welfare State*, 3–4.

⁸² *Ibid.*, 8–9. To be clear, while this dissertation draws on theoretical sources that critique functionalism, in favour of explanations based in structuralism or conflict theory, it does not wholly abandon functionalist explanations for voluntary action, or the development of social and economic structures. In many instances, voluntary provision was driven by a common recognition of a given problem, and consequent organizing to address that problem. Further, Abbott's argument that professional knowledge is spurred by jurisdictional vacancies is essentially functionalist. However, Jack Ross argues for “the nominalist assumption that the organization is an aspect of members' social consciousness of social relations as goals are sought, and there is no organization apart from this consciousness.” Although voluntarist leaders—the “originators” of associations—can be driven by functionalist need, Ross argues that in most cases, voluntary membership is a product of social relations and ascription (in the sociological sense, as a

the activities of the welfare state, which are ostensibly aimed at promoting equality, well-being, and the “common interest” of all citizens, the capitalist mode of production is continually reinforced: “[f]or exploitation to take place all that is necessary is that capitalists (who own the means of production) and workers (who do not) should be treated identically before the law as free and equal partners.”⁸³ Through welfare structures, the capitalist state ensures the continual reproduction of labour power and the maintenance of non-working populations.

Similarly, Claus Offe rejects narrow understandings of the welfare state as a purely ameliorative provider of social services; instead, he argues, it reflects a misguided belief that the social and economic deficiencies of late capitalist societies can be rectified through “improved administration and budgetary management.”⁸⁴ Capitalist systems are both reliant upon and threatened by external regulatory systems, such as the welfare state—which is itself a set of structures and institutions “designed to reconcile and harmonize the ‘privately regulated’ capitalist economy with the processes of socialization this economy triggers.”⁸⁵ Though welfare state policies are meant to be “negatively subordinated” to the commodifying capitalist economy—ensuring its healthy functioning and thereby securing the mass loyalty of the citizenry—they paradoxically employ decommodifying means to create the preconditions for that economy’s success.⁸⁶

What Offe calls the “peace formula” of the welfare state consists of the obligation to provide citizens with social and economic support. However, this obligation is fundamentally analgesic—it is meant to limit class conflict and other disruptive struggles that characterize liberal

means to acquire status). See Jack C. Ross, “Toward a Reconstruction of Voluntary Association Theory,” *The British Journal of Sociology* 23, no. 1 (1972): 21, 27–28.

⁸³ *Ibid.*, 40.

⁸⁴ Claus Offe, *Contradictions of the Welfare State*, ed. John Keane (Cambridge, The MIT Press, 1984), 35.

⁸⁵ *Ibid.*, 51.

⁸⁶ John Keane, “Introduction,” in Offe, *Contradictions of the Welfare State*, 35.

capitalism. Despite the increasingly visible inefficiency of welfare bureaucracies, the system is maintained because of its “social control function: welfare recipients are only considered “deserving” if they adhere to social norms.⁸⁷ As summarized by John Keane, “the welfare state seeks to maintain the economic dominance of capital, to challenge and erode its power, and to compensate for its disruptive and disorganizing consequences.”⁸⁸ Voluntary groups can serve these ends by bolstering the decommodifying functions of the welfare state, while simultaneously ensuring that citizens—whose fundamental needs are thus met—are incorporated into the commodifying economy as they adhere to social norms.

Governmentality

Governmentality, in Michel Foucault’s original conception, refers to the “institutions, procedures, analyses and reflections” that exercise a specific type of diffuse power on a given population. It operates chiefly through “apparatuses of security,” such as legislative bodies and police forces. Governmentality also refers to the gradual historical trend through which modern liberal and neo-liberal government has supplanted other types of power relations in Western states, such as those based on sovereignty or corporal discipline. Foucault argues that the development of complex administrative bureaucracies has been a driving force in guiding democratic subjects into a state of compliant and self-disciplined behaviour.⁸⁹

A caveat is required here: governmentality is not meant to suggest that the exercise of power has always been intentional or straightforward, or that governments and other public bodies necessarily operate out of repressive or sinister intention. Nor do the strategies of governmentality go uncontested, or guarantee success. Rather, proponents of the governmentality perspective find

⁸⁷ Offe, 147, 155–156.

⁸⁸ Keane, “Introduction,” 35.

⁸⁹ Michel Foucault, “Governmentality,” in *The Foucault Effect: Studies in Governmentality*, eds. Graham Burchell, Colin Gordon and Peter Miller (Chicago: The University of Chicago Press, 1991), 102–103.

it useful for approaching omnidirectional power relations—whether detrimental or beneficial to the governed or governing.

According to the governmentality thesis, states have inserted themselves and their interests into the lives and behaviours of citizens—“government” extends beyond the level of the state and permeates relations between individuals, as well as the relation with the self. Ideally, the State produces subjects who do not need governing at all, since they will govern themselves, their families, and their peers in an acceptable manner. The welfare state, then, is another step in the lengthy process of achieving this end. By providing for citizens’ basic needs, the State allows space for the development of self-sufficient, self-regulating democratic subjects—subjects who will police deviance or abnormality in the place of those “apparatuses of security.”

Governmentality can also refer to an analytic strategy for understanding multifaceted power relations. Extending Foucault’s argument, Nikolas Rose draws a distinction between “domination” and “governing,” where “[t]o dominate is to ignore or to attempt to crush the capacity for action of the dominated. But to govern is to recognize that capacity for action and to adjust oneself to it.”⁹⁰ This dissertation does not suggest that voluntarists as a group sought to “dominate” people with mental illness or learning disabilities, but instead mirrored welfare structures by “governing” them, for example by confining them to private spaces (residential homes), regulating day-to-day activity, and emphasizing social norms and commercial productivity.

Rose further argues that this governmental discipline continues to operate even in those liberal and neo-liberal societies that nominally adopt individual freedom as their paramount objective. He writes:

⁹⁰ Nikolas Rose, *Powers of Freedom: Reframing Political Thought* (Cambridge: Cambridge University Press, 1999), 4.

[t]o analyse political power through the analytics of governmentality is not to start from the apparently obvious historical question: what happened and why? It is to start by asking what authorities of various sorts wanted to happen, in relation to problems defined how, in pursuit of what objectives, through what strategies and techniques.⁹¹

In this dissertation, Rose's questions are applied to decisions emanating from either side of the "moving frontier." Among both statutory and non-statutory bodies, what were the objectives of increased welfare provision in mental health and learning disability care, and what strategies were mobilized to push the frontier in one direction or the other? More crucially, did voluntarist groups wholly oppose the encroachment of the state, or did they see opportunity in the new political order?

Mitchell Dean outlines several applications of governmentality to understanding the ways in which power is constituted, distributed, and applied, which he terms "an analytics of government." Societies, according to Dean, are directed through "regimes of practices"—put simply, "coherent sets of ways of going about doing things."⁹² Regimes of practices are constituted by, for example, approaches to punishment, medicine, poverty, and mental health. An analytics of government seeks instances in which existing regimes of practice are "problematized" by new programmes of thought—"the moments and the situations in which government becomes a problem."⁹³ Dean summarizes the goals of this approach, which "thus stands in contrast to theories of government that ask 'who rules?', 'what is the source of that rule?' and 'what is the basis of legitimacy?'" Governmentality studies "[want] to understand how different locales are constituted as authoritative and powerful, how different agents are assembled with specific powers, and how different domains are constituted as governable and administrable."⁹⁴

⁹¹ Ibid., 20.

⁹² Mitchell Dean, *Governmentality: Power and Rule in Modern Society*, 2nd ed. (London: Sage Publications, 2010), 31.

⁹³ Ibid., 38.

⁹⁴ Ibid., 39–40.

By applying an “analytics of government,” this dissertation envisions the mobility of the “moving frontier” as an instance of problematization, in which voluntary groups vied with the state over jurisdictions of knowledge and power. The welfare state entailed a transfer of power, responsibility, and oversight from private bodies to statutory bodies, but this transfer opened space for private bodies to encourage the development of the self-governing, consumerist, and commercially productive private subjects that have come to characterize the modern neo-liberal order. Even as voluntary groups saw sites of power—jurisdictions—wrested from them, they continued developing services and philosophies that served the ends of government. This dissertation seeks to understand how voluntary mental health groups opposed, worked within, and were co-opted by sources of knowledge and power, and in doing so, how they both supported and challenged welfare structures, and contributed to approaches to mental illness and learning disability.

Chapter Outline

Along with the material realities of operating a national voluntary organization, each chapter illustrates different elements of the theoretic underpinnings outlined in this introduction. The work of voluntary groups alongside state welfare in the fields of mental health and learning disability care exemplifies critiques derived from political economy—Marxist or otherwise—as well as understandings of power and subjectivity in the modern state, derived from Foucauldian governmentality. For example, the Ex-Services Welfare Society was dedicated to the rehabilitation of traumatized ex-Service members, and emphasized productive work and vocational skills as the primary means of achieving that goal. This treatment served several ends—it lessened the burden of war pensions, increased self-sufficiency, assisted in the expansion of the nation’s labour pool,

reconfirmed the primacy of the breadwinning male, and arrested perceived deviance from social norms.

Other chapters show how, in dealing with mental health and learning disabilities, voluntary organizations frequently confirmed rather than challenged such norms. Exceptions can be found in certain operations of the NAPBC/NAMHC, which tried to empower a particular constituency—parents—within the welfare system. But perhaps unsurprisingly, voluntary organizations generally reflected—rather than reacted against—the society that had produced them. For many, success rested upon the cultivation of traditional elites for leadership positions, whether that leadership was “honorary” or functional.

While, in different areas, there are clear similarities and contrasts between organizational philosophies and approaches, the goal here is not primarily comparative. The dissertation has been organized into case studies, rather than thematically. This allows for a close examination of each group’s inner workings and development over time, without becoming bogged down in unwieldy or repetitive listings of different ways of addressing similar issues. It also helps to centre the dissertation’s focus primarily on each group’s relationship with the state, rather than with each other (although the latter dynamic is important and unavoidable).

Chapter 2 examines the National Association for Mental Health, which is arguably the most visible and prominent of all voluntary groups in the field of mental health. Formed through a 1946 amalgamation of three existing groups, the NAMH became something of a catch-all organization, incorporating mental health care, learning disability care, and child guidance—all informed by principles of the mental hygiene movement. It would go on to operate residential homes, provide guardianship services, run professional training and public education programs, sponsor

conferences and research, and advocate at all levels of government for people with mental illness and learning disabilities.

Chapter 3 examines the Mental After Care Association, which was the only group to refuse amalgamation with the NAMH in 1946, indicating a fierce sense of independence. The MACA's operations were more limited, confined to providing residential accommodation for convalescing mental patients and the elderly, as well as holiday homes for people still in mental institutions. It offered an employment outlet for many mental health nurses and other workers who aged out of institutional positions (most matrons of residential homes had at some point worked in an institution). It also represented an important middle-ground between the institution and the community, facilitating the shift towards community care in the latter half of the 1950s. Finally, its history demonstrates the trouble that this shift could cause—it was often a battle to secure approval of new homes within communities wary of “lunatics.”

Chapter 4 examines the Ex-Services Welfare Society—a group heavily involved in fundraising and service provision, but mostly disconnected from policy advocacy. This is not to say that the Society was insular—indeed, it maintained contacts at the highest levels of the government, the military, and the aristocracy. However, these contacts were mined for prestige and financial resources, rather than for specific policy outcomes. The Society's work exemplifies new directions idealized masculinity had taken in the inter-war years: while First World War treatments for shell shock generally sought to reinscribe martiality, by the late 1940s the Society was seeking to reinscribe employability. The Society's strategy centred around occupational skills and sheltered employment, with work cast as therapy in and of itself.

Finally, Chapter 5 examines the National Association for Parents of Backward Children/National Society for Mentally Handicapped Children—a group established by service

users themselves. Parents, frustrated by the lack of educational provision for their children with learning disabilities, banded together in regional support societies that eventually merged into a national advocacy group. The Association was mainly concerned with combating stigma, and with occupational training for children labelled “ineducable” by the *Education Act 1944*. While there was less emphasis on employability, the desire to instill occupational and domestic skills reveals a deeply ingrained mindset (evident in the operations of each voluntary group), which was reinforced by the commodifying contradictions of welfare state: good mental health was reflected in self-sufficiency and conformity to social norms.

The logic of the welfare state can be seen clearly in the fields of mental health and learning disability care—both the statutory and voluntary spheres—through a continuous emphasis on self-governance and the dignity supposedly imparted by employment. Viewed through lenses of Marxism and governmentality, welfare state structures have as their end goal a self-governing, commercially consumeristic and productive democratic subject—a goal shared to varying degrees with mid-century voluntarists in the fields of mental health and learning disability. In providing for children, the elderly, people with disabilities, and other non-working groups, the welfare state assumed roles formerly held by kin, community, and charitable bodies, thereby freeing more people to enter the labour pool.⁹⁵ There is a long British tradition of the “Gospel of Work,” whereby work became “an end in itself, a virtue in its own right.”⁹⁶ From the late nineteenth century, when “economic man” shifted from producer to consumer, John Dupré and Regenia Gagnier argue that

⁹⁵ Gough, *The Political Economy of the Welfare*, 47.

⁹⁶ Walter E. Houghton, *The Victorian Frame of Mind 1830–1870* (New Haven: Yale University Press, 1957), 243. See also Rob Breton, *Gospels and Grit: Work and Labour in Carlyle, Conrad, and Orwell* (Toronto: Toronto of University Press, 2005); Patrick Joyce, ed., *The historical meanings of work* (Cambridge: Cambridge University Press, 1987).

work began deriving its value “exclusively ... from its role as an input into productive processes.”⁹⁷ This was the social context in which mental health professionals, welfare bureaucrats, and voluntarists identified full employment as a paramount indicator of successful treatment. In various ways, each organization examined here bears out the dissertation’s central argument: for voluntary mental health and learning disability organizations to survive (and prosper) in the welfare era, it was necessary to propagate the economic and social goals of the welfare state.

⁹⁷ John Dupré and Regenia Gagnier, “A Brief History of Work,” *Journal of Economic Issues* 30, no. 2 (1996): 555.

Chapter 2

The National Association for Mental Health

“I put the conquest of the human mind far beyond the conquest of space.”

R.A. Butler¹

Introduction

In this chapter, activities of the National Association for Mental Health (referred to here either as NAMH or “the Association”) are traced through the late 1940s and 1950s, with occasional overlap into the post-1959 era. Reflecting the thesis of this dissertation, the permeation of the welfare state is evident in NAMH operations. The Association would emphasize the management of disorder through education and destigmatization, but also through the containment and maintenance of people with mental illness and learning disability (even within the context of an ameliorative shift to community care).

The chapter first considers residential services, showing that the accommodation of people with mental illness or learning disability became the Association’s primary insurance against irrelevance within the welfare state. Further, it frequently cooperated with government to set up much-needed facilities. The next section details efforts to establish and promote educational services for professionals working in mental health, and also to raise public awareness and destigmatize mental illness and learning disability. Finally, the chapter shows how the Association interacted with various levels of government to shape policy—both to its own ends and to the benefit of its clients.

Throughout the early years of the welfare state, the National Association for Mental Health repeatedly affirmed the idea that despite the reorganization of health services, voluntarism was

¹ “Plea for ‘Conquest of Human Mind’,” *The Times*, March 23, 1961, 6.

still an essential element of mental health provision. The group's 1950–1951 annual report stated, “[t]he development in the last few years of the vast organisation of the National Health Service, and the many other new measures of social legislation, have not diminished the need for a national voluntary organisation for the promotion of mental health.”² This chapter examines the ways in which the NAMH ensured its social and medical indispensability, maintained its funding base and public image, and grew to become the United Kingdom's premier mental health organization.

In the 1930s, as statutory authorities gradually assumed more responsibility for mental welfare, many voluntary groups in the field suffered both financially and in terms of public interest and sympathy. The Central Association for Mental Welfare (CAMW; est. 1913), which dealt with learning disability, bucked the trend by reorganizing as a service provider for overwhelmed local authorities. The group began generating income by providing guardianship services, running occupation and training centres, and seconding out expert personnel to statutory service providers.³ By 1939, the CAMW dominated the landscape of mental health voluntarism, along with three other organizations: the Mental After-Care Association (MACA; est. 1879), for convalescent mental hospital patients; the National Council for Mental Hygiene (NCMH; est. 1918), which focused on prevention and education; and the Child Guidance Council (CGC; est. 1927), dedicated to child psychiatry.

In London and the Home Counties, where all four organizations maintained a strong presence, statutory and voluntary services often overlapped. In other areas of the country however, there were no statutory services at all, and sparsely-staffed voluntary organizations could find their

² Wellcome Library, London, UK, Mind Collection, SA/MIN/B/80/7/1, *NAMH Annual Report, 1950–1*, 6.

³ Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870–1959* (Oxford: Clarendon Press, 1998), 174.

resources and budgets strained by need.⁴ In 1939, a committee led by the Conservative peer Lord Feversham and consisting of representatives from voluntary organizations and the British Medical Association, recommended amalgamation of the major groups. The Second World War halted any immediate plans, but in 1946 the CAMW, NCMH, and CGC formed the Provisional National Council for Mental Health. The same year, the permanent name, National Association for Mental Health, was adopted.

All three constituent groups of the newly formed NAMH had operated according to the principles of the mental hygiene movement: middle class morality was emphasized, along with the threat of working-class degeneracy and inefficiency.⁵ Until the Second World War, the social causes and effects of mental disorder were largely ignored. Mental hygienists opposed the stigma surrounding mental illness, but not necessarily out of sympathy—they were mainly concerned that stigma could hinder early ascertainment and treatment.⁶ The Association's operations in the period—and the rhetoric employed in promoting those operations—make it clear that a primary goal of psychiatric or psychological treatment was to mould the individual to fit their surroundings, rather than vice versa.

The legislation that established the nation's existing mental health care regime, the *Lunacy Act 1890*, was unanimously considered a disaster by the Feversham Committee, in terms of both adequate service provision and protecting patients' rights. While the ensuing *Mental Treatment Act 1930* had helped with the distribution and quality of provision somewhat, it was clear that its effects had not reached the entire nation.⁷ Where government provision was sparse, the newly-

⁴ Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London: Athlone Press, 1993), 139.

⁵ Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (London: Routledge, 2006), 62–64. See also Jonathan Toms, *Mental Hygiene and Psychiatry in Modern Britain* (Houndmills: Palgrave MacMillan, 2013). The mental hygiene movement is discussed in more detail in the Introduction.

⁶ Crossley, *Contesting Psychiatry*, 66.

⁷ Jones, *Asylums and After*, 139.

formed NAMH was well-positioned to ensure that mental health resources could be made available. Indeed, increased statutory responsibility for mental health care would result in a corresponding increase in the Association's influence, rather than the opposite.⁸

The Feversham Committee also recognized that statutory authorities were increasingly taking on ascertainment and supervisory duties, which had previously been performed by voluntary groups. As such, it recommended that voluntarists move more towards a public education role, within which they could still help coordinate and publicize services.⁹ There was little sense among statutory authorities that they were fully supplanting voluntarism—Mathew Thomson finds “considerable confidence” that “a rationalized voluntary sector could continue to play a vital role working alongside and complementing a state social service.”¹⁰

Following the First World War, advances in both psychiatric medicine and the scope and extent of provision had been allowed to languish. The NAMH was determined not to let such a reversal occur within the new welfare state. Focusing on the Association's establishment and early operations, particularly in the context of 1950s psychiatric apologism and an ensuing anti-psychiatry backlash, Nick Crossley argues that the Association successfully imposed an agenda and a specific conception of mental illness on the rest of the mental health field. The group presented its ideas as self-evidently true rather than open for debate, and relied on significant political, social, and economic capital in promoting these ideas, rather than “the force of a better argument.”¹¹ The Association's mental hygienist foundation served to embody and promote “the values, norms, standards and concerns of middle class Protestant culture, whilst at the same time

⁸ Jones, *Mental Health and Social Policy*, 175–176.

⁹ Thomson, *The Problem of Mental Deficiency*, 177.

¹⁰ *Ibid.*, 178.

¹¹ Nick Crossley, “Transforming the mental health field: the early history of the National Association for Mental Health,” *Sociology of Health and Illness* 20, no. 4 (1998): 464.

claiming to be value free science and thus avoiding the public debate which might be expected in relation to matters of opinion.”¹² It follows that mental health voluntarism—at least in the Association’s case—can be seen to constitute a corrective middle class project, intertwined with the socially ameliorative goals of the ascendant social sciences.¹³

A major question for all voluntary groups was whether their relationship with authorities would remain primarily complementary, or whether they would be asked to shore up overwhelmed state-controlled programs. A *Times* article reporting on the first NAMH committee election noted that as with its predecessor organizations, the group intended to complement statutory service provision, rather than supplement it. However, its separate functions would be “greatly extended in close cooperation with the Government and local authorities.”¹⁴ Rhetoric emphasizing “pioneer” activities was a common trope in NAMH communications—the idea being that statutory encroachment was actually desirable, since it freed up resources for innovative programs and experimentation. Whether this assertion was wishful thinking could vary from case to case, but the Association employed the idea frequently: for example, a 1948 pamphlet refers to the “valuable pioneer work” carried out by the constituent organizations in the years prior to amalgamation.¹⁵

The NAMH maintained a close relationship with government, both in advisory roles and with members occupying various governmental positions in ministries and Parliament. This helped to both embed the Association within the nation’s power structures, and increase public visibility and credibility. Princess Marina, Duchess of Kent, became the Association’s Patron.¹⁶ For the most

¹² *Ibid.*, 468.

¹³ See Mike Savage, *Identities and Social Change in Britain since 1940* (Oxford: Oxford University Press, 2010).

¹⁴ “National Association for Mental Health,” *The Times*, February 12, 1947, 2.

¹⁵ Wellcome Library, Robina Addis Collection, PP/ADD/J/11/1:Box 20, “A positive mental health policy,” 1948.

¹⁶ See Figs. 2.4, 2.5. A member of the royal family of Greece and Denmark, Marina (1906–1968) married Prince George, the Duke of Kent, fourth son of George V and Queen Mary, in 1934. After the Duke’s 1942 death in a flying accident, she dedicated herself to the patronage of several causes—in particular, mental health. The Duchess of Kent would also become Patron of the MACA in 1958. See G.K.S. Hamilton-Edwards, “Marina, Princess

part, associated political figures tended to be members of the Conservative Party—perhaps reflecting the fear of some that the welfare state could deal a blow to the voluntarist impulse. Lord Feversham, who had chaired the committee recommending the group’s establishment, became its first Chairman of Council.¹⁷ R.A. Butler—Minister of Education in the wartime Coalition government, and a leading Conservative reformer—served as the Association’s President, and was surprisingly active for such a busy politician.¹⁸ Feversham and Butler’s participation reflects a commonality among voluntary groups, both then and now: the necessity of co-opting political, aristocratic, wealthy, and increasingly celebrity figures.¹⁹

The NAMH would quickly become the most influential and well-known of the British mental health organizations. At the local, national, and international levels, Crossley notes that the group maintained influence by becoming “a network and generator of networks,” which built organizational bridges largely through conferences and publishing.²⁰ Throughout the 1950s, the NAMH was represented in several international health organizations: the International Committee on Mental Hygiene; the World Federation for Mental Health; the European Committee for Mental

[Princess Marina of Greece and of Denmark], duchess of Kent,” *Oxford Dictionary of National Biography*, accessed June 15, 2020, <https://doi.org/10.1093/ref:odnb/34877>.

¹⁷ Charles “Sim” Duncombe, 3rd Earl of Feversham (1906–1963), had a varied career both in and out of politics, consisting of service in the Second World War as a Colonel of the Yorkshire Yeomanry, and positions as Lord in Waiting to Kings George V and Edward VIII, Parliamentary Secretary to the Minister of Agriculture and Fisheries, and Justice of the Peace and Deputy Lieutenant for the North Riding, Yorkshire. See “Charles William Slingsby Duncombe, 3rd Earl of Feversham of Ryedale,” *The Peerage*, accessed March 20, 2020, <http://www.thepeerage.com/p2258.htm#i22578>.

¹⁸ See Fig. 2.5. Richard Austen “Rab” Butler (1902–1982) was a driving force behind the political consensus of the post-war period. As Chancellor of the Exchequer from 1951–1955, he echoed his Labour predecessor Hugh Gaitskell in promoting a mixed economy and Keynesian demand management. Butler would hold a variety of ministerial positions from the 1940s to the 1960s, including Home Secretary and Deputy Prime Minister. See Ian Gilmour, “Butler, Richard Austen [Rab], Baron Butler of Saffron Walden,” *Oxford Dictionary of National Biography*, accessed March 20, 2020, <https://doi.org/10.1093/ref:odnb/30886>.

¹⁹ The actor and comedian Stephen Fry has been President of Mind since 2011. His role is explained on Mind’s website: “[o]ur President is our figurehead and our leading ambassador—promoting our causes and advocating on our behalf.” See “Our President,” *Mind*, accessed February 5, 2020, <https://www.mind.org.uk/about-us/celebrity-support/our-president/>.

²⁰ Crossley, *Contesting Psychiatry*, 77–78.

Hygiene; the European League for Mental Hygiene; UNESCO; and the World Health Organization.²¹

The inaugural NAMH annual report listed a number of aims and objectives, which cast a wide and ambitious net, and reflected the preventive and educational focus of its mental hygienist members:

To foster a wider understanding throughout the community of the importance of mental health ... To provide and encourage the provision of courses, lectures, and conferences ... to establish and maintain professional standards of work ... To encourage and promote the establishment of treatment and training facilities.²²

Accordingly, facilities and operations included residential and holiday homes (classified variously for children, the mentally ill or “deficient,” convalescent epileptics, the elderly, and the “pre-delinquent”), agricultural hostels, professional training courses, public exhibitions, informational and academic publishing, and conference organization.²³

Residential Services

Though not prominent among the originally stated aims of the NAMH, residential services—primarily for people with learning disabilities, rather than mental illness—would become one of the group’s most important instruments in ensuring its ongoing usefulness within the welfare state. This usefulness, in turn, allowed the Association latitude to pursue its work in other areas—particularly education and advocacy. Despite the gradual transition to community care, an institutionalizing and segregationist mindset persisted in legislation, public awareness, and medical treatment. It is likely that the Association’s executives recognized a continuing desire for four walls surrounding the “insane” or “defective.” Furthermore, the *Education Act 1944* had produced a new classification for certain children with learning disabilities: “ineducable.” These

²¹ Crossley, “Transforming the mental health field,” 481–482.

²² Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1946–7*.

²³ Crossley, *Contesting Psychiatry*, 74.

children were excluded entirely from the education system, with parents left to contend as best as they could; residential homes provided a solution.²⁴

In a brief history of the Association's work, General Secretary Mary Applebey wrote, "[t]hese residential experiments have always helped the Association to keep its finger on the pulse of where national provision was falling short of needs."²⁵ This section first examines the general development of the Association's residential services, which included long and short-stay homes for children and adults, holiday homes for mental hospital patients, and agricultural hostels. It contains two detailed case studies tracing the establishment of residential services: a hostel for "maladjusted" boys and an approved school for girls.²⁶ These show the various means of cooperation and collaboration involved in opening new facilities, as well as the ways in which the Association positioned its residential services in relation to the state.

Homes and Other Facilities

Residential services became one of the major pillars of the Association's indispensability—hard-pressed local and regional governments would rely heavily on these services throughout the period at hand. Small, targeted facilities emphasizing engagement and skill-building were a significant step up from enormous, run down, inattentive institutions. Notably, President R.A.

²⁴ The effects of the Act, and parents' reactions, are discussed in more detail in chapter 5, in reference to the National Association for Parents of Backward Children/National Association for Mentally Handicapped Children.

²⁵ See Fig. 2.1. Applebey was a key figure in the NAMH, serving as General Secretary from 1951 into the 1970s. Nearly all Association initiatives reflected her influence in some manner, indicating her indispensability to the organization. Wellcome Library, Manuscripts, MS.7193/7, Mary Applebey, "The National Association for Mental Health," in *The Expanding Field of Mental Health in England and Wales, 1918–1968*, eds. Doris Odlum and Alexander Walk (unpublished manuscript, 1968), 6.

²⁶ "Maladjustment" was one of eleven categories introduced by the *Education Act 1944* to classify children with special needs. Maladjusted children were those with an emotional or psychological disorder, but not necessarily a learning disability. However, in practice the categories were frequently conflated with "mental illness" as a generalized diagnosis, and all thus fell within the purview of the Association. "Maladjustment" as a concept has a longer history, however, dating to the interwar period. A 1933 definition avoided the connotation of "disorder," and connected maladjustment to societal problems. It was "the failure of the individual or individuals to attain some norm of behaviour," but this failure could be derived from "the socially conditioned, limited, or repressed personality." See "Maladjustment," in *Encyclopedia of the Social Sciences*, vol. X, *Machinery, Industrial-Moratorium*, eds. Edwin Seligman and Alvin Johnson (London: Macmillan, 1933), 61.

Butler was Minister of Education in 1944 and as such, was one of the Education Act's primary architects. It is striking that Butler was heavily involved in an organization dedicated to accommodating those children whom the Act left behind. In 1949, planning documents for a home for maladjusted children in Buckinghamshire noted, "[t]hese children cannot properly be dealt with under the Education Act ... so that the Clinic will quite properly cater for children who come outside the ordinary statutory provisions."²⁷ This is a direct example of policy decisions diverting potential statutory provision to a voluntary body—in this case through the same leading figure, Butler.

The Association's focus on residential accommodation indicates a renewed emphasis on familial relations and a "home" atmosphere in mental health care. Dating back to the late eighteenth century, when Quakers opened the famed Retreat at York, moral therapists (the forerunners to twentieth-century mental hygienists) had emphasized familial hierarchy and authority as organizing principles for mental treatment. Reason—understood as dialectically opposed to madness—was considered attainable only within a rigidly "reasonable" environment, and amidst authoritative relations between patient and practitioner.²⁸ While community care was considered cutting-edge in the period at hand, the operation of smaller facilities brought medical practitioners and voluntarists closer in line with the practice of moral therapy from over a century earlier.

Throughout the 1940s and 1950s, the NAMH would emphasize the extent of its residential services, taking advantage of an urgent sense of need within concerned government ministries. In 1955, long-time NAMH psychiatric social worker (PSW) Robina Addis cited residential services

²⁷ The National Archives, Ministry of Health Records, MH/102/2155, "Proposed Voluntary Home and Residential Clinic for young maladjusted children," March 15, 1949.

²⁸ Jonathan Toms, *Mental Hygiene and Psychiatry in Modern Britain*, 4–6.

as the primary justification for the group's existence.²⁹ Emphasizing complementarity, she situated these services within a general push to "fill gaps" in existing provision, leaning heavily on pioneer rhetoric: "we have become aware of gaps in the provision of mental health facilities which the N.A.M.H. by running a pioneer and demonstration unit, can lead the way in meeting." Addis pointed to the Association's holiday homes, short-stay and long-stay homes for children with learning disabilities, and a home for elderly women who could not care for themselves.³⁰

In medical conferences, voluntarist circles, and public commentary, the lack of mental health care in all areas was evident, but in providing residential services, the Association especially emphasized the needs of children. Many NAMH facilities catered specifically to children, reflecting the enduring importance of child guidance and the mental hygienist principle of early detection and prevention. The Association ran four homes inherited from the CAMW, for children with various learning disabilities: at Rhyl, Bognor Regis, St. Leonards-on-Sea, and Basingstoke. It also operated a boarding home for twenty "maladjusted" children in Wiltshire, which was subsequently transferred to Kent. Further, in 1947 it opened talks with the Home Office on potential management of two new approved schools for "maladjusted" children.³¹

A 1949 NAMH report on special education recommended that "[s]chools of a very informal kind" be established for "ineducable" children. It also recommended the establishment of homes

²⁹ Robina Addis (1900–1986) was one of Britain's first qualified psychiatric social workers. After graduating from the London School of Economics in 1933, she worked first in child guidance clinics, and later joined the NAMH, becoming Deputy General Secretary in 1960. She was involved with several voluntary associations, including the Save the Children Fund, and in 1979 founded the Child Guidance Trust. See "Robina Addis," *The Wellcome Library*, accessed April 5, 2020, <https://wellcomelibrary.org/collections/digital-collections/mental-healthcare/robina-addis/>.

³⁰ Wellcome Library, PP/ADD/J/18/, Robina S. Addis, "The Work of the National Association for Mental Health," June 1955, 5.

³¹ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1946–7*, 7. For more on approved schools and industrial schools in the UK, see Gillian Carol Gear, "Industrial Schools in England, 1857–1933: 'Moral Hospitals' or 'Oppressive Institutions'?" (PhD diss: University of London Institute of Education, 1999); Jim Hyland, *Yesterday's Answers: Development and decline of schools for young offenders* (London: Whiting & Birch, 1993); Ann Davis, *The residential solution: state alternatives to family care* (London: Tavistock Publications, 1981).

to receive these children once they reached school-leaving age. Existing legislation contained only permissive regulations for local authorities, and until the time that these regulations were made compulsory, the report suggested that both types of facilities could be set up on an experimental basis by voluntary groups (recommendations of this kind often alluded to the potential for statutory-voluntary collaboration).³² Further, the report emphasized the importance of vocational training in special schools. It cautioned against framing such training too narrowly, as it was presumed that children with special needs could not partake in the trades that were normally taught in regular schools. Children and adolescents with learning disabilities should be prepared, as far as possible, “to take a normal place in the community,” and should be educated in subjects that would help them in “general self-development and adjustment to normal life.”³³ The importance of self-sufficiency and being able to return to a “normal” existence was evident.

There are further indicators that the state was failing to provide adequate residential services for children with learning disabilities. A 1950 *Times* editorial criticized provision for maladjusted children—particularly residential accommodation—stating, “[s]ome children were leaving the special hostels in a worse state than when they were admitted ... The Ministry of Education has now set up a strong committee to deal with the whole subject.” The British Paediatric Association and the NAMH had previously called for more child guidance clinics to be attached to children’s and general hospitals, but “educational experts” had doubted the necessity of this provision. The editorial concluded, “[i]f maladjustment in childhood can be properly treated

³² Wellcome Library, SA/MIN/B/19A, *Some Special Educational Problems of Physically Handicapped Children* (London: NAMH, 1949), 55–56.

³³ *Ibid.*, 57.

there is ground for hope that juvenile delinquency can be much diminished,” but such sentiments seldom reflected much official conviction.³⁴

NAMH Vice-Chairman Priscilla Reyntiens, Lady Norman, was heavily involved in promoting children’s facilities, both by writing editorial pieces and by making public appearances.³⁵ In 1950 she wrote to the *Times* endorsing an editorial which had called for more short-term residential accommodation—needed to take the burden off exhausted parents. She also called for an increase in the number of occupation centres for children nationwide. These were training facilities for children with learning disabilities; coverage was patchy, and activities were often diversionary and unsystematic, rather than focused on actual skill-building.³⁶ In 1954, attending the opening of an occupation centre at Wigan, called Hope School, Lady Norman stated that there were only 211 such facilities in the country, while 8,000 children remained unable to find a spot. Despite their legislated responsibilities, eighteen local authorities had failed to provide services for “backward children,” and Norman hoped that the new centre would provide an example to follow. Activities at Hope School included music appreciation and occupational skills—building wooden stools, embroidery, and knitting. The centre had space for 63 children, and attendees were given transportation to and from their homes. This was the first such centre

³⁴ “Maladjusted Children,” *The Times*, October 4, 1950, 7. As with mental illness, maladjustment was frequently conflated with delinquency.

³⁵ See Fig. 2.1. Priscilla Reyntiens (1899–1991) was a prominent councillor, voluntarist, and supporter of mental health causes. In 1933 she married Montagu Collet Norman, 1st Baron Norman, Governor of the Bank of England from 1920 to 1944. Both are controversial figures in British history, due to Lady Norman’s support of eugenics programs, and Lord Norman’s transfer of Czech gold to the German Reichsbank immediately prior to the Second World War. See “Priscilla Cecilia Maria Worsthorne Reyntiens,” *The Peerage*, accessed June 15, 2020, <http://www.thepeerage.com/p6970.htm>; Philip Williamson, “Norman, Montagu Collet, Baron Norman,” *Oxford Dictionary of National Biography*, accessed June 15, 2020, <https://doi.org/10.1093/ref:odnb/35252>.

³⁶ Priscilla Norman, “Mental Deficiency,” *The Times*, November 27, 1950, 2. Occupation centres are discussed in more detail in chapter five.

opened in the North, even though the Education Act, which laid the legislative groundwork, had been in operation for a full decade.³⁷



Fig. 2.1: NAMH representatives at Bedford College, March 1952.
Front row, second, third, and fourth from left, are Mary Applebey, Lady Norman, and Dr. Doris Odlum.

Wellcome Library, SA/MIN/B/80/7/1

Aside from running and promoting facilities for children, the NAMH assumed a wide set of responsibilities concerning other accommodation and services. A network of community care teams conducted follow-up care for discharged mental hospital patients, and also initiated “early measures which prevented the development of mental illness.” However, Medical Director Alfred Torrie reported in 1951 that since the inception of the NHS, budget constraints had reduced the

³⁷ *Manchester Guardian*, September 30, 1954, 3.

number of these teams from twelve to two.³⁸ He asserted that if this system of after-care could be adopted nation-wide, “7,000 people every year would be saved from going back into hospital.”³⁹



Fig. 2.2: An NAMH agricultural hostel in Gloucestershire, 1949.
Wellcome Library, SA/MIN/B/80/7/1

As a further example, in 1946 the NAMH took over the operation of nine agricultural hostels for men with learning disabilities, formerly operated by the CAMW.⁴⁰ These hostels, located in Gloucestershire, Hampshire, Shropshire, and the East Riding of Yorkshire, were administered on behalf of County Agricultural Committees and the Ministry of Agriculture, and provided space for men who would otherwise occupy mental hospital beds. Residents were

³⁸ Dr. Alfred Torrie had an extensive career as a consultant psychiatrist. During the Second World War, as a Brigadier, he was one of a number of military psychiatrists associated with the Tavistock Clinic, concerned with psychoanalytic and social psychiatric approaches to mental illness. He also served as NAMH Medical Director from 1948 to 1951, and Physician Superintendent of the Retreat at York from 1951 to 1956.

³⁹ “Averting Mental Illness,” *The Times*, January 13, 1951, 4. Post-treatment care was major concern for the Mental After Care Association, discussed in chapter 3.

⁴⁰ See Fig. 2.2.

selected based on their suitability for agricultural work, and released on license from their respective hospitals. An informational pamphlet directly linked their accommodation with the post-war economy, stating that the hostels were “one of the Association’s contributions to the demand for man-power in agriculture, so essential to the country at this critical time.”⁴¹

Over the years, the Association ramped up its accommodation operations. In 1947–1948, the children’s homes in the seaside resort towns of Bognor Regis and Rhyl provided holidays for 950 patients from mental hospitals, and demand was proving so great that staff began seeking property in other parts of the country. Meanwhile, the agricultural hostels were providing space for 360 men, and the year’s annual report again emphasized the connection with the war-ravaged national economy, noting “the project represents a very real, if modest, contribution to the agricultural man-power situation.”

Local authorities were not always as quick to appreciate these benefits, however; the report noted derisively, “it is evident that many County Agricultural Executive Committees are slow to recognise a good thing when they hear of it.”⁴² It often proved difficult to secure required permissions from local planning committees, wary of inviting mental health facilities into their communities. Nonetheless, by 1949, along with the agricultural hostels, the NAMH operated approved schools, long-term and short-term homes for maladjusted children and children with learning disabilities, holiday homes, and convalescent epileptic homes (people with epilepsy were barred from regular convalescent homes).⁴³

However, the encroachment of statutory services became evident in 1951, when control of the agricultural hostels (by then there were fourteen nationwide) was transferred from the NAMH

⁴¹ Wellcome Library, SA/MIN/B/58, “Agricultural Hostels for Mentally Handicapped Men,” 1948.

⁴² Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1947–8*, 8.

⁴³ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1948–9*, 10–11.

to relevant Regional Hospital Boards (RHBs). This shift, announced the previous year, was justified by the Ministry of Agriculture in economic terms—the hostels would eventually be eliminated, along with all other pool labour programs, and the men living and working at the hostels would be rehoused under various Ministry of Health programs.⁴⁴ The NAMH strongly condemned the action, and pointed to the value produced by the hostels, both in terms of economic output and the benefit to participants. As the transition occurred, the NAMH asserted that it had taken “all possible steps to ensure that the Hostels ... retain the distinctive features of the Association’s scheme.”⁴⁵

Two elements of the NAMH response are notable. First, the group emphasized the importance of producing self-sufficient and self-governing citizens, both for clients’ personal growth and for the benefit of the nation. In 1949, likely anticipating the transfer, President R.A. Butler had written to the *Times* about the hostels’ efficacy, pointing to one that had been in operation since 1941. He stated, “[a]t once the value of these men’s labour made itself apparent, and since that date 11 further hostels have been opened in different parts of the country dealing with 900 men.” He went on to say that 60% of these agricultural workers were “completely satisfactory in conduct,” while 11% had actually been discharged from the oversight of the Mental Deficiency Acts after gaining employment with private farmers.⁴⁶ Announcing the impending transfer, the annual report for 1949–1950 stated:

The aim of the work done in the Hostels is, wherever possible, to train the men to take their place again in the community, and the extent to which this has been achieved is shown by the fact that in the 12 months ended March 31st, 1950, 51 men were placed out on licence, and 25 were discharged from the Mental Deficiency Acts.⁴⁷

⁴⁴ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1949–50*, 9.

⁴⁵ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1950–1*, 15.

⁴⁶ R.A. Butler, “Training of Mental Defectives,” *The Times*, July 9, 1949, 5.

⁴⁷ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1949–50*, 9.

In total, by the time of the transfer 1,335 men had worked and lived at the hostels; 186 had gained discharge from the Mental Deficiency Acts, and 137 had been placed in “carefully chosen individual employment.”⁴⁸

Secondly, the NAMH continued to rely on “pioneer” rhetoric to frame its operations, and to assure members that even though the hostels would be gone, work continued apace in other areas. This is not to suggest that Association executives were being disingenuous—indeed, it is likely they were trying to convince themselves as much as their membership and clientele, indicating a degree of idealized self-positioning within the welfare state. The annual report for 1949–1950 stated, “[t]hrough the establishment of Homes and Hostels, the Residential Services Department fills gaps which the State has not always been able to bridge, and initiates pioneer activities demonstrating the value of new types of services.”⁴⁹

Recall that in the case of children’s homes, the State was failing to bridge those gaps at least partially due to the efforts of the Association’s own President. Thus, a cycle was created whereby the State’s failure opened a certain jurisdiction, which the Association then occupied and developed. In the case of the agricultural hostels, this cycle terminated with the State ultimately assuming responsibility. The Association was loath to relinquish a jurisdiction back to the State—due to the financial pressures created by the hostel transfer, the NAMH Residential Services Committee, “with extreme reluctance,” was forced to increase fees in all homes the following year.⁵⁰

Residential services also created an arena for cross-organization cooperation. In 1952, the NAMH was contracted by the recently established National Association for Parents of Backward

⁴⁸ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1950–1*, 15.

⁴⁹ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1949–50*, 6.

⁵⁰ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1951–2*, 14.

Children to run a home for “defective” children near Liverpool. Not missing a chance to critique statutory services, the NAMH referred to this as a “gesture of self-help ... made by parents in the face of a situation in the Health Service where severely handicapped children in many parts of the country have to wait for admission to institutions for as long as three years.”⁵¹ The Liverpool home shows the need for flexibility in both planning and purpose: by the following year, having received mostly “cot cases” (children confined to bed and requiring constant care) the home was re-fitted with a laundry and isolation unit, with financial help given by the King Edward’s Hospital Fund and the Liverpool Council of Social Service.⁵²

Reynolds House

One of the clearest archival portraits of a residential facility—from inception to operation—concerns a home for “maladjusted” boys in Bromley, Kent, called “Reynolds House.”⁵³ Although this was initially a venture of the Buttle Trust—a charity for impoverished children—the home was planned first in consultation and later in full cooperation with the NAMH. While the home’s operations extend beyond the temporal boundaries of this study, into the 1960s and 1970s, the well-documented accounts of its establishment reflect common experience in voluntary residential services—cooperation with government, the difficulty of finding a suitable location, and excitement about a “pioneer” venture.

