University of Strathclyde

Department of History

From Institutions to Community Care? Learning Disability in Glasgow from c1945

Angela Turner

Lennox Castle Hospital in Glasgow
Source: http://lennoxtownlandscapes.webs.com/Lennox-Castle-LH.jpg

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Abstract

This thesis investigates a largely unexplored area concentrating on the history of learning disability since 1945. In doing so it analyses the development of ‘community care’ from a local perspective critically questioning the adoption of a ‘progressive’ narrative in this history. Extensive analysis has been carried out on written sources such as local archives of voluntary organisations, education authority papers, social work archives and local authority policy documents. Oral testimony has also been collected from a number of respondents where ‘gaps’ in the written sources were apparent. The thesis therefore addresses significant national policy developments such as deinstitutionalisation in Glasgow and demonstrates the ways in which the realities of care for mentally handicapped people were often very different from the rhetoric expressed in social policy.

The thesis also demonstrates the ways a ‘mixed’ economy of care developed in Glasgow in the period since 1945 with voluntary agencies playing an increasingly important role in the provision of essential services for the mentally handicapped. Special education is shown to have developed along segregated lines in the city where the provision of a significant special schools system continued to separate those with mental handicaps from their peers. Adult services in Glasgow are shown to be similarly segregated and to have failed in the promotion of an ‘ordinary’ life for people with mental handicaps. The thesis therefore notes the importance of national developments in learning disability policy, but highlights the ways in which institutions such as hospitals, group homes, special schools, and adult training centres continued to be segregated undermining the idea of 'community care'.

Contents

List of Tables and Illustrations

Abbreviations

ADES	Association of the Directors of Education for Scotland
ADSW	Association of the Directors of Social Work
ATC	Adult Training Centre
CAMW	Central Association for Mental Welfare
CCETSW	Central Council for Education and Training in Social Work
CMH	Campaign for Mental Handicap
CMW	Campaign for Mental Welfare
COS	Charity Organisation Society
JOC	Junior Occupation Centre
GGHB	Greater Glasgow Health Board
JOC	Junior Occupational Centre
LA	Local Authority
LEA	Local Education Authority

MOH	Medical Officer of Health
NAPBC	National Association for the Parents of Backward Children
NHS	National Health Service
SAPHC	Scottish Association for Parents of Handicapped Children
SCRE	Scottish Council for Research in Education
SEN	Special Educational Needs
SDSA	Scottish Down’s Syndrome Association
SOC	Senior Occupational Centre
SSMH	Scottish Society for the Mentally Handicapped
SSMHC	Scottish Society for Mentally Handicapped Children
VIA	Values in Action

Introduction

Throughout the post Second World War period there were many changes and developments in policy for people classed as mentally handicapped both locally and on a national level.[1] There was a string of legislative measures such as the Mental Health Act of 1959, the Social Work (Scotland) Act of 1968, The Chronically Sick and Disabled Persons Act of 1970 and latterly the NHS and Community Care Act of 1990, which increasingly focused attention on the demise of institutionalisation and the promotion of care in the community. Significant legislative developments also came in the form of 'progressive' education acts that gradually increased access to education and promoted integration for those classed as mentally handicapped. Acts such as the Disabled Persons (Employment) Act of 1944 also sought to include disabled people in employment by introducing a quota scheme and promoting the establishment of sheltered workshops. The story emerging from the major changes in policy and legislation is therefore largely linear and suggests that life for people who were designated as 'mentally handicapped' or, later, as 'learning disabled' was to gradually improve throughout the latter half of the twentieth century.

However 'macro' developments in social policy for mental handicap, such as the extension of the welfare state and the creation of community care, were often neither as structured nor as 'progressive' as the legislative narrative suggests. Thus it is easy to over-estimate the influence of these big policy changes on a local level. This local study therefore goes some way towards revealing the impact of these developments, or lack thereof. This approach also reveals that the pressure for these

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[1] Whilst the author notes the outdated terminology of the term 'mental handicap' it will be used throughout the thesis as a period specific term alongside more modern terms such as 'learning disability' and 'learning difficulties' where appropriate.

developments could often come ‘from below’ and not from legislative or medical pioneers. Hence this Glasgow-based study investigates issues such as the expansion of ideas of community care and has discovered that the reality was often more complex and subsequently there was limited success in achieving the aims of integration and assimilation with ‘normal’ life.

The various chapters in this thesis will in fact demonstrate that the lives of people with mental handicaps could often be relatively ‘static’ despite these major developments in policy. For example, it reveals that whilst hospital closures were planned and integration in schools was promoted, many people continued to live either in hospitals or were segregated in their own communities through separate educational programmes. Subsequently it is shown that often they were offered few choices in either their education, place of residence or employment. The adoption of an overarching historical framework which focuses on the movement from reliance on institutions to new adherence to community care, or one which shifts focus from segregation to integration is therefore questioned. Indeed it is clear that developments in community care may only have succeeded, in some cases, in the creation of ‘new’ types of institutions such as special schools or day centres that were now housed physically ‘in’ the community but which often continued to segregate those with learning disabilities from their peers.

This study therefore takes account of the key developments in disability policy but investigates these at a micro level in order to demonstrate that where change came, it was often slow and had much to do with the efforts of charities and parent-led voluntary agencies. Whilst Glasgow may not be unique in its experience of social policy directed towards the mentally handicapped it nevertheless provides an interesting setting for this study. Glasgow has a tradition of strong state-led health, education and social work programmes which attempted to tackle ‘social ills’ such as poverty, infant mortality and poor housing. Maver, for example points to the fact that Glasgow in the immediate post-war period ‘embarked on one of the most ambitious housing and planning programmes in the United Kingdom’.[2] In addition Barton has noted how initiatives by Glasgow's health authorities often ‘continued the 19th century tradition of pioneering health projects’ for example with the famous ‘screening of c. 700,000 people in the one month Mass X-Ray Campaign of 1957, vastly reducing tuberculosis incidence’.[3]

In addition there was also a new focus on the health of children in Glasgow in this period. For example Checkland has noted how ‘the beginnings of the NHS in 1948 accelerated the trend towards the ‘surveillance of the individual and the family’.[4] Children were often the subsequent focus of numerous public health and educational reforms in the city. For example Innes has noted how the ‘city's children benefited from free health care, milk and orange juice’ whilst the ‘ideal of the child-centred family gained ground’.[5] In addition she noted how issues such as the ‘problem family’ and ‘juvenile delinquency’ were given a higher profile.[6] It is within this context that new social policy was to develop for the mentally handicapped.

Traditions of state-led public health and education schemes in Glasgow therefore may go some way towards explaining developments such as the creation and maintenance of ‘specialist’ schools for different impairment groups in the post-war period. Motivation to expand these special schools was thus often largely humanitarian. However, as this thesis will demonstrate, mental handicap was rarely a

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[2] Irene Maver, *Glasgow* (Edinburgh, 2000), p. 212.
[3] Patricia Barton, ‘Health and Sickness’, http://www.theglasgowstory.com/story.php?id=TGSFA05.
[4] Sidney Checkland, ‘British Urban Health in General and in a Single City’, in Olive Checkland and Margaret Lamb, *Health Care as Social History: The Glasgow Case* (Aberdeen, 1982).
[5] Sue Innes, ‘The Family’, http://www.theglasgowstory.com/story.php?id=TGSFA03.
[6] Sue Innes, ‘The Family’, http://www.theglasgowstory.com/story.php?id=TGSFA03.

priority in state policy and there was often a lack of investment in this area as well as the absence of a coherent, structured policy. Barton and others have suggested that the 'constant restructuring of the NHS' was not 'conducive to formulating coherent long- term health strategies'.[7] As a result services for the mentally handicapped were often the responsibility of these various bodies with different remits and policy objectives and who rarely prioritised mental handicap. At different points there were many agencies responsible for delivering services including health boards, the local authority (LA), the Local Education Authority (LEA), and social work. Thus there was rarely an over-all strategy in place or adequate funding for delivering the required services.

Lack of investment was to have an effect on the ways in which mental handicap services were to develop in the city. For example, the result of inadequate service development in the community led to the reliance on the parent-led voluntary sector. Even with the emergence of a new social work authority, determined to enact positive change in the 1970s, mental health continued to be a neglected area resulting in continuing reliance on the work of voluntary agencies. Indeed these parent-led organisations often prompted statutory authorities into action by establishing the most needed services independently then subsequently acquired support from the state to maintain these. From the late 1970s there was a re-framing of welfare policy and the promotion of community care to be delivered through a mixed economy of welfare which allowed for 'consumer choice'. Legislation such as the UK Community Care Act in 1990 therefore cemented the role of charities and other private agencies in the provision of learning disability services. In the case of Glasgow this only served to further acknowledge the situation that had been in place

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[7] Patricia Barton, 'Health and Sickness', http://www.theglasgowstory.com/story.php?id=TGSFA05.

since the 1950s whereby community care was a reality, but one that was not adequately funded or supported by state authorities resulting in the necessity of voluntary provision. A case study of mental handicap in Glasgow therefore allows the inclusion of new perspectives which help to re-examine the history of institutions and community care in this period.

Methodology

In researching this thesis a number of research methodologies were employed which were mainly qualitative. A quantitative approach was utilised to a limited extent to determine, for example, the populations of special schools, day centres or hospitals and statistics for these were collected from a number of sources including Medical Officer of Health Reports and other local authority sources. However, the availability of this type of information was limited as there are many gaps in the statistics available in this area. Extensive qualitative research was carried out at both the Association of the Directors of Social Work Archive and records relating to the closure of Lennox Castle Hospital held at Glasgow Caledonian University. A thorough investigation was undertaken at the Association of the Directors of Education for Scotland Archive and the archive of Jordanhill College of Education. Key periodicals and newspapers were also analysed (using key word searches) such as the *Lancet* and newspapers such as the *Glasgow Herald* and *The Times*. A large amount of time was also spent sourcing and analysing governmental sources such as key legislation, reports and local authority publications in this area.

One of the challenges in researching this history was finding perspectives outside of those written by professionals or medical experts. An effort was made therefore to source new and previously excluded sources in order to address this gap in historical research. One key archive here was that of the charity ENABLE Scotland who permitted access to both their executive committee minutes dating from 1954 but also letters, publicity material, newsletters and publications stored in their extensive library and archive. These provided ample primary and secondary evidence to be analysed using qualitative methods. These sources were often written from the perspectives of families and revealed key information about the organisation's relationship with statutory authorities in Glasgow. In addition Down's Syndrome Scotland, an Edinburgh based charity, were able to provide copies of old newsletters and publicity material from their earlier days which related to work carried out in Glasgow.

Oral History Project

As well as qualitative research utilising written sources, an effort was also made to contextualise findings and to gain experiential perspectives by designing an oral history project. The aims of this were to find a small number of respondents with experience either working in or using the services being investigated in the project. After the project was designed and ethical permission was granted respondents were recruited through local charities and day centres who advertised the project and passed on details to any interested parties. In the first instance respondents were sought who had attended special schools, lived in an institution or who attended a day centre/work centre for people with learning disabilities.

An initial meeting was arranged with respondents to discuss the project along with a support worker/family member if this was appropriate. A preparation interview, which was not recorded, was then carried out whereby respondents (often with the help of a support worker) were given the opportunity to provide background information on their lives and to familiarise themselves with the interview process and equipment. In this meeting it was explained to the respondents how the interview would be conducted, recorded and how the transcript was to be processed before being deposited with the Scottish Oral History Centre at the University of Strathclyde. At this stage the respondents were able to give informed consent to take part in the project and were given the opportunity again to address any concerns or ask questions about any area of the project. They were also asked to sign a 'copyright clearance form' issued by the SOHC to allow the transcripts to be archived.

Whilst the subsequent interviews were to be focussed to some extent on hospitalisation, issues of community care, special schools and day centres, a 'life history' approach advanced by historians such as Atkinson and Walmsley was employed whereby flexibility was allowed in a semi-structured interview process to allow respondents to speak about what they felt were significant or interesting experiences in their lives.[8] They were also encouraged to bring along old photographs which could then be used in the subsequent interviews to stimulate memories and conversation.

The taped interviews were conducted on a one-to-one basis in a variety of locations including day centres and in one case in the home of the respondent. One respondent asked for a support worker to be present who also took part in the interview. All respondents were asked standard questions such as their name, age and

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[8] Texts referencing the use of this methodology include Jan Walmsley, 'Life History Interviews with People with Learning Disabilities', in Robert Perks and Alistair Thomson (eds), *The Oral History Reader* (London, 1998), pp. 71 – 77. Dorothy Atkinson, Mark Jackson and Jan Wamsley (eds), *Forgotten Lives: Exploring the History of Learning Disability* (Kidderminster, 2003). Danny Goodley, 'Tales of Hidden Lives: A Critical Examination of Life History Research with People who have Learning Difficulties', *Disability and Society*, 11 (3), 1996, pp. 333-349.

place of birth in order to familiarise them with the microphone and the situation. Thereafter, most respondents were asked similar types of open-ended questions for example about school, growing up and day centres. The interviews were then largely carried out in a relatively unstructured manner and questions were tailored to the individual experiences of each respondent (using the information collected in the initial interviews). The photographs were used in 4 cases to try to bring up memories of school, family or early life and were useful in helping direct the respondents to talk about the past where the tendency was often to speak about events in the immediate present or the last few years.

The first interview was carried out with a 60 year old former resident of Lennox Castle hospital (from the beginning of the 1970s until the mid 1990s) who was able to give detailed information about daily life in the institution and the reasons for his institutionalisation. At this time it was also discovered that there had been a local community project where testimony had been collected from former patients of this hospital.[9] The decision was taken to utilise this testimony in order to enable more time to be spent collecting oral testimony from those who had not lived in hospitals. The other seven interviews carried out with participants with learning disabilities were all attendees of day centres in Glasgow, most of whom had spent their adult lives in within these centres. Indeed 5 of the 7 of the respondents in this part of the project had attended the same day centre for over 30 years. There were four female and two male respondents interviewed and all, except one, were aged 50 or above. All of these respondents had attended special schools in Glasgow and all

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[9] SHS Trust, *I've got a good life – don't tell anyone keep it a secret; Stories about life after Lennox Castle,* (Edinburgh, 2003).

except the youngest had lived in supported accommodation in group homes or hostels.

Given the nature of this part of the oral history project there was often the need for multiple interviews with the same respondent to allow them full opportunity to engage in the process and time to think about the questions being asked. The location of the interviews may have had some effect on the testimony collected, however it was felt that this was the most convenient location that was accessible for the respondents. Certainly, as with all oral history, due account was taken of the desire the respondents may have had to present their experiences in a certain light. For example there seemed to be an attempt by a number of respondents to avoid being presented as a ‘victim’ in the ways in which they discussed their history. Thus positive descriptions were sometimes given of seemingly tedious and restrictive practices in an old style ‘work’ centre as respondents perhaps wished to assert the importance of their own personal agency in the completion of this work (this particular example is discussed in more detail in chapter 5).

Participants were thus able to provide detailed descriptions of daily life in special schools and day centres although value judgements based on these activities were in some cases difficult to establish. For many of these respondents who had spent most of their lives in day centres, opportunities to express opinions or speak for themselves have only emerged relatively recently. Many have had little control or choice in the past over decisions about their education, residence or work lives. In some cases open-ended questioning was difficult for some respondents who were, at times, eager to provide the ‘right’ answer. However the use of multiple meetings and interviews, the building up of a relationship between respondent and interviewer and in one case the help of a support worker was able to limit some of the challenges encountered in this area. One of the most interesting interviews was indeed the one in which the respondent asked for his long-term support worker to be present. Throughout this interview the respondent was therefore able to use the support of this individual to enable him to discuss and reflect negatively on his history, for example in one case they both discussed his experience of being placed in an old folks home (when he was only in his 40s) because of his mobility problems. The relatively unstructured questioning style and ‘life history’ approach resulted in the collection of a large amount of testimony that has not been able to be utilised in this thesis due to its focus on particular areas in this history. However the testimony that has been included in this thesis has often added new perspectives and interesting levels of detail to this history.

Whilst these interviews provided interesting perspectives and experiences, they often left gaps as to the wider context or timeline of developments. The decision was taken then to identify some key professionals who could provide testimony relating to this. A former support worker and manager of a day centre was therefore interviewed who was able to give testimony relating to her experience of working at the front-line of mental handicap services from the 1970s onwards. In addition a former headteacher of 3 large special needs schools in Glasgow also agreed to be interviewed and provided invaluable testimony as to the Glasgow experience of special education since the 1960s.

The oral testimony collected from this project and the findings of the research carried out in archives and with other written sources provided many new perspectives on the developments in mental handicap policy since 1945. Chapter two investigates these key changes with a particular focus on hospitals and the ways in which their use as the principal institution for treating mental handicap was to go out of fashion. Whilst noting the long history of community care it demonstrates the ways in which it emerged as a positive alternative to long hospitalisation which was now seen to be out of step with wider thinking on mental health and handicap. This chapter utilises the reports of abuse and neglect in both the press and local authority publications which further promoted the move away from institutionalisation. However it also reveals the ways in which other factors impacted on the adherence to new ideas of community care such as the lack of finance for improving and extending hospitals, overcrowding and lack of beds. Ultimately it introduces the 'new' community care plans and demonstrates the ways in which they often failed to enact swift closure of hospitals which remained an important part of care until the 1990s. They also failed in a number of cases to promote 'integration' in any meaningful way with residents in new group homes and hostels continuing to feel isolated from their communities. Lack of investment in community based services to support these 'new' residents in the community therefore was shown to have forced further pressure on families and other private agencies to provide care and other services for the mentally handicapped.

With the introduction of the welfare state in the post-war period, there was a concerted effort to try and improve the health of the nation. However as was the case with the mentally handicapped residents in hospitals, those living in the community were not to see many substantial improvements until much later in the period. Mental handicap continued to be stigmatising for both those diagnosed and their families who were seen as part of the 'problem'. Whilst there were a large number of people still being supervised in hospitals or through guardianship there were also an equally large number who were left without help or support and handicap remained often a 'private' family matter. From the 1950s, however, the 'parental voice' began to emerge through the creation of support groups and voluntary associations up and down the country. The most significant of these in Scotland was the Scottish Society for the Parents of Handicapped Children (later ENABLE) who were based in Glasgow. Chapter three demonstrates how this organisation sought to increase the visibility of mental handicap in the press and other publicity campaigns while using their magazines and other publications to claim a kind of ‘respectability’ whereby families of people with mental handicapped were now to be seen as deserving of help and support.

The work of this and other organisations in both pressuring statutory authorities to provide the services they required and campaigning for improvements is assessed. This chapter demonstrates the ways in which this organisation was itself to become a service provider, in particular in the creation of services for those considered to be ‘ineducable’ or ‘untrainable’ by medical or educational authorities. The chapter therefore provides telling details of the ways in which new day centres, respite facilities and housing were established and became the model for statutory authorities. It also demonstrates the ways in which the relationships between voluntary agencies and the state became inter-dependant creating a mixed economy of care.

Chapter four analyses the most significant developments in special education from a Glasgow perspective, noting the continuing importance of medicine and eugenic assumptions of educability in this field. Whilst reflecting on the importance of IQ and mental testing which provided scientific legitimacy for these developments, it also points to the consequences of this with the large-scale expansion of segregated special schooling for the mentally handicapped. Whilst exploring the many reasons for this adherence to a separate educational system it argues that this was often in conflict with the new ideas of ‘mainstreaming’ education after the Warnock Report and the adherence to a comprehensive schooling system designed to fit ‘all’.

The differing types of educational policies within special education is then investigated with a focus on the importance of ‘practical’ education whereby pupils were to be ‘trained’ in vocational skills to allow them the possibility to become fully active and work-able citizens as adults. Attention is drawn to the numbers of children who were educated in such a way in Glasgow and the ways in which their educational experiences and adult lives were affected. Testimony is utilised from former pupils and teachers therefore to provide different perspectives on the impact of this segregated educational experience. Due note is taken of the importance of the focus on Glasgow in this study where it can be seen that the big investment in the creation of this special educational sector may have discouraged further commitment to ideas of ‘inclusion’ in the 1980s and 1990s. The strength of the segregated special educational sector therefore played a large role in further undermining the desire to encourage people with mental handicaps to be part of the ‘community’.

Provisions and support for adults with mental handicaps is shown to have often operated along similar lines as special education. Chapter five demonstrates how attendance at special school could often result in placement in a day centre. This final chapter thus reveals the ways in which post-war provision, often limited in scope, frequently failed to establish new thinking on mental handicap, instead mirroring the types of ‘work’ training being undertaken in institutions and hospitals. It demonstrates how ‘work’ was in itself viewed as a ‘cure’ for handicaps whereby trainees could gain a sense of achievement and operate within the ‘normal’ patterns of life. However, it also notes the continuing importance of classification here where those deemed the most ‘capable’ were often the first to receive training.

This chapter also investigates the emergence of new ideas of adult training when the value of ‘work’ began to be questioned as the local authority began to adopt principles of ‘normalisation’ in the 1970s. State run centres, which were multiplying in number, are shown to have shifted their emphasis onto the provision of social and vocational activities through which they proposed more ‘integration’ into local communities. However this is shown to have had limited success as some of those attending were felt by some to be taking part in tasks with little relevance to life outside of the centre but instead were living in ‘perpetual leisure’. Adult services therefore provide another example of the failure of community care to bring ‘progression’ into the lives of those with learning disabilities who were often still effectively ‘institutionalised’ in day centres within the communities in which they resided. Chapter five thus provides telling examples of the ways in which the many agencies with a responsibility for community care did not prioritise or had little funding and support to substantially improve the lives of people with learning disabilities.

Chapter 1

Historiography

Introduction

Disability is a relatively new and expanding field of historical research. In recent years, there has been increasing focus on the history of mental handicap. Much of this investigation has emerged in an attempt to include the stories and experiences of those who have previously been excluded from study in the historical past. This chapter therefore investigates and discusses the forces behind this new investigation and the main figures in this field of research. It explores the main theories and debates at the centre of this body of work. It also demonstrates how some historians (and other social scientists) have used these theories in their own methodologies in an attempt to fill this gap in historical investigation.

Tracing the developments in disability history it first notes the importance of the historical context of medicalisation on early scholarship in this area. It subsequently points to noteworthy studies of classification and labelling which have questioned the adoption of a medical model of analysis. This chapter also demonstrates the significance of normalisation theories and the rise of the Disabilities Rights Movement, noting in particular the impact of the adoption of the social model of research. Furthermore it illustrates the ways in which recent scholarship has focussed on the importance of social barriers and on the role of cultural influences in individual experiences of disability. It firmly places this study therefore within the framework of a developing field of scholarship which utilises personal experience and local community sources to suggest new social policy trajectories and ways of understanding the past.

Medicalisation

One of the central issues of contention in disability research in general is the extent to which it has, in the past, focussed on medical aspects of disablement. To properly explore some of the debates over 'medical models' of disability it is first key to put work of this kind into context. It is important to trace the roots of these medical understandings in the literature surrounding mental handicap in order to properly trace the origins of these debates. Firstly, it seems relevant to note here how legislation and policies aimed towards mental handicap became increasingly medicalised and focussed on systems of classification post 1945, the period of this study. For example, the 1944 Education Act helped maintain and promote the importance of both medical and intellectual testing as well as classification in the field of mental handicap. Under this act, local education authorities were obligated to send children for examination by a medical officer if there were grounds to believe that the child was in need of special education. The responsibility for the decision over whether the child was 'handicapped' lay with this medical officer who was to provide the parents, school, or education authority with a diagnosis on the nature and extent of the child's disability. Indeed children as young as two were to be examined with 'the object of providing special educational treatment'.[10] These medical professionals also played a key role in deciding which institutions such children

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[10] Hansard: *Orders of the Day, Education Bill* (355) XXVII.

should attend and the type of education they should receive. It can be seen therefore that although government reports stated that there were many ‘benefits… from instruction’ for children with a mental handicap, they also argued that ‘it must be left to the medical authority to say when and for how long’.[11]

Handicaps were consistently presented as physical organic conditions that medicine, education and training should seek to prevent, treat or remove. Wider social legislation such as the NHS Act of 1946 reiterated this belief as it sought to,

> Promote the establishment of a comprehensive health service designed to secure improvement in the physical and mental health of the people…and the prevention, diagnosis and treatment of illness.[12]

In this and other legislation there was an explicit understanding that people were ‘handicapped’ by their diagnosed disability.[13] The perceived causation of disablement in legislation in this period, as a result, lay directly with the diagnosed impairment. As Mercer argues, these biological/medical understandings of disability suggest that ‘the characteristics of the ‘patient’ as a social being were secondary’.[14] The notion that the ‘whole person and his problem be assessed and treated’[15] reaffirmed this idea of a medicalised identity. Medical aspects of a diagnosed disability could therefore overtake and become the defining category of an

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[11] ‘Primary Education: Reports of the Advisory Council on Education in Scotland’, *House of Commons Commissioners Reports,* Vol 13 (1945 – 46), pp. 593 – 656.

[12] NHS Act, 1946, Quoted in Ruth Levitt, *The Reorganised National Health Service* (London, 1976), p.17.

[13] J. S, Hurt, *Outside the Mainstream: A History of Special Education* (London, 1988), p.8.

[14] Jane R. Mercer, ‘Sociological perspectives on mild mental retardation’, in Will Swann (ed) *The Practice of Special Education* (Oxford, 1981), p. 14.

[15] Glasgow University Archives, Thomas Ferguson Collection, ‘The Handicapped’, (1952), DC57/20

individual. This is essentially an understanding of disability that is of a static nature. Mental handicap in particular was consistently presented as something which was essentially caused by an organic mental defect.

Many of the early histories of disability and mental illness therefore failed to question the ways in which people classed as mentally handicapped were viewed as 'patients' and instead concentrated largely on institutional histories of asylums, hospitals or residential schools. In particular, they often focused on 'advances' in the field by medical professionals, educationalists or legislators and did not generally document the experiences of disabled people.

Classification and Labelling Theories

However, the importance of medicalisation in this period has led to a number of historians and social scientists investigating the ways in which these medical identities were constructed and communicated. Cooper, for example, has explored the ways in which medical terms and medical control served to foster dependence on professionals who subsequently maintained positions of power and status through their diagnosis and treatment of these 'patients'.[16] Borsay has also noted the ways in which policies directed towards people classified as disabled were 'predicated on compassion' and helped to create the idea of 'passive recipients who were expected to bow to professional advice'[17] Recent scholarship has thus sought to highlight the ways in which medicalisation allowed physicians and other medical professionals to

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[16] Charlotte Cooper, 'Can a fat woman call herself disabled', *Disability and Society*, Vol 12, No. 1 (1997), pp. 31 – 42.

[17] Anne Borsay, *Disability and Social policy in Britain since 1750* (Basingstoke, 2005), p. 7

function as gatekeepers for certain social roles and life opportunities for these ‘patients’.

These studies have demonstrated how the process of defining a person or group of persons as ‘sick’ or ‘ill’ has been a way of labelling behavioural or aesthetic deviance which, in turn, has helped to reproduce and re-instate norms of human appearance and behaviour. Much of this was first identified by theorists such as Goffmann who pointed to the production and important effects of the creation of a ‘stigmatised’ and ‘spoiled identity’ for individuals who were considered to be socially ‘abnormal’.[18] Medicalisation and classification can thus be seen as part of a system of social control in the post-war period, which in turn promoted socially validated characteristics. The reproduction of these characteristics will be discussed in more depth later when social model theorists are explored. However, what seems relevant to note here is that it was the centrality of medical interpretation that gave authority, weight and ultimately social acceptance of these classifications. This thesis will demonstrate the ways in which those classed as mentally handicapped continued to be defined as ‘ill’ and were viewed through a ‘clinical perspective’ throughout this period. It will therefore illustrate how these ‘patients’ both within about outside of hospitals were often given a certain (lesser) status in society and how this affected the societal roles they were expected to play.[19]

This thesis will also note the importance of medical dominance in areas such as mental testing, which remained an important tool in education throughout the second half of the twentieth century. Medical diagnoses thus gave weight to categorisation of ‘educational subnormality’ and it followed that mental handicap

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[18] Erving Goffman, *Stigma: Notes on the Management of a Spoiled Identity,* (New Jersey, 1963)

[19] Mercer, ‘Sociological perspectives’, p. 12.

continued to be understood as an inherent, organic impairment of a static nature. Indeed, the government standpoint seemed to be that 'intelligence…[could not] be substantially improved'.[20] The prospects and life choices that people stigmatised through both medical and educational discourses were altered dramatically from their peers.

The process of medicalisation and subsequent labelling has had an effect on the historiography of mental handicap. It has led some to focus on the process whereby mentally handicapped people become defined in such a way. For example, work carried out by Egan looks at the ways in which terminology and classification has changed over the twentieth century.[21] He talks about the stigma associated with labels and segregation and how the growth of the state and medical profession helped this process.[22] Similarly, Johnstone argues that the labelling process 'categorises people by virtue of their position in relation to the dominant structures and values of the society'.[23] An example of this can be seen in the work of Simpson who shows how changing definitions and the altering educational standards contributed to the enlargement of learning disability as a social category.[24] In particular, he focuses on the schooling system and the ways in which it has helped to form the modern category of learning disability. He argues that studies on labelling of this kind must redirect the causation of learning disability away from the medical biological

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[20] *Special Educational Treatment,* p. 18.

[21] Matt Egan, 'Mental Defectives in 1900: People with Learning Disabilities in 2000. What changed?', Presented at Scottish Health History: International Contexts, Contemporary Perspectives, Centre for the History of Medicine, University of Glasgow, 20th June 2003

[22] Egan, 'Mental Defectives in 1900: People with Learning Disabilities in 2000'.

[23] David Johnstone, *An Introduction to Disability Studies* (London, 2001), p. 9.

[24] Murray K. Simpson, 'Mental Defectives in 1900: People with Learning Disabilities in 2000. What changed?: A Reply to Matt Egan', Presented at Scottish Health History: International Contexts, Contemporary Perspectives, Centre for the History of Medicine, University of Glasgow, 20th June 2003

understandings to focus on the ‘complex interactions between people, their environment and prevailing bodies of knowledge’.[25] He states that ‘we need to go as far as to say [that] children do not fail in school because they have a learning disability. Rather they have a learning disability because they fail in school’.[26]

Historians such as Bogdan and Taylor have thus informed this thesis in the ways in which they have investigated the construction of categories and diagnoses of handicap. For example, they have demonstrated how labels such as ‘mental retardation’ (which rest on subjective measures such as IQ) are socially created and have become an obstruction to understanding.[27] They argue that the classification of people as mentally retarded must not be understood as medical or objective but instead dependent upon ‘organisational and societal values, beliefs and processes’.[28] They state therefore that focus on the mechanisms of classification will help to question the idea that the labelling of an individual with a learning disability is an objective, neutral and value-free process.[29] Walmsley however cautions that researchers have to take into account the pressures for labelling which sometimes come from out with the established institutions. She argues that labelling can emerge from pressure from parent groups and wider community groups as a way in which to access the benefits of social services.[30] This thesis therefore takes account of these historiographical developments and utilises the idea of social construction and

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[25] Simpson, ‘Mental Defectives in 1900’, p. 4.
[26] Simpson, ‘Mental Defectives in 1900’, p. 3.
[27] Robert Bogdan and Steven J Taylor, ‘What’s in a name’, in Ann Brechin and Jan Walmsley, *Making Connections* (London, 1989)
[28] Bogdan and Taylor, ‘What’s in a name’, p. 77.
[29] Bogdan and Taylor, ‘What’s in a name’, p. 78.
[30] Jan Walmsley, ‘Mental Defectives in 1900: People with Learning Disabilities in 2000. What’s changed?: a response to Matt Egan’s paper’, Scottish Health History: International Contexts, Contemporary Perspectives, Centre for the History of Medicine, University of Glasgow, 20th June 2003

labelling to explore the developments in classification in education and health post 1945

Normalisation

Another important development in social policy which lies at the heart of this project is the emergence of ideas of normalisation in social policy. This thesis will demonstrate how pressure for this normalisation came from both the top down in the form of education and training and from the bottom up from pressure for parents and families to achieve some kind of life chances for their child or family member. This idea of normalisation was prevalent in social and educational policies (in schools, hospitals and day centres) directed towards people with a mental handicap in the latter half of the twentieth century. Much of this was in an effort to try and make disabled people become 'normal', participating members of society.[31]

However the thesis will also show how principles of normalisation could often help to reinstate the interpretation of disability as a problem within an individual. The application of normalisation in social policy could thus lead to continuation of 'medicalisation' whereby individuals were 'treated' within a curative model in which recovery was presumed to follow treatment. This was problematic for many people diagnosed as disabled who rejected the emphasis these policies seemed to place on the pursuit of normality.[32] Cooper has thus identified the

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[31] R Hurst, 'To Revise or Not to Revise', *Disability and Society,* Vol 15, No. 7, (2000), p 1083

[32] Borsay, *Disability and Social policy*, p. 59.

dominant assumption in social policy that the ‘disabled individual must be rehabilitated to become a useful member of normal, able bodied society’. [33]

At the centre of this focus on normalisation was an assumption that ‘disability is outside the range of human experience’.[34] As Hurst states, social policies focused on normalisation demonstrate how a non-disabled identity is often the yardstick against which disabled people have been measured.[35] Disability is therefore seen as ‘a deviant individual experience within a dominant culture’.[36] The idea of the normal then explicitly represents the idea that the disabled are the ‘other’ in society. However, as Mercer argues, the idea of normal can differ from society to society.[37] Indeed, he states that what is normal in one system may be considered deviant in another. However, he states, in our society mental retardation is an achieved social status, a role in society that is created because of the need to validate what is ‘normal’.[38] This idea of normality has been examined further by some theorists, often to try and explain how and why some groups are ‘othered’ and stigmatised whilst the idea of ‘normal’ is given such social weight. For example, Misztal argues that the ‘threat’ from these ‘othered’ individuals originates from the fact that ‘normality seems to refer to an aspiration for the future’.[39] Although she does not directly relate this idea to disability, the relevance of her work lies in the emphasis she places on the link between what is constructed as ‘normal’ and what society places value on in terms of opportunities or capabilities for the future. This theory is also borne out by

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[33] Cooper, ‘Can a fat woman call herself disabled’, pp. 6 – 7.
[34] Hurst, ‘To Revise or Not to Revise’, p. 1085.
[35] Hurst, ‘To Revise or Not to Revise’, p. 1085.
[36] David Johnstone, *An Introduction to Disability Studies* (London, 2001), p. 10.
[37] Mercer, ‘Sociological Perspectives’, pp. 17 -23.
[38] Mercer, ‘Sociological Perspectives’, p. 17 -23.
[39] Barbara Misztal, ‘Normality and Trust in Goffman’s Theory of Interaction Order’, in *Sociological Theory*, vol 19, No. 3 (November, 2001), p. 315.

the work of Carrier who looks at the links between education and future life chances arguing that 'socially based educational values and practices define a sort of abnormality' which then carries into later life.[40]

However, work carried out by Nirjie in Sweden in the 1960s presented the idea of normalisation from a different perspective. He argued that it was admirable for modern societies to 'let the mentally retarded obtain an existence as close to normal as possible'.[41] He stated that this could only be done by making the 'norms and patterns of mainstream society available' by making available the 'rights to equal opportunities for education, training and development'.[42] He extended this theory in the 1980s to argue that instead of trying to force 'mentally retarded' people to become more 'normal' this principle was designed to 'make available…patterns of life and conditions of everyday living which are as close as possible to regular circumstances and ways of life in society'.[43] This was the only way he could foresee for people regarded as 'mentally retarded' to have 'the freedom to live a life based on the same values and on the same terms as others in society'.[44]

The importance of Nirjie's work, however, lies in the ways in which he concentrated on the effects of external factors on the development of a 'disability' within an individual in modern society. Much of the recent work in the field of disability studies thus comes from a desire to question the medicalised, individualised models of disability. Bury, for example, argues that those who fail to

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[40] Carrier, 'Masking the Social', p. 949.

[41] Bengt Nirjie, 'The Normalization Principle and its Human Management Implications – 1969', in Marvin Rosen et al (eds), *The History of Mental Retardation: Collected Papers*, Vol 2 (London, 1976), p. 363.

[42] Nirjie, 'The Normalization Principle', p. 367.

[43] Burt Perrin and Bengt Nirjie, 'Setting the Record Straight: a critique of some frequent misconceptions of the normalisation principle', in Ann Brechin and Jan Walmsley, *Making Connections* (London, 1989), p. 220.

[44] Perrin and Nirjie, 'Setting the Record Straight, p. 227.

question this model in their work help to redefine disability as ‘a profoundly medical problem’.[45] Many other researchers challenge medical understandings of disability as they believe these only serve to emphasise the physical or mental impairments of an individual. They argue that because of this, impairments have become the key-defining characteristic of an individual. In the 1970s, Blaxter was one of the first to draw attention to these medical interpretations. She argued that the knock on effect of such representations was that ‘the physical [and intellectual] characteristic became the master trail which swamped personal differences’.[46]

The Social Model: Barriers and Materialism

One of the most significant development in disability studies and disability history which informed this project has thus been the renewed focus on the social context of disability. Theorists have questioned processes of medicalisation and classification and argued against a biologically static concept of disability. They have questioned the idea that disability is a fixed category, unchanging and detached from social context. By doing so they have also questioned the implication that disability is an affliction, a condition that exists to be treated or prevented. This scholarship goes beyond the scope of traditional histories of disability which, Bredberg has argued ‘almost invariably come from the perspective of the non-disabled expert who has ‘treated’ the disabled person or the condition that was perceived as disabling’.[47] Bredberg and others in this field therefore have promoted renewed research in this

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[45] Mike Bury, ‘Disability and the Myth of the Independent Researcher; A Reply’, *Disability and Society*, Vol 11, No. 1, 1996, p. 112.
[46] Mildred Blaxter, *The Meaning of Disability* (London, 1976), p. 98.
[47] Elizabeth Bredberg, ‘Writing Disability History: Problems, Perspectives and Sources’, *Disability and Society*, Vol 14, No. 2 (1999), p. 190.

area looking beyond the assumption that ‘patients’ with handicaps should be viewed as ‘depersonalised objects of institutional action’.[48] Longmore in particular has argued that studies written within the medical model only serve to cement the idea that disability is ‘a deficit located within individuals that requires rehabilitation to correct the physiological defect or amend the social deficiency’.[49] Ultimately these historians argue that the medical model must be challenged as it ignores the process of social construction and suggests that there is a static, unchanging core at the root of disability.

Perhaps the most significant development in this new understand of disability was the emergence of the Disabilities Rights Movement which came to the fore in the 1970s fighting for new understandings of ‘disability’. For example, the UPIAS (Union of the Physically Impaired Against Segregation) created their own definitions of disability and impairment that challenged prevailing understandings inherent in social policy and legislation. Whilst they classified impairment as a physical absence, loss or abnormality, they questioned biological models of disability, emphasising:

> The disadvantage or restriction of activity caused by a contemporary organisation which takes no or little account of people who have physical impairments and thus excludes them from the mainstream of social activities.[50]

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[48] Bredberg, ‘Writing Disability History, p. 191.

[49] Longmore quoted in Catherine Kudlick, ‘Disability History: Why We Need Another ‘Other’’, *American Historical Review*, Vol 108, No. 3, 2003, p. 772.

[50] Johnstone, *Disability Studies*, p. 14.

These definitions ran contrary to the contemporary understandings of disability adhered to, for example, the World Health Organisation (WHO) in 1976 defined disability as:

> Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.[51]

The new definitions brought to the fore by the UPIAS were at the root of what Oliver defined as ‘the social model’ theories of disability which have remained a central focus of the disabilities rights movement through to the present day.[52] The social model was extended to cover both learning and physical impairments in an effort to discover the roots of disablement. However it focused on the disabling and handicapping aspects of society as opposed to the diagnosed impairments of individuals themselves. Social models theorists such as Bury redirected the causation of disability and defined it ‘primarily as a form of social oppression’.[53] As Oliver stated, ‘the social model does not deny the problem of disability but locates it squarely within society’.[54] Disablement, he argued, came from ‘society’s failure to

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[51] WHO quoted in Johnstone, *Introduction to Disability Studies*, p. 10.

[52] Colin Barnes, ‘A Legacy of Oppression: A History of Disability in Western Culture’, in Len Barton and Mike Oliver, (eds), *Disability Studies: Past, Present and Future* (Leeds, 1997), p. 8.

[53] Mike Bury, ‘Defining and Researching Disability: Challenges and Responses’, in Colin Barnes and Geof Mercer (eds), *Exploring the Divide* (Leeds, 1996), p. 18.

[54] Mike Oliver, ‘The Individual and Social Models of Disability’, paper presented at Joint Workshop of the Living Options Group and the Research Unit of the Royal College of Physicians, Monday 23rd July 1990.

provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its organisation'.[55]

Barton thus point to 'the significance of social factors in the construction of handicap'.[56] Theorists such as Bury suggest that disability is 'socially and culturally produced….the product of definitions and practices that seek to exclude individuals who might be seen to deviate from the socially constructed norms of the 'able bodied''.[57] Social model social scientists and campaigners as a result investigated the barriers that create 'disability' in the lives of those with a diagnosed impairment in an effort to demonstrate that 'disability is a social state and not a medical condition'.[58]

Furthermore, historical research into the construction of disability by figures such as Stiker in France and Longmore in America has sought to rediscover and re-evaluate the ways in which disability has been viewed in the past.[59] However, historical work of this kind is relatively new, especially in the UK. American historian Kudlick has argued that historians must view disability as a 'key defining social category' in order to understand that it merits the same level of investigation as the construction of other social categories such as gender, race or class.[60] She argues that the socially constructed nature of disability can then be revealed, as historians will discover the fluidity of the label and its dependency on social context.

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[55] Oliver, 'The Individual and Social Models of Disability'.

[56] Len Barton, 'The Politics of Special Educational Needs', in Len Barton and Mike Oliver (eds), *Disability Studies: Past, Present and Future* (Leeds, 1997), p. 1.

[57] Bury, 'Defining and Researching Disability', p. 27.

[58] Oliver 'the Individual and Social Models', p. 3.

[59] See P Longmore and L Umansky, *The New Disability History: American* Perspectives (New York, 2001) and Henri- Jacques Stiker, *A History of Disability* (Ann Arbor, 2002).

[60] Catherine Kudlick, 'Disability History: Why We Need Another 'Other'', *American Historical Review*, Vol 108, No. 3 (2003), p. 764.

Many of the researchers who investigate this construction adhere to a materialist model of disability and often explore the link between modern capitalism and the increase of disability. For example Barnes argues that ‘the more technically and socially sophisticated a society becomes the more impairment and disability it creates’.[61] Similarly, Finkelstein asserts that as labour has increasingly become more technical and specialised, so too has the importance of normality. He argues that as being ‘normal’ is the dominant criterion for employment in industrial societies, disabled or ‘abnormal’ people have increasingly become marginalised from the labour market.[62] This led figures such as Nagi in the late 1960s to suggest that disability had come to mean ‘the reduction or total loss of earning capacity’ in modern technically advanced societies.[63] Ervelles and others have used the social model of disability to demonstrate the low labour value of many disabled people within competitive economic systems. Ervelles states that:

> It is not the physical and /or mental impairment that disables the individual, but the handicapping effects of a society whose interests are geared towards an able bodied population.[64]

She states that concrete economic conditions produce meanings and attitudes about disability. Moreover, she suggests the capitalist economic system and the

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[61] Colin Barnes, introduction in Borsay, *Disability and Social Policy*, p. xiii.

[62] Vic Finkelstein, ‘The Commonality of Disability’, in John Swain, Vic Finkelstein, Sally French and Mike Oliver (eds), *Disabling Barriers – Enabling Environments* (London, 1994), p. 12.

[63] Saad Nagi and Lawrence E. Riley, ‘Coping with Economic Crisis: The Disabled on Public Assistance’, *Journal of Health and Social Behaviour*, Vol 9, No. 4, Special Issue on Patients and Illness (December 1968), p. 317.

[64] Nirmala Ervelles, ‘Disability and the Dialectics of Difference’, *Disability and Society*, Vol 11, No. 4 (1996), p. 519.

‘exploitative economic conditions’ it produces, reinforces an ideological, biological discourse of disability.[65] This discourse, she argues, helps to further oppress people whose position is seen as ‘natural’ in terms of labour value.[66] This helps to reinstate the medicalised belief in the static nature of disability, which states, for example, that ‘a condition of inadequately developed intelligence… impairs a person’s ability to learn and adapt to the demands of society’.[67] Ervelles argues that at the root of this understanding of disability is a set of productive relations which re-instate the belief in ‘the biological’ as the ‘natural’ cause of inequality. She states that this, thereby, helps to justify the social and economic inequality that maintains dominant social hierarchies’.[68] Disabled people are seen as naturally unproductive and this directly affects their subsequent social status.

This thesis utilises the work of Jenkins and other materialists who have identified the link between disability and ‘occupation, class, economic disadvantage and downward social mobility’.[69] Jenkins, for example, demonstrates how ‘the disabled’ are constructed through their lack of participation in the free labour market and notes that those diagnosed with learning disabilities tend to be at the very bottom or excluded from the employment ladder. He argues therefore that their absence is both a function of and a method of reproducing their general marginalisation from society.[70] In particular, he points to the issues of citizenship and social stratification this lack of involvement in the labour market raises. Indeed the disabled seem to

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[65] Ervelles, ‘Disability and the Dialectics of Difference’, p. 520.
[66] Ervelles, ‘Disability and the Dialectics of Difference’, p. 521.
[67] Ronald W. Conley, *The Economics of Mental Retardation* (London, 1973), p1.
[68] Ervelles, ‘Disability’, p. 526.
[69] Richard Jenkins, ‘Disability and Social Stratification’, *British Journal of Sociology*, Vol 42 (December, 1991), p. 562.
[70] I Jenkins, ‘Disability and Social Stratification’, p. 572.

represent a kind of ‘underclass’ who often never gain entry into the world of work and therefore have little relation to the means of production.

As a result disabled people are again ‘othered’ as they are not associated with socially validated characteristics surrounding strength, productivity and ability to work. Kudlick argues that these values and assumptions permeate all aspects of our society. Disabled people, she argues, in both their location outside the labour market and their widespread reliance on the welfare system and charity contributions, are segregated in our society.[71] Hunt argues they are delineated in such a way because of their relation to values of ‘unproductiveness’ and ‘slowness’.[72] He argues that disabled people do not seem to offer any relation to socially and economically validated values such as ‘achievement, productivity and vigour’ and are instead tarred with values which are ‘implicitly if not explicitly deplored’.[73] Barnes asserts therefore that the only way to eliminate oppression in all its forms is to confront the value system upon which capitalism rests.[74]

In his book, *Cabbage Syndrome,* Barnes questions the capitalist system and in particular focuses on its social construction and permeation of ideas of dependence.[75] Similarly, Stone argues that perceptions of need emerge through a complex system of commodity production and consumption. He states that the social construction of dependence is the ‘result of the accumulation of power by the medical profession and the state’s need to restrict access to the state’s sponsored

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[71] Kudlick, ‘Disability History’, p. 770 – 780.

[72] Paul Hunt (ed), *Stigma: The Experience of Disability* (London, 1966), foreword.

[73] Hunt, *Stigma*, foreword.

[74] Barnes ‘A Legacy of Oppression’, p. 4.

[75] Colin Barnes, *Cabbage Syndrome: The Social Construction of Dependence* (London, 1990).

welfare system'.[76] He suggests that the state has set up a dichotomy between the deserving and the undeserving poor. The disabled are constructed as 'incapable' and dependent upon social welfare and positioned differently from other unemployed or poor groups of people. However, this distinction in terms of welfare can have wider consequences. It affects how disabled people are viewed in terms of ability to work and raises issues again over their role in society. This dichotomy allows people categorised as disabled to be thought of as passive recipients of the government's charitable contributions.

The materialist interpretation is taken further by Albrecht and Wolfensberger. Albrecht in his work, *The Disability Business,* argues that the construction of disability has allowed for its commodification. [77] He argues that a commercial enterprise has been created around disability and rehabilitation. Wolfensberger, on the other hand, explores the ways on which the social construction of dependence has allowed human services industries to grow. He argues that these industries help create and sustain large numbers of dependant and devalued people in order to secure employment for others.[78] In all these interpretations therefore, western industrial capitalism lies at the root of disability.

Significantly, some theorists have explored the ways in which teaching and education excluded some groups from the labour market. This project has been informed in particular by the work of Popkewitz who argues that schooling and curriculum selection has 'imposed content on children in ways that channel these

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[76] Cited in Barnes 'A legacy of Oppression', pp. 4 – 7.
[77] G Albrecht, *The Disability Business* (London, 1992).
[78] Barnes 'A Legacy of Oppression', p. 6.

different children to different and unequal occupational and citizenship roles'.[79] Moreover researchers such as Roche have shown how 'education has both intentionally and latently been orientated to the advanced industrial and capitalist economy for the production and reproduction of variously skilled labour forces'.[80] Historians such as Mackenzie have looked back at the development of schooling and IQ tests in the latter half of the twentieth century in order to explore these processes arguing that the development of the schooling system seems to fit with the aims of social eugenists who wished to create 'provision of a rationalised system for ensuring that occupational positions at the various levels of the hierarchical divisions of labour were adequately filled'.[81] He argues that this was part of a planned system of labour which was met by IQ tests and a three tier secondary education system.[82]

Other have provided further scholarship in this area such as Timmons who has shown that from 1944 onwards 'the education system was being transformed into a more efficient form of selection'.[83] In particular, he focuses on Terman, one of the central figures in testing methods in education from the 1940s onwards. He shows how Terman utilises the link between IQ and vocational opportunities. He quotes Terman stating that 'an IQ below 70 rarely permits anything better than unskilled labour'.[84] He also goes on to show how Terman believed that 'this information will

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[79] Thomas Popkewitz, Miguel A. Pereyra and Barry M. Franklin, 'History and the problem of knowledge and the new cultural history of schooling', in Thomas Popekwitz (ed), *Cultural History and Education* (New York, 2001), p. 12.

[80] Maurice Roche, 'Citizenship, Social Theory and Social Change', *Theory and Society*, Vol 16, No. 3 (May 1987), p. 365.

[81] Donald Mackenzie, 'Eugenics in Britain', *Social Studies of Science*, Vol 6 (1976), p522.

[82] Mackenzie, 'Eugenics in Britain', p. 522.

[83] George Timmons, *Education: Industrialization and Selection* (London, 1988), p. 77.

[84] Timmons, *Education: Industrialization and Selection*, p. 80.

be of great value on planning the education of a particular child'.[85] It can be seen here therefore that schooling was explicitly understood by many educationalists as a means through which children could be selected and trained for specific levels of employment. Work like this has shown that prospects and opportunities for children with low IQs or diagnosed learning disabilities were severely limited by this educational ethos.

Barton, in discussing the Report of the Committee of Enquiry into the Education of Handicapped Children and Young People (Warnock Report), has demonstrated how this focus on training for entry into the workforce remained at the forefront of social policy. In 1975, Thatcher stated that the purpose of the committee was to:

> Review educational provision in England, Scotland and Wales for children and young people *handicapped by disabilities of the body or mind*, taking into account the medical aspects of their needs, together with arrangements to *prepare them for entry into employment*.[86] (my italics)

Barton thus demonstrates both how emphasis on the medical and psychological nature of disability still underpinned social policy, and how special educational priorities were 'fundamentally based upon a rationale in which economic priorities were central'.[87] He argues that selection and differentiation between pupils worked like a 'mechanism of exclusion'.[88] He states that education therefore created a social

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[85] Timmons, *Education: Industrialization and Selection*, p. 80.
[86] Barton, 'The Politics of Special Educational Needs', p. 145.
[87] Barton, 'The Politics of Special Educational Needs', p. 147.
[88] Barton, 'The Politics of Special Educational Needs', p. 148.

dichotomy between those who were ‘bright’ or ‘thick’, ‘good with their hands’ or those who could ‘use their head’.[89] School, in his interpretation, is seen as an instrument of social control in which those expected to succeed in employment are given priority and valued over the ‘deviant’ who are not. Prospects, opportunities and expectation of the future for those with learning disabilities are then heavily affected.

Sleeter has argued that the prospects of people with a learning disability have been hampered by the value modern industrial societies places on the written word. This suggests again that the devalued position of disabled people in our society comes from their segregation or inability to achieve certain standards of learning in their schooling years. He asserts that in our society, ‘literacy means power’, which means those without these skills remain outside the circle of power and influence.[90] Likewise, Roche argues that the emergence of the modern nation state has relied heavily on literate forms of communication. This, he argues, has meant that lack of literacy means limited access to processes of citizenship including accessing the public record and other information and access to education and suffrage.[91] This, in his opinion, has helped to reinstate the location of disabled people in the role of ‘second class citizens’.[92] This thesis will thus demonstrate the impact of segregated special education in the subsequent exclusion of people with learning disabilities from traditional subjects of education and the labour market.

The Cultural Model: Identity and the Linguistic Turn

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[89] Barton, ‘The Politics of Special Educational Needs’, p. 149.

[90] Christine Sleeter, ‘Literacy, Definitions of Learning Disabilities and Social Control’, in Barry M Franklin, *Learning Disability: Dissenting Essays* (London, 1987).

[91] Roche, ‘Citizenship’, p. 379.

[92] Roche, ‘Citizenship’, p. 381.

Whilst this project has investigated the importance of social context and social barriers on the construction of disability, it also demonstrates an awareness of the importance of culture and language in the history of disability. In recent years, many researchers (although still operating broadly under the social model ethos) have highlighted the importance of investigation into the cultural arena in disability studies. These historians, who study disability as a cultural concept, argue that this has allowed them to look beyond capitalist economic relations and investigate the role of culture in the production and reproduction of concepts surrounding disability. This shift mirrors the 'linguistic turn', which has affected many different areas of historical research over the last decade or so.

These scholars look at the ways in which disability is 'communicated, reproduced and experienced' noting that disability is not 'defined solely in terms of its relationship to the mode of production'.[93] Historians, such as Kudlick, have argued that this 'linguistic turn' is useful in providing 'valuable analytical and theoretical tools for exploring this new 'other''.[94] Bury, as an example of this, uses discourse analysis to look at narratives which designate disabled people with a particular role in society. [95] He explores the ways in which moral, medical, vocational and many different narrative threads reveal how disability and illness are understood and reproduced in cultural life.

Similarly, Shakespeare explores narrative as a way of understanding the cultural positioning of disabled people. He argues that 'disabled people remind non-

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[93] Shelia Riddell and Mike Watson (eds), *Disability, Culture and Identity* (London, 2003), Intro, pp. 6-7.
[94] Kudlick, 'Disability History', p. 763.
[95] Mike Bury, 'Illness narratives: fact or fiction?', *Sociology of Health and Illness*, Vol 23, No. 3 (2001), p. 264.

disabled people of their own mortality' and efforts are made to distance them from the 'norm of human experience.[96] This, he argues, is reflected in discourses surrounding disability. Barnes has explored charitable discourses in the bible and other literature. He argues that exploring representations such as these allows us to see that 'being presented as objects of charity effectively robbed people of the claim to individuality and full human status'.[97] Likewise Mallet has shown concern towards the representation and portrayal of disabled people. She describes the charitable depictions as 'clichéd, stereotypical and archetypal'.[98] Her work, therefore, has studied representations of disabled people in adverts for charities. Her work utilises the theories of Marks who states that images of impairment 'represent some of our deepest fears concerning normality and belonging'.[99] Mallet also argues that charitable representations are often 'based on a medical view (or model)' and that this 'cannot lead to the empowerment of disabled people'.[100]

Many of the theorists using the cultural model argue that disability is 'a product of definition and practices that seek to exclude individuals who might be seen to deviate from the socially constructed norms'.[101] These figures extend the socio/economic model and study language and discourse in an effort to discover the roots of disablement. In particular, they use the ideas of normality discussed above to identify the process whereby disabled people are 'othered' in the discourses of a

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[96] Tom Shakespeare, 'Cultural Representation of Disabled People: dustbins for disavowal?' in Len Barton and Mike Oliver (eds) *Disability Studies: Past Present and Future* (Leeds, 1997), p228.

[97] Barnes 'A Legacy of Oppression', p. 15.

[98] Rebecca Mallet, 'The Attribution of 'Authorship' in Cultural Interpretations of 'Disability'', part of a Phd presented at Disability Studies: Putting Theory into Practice, 26th – 28th July 2003, Lancaster.

[99] Mallet, 'The Attribution of 'Authorship'.

[100] Mallet, 'The Attribution of 'Authorship'.

[101] Mike Bury, Quoted in David Johnstone, *An Introduction to Disability Studies*, p. 9.

particular time. Thomas, for example, puts forward the argument that the pure/whole body is the measure against which all bodies are created in discourse.[102] In terms of learning disability then this can be applied to the idea of intellectual 'normality' which governs perceptions of disability. Barnes has noted how these perceptions of normality create prejudice in language and socialisation,[103] while Watson asserts that these perceptions must be deconstructed in order to discover how social structures of disability are products of discourse.[104] He states that we must look at language, signs and images through which these structures emerge in order to undermine the view that these structures are indeed a social reality.[105]

An important concept utilised in this thesis, which has been identified in the literature by cultural anthropologists such as Murphy, is the description of the positioning of disabled people, particularly those with learning disabilities, as 'liminal'.[106] Turner has also described this as a position of 'social suspension', a position neither completely part nor completely excluded from modern cultural life.[107] Disabled people are seen as neither sick nor well, out of society or wholly in it, fully segregation nor integration into their communities. Furthermore, Ingstad argues that the social identity of disabled people has been severely affected by notion of loss and competency. She asserts disabled people have to play dual roles in society as both 'injured beings and as citizens/workers like everyone else'.[108] Olney

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[102] Carol Thomas, 'The Disabled Body', in Mary Evans and Ellie Lee (eds), *Real Bodies: A Sociological Introduction* (New York, 2002), p. 67.
[103] Barnes, 'A Legacy of Oppression', p. 10.
[104] Nick Watson, 'Daily Denials: The Routinisation of Oppression and Resistance', in Nick Watson and Shelia Riddel, *Disability, Culture and Identity,* p. 35
[105] Watson, 'Daily Denials', p. 35.
[106] Watson, 'Daily Denials', p. 35.
[107] Watson, 'Daily Denials', p. 35.
[108] Benedicte Ingstad and Susan White, 'Disability and Culture: An Overview', in Benedicte Ingstad (ed), *Disability and Culture* (Berkley, 1995), pp. 7 – 8.

states that this is particularly relevant for those with cognitive or ‘hidden’ disabilities who often ‘exist in a netherworld belonging solidly to neither the ‘disabled’ or ‘non disabled’ community.[109] Stiker argues that this means ‘paradoxically they are designated so as to disappear, they are named so as to go unnoticed’.[110] Murphy explores this idea further noting how disability is treated as unspeakable and invisible using the social convention that children are taught not to point/ stare, or mention impairments.[111] Disability, in this interpretation, is again hidden and constructed as something abnormal and outside the norm of human experience. The consequence of this is that disability in terms of difference and diversity is not culturally acknowledged but still remains the primary identifier of disabled people.

Identity is also explored by Walsh who utilises the theories of Goffman in order to try and explain the social identity of disabled people, particularly those groups who have been represented in film.[112] She argues that in films and other cultural representations of disabled people there is a distinction between the ‘virtual social identity’ and the ‘actual social identity of a disabled character.[113] She states that the ‘virtual social identity’ is the character ‘we, the ‘normals’ believe the stigmatised person possesses’.[114] In turn, therefore she argues that the ‘actual social identity’ is the attributes that they could prove to possess beyond this.[115] She asserts that representation of disability in the majority of films and other cultural mediums

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[109] Marjorie F Olney and Amanda Kim, ‘Beyond Adjustment: integration of cognitive disability into identity’, *Disability and Society,* Vol 16, NO. 4, 2001, pp. 564.
[110] Quoted in Ingstad, ‘Disability and Culture’, p. 9.
[111] Ingstad, ‘Disability and Culture’, p. 9.
[112] Fiona Whittington-Walsh, ‘From Freaks to Savants: disability and hegemony from the *Hunchback of Notre Dame* (1930) to *Sling Blade* (1997), *Disability and Society*, Vol 17, No. 6 (2002), pp. 695 – 707.
[113] Whittington-Walsh, ‘From Freaks to Savants‘, p. 698.
[114] Whittington-Walsh, ‘From Freaks to Savants‘, p. 698.
[115] Whittington-Walsh, ‘From Freaks to Savants‘, p. 698.

has only served to reiterate the importance of impairment in the construction of disabled people's identities. She and others suggest that in investigating disability researchers should allow for the multiple identities of disabled people whose experiences are affected by their race, class, gender, sexuality and a whole host of other social and cultural factors. For example, Thomas has argued for a wider focus in the study of disability. She argues that the only way to explore disability and culture is to have this wide focus, as all these factors mean that 'disablism is experienced differentially'.[116]

It can be seen that the cultural model of research has opened up many new areas of investigation in disability studies which have informed this thesis. However at the root of much of this research remains an effort to try and combat oppression and the low status of disabled people. Many of the researchers using the social and new socio/cultural models are carrying out 'emancipatory' research as a result. Ward argues that the aim of this research is to 'provide the tools and the impetus for change towards a more just society, particularly for those most disadvantaged within it'.[117] She states that disability research is 'aimed at bringing about positive changes in disabled people's lives'.[118] Similarly, Barnes argues that the 'research should be about changing the world not simply describing it'.[119] Indeed, in another article he states that disability research is about researching oppression therefore 'researchers should not be professing mythical independence to disabled people but joining them

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[116] Thomas 'The Disabled Body', p. 68.

[117] Linda Ward, 'Funding for Change: Translating Emancipatory Disability Research from Theory to Practice', in Colin Barnes and Geof Mercer (eds), *Doing Disability Research* (Leeds, 1997), p. 32.

[118] Ward, 'Funding for Change', p. 33.