From the beginning, government functionaries were closely involved with the undertaking. In 1958 and 1959, the Buttle Trust’s Hostel Sub-Committee discussed the possibility of setting up one or more hostels for “maladjusted” children. Notably, the idea had been brought up not by a

⁵¹ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report 1952–3*, 12. The home, called “Orchard Dene,” is discussed in further detail in chapter 5. See Fig. 5.2.

⁵² Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report 1953–4*, 13.

⁵³ For a fuller discussion of the child guidance movement, and its role in promoting political and social stability (as well as the professional aspirations of psychiatrists, psychologists, and social workers), see John Stewart, *Child Guidance in Britain, 1918–55: The Dangerous Age of Childhood* (London: Pickering & Chatto, 2013).

Trust member, but by Mr. J.L.B. Todhunter, a representative of the Ministry of Education. If the “experiment” (as it was called) was successful, Todhunter indicated it would be taken over by the Ministry or by local authorities—there was clear emphasis on providing services complementary to statutory provision, until such time as authority could be transferred to the government.⁵⁴

Given its extensive experience, the Association was consulted on the specifics of opening such a home, and Mary Applebey provided a list of expenses based on the group’s recent experience opening two hostels for “educationally sub-normal” (ESN) adolescents. The Hostel Sub-Committee estimated that the cost of acquiring two houses would be £30,000, while yearly maintenance (including staff) would be around £12,000. To offset these costs, it was suggested that “the children should contribute towards their maintenance from their earnings.”⁵⁵

Todhunter’s enthusiasm for the project waned upon learning of the projected costs. In an internal memorandum, he suggested that if such a scheme were expanded to all “maladjusted” children, the costs would run into millions of pounds. He had in mind a more modest facility than that ultimately proposed by the Trust, which would be “inhabited by a person, or a man and wife who would keep an eye on the inmates in a ratio more like one to 5 or 10 whose lives would be suitable to those surroundings and not to surroundings reminiscent of a finishing school for young grandees of Spain.” He went on to ask whether it was more reasonable to run the “experiment ... without rash outlay and without too much guidance from experts.”⁵⁶

Fortunately for the Trust and the Association, Todhunter’s Ministry colleague Miss H.E. Clinkard took over at this point, responding to Todhunter, “I had better make it clear that our views

⁵⁴ The National Archives, Kew, London, UK, Ministry of Education Records, ED 50/798, Buttle Trust Hostel Sub-Committee Minutes, January 16, 1959.

⁵⁵ The National Archives, ED 50/798, Buttle Trust Hostel Sub-Committee Minutes, January 16, 1959.

⁵⁶ The National Archives, ED 50/798, J.L.B. Todhunter to H.E. Clinkard, February 12, 1959.

coincide much more nearly with theirs [the Trust] than your's [*sic*] on what is required."⁵⁷ Nonetheless, in a meeting between Todhunter, Clinkard, and Hostel Sub-Committee Secretary B.E. Astbury, Clinkard made it clear that neither the Ministry of Education nor the Ministry of Health were in a financial position to take over the project, should it prove successful. However, she proposed that the Trust could offset costs through patient maintenance fees paid by relevant local health authorities.⁵⁸

Sub-Committee members agreed on cost calculations based on twelve patients per hostel, and sent revised proposals to the Ministries of Education and Health, and to the Home Office. Finally, it was decided to ask the NAMH to run the hostels directly, thereby moving the Association from an advisory role to an operational one.⁵⁹ Clinkard agreed with this proposal, and wrote that putting the same group in control of as many types of facilities as possible would allow all involved to more easily address problems that may arise.⁶⁰ The Ministry of Education would help by finding suitable properties on the Ministry of Works surplus list, and obtaining property valuations where needed.⁶¹

Ultimately, the cooperating groups would have difficulty finding a suitable location in the London area, and faced entrenched opposition from several local authorities. At the end of 1961 (by then the project had dragged on for nearly three years), Clinkard pointedly asked the Hostel Sub-Committee "whether local authorities were adversely affected by the use of the expressions

⁵⁷ The National Archives, ED 50/798, H.E. Clinkard to J.L.B. Todhunter, February 17, 1959.

⁵⁸ The National Archives, ED 50/798, H.E. Clinkard to B.E. Astbury, April 3, 1959.

⁵⁹ The National Archives, ED 50/798, R.J. Baker to H.E. Clinkard, May 1, 1959.

⁶⁰ The National Archives, ED 50/798, H.E. Clinkard to B.E. Astbury, May 15, 1959.

⁶¹ The National Archives, ED 50/798, Buttle Trust Hostel Sub-Committee Minutes, September 18, 1959.

‘mal-adjusted’ and ‘mental health’.”⁶² The search area was expanded to include Kent, and a suitable home was finally purchased in Bromley, with renovations completed in 1963.⁶³

The home was named “Reynolds House” in honour of the Trust’s recently deceased Secretary, Herbert Reynolds, and a detailed account of its operations was later written by the home’s first warden, David Wills. Wills, a former PSW and expert on “maladjusted” children, thanked the Association for its ongoing support during his tenure, writing, “[u]nless he is so insensitive that he ought really to be doing a different job, the most experienced residential worker needs to feel that he has someone to lean on, and the NAMH supplied this need abundantly.”⁶⁴

Among the conditions necessitating this support, bureaucratic red tape consistently made it difficult to keep the hostel’s twelve spaces filled. Wills noted his astonishment at this, given the size of waiting lists across the nation, and the widely acknowledged need for such facilities. He suggested that the sheer size of the problem actually contributed to the difficulty—school authorities and social workers tended to assume that a twelve-bed hostel would be full, and so would seek accommodation for their charges elsewhere. Wills tried to address this issue by regularly writing to inform school headmasters of vacancies.⁶⁵

Wills also noted the “administrative gap” that existed for youth of school-leaving age. At that point, local authorities assumed responsibility from schools, but Wills found that they rarely initiated hostel applications—in any case, by the 1960s only four adult hostels were operational.⁶⁶

⁶² The National Archives, ED 50/798, Buttle Trust Project for Mal-Adjusted Children Sub-Committee Minutes, December 18, 1961.

⁶³ The National Archives, ED 50/798, Buttle Trust Project for Mal-Adjusted Children Sub-Committee Minutes, November 5, 1962.

⁶⁴ David Wills, *A Place Like Home: A Hostel for Disturbed Adolescents* (London: Allen & Unwin, 1970), 11.

⁶⁵ Wills, *A Place Like Home*, 125–126. A similar dynamic is discussed in chapter five, with reference to Orchard Dene, the children’s home near Liverpool sponsored by the NAPBC and operated by the NAMH.

⁶⁶ *Ibid.*, 126.

As for the expense involved, Wills framed the argument in both moral and practical terms, echoing the sentiments of mental hygienists going back to the early part of the century. He wrote,

[w]hether the expense of £1,000 a head, or £4,000 a head is justified, is not a financial question, but a moral and political one, as there is no means by which a price can be put upon a human life saved from mental and social breakdown ... much more than £4,000 would have been spent by society on each of these boys if the expected breakdowns had indeed taken place.⁶⁷

The experience with Reynolds House reveals several commonalities in providing residential services. These commonalities indicate that even where voluntarist and welfare goals aligned, bureaucratic requirements and state functionaries' wariness of impetuous action could dramatically slow the planning process. It proved difficult to secure a clear commitment on Reynolds House from statutory authorities, even though the idea had originated with the Ministry of Education. Further, there were difficulties securing a suitable location, which eventually made it necessary to move the project outside of the London area. Finally, even when the facility was operational, inadequate communication channels made it difficult to fill available spaces, despite dire need nationwide. That the Association was willing to put up with these problems indicates a level of tenacity and belief in its own cause—executives were sure that the government needed them, even if the government itself was slow to realize it.

Duncroft Approved School

Similar dynamics can also be observed in the Association's establishment of an approved school for girls at Staines, Surrey.⁶⁸ Approved schools catered to a wide array of children and youth, all of whom were alleged to display some degree of delinquency, but not necessarily "maladjustment" or "sub-normality." They were funded through a combination of Home Office and Treasury payments to local authorities, repayable grants, and parents' fees. In 1933,

⁶⁷ Ibid., 131.

⁶⁸ See Fig. 2.3.

reformatories and industrial schools were merged to form this new type of facility; at the time, there were 86 such establishments, and by 1938 this number had grown to 104. The majority were operated by churches and voluntary groups—particularly religious ones. These included the Church of England, the Roman Catholic Church, National Children’s Homes, Barnardos, the Salvation Army, and various Jewish groups.⁶⁹ While certain specialized schools did exist—for example, “a school for boys of superior intelligence and a school for girls needing psychological treatment”—a 1951 article noted “[f]or reason of economy alone, the large school with its (sometimes rather blind) emphasis upon the normality of the inmates will have to remain the backbone of the system.”⁷⁰ Near the end of the 1940s, the NAMH began planning an approved school of its own, which would be located in Surrey and would house girls over the age of fourteen, in need of psychiatric treatment.

That the Association opted to focus on a facility for “delinquent” girls—when by its own accounting, boys made up a far greater proportion of cases coming before the juvenile courts—is telling, and indicative of gender anxieties concerning mental illness and learning disability in the period.⁷¹ A memorandum of evidence submitted to the Committee on Children and Young Persons (Ingleby Committee), which was enquiring into the juvenile delinquency court system and measures to prevent cruelty to children, argued “[y]oung girls with sex experience present special problems and often would not remain in residential care without some degree of compulsion.”

⁶⁹ Hyland, *Yesterday’s Answers*, 21–23, 29.

⁷⁰ Peter Scott, “The Residential Treatment of Juvenile Delinquents in Approved and Other Schools,” *The British Journal of Delinquency* 2, no. 1 (1951): 15.

⁷¹ According to the Association, in 1955 juvenile courts in England and Wales placed 12,580 boys and 1,380 girls between the ages of fourteen and seventeen on probation, while 2,257 boys and 158 girls were placed in approved schools. The National Archives, Home Office Records, HO 330/92, “Evidence Prepared for the Home Office Committee on Children and Young Persons (Ingleby Committee) by a Joint Working Party of the National Association for Mental Health and the Association of Psychiatric Social Workers,” March 1958, 29.

According to the Association, “[w]hatever the form of a girl’s delinquency, authorities always have the fear of her becoming pregnant,” and as such, “social responsibility” training was emphasized.⁷²

The Home Office governed approved schools nationwide, and in 1949 the Association submitted draft job advertisements for approval. As noted, civil servants often took the lead in planning, securing permissions, clearing red tape, and liaising between the NAMH and relevant ministries. The facility—which would be named Duncroft Approved School—would be “the first of its kind in the country,” and salaries would be determined by the National Health Service scale.⁷³ In July 1949, the new school’s Headmistress notified the Home Office that all positions had been filled.⁷⁴ Staff included psychiatrists Dr. Alfred Torrie and Dr. W.H. Craike, along with an educational psychologist and general psychologist.⁷⁵ It is unclear from archival records whether PSW workers were hired, although it is likely that they at least checked in periodically with the school’s students.

It was generally easy to determine who would be making decisions, but not as easy to determine who would be paying for them. Prior to opening, the NAMH bore the cost of over £9000 in repairs and improvements to the proposed site. Payment for psychiatric treatment in the school could be made through the North West Metropolitan RHB, but for this Duncroft would need to be recognized by the Ministry of Health as a designated residential psychiatric clinic. A Ministry of Health representative informed the Home Office that it was unlikely the school could be classified as a clinic, since it was run by the NAMH, which was technically not a medical organization:

[i]f it is in fact a specialist clinic, it should presumably have been taken over by this Ministry ... If, as I suppose, it is simply an Approved School at which you need

⁷² Ibid., 19.

⁷³ The National Archives, MH 102/2722, Draft Job Advertisement. There were already dozens of approved schools for girls, so it seems the claim that Duncroft would be “the first of its kind” referred to its psychiatric orientation.

⁷⁴ The National Archives, MH 102/2722, A. Brown to Dr. Makepeace, July 13, 1949.

⁷⁵ The National Archives, MH 102/2722.

specialist psychiatric advice ... [the RHB] would appoint the psychiatrist or, rather, would send one of their own staff for the purpose.⁷⁶

Throughout the process of planning and staffing the new school, there was a clear sense of urgency: by the time the school was meant to open, important administrative issues such as salary and jurisdiction had not yet been settled. In many instances, the need for provision appears to have been dire enough that careful planning gave way to speed and pragmatism—although, given the vast difference in “delinquency” rates between genders, it is questionable just how necessary Duncroft was. Nonetheless, the school formed yet another barrier any government would have to traverse, if it were to further displace the Association from its jurisdictional position.

In August 1949, the Duncroft Board of Managers asked the Home Office about payment and superannuation for Dr. Torrie and Dr. Craike. Dorothy Fowle, representing the Duncroft Board of Managers, suggested that since Torrie and Craike were already employed by that RHB, it would be simpler if they were just seconded to Duncroft.⁷⁷ The Ministry of Health did allow both Dr. Torrie and Dr. Craike to continue employment at Duncroft, without affecting their superannuations as part-time contract employees of the North West Metropolitan RHB.⁷⁸ Of course, this did not address the question of who would pay the fees for their work at Duncroft.

A further complication emerged when Torrie—the more senior of the two psychiatrists—decided to pursue secondment from the RHB, while Craike opted to be a direct employee of the School. Torrie noted, pointedly, that his secondment was justified, since his work at Duncroft was “diminishing the case load of the Regional Hospital Board.”⁷⁹ Dr. D. Makepeace of the Home

⁷⁶ The National Archives, MH 102/2724, Ministry of Health (Mental Health Division) to L.G.V. Leeper, October 7, 1949.

⁷⁷ The National Archives, MH 102/2724, Dorothy Fowle to L.G.V. Leeper, August 18, 1949.

⁷⁸ The National Archives, MH 102/2724, Ministry of Health (Mental Health Division) to L.G.V. Leeper, November 15, 1949.

⁷⁹ The National Archives, MH 102/2724, Alfred Torrie to D. Makepeace, January 2, 1950.

Office Children’s Department informed him that it was unlikely the Ministry of Health would allow for one psychiatrist to be seconded while the other was employed directly, and Torrie responded “[m]y main concern was to lessen the burden of the cost of the experiment for the Home Office.”⁸⁰ In responding so, Torrie essentially encapsulated the Association’s entire approach to dealing with government: as a senior consulting psychiatrist, he had little need for a pay raise, and so called attention to the group’s ability to unburden statutory service providers.⁸¹



Fig. 2.3: Duncroft Approved School for Girls, Staines, Surrey.
Wellcome Library, SA/MIN/B/80/7/1

⁸⁰ The National Archives, MH 102/2724, D. Makepeace to Alfred Torrie, January 6, 1950.

⁸¹ A police investigation recently revealed that during the 1970s, the BBC presenter and now-notorious pedophile Jimmy Savile sexually assaulted 22 students at Duncroft Approved School. By this time, administration of the school had passed from the Association to Barnardo’s children’s charity. The intent here is not to unduly condemn Association voluntarists who frequently worked in good faith and in accordance with the best practices of the time, but the episode does indicate the ways in which poorly managed residential facilities can serve to re-victimize marginalized populations. See Josh Halliday, “Jimmy Savile carried out 46 sexual assaults at Surrey girls’ school, say police,” April 29, 2015, *The Guardian*, accessed February 6, 2020, <https://www.theguardian.com/uk-news/2015/apr/29/jimmy-savile-46-sexual-assaults-surrey-girls-school-police>.

Public and Professional Education

The NAMH was generally the most publicly-oriented of the mental health organizations—a remnant of the NCMH’s dedication to mental hygiene-inspired public education efforts. An increase in public sympathy and understanding was among the group’s primary objectives, and in 1955 Robina Addis wrote,

...to promote Mental Health, the support is needed not only of specialist workers and administrative committees but the understanding and co-operation of the public ... Not only through satisfactory casework, but by conferences, discussion groups, lectures and literature the general opinion about such services may become favourable for their best use.

Addis further commented that the public activities of the NCMH, the CAMW, and the CGC “[explained] much of the present work of the National Association.”⁸² This section examines Association efforts to destigmatize mental illness and learning disability in the public mind, and also the development of professional education programs, upon which statutory and medical authorities would come to rely heavily.

Public Awareness

Among its public activities, the Association maintained an advisory service, published handbooks and pamphlets on diverse aspects of mental health, and also published an academic journal entitled *Mental Health*, containing articles on new research and developments in mental health care. Through this work, Addis and other NAMH workers hoped to decrease the stigma surrounding mental illness and learning disability. This was particularly important for children, for whom early ascertainment and treatment were considered vital. Addis noted, “[w]hile the fear and

⁸² Wellcome Library, PP/ADD/J/18/5, Robina S. Addis, “The Work of the National Association for Mental Health,” June 1955.

stigma of mental illness remain ... Such hindrances can be changed to helpfulness, as has been proved in areas where an enlightened attitude has been achieved.”⁸³

In 1950, Torrie spoke at a London conference held by the Citizen’s Advice Bureaux (a charitable network established in 1939 to provide legal, financial, and consumer advice). He explained that of 411,000 hospital beds nation-wide, 190,000 were occupied by patients with mental illness. He believed that early treatment and sympathetic understanding were key to reducing this number, stating that professional caregivers should “walk through the shadow of mental pain with [patients].” Referring to a statement in the conference programme that ten percent of industrial workers suffered some sort of mental affliction which interfered with their efficiency, Torrie emphasized that “you must not advise them to change their jobs, change their wives, or run away from their complaints.”⁸⁴

Of the group’s numerous handbooks and pamphlets, one of the most popular and frequently referenced was *Do Cows Have Neuroses?* (1954). The pamphlet—intended to reduce mental illness to layman’s terms and assuage widespread fears—was originally published by the Mental Hygiene Council of Westchester County, New York, and adapted for English audiences. In a foreword, psychiatrist Dr. Doris Odlum, one of the Association’s Vice-Presidents, wrote,

[a] better understanding of the way in which our minds work should help to dispel the ignorance, the old-fashioned ideas and the superstitions, which have caused so much unreasonable fear of mental illness and a lack of sympathy with those who are mentally ill ... We all have a share in promoting good mental health, both for ourselves and for our fellow human beings, and any effort to increase our understanding of the factors involved is a step in the right direction.⁸⁵

⁸³ Wellcome Library, PP/ADD/J/18/5, Robina S. Addis, “The Work of the National Association for Mental Health,” June 1955.

⁸⁴ *Manchester Guardian*, September 29, 1950, 5.

⁸⁵ Wellcome Library, SA/MIN/B/16, *Do Cows Have Neuroses?* (London: NAMH, 1954). See Fig. 2.1. Doris Odlum (1890–1985) was a force in the spheres of both voluntarism and psychiatry. Initially interested in psychiatric problems in general practice, and the plight of shell-shocked ex-Service members, in the late 1920s she opened one of the nation’s first general hospital psychiatric units at Bournemouth. Aside from her work with the NAMH, she was chairman of the British Medical Association’s psychological medicine group from 1943 to 1946, an executive of the World Federation for Mental Health from 1948 to 1951, President of the European League for Mental Hygiene from

Further publications—which often focused on information for parents—covered subjects ranging from picky eaters and bedwetting to comprehending legislation and navigating adoption or fostering processes.



Fig. 2.4: The Duchess of Kent buys a flag on a Mental Health Flag Day.
Wellcome Library SA/MIN/B/70/1

While the attainment of a full public understanding of mental disorder may have been wishful thinking, increased public consciousness was certainly a possibility, and various campaigns were used both to generate income and raise awareness. Beginning in the mid-1950s, a main source of public fundraising and awareness-building were mental health flag days. Association volunteers sold miniature Union Jacks on street corners, explicitly tying patriotism into the fight against mental illness. The Association’s annual report for 1954–1955 stated, “[t]he Association notes these events as a remarkable trend in the increasing public recognition of the

1953 to 1956, and life President of the Samaritans’ Organisation from 1974 until her death. See Obituary of Doris M. Odlum, *British Medical Journal* 291 (1985): 1356.

magnitude of the problem and an appreciation of work for mental health.”⁸⁶ In 1956, the *Times* reported a new NAMH campaign “to acquaint the public with the possibility of preventive measures, the need for education in principles of mental hygiene and the great need to stimulate and support programmes of research in the mental health field.” A newly formed public information committee counted members of the psychiatric and psychological professions, “but also those concerned with legislation, education, industry, family life, and the formation, through various mediums, of public opinion.”⁸⁷

Not every undertaking was a resounding success, and a number of ventures fell prey to the inexorable realities of bureaucracy. In 1948 the Association tried to set up a regional advisory service, but funding from the government and the British Legion fell through, and they were forced to shutter some regional offices (a Northern Branch would later be opened in Leeds, mitigating this blow somewhat). While the Association had asked that the scheme be maintained at least until local authority mental health officers were familiar with their responsibilities under the new NHS Act, that same Act mandated that voluntary organizations deal individually with local authorities. This made it impractical to organize a nationwide or regional service.⁸⁸ Local branches of the Association did exist under the same name, but generally secured their own funding and were run autonomously.⁸⁹

Professional Education

In 1950, Lady Norman advertised a newly established NAMH course for the staff of day occupation centres, and noted the need for more of these centres across the country.⁹⁰ She thus

⁸⁶ Wellcome Library, SA/MIN/B/80/70/1, *NAMH Annual Report, 1954–5*, 4.

⁸⁷ “Mental Hygiene Campaign,” *The Times*, Apr 20, 1956, 7.

⁸⁸ Madeline Roofff, *Voluntary Societies and Social Policy* (London: Routledge, 1957), 155.

⁸⁹ Crossley, *Contesting Psychiatry*, 79.

⁹⁰ Priscilla Norman, “Mental Deficiency,” *The Times*, November 27, 1950, 2.

drew attention to another major pillar of the group's operations: education for mental health and social work professionals, which was considered as crucial as public education. Even as the NAMH staged increasingly complex courses, which led to officially recognized accreditations in mental health care, Mary Applebey wrote, "[a]t all times ... The Association urged upon the Government that some national educational body ought to undertake the training." The Association initially provided training courses for child psychiatrists and educational psychologists, but after it was decided that these fields were "adequately covered," they turned to mental welfare officers and PSWs.⁹¹

Professional education courses often entailed long and arduous planning processes, and Association workers had to contend with a host of competing interests, as evidenced by the establishment of two training courses in 1946–1947. In 1946, NAMH Honorary Secretary Dame Evelyn Fox proposed a new course for staff of children's homes to the Ministry of Health.⁹² She suggested three potential funding methods: the Ministry of Health could cover all expenses (Fox noted that for teachers' courses, this had been the arrangement between the CAMW and the Ministry of Education); the Ministry could approve the payment of fees by local authorities (this would limit attendance to staff employed by those local authorities); or a fee could be combined with a Ministry grant. Fox closed on a note of urgency, indicating that the NAMH Council would like to discuss the matter with Ministry representatives and get the course running as soon as possible.⁹³ The Council discovered in the meantime that the Ministry had provided a specific

⁹¹ Wellcome Library, MS.7193/7, Applebey, "The National Association for Mental Health," 4.

⁹² Evelyn Fox (1874–1955) was a founding member of the CAMW, and though she retired in 1951, many NAMH initiatives reflected her influence. In particular, she promoted community care, occupation centres, and professional training courses. Aside from her work with the CAMW, and later the NAMH, she served on various other bodies, including the 1927 Mental Deficiency Committee (Wood Committee), and the London County Council mental hospitals committee. She received a CBE in 1937 and a DBE in 1947. See R.R. Thomas, "Fox, Dame Evelyn Emily Marian," *Oxford Dictionary of National Biography*, accessed April 5, 2020, <https://doi.org/10.1093/ref:odnb/33231>.

⁹³ The National Archives, MH 57/292, Dame Evelyn Fox to The Secretary (Ministry of Health [MOH]), May 16, 1946.

amount for such courses in a 1946–1947 block grant, so no further funding was needed—perhaps seeking a backup, Fox asked that the Ministry still approve the payment of course fees by local authorities.⁹⁴ In July, the Ministry confirmed a meeting with Fox to discuss particulars of the scheme.⁹⁵

Once these were worked out, the Ministries of Health and Education and the Home Office began unofficially gauging interest from different organizations, facilities, and local authorities. The “sounding” process for the training course received varied results. The Matron of Children’s Homes for Croydon indicated that she and an assistant would like to attend; the Middlesex and East Ham County Councils were unable to release anyone; the National Council of Associated Children’s Homes and the Surrey County Council were noncommittal, indicating that the proposed course would be discussed further.⁹⁶ All five local authorities that were consulted (including the London County Council) cited staff shortages as a major barrier, framing attendance as a matter of “sparing” someone, rather than participating enthusiastically.⁹⁷

Undaunted, Lady Norman then wrote to Ministry of Health Deputy Secretary Sir Arthur Rucker, in their capacity as acquaintances, to get his views on the proposal. “My Husband,” she wrote, “insists that before taking any decision or step I should appeal to you for guidance on procedure ... please remember that my visit will be quite unofficial.”⁹⁸ Rucker wrote of his meeting with Lady Norman,

[w]e said that we could not find money for grants but that the Ministry of Education or the Ministry of Labour might be able to help with resettlement grants. We thought, however, that they would probably be wiser to wait until it had been

⁹⁴ The National Archives, MH 57/292, Dame Evelyn Fox to The Secretary (MOH), May 21, 1946.

⁹⁵ The National Archives, MH 57/292, H.H. Turner to Dame Evelyn Fox, July 10, 1946.

⁹⁶ The National Archives, MH 57/292, J.S. Cashel to L.I. McCandless, August 22, 1946; G.A. Lewis to L.I. McCandless, August 22, 1946; John H. Litten to J.I. Wall, September 2, 1946; C.M. Ready to L.I. McCandless, September 3, 1946.

⁹⁷ The National Archives, MH 57/292, H.H. Turner to Ruth Thomas, September 12, 1946.

⁹⁸ The National Archives, MH 57/292, Priscilla Norman to Sir Arthur Rucker, October 28, 1946.

decided which central [department] is to be responsible for deprived children and discuss the proposal with them.⁹⁹

Due to uncertainty in 1946 about funding provisions in the new welfare state, ministries were reluctant to take on expensive new projects. It is notable that an upper-class Association member could rely on her society connections to push the group's agenda—even as voluntary organizations increasingly professionalized their services and operations, one-on-one social relationships maintained their importance. This older form of lobbying was a main impetus behind voluntarists' efforts to co-opt aristocrats and politicians to their causes.

Meanwhile, the Association proposed several new subjects in a separate course for boarding-out officers. This course would include lectures on the following: family relationships; keeping siblings together; matching children with foster parents; intellectual development and maladjustment; emotional development and child guidance clinics; transitioning children from institutions to foster homes; and liaising between foster parents and schools. Visits would be arranged to individual homes, child guidance clinics, hospitals, and occupation centres, to gain first-hand experience among children with learning and physical disabilities. Applicants were invited from local authorities as well as all voluntary groups dealing with boarding-out responsibilities.¹⁰⁰

However, securing funding for those applicants was not a given. In December 1946, the Glamorgan (Wales) County Council requested a Home Office grant for one welfare officer to attend the upcoming boarding-out course (the fee was £6.16s.6d, excluding a subsistence allowance and travelling expenses).¹⁰¹ The Home Office sought procedural clarification from the

⁹⁹ The National Archives, MH 57/292, Sir Arthur Rucker, Memorandum, November 8, 1946.

¹⁰⁰ The National Archives, MH 57/292, "Short Course for Officers of Local Authorities and Voluntary Associations Dealing with the Boarding Out of Children," November 11, 1946.

¹⁰¹ The National Archives, MH 102/1421, D.J Parry to Children's Branch, Home Office, December 2, 1946.

Ministry of Health, which generally handled these types of grants, and determined that since no official policy existed, it would have to temporarily deny the funding.¹⁰² The NAMH was “much perturbed” at this denial, and it was unclear whether other potential attendees had withdrawn on similar grounds. A Home Office representative explained that at the time of the Glamorgan Council’s grant request, not enough information had been received about the proposed course. Clare Britton of the NAMH Education Department gave the Home Office further details, including a list of speakers and the facilities to be visited, and “was most anxious to obtain [Home Office] co-operation and said that she would be very glad if someone from the Home Office would attend all or part of the course.”¹⁰³ Miss G.M Wansborough-Jones of the Ministry of Health did attend, and noted rather tersely that “[t]he Association, following its usual practice, had overweighted the syllabus on the psychological side ... It seems unlikely that many of these people [students] would profit by such a concentrated dose in a month’s course.”¹⁰⁴

In May 1947, the Home Office Children’s Branch circularized London-area education authorities, informing them of the new NAMH boarding-out course.¹⁰⁵ Britton had written the Home Office asking “to be able to state to Local Authorities that [they] would qualify for reimbursement” (she likely had the Glamorgan case in mind).¹⁰⁶ In an internal memorandum, Miss M.G. MacGregor of the Home Office noted, “I think we should approve this course. The content

¹⁰² The National Archives, MH 102/1421, M.G. MacGregor to D.J. Parry, January 29, 1947.

¹⁰³ The National Archives, MH 102/1421, Home Office Memorandum, February 6, 1947. Clare Britton (1906–1984) received her education in social work and mental health at the London School of Economics, before meeting psychiatrist Dr. Donald Winnicott while working with evacuees during the Second World War—they married in 1951. She would become known for her work in psychoanalysis, children’s advocacy, and her role in the passage of the *Children’s Act 1948*. See Janie Thomas, “Winnicott [née Britton], (Elsie) Clare Nimmo,” *The Oxford Dictionary of National Biography*, accessed June 15, 2020, <https://doi.org/10.1093/ref:odnb/75176>.

¹⁰⁴ The National Archives, MH 57/192, G.M. Wansborough-Jones, “National Association for Mental Health Course for Boarding Out Officers March, 1947,” March 28, 1947.

¹⁰⁵ The National Archives, MH 102/1425, M.G. MacGregor, “Boarding Out of Children Child Study Course,” May 9, 1947.

¹⁰⁶ The National Archives, MH 102/1425, C. Britton to M.G. MacGregor, April 24, 1947.

may not be quite what we would choose, but I feel sure it will be useful. It is also helpful to let someone try out these short-term and part-time courses.”¹⁰⁷ MacGregor then informed Britton that local authorities could qualify for Home Office grants for the purpose of the course, but asked that funding information be left out of any circular, since this could cause confusion between public assistance and education grants (the Home Office was only responsible for the latter). MacGregor undertook to write to London-area education authorities, informing them specifically that expenses for the course could be reimbursed through a grant.¹⁰⁸ At MacGregor’s suggestion, the Ministry of Health also informed its regional staff of the course.¹⁰⁹ Ultimately, around 50 people were able to attend.¹¹⁰

The other course, for heads of children’s homes, ran in November 1947, and again Wansborough-Jones complained of too much psychological focus, with not enough practical and legislative knowledge: “[f]ar too great a proportion of time is being given to ... lectures on child development ... One or more lectures on the placing and after care of school leavers should be included.”¹¹¹ She made these points known to Britton in July 1947, and also noted that the Ministry of Health desired sessions on proper record-keeping, “the selection of children suitable for boarding-out,” and the various social services available for children, of which “many heads of homes [were] very ignorant.”¹¹² Wansborough-Jones’s correspondence shows that the Ministry recognized the value of delegating training to a voluntary group, but also sought to maintain some degree of control over course content.

¹⁰⁷ The National Archives, MH 102/1425, M.G. MacGregor, Memorandum, April 30, 1947.

¹⁰⁸ The National Archives, MH 102/1425, M.G. MacGregor to C. Britton, May 2, 1947.

¹⁰⁹ The National Archives, MH 102/1425, Miss Aves to M.G. MacGregor, May 7, 1947.

¹¹⁰ The National Archives, MH 102/1425, C. Britton to M. Glyn-Jones, May 30, 1947.

¹¹¹ The National Archives, MH 57/292, G.M. Wansborough-Jones, “National Association for Mental Health Proposed Short Course for Heads of Children’s Homes,” July 17, 1947.

¹¹² The National Archives, MH 57/292, G.M. Wansborough-Jones to Connie Britton, July 22, 1947.

Britton responded that some of those points were already covered in planned lectures, but that the Association would try to fit in the others. She also asked if Wansborough-Jones could deliver the lectures on records and social services.¹¹³ Wansborough-Jones agreed to the latter, and suggested a London County Council staff member, “who does of course know a good deal about children’s homes as well as about record-keeping,” to deliver the former.¹¹⁴ The final timetable stated that the children’s homes course would run November 3 to November 28 at the Association’s Queen Anne Street headquarters, and that lectures would be delivered on the following subjects: those suggested by Wansborough-Jones; the Report of the Committee of Inquiry into the Care of Children (Curtis Committee); children’s emotional and intellectual development and physical care; “the organisation of a children’s community”; recreation; “children’s difficulties,” including child guidance and juvenile delinquency; boarding-out; and home relationships. There would also be visits to the Tavistock Clinic, a prominent psychiatric facility, and the Caldecott Community, a charity for disadvantaged children.¹¹⁵

NAMH courses quickly became sought after, both by individuals seeking work in the social service field, and local authorities seeking to abide by new welfare legislation. By 1950, Association programmes had become standard training for workers in mental illness and mental deficiency—an Association course in child psychiatry was made a recognized qualification for medical directorship at any child guidance clinic.¹¹⁶ A few years later, an ad placed by the Durham County Council in the *Manchester Guardian*, seeking a home teacher for defectives in the Tyneside area, noted that applicants must hold an NAMH diploma “or other similar qualification.”¹¹⁷ In

¹¹³ The National Archives, MH 57/292, Clare Britton to G.M. Wansborough-Jones, August 6, 1947.

¹¹⁴ The National Archives, MH 57/292, G.M. Wansborough-Jones to Connie Britton, August 12, 1947.

¹¹⁵ The National Archives, MH 57/292, “Course for Superintendents and Matrons of Children's Homes on Care of Deprived Children,” October 1947.

¹¹⁶ “Training Courses in Psychiatry,” *The British Medical Journal* 2, no. 4677 (1950): 516.

¹¹⁷ *Manchester Guardian*, June 12, 1953, 11.

1955, an Association course on ESN children at the University of London was recognized by the Ministry of Health as a qualification for local authority medical officers working in mental deficiency, and by the Ministry of Education for school medical officers working in ESN ascertainment.¹¹⁸

However, staffing levels and permissive regulations remained a major problem across the fields of mental health and learning disability. In 1959, a working party chaired by Eileen Younghusband, which counted Robina Addis as a member, called for a doubling of the number of social workers over the next ten years, and for the implementation of a standardized National Certificate in Social Work.¹¹⁹ As strategies around mental illness changed to favour early intervention and the avoidance of hospitalization, social work gained new importance. The same year, discussing the impending *Mental Health Act 1959*, Newcastle Labour MP Arthur Blenkinsop asked the House of Commons why mental health provision would not be made mandatory for local authorities. Conservative Solicitor General Sir Harry Hylton-Foster argued that “the real brake” in implementing the provisions was not financial, but a problem of staffing. He counted only around 600 mental welfare officers nationwide, and noted that there were no standardized academic qualifications. While the NAMH and some universities continued to run preparatory courses, there was a clear shortage of recruits, which, presumably, no quantity of educational programming could address.¹²⁰

Contending with the State

At the Association’s 1960 Annual General Meeting, Mary Applebey envisioned the NAMH organizing a “united opposition” to government, working toward common goals with other

¹¹⁸ “Medical Psychology,” *The British Medical Journal* 2, no. 4938 (1955): 555.

¹¹⁹ “Plan to Double Number of Social Workers,” *The Times*, May 4, 1959, 5.

¹²⁰ “Parliament,” *The Times*, January 27, 1959, 6.

voluntary groups. She went on, “I should like to remember that the N.A.M.H. is an organised opposition and that it takes that opposition with great responsibility and when it attacks, it attacks because it feels that is the right thing to do to persuade the Government to do the right thing.”¹²¹ Persuading the government “to do the right thing” was a major objective—perhaps the main objective—of the Association. However, Applebey’s rhetoric underplayed the degree to which collaboration became a crucial strategy in ensuring the Association’s ongoing influence. This section examines the Association’s sometimes contradictory efforts to remain indispensable as a provider of services, while simultaneously performing its oppositional role—in particular by offering criticism of the mental health system to relevant governmental commissions and committees.

Cooperation

The period at hand saw repeated instances of policy authorship, cooperation, and mutual acclamation between the Association and statutory authorities. The Association publicly welcomed the birth of the welfare state, and various groups and individuals on the statutory side of the “moving frontier” auspiciously affirmed that voluntarism was a welcome and even necessary component of new order. Throughout the late 1940s and 1950s, government communications show an enthusiastic willingness to rely on NAMH services, as far as the public purse would allow. This chapter has already noted several instances of cooperation between government functionaries and Association staff and executives. However, despite official claims to the contrary, the welfare state did constitute a threat to voluntary effort; the NAMH overcame this threat by bolstering statutory

¹²¹ Wellcome Library, MS.7193/7, “Mary Applebey’s Speech, Annual General Meeting, November, 1960,” in *The Expanding Field of Mental Health in England and Wales, 1918–1968*, eds. Doris Odlum and Alexander Walk (unpublished manuscript, 1968), 1.

efforts and embedding itself within processes of policy making. This cooperation was a key reason behind the Association's dominance of the mental health field.

Crossley argues that although the developing welfare state became a significant source of pressure on voluntary organizations, statutory providers in many areas followed voluntarists' example: voluntary organizations, then, "were victims of their own success."¹²² For the NAMH, the boundary between statutory and voluntary provision often blurred, especially as government funding increased in the 1950s. After the passage of the NHS Act, Minister of Health Aneurin Bevan signalled his readiness to rely on non-governmental expertise, since "it was not the business of a Minister of the Crown... to dictate to people how they should use their specialist knowledge," but "to put the best kind of facilities at the disposal of the experts."¹²³ Then, following the Association's first executive committee election in 1947, a *Times* article reported that its operations would be "greatly extended in close cooperation with the Government and local authorities."¹²⁴ During the period at hand, criticism of statutory mental health care began to focus on wrongful detention and poor treatment in large institutions, but Crossley argues that the Association was largely absent among these voices, which could have threatened its close relationship with government.¹²⁵

The Association's annual report for 1948–1949, discussing newly available services, noted "[i]t is increasingly clear ... that the satisfactory working of the new Mental Health Service must depend very largely on the successful establishment of close co-operation between the various Government Departments, Local Authorities and voluntary bodies concerned."¹²⁶ The Chief

¹²² Crossley, *Contesting Psychiatry*, 73.

¹²³ "Mr. Bevan on the Health Service," *The Times*, November 15, 1946, 2.

¹²⁴ "National Association for Mental Health," *The Times*, February 12, 1947, 2.

¹²⁵ Crossley, *Contesting Psychiatry*, 80, 84.

¹²⁶ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1948–9*, 5.

Medical Officer of the Ministry of Health had affirmed, “[n]ever was voluntary service more welcomed than it is now, and I would make special acknowledgment of the great assistance the medical side of the Ministry has received from such sources.”¹²⁷

The annual report for 1950–1951 contained a clear delineation of the problems facing fragmented statutory service providers:

The rapid development of complex medico-social services inevitably produces borderland problems in which co-ordination has not been achieved between the several statutory agencies involved. Handicapped people unable to obtain the aid they need because their ‘case’ does not fit into the closely defined terms of reference of the various statutory bodies, must be succoured.

To this end, the group distinguished between its “complementary” and “supplementary” services, and looked toward developing the former as the latter were made redundant by statutory programs.¹²⁸

The Association’s first opportunity for close cooperation with the state came in the form of an aftercare scheme for invalided ex-Service members, established in 1946 and run in conjunction with the MACA. A 1948 pamphlet asserted that this scheme “proved so valuable that it [was] being extended to civilians and in the past two years it [had] helped over 10,000 new cases.” Originally designed for repatriated prisoners of war, the scheme connected participants with a host of services and community supports, such as personnel at the Ministries of Pensions and Labour, voluntary social workers, and volunteers with the Red Cross and British Legion.¹²⁹

At the local level, however, things did not begin so smoothly. The Association reported that many local authorities failed to prioritize their newly acquired mental health responsibilities, and

¹²⁷ Ibid.

¹²⁸ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1950–1*, 6. Recall the emphasis placed on “pioneer” services.

¹²⁹ Wellcome Library, PP/ADD/J/11/1, “A positive mental health policy,” 1948. This aftercare scheme is discussed in more detail in chapter 3.

despite “many enlightened Authorities,” most did not implement preventive programs.¹³⁰ Financially, the NHS did have several detrimental effects on the Association: an annual £2000 grant was discontinued in 1949, and that same year the Ministry of Health opted to cut the Association out of the Services aftercare scheme, instead taking on the whole project itself. Of course, according to the Association’s own rhetoric, services were meant to be pioneered within the voluntary sphere and then taken over by the authorities—in practice, however, the loss of a developed program like the aftercare scheme could result in a host of difficulties. Aside from losing the income generated through this project, the Association was forced into “the extremely unsatisfactory position” of negotiating new care schemes with individual local authorities.¹³¹

In 1950 the Association reported that, despite having “welcomed enthusiastically” new welfare legislation, “retrogression” was occurring in some areas. Some mental hospitals, unable to handle the volume of new voluntary patient applications, were refusing voluntary admission altogether and taking only certified patients. Similarly, despite recognizing the value of early ascertainment, local authorities similarly did not have the capacity to handle the expected volume of new patients—the Association admitted that “[t]he repercussions of a complete ascertainment of the real mental health needs of the community would be enormous.”¹³²

Thus, the Association set the stage to shore up public perception of its own value—in cooperating with the state to rescue an overtaxed system which could not live up to the hefty goals that had been forced upon it. The 1949–1950 annual report summarized: “[i]t would, therefore, seem that far from the time having arrived for the Association to close down on some of its activities because of the advent of new legislation, these should, in the interests of the community,

¹³⁰ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1948–9*, 5.

¹³¹ *Ibid.*, 8.

¹³² Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1949–50*, 4.

be increased.¹³³ Annual reports would repeatedly reaffirm the ongoing need for voluntary effort: the 1950–1951 report asserted, “[t]he development in the last few years of the vast organization of the National Health Service, and the many other new measures of social legislation, have not diminished the need for a national voluntary organisation for the promotion of mental health.”¹³⁴



Fig. 2.5: R.A. Butler greets the Duchess of Kent at a conference.
Wellcome Library SA/MIN/B/70/1

Memoranda of Evidence

As a further indicator of the Association’s impact, it was regularly called upon to provide evidence to major governmental inquiries. Though it was never guaranteed that the advice would be heeded, this allowed voluntarists an alternative channel into policy development (the usual approach being to cajole a friendly bureaucrat, MP, or peer into bringing up major issues at relevant

¹³³ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1949–50*, 6.

¹³⁴ Wellcome Library, SA/MIN/B/80/7/1, *NAMH Annual Report, 1950–1951*, 6.

Ministries or in Parliament). Produced by various working groups and sub-committees, the Association's memoranda give a sense of the group's major priorities, and offer a view into the exact areas where it considered mental health provision to be lacking—as well as what it expected government to do about the problem.¹³⁵

In 1951, the Association prepared recommendations for potential changes to mental deficiency legislation, to be circulated to relevant ministries. It laid out several “General Principles,” including the following: a balance between the individual liberties of people with learning disabilities and the safety of the community; the provision of welfare, educational, and medical services of equal quality to the rest of the population; and a belief that people with learning disabilities “should be given every opportunity to take [their] place in the community and contribute to [their] own livelihood.”¹³⁶

Integrating people with learning disabilities into the community was a central objective: it was argued that “the concept of Social Inefficiency” should be included in definitions of mental deficiency, and that archaic categories like “feeble-minded,” “imbecile,” “idiot,” and “moral defective” should be updated. It was also suggested that the legislative language “a defective subject to be dealt with” be replaced by “a defective in need of special care.” Further, the Association called for the development of facilities and services of all kinds: training and advice centres for parents and caregivers; day and residential occupation centres; home teaching and supervision; workshops and “handicraft centres” for adults; and social clubs. More residential accommodation was also needed: hostels to keep more independent patients out of institutional

¹³⁵ The Association was not alone in this activity—in chapters 3 and 5, submissions to the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (the Percy Commission) by the MACA and the NAPBC/NAMHC are discussed.

¹³⁶ The National Archives, MH 102/2623, NAMH, “Memorandum on Revision of Mental Deficiency Legislation,” November, 1951.

care; “educational and training centres”; hospital units geared toward both treatment and research; and hospitals for patients in need of “nursing or special care.”¹³⁷

At a 1954 meeting of the Committee of Inquiry into the Rehabilitation of Disabled Persons (Piercy Committee), Association representatives expanded upon memoranda that had previously been submitted in conjunction with the Association of Psychiatric Social Workers (APSW) and the Mental Health Workers’ Association. A number of recommendations were laid out regarding patients with learning disabilities, and it was argued that these represented “the majority view on which there was very considerable agreement.” Across the country, 211 occupational centres for juvenile “defectives” were in operation, with staff trained by the NAMH, but these were not considered “equipped to give the sort of training which might enable the better patients to go into employment and earn a living.” The label “mental defective” was considered unnecessarily broad and inaccurate, and many labelled as such were considered capable of succeeding in regular employment, “with careful selection of employment and employer.”¹³⁸

With regard to psychiatric patients, Association representatives noted that they had no way of knowing the actual scope or size of the problem at hand, and the Ministry of Labour and National Service had the same problem. In government-run Industrial Rehabilitation Units, people registered for physical disabilities were frequently “really in need of rehabilitation because of psychiatric disorders.” While some research had been undertaken, the transient nature of many people affected by mental illness made any assessment difficult—“a great many belonged to the floating population, frequenting lodging houses and probably receiving no psychiatric treatment whatsoever.” Finally, the Association representatives emphasized their own contributions: the

¹³⁷ Ibid.

¹³⁸ The National Archives, Ministry of Labour Records, LAB/20/863, Committee of Inquiry on the Rehabilitation of Disabled Persons Minutes, September 21, 1954.

development of community care facilities and programs had “made a real contribution ... as they enabled more effective work to be undertaken with the patient in his normal environment.”¹³⁹

As previously noted, in 1958 evidence was submitted—again in conjunction with the APSW—to the Ingleby Committee. The Association was interested in the Committee’s work for its relevance to children with mental illness, but also because of the operation of Duncroft Approved School—through which the Association had regular contact with the juvenile courts. The Association noted that approved schools were intended for children who were poorly behaved, but not necessarily “maladjusted.” In practice, the categories were often conflated, and so it was argued it should be made easier to transfer between schools when a child was categorized inappropriately. The memorandum refrained from calling for a complete overhaul of the juvenile court system—indeed, it held that courts gave a better sense of impartiality than alternatives like welfare committees, making punishments or family separations more bearable.¹⁴⁰

Inadequate services and staffing levels are repeatedly referenced throughout the memorandum. The Association did not consider it ideal to imprison parents in cases of child cruelty, but in many areas this was considered the only option, given a lack of facilities and social workers. It was argued that social services were equipped only to deal with “crisis situations,” with few resources allocated to preventive work. To this end, the Association called for more social workers, and “better use made of existing workers.” The ultimate goal was “to see skilled casework readily available to help families throughout the country.”¹⁴¹

After the memorandum was delivered, Ingleby Committee Secretary W.F. Delamare noted “[m]uch of it is in vague terms and in some places it is difficult to know precisely what the

¹³⁹ Ibid.

¹⁴⁰ The National Archives, Home Office Records, HO 330/92, “Evidence Prepared for the Home Office Committee on Children and Young Persons,” March 1958.

¹⁴¹ Ibid.

Association have in mind.¹⁴² It is likely that the Association didn't always know themselves—it is often easier to identify a problem than solve it. Through its submissions of evidence, however, the Association was able to maintain a consistent presence in policy development and ensure its leading role within a “united opposition,” as Applebey put it.

Conclusion

In maintaining a place within the new welfare order, and constructing its own political and social imaginary, the Association employed strategies that were as much rhetorical as practical. From the time that the Feversham Committee's recommended amalgamation brought the Association into being—roughly coinciding with the birth of the welfare state—there were concerted efforts to strengthen voluntarists' claims to the jurisdictions of mental health and learning disability care. NAMH voluntarists relied heavily on social and political capital, and in particular the strategy of co-opting highly-placed politicians and bureaucrats. Further, as noted by Crossley, evidence submitted to governmental ministries, commissions, and committees was presented as fact—the Association's counsel was not up for debate.

Despite its criticisms, the Association would remain closely allied and associated with successive governments until the late 1960s, when it would orient more toward civil rights advocacy.¹⁴³ As seen in this chapter, the alliance took a variety of shapes: even as the Association was positioned as adversarial, its executives recognized the value of cooperating with government to provide and improve residential services, and to develop public and professional education

¹⁴² The National Archives, HO 330/92, W.F. Delamare to Miss Goode, May 28, 1958.

¹⁴³ Crossley, “Transforming the mental health field,” 459. In a rather intrigue-filled incident, in 1970 the Association fought off a takeover by anti-psychiatry Scientologists who had infiltrated the membership. The interlopers were purged from the organization, but from that point on the NAMH turned away from service provision, and more toward pressure group tactics and civil rights advocacy. A 1971 awareness campaign entitled “Mind” lent its name to an organization-wide rebrand, and from 1975 on, the newly named Mind moved away from training programs, instead “embarking on an American-style campaign for reform through legal advocacy.” See Jones, *Asylums and After*, 199–200.

programmes. In relatively rare instances of conflict, the root cause was generally dissatisfaction among Association members at the government's management of a given jurisdiction, or failure to provide sufficient services, facilities, and other resources. This relationship was not particularly remarkable among voluntary organizations, as many recognized the value of maintaining close links to an increasingly interventionist state.

In general, perhaps because it was fulfilling key welfare roles, the Association's jurisdictional claims were not strongly contested by successive Labour and Conservative governments (indeed, the biggest obstacle presented by government tended to be bureaucratic torpor). The former was generally glad to have the help, as statutory service provision remained inconsistent in the welfare state's early years—particularly in areas where local authorities failed to abide by new legislation requiring residential accommodation. The latter had always been ambiguous about the State's displacement of voluntarism, and were generally glad to cooperate as long as financial demands were not too burdensome.¹⁴⁴

This chapter has emphasized organizational strategies employed by the NAMH in navigating a new, yet not wholly unfamiliar world of welfare provision. In her aforementioned comments at the Association's 1960 AGM, Mary Applebey encapsulated the group's contradictory relationship with the State: cooperative, yet combative; amenable, yet oppositional. Yet even as the Association pushed to destigmatize mental illness and learning disability through activism and education, it continually ensured that it was accomplishing key welfare objectives, as suggested by both governmentality and the political economy of the welfare state: the regulation of disorder,

¹⁴⁴ Nicholas Deakin and Justin Davis Smith have argued that, beginning in the New Labour era, both major parties contributed to a re-writing of history that painted the post-war Labour Party as wholly opposed to voluntarism. In reality, Clement Attlee admired working-class mutual aid, Herbert Morrison responded positively to Beveridge's *Voluntary Action*, and even Aneurin Bevan supported voluntarism in limited circumstances—mainly in NHS hospitals. See Nicholas Deakin and Justin Davis Smith, "Labour, charity and voluntary action: The myth of hostility," in *The Ages of Voluntarism: How We Got to the Big Society*, eds. Matthew Hilton and James McKay (Oxford, Oxford University Press, 2011), 71–73, 82–83.

the promotion of self-sufficiency and self-governance, and the maintenance of non-working populations through residential homes and approved schools.

Chapter 3

The Mental After Care Association

*“We rehabilitate—or to use our founder’s simpler word,
we befriend—sufferers from the saddest of all human ills.”
Henry Yellowlees¹*

Introduction

This chapter emphasizes the personalized and contained nature of operations in the Mental After Care Association (referred to here either as MACA or “the Association”), relative to a more expansive organization like the National Association for Mental Health (NAMH). Rather than spread its resources over a variety of areas—public and professional education, research, monetary assistance—the MACA focused mainly on the provision of accommodation and after care for convalescing or long-term mental hospital patients. The chapter shows several “ground level” considerations involved with operating a major voluntary organization such as this: in particular, property management, staffing, the varied needs of a diverse clientele, self-promotion, and fundraising efforts.

First, the chapter covers the most important element of the Association’s operation—its residential homes. These performed a vital welfare function by housing and maintaining non-working citizens, and in limited cases readying them for re-entry into the working world (as will be noted, this latter function took on less importance in the 1950s, as the Association catered increasingly to older and chronic patients). The next section examines ongoing efforts to remain (and, more importantly, be perceived as) cooperative with statutory bodies, the medical profession, and other voluntary groups following the inauguration of the NHS and the amalgamation of the

¹ The Wellcome Library, London, UK, The Mental After Care Association Collection, SA/MAC/E.5/27, Henry Yellowlees, “Appeal on Behalf of the Mental After Care Association,” May 8, 1955.

NAMH. Annual reports repeatedly emphasized the continuing importance of voluntarism in a nationalized health system, and employed clear budgeting as a means of projecting efficacy—particularly as the State faced claims of wasteful spending. Even when conflict arose over funding arrangements (a relatively common occurrence), staff tried to maintain positive relations with the statutory bodies that were increasingly the Association’s lifeblood. Finally, the chapter examines the Association’s public relations efforts and donor appeals. Positive publicity was certainly an ongoing consideration, though the Association was less public-facing than the other organizations considered in this dissertation.

As it shifted toward chronic and elder care in the 1940s and 1950s, the MACA became less concerned with its patients’ employability or skill development. However, this did not mean it could not serve the ends of the welfare state. In terms of social integration, it served as a bridge between the rigid strictures of institutionalized life and the freedom and uncertainty of the outside world. It also freed up medical resources and productive labour that might otherwise be put toward maintaining a generally non-productive population.

The Association was able to guard its jurisdictional position in the period at hand through flexibility and a willingness to accommodate fluctuating statutory needs and priorities. Its ongoing relevance is evidenced by the amount of interest it would field from local authorities, unprepared to fulfill their responsibilities under new legislation and overwhelmed by the need for after care. Most of these requests did not actually result in new services, which indicates a degree of caution and conservatism that likely kept the Association from overextending itself. Executives generally recognized that there was only so much they could accomplish, lacking the resources and prestige of the NAMH.

In the 1960s, Psychiatric Social Worker (PSW) M.H. Bree wrote a brief chapter on the history of Association up to that point, which provides a clear view of the Association's development from its late-nineteenth century founding into the postwar era. The idea of the MACA first emerged in 1879, when Dr. John Bucknill invited several "similarly concerned people" to his London home to discuss the need for convalescent care for recovering asylum patients. Bucknill had been inspired by a recent article published in the *Journal of Mental Science* by Rev. Henry Hawkins, Chaplain of Colney Hatch Asylum in Barnet. The article, titled "A plea for Convalescent Homes in connection with Asylums for the Insane Poor," was concerned with the high rate of relapse and readmission among patients leaving mental asylums—especially those who had little or no employment or external support. Convalescent homes were a common feature of the medical system, but none existed specifically for discharged asylum patients.²

The meeting's attendees agreed to form "The After-Care Association for Poor and Friendless Female Convalescents" (male patients were included after a few years). The philanthropist and social reformer Lord Shaftesbury was made president, with Bucknill and Rev. Hawkins taking the roles of Chair of Council and Secretary, respectively. The Association set forth the following objectives: "to facilitate the re-admission of poor and friendless female convalescents from Lunatic Asylums into social life (1) by obtaining for them, when needful, a brief interval of change of scene and air ... (2) by assisting them to obtain suitable employment."³

Discharged asylum patients would be recommended to the Association by a medical superintendent, and sent to cottage homes to receive care from a "countrywoman" matron, along with regular welfare visits from a responsible member of the local community—usually a vicar or

² The Wellcome Library, Manuscripts, MS.7913/33, M.H. Bree, "The Mental After-Care Association," in *The Expanding Field of Mental Health in England and Wales, 50 years of progress, 1918–1968*, eds. Doris Odlum and Alexander Walk (unpublished manuscript, 1968), 1.

³ *Ibid.*, 2–3.

doctor. This pattern remained mostly unchanged over the ensuing decades. At first, only patients considered “recovered” were accepted for convalescence. However, the increased need brought about by the First World War led the Association to abandon this rule and begin admitting “early” or “preventive” cases referred by hospitals and social agencies. This led to increased professionalization, as the Association contracted its patients out to matrons with experience in mental health nursing, rather than the “kindly cottager” of previous decades.⁴

Volunteers and staff worked consistently to raise the Association’s public profile and secure new donors and clients. In 1923, the Ministry of Pensions contracted the Association to provide after care to all war pensioners leaving mental hospitals, and its work was lauded by the Board of Control and the Royal Commission on Lunacy and Mental Disorder (Macmillan Commission). The Prince of Wales (later King Edward VIII) acted as the Association’s patron, and his appeals for donations granted excellent publicity and funding opportunities. Beginning in 1931, an Association representative sat on the candidate selection committee for a new mental health course at the London School of Economics.⁵

The Depression led to an increase in expenditure, as patients had more difficulty finding employment, and consequently stayed longer in the Association’s care. PSWs employed by the Association kept in regular contact with former patients, providing money, clothing, and tools needed for employment, and also setting up convalescence holidays. Further, they performed home visits and other social work functions on behalf of London-area mental hospitals (many of the social work tasks later performed by the hospitals’ own staff were pioneered by Association visitors).⁶

⁴ Ibid., 3–4.

⁵ Ibid., 4–7.

⁶ Ibid., 5–6.

When the Feversham Committee proposed amalgamation with the Central Association for Mental Welfare, the National Council for Mental Hygiene, and the Child Guidance Council, the MACA held out. In December 1946, MACA executives considered amalgamation and ultimately decided “there did not appear to be any advantage or necessity to become a member” of the NAMH.⁷ There were several reasons for rejecting the plan: while Feversham had seen overlapping services as a major problem, the Association argued that its after care work was unique among voluntary groups, and not replicated elsewhere; it was also felt that private donations made for the Association’s specific purposes should not be put toward other ends; finally, it was argued that the Association’s uniquely personalized services would suffer if its energy were spread among other activities, like public education.⁸ This sense of independence was made possible by the Association’s close ties with private donors and charitable trusts, as well as several local authorities—especially the London County Council (LCC).⁹ Despite this refusal, the Association welcomed the formation of the NAMH, and the two organizations would work in concert in ensuing years.¹⁰

The relationship between statutory authorities and voluntary mental health groups was clarified in Section 28 of the *National Health Services Act 1946* and Section 26 of the *National Assistance Act 1948*.¹¹ The legislation allowed for local authorities to fulfill their obligations to elderly or disabled people by allocating accommodation and other services to voluntary organizations, and to provide payments to said organizations. Certain local authorities did gradually develop their own systems of community care, in the limited areas of the country where

⁷ Wellcome Library, SA/MAC/C.3/1, MACA General Purposes Committee [GPC] Minutes, November 26, 1946.

⁸ Wellcome Library, MS.7193/7, Bree, “The Mental After-Care Association,” 7.

⁹ Madeline Rooft, *Voluntary Societies and Social Policy* (London: Routledge, 1957), 156.

¹⁰ Wellcome Library, SA/MAC/C.3/1, GPC Minutes, December 21, 1946.

¹¹ Wellcome Library, SA/MAC/B.1/60, *MACA Annual Report 1948*, 2.

such ambitions existed. However, the new division of administrative responsibilities between local authorities and Regional Hospital Boards meant that these systems were less cohesive and efficient than before 1948. The Ministry of Health, seeking to mitigate expenditure as much as possible, encouraged the use of voluntary organizations to cover areas where services were lacking, but John Welshman writes that “little was achieved before the publication of the Royal Commission on Mental Health’s report in 1957.”¹² Association patients or their families were expected to pay for services, but only according to their means. These fees were generally supplemented by statutory payments, which accounted for approximately 70 percent of the Association’s income by 1949.¹³ Further funding—particularly for capital projects—was drawn from voluntary contributions and legacy bequests, Guild of Help fundraisers, and periodic grants from large trusts like the Queen Adelaide’s Fund and the King Edward’s Hospital Fund.¹⁴

In 1948, a public notice for the Association’s registration as a limited liability company listed objectives largely consistent with those of the founders: “[t]o facilitate the readmission into the social and general life of the community of persons suffering or who have suffered from any mental or nervous infirmity or disorder by such means and in such manner as may be thought fit.” This facilitation would continue through domestic visiting, residential accommodation, monetary assistance, and employment support.¹⁵

¹² John Welshman, “Rhetoric and reality: community care in England and Wales, 1948–74,” in *Outside the Walls of the Asylum: The History of Care in the Community 1750–2000*, eds. Peter Bartlett and David Wright (London: Bloomsbury Academic, 2001), 208–209.

¹³ Roofe, *Voluntary Societies and Social Policy*, 156.

¹⁴ Bree, “The Mental After Care Association,” 11; SA/MAC/E.5/11, “Notes on Meeting of Psychiatrists and Psychiatric Social Workers”; “Report on Meeting of Doctors and Psychiatric Social Workers,” January 31, 1951.

¹⁵ The National Archives, London, UK, Board of Trade Records, BT 58/915, “Public Notices,” *The Times*, October 22, 1948; Wellcome Library, SA/MAC/A.2/4, “Memorandum of Association of the Mental After Care Association,” December 18, 1948. The LLC registration came after failed attempts to secure a Royal Charter—see below for further discussion.



Fig. 3.1: MACA Chairman Henry Yellowlees.
Wellcome Library, SA/MAC/J.2/4:O/S 11

However, despite this affirmation, the Association's goals had begun to shift during the war, as it increasingly took in chronic patients to free up scarce hospital beds. This would presage a general turn away from traditional "convalescents" (patients needing a finite period of housing and support after a hospital stay), and a reorientation toward the chronically ill and elderly (who, in most cases, were not expected to return to "the general life of the community"). By the end of the 1940s, convalescent work had largely dried up; this transitional process intensified in the 1950s, as medical opinion began to perceive mental illness as curable, rather than permanent, and the NHS accounted for greater numbers of acute cases. Reasoning that curable cases could rely on

statutory services and the NAMH, MACA Chairman Henry Yellowlees took the lead in steering the Association from convalescence to long-term care.¹⁶ Over a decade later, the Mental Health Act 1959 signaled a more substantial shift to community care, but cases considered curable still tended to be prioritized for treatment.¹⁷

After Care Homes

This section first examines the considerations that went into developing residential homes—the Association’s primary tool in the effort to maintain relevance within the welfare order. These considerations included the procurement and maintenance of physical properties, and management of staff and patient experience and concerns. Then, the section employs a case study of one particular property, called Elmstead Lodge, to show the unique challenges involved in the everyday operation of homes, as well as problems with high staff turnover.¹⁸ Much of the information on MACA homes has been preserved in meeting minutes of the Association’s Council and General Purposes Committee (GPC), and especially in regular reports submitted by trained home visitors. PSWs were employed to visit and inspect homes at three to six-week intervals, to ensure adequate patient care and assist matrons wherever possible. By 1959, the Association employed four such PSW visitors: “Miss O’Shaughnessy” (hired 1932); “Mrs. Chartwell” (hired 1941); “Mrs. Jones” (hired 1945); and “Mrs. Haines” (hired 1952).¹⁹ These four women reported

¹⁶ See Fig. 3.1. Dr. Henry Yellowlees (1888–1971) served as a consulting physician in psychological medicine in a variety of capacities. During the First World War, he was a Captain in the Royal Army Medical Corps. He would later teach as a professor of psychiatry at the University of Edinburgh, and, like Dr. Alfred Torrie after him, was Physician Superintendent of the Retreat at York. His son, also named Henry, would become Chief Medical Officer of the United Kingdom from 1973 to 1984. See Gordon Wolstenholme and V. Luniewska, “Henry Yellowlees,” *Royal College of Physicians*, accessed April 6, 2020, <https://history.rcplondon.ac.uk/inspiring-physicians/henry-yellowlees>.

¹⁷ Roofe, *Voluntary Societies and Social Policy*, 157. See also Vicky Long, *Destigmatising mental illness? Professional politics and public education in Britain, 1870–1970* (Manchester: Manchester University Press, 2014), 158–170; Claire Hilton, “Psychiatrists, mental health provision and ‘senile dementia’ in England, 1940s–1979,” *History of Psychiatry* 26, no. 2 (2015): 187.

¹⁸ See Fig. 3.4.

¹⁹ Wellcome Library, SA/MAC/C.3/4, GPC Minutes, April 1, 1959. Certain sources in this chapter are held in restricted files at the Wellcome Library, meaning dissemination of names or personal information is prohibited. Pseudonyms for Association staff, matrons, and patients are indicated with quotation marks upon first use.

on diverse aspects of the Association's homes—operations, upkeep, patient behaviour and routines, difficulties and successes, matron personalities and concerns—and ensured that patients' needs were met.

Property and Operations

Sociologist Peter Townsend, in his 1962 study of care for older people in Britain, *The Last Refuge*, asserted that residential homes in the period tended to be of poor quality—especially those operated directly by local authorities. However, voluntary agencies were found to provide better levels of care. In 39 voluntary homes surveyed, Townsend observed that residents tended to be fitter, more active, and more able to care for themselves; for this reason, he would recommend that voluntary organizations should expand to provide sheltered housing as well as residential care. Ultimately, he argued that large institutions were not needed in elder care, as most older people with physical or mental disabilities could live in small nursing homes, or in their own homes with “appropriate and necessary domiciliary support.”²⁰ While the Association did continue to operate some homes and hostels for younger patients, by the 1940s and 1950s elderly and chronic care homes were its main purview.²¹

Association homes were generally large, older houses and manors, with some accommodating up to forty patients at a time. Some split their rooms between various types of patient (such as long-term, short-term, or holiday patients). Each home and its residents were looked after by a matron—usually an older mental health nurse who sought to continue in the field after retirement. Depending on the size of a home, the matron would occasionally be joined by a

²⁰ Julia Johnson, Sheena Rolph, and Randall Smith, *Residential Care Transformed: Revisiting 'The Last Refuge'* (Basingstoke: Palgrave MacMillan, 2010), 3, 6, 9–10, 68.

²¹ The Association's annual report for 1959 shows that the goal of community reintegration was never wholly abandoned. It reports that at hostels in Cheam, Dartford, and Chiswick, 56 patients were in “continuous employment,” and had thus “not only been restored to the community but had been restored to themselves.” The Wellcome Library, SA/MAC/B.1/71, *MACA Annual Report, 1959*, 8.

warden (almost invariably her husband), and by subordinate staff—medical workers, housekeepers, cooks, gardeners, and secretaries.²² In most cases, the homes were privately owned and operated, with the Association paying patient fees to non-employee matrons. A few homes were directly owned or leased, with Association employees forming the staff.

A small number of private homes operated as regular hotels or hostels as well—further, there were occasionally tiered arrangements for private patients and those admitted through the Association. In 1952 a property in Battle, East Sussex, housing six patients, was deemed unsuitable for also operating a licensed country club.²³ At a property called Langsmeade Hall, in Blindley Heath, Surrey, Mrs. Jones remarked that Association patients were confined to a small living room, “rather hidden away from the rest of the house.” While private patients “must obviously receive ‘better’ attention,” Jones wrote, “[o]ne feels that any difference made between paying & ‘non-paying’ patients should be in the bedroom accommodation and not in the living rooms especially in a house of this size.”²⁴ Her contention signals the ways in which private (presumably more well-off) patients could be separated from non-paying Association patients—both physically and in terms of treatment quality.

As noted, after the First World War the Association began moving its homes toward a more professionalized model, and in 1942 it was decided that all new homes and hostels should be owned (or leased) and operated directly. Several long-serving private matrons retired after the

²² While many accounts have emphasized patient experience, both in larger institutions and small homes and hostels, John Welshman writes, “we need to know much more about the people running a variety of post-war residential services.” He argues that the 1950s saw a shift in residential homes from eugenic-influenced ideas of “convalescence” and the “problem family” to “rehabilitation.” Consequently, he uncovers correspondence between residential home staff and former patients that reveals themes of caring and mutual assurance. Letters written between former patients and the female warden of “The Brentwood Centre,” Lancashire, show “gratitude for the time spent there, and ... close bonds forged with the warden in particular.” See John Welshman, “Wardens, Letter Writing and the Welfare State, 1944–68,” in *Mental Health Nursing: The Working Lives of Paid Carers in the Nineteenth and Twentieth Centuries*, eds. Anne Borsay and Pamela Dale (Manchester: Manchester University Press, 2015), 192, 201, 208.

²³ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, June 4, 1952.

²⁴ Wellcome Library, SA/MAC/F.1/2, Visitor Notes, January 15, 1953.

Second World War, and so it was thought that the new policy could expand as patients were transferred.²⁵ However, it quickly became apparent that directly purchasing and equipping homes meant contending with diverse zoning regulations and other statutory requirements, along with public opposition to the introduction of new mental health facilities into communities. Ultimately, the direct ownership policy was never fully implemented, and the Association would continue contracting private homes and matrons through the 1950s.



Fig 3.2: Patients' lounge at 31 York Road, Cheam, Sutton.
Wellcome Library, SA/MAC/B.1/58

The management of the Association's varied properties could take as much energy as the development and application of its therapeutic work. The acquisition and maintenance of properties were constant concerns, and occupied a great deal of staff and executives' time. In 1951, the Association directly owned or leased only two acres of property, and that year it sought a license

²⁵ Wellcome Library, MS.7193/7, Bree, "The Mental After-Care Association," 9.

from the Board of Trade to operate homes on up to an additional 25 acres. Local authority permission had already been obtained for a home in Wilmington, Kent, and licensed homes in Beckenham, Bromley, and Cheam, Sutton, were added, along with the Association's offices on Jermyn Street in Westminster.²⁶

At the same time, the Association created a reserve fund to repair increasingly run-down homes. In particular, MACA General Secretary Henrietta Syme Russell was constantly attending to the minutiae of maintaining so many homes.²⁷ Newly purchased or contracted properties frequently required a great deal of repair or alteration before they were judged suitable for patients, and ongoing maintenance consumed a great deal of the Association's capital. A 1957 survey report on a property called Hill House in Esher, Surrey, gives an idea of the considerations that went into maintaining safe and well-kept homes. The property, which was built at the end of the nineteenth century, was found to have poorly fitted pipes, uneven and cracked wall plastering, warped doors and cupboards, water damage, cracked chimney stacks, haphazard electrical wiring, and inadequate drainage.²⁸ At a different home, a matron-warden couple were instructed to install a fire escape, but they preferred instead to move to a house with two staircases, necessitating the uprooting of patients.²⁹ A third property needed a chain-link fence installed to keep local children off the grounds, and an employee was tasked with patrolling "to see that the fruit and vegetables were not interfered with."³⁰ The various authorities responsible for patients could also bring specific complaints—in 1949 the LCC complained about the "shabbiness" of a home in

²⁶ See Fig. 3.2. The National Archives, BT 58/914, Speechly, Mumford & Soames (Solicitors) to The Secretary, Board of Trade, October 12, 1951; The Board of Trade, License to Hold Lands, May 26, 1952.

²⁷ H.S. Russell was originally hired in 1936, and took over for retiring General Secretary Ethel Vickers in 1940. As with Mary Applebey of the NAMH, many of the MACA's successes in the 1940s and 1950s would have been unthinkable without Russell's steady organization. Wellcome Library, SA/MAC/C.3/4, GPC Minutes, April 1, 1959.

²⁸ Wellcome Library, SA/MAC/F.5/4, Curtis and Henson Surveyors to Speechly, Mumford and Soames (Solicitors), November 6, 1957.

²⁹ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, May 20, 1947.

³⁰ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, June 17, 1947.

Crowborough, East Sussex, and suggested advancing the home's matron money for furniture repair.³¹

Alterations were not only made for safety or practical purposes—both matrons and patients tried to create warm and inviting spaces wherever possible. Upon visiting a potential home in 1952, one visitor noted that “[a]ll beds have colourful eider-downs & nowhere in the house is one reminded of an institution.”³² In 1953, brand new television sets were purchased for several homes, to allow patients to view the Coronation, and the following year's annual report described patients taking “a personal pride in new decorations about the house and never fail[ing] to point them out when a visit is paid.”³³ After a 1956 visit to a home in Dartford, Kent, representatives of the Hospital Management Committee for Horton Hospital, in Oxfordshire, and the South West Metropolitan Regional Hospital Board recorded that “the atmosphere of the home is informal and friendly and all the patients we spoke to expressed their satisfaction.”³⁴

Concerns over liability and patients' health and hygiene were ongoing in many homes. “Mrs. Alder,” a matron in Margate, Kent, arranged for a chiropodist to visit her patients every two months—a visitor recorded that “the worst case of foot trouble simply screamed at the sight of him and still refuses to have anything to do with him.” It could be difficult to convince male patients to shave every day, and those who were unable found it too expensive to visit a barber frequently. Mrs. Alder could not bring herself to help, as she was “afraid of the sharp blades.”³⁵ If matrons were unable to provide a safe and sanitary environment for patients, the Association was willing

³¹ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, June 1, 1949.

³² Wellcome Library, SA/MAC/F.1/2, Visitor Notes, February 13, 1952.

³³ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, March 25, 1953; SA/MAC/B.1/66, *MACA Annual Report, 1954*, 11.

³⁴ Wellcome Library, SA/MAC/F.5/14, M.E. Clarke, R. Sargood, Memorandum, October 12, 1956.

³⁵ Wellcome Library, SA/MAC/F.1/1, Visitor Notes, March 30, July 13, 1955.

to cut ties entirely—in 1951 the GPC stopped sending patients to a home in Herne Bay, Kent, after “in spite of many suggestions,” the matron “had not been able to improve her standard.”³⁶

More serious cases of patient harm, or even death, were infrequent, but it was only when these incidents occurred that improvements to safety policies were considered. In the late 1940s, a young patient suffering from *Tabes Dorsalis* (a degenerative disease of the spinal cord) died after being placed in a scalding bath by the matron of a private home. The Association was exonerated of wrongdoing in the coroner’s report, but still had its solicitors develop an opinion on the extent of its liability in potentially dangerous situations.³⁷ The opinion recommended that matrons and wardens ensure patients using tools be supervised at all times; that staff be given written instructions on their supervisory duties; and that a system of inspections be instituted to ensure these duties were being met. It is questionable whether these measures could have helped the deceased patient.³⁸

An informational pamphlet from a slightly earlier period emphasized the unremarkable nature of life in these homes—implicitly contrasting the environment with that of the mental hospital:

[t]here are no rules, other than those of an ordinary household. The patients partake of outside activities, such as church and its social life, concerts, cinema-going, shopping, and visiting friends and relatives who may also visit them and take them out or away for week-ends or holidays, on permission being given by the matron in charge. Some younger patients go to evening classes or refresher courses in such subjects as shorthand typing, and to social clubs.³⁹

This relative freedom helped demarcate the homes from more rigid institutions, but could lead to problems ranging from annoyance or discontent in the community to harm befalling the patients

³⁶ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, February 7, 1951.

³⁷ Wellcome Library, SA/MAC/F.5/13, H.S. Russell (Secretary) to W.P. King (Hon. Solicitor), November 15, 1949.

³⁸ Wellcome Library, SA/MAC/F.5/13, T. Humphrey Tilling (Solicitor), “Opinion,” June 29, 1949.

³⁹ Wellcome Library, SA/MAC/H.2/1, “The Mental After Care Association—Information Sheets,” n.d.

themselves. In 1950 a patient described as a “boy” died by suicide in a tool shed at Elmstead Lodge, a farm property in Essex. Again, the Association was not blamed for the incident, but the coroner recommended two measures be imposed: Matrons and Wardens should coordinate more often on checking patients’ movements; and the Association should be provided with better information from hospitals on patients with suicidal tendencies. Miss Russell was instructed to insist on information forms being properly filled out for each patient, especially those sent by Banstead Hospital, where the deceased patient had originally received treatment.⁴⁰



Fig. 3.3: Castle Glen, Sandgate, Kent.
Wellcome Library, SA/MAC/B.1/67

Association staff and executives continually debated required levels of supervision with state bureaucrats and officials. In 1955, the Medical Officer of Health for Kent inspected a property called Castle Glen, in Sandgate, Kent; he wrote that the home was understaffed, and would need to have bars installed on upstairs windows. GPC members, hesitant to recreate the appearance of

⁴⁰ Wellcome Library, SA/MAC/C.3/3 GPC Minutes, March 1, 1950.

a locked ward, dismissed both concerns.⁴¹ However, two years later a Castle Glen patient died by suicide after swallowing hydrochloric acid, which she had purchased at the local chemist's shop. The coroner's report placed no blame on either the private matron or the Association, but there was concern that the consequences could be more dire if ever the Association had to deal with a coroner "less understanding of the freedom enjoyed by ... patients." Then-Chairman W.P. King (Henry Yellowlees resigned in 1956, though he remained a member of the GPC) suggested that in the case of any future deaths by suicide, legal representation should be obtained immediately, whether the incident occurred in a private or directly-owned home.⁴²

Patient freedoms could also lead to outcomes that were less dire, though still troubling by the Association's standards. At Elmstead Lodge, in the same year the young patient died by suicide, two other patients had a sexual liaison in the surrounding woods. It was reported that the woman, "G.E.," was "seduced" by the man, "J.C." Apparently, "necessary action had been promptly taken," but the incident led to a reconsideration of whether both men and women should be accommodated together at Elmstead.⁴³ Though dealt with by the GPC, the topic was conspicuously absent in the minutes of an ensuing Council meeting (although the suicide was reported). Whether this reflects a desire to keep the matter quiet—even internally—is unclear.⁴⁴ In the absence of further details, the GPC's response does indicate anxieties around issues of patients' sexual liberty and consent.

Matrons, Visitors, and Patients

As noted, by the 1950s the Association's patients were mainly elderly and/or chronic cases.⁴⁵ Claire Hilton has shown that in the 1940s and 1950s, general services for elderly people

⁴¹ See Fig. 3.3. Wellcome Library, SA/MAC/C.3/3, GPC Minutes, June 1, 1955.

⁴² Wellcome Library, SA/MAC/C.3/4, GPC Minutes, February 26, 1957.

⁴³ Wellcome Library, SA/MAC/C.3/4, GPC Minutes, March 1, 1950.

⁴⁴ Wellcome Library, SA/MAC/C.3/3, Mental After Care Association Council [hereafter Council] Minutes, February 25, 1950.

⁴⁵ A limited number of homes still took in younger people, and in 1953 a second home was opened in Cheam, reserved "entirely for convalescent and recoverable female patients." Wellcome Library, SA/MAC/B.1/65, *MACA Annual*

with what was termed “senile dementia” were severely lacking. While the need for clinical and social help was apparent, welfare authorities generally failed to address the problem, and medical authority vacillated between geriatric medicine and psychiatry. Occasionally, patients were admitted to “chronic sick” hospitals, but more often they were consigned to mental hospital beds under the assumption that they could not recover—eventually occupying a greater proportion of those beds than any other group.⁴⁶

The Association was thus well positioned to take pressure off crowded institutions. However, the period immediately following the inauguration of the welfare state was reported to be particularly trying for some matrons, as there was a notable increase in the number of patients on the Association’s register. Overcrowding in NHS mental hospitals led to earlier and earlier discharges, with the result that matrons were forced to take in more difficult patients who were not necessarily “recovered”—or as recovered as they had been in the past.⁴⁷ At the Association’s 1951 Annual General Meeting, LCC Medical Officer of Health Sir Allen Daley offered congratulations “on overcoming the difficulties and frustrations of the past year,” and singled out the Association’s matrons for special thanks.⁴⁸

Matrons exhibited a range of attitudes toward their patients, as well as various degrees of enthusiasm for their jobs. They could also demonstrate quick tempers, which Long ascribes to their

Report, 1953, 6.

⁴⁶ Hilton, “Psychiatrists, mental health provision and ‘senile dementia’ in England,” 184. The Association’s 1950 annual report estimated that of 132,000 mental hospital beds in the country, 21,000 were occupied by patients who could be adequately cared for “in homes other than Mental Hospitals.” Wellcome Library, SA/MAC/B.1/62, *MACA Annual Report, 1950*, 3. Charlotte Greenhalgh has argued that elderly Britons were particularly vulnerable to mental illness prior to this, as psychiatrists had only just begun distinguishing conditions like Alzheimer’s Disease from the normal aging process. Sociologists emphasized occupation rather than income as markers of status, and tended to exaggerate the hopelessness that retirement supposedly caused. See Charlotte Greenhalgh, *Aging in Twentieth-Century Britain* (Oakland: University of California Press, 2018), 12–13.

⁴⁷ Wellcome Library, SA/MAC/B.1/60, *MACA Annual Report, 1948*, 3; SA/MAC/B.1/61 *MACA Annual Report, 1949*, 3.

⁴⁸ Wellcome Library, SA/MAC/C.3/3, *MACA AGM Minutes, March 29, 1951.*

training as nurses in understaffed and hierarchical mental hospitals.⁴⁹ A visitor report on an Eastbourne matron captures several common personality traits:

[she] is a strange woman and her appearance and manner tend to belie her basically good qualities; she obviously loves her work and there is a very 'soft streak' beneath that seemingly hard exterior. She makes no claim to superiority or high intelligence, is quite definite and determined in her views & is inclined to be annoyed if she feels she is being imposed upon ... she appears to have little time for the unco-operative and lazy patient while fully realising that mental instability is answerable for much of the outlook and approach to life ... On balance one feels that patients have a good home at Eastbourne and local Authorities are beginning to realise and appreciate this.⁵⁰

A report a little over a year later carried on in the same vein: “[she] has her odd grumbles about patients, conditions, etc. but one definitely feels she has the interest of her patients at heart and would not be doing anything else willingly.”⁵¹

Many matrons were reported to enjoy their jobs, and care deeply for their patients. While the Eastbourne matron had little patience for Association oversight, the visitor contrasted her with the matron of The Eyrie, in Godalming, Surrey, who was “only too pleased that more frequent visits should be made to her Home.”⁵² This matron was particularly hurt when one of her patients was taken to a local hospital for palliative care, and she was accused by a specialist of “merely [wanting] to get rid of the patient so she could die in hospital.” In truth, the matron had held off as long as possible, with the visitor reporting “[she] is possibly over-kind & therefore did not take the opportunity when offered some months ago.” The matron of Langsmeade Hall was described as having “the right attitude towards patients,” and understanding “the benefit of treating them as individuals and not merely as ‘numbers’.”⁵³

⁴⁹ Long, *Destigmatising mental illness?*, 172.

⁵⁰ Wellcome Library, SA/MAC/F.3/12, Visitor Notes, December 9, 1952.

⁵¹ Wellcome Library, SA/MAC/F.3/12, Visitor Notes, January 18, 1954.

⁵² Wellcome Library, SA/MAC/F.1/6, Visitor Notes, April 10, 1953.

⁵³ Wellcome Library, SA/MAC/F.1/2, Visitor Notes, February 15, 1952.

Serious conflict between patients and matrons was rare, but there are numerous examples of frayed nerves and worries over problematic patients. These instances could disrupt the day-to-day operations of homes and the comfort of other patients. Patients themselves occasionally expressed discontent at their arrangements—in 1951, Miss Russell reported that several had complained to the LCC “that the accommodation and amenities were not such as had been represented.” In response, the LCC’s consulting psychiatrist recommended circulating a form letter to all incoming patients, which explained the specifics of accommodation in Association homes.⁵⁴

In general, proper after care was conceived of by most Association executives, staff, and matrons as a privilege, rather than a natural extension of treatment. In particular, visitor and matron reports could exhibit a level of contempt for certain patients who did not accord with their ideas of good behaviour. The criteria used to assess patients often focused on character, ability, and adherence to traditional gender roles, rather than medical needs.⁵⁵ One visitor maintained personalized notes on each patient in her remit, with categories indicating some of the considerations that went into patient care: “Personality and Present Mental Condition”; “Special Diets;” “Baths Herself?”; “Goes Out Alone?”; “Noisy or Quarrelsome by Day”; and “Relatives in Touch?”⁵⁶

Poor behaviour could land patients in trouble, and residence in Association homes could be revoked for rule breakers, those deemed overly unpleasant, or those whose illnesses seemed too severe. At a home in Ashted, Surrey, a visitor reported that the matrons—a mother-daughter duo—“sometimes seem a little over anxious when they get a difficult patient to deal with.” It was noted that one patient at this home tended to upset the others, with the sole proposed solution being

⁵⁴ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, August 10, 1951.

⁵⁵ Long, *Destigmatising mental illness?*, 172–173.

⁵⁶ Wellcome Library, SA/MAC/F.2/1, Visitor Notes, n.d.

“there may come a time when we shall have to move her.”⁵⁷ At a home in Weedon, Northamptonshire, a visitor reported that another patient, “is the most nuisance and there may come a time when she cannot stay any longer. She is very childish and has to have attention all the time and annoys everyone.”⁵⁸ A patient who had enjoyed two-week holidays with the Association for two consecutive years was suddenly excluded after receiving probation for a shoplifting conviction. The patient’s probation officer wrote “that she was sorry she had got in touch ... and that she would remember not to do so again ‘if this sort of thing has to happen’.” Chairman King expressed his disapproval of the officer’s attitude at a GPC meeting.⁵⁹

In 1953, patients at the aforementioned Mrs. Alder’s home were reported to be “anxious to show they are good boys and do not need to be sent back anywhere!”⁶⁰ Mrs. Alder had asked to move a patient who had been with her for sixteen years—he had apparently been complaining to neighbours, who then threatened to speak to a local Councillor on his behalf. Mrs. Alder was incensed at his “disloyalty.” No alternative lodging could be found, so Mrs. Alder repeatedly renewed the patient’s notice—seven months later he was still in residence, and the visitor’s notes record that “he is keeping fairly quiet as he does not want to be turned out.”⁶¹ When the patient finally did leave, Mrs. Alder reported that her patients were “more settled.”⁶²

Two years later, Mrs. Alder informed the Association that in the future she would not accept a particular thirty-six year old holiday patient from St. Ebba’s hospital. She reported that he “was troublesome right from the start,” brought a stranger into the house, and would shout at the dinner table and aggravate other patients. The visitor assigned to Mrs. Alder rather disdainfully noted this

⁵⁷ Wellcome Library, SA/MAC/F.1/3, Visitor Notes, November 14, 1949, May 8, 1953.

⁵⁸ Wellcome Library, SA/MAC/F.1/7, Visitor Notes, January 24, 1955.

⁵⁹ Wellcome Library, SA/MAC/C.3/4, GPC Minutes, GPC, June 5, 1957.

⁶⁰ Wellcome Library, SA/MAC/F.1/1, Visitor Notes, February 2, 1953.

⁶¹ Wellcome Library, SA/MAC/F.1/1, Visitor Notes, February 12, 1953; September 9, 1953.

⁶² Wellcome Library, SA/MAC/F.1/1, Visitor Notes, September 28, 1953.

patient was part of a “batch of St. Ebba’s patients ... of a rather simple type,” who were “particularly dirty.” Mrs. Alder also accused the patient of stirring up trouble with patients from Napsbury Hospital, who then apparently lied about food quality to that hospital’s administrators. As with the St. Ebba’s patients, the visitor criticized the Napsbury group: “by no means particularly nice or pleasant or clear and many of them drank and needed cleaning up after.” Two years prior, the visitor had reported that a “famous [patient] from Shenley ... tried to make out they did not get enough to eat.” Complaints about food were common, though when these arose the Association was quick to cite overwhelming evidence of other patients’ satisfaction with meals. In the same note, the visitor reported that a holiday patient showed the menu from his hospital, and was “going to suggest some alterations in it based on Mrs. [Alder’s] meals!”⁶³

At The Eyrie, one elderly patient was labelled “a bullying type, intensely jealous of the others, unfriendly and bad-tempered & to some extent instils fear into the weaker members of the household.” The patient had disabilities including partial blindness and deafness, but would not be admitted to a home for the blind due to mental instability. She was “a considerable source of annoyance and tribulation” for the home’s matron, who was nevertheless sympathetic and reluctant to have her moved. The patient, along with a companion, continued to cause problems in the home—they are described as “domineering & bullying,” and it is claimed that they continually victimized a third patient. Ultimately, it was suggested that all three patients be transferred, and the matron requested that they be replaced with women under age 60.⁶⁴

When homes closed, usually due to matrons retiring, the Association often found itself scrambling to relocate patients—a task made more administratively difficult by patients’ varied origins. When a Bromley home was closed in March 1959, twelve patients were dispersed to

⁶³ Wellcome Library, SA/MAC/F.1/1, Visitor Notes, August 31, September 28, 1955.