[119] Colin Barnes and Geoff Mercer, 'Breaking the mould? An introduction to doing disability research', in Barnes and Mercer, *Doing Disability Research,* p. 5.

in their struggles to confront and overcome this oppression'.[120] He goes on to state that principles of Weber's value-freedom do not apply here as what we need in disability research is 'engagement not objectivity, and solidarity not independence'.[121]

In being aware of the socially constructed nature of disability then, these researchers also seem to demonstrate an awareness of the socially constructed nature of their own research. For example, Barnes states that objectivity is impossible as 'all knowledge is socially constructed and culturally relevant'.[122] Similarity, Bury argues that 'research is always conducted in a social context'.[123] However, Bury states that, at times we must be more aware of this social context. He argues for example that the idea of oppression may not relate to all disability research. He states that researchers must be willing to see when this 'oppression model does not fit' as researchers must maintain the practice of 'research that does not have an immediate practical outcome'.[124] The idea of 'policy orientated research'[125] then presents the danger that it will miss some voices within the disabled community.

The Lived Experience of Disabled People

Some have criticised 'social model' type studies of disability for being too 'macro' or general in their approach and for generalising about disability without accounting

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[120] Colin Barnes, 'Disability and the Myth of the Independent Researcher', in Len Barton and Mike Oliver (eds), *Disability Studies: Past, Present and Future* (Leeds, 1997), p. 242.

[121] Barnes, 'Disability and the Myth of the Independent Researcher', p. 242.

[122] Barnes, 'Breaking the Mould', p. 5.

[123] Mike Bury, 'Disability and the Myth of the Independent Researcher: a reply', *Disability and Society*, Vol 11, No. 1 (1996), pp. 111 – 112.

[124] Bury, 'Disability and the Myth of the Independent Researcher, pp. 112 – 113.

[125] Barnes, 'Breaking the Mould, p. 1.

for the many different experiences of disabled people. This project has thus been heavily influenced by social and cultural models of disability in education and social policy but has also included significant input informed by the lived experiences of people with learning disabilities. Historians such as Riddell and Watson have argued that early studies had very little to say about the personal experience of disability.[126] They state that there has been a resistance to focus on the individual meaning of disability through fear that this would fragment rather than unite the disability movement.[127] However, they state, this focus on social barriers leaves gaps in the story of disability. Many have then argued that the disability rights movement needs to include individual experiences as 'the personal is political'.[128]

Shakespeare and Watson have stated that (politically at least) one of the major strengths of the social model was its simplicity.[129] For example, he demonstrates how its focus on social barriers helped to give the movement coherence. He argues, however that through the use of the social model, the disability movement has presented the world in black and white. He believes that the movement set up dichotomies between 'we who are oppressed' and 'them who oppress us'[130] demonstrating that the social dynamic over issues of disablement is a far more complicated process than this model allows.[131]

Watson and others argue therefore that, as well as the big social barriers that the social model highlights, researchers must look at the day-to-day interactions that,

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[126] Riddell and Watson (eds), *Disability, Culture and Identity,* intro p. 1.
[127] Riddell and Watson (eds), *Disability, Culture and Identity*, p. 4.
[128] Barnes, Mercer and Shakespeare, *Exploring disability: a sociological introduction*, p. 154.
[129] Tom Shakespeare and Nicholas Watson, 'The Social Model of Disability: An Oudated Ideology', *Exploring Theories and Expending Methodologies*, Vol 2 (2001), pp. 11 -12.
[130] Shakespeare and Watson, 'The Social Model of Disability, pp. 12 – 14.
[131] Shakespeare and Watson, 'The Social Model of Disability, pp. 12 – 14.

he states, lie at the heart of segregation and oppression. They assert that theorists should utilise the work of Goffman in his theory of 'spoiled identity'.[132] However, they also argues that disability theorists must go beyond Goffman's work which explores *how* stigma occurs by looking at *why* this is the case. Watson has thus begun this process by interviewing people with a disability and investigating how issues of prejudice and oppression have emerged in their everyday interactions. Through this process he has discovered subtle forms of prejudice in attitudes and interactions between disabled and non disabled individuals.[133] Deal has also explored issues of prejudice and forms of oppression. However he looks at the attitudes of impairment groups towards one another and has found that a hierarchy of impairments exists in which prejudice remains a central part.[134] This work represents a relatively new and promising form of scholarship on disability, one that directly involves disabled people and their experiences. Watson, for example, shows the opinions of one respondent to disability and social identity. In her interview, Jane asserted that in everyday interactions she felt that she had to 'prove to them [the non disabled] that you're a woman first and disabled second…that you're a human being'.[135]

One of the issues that has emerged through this new focus on experiential accounts in disability scholarship is the extent to which the social model has been criticised for 'not acknowledging the pain/discomfort of some impairments'.[136] Shakespeare and Watson argue that the social model has, wrongly, reinstated the

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[132] Watson, 'Daily Denials', pp. 35-36.

[133] Watson, 'Daily Denials', pp. 38-44.

[134] Mark Deal, 'Disabled People's Attitudes towards other Impairment Groups: a hierarchy of impairments, *Disability and Society*, Vol 18, No. 7, (Dec 2003), pp. 897 – 910.

[135] Watson, 'Daily Denials', p. 45.

[136] Johnstone, 'Disability Studies', p20.

distinction between impairment and disability and chosen to ignore the former.[137] He argues that this distinction between social (disability) and biological (impairment) elements of disablement is not sustainable as ‘everything is already social’.[138] Stone points to the work of Morris who has blurred these distinctions and shown the importance of the interplay between personal experiences and the role of impairment. Morris argues that ‘to deny the personal experience of disability is, in the end, to collude with our own oppression’.[139] Similarly, Shakespeare and Watson note the importance of research which seeks to ‘encompass the pain and limitations that are often part of impairment’ in their analyses.[140] Hughes argues that this work is the beginning of a transition from ‘invisibly to visibility by bringing impairment into the lives of non-disabled people’.[141] Shakespeare and Watson then argue that disability theory needs to move towards an ‘ontology of embodiment’ which accounts for the fact that ‘experientially impairment is salient to many’.[142]

Oliver asserts that experiences are important for disabled people in disability studies as ‘we are increasingly demanding acceptance from society as we are, not as society thinks we should be’.[143] Some historians and social scientists have therefore argued that this allows disability to be seen as something that is part of normal human experience. They suggest that we should look upon those formally regarded as the non-disabled as ‘temporary able’.[144] Disabled people, therefore, can be seen as

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[137] Shakespeare and Watson, ‘The Social Model’, pp. 12-13.
[138] Shakespeare and Watson, ‘The Social Model’, p. 17.
[139] Jenny Morris, *Pride Against Prejudice* (London 1991), p. 183.
[140] Shakespeare and Watson, ‘the Social Model, p. 14.
[141] Bill Hughes, ‘Bauman’s Strangers: Impairment and the invalidation of disabled people in modern and post-modern cultures’, *Disability and Society,* Vol 17, No. 5 (2002), p. 579.
[142] Shakespeare and Watson, ‘The Social Model’, p. 15.
[143] Oliver ‘the Individual and Social Models’, p. 5.
[144] White, ‘Disability and Culture’, p. 4.

on the same continuum of humanity as the rest of the ‘normal’ population. For example, it is argued that ‘we must demolish the false dividing line between ‘normal’ and ‘disabled’ and attack the whole concept of …normality’[145]. Watson suggests that an embodied ontology allows this as it deconstructs the ideas of ‘difference between disabled people and non-disabled people as *we are all impaired*’.[146]

Theorists such as Thomas also stress the importance of personalised experience. They argue against the ideas of Oliver and others who believe that attention should always be redirected away from impairment as this is the only way to combat medicalised approaches to disability. Thomas asserts that bodily experiences are an extremely important factor in the lived experiences of disabled people and therefore that the body should be brought back in to disability research.[147] Thomas here quotes the words of Wendell who states:

> I do not think my body is a cultural representation….I think it would be cruel as well as a distortion of people’s lives, to erase or ignore the everyday, practical, experienced limitations of people’s [impairments] simply because we recognise that human bodies and their varied conditions are both changeable and highly interpreted.[148]

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[145] Quoted in Shakespeare and Watson, ‘The Social Model’, p. 24.

[146] Shakespeare and Watson, ‘The Social Model’, p. 24.

[147] Thomas, ‘The Disabled Body’, pp. 69 – 71.

[148] Susan Wendell*, The Rejected Body: Feminist Philosophical Reflections on Disability* (New York, 1996), p. 44. Quoted in Thomas, ‘The Disabled Body’, p. 72.

Watson, Shakespeare and many others argue therefore that all dimensions of disabled people’s experiences must be explored be they ‘bodily, psychological, cultural, social or political’.[149]

Local and Community Based Studies: New Policy Trajectories

Thus these historians seek to include the testimonies and experiences of people with learning disabilities in their analysis. However Bredberg and others have shown that these ‘accounts of the lived experience of disabled people [still] remain very much under-represented’.[150] This project therefore emerges out of recent endeavours to produce studies and histories of disability with much more of a local and experiential nature. Researchers making inroads into this gap in the historical record include Atkinson, for example, who has led oral history projects in this area. She argues that the benefit of this is ‘including people with mental handicaps in areas of research which directly touch their lives’.[151] Similarly, Walmsley stresses that histories of people with learning disabilities must include their ‘voices’.[152] She states this is the only way to ‘reclaim’ the history of people with a learning disability away from institutional or other histories written on their behalf.[153] Thus texts such as *Forgotten Lives, Crossing Boundaries* and *Witness to Change* published in recent years are

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[149] Shakespeare and Watson, ‘The Social Model’, p. 20.
[150] Bredberg, ‘Writing Disability History’, p. 192.
[151] Dorothy Atkinson, ‘Research Interviews with people with mental Handicaps’, in Ann Beechin and Jan Walmsley (eds), *Making Connections* (London, 1989), p. 63.
[152] Jan Walmsley, ‘Including People with Learning Difficulties: Theory and Practice’, in Len Barton and Mike Oliver (eds), *Disability Studies: Past, Present and Future* (Leeds, 1997), pp. 64-65.
[153] Jan Walmsley, ‘Life History Interviews with People with Learning Disabilities’, in Robert Perks and Alistair Thomson (eds), *The Oral History Reader* (London, 1998), pp. 71 – 77.

some of the works that are most central.[154] These studies use official records, the press, oral testimonies and many other written sources to piece together experiences of learning disability over the last fifty years. Similarly, historians such as French have investigated the history of particular areas of disability such as that of special education through the use of both traditional written sources alongside experiential accounts.[155] Other significant studies which utilise many different types of sources in the creation of the history of learning disability include those which explored the development of significant local and national charities by historians such as Rolph, Davies and Rix.[156]

Another significant development in the history of learning disability is the focus on developments in social policy in its various guises and on life outside of institutions. Researchers such as Abbot and Sapsford noted back in the late 1980s that large numbers of people were never institutionalised. [157] However, as Welshman noted, there is still surprisingly little known about those in the community and about the ways ‘new’ community care policies evolved in the post-war period and were

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[154] Dorothy Atkinson, Mark Jackson and Jan Wamsley (eds), *Forgotten Lives: Exploring the History of Learning Disability* (Kidderminster, 2003) and Lindsay Brigham, Dorothy Atkinson, Mark Jackson, Sheena Rolph and Jan Walmsley (eds), *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster, 2000) and Sheena Rolph, Dorothy Atkinson, Melanie Mind and John Welshman, *Witness to Change: Families, Learning Difficulties and History* (Kidderminster, 2005).

[155] Sally French (ed), *An Oral History of the Education of Visually Impaired People" Telling Stories for Inclusive Futures* (New York, 2006).

[156] Sheena Rolph, *Building Bridges into the Community: The History of Bedford and District Society for People with Learning Disabilities, 1955 – 1990* (Milton Keynes, 2005) and Chris Davies, *Changing Society A Personal History of Scope 1952 – 2002* (London, 2002) and Brian Rix (ed), *All about us! The Story of people with a learning disability and Mencap* (London, 2006).

[157] Pamela Abbott and Roger Sapsford, *Community Care for Mentally Handicapped Children,* (Milton Keynes 1988), p. 39.

implemented, particularly at a local level.[158] Furthermore Welshman and Walmsley pointed out the importance of the inclusion of life stories and experiences of people who 'remained at home with families rather than entering any form of institutional care' in the documenting of this history.[159] This suggests the significance of renewed historical investigation on a micro level in this area.

More recent historiography has therefore begun to take stock of this and more studies have directed attention to the complex and long history of community care. New studies have shifted the focus in disability history away from traditional 'progressive' and often medicalised narratives of the development in 'advances' in disability policy. Particularly significant here is the work of Bartlett and Wright, and Noll and Trent whose work demonstrates the importance of different types of histories which focus on 'community' histories of disability. [160] Borsay, in her seminal work on disability in the UK, describes this new historiography as 'overturning the progressive narrative that dominated scholarship from the early twentieth century'.[161] She stresses that 'policy development is no longer understood as a morality tale in which 'heroic medical experts and reformist politicians' embarked upon a journey of improvement'.[162]

Local studies, such as this one set in Glasgow, therefore seek to take stock of the important developments in social policy at both a national and local level, while

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[158] Welshman John, 'Rhetoric and reality: community care in England and Wales, 1948 – 74' in Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750 – 2000* (London, 1999), p. 205.

[159] John Welshman and Jan Walmsley (eds.), *Community Care in Perspective* (Basingstoke 2006), p. 3.

[160] Peter Bartett and David Wright (eds), *Outside the Walls of the Asylum The History of Community Care 1750 – 2000* (London, 1999) and Steven Noll and James W. Trent Jr, *Mental Retardation in America: A Historical Reader* (New York 2004).

[161] Anne Borsay, *Disability and Social Policy*, p. 3.

[162] Borsay, *Disability and Social Policy*, p. 3.

also readdressing the ‘progressive’ nature of disability history. By drawing attention to both continuities and non-linear development in policy in this area they also demonstrate the complex nature of disability and its relationship with wider developments in healthcare, education and the cementing of a mixed economy of care. Local sources, including oral histories, health and social work archives and records of charities reveal new ways of looking at this history from a local perspective which often challenge macro level assumptions about disability history. They also point to the difficulties of relying on the positive notion of concepts such as ‘integration’, ‘inclusion’ ‘community care’ and reveal the complex ways in which these ideals were, or were not realised in practice. This new history therefore uses a ‘social model’ type of analysis which looks at barriers and significant developments in policy, but also allows for some analysis from the ‘bottom up’, using the experiential accounts from sources such as local charities and oral history testimony.

Chapter 2

Hospitals, Deinstitutionalisation and Community Care since 1945

Introduction

In the last half of the twentieth century there were many developments in the care, treatment and rights for people classed as mentally handicapped. The movement towards ‘community care’ provides an overarching theme to these changes in national policy whereby people were no longer to be kept in hospitals as patients but to live in the local community. However, in reality, the developments in policy for people with mental handicaps were much more complex than a linear move from the institution to the community. For example it must be noted that there were many elements of community care that were not particularly new and had, indeed, been an important part of provision earlier in the century. Whilst historical research has often focussed on institutions and large segregated hospitals, there was always a substantial number of people within this group who were cared for in family homes or under ‘guardianship’ in the community.

The emergence of institutionalised care was certainly an important development in policy for those classed as ‘mentally defective’. Mitchell, for example, has pointed towards the prominence of eugenic ideas in the twentieth century which ‘encouraged the incarceration of so many individuals in purpose built institutions'.[163] The Eugenics Education Societies, alongside the Charity Organisation Society amongst others, were deeply involved in the agitation for an Act of Parliament to institutionalise 'mental defectives'.[164] The Central Association of Mental Welfare in particular played an important role in the administering of eugenic legislation such as the 1913 Mental Deficiency Act in 'ascertaining the mentally deficient in need of institutionalisation in an area and referring them to the proper authorities for certification'.[165] However, their local 'mental deficiency committees' also supervised those who had left or were not placed in institutions, under a scheme of guardianship in the community.[166] Much of this provision therefore operated outside the institution as the Central Association of Mental Welfare and other bodies sought to control and supervise mental defectives in the community. For this reason Walmsley and others have argued that policies of 'care in the community' were not entirely new in the period after World War Two.[167] They question the assumption that community care emerged out of the discrediting of institutional care and the 1954 Royal Commission alone.

The Wood Report in 1929, for example, 'used the expression 'community care' and promoted measures that included day schools, occupation centres and industrial centres', although they promoted sterilisation and segregation alongside

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[163] Duncan Mitchell, 'Parallel Stigma? Nurses and people with learning disabilities', *British Journal of Learning Disabilities,* Vol 28, 2000, p. 80.

[164] Greta Jones, *Social Hygiene in Twentieth Century Britain* (London, 1986), p. 27.

[165] Jones, *Social Hygiene,* p. 27.

[166] Jones, *Social Hygiene*, p. 27.

[167] Jan Walmsley, Dorothy Atkinson and Sheena Rolph, 'Community Care and Mental Deficiency 1913 – 1945', in Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750 – 2000* (London, 1999), pp. 181 – 203.

this policy of ‘socialisation’.[168] The Wood Committee estimated in 1920 that there were around 60,000 individuals in England and Wales in need of non-institutional care.[169] One significant aspect of this, however, is the way in which it questions the assumption that community care naturally promotes concepts like ‘integration’. Indeed, the function of an Occupation Centre in this earlier period can be as both as segregated and as regimented as day-to-day living in an institution. [170] In addition, it provided a supervisory role and was described as ‘one of the most satisfactory ways of keeping in touch with defectives living in their own homes or under guardianship’.[171] Work by Walmsley and others therefore has served to demonstrate how ‘community care could be as controlling as institutional care’.[172]

Todd argued in 1967 that ‘subnormal children and adults have always been cared for in the community, except where some form of family failure had made parents unable or unwilling to look after them’[173] It was stressed therefore that ‘community care’ in this period must imply more than simply family care in order for it to be seen as a new development in policy.[174] Thus it is clear that whilst there existed a great number of people with ‘mental handicaps’ outside of hospitals before and after the 1950s, it is also apparent that there was something new about thinking

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[168] John Welshman, ‘Rhetoric and Reality’: Community Care in England and Wales, 1948 – 74’ in Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750 – 2000* (London, 1999), p. 207.

[169] Walmsley, Atkinson and Rolph, ‘Community Care and Mental Deficiency’, p. 186.

[170] Walmsley, Atkinson and Rolph, ‘Community Care and Mental Deficiency’, p. 181.

[171] Ruth Darwin, ‘The Proper Care of Defectives Outside Institution’, conference paper at the 1926 conference on Mental Welfare quoted Walmsley, Atkinson and Rolph, ‘Community Care and Mental Deficiency’, p. 191.

[172] Walmsley, Atkinson and Rolph, ‘Community Care and Mental Deficiency’, p. 181.

[173] F. Joan Todd, *Social Work with the Mentally Subnormal* (London, 1967), p. 29.

[174] Todd, *Social Work with the Mentally Subnormal,* p. 29.

on the benefits of community integration and negative thinking about institutionalisation. Welshman has explored some of the reasons behind the importance of community care as 'new' policy rhetoric from the 1950s.[175] He points to the importance of a progressive movement which gradually called into question the value of segregated institutionalised provision and highlighted the 'ever-rising costs' of institutional care.[176] This led commentators such as Abbott and Sapsford to argue that by the middle of the twentieth century it had become apparent that 'the aims of segregation were not achievable'.[177] In addition, Welshman also points to the significance of World War Two which had served to focus attention on the public health and the mental health of people.[178] To this end he points to the passing of the NHS Act in1945 and in particular section 28 which stated that local authorities (LAs) might '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'.[179] Welshman states, therefore, that this gave LAs more of a framework for developing a system of community care.[180]

This chapter investigates the ways in which institutionalisation and old patterns of care gave way to 'new' ideas about community care. Concentrating particularly on the Glasgow and Scottish context, it demonstrates the ways in which concerns over overcrowding and bad conditions within hospitals began to be expressed by LAs and other statutory bodies. The impact of increasing emphasis on 'care in the community' is discussed, firstly with reference to the decline of

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[175] John Welshman, 'Rhetoric and Reality', p. 205.
[176] John Welshman, 'Rhetoric and Reality', p. 205.
[177] Pamela Abbott and Roger Sapsford, *Community Care for Mentally Handicapped Children* (Milton Keynes, 1988), p. 39.
[178] John Welshman, 'Rhetoric and Reality, p. 208.
[179] Welshman, 'Rhetoric and Reality, p. 208.
[180] Welshman, 'Rhetoric and Reality, p. 208.

‘supervisory’ types of care such as guardianship. This chapter also points to the importance of the wider context here, noting the importance of national scandals emerging at this time which brought to the forefront concerns about the state of mental deficiency institutions. It investigates the importance of these concerns focussing on discussion about conditions on a local level in Lennox Castle hospital and the ways in which these were increasingly scrutinised by health boards and other agencies.

Subsequent plans to promote community integration through hostels, supported accommodation and day services are highlighted. However the success of these initiatives are shown to be limited with huge shortfalls in the provision of these types of services in Greater Glasgow due to lack of finance, confusion, unclear statutory planning and often resistance of local communities to the building of centres or homes. It describes how mentally handicapped people and their families were often not provided with community based services to support this new ethos and consequently were left to cope with few resources. In addition, it also reveals the conflict emerging over individuals physically living in the community in a period where there was still ‘little reference of integration into the community’.[181]

Hospitals and Guardianship in Glasgow from 1940

In the early part of this period, the benefits of institutionalisation for the mentally deficient individuals were not usually questioned. However, the from the 1940s onwards, attention was repeatedly drawn to overcrowding and cramped facilities in

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[181] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 42.

these institutions. For example, the Medical Officer of Health (MOH) report for Glasgow in 1941 stated that Lennox Castle hospital had 1,136 ‘certified defectives’ as patients who were housed in a ‘state of overcrowding’; the consequence of this was a ‘lack of day room accommodation’ which, it was argued, ‘tends to produce in the patients a state of restlessness and unsettlement which is difficult to overcome’.[182] The MOH report for the City of Glasgow in 1943 stated that these problems were exacerbated by a shortage of materials which had meant that occupational therapy with patients had to be cut back but that ‘there had been an increased number of male patients…employed in the gardens and grounds’.[183] This problem of overpopulation was to increase every year en rule for example, by 1942 there were an additional 127 ‘certified mental defectives’ in Lennox Castle, of which 51 had come from home, 50 from other certified institutions, 19 from other hospitals and institutions and 7 from Barlinie Prison.[184] It was noted in the MOH report for the City if Glasgow in 1943, that the number of ‘certified mental defectives’ in Lennox Castle had grown to 1,247 that ‘accommodation was taxed to the full, and overcrowded still persists to a very marked degree in all the institutions’.[185]

At this time, the Medical Superintendent, Dr Curran, highlighted some of the problems the institution faced with admitting many different types of patients, especially those ‘whose continued detention amongst ordinary defectives is attended

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[182] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1941, p. 111.
[183] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1943, p. 142.
[184] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1942, p. 132.
[185] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1943, pp. 139 -142.

with considerable danger and risk'.[186] In a further report he again pointed to the steady increase in the number of cases admitted 'under Sections 9 and 10 of the Mental Deficiency and Lunacy (Scotland) Act of 1913' pointing out 'that the influence exerted by these patients on the more docile and suggestible defectives is very apparent and harmful'.[187] At this time the hospital was also reported to have accepted a number of 'male educable juvenile delinquent defectives' who further taxed the available facilities.[188] As a result it was argued that:

> The high proportion of dangerous and criminal defectives admitted under Sections 9 and 10 of the Mental Deficiency and Lunacy (Scotland) Act 1913, continues to add to the difficulties of administration of the institution already embarrassed by shortage of staff and overcrowding.[189]

In 1945 it was also reported (as in previous years) that, perhaps in large part due to the pressures of the war, there had been great difficulty in 'maintaining an adequate staff of nurses'.[190] In addition, it was reported in 1954 that Regional Boards in Scotland had been 'unable, within the limits imposed by finance and the needs of other specialities, to increase the numbers of beds for mental patients or defectives in

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[186] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1941, p. 111.

[187] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1942, p. 132.

[188] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1942, p. 132.

[189] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1944, p. 150.

[190] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1945, p. 210.

any very great measure'.[191] It was noted that there had only been an increase in beds made available 'here and there at existing hospitals'. [192] There was, at times, a seemingly ad hoc extension of facilities, for example in Lennox Castle huts previously used by the nurses were converted into accommodation for 120 patients in 1954.[193]

Thus, whilst the numbers of people requiring care continued to grow, the numbers of places in hospitals for these 'patients' did not increase at the same rate. By 1954 there were 4,570 'certified mental defectives' on the registers of National Health Service mental deficiency institutions in Scotland.[194] There were also 2,558 'certified mental defectives under guardianship care in private dwellings'.[195] By 1959 The Annual Report of the General Board of Control for Scotland gave the number of 'certified mental defectives' in Scotland as 8,421, of which 5,995 were in institutions and 2466 were boarded out under guardianship (1,317 of these were in Glasgow).[196] In 1960, for example, there were 100 'mentally defective' patients admitted to institutional accommodation in Glasgow, of which 57 went to Lennox Castle.[197]

A report from the Ministry of Health also demonstrates the national trend for the increase in the number of 'defectives' being admitted to mental deficiency

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[191] Reports of the Department of Health for Scotland and the Scottish Health Services Council (HMSO, Edinburgh, 1954), p. 54.
[192] Reports of the Department of Health, p. 54.
[193] Reports of the Department of Health, p. 54.
[194] Reports of the Department of Health, p. 57.
[195] Reports of the Department of Health, p. 57.
[196] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1960, p. 366.
[197] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1960, p. 366.

institutions, with a total of 3,309 patients admitted in 1950.[198] A large number (around half) of these new patients were described as ‘low grade’ and were ‘unable to give themselves the everyday care needed for dressing, washing and generally keeping clean’.[199] Significantly, the other half were described as ‘higher grade patients who needed care and control because they could not so conduct themselves as to maintain their place in the ordinary labour market’.[200]

Those admitted in Glasgow were not always adults and could be placed in mental deficiency institutions for a number of reasons. For example, a report in 1968 listed 269 children under 15 as resident in mental deficiency hospitals in the City of Glasgow and the County of Argyll with a further 100 children on the waiting list.[201] Of those resident in hospitals, 253 patients were classed as ‘severely subnormal’ and within this group 60% who were classed as ‘idiots’ and the remainder ‘imbeciles’.[202] Admission to the hospitals was on clinical grounds for the majority of these patients, however it was noted that 58 of the children were given priority in admittance because of ‘social circumstances’ and 32 were illegitimate.[203] This suggests that there were a significant number of children being admitted into full time institutions for both ‘social’ as well as ‘clinical’ reasons throughout this period, with many more waiting for places. However it is also noted in this report that the incidence rates,

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[198] Report of the Ministry of Health covering the period from 1st April, 1950 to 31st December 1951, Part III, On the State of the Public Health (London, HMSO, 1953), Cmd. 8787, p. 151.

[199] Report of the Ministry of Health covering the period from 1st April, 1950 to 31st December 1951, Part III, On the State of the Public Health (London, HMSO, 1953), Cmd. 8787, p. 157.

[200] Report of the Ministry of Health covering the period from 1st April, 1950 to 31st December 1951, Part III, On the State of the Public Health (London, HMSO, 1953), Cmd. 8787, p. 157.

[201] D A. A. Primrose, ‘Children in the Mental Deficiency Hospitals of Glasgow and Argyll’, *Develop. Med. Child Neurol*, 1968, Volume 10, pp. 366-370.

[202] Primrose, ‘Children in the Mental Deficiency Hospitals’, p. 367.

[203] Primrose, ‘Children in the Mental Deficiency Hospitals’, p. 367.

particularly for ‘mongolism’ in the population suggests that a substantial number had not been institutionalised as ‘there must be many more outside hospital’.[204]

The ongoing practice of providing care outside of hospitals under guardianship provided an important extension to formal institutionalisation, particularly given the widespread problems of the lack of beds and overcrowding. The 1947 NHS (Scotland) Act stipulated that the local authority was to be responsible for ‘the ascertainment and certification of persons within the area who are mentally defective or who are of unsound mind’.[205] In a letter issued to all GPs in Glasgow in 1948, the role of guardianship was clearly laid out when it was noted that it was now:

> The duty of the local authority to make arrangements for the transfer of such persons to a certified institution or to a mental hospital, or, in suitable cases, for their placement under guardianship, should they, by reason of the mental condition, require supervision for their own protection or for the protection of others.[206]

The emphasis was therefore on the need for supervision through either placement in a hospital or under guardianship. The newly appointed senior medical officers under this act were to make quarterly visits to ‘boarded out mental defectives’ and make

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[204] Primrose, ‘Children in the Mental Deficiency Hospitals’, p. 370.

[205] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1948, p. 32.

[206] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1948, p. 33.

reports to the Board of Control demonstrating again the links with the system of hospitalisation.[207]

In the late 1940s, the MOH reported around 950 boarded out ‘mental defectives’ in Glasgow.[208] These individuals were kept under the watchful eye of the Board of Control who were concerned with issues such as ‘suitability for continued guardianship [and] removal to an institution or discharge’.[209] It was noted that ‘certified mental patients’ and ‘mental defectives’ boarded out under guardianship, ‘thus becoming the responsibility of the Regional Health Boards’, meant this was seen as an extension of the hospital service.[210] There were some concerns over the conditions of some of the housing for individuals under guardianship, for example in 1948 when it was stated that ‘there are cases…where the housing conditions are modestly described as ‘fair’[211]. Despite this the numbers under guardianship continued to grow, often due to the lack of places available in institutions. For example, it was noted in 1949 that ‘the numbers of mental patients and mental defectives on the boarded out rolls increased from 1,304 at 31st December 1948 to 1,337 at 31st December 1949’ which meant there were ‘many ineducable mental defectives on the waiting lists for accommodation in certified institutions but the lack of accommodation is still grave and many urgent cases cannot be accommodated’.[212]

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[207] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1948, p. 33.

[208] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1948, p. 34,

[209] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1948, p. 34.

[210] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1948, p. 34.

[211] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1948, p. 34.

[212] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1949, p. 254.

In the MOH report of 1951, the blame for this was placed firmly with the Regional Hospital Boards who it stated demonstrated an ‘inability to provide a sufficient number of beds to accommodate even the most urgent cases [which] is much to be regretted’.[213]

The lack of accommodation seemed to be a grave problem all over the country and this was expressed in Glasgow in 1951 when it was stated that ‘it is well nigh impossible to get into any institution low-grade mentally defective children whose retention in their own homes created family problems of the gravest order’.[214] Whilst it was acknowledged the problem was national, this report highlighted the seriousness of the situation in this area where ‘through lack of provision by the Hospital Board in Glasgow the position gets worse each year’.[215] Because of this the new Medical Welfare Officers ‘instead of being able to spend their time in positive welfare work, have to devote much time explaining to distraught parents that despite the urgency of their need no definite prospect of admission to a certified institution’.[216] Lack of investment in the mental health sector, for example in extending hospital provision, was key to the lack of places available in Glasgow where resources were being directed to many of the other public health concerns of the city at this time. Mental health was not yet a public issue and as such remained low on the list of priorities for health boards and the local authority.

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[213] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1951, p. 14.

[214] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1951, p. 14.

[215] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1951, p. 14.

[216] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1951, p. 15.

The lack of accommodation and the rising costs of maintaining institutions, as well as emerging ideas of integration and community care were, over the proceeding few decades, to shift the trend of care away from institutions. Similarly, the expanding cost of maintaining the practice of 'guardianship' with its linkage to institutionalisation and supervisory care meant it also became an increasingly unfashionable method of care. By the 1960s the numbers of patients under 'guardianship' began to drop as new arrangements were made for the rising number of mentally handicapped people unable to gain placement in an institution or who were felt to be only in need of 'informal care'. In addition, the passing of the Mental Health (Scotland) Act 1960 meant that more patients were to be placed under 'informal care' meaning the number of patients under formal guardianship in Scotland declined dramatically from 2,442 patients under guardianship in 1960 to 608 in 1971.[217] The numbers of patients under guardianship in Glasgow was reduced from 1,235 in 1961 to 601 in 1962 and 557 in 1963. [218]

However the practice was not to disappear and evidence of the 'value' of 'boarding out' in country areas was highlighted by the MOH medical reports in the 1960s, for example one stressed its importance in allowing 'patients to lead 'healthy and happy lives'.[219] However, the supervisory element was still to remain central as this same report warned against the dangers of certain circumstances for 'boarded out defectives' as it argued that with 'younger boarded-out patients there is always a hankering after city lights which may not be a good environment for mental

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[217] The Mental Welfare Commission for Scotland, *A Duty to Care; An account of the work of the commission between 1962 and 1972* (Edinburgh, HMSO, 1972), p. 12.
[218] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 230.
[219] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 220.

defectives.[220] In 1970 the MOH report recorded the numbers of 'mental defectives' under guardianship in Glasgow as 364 and those under 'informal supervision' as 727 demonstrating the continuing use of this practice.[221] However guardianship was to become under fire, for example from the Mental Welfare Commission in a report in the 1970s which found that 26% of males living under guardianship were living in circumstances described as 'less than satisfactory'.[222] In addition, it was noted that 13% of individuals in this study were living in conditions, which it was argued, 'justified immediate removal'.[223] There was also reference to the problems of 'unregistered homes' which were causing concern.[224] Thus in 1971 the commission set itself the task of locating and surveying individuals who were not under guardianship.[225]

It was noted by the Mental Welfare Commission that guardianship had been used 'as a means of supervising and exercising some control over the mentally ill and mentally handicapped in the community since the middle of the nineteenth century and used to such an extent that there were, in the late 1950s, as many as 2,800 such guardianship cases' in Scotland.[226] However they stressed that in the late 1960s, the responsibilities of the Medical Officer of Health became the responsibility of the

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[220] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 230.
[221] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1970, p. 212.
[222] The Mental Welfare Commission for Scotland, *A Duty to Care; An account of the work of the commission between 1962 and 1972* (Edinburgh, HMSO, 1972), p. 12.
[223] The Mental Welfare Commission for Scotland, *A Duty to Care; An account of the work of the commission between 1962 and 1972* (Edinburgh, HMSO, 1972), p. 12.
[224] Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, 1994, ADSW1/7.1.21.
[225] The Mental Welfare Commission for Scotland, *A Duty to Care; An account of the work of the commission between 1962 and 1972* (Edinburgh, HMSO, 1972), p. 12.
[226] Mental Welfare Commission for Scotland, Report for 1985; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1985), p. 12.

Director of Social Work after 1968.[227] It was noted that changes in the structure of social work and finance and significantly an ‘emerging trend in public attitudes towards the…mentally handicapped [meant that] guardianship has almost fallen into disuse’. [228] Increasing criticism of the care provided and the subsequent decline in the use of guardianship thus represents a movement away from traditional types of care for those with mental handicaps. The increasing use of ‘informal care’ represents a shift in thinking by the statutory authorities on this issue, whereby patterns of care that required full time care and control began to be seen as less than ideal. Guardianship, and in particular the placement of people away from immediate family or relatives, was no longer seen as particularly acceptable alongside the development of care in the community with special schools and training centres. However the removal of this type of provision was relatively slow evidenced by the fact there were still 263 cases of ‘mentally handicapped persons under guardianship’ in Strathclyde in 1979.[229] The delay in the removal of this type of provision from statutory services may be explained by a lack of investment in other options. Therefore it remained in place, albeit on a relatively small scale, even whilst the numerous health authorities and local statutory agencies dismissed the effectiveness and suitability of supervisory types of care. The continuing existence of this outdated practice therefore suggests that there was a conflict between the stated aims of mental handicap policy and the reality of the placements available in Glasgow.

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[227] Mental Welfare Commission for Scotland, Report for 1985; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1985), p. 33.

[228] Mental Welfare Commission for Scotland, Report for 1985; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1985), p. 33.

[229] *Social Work Services for the Mentally Handicapped in Strathclyde* (Strathclyde Regional Council, Glasgow, 1979), p. 18.

The National Context: Institutions and the Emergence of Abuse Scandals

It was stated as early as 1954 that ‘it is the aim of every mental deficiency institution by a process of training and socialisation to enable patients to be discharged to outside employment’, however it was stated that ‘there is little or no possibility of this being done with low grade defectives’.[230] It was also noted in this report that ‘only about 2½ per cent of the defectives resident in institutions can be discharged annually, with a consequent limitation in the number of new admissions’.[231] Subsequent overcrowding and lack of available beds added to further criticisms of institutions and medical patterns of care for this group which began to emerge in the 1950s. For example, the Chief Medical Officer wrote in 1957 and 1958 that ‘the future of the mental health service depends on the community services’ and that ‘long hospitalisation is out of fashion in mental medicine as it is in general medicine and surgery’.[232] In addition, in Glasgow in the early 1960s there were questions being raised about the role of the local authority in providing care and services for the ‘mentally handicapped’. One report highlighted the long waiting lists for places and suggested there was a need to look again at those in hospitals ‘not requiring medical, nursing or custodial care [who] could be transferred to the care of the local authority’.[233] Similarly, a further study on the development of social work in the area of ‘mental subnormality’ stressed the importance of the changing ethos stating that

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[230] Reports of the Department of Health for Scotland and the Scottish Health Services Council (HMSO, Edinburgh, 1954), p. 57.
[231] Reports of the Department of Health for Scotland and the Scottish Health Services Council (HMSO, Edinburgh, 1954), p. 57.
[232] Welshman, ‘Rhetoric and Reality’, p. 210.
[233] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p227.

‘where social rather than clinical categories are the point at issue, the law will be interpreted in the light of contemporary knowledge and the ability of the community to tolerate mentally handicapped people in their midst’.[234]

Alongside this new thinking was still a tendency to rely on traditional hospital services, suggesting that change, in practice, was to be slow and gradual. For example, in 1967 it was stressed that ‘present day attitudes to hospital care’ demonstrate awareness that ‘prolonged care in hospital can be as damaging as or more so than the original condition’.[235] It was argued that ‘because of assumptions about the needs of subnormal patients, the regime in hospitals has also tended to allow them less initiative and participation in decisions concerning their future than is found in other settings’.[236] However this report did not seem to fully advocate complete closure of institutions, for example noting their important work with ‘severely subnormal’ people. In addition it argued, ‘when a subnormal client is unable to make the transition from training centre or S.E.N school to a job without considerable stress, and his family are unable to give him the support he needs, hospital care can be extremely beneficial’.[237]

The Mental Welfare Commission was set up on the back of the Mental Health (Scotland) Act of 1960 which had transferred the functions of the General Board of Control for Scotland to the Secretary of State.[238] This new body was now to administer the former responsibilities of the Board of Control relating to the ‘care

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[234] Todd, *Social Work with the Mentally Subnormal*, p. 18.
[235] Todd, *Social Work with the Mentally Subnormal*, p. 47.
[236] Todd, *Social Work with the Mentally Subnormal*, p. 48.
[237] Todd, *Social Work with the Mentally Subnormal*), p. 51.
[238] The Mental Welfare Commission for Scotland, *A Duty to Care; An account of the work of the commission between 1962 and 1972* (Edinburgh, HMSO, 1972), p. 1.

and treatment of the mentally disordered'[239] exercising the 'protective functions' required.[240] This included investigating 'any case where it appears to them that there may be ill-treatment' or any other matter of concern and bring this to the attention of the manager of any hospital, the Secretary of State or the Health Board.[241]

This was at a time when negative reports about institutions began to emerge in the press. For example, an editorial from the *Glasgow Herald* on the 18th of July 1969 entitled 'Forgotten People' drew attention to the fact that an estimated 65,000 'mentally subnormal' patients occupied hospital places in Britain.[242] It revealed that only £11 a week was spent on these patients and the mentally ill, whereas £30 to £40 a week was spent on patients in ordinary hospitals.[243] However, the article did not go so far as to advocate the closure of these hospitals instead stressing the need for more money to improve conditions in these hospitals.[244] In 1971 the significant white paper *Better Services for the Mentally Handicapped* 'recognised that many individuals with mental handicap living in hospital could, with support, be enabled to live more 'normal' lives in the community'.[245] In Scotland, the report *A Better Life* reiterated these ideas about caring for some people with 'mental handicaps'. However it again stopped short of advocating complete closure of these institutions

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[239] SHHD, Health and Welfare Services in Scotland Report for 1962 (HMSO, Edinburgh, 1963), p34

[240] The Mental Welfare Commission for Scotland, *A Duty to Care; An account of the work of the commission between 1962 and 1972* (Edinburgh, HMSO, 1972), p. 1.

[241] Mental Welfare Commission for Scotland, Report for 1985; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1985), p. 5.

[242] 'Forgotten People', *Glasgow Herald*, 18th August 1969, reprinted in SSMHC, Newsletter, September 1969, p. 8

[243] 'Forgotten People', SSMHC, Newsletter, September 1969, p. 8.

[244] 'Forgotten People', SSMHC, Newsletter, September 1969. p. 8.

[245] Scottish Home and Health Department, *The Future of Mental Handicap Services in Scotland* (HMSO, Edinburgh, 1992), p. 12.

instead pointing to the need for the upgrading of hospitals.[246] It was also stressed in 1978 that 'the government's aim is to enable many mentally handicapped people as possible to live in the community', however this aim was not necessarily seen as urgent or even achievable given that it was also stated that 'hospital care will be required for many of these patients for a long time to come'.[247]

On a national level, both the Ely Hospital Enquiry and *Put Away* by Morris had pointed to the serious concerns over the conditions in hospitals for the mentally handicapped.[248] Further negative reports on the conditions began to appear in the 1970s, for example the Secretary of State for Social Services (Mrs Castle) reported that South Ockendon Hospital had been investigated in 1973 due to concerns over standards of care.[249] Castle noted the significance of a lack of support for staff who were forced to work under 'very difficult conditions' noting that this was largely down to 'successive governments which have failed to ensure that NHS authorities devoted adequate resources for the mentally handicapped generally'.[250] She highlighted 'intolerable overcrowding' as one of the key issues preventing improvements in conditions for the 'mentally handicapped' in hospitals, instead recommending that local authorities be helped and encouraged to 'expand their services for keeping a greater proportion of the mentally handicapped in the community'.[251] In 1978, when the Secretary of State for Social Services and the

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[246] *A Better Life: Report on Services for the Mentally Handicapped in Scotland*, (HMSO, Edinburgh, 1971).
[247] Mr David Ennals, (Secretary of State for Social Services), House of Commons Report, The Times, November 22nd, 1978, p. 6.
[248] Report of the Farleigh Hospital Committee of Enquiry, Cmnd 455 (HMSO, London, 1969) and Pauline Morris, *Put Away* (London, 1969).
[249] Mrs Castle (Secretary of State for Social Services), House of Commons Report, *The Times*, May 16th 1974.
[250] Castle, House of Commons Report, *The Times*, May 16th 1974.
[251] Castle, House of Commons Report, *The Times*, May 16th 1974.

General Medical Council investigated conditions in Normansfield Hospital, the subsequent report was to cause ‘grave concern about the care of mentally handicapped patients generally’ and to prompt the statement that the ‘sort of behaviour and the poor standards of care revealed at Normansfield must not be tolerated in our hospitals’.[252] The Secretary placed the blame for the abusive practices within this institution on a lack of monitoring on the part of the health authority and reported that he was implementing further review of hospitals for the mentally handicapped.[253]

Other similar reports highlighting bullying and abuse in institutions appeared in the press around this time. For example, one article pointed to the conditions in hospitals for the ‘mentally handicapped’ in which patients ‘are in danger of not being considered human beings by the staff who care for them’.[254] Particular attention was drawn to a recent publication on such hospitals describing the ‘lack of privacy and respect for patients’.[255] It went on to illustrate the lack of choice, for example, in the hair styles for male patients where the only option is ‘short back and sides, no one is allowed to refuse…choice of raincoat from a communal pile, communal underwear and socks, communal combs and brushes’.[256] It also noted that ‘drugs were seen as the most effective way of controlling patients’.[257] A report in the early 1980s thus noted how scandals such as the:

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[252] Mr David Ennals, (Secretary of State for Social Services), House of Commons Report, *The Times*, November 22nd, 1978,

[253] Ennals, House of Commons Report, *The Times*, November 22nd, 1978,

[254] Lucy Hodges, ‘Mental patients bullied, former male nurse claims’, *The Times*, September 25th, 1980.

[255] Hodges, ‘Mental patients bullied’, former male nurse claims’, *The Times*, September 25th, 1980.

[256] Hodges, ‘Mental patients bullied’, *The Times*, September 25th, 1980.

[257] Hodges, ‘Mental patients bullied’, *The Times*, September 25th, 1980.

> Ely Hospital Enquiry (1969) gave enormous new drive to what has now become a movement, disturbing the public conscience, forcing governments to think afresh about statutory services, attracting the attention of the media and giving new hope to mentally handicapped people and their families.[258]

In 1981, stories emerged in the press about the conditions of one particular hospital in England in which a documentary film had been recorded. This film showed the impact of staff and space shortages with patients ‘caged in compounds outside’.[259] This film served to draw attention to many deficiencies of care which MIND (Mental Health Charity) argued ‘had been about for years by the Department of Health and Social Security’.[260] MIND urged that immediate action be taken to alleviate some of the problems at Borocourt Hospital highlighted by the film.[261] A report by the Association for the Protection of Patients and Staff featured in *The Times* in 1983 gave further examples of abuse and poor conditions for the mentally handicapped in 16 hospitals in the UK.[262] It was stated that ‘mentally handicapped hospital patients are being subjected to a process of brutalization about which nurses and volunteers are too frightened to complain’.[263] It was noted that one hospital had begun the use of ‘behaviour modification’ without proper training for staff, which had meant this

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[258] David Anderson, *Social Work and Mental Handicap* (London, 1982), p. 78
[259] Lucy Hodges, ‘Mental patients’ plight’ known for years’, *The Times,* June 8th, 1981.
[260] Hodges, ‘Mental patients’ plight’ known for years’, *The Times,* June 8th, 1981.
[261] Hodges, ‘Mental patients’ plight’ known for years’, *The Times,* June 8th, 1981.
[262] Pat Healy, Social Services Correspondent, ‘Mentally handicapped girls hosed like cattle’, *The Times*, February 22nd, 1983.
[263] Healy, ‘Mentally handicapped girls hosed like cattle’, *The Times,* February 22nd, 1983.

became a ‘punishment ward’.[264] In addition, ‘bathtime’ is described in a ward in another hospital as ‘reminiscent of bathing cattle’.[265]

Abusive practices were also revealed in a report on St Lawrence’s hospital for the ‘mentally handicapped’ in which ‘gross overcrowding’ and ‘dangerously low staffing levels’ were revealed.[266] In addition, it was revealed that during a visit to the hospital a freelance producer was also filming images of ‘a child tied to a post’.[267] Mr Patrick Jenkins (Secretary of State for Social Services) commented on the documentary ‘Silent Minority’ in 1981 that had highlighted ‘some of the worst aspects of care provided’.[268] However he stated that, whilst these aspects would be investigated, ‘it has been the policy of successive governments to move mentally handicapped people into the community and to run down large hospitals’.[269]

One criticism levelled at, for example, Manor Hospital in Epson, Surrey, is that ‘it has many able patients yet an appallingly low discharge rate’.[270] This story of patients being ‘stuck’ in hospital appeared in the press, for example in an article in 1981 entitled ‘how many more Arthurs await rescue from mental hospital’.[271] Arthur is described as ‘deaf but not daft’ as it is noted his inability to communicate or do well in intelligence tests had ‘put the medical handcuffs on him’.[272] Attention was

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[264] Healy, ‘Mentally handicapped girls hosed like cattle’, *The Times,* February 22nd, 1983.

[265] Healy, ‘Mentally handicapped girls hosed like cattle’, *The Times,* February 22nd, 1983.

[266] Lucy Hodges, ‘Hospital Censured in Report’, *The Times*. 22nd December, 1981.

[267] Hodges, ‘Hospital Censured in Report’, *The Times*. 22nd December, 1981.

[268] Nicholas Timmons, ‘Minister disturbed by film’, *The Times,* June 11th, 1981.

[269] Timmons, ‘Minister disturbed by film’, *The Times*, June 11th, 1981.

[270] Healy, ‘Mentally handicapped girls hosed like cattle’, *The Times,* February 22nd, 1983.

[271] Peter Brock, ‘How many more Arthurs await rescue from mental hospital?’, The Times, April 8th, 1981.

[272] Brock, ‘How many more Arthurs await rescue from mental hospital?’, *The Times,* April 8th, 1981.

drawn to the many ‘Arthurs’ in hospitals who had been institutionalised ‘mainly because they were unemployable’.[273] Similarly, an earlier report brought attention to the number of women who had been institutionalised for being a ‘moral defective’ after giving birth to illegitimate children.[274] The wider implications of this were noted by David Ennals (then the campaign director of the National Association for Mental Health) who pointed out that ‘the DHSS has estimated that half the patients in mental handicap and mental subnormality hospitals do not require medical and nursing treatment and would be better in hostels outside’.[275]

Another report stressed how ‘most long-stay patients continue to be nursed in huge, old, shabby, stigmatized, and ultimately to be dismantled workhouse hospitals’.[276] A report by the National Development Group for the mentally handicapped subsequently found that four out of ten of patients in long-stay hospitals ‘sit all day with nothing to do’.[277] It was argued that with the thousands of patients with a ‘mental handicap’ in hospitals ‘there are many who could be discharged, were there adequate extramural services to look after them’.[278]

The Local Context: Hospitals and Conditions in Glasgow

On a local level, there were similar concerns about the state of hospital provision, particularly in Lennox Castle Hospital during the 1980s. Initial concerns over

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[273] Brock, ‘How many more Arthurs await rescue from mental hospital?’, *The Times*, April 8th, 1981.
[274] Geoffrey Wansell, ‘Third sane woman, kept in mental hospital for 50 years, may be one of 120 with nowhere to go’, *The Times*, May 22nd, 1972.
[275] Wansell, ‘Third sane woman, kept in mental hospital for 50 years’, *The Times*, May 22nd, 1972.
[276] Dr Tom Arie, ‘Difficulty of attracting long-stay staff’, *The Times*, 25th April, 1974.
[277] ‘Mental Patients ‘sit all day with nothing to do’, *The Times*, 22nd June, 1977.
[278] Tom Arie, ‘Difficulty of attracting long-stay staff’, *The Times*, Thursday April 25, 1974, p. III.

overcrowding in the earlier part of this period were re-asserted alongside the conditions and care being provided for patients. The Mental Welfare Commission visited the institution in November 1984 when it reported it had become 'concerned about some aspects of patient care and about the apparently deteriorated fabric of some parts of the hospital'.[279] The Commission's attention had been drawn to Lennox Castle by articles in the *Scotsman* newspaper[280] whilst subsequent visit by a Medical Commissioner in June 1985 'sharpened the concern', noting the lack of medical and administrative staff and the fact that they were 'scarcely able to maintain minimal standards of medical care'.[281] As a result the Commission made a 'special' visit to the hospital in August 1985 meeting with the Health Board officers and Chief Administrative Medical Officer in order to 'hear of the long-term plans for the care of the mentally handicapped in the Greater Glasgow area in general and in Lennox Castle in particular'.[282] The Commission noted their concern with the 'general appearance of neglect at the hospital' and 'the apparent lack of awareness by many staff of professional standards'.[283] Even after some improvements had been made, the commission still expressed concern about some of the 'unprofessional attitudes of some of the nursing staff and about what they perceived as a wearied acceptance by many hospital staff of quite unacceptable material conditions of care'.[284] As a result it classed Lennox Castle as a 'sick hospital' due to many

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[279] Mental Welfare Commission for Scotland, Report for 1985; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1985), p. 5.
[280] Mental Welfare Commission for Scotland, Report for 1985, p. 5.
[281] Mental Welfare Commission for Scotland, Report for 1985, p. 5.
[282] Mental Welfare Commission for Scotland, Report for 1985, p. 5.
[283] Mental Welfare Commission for Scotland, Report for 1985, p. 6.
[284] Mental Welfare Commission for Scotland, Report for 1985, p. 6.

problems including inadequate staffing and morale, finance, location, size and 'attitudes towards patients held by people both inside and outside the hospital'.[285]

The 1986 Mental Welfare Commission members revisited the conditions in institutions, particularly Lennox Castle, to explore whether there had been any development since they had drawn attention to the 'deficiencies of care'. The report noted that 'extensive comment was made about the contribution which the poor environment at Lennox Castle made to disruptive patient behaviour and poor staff morale and attitudes'.[286] In particular, it pointed to 'attitudes held by some staff which were outdated, neglectful and non-professional and which ran counter to therapeutic progress'.[287] It also highlighted the limits of a move towards 'individualised patient care programmes' when there were still wards with 50 beds with many staff unable to provide very little beyond 'basic nursing care'.[288] The report for the following year, whilst noting that there had been some improvement in buildings and upgrading of wards, also stated that the 'commissioners were most unfavourably impressed with the environment and general living conditions of these patients'.[289] Patients of one particular ward were described as 'largely unoccupied, some wandering aimlessly while others watched television without much apparent comprehension' and another which 'smelled of urine at one end and was very spartan being bare of personal effects or domestic decoration'.[290] They summarised their

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[285] Mental Welfare Commission for Scotland, Report for 1985, p. 6.

[286] Mental Welfare Commission for Scotland, Report for 1986; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1986), p. 9.

[287] Mental Welfare Commission for Scotland, Report for 1986, p. 9.

[288] Mental Welfare Commission for Scotland, Report for 1986, p. 9.

[289] Mental Welfare Commission for Scotland, Report for 1987; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1987), p. 9.

[290] Mental Welfare Commission for Scotland, Report for 1987, p. 9.

impression of this ward stating that 'given that this ward is supposed to be home for 50 patients, it can only be described as a fairly grim place'.[291]

Oral testimony gives further evidence of the abuse, overcrowding and segregation reported in governmental papers and in the press. For example, one former patient remembers that during her time in Lennox Castle:

> People used to take your things from the lockers. The lockers didn't lock because they didn't give us keys. To punish us for doing things we weren't meant to do they used to sit us in the chair and tie your hands to it. And sometimes if you were bad, when you were in bed, you got a jag or they used to give you a sedative to drink.[292]

Another recalls how:

> At Lennox Castle they put you in a moleskin for punishment; it was a jacket and it was itchy, I didn't like it. The staff used to punish everybody. I was out one day and they punished me because I didn't know what spool to get for a camera.[293]

Similarly another male former patient stressed that:

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[291] Mental Welfare Commission for Scotland, Report for 1987. p. 9.

[292] 'Diane's story: I'm getting a place of my own soon', SHS Trust, *I've got a good life – don't tell anyone keep it a secret; Stories about life after Lennox Castle*, (Edinburgh, 2003), p. 15.

[293] 'Elizabeth's story: I cannae find my freedom sometimes', SHS Trust, *I've got a good*, p. 27.

> they werenae nice to the people that were there…it was like being in prison, too many rules and staff. You're given your trial, you're given your sentence. I used to pace up and down in the hospital counting the days to when I was getting out'.[294]

An additional former patient recalled day-to-day life on the wards, and stressed that, 'there wasn't much I really enjoyed doing in Lennox Castle, it wasn't that I was always looking for a way out but once I got out I thought to myself you are not going back there'.[295] He continued 'all did was sit and listen to the radio or watch TV…it got a bit repetitive and the other thing too was the meals weren't good'.[296] Whist he was admitted because of this cerebral palsy but he was put in a ward with other 'mentally handicapped' patients. He recalled:

> My father had died just 6 months before I went to Lennox Castle and I think my mother thought this is the only, or one of the reasons is that I was getting to heavy for her to manage….I was there for 17 years actually, I think it was that anyway, by the time it came to 15 years I felt as if I was in with the bricks.[297]

One of the modern initiatives at Lennox Castle was to provide more homely accommodation in line with what patients would expect outside the institutions. For example, one patient recalled how 'eventually after 6 years I managed to get into

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[294] 'Andy's Story: I'm a person, not a label', SHS Trust, *I've got a good life,* p. 23.
[295] SOCHA/024/5, Guy Shanks interview with Angela Turner, 1st September 2005
[296] SOCHA/024/5, Interviewee Guy Shanks, 1st September 2005.
[297] SOCHA/024/5, Interviewee Guy Shanks, 1st September 2005.

another ward and got outside, not outside Lennox castle, inside Lennox castle but outside the ward…we did basketry'.[298] Thus a number of patients were moved out to smaller scale housing in 'Overton Court', however another former patient suggests that there were not many differences, even given the new type of accommodation. He stated 'It's sort of a hospital for the same kind of people, it's connected to Lennox Castle. It's not in the community, you're not in the community until you go out of there and get your own house'.[299]

Oral testimony collected from former patients and staff at Gogarburn Hospital in Edinburgh reveals similar negative memories of life in an institution during this time. For example one patient, resident in the hospital from 1956-83, recalls that 'Gogarburn at that time was a very rough place…a lot of people did crime…and so I was put in besides them'.[300] Another respondent, resident from 1962-1976, recalled how she was told she would be there for 3 months but she ended up staying for 14 years. She recalled 'I was coming up for seventeen when I went in…when I got there I remember I was flung into the ward. It was being in a dormitory with a lot of strangers. Strangers I never knew. I couldnae sleep'.[301] One nurse who worked in the hospital from the 1960s to the 1990s also recalled how:

> Withdrawing privileges probably would be used as a punishment...Another punishment was, if somebody was misbehaving…people being sent back to bed. Just imagine what you took away – because through the day if you were

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[298] SOCHA/024/5, Interviewee Guy Shanks, 1st September 2005.

[299] Andy's Story: I'm a person, not a label', SHS Trust, *I've got a good,* p. 23.

[300] Jimmy Macintosh quoted in Nigel Ingham (ed), *Gogarburn Lives* (Edinburgh, 2002), p. 9.

[301] Mary Ball quoted in Ingham (ed), *Gogarburn Lives*, p. 13.

> put to bed you would be the only one in the dormitory and then deprived of any form of relationship or communication or whatever.[302]

The same nurse also told of the ways in which highly medicalised and often extremely harsh forms of treatment were used, for example, if a patient broke a window' nurses would have to then:

> Put him to bed, give him a tranquilliser and put him to bed and give him an injection or something like that if he doesn't take it orally or whatever, people were restrained...when I was there at the beginning the restraining jackets that you pulled and their arms folded in front and tied at the back… a straight jacket yes! Those were still used.[303]

A report in the Spring 1989 edition of the Scottish Down's Syndrome Association newsletter reveals the widespread adherence to this type of care and treatment in hospitals alongside the new 'progressive' ideals of integration and community care. For example, in an article on hospital care it was noted that 'music may be used in a therapeutic way to assist in the overall *treatment* and *management* of people with a mental handicap'[304] (my emphasis).

Thus the Mental Welfare Commission (MWC) continued to assess and report on both the 'squalor and neglect' and the deficiencies of care they found at Lennox

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[302] Boris Petrusev, quoted in Ingham (ed), *Gogarburn Lives*, p. 36.

[303] Boris Petrusev, quoted in Ingham (ed), *Gogarburn Lives*, p. 36.

[304] SDSA News, The Magazine of the Scottish Down's Syndrome Association, No 19, Spring 1989, p. 3.

Castle throughout this period.[305] Their work suggests a very slow move towards closing down this and other hospitals and focussing efforts on community-based care. During an unannounced visit in 1988 they discovered ‘conditions that led the Commissioner to report that if they had been found in the private sector of care neither the Commission or any authority would have hesitated to recommend closure’.[306] This was despite the fact that the GGHB had pledged a further £4.6 million for the hospital in 1989 and the Board gave assurances of improvements. Further to this the report stated ‘these assurances were accepted by the Commission but it has to be said that they are similar to the assurances which were given in 1986’.[307] However, whilst it noted that ‘further public criticism might well have had an adverse affect on the emerging good morale and professional self respect at Lennox Castle Hospital’, it also stressed that:

> As each year passes the Board’s attribution to its predecessor and its officers of responsibility for the kinds of neglect which the Commission has reported becomes increasingly unconvincing. It may well be an explanation; five years later it can no longer be an acceptable excuse.[308]

The movement towards community-based care and away from reliance on these failing and overcrowded institutions therefore still seemed a long way off. A report on care and accommodation for people with ‘mental handicaps’ in Glasgow in 1987,

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[305] Mental Welfare Commission for Scotland, Report for 1988; Presented to Parliament by the Secretary of State for Scotland under Section 3 (7) of the Mental Health (Scotland) Act 1984 (Edinburgh, HMSO, 1988), p. 14.

[306] Mental Welfare Commission for Scotland, Report for 1988, p. 14.

[307] Mental Welfare Commission for Scotland, Report for 1988 p. 14.

[308] Mental Welfare Commission for Scotland, Report for 1988, p15.