⁶⁴ Wellcome Library, SA/MAC/F.1/6, Visitor Notes, December 12, 1952, July 10, 1953, February 12, 1954.

various hospitals, private hostels, and other Association homes. These included two from the LCC, two from Cane Hill Hospital, two from the Middlesex County Council, one from Bexley Hospital, one from the County Borough of Coventry, one from Claybury Hospital, and five private patients. Eight additional patients had originally arrived from the Middlesex County Council, the Kent County Council, the London County Council, and St. Francis Hospital; three more remaining were private patients.⁶⁵

Elmstead Lodge

Anne Borsay and Pamela Dale have documented recruitment and retention problems in mental health nursing during this period, noting, “[a]t the start of the de-institutionalisation process many of those caring for the mentally disordered remained chronically overworked and undervalued.”⁶⁶ Given these circumstances, it is likely that many mental health nurses were happy to move into the less rigorous environment of charitable elder care. However, this did not mean that voluntary bodies had no retention problems of their own. Among the records of various Association homes, everyday operations and staffing considerations at Elmstead Lodge are especially well documented.

During the war, this directly-owned property was contracted by the Polish government-in-exile to provide after care to Polish mental hospital patients, as well as some Norwegian, Danish, and Dutch Service members. The home was vacated in 1947 to make way for regular Association staff and patients—but not before the War Damage Commission estimated that repairs would cost around £2000.⁶⁷ The home’s matron, “Mrs. Parker,” was unsure whether she wanted to continue

⁶⁵ Wellcome Library, SA/MAC/F.2/1, Visitor Notes, February 13, 1959.

⁶⁶ Anne Borsay and Pamela Dale, “Mental Health Nursing: The Working Lives of Paid Carers in the Nineteenth and Twentieth Centuries,” in *Mental Health Nursing: The Working Lives of Paid Carers in the Nineteenth and Twentieth Centuries*, eds. Anne Borsay and Pamela Dale (Manchester: Manchester University Press, 2015), 14–16.

⁶⁷ Wellcome Library, SA/MAC/C.3/1, GPC Minutes, October 29, 1946. It is unclear whether the property was damaged by bombing, or if “war damage” encompassed regular wear and tear by the Polish patients.

in her position, but for the time being, she wished to remain and “give every help in her power to ensure [Elmstead’s] success.”⁶⁸ She was ultimately forced to retire due to ill health, and in her stead, an entire family was brought on to run the property. “Mr. and Mrs. Harvey,” an older married couple, would act as groundskeeper and housekeeper, assisted by their mental health nurse son and his bookkeeper fiancé. Before her departure, Mrs. Parker had expressed a desire for an improved occupational therapy regimen, and a live-in occupational therapist, “Miss Nash,” was also hired.⁶⁹



Fig 3.4: Elmstead Lodge, Essex.
Wellcome Library, SA/MAC/H.2/1

⁶⁸ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, GPC, May 20, 1947.

⁶⁹ Wellcome Library, SA/MAC/C.3/2 GPC Minutes, December 31, 1947, January 27, 1948. The discipline of occupational therapy is discussed in further detail in chapter 4.

However, within a month Chairman Yellowlees received several “adverse reports” that Miss Nash was not suited to her position. The substance of these reports was not specified in GPC minutes, but apparently her live-in status had caused tension with the patients. Yellowlees met with Miss Nash and “formed the opinion that she was not likely to become a useful member of the staff at Elmstead Lodge.” He gave her three options: find external accommodation; “settle down and start organizing her work”; or accept three months’ severance and resign. Miss Nash chose the last option, and a Polish Rehabilitation Officer, “Mr. Filipowicz,” was hired in her place, with his wife helping female patients.⁷⁰

Administrative problems continued at Elmstead, with the GPC hearing of “a few difficulties and misunderstandings which seemed to be accumulating among the staff.” Miss Russell and other committee members paid the home a visit, determining that the younger Harveys were “capable and enthusiastic,” and that Filipowicz “was excellent for his job,” despite being a “foreigner” and thus “at a disadvantage where authority was concerned.” The elder Harveys “were unanimously considered to be failures” due to health problems and lack of authority, and Russell began seeking alternate senior assistants. Criticism piled on when the King’s Fund—a major source of Elmstead’s funding—instructed Russell “to communicate ... indicating the general dissatisfaction felt in the management of the house and to lay special stress on the unsatisfactory work of the senior couple.” The elder Harveys were unceremoniously given until the end of the year to vacate.⁷¹

Soon after their departure, the Association hired a trained nurse and secretary, “Miss Page”—it was quickly reported that “patients appeared to appreciate her efforts on their behalf,”

⁷⁰ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, GPC, February 24, May 18, 1948.

⁷¹ Earlier that year, the Fund had provided a major grant of £2500 toward Elmstead’s operation. Wellcome Library, SA/MAC/C.3/2, GPC Minutes, February 24, September 7, October 5, November 2, November 30, 1948.

and that the property was better managed under the younger Harveys, Page, and Filipowicz. In April 1949, the younger Mrs. Harvey broke her collarbone, and was temporarily replaced as matron by a “Mrs. Holton”; then, after Holton left abruptly, by a “Mrs. Lett.” Filipowicz’s occupational therapy activities were popular, and included rug making, leather work, weaving, stool seating, and small-scale farming (growing crops and raising pigs, goats, and chickens). Elmstead patients could also rotate small domestic jobs in return for extra pocket money—tasks like cleaning fireplaces, and sweeping and polishing floors. However, the GPC decided in mid-1949 not to renew Filipowicz’s contract, since the farm and garden schemes were found to be too expensive—this was thought to indicate Filipowicz’s poor judgement. This decision was supported by Sir Edward Bligh, the head of the LCC Welfare Department, who had a major voice in staffing and operational decisions at Elmstead.⁷² While there is no detailed record of the chain of decisions leading to Filipowicz’s dismissal, it is possible that as with patients, Bligh and Association executives held a low opinion of the therapist’s Polish nationality. He was certainly given less latitude than most other staff and matrons, including the departed Miss Nash.

As a main source of patients, the LCC’s approval was consistently sought in staffing decisions. Though Bligh was willing to cut Filipowicz loose, he was evidently fond of the younger Mr. Harvey. Following a visit to the property, Bligh produced a report stating that the transitory matron Mrs. Holton had insulted Harvey by referring to him as a porter; she had also intimated that area doctors were surprised an “unqualified” person could hold his position. Bligh suggested that Harvey enroll in a course to be certified an official “Warden of homes and institutions” with the LCC, and that he be given a commensurate salary increase from £360 to £400 per year. He concluded,

⁷² Wellcome Library, SA/MAC/C.3/2, GPC Minutes, February 9, 1949; SA/MAC/C.3/3, GPC Minutes, March 2, March 23, April 27, September 7, October 5, 1949; SA/MAC/F.5/13, H.S. Russell to W.P. King, April 21, 1949.

[w]e [the Welfare Department] consider that Mr. [Harvey] as Warden, Mrs. [Lett] as Matron and Mrs. [Harvey] as assistant Matron would make a good team. If a suitable resident gardener is appointed, we consider that these four officers would secure sufficient therapic [*sic*] occupation for the patients.⁷³

Occupational therapy was considered important, but not enough to merit a full-time employee's salary.

Still, problems continued: a cook was accused of spreading “detrimental rumours” about the home and Association, and the GPC received complaints about Mrs. Lett's management. The father of a patient complained that Lett misspent £90 he had provided for his daughter's clothing—the GPC considered this “further proof of the unsatisfactory management at Elmstead Lodge.” In May 1950, the Association's Council decided to close the home. Patients were transferred to other homes in November, and the Harveys accepted temporary positions as assistants at Castle Glen.⁷⁴

The various homes—Elmstead Lodge in particular—indicate several common elements in the Association's approach to its after care facilities and patients. It was of paramount importance to preserve the look and feel of a home, rather than a sterile or lifeless institution. Patients enjoyed much more freedom than in institutions, even though this could lead in some instances to harm befalling them, or—as will be seen in a later section—to negative public perceptions of the Association's work. Council and GPC members tended to be more concerned with acquiring, funding, and maintaining homes, and were happy to leave care decisions to individual matrons, PSWs, and other medical workers—they would only become involved when patients or staff were thought to be behaving inappropriately, or not meeting certain standards. Finally, the homes employed a wide range of staff, with diverse personalities and motivations. Even where matrons appeared gruff or ill-tempered, they, along with visitors, generally had patients' best interests in

⁷³ Wellcome Library, SA/MAC/C.3/3, Sir Edward Bligh, “Report,” October 17, 1949.

⁷⁴ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, March 1, May 30, 1950; Council Minutes, May 26, 1950.

mind, however constrained they may have been by the limits of contemporary medical practice and understandings of mental health. Whether patients had a positive or negative experience depended on a number of factors: the number of fellow patients and their personalities; their matron's flexibility (or rigidity, in some instances); and the funding capacity of their respective local authority.

Cooperating with the State

This section examines the ways in which the Association positioned itself as cooperative and collaborative within the new welfare state—both in relation to statutory authorities and other voluntary groups. This was particularly important, as the decision to remain independent following the NAMH amalgamation could have resulted in isolation and a loss of influence. The Association participated enthusiastically in certain statutory efforts, and as will be seen, was quick to protest if it seemed it was being sidelined in favour of another group. Interest in after care services was widespread, but the Association tended to act conservatively in responding to requests for new properties—particularly from authorities outside the London area. Finally, the section shows some of the funding arrangements made with local authorities, and also the difficulty that could emerge in collecting payment for services rendered.

Collaboration

Tracing the Association's work in the 1950s, M.H. Bree wrote:

The decade between the National Health Service Act and the Mental Health Act was one of quiet consolidation and anticipatory work in preparation for a new adjustment to whatever new demands might be made upon the Association and whatever new needs might arise from new provisions.⁷⁵

In the year following the inauguration of the NHS, the Association optimistically reported that “the opinions expressed by so many knowledgeable people about the value of the voluntary services

⁷⁵ Wellcome Library, MS.7193/7, Bree, “The Mental After-Care Association,” 10.

even in a nationalised State have been amply justified.” Voluntary associations were thought to be particularly well-suited to assisting statutory bodies with “sudden problems”—those unexpected issues that arose for which no legislation or medical policy had been developed.⁷⁶

Despite the Association’s relative isolationism—having refused the NAMH amalgamation—cooperation was deemed essential to maintaining influence in the new welfare state, and “anticipatory work” took the form of frequent contacts with various levels of government, other voluntary groups, and the medical profession. In 1947 Sir Allen Daley joined the Association’s Council, and in 1952 a member of the Board of Control, Dr. Isobel Wilson, did the same.⁷⁷ The Association’s 1946 annual report emphasized links with local government, and particularly the LCC: “[t]he Mental After Care Association has always been in closest touch with the London County Council. This close relationship has grown with years of successful service.” The report reinforced the decision to remain independent from the NAMH, but noted “[a]t the same time the Council wish it to be clearly understood that they are willing and anxious to cooperate with all public and private bodies for the better treatment of the patient.”⁷⁸

In 1946, Association members were included in a new committee formed in the London area for the purpose of coordinating “the rehabilitation, after care and employment of the disabled”—one of many such Local Rehabilitation Committees established across England and Wales, at the recommendation of the Order of St. John, the British Red Cross, the Women’s Voluntary Services, the British Legion, and the Ministries of Health, Labour, and Pensions. The Committee’s first meeting, held in December, included representatives of “the voluntary hospitals, the voluntary organisations engaged in welfare work for the disabled and handicapped, the

⁷⁶ Wellcome Library, SA/MAC/B.1/61, *MACA Annual Report, 1949*, 2.

⁷⁷ Wellcome Library, SA/MAC/C.2/1/6, *MACA Annual Report, 1947*, 6; Council Minutes, October 31, 1952.

⁷⁸ Wellcome Library, SA/MAC/B.1/58, *MACA Annual Report, 1946*, 2–3.

Ministries of Health, Labour[,] and Pensions[,] and the London County Council.” The LCC Vice-Chairman “stressed the fact that legislation both present and pending was likely to enlarge the scope of voluntary effort.” Another LCC representative stated that in the past, overlapping objectives among voluntarists had led to “jealousy between competing organisations in the same field”—however, she argued that “all had a contribution to make.”⁷⁹ The Association’s policy influence could also extend beyond local committees—as the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission) got under way in 1954, it reached out to the Association to provide memoranda of evidence. A sub-committee consisting of Chairman Yellowlees, Miss Russell, and GPC member Dr. Caldwell was formed for this purpose.⁸⁰

In several instances, the Association provided services to statutory bodies that went beyond its traditional role in convalescence and residential services. During the Second World War, the Ministry of Health contracted the Association to work with the newly-formed NAMH on an ex-Services visiting scheme, based mainly in Essex and Kent.⁸¹ Ex-Services members discharged from psychiatric hospitals were referred to the two organizations by the Board of Control, and Association PSWs mainly conducted domiciliary visits, but also recommended patients to homes and hostels where needed.⁸² Funding was channeled through the NAMH, which would pay the MACA a set amount for each patient taken on. One MACA employee, a PSW named Mrs. Seglow, became so integral to NAMH activities that she was directly paid a salary of £350 by that organization—in line with their own PSWs.⁸³ Later, after prompting from Miss Russell, the NAMH agreed to hire a clerical assistant for Mrs. Seglow.⁸⁴

⁷⁹ Wellcome Library, SA/MAC/C.3/1, Local Rehabilitation Committee for the Disabled Minutes, December 11, 1946.

⁸⁰ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, April 7, 1954.

⁸¹ Previously discussed in chapter 2.

⁸² Wellcome Library, MS.7913/33, Bree, “The Mental After-Care Association,” 9.

⁸³ Wellcome Library, SA/MAC/E.5/8, Mrs. Welfare (PNCMH) to Miss Russell, November 30, 1944.

⁸⁴ Wellcome Library, SA/MAC/E.5/8, Mr. Conrad Ormond (PNCMH General Secretary) to Miss Russell, February 25, 1946.

The ex-Services arrangement only lasted until late 1946, when Chairman Yellowlees and NAMH Medical Director Dr. Kenneth Soddy agreed that the latter organization would take on the full burden.⁸⁵ The Association's Council regretted "the severance of their connection from this region," but saw the utility of having the scheme under a unified administration.⁸⁶ At an ensuing GPC meeting, Miss Russell argued that it was essential to clear up potential misunderstandings over the Association's withdrawal from the scheme—particularly the idea that it reflected a lack of capacity or influence. She had already circulated a letter to the Association's client hospitals, arguing, "[the] Association is continuing its usual activities and is in no way subsidiary to any other organisation."⁸⁷

Inter-organizational relations were not always entirely smooth, and an instance of conflict between the MACA and the NAMH shows how responsibility could flow back and forth—particularly when working in partnership with fickle statutory authorities. Only two years after giving up its part in the ex-Services visitation scheme, the Association complained to the Ministry of Health that it had been excluded from instructions to local authorities about ex-Services after care as well—local authorities were instructed to provide ex-Services after care themselves, or to contact the NAMH. The LCC responded to the new rules by establishing its own after care program—for both civilians and ex-Services members—that would make use exclusively of MACA PSWs, and would cover 90 percent of the expenses. The NAMH then objected to this arrangement, and Sir Allen Daley was forced to convene a meeting with the two organizations to

⁸⁵ SA/MAC/C.3/1, GPC Minutes, October 1, 1946. As noted in chapter 2, in 1949 the Ministry of Health took over the entire scheme from the NAMH.

⁸⁶ Wellcome Library, SA/MAC/B.1/58, *MACA Annual Report, 1946*, 5.

⁸⁷ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, January 29, 1947.

hammer out a division of labour. It was ultimately decided to divide cases equally, with each organization responsible for reporting if and when they hit capacity.⁸⁸

This arrangement lasted for five years—in 1953, all of the LCC’s “temporary agreements” with voluntary agencies were ended, and it was announced that going forward, the care and after care of people needing out-patient or in-patient psychiatric treatment would be undertaken solely through the Public Health Department. However, the relationship between the Association and the LCC was not completely severed, as the announcement circular noted that where necessary, home visitation and other assistance would be undertaken in conjunction with “doctors, hospitals, employment exchanges, voluntary organisations, etc.” Further, the MACA would continue providing two to three week “recuperative holidays.”⁸⁹ At a 1951 meeting between Association staff, mental hospital psychiatrists and superintendents, PSWs, and government representatives, the value of these short holidays had been heavily extolled.⁹⁰

Interest in Services

Association representatives would make repeated overtures to the Ministry of Health and local authorities throughout the 1950s—in 1959 Chairman King circulated a letter suggesting that local authorities could “relieve present hospital congestion” by renting homes to the Association “on favourable terms.”⁹¹ However, he mainly had in mind properties in London, or at least in the Home Counties. The Association frequently entertained interest from local and regional authorities, among other groups, across the country. More often than not, however, these contacts failed to produce new homes or services. The Association was open to cooperation at any level,

⁸⁸ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, October 5, 1948, February 9, 1949.

⁸⁹ Wellcome Library, SA/MAC/E.1/7, “Copy of L.C.C. Circular: Psychiatric Preventive Care and After-Care,” March 1953.

⁹⁰ Wellcome Library, MS.7193/7, Bree, “The Mental After Care Association,” 10.

⁹¹ Wellcome Library, SA/MAC/C.2/1/6, Council Minutes, February 29, 1959.

but generally required that properties and financial guarantees be secured before its staff would become involved in any scheme—especially outside the London metropolitan area.

Requests for services or support could come from far afield: in 1946, doctors with the Scottish Board of Control asked the Association to indicate its interest in an after-care scheme to the Scottish division of the Royal Medico-Psychological Association (RMPA). The RMPA Secretary replied that “he was sure [the suggestion] would receive an enthusiastic response from his colleagues.”⁹² The following year, Russell was authorized to make a promise of financial help to any realistic scheme, and met with RMPA members at Lennox Castle.⁹³ The meeting did not produce anything concrete, but the idea of opening a Scottish branch persisted into the ensuing decade. In 1953, however, Russell was instructed to respond to a probing letter that “in view of previous experience, [the Association] could not open up negotiations on this subject again, unless a very strong appeal with an assured backing could be given.”⁹⁴

In 1949 the Association was approached by St. Crispin’s Hospital in Northampton, as well as Moorhaven Hospital in Plymouth, but in both cases the distances involved posed a problem.⁹⁵ In the case of a proposed home for Devon and Cornwall, Russell noted that it would be impossible to provide services so far from London, “unless [the MACA] had a safeguard against loss through lack of patients or payment of maintenance.”⁹⁶ In 1951, the Medical Officers of Health for South Lancashire and Cheshire wrote about potential homes they had scouted in the Midlands. They then visited an existing Dorking home with W.P. King (at the time the Association’s Solicitor), and

⁹² Wellcome Library, SA/MAC/C.3/1, GPC Minutes, July 9, 1946; Council Minutes, September 3, 1946.

⁹³ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, May 20, 1947.

⁹⁴ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, August 5, 1953.

⁹⁵ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, March 4, 1949.

⁹⁶ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, June 1, 1949. The South Western region still lacked a convalescent home over six years later, and Moorhaven again contacted the Association. This time hospital representatives secured a meeting with the Association, but again, nothing appears to have come of their efforts. SA/MAC/C.3/3, GPC Minutes, December 7, 1955.

while it was reported that the meeting went well, ultimately no new home was established.⁹⁷

Medical authorities closer to London had a much better chance of securing the Association's services. In 1954 Miss Russell took a meeting with the Medical Officer of Health for Croydon, who had asked about establishing "a hostel for elderly persons in need of special care after discharge from a mental hospital or to prevent their entry to such an institution"—the Association's exact remit.⁹⁸ This proposal was helped by a favourable financial outlook, but also by an assurance from Dr. T.P. Rees, a member of the MACA Council, that relapsed or "unsuitable" patients would be accepted for treatment at Warlingham Park Hospital, where he was Medical Superintendent.⁹⁹ This latter condition was particularly important, as the following year's annual report recorded: "[a]lthough all must welcome the diminution in certified patients, matrons have certainly had some trying and difficult experiences with discharged voluntary patients who have relapsed and with whose re-admission the referring hospitals have refused to help."¹⁰⁰ The resulting home was the aforementioned Langsmeade Hall in Blindley Heath, which eventually housed thirty elderly patients.¹⁰¹

Statutory Funding

Croydon authorities paid maintenance fees of £4 per week, per Langsmeade Hall patient (the fees were slightly higher than in other areas, "in view of the very high rent and rates to be met by the Association").¹⁰² While Croydon was willing to pay what was needed, and despite widespread interest in Association facilities and services, it could prove difficult to secure payments from other statutory bodies. Residential homes were generally funded through a

⁹⁷ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, May 2, 1951; Council Minutes, May 25, 1951.

⁹⁸ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, August 4, 1954.

⁹⁹ Wellcome Library, SA/MAC/C.2/1/6, Council Minutes, October 29, 1954.

¹⁰⁰ Wellcome Library, SA/MAC/B.1/67, *MACA Annual Report, 1955*, 11.

¹⁰¹ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, May 2, 1956.

¹⁰² Wellcome Library, SA/MAC/C.3/3, GPC Minutes, June 6, 1956.

combination of patients' payments, grants from the medical and welfare departments of Local Authorities, and benefits from National Insurance and/or the National Assistance Board (NAB).¹⁰³ However, statutory officials could prove recalcitrant, and some exploited bureaucratic ambiguities to avoid paying their full share. Local authorities in Kent were adamantly opposed to maintenance payments going to patients in homes that were not directly owned by the Association, on the principle that private homes should not be eligible for funding under relevant legislation (the *National Health Service Act 1946* and *National Assistance Act 1948*), and despite other local authorities providing the payments without complaint. This policy meant that most Association homes in the Kent area were denied full funding.¹⁰⁴ In other cases, maintenance payments would be refused if the patient in question was not officially certified under existing mental health legislation—which had become less common since the loosening of certification rules in the 1930s.¹⁰⁵ At all levels, there seemed to be an official desire for the Association to negotiate payment agreements with individual local authorities, regardless of how cumbersome this proved.

Bureaucrats could also make funding decisions based on incomplete or incorrect information, making the Association's administrative tasks more complicated. In 1956, Miss Russell wrote to the NAB Area Officer for Northampton, to correct the misapprehension that matrons were directly receiving payments of £3 per week, per patient. Russell explained that she had arranged for £3.5s. maintenance payments, but that this covered pocket money and clothing

¹⁰³ As an example, in 1946 a private home in Weedon charged £1.10s. per week, per patient. In 1951, Russell indicated that there was a "vast discrepancy" between patients receiving pensions or sickness benefits and those with National Assistance Grants. Wellcome Library, SA/MAC/F.1/7, C.W. to Assistance Board, March 4, 1946; SA/MAC/F.1/1, Miss Russell to Mrs. [Alder], April 12, 1951.

¹⁰⁴ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, December 7, 1955.

¹⁰⁵ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, August 4, 1954. One of the main thrusts of the Mental Treatment Act 1930 had been to remove the necessity for certification and encourage voluntary institutionalization. See Joan Busfield, "Class and Gender in Twentieth-Century British Psychiatry: Shell-Shock and Psychopathic Disorder," in *Sex and Seclusion, Class, and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, eds. Jonathan Andrews and Anne Digby (Amsterdam: Rodopi, 2004), 300.

purchases as well as supervision fees. The remaining matrons' fees were cobbled together from "the Hospitals, Local Authorities, private sources, etc." Russell was keen "to correct the somewhat grave error which [had] arisen in the minds of authorities."¹⁰⁶

Yellowlees and Russell—perhaps not wanting to ruffle feathers—initially approached the problem through a semi-official channel. Over several months in 1956, they contacted Dr. Charles Hill, MP for Luton, who agreed "to interest some Members of Parliament" in the issue.¹⁰⁷ However, following a series of meetings with MPs and representatives of the NAB, the Ministry of Health, and the County Council Association, Association executives felt no closer to obtaining secure payments for all their patients.¹⁰⁸ They informed the NAB that they could no longer accept patients whose supervision and incidental payments were not covered—in return, the NAB asserted that it would no longer offer such payments to voluntary organizations.

A rather Byzantine funding arrangement was finally settled, whereby the Association would apply to relevant local authority welfare departments for required fees (though only for homes it owned and operated directly). Where a patient's treatment would result in financial loss for the Association, patients could be referred to their local welfare department for alternate accommodation. The NAB did increase patient maintenance payments from £3.5s to £3.10s per week, and the following year to £3.15s. per week. However, this amount did not match the increase that had been requested by the Association; an irritated Chairman King declared that if payments

¹⁰⁶ Wellcome Library, SA/MAC/F.1/7, Miss Russell to Area Officer, NAB, Northampton, April 11, 1956.

¹⁰⁷ Dr. Charles Hill (1904–1989) was a central figure in British medical politics. As Secretary of the British Medical Association from 1944 to 1950, he conducted negotiations over the structure of the National Health Service. He would go on to hold several Cabinet positions in successive Conservative governments. See Asa Briggs, "Hill, Charles, Baron Hill of Luton," *The Oxford Dictionary of National Biography*, accessed June 15, 2020, <https://doi.org/10.1093/ref:odnb/40159>.

¹⁰⁸ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, January 5, April 6, 1955, April 4, 1956.

remained at that level, the Association would be unable to provide clothing to its patients, and “would look to [the NAB] to do so when the need [arose].”¹⁰⁹

When the new Mental Health Bill was presented in Parliament in 1958, it was projected to have little effect on the Association’s operations—legislation governing the admission of residential patients had been in operation for a decade. However, it had been hoped that the ongoing finance problems would be addressed. This was not to be the case, as the annual report for 1958 stated,

...we had hoped that certain legal curiosities which hamper the collection of maintenance payments would have been swept away. Unfortunately, nothing has been done in this respect. It had also been widely hoped that the powers of the Authorities in respect of mental after-care, at present permissive, would have been made compulsory and that provision would have been made for the necessary finance to enable the Authorities to deal with the crying need for more Homes, either by providing them themselves, or through the voluntary associations.¹¹⁰

Despite heralding a shift toward the kind of community care at which the Association excelled, the legislation would ultimately prove disappointing for its lack of funding provisions.

Publicity and Donors

Efforts to engage the public—at least, on the same level as an organization like the NAMH—were relatively rare for the MACA. Association staff and executives often preferred to let their work speak for itself, and focused instead on maintaining relationships with well-connected trusts and the local authorities and related bureaucracies that provided the majority of their patients (and associated maintenance payments). However, this does not mean that there were no attempts to raise the Association’s public profile in the years at hand, and this section first considers various efforts to secure both statutory and public approval. It then examines relatively

¹⁰⁹ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, May 2, June 6, 1956; SA/MAC/C.3/4, GPC Minutes, January 2, 1957.

¹¹⁰ Wellcome Library, SA/MAC/B.1/70, *MACA Annual Report, 1958*, 6.

muted efforts to secure private donations—which, as the Association relied increasingly on statutory funding, took on less importance.

Public Relations

The Association's 1949 annual report noted,

[d]oubt still exists in the public mind as to the status of the voluntary associations under the new régime and not a few people are under the impression that all health organisations automatically became state controlled in July, 1948, or if not automatically so, it is only a matter of time until they are.¹¹¹

Publicly demonstrating the opposite, and ensuring that in the “public mind,” the Association remained a leading and prestigious mental health charity, would be a crucial and ongoing effort. In 1945, the Association had applied to the Home Office for permission to include the title “Royal” in its name, and the following year applied for a Royal Charter. Executives were given relatively free reign in accomplishing this goal—Yellowlees was instructed by the Emergency Committee (soon retitled the General Purposes Committee) “to incur what expense was necessary in the way of Counsel's fees and other matters.”¹¹²

The Association was refused in both cases, and the reasons given indicate an ambivalent opinion in official circles during the 1940s. This low regard was likely a function (at least partially) of the poor general standing of mental health practice—at the Association's 1951 Annual General Meeting, Yellowlees lamented “that psychiatry had become the jester's butt.”¹¹³ The Board of Control had informed the Home Secretary, James Chuter Ede, that while the Association was “a very valuable body, its beneficent activities [were] of a limited character.” The Board judged that the Association was neither “unique” nor “pre-eminent” among the mental health services, and so

¹¹¹ Wellcome Library, SA/MAC/B.1/61, *MACA Annual Report, 1949*, 2.

¹¹² Wellcome Library, SA/MAC/B.1/61, MACA Emergency Committee Minutes, January 22, 1946.

¹¹³ Wellcome Library, SA/MAC/C.3/3, MACA AGM Minutes, March 29, 1951.

should not hold the title “Royal.” The Home Office concluded that the title should be granted only where “the institution is pre-eminent among other bodies of its kind, or has done work of excellent and outstanding importance, or has some special and close connection with Royalty”—the MACA was not thought to meet any of these criteria.¹¹⁴



Fig. 3.5: MACA members at the 1959 Annual General Meeting.
Wellcome Library, SA/MAC/J.1/3

The Association’s public standing began improving in the ensuing decade, though it was never as associated with the monarchy as some other groups—particularly the Ex-Services Welfare Society. Following the Charter refusal, the Association’s fortunes with the aristocracy vacillated somewhat—Edward VIII had been patron in the 1920s, but after three decades and an abdication, he was hardly anyone’s idea of a first-rate royal. In 1950, then-Princess Elizabeth was invited to

¹¹⁴ The National Archives, Home Office Records, HO 144/23257, F.J. Dadd to The Clerk of the Council, Privy Council, March 11, 1947; H. McCullah, Home Office, to W.G. Agnew, Privy Council Office, July 24, 1947.

become President of the Association, following the resignation of Princess Arthur of Connaught. Elizabeth's representatives politely declined, but did suggest a substitute—Elizabeth's aunt, Mary, Princess Royal.¹¹⁵ In 1957, a newly purchased home in Chiswick was in need of a “suitable person” for its grand opening—the Queen Mother “regretfully declined,” and the home was eventually opened by Labour MP Kenneth Robinson. The Association was not wholly shut out of royal affairs—in 1953 it was granted two tickets to view Elizabeth's coronation, and these were “ballotted among the office staff and temporary workers.”¹¹⁶

Occasionally, problems with patients, homes, and other involved people or groups threatened to explode into lawsuits or negative publicity. Aforementioned cases of patient harm or suicide were certainly kept quiet—in some instances only being discussed in the closed meetings of the GPC. In 1947, a patient's parents threatened legal action after she had a “misadventure” following her discharge from certificate and return from an Association holiday at Seaford. It is unclear what this “misadventure” was—it does not seem that the patient died or was injured—but the incident suggests an assumption that the Association should be responsible for the behaviour of even uncertified and discharged patients.¹¹⁷

Furthermore, the Association was forced to field occasional complaints from a less-than-understanding public—both before and after establishing a home in a given area. While Association staff and executives could see that negative public stigma was a deterrent to their efforts, Long has shown they usually did little to publicly combat such stigma—choosing instead to downplay the severity of their patients' conditions.¹¹⁸ At the beginning of 1951, it was reported

¹¹⁵ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, March 1, 1950.

¹¹⁶ Wellcome Library, SA/MAC/C.2/1/6, Council Minutes, February 27, 1953, May 28, 1957, May 27, 1958.

¹¹⁷ The Association's solicitor opined that there was no merit to the suit, and it appears to have gone no further. Wellcome Library, SA/MAC/C.3/2, GPC Minutes, January 29, 1947.

¹¹⁸ Long, *Destigmatising mental illness?*, 186.

that “Clovelly House” in Warlingham, Surrey, had complied with all “official technicalities,” but that concerned area residents were asking about the types of patients that would be housed there. Miss Russell was instructed to euphemistically affirm “that the house would only be used for patients suffering from a mild attack of nerves.” It later turned out that only one neighbour had actually complained.¹¹⁹

Local authority consent was vital in opening any new homes, and could easily be revoked due to public opposition. In 1950, plans for a potential replacement for Elmstead Lodge fell through after a neighbour objected, even though negotiations had been ongoing for seven months.¹²⁰ In 1956, the Medical Officer of Health for Manchester began working with the Association to find a new home either in Wales or North-Western England, and the two parties eventually settled on a decommissioned hotel in Grange-over-Sands, Cumbria. The Association applied for and received consent from the area Town Planning Committee, but quickly received a letter from a local Councillor “to the effect that great opposition had been shown by the residents.” 99 percent of the town’s inhabitants were reported to have signed a petition demanding that planning consent be revoked. The Councillor recommended two more isolated properties in the area, but the Association opted to break off the purchase negotiations. In another case, the GPC responded positively to a North Wales hospital looking to open a home in the area, but noted that cooperation hinged on the likelihood of Town Planning consent.¹²¹

By the end of the 1950s, community-based convalescence homes were less unusual than a decade prior, but the Association was still working to quell public concern. In a 1961 letter to the *Bexhill-on-Sea Observer*, Chairman King again minimized the “danger” posed by patients: he

¹¹⁹ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, January 10, 1951; Council Minutes, February 23, 1951.

¹²⁰ Wellcome Library, SA/MAC/B.1/62, *MACA Annual Report, 1950*, 4–5.

¹²¹ Wellcome Library, SA/MAC/C.3/4, GPC Minutes, November 6, December 4, 1957, March 5, 1958.

assured the community that a newly proposed hostel would be reserved mainly for elderly patients who were healthy, but lacked a social or familial support system or a place to live. “Their presence in a neighbourhood,” he wrote, “would normally pass quite unnoticed,” and he was also careful to emphasize that “[t]he Association exercises the greatest care in the selection of patients and any such in a hostel of this kind who might show symptoms of relapse or even unpleasant eccentricities would be forthwith returned to hospital.”¹²² This approach is reflected in the aforementioned records of individual convalescent homes, which show matrons and PSWs tending to favour more well-behaved patients.

As noted earlier, food quality was a common theme in complaints by patients and their families, and a peculiar incident in 1950 shows that these complaints could threaten to boil over into negative publicity. In 1950, a letter writer, who had been Honorary Secretary for the Charity Organisation Society in the London borough of Lewisham, complained to Miss Russell about a home in nearby Sutton. The home served a dual function, catering to ordinary boarders as well as convalescent patients. Apparently, the complainant’s friend had stayed there, and had told her that the regular guests were served much higher quality food than the patients, who received no milk or sugar. The friend had seen parcels being removed by the housekeeper of an adjacent home, and assumed that food was being sold or given away, rather than given to patients.¹²³

Russell responded, with some incredulity, that the house was visited regularly, with PSW visitors eating the same meals as patients. It could be difficult to keep enough sugar on hand, as matrons liked to make home-made preserves. She also asked for the name of the complainant’s friend, explaining that she could not begin an investigation based on third-hand information. The

¹²² Wellcome Library, SA/MAC/H.2/2, W.P. King, “Scope of hostel explained: Assurance to town,” *Bexhill-on-Sea Observer*, December 2, 1961.

¹²³ Wellcome Library, SA/MAC/F.1/4, “WL” to Miss Russell, February 19, 1950.

letter writer repeatedly refused: “[i]t is I, who as a member of the public and a social worker of many years’ experience, is asking for a report on the above Home, and for information as to who is responsible for it.” Russell contacted the home’s matron, who informed her that the parcels in question contained plants, and that the home’s sugar ration went mainly into preserves, puddings, and cakes—sugar was not freely available on the table since it was often unfairly divided, but patients could have it in their tea if they asked.¹²⁴

The letter writer was still not satisfied, and demanded a full report on the home—“its management, staff, numbers, fees, etc.” She had spoken directly with the home’s matron, and was perturbed that people considered “not ‘compos mentis’” needed to ask for sugar; she argued “[i]t is only because I have seen much of Homes and mental people, who are so particularly helpless that I brought it to your notice.” Russell and the matron were surprised, but Russell arranged to have additional social workers inspect the home—she let the matron know about the increased scrutiny, and noted that she would allow the letter writer “to come and see me at the office when she can interview every one of us.”¹²⁵ It is perhaps surprising that an organization as busy as the MACA would go to such lengths to appease a single agitated party—indeed, one who did not have a direct stake in the Association as either a client or donor. However, these lengths are an indication of Russell’s desire to avoid the public controversy that a well-connected interloper could undoubtedly drum up.

Private Donations

By the end of the 1940s, the majority of the Association’s income came from statutory payments—mainly individual maintenance payments and other operating grants. Nonetheless,

¹²⁴ Wellcome Library, SA/MAC/F.1/4, Miss Russell to “WL,” February 20, 1950, March 3, 1950; “WL” to Miss Russell, July 2, 1950; H.S. Russell, Note, July 4, 1950.

¹²⁵ Wellcome Library, SA/MAC/F.1/4, “WL” to Miss Russell, July 17, 1950; Miss Russell to “Miss D.,” July 27, 1950.

maintaining a strong donor base was a major priority, more for the publicity such efforts promised than the actual revenue produced.¹²⁶ In 1946, the Emergency Committee discussed some subscribers' concerns that the welfare state would negatively affect the Association's operations, and specifically that donations would be diverted to ends not previously agreed upon.¹²⁷ Subscribers liked to know precisely where their money was going, and an earlier informational pamphlet proudly proclaimed (with a touch of hyperbole), "it is extremely doubtful whether any charity in the world has ever managed to do so much work with so low an administrative expenditure."¹²⁸ As always, it was important for the Association to emphasize its independence from statutory authorities, but also how little change was expected with the inauguration of the NHS. Russell was instructed to inform subscribers that nationalization was unlikely to have much effect, "and in any event whatever happened [the Association] would be allowed to observe [its] commitments."¹²⁹

Charitable trusts were occasionally solicited for donations when substantial capital was needed, which granted them some clout in influencing Association goals and operations. The King's Fund provided the aforementioned £2500 for furniture at Elmstead, in addition to "a substantial annual subscription." In April 1948, King's Fund representatives inspected several private Association homes and offered a number of criticisms; GPC minutes record, "the matrons would be specially advised where our visitors felt there was a need." However, payments from the fund ceased after 1948, for reasons that are unclear. Nearly a decade later, Miss Russell and

¹²⁶ For example, the Association's revenues in 1950 included £43,427 from public authorities and private contributors, for services rendered. Donations were a much lower proportion of revenue, totalling £1215.9s.7d provided by 131 individual or institutional subscribers. The ratio was even more stark in 1959, when these numbers were, respectively, £69,156.15s.6d. and £1893.6s.4d. (individual donors were no longer listed in the annual reports). Wellcome Library, SA/MAC/B.1/62, *MACA Annual Report*, 1950, 14; SA/MAC/B.1/71, *MACA Annual Report*, 1959, 16.

¹²⁷ Wellcome Library, SA/MAC/C.3/1, Emergency Committee Minutes, January 22, 1946.

¹²⁸ Wellcome Library, SA/MAC/H.2/1, MACA Information sheet, n.d.

¹²⁹ Wellcome Library, SA/MAC/C.3/1, Emergency Committee Minutes, January 22, 1946.

Chairman King met with the Secretary of the Fund's Convalescent Homes Committee, and after an inspection of homes, the Association was placed back on the Fund's "approved list." The Fund then contributed £3000 toward the refurbishment of a home in Esher, for "older patients of both sexes."¹³⁰ In 1957, the Queen Adelaide's Fund purchased a home in Chiswick for the Association's use, and a representative of that organization was named to Council, joining co-opted members of other external bodies like local authorities and the Board of Control.¹³¹

Another common source of fundraising was the mental health flag day, during which volunteers would hand out small Union Jacks on street corners in return for donations.¹³² The Association did not participate in many of these events, as members apparently believed fundraising resources were better committed elsewhere. MACA volunteers did take part in 1957, at the invitation of the NAMH—they collected £91.4s.8d, but were entitled to only 25 percent.¹³³ The following year brought another invitation, and the GPC pushed for a 50 percent split—the NAMH balked, and so the MACA did not participate.¹³⁴ Both experiences seems to have soured members on the idea, but the NAMH again invited them to participate in 1960—the MACA agreed on the condition that they receive 40 percent of proceeds, and that the Ladies' Guild of Help organize the fundraiser.¹³⁵

Finally, in 1954, Miss Russell was instructed to apply to the BBC to have the Association appear on the charity appeal series, "The Week's Good Cause"—she was also asked to find "a

¹³⁰ Wellcome Library, SA/MAC/C.3/2, GPC Minutes, April 20, 1948; SA/MAC/C.2/1/6, Council Minutes, May 27, May 28, 1958.

¹³¹ Wellcome Library, SA/MAC/C.3/4, GPC Minutes, June 5, 1957; SA/MAC/C.2/1/6, Council Minutes, May 28, 1957.

¹³² NAMH participation is discussed in chapter 2. The Ex-Services Welfare Society also participated frequently, given the patriotic connotation.

¹³³ Wellcome Library, SA/MAC/C.3/4, GPC Minutes, August 7, 1957.

¹³⁴ Wellcome Library, SA/MAC/C.3/4, GPC Minutes, April 2, 1958.

¹³⁵ Wellcome Library, SA/MAC/C.2/1/6, Council Minutes, February 23, 1960.

suitable recovered patient who could be asked to make an appeal.”¹³⁶ It seems that no suitable patient was found (or willing), and Chairman Yellowlees went forward with the appeal in May of the following year. He called the Association “the first piece of organised psychiatric social service in this country,” and emphasized its independence and consequent need for stable funding:

We are an independent society, without Government support. We work in close, friendly co-operation with many local authorities who pay an agreed maintenance rate for each patient and decide when the patient should contribute a portion of this for himself. These rates are far below our costs of maintenance but, up to the limits of our resources, we respond to the ever increasing calls on our services...

The Association, Yellowlees continued, was operating over thirty homes, intended to “bridge the gap between discharge from hospital and full normal activity in the outside world.” He further emphasized “the personal befriending on which our founder laid such stress,” and which, in his opinion, differentiated the Association from other mental health groups.¹³⁷ A few months later the GPC heard that the appeal had directly produced over £1200 in donations.¹³⁸

Conclusion

Among the groups surveyed in this dissertation, MACA records contain the clearest view of everyday life within residential homes, even if this view is largely filtered through the perception of PSW visitors. These records reveal a wide variety of experience, for patients as well as matrons and other Association staff members. Generally, the environment and tone of a given home were determined by the attitude of the matron, and whether she was willing to take in and serve more behaviourally difficult patients—many were not, and this was considered perfectly legitimate by Association executives and PSW visitors. As with the NAMH, residential homes formed the

¹³⁶ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, August 4, 1954.

¹³⁷ Wellcome Library, SA/MAC/E.5/27, “Appeal on Behalf of the Mental After Care Association,” May 8, 1955.

¹³⁸ Wellcome Library, SA/MAC/C.3/3, GPC Minutes, August 3, 1955.

backbone of the Association's indispensability, and though some matrons faced reprimand or dismissal for major negligence, most were granted a great degree of latitude.

As evidenced by the trouble experienced in securing official recognition in the 1940s, the MACA faced a difficult task in establishing itself within the welfare order. Since its establishment in the late nineteenth century, it had been dedicated to one major function: providing homes through which convalescing mental hospital patients could gradually transition back into the community and the workplace. As such, the Association was fulfilling one of the eventual objectives of the welfare state—the integration of citizens and regeneration of the labour pool—long before that regime officially came into existence. While this remained a nominal goal into the postwar era, developments in psychiatry and psychopharmacology, as well as legislative changes emphasizing voluntary admission and community care, were beginning to render it obsolete.

To maintain its relevance, the Association adjusted in several ways. Despite briefly entertaining the idea of directly owning all of its own residential facilities, Association executives may have realized they held more value as intermediaries between overburdened local authorities and private matrons with the means to assist, but few options for advertising their services or securing far-flung patients. As a result, the Association continued contracting patients to private convalescence homes throughout the 1950s—as long as those homes adhered to certain standards. More importantly, the Association increasingly turned to elder and chronic care, which helped with overcrowding in NHS medical facilities. It thus turned from one welfare objective to another: the maintenance of non-working and potentially socially burdensome populations. It is notable that Yellowlees continued to focus on the Association's role in returning patients to "normal activity," since by 1955 this was a somewhat misleading assertion—the Association was largely focused on

long-term care, rather than convalescence. It indicates the ongoing importance of patients' reintegration, and the perceived promotional value of that activity.

Chapter 4

The Ex-Services Welfare Society

“My Society believes that a disabled man ought to feel that he is earning a living wage by making something that has commercial value.”
Everett Howard¹

Introduction

In this chapter, several elements of the Ex-Services Welfare Society’s (renamed “Ex-Services Mental Welfare Society” in 1957; referred to here either as the ESWS or “the Society”) treatment program and publicity efforts are examined, with a focus on the ways in which the Society maintained its independence and pre-eminence in the field of ex-Services mental health care. This introduction establishes the perceived importance of employment and vocational skills in treating trauma disorders, since the Society—more than the other organizations surveyed in this dissertation—focused on occupational training as a form of therapy.² In the period at hand, the Society operated two main treatment facilities at Leatherhead, Surrey, named for former Society Presidents. These were Milner House, opened in 1926 and named for former Conservative Member of Parliament Sir Frederick Milner, and Tyrwhitt House, opened in 1946 and named for Admiral of the Fleet Sir Reginald Tyrwhitt. Following psychiatric treatment and training in vocational skills, most patients were streamed into sheltered employment at Thermega Ltd., a private, Society-affiliated company opened in 1927, that manufactured patented electric blankets. In the late 1940s and 1950s, Thermega began experiencing financial difficulties which were solved

¹ Everett Howard, “Training the Disabled,” *The Times*, September 1, 1944, 8.

² The set of psychiatric disorders affecting traumatized veterans went by several names in the decades after the First World War: “shell shock,” “neurasthenia,” “war neuroses,” and “battle stress,” among others. Trauma disorders are now understood as a range of stressor-related reactions that can manifest in the aftermath of any traumatic event—not just warfare. The most well-known of these disorders is likely post-traumatic stress disorder (PTSD). “Trauma disorder” is the general term employed here, unless other terms are contextually appropriate. See *Diagnostic and Statistical Manual of Disorders*, 5th ed. (Arlington: American Psychiatric Association, 2013); Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 2005).

through government intervention—a rarity for the generally independent Society. The chapter also assesses the Society’s advocacy work—both at the levels of policy and individual assistance. Finally, the chapter examines the ways in which the Society maintained prestige and funding through close association with aristocratic, military, and upper-class figures.

Two months before the start of the Second World War, the enduring problem of veterans afflicted with psychological trauma was discussed at the fifth annual ESWS medical conference. The conference was attended by several government representatives with close ties to the Society, and experienced in the challenges presented by “war neuroses.” The Conservative Minister of Works, Herwald Ramsbotham, asserted “that ex-Service men suffering from nervous disorders were not only demonstrably the most difficult cases, but also the most pathetic and most tragic.” However, he also noted that Milner House, the Society’s industrial training facility, “was a highly successful and most useful work.” Ministry of Pensions Secretary Sir Adair Hore further praised the Society for the sense of security it provided at the Leatherhead “colony,” which he considered essential in treatment for “neurasthenia.” It was predicted that in any upcoming conflict, Society expertise would be crucial in treating psychological casualties more efficiently than in the Great War.³

The challenges facing demobilized ex-Service members reintegrating into civilian society were greatly exacerbated by the experience of trauma. The shell shock epidemic of the First World War profoundly destabilized conceptions of courage and British “character,” and seemed to confirm the warnings of social commentators who fixated on hereditary weakness and national degeneration.⁴ In particular, shell shock sufferers were thought to experience a profound rupture

³ “Nervous Disorders from War Service,” *The Times*, July 8, 1939, 18.

⁴ See Anthony Babington, *Shell-Shock: A History of the Changing Attitudes to War Neurosis* (London: Leo Cooper, 1997), 51; Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Hove: Psychology Press, 2005), 52.

in their sense of masculinity, which early treatments were designed to reinscribe.⁵ Within military medicine, psychiatrists experienced suspicion and disdain from the more established branches—neurologists, surgeons, and general practitioners in particular.⁶ In 1922, a War Office Committee of Enquiry concluded that hereditary predisposition played a major role in susceptibility to shell shock, thereby blaming ex-servicemen themselves for the disorder, rather than the novel conditions of industrialized warfare.⁷ As the nation went back to war in 1939, the State and medical profession were somewhat more prepared to treat and provide for traumatized Service members. However, many of the previous war’s lessons had been allowed to fade.

While attitudes toward combat trauma improved somewhat in the interwar years, negative stigma still permeated medicine, the military, government ministries, and the wider culture. Military psychiatry had regressed since the Great War, as doctors who had gained first-hand knowledge of shell shock moved into less demanding and more highly regarded private positions. Alan Allport notes that many Army doctors “remained bewildered by psychiatric problems,” and that treatment “was often so eccentrically practised as to verge on the brutal.”⁸ Officials including Army medical services director Major-General E. Philips and Prime Minister Winston Churchill were suspicious of psychiatric medicine, and the Royal Air Force labelled traumatized air crew as “LMF”—Lacking Moral Fibre.⁹

⁵ See Lisa L. Diedrich, “Hysterical Men: Shell-shock and the Destabilisation of Masculinity,” in *Vital Signs: Feminist Reconfigurations of the Bio/Logical Body*, eds. Margrit Shildrick and Janet Price (Edinburgh: Edinburgh University Press, 1998); Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830–1980* (New York: Pantheon, 1985), 176–178; Michael Roper, “Between Manliness and Masculinity: The ‘War Generation’ and the Psychology of Fear in Britain, 1914–1950,” *Journal of British Studies* 44, no. 2 (2005): 343–362.

⁶ Jones and Wessely, *Shell Shock to PTSD*, 44, 51.

⁷ See Ted Bogacz, “War Neurosis and Cultural Change in England, 1914–22: The Work of the War Office Committee of Enquiry into ‘Shell-Shock’,” *Journal of Contemporary History* 24 (1989): 227–256.

⁸ Alan Allport, *Demobbed: Coming Home After the Second World War* (New Haven: Yale University Press, 2009), 194–196. In the First World War, as an example, Dr. Lewis Yealland “cured” traumatized soldiers of mutism with cigarette burns to the tongue, hot plates on the back of the throat, and electric shocks. See also Showalter, *The Female Malady*, 176.

⁹ Allport, *Demobbed*, 194; Martin Francis, *The Flyer: British Culture and the Royal Air Force, 1939–1945* (Oxford: Oxford University Press, 2009), 125.

Regardless of how the condition was viewed, one of the most pressing concerns was what could be done for and with ex-Service members discharged for war neuroses. What responsibility would the State bear for their treatment? Would they be eligible for special pensions? Could they be returned to employment? At a 1943 ESWS luncheon, Conservative Minister of Pensions Sir Walter Womersley claimed, “[t]he worst type of ex-Service man was he who through disability had an inferiority complex and felt that he could no longer take his place among his fellow citizens.”¹⁰ Two months later, at the annual Society conference, Womersley asserted,

... while the Ministry were ready to grant pensions to men whose mental state made them totally unfit for employment, they were more concerned, in the men’s own interests, with the treatment and after-care of those who could wholly or partially be restored to health and placed in employment.¹¹

“Resettlement” was considered successful when a discharged serviceman was returned to gainful employment, and it was assumed that treatment was not needed beyond that time. As evidenced by Womersley’s remarks, the Ministry of Pensions was less concerned with those considered completely unemployable (it is unclear whether Womersley thought these cases could be helped through psychiatric treatment or work therapy).

Following the First World War, disability pensions were cast as a significant public burden, and the 1922 War Office Committee was convened in direct response to the number of veterans receiving disability benefits.¹² By the end of the Second World War, around 30,000 pensions had been granted to ex-Service members displaying psychoneurotic problems, but this was less than half the number of the previous war. In 1944, Dr. J.F.E. Prideaux, psychiatric advisor to the Ministry of Pensions, argued that “[t]here was no doubt that the pension was the worst kind of ‘therapeutic instrument’, as anyone who had treated side by side the serving soldier and the

¹⁰ “Aiding Disabled Service Men,” *The Times*, January 8, 1943, 2.

¹¹ “Mental Illness Due To The War,” *The Times*, March 12, 1943, 2.

¹² Bogacz, “War Neurosis,” 227.

pensioner for the same kind of ailment would agree.”¹³ As Allport puts it, “[w]hat happened to these men after their return to Civvy Street was not ... a particular concern of the War Office, so long as they weren’t a drain on the public purse.” By linking trauma to individual weakness and pre-existing conditions in public and medical discourse—as in 1922—the War Office and the Ministry of Pensions justified the denial of thousands of claims.¹⁴

Some help did exist in the form of state-run employment resettlement programs and residential in-patient facilities. These were generally targeted at narrow groups—particularly repatriated prisoners of war (POWs). As noted in chapters 2 and 3, the National Association for Mental Health and Mental After Care Association were contracted to run an ex-Services resettlement scheme, which was eventually extended to include civilians. However, such programs did not have a wide reach; in 1946 it was estimated that only five percent of veterans discharged on grounds of combat trauma had received follow-up care. An army psychiatrist further estimated that 35 percent of the 12,000 casualties he had treated for trauma disorders were suffering chronic mental illness.¹⁵

The same year, two reports emerged detailing the resettlement problems facing ex-Service members—both in terms of social relations and employment. In both reports, secure employment and occupational satisfaction were presented as major indicators of successful readjustment into civilian life. The first report, by psychiatrist Dr. Eric Guttman and Psychiatric Social Worker (PSW) Elsie Thomas, was commissioned by the Ministry of Health in 1943 to determine the effectiveness of Emergency Medical Service (EMS) neuroses centres. Guttman and Thomas studied a sample of 382 men invalided for a variety of psychological issues, who all displayed

¹³ “Neurosis After War Service: Rehabilitation and Resettlement,” *The British Medical Journal* 1, no. 4338 (1944): 292.

¹⁴ Allport, *Demobbed*, 196.

¹⁵ *Ibid.*, 208–209.

difficulty readjusting to social and domestic life.¹⁶ Only 47 men were receiving pensions, with 38 of those having been awarded for psychiatric problems.¹⁷

Emphasizing the neuroses centres' objective of "occupational resettlement," Guttman and Thomas found that the majority of their subjects had been able to find work, whether by returning to previous employers or their own businesses, obtaining work through friends or family, visiting local labour exchanges, or being directed into specific wartime industries through an Essential Works Order passed in 1941. The government had set up a vocational training scheme, but only sixteen of the surveyed men had been offered training, with nine accepting the opportunity. Sympathetic private employers were particularly helpful—Guttman and Thomas noted that in 32 cases, "special allowances" made by employers were "essential for the man's adjustment." For the most part, Guttman and Thomas's subjects appreciated any help they received, and many "made no adverse comment and seem to have been satisfied." There were some complaints about the Essential Works Order—mainly that it forced men into positions which were unlikely to be needed after the war.¹⁸

Guttman and Thomas's conclusions further strengthened the importance of employment as a metric of postwar readjustment. They wrote,

A history of neurosis or psychosis, or of invalidism in the family, a personal history of neurotic traits, nervous breakdowns, or physical ill-health, have little bearing on the subsequent readjustment. The one fact that seems of definite prognostic value is the past work record.

¹⁶ Eric Guttman and Elsie Thomas, *A Report on the Re-adjustment in Civil Life of Soldiers Discharged from the Army on Account of Neurosis* (London: HMSO, 1946), 2–3.

¹⁷ Guttman and Thomas, *A Report on the Re-adjustment in Civil Life of Soldiers*, 23.

¹⁸ The Essential Works Order prohibited workers in occupations deemed essential to the war effort—munitions, mining, and agriculture—from quitting or engaging in collective action, and also prevented employers from sacking workers. Guttman and Thomas, *A Report on the Re-adjustment in Civil Life of Soldiers*, 24–26.

For recovery, then, the ability to work was thought to be crucial—even more so than a history of mental illness. Guttman and Thomas noted that fifteen months after discharge, many of their subjects found it difficult to return to civilian occupations, and were frequently absent due to sickness. They directly connected this difficulty to personal and familial readjustment, writing, “[m]oreover, the men feel unhappy in their private lives; they feel self-conscious, and they are liable to social frictions.”¹⁹

The second report was authored by Brigadier Lionel Bootle-Wilbraham, an Army officer who helped to administer the government’s Civil Resettlement Units (CRUs)—residential facilities designed to help repatriated prisoners of war (POWs) readjust to civilian life. He noted a number of problems common in ex-POWs, but asserted that these could also be experienced by any veteran, due to “long absence from home.” These problems included moodiness, disillusionment, “ignorance of conditions at home,” and employment difficulties. He wrote,

The objective of civil resettlement, then, was to give a period of temporary security, during which a man [could] experiment in suiting himself to a job and recover that independence of mind and thought necessary to the conduct of his life as a civilian; to make him assume the responsibility of his own life.

To this end, in 1945 the first official CRU was set up at Hatfield House in Hertfordshire—eventually twenty units would cover the whole of the United Kingdom.²⁰

CRUs were designed to house 240 men at a time, and employed doctors, dentists, Ministry of Labour liaisons, social workers, and physical therapists. Families were not housed in the units, but organizers used census data to ensure that they were relatively close to patients’ homes, thereby facilitating family visitation.²¹ The units all contained workshops, which, Bootle-Wilbraham argued, satisfied two crucial needs:

¹⁹ Guttman and Thomas, *A Report on the Re-adjustment in Civil Life of Soldiers*, 37, 42.

²⁰ L. Bootle-Wilbraham, “Civil Resettlement of Ex-Prisoners of War,” *Journal of Mental Health* 6 (1946): 39–40.

²¹ Alice Victoria White, “From the Science of Selection to Psychologising Civvy Street: The Tavistock Group, 1939–

[f]irst of all the need of the man to do something creative with his hands; and secondly, they give a chance to those men who are tradesmen to handle their tools again and to regain some of the confidence which is necessary to them before they take on their old job.

However, the CRUs did not employ full-time psychiatrists for medical treatment, and “clinical cases” were sent to hospital.²²

CRUs were dedicated primarily to vocational skills and workplace reintegration, with psychiatry cast as something of an afterthought. The idea that a man’s years in a POW camp had rendered him out of touch with the job market was evidently more palatable than the idea that the experience of war had driven him mad. Public advertising for the CRUs downplayed the psychiatric side of treatment, and an article in the *British Journal of Industrial Medicine* asserted, “[i]t would be a mistake to assume ... that every ex-prisoner of war is a potential patient for the psychiatrist, or that the majority of returning servicemen are unhappy or depressed by civil life.”²³ Regardless, once men entered the programs, the stigma could gradually wear away—one CRU recorded that in the first three to four months of operations, requests for private psychiatric visits rose from five percent to sixty percent of cases.²⁴ The units were closed in June 1946, with a War Office official tellingly pointing out that “the majority of chaps were back to work.”²⁵ The CRUs were meant to psychologically rehabilitate soldiers only to the point that they were able to re-enter the workforce—beyond this, extended treatment was thought to be unnecessary.

This, then, was the state of provision for ex-Service members with trauma disorders in the late 1940s, and the environment in which the ESWS vied for a stable jurisdiction in the new welfare

1948 (PhD diss., University of Kent, 2016), 188.

²² L. Bootle-Wilbraham, “Civil Resettlement of Ex-Prisoners of War,” 40–42.

²³ Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge: Harvard University Press, 2003), 317; “Resettlement and Industrial Medicine,” *British Journal of Industrial Medicine* 2, no. 4 (1945): 222

²⁴ “Psychiatric Problems of Repatriated Prisoners,” *The British Medical Journal* 1, no. 4445 (March 16, 1946): 403.

²⁵ Quoted in Shephard, *A War of Nerves*, 322.

state. As in the First World War, treatments were still geared toward the reinscription of “lost” masculinity, but conceptions of masculinity had shifted drastically in the interwar years. An emphasis on domesticity and emotional reserve as markers of proper masculinity emerged following the turmoil of the First World War, along with the particular importance of work and working-class identity.²⁶ In the 1920s, the Society disassociated itself from the wider issue of lunacy reform, and began focusing instead on veterans’ social and workplace reintegration.²⁷ This shift meant that the Society’s approach fit well with the employment-oriented treatments dominating the field after the Second World War, and it was consequently able to expand operations in the 1940s and 1950s.

The first meeting of what would become the ESWS was held on November 1, 1918, and the Society was registered under the War Charities Act the following year. Offices were established near Hyde Park in 1920, and the Society’s first treatment home opened in Putney in 1921.²⁸ At the time, the Society was the only charity specifically devoted to trauma casualties and ex-Service members “who [fell] foul of official welfare provision.”²⁹ The Society fell into debt early on, but upon his hiring in 1922, long-time General Secretary Everett Howard set about putting things right.³⁰ By the early 1940s, the Society had raised over £800,000, and counted

²⁶ See Sally Alexander, “Men’s Fears and Women’s Work: Responses to Unemployment in London Between the Wars,” *Gender & History* 12, no. 2 (2000): 401–425; Sonya Rose, *Which People’s War?: National Identity and Citizenship in Wartime Britain, 1939–1945* (Oxford: Oxford University Press, 2003), ch. 5.

²⁷ Fiona Reid, *Broken Men: Shell Shock, Treatment and Recovery in Britain, 1914–1930* (London: Continuum, 2010), 127.

²⁸ The Wellcome Library, London, UK, Manuscripts, MS.7913/7, Frank W. Lipscomb, “The Ex-Services Mental Welfare Society,” in *The Expanding Field of Mental Health in England and Wales, 1918–1968*, eds. Doris Odlum and Alexander Walk (unpublished manuscript, 1968), 1.

²⁹ Reid, *Broken Men*, 100.

³⁰ See Fig. 4.2. There is not a great deal of biographical material available on Howard. Though he served as a Major in the Army, he tended not to advertise his rank. Unlike others among the Society leadership—generally staid, Conservative military men—Howard was “not a refined man in the traditional mould.” As will be seen below, he was often eager to challenge what he saw as inefficiencies and injustices in the nation’s ex-Services resettlement system. See Peter Barham, *Forgotten Lunatics of the Great War* (New Haven: Yale University Press, 2004), 295.

70,000 annual subscribers.³¹ The Society's unique function was acknowledged both within and outside of the United Kingdom, and donations frequently came in from the wider Commonwealth, and occasionally from other sources—in 1950 a £2,500 donation was received from the British War Relief Society of the United States.³²

While government allowances and grants for training and treatment were gladly accepted, the Society tended to de-emphasize any reliance on the state, preferring instead to cultivate funding and patronage from the upper echelons of society. Tellingly, in executive meetings held close to the “Appointed Day” of July 5, 1948, there was no recorded discussion of the newly established National Health Service, or indeed, of any component of the nascent Welfare State. There seems to have been no acknowledgment that these momentous shifts would change the Society's operations in any way.³³ The Society's 1949 Annual Report affirmed, “[t]he transfer to the State of social and welfare Services, which owed their origin to voluntary enterprise and public spirit, has not done away with the need for maintaining, developing, and widening the scope of Independent Organisations.”³⁴ It was not until the end of the 1950s—when the Mental Health Act 1959 loomed—that the Society's President, Admiral of the Fleet Sir Arthur Power, “very tentatively” suggested “that [the Society] might aid the Government by placing at its disposal all the expert advice and knowledge which [it was] fortunately in a position to bestow.”³⁵

Rehabilitation and Sheltered Employment

This section examines the Society's main operations: the provision of accommodation, medical and psychological rehabilitation services, and sheltered employment for traumatized ex-

³¹ “Aiding Disabled Service Men,” 2.

³² “Ex-Services Welfare Society,” *The Times*, March 2, 1950, 9.

³³ Combat Stress Archive, Leatherhead, Surrey, UK, Ex-Services Welfare Society Executive Committee [EC] Minutes, July 8, September 2, 1948.

³⁴ Combat Stress Archive, *ESWS Annual Report, 1949*, 3.

³⁵ Combat Stress Archive, Annual General Meeting [AGM] Minutes, 1959.

Service members. Treatment was mainly administered mainly through three ventures, all located in the Leatherhead area: Milner House, Tyrwhitt House, and Thermega Ltd. The Society did hold other properties—by the 1950s it owned a 400-acre estate in Herefordshire donated for use as a treatment home, as well as a home for aged ex-Servicemen at Lower Kingswood, Surrey—but the majority of its patients were streamed through these three entities.³⁶

Beth Linker has shown how an emphasis on work and employability permeated rehabilitative military medicine in the period. For many middle-class, white Protestant families, “work formed the core of a moral life,” and by the First World War, work was considered “both the means and the end of recovery.” Rehabilitation was intended to restore men as “producers of capital”—thereby restoring their masculinity. While Linker focuses mainly on the United States, she notes that the medical reformers and orthopedic surgeons involved in military rehabilitation obtained much of their knowledge from Britain, France, and Germany. They generally believed “[d]isability could be cured ... only when the patient became employable.”³⁷

The treatment program developed over the Society’s first five decades of operation relied heavily on the principles of occupational therapy, which were first elucidated in 1922 by the psychiatrist Dr. Adolf Meyer, practicing at Johns Hopkins University in Baltimore. Meyer argued that the role of the physician was not merely to diagnose and prescribe, but to recognize the fundamental links between performance, environment, and happiness, and to promote “opportunities to work, opportunities to do and to plan and create, and to learn to use material.”³⁸ This was not an entirely novel approach: Susan Lamb shows that “[m]anual occupation was an old

³⁶ “400-Acres Estate for the Disabled,” *The Daily Mail*, January 8, 1943, 10; “New Home for Aged Ex-Service Men,” *The Times*, October 1, 1954, 10.

³⁷ Beth Linker, *War’s Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011), 3–4, 37.

³⁸ Adolf Meyer, “The Philosophy of Occupation Therapy,” *Archives of Occupational Therapy* 1 (1922): 7.

form of treatment that had long capitalized on the therapeutic dividends of work,” and that this therapeutic approach was revitalized at the beginning of the twentieth century in both Europe and North America.³⁹

Lamb notes that at the time, Meyer was “the most recognizable, authoritative, and influential psychiatrist in the United States,” and that over ensuing decades, “a Meyerian diaspora transported his ideas and practices throughout the United States and beyond to Canada, Britain, and parts of Asia and Europe.”⁴⁰ Accordingly, though separated by an ocean, Meyer became a source of guidance and inspiration for several British psychiatrists, including Edward Mapother, medical superintendent of the Maudsley Hospital (one of London’s preeminent psychiatric institutions) and consultant psychiatrist to the Society until his death in 1940.⁴¹

Milner and Tyrwhitt Houses

Prior to 1946, patients generally underwent a three-month training period at Milner House, during which they learned to manufacture the appliances produced by Thermega Ltd—mainly electric blankets and refurbished washboilers. Patients generally did not have to live separately from their families, as along with a residential hostel for single men, the grounds of Milner House contained sixteen cottages “reserved for married couples and families.”⁴² Following training, patients would either be taken on as waged Thermega employees, or discharged to seek regular employment (with assistance in the job search). While Milner House provided functional skills, it was thought that something more akin to a convalescent home was needed. Thus, Tyrwhitt House,

³⁹ S.D. Lamb, *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry* (Baltimore: Johns Hopkins University Press, 2014), 170.

⁴⁰ Lamb, *Pathologist of the Mind*, 1–2.

⁴¹ Shephard, *A War of Nerves*, 162. See also Edgar Jones, “Aubrey Lewis, Edward Mapother and the Maudsley,” in *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s*, eds. Katherine Angel, Edgar Jones and Michael Neve (London: The Wellcome Trust Centre for the History of Medicine at UCL, 2003).

⁴² Combat Stress Archive, *ESWS Annual Report, 1949*, 5.

a “curative home,” was opened in 1946. The opening of Tyrwhitt House was a direct response to a spike in psychoneuroses cases precipitated by the Second World War, and the facility was intended “to bridge the gap between the mental hospital and the rehabilitation centre [Milner House], and to be able to take in patients direct from their homes, if treatment in a mental hospital was not necessary.”⁴³

In this way, the Society provided an alternative path to the fraught process of mental hospital admission and certification—made more complicated for ex-Service members by the need to navigate bureaucratic pension and allowance systems.⁴⁴ At the opening ceremony for Tyrwhitt House, Everett Howard gave a speech extolling the Society’s accomplishments: it was the only one of its kind in the whole Commonwealth, and since its founding, the Society had helped more than 31,000 people. Tyrwhitt House would add fifty spaces to the Society’s existing capacity, and would cater to all ex-Service members, as well as those who had served in the Civil Defense Service and the Auxiliary Fire Service.⁴⁵

From 1946 on, clients were first admitted to Tyrwhitt House under the supervision of a psychiatric consultant and mental health nurses. If needed, any physical health problems would be addressed, including optical, dental, and nutritional treatment. Occupational therapy was emphasized, and was “designed to have some resemblance to normal working conditions.” Activities included gardening, maintenance work, furniture-making, and manufacturing packing materials that would then be used at Thermega.⁴⁶ From this stage, under the direction of the psychiatric consultant, patients deemed suitable would be provided with appropriate clothing and tools, and either transferred on to Milner House and Thermega, or helped to find unsheltered

⁴³ Lipscomb, “The Ex-Services Mental Welfare Society,” 3.

⁴⁴ Combat Stress Archive, *ESWS Annual Report*, 1957, 10.

⁴⁵ “Tyrwhitt House,” *The Manchester Guardian*, September 18, 1946,.

⁴⁶ See Fig. 4.1.

employment.⁴⁷ The number of patients treated in a given year at Tyrwhitt House ranged from 130 to 150, and they tended to stay on average from six to eight weeks. By 1956, 1300 patients had been through the program.⁴⁸



Fig 4.1: ESWS Occupational Therapy department, c. 1950s.
Combat Stress Archive

The Society's role in helping ex-Service members reintegrate into society was frequently referenced in promotional materials. The 1958 annual report asserted,

...many cases by their very nature are men without ties, who are inclined to wander from job to job and place to place, with no family doctor to understand their needs and difficulties. Yet such cases often regain hope and self-respect after treatment at Tyrwhitt House, finding jobs where they can settle down and become useful members of society.⁴⁹

In evidence provided to the Committee of Inquiry on the Rehabilitation of Disabled Persons (the Piercy Committee) in the 1950s, the Society noted it was difficult to assess the program's overall

⁴⁷ The National Archives, London, UK, Ministry of Labour Records, LAB 20/863, Committee of Inquiry on the Rehabilitation of Disabled Persons, "Written Evidence Submitted by the Ex-Services Welfare Society," 1–2.

⁴⁸ Combat Stress Archive, *ESWS Annual Report, 1956*, 4.

⁴⁹ Combat Stress Archive, *ESWS Annual Report, 1958*, 9. The reference to the family doctor in the treatment of psychiatric disorder is reflective of the period, during which "the family doctor moved into the front line of psychiatric surveillance." See Rhodri Hayward, *The Transformation of Psyche in British Primary Care, 1880–1970* (London: Bloomsbury Academic, 2014), 82.

success rate, but affirmed, “there is not a doubt at all that the great majority of trainees enjoy very much more stable lives thereafter, and a considerable portion make an excellent readjustment.”⁵⁰ Outside supporters also noted this crucial role. In July 1944, Sir Walter Womersley lauded the work done at Milner House, stating, “they have taken on the most difficult job of all, that of dealing with nervous disorders ... They teach these men useful occupations, and that does more than anything else to restore their health. They are doing a very fine job of work.”⁵¹ A 1946 *Manchester Guardian* article enthused, “hundreds of men have worked their way back into industrial life” at Milner House.⁵²

Thermega, Ltd.

During and after the Second World War, it was generally acknowledged that disability—whether physical or mental—constituted a major disadvantage in the employment market. In 1945, Minister of Labour George Isaacs asserted that “[t]he term ‘disabled person’ includes persons suffering from any disability, including neurosis, which substantially handicaps them in getting or keeping employment or work.”⁵³ From the late 1920s, the Society’s ultimate goal in treatment and occupational training was to enable clients to overcome this disadvantage by entering sheltered employment at a unique entity—Thermega Ltd. That an entire business was established, emphasizing vocational skills and commercial productivity over more medicalized treatment (indeed, the work was considered a suitable stand-in for treatment), further reflects the importance of employment as a marker of active citizenship and good health in British society, even before the birth of the welfare state.

⁵⁰ The National Archives, LAB 20/863, Committee of Inquiry on the Rehabilitation of Disabled Persons, “Written Evidence Submitted by the Ex-Services Welfare Society,” 2–3.

⁵¹ 401 Parl. Deb. H.C. (5th ser.) (July 7, 1944) cols. 1441–1540.

⁵² “Tyrwhitt House,” *The Manchester Guardian*, September 18, 1946.

⁵³ 415 Parl. Deb. H.C. (5th ser.) (November 8, 1945), cols. 1590–2W.

In 1927, Everett Howard toured the European continent in search of a suitable, patented product which could be manufactured by Society patients. He settled on electric blankets, and the new company was swiftly set up on the grounds of Milner House, manufacturing the first such blankets produced in England.⁵⁴ Thermega's memorandum of association listed the following objectives:

To provide, establish, support and maintain ... training and other centres for discharged or disabled officers and men of Navy, Army, Air Force and other allied services, and civilian disabled and subnormal workers, where they may be trained and/or employed.⁵⁵

Along with electric blankets, the company produced other electrical components, and also sold refurbished washboilers. Dr. Mapother, though generally wary of similar Industrial Centres due to a lack of trained medical officers, nonetheless visited Thermega several times and "paid generous tribute to the successful experiment."⁵⁶

Charting Thermega's establishment in the 1920s, Fiona Reid argues that the company "involved a recognition that mentally wounded ex-servicemen could not compete in the marketplace, alongside a refusal to withdraw those men from the world of respectable, productive work." The company's existence constituted an acknowledgement of the centrality of work to treatment and recovery. Productivity and rehabilitation were explicitly linked, and employees were exhorted to think of themselves as workers, rather than patients.⁵⁷ As a rough guide to the number of Thermega employees at any given time, at the end of the period at hand (1959), the company employed 41 former Tyrwhitt and Milner patients, in addition to 61 civilian employees.⁵⁸

⁵⁴ Lipscomb, "The Ex-Services Mental Welfare Society," 2.

⁵⁵ The National Archives, LAB 20/693, "Memorandum of Association of Thermega Limited," 1927, 2.

⁵⁶ The National Archives, LAB 20/693, Everett Howard, "Report; Introduction," December, 1944.

⁵⁷ Reid, *Broken Men*, 159.

⁵⁸ Combat Stress Archive, *ESWS Annual Report, 1959*, 9. See below for a discussion of civilian hiring.

From the outset, Thermega was meant to be run as a business, in contrast to prior work schemes that—though involving disabled ex-Service members’ labour—tended to rely on charity and customers’ goodwill to turn a profit. In particular, Thermega Chairman Sir Ralph Millbourn was keen to show that work therapy had moved beyond the “hobby stage,” and could be incorporated into a viable business.⁵⁹ While the company downplayed its voluntarist connection, the ESWS still made sure to emphasize the relief it offered to overburdened statutory authorities and labour exchanges. As noted, employees were generally introduced through the Society’s rehabilitation program, but could also be directly referred by the Ministry of Labour, the Ministry of Pensions, or other voluntary organizations. Company Directors worked without compensation, and all profits were reinvested in the business or diverted to the ESWS. All managers were trained in “the ‘handling’ of the disabled employees,” and worked closely with local authority Disablement Rehabilitation Officers (DROs) in accepting and training clients.⁶⁰

Thermega was financially successful through its first two decades, and in 1944 Howard proudly announced that the company was entirely “self-supporting,” with no government grants required to prop it up.⁶¹ While other enterprises set up to employ people with disabilities did exist, they tended to be directly run—or at least subsidized—by the government. The most visible of these was the Disabled Persons Employment Corporation (DPEC), established in 1945 and later renamed Remploy.⁶² However, Thermega’s profits waned in the postwar years as the company

⁵⁹ Reid, *Broken Men*, 159.

⁶⁰ The National Archives, LAB 20/863, Committee of Inquiry on the Rehabilitation of Disabled Persons, “Written Evidence Submitted by the Ex-Services Welfare Society,” 3.

⁶¹ The National Archives, LAB 20/693, Everett Howard, “Report; Introduction,” December 1944.

⁶² For a complete history of Remploy, see Andrew Holroyd, “Sheltered Employment and Disability in the Classic Welfare State: Remploy c. 1944–1979” (PhD diss., University of Huddersfield, 2019). The DPEC was created by the *Disabled Persons (Employment) Act 1944*, which also established a quota system for regular employers. However, Mark Hyde argues that in the time since, quotas have rarely been met, and so people with disabilities have been largely forced into sheltered employment. See Mark Hyde, “Sheltered and Supported Employment in the 1990s: the experiences of disabled workers in the UK,” *Disability and Society* 13, no. 2 (1998): 200.

experienced difficulty on several fronts, and increasingly relied on government payments to maintain operations. It is perhaps ironic that a private corporation became the undertaking which would bring the ESWS closest to the sphere of public funding and the influence of statutory authorities.

Immediately after the war, Thermega began having trouble finding an adequate number of trainees. The company had not qualified for training allowances—reimbursements paid to industry trainees for travel and other incidentals—and so potential candidates were streaming into other, qualifying training programs. As a result, several non-disabled civilians were hired to keep up with nationwide demand for electric blankets. This was a last resort for a company whose identity rested on assisting ex-Service members, but civilian labour would remain crucial in keeping up with demand over the ensuing decade. Thermega Secretary R.E. Mackenzie wrote about the problem to the Ministry of Labour, and a Ministry representative recommended that the company apply to be recognized as a training centre under the government’s system of sheltered industry, established in Section 15 of the *Disabled Persons (Employment) Act 1944*.⁶³ Mackenzie promptly did so, and Thermega was approved for inclusion—in August 1945, the Ministry of Labour began referring “suitable severely disabled persons.”⁶⁴

Further difficulties stemmed, somewhat counterintuitively, from the popularity of Thermega’s products. Overwhelmed by orders to its relatively small Leatherhead factory, in 1946 the company contracted out the manufacture of electric blankets to Glasgow-based Haven

⁶³ The National Archives, LAB 20/693, R.E. Mackenzie to E. Harrison, February 2, 1945; Norah Hill to Mr. Peterson, March 29, 1945. This section stated: “Facilities may be provided ... for enabling persons registered as handicapped by disablement ... to obtain employment or to undertake such work under special conditions ... The nature of the facilities to be provided under this section shall be such as the Minister may determine, and the Minister may with the approval of the Treasury make arrangements for the provision thereof by any of one or more companies which may be formed for that purpose and incorporated under the Companies Act, 1929...” Thermega clearly met these criteria. See *Disabled Persons (Employment) Act 1944*, 7 & 8 Geo. 6, c. 10, § 15.

⁶⁴ The National Archives, LAB 20/693, R.E. Mackenzie to T.H. Patterson, April 13, 1945; Ministry of Labour to R.E. Mackenzie, August 2, 1945.

Products, another company that had been established specifically to employ people with disabilities. A similar arrangement with the DPEC was agreed upon in 1947, but a number of delays meant that company was unable to begin production in time to meet winter demand, and as a result, Thermega was left with 9,000 unsellable electric pads. At the same time, the Ministry of Supply had issued permission to several other companies to produce similar goods. Thermega had previously enjoyed patent protection for its products, and the British Electrical Manufacturers Association protested on its behalf, but ultimately the company was forced to contend with a decreased market share.⁶⁵

After five years operating under the Ministry of Labour's sheltered industry scheme, Mackenzie was forced to inquire about deficiency grants, which were statutory payments directed to qualifying companies operating at a loss. He also asked about training grants—different from training allowances in that they were awarded directly to the employer—arguing, “the time of skilled Operatives, as well as that of Supervisors, is taken up in training these men; in addition a certain amount of material is used up during the period of training.” From the outset, it seems that the Ministry had been prepared to offer a hard refusal on additional funding outside of the original agreements. In 1945, a Ministry of Labour memorandum had outlined the terms under which Thermega could apply for recognition, and noted, “[t]hey will not apply for a Training Grant for Employer as the additional trainees will not add appreciably to the expense of instruction ... Neither will they apply for a Deficiency Grant.” Given the circumstances, however, the alternative was to shutter the company altogether—it was evidently important that Thermega be kept running, as the Ministry committed to a training grant of 15s. per week per trainee.⁶⁶

⁶⁵ Combat Stress Archive, EC Minutes, July 11, 1946, March 4, 1947, May 6, 1948.

⁶⁶ The National Archives, LAB 20/693, Norah Hill to Mr. Peterson, March 29, 1945; Ministry of Labour to R.E. Mackenzie, November 15, 1950; R.E. Mackenzie to Ministry of Labour, November 21, 1950; Ministry of Labour Memorandum, November 28, 1950.

Thermega continued to experience trouble into the 1950s. The Society's 1956 annual report contained a detailed description of the company's problems, largely blaming economic conditions and noting that the employees' "sub-proficiency standards" made the company uncompetitive. This meant the company's profit margin was "inadequate to enable it to re-equip and expand in order to cope with the larger number of the more severely handicapped men from the 1939/45 War."⁶⁷ The following year's annual report noted a grant of £7,500 transferred from the Society to Thermega, intended "to assist—in exceptionally difficult trading conditions—in the carrying on of its activities."⁶⁸

However, the decade also saw a general increase in governmental interest and support—in addition to the provision of training allowances and grants—which allowed Thermega to improve its facilities and generate publicity. In 1951, the Ministry of Labour supported a proposal to add a covered area between two existing workshops, after a Ministry Technical Officer noted that the work floors were congested and lacking storage space.⁶⁹ The Ministry of Labour and the Ministry of Works also provided the company with new canteen equipment and telephone installation—ESWS Appeals Secretary Commander Frank Lipscomb later wrote that these improvements were made "so that men passing through would have the experience of modern factory conditions."⁷⁰ A Ministry of Labour representative also reached out to the Ministry of Supply to see if it had any need for Thermega products. In 1954 a representative of the Ministry of Labour's Manchester office circulated the Society's "bona fides" to area DROs, noting that "one of our most difficult cases has recently been found employment by the Society in this factory [Thermega], which we

⁶⁷ Combat Stress Archive, *ESWS Annual Report, 1956*, 7.

⁶⁸ Combat Stress Archive, *ESWS Annual Report, 1957*, 11.

⁶⁹ The National Archives, LAB 20/693, H. Critchley, "Report on Visit to Thermega Limited, Leatherhead," September 8, 1951.

⁷⁰ The National Archives, LAB 20/693, P.W. Stevens to R.E. Mackenzie, November 15, 1950; Lipscomb, "The Ex-Services Mental Welfare Society," 3–4.

hear very good results.”⁷¹ In 1957, Ministry of Pensions and National Insurance Parliamentary Secretary Richard Wood toured the factory, and that year’s annual report noted Wood’s “special sympathy” for disabled soldiers, having himself lost both legs during the war.⁷² As will be seen in the next section, the Society had mixed results in lobbying statutory authorities, but it is clear that those authorities saw value in Thermega’s training programs.

Advocacy Work

More than most other mental health organizations, the ESWS could rely on all political parties desiring to be seen assisting its clients. Ex-Service members had suffered and sacrificed for their country, and the alleged inadequacy of their care and pensions became a reliable stick with which to beat the party in power—a relatively easy undertaking, considering successive governments’ aforementioned tendency to deny war pension claims. This created a favourable environment for voluntarists’ advocacy efforts, at both the levels of policy and the individual ex-Service member, and these elements of the Society’s work are examined in this section. While the Society did function as a pressure group in certain instances, seeking to influence broader policy decisions, attempts to insinuate itself within the State’s industrial resettlement system ultimately failed. As a result, it more frequently worked on individual cases where ex-Service members were encountering difficulties—either personal, social, financial, or related to interactions with welfare bureaucracy.

⁷¹ The National Archives, LAB 20/693, P.W. Stevens to R.E. Mackenzie, August 2, 1952; I.B. Harvey to W.H. Pounds, March 12, 1954.

⁷² Combat Stress Archive, *ESWS Annual Report, 1957*, 8–9. It was common for news items and promotional materials to focus more on Society patients’ physical disabilities than their “neuroses”—perhaps reflecting a lack of comfort with the topic, or an acknowledgment of popular stigma. In 1947, the Society’s newly elected President, RAF Marshal Lord Portal of Hungerford, visited Milner House—a newspaper report noted that he met several ex-Servicemen, but pointed specifically to two who had lost limbs in air combat. “Lord Portal and Disabled Men,” *The Times*, September 5, 1947, 6.

Rehabilitation and Employment Policy

In 1944, Sir Walter Womersley referred to the “dual duty” he was forced to perform as Minister of Pensions—on one hand helping pensioners “faithfully and well,” and on the other, ensuring that taxes were spent judiciously, and that “those who [were] not deserving” received no public money.⁷³ Over a decade later, Conservative Minister of Pensions John Boyd-Carpenter received a deputation from ex-Services organizations—which included ESWS Administrative Secretary Major John R. Donnelly—requesting an increase in pension amounts.⁷⁴ The deputation was unsuccessful, and Labour MPs then accused the government of failing to provide for ex-Service members, while cutting surtax on the nation’s wealthiest citizens.⁷⁵

Donnelly’s participation in this deputation was part of the Society’s extensive advocacy work, which included some policy lobbying, though not at the same pace as a dedicated pressure group like the NAMH. In 1954, Donnelly submitted evidence to the Piercy Committee, laying out three “general principles” the Society hoped would guide rehabilitation policy: ex-Services patients required flexible time limits—particularly the “psychiatrically disabled”; caregivers in rehabilitation programs needed to be properly trained and given “the fullest appreciation of the patient’s difficulties”; community acceptance and support were essential to rehabilitation, but where these could not be assured, it was vital to at least provide “suitable employment.”⁷⁶

Most Society efforts, including treatment programs and advocacy, emphasized ex-Service members’ need for stable work. The 1950 annual report stated,

The resettlement of the war neurotic is a difficult and complex question but, on the advice of the medical and psychiatric authorities, every effort is made by the Employment Officer to provide a man or woman with the employment suitable to

⁷³ 401 Parl. Deb. H.C. (5th ser.) (July 7, 1944) cols. 1441–1540.

⁷⁴ Combat Stress Archive, EC Minutes, April 4, 1957.

⁷⁵ 568 Parl. Deb. H.C. (5th ser.) (April 15, 1957), cols. 1531–1533.

⁷⁶ The National Archives, LAB 20/863, Committee of Inquiry on the Rehabilitation of Disabled Persons, “Written Evidence Submitted by the Ex-Services Welfare Society,” 1.

his or her condition ... thanks are extended to employers of labour and the Disablement Rehabilitation Officers of the Ministry of Labour for their assistance and co-operation.⁷⁷

The employment issue was thought to be so crucial that in 1944, Everett Howard submitted a report to the Ministry of Labour on the state of mental hospitals and occupational training centres in several jurisdictions, which proposed a detailed plan for workplace rehabilitation. According to Howard, “[t]he purpose of my tour was to enable [the Ministry] to review the possibilities of the Ministry of Labour and National Service establishing Training Centres, solely for those suffering from psychoses and neuroses.”⁷⁸

Howard prefaced the report by noting Thermega’s success and independence (of course, this view would have to change somewhat in ensuing years), and he hoped to model other training centres on the company’s example. He envisioned a system wherein Ministry of Labour Liaison Officers, Mental Hospital superintendents and staff, and managers of Training Centres and Labour Exchanges would all work together to place candidates in suitable industries—whether government run, private, sheltered, or unsheltered. Howard wrote, “[w]ith this friendly co-operation between the medical men and the Ministry of Labour Officials, this machinery should work smoothly and efficiently and would render unnecessary the present system of sending unfit men to Labour Exchanges.”⁷⁹

Howard thought that his suggestions would be particularly attractive to employers seeking to meet hiring quotas established under the Disabled Persons (Employment) Act. Sheltered industry would decrease the “burden of taxation” supposedly created by disabled people, would

⁷⁷ Combat Stress Archive, *ESWS Annual Report, 1950*, 10.

⁷⁸ The National Archives, LAB 20/693, Everett Howard, “Report; Conclusion,” December 1944. The areas that Howard surveyed were Bristol, Cardiff, Birmingham, Edinburgh, Glasgow, Aberdeen, Newcastle-on-Tyne, Sheffield, Leeds, Manchester, and Nottingham.