The Balance of Care for Adults with a Mental Handicap in Scotland, suggested that 'more than 90% of hospital residents would be capable of being accommodated in other circumstances'.[309] It stated that 'people with a mental handicap should only be in NHS facilities when they have medical or nursing needs which cannot practicably be met other than in such facilities'.[310] However, whilst reports such as the SHARPEN[311] report in 1988 spoke about community care and advocated this philosophy of moving towards 'normalisation', it was also 'recognised that such a move would involve the education of the public' and a massive increase in the availability of facilities and other resources in the community before patients were to be released.[312]

Indeed, reports by the MWC on 'closed wards', such as those for the 'mentally handicapped', suggest a hesitation to promote full integration by putting all resources into the community. It was stressed that these wards existed to protect patients from the 'dangers' of the outside world.[313] As a result such patients were are 'not permitted to have 'free-exit' from the wards therefore because of 'wandering behaviour' which, if permitted, would place these patients in jeopardy by self-neglect of lack of awareness of possible danger'.[314] However it was also noted in the report that the Commission was concerned to have found 'such a great number of informal patients for most of whom there appears to be no indication of any clinical need for

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[309] Quoted in SHS Trust, *I've got a good life*, p. 8.
[310] *Caring for People Community Care in the Next Decade and Beyond* (HMSO, London, 1989), p12
[311] Scottish Health Authorities, *Review of Priorities for the Eighties and Nineties*, (HMSO, Edinburgh, 1988).
[312]Scottish Home and Health Department, *The Future of Mental Handicap Services in Scotland* (HMSO, Edinburgh, 1992), p. 13.
[313] Mental Welfare Commission for Scotland, Report for 1985, p. 26.
[314] Mental Welfare Commission for Scotland, Report for 1985, p. 26.

nursing in closed ward alongside patients who do need that special provision'.[315] The report also notes that there appeared to be 'about 1,000 handicapped patients in Scotland in conditions of *de facto* detention and that probably less than 5% of these were legally detained' but states that 'the Commission thinks it entirely appropriate and believes that relatives and the public would expect that exits from the wards in which such patients are nursed should be under close staff surveillance'.[316] The patients, it was argued, 'do not therefore seem to the Commission to be significantly or materially deprived of any human right in being so safeguarded by an informal process of *de facto* detention…indeed it could be argued that failure so to safeguard them would be reprehensible'.[317]

The reports of the MWC, whilst critical of the conditions in institutions such as Lennox Castle, also, at times, focussed attention on the need for a medical type of care for these patients. For example, the report from 1985 described 'some difficult cases' in the field of 'mental handicap'.[318] One such case is described as woman of 36 who was 'severely mentally handicapped' and whose case was brought to the Commission as her 'assaults' against other patients and staff were so 'severe' that it had resulted in her being secluded for up to 9 hours during the day.[319] The Commission intervened and, whilst they noted the ferocity of the patient's attacks, they also noted that they could not condone the seclusion for such an extended period of time, recommending instead changes in management of 'A' which they had helped with and had resulted in a general improvement in her condition.[320] The remit

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[315] Mental Welfare Commission for Scotland, Report for 1985, p. 27.
[316] Mental Welfare Commission for Scotland, Report for 1985, p. 29.
[317] Mental Welfare Commission for Scotland, Report for 1985, p. 29.
[318] Mental Welfare Commission for Scotland, Report for 1985, p. 30.
[319] Mental Welfare Commission for Scotland, Report for 1985, p. 30.
[320] Mental Welfare Commission for Scotland, Report for 1985, p. 30.

of the Commission's work was therefore largely concerned with the improvement of conditions and treatment for patients within existing institutions rather than the promotion of community care and the closure of such hospitals.

However, the consequence of both negative reports on hospitals and the appearance of similar stories in the press added to the growing movement for de-institutionalisation. The Department of Health report 'Caring for people' in 1989 defined community care as 'providing the services and support which people affected by problems of ageing, mental illness, mental handicap or disability need to live independently in their homes or in 'homely' settings in the community' and stressed that the government was firmly committed to community care.[321] Statutory authorities therefore began to express the desire to support 'near-normal, community based lifestyles for people with a mental handicap'.[322]

The Development of Community Care from the 1970s

The stated aim of concentrating on and extending community provision however was not easily realised. Todd's study of social work services for the 'mentally subnormal' in 1967 noted the importance of projects such as the building of hostels in an effort to improve community care.[323] It stressed that these were to be seen as both 'half-way houses' from institutions to the community and as permanent homes in themselves, which provided an alternative model of care from large institutions.[324] In

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[321] John Welshman, 'Rhetoric and Reality', p. 204.

[322] Charles Abraham, 'Supporting People with a Mental Handicap in the Community: a social psychological perspective', *Disability, Handicap and Society,* Vol 4, No2, 1989, p. 121.

[323] *Social Work with the Mentally Subnormal,* p.40.

[324] *Social Work with the Mentally Subnormal,* p.40.

1968 the MOH stressed the importance of ‘the setting up and administration of hostels’ however it was also stated that ‘it would be unwise to advocate a rapid influx of hospital patients into community hostels if, at the same time, the supporting services like occupation centres and workshops, were seriously inadequate’.[325] However in subsequent years there was often a resistance to fully endorse and commit to the development of community care as there was often a conflict between the desire to increase community services in this way whilst resources were still needed for modernising and improving conditions in hospitals where many patients with mental handicaps remained. For example, the Association of the Directors of Social Work stressed at this time that, whilst they welcomed improved quality of life for patients in these hospitals, ‘it must be a matter of concern that so much money is being spent on these old hospitals while at the same time care in the community is floundering because of lack of funding’.[326] It was stressed that ‘perhaps some of that money could have been spent in community schemes’.[327] Local statutory authorities then were slow to prioritise community-based care, concentrating to some extent on the maintenance of hospitals which were still in dire need of financial investment.

The Association of the Directors of Social Work (ADSW) reported on the Statement of the Royal College of Psychiatrists in 1988, which argued that:

> Care in the community is the more desirable alternative for many long-stay patients. This requires a more helpful, positive attitude amongst the general

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[325] SSMHC, Newsletter, December 1968, p. 4.

[326] Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, 1994, ADSW1/7.1.21.

[327] Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, 1994 ADSW1/7.1.21.

> public, the provision of houses for small groups and their caring staff and Health Authorities must know where former patients are living in the community[328].

Whilst this suggests an affiliation with old ideas of supervision in the community, it also demonstrates a widespread belief in the provision of community care. However they also suggested the need for maintenance of the hospital system,which may still be required, suggesting there must be services:

> Willing to provide respite care when the need arises. The provision of jobs, day centres for recreation, training and development of social relationships are all important ingredients in social care and rehabilitation but if a breakdown occurs, psychiatric care in hospital must be available.[329]

The emphasis, to some extent, was still therefore on monitoring these individuals and the desire to continue similar types of training and 'normalisation' in new institutions in the community. This report emphasised the size of the population needing psychiatric care as 2% of the population nationally, with 1% (around 500,000) of people in the UK requiring some kind of special care for mental handicap.[330] For this reason they stressed that 'we recommend that before any psychiatric hospital is

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[328] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[329] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[330] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

closed or drastically reduced in size, an effective system is set up to replace all the services previously provided by that hospital'.[331] Thus, there was resistance to promote complete de-institutionalisation with the suggestion that there could be a 'fine line' sometimes drawn in these cases between 'liberty and neglect' and that 'even in a well funded and responsive local service' there will still be a need for institutional care for a small number of people'.[332] This report also highlighted the problems facing LAs at this time owing to reductions in funding for social workers which it stated 'erodes what have been designated, by the Department of Health, as priority services'.[333] It can therefore be seen that even where there were statements of support for community care and the closure of hospitals, the message was not always clear and these changes were far from rapid. In similar ways, community based statutory services for the mentally handicapped in Glasgow were slow to develop. There were huge gaps in these services, which were often left to families or voluntary associations to fill. The table below demonstrates the situation of community services in Scotland the 1970s:

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[331] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[332] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[333] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

Guidance given to local authorities on the development of education and social work services for the mentally handicapped in Scotland 1972

	Facilities required		Places provided	Shortfall in places
	Per 100,000	Places		
Junior Occupation Centres	35	1,800	1,750	50
Day Care Centres	20	1,040	618*	422
Senior Training Centres	150	7,800	2,863^	4,937
Local Authority Hostel Places	43	2,200	59	2,141
Hospital Beds	120	6,300	7,713	-

* Includes 350 local authority and 268 voluntary

^ Includes 2,136 local authority and 727 voluntary

Table taken from Scottish Education Department, *Social Work in Scotland in 1972* (HMSO, Edinburgh, 1973), p1

This table records the minimum level of services that were required at this point to allow adequate provision of community care and allow the movement away from hospital provision. Thus it was asserted that:

> One of the principal features of recent developments in services for mentally handicapped people has been the principle of normalisation allowing them to enjoy the same facilities and services available to the rest of the community, and not to segregate and isolate them from community life.[334]

Similarly the Jay Report in 1979 stressed that community care was too low an aim and again the target should be ‘normalisation’.[335] As a result it was argued that the move to community care should be ‘confined to smaller units, integrated within the local community and creating home-like surroundings’.[336]

However, in practice, providing this ‘normal life’ in Glasgow in the late 1970s and 1980s meant planning to develop more community-based day centres, training centres and places of residence to allow for the closure of hospitals. It was estimated in 1979 that 0.6% of the Strathclyde population was ‘mentally handicapped’ which meant at least 15,000 people were to be catered for in this way.[337] Of this total, 530 were pre-school age, 6,380 were school age and 9,280 adults were classed as ‘mentally handicapped’ in the region, although this was said to

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[334] *A Better Life*, p. 22.

[335] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 42.

[336] Christopher P Hanvey, *Social Work with Mentally Handicapped People* (London, 1981), p. 79.

[337] Strathclyde Regional Council, *Social Work Services for the Mentally Handicapped in Strathclyde* (Glasgow, 1979), p. 3.

be ‘conservatively estimated’.[338] Thus, in Strathclyde alone it was reported that there would be a need for 3,623 places in Adult Training Centres (ATCs) by 1981 whilst there were only 1,174 available in 1979.[339] It was also noted that work still needed to be done on a large scale to provide enough hostel accommodation for both social worker and health board staff identifying ‘patients who could be discharged into the community and to devise and implement training programmes to prepare them for the new freedom’.[340] The report ‘A Better Life’ estimated that there would be a need for residential care places for 1.8 per every 1000 of the population by 1979.[341] It stressed that this should account for 0.6 per 1000 in the community and 1.2 per 1000 in hospitals.[342] It stated that ‘close co-operation between a wide variety of statutory bodies and voluntary organisations, and from the community at large, is necessary for the planning and development of services’.[343]

However it was reported that in 1975 there were still 7,102 patients in Mental Deficiency Hospitals in Scotland and 970 in local authority hostels and homes run by voluntary agencies. Although at this time there were no official statistics on the number of patients suitable for transfer to local authority care in Scotland as a whole it was thought to be at least 25% of this hospital population.[344] It was therefore estimated that 3,125 places were required in the community, where there were now less than 1000. In addition in 1979 it was also noted that from a target of 1,070 places in Mental Handicap Hostels in Strathclyde only 230 places (or 21% of the

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[338] *Social Work Services for the Mentally Handicapped in Strathclyde*, p. 3.
[339] *Social Work Services for the mentally handicapped in Strathclyde*, p. 4.
[340] *Social Work Services for the mentally handicapped in Strathclyde*, p. 4.
[341] *A Better Life*, p. 2.
[342] *A Better Life*, p. 2.
[343] *A Better Life*, p. 2.
[344] *A Better Life*, p. 20.

target) had been provided.[345] This, it reported, had led to a situation where hospitals had been scheduled for closure for 20 years, but two decades on the 'patients are still there, and each year some of them die and new ones are admitted to take their place'.[346] In addition, the hospitals were said to have 'decayed and the staff have seen no certain future'.[347] Whilst it was reported in 1979 that the number of patients in mental deficiency hospitals had fallen (by 7000 since 1969) it was also noted that the subsequent numbers of places in local authority residences had increased by only 4000 during this time.[348] This suggests that the balance of care, where it was required for these individuals not housed in hospitals, was now largely with families or other voluntary run provisions. Indeed, in 1978, the ADSW met with representatives of the Hospital Advisory Service and the SWSG in to review current problems and developments regarding the long-stay population. They noted in particular 'the problem of community facilities for psychiatric, geriatric and mentally handicapped patients' and agreed that 'the voluntary housing associations were making a valuable contribution here'. [349] The meeting also stressed the importance of linking the statutory and voluntary services and highlighted the shortages of staff in the field of 'mental handicap'.[350]

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[345] *Social Work Services for the Mentally Handicapped in Strathclyde*, p. 51.

[346] Dr Tony Smith, Medical Correspondent, 'The 20-year-old error that has left mental patients trapped in grim isolation', *The Times*, 1st April, 1976.

[347] Dr Tony Smith, Medical Correspondent, 'The 20-year-old error that has left mental patients trapped in grim isolation', *The Times*, 1st April, 1976.

[348] Mrs Castle (Secretary of State for Social Services), House of Commons Report, *The Times*, May 16th 1974.

[349] Minutes of Meeting held with ADSS, Hospital Advisory Service and SWSG, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th July 1978, ADSWA1/1.1.63.

[350] Minutes of Meeting held with ADSS, Hospital Advisory Service and SWSG, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th July 1978, ADSWA1/1.1.63.

Hospital provision was therefore to remain a significant means through which to treat and train people with mental handicaps, as the required alternative community-based services were not in place by the 1980s. For example, one study of 'mentally handicapped' school leavers in Scotland in the early 1980s stressed that hospital provision was still very much a central part of provision for this group. It noted that 'virtually alone among closed institutions surviving in contemporary Britain, hospitals for the mentally handicapped regularly provide care for a high proportion of a client population from infancy until death'.[351] In this study, 'new' patterns of care in one hospital with a 'family' type setting for young patients was assessed. However, the study found continuing traditions of older large-scale institutions which undermined real moves away from this type of medicalised care. It was noted for example that 'the ease with which the children fell in with a degree of regimentation is, of course, one of the principal difficulties that staff faced in securing any move towards normalisation of life on the ward'.[352]

In addition, there was resistance to consider options other than institutionalisation for groups such as those classed as 'severely mentally handicapped'. For example in *A Better Life* argued that hospital accommodation was 'an essential part of services for the severely mentally handicapped and will remain so for the foreseeable future'.[353] Its focus therefore was on 'investment in buildings and the further development of these types of services'.[354] In addition the responsibility of different authorities was sometimes not conducive to developments. For example, whilst it was noted that priority in provision should be given to areas

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[351] David Hughes, David May and Susan Harding, 'Growing up on Ward Twenty; the everyday life of teenagers in a mental handicap hospital', *Sociology of Health and Illness*, Vol 9, No. 4, Dec 1987, p. 379.

[352] Hughes, May and Harding, 'Growing up on Ward Twenty', p384.

[353] *A Better Life*, p. 7.

[354] *A Better Life*, p. 7.

'presently relying on Lennox Castle Hospital' it was also noted that provision of this residential patient accommodation outside the hospital was not the function of the health service.[355]Whilst they wished to 'phase out redundant hospital accommodation', it does not seem unclear as to what the strategy was to achieve this.[356] Thus it was noted that 'many hospitals still accommodate patients who need not be there if alternatives community facilities were available and hospitals remain under pressure to admit patients of this kind'.[357]

This seemed to be a common problem in the movement to this new strategy of community care. The Commons Social Services Committee, in 1985, for example criticised the movement of patients into the community without proper planning. They stated that 'any fool can close a long-stay hospital…it takes more time and trouble to do it properly and compassionately'.[358] It stressed that more money needed to be spent on providing community services as 'community care on the cheap would prove worse in many respects than the pattern of services to date'.[359] As a result it was advised that the removal of hospital services be done whilst at the same time devoting extra monies and effort in building up the required equivalent community services.[360] The Mental Welfare Commission had similar concerns, stating that whilst 'community care remains the aim of all those with responsibility for the mentally ill and those with mental handicap…any movement of an individual whether to another ward in the hospital or to residential accommodation or to a home

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[355] *A Better Life,* p. 7.
[356] *A Better Life,* p. 8.
[357] *A Better Life,* p. 13.
[358] Nicholas Timmons, Social Services Correspondent, 'Community care for the mentally ill and handicapped 'inadequate', *The Times,* March 1st, 1985.
[359] Timmons, 'Community care for the mentally ill and handicapped 'inadequate', *The Times,* March 1st, 1985.
[360] Timmons, 'Community care for the mentally ill and handicapped 'inadequate', *The Times,* March 1st, 1985.

in the community must be seen to be to the benefit of that person and must enhance the quality of life'.[361]

Numerous commentators have argued that as well as the rising awareness of unsatisfactory conditions in institutions, part of the appeal of community care was that it could be seen as a cheaper option. Borsay, for example, argued in 1986 that the development of community care was certainly, 'stimulated partly by a reaction to the horrors of institutional life and partly by the belief that community care is a cheaper solution'.[362] However she also noted that the assumption that community care is more economical than institutional care often failed to take into account issues of calculating such 'hidden expenses as the unpaid support upon which community care rests'.[363] She stated that because of this 'successive governments have failed to spell out the exact pattern and organisation of services necessary to make the community ideal a feasible option'.[364] Similarly, Abbott and Sapsford stated in 1988 that 'an important selling point seems also to have been that policies of community care appeared to be a cheap as well as a humanitarian alternative to institutional care'.[365] They noted however that, in practice, 'community has meant shifting the major part of the costs from the public purse to the private individual or family' as 'hospitals have been closed down but local authority social service departments have not increased their spending to a comparable degree'.[366]

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[361] Report of the Mental Welfare Commission for Scotland 1989 (HMSO, Edinburgh, 1990), p. 8.
[362] Anne Borsay, *Disabled People in the Community: A study of Housing, Health and Welfare Services, Occasional Papers on Social Administration No. 80* (London, 1986), p. 1.
[363] Borsay, *Disabled People in the Community*, p. 1.
[364] Borsay, *Disabled People in the Community*, p. 3.
[365] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 43.
[366] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 43.

The aim was therefore to base care and any ‘treatment’ needed ‘within people’s ordinary life and domestic surroundings’.[367] However it was asserted that there was ‘a real need to safeguard the existing funds being put into this field, for example from the land sales of the large hospitals’.[368] Finance for community care plans seemed to be a continuing problem leading the Griffiths Report of 1988, ‘Community Care an Agenda for Action’, to recommend that money contributed for community care by Regional and District Health Authorities should be ‘ring fenced’.[369] However there was also the recommendation that resources should be found elsewhere, for example in the expansion of the private and voluntary sector.[370] There were some concerns about the care that may be provided in this way with the Royal College of Physicians suggested that ‘the quality of care should not be affected by the wish to get the best possible price’.[371]

The lack of resources and money to achieve the stated aims of community care was not always aided by the relationships and mixed responsibilities of the different statutory authorities. As seen above, the health board and bodies such as the Mental Welfare Commission were often more concerned with the improvement of conditions for patients in existing hospital facilities. Sources also suggest an uneasy

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[367] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[368] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[369] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[370] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[371] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

relationship between the different authorities. For example, a letter in 1989 from Mary Hartnoll (Association of Directors of Social Work) to Richard Scott (Scottish Home and Health Department) discussed the NHS Circular No 1989 (GEN) 5 Establishment of Community Care Facilities by Health Boards for People being Discharged from Long Stay Hospitals. This document itself had asserted the need for joint planning of services with good relationships between local authorities, social work departments and 'relevant voluntary agencies'.[372] This was to ensure that 'patients who can live in the community with the right kind of support [were] not to be cared for in long-stay hospital wards'.[373] However Hartnoll was concerned that the process of establishing community care was presented in this source as the lead (or even sole) responsibility of Health Boards.[374] She notes that this was at odds with various other statements of policy which suggest a joint planning system (including health boards, LAs and the voluntary sector). Indeed she points to the Griffiths Report which stated that LAs should take a lead role in the development of community care.[375] The matter did seem to be cleared up to some extent as R Winter wrote to Sam Galbraith (Director of Social Work) stating that the circular had been

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[372] Discussion of NHS Circular No 1989 (GEN) 5, Establishment of Community Care Facilities by Health Boards for People being Discharged from Long Stay Hospitals, 28th February 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers ADSWA 1/7.2.2.

[373] Discussion of NHS Circular No 1989 (GEN) 5, Establishment of Community Care Facilities by Health Boards for People being Discharged from Long Stay Hospitals, 28th February 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers ADSWA 1/7.2.2.

[374] Letter from Mary Hartnoll (ADSW) to Richard Scott (SHHD), 25th April 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW 1/7/2.2.

[375] Letter from Mary Hartnoll (ADSW) to Richard Scott (SHHD), 25th April 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW 1/7/2.2.

for Health Boards only and the role of LAs was taken as given.[376] However this points to a confusion at a high level over who was responsible for community who was responsible for maintaining institutions as well as planning for their closure by providing community services.

In the 1990s it was re-asserted that 'a higher quality of life can be achieved in valued community settings than is possible in a large remote institution such a Lennox Castle Hospital'.[377] It was stated that institutions such as this 'reduce opportunities for choice and increases segregation from the wider world'.[378] It was reported that the aim seemed to be 'to enable such people to become respected members of the community, being treated as individuals and not discriminated against because of intellectual impairment'.[379] Thus the NHS and Community Care Act 1990 made community care, (which the Greater Glasgow Health Boards (GGHB) argued had been 'the policy of central government since the early seventies'), official policy and made social work the lead authority on its implementation.[380] However this was still to involve a number of agencies in Glasgow, including the regional council, social work, the housing department,

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[376] Letter from Mary Hartnoll (ADSW) to Richard Scott (SHHD), 25th April 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW 1/7/2.2.

[377] Greater Glasgow Health Board. *Development of Community Services for People with Learning Disabilities and the Closure of Lennox Castle Hospital*; *Consultation Paper*, December 1994, p. 1.

[378] Greater Glasgow Health Board. *Development of Community Services for People with Learning Disabilities and the Closure of Lennox Castle Hospital: Consultation Paper*, December 1994, p. 1.

[379] Discussion of NHS Circular No 1989 (GEN) 5, Establishment of Community Care Facilities by Health Boards for People being Discharged from Long Stay Hospitals, 28th February 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers ADSWA 1/7.2.2.

[380] GGHB, *Development of Community Services*, p. 1.

mental health services and the voluntary sector.[381] Services were now to be ‘tailored’ to individuals and delivered locally with the involvement of service users in the planning and evaluation of their care.[382] Whilst noting the importance of providing supported housing in the community, it was also stressed that these individuals should be given ‘something meaningful to do’ such as attending day centres and having access to education, employment or leisure opportunities.[383] Thus, whilst stating the importance of implementing community care it was also stressed that ‘the pace at which the development programme is implemented will depend on the availability of bridging finance from central government to support double running costs’.[384]

The consequences of this slow progress and perhaps lack of financial investment can be seen in Glasgow in particular where the continuing hospital provision seemed to be at odds with the stated aims of community care and integration. The number of mentally handicapped people living in Lennox Castle hospital declined at what can be seen as a very slow rate with individuals still being referred as full-time patients well into the 1990s. In 1982 there were still 1,272 beds for the mentally handicapped, with the majority coming from the Greater Glasgow area. [385] By 1991, 830 patients remained at Lennox Castle, most of whom were middle-aged or elderly, with 60% having lived in the hospital for over 25 years. [386] Indeed 300 such patients were living in the institution when it was closed in 2002.[387] Well into the 1990s, people with mental handicaps and their families were often left

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[381] GGHB, *Development of Community Services*, pp. 1-2.
[382] GGHB, *Development of Community Services*, p. 5.
[383] GGHB, *Development of Community Services*, p. 8.
[384] GGHB, *Development of Community Services*, p. 9.
[385] GGHB, *Development of Community Services*, p. 4.
[386] SHS Trust, *I’ve got a good,* p. 9.
[387] SHS Trust, *I’ve got a good life*, p. 9.

faced with stark choices of life segregated in an institution or isolated in the community with very little support. Indeed Scotland seems to have been even slower than elsewhere to enact change through promoting community services. Chapman, for example, has pointed to the consistency of number attending day centres into the 1990s, 'suggesting that long-stay hospitals had also taken longer to close than in England'.[388] In addition he identified the particular problem in Scotland, which had been 'the difficulty of finding appropriate places for people to move in to'.[389]

Seed found that there were 4,817 people with learning difficulties in long-stay hospitals in Scotland on 31st December 1988 and 3,492 remaining there in 1990.[390] In 1990, he measured the balance of care for the mentally handicapped as 35% (4817) resident in hospital, 26% (3492) living in supported or staffed accommodation and 39% (5338) living with carers at home.[391] The proportion of those living in institutions therefore was still relatively high and there were still a considerable number living in unsuitable conditions, for example in 'old folks homes'.[392] Oral testimony collected from one respondent with the aid of a support worker recalled his living conditions in the 1980s (when he was in his late 40s), noting that:

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[388] Rohhss Chapman, 'Devolved Policy for People with Leaning Difficulties' in John Welshman and Jan Walmsley, *Community Care in Perspective*, p100.

[389] Chapman, 'Devolved Policy for People with Leaning Difficulties', p100.

[390] Dr Philip Seed, *Supported Accommodation and Day Services foe People with Learning Difficulties*, Paper given to Dundee and Stirling Universities Seminar 11th October 1990, published by University of Dundee, Department of Social Work, 1990, p. 3.

[391] Seed, *Supported Accommodation*, p. 3.

[392] Seed, *Supported Accommodation*, p. 3.

> Because John had mobility problems, although at that stage he wasn't a pensioner, it was felt that they could offer him the best care at the time in an old folks home… and John didn't see himself as being old.[393]

John recalled his feeling that the home was unsuitable for him as 'there were no young people'.[394] As in many other cases, the practical realities of care in the community were that many people were placed in form of residences that were not ideal.

This led some to point out the contrast between the reality and the rhetoric in the new movement towards community care. Barr, for example, argued in 1989 that 'one of the characteristics of the last two decades has been an increasingly popular attachment to the idea of community… [which] often has more to do with the aura that it creates, a sense of well-being or belonging, than to do with specifically measurable features of human relationships and experience'.[395] He pointed to the 'emergence of what might be called the 'community prefix' syndrome' and warned against the tendency for developments like those in 'community social work', whereby the growth of these services 'could simply lead to abuse of the goodwill of ordinary people to supplement the resources of an increasingly stretched social work service'.[396]

The records of the Association of Directors of Social Work certainly reveal a shift in ethos and language when discussing institutions and learning disability. In a

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[393] SOCHA/024/9 John Smyth and Alan Mack interview with Angela Turner, 4th March 2006,

[394] SOCHA/024/9 Interview with John Smyth and Alan Mack, 4th March 2006.

[395] Alan Barr, 'New Dog – New Tricks? Some Principles and Implications for Community Social Work', in Gerald G. Smale and William Bennett (eds), *Pictures of Practice: Volume 1, Community Social Work in Scotland* (National Institute of Social Work, London, 1989), p. 163.

[396] Barr, 'New Dog – New Tricks', p. 163.

report in 1991 for example, they highlighted concerns over the delay in the move towards community care and agreed that ‘people should only be cared for or treated by the NHS when they have a medical condition which is amenable to treatment’.[397] Issues such as ‘consumer choice’ and ‘quality of life’ are stressed in the report, which noted that ‘whilst regional facilities providing security may be appropriate for mentally ill people, but not for people with a mental handicap’.[398] In addition the report asserted that community care should not just be about accommodation but also include ‘employment opportunities’.[399] However this seemed to be undermined by the services available and the continuing reliance on institutional provision.

In the 1990s therefore, there were still not enough places in day services or residential services to cope with both the numbers leaving hospitals and those already in the community. A report from the Strathclyde Regional Council in 1992/93 stated that there were about 14,000 people with ‘mental handicaps’ in Strathclyde, of which 9,500 were adults.[400] It was noted that there were only around 4,000 ‘day activity or training places’ offered by Strathclyde Social Work Department mostly ATCs to ‘develop new ways of training people for employment’.[401] The report also listed the number of places available in Strathclyde for hostel and supported accommodation as around 1,200 en rule however it was noted that the majority of this provision is made through voluntary organisations

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[397] Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, 1992, ADSW1/7.1.13.

[398] Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, 1992, ADSW1/7.1.13.

[399] Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, 1992, ADSW1/7.1.13.

[400] Strathclyde Regional Council, Social Work Department, *Community Care Plan 1992/93 – 1994/95: Community Care in Action: Your Chance to Comment on our Plans*, Glasgow, 1992, p. 13

[401] *Community Care Plan*, p. 13.

with the financial support of the Regional Council.[402] It was also stated that there were still about 1,900 people with 'mental handicap or learning disability' in Strathclyde living in hospitals.[403]

One consistent barrier to the movement towards community care was community resistance to integration, in part a by-product of decades of segregation in mental hospitals of people classed as mentally handicapped. Indeed, Pilkington stated in the early 1970s that 'there is confusion, for example, between mental illness and mental subnormality, so that even a friendly mongol may be regarded as potentially dangerous'.[404] Similarly Shearer stated in 1972:

> It is still widely believed that mentally handicapped people are uncontrolled and perverted in their sexual appetites. In the past this belief has been one of the main incentives for shutting them away in segregated institutions'.[405]

Similarly, in Tredgold's influential textbook of 'mental retardation' in 1970 it was claimed that both men and women with 'mental retardation' can often behave inappropriately sexually, stating that often the problems with 'subnormal girls…are even more intractable…some subnormal girls have comparatively strong direct sex drives'. It was also stated that because of this 'the self –gratification aspects of their need can also drive girls into sexual promiscuity'.[406]

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[402] *Community Care Plan*, p. 13.
[403] *Community Care Plan*, p. 13.
[404] T. L Pilkington, 'Public and Professional Attitudes to Mental Handicap', *Public Health London,* Volume 87, p. 63.
[405] Alan Shearer, A Report on Public and Professional Attitudes Towards the Sexual and Emotional Attitudes of Handicapped People (London, 1972). p.3. Quoted in, Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 51.
[406] A. F. Tredgold, *Tredgold's Mental Retardation* (London, 1970), p. 91. Quoted in, Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 52.

It was argued in the 1970s therefore that ‘it would be some years before it would be possible to overcome the resistance of the public to allow hostels for the handicapped near their homes’.[407] Similarly it was reported in *The Times* that one of the biggest obstacles to extending community-based care was the ‘near certainty that any proposal for a hostel, or after-care unit would provoke vociferous opposition from ratepayers who do not want ‘mental cases’ as neighbours.[408] The ADSW Policy, Planning and Review Committee reported on evidence given to the Scottish Housing Advisory Committee in 1979 ‘Allocation and Transfer’. The committee received the question ‘is it possible to house such groups in housing schemes without adverse reactions from neighbours?’.[409] In answer they stated:

> Our experience overwhelmingly shows that group homes can be satisfactorily incorporated into housing schemes without adverse reaction from neighbours…a balance has to be struck between the community’s legitimate interests and the rights of the potential tenants to privacy.[410]

Resistance to the building of community-based centres and residences seemed to continue however and could have a major effect on the success of new community care programmes. The NHS circular of 1989 laid down general guidelines for

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[407] ‘Hostels for mentally handicapped needed’, *The Times*, 11th May, 1972.

[408] Dr Tony Smith, Medical Correspondent, ‘The 20-year-old error that has left mental patients trapped in grim isolation’, *The Times*, 1st April, 1976.

[409] Evidence to Scottish Housing Advisory Committee, Sub-Committee on Allocation and Transfer, Records of the Association of Directors of Social Work, Executive Committee Minutes, 23rd of March 1979, ADSWA1/1.1.67.

[410] Evidence to Scottish Housing Advisory Committee, Sub-Committee on Allocation and Transfer, Records of the Association of Directors of Social Work, Executive Committee Minutes, 23rd of March 1979, ADSWA1/1.1.67.

provision of ‘community care’ for ex-patients of long-stay hospitals.[411] It stressed that the property should ‘most likely be of the same or similar size as other residential properties in the street’ and that it should ‘not be situated alongside other houses for people with a mental handicap’ as this could lead to ‘labelling’ of areas being for ‘special people’.[412] However it also pointed towards some of the potential problems, stressing the importance of consultation with the local residents owing to the fact that ‘attitudes to mental handicaps are evolving but, while the principle of care in the community is widely accepted, reservations may commonly be encountered where residence is in [close] proximity’.[413]

A Social Work report addressed this issue in Strathclyde giving planning advice for these new residences ensuring they were ‘unobtrusive’ and that ‘no external feature should be allowed to make it stand out as different’.[414] It was also noted that ‘the neighbours, or prospective neighbours should be fully informed from the outset’.[415] Potential challenges with the local communities were envisaged in the planning stages, the report stated for example:

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[411] Discussion of NHS Circular No 1989 (GEN) 5, Establishment of Community Care Facilities by Health Boards for People being Discharged from Long Stay Hospitals, 28th February 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers ADSWA 1/7.2.2.

[412] Discussion of NHS Circular No 1989 (GEN) 5, Establishment of Community Care Facilities by Health Boards for People being Discharged from Long Stay Hospitals, 28th February 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers ADSWA 1/7.2.2.

[413] Discussion of NHS Circular No 1989 (GEN) 5, Establishment of Community Care Facilities by Health Boards for People being Discharged from Long Stay Hospitals, 28th February 1989, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers ADSWA 1/7.2.2.

[414] Strathclyde Regional Council, *Social Work Services for the Mentally Handicapped in Strathclyde*, Glasgow, 1979, p. 40.

[415] *Social Work Services for the Mentally Handicapped in Strathclyde*, p. 40.

> There will probably be opposition or protest, but it is essential that the objections are heard and respected and that the people most closely involved are given an opportunity to talk around the problem until all facets have been aired and understood…resentment can turn to sympathy, and later be replaced by genuine liking, when initial fears are shown to be groundless.[416]

Abbott and Sapsford also described the resistance that could be faced when local authorities tried to create community-based care facilities such as hostels in the early 1980s. A study by Abbott showed many villagers in a particular village had objected to the hostel and 'expressed fears for the safety of the village's children' because of 'violent or sexually uncontrolled behaviour'. In a later study Abbot found similar attitudes in other social groups such as A Level students, many of whom showed 'no knowledge of mental handicap …and held views and expectations obviously based on the most extreme and bizarre degrees of mental handicap'.[417] A further report again asserted the importance of supportive public attitudes but argued that the implementation of 'community homes' for people with learning disabilities did not automatically mean individuals would become part of the community. It noted that these homes could be both 'geographically part of a neighbourhood' and 'socially ostracised'. It stressed therefore that 'the most effective methods of altering public attitudes still need to be studied' and that 'such campaigns should certainly involve schools'.[418]

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[416] *Social Work Services for the Mentally Handicapped in Strathclyde*, p. 41.

[417] Shearer quoted in, Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 51.

[418] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

Testimony from residents in new hostels and homes ‘in the community’ suggests there could still often be a feeling of segregation. One hostel resident recalled, ‘I couldn’t live outside because matron said so. She said I’m better off here. You see I have got no worries. We get all our meals cooked and we are well looked after’.[419] However there was also a desire to be independent and live outside this protective environment in many respondents interviewed for a 1983 project carried out by the Campaign for People with Mental Handicaps who stressed, for example, ‘I would prefer to be on my own rather than live here’ or ‘I’d like to get married to my girlfriend and live in an ordinary flat’.[420] Similarly, former patients of institutions commonly expressed these types of desires for an ‘ordinary’ life in further oral testimony. One former patient for example realised upon leaving an institution ‘now I like to just sit and listen to the silence, I don’t have to share it with others’.[421] Similarly, another recalled that, ‘the big difference from Lennox Castle although it didn’t strike me right away but I know it now it was a big difference…I felt as if I could do what I wanted without bothering anybody, which was true because I was there myself’.[422] Another report which also included a study of 249 respondents with learning disabilities living in supported accommodation and hostels in 1990 found that a quarter of these respondents desired to live elsewhere for reasons such as ‘I would like a house of my own. I don’t like sharing a room. I would like a room of my own’ and ‘I would like a house and a garden and my own front door.[423] The key emphasis from most of the respondents and individuals approached for Seed’s study seemed to be the need for choice in living situations and a respect for individual

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[419] David Brandon and Julie Ridley, *Beginning to Listen: A study of the views of residents living in a hostel for mentally handicapped people’* (London, 1983), p. 16.
[420] Brandon and Ridley, *Beginning to Listen*, p. 17.
[421] ‘Paul’s Story, My Life’, *I’ve got a good life*, p. 43.
[422] SOCHA/024/5, Interviewee Guy Shanks, 1st September 2005.
[423] Seed, *Supported Accommodation and Day Services*, p. 9.

needs and requirements.[424] It is clear therefore that the movement toward ‘integration’ and ‘normalisation’ was not always realised in practice, even given the reduction and final closure of the large mental deficiency hospitals and other institutions.

Conclusion

The provision of care for the mentally handicapped was to undergo many changes from 1945 until the 1990s. In the immediate post-war period there was a tendency to rely on supervisory types of care including institutionalisation and guardianship as well as a substantial number of families who were left with very little support to cope on their own in ‘the community’. However, as historians Welshman and Walmsley have shown, by the 1950s, criticism had begun to emerge on a national level about conditions and aims of hospitals and homes that were providing care and treatment. In addition there was new critical thinking over the value of segregated provision in general. On a national scale, reports began to appear over mistreatment of patients, abuse scandals and numerous stories about patients being ‘stuck’ in institutions who did not need to be there. In Glasgow, in the 1980s in particular, there were numerous reports over the unsatisfactory and often cruel practices being relied on in hospitals such as Lennox Castle.

Reports of bad conditions and treatment added to the growing calls for alternative types of provision that allowed mentally handicapped people the chance to be integrated into society. Abraham for example has shown how, throughout the country, statutory authorities now focussed on the creation of ‘normal’ community-

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[424] Seed, *Supported Accommodation and Day Services*, p. 10.

based lives for people with mental handicaps.[425] In a similar way to LAs throughout the country, in Glasgow from the 1970s onwards there were plans and calls from the various statutory authorities to advocate a move towards community care.

In Glasgow however this change in direction was often frustrated by a number of factors, including confusion over statutory responsibility such as the conflicting desire to improve hospitals whilst preparing for their closure by building community services. Financial constraints and in some cases resistance from local communities meant that the closure of hospitals was to come many years after the initial statements of desire for 'care in the community'. Whilst it is difficult within the scope of this project to compare this with developments elsewhere, what is clear from this study is that hospital provision was to continue in Glasgow on a relatively large scale well into the 1990s, suggesting an extremely slow push towards de-institutionalisation. As the next chapter will demonstrate, this often left families and voluntary associations in Glasgow with a situation where the required community services had to be created without the help of statutory services who were unable to provide the extent of centres and homes that were needed for those in the community. Clearly, policy statements advocating concepts such as inclusion and community integration were not in keeping with the realities of provision available at this time.

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[425] Charles Abraham, 'Supporting People with a Mental Handicap in the Community: a social psychological perspective', *Disability, Handicap and Society*, Vol 4, No2, 1989, p. 121.

Chapter 3

Enabling a Better Future? Voluntary Associations and Welfare in Glasgow since 1945

Introduction

Voluntary agencies concerned with 'mental deficiency' certainly existed and played an important role in providing services before 1945. Jones has shown how the 'mixture of governmental and private agencies was an important feature of social welfare in the late nineteenth and early twentieth century'.[426] For example in the nineteenth century voluntary organisations such as the Charity Organisation Society (COS) had attempted to protect the deserving poor who had suffered 'unfortunate accidents of fate' such as the 'mentally deficient'.[427] However this organisation and The Eugenics Education Societies were also deeply involved in agitation for legislation to institutionalise mental defectives.[428] Organisations such as the Central Association for Mental Welfare (CAMW) carried on this tradition of furthering segregationist aims in the early twentieth century. The CAMW operated as an agent of the state in ensuring the successful implementation of legislation such as the Mental Deficiency Acts of 1913 and 1927. Walmsley explains how this organisations sought to 'do good' from a 'lofty position, by filling in gaps in state provision'.[429] She explored how the CAMW maintained control of 'mental deficiency' by providing supervision in the community through home visits and running Occupation Centres.[430] Similarly Jones has described how the CAMW played an important role in the administering of eugenic legislation by 'ascertaining the mentally deficient in need of institutionalisation in an area and referring them to the proper authorities for certification'.[431] She also explains how local 'mental deficiency committees' supervised those who had been allowed to remain outside the institution under guardianship in the community.[432] Jones and others have noted how between 1918 and 1939 the CAMW became the main organisation concerned with 'mental

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[426] Greta Jones, *Social Hygiene in Twentieth Century Britain* (London, 1986), p. 13.
[427] Jones, *Social Hygiene,* p. 13.
[428] Jones, *Social Hygiene,* p. 27.
[429] Jan Walmsley, 'Straddling Boundaries: The changing roles of voluntary organisations, 1913 – 1959', in Lindsey Brigham, Dorothy Atkinson, Mark Jackson, Sheena Rolph and Jan Walmsley (eds) *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster, 2000), p. 104.
[430] Walmsley, 'Straddling Boundaries', p. 108.
[431] Jones, *Social Hygiene,* p. 27.
[432] Jones, *Social Hygiene,* p. 27.

deficiency' even extending its remit to deal with things such as the training of social workers in mental health, organising training and conferences for the medical profession and publishing new findings on mental deficiency in its magazine.[433] Walmsley has shown how their work served to encourage and extend segregationist policies with an inherent eugenic tone.[434]

As Stainton and others have noted, the Nazi regime's use of eugenic rhetoric to justify the many of the atrocities committed against groups including the disabled meant that in the period following the Second World War eugenic assumptions which had been inherent in policies directed towards 'mental deficiency' were considerably undermined.[435] It was at this time that a new type of voluntary organisation emerged with the formation of the National Association for the Parents of Backward Children (the NAPBC who later became MENCAP) in 1946 in England. Walmsley argues that the creation of this organisation 'symbolised a watershed in the history of voluntary organisations in the UK'.[436] The NAPBC signified the emergence of parent-led voluntary organisations concerned with the fate of their 'backward children' and who fought against segregation and for the provision of services in the community.[437] In doing so they continually challenged the dominance of institutional care, one of the most visible symbols of the strength of eugenic polices in the first half of the twentieth century. The NAPBC also challenged the assumption that 'backwardness' was something which should be hidden and brought together parents and families in similar situations in an effort to combat this

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[433] Jones, *Social Hygiene,* p. 27.

[434] Walmsley, 'Straddling Boundaries', p. 104.

[435] Tim Stainton, 'Equal Citizens? The discourse of liberty and rights in the history of learning disabilities', in Brigham and Atkinson (et al), *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster, 2000) pp. 87 – 101.

[436] Walmsley, 'Straddling Boundaries', p. 104.

[437] Walmsley, 'Straddling Boundaries', p. 107 -109.

isolation. The NAPBC proved popular with these families and grew quickly over the next decade helping to provide welfare services in the community and, where possible, campaigned for increased statutory provision in areas such as education and training. By 1955 the NAPBC had 167 local branches and had raised its profile to the extent that it was asked to give evidence to the Royal Commission on the Review of Law Relating to Mental Illness and Mental Deficiency. [438]

Until 1954 these developments were not mirrored to any great extent north of the border. The roots of the Scottish Association for the Parents of Handicapped Children (SAPHC) in Scotland were similar to the NAPBC in England and Wales. It began as a network for parents who were in a similar situation in having very few services or support available to them. Four couples with children diagnosed as 'mentally handicapped' came together to try and form an organisation in the early 1950s. Amongst these parents were Dr Samuel Curran (later principal of University of Strathclyde from 1964 – 1980) and his wife. One of the other founder members, Jim Henderson, on the 50th anniversary of the charity spoke of what prompted him and the other 4 couples to form such an organisation. He explained that he was watching a TV broadcast which explored some of the problems of bringing up a handicapped child. He noted, 'it was typical of the outlook of that time that, during the entire broadcast, the mother's face was in shadow and her name was never divulged'.[439]

At the end of this programme there was an advert for the NAPBC in London, however, Mr Henderson and a few others who contacted the National Society were advised to establish a Scottish based organisation. Thus both the National Society

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[438] Walmsley, 'Straddling Boundaries', p. 110.

[439] ENABLE, *Far Beyond Our Dreams*, Booklet produced by ENABLE in 2004 to celebrate the 50th Anniversary of the formation of the organisation, p. 1.

and the original group of parents agreed that a Scottish society, educated on Scottish law and policies and with local branches was the only way to offer support and increase public awareness at grass roots level. It was decided therefore that this a Scottish organisation was to operate autonomously (but often in partnership with the NAPBC on national issues). A public meeting was advertised for interested parties to be held at the Glasgow Corporation Education Offices on the 9th April 1954. Over 300 people turned up for this initial meeting where the SAPHC was officially formed.[440] Within ten years the Society had 40 branches and over 4000 members in Scotland.[441] In addition the Glasgow Branch of was one of the earliest created and had over 1000 members by 1970.[442]

Important in these developments was the large numbers of people resident in the community who needed services and support. For example it has been shown that in America as well as Britain ‘large numbers of people were never institutionalised; many were cared for by their families, with little or no help from the community or the state’.[443] One DHSS report in 1978, for example, found that 80% of ‘severely subnormal’ children, 40% of ‘severely subnormal’ adults and the vast majority of ‘mildly mentally handicapped’ people lived with relatives or in some form of residence in the community.[444] Similarly it was noted that whilst there were around 65,000 people classed as ‘mentally subnormal’ occupying hospital places in

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[440] The Charity was called the Scottish Association for the Parents of Mentally Handicapped Children until 1961 (SAPMHC) when it became the Scottish Society for Mentally Handicapped Children (SSMHC). It was later renamed the Scottish Society for the Mentally Handicapped (SSMH) in 1973 and became ENABLE in 1993.

[441] ENABLE, *Far Beyond Our Dreams*, Booklet produced by ENABLE in 2004 to celebrate the 50th Anniversary of the formation of the organisation, p. 2.

[442] SSMHC, Newsletter, December 1970, p. 5

[443] Pamela Abbott and Roger Sapsford, *Community Care for Mentally Handicapped Children* (Milton Keynes, 1988), p. 39.

[444] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 42.

Britain,[445] the SSMHC noted that there were many more, around 50% of the total, who lived at home with their families.[446] Voluntary organisations as a result were to play an increasingly important role in identifying the need for services and support for these people resident outside of hospitals.

This chapter explores the background to these organisations and some of the factors which led to the growth of parent-led groups in general. It demonstrates the ways in which the SSMHC attempted to publicise the voices of their members and to allow its agenda to be heard in an effort to challenge dominant assumptions about mental handicap. However, it also explains how the messages sent out, at least in the earlier period, often suggested continued adherence to medical models of disability. It demonstrates how initially these organisations, such as the SSMHC and later the Scottish Down's Syndrome Association (SDSA), functioned as support groups for parents providing an outlet for discussions about their experiences. Subsequently it investigates the ways in which the voices of these parents began to appear through articles, letters and poems in the newsletters and other publications. By engaging with contemporary debates on handicap it will show how these publications often stopped short of questioning the ethos and dominance of medical understandings of mental handicap continuing to focus, to some extent, on prevention and treatment. However extracts also demonstrate how these newsletters allowed opportunities for these families to speak openly about their experiences, often for the first time, and to engage with others in similar situations.

In addition this chapter investigates how constructions of disability, more focussed on social and cultural barriers, began to creep into the agenda resulting in

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[445] 'Forgotten People', Editorial from *Glasgow Herald* 18th August 1969, Reprinted in Scottish Society for Mentally Handicapped Children, Newsletter, September, 1969, p. 2

[446] Scottish Society for Mentally Handicapped, Newsletter, December, 1973, p. 4

renewed efforts to increase education and training facilities for people with learning disabilities. Whilst the focus was very much on parents, individuals at the centre of these organisations often managed to utilise their connections and work with the media and statutory authorities to increase the visibility of people with mental handicaps. Thus publicity campaigns from the SSMH, and later the SDSA, were able to promote the cause of better services both locally and nationally. There was also co-operation with similar organisations south of the border and internationally allowing the SSMH in particular to remain at the forefront of new directions and developments in this field. It will be shown how the social status and drive of those at the helm of these organisations was certainly significant and had an impact on the success of these ventures.

The work of the SSMH is identified as important in the establishment of mental handicap services. Thus this chapter demonstrates how parents were instrumental in the development of the organisation from a relatively small support network into the biggest pressure group and voluntary service provider for people with learning disabilities in Scotland. As a result this chapter will reflect briefly on the important relationships which developed between these voluntary agencies and statutory authorities in this period noting the dynamic of interdependence that often emerged as organisations such as the SSMH sought to provide essential support to families in the community.

The Emergence of the SAPHC and the Parental 'Voice'

Throughout the whole of this period the primary agents of care were often ‘the mothers of mentally handicapped people’.[447] Abbott and Sapsford, in their study of these mothers noted that there was often:

> A price which is paid by the whole family for the fact of having a mentally handicapped member – a price made up of shattered expectations which have to be rebuilt, the disturbance to family life, the reactions of others, the constraints on the mother’s life, and the disturbance of normal expectations for the family’s future.[448]

One mother in their study stated ‘let’s put it this way, there were relations we have not seen since we found out about Trevor… [and] we have only been invited to tea with Trevor once to my brother-in-law. He thinks we should put Trevor away’.[449] Another expressed feelings of guilt and blame, stating, ‘I felt inadequate, I felt it must be me’.[450] Indeed, a number of mothers interviewed for this study were described as having ‘some kind of hereditary taint’ suggesting the ‘survival in popular consciousness of the science of the eugenics movement’.[451] This led Abbot and Sapsford to suggest that ‘mental handicap is a stigmatising condition in our culture, and it is not only the retarded themselves who carry the stigma, but also their families’.[452]

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[447] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 43.

[448] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 46.

[449] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 53.

[450] Abbott and Sapsford, *Community Care for Mentally Handicapped Children* p. 48.

[451] Abbott and Sapsford, *Community Care for Mentally Handicapped Children* p. 48.

[452] Abbott and Sapsford, *Community Care for Mentally Handicapped Children*, p. 50.

This stigma was at least partly associated with the desire to promote mental hygiene. Subsequently, there was a focus on medical research in an effort to try and reduce the incidence of mental handicap. Consequently the mental health of whole families was now to be addressed and used as treatment for mental disorders. The MOH report for Glasgow in 1953, for example, draws attention to the rise of 'preventative psychiatry as applied to child health'.[453] It was noted therefore that 'child welfare officers and health visitors have a unique opportunity of helping and advising mothers about their own mental attitudes and the emotional development of the child'.[454] Thus the 'Problems Clinic' was established in Glasgow in the early 1950s to deal with these types of issues.[455] This clinic was there to help parents 'resolve difficulties which are arising in the upbringing of the child and to relieve possible tensions in the child's environment'.[456]

The treatment itself was not always welcomed, for example, it was noted in the 1953 MOH report that child psychiatry was often a complex area as there could be resistance to involvement by mothers who were aware of the stigma it may cause their child and family.[457] The report stated 'an anxious mother who is referred by her doctor to a 'child guidance' clinic is often upset by the supposed suggestion that her child is 'mental' or 'defective'.[458] Therefore it was argued that it was 'better to refer to the clinic by some such non-committal term such as the 'problems clinic' and to

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[453] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 8.

[454] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 8.

[455] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 8.

[456] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 8.

[457] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 58.

[458] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 58.

consider its main function as preventative and advisory in the field of mental health'.[459]

This institution is representative of contemporary medical attitudes towards mental deficiency in its desire to be placed on the 'curative side of the boundary between normality and mental abnormality'.[460] The clinic was therefore set up as an institution explicitly focussed on the normalisation of 'abnormal' children and their families. In particular there was a focus on early childhood as it was stressed that a strong 'beginning must be made in childhood to try to secure good mental health and capacity and prevent its breakdown'.[461] This was an attempt to use the well-adjusted family unit as a means of treatment citing things like 'depression of mothers'[462] as a contributing factor to maladjustment or emotional handicaps in children. The clinic was thus praised in the 1954 MOH report as a 'most valuable preventative service'.[463]

Consequently it was often the mental health of the mother which was discussed and called into question through the treatment given. Indeed it was stated in the MOH report in 1954 that 'the method of treatment is usually through play therapy unless the child is too young, in which case help is given entirely indirectly through the mother'.[464] It is mentioned that the father may also be interviewed,

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[459] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 58.

[460] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 58.

[461] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 9.

[462] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 9.

[463] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 58.

[464] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1954, p. 63.

however the focus of treatment and cause seems to be with the mother throughout.[465] The Child Guidance services were again discussed in the 1963 MOH report for Glasgow where Miss C. McCallum (Principal Educational Psychologist) gave a report. She stated that the Child Guidance Services had dealt with a total of 5,493 pupils in Schools in 1963 of which there had been 1,156 'cases for ascertainment of mental handicap and examinations of High School entrants'.[466] In addition it was noted that 'in the past few years it has become increasingly apparent that it is fundamentally important to make an accurate assessment of the mental progress of the infant and the young child just as much as physical progress is at present being supervised'.[467] It went further stating that 'the first six years of life are as important for the creation of a stable, well balanced personality as for the laying of the foundation of a good physique'.[468] This was later emphasised in reference to pre-school provision for the 'mentally deficient' scheme as it was argued that the child was 'demanding so much attention from the parents that the other normal children in the family were not receiving an adequate share of the parent's attention and the family life was seriously disrupted'.[469] Thus reports such as *The Carnegie Report*, which looked at the problems of the 'handicapped child' and the 'burden of care' in the early 60s highlighted the importance of studying not just the 'handicaps' of these children but also wider 'social and environmental factors' in order to:

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[465] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1954, p. 63.

[466] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 137.

[467] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 111.

[468] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 111.

[469] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 16.

> Provide information about the needs of the children with different handicaps and at different staged of growth, the family circumstance of these children and the factors which hinder families from giving all the help needed by their handicapped children.[470]

The home life of children with mental handicaps, specifically the role of parents in the creation and success of treatment was therefore often of central concern. McKnight for example argued that ‘it is well established that the extent to which a child’s disability becomes a handicap is determined largely by the parents’ attitudes’.[471] A paper given on language and development at the Annual Conference of the Guild of Teachers of Backward Children in 1963 detailed the role of the mother in the creation of handicap stating:

> Sometimes one suspects that an emotional factor is operating and that the child, perhaps with his mother’s connivance, is seeking to prolong his infancy by constantly demonstrating that he cannot talk properly.[472]

This paper also gave a further example of the effects of parental involvement detailing a case where a young boy was diagnosed with speech problems. The cause for these communication difficulties is firmly placed on the mother who it is stated

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[470] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 111.

[471] R K McKnight, ‘The Development of Child Guidance Services’, in W. B, Dockrell, W. R. Dunn and A Milne, *Special Education in Scotland* (Edinburgh, 1978), p. 103.

[472] P Mittler, MA, ‘Language, Development of the Withdrawn Child’, paper given at Annual Conference of the Guild of Teachers of Backward Children, Leicester, 1963, papers collected in booklet published by National Society for Mentally Handicapped Children.

‘waited on her son hand and foot’ and had not allowed him to gain any independence.[473] Her perceived overprotection of her son is therefore presented as a major contributing factor in the creation of disability and in the failure of treatment for that disability. Another paper, presented at the Association for Special Education Conference in Dundee, 6th May 1967, ‘Parents of Mentally Handicapped Children’ discussed the issue of parental attitudes, arguing that ‘the mother may be ashamed to confess to this resentment. Such a mother needs compassion not reproof’ also ‘a mother may deny a child can fiercely molly coddle it because such action is a socially acceptable way of expressing her hostility to the child’.[474]

One parent, who represented the Society for Autistic Children, also spoke out against this type of interpretation at the Annual Conference of the Guild of Teachers of Backward Children in 1963. In his paper he discussed an article from the *Lancet* on parents of autistic children. This article had claimed that ‘some 88% of the fathers [of autistic children] were obsessive, detached and humourless [and] where the father was warm and affectionate, the mother was found to be mentally ill’.[475] Fox argued that whilst ‘it is a terrible anguish to realise that one has a handicapped child’ he had yet to come across parents like those described in the *Lance*t article.[476] He stated that ‘first and foremost our members are loving parents, desperately anxious to do what is best for their child and all too often unable to get any constructive advice’.[477]

Parental support groups therefore began to emerge in the early 1950s where they began to seek solace in communicating with others in similar situations and to

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[473] Mittler, ‘Language, Development of the Withdrawn Child’.
[474] SSMHC, Newsletter, September 1967, p. 4.
[475] G Fox, ‘A Parent’s View’, paper given at Annual Conference of the Guild of Teachers of Backward Children, Leicester, 1963, papers collected in booklet by National Society for Mentally Handicapped Children.
[476] G Fox, ‘A Parent’s View’.
[477] G Fox, ‘A Parent’s View’.

use their new groups to represent themselves in a much more favourable light. Principal amongst these early organisations in Scotland was the SAPHC in which was established in 1954. The organisation originated from a group of parents who were in a similar situation in having very few services or support available to them in the care of their disabled children. The SAPHC and the NAPBC (which became the National Association for the Parents of Mentally Handicapped Children in 1955) had a good working relationship converging on national issues and allowing a flow of information on any new research or developments in the field. However they remained two independent organisations who dealt with local priorities through the mechanism of local branches. Both organisations sought to consult with parents to identify problems in local communities and led campaigns against unsympathetic statutory authorities as they argued ‘the better well being and future of our mentally handicapped children depends on our efforts’.[478]

Rolph has explored many of the reasons for the emergence of this relatively new type of voluntary agency in the 1950s. She has looked at the origins of the Bedford MENCAP Society in 1955 where she argues ‘parents in Bedford finally lost patience and became agents of change and the key figures agitating for improvements’.[479] She draws attention to some of the wider social factors that had an impact on parents in Bedford and may have had a similar impact north of the border arguing that:

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[478] ENABLE, *Far Beyond Our Dreams*, Booklet produced by ENABLE in 2004 to celebrate the 50th Anniversary of the formation of the organisation, p. 2.

[479] Sheena Rolph, *Building Bridges into the Community: The History of Bedford and District Society for People with Learning Disabilities, 1955 – 1990* (Milton Keynes, 2005), p20.

> Exclusion of children from educational opportunities and a dawning realisation that despite the new Education Act, little was being done for children and adults with learning difficulties, goaded parents into action in 1955.[480]

She describes how, in Bedford in particular, there were no special schools or classes and very limited provision in occupational centres.[481] This, she states, left parents with the 'renewed recognition that it was now up to them to campaign for equality'.[482] In addition she argues that the establishment of the Welfare State may also have been a similar catalyst for action. She notes how the NHS and Education Acts excluded children deemed 'ineducable' from new initiatives such as free school meals and free milk.[483] This may have had an effect on parents throughout the whole of the UK who were faced with the growing realisation that the needs and rights of their children were not being met by this supposed progressive legislative programme. Similarly Metzel describes organisations in America whose original agenda was to focus attention on 'their children who were excluded from public education of the basis of their handicap'.[484]

Increasingly then parents came together in these new organisations to discuss their isolation and shared concerns. Rolph argues that new occupation centres provided a meeting place for these parents who had a place to come together to vent their dissatisfaction. Once the National Society was formed in 1954 it served as a

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[480] Rolph, *Building Bridges into the Community*, p. 20.
[481] Rolph, *Building Bridges into the Community*, p. 21.
[482] Rolph, *Building Bridges into the Community*, p. 23.
[483] Rolph, *Building Bridges into the Community*, p. 23.
[484] Deborah S. Metzel, 'Places of Social Poverty and Service Dependency of People with Intellectual Disabilities: A Case Study in Baltimore', *Health and Place*, Vol 11, Issue 2, June 2005, p99.

model for smaller local groups who would form local MENCAP organisations.[485] An early aim of the SAPHC was to provide parents with opportunities to meet others in similar situations. They explained in 1954:

> It was obvious that parents must be brought together in a friendly atmosphere to meet others with similar problems and, possibly for the first time, feel free to discuss their difficulties and needs.[486]

These discussions and this new openness allowed for comparison of experiences and the opportunity to identify the huge gaps in local provision. The SSMHC stated, ‘the result was a tremendous moral uplift and an enthusiasm to work together to create happier conditions for the children’.[487] A welfare committee was established to aid this communication between parents and to ensure they were aware of the help the Society could give them.[488] The government report, *A Better Life,* in 1971 argued that it was ‘this motive of personal involvement which largely accounts for the success of the Scottish Society for the Mentally Handicapped and other parent based organisations’.[489] It explained that where relatives and families identify needs, the local branch structure allowed the organisation to ‘exhort involvement or, where this fails, to enlist the support of an elected representative, either at local or central government level’.[490] The report highlighted the importance of the SSMH in providing information and support to parents and mentioned the initiatives put in

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[485] Rolph, *Building Bridges into the Community,* p. 24.
[486] SSMHC, Newsletter, December, 1965, p. 5.
[487] SSMHC, Newsletter, December, 1965, p. 5.
[488] SSMHC, Newsletter, December, 1965, p. 5.
[489] *A Better Life*, p. 91.
[490] *A Better Life*, p. 92.

place such as meetings, day and evening services, short stay accommodation and social activities.[491]

Meztel has investigated similar developments in America where ‘after World War II, middle-class parent associations became the lead voluntary advocacy and service organizations for people with intellectual disabilities’.[492] In addition Metzel and others have stressed that ‘by claiming the disability of their children as a medical, and therefore respectable charitable condition, they attempted to break the association of intellectual disabilities with the lower classes and also separate these disability from professional control’.[493] The SAPHC similarly sought to shift attention onto the children with mental handicaps in a way which broke down associations with ‘problem families’ or eugenic assumptions about genetic predispositions to mental unfitness. One of the first measures implemented by the Society therefore was a newsletter which gave parents a public space in which they could openly discuss their experiences and feelings through letters, articles and poems. This helped to give an alternative viewpoint to that of the ‘problem family’ or ‘incapable mother’ and instead emphasising the loving family unit and the ways in which these families coped with their mentally handicapped members. This newsletter seems to have been well received by both professionals and parents and had a circulation of over 5000 in Scotland by the 1970s.[494]

Commonly the newsletter was used to express the experiences and emotions experienced by these parents in a much more open way than had perhaps been possible elsewhere. One regular feature was the inclusion of works of poetry by parents discussing their feelings about their children. For example one poem entitled

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[491] *A Better Life*, p. 92.
[492] Metzel, ‘Places of Social Poverty’, p. 99.
[493] Metzel, ‘Places of Social Poverty’, p. 99.
[494] SSMHC, Newsletter, June, 1963, p. 1.

‘Those Afflicted’ written by a parent in 1963 described the physical and temperamental characteristics that she felt were common amongst children with learning disabilities:

> The side long look of the mentally sick
> The half open Mouth of Dim Perception
> And yet Preoccupation with Beauty…
> It is not sad – and all those afflicted
> Know not of their affliction.[495]

Another poem by a parent was printed in the newsletter in 1963 was entitled ‘The Mongol Babe’. This poem, printed in full in the magazine, described some of the feelings of parents and contained sentiments such as ‘an acrobat with crowing smile/ No sense as we rate such/But a heart that loves/All who supply his needs’.[496] And later the poem describes the love the child has given the parent as ‘unchecked by reason, age or intellect’.[497] Another poem ‘Kevin’ further pointed to the feelings of the parents about their mentally handicapped child:

> When born he was different, though little we know
> Although otherwise normal, he was one of the few
> It still lives in our mind the day we were told
> Irrespective of age, he will never grow old.[498]

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[495] SSMHC, Newsletter, December 1959, p. 5.
[496] SSMHC, Newsletter, December 1963, p. 3.
[497] SSMHC, Newsletter, December 1963, p. 3.
[498] SSMHC, Newsletter, December 1963, p. 3.