⁷⁹ The National Archives, LAB 20/693, Everett Howard, “Report; Suggestions,” December 1944.

encourage products which were “simple to make and profitable,” and would provide a labour reserve in case of shortages (which, it remained unsaid, would also keep wages low). Health, self-sufficiency, and productivity were all closely linked, and Howard proposed that sheltered industry should provide “a remuneration that will enable [the candidate] to contribute to his maintenance.” The ambitious scheme involved the creation of a public company, with shareholders including major charities, employers, and government. Howard suggested that the “novelty” of the scheme would overcome any disinterest on the part of major companies.⁸⁰

Howard’s report was received by several ministries, although it is unclear whether it figured in the development of the government sponsored DPEC the following year. Correspondence between the Ministries of Health and Labour was dismissive, referring to the report as “rather discursive,” and asking that no officials speak to its suggestions until a full response could be produced by the Board of Control.⁸¹ R.E. Gomme, a representative of the Ministry of Labour, thought the report’s recommendations should be forwarded to the inter-departmental Standing Rehabilitation and Resettlement Committee (Ince Committee), chaired by senior civil servant Sir Godfrey Ince. First, however, Gomme was having his own summary produced of Howard’s “rather rambling papers.”⁸²

In February 1945, Howard met with Gomme and other representatives of the Ministries of Health, Labour, and Pensions, to discuss further action based on his recommendations. Minutes of this meeting note,

Although we were doing our best to deal with neurosis cases that came to our notice under the existing procedure, we were not satisfied that our measures made any real or permanent provision ... It was, however, essential that we should be preparing our plans for future action and Mr. Howard’s report would assist us in this purpose.

⁸⁰ Ibid.

⁸¹ The National Archives, LAB 20/52, A.W. Neville to R.E. Gomme, January 11, 1945.

⁸² The National Archives, LAB 20/52, R.E. Gomme to A.W. Neville, January 12, 1945.

While it is unclear what “real or permanent provision” would look like, it most likely was a reference to full employment and economic self-sufficiency. The discussion centred around the need to return neuroses cases to the workplace—many were engaged in occupational therapy at Government Training Centres (GTCs), but it was suggested that this training could “be given a more practical bias with a view both to arousing interest in future employment and, perhaps, of testing suitability.” The meeting also picked up Howard’s earlier suggestion that Thermega could provide a model for facilities established in the future—this was welcomed as “the most practical step.”⁸³

After the meeting, Ministry of Health representative A.W. Neville called Howard’s remarks “somewhat discursive and vague,” but listed the major proposals that had emerged: the Ministry of Labour should employ a technical advisor to direct hospitals and EMS centres on “the forms of occupational or industrial therapy best suited to the needs of individual patients”; the stigmatizing words “mental” and “psychiatric” should be avoided in any dealings with patients or clients; DROs should be equally free to visit mental hospitals as they were general hospitals; and neurotics should not be segregated from physically disabled people in GTCs, industrial rehabilitation centres, or sheltered employment.⁸⁴

To Howard’s suggestion that employers would have more incentive to participate if they held a financial stake in patients’ rehabilitation and resettlement, Neville argued that Section 15 of the Disabled Persons (Employment) Act would accomplish this goal. He also pointed to the nascent DPEC as a positive step forward, noting that this undertaking was only meant “to fill up gaps left by voluntary effort” (an interesting reversal of usual statutory-voluntary relationship).⁸⁵ However,

⁸³ The National Archives, LAB 20/52, “Note of a Meeting with Mr. Everett Howard (Ex-Services Welfare Society),” February 9, 1945.

⁸⁴ The National Archives, LAB 20/52, A.W. Neville, “Note of Conference,” February 9, 1945.

⁸⁵ *Ibid.*

when a choice had to be made between Thermega or the DPEC, the government went with the latter. The increased need for workplace resettlement was discussed at a July meeting of the Ince Committee, and while Ince suggested that “use could be made of the Ex-Services Welfare Society or the Disabled Persons Corporation,” H.H. Wiles of the Ministry of Labour—who had been present at the February meeting with Howard—recommended going solely with the DPEC, since it was run on a non-residential (and thus cheaper) basis.⁸⁶



Fig 4.2: ESWS General Secretary Everett Howard.
Combat Stress Archive

⁸⁶ The National Archives, LAB 20/52, Standing Rehabilitation and Resettlement Committee Minutes, July 19, 1945.

It appears Howard's efforts, though contributing to an environment of greater concern around rehabilitation and workplace resettlement, ultimately failed to bring clients closer within reach of the ESWS and Thermega. Over a year elapsed with no word, and Howard eventually contacted the Ministry of Labour to inquire whether any of his suggestions had been adopted.⁸⁷ Wiles assured Howard that his suggestions had been considered, and attached a note detailing advances made in line with Howard's report.⁸⁸ However, it is difficult to see this response as anything but a brush-off. No action had been taken on hiring technical advisors, eliminating stigmatizing language, or attaching residential hostels to GTCs. The Ministry did plan to convert four CRUs into civilian Industrial Rehabilitation Centres, and to establish "experimental diagnostic centres" at Sutton Hospital in Surrey, and Barrhead, Scotland. Further, it had been suggested that the Sutton Centre could work with the ESWS to place ex-Service members in employment at Thermega, but nothing firm was established.⁸⁹

The DPEC had opened three workshops, in South Wales, Staffordshire, and Lancashire, and more were planned. Wiles assured Howard that his recommendations against segregation in the workshops had been implemented, but of course the Society was not running the facilities.⁹⁰ Thus, before the welfare state had been fully established, the ESWS was already cut out of the government's industrial training strategy in favour of the newly established DPEC. This could help to explain the Society's step back from attempts to influence policy in the 1950s, in favour of more personalized advocacy. Nonetheless, the ESWS responded proactively and in a cooperative

⁸⁷ The National Archives, LAB 20/52, Everett Howard to the Ministry of Labour, October 15, 1946.

⁸⁸ The National Archives, LAB 20/52, H.H. Wiles to Everett Howard, November 1, 1946.

⁸⁹ The National Archives, LAB 20/52, H.H. Wiles, "Notes on the Suggestions made in Mr. Everett Howard's Report of 11th December, 1944," November 1, 1946.

⁹⁰ The National Archives, LAB 20/52, H.H. Wiles, "Notes on the Suggestions made in Mr. Everett Howard's Report of 11th December, 1944," November 1, 1946.

spirit—Howard informed Wiles that the ESWS was negotiating with the DPEC to have the latter produce Thermega blankets and pads in its factories, using the trademarked name “Remployed Products.”⁹¹ While the sphere of industrial resettlement had not proved the boon to the Society that Howard had perhaps hoped when he submitted his report, he seemed satisfied that people in need of rehabilitation and resettlement were being employed.

Individual Advocacy

The Society’s 1957 annual report contained several implicit criticisms of the existing system of ex-Services health care. It was made clear that the ponderous medical and bureaucratic systems could lead to dire results:

A panel doctor may not be able to arrange for a patient to see a specialist in under six to eight weeks. To a victim of nerves long delays can be attended with the most serious consequences; in extreme cases it may mean the gas oven or the river. In the Society the longest waiting period is six days; instant action is taken to relieve all the patient’s difficulties.

It was further reported that one patient had not left his house for two years, and was only persuaded to visit Tyrwhitt House after he was “assured of privacy, of a deep understanding, sympathy and no red tape.” Another had “[ruined] his home because he could not stand the delay about his request for a pension.”⁹² It is important to note here that the report was not critiquing general practitioners or specialists, but rather the overburdened medical system as a whole.

ESWS staff would represent and advocate for ex-Service members whether or not they were actively receiving treatment, or engaging in sheltered employment. Though the number of Tyrwhitt patients was generally around 150 per year, the Society dealt in other ways with thousands of cases. As an example, in 1949 the Society’s headquarters saw over 7,000 meetings and 1,345

⁹¹ The National Archives, LAB 20/52, E. Howard to H.H. Wiles, November 8, 1946. Not to be confused with Remploy, the name later adopted by the DPEC.

⁹² Combat Stress Archive, *ESWS Annual Report, 1957*, 10.

new cases, administratively divided into the categories “relief,” “medical,” “pensions,” “employment,” and “after care.”⁹³ Staff also performed hospital outreach—every year Christmas gifts (usually cigarettes or cash) were distributed to “every ex-Service man or woman in mental hospitals, whether on pension or not.”⁹⁴ In 1951 Society representative Sir Robert Napier visited 142 hospitals, contacting 4,869 individual patients. That year’s annual report established a clear delineation between the quality of care in state-run hospitals, and the personalized benefits provided by the Society: “[w]hat these visits mean to those unfortunate men and women, many of whom have lost all contact with the outside world, is well shown by numerous pathetic letters of appreciation.”⁹⁵

Writing to the Ministry of Pensions in 1947, the Secretary of the King Edward’s Hospital Fund praised the Society’s cooperation and innovation, and singled out Everett Howard’s personal advocacy efforts. In one case, Howard had ensured that a destitute veteran with psychoneurosis was able to make payments on the furniture in his home. In another, he kept an epileptic veteran whose condition was not covered under Ministry guidelines out of the workhouse. Where statutory providers were often restricted by the parameters of legislation and policy, it was noted that the ESWS “appear[ed] to be quite free of restrictive rules which would limit the variety and the degree of help which they are able to give their special clients.”⁹⁶

During the war, the Ministry of Pensions agreed that ex-Service members could receive treatment allowances—statutory benefits provided to hospital in-patients—for their stays in ESWS

⁹³ Combat Stress Archive, *ESWS Annual Report, 1949*, 5. Not all ex-Service members were automatically entitled to the Society’s assistance—in 1957 the organization’s name was changed to the Ex-Services *Mental Welfare Association*, in an attempt to cut down on the number of healthy ex-Service members seeking out its services. Combat Stress Archive, EC Minutes, February 7, 1957.

⁹⁴ Combat Stress Archive, *ESWS Annual Report, 1952*, 10.

⁹⁵ Combat Stress Archive, *ESWS Annual Report, 1951*, 11. Occasional digs at the quality of care in NHS hospitals were common in voluntarists’ promotional materials.

⁹⁶ The National Archives, Ministry of Pensions and National Insurance Records, PIN 15/3144, Secretary, King’s Fund, to Mr. Ludgate, Ministry of Pensions, November 27, 1947.

facilities, as long as no capital expenditure was required. In 1947, the Ministry judged Tyrwhitt House to be “eminently suitable for the treatment of neuroses”—the reason this decision was left to pension bureaucrats instead of medical professionals is unclear—and pensioners began receiving subsidized treatment there.⁹⁷ The Ministry proposed that allowances be paid for a period of eight weeks, and then cease upon the patient’s transfer to Milner House (at which time the patient would presumably be contributing to their own upkeep).⁹⁸ The Society tried to ensure that all eligible benefits were claimed, and the 1958 Annual Report remarked that “[an] approach from a recognised Society will nearly always meet with a weekly addition to the income, which we are afraid would not always be forthcoming if the applicant made his own representations.”⁹⁹ There was often little uniformity or cohesion in the disbursement of treatment allowances—payments could emanate from (or be denied by) several different ministries, and could be revoked after treatment had begun if a client was deemed to be suffering from a pre-existing disorder aggravated by the war experience, rather than attributable to it.

In many cases, ex-Service members needed help navigating the bureaucracies involved in pensions and treatment allowances—particularly when their claims were denied. In July 1955, ESWS staff member H.D. Bushill wrote to the Ministry of Pensions and National Insurance to find out why a veteran in the Society’s care at Tyrwhitt House, named Thomas, had been denied treatment allowances for a stay at Killowen Hospital in Belfast. Thomas had been awarded a pension for psychoneurosis attributable to war service, but had not received the additional allowance that was generally awarded. The Ministry eventually responded that while Thomas’s psychoneurosis was indeed considered attributable to his Naval service, doctors at Killowen had

⁹⁷ The National Archives, PIN 15/3144, Ministry of Pensions Memorandum, s.d.

⁹⁸ The National Archives, PIN 15/3144, Ministry of Pensions to Dr. C.J.P. Grosvenor, December 2, 1955.

⁹⁹ Combat Stress Archive, *ESWS Annual Report, 1958*, 8.

determined that his need for treatment arose from other causes (which were not specified). Major Donnelly took over the case, and noted that the Society had always understood that the issuance of a pension on an attributable basis automatically made a veteran eligible for treatment allowances. The question was important, since the Society often represented veterans in Pensions Appeal Tribunals. Fortunately, the Ministry reversed its decision, and Thomas was awarded a treatment allowance for his time at both Killowen and Leatherhead.¹⁰⁰

Whether a patient's disablement was judged medically attributable to war service was crucial to the prompt payment of pensions and treatment allowances, and in many cases Society staff had to advocate for ex-Service members whose status came into question. The 1951 annual report noted, "as the years pass since the cessation of hostilities, it becomes more difficult to establish [pension] claims which are based on incidents that happened in some cases over ten years ago."¹⁰¹ That year, Dr. T.P. Linehan of the ESWS Medical Department applied for a treatment allowance on behalf of Robert, a patient recommended for treatment at Tyrwhitt House and receiving a pension on an attributable basis. As with Thomas, the application was denied on the puzzling grounds that while Robert's condition was attributable to war service, his need for treatment was not.

In a letter from the Ministry of Pensions and National Insurance, Robert's condition was described as "Psychoneurosis Aggravated," even though in his original diagnosis, his condition had been labelled attributable. Despite Linehan pointing out the error, and the Ministry acknowledging it as such, the allowance denial was upheld following review. Referring to the earlier case involving Thomas, Linehan followed Major Donnelly in noting that the ESWS

¹⁰⁰ The National Archives, PIN 15/3144, H.D. Bushill to Secretary, Ministry of Pensions and National Insurance, July 22, 1955; M. Sincock to H.D. Bushill, August 26, 1955; John R. Donnelly to the Secretary, Ministry of Pensions and National Insurance, September 15, 1955; L. Firth to John R. Donnelly, October 18, 1955.

¹⁰¹ Combat Stress Archive, *ESWS Annual Report, 1951*, 10.

understood that treatment allowances would be provided for veterans receiving attributable pensions. The Ministry responded that Robert's case was different than Thomas's—a consultant had determined that the need for treatment arose from “domestic and other factors.” Linehan argued that these “domestic factors” were directly tied to Robert's nervous condition, which was itself attributable to war service.¹⁰²

The Ministry agreed to forward Robert's case to headquarters for further review, but after nearly two months passed with no word, Linehan's exasperation was evident:

I write again, five weeks having elapsed, to enquire whether a decision has been reached. Surely it is possible by now to quote the Article of the Royal Warrant under which you are declining the grant of allowances to this man to which he would appear to be entitled.¹⁰³

After receiving yet another refusal, citing Robert's “personal problems,” Linehan wrote again, this time typing the word “ATTRIBUTABLE” in capital letters. He noted that after the debacle involving Thomas, the ESWS had requested clear guidelines on the types of patients eligible for treatment allowances, and had received no reply—it would be pointless to pursue similar cases if the Society knew in advance that allowances would be denied. Though Thomas's allowances had eventually been approved, the Society had ended up in the same frustrating situation with a new patient.¹⁰⁴

Fortunately, as had happened with Thomas, the Ministry rather abruptly approved Robert's allowance, and Linehan was informed that the matter of a firm policy would be considered. Two

¹⁰² The National Archives, PIN 15/3144, T.P. Linehan to Director of Medical Services, Ministry of Pensions and National Insurance, March 1, 1951; M.F.T. Ellis to Robert Montgomery, March 8, 1957; M.F.T. Ellis to T.P. Linehan, March 8, 1957; T.P. Linehan to the Manager, Ministry of Pensions and National Insurance, War Pensions Welfare Service, March 25, 1951; Ministry of Pensions to T.P. Linehan, April 5, 1955; T.P. Linehan to Director of Medical Services, War Pensions Welfare Service, April 15, 1957.

¹⁰³ The National Archives, PIN 15/3144, T.P. Linehan to War Pensions Welfare Service, June 14, 1957. The warrant referred to here is the *Royal Warrant Concerning the Pay, Pensions and Other Grants in Cases Where the Disablement or Death of Members of the Military Forces or Home Guard is Due to Service During the Present War, 1944* (Cmd. 6832).

¹⁰⁴ The National Archives, PIN 15/3144, T.P. Linehan to The Controller, Ministry of Pensions, July 19, 1957.

months later, Linehan was contacted by J.E. Stanley, a representative of the Ministry's Blackpool branch, who asserted that since each case was considered on an individual basis, "it [was] inadvisable to lay down any hard and fast rules." Linehan noted that this was creating ongoing problems, especially since local Medical Officers were not empowered to make decisions regarding allowance eligibility. There had been several instances where treatment allowances had been substantially delayed—in one case postponing a patient's admittance to Belmont Hospital, and in another necessitating a hardship grant to a patient's wife over Christmas.¹⁰⁵

Linehan also criticized the difference in priority afforded to patients deemed to have what was called "high" or "low" disablement. Another Ministry representative responded that attributable conditions causing a high degree of disability were eligible for treatment allowances, whether the condition worsened or not. However, the representative wrote,

...if the degree of disablement is a low one, although the disability itself is attributable to service, later deterioration or increased disablement necessitating hospital treatment may be found to be due to factors which clearly are in no way associated with service disablement.

A handwritten note attached to this letter states that its terms were agreed upon by the Prime Minister's office, indicating this would be the officially sanctioned policy.¹⁰⁶ Nearly three years had elapsed since Bushill had written about Thomas's denial.

Evidently, access to treatment and statutory benefits was not a sure thing, and ESWS staff often had to be vigilant in ensuring that ex-Service members received what they were owed. However, records also reveal conflict within government over funding. One Thermega employee, named William, served with the Royal Artillery in North Africa before being discharged for a nervous breakdown in 1942. Since then, he had worked as a labourer and cleaner in Northern

¹⁰⁵ The National Archives, PIN 15/3144, Controller, Ministry of Pensions to Linehan, October 8, 1957; J.E. Stanley to T.P. Linehan, December 31, 1957; Linehan to Stanley, January 3, 1958.

¹⁰⁶ The National Archives, PIN 15/3144, Linehan to Stanley, January 23, 1958.

Ireland, but became unemployed in 1954, suffering from “acute anxiety with a wide range of symptoms.”¹⁰⁷ After a ten-week stay at Tyrwhitt House, William was declared by ESWS consulting psychiatrist Dr. Thomas Tennent “quite unfit for employment in the open market,” and he thus began work at Thermega (apparently some patients could bypass Milner House altogether). The Ministry of Labour’s Belfast branch initially agreed to pay a training allowance for William’s time at Thermega, but a representative suggested that he should stay in England following this work, due to the poor employment situation in Northern Ireland. When William took the advice, the Belfast branch reversed its earlier funding commitment. The training allowance was ultimately reinstated, but it took a representative from Ministry headquarters pointing out that the Belfast branch had recommended William’s staying in the first place.¹⁰⁸

The Society’s advocacy work was acknowledged in 1960 by Minister of Health Derek Walker-Smith, speaking on the newly introduced Mental Health Act 1959:

[i]t is agreed that voluntary services have a vital part to play, and one of the most enterprising in this field has been the Ex-Services Mental Welfare Society ... Year by year it has given every help and material assistance to ex-Service men and women in need. All these are indeed great enterprises for which the Society has earned and should receive the thanks of the community.

It was hoped that the Act’s focus on community care would bring greater attention to industrial training efforts, but the 1959 annual report made it clear that the Society continued to play vital roles as a service provider and advocacy group: “as a correspondent points out in a letter to the press, and indeed to our own subscribers [*sic*] certain knowledge: ‘way back in 1919 the Ex-Services Mental Welfare Society tackled this problem and they are still dealing with it’.”¹⁰⁹

¹⁰⁷ The National Archives, LAB 20/693, “Social History of Mr. [W.A.],” July 12, 1955.

¹⁰⁸ The National Archives, LAB 20/693, G.A. Waring to P.W. Stevens, August 2, 1955; G.A. Waring to T.E. Fenwick, December 2, 1955; T.E. Fenwick to Miss B.M. Rand December 6, 1955.

¹⁰⁹ Combat Stress Archive, *ESWS Annual Report, 1959*, 6.

Prestige and Funding

While most voluntary groups were, by their nature, “promotional and diffuse,” the ESWS was particularly skilled at self-promotion and fundraising, and relied heavily on upper-class contacts.¹¹⁰ The annual report for 1959 argued that “if the Society is to succeed in its primary object, considerable expenditure must be incurred each year on advertising and publicity and the maintaining of offices and reception centres in order that its existence may become known as widely as possible.”¹¹¹ This section traces Society efforts to publicize its services and encourage donations, and also to secure and maintain patronage from political, military, and aristocratic figures. Public appeals provided the bulk of the Society’s funding, and where a political pressure group like the NAMH drew on political capital to ensure it was positioned to influence policy, the ESWS more frequently mined its contacts for prestige, publicity, and income.

Publicity and Fundraising

In 1946, Everett Howard wistfully recalled the success of social events held before the war, “which had given great publicity to the Society and stimulated its appeals.” The end of the war brought a slight downturn, as these events dropped off and new subscribers failed to materialize—Howard blamed “shortages of paper and other conditions which did not exist before the war.”¹¹² However, there was no suggestion of turning to state subsidies, and the annual report for 1949 proudly proclaimed to readers, “[the Society] receives no State grant, and therefore, if this great work is to be carried on unabated, your continued support is vital.”¹¹³ The funding slowdown

¹¹⁰ Chris Nottingham, “The Rise of the Insecure Professionals,” *International Review of Social History* 52 (2007): 465.

¹¹¹ Combat Stress Archive, *ESWS Annual Report, 1959*, 21.

¹¹² Combat Stress Archive, EC Minutes, February 7, 1946.

¹¹³ Combat Stress Archive, *ESWS Annual Report, 1949*, 3.

would prove temporary, as £36,000 were raised from appeals in 1946–1947, against £25,000 the previous year.¹¹⁴ By the end of the 1950s, the Society enjoyed a healthy surplus of around £70,000, and an annual income of between £60,000 and £70,000 per year.¹¹⁵

Commander Lipscomb was incredibly active as Appeals Secretary throughout the period, travelling the nation and organizing gala fundraisers, flag days, and film, music, and theatre performances.¹¹⁶ He worked steadily to secure donations from individuals as well as various funds and trusts. This was a major undertaking, and in 1949, Lipscomb asked to bring on an assistant on a voluntary basis, to help with “the weight of correspondence.” Everett Howard opposed the appointment, but only because he “made it a rule never to have voluntary workers in the Appeals Department, which was the heart of the Society’s work.”¹¹⁷



Fig. 4.3: ESWS Flag Day fundraiser, c. 1950s.

¹¹⁴ Combat Stress Archive, EC Minutes, March 7, 1946.

¹¹⁵ Combat Stress Archive, *ESWS Annual Report, 1958*, 23; *ESWS Annual Report, 1959*, 21.

¹¹⁶ See Fig. 4.3.

¹¹⁷ Combat Stress Archive, EC Minutes, January 6, 1949.

Combat Stress Archive

A decade later, as mental health voluntarists assessed the likely effects of the oncoming Mental Health Bill, Lipscomb spoke at a Townswomen's Guild meeting in North London. There, executive committee minutes record, "[t]here was no suggestion in people's minds that the Bill might obviate the necessity for an appeal. Indeed the reverse seemed to be the case, and there was [genuine] willingness to help the Society financially." Still, it remained important to keep the Society at the forefront in any statutory decisions concerning funding or influence—the Executive Committee agreed "that every effort must be made to see that the Society's functions were brought to the notice of the appropriate departments of the Ministry of Health, the Ministry of Pensions and the Local Authorities." During parliamentary debate over the Charities Act 1960, which rationalized government oversight and dissolved stagnant charitable trusts, the Society's lawyer advised "the Society should remind the Charity Commissioners of its objects and request that when moribund trust money was being considered for distribution this Charity would like to be remembered."¹¹⁸

The Society's promotional efforts underwent a shift over the course of the 1940s and 1950s: during the Second World War, advertising positioned the organization as subordinate to state-directed treatment efforts, but by the 1950s public advertising was depicting the Society as the only sensible destination for effective treatment and cure. In August 1939, President Tyrwhitt issued a public appeal that staked out the Society's specialized position within the mainly state-run world of ex-Services treatment. He noted that at least 30,000 veterans of the previous war were in mental hospitals or otherwise suffering from nervous disorders, and praised governmental

¹¹⁸ Combat Stress Archive, EC Minutes, June 4, 1959, August 6, 1959. March 3, 1960. See also John S. Burt, "The Charities Act 1960," *Social Work* 17, no. 4 (1960): 109–113.

efforts: “[a]ll that the State can do for them it does.” However, he also alluded to the detached and generalized nature of statutory provision:

...no official action, however well disposed, can give the individual help and treatment provided by the Ex-Services Welfare Society, which offers [patients] specialized care in its curative homes, sheltered employment in its industrial centre, and the aid and understanding that mean so much to them in sudden emergency.¹¹⁹

In November, after hostilities had commenced, Tyrwhitt announced that the ESWS would be extending its work in assisting the state, but again referenced “the human and specialist touch” that could supposedly only be found in Society facilities.¹²⁰

Following the war and into the 1950s, the ESWS stayed alert to opportunities for publicity, but repeatedly positioned itself as the nation’s only real haven for ex-Service members suffering from mental disorders—efforts to credit statutory provision had been largely abandoned. In 1952, the Society was featured in the BBC’s regular “Week’s Good Cause” broadcast, with an address delivered by then-President Field Marshal Henry Maitland “Jumbo” Wilson, 1st Baron Wilson. An advertisement for the broadcast emphasized the Society’s credentials—it was registered under the National Assistance Act 1948, and was “the only voluntary organisation dealing exclusively with the welfare of Ex-Service men and women of all three services.”¹²¹

The following year, an appeal advertisement was headed by an image of the sun breaking over the horizon, labelled “THE DAWN.” It began in alarmist terms: “27,000 ex-Service men and women are in mental hospitals. A further 74,000 scattered over the country draw neurosis pensions. Thousands of other sufferers carry on as best they can.” The advertisement then turned to the obvious—and importantly, only—solution: “[m]any of these need the assistance and

¹¹⁹ “Men with Nerves Wrecked By The War,” *The Times*, August 4, 1939, 7.

¹²⁰ “Mentally Disabled Soldiers,” *The Times*, November 10, 1939, 5.

¹²¹ “The week’s good cause for the mentally and nerve shattered disabled,” *The Manchester Guardian*, August 22, 1952, 8.

understanding which only this voluntary Society, with specialist staff, its own Curative Home and sheltered industry can provide. To all those who turn to the Society for help it offers THE DAWN OF A NEW LIFE.”¹²² The Society also relied on celebrity endorsements. In 1960, the actor Kenneth More, familiar to cinema audiences as the star of such wartime dramas as *Reach for the Sky* (1956), conducted a broadcast appeal, noting “[t]housands of war victims suffering from neurasthenia and mental disorders rely on the Ex-Services Mental Welfare Society which is the only specialist organisation working exclusively on their behalf.”¹²³



27,000 ex-Service men and women are in mental hospitals. A further 74,000 scattered over the country draw neurosis pensions. Thousands of other sufferers carry on as best they can. Many of these need the assistance and understanding which only this voluntary Society, with specialist staff, its own Curative Home and sheltered industry can provide. To all those who turn to the Society for help it offers THE DAWN OF A NEW LIFE.

WE NEED YOUR SUPPORT. £60,000 required annually. No Government Grant.

EX-SERVICES WELFARE SOCIETY
 (Registered in accordance with National Assistance Act, 1948)
FOR THOSE WHO SUFFER IN MIND
 Patron: H.M. QUEEN ELIZABETH, THE QUEEN MOTHER
 President: Field-Marshal The Lord Wilson of Libya, G.C.B., G.B.E., D.S.O.
 Temple Chambers, Temple Avenue, London E.C.4

★ In order to bring the facilities of the Society nearer to Ex-service men and women in the North of England
**NEW CONSULTING ROOMS AND OFFICES HAVE BEEN OPENED
 AT 76 VICTORIA STREET, MANCHESTER 3**

¹²² See Fig. 4.4. *The Manchester Guardian*, November 27, 1953, 3.

¹²³ *The Manchester Guardian*, November 12, 1960, 3. The term “neurasthenia” is notable, as it had largely fallen out of fashion in medical circles by the 1960s. There are several possible explanations for its use: whomever wrote the ad copy for More was unfamiliar with more modern terminology, such as “neurotic disorder”; or perhaps it was assumed that the listening audience would be more familiar with the older term. Its use is a reminder that, although they structured themselves as professionalized organizations, voluntary associations were mainly staffed by laypeople, not medical workers.

Fig. 4.4: ESWS fundraising appeal.
 Manchester Guardian, November 27, 1953, 3.

Patronage

Aside from advertising publicly, the Society recognized the value of patronage and connections in high places. It energetically courted the aristocracy and upper echelons of the military, seeking both patronage and publicity. In 1946, it was proposed that Brigadier H.A. Sandiford, formerly Deputy Medical Director of the War Office, be hired as the Society's medical director, and Executive Committee minutes noted that "his connections would probably be of great advantage to the Society." Everett Howard was authorized to hire Sandiford at a salary of £1,000, but he ultimately was brought on at £1,200—indicating the perceived value of those connections.¹²⁴

Royals and other Society grandees were frequently invited to Society functions, and Howard maintained running correspondence with various staff members of the Royal Households—Sir Clive Wigram, King George V's private secretary, appears to have been a personal friend. In 1928 the King and Queen visited Milner House, and were "delighted with the establishment and with all they saw."¹²⁵ In 1931 Queen Mary visited ESWS neurasthenic homes in Kent, and during a 1932 visit, the Duke and Duchess of York were gifted an electric pad and blanket manufactured by Thermega.¹²⁶ Princess Alice, Duchess of Gloucester, officially opened Tyrwhitt House in 1946, unveiling a large portrait of Sir Reginald Tyrwhitt. The event was attended by a several prominent representatives of the monarchy, including the Lord Lieutenant of Surrey.¹²⁷ In 1951 the Queen attended a Society-sponsored performance of the musical *Gay's the Word*, and

¹²⁴ Combat Stress Archive, EC Minutes, May 30, 1946.

¹²⁵ Combat Stress Archive, C. Wigram to F. Milner, April 14, 1928.

¹²⁶ Combat Stress Archive, H.G. Campbell to E. Howard, July 20, 1932.

¹²⁷ "New Leatherhead Home For Nervous Diseases," *The Times*, October 9, 1946, 7. The portrait dominates the reception area of Combat Stress to this day.

in 1954 Princess Margaret was an honored guest at a ball thrown in aid of the Society at London's prestigious Hurlingham Club.¹²⁸

Currying favour among the upper classes was common to most voluntary groups, but the Society prioritized these efforts highly, and here Everett Howard was key. His desire for high society affiliations can be understood in the context of an unfortunate series of events that arose in the 1920s, which temporarily cost the Society its Royal patronage. On November 11, 1924—Armistice Day—the ESWS circulated an appeal pamphlet to raise funds for a new residential facility for “mentally broken ex-Service men.” The appeal was championed by Howard, and sharply criticized mental asylum care and pension arrangements for ex-Service men—particularly those being treated in “pauper asylums.”

The appeal was attacked as inaccurate and distasteful in the pages of the *Daily Herald*, and the Keeper of the Privy Purse, Frederick Ponsonby, complained directly to then-President Milner about supposed inaccuracies.¹²⁹ In particular, the appeal claimed the King had made a donation to the Society, which Ponsonby held to be untrue. Crucially, Ponsonby wrote, “it is important that the King should in no way be associated with an attack on a Government Department.” He warned that if the pamphlet were not withdrawn, he would advise Prince George (later the Duke of Kent) to terminate his patronage of the Society.¹³⁰

Milner was ill at the time, and so Howard responded that the Society had withdrawn the pamphlet, which had been intended “for private circulation only among charitable people.” As for the King's apparent donation, the Society's 1920 annual report had recorded £25 donated in the name of the King through the Duchy of Lancaster. Howard maintained that while the Society

¹²⁸ “News in Brief,” *The Times*, January 11, 1951, 8; “Purple Cross Ball,” *The Times*, June 16, 1954, 10.

¹²⁹ *Daily Herald*, November 15, 1924.

¹³⁰ Combat Stress Archive, F.M. Ponsonby to F. Milner, November 18, 1924

generally sought to be apolitical, its members were distressed by the relegation of ex-servicemen to what were essentially pauper asylums rebranded as mental hospitals.¹³¹ Despite the pamphlet's withdrawal, the patronage was still terminated, with Ponsonby advising Prince George "that it is most inadvisable that he should be in any way associated with a Society, the objects of which are to attack the Minister of Pensions."¹³²

The controversy continued into 1925, as Conservative MP Philip Colfox—himself a disabled veteran—latched on to the pamphlet and initiated a contentious back-and-forth with Howard. Colfox claimed that there were no disabled ex-servicemen in pauper asylums—indeed, that such asylums no longer existed—and that hospital conditions were not as bad as claimed. Reports of inadequate food, or of large groups of men being given a single pumice stone to shave with, were exaggerated—mental hospitals produced their own food, and only men too insane to be given razors were going unshaven. Colfox also questioned the charitable motives of the Society's executive—to Howard's suggestion that "it is not always wise to look at ex-Service men through the spectacles of a Government Department," Colfox sniped,

...it is much more unwise, and certainly less creditable, to make use of ex-Service men and their misfortunes to provide comfortable salaries and occupations for designing people not unduly hampered by conscience. I must congratulate your Society on having obtained a large sum of money without having overstepped the law with regard to fraud and false pretences.¹³³

Howard seems to have had the last word—his final missive cited a letter received from an ex-serviceman who, in response to a newspaper article paralleling Colfox's view that there were no ex-servicemen in pauper asylums, pointed out that he and around 80 others were currently in a facility that was asylum in all but name. Howard also asked why, if hospitals were producing so

¹³¹ Combat Stress Archive, E. Howard to F.M. Ponsonby, November 24, 1924.

¹³² Combat Stress Archive, R. Bowes Lyon to F. Milner, December 9, 1924.

¹³³ Combat Stress Archive, W.P. Colfox to F. Milner, June 26, 1925; W.P. Colfox to E. Howard, July 16, 1925; E. Howard to W.P. Colfox, July 22, 1925; W.P. Colfox to E. Howard, July 30, 1925.

much food, reports showed patients being fed only bread, margarine, and small amounts of meat for much of the year. In response to the insinuation of fraud, Howard sent Colfox the Society's balance sheet and annual report for the year 1924.¹³⁴

Finally, Howard circulated copies of the correspondence to various Conservative MPs, several of whom apologized for Colfox's attacks. One wrote "I know Major Colfox well, and he's a very gallant Ex-Service Man (badly disabled) himself. I can't think how he came to write in such a stupid discourteous way ... I am so sorry that you've had to put up with all this."¹³⁵ Having put the controversy to bed, it is possible Howard resolved to avoid such incidents in the future, which would help to explain the Society's hesitance to publicly criticize government. Over the ensuing decades, as Society advertising continually emphasized that it was the only refuge for psychoneurotic veterans, the obvious corollary went unsaid: the State was failing to provide such a refuge.

Howard worked hard to rebuild relations between the Society and the aristocracy (if not the government). The various royal visits to Society facilities have already been noted. In 1929, the Society requested the reinstatement of Prince George's patronage, but was given the excuse that the Prince could not take on any additional public duties.¹³⁶ Howard's efforts finally paid off in 1942, when Queen Elizabeth (later the Queen Mother) became the Society's patron, and allocated a donation of £500.¹³⁷ According to Howard, the patronage was obtained after one of the Queen's Ladies in Waiting had brought to his attention the case of an ex-serviceman denied by the Ministry of Pensions. Howard "dealt with it in a way that left no embarrassment"—perhaps a

¹³⁴ Combat Stress Archive, E. Howard to W.P. Colfox, August 5, 1925.

¹³⁵ Combat Stress Archive, G. Bowyer, MP, to E. Howard, August 3, 1925.

¹³⁶ Combat Stress Archive, Letter to F. Milner, November 28, 1929.

¹³⁷ Combat Stress Archive, *ESWS Annual Report, 1942*, 3.

veiled reference to the events of two decades earlier—and the patronage was secured.¹³⁸ The Queen would congratulate Howard on the occasion of his retirement, giving “her sincere gratitude for the devotion which he has given to the ex-Services Welfare Society.”¹³⁹

Conclusion

The epidemic of shell shock in the First World War caught the British government and medical establishment off guard, and the Ex-Services Welfare Society was conceived in response to a perceived failure to adequately treat and compensate traumatized ex-Service members. Three decades later, the Society had built up a network of care homes and a strong donor base, and considered itself the nation’s preeminent source of care and advocacy for ex-Service members with mental illness. While the government did offer better treatment options at the end of the Second World War—particularly in CRUs—these were confined to a relatively small number of ex-Service members. Furthermore, there were greater restrictions on pension allocation, leading the Society to develop from solely a service provider to an advocacy group as well.

The Society’s primary goal through the decades—returning ex-Service members to work—was strongly informed by the practice of occupational therapy, but also by a traditionalist association of character and citizenship with commercial productivity. At its core, the Society was driven by its leaders’ paternalistic Toryism, and the strong association between the military and the nation’s conservative upper class. S.P. MacKenzie has traced the generally conservative outlook of the Army’s officer corps through the First and Second World Wars—particularly as it relates to opposition to the supposedly radicalizing efforts of Army education programs.¹⁴⁰ Officers such as these, carrying traditional values and conceptions of character into the postwar era,

¹³⁸ Combat Stress Archive, E. Howard to Lord Portal, April 5, 1948.

¹³⁹ Combat Stress Archive, T.C. Harvey to K.R. Walker, October 15, 1948.

¹⁴⁰ S.P. Mackenzie, *Politics and Military Morale: Current Affairs and Citizenship Education in the British Army 1914–1950* (Oxford: Oxford University Press, 1992).

continually occupied Society executive positions and influenced its direction and relationship to the welfare state—Presidents Tyrwhitt, Portal, Wilson, and Power, among others.

ESWS executives were wary of welfare entitlement programs (unless they directly benefited their clients and patients), and so they generally shunned governmental subsidy in favour of individualized charity. Where statutory payments were accepted, they tended to be targeted treatment or training allowances allocated to ex-Service members through legislation—it was a happy coincidence that such payments helped to prop up Thermega as it encountered financial difficulties in the 1940s and 1950s. The Society's efforts to re-integrate ex-Service members into the world of employment—through its work at Tyrwhitt and Milner Houses, and Thermega Ltd.—did not constitute a recognition of the welfare state's legitimacy, or a desire to bolster the nation's economic health. Rather, they reflect the more traditional belief that steady employment reflected personal character, which had been stripped away by the ravages of trauma. For the government, this led to a desirable outcome: self-sufficient citizens, capable of reintegration into the labour pool.

Chapter 5

The National Association for Parents of Backward Children

“It is YOUR A.P.B.C., not mine...”
Judy Fryd¹

Introduction

This chapter shows how the National Association for Parents of Backward Children (referred to in this chapter either as “the Association” or, reflecting its 1955 name change to The National Association for Mentally Handicapped Children, “NAPBC/NAMHC”) grew from an informal grouping of concerned parents to the United Kingdom’s premier learning disability advocacy organization within a decade of its establishment.² After examining the National Association, the chapter moves on to focus more narrowly on three branches—two regional and one metropolitan—affiliated with and inspired by the National Association, but generally run independently.³ It focuses in particular on efforts to influence both government and public opinion,

¹ Wellcome Library, London, UK, National Birthday Trust Fund Collection, SA/NBT/F.9/, APBC Newsletter 2, no. 9, May 1950, 1.

² Following the British example, “learning disability” is the term preferred here, unless other terms are contextually appropriate—in those cases, they are signaled with quotation marks. For a more complete discussion of the terminology employed in this dissertation, see chapter 1, footnote 1.

³ NAPBC/NAMHC operations at the national level have been extensively documented by Victoria Shennan, and more recently Rubahanna Choudhury has used the group’s newsletter, *Parent’s Voice*, to trace shifts in philosophy over time, with an emphasis on the group’s efforts to combat the legacy of the eugenics movement. Sheena Rolph has contributed detailed accounts of local and regional branches, focusing on personal narratives and oral history as well as archival material. See Victoria Shennan, *Our Concern: The Story of the National Society for Mentally Handicapped Children and Adults, 1946–1980* (London: National Society for Mentally Handicapped Children and Adults, 1980); Rubahanna A. Choudhury, “The Forgotten Children: The Association of Parents of Backward Children and the Legacy of Eugenics in Britain, 1946–1960” (PhD diss., Oxford Brookes University, 2015); Sheena Rolph, *‘A Little Glamour with a Strict Tempo’: The History of Cambridge Mencap Volume 1, 1947–1990* (Milton Keynes: The Open University, 2005); Sheena Rolph, *A New Voice: The History of South Norfolk Local Mencap Society, 1974–1990* (Milton Keynes: The Open University, 2005); Sheena Rolph, *‘A Place in the Sun’: The History of Lowestoft and District Local Mencap Society, 1974–1990* (Milton Keynes: The Open University, 2005); Sheena Rolph, *Building Bridges into the Community: The History of Bedford and District Society for People with Learning Difficulties, 1955–1990* (Milton Keynes: The Open University, 2005); Sheena Rolph, *Captured on Film: The History of Norwich and District Mencap Society, 1954–1990* (Milton Keynes: The Open University, 2005); Sheena Rolph, *Taking to the Stage: The History of Great Yarmouth and District Mencap Society, 1969–1990* (Milton Keynes: The Open University, 2005); Sheena Rolph, *Reclaiming the Past: The Role of Local Mencap Societies in the Development of Community Care in East Anglia, 1946–1980* (Milton Keynes: The Open University, 2002).

and to improve available services and facilities. The Association tacitly served the goals of the welfare state—as envisioned by Gough and Offe, and detailed in chapter 1—by offering care and vocational skills to an otherwise non-productive population, and often freeing parents and other family members from round-the-clock care duties. However, Association members—mostly parents of children with learning disabilities—envisioned their work extending beyond this function. They focused heavily on their children’s capacity for improvement, and the development of social and occupational skills that would allow those children to integrate into the community.

The speed of the Association’s development reflects the tenacity and drive of the group’s founders, executives, and members, and also the dearth of grassroots advocacy for people with learning disabilities—at both the national and local levels. It also indicates the sheer scale of need for services, facilities, and mutual aid among a historically underserved and marginalized population. The organization’s success was a distinct accomplishment, particularly as its founding coincided with the birth of the welfare state, which could have had the effect of suppressing voluntary effort.

Prior to the 1950s, facilities and services did exist for children with learning disabilities, but these were often haphazardly assembled home teaching programs and training centres. The Association’s main goal was the development of services that would help children with their intellectual and social development, and integration into broader society. This focus reflects the influence of attachment theory, developed by psychologist John Bowlby. Mathew Thomson argues that through Bowlbyism, children experienced both an extension and contraction of freedom—it emphasized “the protection and love of home and family,” but also “the importance of play, freedom, and social relations.”⁴

⁴ Mathew Thomson, *Lost Freedom: The Landscape of the Child and the British Post-War Settlement* (Oxford: Oxford University Press, 2013), 79.

To be able to integrate children with learning disabilities into such an environment would require wholesale institutional reform—a novel and challenging idea within a legislative and cultural milieu that painted “mental deficiency” as unchanging, incurable, and potentially dangerous.⁵ Simon Jarrett argues that to speak of “integrating” people with learning disabilities was a relatively new concept in the twentieth century, since historically, they were usually not excluded from their respective communities. From the nineteenth century, attempts to medicalize disability, police deviance, and “extend the boundaries of state intervention” resulted in increased segregation.⁶ By the beginning of the twentieth century, as Mark Jackson puts it, “[u]nemployed, troublesome, and the source of further mental defectives, the feeble-minded were considered a burden to society and a threat to the future health of the nation.”⁷

The Association was founded in 1946, and so, uniquely among the organizations surveyed in this dissertation, it had no pre-war foundation upon which to build. It also had none of the pre-welfare era baggage of older organizations, and its advocacy tended to reflect a sense of postwar entitlement rights among parent-members—they held high expectations of government functionaries and were amenable to local grassroots organizing.⁸ This was a useful stance,

⁵ Ibid.