Thus these poems allowed parents to explore how they felt about the birth of their mentally handicapped child, often focussing on the sense of loss they felt and the ways in which their child looked or acted differently from other children. This idea of their children never growing up and remaining ‘innocent’ and ‘unaware’ was often expressed. However in these poems the parents also spoke about their feelings of love and acceptance for their children. For example one stated:

> To those with a child who is not the ‘Norm’
> Have faith and take heart, you will weather the storm
> Somehow, from somewhere, comes the strength you will need
> The child although different, is yet ‘Special’ indeed.[499]

These new opportunities for parents to express how they felt about their children and share their experiences thus allowed them to demonstrate the ‘burden’ of care they dealt with and also the joys that their children could bring to the family. However the poems and other articles in the newsletter also repeatedly focussed on medical aspects of handicap and the SSMH continued to encourage ‘research into the causes and treatment of mental handicap’.[500] Medical advances, such as genetic counselling and neonatal testing, were usually discussed from the perspective of a medical expert who stressed the need for prevention to combat the ‘heavy burden on families and on our medical services’.[501] Therefore the attention was shifted away from criticism of mothers or families to the ‘tragedy’ of handicap and the heavy ‘burdens’ placed on families trying their best to provide for their children with little help. For example an

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[499] SSMH, Newslink, Spring, 1982, p. 6.
[500] SSMHC, Newsletter, June 1963, front cover.
[501] SSMHC, Newsletter, December 1968, p. 11.

advert by the national society, printed in *The Times* in 1958, focussed on the negative aspects of mental handicap for these families. The advert pictured a young boy and the slogan read:

> His future is dark and uncertain. Please give in thankfulness that you have been spared the tragedy of a mentally handicapped child. The Society seeks to bring light into his dark world, and that of 140,000 others like him.[502]

As a result the SSMH newsletter often devoted considerable space to emerging research on the prevention of mental handicap. For example, a report on an article by Peggy Follis, Bureau for General Practitioner Affairs in the newsletter in 1968 estimated that the decline in deaths related to 'mental handicap' in childhood meant that on the average street there was at least one home with a 'mentally handicapped' child.[503] She went on to describe different methods of prevention of mental handicap in order to reduce the number of people affected in the population.[504] These included genetic counselling and early detection and treatment. Dr Cedric Carter, Consultant in Genetics at Great Ormond Street Hospital noted that:

> Some people take the view that it is presumptuous for us to judge human quality and we should not try to concern ourselves with the quality of future generations. I think this view is quite wrong…New knowledge of human

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[502] 'Appeals', The Times, June 28th, 1958, p. 5.
[503] SSMHC, Newsletter, December 1968, p. 11.
[504] SSMHC, Newsletter, December 1968, p. 11.

> genetics brings with it the responsibility to use this knowledge in the interests of future generations.[505]

Dr Carter noted that ‘the very success of the health services has resulted in an increasing proportion of all handicaps’ these children she stressed then ‘are a heavy burden on their families and on our medical services’.[506] This was in keeping with reports such as *A Better Life* which discussed the ‘very real prospect of prevention of some defective births through improvements in genetic counselling and the introduction of pre-natal screening’.[507] There was also a focus on the need to ‘lessen the likelihood of handicapped children’ through better education programmes, improved nutrition, development of vaccinations, and better obstetric and neonatal care and advice ‘particularly in cases where severe social deprivation exists’.[508]

Thus, whilst offering space for parents to share experiences and ideas, there was continuing focus on medicine and ideas of prevention and research into causes of handicap in the SSMH newsletter. For example the technique now commonly known as amniocentesis was discussed in an STV programme ‘Tomorrow’s Child’ and analysed in the newsletter in 1969.[509] This test was to involve taking and testing fluid from the wombs of mothers aged 35 to 45 as a means by which early diagnosis of ‘mongol’ children could be made.[510] The mothers would then be offered an abortion to prevent them giving birth to such a child. Reports such as *A Better Life* in 1979 stressed that ‘there is a need to increase the availability of diagnostic services to develop educative programmes for pregnant women which will lessen the likelihood

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[505] SSMHC, Newsletter, December 1968, p. 11.
[506] SSMHC, Newsletter, December 1968, p. 12.
[507] *A Better Life,* p. 16.
[508] *A Better Life,* p. 28.
[509] SSMHC, Newsletter, December, 1969, p. 4.
[510] SSMHC, Newsletter, December, 1969, p. 4.

of a handicapped child being born'.[511] The need for 'detection' at an early age through assessment of 'vocational and social capabilities' was therefore highlighted.[512] It was also asserted that 'when a child is born with an obvious handicap it is necessary to explain to both parents as early as possible whether genetic factors may be present and whether they should take genetic advice before having further children'.[513]

An editorial in the 1968 newsletter of the SSMHC discussed an attempt by the BBC to portray some of the challenges families faced in a documentary called 'The long childhood of Timmy'.[514] They pointed out that the documentary had brought the issue to the attention of the *Scotsman* newspaper in which it had been noted that Timmy was seen as a lovable and loving child.[515] Indeed the paper pointed to the issues raised in the documentary about life for Timmy such as whether he should 'be kept in the protective environment of his family for as long as possible, or should he be encouraged to make some sort of life on his own'.[516] However the SSMHC stressed that it had been reported in the *Financial Times* that even the title of the documentary was a 'sentimental distortion' as 'the boy's childhood was not going to be merely long; it was going to be perpetual'.[517] They pointed to the dangers of presenting 'an idealised picture of continuous family affection [which] makes things seems easier than they are, as other families similarly placed might discover to their cost'.[518] The emphasis therefore seems to be on the lack of support/services for families and not so much on the individual perceptions of disability. The SSMHC

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[511] *A Better Life,* p. 3.
[512] *A Better Life,* p. 3.
[513] *A Better Life,* p. 37.
[514] SSMHC, Newsletter, July 1968, p. 1.
[515] SSMHC, Newsletter, July 1968, p. 1.
[516] SSMHC, Newsletter, July 1968, p. 1.
[517] SSMHC, Newsletter, July 1968, p. 1.
[518] SSMHC, Newsletter, July 1968, p. 1.

policies therefore often came from the perspective of struggling parents who did not necessarily question the medical dominance of mental handicap and the focus on prevention, but instead focussed attention on the need for help with basic care and services.

Often parents concentrated on welfare issues, for example a poem from a parent published in 1971 focused on the services in place for ‘Jamie’ who is described as having a ‘young man’s body and a bairn’s brain’.[519] The author wonders:

> Whit’s tae become o’ him
> Whit’s tae happen when fond parents, worn oot, canna cope?
> Will it be The Asylum, A Institution, A Home
> It disnae bear thinkin’ o’[520]

Another story of a little girl ‘Sheenagh’ is told in 1972 by her parents who try to piece it together from their daughter’s point of view. This diary was printed across several issues where it gave detailed information on all aspects of the girl’s life from her initial diagnosis and the negative medical prognosis to her daily life as a baby and child. One extract demonstrates the mixed emotions they could have when it is stated:

> When they first knew about my condition their outlook was grim and black; they feared the worst and thought that I would never be able to do anything for myself and never be able to walk and talk. How wrong they were!

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[519] SSMHC, Newsletter, December 1971, p. 1.
[520] SSMHC, Newsletter, December 1971, p. 1.

> Fortunately for them I have turned out to be a high grade mongol although this hits them hard too because there is such a fine hair's breath between a normal child and myself that it's difficult for them to accept the situation at times.[521]

The resulting diary is very revealing and self-aware but presents a largely positive story of the child's life. These parents were trying to raise awareness and challenge perceptions that such parents experience a 'hell on earth'.[522] Indeed they wanted to question the assumption of that they lived suffered from an 'ashamed existence' and to 'let other couples who may be going through the same [experience] know what it is all about'.[523] They felt this was essential as they felt that 'no one is in any position to speak about these things unless they have actually experienced them'.[524]

These types of parental experience stories were common in the information and support provided by the SSMH evidenced by the inclusion of the book 'Mummy why have I got Down's Syndrome' in their library to be accessed by parents. This book, published in 1992, took the form of a diary again to let other people understand the experiences they have had with their child.[525] The mother recalled how in trying to find a place in a school for her daughter she often 'felt the unfairness of having to beg as a big favour for my child to go to our local school, when all other children – by virtue of being 'normal', regardless of whether they were co-operative or even very bright – automatically had a right to go'.[526] She recalled how 'I felt like an intruder…there was always the threat 'if she isn't good

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[521] SSMHC, Newsletter, September 1972, p. 25.
[522] SSMHC, Newsletter, December 1972, p. 12.
[523] SSMHC, Newsletter, December 1972, p. 12.
[524] SSMHC, Newsletter, December 1972, p. 12.
[525] Caroline Philips, *Mummy why have I got Down's Syndrome* (Oxford, 1991).
[526] Philips, *Mummy why have I got Down's Syndrome*, p. 66.

enough, she will have to leave'...or had I worked hard enough to make Lizzie 'acceptable'.[527]

The parents involved with the SSMH therefore used the newsletter and other publications, not only to share experiences with one another, but also increasingly to challenge the exclusion of their children from services and education. This became a battle as often, in the early part of this period, parents had little power over the types of care offered to their child. For example it was stated in the MOH report for Glasgow in 1961 'as has already been said, when mentally handicapped children were of school age the parents sometimes felt the child's condition was being summarily dismissed without fair hearing'.[528] Yet it was claimed in the MOH report in 1964 that through liaison with the School Health Service and Medical Officers the parents were to be involved in the placement of their children and advised about the type of education or training they were to receive. It was stressed therefore that 'the parents are very appreciative of this joint consultation and it makes the final decision acceptable to them'.[529]

However an H.M.I report from 1977 discussed parental involvement in the education of 'handicapped children' stressing that 'parents of handicapped children frequently complain that they receive little information on how to develop their child's potential'.[530] The result of this, they argued, was the production of 'feelings of frustration and inadequacy' which are counterproductive as they can lead to lack of support. They emphasised that this must be avoided as 'to abandon a child as a

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[527] Philips, *Mummy why have I got Down's Syndrome*, p. 66.
[528] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 180.
[529] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 110.
[530] H. M. Inspectors of Schools (in collaboration with colleagues from Scottish Home and Health Department and Social Work Services Group), *Survey of Profoundly Mentally Handicapped Children, One Year On*, June 1977.

vegetable is the best way of ensuring he becomes one'.[531] A similar H.M.I report in the following year also pointed to the importance of maintaining parental support noting that the lack of it could hamper the progress of the child. It stated 'possibly the greatest problem is to sustain the interest and support of the parent once he has been told of, at best, only limited progress for his child'.[532] However there seems to be an assumption in both these reports that the progress of the child depends largely on the knowledge and co-operation of its parents. Their role as care givers and educators therefore is left open to scrutiny by professionals and educationalists who openly criticise when they feel parents are to blame for lack of progress in a child's education. Indeed the 1978 report stresses that it is the responsibility of the school to keep watch on parents and 'when signs appear that parental involvement in beginning to flag, they must do all in their power to revive it.'[533] A study of the Mary Russell School in 1978 expressed a similar sentiment arguing that 'where there is a caring, supportive family, the battle is half won'.[534]

This belief is borne out by oral testimony from a former head teacher of special schools in Glasgow from the late 1960s onwards. In reference to parental contributions she recalled how, in the 1960 and 1970s:

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[531] H. M. I., *Survey of Profoundly Mentally Handicapped Children, One Year On,* June 1977.

[532] Scottish Education Department, *The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland: A Progress Report by H M Inspectors of Schools* (HMSO, Edinburgh, 1978).

[533] Scottish Education Department, *The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland: A Progress Report by H M Inspectors of Schools* (HMSO, Edinburgh, 1978).

[534] Jean Reid, 'Description of a Urban Special School – The Mary Russell School in Glasgow', in W. B. Dockrell, W. R. Dunn and A Milne, *Special Education in Scotland* (Edinburgh, 1978), p. 28.

> Coming into Rottenrow the parents had no say at all, you know Sally's father or mother you know they could have said…my girl's to bright to be here and it would have made no difference, she had no validity. But by the time I got to Summerton then there was a whole team on the side of the child, psychologist, social worker, parent and the bill following Mary Warnock's report gave tremendous power to the parents. Oh yes they could appeal and their appeal would have validity, an articulate parent is the best thing that can happen to a child who had any kind of difficulty.[535]

By the end of this period the 'articulate' knowledgeable parents involved with the SSMH were now appealing for change on behalf of their children. Involvement in the SSMH had allowed them the opportunity to openly discuss some of their experiences for the first time and to question the assumption that mental handicap in children was a direct consequence of parental genes or environment. The SSMH was used as a force to legitimise their role as advocates for their children. Their continued use of medicalised understandings of handicap may be related to this concern with gaining respectability from the medical and educational professionals involved with mental handicaps. These relationships between educated and loving parents could then be utilised to point the discussion towards lack of services and support in the community. In addition it allowed these parents the opportunity, perhaps for the first time, to communicate with others in similar situations raising consciousness about the lack of provision and support available. The emergence of this organisation was therefore to be a catalyst in the new promotion of parental power in the field of

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[535] SOCHA/024/6 Betty Dowling interview with Angela Turner, 2nd March, 2007

mental handicap and although this began on a relatively small scale it represented an important shift in power away from medical dominance and educational exclusion.

Voluntary Associations: Publicity and Profile

One parent stressed in the 1959 SAPHC newsletter that ‘our strength rises from the knowledge that the better well being and future of our mentally handicapped children depends on our efforts’.[536] Key to these efforts was the desire to raise the profile of the mentally handicapped and their families. The Society relied on various methods of publicity to disseminate their message such as the production of films like ‘Handicapped but Happy’ (1960) and ‘Room for More’ (1965). They stated that the aim of this was, ‘to focus attention on the problem of mental handicap and the needs of those affected by it’.[537] They also used many other methods of promotion, often as a means of raising money as well as the profile of their cause. These included collection boxes in shops, selling Christmas cards and dissemination of publicity material at public events such as football matches. They also invested in publicity and fundraising appeals on TV and radio.[538] They were very aware of the power of the media and the influence it could have on cultural perceptions of people with mental handicaps. Their press advertising was carried out therefore with the help of public relations consultants from the 1960s onwards.[539] In particular they were concerned that their public ‘image’ would affect their prestige in consultation and negotiation with bodies such as Local Authorities and Education Boards.[540]

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[536] SAPHC, Newsletter, December 1959, p. 1.
[537] SAPHC, Newsletter, September 1960, p. 1.
[538] SSMHC, Newsletter, September, 1968, p. 12.
[539] SSMHC, Newsletter, September 1962, p. 2.
[540] SSMHC, Newsletter, June 1967, p. 9.

One of the major initiatives used to promote this image with the public was an annual stand held at the Modern Homes Exhibition at the SECC in Glasgow. This advertised the different aspects of the work of the Society, for example stating in 1961 that it sought to demonstrate how ‘the mentally handicapped are capable of doing a job of work and doing it well’.[541] At this particular ‘DIY’ stand, clients of the Glasgow Branch gave demonstrations of the kinds of work they carried out in the Work Centres ran by the Society. At this stand they had the ‘boys’ and ‘girls’ from the centre showing the types of work they were doing and reported that this was ‘proving a great attraction’.[542] Indeed they highlighted the fact that the ‘eagerness with which they work on their jobs...is admired’.[543] The stand also sold the Christmas cards and gave out educational and promotional material about their work. Other ways of attracting attention to the cause were tried throughout the years. For example in 1963 it was reported that ‘our propaganda was put across entirely by means of a rather unusual tape recording of songs sung by a choir of mentally handicapped children in Glasgow’ which was said to have been ‘interspersed with appeals’.[544] In addition slogans were displayed above the stand such the one below in 1961 which read, ‘Do you turn your back on mental deficiency’.[545]

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[541] SSMHC, Newsletter, June 1967, p. 8.
[542] SSMHC, Newsletter, September, 1961, p. 3
[543] SSMHC, Newsletter, September, 1961, p. 3.
[544] SSMHC, Newsletter, December 1961, p. 3.
[545] SSMHC, Newsletter, September, 1961, p. 4.

Photo taken from SSMH Newsletter, December 1961, front cover

The early work of the SSMH therefore focussed on two key areas, that of fundraising and of raising the profile of the mentally handicapped. They also became aware of the challenges of attracting support from the public where there was competition from other charities. For example at one county ‘festival’ in 1962 it was noted that:

> Stands run by other charities who had obviously done this sort of thing before were playing down the publicity angle and instead doing a roaring trade in commodities such as hot dogs. We came to the conclusion that we would be well advised to go into the catering line on any future occasions.[546]

Similarly it was noted in a later newsletter that competition for publicity could make it more difficult to have reports in the press particularly ‘in a city like Glasgow

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[546] SSMHC, Newsletter, September, 1962, p. 2.

where charitable organisations proliferate and all of them clamour for newspaper space'.[547] Publicity however was seen as essential in arousing favourable public interest to encourage help and tolerance for the 'the handicapped child [to] live and work in the community when he left school'.[548] As a result they utilised their position to gain press and media where possible and to promote their cause. For example one particularly successful appeal was shown on the television in 1964 and it was noted that this had led to over 750 individual donations. [549]

One of the leaders of the organisation, D G McIntosh, wrote an editorial for the newsletter in 1963 where he expressed his belief in the value of publicity for their organisation. However he also stressed that this much encourage integration stating that 'the public as whole must still be educated into accepting our children as part of the community and not just something to be assisted with a few coins in a collecting box'.[550] One of the founder members Mrs Shapter noted how, in the early days, publicity had played a particularly important role stating that 'it was our only real link with the general public, and we had to get our message over to help remove the stigma and 'hush hush' which accompanied a mental handicap'.[551]

Nevertheless the images, articles and debates printed in the newsletter and in the publicity campaigns often failed to challenge the idea of that people with mental handicaps were principally objects of charity. Families continued to be presented as 'burdened with care' and therefore deserving of support and services.[552] Letters such as one printed in the newsletter in 1969 argued that the SSMHC sought to help 'new parents faced with the awful nightmare from which there is no awakening' which

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[547] SSMHC, Newsletter, December, 1965, p. 13.
[548] SSMHC, Newsletter, September 1962, p. 2.
[549] SSMHC, Newsletter, December 1964, p. 4.
[550] SSMHC, Newsletter, September, 1963, p. 1.
[551] SSMH, Newsletter, April, 1975, p. 12.
[552] Rolph, *Building Bridges into the Community*, p. 27.

only served to re-enforce this idea of ‘pity’.[553] Much of the written material produced in the earlier years of the Society continued to operate under the assumption that learning disability was equal to tragedy or loss. For example Samuel Curran commented in the editorial of the newsletter in 1975 that ‘one of the problems of some of the mentally handicapped is that they never grow up and although they reach the age of 21 and more, they remain in a sense children’.[554]

Publicity material, at least on the early days, sought to ‘get to the root of the problem by encouraging research by specialists, not sometime – NOW – as a matter of urgency’.[555] This was also to be done by encouraging ‘influential recruitment from out with the parental field’ this was to be done to allow for desirable representation ‘on committees where deemed wise’.[556] This expert opinion from doctors, teachers or other such professionals was commonly used in both the newsletter and other publicity perhaps as it offered medical or academic legitimacy to their cause. One of these articles was written by Dr Gunzberg in which he discussed ideas of ‘Social Failure’.[557] Gunzberg concentrated on the ‘social incompetences’ of a number of ‘subnormal’ 18 to 29 year olds he had studied. He went on to present his findings which included the fact that 2/3rds of this group could not use a telephone and half did not know what a post office was for.[558] Therefore he focussed on the deficits he had identified with these individuals and failed to challenge negative perceptions of disabled people. The Society also raised money to donate to medical research, for example in 1981 they donated £15,000 to the Scottish Inborn Errors Screening

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[553] Letter in *Evening Times,* 11th August, 1969, reprinted in SSMHC, Newsletter, September 1969, p2.
[554] SSMH, Newsletter, April, 1975, p. 10.
[555] SSMHC, Newsletter, June, 1967, p. 1.
[556] SSMHC, Newsletter, June, 1967, p. 7.
[557] SSMHC, Newsletter, September 1962, p. 6.
[558] SSMHC, Newsletter, September 1962, p. 7.

Laboratory at Stobhill to help buy equipment to detect ‘cretinism’ stating that ‘the great attraction of a neonatal screening programme…is that the earlier a case is detected the sooner treatment can begin’.[559]

Medical developments then were still seen as central to the furthering the work of the SSMH. For example, an article in the newsletter in the 1960s by Dr R McGillvany (Physician Superintendent, Lennox Castle Hospital) discussed the developments in the field of ‘mental deficiency’.[560] He stated that this ‘is a symptom of a wide variety of interferences with normal development’ which he argued needed further co-ordinated research in order to ‘stem the tide of inflow to mental deficiency institutions’.[561] In this discussion, he pointed to the medical implications of ‘injury to the brain’, ‘German Measles’ ‘genetic factors’ and ‘prematurity’ in the incidence of mental deficiency and the subsequent populations of hospitals such as Lennox Castle.[562] An article, by Dr Curran (president of SSMHC), discussed ‘advances’ made by voluntary organisations in America and expressed similar concerns with prevention noting that:

> The US is an optimist’s country [with] the field of mental handicap especially suited for their efforts. Major advances seem to a scientist to indicate that four out of every five said cases can be *prevented* as our knowledge expands along lines now showing. The *problem* can and must be overcome! [my italics][563]

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[559] SSMH, Newslink, Spring 1981, p. 15.
[560] SSMHC, Newsletter, December, 1961, p. 3.
[561] SSMHC, Newsletter, December, 1961, p. 3.
[562] SSMHC, Newsletter, December, 1961, p. 3.
[563] SSMHC, Newsletter June, 1962, p. 2.

Thus they wanted to ‘get to the root of the problem by encouraging research by specialists’[564] into the ‘diseases or conditions’ which cause the state of ‘subnormality’.[565]

Alongside these articles about prevention, there were also those which focused on the need for more education and training to allow ‘each mentally handicapped person to develop his or her potential to the full’.[566] A large part of the publicity material produced therefore concentrated on providing the mentally handicapped with the ‘best environment possible’.[567] For example they stated in 1985 that ‘these children develop within the confines of their handicap and …this growth would be stopped by the lack of provision’.[568] They did caution against giving parents false hope however stressing that focussing on the importance of environmental factors in the education of children classed by the state as ineducable ‘may only encourage intemperate parents not to accept the limitations of their handicapped children and so lead to disappointment and frustration’.[569]

However, there was a definite new focus on environment (perhaps in tune with an emerging ‘social model’ of disability common in the new disability rights movement) in the creation of handicap. For example discussion on the importance of the environment on the progress of children who have been classed as ‘educationally subnormal’ (ESN) was common.[570] In addition some parents began to question the very idea of prevention arguing for example ‘it is the parents we have been thinking

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[564] SSMHC, Newsletter, June 1967, p. 1.
[565] SSMHC, Newsletter, December 1967, p. 2.
[566] SSMHC, Newsletter, June 1965, p. 6.
[567] SSMHC, Newsletter, June 1967, p. 1.
[568] SSMH, Newslink, 1985, p. 6.
[569] SSMHC, Newsletter, December 1967, p. 4.
[570] SSMH, Newslink, 1985, p. 6.

of not the handicapped child'.[571] This same parent stressed that 'at birth it is impossible to tell how much progress is going to be possible'.[572] Similarly another parent challenged the belief that the disabled children should be prevented in stating:

> I cannot regard my happy smiling four year old mongol boy as a tragedy…the problem is more due to lack of facilities than to any difficulties in his upbringing because of his handicap'.[573]

She went on to state:

> Is he not a human being with all the rights of a human being? He must have the education he is capable of absorbing, and a social life. And the training to fit him for a job, whatever it might be surely it is reasonable to ask for these basic human rights?'[574]

Thus, even given their continued focus on medical developments, the Society was also often at the forefront of new thinking on social policies for people with mental handicaps. Articles from national and local newspapers about wider developments in the field were reprinted in the newsletter in order to 'stimulate readers into re-assessing their views and opinions'.[575] They stressed in 1969 that 'a tremendous social revolution is taking place, and if we want to be an effectual cog in this wheel,

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[571] SSMHC, Newsletter, June 1964, p. 8.
[572] SSMHC, Newsletter, June 1964, p. 8.
[573] SSMHC, Newsletter, March 1970, p. 1.
[574] SSMHC, Newsletter, March 1970, p. 1.
[575] SSMHC, Newsletter, December 1969, p. 2.

we must be up to date, well informed, and more forward looking'.[576] The Society also put itself in such as position whereby it could be in the many levels of debate and consultation about provision of services for the mentally handicapped. For example in 1962 it was reported that they gave evidence to the Scott Committee on the training of staff for training centres for the mentally handicapped which was then accepted and included in a later report.[577] Indeed it is reported that it was part of the process which led to a letter published in *The Times* by Lord Longford 'pointing out the urgency of the need for improved training and status of teachers'.[578]

For the Society this meant always being aware of provisions that were statutory in order to allow them to effectively push Local Authorities (LAs) into increasing their services.[579] For example in 1969 they drew attention to the newly established Department of Social Work stressing the importance of the Association of the Directors of Social Work (ADSW) who, they stated, were for the first time able to 'administer to the community as a whole'.[580] They urged the new directors to implement long-term change rather than plugging gaps in existing legislation and encouraged their members to use this opportunity to find ways to put forward their views on the need for hostels, sheltered workshops, day centres and other community based provision.[581]

The Society was also very involved in international debates on mental handicap and often used foreign visits and international research as a means by which to reassess their projects in local communities. They were accepted into the International League of Societies for the Mentally Handicapped in Madrid in

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[576] SSMHC, Newsletter, December 1969, p. 2.
[577] SSMHC, Newsletter, September 1962, p. 1.
[578] SSMHC, Newsletter, September 1962, p. 2.
[579] SSMHC, Newsletter, December 1969, p. 2.
[580] SSMHC, Newsletter, December 1969, p. 2.
[581] SSMHC, Newsletter, December 1969, p. 3.

1965.[582] This membership formalised the partnership they had with other European and North American Societies and allowed representatives from the Scottish Society to visit and comment on international provisions. For example in 1965 representatives visited an institution in Madrid which housed 300 pupils with 'all types of handicap' to see the kinds of work they were doing.[583] This allowed them to draw attention to the benefits of small class sizes and the use of modern equipment.[584] Similarly, Tom Fortune (Chairman) attended a symposium on sheltered workshops, held by the International League of Societies for the Mentally Handicapped in Frankfurt in 1966. Here he was one of 40 delegates from European countries, New Zealand and Canada and was given the opportunity to visit sheltered workshops. He noted that in one particular centre, employing over 140 persons with 'mental handicaps', trainees received 8hrs, educational instructions until they turned 21 and they were also 'taught the social graces'.[585] A delegation also went on tours of Ottowa and Toronto visiting the National Institute of Mental Retardation, York University, Toronto in 1972. [586] These and many other tours allowed many emerging ideas on the international stage to be considered in relation to provision in Scotland.

Membership of the International League and the foreign visits it fostered allowed the Society to gain wider perspectives on services for people with learning disabilities all over the world. It also allowed them to be at the centre of emerging ideas and concepts in disability policy. As an independent body the Society signed off on the 'Declaration of General and Special Rights of the Mentally Retarded' in 1969 which extended on the stipulations laid out for all in the United Nations

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[582] SSMHC, Newsletter, March 1965, p. 4.
[583] SSMHC, Newsletter, March 1965, p. 4.
[584] SSMHC, Newsletter, March, 1965, p. 5.
[585] SSMHC, Newsletter, December 1966, p. 3.
[586] SSMHC, Newsletter, December 1972, p. 8.

Universal Declaration of Human Rights.[587] Amongst the basic rights the League sought to ensure were rights to education, training, a decent standard of living, participation in the community and productive work or other meaningful occupations.[588] The League also fostered discussion over emerging concepts like normalisation such as took place at the international congress in Montreal in 1972 with over 3000 delegates from 45 countries .[589] Similarly a League Symposium in 1973 argued for the 'basic human right to leisure'.[590] These international developments combined with local needs seemed to have an impact on the ways in which services were established by the Society. Developments on the international stage could sometimes have a more direct impact. For example, a delegate at the International Conference at The Hague in 1970 stated 'how much longer are we to claim that we look after children only' leading the League to reassess their priorities and attempt to encompass the needs of the over 16s more.[591] The Society had been dealing with services for adults for some time, however this seems to have been a factor in the eventual removal of the 'children' prefix in their name in 1973.

The newsletter also devoted a considerable amount of space to developments in international research, for example, they printed an extract from 'Tracks' published by the Kansas Association for Retarded Children in which discussed new thinking on the importance of parental attitudes on the development of a 'retarded' child.[592] This research pointed to how the socio-economic situation of families could affect parental attitudes and the subsequent life opportunities of their children,[593] In

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[587] SSMHC, Newsletter, March 1969, p. 2.
[588] SSMHC, Newsletter, March 1969, p. 2.
[589] SSMHC, Newsletter, December 1972, p. 10.
[590] SSMHC, Newsletter, March 1973, p. 4.
[591] SSMHC, Newsletter, December 1970, p. 16.
[592] SSMHC, Newsletter, March 1966, p. 9.
[593] SSMHC, Newsletter, March 1966. p. 9.

1968 they printed a section called 'Research Reports and Reviews' which contained a report on the 'common problems' of siblings of 'retarded children' reported by the Canadian Association for Retarded Children.[594]

Reports of international tours and visits also gave an international dimension to the challenges facing people with learning disabilities. One member travelled around America in 1967 comparing the welfare provisions in different cities to the situation in Scotland. She noted that that a group of psychologists had told her that they lagged behind the UK in attitudes and her tour left her with the impression that there was less educational provision.[595] She visited a sheltered workshop who were funded through work provided by IBM but noted that except for visits to special centres, in her journey 'in Kentucky, Washington and New York, [she] did not see a single mentally handicapped child' concluding that the attitude seemed to be 'to keep such children out of sight'.[596] Another report on Hong Kong in 1969 noted how the 'mentally handicapped' were often abandoned by their parents and called for more services and the need for civic education.[597] The Swedish system was often presented as a useful model for comprehensive provision of welfare and services. The new Swedish Laws were reported in 1967 where special attention was given to the comprehensive provision of special educational provision up to 21 years old (ending in vocational school) and mandatory day centres.[598] The relative successes of the Scandinavian Countries in setting up of hostels for the 'mentally handicapped' was also highlighted at the Scottish Society AGM in 1968.[599]

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[594] SSMHC, Newsletter, December 1968, p. 9.
[595] SSMHC, Newsletter, September 1967, p. 9.
[596] SSMHC, Newsletter, September 1967, p. 11.
[597] SSMHC, Newsletter, September 1969, p. 3.
[598] SSMHC, Newsletter, December 1967, p. 8.
[599] SSMHC, Newsletter, December 1968, p. 3.

Particularly in the earlier years, the social position of many the leading players of the Scottish Society allowed it to have access to these wider developments in ways that might not have been possible otherwise. Metzel has pointed to a similar development in the US where middle-class parent associations became the lead voluntary advocacy and services organizations for people with intellectual disabilities'.[600] She points to a number of studies in America which point to the majority membership of white middle class parents in the new parent-led organisations.[601] This seems to have been the case with the original members of the SSMHC and was to have a positive impact on their efforts to publicise their cause. Not only were the parents often white and middle class, they also were often well connected with statutory authorities or other important groups. For example whilst most of the initial members were parents, also present at the initial meeting were 'Doctors, Social Workers, Ministers, Priests, Nuns, Teachers, Occupational Centre Assistants and members of the Scottish Association of Mental Health and other interested organisations'.[602] In addition one couple who were instrumental in the founding of the organisation were Mr and Mrs Curran who had a child who was described as 'severely mentally handicapped'.[603] Samuel Curran (later Sir Samuel Curran) was president of the SSMH in its various forms for 37 years and was also the principal of The University of Strathclyde. In addition Joan Curran was a member of

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[600] Metzel, 'Places of Social', p. 99.

[601] For example B Farber, *Mental Retardation: Its Social Context and Social Consequences* (Boston, 1968), quoted in Metzel, 'Places of Social', p. 99.

[602] Mrs Shapter, Anniversary Newsletter, SSMH, April 1975, p6

[603] Samuel Curran Biography on http://www.rse.org.uk/fellowship/obits/obits_alpha/curran_samuel visited on 27/7/06.

the Greater Glasgow Health Board where she ‘championed the needs of the disabled’ for example on the ‘Council for Access for the Disabled’.[604]

Curran’s role in the university allowed for links to be fostered with academics and professionals in the field and for a place to house conferences and meetings. For example one conference was held there in 1964 on ‘The Mentally Handicapped and their Future’ and another in 1968 on ‘Current Trends on Research and Training’.[605] At these events established researchers or professionals in the field were invited to share their findings and recommendations.[606] For example the 1964 conference brought together Dr F. H. Stone (Consultant in Child Psychology in Glasgow) and Dr R. C. MacGilliway (Lennox Castle hospital).[607] Similarly in 1981, the International Year of Disabled People, a Scottish Conference was held at the University in which speakers included Russell Fairgrieve, M.P. (Minister for Health and Social Work at the Scottish Office), Professor Gunner Dybwad (President of the International League of Societies for the Mentally Handicapped) and Professor Peter Mittler (Professor of Social Education at the University of Manchester).[608]

Other important members had links with statutory authorities such as the General Secretary of the Society from 1967, Ian McMurray, who was also in charge of the Department of Education offices of the Corporation of Glasgow[609]. The high profile of some of the members was confirmed in 1965 when another member, Thomas Fortune was awarded an MBE for his work with the Society. [610] These and

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[604] Obituary: Joan Curran, The Independent, Friday 19th February 1999, http://www.independent.co.uk/arts-entertainment/obituary-joan-curran-1071704.html visited on 10/9/09.
[605] SSMHC, Newsletter, September 1968, p. 5.
[606] SSMHC, Newsletter, March, 1964, p. 3.
[607] SSMHC, Newsletter, June, 1964, p. 1.
[608] SSMH, Newslink, 1981, p. 1.
[609] SSMHC, Newsletter, March, 1967, p. 1.
[610] SSMHC, Newsletter, September, 1965, Editorial, p. 1.

other members of the Society allowed negotiations with statutory authorities to have more weight. For example, in the production of the government report, *A Better Life*, the General Secretary of the Society was able to have a substantial impact on the discussions taking place between Health Services and Social Work.[611] The report sought to encourage 'closer co-ordination between a wide variety of statutory bodies and voluntary organisations and the community at large'.[612] The benefits of links with voluntary organisations were continually emphasised, for example, attention was drawn to the opportunities they provide for dialogue between professionals. In reference to the SSMH in particular the report pointed to their 'structured meetings [which] constitute one of the most positive factors in the family's ability to gain information as to the management of the handicapped individual and the range of services and benefits available'.[613] The SSMH themselves stressed that for their first 25 years they had focussed on parents voicing their needs and informing the statutory bodies about what they required.[614] This, they noted, had led to a 'continuous build up of active professional involvement' as they wished to maintain 'dialogue between parents and professionals both of whom are concerned with the future and well being of the handicapped'.[615]

Another important organisation which emerged from similar roots was the Scottish Down's Syndrome Association (later Down's Syndrome Scotland) which was established in 1982 as a parent run voluntary association to support parents and give information to those affected by Down's syndrome. This organisation maintained a strong link between the parents and the medical profession. For

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[611] *A Better Life*, p. 2.
[612] *A Better Life*, p. 2.
[613] *A Better Life*, p. 8.
[614] SSMH, Newsletter, Spring 1980, Editorial, p. 1.
[615] SSMH, Newsletter, Spring 1980, Editorial, p. 1.

example Dr Raeburn, an expert in human genetics based in Western General Hospital in Edinburgh, held a high level position within the organisation which, it was reported, fostered greater relationships between doctors and patients.

Dr Raeburn was an important figure in the formation of the SDSA as he was instrumental in the forming of a ‘self-help’ group for parents who had babies with Down’s syndrome which eventually grew into the SDSA. These parents originally met at his home in 1977 and established the Aid to Down’s Babies Edinburgh (ADE). One of the key activities of this group was to set up links with staff at maternity units so that they could be put in touch with new parents of babies with Down’s syndrome and ‘visit and give them understanding and support’.[616] This then led to the formation of the ADE mothers and toddlers group (in Edinburgh). In addition Dr Raeburn was to contribute to the ADE public lectures which were held annually for other professionals and parents. Other speakers included big names in the field such as Rex Brinkworth, a teacher who had a child with Down’s syndrome who became the founder member of the national Down’s Syndrome Association in 1970. Brinkworth was part of numerous publications of early intervention and education of ‘mongol’ babies in the 1970s and was an important figure in the production of information for new parents.[617] These ADE lectures were given to over 200 people and formed the basis of the SDSA when it combined efforts with parents who were ‘becoming active’ at the same time in Glasgow and Aberdeen. Dr Raeburn

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[616] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 22, Winter 1989/90, p. 4.

[617] For example, Rex Brinkworth, *The reaction of parents to the diagnosis of mental subnormality* (London, 1970) and Rex Brinkworth et al, *Improving Mongol Babies and Introducing them to school* (London, 1970).

became one of the early Chairman of the organisation, however he encouraged the parents to form their own leadership after 1984.[618]

Based initially in Edinburgh it soon grew to cover the whole of Scotland where it concentrated largely on providing support and information to parents. This organisation sought to increase public awareness, for example through poster campaigns in and around Glasgow on the underground and in the local press in Glasgow.[619] For example one poster (pictured below) tried to educate the public about the causes of Down's syndrome and to dispel any belief that it was the fault of mothers and their lifestyles. In this poster the mother is dressed conservatively, and looks the picture of respectability smiling and holding a young baby with Down's syndrome.[620] Underneath the picture of the mother it is stated, 'Jenny gave up late nights, Jenny gave up smoking, Jenny gave up alcohol, Jenny gave birth to a baby with Down's syndrome. Jenny can give her child a future with our help'.[621]

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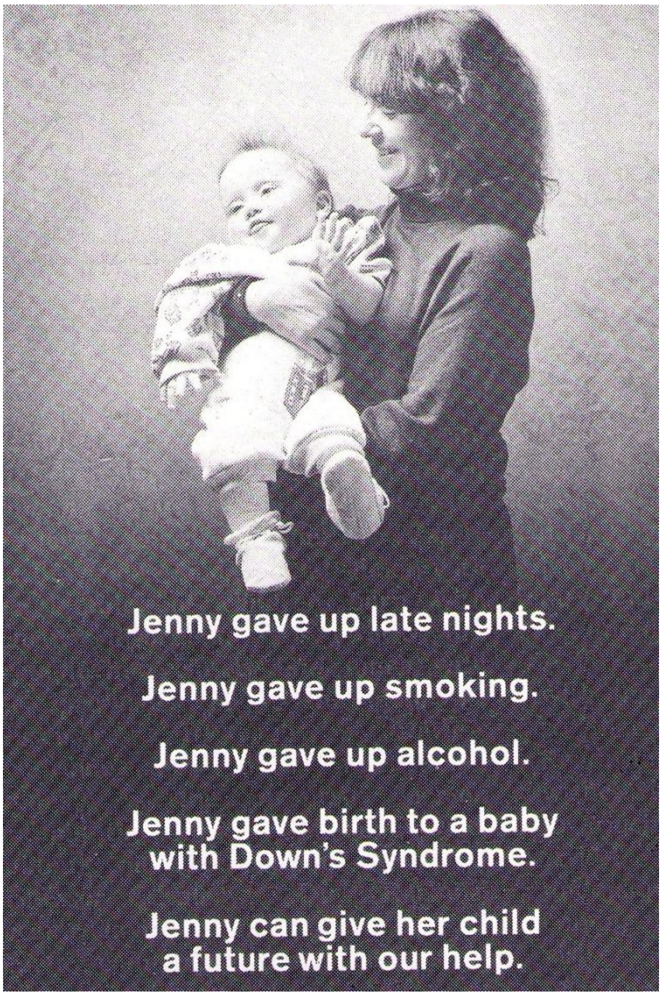
[618] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 4.
[619] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, pp. 3-4.
[620] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 4.
[621] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 4.



Another poster produced by the organisation at this time was one showing a photo of a young man paddling a canoe with the information that ‘one child in 600 is born with Down’s Syndrome’.[622] This poster was placed at bus stops and other prominent locations in Glasgow and declared ‘Down’s syndrome hasn’t stopped Jeremy paddling his own canoe’.[623] This poster focussed on the independence and abilities of those with Down’s syndrome and the SDSA reported that the campaign was well received and had prompted discussion. They also reported they would start a new campaign again focussing on this theme of ‘independence’ with the slogan ‘Down’s

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[622] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 19, Spring, 1989, p. 12.

[623] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 19, Spring, 1989, p. 12.

syndrome hasn't stopped Tessa building a brighter future'.[624]The Strathclyde branch of the SDSA thus made up information leaflets which they sent into all hospitals, health centres and social work departments.[625]

The SDSA stated in their magazine in 1989 that 'our readers are not only parents and relatives, but also carers, social workers, teachers, doctors, speech therapists, physiotherapists and all sorts of people with an interest in Down's syndrome.[626] The SDSA, like the SSMH, had good links with statutory and medical authorities in Edinburgh and Glasgow. For example it was reported that the Department of Social Work in Strathclyde attended a parents event and chaired a general discussion forum in 1989.[627]They also maintained close ties with medical and other professionals, some of whom were parents of children with Down's syndrome themselves. In addition their magazine had a regular 'Link Up' section which advertised and promoted the work of other relevant groups or opportunities for their members. In Glasgow, in particular, they worked closely with the SSMH and recommended their employment services and holidays to their members.[628] They also advertised SSMH Homes and their day activities that were supported by social work.[629] They also advertised the work of the Campaign for Mental Handicaps and

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[624] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Spring, 1989, p. 12.
[625] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 18, Winter 1988/89, p. 5.
[626] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Spring 1988/89, p. 2.
[627] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 9.
[628] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 18, Winter 1988/89, p. 6.
[629] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Spring, 1989, p. 8.

recommended that members join and take part in this organisation.[630] The SDSA also worked with the Scottish Council for Voluntary Organisations, for example using their research in their magazine. In 1989 they re-printed their details of the residential care facilities in Scotland listed by region, category and number of places available. This is described as an 'invaluable tool for social workers in the voluntary and statutory sectors.[631]

However the SDSA still devoted a substantial part of their publicity material to issues such as the treatment and prevention of disability, particularly focussing on advancements in genetic counselling. For example in 1989 they pointed to the concern for genetic counselling provision with Dr Raeburn leaving Edinburgh. Indeed the article stated that 'families are in danger of having more handicapped children because a health board is not replacing a specialist'.[632] In addition a spokesperson from Edinburgh Community Health Council is quoted as cautioning 'if the service is no available to parents who are at risk it could lead to there being larger numbers of handicapped children'.[633] To this Dr Raeburn asserted that 'families would bear the heaviest cost [as] all sorts of problems arise if there is a handicapped child'.[634] He expressed similar concerns in another article noting the 'detection rate for high risk pregnancies' which he stated could soon reach 80% which could mean

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[630] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 18, Winter 1988/89, p. 6.

[631] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Spring, 1989, p. 8.

[632] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 5.

[633] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 5.

[634] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 5.

‘more couples to consider amniocentesis and possible termination.[635] He stressed, however, that he did not wish to encourage new pressure for termination stating that:

> My hope is that from these studies and others knowledge of Down’s syndrome will increase – and especially that the primary cause can be found so that in future the handicap is decreased without a need for termination.[636]

The wider organisation was, however, critical of the use of negative imagery of people with Down’s syndrome. For example, the Director of the Down’s Children’s Association 1983 wrote of the challenges of gaining publicity which brings up the dilemma ‘of whether of not to exploit the pathetic in trying to pluck money from the heart strings’.[637] She argued that:

> As hard as we struggle to present these children positively, picturing them in loving families or carrying on normal, everyday activities, others use them in lonely or helpless poses to try and raise money.[638]

One campaign which was criticised included an ‘award winning poster’ from the Royal Society for Mentally Handicapped Children and Adults which showed a young ‘Down’s girl’ who is described as looking ‘mournfully’ over the slogan ‘Twenty children born on Christmas Day will always have a cross to bear’.[639]

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[635] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 18, Winter 1988/89, p. 3.

[636] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 18, Winter 1988/89, p. 3.

[637] Maggie Emslie, ‘Exploiting Sadness’, *The Times*, December 21st 1983, p. 11.

[638] Maggie Emslie, ‘Exploiting Sadness’, *The Times*, December 21st 1983, p. 11.

[639] Maggie Emslie, ‘Exploiting Sadness’, *The Times*, December 21st 1983, p. 11.

Similarly another poster was produced with the same little girl, who had appeared in the television soap ‘Crossroads’, with the slogan ‘you can switch off Nina’s problems, her mother can’t’.[640] Therefore the Director stressed that, ‘Down’s families don’t mind advertising for the need for help for the mentally handicapped, but let them also be leaders of a new era of positive understanding’.[641]

Subsequently the SDSA were often behind campaigns for a ‘better life’, for example, at their AGM in 1990 they focussed on the theme of ‘making integration work’ as they stressed that ‘to segregate is to de-value people.[642] Thus they stated:

> When people with a handicap are gathered together they are very noticeable and it can be very off-putting and detrimental to creating positive relationships within a community’.[643]

One speaker at their conference, Sandy Murray, Director of Social Work for the Grampian Region, stressed ‘the importance for the employment of people with a mental handicap of the continuation of the sheltered placement scheme’.[644] Parents within the organisation thus demonstrated concern with both the social training and the integration of their children into society. For one article in the 1989 magazine stressed that ‘from his birth we’d believed that if Mitchell could learn to behave

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[640] Maggie Emslie, ‘Exploiting Sadness’, *The Times*, December 21st 1983, p. 11.

[641] Maggie Emslie, ‘Exploiting Sadness’, *The Times*, December 21st 1983, p. 11.

[642] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 24, Summer 1990, p. 4.

[643] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 24, Summer 1990, p. 4.

[644] Scottish Down’s Syndrome Association News, The Magazine of Scottish Down’s Syndrome Association, No 24, Summer 1990, p. 4.

appropriately he could be an accepted member of society'.[645] They stressed the value of education arguing that 'if he isn't taught, he simply won't learn'.[646] Another parent, Rev Bryan Owen (Rector of St Aidens Episcopal Church, Glasgow) gave an 'open account of his feelings of coming to terms with his daughter's handicap' in the SDSA magazine in 1989. He wrote that the doctor had informed them that 'I am afraid your child has down's syndrome' and recalled that 'the birth of a mentally handicapped child is as shattering to all that you believe in as the severest earthquake'.[647] However he stressed that 'she has no parents but us. She asks us to love her and keep her… [then we gained] a new perspective and a new beginning and joy and fulfilment'.[648]

Sporting organisations and events were also to have an impact on awareness of mental handicap and promoting integration.[649] One event which served to increase the visibility of local people with mental handicaps was the National Sports Day held at Meadowbank Stadium in Edinburgh which was organised through Adult Training Centres. [650] Further to this the European Games of the Special Olympics were held in Glasgow in from July 21st to 27th 1990. This was a large international event held for people classed as mentally handicapped from teams all over the world. The aims of this event were 'to bring people with a mental handicap acceptance and respect in the

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[645] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 10.

[646] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 22, Winter 1989/90, p. 10.

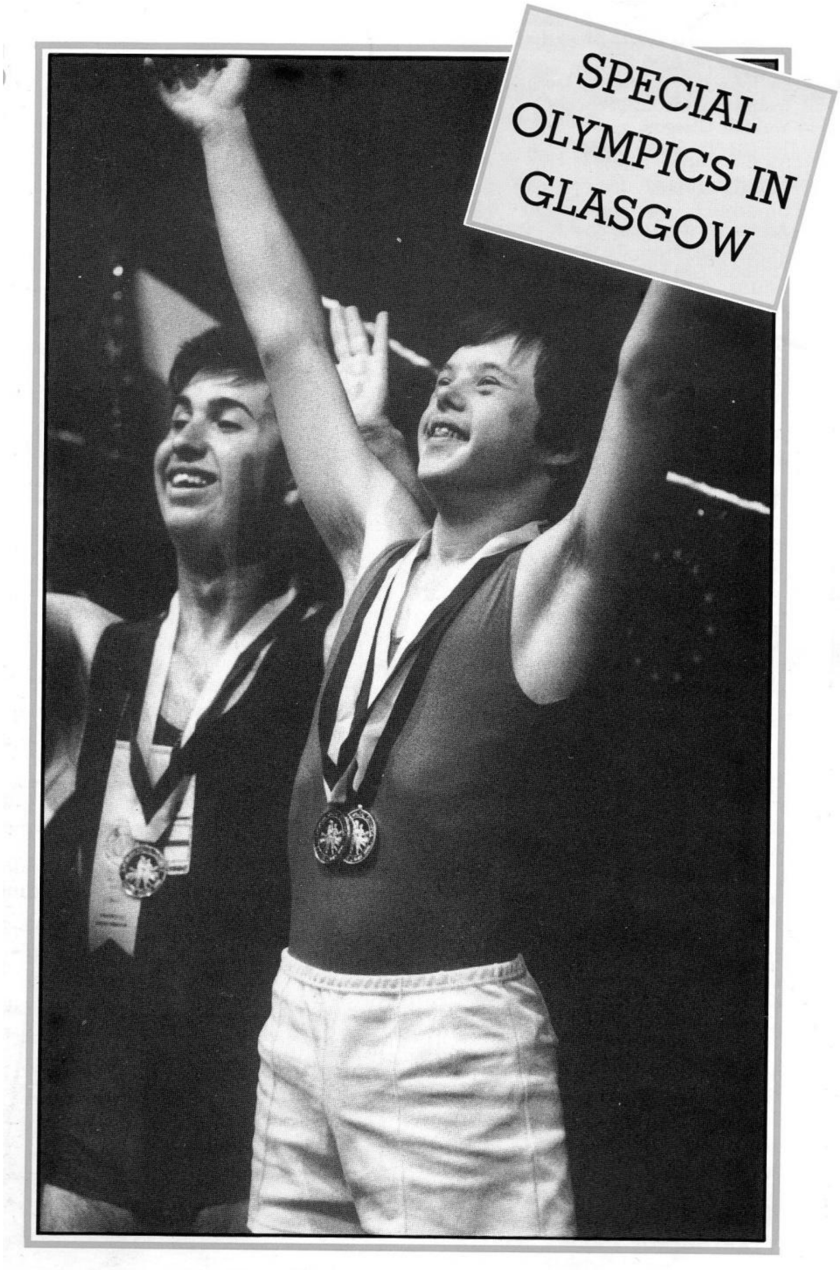
[647] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Spring, 1989, p. 10.

[648] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Spring, 1989, p. 10.

[649] SSMH, Newslink, Summer 1982, p. 1.

[650] SSMH, Newslink, Summer 1982, p. 1.

wider community'.[651] The Games were covered through the SDSA and who used images two Special Olympics gymnasts on the front covers of two of their issues around this time (one pictured below).[652]



Cover Image from the 1990 European Special Olympics Summer Games in Glasgow. Taken from the SDSA magazine from Summer 1990.

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[651] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Summer 1990, p. 6.
[652] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Winter 1989/90 and Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 24, Summer 1990.

The Games in Glasgow had over 2000 competitors and included the help of over 2000 volunteers from Strathclyde area.[653] It was reported that the wider remit of the Games was to 'raise public awareness of people with mental handicap in the community'.[654] This was achieved to some extent with media coverage through newspapers such as the *Glasgow Herald* and the *Scotsman*. However the SDSA also pointed towards the lack of 'background features on the people concerned' and how 'the Games tended to be treated like a Glasgow event rather than a European one, by the UK media as a whole'[655]

It must be noted here, however, that often the voices of mentally handicapped people themselves were absent in the development of voluntary organisation. Their views, often, did not come through in newsletters or other publicity material from either the SSMH or the SDSA until the 1990s when the self-advocacy movement began to come to the fore. It must be noted that in terms of self-advocacy and allowing a voice for disabled people these organisations were again to lead the way in later years, however this was not the case in their earlier years. This has led Robinson to point to the growth in organisations claiming to speak for people with mental handicaps who were not always given the opportunity to fully express themselves[656]. She stressed that these types of organisations most often involved

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[653] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Summer 1990, p. 6.

[654] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Summer 1990, p. 6.

[655] Scottish Down's Syndrome Association News, The Magazine of Scottish Down's Syndrome Association, No 19, Summer 1990, p. 6.

[656] Hazel Robinson, *Community Care with Mentally Handicapped People*, Social Work Monographs, (Norwich, 1987), p. 2.

parents with the most notable one in England being MENCAP.[657] However Robinson also stressed that it could be argued that ‘while acting as effective pressure groups, parent-directed organisations have prolonged the exclusion of mentally handicapped people for the continuing debate on service provision’.[658] She noted however the earlier work of organisations such as the Campaign for Mental Handicap (CMH), which is run without the involvement of parents, in the bringing together of handicapped and non-handicapped people.[659]

Organisations such as the SSMH and later the SDSA, certainly in their inception and earlier years, were principally parent’s organisations who sought to use publicity in this period to increase the services available to the mentally handicapped and their families. The work of both organisations, given the links they held with statutory authorities, medicine and academia was certainly effective in increasing the visibility of the issue of mental handicap in the press and with the bodies legislating in this area. However these organisations were not anti-establishment or revolutionary in their ideas. Whilst parents in the SSMH focussed their efforts on educating themselves about developments abroad and promoting discussions amongst experts in the field, they then used this new knowledge to enter into discussion and to forge a working relationship with the state. Both the SSMH and the SDSA fostered these relationships with medicine and goaded the statutory authorities into action, advised parents of their welfare rights or extended provision where little was available with the help or blessing of the authorities. As the next section will explore it was often through these relationships which the SSMH in particular had

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[657] Robinson, *Community Care with Mentally Handicapped People*, p. 2.
[658] Robinson, *Community Care with Mentally Handicapped People*, p. 2.
[659] Robinson, *Community Care with Mentally Handicapped People*, p. 3.

built up with the state that they were then able to provide services that were badly needed for their members.

The SSMH as a Service Provider in a Mixed Economy of Welfare

From its inception the SSMH was often reliant on good relationships with statutory agencies. Often they led negotiations with local state authorities to try to prompt them into action and if this failed they would attempt to establish the required service themselves.[660] In this case dialogue and negotiation with LAs was still of importance as it could provide them with the means, through providing property or grants, to establish projects themselves.[661] Whilst they kept up pressure to implement the various provisions laid out in new legislation they also built up significant relationships, particularly with different departments of the LA in Glasgow. They highlighted the importance of maintaining their 'image' and prestige in order to give them the weight they needed to be taken seriously in negotiations. [662] Therefore as well as campaigning on legislation and keeping up pressure on LAs to reform and improve services, the SSMH relied on their own initiatives to provide parents and disabled children with those services that were most needed. Thus one of the founder members recalled how:

> When the Association began in 1954, Glasgow Education Authorities catered very well for mentally handicapped children, but there were many towns on Glasgow's doorstep who made little or no provision for the mentally

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[660] SSMHC, Newsletter, June 1967, p. 8.
[661] SSMHC, Newsletter, September 1963, p. 11.
[662] SSMHC, Newsletter, June 1967, p. 8.

> handicapped. The figure quoted in 1954 in Glasgow was 3,500. Most of them were catered for in Special Schools and Occupational Centres, but there remained a group, approximately 160 at that time, for whom no provision was made because they were so severely handicapped. Although Local Authorities made no provision for this group, who were much more difficult to cope with, yet a 24 hour vigil had to be kept by their parents, Our son, Johnny, came into this category.[663]

One of the early projects therefore was the provision of a service for these excluded children and their parents. Metzel has identified similar development in the US whereby 'professionals and parents were the principal agents in obtaining private and public funding for, and directly providing community services for children with intellectual disabilities'.[664] In Glasgow one member of the newly established SAPHC, Mrs Margaret Barton, offered part of her house to be used as what was to be called the 'Broomhill Centre'.[665]As Metzel also identified in many places in America new small-scale services such as pre-schools for the mentally handicapped were:

> Usually within short driving distance of the families homes in their middle-class and white neighbourhoods, sited in church and school basements, vacant school buildings, and other redundant and unobtrusive spaces in the communities.[666]

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[663] Mrs Shapter, Anniversary Newsletter, SSMH, April 1975, p. 7.

[664] Deborah S. Metzel, 'Places of Social Poverty and Service Dependency of People with Intellectual Disabilities: A Case Study in Baltimore, *Health and Place,* Vol 11, Issue 2, June 2005, p. 100.

[665] Mrs Shapter, Anniversary Newsletter, SSMH, April 1975, p. 8.

[666] Metzel, 'Places of Social Poverty', p. 100.

This particular centre, the first of its type in Scotland, was established to 'give some parents a break from caring all day, every day for their children'.[667] Around twenty children attended the service for part of the week, most of whom had been classed as 'ineducable' under the Education Scotland Act of 1945 and had few, or no other mechanisms of state support for care available to them. Instrumental in the creation of this service were the links Samuel Curran formed with the MOH, Dr Stuart Laidlaw who 'showed great interest and enthusiasm for the project'.[668] For example it was reported in the MOH report for 1967 that the SSMHC was again providing the only available service for children excluded from schooling'.[669] It was noted that they catered for 'all grades of handicap down to the most helpless and including the most active and unmanageable' and that 'the volunteer helpers have been meeting this need for some ten years'.[670] The LA was therefore persuaded to provide transport to the centre and later bigger premises whilst at the beginning the Society was to provide both premises and voluntary helpers.[671]

It was stated in the MOH report in 1962 that under section 65 of the Education (Scotland) Act of 1962, the local health authority were to be notified of those children of school age who are considered unsuitable for education or training in a special school.[672] Under Section 12 of the Mental Health Act the health authority

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[667] ENABLE, *Far Beyond Our Dreams*, Booklet produced by ENABLE in 2004 to celebrate the 50th Anniversary of the formation of the organisation, p. 3

[668] Mrs Shapter, Anniversary Newsletter, SSMH, April 1975, p. 8.

[669] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 27.

[670] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 27.

[671] Mrs Shapter, Anniversary Newsletter, SSMH, April 1975, p. 8.

[672] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 207.

had the duty to provide training and occupation for these children.[673] However in Glasgow this provision had not yet got any further than the planning stages.[674] It was argued by the MOH therefore that ‘this is one of the most urgent needs requiring to be met in the city’.[675] This recognition of need however was not to be followed by sizeable investment of finance or resources to provide centres or places for these individuals. These services provided by the SSMH therefore were to become ‘a foothold in the communities, and marked not only a stand against the institutionalization of their children, but marginal visibility in the community’.[676]

The Glasgow branch, formed in 1957, went on to set up and maintain many other local projects to plug the gaps in local government provision.[677] The day care was extended and moved out to Laurieston House (premises lent by Glasgow Corporation Health and Welfare Department) in order to offer more places. This service was extremely over-subscribed with the ‘heavy work involved’ and often each child could only attend the centre one day a week. This meant that around 75 children were attending the centre in 1962 and ‘because they attend only one day per week the training function is limited and the emphasis is on the relief provided for the mother.[678] The day centre convener, Mrs Archibald, recognised this in 1965 stating that the purpose of the centre as well as encouraging ‘the development of

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[673] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 207.
[674] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 207.
[675] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 207.
[676] Metzel, ‘Places of Social Poverty’, p. 103.
[677] SSMHC, Newsletter, December, 1965, pp. 1-11.
[678] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p208.

children…through enjoyment of music, games and companionship' was in large part to 'relieve stress for mothers of our children'.[679] The SSMHC noted in 1965:

> In the early days we were very much concerned with social functions for the parents because at this stage it was obvious that parents must be brought together in a friendly atmosphere to meet others with similar problems and possibly for the first time, feel free to discuss their difficulties and needs.[680]

Initially this was said to have given these parents a 'tremendous moral uplift'.[681]It was also noted that the SSMHC had come to the 'realisation that it is wrong to expect the parents of a severely handicapped child to bear alone this special problem'.[682] One parent recalled how she met another mother from the 'Welfare Committee' of the SSMHC who told her 'I have a child like yours and I've come to see if I can help you'.[683] She recalled how 'we talked and discovered we shared the same thoughts, the same fears. Then, and only then, did I realise I was not alone and my load was lightened'.[684]

Thus SSMHC further utilised their contacts to help create other essential services for families such as respite accommodation. For example they were gifted Craigrownie Castle near Cove, Helensburgh by Miss Ella Steward in 1956.[685] Two years of fundraising and renovation work allowed the opening of the short stay residential Stewart Home on this property in 1958. This was the first short-stay

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[679] SSMHC, Newsletter, December, 1965, p. 8.
[680] SSMHC, Newsletter, December, 1965, p. 6.
[681] SSMHC, Newsletter, December 1965, p. 7.
[682] SSMHC, Newsletter, December, 1965, p. 10.
[683] SSMHC, Newsletter, December, 1965, p. 11.
[684] SSMHC, Newsletter, December, 1965, p. 11.
[685] Sir Samuel Curran, Anniversary Newsletter, SSMH, April 1975, p. 5.

respite home for children with learning disabilities in Scotland. The demand for this kind of provision in the Glasgow area can be seen in the fact that the Stewart Home provided accommodation for over 500 children in its first 27 months.[686] They also opened Viewpark Home in 1966 to extend this short stay provision by offering holidays for mentally handicapped boys. Both these homes were then extremely popular throughout the 1960s and 70s in providing holidays and respite. This provision served to highlight the desperate need for more care services throughout Scotland. This was at a time when there was a long waiting list for beds in institutions such as Lennox Castle. It was noted therefore by the MOH that in the community it largely falls upon the LA to look after 'mental defectives' or assist their families.[687] It noted that those who are not covered by local authority provision were under the care of the Health and Welfare Department but that 'considerable work is done in this field by the SSMHC'.[688]

As Ward argued, services for the school leaver were 'one of the most inadequate features of all the…social, educational or health services for handicapped people'.[689] Therefore the SSMH did not only campaign for an increase in services for the over 16s, they created their own clubs and centres to attempt to plug the gaps in statutory provision that the LAs could or would not.[690] The Glasgow Branch opened Curran House as its central offices in 1964. Here they sought to provide 'a social centre for mentally handicapped girls and boys'.[691] Evening clubs were established

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[686] SSPHC, Newsletter, September 1960, p. 2.