⁶ A focus in service provision on the process of re-integration—reflected in the Association’s advocacy objectives—can further serve to situate people with learning disability as outsiders. Within this conception, they are “neither fully within [community] nor fully outside it.” Simon Jarrett, “The History of Intellectual Disability: Inclusion or Exclusion?” in *Community Care and Inclusion for People with an Intellectual Disability*, eds. Robin Jackson and Maria Lyons (Edinburgh: Floris Books, 2016), 29, 34–38; Simon Jarrett, “The meaning of ‘community’ in the lives of people with intellectual disabilities: an historical perspective,” *International Journal of Developmental Disabilities* 61, no. 2 (2015): 107.

⁷ Mark Jackson, *The borderland of imbecility: Medicine, society and the fabrication of the feeble mind in late Victorian and Edwardian England* (Manchester: Manchester University Press, 2000), 2.

⁸ Pat Thane has questioned Richard Titmuss’s “assumption that the war period bred decisively new attitudes to social policy.” Instead, she argues that since investigations of public attitudes toward welfare policy are lacking for the interwar period, “we have no way of knowing whether public acceptance of more redistributive policies was actually heightened during the war.” However, Walmsley, Tilley, Dumbleton, and Bardsley have argued that—at least in the area of learning disability advocacy—efforts that were “muted and personal” before the war became professionalized and collective as the welfare state emerged, indicating a degree of newly discovered enthusiasm. See Pat Thane, *The Foundations of the Welfare State* (London: Longman, 1982), 223, 263; Jan Walmsley, Liz Tilley, Sue Dumbleton, and Janet Bardsley, “The changing face of parent advocacy: a long view,” *Disability and Society* 32, no. 9 (2017): 6.

particularly as local authorities became the major providers of disability services under the National Health Service Act 1946. As will be seen, local Association branches relied more on member participation than the other groups surveyed in this dissertation, which tended more toward top-down organization. Where other voluntary organizations acted as an intermediary between their clients and the government, the Association allowed parents to directly insinuate themselves in processes of policy advocacy and service provision—they were included in campaigns, activities, and important decisions, and it was rare that the executives of a given branch did not themselves have children with learning disabilities.

The backbone of twentieth century “deficiency” policy was the *Mental Deficiency Act 1913*, which John Welshman, Melanie Nind, and Sheena Rolph call a “legislative triumph of the eugenics movement.”⁹ It is important to note here that eugenic ideals were largely discredited in Britain in the 1930s and 1940s—particularly as the atrocities of the Nazi regime became evident. However, eugenic campaigns for sterilization and segregation of “defectives” were prominent in the decades prior, and the ideology led directly to the “essentially pessimistic view” of the potential of people with learning disabilities. The 1913 Act created new categories for people considered deficient: “idiot,” “imbecile,” “feeble-minded,” and “moral imbecile.” Isolated deficiency colonies were established, along with a mandatory licensing system prescribing either institutionalization, guardianship, or supervision, depending on the severity of a given disability. Guardians were designated caretakers from local communities, who could receive statutory financial assistance,

⁹ John Welshman, Melanie Nind, Sheena Rolph, “General Introduction,” in *Witnesses to change: Families, learning difficulties, and history*, eds. Sheena Rolph, Dorothy Atkinson, Melanie Nind, and John Welshman (Kidderminster: BILD, 2005), 16. The recommendations of the 1904 Royal Commission on the Care and Control of the Feeble-Minded, upon which the Act was based, passed into law after having only the “most obviously eugenic measures” scrubbed. See Tim Stainton, “Equal citizens? The discourse of liberty and rights in the history of learning disabilities,” in *Crossing Boundaries: Change and Continuity in the History of Learning Disability*, ed. Lindsay Brigham (Kidderminster: BILD, 2000), 91–92.

while patients under supervision were visited in their own homes (usually their family's home) by local authority officials or voluntary workers.¹⁰

The rise of eugenics since the 1880s had stoked fears of national degeneration, and Thomson shows that by the first decade of the twentieth century, “mental defectives became defined as the central eugenic threat facing the nation.”¹¹ Thus, the assumptions codified in the Act—that people with intellectual disabilities were incapable of improvement, and unworthy of consideration in terms of individual liberties—were opposed by few.¹² The legislation would expand a process of institutionalization and segregation that had been ongoing for a century. William Beveridge later explicitly linked individual rights with competence and productivity, arguing that since people with intellectual disabilities were “unemployable,” they should be considered dependents of the state, and lose all rights to parenthood and the franchise. As Tim Stainton puts it, Beveridge’s contention reflects “the belief that when one requires state supports and services, rights must be exchanged for the privilege.”¹³ It further illustrates the close association between employability and citizenship in an increasingly commercialized society.

Educational provision improved somewhat with the *Mental Deficiency Act 1927*, which emphasized preventive measures and mandated that local authorities provide loosely defined “training.” However, in 1929 a governmental Mental Deficiency Committee (Wood Committee) reported on the needs of “deficient” children and adults, and found widespread gaps and failings

¹⁰ John Welshman, “Ideology, Ideas and Care in the Community, 1948–71,” in *Community Care in Perspective: Care, Control and Citizenship*, eds. John Welshman and Jan Walmsley (Basingstoke: Palgrave MacMillan, 2006), 19–20; Jarrett, “The History of Intellectual Disability,” 38; Welshman, Nind, and Rolph, “General Introduction,” 16. See also Harvey G. Simmons, “Explaining Social Policy: The English Mental Deficiency Act of 1913,” *Journal of Social History* 11, no. 3 (1978): 387–403.

¹¹ Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870–1959* (Oxford: Clarendon Press, 1998), 20.

¹² Most notably, the Liberal (and later Labour) MP Josiah Wedgwood (Newcastle-under-Lyme) opposed both the 1913 Act and the *Mental Deficiency Act 1927*, considering them affronts to personal liberty. See Stainton, “Equal citizens?,” 92–93.

¹³ *Ibid.*, 94.

in the nation's special education services. Seventy-seven percent of "feeble-minded" children between ages seven and sixteen were attending non-specialized schools, and the total number of "defectives" in the nation was found to be much higher than previously thought.¹⁴

Kathleen Jones finds that "positive action" to develop specialized learning disability services was patchy in the interwar years. The quality of provision in a given geographic area largely depended on the initiative of individual local authorities (or lack thereof). In 1937, Dame Ellen Pinsent—who had served on the Royal Commission that influenced the 1913 Act—conducted a survey of Oxford mental health services, which were considered the best in the country. Even there, she found that individual conditions were often not properly diagnosed—mainly due to ignorance on the part of administrators—and that patients were often not referred to "the proper authority." Pinsent concluded that authorities were not making efficient use of available services, and that there was no incentive to improve those services that did exist.¹⁵ Intelligence testing was intended to underpin the classification of children, but Thomson notes that its application was inconsistent across local authorities, and that psychological tests were "rarely as fundamental a trigger to action as was social inefficiency."¹⁶ While community mental health care options had existed since the 1920s, the welfare legislation of the late 1940s made local authorities solely responsible for both preventive and community care. These responsibilities would be reinforced in the *Mental Health Act 1959*, although they were not made compulsory, and were not accompanied by adequate financial resources.¹⁷

¹⁴ Welshman, Nind, and Rolph, "General Introduction," 16; Madeline Roof, *Voluntary Societies and Social Policy* (London: Routledge, 1957), 114–115.

¹⁵ Kathleen Jones, *Mental Health and Social Policy 1845–1959* (London: Routledge & Kegan Paul, 1960), 135–138.

¹⁶ Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006), 111–112.

¹⁷ Welshman, Nind, and Rolph, "General Introduction," 17. As argued in this chapter, the Mental Health Act 1959 was welcomed by the Association for the improvements it heralded, but was also a disappointment in several important respects.

Though, as noted, eugenic ideas had largely dissipated by the period at hand, there had been few state-driven improvements in care for people with learning disabilities, and medical professionals continued to hold pessimistic views of their disabled patients' social and productive value.¹⁸ A.F. Tredgold's 1913 *Textbook on Mental Deficiency*, which was concerned mainly with social control and segregation, was still the main source of information on the subject.¹⁹ Training for children with learning disabilities was designed to pass the time, and perhaps to provide some relief for parents or caregivers—little thought was given to developmental potential. In the 1950s, research into this potential would begin to refute negative beliefs about children with learning disabilities. Jack Tizard, Neil O'Connor, and Ann and Alan Clarke all conducted studies that challenged widely held ideas around trainability, the necessity of segregation, the immutability of IQ, and commercial productivity.²⁰

However, some within the Association itself continued to reflect the legacy of the British eugenics movement. At the Association's 1955 National Convention, held in Birmingham, a Warwickshire Alderman (and Chairman of that County's Mental Health Committee) was met with applause upon suggesting the formation of "euthanasia panels" to consider "gross cases" of learning disability. Perhaps understanding the negative ramifications of his proposal, the Alderman stated, "I know it has been said that human instincts would run riot, but I have the greatest faith in the people of this country. They do not want to inflict cruelty on anybody: they want to help."²¹

¹⁸ David Race, "Historical Development of Service Provision," in *Services for People With Learning Disabilities*, ed. Nigel Malin (London: Routledge, 1995), 52.

¹⁹ David Race, ed., *Learning Disability: A Social Approach* (London: Routledge, 2012), 33–34.

²⁰ Welshman, "Ideology, Ideas and Care in the Community, 1948–71," 29. Tizard's work is discussed in further detail below.

²¹ "Euthanasia Urged For Children," *The Manchester Guardian*, June 13, 1955, 4; "Handicapped Children," *The Times*, June 13, 1955, 4.

The belief that people with learning disabilities remained developmentally static buttressed the system of disability classification written into the *Education Act 1944*.²² Children were tested for intelligence from age two, with those deemed “educationally subnormal” or “maladjusted” placed in special schools.²³ However, children falling under an IQ score of 50 were labelled “ineducable,” and no provision was made for their education outside of local authority occupation centres—generally under-resourced, intermittently operational facilities more focused on diversionary activities than genuine skill-building. Ineducable children were also denied supports like the free milk and nutritional supplements given to school attendees, and their parents were granted no respite from the stress of caring for children with disabilities. Even the parents of “educable” children with disabilities opposed the transfer of authority from education to health authorities upon the child’s sixteenth birthday, as this disrupted any established continuity of care.²⁴

Affected parents resented the exclusionary Education Act, and its passage corresponded with a burgeoning interest in voluntary advocacy—eventually culminating in the formation of the NAPBC. Prior to the Second World War, charitable provision for people with learning disabilities was administered mainly through the Central Association for Mental Welfare (CAMW). However, Jan Walmsley argues that this group “acted largely as an extension of the state’s machinery.” Working in conjunction with the Board of Control, in many cases the CAMW forced people with learning disabilities and their families to endure an unwelcome “public gaze.” Where the CAMW “sought to ‘do good’ from an abstract, rather lofty position,” the NAPBC/NAMHC allowed parents

²² John Welshman notes, “[w]e can characterise the view of people with learning difficulties in 1948 as one in which their neediness and passivity were unquestioned. They were seen as people who needed physical care and control, either within institutions or carefully policed within their families on the basis of an unchanging and unchangeable individualised pathology.” See Welshman, “Ideology, Ideas and Care in the Community, 1948–71,” 18.

²³ For a more complete discussion of “maladjustment,” see chapter 2, footnote 26.

²⁴ Welshman, Nind, and Rolph, “General Introduction,” 19, 22; Shennan, *Our Concern*, 5, 7.

to speak for themselves in advocating for better services and engaging major stakeholders.²⁵ As a source of social and political pressure, the Association thus deviated somewhat from the development of state-friendly supplementary voluntarism suggested by Jane Lewis and outlined in the first chapter of this dissertation.²⁶

A National Association

This section traces the establishment and growth of the Association at the national level. Beginning as the brainchild of a frustrated Hertfordshire mother, Judy Fryd, and with the support of existing groups like the NAMH, the Association developed an extensive network of local and regional branches, through which members were able to participate in major efforts and decisions. The group's initial goal was to provide mutual support for parents in the face of the exclusionary Education Act. However, it soon developed additional objectives: to improve existing provision and facilities; to provide services where none or few were available; to contribute financially to research on learning disability; and to diminish the stigma, fear, and shame surrounding a diagnosis of “deficiency” or “ineducability.”

In 1946, Fryd wrote to the magazine *Nursery World* about the difficulties she was finding in securing care and education for her daughter, Felicity, who had been judged “ineducable” and removed from school.²⁷ Her letter—along with a subsequent newsletter written by Fryd and advertised in the magazine *Sunday People*—led to a flood of correspondence from similar families. Fryd thus perceived a need for a national advocacy organization and began working to that end. In the meantime, she started putting closely located families in touch, facilitating the development of

²⁵ Jan Walmsley, “Straddling boundaries: The changing roles of voluntary organisations 1913–1959,” in *Crossing Boundaries: Change and Continuity in the History of Learning Disability*, ed. Lindsay Brigham (Kidderminster: BILD, 2000), 104, 109, 119.

²⁶ Jane Lewis, *The Voluntary Sector, the State and Social Work in Britain: The Charity Organisation Society/Family Welfare Association since 1869* (Aldershot: Edward Elgar, 1995), 13. The point should not be made too strongly—as will be seen, Association executives were often as glad to co-opt government bureaucrats as to oppose them.

²⁷ See Fig. 5.1.

local parents' groups. In 1948, Fryd and a like-minded group of parents were provided with office space by the NAMH, and set up an *ad hoc* "friends group" for the country's South-East region. Fryd's somewhat haphazardly published newsletters would soon be organized into a more formal publication, called *Parents' Voice*. She would eventually give up her position as an Association executive to focus full-time on this work.²⁸



Fig 5.1: NAPBC founder Judy Fryd with husband John and daughter Felicity.
<https://www.mencap.org.uk/sites/default/files/inline-images/John-Judy-Felicity%202.jpg>

From the beginning, the group had national ambitions: in a 1950 newsletter, Fryd affirmed that members should “redouble [their] efforts to establish branches in every part of [the] country,” and accordingly, the title “National Association for Parents of Backward Children” was adopted (as noted, this would be changed to the more modern-sounding “National Association for Mentally

²⁸ Wellcome Library, SA/NBT/F.9/7, APBC Newsletter 2, no. 7, February 1950, 1; Lord Rix, ed., *All about us! The story of people with a learning disability and Mencap* (London: Mencap, 2006), 25–26, 33–34; Choudhury, “The Forgotten Children,” 27–28. Thomson argues that parents’ magazines like these—in particular, the aptly named *Parents*—were crucial in mediating and circulating Bowlbyist theory for a popular audience. See Thomson, *Lost Freedom*, 90.

Handicapped Children” in 1955).²⁹ The Association’s organizational model relied more on independently operating local groups than in other mental health organizations, and its constitution provided for local and “functional” branches (i.e., affiliated with individual schools, centres, or institutions), which would pay membership fees either directly to the National Office or to a collective regional branch.³⁰ In 1950, there were local branches and occupation centre parents’ groups in Cambridge and Ipswich, a parents’ group in Torquay, and larger regional branches for Manchester, Middlesex, and Southern England.³¹ Within five years, the Association had grown to 167 local branches, and in 1957 it counted 185 branches and over 12,000 members.³²

Fryd quickly became a sought-after public speaker and commentator on the needs of children with “mental handicap.”³³ Under her direction, the Association firmly opposed the pathologization of intellectual disability and the exclusionary education system, with Fryd delineating the group’s objectives in an early newsletter:

[w]e have made known to the Ministers of Health and Education our desire that all children under 16 should be the responsibility of the Education Authorities, who should provide education of one sort or another for every child according to his handicap. All occupation and training centres and school departments of Institutions, Colonies, and Approved Homes should be inspected by the Ministry and regarded as part of the Education system.³⁴

The Association’s aims, as listed in its constitution, were: “[t]o promote the material, mental, and spiritual welfare of backward children”; “[t]o foster mutual help and support among the parents and relatives of such children”; and “[t]o promote closer co-operation and understanding between their parents and others responsible for their welfare.”³⁵ Upon adopting an official constitution and

²⁹ Wellcome Library, SA/NBT/F.9/7, N.A.P.B.C. Newsletter 2, no. 10, June, 1950, 1, 3; Shennan, 11.

³⁰ Wellcome Library, SA/NBT/F.9/7, N.A.P.B.C. Newsletter 2, no. 10, June, 1950, 2.

³¹ Wellcome Library, SA/NBT/F.9/7, APBC Newsletter 2, no. 8, April 1950, 3, SA/NBT/F.9/7.

³² Shennan, *Our Concern*, 11; *The Manchester Guardian*, March 8, 1957, 13.

³³ Shennan, *Our Concern*, 8–9.

³⁴ Wellcome Library, SA/NBT/F.9/7, APBC Newsletter 1, no. 12, November 1948, 2.

³⁵ Wellcome Library, SA/NBT/F.9/7, “Draft Constitution and Rules, National Association of Parents of Backward Children,” 1.

electing a national council, a clause was added to these aims, encouraging “more research into causes and treatment of mental handicap.”³⁶

Fryd was especially critical of existing occupation centres, and the apparent haste and carelessness of authorities in setting up such facilities:

I deplore the niggling spirit in which these places [occupation centres] have been established, (any old thing is good enough for the ‘duds’ seems to be the slogan in some quarters) and feel that with proper buildings and storage facilities and plenty of equipment that improvement in the Centre children would have been even more startling than it has been.³⁷

However, she was careful to differentiate these feelings from her admiration for those facilities’ staff members. In 1950, she affirmed, “[w]e give all credit to the devotion and skill of the [occupation centre] Supervisors and their helpers, and acknowledge gladly that the children love going and many of them make wonderful progress there.” Though she had been accused of condemning all mental hospitals and other institutions, along with the parents who committed their children to them, she stated that “[m]any [institutions] make a real effort to train and educate the patients and fit [patients] as far as possible for life in the Community.” Further, parents without money had little choice aside from institutionalization, and all facilities had problems with long wait lists and overcrowding.³⁸ It is important to note here that for Fryd, what value institutions did hold was in preparing patients for reintegration into community life.

Fryd consistently sought to cooperate and affiliate with like-minded bodies, which greatly facilitated the Association’s ability to further its objectives and reach a wide audience.³⁹ There seems to have been little territorial jealousy between the Association and its most significant

³⁶ Wellcome Library, SA/NBT/F.9/7, N.A.P.B.C. Newsletter 2, no. 10, June, 1950, 1.

³⁷ *Ibid.*, 7.

³⁸ Wellcome Library, SA/NBT/F.9/7, APBC Newsletter, 2, no. 8, April, 1950, 5; N.A.P.B.C. Newsletter 2, no. 10, June, 1950, 6–7.

³⁹ Choudhury, “The Forgotten Children,” 29–30.

counterpart, the NAMH. The two organizations often worked closely, and each publicized the other's efforts. In pushing for better conditions for occupation centre workers, Fryd repeatedly referenced NAMH training courses, as well as efforts by the NAMH and the Association of Mental Health Workers to improve compensation.⁴⁰ A 1957 NAMH leaflet recommended that in areas of the country lacking adequate services, parents should join the NAMHC to be connected with others in similar circumstances, "so they no longer feel they are alone with their problems."⁴¹ The same year, the Association also donated £7,500 to the Mental Health Research Fund, an NAMH-affiliated research organization.⁴²



Fig. 5.2: Children playing at Orchard Dene short-stay residential home.
Wellcome Library, SA/MIN/B/80/7/1

⁴⁰ Wellcome Library, SA/NBT/F.9/7, APBC Newsletter, 2, no. 8, April, 1950, 5, 7; N.A.P.B.C. Newsletter 2, no. 10, June, 1950, 7.

⁴¹ "Training Retarded Children," *The Manchester Guardian*, June 27, 1957, 7.

⁴² "Helping Defective Children," *The Manchester Guardian*, October 4, 1957, 5.

The most significant collaboration between the two groups was a short-stay residential home for children at Rainhill, Merseyside, called “Orchard Dene.”⁴³ Writing to the *Manchester Guardian* in 1952, NAPBC Honorary Secretary R. Beck lauded a recent article detailing the systemic difficulties faced by children with learning disabilities, and noted that the Association hoped to alleviate some of these difficulties by opening the home. Orchard Dene provided up to six weeks of care, allowing relief for “overtaxed families” without committing to institutionalization—benefiting children and alleviating the burden felt by their families were considered equally important objectives. Initial funding was raised through a “Week’s Good Cause” appeal on the BBC, and the NAPBC bought the property and provided ongoing funding. The Association contracted the NAMH—which was more experienced in residential care—to manage the home.⁴⁴

Despite the dire need for such facilities nationwide, and the name recognition of the NAMH, Orchard Dene consistently operated under capacity.⁴⁵ Beck blamed this on a lack of statutory funding, which necessitated a weekly user fee of four-and-a-half guineas to keep the home running. Local authorities could subsidize this charge in cases of hardship, but most seemed unaware of their responsibilities under relatively new welfare legislation—a situation the Ministry of Health was trying to rectify with informational circulars. Local authorities tended to overlook such short-stay homes altogether—they would send institutionalized children home for the summer on license, and fill their spots in hospitals with wait-listed children more suited to a home like Orchard Dene. This practice indicates the pressures experienced by both institutions and local authorities in situating children with learning disabilities, as well as a lack of communication

⁴³ See Fig. 5.2.

⁴⁴ R. Beck, “Helping Backward Children,” *Manchester Guardian*, August 5, 1952, 4. As seen in preceding chapters, the “Week’s Good Cause” BBC broadcast proved a boon to several groups in terms of fundraising.

⁴⁵ A similar problem was noted at Reynolds House, the NAMH home for “maladjusted” boys. See chapter 2.

around available capacity. In his letter, Beck made a general call for more residential provision to be established through the NHS.⁴⁶

Though the Association did not prioritize research as much as the NAMH—the inclusion of a clause on research in the group’s constitution was a last-minute addition—it did contribute to several crucial projects in the mid-to-late 1950s. In 1954 a Research Sub-Committee was established, chaired by educational psychologist Sir Cyril Burt.⁴⁷ The following year, the Sub-Committee distributed a questionnaire to parents nationwide, seeking insight into family histories and the genesis of learning disability. The questionnaire asked questions such as “Did you have a severe shock or worry while the baby was on its way[?] Was there any family anxiety at the time, such as difficulty with the husband or the wife’s own parents?”⁴⁸ In 1957, the Sub-Committee began publishing an academic journal, the *Journal of Mental Deficiency Research*.⁴⁹ Perhaps most notably, the Association funded the 1958 Brooklands Experiment, in which psychologist Dr. Jack Tizard compared a sample of “ineducable” children in small residential facilities with those in institutions, and demonstrated marked educational and developmental improvement in the former group. Association members thus felt validation in having pushed for such facilities over the previous decade.⁵⁰

⁴⁶ R. Beck, “Helping Backward Children,” *Manchester Guardian*, August 5, 1952, 4. See also Rix, *All about us!*, 34; Wellcome Library, Robina Addis Collection, PP/ADD/J/18/5, Robina S. Addis, “The Work of the National Association for Mental Health,” June 1955, 7.

⁴⁷ Rix, *All about us!*, 36. Cyril Burt (1883–1971) was a prominent psychologist and eugenicist, indicating the discipline’s ongoing (yet waning) influence in mental health care. His reputation suffered after his death, when it was discovered that he had fabricated data in studies of twin children. However, he has been rehabilitated somewhat, with defenders suggesting that the problems with the twin studies were a result of carelessness, rather than fraudulence. See Pauline M. H. Mazumdar, “Burt, Cyril Lodowic,” *The Oxford Dictionary of National Biography*, accessed March 26, 2020, <https://doi.org/10.1093/ref:odnb/30880>.

⁴⁸ “Question Paper on Backward Child,” *The Times*, May 13, 1955, 13.

⁴⁹ The journal is still published by Mencap, as the *Journal of Intellectual Disability Research*.

⁵⁰ Rix, *All about us!*, 36; Shennan, *Our Concern*, 14–16. Dr. Jack Tizard (1919–1979) was a New Zealand-born psychologist, who worked from 1946 to 1964 with the Medical Research Council unit for occupational adaptation (later social psychiatry), under Dr. Aubrey Lewis. There, he researched “the suitability of people with mild mental handicaps for industrial employment and social independence,” and his work heavily influenced the Royal

George Lee, NAPBC Secretary-General from 1957 to 1980, wrote that in the organization's early years, "there was little formal national or regional structure." The importance of establishing and maintaining a national profile was clear, and he continued,

[m]y first task was to gain the patronage and support of nationally organised figures to establish the Society in the public eye and to impress Government departments, health and local authorities and, hopefully, donors. Without a creditable letterhead one's approaches tended to be put in the waste paper basket.

The work of the National Office was "widened and strengthened" by appointing paid officers to each of the organization's eleven regions—when Lee began, there was only one in Manchester.⁵¹

The Association certainly expanded its operations and influence under Lee's direction, but his assertion of a previously low profile somewhat underplays the extent of the group's fundraising and publicity efforts in the late 1940s and 1950s. In 1955, Association member Doris Drown (originally of the Middlesex Branch) organized an annual Christmas card sale, which brought in £1,750 in its first year. In 1956 a professional appeals organizer was hired, and an anonymous donation of £500 per year for seven years allowed the Association to set up new offices in the Strand (larger offices would be acquired in Holborn in 1960). Religious patronage was provided by the Archbishop of Canterbury, the Archbishop of Westminster, the Moderator of the Church of Scotland, and the Chief Rabbi of England.⁵² Lee did manage to secure Lord Pakenham (later the Earl of Longford) as Chairman of the Association in 1957, presaging further connections with various peers over ensuing decades. These included Lords Stonham, Grenfell, Segal, Renton, and

Commission that produced the *Mental Health Act 1959*. See Neil O'Connor, "Tizard, Jack," in *The Oxford Dictionary of National Biography*, accessed April 8, 2020, <https://doi.org/10.1093/ref:odnb/31764>.

⁵¹ George Lee, "George Lee OBE: Secretary-General 1957–80," in *All about us! The story of people with a learning disability and Mencap*, ed. Lord Rix (London: Mencap, 2006), 89–90.

⁵² Shennan, *Our Concern*, 13.

Allen of Abbeydale.⁵³ In 1960, as part of “World Mental Health Year,” Grenfell opened a widely publicized Association exhibit in the Underground Station Exhibition Hall at Charing Cross.⁵⁴

The Association frequently sought opportunities to influence government policy at the national, regional, and local levels. As such, members continually identified sympathetic politicians, including parents of children with learning disabilities at all levels of government.⁵⁵ Representatives of relevant Ministries frequently addressed Association conventions and conferences—in 1956, Minister of Health Robin Turton assured a concerned Association audience that he had halted the “temporary slowing down” of loans for the construction of new occupation centres.⁵⁶ Having relevant issues broached in Parliament was also considered vital. In 1949 Fryd reported with satisfaction that Labour MP Frederick Skinnard (Harrow East) had asked the Labour Minister of Education George Tomlinson whether, in areas where local authorities did not offer adequate provision, parents could be given subsidies for private clinics and occupation centres. Tomlinson responded that the Education Act prohibited such expenditure, and Fryd wrote, “[w]e feel that Mr. Tomlinson ... could have shown more concern for the plight of the 30,000 or so ‘excluded’ children, and could have given in his reply more of a lead to local Education Authorities...” She went on, crystallizing the Association’s expectation of government:

...it should be incumbent upon the State to ensure that every child who can secure a vacancy in a private Home, School, or Occupation Centre should be enabled to do so irrespective of the means of his parents. The rigid departmentalising of the education of different grades of children stands in the way of implementing this policy.⁵⁷

⁵³ Rix, *All about us!*, 35–36. The Association tended to be more politically inclusive than the Conservative-oriented NAMH, MACA, and ESWS. Fryd’s obituary noted that she was a lifelong Labour party member, and while Labour peers tended to affiliate with the Association more often, there was also representation from Tories and crossbenchers. “Judy Fryd,” *The Guardian*, accessed April 8, 2020, <https://www.theguardian.com/news/2000/oct/24/guardian-obituaries1>.

⁵⁴ Shennan, *Our Concern*, 17.

⁵⁵ Choudhury, “The Forgotten Children,” 79.

⁵⁶ “‘Saintly Devotion’ in Hospital Wards,” *The Times*, May 7, 1956, 12.

⁵⁷ Wellcome Library, SA/NBT/F.9/7, APBC Newsletter 2, no. 6, December 1949, 2–3. By “departmentalising,” Fryd meant the exclusion of “ineducable” children from regular schooling—the main focus of the Association’s opposition.

Outside of Parliament, editorial pieces—as they did with most voluntary groups—helped the Association participate in policy debates. In 1953, Association Chairman Dudley Drown (husband of Doris) wrote to *The Times* in response to a recent debate on understaffing in mental institutions. Parliamentary recommendations on the matter of recruitment and retention centred mainly around pay levels, which were subject to the will of the Treasury. While Drown encouraged any talk of pay raises, he also noted that the special qualities of mental nurses “could not be bought”—these included “sympathy, understanding, and enduring patience.” As such, he recommended that mental deficiency be included as a subject in general nursing curricula, under the assumption that well-informed and educated nursing candidates would be drawn to this specialized field.⁵⁸

As the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission) began its work in 1954, the Association was asked to provide evidence. After consulting local branches and sending a delegation to meet with representatives of the Ministries of Health and Education, the National Office submitted a number of recommendations. Collectively, the various recommendations provide a clear guide to precisely what was thought to be lacking in learning disability provision in the 1950s. Fryd personally criticized the existing system of certification—which had been in effect since the passage of the *Lunacy Act 1890*—noting that many children needed to be certified to gain admission to a care home, but that their parents were often wary of associated stigma. Further suggestions centred around facilities, ascertainment, home help, and destigmatization. They included: making the operation of occupation centres compulsory for local authorities; developing “halfway hostels” to allow institutionalized patients to reintegrate into community life (much like the convalescent homes

⁵⁸ Dudley Drown, “Mental Health Service,” *The Times*, November 16, 1953, 9.

offered by the Mental After Care Association); improving the medical system's ability to recognize early signs of learning disability; increasing the "willfully inadequate" provision of home teachers; and halting the use of descriptors like "imbecile," "defective," and "ineducable."⁵⁹ Four years later, Conservative Minister of Health Derek Walker-Smith assured the Association that the elimination of terms like "sub-normal" and "psychopathic" was being "closely considered."⁶⁰

However, when the Commission released its own recommendations, it was clear that many of the Association's suggestions had not been adopted.⁶¹ At a Manchester conference for the Association's North-West region, working groups developed a series of new proposals based on the Commission's work, but it is unclear whether these had any effect. The new proposals included: replacing all "high-walled, bleak mental institutions" with individual care homes; increasing home help and providing training for those over age sixteen; promoting the study of learning disability among medical students, rather than solely "mental instability" (i.e. mental illness); and providing ongoing support for those who had left care homes for "the ordinary world."⁶²

The Mental Health Bill that developed from the Percy Commission's work was disappointing for the Association in many respects. George Lee would refer to the amount of new funding for local authorities—£6 million—as "chicken feed."⁶³ He went on, "[t]he money does not match the problem, which is the greatest single problem of social service remaining to-day."⁶⁴

⁵⁹ "Avoiding the 'Social Stigma' of Certification," *The Manchester Guardian*, June 30, 1954, 4. Presumably, these terms were meant to be abandoned in favour of "mentally handicapped," which was used in the Association's name after 1955. There were several shifts in terminology around both mental illness and learning disability in the 1940s and 1950s, in an effort to reduce the stigmatization of those conditions—for example, the terms "ineducable," "educationally subnormal," and "maladjusted" were introduced by the Education Act as replacements for the blanket term "mentally deficient." Of course, the new terms would themselves come to be seen as stigmatizing. See Welshman, Nind, and Rolph, "General introduction," 10.

⁶⁰ "Pledge on Mental Health Laws," *The Times*, April 22, 1958, 7.

⁶¹ "Avoiding the 'Social Stigma' of Certification," 4.

⁶² "When a Child is Backward," *The Manchester Guardian*, September 23, 1957, 3.

⁶³ "For Mentally Handicapped" *The Manchester Guardian*, May 28, 1959, 10.

⁶⁴ "Mental Health Experiment," *The Times*, May 28, 1959, 5.

As noted previously, local authority responsibilities for people with mental illnesses or learning disabilities were not made compulsory, and there was no funding to incentivize the creation of new services. Five years after the Bill's passage, in 1964, it was reported that the waiting list for special schools had remained fairly constant for a decade, at approximately 10,000 children. Though more children were being admitted to existing schools, and a plan was in place to build more facilities, the Association's annual report for that year claimed that "educational provision in many instances had not progressed much beyond that of 1870."⁶⁵

The Association also noted that its proposal to officially distinguish between mental illness and learning disability had not been heeded. People with learning disabilities continued to be inappropriately classified together with mentally ill people, and could still be forcibly detained and hospitalized.⁶⁶ After Pakenham criticized the Bill's shortcomings—particularly the lack of compulsion for local authorities—Minister Walker-Smith promised to issue a directive "making it a duty for local authorities to provide services." However, the government would not follow through on this promise.⁶⁷ Ultimately, it was felt that despite its limitations, the Bill was better than no change at all. Despite initial criticisms, Pakenham was also recorded as saying "[e]veryone who works in this field is grateful for it."⁶⁸ In terms of educational and training provision, as Chairman Lord Rix would put it much later, "at least it was a start."⁶⁹

⁶⁵ "10,000 Handicapped on Waiting Lists," *The Times*, April 27, 1964, 7.

⁶⁶ David Congdon, "Westminster Watch," in *All about us! The story of people with a learning disability and Mencap*, ed. Lord Rix (London: Mencap, 2006), 264–266.

⁶⁷ "Mental Health Order," *The Times*, April 27, 1959, 15.

⁶⁸ "Mental Health Experiment," *The Times*, May 28, 1959, 5. In the House of Lords, Pakenham would call the Percy Report "comprehensive, courageous and progressive," and recommended a summarizing pamphlet, produced by the NAMH, to "any noble Lord who wants to know what is in the Report without spending many weeks, and even months, with a towel round his head." 207 Parl. Deb. H.L. (5th ser.) (February 19, 1958), cols. 813–80.

⁶⁹ Rix, *All about us!*, 37.

Local Branches, Local Concerns

In 1957, Judy Fryd's husband John wrote to the *Sunday Times*, admonishing local councillors and health authorities who were unfamiliar with services for people with learning disabilities in their respective areas. He praised members of the Association's local branches, who, along with providing "mutual help and comfort," organized outings and other activities for children with learning disabilities, and donated equipment and volunteer hours to occupation centres and other training facilities. Through its numerous branches, the Association's main goals were the development of a sense of community—effectively countering the sense of isolation that parenting a child with learning disabilities could induce—and an improved ability to lobby statutory authorities. Parents "[pressed] the local and national authorities for additional facilities," Fryd wrote, thereby overcoming the sense of helplessness "which is inevitable for those parents who feel they are on their own."

The chapter now turns to these branches, which were at the forefront of NAPBC/NAMHC service provision and political advocacy. Much of this happened at the local level, as local authorities were chiefly responsible for statutory provision.⁷⁰ Regional, predominantly rural branches in Norfolk and Bedfordshire are considered, along with a smaller metropolitan branch in Lambeth, London. Each branch showed a similar pattern of development: they were formed as area parents grew frustrated with stigma and the lack of statutory provision for learning disability; they were more purely voluntary and heavily reliant on member involvement than other associations, which were often run by waged staff; they strongly supported area occupation centres, while also pushing for their improvement; they followed the lead of the Association's

⁷⁰ John Fryd, "The Mentally Handicapped," *The Sunday Times*, February 17, 1957.

National Office, but also forged their own independent paths; and they cultivated relationships with other voluntary groups and with local and national politicians.

Norfolk and Norwich

The National Association for Parents of Backward Children, Norfolk and Norwich Branch, was formed in July 1954.⁷¹ Sheena Rolph has found that the group's main impetus was the lack of adequate community care in the area: "both Norfolk and Norwich Councils were aware of the gaps in care, but had neither the political will nor the resources to address them in any positive or comprehensive way."⁷² Branch members decided on the more expansive "National" name to keep city-dwellers from thinking services were only confined to "county people." Echoing the National Office, the next year the name was changed to "Norfolk and Norwich Society for Mentally Handicapped Children" (referred to in this sub-section as "the Society"). At the Association's first meeting, Mr. R. Talbot was elected as the first Chairman, and Mrs. Gladys Abbs as Secretary.⁷³

Fundraising for the new organization relied largely on member initiative. Donations came from all over the county and the nation—often from surprising sources. The Society received several donations from national unions, including the Transport and General Workers Union and Constructional Engineering Union—perhaps an acknowledgement of the Association's skills-oriented training philosophy. The US Air Force, based at RAF Sculthorpe, donated £10 in late 1954. Two years later, the BBC donated £100, with the stipulation that the amount be spent on children under the age of sixteen; some of the funds went toward a summer outing and a Christmas

⁷¹ Norfolk is and was a largely rural and agricultural county located in East Anglia, with a generally lower-middle class to middle class demographic makeup. It is slightly under 200 km northeast of London, and forms part of the North Sea coast. Its major urban centre is the city of Norwich.

⁷² Rolph, *Captured on Film*, 25.

⁷³ Norfolk Record Office, Norwich, UK, Norwich Mencap Society Records, ACC 2002/225, Norfolk and Norwich Branch General Committee [Norfolk GC] Minutes, July 10, 1954. Mrs. Abbs, in the same vein as General and Honorary Secretaries of the other organizations surveyed here, would prove a driving force behind most of the Branch's operations.

party. In mid-1957, a donation was received from the Industrial Council of the Labour Party, and the General Committee made plans to approach the Conservative and Liberal Parties as well. Local assistance was also important: the Coronation Hall Church in the village of Hellesdon provided space for a children's party soon after the Association's founding, and community members organized frequent fairs, whist drives, and derby draws as fundraisers. A 1955 derby draw produced a profit of £50, and the following year a draw organized to pay for a summer outing saw 3000 tickets distributed.⁷⁴

One of the main ways the Society sought to publicize its efforts was through the distribution of short films. The Society's first Christmas party was filmed, with Secretary Abbs in charge of arrangements. The following year, permission to film at the Norwich Occupation Centre was granted by the Norwich City Council (NCC). Permission was also required from the staff of the Occupation Centre, and it was granted, subject to parents' consent. A representative of the local Health Authority asked to view the film before it was released to the public, and the Council reserved the right to cut any portion, but it was eventually created and approved, almost eight months after first being proposed. The use of film indicates a recognition of the symbolic power of children, and a desire to employ that power in generating both understanding and sympathy. This desire is further exemplified by the logo used by the National Association from the 1950s to the 1990s: a downcast boy named "Little Stephen."⁷⁵

⁷⁴ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, July 31, 1954, December 11, 1954, July 23, 1955, January 28, 1956, May 12, 1956, April 24, 1957.

⁷⁵ See Fig. 5.3. Walmsley, et. al. "The changing face of parent advocacy," 7. The authors argue that the use of "Little Stephen" represented a shift from viewing those with learning disabilities as "the menacing 'other'" to viewing them as "burdened; deserving of both sympathy and support." However, they continue, "the paternalism implied by the image has since been dismissed as incompatible with a contemporary discourse of equal citizenship." As a point of contrast, the Mental After Care Association, which by the 1950s dealt mainly with elderly patients, almost never showed those patients in publicity materials—the organization's annual reports only contained images of empty lounges and other common areas, or the facades of its numerous after care homes.



Fig. 5.3: NAMHC logo, “Little Stephen.”
 “News: Mencap,” *Nursing Standard* 7, no. 7 (1992): 10.

The NCC’s Mental Health Sub-Committee did initially require that no children’s faces be shown, but it was argued this would negate the film’s destigmatizing intent, by reinforcing the notion that it was somehow shameful to be attending the centre. The Society successfully pushed the Town Clerk to reverse the decision. Evidently, the Society demonstrated that it could appropriately handle the potentially sensitive material, as a second film of an occupation centre at Sprowston was created and approved within a month.⁷⁶ The stringent approval process indicates statutory concern for the privacy of parents and children, as it was likely assumed that some parents would still not want the community knowing they had a child with a learning disability. However, the entire point was to let the children be seen, to make it easier for parents to feel part of a community.

Public exhibitions and other events were also excellent opportunities for publicity, and in 1955, a stall was organized at Norwich Civic Week. No official photographs were available, so

⁷⁶ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, November 20, 1954, June 4, 1955, July 23, 1955, October 22, 1955, November 12, 1955, January 28, 1956, February 18, 1956; Sheena Rolph, *Captured on Film*, 39.

Mrs. Abbs offered to provide some of her son, “to show what work the children are capable of given proper training”—again, it was considered crucial that the public be able to see children with learning disabilities. The National Office also supplied emblem pins, and it was decided that the main message of the stall would be “We Need an Industrial Centre for Mentally Retarded Young Adults.” In 1956, a public meeting was organized around an address by Dr. Jack Tizard, who spoke on “Developing the Assets of the Mentally Handicapped.” The Society printed 500 advertising handbills to distribute to doctors, public health officers, local employers, and others. In late 1957, 10,000 handbills were printed to distribute at that year’s Norwich Trade Fair.⁷⁷

Providing parties, holidays, and outings was another major function; these offered entertainment for children often left out of other activities, allowed families to engage in leisure and social activity, and also gave some respite to potentially overwhelmed parents. A summer outing to the coastal village of Mundesley was arranged in 1955—parents and “any normal child” were charged a small amount, while the event was “free for the backward child.”⁷⁸ For the Society’s 1955 Christmas party, an entertainer was hired (at a reduced fee) to give a Punch and Judy show. The Women’s Voluntary Service (WVS) provided transport and tableware for the party, and the Hellesdon Women’s Institute made a donation toward food costs. Local politicians and other prominent Norfolk citizens also regularly provided books and toys for these parties.⁷⁹

In terms of facilities and services, the Society both provided its own and advocated for better local authority provision (which, as noted, was still not compulsory). In mid-1954, there were discussions around hiring a speech therapist, if enough parent members showed interest. A

⁷⁷ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, April 23, 1955, June 4, 1955, January 28, 1956, September 21, 1957.

⁷⁸ In all three local branches surveyed here, it was rare that financial constraints were allowed to prevent poorer families from participating. Parents were generally asked to pay for outings and other activities, but if they were unable to do so, the branches would cover the cost.

⁷⁹ The WVS again provided transport for the 1956 Christmas party. Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, March 26, 1955, October 22, 1955, November 12, 1955, October 12, 1956.

year later, Mrs. Abbs and the Society's Treasurer, Mr. King, began visiting area parents thought to be in need of support, and "found them most eager to discuss their problems." The General Committee decided that this visiting work should continue, as a way to assist parents and also to inform those who may not have been aware of the Society's work. In 1956, a designated Welfare Officer was appointed to continue these home assistance visits. As the Society covered all of Norfolk, accessibility was a consistent concern, and there was talk of forming a sub-section in Mundesley, "as it was difficult for some people to get into Norwich."⁸⁰

By 1956, local authorities operated occupation centres at Norwich, Sprowston, and Great Yarmouth, and an additional centre was being planned for Attleborough. The government had hoped to spur such activity by promising loans to local authorities, specifically for the construction of occupation centres. However, the following year, a site for the Attleborough centre had still not been selected. There was no provision beyond the occupation centres, and so a General Committee meeting at the beginning of 1955 established a major objective: the creation of "an Industrial, or Follow-on Center for those who have completed their training in an Occupation Centre." Industrial centres extended the few benefits offered by occupation centres to children who had aged out of the latter, and in particular, continued to offer vital respite to overburdened parents. Whereas occupation centres focused largely on diversionary activities, industrial centres were intended for simple skill-building, with an eye to improving potential employability.⁸¹

This objective was formalized at the Society's 1955 AGM, and advocacy for the establishment of an industrial centre would occupy the General Committee over the next several years. An Industrial Management Committee (IMC) was split off from the General Committee,

⁸⁰ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, July 31, 1954, March 5, 1955, July 23, 1955, June 9, 1956; Norfolk and Norwich Branch AGM Minutes, March 5, 1955.