[687] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 206.

[688] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 206.

[689] Linda Ward, *People First: Developing Services in the Community for People with Mental handicap* (London, 1981), p. 63.

[690] SSMHC, Newsletter, December 1964, p. 6.

[691] SSMHC, Newsletter, June 1964, p. 5.

which they argued were ‘bringing more happiness into the lives of those who formerly felt themselves to be outwith normal social life’.[692] This they stated was helping by ‘giving our young people an interest in life they had so often lacked’.[693] Although Curran House and other similar clubs had a ‘social’ purpose the children and young adults were also given the opportunity to receive tuition in reading and writing. The Society brought in qualified teachers as they argued there was little or no educational opportunities for many children after they left occupational centres at 16.[694] They felt that this was important as ‘the mentally handicapped girl or boy may be more ready in their late teens to absorb a little formal education [but] there is no opportunity for it after they leave occupational centres’.[695]

In addition Ward noted how there was often a drop in the standard of living when a child left school and how new ‘problems of behaviour’ could emerge as the result of lack of occupation.[696] This, she explains, is often why hospital admissions peaked for young adults. She stated that in 1977 for the age group 16 – 20 there were 25 long-term admissions per 100,000 of the population whilst there were only 11 per 100,000 for all other ages.[697] As a result the SSMH pushed the LAs to help them set up and maintain various day centres in Glasgow for such adults to avoid more pressure for places in institutions and to provide services for those who were to remain in the community. Services were therefore established in both the Easterhill Day Centre and Levern centres in the 1970s. These centres were to provide care and training service for ‘profoundly mentally handicapped young adults’.[698] The aims

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[692] SSMHC, Newsletter, September 1960, p. 2.
[693] SSMHC, Newsletter, September, 1963, p. 1.
[694] SSMHC, Newsletter, March 1960, p. 4.
[695] SSMHC, Newsletter, March 1960, p. 4.
[696] Ward, *People First*, p. 63.
[697] Ward, *People First*, p. 63.
[698] SSMH, Newslink, Spring, 1982, p. 10.

were to focus on the development of 'self help skills' and building independence. The report in the 1982 newsletter argued that all the 'clients have suffered though lack of previous experience and service'.[699] The SSMH was also heavily involved in improvements and developments of the Junior Occupational Centre in Govan where 40 – 50 children were taught. Many of these children had previously been or still were regarded as ineducable. However they kept up pressure on educational authorities and other governing bodies to maintain and extend education and training services as they argued the benefits of these centres to the children could be social as well and educational for example stating that the centres 'help to counteract the more sheltered, and narrower life, which [these] children tend to lead'.[700]

Another important service established by the SSMH was the Thomas Fortune Work Centre which was opened in Glasgow in 1960. This centre sought to provide for 'young people who had not been admitted into senior occupational centres' and who were described as 'not employable under ordinary working conditions'.[701] The first premises were in Buccleuch Street until the Health and Welfare Department of The Glasgow Corporation were persuaded to provide larger premises in Moffat Street and then in Broomhill.[702] The centre moved from the Broomhill building, as it was deteriorating badly, to alternative premises in an old primary school in Garscadden Road, Old Drumchapel. Eventually in the last few years ENABLE were able to house the centre in a modern purpose built premises in Drumchapel.

The centre provided training for over 70 men and women by 1970. Initially the focus was on providing relief for families as it was argued that 'it means a great deal to them to know that their children are being guided and looked after at the work

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[699] SSMH, Newslink, Spring, 1982, p. 10.
[700] SSMHC, Newsletter, December, 1964, p. 5.
[701] SSMHC, Newsletter, December, 1965, p. 10.
[702] SSMHC, Newsletter, December, 1965, pp. 10-11.

centre'.[703] However as the activities of the centre were to develop more the emphasis was on the aim of moulding 'socially adequate members of society'.[704] Ian McMurray (General Secretary of the Society) argued in 1975 that the aim was, 'more educational and less custodial emphasis to 'produce a more competent generation of mentally handicapped'[705] They argued that the potential of adults with learning disabilities had not been realised as 'no-one knows how well they may be able to perform any area of human behaviour unless they are taught the necessary skills and allowed to practice them'.[706] McMurray and others in the Society argued that the educating and training of people with learning disabilities allowed them to be 'able to contribute to the nation's life'[707] They advocated therefore the need to attempt to develop 'social fitness' which would allow them to participate in the norms of social and cultural life. They argued that the adults in the centre had achieved 'a great boost to their morale' and highlighted their 'evident enjoyment and pleasure in having a job to do'.[708]

The SSMH therefore developed relationships with different branches of statutory authority to provide the services most needed by parents and their mentally handicapped children. These reciprocal relationships with the state often resulted in authorities providing grants or help with premises in return for the SSMH running a service, such as in the case of the Stewart Home [709] or the work centre.[710] Other examples include the loaning of premises from the Glasgow Corporation Health and Welfare Department for the Broomhill day care centre or LA provision of transport

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[703] SAPHC, Newsletter, September, 1960, p. 6.
[704] SAPHC, Newsletter, September, 1960, p. 6.
[705] SSMH, Newsletter, April, 1975, p. 7.
[706] SSMH, Newsletter, February, 1977, p. 6.
[707] SSMH, Newsletter, April, 1975, p. 7.
[708] SAPHC, Newsletter, September 1960, p. 7.
[709] SSMH, Newsletter, December, 1962, p. 1.
[710] SOHCA/024/1 Interview with Ann Ainsworth, 6th June 2006, interviewed by Angela Turner.

and school meals at the Junior Occupational Centre at Laurieston House. [711] They worked together in other ways, for example, Curran House was used to provide day clubs for those waiting for places at LA Adult Training Centres (ATCs) from the late 1970s onwards. These clubs were run by volunteers to 'provide respite for caring relatives, and social and leisure opportunities for those who attend'.[712] The funding for this project came jointly from fundraising and from a Strathclyde Social Work grant.[713]

It was noted therefore by the MOH that the SSMH in Glasgow were making a 'considerable contribution to the needs of the mentally defective children outside the Education Services'.[714] It noted the use that was being made of Laurieston House where they provided accommodation for children, 20 a day including 'helpless or cot cases' and noted indeed that the 'demand for their services is greater than they can meet'.[715] The existing places were so in demand that they were filled by children from a different part of the city each day meaning there were around 90 children regularly attending the centre.[716] The short stay home (Stewart Home) at Cove was also highlighted for praise by the report who noted the 'invaluable work in providing holidays for mentally handicapped children and temporary relief for their parents'.[717]

The Society continued to draw attention to the numbers of children and adults with learning disabilities who still did not have access to such services on a national

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[711] SSMHC, Newsletter, December 1965, p. 7.
[712] Jane Britten, *Putting People First*, p. 26.
[713] Jane Britten, *Putting People First*, p. 26.
[714] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 227.
[715] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 229.
[716] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 229.
[717] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 230.

level and subsequently kept up pressure for change. For example they stated that at the end of 1965 that 32 LAs in Britain had no ATCs and 11 had no junior training centres (JTC).[718] They found that there were therefore still 1,630 children on waiting lists for a place in a JTC even with the introduction of new centres and places.[719] This, they argued, demonstrated the fact that 'only provision of new services brings to light the full extent of need'.[720] They tried to work with local statutory services to try to ensure full implementation of new legislation or policy. For example they reported in 1967 that a new directive would mean they would place 'the onus firmly on the shoulders of LAs'.[721] Furthermore they stressed that where 'there exists a document required to be rendered by LAs to the Ministry of Health, open to inspection by anyone, and where in is written the intentions of LAs in implementation of legislation…This is our instrument of negotiation.[722] They wished to force the LA into action and provide the services required, however after 'every possible avenue was explored' they would then do their best to provide services themselves.[723]

They wished to extend their 'national prestige' in order to be able to do this noting that 'it should never be forgotten that we are a national entity intent on long-term…and widespread policy'[724] They stressed therefore that 'in negotiating with LAs or appealing to the public, the existing image of the Society is all important'.[725]- McMurray (Dept of Education, Glasgow Corporation) was new General Secretary of the Society thus stressed in 1967 that 'while the work of the local branch is most

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[718] SSMHC, Newsletter, December, 1968, p. 8.
[719] SSMHC, Newsletter, December, 1968, p. 8.
[720] SSMHC, Newsletter, December, 1968, p. 8.
[721] SSMHC, Newsletter, June 1967, p. 7.
[722] SSMHC, Newsletter, June 1967, p. 8.
[723] SSMHC, Newsletter, June 1967, p. 8.
[724] SSMHC, Newsletter, June 1967, p. 8.
[725] SSMHC, Newsletter, June 1967, p. 9.

important we must remember that we are part of a Scottish Society and our efforts must be on behalf of all the mentally handicapped children in Scotland.[726] However despite their efforts in this area the report *Those Without* produced by the Society in 1981 revealed that many of the problems identified in the earlier period were still prevalent. The report drew attention to the lack of resources for over 16s in the Glasgow area stating:

> The plight of the mentally handicapped after leaving school is appalling. Not only do they become housebound, but regression sets in, negating all the investment of the school years…for their parents, probably middle aged and above, renewed constant care after the relief provided by school must be a crushing imposition.[727]

LA provision of community-based facilities, which would help these families, was hampered by lack of financial and administrative support. Ward has argued that the economic problems of the 1970s and 1980s led to further constraints on public expenditure and limited the expansion of community based facilities. The rise of community care in this period may have also represented an ideological shift in public policy which placing more responsibility on private agents such as the family and voluntary organisations rather than the state. Feminist critiques have thus ‘highlighted the ways in which care in the community largely meant care by the

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[726] SSMHC, Newsletter, March, 1967, p. 2.

[727] SSMH, *Those Without: A Report on Two Urban Programme Funded Day Centres for Profoundly Mentally Handicapped Adults and Local Community Development Initiatives* (November, 1981), p. 31.

family and, in most cases…care by women'.[728] Indeed a survey of carers carried out by the Society in the Monklands District in Glasgow in 1989 found that 80% of main carers were mothers and 71% of all carers had received no formal respite care provision for over twelve months.[729] Significantly it also found that voluntary organisations provided more respite than social work and health service combined.[730] Recent collections of family histories, such as those brought together in *Witness to Change* by Rolph and Atkinson, suggest a more complex understanding of relationships involved in care. These testimonies suggest the importance of male as well as female careers and the inverse relationships that often develop in later life when often people with learning disabilities become carers themselves.

However the pressures and the lack of support available for these families in general may help provide an understanding of why parents became involved with the SSMH as members or through establishing and supporting their own community-based facilities. Britten's work also highlights the significance of this as a catalyst for action stating that over 75% of the users of the day facilities run by voluntary organisations in Scotland in the 1980s lived at home with their parents.[731] Ward has also drawn attention to the importance of personal circumstances in the establishment of these private projects noting the importance of 'parents and professionals in different parts of the country [who] established imaginative, pioneering schemes – often on shoestring budgets – to meet the needs of mentally

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[728] Sarah Payne, 'Outside the walls of the asylum? Psychiatric treatment in the 1980s and 1990s', in Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750 – 2000* (The Athlone Press: London, 1999), p. 249

[729] Fraser Mitchell, *Listening to Carers: A Survey of the demand for respite care for adults with a mental handicap in Monkland District* (Glasgow, 1989), p. 3.

[730] Fraser Mitchell, *Listening to Carers*, p. 3.

[731] Jane Britten, *Putting People',* p. 11.

handicapped people and their families'.[732] Furthermore Welshman has noted how the authorities were often happy to allow and often support these voluntary agencies in their project in order to help plug gaps in statutory provision.[733] Britten has pointed towards the importance of the voluntary state alliance in her study of voluntary run day centres in early 1980s. She argued, 'the present government has repeatedly emphasised its desire to promote voluntary effort'.[734] However she also noted how, inversely, the voluntary sector had succeeded in extending provision by increasing the amount of resources available to social services 'that would not have been attracted by statutory organisations'.[735]

Voluntary organisations also later helped to maintain an element of choice for people with learning disabilities by providing different kinds of services than the LA.[736] For example the SSMH run Work Centre in Glasgow continued to focus on the importance of vocational and work-based training when other day centres were shifting emphasis onto social and cultural education and training.[737] They also continued to spread awareness of learning disability through national media campaigns, making and showing films, and dispersing leaflets and posters throughout local communities. For example the leaflet, 'Opening Doors' was produced in 1991 to try and promote the education of the wider community about 'mental handicap'. In this they stated:

> Scarcely a week goes by without some new horror story in the press of discrimination against people with mental handicaps. Neighbours refuse to

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[732] Ward, *People First* p. 3.
[733] John Welshman, 'Rhetoric and Reality', p. 208.
[734] Jane Britten, *Putting People First,* p. 26.
[735] Jane Britten, *Putting People First*, p. 26.
[736] Jane Britten, *Putting People First,* p. 30.
[737] SOHCA/024/1 Interview with Ann Ainsworth, 6th June 2006.

> accept a group home in their street; parents are asked to leave a holiday centre because of what their son "might do".[738]

This report argued that they must strive to prevent community care becoming more than 'another piece of jargon' by educating the community.[739] In 1970 the Society had reprinted the article 'How the Outsider Sees the Mentally Deficient' from *Glasgow Herald*.[740] Whilst it continued to propagate medicalised explanations of 'mental deficiency' emphasising the importance of research 'in order to identify and warn parents who are most likely to produce defective children', it also stressed the need to cut down on unnecessary hospitalisation.[741] It pointed to the need for alternative types of accommodation such as hostels in the community to make this possible but argued that plans for these would never come to fruition unless the government began to invest money instead of simply 'reiterating statements of policy'.[742]

In 1965 the Scottish Home and Health Department urged LAs to provide hostel places however, as was the case with day centres and other services, they were slow to act. The SSMH therefore developed the hostel plan in 1968 which would offer selected local authorities interest free loans from the Society of up to £10,000.[743] This led to plans to establish 14 hostels in Scotland within 3 years.[744] In

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[738] Roy McConkey, *Opening Doors: Educating the Community about Mental Handicap* (Glasgow, 1991), p. 3.

[739] McConkey, *Opening Doors*, p. 3 .

[740] *Glasgow Herald*, 'How the Outsider sees the Mentally Deficient', reprinted in SSMHC, Newsletter, March 1970, pp. 2-5.

[741] *Glasgow Herald*, 'How the Outsider sees the Mentally Deficient', reprinted in SSMHC, Newsletter, March 1970, p. 3.

[742] Glasgow Herald, 'How the Outsider sees the Mentally Deficient', reprinted in SSMHC, Newsletter, March 1970, p. 5.

[743] ENABLE, *Far Beyond Our Dreams*, Booklet produced by ENABLE in 2004 to celebrate the 50th Anniversary of the formation of the organisation.

Glasgow the local branch also set up the independent Balshagery Hostel which housed 14 people full time, most of whom also attended the Work Centre. [745] Dr Short stated in 1968 that one of the most positive aspects of hostels such as these was that they could ‘lead to new dimensions of independence’.[746] Similarly The Jay Report argued in 1979 that:

> Accommodation varying from highly staffed homes to unstaffed houses and flats should be provided [to] allow the handicapped person to make a choice, jointly with his family, to move on and to establish a life independent of the parental home.[747]

It was reported at the end of 1974 that the SSMH was continuing to play a ‘major role in helping to provide more group homes for the mentally handicapped by making available interest free loans to local authorities’.[748] In particular the Society was focussing attention on the creation of group homes for 8-14 adults ‘living in family-type accommodation and supervised by a housemother and assistant’.[749] However, the report, *A Better Life*, estimated in 1979 that over 3000 places were required in Scotland to allow people with learning disabilities to be housed in the community.[750] The Society applied to the Housing Corporation to establish the Key Housing Association in 1979 in an attempt to begin providing these types of homes.

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[744] ENABLE, *Far Beyond Our Dreams*, Booklet produced by ENABLE in 2004 to celebrate the 50th Anniversary of the formation of the organisation.

[745] Britten, *Putting People First*, p. 64.

[746] SSMHC, Newsletter, December 1968, p. 4.

[747] The Jay Report, reprinted in Linda Ward, *People First: Developing Services in the Community for People with Mental handicap* (London, 1981), p. 82.

[748] Scottish Education Department, *Social Work in Scotland in 1974* (HMSO, Edinburgh, 1975), p16.

[749] *Social Work in Scotland in 1974*, p. 16.

[750] *A Better Life*, p. 21.

They adhered to the objective of providing a ‘normal’ life arguing that the aim was to ‘provide the types of accommodation that we would be happy to live in ourselves’.[751]

Key Housing therefore started to identify appropriate sites in late 1979 in Glasgow such as Ibrox and Cessnock and in the surrounding areas such as Cumbernauld and Paisley.[752] This was to be carried out with the support of the Directors of Social Work and Health Board Officials and the Housing Corporation.[753] It was noted that the first project in Ibrox was progressing well with approval from Glasgow District Council ‘despite objections in the form of petitions, letters, articles in local newspapers’. Here it was noted that ‘community education is probably our most formidable task’.[754]

It was reported in 1980 that the SSMH was working with Social Work and Health Authorities to get support finances for the Key Housing hostels they were setting up.[755] The Association opened its first house in Glasgow in 1982 but was dependant on grants or other monies to allow them to extend provision further. They stressed that it was ‘imperative that branches assist our negotiations with Social Work Departments and Health Boards at a local level to ensure that sufficient revenue funding will be available’.[756] Lack of financial support in 1981 meant that plans for numerous housing developments in Glasgow and Scotland wide had to be cut back at a time when ‘special needs’ groups were supposedly highest priority in the governmental allocation of monies to housing associations.[757]

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[751] SSMH, Newsletter, April 1979, p. 4.
[752] SSMH, Newsletter, August 1979, p. 2.
[753] SSMH, Newsletter, August 1979, p. 2.
[754] SSMH, Newsletter, August 1979, p. 3.
[755] SSMH, Newslink, Spring 1980, p. 3.
[756] SSMH, Newslink, Spring 1980, p. 3.
[757] SSMH, Newslink, Spring 1981, p. 17.

In 1989 a circular from the Department of Health, *Caring for People* reasserted the importance of providing different types of accommodation in residential settings arguing that successful care in the community meant 'providing the services and support which people affected by problems of ageing, mental illness, mental handicap or disability need to live independently in their homes or in 'homely' settings in the community'.[758] However, through Key Housing, it was initially the SSMH who instigated and implemented new projects as opposed to health or other authorities. It was not until 1987 that the Housing (Scotland) Act stipulated that LAs were to consider housing needs in their areas, including disabled people's needs and were given the power to pay improvement grants. However the Society always seemed to be one step ahead, for example in this same year it set up SSHM Homes in order to provide family sized homes for adults with complex needs which was an area they felt, despite new legislation, was still seriously lacking in statutory provision.

The mixed economy of welfare can be seen as essential in many ways to the development of new types of housing, day care and other provision in the general aim to provide community care. *A Better life* stated the belief the people with mental handicaps could benefit from this mixed economy stating that 'voluntary organisations should be encouraged to play a major part in initiating new forms of care and training which may serve as a model for statutory services'.[759] In the 1975 newsletter the Secretary of State for Scotland, William Ross, again highlighted the importance of voluntary efforts in 'a period such as the present when, for economic reasons, it is essential to restrain public expenditure'.[760] He forecast a lasting role for

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[758] John Welshman, 'Rhetoric and reality', p. 204.
[759] *A Better Life*, p. 8.
[760] SSMH, Newsletter, April 1975, p. 2.

the Society and other voluntary organisations. Similarly a Conservative MP, Alick Buchanan-Smith stressed that there would be ‘tremendous scope and need for voluntary effort’.[761]

It was reported in 1972 that senior training and day care facilities were being provided by LAs at 85 centres and by voluntary associations at 25 centres in Scotland.[762] In addition more than half the 140 hostel places for the mentally handicapped in Scotland were being provided by voluntary organisations.[763] The SSMH was mentioned in particular for the work they were doing with the LA in Glasgow in setting up more projects for hostels and group homes.[764] Often these projects were to become the models for subsequent statutory provision or were even taken over by LAs. For example the Society argued that provision of short stay in the Stewart Home had led to ‘an awakening to the value of short stay accommodation for the mentally handicapped’ within LAs. This eventually led to the closure of both the Stewart Home and the Viewpark Home in the 1980s as other (statutory) services increased their holiday and respite facilities. In addition reports, such as *A Better Life*, advocated the establishment of ‘work centres’ along the lines of the Thomas Fortune Work Centre noting the potential of such ‘industrial enclaves’.[765] It recommended therefore that the social work authorities enter into discussion with voluntary organisations and leaders from industry ‘with a view of ensuring the provision of better employment opportunities for mentally handicapped persons’.[766] Furthermore projects that were established by the SSMH such as the Easterhill and

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[761] SSMH, Newsletter, April 1975, p. 3.
[762] Scottish Education Department, *Social Work in Scotland in 1972* (HMSO, Edinburgh, 1972), p19.
[763] *Social Work in Scotland in 1972*, p. 19.
[764] *Social Work in Scotland in 1972*, p. 19.
[765] *A Better Life*, p. 95.
[766] *A Better Life*, p. 95.

Levern day centres, originally run with the help of urban aid funding, were eventually taken over by the Strathclyde Social Work Department in the 1980s.[767]

The SSMH also played a large role in providing information and consultation on these services and the needs of mentally handicapped people on numerous occasions. For example The SSMHC sent a letter into the Association of the Directors of Social Work (ADSW) in March 1974 asking for a guide for all establishments dealing with mentally handicapped children. They were told that the SISD were the best people to approach for this, perhaps suggesting the relationships between statutory authorities and the services provided by them were not always clear.[768] In this case the SSMHC was the central institution through which parents and other interested parties could go to for help and information gathered from all the different statutory authorities. In addition, in 1981, the SSMH was part of a group of charities who came together to form the Independent Development Council for People with Mental Handicap whose 'prime purpose is to offer informed and independent advice to Government on all aspects of services for mentally handicapped people and their families'.[769] Those involved included the CMHP (Campaign for Mentally Handicapped People), MENCAP, MIND and the Spastics Society.[770] All these bodies came together with representatives of education, hospitals, and social services to create a booklet to outline a 'comprehensive local service' which was to be issued to LAs and health bodies.[771]

Evidence of the importance of the links between voluntary and statutory authorities in this area can be seen in a letter from Ross Flockhart (Director of

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[767] Britten, *Putting People First*, p. 9.
[768] Records of the Association of Directors of Social Work, Executive Committee Minutes, 15th March 1974, ADSWA1/1.1.45.
[769] SSMH, Newslink, Summer 1982, p. 3.
[770] SSMH, Newslink, Summer 1982, p. 3.
[771] SSMH, Newslink, Summer 1982, p. 3.

Scottish Council of Social Services) to R Winter (ADSW) in 1974 where it is noted that the 'new regions' had to work on relationships with national voluntary organisations.[772] There was a desire therefore to organise co-operative arrangements by the summer of 1975 'to put voluntary organisations in each region so that they could establish for themselves a service'.[773] This was to allow the regions to provide 'a communication network…to enable organisations to share ideas, plans, resources and general information; and to feed in relevant information from the LAs, Health Boards and other sources'.[774] They were also 'to help and stimulate the formation of ad hoc groups and working parties to peruse particular tasks that may be identified locally'.[775] Significantly this letter stressed that they should 'encourage and help voluntary organisations to establish appropriate links with the LAs, Health Boards and other Public Bodies'.[776] The stated objective therefore was 'to suggest to voluntary organisations in the region that it is desirable to work towards the co-operative involvement'.[777] Evidence of this consultation with appropriate voluntary agencies can be seen, for example when the ADSW reported passing on reports,

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[772] Letter from Ross Flockhart (Director), Scottish Council of Social Services to R Winter, ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th November 1974, ADSWA1/1.1/51.

[773] Letter from Ross Flockhart (Director), Scottish Council of Social Services to R Winter, ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th November 1974, ADSWA1/1.1/51.

[774] Letter from Ross Flockhart (Director), Scottish Council of Social Services to R Winter, ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th November 1974, ADSWA1/1.1/51.

[775] Letter from Ross Flockhart (Director), Scottish Council of Social Services to R Winter, ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th November 1974, ADSWA1/1.1/51.

[776] Letter from Ross Flockhart (Director), Scottish Council of Social Services to R Winter, ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th November 1974, ADSWA1/1.1/51.

[777] Letter from Ross Flockhart (Director), Scottish Council of Social Services to R Winter, ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 19th November 1974, ADSWA1/1.1/51.

information and consulting with the SSHM on issues such as the Warnock Report.[778] This consultation between the ADSW and other statutory bodies and the SSMH is clearly apparent in ADSW records. For example in 1981 a plan for the re-development of two hospitals for the mentally handicapped is mentioned and it is agreed that the standing committee for Mental Health and Mental Handicap would approach the SSMH for their position on this issue.[779] Similarly in a meeting of the statutory authorities on community care in 1983 the ADSW again reported a working relationship with the SSMH whose evidence on local provision they were to utilise in future plans.[780]

The ADSW also was to work with other voluntary organisations on other significant issues, for example, The National Campaign with People who have Learning Disabilities wrote to the ADSW in 1992 to ask for support for a VIA (Values in Action) base in Scotland. VIA was part of the Campaign for Mental Handicaps who were seen as being at 'the leading edge of policy and service development'.[781] The VIA was established to bring new ideas and disseminate these throughout the UK (for example normalisation and self advocacy).[782] The organisation also sought to bridge better relations between interest groups, parents

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[778] ADSW, Records of the Directors of Social Work, Executive Committee Minutes, 13th May 1980, ADSWA1/1.1.71a.

[779] Mental Health and Handicap Standing Committee, Records of the Association of Directors of Social Work, Executive Committee Minutes, 16th September 1981, ADSWA 1/1.1.79.

[780] Meeting 11 Jan 1983, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/1.90.

[781] Mental Health and Handicap Standing Committee, General Papers 1992, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.

[782] Mental Health and Handicap Standing Committee, General Papers 1992, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.

and direct users. They were therefore to 'collaborate and complement' the work of the SSMH.[783]

Linkage between the voluntary organisations and the state authorities is therefore clear, particularly in the provision of services in local communities. For example, the report *Caring for People* argued that 'voluntary organisations should contribute more to the 'mixed provision of care''.[784] Britten estimated that in 1984 the voluntary section provided formal day-time activity for at least 22% of the mentally handicapped adults in Scotland, some 1,634 people.[785] She noted LAs were empowered by the Social Work Act of 1968 and the Mental Health (Scotland) Act of 1984 to 'collaborate with voluntary organisations in meeting its duty to provide suitable training and occupation for persons suffering from mental handicap who are over school age'.[786] However Britten also points to the fact that over half the day centres run by voluntary agencies were originally set up to provide a service for people for whom no other state run facilities were available.[787] The impetus for much of the later statutory provision therefore came from voluntary organisations such as the SSMH.

Further to this Borsay commented that by end of the 1960s, in general, 'confidence in the state sector was stalling..[as] the state only had had only limited resources to invest in welfare; the costs were rising relentlessly; and users complained that services were insensitive to requirements'.[788] She notes that as a result there was a greater reliance on the voluntary sector from the 1970s due to

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[783] Mental Health and Handicap Standing Committee, General Papers 1992, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.

[784] Welshman, 'Rhetoric and Reality', p. 204.

[785] Jane Britten, *Putting People First,* p. 2.

[786] Jane Britten, *Putting People First,* p. 4.

[787] Jane Britten, *Putting People First,* p. 10.

[788] Anne Borsay, *Disability and Social Policy,* p. 4.

dissatisfaction with ‘selective public services’.[789] As the SSMH had already carved out a strong position as a force in disability policy and service provision, they were well placed to cement this central role in welfare when the mixed economy of care became legislative policy. Thus, whilst reliance on voluntary effort in the field of mental handicap in Glasgow was not necessarily ‘new’ in the 1970s and 1980s, it was recognised and encouraged by the state with the shifting economics of welfare. For example, the *NHS and Community Care Act 1990* promoted the mixed economy of care whereby LAs were to become ‘enabling authorities responsible for assessing people’s needs and arranging packages of care from a variety of providers’ (mainly private and voluntary agency suppliers).[790] Thus Britten has shown that the lack of state investment and a state led strategy in this area throughout this period in turn left the voluntary sector in a dominant position as they ‘responded in an ad hoc manner to meet service needs as they have perceived them’.[791] Their efforts to fundraise and provide a measure of care in the community before the arrival of big legislative ‘community care’ polices meant they were at the forefront of developments well before many of the statutory authorities.

Conclusion

Historians such as Rolph have demonstrated the importance of local societies in the eventual formation of large parent-led organisations such as the NAPBC in England. Both Walmsey and Rolph in the UK and Mitszel in her work in the US have shown

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[789] Borsay, Disability and Social Policy, p. 4.

[790] Julia Johnson, ‘The Emergence of Care as Policy’, in Ann Brechin, Jan Walmsley, Jeanne Katz and Sheila Peace, *Care Matters: Practice and Research in Health and Social Care* (London, 1988), p. 147.

[791] Jane Britten, *Putting People First,* p. 30.

how these new groups sought to challenge the ‘hidden’ and stigmatising nature of mental handicap. It is apparent then that these historians attempted to challenge the treatment of the mentally handicapped which, in the period after the Second World War, had often retained its links with eugenic policies of the past. For example the focus was often still on mental hygiene meaning that families were often seen as part of the ‘problem’ to be treated.

It is clear that the emergence of the welfare state and new education policies in the 1940s and 1950s brought little change for the mentally handicapped and their families. Whilst there was little provision across the board, there was often no care and support facilities for those classed as ‘ineducable’ who either had to be institutionalised or kept at home with very little help from the state. Organisations such as the NAPBC and the SAPHC in Scotland thus emerged, at least initially as support networks for these parents. These new organisations sought to create a ‘voice’ for parents and to address the stigma of mental handicap. Such parents in Glasgow were often to take full advantage of this new development, for example, by including works of poetry, letters and other pieces of writing in the newly created SAPHC newsletter.

Significantly, whilst parents were now able (to a limited extent) to share their experiences of having a handicapped child, they often failed to question medical dominance in this field. Issues such as the prevention of handicap therefore remained high on the agenda. However these new organisations were key in providing legitimacy and a strong voice to families who were now able to form important relationships with professionals and key figures in the field. The SSMHC, for example, allowed parents to take on a new positive role in the field of mental handicap and in turn distance themselves from concepts such ‘problem families’.

As a result attention was drawn to the lack of services and support available for families in local communities through publicity campaigns. The SSMH in particular utilised new ideas of integration and normalisation emerging in the international movement from the 1970s and called for more provision of 'normal' patterns of life through the right to education, training, work, leisure and residence in the community. These developments were often similar to those developing south of the border in local MENCAP societies. However the social status of figures such as Curran in Glasgow also gave the organisations access to areas such as new research in the field and provided an important element of legitimacy and prestige in their negotiations with the state. Similarly, the SDSA in Edinburgh, through their linkage with important medical figures such as Raeburn, were able to established a central role for themselves, for example in mainstream services such as early family support groups.

The SSMH was able to fully utilise their contacts to enable the organisation to become a service provider in areas in which the state was not being active. In particular, they focussed from the 1950s onwards on services such as day centres, training centres, respite and leisure. Indeed many of these new services such as short-stay accommodation were to form the basis and a model for state services that were to emerge later in the period. One important development here was the establishment of Key Housing in 1979 through which they provided group homes and community housing for mentally handicapped people in an effort to fully engage with the concepts of community care. The relationship between the state (health, social work and LA) and the SSMH was thus instrumental in its ability to form these services where they were able to gain an element of financial support or other resources from the state. Significant here is the impetus this gave to the acceptance of a mixed economy of welfare which was to be advocated by national and local government from the 1980s onwards.

Chapter 4

Education, Training and Social Competence: Special Education in Glasgow since 1945

> Like a cutting from a healthy tree, blighted in the early season, but later sprouting and bearing good fruit once it has been bedded out and treated with expert care.[792]

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[792] Sir Cyril Burt, *The Backward Child* (London, 1950), p. 8.

Introduction

In the period from 1945 to the early 1970s, special education in Glasgow expanded as part of general developments in education born out of a post war concern for the health of the nation. The Education Act of 1944 made it the duty of local authorities (LAs) to educate all primary and secondary school age children within their jurisdiction. Specifically this act made it the responsibility of the state to discover the pupils requiring special educational treatment and make provision as to the special methods appropriate for the education of pupils of each category.[793] In a similar move the Education (Scotland) Act of 1945 made it the duty of the education authority to ascertain which children might require 'special educational treatment'.[794] This 'special educational treatment' was to be provided for pupils with handicaps ranging 'from trifling to total'.[795] These handicaps were categorised by both the Ministry of Education pamphlet 'Special Educational Treatment' in 1946 and the Handicapped Pupils and School Health Regulations of 1954.[796]

The nine categories of handicap, including 'educational subnormality' were to be used to allow authorities to decide on the best methods of educational 'treatment' for a given child. They were extended in the 1970 Chronically Sick and Disabled Persons Act which added three further categories which were autistic, deaf-blind and dyslexic. Ascertainment of handicaps was to be carried out, where

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[793] J. S, Hurt, *Outside the Mainstream: A History of Special Education* (London, 1988), pp. 171-173.
[794] W. B Dockrell, W. R. Dunn and A Milne, *Special Education in Scotland* (Edinburgh, 1978), p. 2.
[795] 'Primary Education: Report of the Advisory Council of Education in Scotland', *House of Commons Commissioners Reports* (1946 – 47), Vol XI, p. 107.
[796] Ministry of Education, Statutory Rules and Orders No. 1076, *Handicapped Pupils and School Health Regulations,* (HMSO, London, 1945) and Ministry of Education, *Special Educational Treatment*, Pamphlet No. 5 (HMSO, London, 1946), CMND 6922.

possible, by a team usually including a child's teacher, medical officer, educational psychologist and, possibly, social worker.[797] However, ascertainment was also, until the Education (Mentally Handicapped) (Scotland) Act of 1974, to be used to discover those with 'severe' learning disabilities who were excluded from educational provision because of their perceived lack of 'educability'. The 1974 Act introduced the principle of education for all children including those previously diagnosed as 'ineducable'. Additionally the publication of the Warnock Report in 1978 heralded in a new era in special educational policy in the whole of the UK. Its publication and the passing of the subsequent education acts sought to promote integration and inclusion. Furthermore they stressed the need for structuring understanding of handicap around the idea of a continuum of needs and the movement away from designated categories of impairment.

However, the promotion of this new cultural understanding of disability was not always realised in practice. This chapter demonstrates how medical understandings of disability continued to dominate policy and how, particularly in the case of Glasgow, many pupils with learning difficulties continued to be segregated from the mainstream. Whilst people with mental handicaps continued to be sent to live in hospitals and institutions, those in the community were likewise viewed as 'patients' to be 'treated' in special schools and occupational centres. As a result, medicine continued to play a large role in the shaping of provision and the definitions of handicaps. This chapter therefore looks beyond the story of progress (from exclusion to integration) emerging from the official discourses in legislation and explores mental handicap and education from many different perspectives. As

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[797] R. K. McKnight, 'The Development of Child Guidance Services', in W. B. Dockrell, W. R. Dunn and A Milne, *Special Education in Scotland* (Edinburgh, 1978), p. 103.

well as highlighting the development of key concepts, debates and discourses it also notes some of ways these impacted on experiences in special schools. For example, it highlights the continuing centrality of IQ and intelligence testing alongside the emergence of these new social and cultural understandings of disability. Additionally the importance of social education and citizenship training is explored in such a way that allows the role of teachers, parents and policy makers to be considered.

Ultimately this chapter aims to bring together these many different developments in special education in this period and consider them at a local level. Whilst acknowledging the wider context of these changes it examines these from the perspectives of many different groups, governing bodies, institutions and individuals. The particular focus on Glasgow also helps give some insight into the ways in which national developments in legislation and policy could impact on LA policy and the knock on effects of this on experiences of pupils in the special educational system. This focus on Glasgow also brings out many issues such as the continued reliance on segregated provision well into the era of supposed integration. It also provides telling examples of how special education impacted on individuals such as parents of disabled children and the pupils themselves. By doing so it goes some way towards piecing together a story of change and sometimes progress but all too often one of continuity, isolation and segregation.

Medicalisation and Special Education

Medical involvement and control, key characteristics of pre-1945 policies dealing with impairment and ‘mental deficiency’, continued to be evident in special educational policies after the Second World War. Membership of governmental committees on this matter (for example the Advisory Committee on Handicapped Children in 1945) was led largely by medical professionals (in this case Senior School Medical Officer, Dr A. E. Newth, and Professor of Public Health at London School of Hygiene, Dr J. M. Mackintosh).[798] North of the border the Association of the Directors of Education in Scotland (ADES) also gave a central role to medicine in the development of special education. For example a key speaker at their Winter Conference in 1946, (Dr A G Mearns, University of Glasgow) identified those responsible for special education at this time as ‘the state, the medical profession and the educationalists’.[799]

One of the key objectives was the full utilisation of all figures/authorities responsible for special educational treatment in an effort to try and ‘treat’ or even ‘cure’ a diagnosed handicap. For example, Mr Butler (Education Minister) stated in 1944 that one of the advantages of this linkage of education and medicine was that schools could ‘take advantage of new developments in medical education or psychological diagnosis and practice as they came along’.[800] Similarly figures like Sir Henry Cohen (Professor of Medicine at Liverpool University) stated in *The Times* in 1944 that this dual emphasis was important so that ‘when a child was discharged from a special school’ he or she would be able to be both ‘educationally fit’ and ‘medically fit’.[801] Legislation therefore ensured that medical professionals maintained a dominant position in consultation and in shaping special educational

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[798] ‘Question Time: Education of Handicapped Children’, *Lancet*, (Feb 17th, 1945), p223 (No author stated).
[799] Jordanhill Archives, Records of Directors of Education in Scotland, Dr AG Mearns, Institute of Hygiene, University of Glasgow, Speech on ‘Health of the Nation’, ADES Winter Conference, 3rd November, 1946, GB2134ADES.
[800] Mr Butler, Quoted in ‘From the Press Gallery: Health Services in Schools’, *Lancet* (29th January 1944), p. 166.
[801] Sir Henry Cohen, Professor of Medicine, Liverpool University, Quoted in ‘New Influences in Medicine’, *The Times*, Wednesday 13th July, 1950, p. 27.

policies. Both the 1944 Education Act and the 1945 Education (Scotland) Act made certain that doctors and other medical professionals would continue to play a central role in the diagnosis, classification and treatment of individuals deemed to be 'impaired'.

Conrad has defined medicalisation as the 'process by which non-medical problems become defined and treated as medical problems'.[802] He demonstrates how this medicalisation happens as 'more and more of everyday life comes under the medical domain, influence and supervision'.[803] In 1944 a new category of handicap was included in the new education legislation, that of 'maladjustment'. This newly defined group therefore became one of these new 'medical problems'. This helped to cement the idea that certain types of individual characteristics and behaviours were deviant and those with these characteristics were viewed as ill or 'emotionally handicapped'. Children defined as 'maladjusted' were therefore said to require 'special educational treatment in order to affect their personal, social or educational re-adjustment'.[804]

The diagnosis of this category of handicap was, in part at least, based on subjective emotional and behavioural criteria which had been defined as deviant by medical experts. Conrad stresses that medicalisation of this kind functioned by 'defining behaviour as a medical problem… [therefore] mandating or licensing the medical profession to provide some type of treatment for it'.[805] This process extended the regulating power of medicine in society by removing individuals with particular learning difficulties, low IQs or nonconforming behaviours from the

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[802] Peter Conrad, 'Medicalisation and Social Control', *Annual Review of Sociology,* Vol. 18 (1992), pp. 209 – 232.
[803] Conrad, 'Medicalisation and Social Control', p. 210.
[804] *Special Educational Treatment*, p. 9.
[805] Conrad, 'Medicalisation and Social Control', p. 210.

mainstream educational system. This has led some disability theorists, such as Bury, to argue that medical knowledge of this kind is, at the root, socially dependant upon the ideological and material needs of a particular society.[806] Consequently this has led Carey and others to suggest that it was through these diagnoses that the, 'medical profession held considerable power in establishing the bases for judging and regulating the behaviour of the citizenry'.[807]

The work of these theorists therefore helps to provide some insight into the ways in which legislation and 'new medical knowledge' in the immediate post-war period helped to create a wide and negotiable set of symptoms and behaviours that could be portrayed by medical professionals as 'scientifically objective and benevolent'.[808] It is interesting to note therefore some of the ways in which the dominance of medical understandings filtered down into educational policy. Specifically it seems significant that special education was repeatedly discussed in medical terminology and using clinical language. For example one early report by the Advisory Council of Education in Scotland stated that special education was a process of 'diagnosis, proper grading and continuing treatment'.[809] Central figures in this field such as Cyril Burt presented special education in a similar way stressing that it was a process by which to discover 'backward children' in order to 'classify, treat and train them'.[810] Children diagnosed as 'handicapped' were still regarded as

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[806] Mike Bury, 'Defining and Researching Disability: Challenges and Responses', in Colin Barnes and Geof Mercer, *Exploring the Divide* (Leeds, 1996), p. 30.

[807] Allison Carey, 'Beyond the Medical Model: A Reconsideration of 'Feeblemindedness', Citizenship and Eugenic Restrictions', *Disability and Society,* Vol 18., No 4 (2003), p. 413.

[808] Carey, 'Beyond the Medical Model', p. 413.

[809] 'Primary Education: Report of the Advisory Council of Education in Scotland', *House of Commons Commissioners Reports* (1946 – 47), Vol XI, p. 107

[810] Burt, *The Backward Child*, p. vi.

‘patients’ whose ‘handicaps’ meant the education they were to receive was to be differ from those considered to be ‘healthy’ or ‘normal’.

The construction of handicap within this medical framework also helped to re-instate what were considered norms of human appearance, learning and behaviour and encouraged the promotion of socially valued characteristics in special educational policy. Those perceived to be ‘abnormal’ were therefore often treated as the ‘other’ in education, that is to say as a distinct group who’s ‘education’ was much more about ‘treatment’. It is clear therefore that the objective was the achievement of a ‘healthy’ status. It follows therefore that those perceived as ‘unhealthy’ were viewed in largely negative terms through clinical language which served to highlight their ‘impairment’ or ‘illness’. For example the 1944 Education Act presented those children requiring special education as ‘handicapped by…disability’.[811] The perceived causation of handicap therefore was the diagnosed impairment itself. Mercer suggests therefore that this medical/biological understanding of disability often resulted in the characteristics of ‘the ‘patient’ as a social being becoming secondary’.[812]

Indeed numerous papers by Thomas Ferguson, (Professor of Public Health, University of Glasgow, 1944 - 1964) suggest the use of this medical model in special education meant that every aspect of a child’s life and identity could become medicalised. He noted that the diagnosis of handicap could result in a focus on the ‘whole child’ in order that ‘his problem be assessed and treated’.[813] This helped to reaffirm a medicalised identity for such children who were now to be under the care

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[811] Education Act 1944

[812] Jane R. Mercer, ‘Sociological perspectives on mild mental retardation’, in Will Swann (ed) *The Practice of Special Education* (Oxford, 1981), p. 14.

[813] Glasgow University Archives, Thomas Ferguson Collection, ‘The Handicapped’, DC57/20, Date not specified.

of ‘several doctors, specialists, and educationalists’ who would work together to try and deliver appropriate educational treatment.[814]

This treatment could begin at a very early age, particularly after the Mental Health (Scotland) Act of 1960, which promoted the ‘ascertainment’, training, and care of ‘mental deficiency’ in pre-school children. [815] A Child Welfare Clinic which housed a special day nursery was set up in 1964 on Balvicar Street in Glasgow (with the help of funding from The Carnegie Trust). The stated aim of the centre therefore was to ‘provide facilities for the mental and physical assessment of children who are not developing properly’.[816] The Medical Officer of Health (MOH) Report for Glasgow, 1961, reported that a similar centre was also to be built in Broomhill which would house a special day nursery. [817] This was presented as an important step in the ‘adequate training of medical and nursing staff in the early detection of defects in children’.[818] To further this aim Child Welfare and School Medical Officers were also sent on short training courses on the diagnosis of ‘mental deficiency’ in particular for pre-school children.[819]

Diagnosis or categorisation of ‘mental handicap’ or later ‘learning disability’ at a very young age could often subsequently result in a segregated educational experience, particularly in Glasgow. It is interesting to note how services developed along these lines in the city, in part due to the initiatives of particular bodies who

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[814] Glasgow University Archives, Thomas Ferguson Collection, ‘The Handicapped’, DC57/20, Date not specified.

[815] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 15.

[816] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 16.

[817] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 16.

[818] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 16.

[819] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 179.

were concerned with the fate of particular impairment groups. For example The Carnegie Trust funded research (carried out by Dr Andrew P. Curran and Miss Elizabeth McSwan under the direction of Professor Thomas Ferguson) into the problems of handicapped children in the early 1960s in Glasgow in an effort to suggest ways of mitigating the burden of their care at home.[820] The trustees therefore allocated £30,000 to Glasgow to help provide a centre for ‘the co-ordination of the services of the handicapped and for a special day nursery for mentally handicapped children’.[821] The nursery was opened officially in 1964 in order to help ‘relieve mothers, especially those with other children to care for, and to train the children’ in an effort to ‘make them more socially acceptable’.[822]

Emphasis seemed to be on ascertainment of handicap at a young age to ensure placement in the proper stream of educational provision. The Carnegie study, for example, revealed wider deficiencies in services for handicapped children in Glasgow, in particular it emphasising the ‘delays which occur in obtaining the adequate assessment of children who are not developing satisfactorily and the provision of necessary facilities for their care’.[823] The report highlighted the issue that children with ‘mental defects’ were not being ‘dealt with’ until they were of school age. It was stated that ‘there were also cases of children who failed to reach entry to the special schools or occupational centres due to not being toilet trained or

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[820] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 17.

[821] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 17.

[822] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 207.

[823] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 179.

not being able to meet the requirements for entry'.[824] The centre therefore represents a further example of the attempt to diagnose handicaps at an earlier age and as a result encouraged earlier segregation of children into the special educational sphere.

In addition, throughout this period, the assumption remained that the cause of the educational problems for mentally handicapped children was their limited capacity to learn. For example the Association of Directors of Education for Scotland (ADES) Report in 1963 stated that:

> Particular attention [should be] drawn to the special educational problems created by the substantial number of less able boys and girls in the schools. The aim of the schools should be to provide these pupils, *within the limits of their capacity*, with as good a general education as possible.[825] (my italics)

Teachers therefore operated within this medical framework and which was re-instated through their usage of medicalised language. For example one teacher, Mrs Chokio, who worked in a school for 'non-communicating' children stated in 1963, 'I think that the school, or the classroom if you like, should be an important part of the whole treatment set-up'[826] Indeed Warnock was to argue as late at 1979 that 'to educate is to care and often to cure'.[827] Teacher training also played a large role in the spreading of these medicalised ideas in special education. For example one

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[824] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 179.

[825] Jordanhill Archives, Archive of the Association of the Directors of Education in Scotland (ADES), Papers 1961 – 1963, C.C (63)6.

[826] Mrs Margaret Choiko, 'The Teacher and the Child', paper given at Annual Conference of the Guild of Teachers of Backward Children, Leicester, 1963, papers collected in booklet by National Society for Mentally Handicapped Children (London, 1963).

[827] Quoted in SSMH, Newsletter, January 1979, p. 11.

teacher recalled that during her time at Jordanhill College in the 1960s in Glasgow the training 'was very rigid…the colleges of education don't teach you to go in and deal with specific things…they give you lists of what impairments the children may have'.[828] Her experience therefore demonstrates the medical focus of training of teachers which subsequently passed into schools and into the classroom. However, running concurrent to this was the ways in which medical models of disability helped to give authority to diagnoses of 'ineducability' of more 'severely handicapped' pupils who were subsequently excluded from education and often from any further state provision on the basis of these diagnoses. The use of medicalised understandings therefore helped structure the types of provision for many children which in turn could have a major affect on their life course.

The Scottish Society for Mentally Handicapped Children (SSMHC) pointed out in 1963 that there were still a long list of mentally handicapped people with no provision in place for their education.[829] They stated that:

> In some areas there is excellent provision for the handicapped and in others it falls below the standard we have a right to expect. There are still local authorities where the educational future of a child is settled by the medical officer without the assistance of an educational psychologist and experienced teachers.[830]

Similarly they pointed to the danger of the shortage of appropriate staffing in special education, in particular stressing that it was 'damaging in the field of mental

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[828] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007, carried out by Angela Turner.

[829] SSMHC, Newsletter, June 1963, p. 3.

[830] SSMHC, Newsletter, June 1963, p. 3.

subnormality [that] assessment of children as unfit for education –a much criticised classification anyway – was found to be the responsibility of the local medical officer of health'.[831]

An area which further promoted the medicalisation of special education was the subsequent development of child psychology and child guidance. The Education (Scotland) Act 1945 had empowered LEAs to establish Child Guidance Services in Scotland stating that it was:

> The function of a Child Guidance Service to study handicapped, backward and difficult children, to give advice to parents and teachers as to appropriate methods of education and training and in suitable cases to provide special educational treatment in Child Guidance Clinics.[832]

These services were therefore to categorise children according to degree and nature of handicaps and would undertake assessment, treatment, prevention, advisory services and research.[833] Other professionals as medical officers and psychiatrists were also to play a role in carrying out these tasks. Douglas Bain, Assistant Principal Psychologist in Glasgow Child Guidance Service, consequently stated in 1975 that a key objective of the clinic was to bring together 'remedial teachers, psychologists, speech therapists, psychiatrists, neurologists' in the diagnosis and treatment of children with learning difficulties.[834] He stated they were also there to support teachers in remedial work and to undertake research to 'make theoretical

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[831] SSMHC, Newsletter, September 1968, p. 2.

[832] McKnight, 'The Development of Child Guidance Services', p. 98.

[833] McKnight, 'The Development of Child Guidance Services', p. 104.

[834] Douglas Bain, Assistant Principal Psychologist, Glasgow Child Guidance Service, 'Remedial Centres in Glasgow', in Scottish Council for Educational Technology, Occasional Working Paper 1, *Resources in Special Education*, 1975, p. 48.

contributions to the understanding of the nature of these learning disabilities'.[835] The Education (Scotland) Act of 1969 had made it mandatory for Education Authorities to provide a Child Guidance Service.[836] It had also called for a team approach to ascertainment for children to be examined psychologically as well as medically before being placed in special education.[837]

As a result Stewart has noted how 'medicalization was embedded in the very language of the child guidance' where children, for example, were referred to as 'patients' undergoing 'treatment' in a clinical setting.[838] Diagnoses of handicap, which were key decisions about the subsequent special educational treatment to be provided, were therefore increasingly provided through methods pioneered by psychological medicine. For example psychological examinations were used to provide 'appropriate diagnostic and remedial measures'[839]. Additionally they were thought to be key in the discovery and understanding of 'abnormalities of behaviour' in 'retarded individuals' and were consequently utilised to provide 'methods of correction for these handicaps'.[840]

These and other tests help to identify 'deviant' behaviours and, as Bogdan and Taylor state, 'provided a cloak of scientific legitimacy to social control over behaviour'.[841] Furthermore these tests, which operated within a scientific model of

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[835] Bain, 'Remedial Centres in Glasgow', p. 48

[836] McKnight, 'The Development of Child Guidance Services', p. 100.

[837] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age in Special Schools and Units in Scotland: A Report by H M Inspectors* (HMSO, Edinburgh, 1981), p. 7.

[838] John Stewart, 'Child Guidance in Interwar Scotland: International Influences and Domestic Concerns', in *Bulletin of the History of Medicine* (2006), Vol. 80, p. 513.

[839] Fred J Schonell, *Backwardness in the Basic Subjects* (Edinburgh, 1945), p. vi

[840] Dr Norman Munn, *Psychology: The Fundamentals of Human Adjustment* (London, 1946), pp. 11-15.

[841] Robert Bogdan and Steven J Taylor, 'What's in a Name', in Ann Brechin and Jan Walmsley, *Making Connections* (London, 1986), p. 79.

mental testing,[842] helped to produce the ‘medicalisation of behaviours that had hitherto been found acceptable and within the ‘normal range’’.[843] Assumptions about the organic nature of disability and of its ‘abnormal’ nature, were therefore reinforced by the intervention and widespread use of medicine in this way. Behavioural norms were objectified (that is were presented as objective realities that could be tested) and reproduced through the use of these psychological tests.

McKnight identified one of the key figures in the development of child guidance as Cyril Burt who, he argues ‘exerted a powerful influence over the practice of educational psychology and the service he established [was] the forerunner of the present day Child Guidance Services in Scotland’.[844] Indeed Burt’s testing techniques, such his word reading test, were employed in many schools in Scotland throughout this period. These and further standardised tests were used in 28 schools in Glasgow in 1972.[845] The remaining 20 schools relied on similar methods of testing (carried out by the Child Guidance Services) and reports by Guidance Teachers as the key methods of identification of pupils with learning disabilities.[846]

In addition McKnight has also noted the central role of psychology in Scottish special schools given its place in teacher training institutions who made it an essential part of their curriculum.[847] As a result when child guidance clinics were

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[842] Sally Tomlinson, Professionals and ESN (M) Education, in Will Swann (ed), *The Practice of Special Education* (Oxford, 1981), p. 270.

[843] Lorna Selfe, ‘Concerns about the Identification and Diagnosis of Autistic Spectrum Disorders’, *Educational Psychology in Practice,* Vol. 18, No. 4 (2002), p. 6.

[844] McKnight, ‘The Development of Child Guidance Services’, p. 97.

[845] The Corporation of Glasgow, *Report of the Working Party on the Provision made for Slow Learning Children in the First Two Years of Secondary School*, June, 1972, p. 6.

[846] The Corporation of Glasgow, *Report of the Working Party on the Provision made for Slow Learning Children in the First Two Years of Secondary School*, June, 1972, p. 18

[847] McKnight, ‘The Development of Child Guidance Services’, p. 96.

established in Scotland they became part of the education service and not another branch of medicine.[848] The Child Guidance Services in Glasgow therefore played a key role in testing children for ‘handicaps’ such as ‘educational backwardness’ and ‘maladjustment’ and in recommending ‘treatment’ through education. They also played a major role in the provision of both this treatment and wider aspects of ‘remedial education’.[849] For example, psychologists from the clinics were involved in ‘establishing policies, selecting remedial teachers and providing in-service training, advising teachers on the needs of individual children and appropriate materials and methods, and in promoting and evaluating new developments’.[850] The growth of the child guidance sector therefore helped to further medicalise and give authority to diagnoses and treatment of mental handicaps. Furthermore the tests utilised by these clinics and professionals were significant in providing legitimacy and scientifically measurable categories which related to medical diagnoses and educational categorisation.

IQ as a ‘scientific’ measure handicap

One key measure of mental handicap throughout this period was IQ scores which were to be discovered through the application of intelligence tests. These tests therefore remained a significant part of special educational discourse and policy. They were utilised by teachers, educational psychologists and others to identify those whose intelligence was below average. This became increasingly important in the period after 1945 when there was more emphasis on selection and placement of

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[848] McKnight, ‘The Development of Child Guidance Services’, p. 96.
[849] McKnight, ‘The Development of Child Guidance Services’, p. 105.
[850] McKnight, ‘The Development of Child Guidance Services’, p. 105.

children in suitable educational establishments from grammar schools at the top end to special schools for those it was felt could not benefit from ‘usual instruction’. IQ and other intelligence tests were also particularly important as the results could often determine whether or not a child was ‘educable’ and therefore entitled to educational provision.

Binet had devised the original tests in France in 1905 in order to measure the intellectual capacity and retardation of children.[851] These tests were formulated to measure the ‘mental age’ of the children examined in relation to the results of tests given to the group on a rising scale of difficulty.[852] This concept of mental age was used therefore to represent the level of intelligence achieved in relation to expectation of children at each particular stage of their growth and education. IQ was adopted therefore ‘as a measure of relative brightness or dullness’.[853] The first child psychologist to be appointed in Scotland (Dr Kennedy Fraser in 1923) promoted the use of these tests. A Scottish Education Department report of 1981 described him as a ‘pioneer’ whose work had encouraged handicapped children to work to their own level of ability.[854] Specifically, they noted how his methods were ‘encouraged by the development of instruments such as diagnostic and attainment tests which measured individual performance more precisely’.[855] Whilst figures like Fraser revised the scope and content of early IQ tests, the fundamental principles remained largely

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[851] Alison Davis, ‘How does Cultural Bias in Intelligence Tests Arise’, in Kenneth Elles (eds), *Intelligence and Cultural Differences* (Chicago, 1951), p. 30.

[852] Dr Kennedy Fraser, ‘The Terman-Merrill Intelligence Scale in Scotland’, *Publications of the Scottish Council for Research in Scotland XXIII* (London, 1945), p. 1.

[853] Fraser, ‘The Terman-Merrill Intelligence Scale’, p. 1.

[854] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils* p. 5.

[855] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils*, p. 5.

unchanged. Concepts such as ‘mental age’ for example were widely accepted and used extensively in post-war educational policy.

The Stanford-Binet revisions of the original tests in particular became a central part of the educational discourse, particularly for those considered to have below average mental capacity. Terman and Merrill published *Measuring Intelligence* in 1937 as a guide to administering these Stanford-Binet IQ tests in schools.[856] By 1945 Fraser noted that this scale of intelligence adapted by Terman and Merrill was now used extensively throughout Scottish and English education.[857] There seemed therefore to be widespread acceptance of the need for mental testing and the scientific methods used carry out these tests. The psychologist Munn, for example, used these categories in 1946 when he graded children with an IQ of 90 – 110 as ‘normal’ and children with IQs of 50 – 70 as ‘morons’.[858] The Ministry of Education, in a pamphlet in 1946 took this a stage further designating stages of education for those in particular IQ brackets. It stated that children with IQ results of 65 – 75 were to be educated in special schools and children with IQ’s of 55 – 65, considered to be of ‘severely limited intelligence’, were to be educated (where possible) in boarding special schools.[859] Furthermore it stated that, on the whole, ‘children cannot be educated at school if their intelligence quotient is below about 55’.[860]

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[856] Lewis Terman, *Measuring Intelligence: A guide to the administration of the new revised Stanford-Binet tests of Intelligence, by Lewie M. Terman and Maud A. Merrill* (Boston, 1937).

[857] Dr Kennedy Fraser, ‘The Terman-Merrill Intelligence Scale in Scotland’, *Publications of the Scottish Council for Research in Scotland XXIII* (London, 1945), p. i.

[858] Dr Norman Munn, *Psychology: The Fundamentals of Human Adjustment* (London, 1946) p. 416.

[859] *Special Educational Treatment*, p. 25.

[860] *Special Educational Treatment*, p. 19.

Many commentators and policy makers argued that the difference in ability to learn therefore came from the inherited or innate nature of dullness in children with low IQ levels. For example Munn argued that ‘a congenital idiot, whose idiocy results from defective inheritance…will make relatively little of the opportunities for development offered by a human environment’.[861] Indeed he even went as far to say that in the case of an ‘innately dull’ child, ‘his mental growth may be no more influenced by the educational opportunities than would be that of a chimpanzee’.[862]

From the beginning then these tests were often utilised to discover which children had insufficient intelligence to benefit from usual instruction.[863] However there was a distinction made in the much of the literature between those considered to be ‘innately dull’ and those who were merely ‘backward’. Fergusson for example stated that ‘dull children are born with inferior mental equipment’ backward children on the other hand were ‘hindered in their normal development by external agencies’.[864] Children deemed to have an ‘inborn intellectual deficiency’[865] were therefore seen as incapable of receiving much benefit, at least intellectually, from education. This led the Ministry of Education to state in 1946 that ‘retardation due to limited ability…is not likely to be…overcome by even the best forms of special educational treatment’.[866] In addition they stressed that if children were so ‘retarded’ as to be unable to do work designed for children half their age it called into question ‘whether [they are] educable at school at all.[867]

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[861] Munn, *Psychology*, p. 424.
[862] Munn, *Psychology*, p. 423.
[863] Munn, *Psychology*, p. 411.
[864] Glasgow University Archive, Thomas Ferguson Collection, ‘Handicapped Children’, 1945, DC 57/104.
[865] Fred J Schonell, *Backwardness in the Basic Subjects,* (Edinburgh and London, 1945), p. i.
[866] *Special Educational Treatment,* p. 18.
[867] *Special Educational Treatment*, p. 19.

There was also a desire to remove those considered to be mentally handicapped and those who were thought to be ‘backward’ from mainstream classrooms to enable teachers to concentrate on ‘normal’ pupils. It was noted in the *Lancet* in 1945 for example that many guide books had been produced to ‘prevent any failure in [this] early recognition of marked deviations from normal ability’.[868] Similarly the ADES stressed in 1946 that there was a real need for ‘every teacher [to] be thoroughly trained in the technique of mental testing’.[869] This focus on intelligence levels also developed on a wider scale with the commissioning of large surveys on this area such as the Scottish Mental Survey carried out in 1947.[870]

Much of this reflected a general concern over the perceived decline in intelligence nationally in the post-war period. One article from the *Glasgow Herald*, clearly demonstrated this concern, for example in showing that Department of Health for Scotland were focussed on the need for ‘far greater attention’ on mental hygiene’.[871] It was noted that average intelligence is ‘now tending to fall about one point in each generation’ perhaps in part due to the ‘differential birth rate’ which was ‘highest in the lowest social classes’.[872] It was stated therefore that in effect this had meant ‘we are breeding from the least intelligent and least socially efficient stock

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[868] ‘Review of Books: Intelligence Tests for Young Children’, *Lancet*, 21st July, 1945.