⁸¹ Norfolk Record Office, ACC 2002/225, Norfolk AGM Minutes, March 5, 1956, March 16, 1957; Norfolk GC Minutes, January 20, 1955, April 21, 1956.

leaving the latter to—in their own words—“deal with the social side.” It was recognized that this project would necessitate a public pressure campaign, and so Committee members agreed to attend meetings of the National Association in London, and meet with statutory authorities on the matter as frequently as possible. In 1956, a “committee of experts” was incorporated into the IMC, composed of non-members “experienced in dealing with this matter.” A few months later, the IMC selected a church hall in Norwich—St. Swithin’s—as the centre’s future site. An attached hut would act as a nursery class, and the property could be leased for a five-year term, at £200 per year.⁸²

In early 1958, the new facility, named “The Norfolk and Norwich Industrial Centre,” was opened. The previous year, Mrs. Abbs had reported that efforts were underway to secure contracts with area employers, “to help make the centre pay.” Employment schemes were duly established with local firms, employing Centre attendees in fabricating concrete parts and carving handles for handbags. The Centre had a notable limitation, however—it catered only to boys. Mrs. Abbs argued it was “not practicable” to mix genders in the same building, and the then-President, a Dr. Morris, argued that the cost of hiring more staff and transport, and installing separate toilets, would likely be prohibitive. Area girls could still attend existing Occupation Centres, until they aged out, but it was not considered as important to train them in vocational skills—domestic skills were emphasized instead, indicating the types of futures imagined for both genders.⁸³

In ensuring access to services and facilities, one of the Norfolk Society’s (indeed, most branches’) strategies was the cultivation of relationships with other voluntary bodies and statutory

⁸² In the Summer of 1957, a Branch deputation consisting of Mrs. Abbs and three other General Committee members met with representatives of both the City and County Councils on the matter. Norfolk Record Office, ACC 2002/225, Norfolk AGM Minutes, March 5, 1955; Norfolk GC Minutes, June 4, 1955, November 12, 1955, April 21, 1956, September 22, 1956, November 17, 1956, August 24, 1957.

⁸³ Norfolk Record Office, ACC 2002/225, Norfolk AGM Minutes, March 16, 1957, March 29, 1958; Norfolk GC Minutes, January 19, 1958, March 22, 1958, April 12, 1958.

authorities, and the maintenance of positive relations with the National Office. With the proposed industrial centre, the Committee hoped especially to “join forces” with the Spastic Association (an advocacy society for children with cerebral palsy), whose Norfolk members would presumably make use of the facility as well. Other groups offering assistance and material aid to the Society mainly included women’s organizations like Inner Wheel and the aforementioned WVS—in 1954, a Miss Brown of the WVS agreed to serve on the Society’s General Committee.⁸⁴

The Society’s relationship with the National Office was harmonious for the most part, although members occasionally bridled at certain top-down impositions. All branches paid regular “affiliation fees” collected from the local membership, but in 1956 the National Office required contributions to a “reorganization fund” as well. At the 1956 AGM, it was resolved not to send any extra funds, but rather to hold over an amount under £50, pending more information.

This mild sense of mistrust over what National was doing with members’ fees was shared in other branches. As noted, the National Office regularly raised funds by selling Christmas cards—either selling them directly or wholesaling them to local branches for further distribution. However, in 1956 the Norwich Society refused to purchase and resell these cards, or to set out collection tins for the National Office. Instead, a single member sold 500 scented cards from a local perfumerie, and planned to order 1,000 more, with proceeds benefiting only the local branch. The Norwich and Norfolk Society was also selling its own Christmas cards—£200 had been raised by late September, and Mrs. Abbs had ordered another £140 worth.⁸⁵

It was important for the Society to maintain standing with area politicians, some of whom helped in a variety of capacities. The Norwich North Labour MP John Paton attended a Committee

⁸⁴ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, June 4, 1954, July 31, 1954, September 25, 1954.

⁸⁵ Norfolk Record Office, ACC 2002/225, Norfolk AGM Minutes, March 5, 1956; Norfolk GC Minutes, September 22, 1956.

meeting in September 1954, and Brigadier Frank Medlicott, Conservative and National Liberal MP for Central Norfolk, regularly interacted with the Society—he and the Lady Mayoress of Norwich were in attendance at the first annual Christmas party. The General Committee made sure to congratulate Medlicott on the occasion of his knighthood in 1955, and the following year he agreed to become one of the Society’s four Vice-presidents. In this capacity, he promised to “pursue further the matter of training for special cases” in Parliament.⁸⁶

While it proved relatively easy to cultivate the good graces of parliamentarians—who had no direct responsibility for disability services, even if they did have some control over local authority purse strings—the Society’s relationship with the NCC was more fraught. The NCC often seemed to want to ignore the Society altogether, and the General Committee was repeatedly forced to temper its expectations in demanding improved services and communication. In September 1954, the General Committee resolved to request a meeting with the Council’s Health Committee, “to discuss facilities for training at Occupation Centres and parents [*sic*] problems.” The Health Committee would not commit to a meeting, but did reassure the Society that two day centres were being planned. Several months later, the General Committee was again denied a meeting, and two local authority doctors declined an invitation to the upcoming Annual General Meeting, attending a conference instead.⁸⁷

At that AGM, Gladys Abbs encouraged members to attend any events held by Council candidates, “and refuse to give their vote to those who were not in sympathy with the cause.” While it is unclear how many members took Abbs up on this suggestion, within a few weeks the NCC had requested a new meeting between its Mental Health Sub-committee and Society

⁸⁶ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, September 25, 1954, October 30, 1954, January 20, 1955, February 18, 1956, October 12, 1956.

⁸⁷ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, September 25, 1954, December 11, 1954, February 26, 1955.

members. Chairman Talbot hoped that all interested parents would be able to attend, but it was noted that the Council “would probably stipulate who they wanted.” After the meeting was held, General Committee Minutes record disappointedly that the Mental Health Sub-committee had “nothing concrete to offer ... at the moment.” The General Committee then asked that a Society member be co-opted into the Mental Health Sub-committee, but this request was refused. The Council did assert that once the Society completed work on its industrial centre, it “would receive a request for help most sympathetically”—though few specifics were forthcoming.⁸⁸

When the NCC did provide new services, it was generally done without consulting the Society—reflecting Welshman, Nind, and Rolph’s observation that provision considered “progressive” by statutory authorities could often appear ill-conceived or burdensome by the families it was meant to help.⁸⁹ In 1956 it was reported that the Mental Health Sub-committee had decided not to allow “special cases”—children with particularly severe disabilities—to attend nursery classes at the Norwich Occupation Centre. Instead, it had organized a home visitation scheme, intended to relieve mothers for only three hours per week. The General Committee decided to protest, arguing that the scheme “[did] not provide any training for the children which is what they [needed].”⁹⁰

Despite this discord, the Society still sought to link the two bodies wherever possible, and in 1957 an NCC representative was appointed to the Society’s Industrial Management Committee. However, shortly following this appointment, some on the General Committee complained about “unqualified” members on the IMC—an apparent reference to those who either did not have children with learning disabilities, or were not full members of the Association. The protesters

⁸⁸ Norfolk Record Office, ACC 2002/225, Norfolk AGM Minutes, March 5, 1955; Norfolk GC Minutes, June 4, 1955, July 23, 1955.

⁸⁹ Welshman, Nind, and Rolph, “General Introduction,” 23.

⁹⁰ Norfolk Record Office, ACC 2002/225, Norfolk GC Minutes, February 18, 1955.

were reminded by executives that these members “were co-opted for the advice and special services they could give.” Two Medical Officers of Health—presumably for Norfolk County and Norwich—were later added to the IMC, and were both subsequently made Vice-Presidents of the Society.⁹¹ The protest indicates that even as outsiders were incorporated to increase the Society’s advocacy abilities and body of expertise, there were some who clung to its original identity as a parents’ support group.

Bedford and District

The Bedford and District Society for Mentally Handicapped Children (referred to in this sub-section as “the Society”) was formed in October 1955.⁹² The Society’s original General Committee consisted of Chairman Mr. J.B. Irwin, Secretary Mr. J.E. Nickson, and eight other members. In an approach common to Association branches, two of these members were co-opted representatives of local authorities. Three years later, Mr. H.A.A. Beale would be elected Chairman, but Nickson remained a steady presence as Secretary. By the beginning of 1956, the Society counted 92 members. The following year this had risen to 101, and by 1958 there were 112—however, Chairman Irwin believed “a much larger membership [was] necessary ... if a true understanding [was] to be given to the public of the problem of mental handicap.”⁹³

Throughout the period at hand, Committee members repeatedly expressed concern that parents were not receiving adequate information, resources, and access to statutory services. In 1956, Chairman Irwin met with a representative of the local Education Department, hoping to have

⁹¹ Norfolk Record Office, ACC 2002/225, Norfolk AGM Minutes, March 29, 1958; Norfolk GC Minutes, November 2, 1957, November 30, 1957.

⁹² The county of Bedfordshire is located approximately 40 km north of London. It is characterized by small market towns and rural districts, and the largest settlements are the towns of Bedford and Luton.

⁹³ Bedfordshire Archives & Records Service, Bedford, UK, Records of Bedford Mencap, X682/1, Bedford and District Society General Committee [Bedford GC] Minutes, October 3, 1955, February 27, 1956, May 14, 1957; Bedford and District Society AGM Minutes, March 18, 1958; Bedford and District Society, “Report of the Committee for the Twelve Months Ending December 31, 1957.”

him speak at a public meeting on available facilities for “sub-normal” children. A similar meeting held four years later was poorly attended, and the General Committee urgently discussed “alternative methods of publicising Mental Health.” In 1959, the wives of the then-Chairman and Secretary, along with a Committee member, resolved they would carry out regular visits to parent-members, “particularly in outlying areas with whom the Society had little contact.”⁹⁴

The Society generally got along well with its local counterparts, as well as the National Office. A 1959 summer holiday was run jointly with the Association’s Luton Branch, and received more applications than there were available spaces. However, the Society also guarded its independence, turning down an offer to have a subordinate “formal connection” with the larger Hertfordshire Branch nearby. Representatives of the National Office were generally held in high esteem—the General Committee eagerly anticipated a possible visit by Judy Fryd, and later an address by George Lee. The respect was mutual, as the National Office published an appreciation of Chairman Irwin in *Parents’ Voice* upon his resignation in 1957.

The one element that could cause friction was the affiliation fee owed to National. In late 1958, the National Office revised their scheme of charges to local branches, increasing fees to better reflect total membership tallies, and a General Committee member argued that “this might encourage Head Office to be extravagant at the expense of local Societies.” It was agreed that the nearest regional branch—Thames North—should be approached about safeguards against this possibility.⁹⁵

Advocacy in Bedford was largely confined to local concerns, and attempts to influence broader policy goals were infrequent. In the months leading up to passage of the Mental Health

⁹⁴ Bedfordshire Archives, X682/1, Bedford GC Minutes, May 28, 1956, March 23, 1959, April 27, 1959, July 25, 1960.

⁹⁵ Bedfordshire Archives, X682/1, Bedford GC Minutes, October 10, 1955, January 16, 1956, November 24, 1958, February 9, 1959, March 23, 1959; “Report of the Committee.”

Act, Secretary Nickson did write to George Lee, asking whether he should approach local MPs about amendments to the Bill. Lee advised that Nickson do so, and Nickson promptly requested meetings with Conservative MPs Christopher Soames and Alan Lennox-Boyd, “to put forward the Society’s view.” Though responses were received from both, Nickson appears to have been brushed off. He had to remind the politicians the following month, and the meetings were not ultimately held until January 1960—after the Act had received Royal Assent.⁹⁶

In a similar vein, publicity efforts were somewhat more muted than in Norwich, and the Bedford Society relied more heavily on direction from the National Office. Advertising leaflets were obtained through the National Office rather than written and printed directly, and in 1957 arrangements were made with the Bedford Library to display copies of *Parents’ Voice*. The Committee frequently sought notable figures from the medical community for public meetings, and perhaps their most significant speaker was Dr. Alfred Torrie, NAMH Medical Director and Physician Superintendent of The Retreat at York. In 1959, the Society submitted details for inclusion in an informational Home Office circular, along with an accompanying poster for display at the General Post Office. The end product seems not to have been satisfactory, as Secretary Nickson wrote to the National Office with several complaints. The Society staged a more successful display in 1960 at a local nursing exhibition, obtaining photos from the *Bedfordshire Times*, and providing a film produced during the previous summer’s holiday.⁹⁷

Holidays, outings, and other activities occupied much of the Committee’s energy. In 1957 the Society booked a springtime holiday to the coastal village of Overstrand, with room for 40 guests at a holiday home run by the religious organization Christian Endeavour—22 children and

⁹⁶ Bedfordshire Archives, X682/1, Bedford GC Minutes, June 1, 1959, June 29, 1959, October 13, 1959, November 30, 1959, January 25, 1960.

⁹⁷ Bedfordshire Archives, X682/1, Bedford GC Minutes, October 31, 1955, May 14, 1957, March 23, 1959, April 27, 1959, January 25, 1960; “Report of the Committee.”

10 “helpers” ultimately attended (these were likely parent supervisors). The Committee resolved to cover the cost of transport and half the cost of the accommodation, and to provide £20 towards “excursions and entertainment.” It was agreed that parents should pay more if able, but if they were not able to bear even half the cost, the holiday would be provided free of charge. The same year, children’s parties were held in the Summer and at Christmas—the former had a “conjurer” who “was much enjoyed,” and the Bedfordshire County Council (BCC) provided a school field, a large tent, and other equipment. In 1959 an outing was planned to Whipsnade Zoo—transport and entrance fees would be covered, but parents had to be present to provide supervision. It was noted that while a coach could not enter the grounds, “push chairs” would be available for any children who needed them.⁹⁸

The Bedford Society seemed generally satisfied with the level of provision in the area, and did not advocate strongly for the creation of new training facilities (though it did push the local authorities for a new outpatient clinic). The Committee instead sought to maintain and improve existing services wherever possible. The Society cultivated a close relationship with Bromham Hospital (formerly the Bedford Lunatic Asylum), purchasing a wireless set for patients and organizing an outing for “older patients” to a pantomime show. The generosity of local groups and individuals was crucial to this kind of work—“sponsors” were found for all Bromham patients without friends or relatives in the area, and appeals for Christmas gifts were regularly sent to Bedfordshire churches. At Christmas, the Society spent approximately £20 on a play house and a water table for the children at Bromham, and also helped organize a Bromham Hospital Parents’ Association. Aside from its work with Bromham patients, in 1959 the Society donated a sand pit and swings to the local Bedford Occupation Centre, at a cost of around £70. A “handing over

⁹⁸ Bedfordshire Archives, X682/1, Bedford GC Minutes, February 19, 1957, April 27, 1957; “Report of the Committee.”

ceremony” was arranged, with the involvement of Secretary Nickson’s wife and Dr. V.C.V. Brothwood, Medical Officer of the BCC Health Department.⁹⁹

While local advocacy groups of all types could have difficult relationships with local authorities, the BCC was generally supportive of the Society’s endeavours. In December 1955, it was reported that the Council had suspended an occupation centre at Kempston, following a government directive to avoid as much capital expenditure as possible. The General Committee went into action: appeals would be made to the Council and to local MPs, and the Press would be contacted. However, the Committee was not wholly optimistic, and agreed that “it might be worthwhile pressing for alternative accommodation.” No progress had been made by the following month, and it was agreed that the Council should be contacted for “assurances that action would not be permanently postponed.” The Council Chairman returned a “sympathetic reply,” giving a sense that the centre would be reinstated.¹⁰⁰

The centre reopened in 1958, and an annual report noted that Dr. Brothwood—the main point of contact between the Society and the Council—had been a source of “support and co-operation.” In 1958, Secretary Nickson wrote to the doctor with several suggestions—including improved coordination between mental health practitioners and regular practitioners—and his letter resulted in a “very cordial meeting” with authorities. There, Dr. Brothwood assured Society members that the Health Department “had taken steps to ensure that liaison between the Health Visitors and the Mental Health Officers was effective,” and also that “Health Visitors were adequately trained for advising on the care of mentally handicapped children under 5.” However, the voluntary-statutory relationship was still not entirely trusting, as Nickson was sceptical of the

⁹⁹ Bedfordshire Archives, X682/1, Bedford GC Minutes, October 3, 1955, May 28, 1956, October 15, 1956, February 19, 1957, October 8, 1957, February 14, 1958, February 9, 1959, March 23, 1959; “Report of the Committee.”

¹⁰⁰ Bedfordshire Archives, X682/1, Bedford GC Minutes, December 5, 1955, January 16, 1956, February 27, 1956, February 14, 1958, April 24, 1958.

latter point. The Committee agreed they would examine the matter further and seek information directly from parents.¹⁰¹

Lambeth and District

Reflecting its more localized operations, the Association's Lambeth branch was originally known as the "National Association of Parents of Backward Children, Herne Hill Section."¹⁰² The group was established in January, 1953, with Mr. J. Woodall as its first Chairman (though General Committee roles would frequently be exchanged between different executives). Initially, 60 informational letters were sent to parents in the area, and the group began operations with fourteen paying members and eleven "potential" members.¹⁰³ The name would later be changed—in line with the National Association's name change—to "Lambeth and District Society for Mentally Handicapped Children," (referred to in this sub-section as "the Society") under the assumption that a more expansive name would generate more public interest. At the time, the General Committee had polled members and suggested the name "Peter Pan," which the National Office rejected. This was a questionable choice, as it suggested that members' children could never grow up—a notion advocated against fiercely by the Association as a whole.¹⁰⁴

The Society would have mixed success in fundraising and securing facilities from other groups in the area. Initial fundraising outreach included the Dulwich Football Club, which did not contribute, but the use of a community centre in the district of Tulse Hill was offered at a small charge for Society events. A Coronation party was planned there in 1953. The Society also sought

¹⁰¹ Bedfordshire Archives, X682/1, Bedford GC Minutes, February 14, 1958, May 29, 1958; "Report of the Committee."

¹⁰² Herne Hill is an inner-city London district that overlaps the boroughs of Lambeth and Southwark. Lambeth is located on the south side of the Thames, and also encompasses districts including Brixton and Streatham. In the 1940s and 1950s, Lambeth housed significant working class and immigrant populations.

¹⁰³ Lambeth Archives, London, UK, Royal Society for Mentally Handicapped Children and Adults (Mencap): Lambeth Branch Collection, ARC/2015/8, Lambeth and District Society General Committee [Lambeth GC] Minutes, January 30, 1953, December 14, 1954, March 3, 1955; Lambeth AGM Minutes, February 19, 1957.

¹⁰⁴ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, March 3, 1955.

to hire a hall at Dulwich Road Methodist Church for a sale of work (similar to a craft fair), but they were turned down on the grounds that the church could not hold non-religious events (several years later they were permitted to regularly rent space at the nearby Stockwell Methodist Hall). As with other branches, the Lambeth Society raised its own funds by selling stationery purchased wholesale through the National Office: in 1954 it purchased 500 stickers at a cost of 5s., and in 1957 it received around £330 worth of Christmas Cards to sell.¹⁰⁵

While local charity was not always forthcoming, the Society was generally able to secure local dignitaries to attend its functions and fundraisers. The Mayor and Mayoress of Lambeth attended several Society parties, with minutes from February 1957 recording that they had appeared “in full regalia.” The following year, the Mayor and Mayoress attended the annual Christmas party, along with the Labour MP for Brixton, Marcus Lipton—all three then agreed to become Honorary Patrons. In 1959 the Bishop of Southwark was also made a Patron.¹⁰⁶

Due to its relatively small geographic area, the Herne Hill/Lambeth Society tended to be more compartmentalized and less independent than the regional branches. It, along with other London sections like Lewisham and Bermondsey, belonged to the larger Southeast London Branch, which usually interposed between them and the National Office. National kept the London sections abreast of developments by frequently distributing leaflets, informing them of general meetings, regional conferences, the existence of local youth clubs, and the workings of the Association’s short-stay children’s home, Orchard Dene. In 1957, the Society was informed that complaints should no longer be sent directly to National, but should be routed through the Southeast Branch. The General Committee was evidently unsatisfied with its membership

¹⁰⁵ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, March 27, 1953, May 11, 1953, May 26, 1953, August 19, 1953, March 16, 1954, August 28, 1957, September 27, 1957.

¹⁰⁶ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, February 6, 1957, December 12, 1958, January 27, 1959, July 7, 1959.

arrangement, as shortly thereafter, it decided to resign from the Southeast Branch and deal directly with National—ongoing membership in the former was considered “unwarranted.” However, the following month, having received a pleading letter from the Southeast Branch, which was evidently in the midst of a membership crisis, the Committee reversed course and sent a donation of £4.¹⁰⁷

Occupation centres in Lambeth were under the direction of the London County Council (LCC) and the Society had no direct role in operating facilities (unlike the Norfolk and Norwich Society, with its industrial centre). As a result, the General Committee took on more of an advisory and advocacy role. In 1953, it was agreed to bring a number of concerns and suggestions regarding local occupation centres—particularly around the lack of adequate transportation—to the Southeast Branch. A few months later, at a Southeast Branch meeting, an LCC representative “agreed that most Centres required great improvement—and that the L.C.C. would try to cooperate if alternative accommodation could be found.” It was unclear who would be responsible for finding this accommodation, although the implication seems to have been the NAMHC.¹⁰⁸

Among its various activities, the Society staged outings, children’s parties, and social evenings for parents, and also monitored conditions at area occupation centres. In 1955, three coaches were hired for an outing to the seaside town of Littlehampton. Two years later, a visit to Dymchurch on the Kentish coast was hailed as “a great success,” and a double decker bus was rented to transport children to a sports day. In 1957, Society representatives notified the Southeast Branch that children had been transferred out of the Peckham centre without their parents being notified. In 1958 the Committee resolved to buy “something useful” for each occupation centre in

¹⁰⁷ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, March 3, 1955, February 6, 1957, March 6, 1957, August 28, 1957, September 27, 1957, November 11, 1957, March 5, 1958.

¹⁰⁸ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, March 27, 1953, May 26, 1953, July 10, 1953.

its remit—it is unclear what items were purchased that year, but in 1959 the Society supplied gym tunics to the Herne Hill centre.¹⁰⁹

As with the other branches, Executive Committee members were often personally involved in members' welfare. However, somewhat uniquely among the various sets of minutes examined in this dissertation, disappointment over low member participation is a common theme in the Society's archival materials. At a 1955 meeting, it was noted that one member's subscription had not been renewed, and the then-Chairman, a Mr. Thompson, resolved to visit the member personally with someone else from the Committee. The Chairman's personal interest could be construed as a heavy investment in member participation and welfare, or perhaps in subscription revenue.¹¹⁰ It is entirely possible that, being located in a largely working-class area, Lambeth Society members simply had less leisure time, and thus less time for voluntary activity. The same anxieties over participation are not evident in the records of Norfolk or Bedfordshire—areas more characterized by lower-middle-class and middle-class communities.

This anxiety over participation was likely made more acute by a Southeast Branch representative's 1955 assessment that “very little was being done by the Herne Hill Section”—the Southeast General Committee had debated whether it made sense to keep the Society running altogether. In March 1956, a dancing display fundraiser was “[n]ot well [supported] by ... members.” In April, Chairman Thompson announced that collectors were needed for an upcoming Mental Health Flag Day, but support was generally lacking for this as well. A whist drive held the same month at a parents' meeting was considered “a great success”—it may simply be that whist was more enjoyable than watching a dance troupe or distributing flags on a street corner.¹¹¹

¹⁰⁹ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, May 3, 1955, July 3, 1957, August 28, 1957, November 11, 1957, March 4, 1958, March 31, 1959.

¹¹⁰ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, September 13, 1955.

¹¹¹ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, March 3, 1955, April 5, 1956; Lambeth AGM, February

At the Society's 1958 AGM, repeated references were made to the General Committee's ongoing disappointment with the membership. The Chairman, by then a Mr. Pearson, gave a mixed account: he was "very disheartened at the poor attendance during the past year," but also noted it was "otherwise a very good year." With that said, he warned that "only by very hard work shall [the Society] get funds." The Society at that point counted 72 subscribers, but the Secretary, Miss Hewlett, was also "[v]ery disappointed at support given by members." The Social Secretary, Mr. Demmery, was "very disappointed at help given by the majority of our members for the Sale of Work"—a refreshment stall had lost the Society money, and like Mr. Pearson, the Social Secretary was disappointed at attendance levels. Indeed, the AGM at which these complaints were made was almost not held due to low attendance. Nineteen members—nine of whom sat on the General Committee—decided to go forward, after some debate.¹¹²

In July, it was noted that only three responses had been received to a call for support for that year's Flag Day. In September, a proposed Sale of Work received "no response at all," and only four letters were received regarding a proposed jumble sale. A social evening held for parents was deemed "not a success" by Social Secretary Demmery. Continuing this trend, Demmery complained at the 1959 AGM "of the lack of support at the outings and [parties]"; he looked forward to a planned outing with only children—no parents. Finally, at the first meeting held in 1960, it was proposed "to raise interest" in the Society, especially given that it was Mental Health Year.¹¹³

19, 1957.

¹¹² Lambeth Archives, ARC/2015/8, Lambeth AGM, March 18, 1958.

¹¹³ Lambeth Archives, ARC/2015/8, Lambeth GC Minutes, July 1, 1958, September 10, 1958, February 24, 1959, January 5, 1960; Lambeth AGM, April 21, 1959.

Conclusion

In a brief history of the Association's early political advocacy work, David Congdon—who worked as Head of Campaigns and Policy—writes that without the organization,

[i]n all probability, hundreds of thousands of children with a learning disability wouldn't be able to go to school ... Thousands more adults would still be living in terrible conditions in out-dated institutions—away from their families and friends—deprived of the right to live as independently as possible in the community.

He lists five “rights” that the Association helped to promote over its decades of operation: “the right to education, the right to live in the community, the right to liberty, the right to equal rights and opportunities and the right to services that meet people's needs.”¹¹⁴

More so than the other groups surveyed in this dissertation, the NAPBC/NAMHC cultivated an adversarial relationship with government, premised on parents' own observation of how the welfare state was failing their children. Unlike those other groups, which all existed in some form prior to the birth of the welfare state, the Association was established just as local authorities received new responsibilities for mental welfare. It was structured with a local, grassroots emphasis, the better to influence local policy, and its tenacious advocacy emerged from members' and executives' direct experience with learning disability. While there were, of course, members and executives of the NAMH, MACA, and ESWS with experience of mental illness, those groups were generally spurred more by philanthropic impulse than direct need. Despite its criticism—indeed, probably because of it—the NAPBC/NAMHC was not fully shut out by governmental bodies. Even a relatively hostile body like the Norwich City Council recognized the value of a local group committed to tasks for which it was nominally responsible. The appointment

¹¹⁴ David Congdon, “Westminster Watch,” in *All about us! The story of people with a learning disability and Mencap*, ed. Lord Rix (London: Mencap, 2006), 262.

of county and city officers to organizing committees Association-wide indicates that the voluntary-statutory relationship was never entirely sour.

While the parent movement achieved many of its early goals—particularly improving entitlement to education and access to community services—the process revealed “underlying tensions.” These included disagreements over the extent of deinstitutionalization, the character of interest group political representation, and the level of self-advocacy needed among people with learning disabilities.¹¹⁵ The goals of the NAPBC/NAMHC—as with almost any voluntary advocacy group—were frequently at odds. On one hand, the Association fought to establish itself as a national authority on learning disability, to influence policy at all levels of government, and to maintain its relevance as the welfare state occupied much of its traditional jurisdiction (or at least, the jurisdiction of similar organizations—the Association and the welfare state were formed relatively concurrently). On the other hand, if the Association was wholly successful in its aims—if government acceded to all demands, if services were drastically improved, if the rights of people with learning disabilities could be guaranteed—it could have advocated itself right out of existence.

Conditions did gradually improve for children with learning disabilities—although this improvement should not be overstated—“ineducable” children would not be officially incorporated into the education system until 1970. At the ground level, however, the transition from dearth to abundance could be frustrating and uncertain. For a small local branch like Lambeth/Herne Hill, improvements in attitudes, services, and facilities coincided with a disheartening decrease in participation levels. However, the National Association and larger

¹¹⁵ Walmsley et. al., “The changing face of parent advocacy,” 16.

regional branches like Norfolk and Bedfordshire were able to maintain a sense of vitality, influence, and forward motion, as there was always more to accomplish.

The Norfolk and Norwich Society's commitment to establishing an industrial centre reflects a firm belief in the developmental potential and social value of children with learning disabilities—a belief that, at all levels of government, was either opposed for cost reasons, or simply not considered. A major goal for the Association's branches was to ensure that local occupation centres instilled valuable social, vocational, and—where girls were concerned—domestic skills. While industrial skills were not heavily emphasized in occupation centres, Association members were still keen to show off their children's creations through sales of work and informational films. Near the end of the period examined here, George Lee signaled an increased interest in productive skills, announcing a new effort to build a hostel and sheltered workshop at Slough, “where goods of marketable value would be produced.”¹¹⁶

The group did not remove the word “children” from its name until 1969, when it adopted the name “Mencap” and signaled a shift to advocacy for all people with learning disabilities.¹¹⁷ That adults were not initially considered indicates several things about the Association's early priorities and contemporary thinking around learning disability. It reflects the Association's essential identity as a parents' organization—parents being understood as having young children, rather than adult dependents. Much of the Association's early advocacy work was premised on sympathy for children (which explains the drive to include children in occupation centre films and public exhibitions). As a matter of resource allocation, children were thought to need a greater share of the kinds of services the Association provided and advocated for. Further, Association

¹¹⁶ “For Mentally Handicapped” *The Manchester Guardian*, May 28, 1959, 10. *The Times* reported that approximately 50 children and youths at a time would be housed and trained, and that the scheme was expected to cost £40,000. “Mental Health Experiment,” *The Times*, May 28, 1959, 5.

¹¹⁷ “Mencap's history,” accessed February 22, 2020, <https://www.mencap.org.uk/about-us/mencaps-history>.

members may have clung loosely to traditional beliefs about the immutability of learning disability: children could be molded and improved, but for adults with learning disabilities, the die had been cast. They could be cared for and made comfortable, but any notion of education, improvement, or development was generally discounted.

Unlike many mental illnesses, learning disability is generally a lifelong condition, evident from a young age. Thus, relative to a group like the ESWS, which was wholly committed to workplace reintegration, expectations for a “normal” life of work and family were tempered somewhat in the NAPBC/NAMHC. This did not mean, however, that occupational skills and productivity fell completely by the wayside. A major goal of the NAPBC/NAMHC was to advocate for services that were constructive and educational, rather than merely diversionary. The Association subscribed to the argument—made most forcefully by Dr. Torrie—that the “one talent” (i.e. “deficient”) child could dramatically improve IQ scores and become a productive member of society, given the proper support, environment, and education.¹¹⁸

¹¹⁸ Parts of Torrie’s speech on “one talent” children are reproduced in Choudhury, 57–58.

Conclusion

This dissertation has explored the relationship between the state and voluntary organizations around the provision of mental health care and learning disability care in two main ways. First, it offers an institutional history of four distinct voluntary organizations, concerned with operations, administration, leadership, and publicity, among a host of other day-to-day affairs. Second, it asks how these organizations maintained their vitality (and importantly, their sources of support and funding) within a landscape of expanding statutory service provision. That they did survive, and thrive, into the present suggests that the interventionist, “cradle-to-grave” welfare state was not as all-encompassing as originally envisioned—at least in the field of mental health care.

From its inception in 1946, the National Association for Mental Health followed the course laid out by its mental hygienist predecessor organizations, by emphasizing education and early prevention, taking over stewardship of existing mental health facilities, and pushing for the development of new ones. Within the welfare state, NAMH representatives would consistently emphasize their role as equal and complementary service providers—in publicity materials and communications with the government, they reinforced the notion that they would not simply bolster statutory efforts. Instead, they envisioned themselves contributing to mental health care by innovating (“pioneering,” to use their preferred term) and supplying facilities and services that statutory authorities ostensibly could not otherwise provide. Two of the group’s main tools in ensuring ongoing indispensability were residential facilities and professional education courses. Further, the NAMH co-opted highly-placed bureaucrats and politicians—like Rab Butler and Lord Feversham—to its cause, securing access to levers of power that were often out of reach for

smaller, less influential groups. As noted in chapter 2, Butler himself was largely responsible for the legislation that ensured an ongoing need for NAMH facilities: the *Education Act 1944*.

Through its varied efforts, the NAMH ensured that decommodifying welfare goals were supported and furthered. In particular, its residential homes were intended to ease economic and emotional burdens on both families and people with mental illness or learning disabilities (given some of the problems at Duncroft and Reynolds House, the degree to which this was accomplished in certain instances is arguable), and its educational efforts were meant to make the delivery of mental health care more modern, efficient, and humane. When the organization positioned itself in opposition to government, it tended to exaggerate the level of that opposition. As a pressure group, the NAMH did challenge government to do better by its clients—however, NAMH leaders recognized that such an approach could only bring them so far. In the 1950s, as the welfare state and the NHS became increasingly entrenched facts of life, the NAMH positioned itself as innovative, cooperative, and generally amenable to state directives. It was thus embedded in the provision of mental health and learning disability care, regardless of the degree of statutory encroachment.

Where the NAMH operated in an expansive and collaborative manner, the Mental After Care Association tended more toward insularity, independence, and a relatively constrained operational focus. The MACA developed and maintained relevance in the welfare state through the accommodation of patients who would otherwise occupy much-needed NHS hospital beds. The records of individual homes show environments that, despite a tendency to shun more difficult or disruptive cases and deny responsibility in cases of patient harm, were generally sympathetic and caring (although admittedly, patients' voices are mostly absent in archival sources). Indeed,

most of the operational problems faced by MACA executives stemmed not from patients, but from staffing turnover, and a less than understanding public.

Despite its relative independence, the MACA was generally cooperative toward statutory authorities. The organization faced a rocky path, as amidst advances in psychiatry, a gradual shift toward community care, and increased statutory responsibility for acute cases, its traditional role in the convalescence and reintegration of mental hospital patients took on less importance. Further, following its refusal to join the NAMH, the MACA faced an uphill battle in securing esteem in the eyes of ministerial bureaucrats. MACA leaders, recognizing the shifting landscape, thus turned toward elder and chronic care, and maintained positive relations with the statutory authorities on whom they came to rely for a supply of patients. They accomplished this mainly by assigning patients from local authorities—which were often unprepared or unwilling to fulfil new obligations laid down by welfare legislation—to third-party residential care homes and the private matrons running them.

The Ex-Services Welfare Society was generally less concerned with appearing cooperative, and could occasionally act as a thorn in the side of the welfare bureaucracy. Indeed, the Society tended to avoid attempts to cultivate relationships with politicians and ministerial functionaries, instead securing the support of highly positioned military and aristocratic figures who could use their connections to exert political and social influence in more unofficial ways. The Society would fiercely advocate for the rights and entitlements of ex-Service members. In an effort to balance the needs of disabled pensioners and the stipulations of the Treasury, various ministries developed a complex allowance system, with stringent eligibility requirements. When ex-Service members in need of support were inevitably unable to penetrate the requisite red tape, they could turn to the ESWS for assistance.

The close association between employability, citizenship, and good mental health is perhaps most clearly exhibited by the ESWS. The First World War had seen shell shock treatments emphasizing a supposedly feminized lack of martiality, but by the Second World War, understandings had shifted toward vocational skills and the ability to hold employment. In the 1940s and 1950s, Thermega Ltd. would operate in tandem with the Society's other main facilities—Tyrwhitt House and Milner House—to prepare ex-Service members to re-enter the working world. The emphasis on work was influenced by developments in occupational therapy, but also by an older conception of character and citizenship, based on commercial productivity and promoted by traditionalists from the military's officer class. This aligned the Society with the state in one important regard—the desire to return traumatized ex-Service members to work.

The National Association for Parents of Backward Children—later renamed the National Association for Mentally Handicapped Children—was initially conceived as a network of support groups for beleaguered parents, whose children with learning disabilities had been legislated out of the education system. This basis as a parents' organization would remain crucial to the organization's identity, so much so that the co-optation of outside experts into organizational hierarchies could prove controversial. The Association's local branches would provide social events, holidays, and other outings, and parents were expected to take an active role in fundraising, planning, and supervisory duties. Parents' importance to the organization is particularly evident in records of the Lambeth branch, where acute anxieties emerged over low participation rates.

Unlike the other three groups under study here, the NAPBC/NAMHC was generally not a direct service provider, but an advocacy group (although, as seen, the National Office set up Orchard Dene in conjunction with the NAMH, while at least one local branch established its own industrial training centre). While the organization's adversarial tone could lead to antipathy from

statutory bodies (recall the Norwich City Council’s tendency to ignore the local branch), they maintained momentum and vitality by cultivating community support and—wherever possible—promoting the message that with the proper training, children with learning disabilities were capable of intellectual and social development, and integration into the community. The NAPBC/NAMHC thus provided parents with a collectivized venue for ensuring that local authorities were meeting expectations laid down by welfare legislation.

Histories of mental health tend to be based on institutional and medical records, and so narratives derived directly from patients and clients are often absent. This is largely the case in this dissertation, but the lack of direct experience suggests future avenues of research that emphasize oral history and personal narratives. Where the NAPBC/NAMHC is concerned, several researchers have used oral history techniques to directly incorporate the stories of people with learning disabilities into the historical record. In particular, Sheena Rolph has used personal narratives in her histories of local and regional Mencap branches, while Jan Walmsley and Kelley Johnson have emphasized the need for a style of research that is more inclusive of people with learning disabilities.¹ As noted in the first chapter, histories that deal with individual institutions tend to be better positioned to access patient experience—at least, more so than broader histories spanning many different bodies.²

Another area for potential research, informed by governmentality or an “analytics of government,” involves a closer look into voluntarists’ specific integrative goals, and efforts to create a “self-governing” population where formerly there was none. The desire across all four

¹ See Bibliography for a list of Rolph’s publications. See also Jan Walmsley and Kelley Johnson, *Inclusive Research with People with Learning Disabilities: Past, Present and Futures* (London: Jessica Kingsley Publishers, 2003).

² These include, for the United Kingdom, Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrews Hospital c. 1810–1998* (Woodbridge: The Boydell Press, 2003); Diana Gittins, *Madness in Its Place: Narratives of Severalls Hospital, 1913–1997* (London: Routledge, 1998). For work on a Canadian hospital, see Geoffrey Reaume, *Remembrance of Patients Past: Life at the Toronto Hospital for the Insane, 1870–1940* (Toronto: University of Toronto Press, 2009).

organizations to introduce or reintroduce their clientele into the education system, the labour pool, or the community more broadly, indicates a sharp desire to be able to establish a sense of normalcy. It is important to question what, exactly, constitutes “normalcy,” when one group seeks to render another fundamentally more governable. Despite destigmatizing efforts, voluntary groups generally sought to fit people with mental illness or learning disabilities into a normative environment, rather than vice versa. Indeed, the normalcy that voluntary groups sought to create for people with mental illness or learning disabilities can serve as a barometer of what, exactly, was considered “normal” and “governable” by the cultural standards of the 1940s and 1950s.

Finally, while this dissertation has emphasized relations between voluntary associations and the state, research could be conducted into relations between those same associations and the medical profession, and the degree to which they promoted medicalized or social solutions to the problems they addressed. Though largely operated by laypeople, many organizations counted medical professionals among their members and leadership, who imbued them with various (occasionally competing) medical outlooks. Future work on voluntary mental health and learning disability associations could assess the degree to which they influenced medical discourse, promoted relations between disciplines, and contributed to the social permeation of psychological ideas.

While the existence of these four organizations—the NAMH, MACA, ESWS, and NAPBC/NAMHC—into the present may lead one to assume that they met the challenge of the welfare state by forging ahead, heedless of statutory encroachment and divorced from welfare structures, and carrying the torch for a voluntary impulse that stretched back to the Victorian era, in reality they succeeded mainly through cooperation and mutual intention. Instead of challenging the state, voluntarist service providers recognized the inevitable, and set about making their

organizations appear useful, capable, and ready to collaborate. Even where voluntarist leaders critiqued specific policies, contested the inadequacy of statutory service provision, or positioned their own services as inherently superior, they still reinforced specific objectives, as suggested through the political economy of the welfare state: reconciling the destabilizing socialization processes of the capitalist economy by regulating disorder, maintaining non-productive populations, and ensuring a ready supply of employable labour.

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Appendix

Mental Health Organizations in Britain, 1949

Below is a list of Mental Health Organizations in Britain, originally compiled in 1949 by Dr. Derek Richter, Director of the Neuropsychiatric Research Centre at Whitchurch Hospital, Cardiff. Echoing rhetoric that justified voluntary groups' continuing operation within the welfare state, Richter wrote, "[i]n promoting the study of mental health and providing for the training of mental health workers, as well as in encouraging research and fostering new experimental methods of treatment, [voluntary bodies] continue to fulfil an essential role in the mental health activities of this country." He further noted that while much of the burden of psychiatric care had been transferred to NHS mental hospitals and out-patient departments, specialist and maternal and child welfare services remained the purview of voluntary groups.¹ The list gives an idea of the extent of voluntary provision in the field of mental health, but it is not exhaustive, and includes several bodies that should not be considered "voluntary" (such as the Board of Control). Two notable omissions are the Brighton Guardianship Society and the Jewish Board of Guardians—both organizations dedicated to securing guardians for people with learning disabilities.

1. Association for Education in Citizenship
2. Association of Mental Health Workers
3. Association of Occupational Therapists
4. Association for Promoting Employment of the Mentally and Physically Defective
5. Association of Psychiatric Social Workers
6. Aylesbury After-Care Association

¹ Derek Richter, "British Organizations Concerned with Mental Health," *British Medical Bulletin* 6, no. 3 (1949): 213–217.

7. Biochemical and Endocrinological Research Department, Bristol Mental Hospitals
8. Board of Control
9. British Council for Rehabilitation
10. British Institute of Management
11. British Psychological Society
12. British Rorschach Forum
13. British Social Hygiene Council
14. British Society for Research on Ageing
15. Burden Neurological Institute
16. Central After-Care Association
17. Central Association for the Aid of Discharged Convicts
18. Central Council for Health Education
19. Child Guidance Training Centre
20. Child Study Society
21. Electroencephalographic Society
22. Eugenics Society
23. Ex-Services Welfare Society
24. Family Planning Association
25. Federation of Committees for the Moral Welfare of Children
26. Guild of Health
27. Home and School Council of Great Britain
28. Howard League for Penal Reform
29. Industrial Health Research Board

30. Industrial Neurosis Unit
31. Institute of Child Health (University of London)
32. Institute of Child Psychology
33. Institute of Education (University of London)
34. Institute of Psychiatry
35. Institute of Psycho-Analysis
36. Institute for the Scientific Treatment of Delinquency
37. Institute of Social Medicine
38. Institute of Social Psychiatry Limited
39. Institute of Sociology
40. London Police Court Mission
41. The Magistrate's Association
42. Medical Research Council Unit for Applied Psychology
43. Mental After-Care Association
44. Mental Health Research Fund
45. Mental Nurses and Mental Deficiency Nurses Guild of the Confederation of Health Service
46. Moor House School
47. National Association of Boys' Clubs
48. National Association of Discharged Prisoners' Aid Societies
49. National Association for the Feeble-Minded
50. National Association of Girls' Clubs and Mixed Clubs
51. National Association for Maternity and Child Welfare
52. National Association for Mental Health

53. National Association of Prison Visitors
54. National Association of Probation Officers
55. National Council of Social Service
56. National Council for the Unmarried Mother and her Child
57. National Hospital
58. National Institute of Industrial Psychology
59. National Marriage Guidance Council
60. National Society for Epileptics
61. Neuropsychiatric Research Centre
62. New Education Fellowship
63. Nursery School Association of Great Britain and Ireland
64. Rationalist Press Association
65. Roffey Park Rehabilitation Centre
66. Royal Medico-Psychological Association
67. Royal Society of Medicine: Section of Psychiatry
68. Scottish Association for Mental Health
69. Scottish Council for Health Education
70. Society of Analytical Psychology, Limited
71. Society for the Study of Inebriety, Alcoholism and Drug Addiction
72. Tavistock Clinic
73. Tavistock Institute of Human Relations
74. Usher Institute
75. Village Centres Council

76. West of Scotland Neuro-Psychiatric Research Institute

77. World Federation for Mental Health: British Branch