[869] Jordanhill Archives, Records of the Association of Directors of Education in Scotland, Mr Collins (Executive Committee Spokesperson), ‘The Training and Supply of Teachers’, ADES Conference Reports, 2nd November, 1946, GB2143ADES.

[870] Discussion of this survey can be seen in Dr D. M. McIntish (SCRE), ‘Discussion of Mental Survey’, Association of Directors of Education Conference Reports, 1st November 1946 and Professor Thomson (SCRE), ‘Scottish Mental Survey’, Association of Directors of Scottish Education, Conference Reports, 13th May, 1949.

[871] ‘Average Intelligence Lower Each Generation’, *Glasgow Herald*, 4th January, 1952, p. 3.

[872] ‘Average Intelligence Lower Each Generation’, *Glasgow Herald*, 4th January, 1952, p. 3.

and failing to breed from the best'.[873] Eugenic concerns therefore were clearly still evident in this period and may explain a continuing adherence to educational selection and subsequent segregation.

McLelland's inquiry, carried out for the Scottish Council for Research into Education (SCRE) published in 1949, was undertaken to analyse and assess the success of these selection techniques in terms of the number of children placed in each classification of intelligence from A-D in Scottish Secondary Schools.[874] It demonstrated some of the same concerns of the above article in stressing the need for more testing as a way to find the 'non achievers' in secondary school earlier and remove them from the mainstream system. Indeed McLelland argued that those classed as D grade pupils were not fit for promotion into any mainstream secondary schools and stated 'if these pupils could have been detected at the first presentation they could have been sent to backward classes at once thus relieving…teachers of some *dead weight*' (my emphasis).[875]

Research on the causes of learning handicaps in this early period also tended to focus on those with emotional or behavioural handicaps rather than those with very low IQs who were considered as having an inherent intellectual impairment. For example, Birch's study on the treatment of reading disability in a number of backward boys in Burton upon Trent in the 1940s stated that 'those with below average intelligence were to be excluded'[876] and a study carried out by the Scottish Council for Research in Education (SCRE) into intelligence excluded many children

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[873] 'Average Intelligence Lower Each Generation', *Glasgow Herald*, 4th January, 1952, p. 3.

[874] William McLelland, 'Selection for Secondary Education', *Publications for the Scottish Council for Research in Education XIX* (London, 1949).

[875] McLelland, *Educational Reconstruction*, p. 209.

[876] L.B. Birch, 'The Remedial Treatment of Reading Disability', *Educational Review*, Vol. 1 (October, 1948), pp. 107 – 118.

in special schools.[877] This SCRE study looked at the links between, among other things, family size and intelligence. However when it came to special schools 'testing was only undertaken when the pupils handicap could not invalidate the test'.[878] Similarly Fred Schonell (Professor of Education, University of Wales) stated in 1945 that 65% of children in special classes were 'debarred from achieving scholastic standards commensurate with their chronological age because of inborn intellectual deficiency'.[879] The other 20 – 25%, he argued had educational difficulties because of 'combination of extrinsic conditions'.[880] He therefore undertook a survey of 15,000 pupils in London schools to investigate causes of 'backwardness'.[881] His stated aim however was to 'select cases of specific backwardness in as pure a form as possible… unobscured by additional intellectual and emotional handicaps of 'innate dullness'.[882] He looked at the social, cultural and educational factors affecting the achievements of those who were 'purely' backward whereas those categorised as 'innately dull' were again excluded from consideration in this way. Their achievements in education, or lack thereof were seen as solely attributed to the existence of an intellectual defect.

Another interesting example of the use of IQ tests alongside other methods of analysis can be seen in a report produced by the Corporation of Glasgow Headmasters and Headmistresses Association in 1947. In this report they noted how

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[877] 'The Trend of Scottish Intelligence: A Comparison of the 1947 and 1932 surveys of 11year old pupils', *Scottish Council for Research in Education Papers* (London, 1949).

[878] 'The Trend of Scottish Intelligence: A Comparison of the 1947 and 1932 surveys of 11year old pupils', *Scottish Council for Research in Education Papers* (London, 1949), p. 4.

[879] Fred J Schonell, *Backwardness in the Basic Subjects,* (Edinburgh and London, 1945), p. i.

[880] Schonell, *Backwardness in the Basic Subjects,* p. vi.

[881] Schonell, *Backwardness in the Basic Subjects,* p. vii.

[882] Schonell, *Backwardness in the Basic Subjects,* p. vii.

the development of education had affected those described as ‘backward pupils’.[883] They carried out a study, in conjunction with the director of education and the developing child guidance sector (principally head of clinics, Miss McCallum), on ‘C pupils’, those whose intelligence lay somewhere between ‘normal’ and ‘mentally defective’.[884] The report calculated that in 1947 there were 4000 such pupils in 29 advanced centres, 2700 in 17 junior secondary schools and 1300 in 4 senior secondary schools in Glasgow.[885] This group of children were considered in an effort to discover some of the reasons (psychological, emotional or situational) for their ‘backwardness’. IQ therefore was considered here alongside other factors as within this group 45% of individuals had IQs which lay outside the designated range for backwardness of 70 -90.[886] It was stressed therefore that in the case of these pupils, wider cultural factors could have affected academic performance. For example it was stated, ‘the ‘C’ pupil has usually an impoverished social background…[and] too often…comes from a dull, overcrowded home’. Additionally it was noted how there were ‘very few ‘C’ pupils in the good residential suburbs’.[887]

Social factors such as a home environment and general health were considered important by others seeking to find the ‘causes’ of ‘backwardness’. Subsequently there was also an emphasis on the relevance of physical impairments, illness and poor attendance. With children of ‘normal intelligence’ therefore causal influences were taken into account when deciding upon special educational

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[883] Corporation of the City of Glasgow, Education Department, Headmasters Association and Headmistresses Association, *Backward Pupils in Secondary Schools*, 1947.

[884] Corporation of the City of Glasgow, *Backward Pupils in Secondary Schools*, p. 2.

[885] Corporation of the City of Glasgow, *Backward Pupils in Secondary Schools*, p. 9.

[886] Corporation of the City of Glasgow, *Backward Pupils in Secondary Schools,* 1947, p. 5

[887] Corporation of the City of Glasgow, *Backward Pupils in Secondary Schools*, p7.

treatment.[888] Whilst those diagnosed as 'innately dull' were thought to be 'socially incompetent' those classed as 'maladjusted' were thought to be simply 'socially unfit'.[889] The treatment of the maladjusted was therefore an effort to try and regain 'social fitness', which would be aided by the fact that it was deduced that 'maladjustment was no indicator of intelligence level'.[890] It is clear therefore that there was an important distinction made between those labelled 'innately dull' and those considered 'merely backward'. The latter were considered in terms of their background, their family situation and a whole host of other social and cultural factors. The 'mentally handicapped' on the other hand were frequently considered in medical terms and consequently social factors were not considered. For example Burt argued that those with a low IQ had impairments that were 'inborn' and therefore 'irremediable' whereas those with an average or above average IQ had to be understood in terms of the 'many contributory causes'.[891]

IQ therefore remained an extremely important measure of the educability of a particular child and was consistently understood and used therefore as an objective, scientifically measurable, scale of intelligence which could aid the process of segregation of those with learning disabilities into specialised educational establishments. Recently, however, many have drawn attention to the environmental influences that can affect IQ. Botherwick, for example, argued in 1996 that 'objective' IQ tests failed to take account of the influence of class and race and other social and cultural factors.[892] He argued that IQ scores for those with an 'intellectual disability' have been affected by the fact that this group has 'historically been

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[888] Archives of the ADES, ADES Conference Reports, 13th May 1949, ADES/C5.

[889] 'The Naughty Defective', *Lancet* (June 24th, 1944), p. 829 (No author stated).

[890] 'Maladjusted Children', *Times* (October 20th, 1950), p/ 5.

[891] Burt, *The Backward Child*, p. vii.

[892] Chris Borthwick, 'Racism and IQ and Down's Syndrome', *Disability and Society*, Vol. 11 (1996), pp. 403 – 410.

socialised into acceptance of subordination'.[893] He therefore stated that expectations and educational opportunities available to respondents have affected their ability to score well in IQ tests. Similarly Carrier argues that the belief in IQ as an 'objective reality' has hidden the 'social influences' which affect it.[894] Additionally Bowman points to many contemporary studies which prove a link between social class/status and ability to achieve high scores in IQ tests.[895]

There were also psychologists and educationalists in this period who emphasised the importance of environmental and cultural influences when measuring IQ. Fleming, for example, in 1953, argued that IQ could be raised by up to 20 points in some children by raising the quality of their home and schooling environment.[896] Similarly Gunzburg argued that social and cultural factors could affect IQ scores in his discussion of institutionalisation and how it could deprive children of the 'moulding and teaching processes of home and school'.[897] He argued therefore that questions in IQ tests surrounding family and home life could be difficult to answer for those who had spent their lives in an institutionalised environment.[898]

An article in the *Glasgow Herald* on the Glasgow Education Committee of 1951 highlighted some criticisms of IQ in general by leading figures on this panel. One parent described intelligence tests as 'unfair, useless and a terror to parents and

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[893] Borthwick, 'Racism and IQ and Down's Syndrome', p. 404.

[894] James G. Carrier, 'Masking the Social in Educational Knowledge: The Case of Learning Disability Theory', *The American Journal of Sociology*, Vol. 88, No. 5 (March 1983), p. 949.

[895] Discussion on the link between IQ and class in Irene Bowman, 'Maladjustment: A History of the Category, in Swann (ed) *The Practice of Special Education*, pp 102 – 117 and Kenneth Ellis (ed) *Intelligence and Cultural Differences* (Chicago, 1951).

[896] C. M. Fleming, *The Social Psychology of Education* (London, 1953), p. 43.

[897] Herbert Gunzburg, 'Experiments in the Improvement of Reading in a Group of Educationally Subnormal Boys', *Journal of Mental Science*, Vol. XCIV (Oct, 1948).

[898] Herbert Gunzburg, 'Experiments in the Improvement of Reading in a Group of Educationally Subnormal Boys', *Journal of Mental Science*, Vol. XCIV (Oct, 1948), p. 819.

children'.[899] One speaker, Councillor Galpern, also argued that it was 'a minor tragedy that at the age of 11-plus, the type of education that a particular pupil should pursue should be decided in this way, finally sealing the type of life to be led by the pupil for the rest of his life'.[900] The Councillor also stressed how the system was not fair to all as parents could buy books on tests 'a study of which before a test could raise IQ by 20 marks'.[901] The Councillor and others like him therefore suggested that IQ and ability to score well in these kinds of tests was something that could ultimately be taught and this meant IQ could not be used as a neutral measure of intelligence. However, whilst there were these voices of dissent on the continued reliance of IQ and other intelligence tests, these measures were to remain a central part of educational policy throughout this period. Indeed McLennan stressed that the teaching profession had accepted IQ as an independent neutral test and that it was to be used extensively and successfully throughout Scottish education.[902]

The Corporation of Glasgow Reports demonstrate this continued use of IQ tests in the education system, even when there were stated concerns about its suitability as an objective measure of intelligence. One report from 1972 highlighted the fact that the authorities were aware of the limited nature of these types of measures and had 'tried to keep in mind the wide variety of factors which cause children to learn slowly'.[903] However they still used IQ scores to define groups of children and carried out studies, for example on 'slow learners' who had IQs of

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[899] Intelligence Tests in Schools Criticised', *Glasgow Herald*, 13th October 1951.
[900] Intelligence Tests in Schools Criticised', *Glasgow Herald*, 13th October 1951.
[901] Intelligence Tests in Schools Criticised', *Glasgow Herald*, 13th October 1951.
[902] Intelligence Tests in Schools Criticised', *Glasgow Herald*, 13th October 1951.
[903] The Corporation of Glasgow, *Report of the Working Party on the Provision made for Slow Learning Children in the First Two Years of Secondary School*, June, 1972, p. 3.

between 70 and 90.[904] IQ was used in a similar way in a later report produced by the Scottish Education Department on the back of the Warnock Report in 1981 in which it was stated that 80% of all pupils needing special education had IQs between 50 and 70.[905] This was despite the fact they were aware that IQ was ‘too imprecise in its implications to serve as a substitute for critical assessment of all the factors influencing individual cases’.[906]

A closer look at developments at a local level in this period seem to suggest that there were some significant developments in understandings of disability, at least in the official discourses. A working paper from the Scottish Council for Educational Technology in 1975, for example, pointed to this change in attitude. It noted how the emphasis in special education had extended from a focus on ‘pupils who suffer from disability of mind or body’ in the Education (Scotland) Act of 1962 to the its description in the 1969 Education (Scotland) Act as:

> Education by special methods appropriate of pupils whose physical, intellectual, emotional and social development cannot (in the opinion of the education authorities) be adequately met by ordinary methods of education.[907]

Furthermore it pointed to the new developments brought about by, for example the Melville Committee stating:

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[904] The Corporation of Glasgow, *Report of the Working Party on the Provision made for Slow Learning Children*, p. 3.

[905] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils*, p. 4

[906] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils*, p. 6

[907] Scottish Council for Educational Technology, Occasional Working Paper 1, *Resources in Special Education*, 1975, p. 4

> It is no longer appropriate to describe any person as ineducable. In these terms the most profoundly handicapped has as much right to education as the most able.[908]

However, even given this use of new terminology in government reports there was still a great deal of continuity between the old and new descriptions of disablement. The term ‘profoundly mentally handicapped’ (PMH) was now used to describe children who had, until the Education (Mentally Handicapped Children) (Scotland) Act of 1974, been regarded as ‘ineducable and untrainable’ and whose IQ usually measured below 35.[909] The term ‘severely mentally handicapped’ (SHM) on the other hand was used to describe those who had been regarded as ‘ineducable but trainable’ and whose IQ tended to fall between 30 and 50.[910] It is clear therefore that although new terminology was developing alongside a changing ethos in special educational policy, in essence the categorisation of children with mental handicaps took place along similar lines as in the past. Put plainly, there were those who were considered able and likely to learn and those who were not. Those in the second classification continued to receive second rate, limited ‘training’, some of which will be discussed later in this chapter. One report noted how this had resulted in a number of children in Scotland, classed as PMH, being unable to attend school. Its conservative estimate of 180 such children, ‘does not include the fairly large number

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[908] Scottish Council for Educational Technology, *Resources in Special Education*, p. 4

[909] H. M. Inspectors of Schools (in collaboration with colleagues from Scottish Home and Health Department and Social Work Services Group), *Survey of Profoundly Mentally Handicapped Children, One Year On*, June 1977, p. i

[910] H. M. I, *Survey of Profoundly Mentally Handicapped Children, One Year On*, p. i

of children in mental deficiency hospitals not yet receiving education, for a variety of reasons including accommodation and staffing'.[911]

However, the changes in language and, in some cases, a developing awareness of disabling social factors did have some effects on, for example, teaching training and educational policy for disabled people. A collection of reports from Jordanhill College of Education in 1983 explained how, in the 1970s, more emphasis began to be put on the importance of social and cultural factors in the creation of handicaps arguing:

> There was a growing awareness that inadequate pupil performances were much more varied and extensive than had been first thought and, furthermore, that the learning difficulties arose from inappropriate methodology and allied curricular factors rather than from deficits within the child.[912]

A later report from this source also described the change in ethos in special education noting how the conclusion must be drawn that 'the 'cure' lies in the development of an appropriate curriculum'.[913] One Glasgow paper on special education in 1984 noted the importance psychologists and schools now placed on 'the various settings of school, family, groups of friends and so on that create the environment in which a

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[911] H. M. I., *Survey of Profoundly Mentally Handicapped Children, One Year On*, p. 5

[912] Jordanhill Archives, Jordanhill College of Education Diploma in SEN: Submission to the Council for National Academic Awards (1983), p. 15 JCE/12/18/13.

[913] Jordanhill Archives, Jordanhill College of Education, Diploma in SEN: Inservice Diploma Course: Submission to the Council for Academic Awards (1987), JCE/12/18/4.

person has to live'.[914] A Scottish Education Department report thus sought to move away from medicalised interpretations of disability noting in 1980 that 'many learning difficulties stemmed from inappropriate curriculum and methodology'.[915] Increasingly legislation and policy in education sought to take account of the wider social and cultural influences affecting a child's development. The Warnock recommendations for example stressed that any external factors included in the records of needs by a teacher, parent or other individual should be taken on board when deciding the course of action in the education of a particular child. As Mackay noted in 1984:

> This change of focus gives …a much broader scope for helping to improve people's lives because it does not start from the assumption that it is the individual himself who must change before improvement may take place.[916]

Another paper, given by HMI Davidson in 1982 similarly brought attention to this re-defining of disability and the inclusion of external factors in analysis. He argued that one of the central aspects of 'this re-definition was the statement that there was a range of causes of learning difficulties that went far beyond our traditional patterns of thinking'.[917] Rather than looking to the child for 'some handicap or deficit', a factor that was thought to be 'external to the school', he suggested the change in

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[914] Gilbert F. Mackay, 'The Named Person in Context', in *The Named Person*, A set of papers based on a series of meetings held in November and December 1984, at Jordanhill College of Education, p. 4.

[915] Scottish Education Department, *Special Educational Needs in Scotland* (HMSO; Edinburgh, 1980), p. 4.

[916] Mackay, 'The Named Person in Context', p. 4.

[917] HMI Mr A.H.B. Davidson, 'The Pressure for Change', in *Learning Difficulties and Special Educational Needs,* Jordanhill College of Education Publications, Number 10, p. 2.

attitude in education lay in the acceptance that, in many cases the structure of the school could be at fault. He stated:

> For many pupils the main causes of their learning difficulties were INTERNAL to the school. They lay in the nature of the curriculum on offer in the school and in the limited range of methods used to present it.[918]

In 1988 a review of the previous 10 years noted how in the years between 1975 and 1980 almost every Education Authority reviewed their provision of remedial education and reassessed the traditional roles of the service.[919] The review argued this represented an 'awareness of the need for change'.[920] Much of this work concentrated on the need to examine and broaden the curriculum and to look beyond individuals to the organisation of schools in general. This report states that therefore the 'quality of instruction as a major feature in education came much more to the fore'.[921] Schools and education authorities therefore were to adopt a wider strategy in training and social educating young people in special education, even given their low scores on IQ tests.

Citizenship and Vocational Training

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[918] Davidson, 'The Pressure for Change', p. 2.

[919] Marion Blythman, 'The Education of Pupils with Learning Difficulties in Mainstream Schools in Scotland', *Ten Years On,* A Review of developments since the publication of the HMI Report, 'The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland', The Joint Committee of Colleges of Education in Scotland, October 1988, p. 2.

[920] Blythman, 'The Education of Pupils with Learning Difficulties in Mainstream Schools', p. 2.

[921] Blythman, 'The Education of Pupils with Learning Difficulties in Mainstream Schools', p. 3.

Important then in the consideration of special education in this period is the ways in which its objectives were affected by wider developments in education and concerns over the health of the nation. For example the ADES stated in 1944:

> The future is entirely dependant on what we make of our people…[it is] primarily the job of the educational service of the future to produce a people, a working population to fit into this state of affairs.[922]

Sister Marie Hilda, founder of the Notre Dame Child Guidance Clinic in Glasgow, also stressed similar concerns stating the aims were:

> To socialise the neurotic and the aggressive, encourage the dull and retarded…reduce the number of prison inmates in later life…build up integrated personalities capable of taking their place as members of the family, of the church, and of the state.[923]

Both these organisations therefore viewed their work as part of a wider movement to educate, treat and train individuals so they could successfully integrate into the community. The ADES in particular saw its role as ensuring the country's 'continuance in the competitive world as a highly industrialised nation'.[924] The production of a skilled workforce therefore lay at the centre of educational objectives. In addition it was stated that children with impairments should also be

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[922] JA, Archives of the ADES, ADES Conference Reports, 26th May, 1944

[923] Quoted during paper by John Stewart, 'Mental Health and Hygiene in Inter-War Scotland', given at From the Cradle to the Grave seminar, Glasgow Caledonian University, 3rd October, 2006.

[924] JA, Archives of the ADES, ADES Conference Reports, 26th May, 1944.

part of this process as they were also ‘in need of training in order to render them competent to undertake employment’.[925] The Education Minister in 1944 stated that the aim of the Education Act was to create ‘an educational system…to make better citizens’ and to ‘oil the wheels of industry’.[926] The Disabled Persons (Employment) Act of 1944 also sought to further this aim by ‘making further and better provision for enabling persons handicapped by disablement to secure employment’. [927] The focus on getting disabled people trained and capable of work therefore served a dual purpose in providing the persons in question with ‘useful employment’ but more importantly in giving them the opportunity for ‘full citizenship’.[928] For example a pamphlet produced by the Scottish Education Department in 1945 stated that secondary education should be a means by which to ‘provide opportunities of practising citizenship’.[929] Similarly the ADES stated that all children should leave school ‘thoroughly imbued with a sense a citizenship and service to the community’.[930]

An article in the *Glasgow Herald* in 1950 reported that ‘the importance of vocational training’ was highlighted by a conference with the ADE and Scottish Council for Health Education held in December of that year. It recorded a statement from the Dr John Jardine, SED, who stated ‘the aim of special education was not only to help the child learn something of the ordinary education system but to equip

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[925] JA, Archives of the ADES, ADES Conference Reports, 26th May, 1944.

[926] Hansard: *Orders of the Day, Education Bill* (355), XXVII, 1944, col. 208 – 216.

[927] Mary F. Robertson, ‘Social Policy in Relation to Industry’, in David Charles Marsh, *Introducing Social Policy* (London, 1979), p. 40

[928] R Watson-Jones, ‘Disablement and Employment’, *Lancet* (March 31st, 1945), p. 451.

[929] Quoted in G. S. Osborne, *Scottish and English Schools: A Comparative Survey of the past 50yrs* (London, 1960).

[930] JA, Archives of the ADES, ADES Conference Reports, 2nd November, 1946.

them for after life'.[931] He argued that special education should try to 'make these children feel that when school days were over, they would be able to get a job'.[932] Similarly Director of Education, Dr H Stewart Macintosh, stated that 'handicapped children' should receive education they could best profit from 'after all securing a useful job was of supreme importance to the handicapped'.[933] In addition the SSMHC noted 1963 that 'the problem of educationally subnormal children had increased as society and working conditions became more complex and demanding'.[934] In this report they noted how 'with patient teaching and constant repetition many jobs of commercial value can eventually be undertaken by subnormal young people'.[935]

There was a subsequent emphasis on fostering independence for the children from their parents and building on the ability to work. In particular, day centres and special schools were to focus on the need to train 'dull' children to allow them to 'play a useful part in the community'.[936] Indeed the Ministry of Education stated that, 'the uneducated mentally retarded child grows up into an unemployable or unstable casual worker, the educated one into a more dependable and useful citizen.[937] It was stressed therefore that these children could 'make useful citizens if properly trained'.[938] Borsay has argued that Conservative governments from the 1970s onwards in particular continually emphasised the 'obligations of

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[931] 'Handicapped Children', *Glasgow Herald,* 4th December, 1950, p. 3.
[932] 'Handicapped Children', *Glasgow Herald,* 4th December, 1950, p. 3.
[933] 'Handicapped Children', *Glasgow Herald,* 4th December, 1950, p. 3.
[934] SSMHC, Newsletter, September 1962, p. 4.
[935] SSMHC, Newsletter, September 1962, p. 4.
[936] Ministry of Education, *Special Educational Treatment*, p. 18.
[937] Ministry of Education, *Special Educational Treatment*, p. 36.
[938] Dr Norman Munn, *Psychology: The Fundamentals of Human Adjustment* (London, 1946), p. 424.

citizenship'.[939] She stresses that through this they emphasised 'the duty to work, and hence avoid the curse of state dependency'.[940] This focus on the development of social competency and 'personal responsibility' can be seen therefore in education and social policy on learning disability which encouraged the development of citizens willing and able to contribute to the nation's economy.

Symptomatic of this was an emphasis on 'practical things' in the education of pupils with learning disabilities instead of 'symbolic activities that were beyond them'.[941] It was argued that this would give these children the best chance by making them 'self-supporting'.[942] Figures such as Ferguson (who served on the Advisory Council for the Employment of the Disabled for the Ministry of Labour in 1945) argued that educational authorities needed to realise the 'educational need and future potential' of these children.[943] However, the types of jobs these children were trained for were often at the low paid menial end of the labour market with 'routine work in factories or workshops' recommended'.[944] Indeed the ADES suggested that it was:

> In that part of industry where repetitive processes predominated that there was excellent opportunity for the employment of the less mentally equipped

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[939] Anne Borsay, *Disability and Social Policy in Britain since 1750* (Basingstoke, 2005), p. 4.

[940] Borsay, *Disability and Social* p. 4.

[941] Dr Norman Munn, *Psychology: The Fundamentals of Human Adjustment* (London, 1946), p. 423.

[942] GUA, Thomas Ferguson Collection, 'Handicapped Children', 1945 DC57/104.

[943] GUA, Thomas Ferguson Collection, 'Handicapped Children', 1950, DC57/20.

[944] Marjorie Day, 'Letter to Editor', p. 5.

> person who would be perfectly happy under conditions which would be quite soul destroying for the more gifted boy or girl.[945]

The labour prospects and life choices given to these children were therefore built around preconceived ideas of their capabilities. This process was also aided by the increase of selection at an early age in education. As Borsay has noted, one of the results of the 1944 Act was that it:

> Preserved a hierarchical structure of secondary schooling in which the IQ test that demarcated intellectually impaired children was used to select 'able' children for privileged grammar schools and condemn 'less able' children to low status, under-funded secondary modern schools'.[946]

Similarly in Glasgow the qualifying exam was used to place pupils into either junior secondary or senior secondary schools until the advent of comprehensive education in late 1960s.

This has led figures such as Timmons to argue that the education system was being transformed into a more efficient form of selection for industry.[947] Similarly scholars such as Popkowitz have argued that the education system and curriculum channelled 'different children to different and unequal occupational and citizenship roles'.[948] Education was therefore using labour ideals and having them 'translated

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[945] JA, Archives of the ADES, ADES Conference Reports, 3rd November 1946, ADESC5.

[946] Borsay, Disability and Social Policy, p. 111.

[947] George Timmons, *Education, Industrialisation and Selection* (London, 1988), p. 79.

[948] Thomas S. Popkewitz, Miguel A Pereyra and Barry M Franklin, 'History, the Problem of Knowledge, and the New Cultural History of Schooling', in Thomas S. Popkewitz, (ed) *Cultural History and Education* (New York, 2001), p. 12.

into pre-conceived types of children'.[949] Others have gone further arguing for a more materialist interpretation of the education system which they argue was orientated towards the 'production and reproduction of variously skilled labour forces'.[950] For example Simon argued in 1952 that 'fundamentally, the present selective and graded system of schools serves the needs of a class-divided society which is not able to utilise the abilities of all its citizens, and so dare not develop them to the full'.[951] The selection though intelligence testing, he stressed, was the 'keystone of the present educational system' therefore dividing children into different groups because of their 'mental capacities' which would 'determine their whole future development'.[952] Some were also critical of the effectiveness of this selection in educational policy. For example Hurt pointed to a report by Central Council for Education (England) which presented evidence 'casting doubt on the efficacy of selection at the lower end of the ability range'. Indeed it stated that 'some witnesses have made the point that there can be no firm and accurate division between children who are suitable for "education" and those who are not'.[953]

However, there is evidence to support the relationship between IQ, selection and employment prospects in educational policy. For example at the winter conference of the ADES in 1962 one speaker (Headmaster of Torry Secondary School, A, M, Rennie) argued for the importance of 'linkage' from secondary

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[949] Peter Gordon, 'A Unity of Purpose: Some Reflections on the School Cirriculum 1945 – 70', W. E. Marsden (ed), *Post-War Curriculum Development: A Historical Appraisal* (Leicester, 1979), p1.

[950] Maurice Roche, 'Citizenship, Social Theory and Social Change', *Theory and Society*, Vol. 16, No. 3 (May, 1987), p. 365.

[951] Brian Simon, *Intelligence Testing and the Comprehensive School*, (London, 1953), p. 26.

[952] Simon, *Intelligence Testing and the Comprehensive School*, p. 29.

[953] J. S Hurt, *Outside the Mainstream: A History of Special Education* (London, 1988), p. 182.

education to further education and industry which he stated in recent years had become ‘a political and economic necessity’.[954] Mr Rennie stressed that:

> In the years ahead, the real prosperity of this country is likely to be determined by our successes as educationalists in making it possible for each child to reach the highest grade of learning skill or technique he is capable of…although there are exceptions, the lower the IQ, the more immediate the appeal must be.[955]

The post-school fate of children with low IQs, including those considered mentally handicapped therefore seemed to be of central concern. The employment of all individuals was seen as central to the assurance of a healthy economy and nation. Steps were taken therefore, in special schools and occupational centres, to instil the required knowledge and skills in the leavers programme. In an article in 1962 about Dalton School (Glasgow) the head teacher (Mrs Broadley) and the principal guidance teacher (Mrs Rogerson) explained:

> The general aim of the school leaver’s programme is to prepare pupils for adult/working life outside [the] teacher…now begins to give precedence to self-discipline. Society’s rules must now be discussed with a view to understanding the reasons behind them.[956]

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[954] Jordanhill Archives, Records of the Association of the Directors of Education, Winter Conference Report, 12-14 October 1962.

[955] Jordanhill Archives, Records of the Association of the Directors of Education, Winter Conference Report, 12-14 October 1962.

[956] Mrs E. A. Broadly and Mrs B Rogerson, ‘A School Leavers Programme’, in Scottish Council for Educational Technology, Occasional Working Paper 1, *Resources in Special Education*, 1975, p. 11.

Additionally they explained how Maths, English and Religious Studies were to be tailored towards social competence and employment. For example, lessons were to be to be focussed on topics such as the wages, factory language and safety at work.[957] Even religious studies were to concentrate on bible stories centred around issues such as 'honesty at work… and the temptation to indulge in petty pilfering…boy/girl relationships and alcoholism'.[958] Another teacher recalled her use of 'practical education' in her early teaching years in special schools in Glasgow in the 1960s and 1970s and pointed to particularly gendered aspects of it. She explained:

> The girls were then taught laundry, sewing, cooking, how to care for a baby and we based a lot of the reading on practical things. One of the girl's baby had died, a former pupil, because she couldn't read the instructions on, whatever it was, a tin or something that she was using and we had a brilliant head of domestic science Mrs McMurtry who said we will never have that again. So we taught them to read from recipes from tins from soap packets.[959]

A study of 50% of all schools and units for 'mildly mentally handicapped' children in Scotland pointed to the importance of similar types of activities.[960] The HMI in the late 1970s noted how:

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[957] Broadly and Rogerson, 'A School Leavers Programme', p. 12
[958] Broadly and Rogerson, 'A School Leavers Programme', p. 12
[959] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007.
[960] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School*, p. 1

> Considerable emphasis was put on practical activities because of their importance in gaining employment. Cobbling and rug and basket making were included in the education of boys, and cookery, sewing and laundry in that of the girls.[961]

In the 1980s the importance of these vocational and practical lessons was again emphasised. Gilbert MacKay (Lecturer in Special Educational Needs, Jordanhill College of Education) stressed that recent research had shown that even 'children affected by extremely severe degrees of mental handicap and emotional disturbance can learn when the right conditions for learning have been created'.[962] He re-instated the emphasis highlighted in previous decades on practical training and vocational skills stressing that 'what the children learn may be a far cry from traditional school subjects, but it is also likely to be considerably more useful to them than school subjects'.[963]

A later report from the Scottish Education Department in 1981 also noted the importance of practical training and a leaver's programme which would 'prepare pupils for the transition to the adult world'.[964] It noted how these pupils were encouraged to look outwards spending more time in the community and that more time was given to practical education in subjects such as home economics.[965] This report argued that the schools and units ultimately must prepare leavers to be 'employable', instilling the importance of having 'readiness to learn, being reliable

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[961] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age*, p. 30

[962] Mackay, 'The Named Person', p. 4.

[963] Mackay, 'The Named Person', p. 4.

[964] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age*, p. 30

[965] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age*, p. 30

and having an awareness of what going to work involves'.[966] The aim was therefore to prepare these children to be active citizens who would 'play an active part in the community'.[967]

However, anecdotal evidence collected from interviews had pointed towards the unsuitability of some of this teaching. One headteacher for example pointed towards the fact that the material used in special schools was not always age appropriate and this may have been down to many still regarding such individuals as unsuitable for education. She recalled an inspector's visit to her school stating:

> The thing that he noticed, and until he said it I should have been aware of it and I always blame myself for this, but the reading material was geared to younger children…We changed over right away. We did teen reading and magazines and things and that was a big improvement…The head teacher was keen for things to be better but there were people, including the advisor, who thought, you know, that you can train these children but education its just a burden for them but he was wrong about that.[968]

Special schools were often focussed on the importance of this social and vocational training as they felt:

> Failure may mean an addition to the ranks of the delinquent and the petty criminal…success can produce from unpromising material a valuable

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[966] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age*, p. 30

[967] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age*, p. 30

[968] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007.

> addition to the ranks of self-respecting young people and worthwhile citizens'.[969]

It was also seen as important that 'as a future citizen the pupil should be trained to develop proper pride in his own city'.[970] In Glasgow a resource pack, 'The Kerr Family', was produced in the 1970s as a method of delivering this 'social education' in special needs schools.[971] This was produced to 'help the teacher to prepare the pupils to take their place in society'.[972] The social background of this fictitious family was constructed in such as way as to localise wider social issues. The problems and challenges facing this family were studied using a variety of methods and media in an attempt to educate pupils in issues that may affect their lives. It involved the story of a working class family living in a building due for demolition in Glasgow, a predicament that was described as 'style of life with which the pupils are familiar'.[973] This may suggest that there were social class assumptions at play in the education of those with learning disabilities. This may have been particularly the case in a large industrial city like Glasgow where there was a good deal of urban poverty.

Indeed a report carried out by HM Inspectors of Schools in Glasgow in 1978 revealed concerns over the social status of many pupils with learning disabilities. In a survey of 1000 pupils who had entered secondary school with poor performances it

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[969] Corporation of the City of Glasgow, *Backward Pupils in Secondary Schools,* 1947, p. 6.

[970] Corporation of the City of Glasgow, *Backward Pupils in Secondary Schools,* 1947, p. 7.

[971] Frank McKee (Psychologist, Glasgow Child Guidance Service), 'Social Education for the Mentally Handicapped', in Scottish Council for Educational Technology, Occasional Working Paper 1, *Resources in Special Education,* 1975, p. 37.

[972] McKee, 'Social Education for the Mentally Handicapped', p. 38.

[973] McKee, 'Social Education for the Mentally Handicapped', p. 38.

was stated ‘the picture was depressing, one of impoverished homes…the stamp of failure on them’.[974] Further articles in the collection of the Scottish Council for Educational Technology papers, specifically on the implementation of ‘The Kerr Family’ in St. Aidens School (pictured below) also stated that ‘many of these children come from less well-off families, often with a tradition of unemployment and consequently housing conditions tend to be poor’.[975]

St Aidens School, Glasgow, 1970s[976]

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[974] Scottish Education Department, *The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland: A Progress Report by H. M. Inspectors of Schools, Scottish Education Department* (HMSO, Edinburgh, 1978), p. 5

[975] Peter Feely, ‘The Kerr Family’ in St Aidens School, Glasgow, Scottish Council for Educational Technology, Occasional Working Paper 1, *Resources in Special Education*, 1975, p. 40

[976] Image taken from http://www.theglasgowstory.com/imageview.php?inum=TGSA02510&PHPSESSID=3992a6426d706337f291e71fb7acc505 visited on 1/9/08.

Further testimony collected from a former teacher, in which she described her time in Rottenrow Special Needs School in Glasgow in the 1970s, even suggested that the diagnoses of handicap and types of educational provision children were to receive were more directly linked to their social status recalling:

> It was a special needs school, girls only when I arrived and these girls were classified as mildly mentally handicapped, MMH, but in fact most of them weren't…Most of them came from the east end schemes and they just needed nurtured. There were 3 girls in my class who shouldn't have been there who all went on to get jobs in offices but you couldn't say anything to influence either the doctor or the psychologist who said they are better here, they are looked after.[977]

The decision to education these children in special schools therefore could be down to a number of factors and did not necessarily relate to their ability to learn or diagnosed handicaps. For example she also recalled how:

> Rottenrow had been there since a way back before 1945, and the children were being signed in and there were bad things. If you came from a family with one child who was in a special school and classified as they used to say then it was likely that the brothers and sisters would be considered seriously for it even if they didn't exhibit the same problems.[978]

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[977] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007.
[978] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007.

Social status and social class then can be seen to have played an important role in the decision to send the girls to this partular school and subsequently they were often keen to avoid the related stigma. For example, this teacher recalled how she ‘met them in town later and Sally especially, I still remember it, she said don’t say to anyone Mrs Dowling that I was in a special school’.[979] She recalled how:

> The girls used to hide up closes cos no-one would have known they came from a special school…they looked ordinary… they would score out Rottenrow on their ticket and they lived normal lives outside the school but as I say they were all from the schemes.[980]

Segregation in special schooling was therefore often about both the diagnosis of mental handicap due to low scores on IQ tests and perhaps, as has been suggested by one respondent, due to the social status of the child’s family. This led the SSMH in Glasgow to report in 1977 that a third of the children admitted to special schools had IQ scores of over 70 leading them to state that ‘it is pertinent to enquire whether the social and other factors which led to such labelling offered a justifiable basis for classification of this kind’.[981]

Segregation and Regionality

Cole has noted the increase in separate provision for the mentally handicapped and the ‘severely mentally handicapped’ particularly in Scotland, where, unlike in

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[979] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007.
[980] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007.
[981] SSMH, Newsletter, February 1977, p. 6.

England, instruction was to be provided by the education authorities in occupational centres.[982] Separate educational provision for mentally handicapped children in special classes and schools thus was often borne out of concern for their ability to learn, as well as others in the class. For example, Cole points to a Scottish Advisory Council report in 1951 which discussed the 'ruthless unconcern for the less able'.[983] Here it was noted that it could be 'a mortifying and hurtful experience for children to be perpetual failures' which meant 'a child often developed a sense of crippling inability which magnifies the task of recovery'.[984] Cole noted the contemporary thought which dictated that 'a child cannot be more cruelly segregated than to be placed in a room where his failures separate him from other children who are experiencing success'.[985]He stressed therefore that there was often a 'genuine wish to help such children achieve the dignity of self-supporting, integrated adulthood with acquiring economic independence through a job…the most potent touchstone of 'normality' to the handicapped person'.[986] Armstrong similarly points to the expansion of special education, from 15,173 children ascertained as moderately educationally subnormal in England and Wales in 1950 to 66,836 in 1976 and also argues that 'the rationale for this expansion had largely been humanitarian'.[987] For example W. Brennan, President of the National Association for Remedial Education similarly noted in 1971 that the 'backward child who does not enter the special school is left in the most hazardous situation'.[988] Armstrong therefore stated that 'the

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[982] Ted Cole, *Apart of A Part: Integration and the Growth of British Special Education* (Milton Keynes, 1989), p. 104.
[983] Cole, *Apart of A Part*, p. 104.
[984] Cole, *Apart of A Part*, p. 104.
[985] Cole, *Apart of A Part*, p. 104.
[986] Cole, *Apart of A Part.* P. 169.
[987] Derrick Armstrong, *Experiences of Special Education: Re-evaluating policy and practice through life stories* (London, 2003), p. 80.
[988] Cole, *Apart of A Part*, p. 154.

post-1945 political ideal was centrally concerned with extending both opportunities and citizenship for people who in the past had been marginalised and disadvantaged in their own society'.[989] He argued that 'post-war education, far from enacting a policy of exclusion through the rapidly expanding special school sector actually represented an attempt to engineer an inclusive society in which the needs of all citizens were addressed through school which were designed to meet their needs.[990]

In Glasgow there was a gradual expansion of this sector of education as part of a wider scheme to provide special education for specialist needs. In 1962 there were 178,852 children on the registers of all 372 schools in Glasgow.[991] Of these 25 schools were for 'handicapped children' and there were a further 11 Occupational Centres for the 'trainable' mentally handicapped. [992] The MOH reported a steady increase in the places available in these special schools. There were 18 schools providing education for 2,509 'educable' mentally handicapped children in Glasgow in 1963.[993] In 1964 it was reported that there were 19 schools in Glasgow providing education for 2,620 similarly classified children.[994] By 1970 there were 21 day schools providing education for 3,231 'educable' mentally handicapped children and alongside 11 occupational centres for 429 'trainable' mentally handicapped children in Glasgow.[995] Pupils in Glasgow therefore made up a large proportion, at least a third, of the total number of children diagnosed as mentally handicapped attending

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[989] Armstrong, *Experiences of Special Education,* p. 78.

[990] Armstrong, *Experiences of Special Education*, p .78.

[991] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 107.

[992] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 107.

[993] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 105.

[994] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 105.

[995] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1970, p. 82

special schools Scottish, estimated in 1974 to be approximately 8,000 and 10,000 pupils (example of Summerton Special Needs School pictured below).[996]

Summerton School for Physically and Mentally Handicapped Children, Ibrox, 1970s[997].

Cole has noted how in 1965 the Labour Government's 'declared objective was to end selection and separatism in secondary education'.[998] In particular he noted the feelings of the Scottish Education Department who believed integration to be a 'sound principle' and that 'special education should be a last resort'.[999] Both the move to integrated comprehensive education and the publication of the Warnock

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[996] A Milne, 'Current Provision in Special Education in Scotland' and Margaret M Clark, 'A Study of Ascertainment for Special Education in Scotland 1973 – 75, in W. B. Dockrell, W. R. Dunn and A Milne, *Special Education in Scotland* (Edinburgh, 1978), p .120

[997] Image taken from http://www.theglasgowstory.com/imageview.php?inum=TGSA02509, visited on 29/7/08.

[998] Cole, *Apart or A Part*, p. 131.

[999] Quoted in Cole, *Apart or A Part*, p. 131.

Report in 1978 (which led to an Act of Parliament in 1981) called for integration for all pupils. In particular it called for mainstream education for all children who were now to be seen as being as on a continuum of needs as opposed belonging to one of the several different categories of handicap. However, the 1981 Act was seen by some as ‘a limited measure which only addressed some recommendations of the Warnock Committee’.[1000] Indeed it was noted that ‘disappointingly, for many observers, the government was to make no additional funding available to help implement the Act [and] during the ensuing years this was often seen as the major reason for the limited advance towards integration’.[1001]

The level of provision available regionally throughout this period, despite this new call for integration, was dependant on a number of factors, some of which were discussed in a Scottish Education Department (SED) report in 1981. In this they highlighted the importance of LA policy on teacher training and funding which meant that ‘placement in a special school became dependant to some extent on where a pupil lived’.[1002] Cole similarly noted that for a mentally handicapped pupil ‘his educational future is at the mercy of completely fortuitous circumstances which may differ not only from area to area but also from school to school’.[1003] Cole identified ‘adventurous’ and ‘integrationist’ policy in Glasgow where the Regional Study Group in 1982 called for abolition of MLD (moderate learning disabilities) special classes noting that the ‘trend in the Glasgow area had been away from separate remedial provision and towards mixed ability organisation’.[1004] However, whilst this ‘adventurous’ policy may have been evident in some remedial settings, evidence

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[1000] Ted Cole, *Apart or A Part*, p. 136.
[1001] Ted Cole, *Apart or A Part*, p. 136.
[1002] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age*, p. 7.
[1003] Cole, *Apart or A Part*, p. 154.
[1004] Cole, *Apart or A Part*, p. 158.

suggests that the trend in Glasgow did not, in fact, alter as resources were still used for maintaining impairment-specific schools rather than prioritising integration. This suggests that there again is some distance between educational objectives and the aims and the reality of the special educational sector in Glasgow.

Cole argues that whilst ‘schools for all’ were promoted with the creation of the comprehensive school in the 1970s and 1980s, in fact the numbers in special education continued to expand. [1005] In Glasgow the number of specialist schools continued to grow resulting in a culture of segregated education for mentally handicapped children. Indeed the SED reported in 1981 that an estimated 75% of ‘mildly mentally handicapped’ pupils of secondary school age attended special schools.[1006] Diagnosis or categorisation of ‘mental handicap’ or later ‘learning disability’ therefore most often resulted in a segregated educational experience. This growing provision of special education for the mentally handicapped was, however, slow to take account of those designated as ‘ineducable’ and ‘untrainable’. The MOH report in 1962 stressed that, under section 65 of the Education (Scotland) Act of 1962, the local health authority (LHA) was to be notified of those children of school age who were to be considered as unsuitable for education or training in a special school and Under Section 12 of the Mental Health Act the LHA had the duty to provide training and occupation for these children.[1007] However, they also reported that in Glasgow in 1962 this provision had not yet got any further than the planning stages’ even though it was described as ‘one of the most urgent needs requiring to be

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[1005] Cole, *Apart or A Part*, p. 158.

[1006] Scottish Education Department, *The Education of Mildly Mentally Handicapped Pupils of Secondary School Age*, p. 15

[1007] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 207.

met in the city'.[1008] As discussed in chapter 3 the SSMHC were, at this stage, 'providing the only available service for children excluded from schooling' with services for 'all grades of handicap down to the most helpless and including the most active and unmanageable'.[1009]

It was reported in 1962 that 15 children from the SSMHC centre were given a trial at the Education Department's Occupational Centres. However the separation of the 'educable' and 'trainable' was again evident as 4 of these children were subsequently rejected and denied access to provision.[1010] It was also reported that 5 children who were attending the centre were subsequently admitted to hospitals for 'mental defectives'.[1011] Cole reported that between 1951 and 1960 in England and Wales alone there were 3,804 appeals against LEAs exclusion of mentally handicapped children from education due to their being 'ineducable'.[1012] He reported that only 4% of these appeals were successful.[1013]

Categorisation therefore continued to play an important role in the types of educational provision that was to be provided for mentally handicapped children. This was sustained even when wider governmental reports, such as *A Better Life* in 1971, began to express concerns with the statutory selection of children into categories of impairment stressing that 'very few children fall easily into tidy compartments' and suggesting that LAs begin to recognise the 'varied nature of

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[1008] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 207.

[1009] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 27.

[1010] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p208.

[1011] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p208.

[1012] Cole, *Apart or A Part*, p. 108.

[1013] Cole, *Apart or A Part*, p. 108.

individual educational needs'.[1014] However, the ADSW had some concerns about this new type of approach which abandoned old categorisations in favour of new individualised approaches.[1015] In 1979 they stated:

> The Executive Committee view that one of the difficulties in the Warnock Report is that too many children would be treated as handicapped, and that there required to be a narrowing of the criteria for ascertainment as handicapped, with the resultant continued process to integrate handicapped children into normal educational life and schools.[1016]

It is clear therefore that new ideas such as integration and the 'continuum of needs' could result in practical difficulties. Again this was particularly the case in cities such as Glasgow where there had been a growth in impairment-specific centres and schools. One paper by the Scottish Council for Educational Technology in 1975 noted the rationality of this special educational provision for the 'handicapped' in Glasgow arguing that 'the reasons for such choices are not always educational ones; it is obviously easier to operate a separate school system in districts where there is a greater concentration of population'.[1017] An earlier report from the Secretary of state for Education in Scotland in 1967 similarly noted the distinctive and large proportion of separate facilities for children with disabilities in Glasgow stressing that:

[1014] *A Better Life*, p. 37.

[1015] Letter from European Social Fund, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/1.1.62.

[1016] Records of the Association of Directors of Social Work, Executive Committee Minutes, 2nd May 1979, ADSWA1/1.1.66.

[1017] Scottish Council for Educational Technology, Occasional Working Paper 1, *Resources in Special Education*, 1975, Introduction.

> Glasgow and Edinburgh have been the only authorities able to establish considerable numbers of medium sized schools, with limited catchment areas for mentally and physically handicapped pupils…in most industrialised lowland counties the tendency has been to build considerably larger schools which cater for a wide variety of handicaps and bring in pupils from a wider area.[1018]

One teacher also suggested in her testimony that parental pressure and wider assumptions about 'mental handicap' helped to promote the growth of these impairment specific schools in Glasgow. She recalled how:

> One of the PH [physically handicapped] boys in a Catholic school [in Glasgow]…his parents sued the Corporation, as it was then, because they were bringing Charlie up, they were educating him with pupils who were mentally handicapped and Glasgow was forced to set up a school for children with physical and visual impairments.[1019]

The provision of specialised education services for those with special needs in the post-war period left Glasgow therefore in a difficult position when a more integrationist agenda began to creep into educational policy. Money and resources had been put into establishing and maintaining an extensive special educational resulting in the tendency to send children with even 'moderate' learning disabilities to these institutions rather than trying to cope with their learning needs in a

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[1018] *Special Education: An Extract of the Report of the Secretary of State for Scotland on Education in Scotland in 1966* (HMSO, Edinburgh, 1967), p. 3

[1019] SOCHA/024/6 Interview with Betty Dowling, 2nd March, 2007.

mainstream setting. One report, produced by Jordanhill College in 1989, noted some of the subsequent effects of this extensive provision of segregated special education arguing that the vast majority of children diagnosed as having moderate learning difficulties in Glasgow attended special schools and that:

> Young people staying on at school appears to be a Strathclyde phenomenon, and is particularly true of Glasgow. It would seem that where there are large special schools with extra accommodation currently available, there is a greater tendency to retain young people beyond the school leaving age.[1020]

The report stated that this extended provision had developed as for most of these pupils 'open employment prospects are negligible'.[1021] It was noted therefore that by the 1970s 'remedial education had become little more than a 'safety net' designed to stop pupils dropping through the educational system with around 7% of primary school and 8% of secondary pupils (in years 1-4) receiving special education in 1976 in Scotland.[1022] This amounted to 42,687 children in primary schools and 25,074 children in secondary schools.[1023] Similarly the SSMH reported that in 1973-74 there had been 1,742 new admissions to special education in Scotland (1,273 of

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[1020] Howel Jones, Christine Kemp and Frances McIlhenny, *Still at School: A report of a research project into school provision for young people over 16 years of age recorded as having moderate learning difficulties,* Division of Special Educational Needs, Jordanhill College, 1989, p22.

[1021] Jones, Kemp and McIlhenny, *Still at School*, p. 22.

[1022] Marion Blythman, 'The Education of Pupils with Learning Difficulties in Mainstream Schools in Scotland', *Ten Years On,* A Review of developments since the publication of the HMI Report, 'The Education of Pupils with Learning Difficulties in Primary and Secondary Schools in Scotland', The Joint Committee of Colleges of Education in Scotland, October 1988, p. 4.

[1023] Blythman, 'The Education of Pupils with Learning Difficulties in Mainstream Schools' p4.

whom were classed as mentally handicapped).[1024] Tomlinson as a result has argued that 'special' or 'remedial' education operated as 'a safety valve for the mainstream, allowing it to function unimpeded by these troublesome deviants'.[1025]

In 1978, one article described the work of an 'urban special school' in Glasgow where the objective was to 'produce young men and women who are socially acceptable and competent' noting how these 300 children 'arrived on a special bus'[1026] It was stressed that many of them attended the school as they could not cope in a mainstream setting. Thus it emphasised the protective environment offered by the school whereby the teachers can 'detach themselves to the extent that they can treat the children as nearly normal' and the pupils can 'widen their horizons and add to their skills for personal enjoyment as well as survival in the outside world'.[1027]

However, this article also highlights the feelings of exclusion felt by some who attended the school, for example one pupil stated that 'they think we are all daft in here'.[1028] Testimony from a formal pupil of special schools in Glasgow in the 1960s and 1970s also recalled feelings of difference when she stated, 'I went to Middlefield you know the special school… she [her sister] went to an ordinary school, I didn't, I went to special schools … I didn't study anything'.[1029] Another respondent similarly remembered how in the 1960s his brothers had went to the local

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[1024] SSMH, Newsletter, February 1977, p. 26.

[1025] Tomlinson, Sally Professionals and ESN (M) Education, in Will Swann (ed), *The Practice of Special Education* (Oxford, 1981), p. 265.

[1026] Jean Reid, 'Description of a Urban Special School – The Mary Russell School in Glasgow', in W. B. Dockrell, W. R. Dunn and A Milne, *Special Education in Scotland* (Scottish Council for Research in Education: Edinburgh, 1978), p. 26.

[1027] Reid, 'Description of a Urban Special School' p. 27.

[1028] Reid, 'Description of a Urban Special School' p. 27.

[1029] SOCHA/024/4 Interview Angela Turner with Marilyn Goodson, 31st February 2006.

primary school whilst he 'went to the special school' recalling how 'they had reading and writing where we had things like plastersine'.[1030]

Oral testimony therefore reveals a number of different perspectives about the impact of the segregated educational experience. One teacher recalled how some of the pupils responded to this special treatment noting that 'the children disliked being either pitied, patronised or treated in too soft a way'.[1031] Another former pupil stressed in her testimony that she rejected the label of 'handicapped' given to her as a child. She stating 'I dunno I just don't like the word handicapped, I'm not blind, right, I can walk and there is nothing wrong with me, there is nothing wrong with me at all that's how I'm not handicapped'.[1032] She also recalled how her father organised for her to go to college as he felt she had had come out of school with little basic education when she recalled how 'a long time ago I went to college as well cos my father he flared up cos I didn't know anything about money'.[1033] One respondent recalled how she was keenly aware that it was a 'special school' stating 'my brothers and sisters all went to the ordinary school, I have to have a special bus and it didn't feel nice'.[1034] Similarly another argued that 'because I have been to a special school sometimes people out there give people a sort of label. I feel angry about that'.[1035]

The White Paper 'Special Educational Needs' suggested the implementation of a record of needs (as opposed to categorisation of pupils with special needs),

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[1030] SOHCA/024/3, Interview Angela Turner with David Colston, 24th February 2006.

[1031] SOCHA/024/6 Interview Angela Turner with Betty Dowling, 2nd March, 2007.

[1032] SOCHA/024/4 Interview Angela Turner with Marilyn Goodson, 31st February 2006.

[1033] SOCHA/024/4 Interview Angela Turner with Marilyn Goodson, 31st February 2006.

[1034] 'Keith', Quoted in Derrick Armstrong, *Experiences of Special Education: Re-evaluating policy and practice through life stories* (London, 2003), p. 52.

[1035] 'Trevor', Derrick Armstrong, *Experiences of Special Education*, p. 58.

which was estimated as 1.3% of pupils in Scotland.[1036] This and many other ideas were incorporated in the 1981 Education Act which set out to undermine 'previous terms associated with handicap…breaking down boundaries between the normal, the remedial, the maladjusted and the handicapped, making them all in one sense 'special'.[1037] Additionally a Glasgow Council for Remedial Education working report in 1984 noted some of the changes that 'remedial' education had gone through since the 1960s.[1038] It similarly described the evolution in the 'treatment' of pupils with learning difficulties as a story of progress. The report highlighted the development from separate schools founded on categorisations of pupils by IQ tests, to the contemporary situation of extraction classes in mainstream schools.[1039] However, complete inclusion of children with learning disabilities was rarely was presented as an objective in educational sources. Indeed the Scottish Council for Educational Technology argued in 1975 that 'no-one would ever claim that complete integration could ever be a possibility'.[1040] The continuing segregated special educational system meant that this view was shared by many in education.

Warnock claimed in 1979 that special education was now to be taken to mean the provision of education to meet the needs of as many as 20% of all children at school and suggested that 'the notion of the handicapped and the normal as two

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[1036] Jordanhill Archives, National Prospectus: Diplomas in Special Educational Needs, JCE/12/18/13x.

[1037] Alan Peacock, Kevin Denvir, *Scottish Postgraduate Research into Maladjustment 1974 – 1983*, Scottish Council for Research into Education (Edinburgh, 1985).

[1038] Strathclyde Department of Education, Glasgow Council for Remedial Education in Secondary Schools, Report of a Working Party on Remedial Education, 1984.

[1039] Strathclyde Department of Education, Glasgow Council for Remedial Education in Secondary Schools, Report of a Working Party on Remedial Education, 1984, p. 10.

[1040] Scottish Council for Educational Technology, Occasional Working Paper 1, *Resources in Special Education*, 1975, p. 4

distinct parties has, I believe, been effectively overcome'.[1041] One former headmistress recalled how in the early 1980s the impact of Warnock was that it was felt 'they would close all special schools'.[1042] However, she noted that there were only a small group in Glasgow who were then to move into mainstream schools. She recalled how:

> What happened really was that when the children were moving from primary to secondary those that could started to go into the secondary schools, the psychologist would place them. You wanted the children who could cope, you didn't want the children to go who could not cope.[1043]

This has led commentors such as Cole to argue that 'in national terms, although integration was much talked about…DES statistics did not indicate substantial movement towards it beyond what already existed in 1965'.[1044] He noted that 'new schools continued to be opened and many special schools continued to flourish, while others with the active support of the parents of the pupils fought off attempts to close them.[1045] Integration was consistently presented by many groups as the ideal in educational services. For example an article in the SDSA magazine in 1990 noted that 'arguments in favour of integrated provision for all children derive from their

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[1041] Mary Warnock, 'The Way Forward' from the Times Educational Supplement, reprinted in SSMH, Newsletter, January 1979, pp. 8-11.
[1042] SOCHA/024/6 Betty Dowling, 2nd March, 2007.
[1043] SOCHA/024/6 Betty Dowling, 2nd March, 2007.
[1044] Cole, *Apart or A Part*, p. 132.
[1045] Cole, *Apart or A Part*, p. 132.

moral force from the belief that any selective model of education will inevitably undermine the social status of some groups in the community'.[1046]

In Milne's article, 'Current Provision in Special Education in Scotland', published in 1978 he noted that in the previous 5 years there had been 24 new purpose-built special schools completed, this to add to the 46 built in the previous 10 years. [1047] By far the largest number of schools available for a particular category of disabled children were those for 'mentally handicapped' pupils, some 110 schools (this not including Occupational Centres).[1048] The story of progress towards integration therefore fails to take account of the numbers of children who continued to be educated in segregated schools. This seemed to be particularly true in Glasgow where one report in 1989 listed at least ten segregated secondary special schools in Glasgow, and that number only accounted for those categorised as having 'moderate' learning disabilities.[1049] There were at least the same number of schools for primary school children with special needs and those considered to have more 'complex' needs. Indeed an HMI report in 1980 noted that 'few severely and profoundly handicapped pupils are educated in units in ordinary schools'.[1050] Similarly the report *Every Child is Special* was produced in Strathclyde in 1992 and laid out the key principles of the educational authority. These included positive discrimination, the non-segregation of children with special needs and recognition of individual learning

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[1046] SDSA, News, Magazine of the Scottish Down's Syndrome Association, Summer 1990, No 24.

[1047] A Milne, 'Current Provision in Special Education In Scotland', in W. B. Dockrell, Dunn and Milne, *Special Education in Scotland*, p. 121.

[1048] Milne, 'Current Provision in Special Education In Scotland', p. 121.

[1049] Jones, Kemp, and McIlhenny, *Still at School*, p. 30

[1050] H. M. Inspectors of Schools (in collaboration with colleagues from Scottish Home and Health Department and Social Work Services Group), *Provision for Profoundly Mentally Handicapped Children, Three Years On*, June 1980, p. 10

needs.[1051] However significantly it continued to see a place for special schooling for specialist needs.[1052] Certainly this seems to contain little to suggest that the trend for separate special educational establishments in Glasgow was in decline.

Conclusion

It is clear that there was often a gap between the aims of educational policy at a national level and in the practice of special education in the local context. Timmons and Popewitz have shown how the education system, post-1945, was increasingly concerned with the selection of children for particular streams of education, which would prepare them for different occupational roles post school. As a result historians such as Borsay have pointed to the importance of the emergence of a 'hierarchical' system of education in this period. Significantly, intelligence testing was to become increasingly important in deciding the types of educational provision children were to receive. For those with mental handicaps this meant they could still be excluded from schooling on the basis of being categorised as 'ineducable'.

Mentally handicapped children thought to be 'educable' were most often placed in special schools where medicine retained a significant role. Historians such as McKnight and Stewart have demonstrated the importance of the development of child guidance in this continuing adherence to medical control. This played a role in the medicalisation of behaviours and the categorisations of 'types' of handicapped children. Inclusion of social and cultural factors into the diagnoses of disability did

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[1051] Strathclyde Regional Council, Department of Education, *Every Child is Special: A Policy for All*, 1992, p. 6.

[1052] *Every Child is Special*, p. 6.

little to reduce reliance on the authority of medical knowledge, and often encouraged examination by other ‘experts’ who sought to ‘normalise’ and ‘treat’ such pupils.

Cole and others have shown that the expansion of the special educational sector was often borne out of concern for mentally handicapped children. This can be seen in Glasgow where it was felt that specialist schools for special needs was the best way to offer suitable ‘treatment’ and ‘training’ for these pupils. However, whilst Armstrong and others have also identified this ‘humanitarian’ drive in the creation of separate special schools, nevertheless the result of this was to segregate these children from their peers and to affect their chances of employment in later life. Many of these effects will be discussed in chapter 5. However, it is significant to note, for example, that in the late 1970s ‘the majority of intellectually impaired school leavers were transferring to local authority adult training centres’[1053] and not into employment or further education.

In Glasgow the creation of a large special educational sector for those with mental handicaps was significant as it was to have an impact on its subsequent failure to engage with national developments in integration. Neither the advent of the comprehensive school system in the 1970s nor the publication of the Warnock Report were to have a substantial impact on the numbers educated in special schools. Cole has identified the desire to end separatism and selection throughout the country, however large special schools providing education for even the ‘mildly’ or ‘moderately’ mentally handicapped continued to flourish in Glasgow. Whilst other regions were perhaps more able to successful embrace inclusion, Glasgow continued to be heavily invested in maintaining and expanding special schooling.

[1053] Borsay, *Disability and Social Policy*, p. 137.

Oral testimony has demonstrated the ways in which placement in special schools could affect pupils and impact on their experiences outside of school. Numerous reports also point to the ways in which the education they recieved was often geared towards more ‘practical’ things and neglected to focus on age appropriate materials or traditional reading and writing skills. This was often to have a profound effect on their chances for work, independence or ‘integration’ in later life. Developments in special education in Glasgow in this period therefore again demonstrate the gap between big policy directives and the practical realities of segregation felt by many mentally handicapped people. Thus, despite the introduction of new ideas such as inclusion and the ‘continuum of needs’ into educational legislation there continued to be a reliance on segregated provision and outdated categories of impairment.

Chapter 5

The Development of Adult Day Services in Glasgow since 1945

Introduction

This chapter explores the development of day centres for mentally handicapped adults in Glasgow since the Second World War. In doing so it questions the adoption of an overarching ‘progressive’ narrative of community care by first pointing to continuities with past provision for mentally handicapped people. For example it demonstrates the ways in which ideas such as work training, prevalent in mental hospitals, were often mirrored in new services ‘in’ the community. Thus it reveals how adult services operated in a similar way to special schools in their desire to ‘treat’ and ‘train’ people with mental handicaps who were past school age throughout this period. In particular it demonstrates the ways in which work was used both as therapy and as a mechanism through which the mentally handicapped were to become active and productive citizens. Early day centres, like the hospitals and institutions before them, focused on the therapeutic value of work as a method through which to socialise and normalise these individuals through ‘useful’ occupation.

Glasgow provides an interesting setting for this study due to its large urban population and tradition of segregated special educational provision for children with mental handicaps. Glasgow was also the first city in Scotland to develop these new day services for adults with mental handicaps in the period after 1945. A case study of this area therefore provides an opportunity to assess both wider national developments and at a local level the ways in which local authorities and charities in Glasgow shaped their own community services. Therefore whilst taking account of the lack of provision for adults in the earlier part of this period this chapter also notes the continued importance of classification post-school for mentally handicapped people and the ways in which this impacted on individuals considered to be unsuitable for training. The importance of continuity with previous decades is also highlighted with particular examples given of a continued focus on supervision and separation of the sexes.

However this article also demonstrates how the emphasis of day provision was to undergo a major shift in the later half of this period when the objectives of integration through work were seen to be failing. It investigates the change in focus as state run centres now directed their efforts to providing social and cultural activities in an effort to 'normalise' and integrate individuals using techniques such as social role valorisation (SRV). In addition it provides telling examples of daily life in these new centres exploring issues such as segregation from local communities and further demonstrates some of the ways in which these new types of services, explicitly focussed on integration and normalisation, often remained segregated from the community. In doing so it highlights how these new services, housed within the community, could face similar challenges of separation and isolation which was prevalent in the old style services. Utilising oral testimony therefore it draws attention to continued feelings of institutionalisation and segregation even within these ‘new’ community settings. In doing so it suggests that investigating the history of community services from this local perspective can reveals a much more static picture of developments in community care and ‘mental handicap’ than perhaps the ‘progressive’ leaning national legislative narrative and histories of de-institutionalisation may imply.

Lastly this chapter explores the key developments in the relationship between the numerous agencies responsible for this provision. In particular it noted the continuing importance of voluntary provision which could form the basis for latter-day state services. The importance of the emergence of social work is highlighted and the ways in which a complex relationship between the different authorities often resulted in an inter-dependant mixed economy of care. This chapter will therefore demonstrate that with development of these service since World War Two there was rarely a coherent statutory overall strategy for service delivery for the mentally handicapped which developed in various ways resulting in an over-reliance on day centre where there was often little opportunity combat the segregation of mentally handicapped people from their communities.

The ‘work cure’: Adult day services in the post-war period

Pre-dating the day centres and workshops that emerged for people with ‘mental handicaps’ after the Second World War, was a culture of therapeutic treatment through labour in institutionalised settings. In hospitals and asylums there was often a focus on the importance of ‘work’ for patients as a means by which to instil important skills and opportunities to become fully ‘rehabilitated’. This was as part of a concerted effort to mould patients into ‘useful’ work ready citizens capable of living in the community (although very few patients were given the opportunity to leave these institutions). For example, a small number of historians have pointed to the important role of work and occupational programmes in Glasgow Asylum and later in Lennox Castle Hospital in Glasgow.[1054] These occupational activities were used as a means by which to encourage useful employment and ‘moral management’ of patients.[1055] Indeed the Department of Health for Scotland in 1954 stated that ‘it is the aim of every mental deficiency institution by a process of training and socialisation to enable patient to be discharged to outside employment’.[1056]

When day services for adults with ‘mental handicaps’ living in the community emerged in Glasgow in the immediate post-war period these ‘work centres’ or ‘senior occupational centres’ often demonstrated a similar emphasis to programmes in mental deficiency hospitals. They aimed to provide opportunities for adults with ‘mental handicaps’ to participate in work based activities whilst living in the community. This concern with the therapeutic and social rehabilitative functions of work was continually stressed by many leading figures in this field from the early part of this period. In 1954, for example, The Medical Officer of Health (MOH) for Glasgow emphasised the importance of ‘rehabilitation and employment’ for the

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[1054] Stephen Baron, Kisten Stalker, Heather Wilkinson and Shelia Riddel, ‘The Learning Society’ the highest stage of human capitalism’, Frank Coffield (ed) *Learning at Work* (Sheffield, 1998), and Frank Rice, ‘Care and Treatment of the Mentally Ill’, in Olive Checkland and Margaret Lamb, (eds), *Health Care as Social History: The Glasgow Case* (Aberdeen, 1982).

[1055] Baron (et al), ‘The Learning Society’ p52 and Rice, ‘Care and Treatment of the Mentally Ill’, pp. 66-67.

[1056] Reports of the Department of Health for Scotland and the Scottish Health Services Council, HMSO, Edinburgh, 1954, p. 57.

‘handicapped’.[1057] He later stated that the aim of this ‘work’ was ‘to enable handicapped people to live as full a life as they are capable of both…mentally as well as spiritually’.[1058] This was also stressed by the SSMHC in 1968 who stated that ‘rehabilitation’ through work could mean that someone diagnosed as mentally handicapped could become ‘a national asset instead of a liability’.[1059] A similar note was made by Miss M Martin, principal lecturer in Remedial Education, Jordanhill, in 1968 when she stressed that:

> The value of employment for the handicapped is not the earning money but the achievement of competence in both work and social activity which enables them to be accepted into society in general.[1060]

This concern with training which was evident throughout the special educational curriculum was therefore carried over into provision for adults with learning disabilities in the community. These young adults were to be provided with opportunities for ‘rehabilitation though work’ in day centres and occupational centres where ‘remedial treatment and training’ could be provided.[1061]

As a result when day centres began to emerge in Glasgow in the post-war period they were most often created on some form of an ‘industrial model’ which mirrored the set-up of workshops in mental deficiency institutions and concentrated

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[1057] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1954, p. 18.

[1058] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1959, p. 363.

[1059] SSMHC, Newsletter, December 1968, p. 1.

[1060] SSMHC, Newsletter, September, 1968, p. 3.

[1061] Report of the MOH, City of Glasgow, The Corporation of the City of Glasgow, p. 231.

mainly on laundry work, horticulture or industrial pursuits.[1062] For example, the first senior occupational centre was opened in Glasgow on South Portland Street in 1951and provided places for males who could attend up to five times a week. [1063] Their work was to include 'rug making, lamp shades, sea grass stools and horn work'.[1064] The *Glasgow Herald* in June 1951 stated that this was the first centre of its kind provided by any LA in Scotland.[1065] In addition the article stressed that 'Glasgow had led the way over the years in a wide field of health of welfare developments and was leading the way again' thus re-instating the perception that Glasgow was at the forefront in the creation of these types of services in comparison to other areas of the country.[1066]

However, even if these services were seen to be new and progressive, in the initial stages they were to provide places for a very limited number of individuals and often excluded potential trainees from the beginning because of their perceived inability to learn. For example, out of the 22 males attending the centre in 1953 it was reported that 'some of the boys under training the previous year failed to reach the necessary standard to justify further training and now only attended the centre one day only per week'.[1067] There were equally small numbers at some of the other centres such as one which opened at Kilearn Street 1952, initially for 17 girls, where the main activities to be taught were knitting and sewing and other crafts such as card making.[1068] They were to be further instructed in 'general domestic work' and

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[1062] John Welshman, 'Organisation, Structures and Community Care, 1948 – 71: From Control to Care?', in John Welshman and Jan Walmsley (eds), *Community Care in Perspective; Care, Control and Citizenship,* (Basingstoke 2006), p. 2.
[1063] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1951, p. 14.
[1064] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1951, p. 305.
[1065] 'Handicapped Boys Training Centre', *Glasgow Herald*, 12th June, 1951, p. 5.
[1066] Handicapped Boys Training Centre', *Glasgow Herald*, 12th June, 1951, p. 5.
[1067] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1952, p. 297.
[1068] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1952, p. 297.

‘baking’.[1069] By 1953 there were a total of only 25 boys and 25 girls in each of these respective Health and Welfare Department centres. This was to rise a little to 36 men and 33 women by 1957 and to keep rising annually so that there were 62 female and 99 male places available in 1963.[1070]

These centres, and the many others which emerged and run by both voluntary agencies and statutory authorities, mostly ‘carried out work for the fulfilment of outside orders in making rugs, canework and woodwork’.[1071] Claridge pointed out in 1973 that ‘the emphasis in this new movement was on training, rather than on merely occupying the defective’.[1072] In addition he also stressed that this had emerged out of a desire to ‘bring the role of the occupation centre more into line with recent thinking on the trainability of the mentally defective’.[1073] He noted that ‘when visiting other workshops for the mentally handicapped…one often comes across a worker who seems to have extremely limited intelligence but is engaged in some simple task’.[1074] He then went on to state that this ability to take part in basic training and work questioned the assumption that ‘very low performance on an intelligence test or diagnosis as profoundly retarded… [should] be taken as criteria for exclusion from industrial training and employment’.[1075] Training in community-based day services was to become ‘more educational and less custodial’ in its emphasis in an attempt to

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[1069] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1958, p. 372.
[1070] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1953, p. 291 and Report of the MOH, City of Glasgow, Corporation of Glasgow, 1963, p. 351.
[1071] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1960, p. 31.
[1072] G. S Claridge, ‘The Senior Occupation Centre and the Practical Application of Research to the Training of the Severely Subnormal’, H. C Gunzburg (ed), *Advances in the Care of the Mentally Handicapped*, (London 1973), p. 158.
[1073] Claridge, ‘The Senior Occupation Centre’, p. 158.
[1074] Claridge, ‘The Senior Occupation Centre’, p. 161.
[1075] Claridge, ‘The Senior Occupation Centre’, p. 161.
[1075] Claridge, ‘The Senior Occupation Centre’, p. 161.

‘produce a more competent generation of mentally handicapped’[1076]. Both statutory authorities and voluntary organisations seemed to recognise the importance of these ‘work centres’ and in grouping adults with ‘mental handicaps’ into ‘industrial enclaves’.[1077]

The significance for adults with ‘mental handicaps’ in developing these competencies was also stressed in the MOH report for Glasgow in 1953 stated that its, ‘great importance…cannot be over emphasised’.[1078] It was stated that there was now a growing recognition over ‘how well the mentally handicapped can maintain employment in routine work’.[1079] The central purpose of these centres to was then to ‘train’ these individuals and help them to become competent workers, who would be able to carry out ‘routine jobs’ well. The MOH Report in 1961 described some of the work centre trainees and how they had responded to the work. For example it was noted that:

> Some of the outstanding successes are not the expected ones but the quiet, silent, willing workers with fair practical ability who surprise everyone by settling down and overcoming many of the difficulties such as time-keeping, travel and social adjustments.[1080]

There seemed to be an overall objective in mind here which was focussed on producing a malleable and ‘willing’ type of worker who would be able to become part of the general workforce with relative ease. This tied in with contemporary

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[1076] Ian McMurray quoted in SSMH, Newsletter, April, 1975, p. 4.
[1077] *A Better Life*, p. 95.
[1078] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1953, p. 291.
[1079] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1953, p. 291.
[1080] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1961, p. 359.

thinking on ‘handicaps’ which had aimed to disprove some of the negative views of the ‘mentally handicapped’ by focussing on their ‘trainability’. It was argued for example that a considerable number of these individuals should now be regarded more as ‘young trainable adults’ and there should be more awareness that ‘imbeciles could work reliably and well, earning money, and enjoying more active work’.[1081]

There is some reference to the idea of the mentally handicapped taking up jobs in open employment. For example in 1975 the SSMH reprinted an article from ‘Management Today’ in which the opportunities for the ‘subnormal employee’ are discussed. The article points to a very interesting point that ‘industry has a legal obligation to employ some disabled people but few employers consider that the disabled include the mentally handicapped’.[1082] The author of the article, Peter Lowman ran a food processing factory in Great Yarmouth and had instigated an experiment in the factory whereby they employed a group of people from a local day centre. However his reasons for doing this and the ways in which he presents the project are very interesting. He states that he first considered the idea because he had ‘a range of tasks which were both essential and boring’ and that ‘no amount of persuasion seemed likely to make the normal man persevere with some of our production processes for long’.[1083] He therefore employed a 10 people with mental handicaps to fulfil these roles. He commented that one of the benefits of these employees was that they ‘understood [their] capabilities and wanted to go no further’.[1084] He stated that ‘like anybody else, a mentally handicapped person is an

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[1081] John Welshman, ‘Ideology, Ideas and Care in the Community, 1948 – 71’, in John Welshman and Jan Walmsley (eds), *Community Care in Perspective; Care, Control and Citizenship,* (Basingstoke, 2006), pp. 28-29.

[1082] SSMH, Newsletter, February, 1975, p. 5.

[1083] SSMH Newsletter, February, 1975, p. 6.

[1084] SSMH, Newsletter, February, 1975, p. 6.

individual who needs to know that somebody believes in his potential, if it is to be developed and used'.[1085]

As a result the early day centres had a consistent emphasis on the importance of training for work as a method of 'rehabilitation' and producing useful citizens. This use of work training, in some ways, questioned assumptions about the static nature of 'mental handicap' by stressing the suitability of these individuals for education, instruction and training. For example Claridge in 1973 highlighted the importance of expectations in the abilities of 'mentally handicapped' individuals stating that 'contrary to some opinion, then the severely subnormal person is very responsive to social approval of his achievements and incentives'.[1086] In particular he underlined the importance of the 'work atmosphere' in workshops and day centres in which these individuals were employed as a way of helping to motivate activity.[1087] He argued that in the two previous decades there had been a gradual acceptance of these ideas through the 'realisation that, up to the limits of their capacities, the mentally subnormal can benefit from the right kind of training applied in the right kind of way'.[1088] This, he asserted positively, was part of a 'new enlightenment' which represented a 'general change in society's attitude towards mental health as a whole, a change fostered, in the case of mental subnormality, by research into the suitability of the mental defective for full social rehabilitation'.[1089]

The focus was therefore on instilling the values and importance of work. This seems to have been carried out with the ultimate aim of achieving of a kind of 'active' citizenship which would allow these individuals to become fully fledged

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[1085] SSMH Newsletter, February, 1975, p. 7.
[1086] Claridge, 'The Senior Occupation Centre', p. 157.
[1087] Claridge, 'The Senior Occupation Centre', p. 155.
[1088] Claridge, 'The Senior Occupation Centre', p. 155.
[1089] Claridge, 'The Senior Occupation Centre', p. 155.

members of society through their role in the workforce. Marshall's essay on 'Citizenship and Social Class', in 1950 laid out the key elements which helped define 'citizenship' in the post war period.[1090] This was to be understood through the achievement of civil, social and political rights. This foundation for citizenship formed the basis of later debates over the role of the citizen and the state. Kymlicka for example argued that 'good citizenship' is often measured by the extent and 'quality' of one's participation in their community.[1091] Therefore mentally handicapped adults could become 'good' or 'active' citizens through 'economic self-reliance'.[1092] This ideal certainly resonated in popular consciousness where ability to work was, and is often perceived as the measure of ability to participate in normal patterns of life and becoming a 'deserving' citizen entitled to welfare in times of need. However ideas about citizenship have constantly been in flux throughout the second half of the twentieth century, often in ways that were to have a large impact on the rhetoric of care and training for people with learning disabilities.

Kymicka for example notes the arguments of figures such as Mead in 1986 who stressed that 'by failing to meet the obligation to support themselves, the long-term unemployed are a source of shame for society as well as themselves'.[1093] Mead and others within his school of thought stressed the need for society to look at welfare and citizenship in a way that was 'beyond entitlement'.[1094]This was to become even more apparent in the Thatcher era when the obligations of citizenship were to be continually stressed and there was a 'willingness to engage the left in

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[1090] Trevor Marshall, *Citizenship and Social Class* (London, 1991).

[1091] Will Kymlicka and Wayne Norman, 'Return of the Citizen: Survey of Recent Work on Citizenship Theory', *Ethics*, Vol 104, (2), (Jan 1994), p. 353.

[1092] Kymlicka, 'Return of the Citizen', p. 355.

[1093] Mead, Quoted in Kymlicka 'Return of the Citizen', p. 356.

[1094] Lawrence Mead, *Beyond Entitlement: The Social Obligations of Citizenship* (New York, 1986).

battle over the domain of social citizenship itself'.[1095] Kymlicka noted the arguments of the New Right who maintained that the welfare state had 'promoted passivity among the poor…and created a culture of dependency'.[1096]

The publication of the Warnock Report in 1978 thus urged a focus on education for the mentally handicapped 'to enable entry into the world as an 'active participant in society and a responsible contributor to it, capable of achieving as much independence as possible'.[1097] Welshman has argued that in the 1970s work came to be seen as a 'social good' to be aspired to.[1098] In addition Welshman has reasoned that ideas of 'getting people to make an economic contribution to society, or at least to defray the costs of their own care, has surfaced consistently'.[1099] Therefore there was an acknowledgement of 'the dignity, status and values which accompany work, together with the development of economic security and independence'.[1100] This was seen to 'have a special importance for mentally handicapped people'.[1101] Indeed a report in the early 1980s continued to stress that, 'certain values are placed by society on income produced by labour and on the person offering that labour which are very different to those held about people whose income derived from state benefits or other means', therefore emphasising the 'status inherent in work itself'.[1102] There was thus an inherent assumption that 'a direct

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[1095] Ronald Beiner, *Theorizing citizenship* (New York, 1995), p. 287.
[1096] Will Kymlicka and Wayne Norman, 'Return of the Citizen: Survey of Recent Work on Citizenship Theory', *Ethics*, Vol 104, No 2. (Jan 1994), pp. 355.
[1097] Warnock quoted in, *'Adults Only', A Report on Day Services for Mentally Handicapped Adults,* Lanark Divisional Management Team, Department of Social Work in Strathclyde (January, 1985), p7.
[1098] John Welshman, 'Organisation, Structures and Community Care, 1948 – 71: From Control to Care?', in John Welshman and Jan Walmsley (eds), *Community Care in Perspective; Care, Control and Citizenship* (Basingstoke, 2006), p. 73.
[1099] Welshman, 'Organisation, Structures and Community Care' p. 73.
[1100] *'Adults Only',* p. 29.
[1101] *'Adults Only'*, p. 29.
[1102] *'Adults Only'*, p. 29.

consequence of work for mentally handicapped people can be, therefore, the lessening of social handicap associated with mental handicap'.[1103]

However Dwyer and others have pointed to the difficulties with the concept of citizenship for this group as these theories often operated under 'common sense' assumptions about disabled people who are seen as 'lacking the capabilities required to function as 'normal' citizens'.[1104] In addition. as we will see throughout this chapter, the ability of many 'disabled' people to achieve 'full' citizenship' was severely hampered by lack of opportunity for participation in the workforce. Borsay, for example has argued that this idea of 'social citizenship' was often 'an empty promise for the many disabled people who were not properly integrated into the labour market'.[1105]

Local authorities and other agencies were either unable or unwilling to support open employment for many disabled people, instead concentrated their efforts on day centre and workshop provision where the aim seemed often to be the sense of the importance of 'work' and the avoidance of idleness. Borsay has noted the historical and contemporary importance of the work ethic in Britain which is often 'considered essential to economic survival'.[1106] She stresses that 'it is believed that talent and effort must be materially rewarded and an income differential between the economically active and economically inactive preserved, in order that citizens

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[1103] *'Adults Only'*, p. 29.

[1104] Peter Dwyer, *Understanding Social Citizenship: Themes and Perspectives for Policy and Practice* (Bristol, 2004), p. 113.

[1105] John Welshman, 'Organisation, Structures and Community Care, 1948 – 71: From Control to Care?', in John Welshman and Jan Walmsley (eds), *Community Care in Perspective; Care, Control and Citizenship* (Basingstoke, 2006), p. 70.

[1106] Anne Borsay, 'Personal Trouble or Public Issue? Towards a model of policy for people with physical and mental disabilities', Len Barton and Mike Oliver (eds), *Disability Studies: Past Present and Future*, (Leeds, 1997), p. 126.

have an incentive to find and keep employment'.[1107] Jones has noted how this rewarding of the economically active has often further complicated the relationship between disabled people and the state and in the fact that 'their labour power [is seen as] too difficult to exploit and extract'.[1108] Achievement of 'full citizenship' was therefore to become a difficult challenge to many disabled people, who were given little opportunity to 'earn' this through active participation in the nation's economy.

The 'work' carried out in centres, whilst usually not providing an income for the trainees, was usually seen as having a 'normalising' influence on mentally handicapped people. The centres were seen as places in which these individuals could be occupied in 'useful' training in a controlled and protected environment. One example of this is given in the MOH report from 1961 where there is a description of a girl whose 'appearance made her unacceptable to employers and was rejected by her own family'. The work of the centre in which she is placed is singled out for praise as, it is noted she had 'settled down nicely' and is 'having her confidence restored'.[1109] In a similar way to special schools the day services seemed to be operate as a kind of 'safety valve' for mainstream culture in which 'abnormal' individuals could be housed, trained or 'occupied'. The 'good work' of the local authority SOCs in Glasgow was highlighted again in 1970 where their role in 'making their charges socially acceptable' was praised.[1110] It was also suggested they supplied a valuable service in 'providing play and playmates in happy surrounding

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[1107] Borsay, 'Personal Trouble or Public Issue?, pp. 126-127.

[1108] Chris Jones, *State Social Work and the Working Class* (London, 1983), p. 24.

[1109] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1961, p. 359.

[1110] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1970, p. 211.

and in improving their chances of some form of education or occupation'.[1111]

The value of these centre was therefore in providing the socialising and therapeutic functions of carrying a work atmosphere which was a structured and regulated environment. A Report from Royal College of Psychiatrists asserted the importance of this, for example stressing that:

> The provision of occupation and the opportunity to earn money is an important ingredient in social care. Work provides a social supportive situation, regulated activity and opportunity to regain confidence and self-esteem.[1112]

The importance of work both as a means by which to train mentally handicapped people, to normalise the patterns of their lives and allow them to become fully participating citizens carried on throughout this whole period. The Mental Welfare Commission for Scotland, for example, used similar arguments reports in claiming that 'work has social and psychological benefits for all people'.[1113] They discussed this with particular reference to mentally handicapped people stating:

> As well as employment potentially providing the financial means with which to raise standards of living, work (which can include studying and voluntary

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[1111] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1970, p. 211.

[1112] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[1113] Mental Welfare Commission for Scotland Annual Report 1991, Mental Health and Handicap Standing Committee, General Papers, 1992, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.

> work as well as employment) can give personal identity, daily structure to life, wider social horizons and a sense of shared purpose and achievement'.[1114]

Ideas about the value of work as a rehabilitative tool which could help give disabled people access to 'normal' patterns of life therefore remained central throughout this period. Indeed as the Mental Welfare report stated, it was continually stressed that 'work has intrinsic value, even if it is not in the form of paid employment'.[1115]

Levels of Provision and the Continuing Importance of Classification

There were many statements of intent by the LA and national legislative programmes to improve services and emphasising the importance of 'work' and 'training' for adults with 'mental handicaps' in the community, there was in fact very little done to substantially increase the day services available. The table below demonstrates the low level of provision of SOCs throughout Scotland in this period.

Numbers of Senior Occupation Centres in Scotland in 1963:

[1114] Mental Welfare Commission for Scotland Annual Report 1991, Mental Health and Handicap Standing Committee, General Papers, 1992, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.

[1115] Mental Welfare Commission for Scotland Annual Report 1991, Mental Health and Handicap Standing Committee, General Papers 1992, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.

Town/City	No. of Centres	Places for Mentally Handicapped	Places for the Physically Handicapped	Places in Combined Centres
Aberdeen	1	-	20	-
Coatbridge	1	20	-	-
Dumbarton	1	40	-	-
Dundee	2	47	-	-
Edinburgh	3	116	-	-
Fife	2	64	-	-
Glasgow	2	-	-	144
Greenock	1	30	-	-

Figures from SSMHC, Newsletter, September, 1963, p10

As would be expected because of population concentration, Glasgow and Edinburgh have the most provision available with 3 and 2 centres in each place respectively. However it is clear these were providing for an extremely small number of individuals given the relative sizes of the populations in question. Indeed the 144 places listed in Glasgow accounted for places in ‘combined centres’ which means it covered the numbers of those classed as both mentally handicapped and physically handicapped. The small-scale level of provision can be further put into perspective when we look at some figures on mental handicap estimated by the report *A Better Life*. In this report it was estimated that the numbers of mentally handicapped in Scotland who were in need of services in Scotland in the early 1970s was around 12,700 for those with ‘moderate or severe handicaps’ (7,600 of whom were adults) and 17, 950 with 'mild mental handicaps' (9,250 of whom were adults).[1116]

It had been reported in 1949 that day services for the mentally handicapped were being 'built up gradually' for example with the establishment of a section to deal with the 'aftercare' of 'handicapped' young people over school age .[1117] By 1959 there were 2,372 children with various 'handicaps' listed on this roll however there seems to have been relatively little done to provide services for these individuals.[1118] In addition there were still a great number of adults with mental handicaps who were not under consideration for community based centres at all during this time. This was due to the severity and nature of an individual's 'handicaps' which could often determine the course of action the Health and Welfare Department was to take.

As a way keeping track of the numbers diagnosed and the types of 'handicaps' present the 'Handicapped Register' was compiled by the Health and Welfare Department from 1953 onwards. This scheme was again to deal with relatively low numbers of people. For example in 1968 there were only 66 individuals added to the register because of their 'mental defects'.[1119] Furthermore the ways in which individuals were listed on this register gives some insight into the continuing problematic categorisation of these individuals and the subsequent effects this could have on their opportunities for work or 'training', post school. For example, in 1953 of the 34 people examined and added to the list for 'mental defects', 6 were classed as 'suitable for training', 7 were referred to 'occupational

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[1116] *A Better Life*, p. 12.

[1117] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1949, p. 252.

[1118] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1958, p. 371.

[1119] Reports of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1968, p. 78.

centres' and 6 were classed as 'unsuitable for training'.[1120] This type of classification was used in a similar way in 1954 where a further 9 individuals were classed as 'not interested in training or so seriously mentally handicapped as to require institutional treatment'.[1121] As we have seen in the previous chapter, categorisation continued to be significant in childhood, for example there were 35 children referred (under Section 65 of the Education (Scotland) Act, 1962) to the Health and Welfare Department as 'unsuitable for education or training at a special school' in Glasgow in 1963.[1122] However the affects of this were also to carry on into adulthood where the same diagnosis could restrict opportunities to access services in the community such as SOCs or other day centres.

A report on a JOC in Broomhill, Glasgow in 1968 helps to illustrate the effects this classification could have.[1123] This centre, which provided places for 25 children, claimed to be producing 'marked improvement physically, mentally and socially' for the 25 children. Indeed it was noted that, like many other junior and senior occupational centres, 'there [was] great demand for admission and consequently a long waiting list'.[1124] However the destinations of the post-school gives some insight into the continuity in classification from childhood to adulthood. For example of the ten children who left the school in 1968, five went to occupational centres, two left to attend different schools, two (who were presumably classed as 'untrainable') were placed in Lennox-Castle Hospital, and one went on to

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[1120] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1953, p. 292.
[1121] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1954, p. 301.
[1122] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 136.
[1123] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1968, p. 88.
[1124] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1968, p. 88.

be cared for at home.[1125] Although this example covers only a small number of people from one JOC in Glasgow, in many ways it seems to be a microcosm of the post-school destinations for people educated in these types of centres. Policy seemed to operate on the assumption that the majority were to be placed in training or occupational centres (although there were very places available in these), that those who had been deemed ‘untrainable’ or ‘ineducable’ were either to be placed in institutions or to be cared for at home, usually with very little support.

Claridge demonstrated in 1973 that main focus in provision had been on ‘the largest section of the mentally defective population, viz, the mildly subnormal or feeble-minded’ because ‘being only mildly impaired they were most likely to respond to any attempts at rehabilitation’.[1126] He went on to state that ‘more debatable is the possibility of achieving complete social independence for anything other than a small proportion of the severely subnormal’[1127] Similarly Williams observed in 1973 that ‘very low performance on an intelligence tests or diagnosis as profoundly retarded do often seem to be taken a criteria for exclusion from industrial training and employment’.[1128]

The general low level of provision available may have had an impact on this exclusion of certain ‘types’ of individuals from these services. An HMI Report in 1980 for example stressed that given the current dearth of opportunities ‘post school provision for the handicapped should be one of the most urgent areas for

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[1125] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1968, p. 88.

[1126] Claridge, ‘The Senior Occupation, p. 156.

[1127] Claridge, ‘The Senior Occupation Centre’, p. 156

[1128] Paul Williams, ‘Industrial Training and Remunerative Employment of the Profoundly Retarded’, H. C. Gunzburg (ed), *Advances in the Care of the Mentally Handicapped* (London, 1973), p. 161

attention'.[1129] In particular it highlighted the issue of waiting lists for ATCs which, it stated, had resulted in many school leavers having to 'stay at home or, in some instances, be placed in a mental deficiency hospital'.[1130] The Report stated that there were almost 4,500 places available in ATCs in Scotland in 1980, this fell far short of the number needed, estimated to be over 7,800 by the report '*A Better Life'*.[1131] In addition it was noted that the greatest shortfall of places for post-school provision for people with learning disabilities was in the Strathclyde Region.[1132]

One leaflet, produced by the Association of the Directors of Social Work claimed that 'over the course of the last 20 years the level and quality of services available in Scotland for mentally handicapped people have improved enormously…since 1976, the number of day care places had almost doubled from 3637 to 7074, since 1971 the number of places in residential establishment has increased almost 7-fold to the 1987 total of 1772'.[1133] However numerous other reports produced in this period contradict this showing that the level of provision remained inadequate. A report by the Mental Welfare Commission for Scotland in 1991, for example, noted that 'training and work opportunities including paid employment are aspects of community care which are often given insufficient

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[1129] *Provision for Profoundly Mentally Handicapped Children, Three Years On, A Progress Report by HM Inspectors of Schools* (In collaboration with colleagues from SHHD and Central Advisory Service of SWSG), February 1980, p. 6

[1130] *Provision for Profoundly Mentally Handicapped Children, Three Years On, A Progress Report by HM Inspectors of Schools* (In collaboration with colleagues from SHHD and Central Advisory Service of SWSG), February 1980, p. 6

[1131] *Provision for Profoundly Mentally Handicapped Children, Three Years On, A Progress Report by HM Inspectors of Schools* (In collaboration with colleagues from SHHD and Central Advisory Service of SWSG), February 1980, p6 and *A Better Life*, p. 12

[1132] *Provision for Profoundly Mentally Handicapped Children, Three Years On, A Progress Report by HM Inspectors of Schools* (In collaboration with colleagues from SHHD and Central Advisory Service of SWSG), February 1980, p. 6

[1133] Mental Health and Mental Handicap Standing Committee, General Papers, Records of the Directors of Social Work, Executive Committee Minutes, ADSWA1/6.2.1

attention'.[1134] They stressed that for 'mentally disabled people…being out of hospital all too often means being out of work'.[1135]

After-Care and 'Occupational' Centres; Continuity with the Previous Era

MOH reports throughout the 1950s and 1960s seemed to suggest that the After Care Services had produced a level of success in provision for adults with 'handicaps' in Glasgow. It noted in 1959 that the After Care Service had been in place for 10 years and had interviewed some 6000 young 'handicapped' persons.[1136] It was reported that all children leaving the 9 special schools and 11 JOC and receiving home tuition were interviewed when they reached 16.[1137] In these interviews 'general advice about the children's future' is given along with encouragement to seek the use of the departments services.[1138] The After-Care Section reported in 1968 that since its inception 19 years previously 10, 808 young handicapped people had used their services. It argued that 'the majority have been helped to find their place in life and are now independent and fairly responsible members of the community'.[1139] This again is contradicted by firstly, the level of provision available for adults 'in the community' in Glasgow and indeed by the fact that in the late 1960s and early 1970s

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[1134] Mental Welfare Commission for Scotland Annual Report, 1991, Mental Heath and Handicap Standing Committee, General Papers 1992, Records of the Association Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5

[1135] Mental Welfare Commission for Scotland Annual Report, 1991, Mental Heath and Handicap Standing Committee, General Papers 1992, Records of the Association Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5

[1136] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1959, p. 33.

[1137] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1959, p. 33.

[1138] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1959, p. 33

[1139] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1968, p. 339.

there were still over 1,500 patients in Lennox Castle hospital alone, most of whom were ‘capable’ of living in the community if there were the day and support services in place.[1140]

The MOH reports however continually stressed the importance of home visits by the After-Care Section.[1141] For example, in 1951, it was reported that there were 1,700 on the roll of the After-Care Section and that there had been almost 4000 visits paid by the After-Care officer and her two assistants.[1142] It was argued again in 1952 that ‘the home visitation of children who have just left special schools continues to be of great value’ stressing that ‘the necessity of placing handicapped boys and girls in employment suitable to their disability cannot be over-estimated’.[1143] Home visit were therefore presented as a means by which to assess the individual’s ‘working capacity and ability’.[1144]

However it can be suggested that, given the numbers of places available in training centres at the time, the success of the After-Care Section was, at best, limited. Indeed in some ways the work of the After-Care Section can be seen as a continuation of the work of Guardians and Supervision Boards of the earlier period. During this time the Mental Deficiency Acts of 1913 had stipulated that institutions, guardians and occupational and industrial centres were to provide care, supervision and control.[1145] These aims do not seem so far removed from the work, highlighted

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[1140] GGHB, *Development of Community Services*, p. 4.
[1141] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1951, p. 305.
[1142] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1951, p. 305.
[1143] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1952, p. 297.
[1144] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1952, p. 297.
[1145] Jan Walmsley, Dorothy Atkinson and Sheena Rolph, ‘Community Care and Mental Deficiency 1913 – 1945’, in Peter Bartlett and David Wright, *Outside the*

here with one of the main emphasis of the After-Care Section being on 'home visits', with the continued institutionalisation of a number of the 'untrainable mentally handicapped' and with the provision of 'occupational' centres where vocational and 'social' training was to take place.

In addition there seemed to be a continued concern with sexuality, a characteristic of earlier 'eugenic' policies of care, control and supervision. Reference was made, for example, in the MOH Report of 1957 to the 'large increase in marriages of handicapped persons throughout the year which gives cause for not a little concern'.[1146] The following year's report also stressed that marriage should be discouraged among 'educationally subnormal females' who should instead be encouraged to take up employment as there were positions available for those who were 'willing and anxious to work'.[1147] This was seen as one solution to the problem as the report stated that 'unfortunately many marry at an early age and household responsibilities of a wife, and later of a mother, are rather beyond their capacity'.[1148] In addition the male and female trainees in SOC and day centres were intentionally kept separate for most of the period. In the case of the local authority centres the men and women were 'trained' in separate facilities and in others such as the Thomas Fortune Work Centre (TFWC) opened by the SSMH in the 1950s, men and women were brought in on different days, or trained in different rooms and friendships or relationships between the two groups were discouraged whenever

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Walls of the Asylum: The History of Care in the Community 1750 – 2000 (The Athlone Press: London, 1999), p. 184.

[1146] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1957, p. 383.

[1147] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1958, p. 371.

[1148] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1957, p371 possible.[1149] This was highlighted by a manager who came to the centre in the 1980s when she stated that 'the reason for the separate days was that people had a fear that people may well enter into any kind of intimate relationship'.[1150]

The work of the After-Care Officers therefore seemed to involve the encouragement of these individuals into 'suitable' occupations or training and, particularly in the case of the girls, discourage ideas of marriage and parenthood for those who were deemed to be 'incapable'. The work of the After-Care Section alongside the training to be provided by occupational and training centres did not seem to differ too much therefore from the old system of Guardianship and Supervision. Indeed one statement made by a commentator in 1926 that the Occupation Centre was 'one of the most satisfactory ways of keeping in touch with defectives living in their own home or under guardianship' did not differ to much from the thought behind occupational centre provision and home visitation in the post war era.[1151]. Indeed Walmsley's claim that 'some care in the community can be as regimented and institutionalised as care in institutions' may have prevalence here.[1152]

Jones and others have highlighted role of the LA, and later social work departments, in providing a means by which to maintain contact and supervision. For example Jones stated in the 1970s there was an 'increasing emphasis…[on] the

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[1149] Reffered to in SOHCA/024/1 Interview with Ann Ainsworth, 6th June 2006 and SOCHA/024/9 Interview with John Smyth and Alan Mack, 4th March 2006

[1150] SOHCA/024/1 Interview with Ann Ainsworth

[1151] Ruth Darwin, Paper given at Mental Welfare Conference 1926, quoted in Jan Walmsley, Dorothy Atkinson and Sheena Rolph, 'Community Care and Mental Deficiency 1913 – 1945', in Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Community Care 1750 – 2000* (London, 1999), p. 191.

[1152] Jan Walmsley, Dorothy Atkinson and Sheena Rolph, 'Community Care and Mental Deficiency 1913 – 1945', in Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Community Care 1750 – 2000* (London, 1999), p. 181.

monitoring and control of individuals and families'.[1153] Furthermore Younghusband has pointed to similar concerns whereby 'social workers had to face, as probation officers had long done, the dilemma of exercising control as well as care functions'.[1154] This, she argued, meant that 'to some social workers care and control were part of the same continuum'.[1155] As a result there was some continuity in the new types of services provided in SOCs and ATCs with those identified in older services that were explicitly concerned with supervision. However training centres for adults with mental handicaps were to become even more dominant in the 1970s as employment opportunities elsewhere were to decrease.

The Wider Picture; Employment Opportunities and Continued Segregation

In 1968 the After-Care Section claimed that 81% of the educationally subnormal school leavers had obtained employment 'which is the highest for several years'.[1156] However this figure, and indeed the claim that the vast majority of this group were in employment is refuted by other sources in this period. The MOH Report of 1958 had first highlighted the problems 'high unemployment' for this group referring to the importance of the work of the After Care Section. It was noted for example how 'it is difficult to get these young people to maintain good standards of tidiness and cleanliness where there is to them no apparent need'.[1157] After-Care officers were

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[1153] Chris Jones, *State Social Work and the Working Class* (London, 1983), introduction

[1154] Eileen Younghusband, *The Newest Profession, A Short History of Social Work* (Sutton, 1981) p. 26.

[1155] Younghusband, *The Newest Profession*, p. 26.

[1156] Report of the Medical Officer of Health, City of Glasgow, Corporation of the Glasgow, 1968, p. 339.

[1157] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1958, p. 371.

therefore to be responsible for trying to stop this ‘deterioration’ of school leavers presumably in a time where there were little other opportunities of ‘occupation’ or employment. This seemed to affect certain types of individuals more than others. For example it was reported in 1960, ‘the majority of leavers from the junior occupational centres have been unable to secure employment and consequently they have remained at home attending the senior occupational centres’.[1158]

In addition the MOH reports pointed to the gendered aspect of post-school opportunities, for example, stating in 1960 that:

> For the girls the pattern of work has not changed much over the year, but for the boys the picture is quite different, only a very few of the high grade lads, and usually the declassified have been able to get an apprenticeship, and then usually with family support.[1159]

Similarly the MOH report in 1964 pointed to the reduction of traditional types of jobs for ‘sub-normal’ boys stressing:

> Only the higher grade and more enterprising educationally sub-normal boys obtained fairly good jobs immediately after they left school…the less capable after several months unemployment accepted any type of work available and some are working long-hours for fairly low wages.[1160]

[1158] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1960, p. 31.

[1159] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1960, p. 375.

[1160] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 375.

Economic circumstances and unemployment rates are implicated as it is stressed that 'very few of the boys are workshy'.[1161] The situation for girls however is presented as different as it was reported that there were 'sufficient jobs for those able to work'.[1162] This was more down to the types of jobs female 'ESN' school leavers were expected to take in low paid positions.

Furthermore many sources in the 1970s and beyond pointed to an altogether more desperate situation for 'mentally handicapped' school leavers. A Report by the National Development Group for the Mentally Handicapped in 1976, for example, stated that 'whilst much effort is expended on educating and training mentally handicapped adults the success rate for obtaining employment has been dismally low'.[1163] Similarly the report, *A Better Life,* in 1979 highlighted the serious lack of employment provision and opportunities for both boys and girls with 'mental handicaps' post school. It stressed the need for more 'work centres' which they foreseen as filling the gap between the traditional ATC and more specialised sheltered workshops where the individuals would be in supported jobs.[1164] It stressed that there had been very little progress by the statutory agencies with this type of provision noting that 'employment opportunities for the mentally handicapped are, if anything, worse than they were in 1972'.[1165] A report on day services in Strathclyde in 1984 pointed again to the 'extreme difficulties' in gaining employment for 'mentally handicapped' adults. In particular it pointed to a recent National Children's Bureau study which demonstrated that 'handicapped young people in general are

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[1161] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 375.

[1162] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1964, p. 375.

[1163] *Mental Handicap: Planning Together,* National Development Group for the Mentally Handicapped, HMSO, Pamphlet No. 1, July 1976, p. 15.

[1164] *A Better Life*, p. 6.

[1165] *A Better Life*, p. 12.

restricted to a very narrow range of insecure, low level jobs and are five times more likely to be "underemployed" than their non-handicapped counterparts'.[1166] It also drew attention to the 'current economic climate' as a 'period of cut-back and recession, with basic rights to employment being continually eroded'.[1167]

In addition *A Better Life* also noted some further reasons for the lack of progress in the previous decade distinguishing between the rhetoric of progress and development in policy documents and the real situation whereby the local authorities were restricted in the expenditure available for ventures in the area of employment. Indeed the report stated that with the 'constraints of LA expenditure…objectives set in 1972 have little chance of being met by 1980'.[1168] Records of the Association for the Directors of Social Work in Scotland suggest that there may have been other parts of provision which were seen as higher priority than these types of services. In one report, from 1978, the convener of the Mental Health and Mental Handicap Committee reported that it had been difficult to generate any interest in this committee.[1169] In the end this individual resigned from his role as convener the following year, the minutes suggesting that there was confusion over the roles and position of this Standing Committee.[1170] Jones argued in 1983 that the growth rates in personal social expenditure had dropped repeatedly since 1974. He pointed to the 'impact of these reductions' which had been 'magnified' by unemployment and recession and had resulted in widening 'acute' poverty.[1171] He stressed that 'never has poverty in material terms been such as factor in whether people…require to be

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[1166] '*Adults Only',* p. 29.

[1167] *'Adults Only',* p. 29.

[1168] *A Better Life*, p. 12.

[1169] Records of the Association of the Directors of Social Work, Executive Committee Minutes, 8th December 1978, ADSWA1/1.1.64

[1170] Records of the Association of the Directors of Social Work, Executive Committee Minutes, 28th March 1979, ADSWA1/1.1.65b

[1171] Jones, *State Social Work and the Working Class*, p. 1.

‘in care’ or can survive in the community’.[1172] Jones argued that ‘most local authorities have been compelled to reduce their service provision annually since 1976’.[1173] He noted that ‘these reductions do not, however, reflect a decreasing demand by clients for these services’.[1174] In fact, as we have seen in the case of day services, demand was increasing at a time when provision was not a priority for the LA or social work and there was little investment in extending services.

This was all to affect the employment and training opportunities for ‘mentally handicapped’ people upon leaving school. The table below demonstrates the results from one study carried out by social work in Strathclyde in 1985 looking at the importance of day services. It gives a picture of the typical ranges of post-school placements for each type of special school group (formally known as Mild, Severe and Profound), the most common placements for each group are marked with an asterisk (*).

[1172] Jones, *State Social Work and the Working Class*, p. 1.
[1173] Jones, *State Social Work and the Working Class*, p. 2.
[1174] Jones, *State Social Work and the Working Class*, p. 2.

Post School Placement by Type of Special School

Type of School	**Range of Placements (Post School)**	**Range of Places of Residence**
Moderate Learning Difficulties	Open Employment	Independent Living
	Sheltered Employment	Group Tenancies
	FE College*	Sheltered Housing
	Adult Training Centre*	Hostel
	No placement	Family Home*
Severe Learning Difficulties	FE College	Group Tenancies
	Adult Training Centre*	Sheltered Housing
	No placement	Hostel
		Family Home*
Complex Learning Disabilities	Day Centre	Hostel
	Hospital	Family Home*
	No Placement*	Hospital

Taken from *Adults Only', A Report on Day Services for Mentally Handicapped Adults*, Lanark Divisional Management Team, Department of Social Work in Strathclyde (January, 1985), Appendix 8

It is clear from this table that the opportunities for mentally handicapped adults post school were still dependant largely on the ‘severity’ of their diagnosed impairments. This was after the publication of the Warnock Report and in an era where there was a focus on a ‘continuum of needs’ and a move away from impairment classifications. However it is clear here that classifications still played an important part in post-school provision. In addition it is clear that movements towards more employment and integration up until this point had been largely unsuccessful as the most common placements still seemed to be at ATCs alongside college placements for those with ‘moderate learning difficulties’. It is also clear from this study that care at home was the most common of all living arrangements for all groups and that places in ATCs were the most in demand. However, whilst demand for ATC and day centre places was to remain in this later part of the period, the functions and activities of these centres were to come under more scrutiny resulting in a shifting in ideology.

The Shifting Functions of Day Centres

Towards the end of the 1970s differing views began to emerge about the value of centres that concentrated largely on filling orders for contract work. Some began to comment about the failure of occupational centres or work in training adults with mental handicaps in centres as a stepping stone to opportunities in open employment in similar types of jobs. For example one survey of 11 local authorities in England and Wales in 1975 stated that ‘two-thirds of trainees did not have the basic skills which would make them immediately employable in modern industrial society'.[1175] It was stressed that the focus on industrial training had often meant that the 'completion of contracts took precedence over the development of skills'.[1176]

The report *A Better Life* stated that 'employment opportunities for the mentally handicapped are, if anything, worse than they were in 1972'.[1177] Indeed, work centres and other 'work' driven day services had not made inroads into extending their training to allow the clients to work in open employment. For example, the SSMH in 1963 stated that the role of their work centre was to provide an environment to promote 'assimilation to simple jobs in industry'.[1178] However they reported in 1981 that 'over the years few trainees have been able to progress to outside employment'.[1179] Similarly, the MOH reported in 1960, that 'the majority of leavers from the junior occupational centres have been unable to secure employment and consequently they have remained at home attending the senior occupational centres'.[1180]

A report by the National Development Group for the Mentally Handicapped in 1976 stated that 'whilst much effort is expended on educating and training mentally handicapped adults the success rate for obtaining employment has been dismally low'.[1181] Similarly the report *A Better Life* in 1979 highlighted the serious lack of employment provision and opportunities for both boys and girls with mental handicaps post school.[1182] A report on day services in Strathclyde in 1984 pointed again to the 'extreme difficulties' in gaining employment for mentally handicapped adults.[1183] In particular, it pointed to a recent National

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[1175] Kathleen Jones, *Opening the Door: A Study of New Policies for the Mentally Handicapped* (London 1975), p. 164.
[1176] Jones, *Opening the Door,* p. 164.
[1177] *A Better Life,* p. 12.
[1178] SSMHC, Newsletter, March, 1963, p. 2.
[1179] SSMHC, Newslink, 1981, No. 3, p. 10.
[1180] Report of the MOH, City of Glasgow, Corporation of Glasgow, 1960, p. 31.
[1181] Mental Handicap: Planning Together, National Development Group for the Mentally Handicapped, HMSO, Pamphlet No. 1, July 1976, p. 15.
[1182] *A Better Life*, p. 6.
[1183] Quoted in *Adults Only*, p. 29.

Children's Bureau study which demonstrated that 'handicapped young people in general are restricted to a very narrow range of insecure, low level jobs and are five times more likely to be "underemployed" than their non-handicapped counterparts'.[1184] It also drew attention to the 'current economic climate' as a 'period of cut-back and recession, with basic rights to employment being continually eroded'.[1185] Similarly a later report by the Mental Welfare Commission stated that the rise in automation and high rates of unemployment had led to a shrinking of the manufacturing industries and the types of roles these 'work' or 'occupation centres aspired to.[1186] This led some to question the focus on preparation for work in a climate where few 'suitable' positions were available, noting that this was purely preparation for disillusionment.[1187]

The overall aims of occupation centres and work centres were therefore not being realised as very few 'trainees' had been able to use the centres in the way they had been envisaged. As opposed to the ideal 'work' model of care whereby trainees were to be given the opportunities to develop skills and ultimately 'progress' onto jobs in open employment, these centres had often become a permanent fixture in the lives of people with mental handicaps. Consequently, the day-to-day activities in these centres came under more scrutiny. For example, one report noted that the attendees were engaged in 'mundane' tasks such as assembling or packaging simple pieces of equipment.[1188] The report also stressed that contract work was often hard to come by as 'it had to be of a type which provided

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[1184] Quoted in *Adults Only*, p. 29.
[1185] Quoted in *Adults Only*, p. 29.
[1186] Mental Welfare Commission for Scotland Annual Report, 1991, Mental Health and Handicap Standing Committee, General Papers 1992, Records of the Association Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.
[1187] Mental Welfare Commission for Scotland Annual Report, 1991, Mental Health and Handicap Standing Committee, General Papers 1992, Records of the Association Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.
[1188] Jones, *Opening the Door*, p. 166.

remuneration but not enough to make it attractive to outside workers.[1189] It was also described as often ‘dull and repetitive, providing little opportunity for moving trainees from simple tasks to more complex ones’.[1190] This led Jones to comment in 1975 that ‘the result was a system which sometimes bears more relation to the nineteenth-century concept of ‚setting the poor to work’ than to modern ideas of social development’.[1191]

Reports on one work centre in Glasgow provide similar descriptions of the types of activities that took place during the day with the work in one centre described as being ‘of a simple repetitive kind’.[1192] Tasks were said to involve folding, cording, making tags packing plasters and cardboard box divisions.[1193] These activities, witnessed by one respondent, were described as:

> High volume, low paid…some of the work was extremely mundane it was bagging single plasters into bags. It was an old school building you can imagine therefore…the whole building still held the cultural thing of a classroom and of a teaching set up. So people were in their own rooms with their desk, their seat and their instructor, or teacher almost, and it was mainly bagging plasters.[1194]

As a result, the daily activities of these centres began to come under further scrutiny from those who saw little value in simply occupying the clients. Welshman and Walmsley state that in the 1970s, although the rhetoric of care services was about development and potential, the reality was that many services concentrated on basic physical care.[1195] Indeed they

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[1189] Jones, *Opening the Door,* p. 166.
[1190] Jones, *Opening the Door,* p. 166.
[1191] Jones, *Opening the Door,* p. 167.
[1192] SSMHC, Newsletter, December, 1965, p. 11.
[1193] SAPHC, Newsletter, March, 1960, p. 3.
[1194] SOHCA/024/1, Interview with Ann Ainsworth, 6th June 2006
[1195] Welshman and Walmsley, *Community Care in Perspective*, p. 11.

commented that these centres, ‘were in danger of becoming little more than big buildings in which the mentally handicapped are protected from the outside world’.[1196] Some commentators began to argue that there needed to be a distinction made between approaches ‘which sustain or maintain an existing pattern of living, and those which promote change’.[1197] Questions began to emerge about the assumption that the ‘client’ was gaining ‘satisfaction from pretending to be at work while the parent gets respite and the tolerability of the home situation for both parties is sustained’.[1198]

Indeed it was revealed in a study of the ‘consumers’ of services in hostels and ATC’s was carried out in Wandworth in 1974 that 62% preferred creative activities to industrial work and 66% said that they would have liked ordinary jobs.[1199] The responses of these individuals were compared against the answers of staff and relatives and it was found that both groups ‘significantly underestimate the degree to which handicapped people saw a proper job and their eventual goal, and also the extent to which they wanted serious friendships with members of the opposite sex’.[1200] Parents and carers therefore, in this case were at times seen to be preventing the progress of ‘normalisation’ in their ‘low’ expectations of individuals classed as ‘mentally handicapped’. In addition a total of 25 of the residents interviewed for the CMH project attended local ATCs and had mixed feelings about these institutions. Both of the centres concentrated mainly on fulfilling industrial contracts and whilst 14 of the residents reported to like going to the ATC, 8 of these were reported to

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[1196] Welshman and Walmsley, *Community Care in Perspective*, p. 11.

[1197] Dr Philip Seed, Supported Accommodation and Day Services for People with Learning Difficulties, Paper given to Dundee and Stirling Universities Seminar 11th October, 1990, p. 11.

[1198] Dr Philip Seed, Supported Accommodation and Day Services for People with Learning Difficulties, Paper given to Dundee and Stirling Universities Seminar 11th October, 1990, p. 11.

[1199] David Brandon and Julie Ridley, *Beginning to Listen: A study of the views of residents living in a hostel for mentally handicapped people’* (London, 1983), p. 7.

[1200] Brandon and Ridley, *Beginning to Listen*, p. 7.

imagine themselves working outside the centre and would prefer to do this.[1201] In addition it was noted that ‘the desire to do an ordinary job and earn ‘real wages’ was expressed repeatedly’.[1202] Furthermore it was stressed that:

> It became clear that most people did not know what the finished article they were working on was going to be [therefore] the activity was often felt to be meaningless, and the interviewees experienced a sense of powerlessness over their situation.[1203]

Local authorities now began to look more towards emerging ideals of normalisation and social role valorisation which suggested a new emphasis on ‘behaving in a socially valued way and in being positively valued by others’.[1204] Robinson stressed that normalisation, such as that advocated by Wolfensberger, emerged ‘from the premise that a major handicap of disabled people is their devaluation in society, and it seeks to remedy this by enabling disabled people, as far as possible, to have experiences that are generally valued in society’.[1205] This new set of principles suggested ‘the utilisation of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible’.[1206] This, Walmsley explains, ‘was intended to enhance people’s behaviour, appearances, experiences, status and reputation so that they would not be socially devalued.’[1207]

[1201] Brandon and Ridley, *Beginning to Listen*, p. 17.

[1202] Brandon and Ridley, *Beginning to Listen*, p. 18.

[1203] Brandon and Ridley, *Beginning to Listen*, p. 18.

[1204] Shulamit Ramon, *Beyond Community Care: Normalisation and Integration Work*, (London 1991), p. 9.

[1205] Robinson, *Community Care with Mentally Handicapped People*, p. 5.

[1206] Jan Walmsley, Ideology, Ideas and Care in the Community, 1971 – 2001, in Welshman and Walmsley (eds.), *Community Care in Perspective*, p. 43.

[1207] Jan Walmsley, Ideology, Ideas and Care in the Community, 1971 – 2001, in Welshman and Walmsley (eds.), *Community Care in Perspective*, p. 43.

Centres were now encouraged to focus on wider ‘social’ training for example in raising awareness of ‘personal health’ in areas such as ‘bodily function, hygiene, diet, dental and general health’.[1208] Robinson has also shown the importance of this new focus on utilising an ‘ordinary life philosophy’ as laid out by the Campaign for Mental Welfare in 1984, which included the provision of new types of adequate day services with awareness of individual plans and age-appropriateness of activities.[1209] Significantly areas such as personal appearance were to become more significant as was the importance of an ‘adult’ image with the avoidance of ‘childish’ associations.[1210] This was linked to the dissatisfaction that some had expressed over the state of adult services and, in some cases, the lack of distinction between child and adult provision. Jones, for example, in 1975 pointed towards the continued reliance on old-style day centres housed in unsuitable buildings, one which she described as looking ‘more like an old prison than a training centre’.[1211] She went on to describe other centres which were housed in ‘ex-Board schools from the beginning of the century…no longer deemed suitable for ‘normal’ children“.[1212] The report also highlighted the fact that a good number of centres for adults were still joined onto junior training centres, which could cause ‘administrative confusion’ as two different authorities were responsible for each part.[1213]

A Scottish HMI report from 1980 pointed to a lack of provision of adults services which, it was again noted, were often housed within special schools. The report gave an example of an adult training centre and a special school housed under one roof in premises owned by social work and stressed ‘this can raise problems, particularly, for example,

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[1208] *A Better Life*, p. 95.
[1209] Robinson, Community Care with Mentally Handicapped People, p. 8.
[1210] Walmsley, Ideology, Ideas and Care in the Community, 1971-2001, p. 43.
[1211] Jones, *Opening the Door*, p. 162.
[1212] Jones, *Opening the Door*, p. 162.
[1213] Jones, *Opening the Door*, p. 162.

difficulties over shared transport'.[1214] This report also argued that 'wherever possible school age and adult provision should be separate because the regime and ethos have to be different'.[1215] However this separation of children and adult services was not always realised in practice. One respondent, who had attended a work centre for most of her adult life, recalled the importance of the location stating, "well it was ok; it used to be my old school…then they made it into a work centre and I went back and I went what the hell is this, you know, and I was looking and it was the old work centre and I though wit am I doing here…back at the old school".[1216] An example is given below of a training centre in Glasgow housed in a former school.

[1214] Provision for Profoundly Mentally Handicapped Children, Three Years On, A Progress Report by HM Inspectors of Schools (In collaboration with colleagues from SSHD and Central Advisory Service of SWSG), HMSO, Edinburgh, February, 1980, p. 6.

[1215] Provision for Profoundly Mentally Handicapped Children, Three Years On, A Progress Report by HM Inspectors of Schools (In collaboration with colleagues from SSHD and Central Advisory Service of SWSG), HMSO, Edinburgh, February, 1980, p. 6.

[1216] SOHCA/024/2 Interview Margaret Macallon, 31st February 2006.

Dalmarnock Adult Training Centre in Glasgow, Formerly Strathclyde Primary School in the 1970s.[1217]

In addition to the centres being housed in less than ideal premises one respondent also pointed towards some of the language that was used in the centre which, she stated, in some cases had helped to re-instate this perception of the adults attending the centre childlike. For example she noted that they were called the 'boys' and the 'girls' irrespective of their age.[1218] She also mentioned that she had, on occasion, noticed the support workers and instructors, speaking to people using the service in a very kind of punitive manner'.[1219]

As a result there was a need for a concerted effort to separate children and adults, particularly in state services. Another requirement was to further 'encourage mentally handicapped people to learn new skills and take on characteristics which are more like others of their own age, regardless on the severity of their handicap'.[1220] Some warned of the danger of this type of approach such as Ryan who commented in 1980 that 'normalization should be adopted with care, since it could develop into a narrow ideology, or mean greater pressure on mentally handicapped people to adjust to prevailing customs and standards rather than being able to determine their own'.[1221] However, Walmsley and others have shown that throughout the country more than ever before services and service providers were now to become 'key agents in the promotion of an ordinary life'.[1222] This was to have a knock-on effect on the daily activities of many local authority run day centres throughout Glasgow which were now

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[1217] The premises were used for Strathclyde Primary School until 1974 and were re-opened in 1976 to house the Dalmarnock Adult Training Centre.. http://www.theglasgowstory.com/imageview.php?inum=TGSA02453.

[1218] SOHCA/024/1 Interview with Ann Ainsworth, 6th June 2006.

[1219] SOHCA/024/1 Interview with Ann Ainsworth, 6th June 2006

[1220] Robinson, *Community Care with Mentally Handicapped People*, p. 8.

[1221] Robinson, *Community Care with Mentally Handicapped People*, p. 8.

[1222] Jan Walmsley, 'Ideology, Ideas and Care in the Community', p. 43.

to focus less on traditional work training and more on the development of ‘well rounded’ individuals.

Walmsley has shown that the impact of adherence to ideals of normalisation and social role valorisation was to discredit the activities of large-scale training centres and promote more community based options. However she also notes that these centres did not, in fact, disappear, but in England and Wales they were renamed Social Education Centres and the old traditions of contract work were discontinued.[1223] The consequences of this, she argues, were ‘those attending were subject to a life of perpetual leisure and ‘education’, but education for what was rarely articulated’.[1224] Similarly she points to the dislike of some service users of these types of activities ‘regretting the loss of associations, however exploitative, with the adult world of wages, regular working hours and productivity’.[1225]

One of the charity run centres in Glasgow, which resisted the general movement towards ‘social’ or ‘cultural’ activities in favour of the continuation of contract work, emphasised that this gave ‘immediate benefits to the workers through having companionship and a sense of purpose in their lives’.[1226] One respondent recalled that whilst ‘city council run establishments changed to offer social and educational and recreational activities…they [the charity run centres] continued to focus on the work because they continued to hold onto the belief that people had a sense of achievement in that they were going to their work like other people’.[1227] Much of the personal testimony collected from trainees re-instated this idea. One, for example, talked with a degree of pride about how he enjoyed going to ‘his work’ for ‘the

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[1223] Jan Walmsley, ‘Ideology, Ideas and Care in the Community’, p. 46.
[1224] Jan Walmsley, ‘Ideology, Ideas and Care in the Community’, p. 46.
[1225] Jan Walmsley, ‘Ideology, Ideas and Care in the Community’, p. 46.
[1226] SSMH, Newsletter, June 1970, p. 5.
[1227] SOHCA/024/1, Interview with Ann Ainsworth, 6th June 2006.

company'.[1228] This was reiterated by another who stressed the importance of the relationships she had developed with the other trainees, stating, for example, 'well it was really good cos, you know, I used to get my friends up and down on the bus'.[1229]

However, further testimony from a former support worker proposes that this may be due to the length of time many of the service users had been attending the centre suggesting that the culture of the centre in the past had encouraged low expectations and resistance to change amongst this older generation. For example she pointed towards 'some of our older people here whose expectations now are such that they are quite happy to remain perhaps within a day centre'.[1230] In addition she stated that, 'some of our folks probably even miss the very traditional service that was down the road you know and yet… it was a disservice that we were doing a lot of the times because you know we had people almost dependant on us'.[1231] Indeed one former long-term 'trainee' at this particular centre when asked about life aspirations beyond the centre stated, 'I just wanted to do something different….cos there are some things I wanted to do that I don't get the chance to in here'.[1232]

This particular centre seemed to be atypical in its continued use of the old style traditions of work and industrial training. In 1985, a report was produced from 12 months of investigations by the working party on day services for the mentally handicapped in the Greater Glasgow area.[1233] Members of the working party included senior social workers, psychologists from child guidance clinics, community education representatives as well as leading members of local voluntary agencies and managers of centres. The report pointed to the need to 'question, review and amend policies in provision of services to mentally

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[1228] SOHCA/024/3, Interview David Colston, 24th February 2006.
[1229] SOHCA/024/2, Interview Margaret Macallon, 31st February 2006.
[1230] SOHCA/024/1, Interview with Ann Ainsworth, 6th June 2006.
[1231] SOHCA/024/1, Interview with Ann Ainsworth, 6th June 2006.
[1232] SOHCA/024/2, Interview Margaret Macallon, 31st February 2006.
[1233] *Adults Only*, p. 29.

handicapped people'.[1234] It demonstrated that there had been a general shift in the focus of day centres in this area towards 'social education' and this was to be developed further with more focus on 'the provision of services designed to increase social skills and basic education, and less emphasis…on traditional methods of training'.[1235]

Yet, whilst there was a move away from a focus on contract work and a new affinity with aspects of normalisation and social role valorisation discussed earlier, there was also a focus on the shared responsibilities for the new focus on community integration. For example, whilst stressing the role of communities in being more open to mentally handicapped individuals, the importance of access to 'normal' patterns of life through integrated work, housing and leisure, it also stressed that the mentally handicapped themselves had a role in easing their integration into the community.[1236] For example, it was asserted that 'subtle reciprocal elements come into play…mentally handicapped adults will need to be aware both of their own requirements and the legitimate needs of other people within their community'.[1237] Further to this was pointed to areas of concern which the service users should be aware of such as 'the complex area of learning how to approach people sensitively, how to listen well and to communicate effectively'.[1238] The report stated therefore, 'if we do intend to promote integration within the community then the philosophy and the objectives of the adult training centre will require radical change' with a focus of 'providing a social, educational and recreational programme for adults with special learning and care needs'.[1239]

There was also a new emphasis on the 'rights' of service users stressing services must strive to 'acknowledge the rightful place of mentally handicapped adults in ordinary everyday

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[1234] *Adults Only*, p. 1.
[1235] *Adults Only*, p. 2.
[1236] *Adults Only*, p. 5.
[1237] *Adults Only*, p. 5.
[1238] *Adults Only*, p. 5.
[1239] *Adults Only*, Appendix 9.

life in their own communities and in society generally'.[1240] This suggested a move away from both 'occupying' people and the reliance on traditional ideas of 'work training' and resistance to ideas of supervision and control perhaps implicit in previous types of services. It was critical, for example, of the use of training centres as 'full-time, permanent segregated solutions' and highlighted the overuse of 'batch strategies' where large groups of 'mentally handicapped people' were bussed on outings.[1241] In additional, it promoted both integration and a rights-based agenda for the clients of these services, for example stating that:

> Security has for too long been the dominating concept in providing services to such adults…mentally handicapped people, no less than their brothers and sisters have a variety of roles within our society and have equal rights…[The report] suggests that the door need no longer be locked, and access by the mentally handicapped adult to the wider community barred by our own actions.[1242]

This movement towards 'normal' patterns of life and opportunities for integration as well as less segregated 'occupation' was certainly apparent. However the day centre remained the key institution 'in the community' through which society was to deal with adults with mental handicaps, even when it was demonstrated that these centres were not always helpful in the aim of achieving these 'normal' pattern of life.

In addition, the relationship of centres to the local community was sometimes to undermine the idea of integration and access to a 'normal' life. For example, testimony from one centre suggests that although it was housed within the local community, it still remained largely excluded. For example one respondent recalled how it was 'a segregated building…it

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[1240] *Adults Only*, p. 1.
[1241] *Adults Only*, p. 5.
[1242] *Adults Only*, p. 3.

was isolated, although we were in the community we weren't part of the community'.[1243] One of the clients of the service suggested that one of the reasons for the lack of community participation was a concern for the safety of the trainees. She stressed 'we did not go anywhere out in the community in case anything happened to any of us'. [1244]

This issue of segregation even 'within' communities continued to be of relevance to the opportunities offered to people with mental handicaps. For example, it was stressed in 1971 that there was a need to 'increase public awareness and understanding of the mentally handicapped…barriers of ignorance, fear and prejudice undoubtedly exist at present…increased understanding will improve public attitudes and perhaps lead to pressure for better services'.[1245] However, figures such as Metzel's in her work on 'mental retardation' in the USA point to the realities of this increased exposure to services for adults with 'mental retardation' in the local community. In particular, she highlights the 'volatile issue' of care in the community as new hostels/day centres were being built in residential areas.[1246] Similarly, a report from Scotland noted the importance of public attitudes noting that the implementation of 'community homes' for people with learning disabilities did not automatically mean individuals would become part of the community. It noted that these homes could be both 'geographically part of a neighbourhood' and 'socially ostracised'.[1247] Turner's ideas of 'social suspension' thus seems particularly relevant here as these individuals were often in a position of being 'nether completely a part or completely excluded from modern life'. [1248]It stressed therefore that 'the most effective methods of altering public

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[1243] SOHCA/024/1 Interview with Ann Ainsworth, 6th June 2006.

[1244] SOHCA/024/2, Interview Margaret Macallon, 31st February 2006.

[1245] *A Better Life*, p. 29.

[1246] Walmsley, 'Ideology, Ideas and Care in the Community', 1971-2001, p38.

[1247] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[1248] Nick Watson, 'Daily Denials: The Routinisation of Oppression and Resistance', in Watson and Riddel, *Disability, Culture and Identity,* p35.

attitudes still need to be studied' and that 'such campaigns should certainly involve schools'.[1249]

Oral testimony also suggests the impact of 'community attitudes' which could be a major barrier in the aims of promoting 'normal' patterns of life and 'integration' in day centres. For example one participant explained, 'there wasn't a lot of community participation, people were probably hoping that we would move out because it was within the village of Drumchapel and a prime site that we were holding that now has beautiful luxury flats in it…people round about the building then…kind of thought…we've got lunatics on our doorstep which brings the prices of our houses down and therefore we didn't feel kinda welcome or feel comfortable'.[1250]

Drumchapel School in 1970s which became the TFWC in the late 1980s.
http://www.theglasgowstory.com/imageview.php?inum=TGSA02508

[1249] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[1250] SOHCA/024/1 Interview with Ann Ainsworth, 6th June 2006.

Jones has therefore argued that in many cases sites for centres were chosen, not to encourage 'normalisation' or integration into the surrounding community but, 'because they happen to be available at the time….or because the local population does not object too strongly, because they are close to industrial plants'.[1251] Thus many of these centres continued to be run out of less than suitable premises. For example, 22 of the 32 services listed in a report on voluntary run centres in Scotland in 1986 were found to be housed in facilities built for other purposes such as schools and houses. [1252] These day services, run by voluntary agencies, also often had a regional bias, for example 60% were in the Strathclyde (Greater Glasgow) Region. [1253] Whilst this suggests that adults with mental handicaps in Glasgow and the surrounding areas may have had more access to day centre service than elsewhere in Scotland, Britten suggests that this may have been more due to the prevalence of non-residential areas or 'industrial estates with no local community to worry about'.[1254] This continued feeling of segregation from community participation, even when people with mental handicaps were accessing services outside of hospitals that were physically housed in the community, suggests that the aims of 'normalisation' and later 'integration' were often far from being met.

A Mixed Economy of Care: The Role of Voluntary Organisations and the Emergence of a New Authority

As noted earlier, day centre provision was often established by voluntary agencies or charities, sometimes in less than ideal premises or surroundings, to plug gaps in the provision

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[1251] Jones, *Opening the Door,* p. 165.

[1252] Jane Britten, *Putting People First: Day Services in Scotland run by Voluntary Organisations for Adults with a Mental Handicap,* Edinburgh 1986, p. 16.

[1253] Britten, *Putting People First,* p. 16.

[1254] Britten, *Putting People First,* p. 16.

available through local authorities. Indeed these charity run establishments were often the only places available for a number of individuals with mental handicaps, particularly in the earlier part of this period for the ones who had been classified through the education system as ‘ineducable’ or ‘untrainable’. Voluntary organisation such as the SSMH therefore played a major role in providing services to individuals ‘in the community’ who may otherwise have been placed in institutions or hospitals.

The After-Care Section of the Health and Welfare Department, which emerged in the 1950s, pointed towards the importance of these organisations in providing day services. For example, the significant contribution of the ‘Glasgow Association for the Welfare of the Handicapped’ was highlighted in 1950.[1255] This organisation played a major role in the setting up of this Section by providing them with the names of all children who had left special schools from 1948 onwards.[1256] It was reported that this had aided the Section in its initial stages and it was now in contact with all the special schools and JOC in the hope that in the future they should now be able to include all suitable young adults in their work.[1257]

The importance of voluntary efforts was stressed by John Jardine (Chairman of General Board of Control) in 1951 when he presided over a meeting on ‘how to achieve an ideal mental health service through the co-operation of statutory and voluntary bodies’.[1258] Additionally Dr W Boyd (Superintendent, Springfield Mental Hospital, Fife) said he wished to encourage the work of voluntary bodies with patients as ‘these bodies would be bringing in something from the outside’.[1259] The role of these agencies was further highlighted in the MOH report in 1959 where it was noted that ‘the work of the Voluntary Associations is of

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[1255] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1950, p. 300.

[1256] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1950, p. 300.

[1257] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1950, p. 300.

[1258] ‘North’s Mental Defectives’, *Glasgow Herald, 30th June*, 1951, p. 6.

[1259] ‘North’s Mental Defectives’, *Glasgow Herald, 30th June*, 1951, p. 6

great value' particularly in the provision of post school services.[1260] In the MOH report for Glasgow in 1960 it stated that 'the majority of leavers from the junior occupational centres have been unable to secure employment and consequently they have remained at home attending the senior occupational centres',[1261] however the report pointed towards the important work of the SSMHC particularly for a number of these individuals who relied on the services provided by the sheltered workshop this organisation ran on Moffat Street.[1262]

Voluntary provision often seemed to provide a kind of 'model' and impetus for the local authority day service provision which was to follow. The MOH report of 1962, for example, pointed towards the work of the SSMHC in the provision of a 'work centre' for adult 'mental defectives' at Moffat Street in Glasgow. It described the activities of the centre reporting that it provided 'work on such simple items as cardboard packing or calendars [which] is obtained from commercial concerns'.[1263] This centre was therefore held up as an example of what the 'mentally handicapped' were 'capable' of doing if given the right support and training. The report 'A Better Life' therefore noted in 1971 that 'voluntary organisations should be encouraged to play a major part in initiating new forms of care and training which may serve as a model for statutory services'.[1264]

The 1963 MOH report also listed a number of centres which were not under the management of the Corporation but who were providing privately funded education and accommodation for children with 'mental handicaps'.[1265] Many of these were provided in

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[1260] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1959, p. 266.

[1261] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1960, p. 31.

[1262] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1960, p. 31.

[1263] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1962, p. 209.

[1264] *A Better Life,* p. 8.

[1265] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 136.

conjunction with particular churches for example Waverly Park Certified Institution, Kirkintilloch which cared for '14 Protestant mentally handicapped girls' or St. Charles Certified Institution, Carstairs which cared for '29 Roman Catholic mentally handicapped children'.[1266] The importance of voluntary organisations in the provision of these types of services was highlighted in the Glasgow Herald in 1951 where it was stated that Councillor Mrs M A McAllister had demonstrated that 'no matter how widespread might be the good intentions of the state there was always room for the voluntary worker'.[1267]

The Welfare Department worked alongside voluntary agencies in some cases, for example in providing specific parts of provision for voluntary associations who still maintained a level of responsibility for the services offered. The Welfare Department, for example in 1956 announced that it was going to increase recreation, training and accommodation through Laurieston House, Carlton Place.[1268] This was opened in 1957 and the facilities were utilised by various voluntary organisations including the 'Association for the Mentally Handicapped' and the 'Association of Parents of Handicapped Children'.[1269] The latter of these used the accommodation for five days a week to run a centre for 'severely handicapped' children staffed by volunteers. The education department was also persuaded to help by providing lunches and the Health and Welfare Department provided accommodation and transport.[1270] There were also evening classes ran by the Corporation's Further Education Scheme at Laurieston House for former special school pupils. These were described as

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[1266] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1963, p. 136.

[1267] 'Handicapped Youths to be trained', *Glasgow Herald*, 12th June, 1951, p. 6.

[1268] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1956, p. 20.

[1269] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1957, p. 26.

[1270] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1957, p. 26.

‘helpful for those whose educational standard can be improved’.[1271] This centre then was utilised by many different agencies including education, welfare and voluntary associations.

In the 1960s there was movement towards bringing the many different types of services responsible for welfare and social care together under a new umbrella authority which would involve responsibilities such as probation and after-care services.[1272] Social work developed in Scotland in the 1960s from a number of separate services designed to meet specialised needs into a unified authority.[1273] The 1968 White Paper, *Social Work and the Community* laid out the basis of this ‘generic’ approach in ‘local authority services designed to provide community care and support, whether for children, the handicapped, the mentally and physically ill or the aged [who] should be brought within one organisation’.[1274] The Social Work (Scotland) Act 1968 therefore followed this paper in bringing together these different bodies and services.[1275] In particular, the new social work department was to take over responsibility from the health and welfare departments for ‘the various functions related to the needs associated with the care of the mentally and physically handicapped’.[1276] In the area of ‘Senior Training Centres’ it was noted that there is a real need to increase provision, whilst acknowledging that ‘provision so far has been very uneven, and social work departments inherit a difficult responsibility’.[1277] However the importance of developing this service was noted when it was stated that ‘these centres may do a good deal to develop the capabilities of adolescent and adult defectives, and for some may lead on to production in

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[1271] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1959, p. 366.

[1272] Younghusband, *The Newest Profession,* p. 27.

[1273] Ian Brodie, Chris Nottingham and Stephen Plunkett, ‘A Tale of Two Reports: Social Work in Scotland from *Social Work and the Community* (1996) to *Changing Lives* (2006), *British Journal of Social Work* (2008), Vol 38, p. 698.

[1274] Brodie, Nottingham and Plunkett, ‘A Tale of Two Reports’, p. 700.

[1275] *Social Work in Scotland: Report by A Working Party on the Social Work Scotland Act, 1968,* (University of Edinburgh, 1969), p. 3.

[1276] *Social Work in Scotland,* p. 27.

[1277] *Social Work in Scotland,* p. 42.

sheltered employment'.[1278]

It was noted in 1969 that the Social Work Act had provided an opportunity of reviewing 'agency arrangements with voluntary organisations [and] of considering whether and in what way these should continue'.[1279] This seems to point towards the argument put forward by Nottingham (et al) who stress that 'from the 1960s and into the 1990s, most professional leaders accepted the voluntary sector in practice, but assumed that, in the course of time, its functions eventually would be absorbed by the state sector'.[1280] However there was an acknowledgment that in the area of welfare for the disabled 'voluntary bodies have been specially active, making available a wider range of services which might not have been provided otherwise'.[1281]

In addition it was stressed that often these voluntary bodies have 'distinct functions' and have 'pioneering new ideas...in a manner not always practicable for statutory bodies'.[1282] A similar view was put forward in a planning report by the National Development Group for the Mentally Handicapped also stressed this view arguing that 'voluntary workers and parent groups can add a new dimension to mental handicap services'.[1283] Indeed it went on to stress 'because of their flexibility of action, they can often accomplish things which would be more difficult for the statutory authorities to achieve'.[1284] For example the European Social Fund had been set up through the Treaty of Rome and was 'intended to promote employment through measures to assist vocational training and re-training and to correct problems arising

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[1278] *Social Work in Scotland,* p. 42.

[1279] *Social Work in Scotland,* p. 145.

[1280] Ian Brodie, Chris Nottingham and Stephen Plunkett, 'A Tale of Two Reports: Social Work in Scotland from *Social Work and the Community* (1996) to *Changing Lives* (2006), *British Journal of Social Work* (2008), Vol 38, p. 698.

[1281] National Development Group for the Mentally Handicapped, *Mental Handicap: Planning Together,* Pamphlet No. 1 (HMSO, London, 1976), p. 145.

[1282] *Mental Handicap: Planning Together,* p. 146.

[1283] *Mental Handicap: Planning Together,* p. 12.

[1284] *Mental Handicap: Planning Together,* p. 12.

from industrial change and technological progress'.[1285] Included in this was 'ATCs whose object is to enable disabled people to enter open employment'.[1286] The SSMH run TFWC in particular utilised this funding in setting up a sheltered workshop for people to try to achieve the aim of open employment. Britten stressed in 1986 therefore that voluntary organisations had helped to maintain an element of choice for people with learning disabilities by providing different kinds of services than Local Authority run centres.[1287]

The report, *A Better Life*, recommended in 1971 that social work authorities enter into discussion with voluntary organisations 'with a view of ensuring the provision of better employment opportunities for mentally handicapped persons'.[1288] Arguably this could mean a bigger role for social work in voluntary association run initiatives and projects. The Easterhill and Levern day centres, for example, had been originally run by the SSMH with the use of urban aid funding, and these were now to be taken over and run by the Strathclyde Social Work Department in the 1980s.[1289] Seed acknowledged that this could be the case with numerous day services for people with learning disabilities arguing that voluntary sector initiatives 'which were pioneering services 10 to 20 years ago' had now been taken over by the local authority.[1290] Alternatively it is clear that the movement towards the 'generic approach' of 'comprehensive state provision'[1291] was not always fully realised. In the field of 'mental handicap' and the provision of day services for adults in particular, the social work department continued to utilise and in some cases rely on the services provided by voluntary associations.

Leading policy makers in this field of provision continued to assert the significance of

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[1285] *Mental Handicap: Planning Together,* p. 12.
[1286] *Mental Handicap: Planning Together,* p. 12.
[1287] Jane Britten, *Putting People First,* 1986, p. 30.
[1288] *A Better,* p. 95.
[1289] Jane Britten, *Putting People First,* p. 9.
[1290] Philip Seed, *Day Services for People with Learning Disabilities* (London, 1996), p. 1.
[1291] Brodie, Nottingham and Plunkett, 'A Tale of Two Reports', p. 704.

the role of this voluntary sector (and indeed volunteers in general) in the provision of welfare and training services. For example, in 1975 a letter to R Winter (Director of Social Work), from Ross Flockhart (Scottish Council of Social Service) noted the development of the use of volunteers in both statutory and voluntary agencies. He stated that it was 'with pleasure that we have noted the rising attention that is being given to the use of volunteers by the Social Work Department'.[1292] Similarly the report 'A Better Life' noted that the use of volunteers 'adds a new dimension to mental handicap services and should be encouraged'.[1293] Bodies such as the Royal College of Psychiatrists in the late 1980s also stressed the importance of 'excellent voluntary organisations [who] provide this sort of work'.[1294]

Further to this, the report, *Caring for People,* went even further that this stating in 1989 that 'voluntary organisations should contribute more to the 'mixed provision of care'.[1295] Furthermore it put the focus onto the responsibilities of families and local communities in the provision of care stating that 'the government acknowledges that the great bulk of community care is provided by friends, family and neighbours' and the role of the new arrangements would be to support these carers.[1296] In addition this report used the new language surrounding emerging ideas of 'community care' describing the aim of this work as being the provision of 'services that allow a range of options for *consumers*' (my italics) and in addition 'promote the development of a flourishing independent sector alongside good quality public services'.[1297]

The development of day centres and ATCs in Glasgow therefore needs to be

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[1292] Records of the Association of Directors of Social Work, Executive Committee Minutes, 7th February 1975, ADSWA1/1.1.53.

[1293] *A Better Life*, p. 8.

[1294] Statement of Royal College Psychiatrists, Renne Short, 27/10/88, Records of the Association of Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.1.

[1295] John Welshman, 'Rhetoric and reality', p. 204.

[1296] *Caring for People: Community Care in the Next Decade and Beyond* (HMSO, London, 1989), p4.

[1297] *Caring for People*, p. 5.

considered within this new context of 'making maximum use of private and voluntary providers' in a 'mixed economy'.[1298] This concern had emerged from the Griffiths Report in 1988 whereby recommendations were made 'to move to a mixed economy of care through a purchaser (state)/provider (voluntary, private and state mode), indicating an ambition to reduce state responsibilities and stimulate external markets'.[1299] Debates on the acceptance of this mixed economy of care appear often in the ADSW minutes in the early 90s. For example it was stated that 'it was…felt to be important to contribute to the national debate on extent to which LAs should or should not remain as service providers'.[1300] They discussed their concerns with 'Care in the Community' contracts with voluntary organisations in 1990s noting the 'strength of voluntary liaison' which offered 'significant advantages in terms of the involvement of housing agencies, voluntary organisations and churches' they also stressed 'the need to move from capital led plans/agreements to need led agreements'. [1301] In addition they raised a concern about 'the difficulties in assuming that the voluntary and private sectors would be able to discern a shared position within the respective sectors were considerable, given the differing and competitive interests in both'.[1302]

It should also be noted that in 1983 the ADSW had agreed that the standing committee on Mental Health and Mental Handicap would monitor these trends in the 'privatisation' of care for the handicapped'.[1303] With the publication of the findings of the

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[1298] *Caring for People,* p. 5.

[1299] Brodie, Nottingham and Plunkett, 'A Tale of Two Reports', p. 705.

[1300] Health and Handicap Standing Committee, Mental Health Group, Records of the Association of Directors of Social Work, Executive Committee Minutes, 8th March 1990, ADSWA1/6.1.12

[1301] Meeting of Representatives of Scottish Health Service General Managers Group and ADSW, Mental Health and Mental Handicap Standing Committee, Records of the Directors of Social Work, Executive Committee Minutes, 9th March 1990, ADSWA1/6.1.13.

[1302] Meeting of Representatives of Scottish Health Service General Managers Group and ADSW, Mental Health and Mental Handicap Standing Committee, Records of the Directors of Social Work, Executive Committee Minutes, 9th March 1990, ADSWA1/6.1.13.

[1303] Records of the Association of Directors of Social Work, Executive Committee Minutes, 7th September 1983, ADSWA1/1.95.

Griffiths Report, and the movement towards the ‘mixed economy’, these concerns were further discussed by this committee. There certainly seems to have been some resistance from the ADSW to the full acceptance of this new direction in social work and its related services.[1304] However, this new relationship with the voluntary/private sectors in the provision of welfare services in the wider context was framed within the ‘language of progressiveness claiming to meet consumer demand’ and ‘empower individuals’.[1305] Ultimately the ADSW and social work as a whole accepted this new emphasis, at least in stated policy objectives, for example stating in 1988 that ‘this association warmly welcomes the intention expressed by Sir Roy Griffiths…drawing upon all sectors of society and bringing together the contributions of all relevant agencies.[1306]

In addition, whilst it must be noted that the language in which this new ethos of ‘community care’ was framed was relatively new and, in many ways demonstrated the movement towards ‘Thatcherite’ policies; it must also be pointed out that within the area of learning disability services the relationship between charities/voluntary organisations and the state was well established and not really something which differed from previous provision. As shown above social work, and earlier the Health and Welfare Department in Glasgow had long relied on or worked with these agencies in providing day services for such adults. A planning report by the National Development Group for the Mentally Handicapped, for example, had stressed in 1976 that the ‘mentally handicapped’ and their families ‘need help from a wide variety of statutory and voluntary service agencies…and from community at large’.[1307] They had advocated a mixed economy of care in the co-ordination between voluntary agencies, health and social services, housing and employment associations and

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[1304] Mental health and Mental Handicap Standing Committee, Minutes and Papers, 2nd June 1989, ADSWA1/6.1.1.

[1305] Brodie, Nottingham and Plunkett, ‘A Tale of Two Reports’, p. 706.

[1306] ADSW Policy, Planning and Review Standing Committee, quoted in Brodie, Nottingham and Plunkett, ‘A Tale of Two Reports’, p. 706.

[1307] *Mental Handicap: Planning*, p. 2.

parents in the planning of services. In addition it was noted in 1970 that the social work department would also be working alongside other bodies such as 'Health Department personnel [who] are still involved and co-operating in some aspects of the work'.[1308] This was also a step towards this mixed economy as it was announced in 1978 in a draft circular by the ADSW that suitable projects set up by voluntary organisations may be eligible for support financing by Health Boards and these organisations were encouraged to submit proposals to local authorities.[1309]

The ADSW stated in 1980 that 'the needs of clients such as the mentally and physically handicapped span services provided by the Social Work Department and Health Boards'.[1310] They argued that 'there are, therefore, many inter-relationships between the policies of and services provided by the Social Work Authority and the Health Board'.[1311] Examples are given such as 'hospital discharge' where it is noted that Health Boards must 'take account of the community based services available to support people being discharged from hospital'.[1312] This report also stated the importance of close working relationships with other authorities such as educational departments 'for example in the assessment and support of mentally handicapped children and families'.[1313] In addition it stressed the importance of community education facilities for mentally handicapped adults. Importantly however, it also

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[1308] Report of the Medical Officer of Health, City of Glasgow, Corporation of Glasgow, 1970, p211

[1309] Records of the Association of Directors of Social Work, Executive Committee Minutes, Draft Circular December 1978, ADSWA1/1.1.65.

[1310] 'Response to request by Committee of Inquiry into Local Government in Scotland', Records of the Association of Directors of Social Work, Executive Committee Minutes, 13th May 1980, ADSWA1/1.1.71a.

[1311] 'Response to request by Committee of Inquiry into Local Government in Scotland', Records of the Association of Directors of Social Work, Executive Committee Minutes, 13th May 1980, ADSWA1/1.1.71a.

[1312] 'Response to request by Committee of Inquiry into Local Government in Scotland', Records of the Association of Directors of Social Work, Executive Committee Minutes, 13th May 1980, ADSWA1/1.1.71a.

[1313] 'Response to request by Committee of Inquiry into Local Government in Scotland', Records of the Association of Directors of Social Work, Executive Committee Minutes, 13th May 1980, ADSWA1/1.1.71a.

indicated the importance of the links with voluntary agencies who provide what they describe as ‘complimentary services to those provided by the department’.[1314] It pointed to the fact that organisations such as these generally have ‘client group focus’ and therefore their interests would span a number of local authority and health board functions.[1315]

The HMI similarly stated the importance of inter-agency co-operation in a report in 1980 stating that responsibility for post-school development must rest with health and education authorities as well as social work departments.[1316] A further report on the provision day services in Strathclyde in 1985 also pointed to the importance of these different groups and agencies in recognising the ‘role of other agencies and their willingness to demonstrate responsibility in a new, or at least developing field’.[1317] It went on to note the ‘the report acknowledges that the Department of Social Work no longer has exclusive rights to providing services to adult MH persons’.[1318] The ADSW and LAs therefore aimed to ‘promote voluntary sector involvement in joint planning’.[1319] In discussions over publicity materials the ADSW designed hypothetical case studies to explain these inter-related agencies and to explain how it had ‘progressed over the last 20 years’ with ‘two decades of achievement’.[1320] In one particular study they wanted to highlight the many different agencies responsible for services. This hypothetical case study involved a woman called ‘Helen…a woman of 34 who

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[1314] ‘Response to request by Committee of Inquiry into Local Government in Scotland’, Records of the Association of Directors of Social Work, Executive Committee Minutes, 13th May 1980, ADSWA1/1.1.71a.

[1315] ‘Response to request by Committee of Inquiry into Local Government in Scotland’, Records of the Association of Directors of Social Work, Executive Committee Minutes, 13th May 1980, ADSWA1/1.1.71a.

[1316] *Provision for Profoundly Mentally Handicapped Children, Three Years on*; *A Progress Report by HM Inspectors of Schools*(In collaboration with colleagues from SHHD and Central Advisory Service of SWSG), February, 1980, p. 6.

[1317] *Adults Only’*, introduction, p. 2.

[1318] *‘Adults Only’,* introduction, p. 2.

[1319] Mental Health and Handicap Standing Committee, Minutes and Papers, 14th September 1989, ADSWA1/6.1.4.

[1320] Mental Health and Handicap Standing Committee, General Papers, Records of the Association of Directors of Social Work, Executive Committee Minutes,1989, ADSWA1/6.2.1.

has a mental handicap'.[1321] The work of all these agencies was highlighted when it was noted that she lived in a tenant in a flat provided by a Housing Association and goes to a Day Centre run by the local authority from Monday to Friday'.[1322] It went on to describe 'Helen' as 'a very outgoing and friendly person…she's hoping to start work soon…under a Sheltered Employment Scheme arranged by the District Council and the Department of Education'.[1323]

This inter-dependent relationship between the different agencies with responsibility for services 'in the community' for people with 'mental handicaps' therefore had been developed in many respects before the publication of the Griffiths Report and movement of social work towards 'new' models of community care. In particular Britten estimated in 1984 that the voluntary sector provided formal day time activity for at least 22% of 'mentally handicapped' adults in Scotland, some 1,634 people.[1324] She noted local authorities were had been empowered by the Social Work Act of 1968 and the Mental Health (Scotland) Act of 1984 to 'collaborate with voluntary organisations in meeting its duty to provide suitable training and occupation for persons suffering from mental handicap who are over school age'.[1325] Indeed Britten also points to the fact that over half the day centres run by voluntary agencies were originally set up to provide a service for people for whom no other stated run facilities were available.[1326] The impetus for much of the later statutory provision therefore came from voluntary organisations such as the SSMH.

The tradition of voluntary provision in this area emerged out of necessity and

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[1321] Mental Health and Handicap Standing Committee, General Papers, Records of the Association of Directors of Social Work, Executive Committee Minutes, 1989, ADSWA1/6.2.1.
[1322] Mental Health and Handicap Standing Committee, General Papers, Records of the Association of Directors of Social Work, Executive Committee Minutes, 1989, ADSWA1/6.2.1.
[1323] Mental Health and Handicap Standing Committee, General Papers, Records of the Association of Directors of Social Work, Executive Committee Minutes, 1989, ADSWA1/6.2.1.
[1324] Jane Britten, *Putting People First,* p. 2.
[1325] Jane Britten, *Putting People First,* p. 4.
[1326] Jane Britten, *Putting People First,* p. 10.

desperation from families who may have felt that they had little other option but to work together to provide day services and other types of provision though these, often parent led organisations. Walmsley and Welshman argue that families have always played an important role in care in the community, however they also noted that the development in this area came from the fact that at the beginning of this period care in the community served as an adjunct to the institution and gradually over these decades it began to develop more into an alternative to the institution.[1327] Support services and day centres were not always forthcoming and organisations such as the SSMH had often to develop their own alternatives. Welshman and Walmsley argue that the motives behind the development of 'community care may often have been more about finance than ideas of inclusion and integration. They argue, for example that,

> Private care offers a cheap alternative to publicly funded and provided services and, from the mid-1970s, community care has been reinterpreted from the development of public community services to that of private care in the community…as an adjunct no to the institution but to family-provided care'.[1328]

Issues of funding and lack of resources may also explain the inability of social work in Scotland to create the kind of extensive state provision they had envisaged with the creation of the new authority. Nottingham (et al), for example point towards the issue of funding for social work provision, noting for the significant cuts faced by the ADSW in 1979.[1329] The problems of relying on voluntary provision was highlighted in the ADSW minutes in 1989 where concern was expressed over 'funding anomalies in LA, voluntary, private and health

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[1327] Welshman and Walmsley, *Community Care in Perspective*, introduction, p. 8.
[1328] Welshman and Walmsley, *Community Care in Perspective*, introduction, p. 9.
[1329] Brodie, Nottingham and Plunkett, 'A Tale of Two Reports', p. 703.

authority sectors.[1330] It was pointed out, for example, that ‘many voluntary agencies are currently experiencing difficulty in recouping costs from recipients of respite care’.[1331] The ADSW stressed in 1989 ‘the funding issue is key to the development of community care and requires to be highlighted as such’.[1332] One of the issues the committee was in need of addressing in the minutes of the MH and MH Standing committee minutes was ‘the need for a differentiated approach to client groups’. It also stressed that ‘normalisation policy is at present subverted by funding policy which limits clients to pocket money and assumes provision of all other necessities en bloc’.[1333] Moreover the Mental Welfare Commission report in 1991 highlighted the gross lack of long-term sheltered employment opportunities but commended the provision of these types of opportunities by voluntary organisations. However the problem of having to reapply for funding every 3 years was pointed out and the ways in which this hampered long term planning and meant these services were very insecure.[1334] In addition work by the ADSW suggests that financial arrangements in Scotland for such services were not as well supported as those down south. For example the table below show the support finance received by both countries in relation to population and the percentage of costs that were met in 1990.

Support Finance for the Development of More Resources in the Community for Mentally Handicapped and Mentally Ill people.

	Scotland	England

[1330] Mental Health and Mental Handicap Standing Committee, Minutes and Papers, 2nd July 1989, ADSWA1/6.1.1.

[1331] Mental Health and Mental Handicap Standing Committee, Minutes and Papers, 2nd July 1989, ADSWA1/6.1.1.

[1332] Mental Health and Mental Handicap Standing Committee, Minutes and Papers, 2nd July 1989, ADSWA1/6.1.1.

[1333] Mental Health and Mental Handicap Standing Committee, Minutes and Papers, 2nd July 1989, ADSWA1/6.1.1.

[1334] Mental Welfare Commission for Scotland Annual Report 1991, Mental Health and Handicap Standing Committee, General Papers 1992, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/7.2.5.

Total population	5 Million	45.5 Million
Support Financing (Scotland) or Joint Financing (England)	£2 Million	£87 Million
% Capital Costs Met	60%	100%
Revenue Arrangements	60% tapering over max 5 years	Up to 100% for 7 years the tapering over 3 further years

Table Taken from Report of ADSW of meeting at House of Commons, Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/1.90

This report noted that ‘it is hardly surprising in the current economic climate that local authorities have been reluctant to undertake projects which will result in LAs taking on the full financial commitment within 5 years’.[1335] Further it noted that there was ‘no doubt English financial arrangements, if introduced in Scotland would provide realistic financial support which would enable Scottish local authorities to undertake the increase in community resources we all wish to see’.[1336] The ADSW therefore recommended an increased budget for Scotland over a period of 3 years from £2 million to £9.5 million to ensure parity with the rest of Britain.[1337] Therefore whilst the Griffiths Report and subsequent Scottish *Caring For People* policy response led to the assertion of the benefits of a mixed economy of welfare involving health and social work and urged LAs and Social Work to ‘maximise the use of voluntary, not for profit and commercial sectors’[1338] it was also noted that the government ‘did not intend to provide resources to match plans or ring fence funds for community

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[1335] Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/1.90.

[1336] Records of the Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/1.90.

[1337] Records of Association of Directors of Social Work, Executive Committee Minutes, ADSWA1/1.90.

[1338] Mental Health and Mental Handicap Standing Committee, Minutes and Papers, 14th July 1989, ADSWA1/6.1.4.

care'.[1339] They also stressed that 'in the Scottish context the unified responsibility principle is positively contradicted by the separation of the ministerial portfolios of health and social work'.[1340]

There was a continuing concern with the lack of provision and funding in adult services for the training of staff. Reference was made in ADSW records in 1974 to the need for training course for instructors in ATCs and particularly the need to set up courses in the West of Scotland. Many of the directors were stressing the need for this training as well as a focus on this aspect by the Standing Committee on Physical and Mental Health.[1341] A letter from R A Haxby (Assistant Director of the Central Council for Education and Training in Social Work) to R Winter in this same year pointed to some confusion over the training for of staff in Occupational Centres stating that:

> The position has changed considerably since the publication of [the Melville] report…in particular the decision of government to ask CCETSW to be responsible for training needs of all kinds of day centre staff… and not responsible for those parts of Melville that relate to JOCs and the needs of severely handicapped children who will be dealt with within the frame of the education services.[1342]

From this therefore it seems clear that the education services were to be responsible for those in JOCs but the CCETSW to be responsible for training of day centre staff in general. Many

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[1339] Mental Health and Mental Handicap Standing Committee, Minutes and Papers, 14th July 1989, ADSWA1/6.1.4.

[1340] Mental Health and Mental Handicap Standing Committee, Minutes and Papers, 14th July 1989, ADSWA1/6.1.4.

[1341] Records of the Association of Directors of Social Work, Executive Committee Minutes, 29th March 1974, ADSWA1/1.1.45.

[1342] Letter R A Haxby, Assistant Director of CCETSW to R Winter, ADSW, Records of the Association of the Directors of Social Work, Executive Committee Minutes, 29th July 1974, ADSWA1/1.1.49.

agencies therefore were involved in the provision of these types of services and it was not always clear where the responsibilities lay. The CCETSW, however, stated that they were extremely concerned in general about the lack of training for staff in day centres for the 'mentally handicapped' and were anxious to establish courses at the earliest opportunity.[1343]

The ADSW in discussing the development of 'remedial professions', such as those who dealt with ATCs and in other centres, noted that they had generally expressed a desire for professional recognition which should be reflected in 'salary, status and career structure'.[1344] It was noted however that 'any professional group which is described as 'ancillary' or 'auxiliary' or a similar term likely to experience a lower status in relation to the dominant professional group with whom it is required to operate'.[1345] In addition concern was expressed by the Occupational Centres Association who were concerned that salaries of staff in Occupational Centres were lower in Scotland than in England and that staff could not proceed beyond a 'bar' placed on salaries.[1346]

It was reported in November 1974 that changes were to be made in pay scales for instructors in ATCs however it was stressed that 'it has taken a considerable time for Scottish instructors to be given parity with England'.[1347] A letter from Mrs Mclean of Rosyth Work Centre stressed that things still needed to be improved, for example, with the inclusion of the recognition of length of service. She asked the ADSW to support this demand in odder 'to

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[1343] Letter R A Haxby, Assistant Director of CCETSW to R Winter, ADSW, Records of the Association of the Directors of Social Work, Executive Committee Minutes, 29th July 1974, ADSWA1/1.1.49.

[1344] Records of the Association of Directors of Social Work, Executive Committee Minutes, 29th March 1974, ADSWA1/1.1.46a.

[1345] Records of the Association of Directors of Social Work, Executive Committee Minutes, 29th March 1974, ADSWA1/1.1.46a.

[1346] Records of the Association of Directors of Social Work, Executive Committee Minutes, 28th June 1974, ADSWA1/1.1.47.

[1347] Letter Mrs Mclean, Rosyth Work Centre to R Winter ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 6th November 1974, ADSWA1/1.1.51.

help instructors have their just rewards within the new scale'.[1348] The new grading meant payment of qualified instructors was to vary from £1923 to £2316 and was to apply to:

> Those instructors with responsibilities for instructing in workshop processes and techniques, assembly work etc on a work habit training basis and executing a planned programme of training, including social training.[1349]

This description therefore gives interesting an insight into what was seen as the aims of such a centre and the varying roles such individuals were expected to play in the delivering of 'training' both 'social' and 'technical'. It was noted here that entrants should therefore hold the 'Diploma in Training and Further Education of Mentally Handicapped Adults' or have completed at least 5 years continuous service as an instructor and have certificate of instructors granted by Jordanhill College.[1350]

Further to this the ADSW asserted that there was 'general agreement that services for the mentally handicapped would be expanded, with more day centres being established and there would be a growing need for appropriately trained staff'.[1351]However other sources suggest that this was not always carried through and indeed that there was often problems over communication between all the different agencies involved in services for adults with 'mental handicaps'. Correspondence from the ADSW in particular often points to tension/confusion

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[1348] Letter Mrs Mclean, Rosyth Work Centre to R Winter ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 6th November 1974, ADSWA1/1.1.51.

[1349] Letter Mrs Mclean, Rosyth Work Centre to R Winter ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 6th November 1974, ADSWA1/1.1.51.

[1350] Letter Mrs Mclean, Rosyth Work Centre to R Winter ADSW, Records of the Association of Directors of Social Work, Executive Committee Minutes, 6th November 1974, ADSWA1/1.1.51.

[1351] 'Training for Instructors', Records of the Association of Directors of Social Work, Executive Committee Minutes, 30th May 1978, ADSWA1/1.1.63.

over responsibilities and communication. In 1975, for example, the Committee of Enquiry into Special Education noted a concern with the lack of information being transmitted from Social Work Department to staff working in ATCs.[1352]

Consequently initiatives were undertaken such as that proposed by letter from the Department of Employment, Career Service Branch in 1989 to the directors of social work (M Hartnoll and R Winter) which suggested a new scheme to tackle some of these issues with the aim of 'ensuring that young people with disabilities are not placed in unsuitable employment and training'.[1353] The ADSW endorsed this scheme as they recognised some of these issues and recognising the benefit of increasing awareness and improving the flow of information. [1354] The status of staff, funding for training and the problems of communication between different agencies therefore added to the challenges facing those who accessed these types of services, whether through voluntary agencies or the state.

Conclusion

Day services in Glasgow for the mentally handicapped underwent many important changes from the 1950s to the 1990s. Borsay argues that in being 'essentially a reaction to incarceration, community strategies have grown up in an ad hoc fashion, without a coherent framework to guide policy development'. [1355] Certainly the way in which day centres and other similar centres developed over this period seem to suggest that this was the case in

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[1352] Records of the Association of Directors of Social Work, Executive Committee Minutes, 31st January 1975, ADSWA1/1.1.52.

[1353] Letters from Mary Hartnoll and R Winter (ADSW) and Department of Employment, Career Service Branch, 24th Feb – 13th March 1989, Records of the Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.2.

[1354] Letters from Mary Hartnoll and R Winter (ADSW) and Department of Employment, Career Service Branch, 24th Feb – 13th March 1989, Records of the Directors of Social Work, Mental Health and Mental Handicap Standing Committee, General Papers, ADSW1/7.2.2.

[1355] Borsay, 'Private Trouble or Public Issue', p. 115.

Glasgow. Centres were created by different bodies firstly as places in which adults with ‘mental handicaps’ could be ‘occupied’ and also as a means through which agencies such as the SSMH or the Health and Welfare Department could to remove the ‘burden’ of care from the family.

Centres concentrated on ‘work’ training in a way which often mirrored the types of activities in workshops in mental handicap hospitals and institutions. The stated aim of these centres was to produce citizens capable of moving into open employment and to use work more generally as a rehabilitation tool to help mould trainees into more ‘socially acceptable’ individuals. People with ‘mental handicaps’ were thus increasingly viewed as ‘trainable’ and these day services were charged with the responsibility of creating capable workers who, it was envisaged, could have access to the ‘normal’ patterns of life through this focus on work. Centres were to become vehicles through which expressions of ‘normalisation’ were to be realised through ‘work training’ and the aim of achieving ‘active citizenship’.

The level of provision in the 1950s and 1960s was very limited and this left many in Glasgow without places. The new centres often continued to classify adults in a similar way that they had to children in excluding those felt to be ‘ineducable’ or ‘untrainable’. Whilst Glasgow was the first authority in Scotland to develop these services, it was again left to voluntary organisations to provide services to those who were otherwise excluded and may otherwise have been institutionalised. In addition those who were given places and became the responsibility of the ‘After-Care Section’ in Glasgow were often treated in a similar way to the ‘mentally deficient’ earlier in the century. Specifically the centres, the after-care workers and social workers had a responsibility to supervise as well as train the attendees. However these types of concerns began to be questioned with the advent of new policies more focussed on ‘normalisation’.

By the 1970s it was clear that the aims of the work centres were not being met as the focus on contract work left the trainees with few transferable skills and the vast majority of trainees had little opportunity to ‘progress’ to jobs in the wider economy. Criticisms began to emerge over the types of activities taking place in these centres where it was increasingly felt that the singular focus on contract work was both detrimental and unrealistic in terms of future prospects for the integration of the adults attending the centres into the community. There was therefore a shift in the focus of the centres towards social and cultural activities to achieve the aims of ideals of normalisation and social role valorisation. The individuals attending centres, particularly in the state sector, were now expected to take part in both education and in social activities in an attempt to integrate them into their communities.

However oral testimony suggests that this might not always have been a positive experience for the clients of these services who missed the traditional work based activities and were now often faced with a life of ‘perpetual leisure’. In addition there was also the danger that the new focus on normalisation only served to continue the tradition of placing the emphasis on individuals to ‘change’ to become ‘socially adequate’. There are certainly signs of this when the success of community integration is stated to be both the responsibility of the community and mentally handicapped individuals ‘easing themselves’ into these communities. In addition there is evidence to suggest that the new focus on social and cultural activities did little to aid the integration of community services ‘in’ the community. Indeed oral testimony points to continued segregation even when the services where physically housed within communities.

Different agencies therefore held responsibility for these services at different times. At first glance it may seem that the trajectory of these services developed out of voluntary provision to state run initiatives and finally developing into a ‘mixed economy’ in the last few decades. However the discussion on the development of social work in this period has shown that the picture that emerges is much more complicated and interrelated. Health boards, social work and voluntary associations had an interdependent relationship in the provision of these services and the end result was often more dependent on the availability of premises, staff and funding that on any overarching theoretical framework. In addition the monopoly of the day centre was very rarely questioned until very recently when it was suggested that 'traditional day services are no longer appropriate descriptions of the ways in which people with learning difficulties want to spend their days’ as it was noted that ‘93% of people going to day centres do NOT have paid work and that only 20% of activities in day centres takes the form of education and employment’.[1356] The overall sense from the provision of day centres since 1945 is one that suggests a lack of development and progress with a subsequent effect on the life choice of people who have spent a significant proportion of their lives in attendance of such institutions.

This chapter therefore reveals some of the weaknesses s of many of the ‘new’ services in this area from the 1970s to the 1990s pointing towards evidence that centres often did little to undermine segregation and were unsuccessful in integrating service users into the community in any meaningful way. Further histories could look beyond the ‘progression’ of services from the hospital to the community or from segregation to integration. This study suggests a much more static picture of daily life for those in the community who spent much their lives within day centres. Therefore whilst it has been shown that the ethos and the focus of activities within the centres may have shifted, it can also be seen that these services largely remained based around day centres where there was limited success in community integration.

[1356] The Same as You, Review of Services for people with learning disabilities, Scottish Executive, http://www.scotland.gov.uk/ldsr.

Conclusion

In recent years there has been a focus on the history of learning disability amongst both social and medical historians. Many of these historians, such as Welshman and Walmsley, have stressed the need for a renewed focus on areas such as community care to counteract the dominance of 'the institution' in the historiography of learning disability.[1357] Studies, such as those by Bartlett and Wright, have therefore focussed attention on the development of care outside of hospitals.[1358] This has reframed the ways in which disability, as a social and medical category, has been understood in the past. An element of this has been the use of 'micro' level local studies which offer new perspectives on this history. These attempt to look beyond official discourses or legislation which often present a 'progressive' narrative and can lead to a 'whiggish' account of learning disability history. However very few of these studies have taken the Scottish perspective into account.

This thesis has provided further scholarship in this area by analysing developments in community care from both a national and a local perspective, focussing on Glasgow. As a result it has identified significant agencies in mental handicap policy and the relationships between these that were important in policy development. For example, it has pointed to the growing dissatisfaction of the state with the reliance on institutionalised provision. However it has also shown the ways in which hospital provision remained a priority in the field of mental health for health boards and other statutory authorities. The findings of this project also suggest the need for a re-assessment of the history of community care, identifying similar patterns to those highlighted by Welshman and Walmsley. For example it has shown the importance of care by families outside of institutions before the advent of policies of

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[1357] John Welshman and Jan Walmsley, (eds), *Community Care in Perspective: Care Control and Citizenship*, p. 8.

[1358] Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750 – 2000* (London, 1999).

‘community care’.[1359] This thesis has therefore noted both the significance of care in the community by private agencies in the immediate post-war period as well as highlighting the continuing reliance on hospital provision for others.

Due note has also been taken of ways in which national abuse scandals and local stories of overcrowding or poor conditions began to raise awareness of the inadequate care being provided for the mentally handicapped in hospitals in this period. As a result, it has been shown how the movement away, to some extent, from eugenic assumptions about mental deficiency meant that long hospitalisation became unfashionable and the emphasis shifted towards both family-led care and community living. However, this thesis has pointed to the continuing large numbers of people who were institutionalised in Glasgow due to mental handicap throughout this period. As a result this thesis has demonstrated that Glasgow was often slow to close hospitals or to create the community based alternatives required to allow these closures to take place. Glasgow was slow to invest in de-institutionalisation, a pattern that Chapman has also demonstrated in Scotland as a whole.[1360]

As a result this thesis has largely supported the findings of Welshman and Walmsley who have identified the prioritising of building and maintaining asylums over the creation of community services in the field of mental handicap. [1361] The local nature of this study has thus provided a significant example of a city where the conflicting priorities of different statutory authorities could affect the success of community care. Specifically, analysis of reports from the Mental Welfare Commission in Glasgow in the 1980s has revealed the extent to which improving hospital conditions remained a priority for their services. This thesis has thus added to the work of Welshman and others in further questioning the adoption of a simplistic model of community care which can often place too much emphasis on the

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[1359] Welshman and Walmsley, (eds), *Community Care in Perspective: Care Control and Citizenship*, p. 1.
[1360] Rohss Chapman, ‘Devolved Policy for People with Learning Difficulties’, in
Welshman and Walmsley (eds) *Community Care in Perspective: Care Control and Citizenship*, p. 100.
[1361] Welshman and Walmsley, (eds), *Community Care in Perspective*, p. 1.

adoption of ideas of integration alongside the demise of hospitals, significantly identifying a lack of investment in community-based alternatives.

However, this thesis has also investigated some of the other reasons for the increasing dissatisfaction with long-term hospitalisation. For example it has pointed to the importance of the ways in which community care was increasingly seen as the 'cheap alternative to publicly funded and provided services'.[1362] However it has also noted the effect of this on the success of community care identifying the lack of financial investment and commitment of resources. In addition oral testimony has suggested that new community-based services could often be as segregated as old hospitals and residents/trainees often continued to feel separated from their communities. In addition this study has also demonstrated that large numbers of people continued to receive very little state support, resulting in the maintenance of a key role for families who remained principal agents in the care of the mentally handicapped.

Historians such as Rolph and Tilley have identified the importance of MENCAP and other voluntary agencies in providing support for such families in England in the period after 1950.[1363] However, there has been little investigation into similar developments north of the border. This thesis has thus noted the ways in which the Scottish Society for the Mentally Handicapped (SSMH) developed and owed much to the continued exclusion of the mentally handicapped with the advent of the welfare state. Rolph has demonstrated similar concerns amongst parents who formed local MENCAP societies in Bedford and District the 1950s.[1364] She has also shown how, in a similar way to the SSMH, these new agencies in England allowed the parents of handicapped children to have a 'voice', often for the first time, and

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[1362] Welshman and Walmsley, (eds), *Community Care in Perspective: Care Control and Citizenship,* p. 9

[1363] Liz Tilley, 'The Voluntary Sector', in Welshman and Walmsley, (eds), *Community Care in Perspective: Care Control and Citizenship,* pp. 219 – 232 and Sheena Rolph, *Building Bridges into the Community: The History of Bedford and District Society for People with Learning Disabilities*, *1955–1990* (Milton Keynes, 2005).

[1364] Sheena Rolph, *Building Bridges into the Community: The History of Bedford and District Society for People with Learning Disabilities, 1955 – 1990* (Milton Keynes, 2005), p. 20.

their groups and newsletter gave them the opportunity to discuss their experiences and segregation.

However, this thesis has also identified the importance of Glasgow to the development of the SSMH. It has been shown that this is the city where they were the most active and where they were most able to forge important relationships with the state. Whilst Rolph has noted the ways in which branches in Bedford were also to establish ventures like training centres and establish links with local authorities (LAs) [1365] this thesis has demonstrated the ways in which the founder members of the SSMH were able to use their links with the LA and other important agencies to raise the profile of mental handicap and establish services. For example, it has noted the ways in which the profile of some of its founding members, such as Samuel Curran, was utilised to gain funding and support for the creation of new community based services such as day centres, nurseries, respite care and latterly supported housing. Most of these services were created independently by parents but were later supported or taken over by the state. What is clearly evident is also the importance of organisations such the Scottish Down's Syndrome Association who were able to further raise the profile of mental handicap and maintain significant relationships with both medicine and the state.

Borsay has noted how successive governments since 1979 have promoted the virtues of *laissez-faire* principles, particularly in reference to the mixed economy of welfare which creates an 'enhanced role' for voluntary organisations.[1366] However, this thesis has further noted that in the case of Glasgow this 'mixed economy' was evident in the field of mental handicap from the 1950s where a key role in service provision was often played by organisations such as the SSMH. Voluntary organisations thus often prompted the state into action and offered support or provision where the state was unable or unwilling to do so. As a

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[1365] Liz Tilley, 'The Voluntary Sector', p. 226.
[1366] Borsay, *Disability and Social Policy*, pp. 201-202.

result the impetus for this ‘mixed economy’ of welfare often came from the voluntary organisations. They were then to play an increasingly important role in service provision with the shift in welfare ideologies towards community-based care in tune with the principles of ‘consumer choice’. ‘New’ ideas about the mixed economy of welfare that were expressed, for example in the NHS and Community Care Act in 1990, only served to cement an existing relationship between the voluntary sector and the state in Glasgow in this field.

In the post-war period there were also significant developments in special educational policy. This thesis has largely supported the work of theorists such as Popkewitz and Timmons who have identified the increase of ‘selection’ and ‘streaming’ in education after 1945[1367]. It has been noted how mental testing such as the measuring of IQ was to remain significant in decision over a child’s education. For example it has identified the ways in which children with mental handicaps who were felt to be ‘educable’ were often sent to special schools to receive special educational ‘treatment’ and those classed as ‘ineducable’ were not to be eligible for school at all until the Education Act of 1974. The significance of medical control in Scottish education has also been highlighted with both the continuing adherence to impairment classifications and in the expansion of the child guidance movement. What has been demonstrated therefore, are the many ways in which the special education sector attempted to ‘treat’ and ‘train’ the mentally handicapped in an attempt to ‘normalise’ them.

Whilst Cole has identified the humanitarian concerns of state agencies who felt they were providing the best education for all by providing specialist education for special needs[1368], this thesis has demonstrated the subsequent affects of this on developments in special education in Glasgow. The expansion of the special educational sector may have not been purely segregationist in design, nevertheless it resulted in the establishment of a

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[1367] George Timmons, *Education, Industrialisation and Selection* (London, 1988) and Thomas S. Popkewitz, (ed) *Cultural History and Education* (New York, 2001).

[1368] Ted Cole, *Apart of A Part: Integration and the Growth of British Special Education* (Milton Keynes, 1989).

significant system of special schools in the city where even the ‘mildly’ mentally handicapped were to be educated. Few efforts were made to try and include these children within mainstream schools as the large special educational sector operated as a ‘safety valve’ whereby troublesome ‘deviants’ could be removed and dealt with elsewhere. Oral testimony and other sources have also suggested that placement in special schools could owe much to the low social status of families who were left with few choices in the types of education their children would receive.

The advent of the comprehensive system of education and the publication of the Warnock Report did little to threaten the dominance of segregated special schooling in Glasgow. Ideas of integration and inclusion thus in practice remained abstract concepts with little relation to the realities of provision. Thus for both hospitals and schools in Glasgow, the city had invested so heavily in the expansion of specialist (but segregated) institutions for the mentally handicapped, that they were left in a difficult position when ideas about integration came to the fore. The result of placement in a special school was that mentally handicapped adults often left with few choices post-school.

Welshman has stressed that in the history of community care since the 1950s,‘little is known about the ways that policy evolved and was implemented, particularly at local level’.[1369] This thesis has thus investigated the ways in which adult services developed at a local level in Glasgow, for example in noting the importance of links between segregated schooling and subsequent placement in day centres. It has demonstrated how, in the immediate post-war period, the special school leaver was often either institutionalised, continued to live with their family with no support at all or was one of the few able to gain a place in a centre where they would receive ‘work’ training and carry out contract work. With the expansion of the numbers of places available, in centres run by both voluntary

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[1369] Welshman John, ‘Rhetoric and reality: community care in England and Wales, 1948 – 74’ in Peter Bartlett and David Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750 – 2000* (London, 1999), p. 205.

associations and the state, there was a focus on the value of ‘work’ as therapy as a way in which the mentally handicapped could gain access to ‘normal’ patterns of life.

However, this study has demonstrated how, from the 1970s, the activities in these centres began to come under further scrutiny as ideas of normalisation became fashionable in social policy. There was a realisation that the focus on contract work was often futile as very few trainees were able to ‘advance’ into the open employment market. As a result, state run centres have been shown to have developed a programme which focussed more on social and vocational activities which were felt important in the aims of integration. These centres, in Glasgow, often continued to be segregated from their local communities and what is evident is the ways in which some attendees disliked the activities which seemed to promote ‘perpetual leisure’.

Significantly, this focus on the work of day centres for adults with mental handicaps has also allowed further investigation into the ways in which different authorities in Glasgow were often unable to co-operate or to develop overall strategies, which prioritised meaningful integration. It has been demonstrated that the health board, the LA, social work authorities and voluntary associations all had responsibilities for provision at various points, but often that no agency took on a ‘lead’ role resulting in ‘patchy’ provision which was rarely ‘progressive’ in application. Developments in ‘new’ community based services such as day centres therefore have been shown to have often had little impact on the segregation of mentally handicapped people.

Therefore it has been shown that special schools, sheltered housing and day centres in post-war Glasgow could effectively institutionalise those with mentally handicaps. They could often become ‘big buildings in which the mentally handicapped are protected from the outside world'.[1370] This does not seem to be so far removed from old traditions of protective hospitalisation in long-stay institutions. Indeed Bartlett and Wright have noted that in the late twentieth century the movement of care outside of long-stay hospitals and asylums often only resulted in the movement of 'social control…into the community at large, led by a vanguard of professionals and experts'.[1371] This thesis has thus demonstrated the ways in which 'new' community care policies in Glasgow failed to effectively challenge the reliance on segregated institutions and that there was often continuity between the 'new' types of community care and that which had been provided in the community in the past. The picture of life for many people with mental handicaps can be seen to be largely static with very little significant change in the ways in which they were treated, trained or educated in the period since 1945. This refutes the notion that the development of community care was ultimately progressive or wholly positive for the lives of mentally handicapped people.

This thesis therefore adds much to the historiography of disability in this period. It has utilised a social model type of analysis in order to identify significant barriers to the integration of people with a learning disability in Glasgow and beyond. It therefore demonstrates the ways in which these barriers and other social factors could be 'significant…in the construction of handicap'.[1372] It illustrates the ways in which a social model type approach can reveal the restrictive economic and social structures in social policy and how these could result in exclusion from the labour market and subsequent denial of opportunities to become 'active citizens'. In doing so it analyses the ways in which disability could mean 'the reduction or total loss of earning capacity'.[1373]

[1370] Welshman and Walmsley, (eds), *Community Care in Perspective: Care Control and Citizenship*, intro, p. 11.

[1371] Peter Bartlett and Davd Wright, 'Community Care and its antecedents', in Bartlett and Wright, *Outside the Walls of the Asylum: The History of Care in the Community 1750 – 2000*, p. 13.

[1372] Len Barton, 'The Politics of Special Educational Needs', in Len Barton and Mike Oliver (eds), *Disability Studies: Past, Present and Future* (Leeds, 1997), p. 1.

[1373] Saad Nagi and Lawrence E. Riley, 'Coping with Economic Crisis: The Disabled on Public Assistance', *Journal of Health and Social Behaviour*, Vol 9, No. 4, Special Issue on Patients and Illness (December 1968), p. 317.

This study investigated the roots of the segregation of people with learning disabilities in special education and in the continuing reliance on medicalised care in hospitals. It subsequently adds to the scholarship in this area demonstrating the importance of studying language and culture in assessing the social status of disabled people. It further develops the work of Borsay and others who have identified the importance of continuing medical control and the use of medical language in social policy. [1374] The thesis therefore gives numerous examples of the ways in which classification, labelling and medical terminology had an impact on the failure to integrate people with learning disabilities who were to be 'treated', 'cured' or 'trained' in various ways during this period.

This study reveals the significant social policy trends in this area such as such as normalisation. The ways in which this concept was implemented and understood have been shown to have helped re-instate the differences between the 'abled' and 'disabled'. In addition the thesis has demonstrated the ways in which those classed as mentally handicapped continued to be seen as 'other' who were to be 'normalised' through a series of education and training programmes for both children and adults. Further to this it has shown how social polices, which created initiatives such as day centres or group homes, often continued to place people with learning disabilities in a position of 'liminality' or 'social suspension' where they were neither wholly integrated nor excluded from the rest of the community. The importance of the study of language was also demonstrated in the investigation of charities in this thesis whereby the medicalised representations used by some organisations were shown to have undermined any movement towards empowerment of disabled people in their provision of new community services.

Significantly this thesis adds much to the historiography of disability, social policy and education by presenting examples of lived experience which undermine legislative

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[1374] Anne Borsay, *Disability and Social policy in Britain since 1750* (Basingstoke, 2005), p. 7

narratives of progress in a number of areas. This local study has critically explored ideas such as segregation and integration demonstrating how community-based studies reveal different ways of understanding disability in the past. Disability has been critically examined and understood as a fluid concept allowing investigation into its social and cultural roots and a better understanding of the ways in which its production and reproduction can impact experiences. Oral testimonies and local sources therefore have shown how the lives of people with learning disabilities were often largely static, unaffected by wider changes in macro social policy. The study has therefore added to work of Walmsely, Welshman, Borsay and others in demonstrating the ways in which local archives, oral testimony, and other local sources can offer new perspectives and allow historians to deconstruct macro concepts such as community care revealing how policies evolved, were implemented and experienced in this period.

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