

**The Forgotten Children: The Association of Parents
of Backward Children and the Legacy of Eugenics in
Britain, 1946 – 1960**

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Abstract

The subject of disability has received considerable attention from various academic disciplines. Similarly, the history of eugenics has been widely examined. However, the important connection between these two topics in Britain requires further analysis, particularly in the case of children with learning disabilities. This dissertation seeks to address this historiographic imbalance and to assess the effect eugenics had on British society's attitude towards children with learning disabilities in the mid-twentieth century. The British eugenic movement highlighted the importance of individual and collective mental and physical health. However, individuals who did not conform to this standard were alleged to be contributing to the decline of the nation. Not surprisingly, within this framework, those with learning disabilities became the subject of much public and scientific debate. Yet, eugenic measures, such as compulsory sterilisation and permanent segregation, were never legalised in the UK. Despite this, eugenic ideas of stigma were used to exclude individuals with learning disabilities from the full benefits of society. These ideas remained heavily ingrained in the public consciousness long after the supposed end of eugenics. In the late 1940s, Judy Fryd, the mother of a supposed 'backward' child from Hertfordshire, tired of her isolated life, penned a letter asking if others felt the same way; the response she received from members of the public was overwhelming. Soon after, the Association of Parents of Backward Children (APBC) was formed and helped to combat the deep-seated eugenic attitudes in the political and public spheres.

In the main, this dissertation evaluates the APBC and its activities, relating to the social isolation and the result of stigma; the process of institutionalisation and the lack of alternative, the lack of adequate research into 'mental deficiency'; and finally, the inherent inequality of the British education system during the 1940s and early 1950s. Ultimately, this

dissertation argues that the legacy of the eugenic movement continued to shape the public perception of disability after 1945, and that the political and social transformations needed to sustain change in the field of disability began, in fact, decades prior to the emergence of the British disability movement of the late twentieth century.

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Any errors in this work are entirely my own responsibility.

Declaration

I certify that this is my own original work and that all sources used in producing it have been duly acknowledged and cited in the text.

Rubahanna Amannah Choudhury

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List of Abbreviations

APBC	Association of Parents of Backward Children
CBE	Commander of the Most Excellent Order of the British Empire
DBE	Dame Commander of the Most Excellent Order of the British Empire
DCH	Diploma in Child Health
DIG	Disablement Income Group
DPM	Doctor of Podiatric Medicine
EES	Eugenic Education Society
ESN	Educationally Subnormal
FRCP	Fellow of the Royal College of Physicians
HOC	House of Commons
IQ	Intelligence Quotient
JP	Justice of the Peace
KBE	Knight Commander of the Most Excellent Order of the British Empire
LA	Local Authority
LEA	Local Education Authority
LHA	Local Health Authority
LRCP	Licentiate of the Royal College of Physicians
MA	Master of Arts
MBBS	Bachelor of Medicine
MBE	Member of the Most Excellent Order of the British Empire
MD	Doctor of Medicine
MO	Medical Officer
MOE	Ministry of Education

MOH	Ministry of Health
MOJ	Ministry of Justice
MOL	Ministry of Labour
MP	Member of Parliament
MRCP	Member of the Royal College of Physicians
MRCs	Member of the Royal College of Surgeons
NAMH	National Association for Mental Health
NAPBC	National Association of Parents of Backward Children
NHS	National Health Service
NSMHC	National Society for Mentally Handicapped Children
QC	Queen's Counsel
RAF	Royal Air Force
RECI	Royal Eastern Counties Institution
UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund
UPIAS	Union of Physically Impaired Against Segregation
USA	United States of America
WHO	World Health Organisation
WW1	World War One
WW2	World War Two

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1. The Judy Fryd commemorative stamp (2009)
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Introduction

This dissertation argues that eugenics was far more influential on contemporary and post-war understandings of disability than has previously been recognised. To achieve this, I will assess the establishment of the Association of Parents of Backward Children (hereafter APBC) in 1946 and its activities in the following decade. As will be argued, the APBC emerged as a response to longstanding eugenic biases and a growing sense of social injustice towards the so-called ‘weaker’ members of the community. Importantly, the APBC chronicled their campaigns for social acceptance and political equality in their quarterly journal, *Parents’ Voice*. This rich and previously unexamined source will be used to explain the legacy of eugenics and its impact on disability at personal, social and political levels in 1950s Britain.

The involvement of parent reform groups in Britain during the 1950s has been largely neglected by the scholarship on the history of disability and the history of eugenics. This introduction, therefore, seeks to contextualise the subjects of disability and eugenics by connecting them with the APBC’s work and the appropriate historical framework. To this end, the existing literature and approaches to disability and eugenic studies will be discussed, highlighting the lack of focus on the work of parent reform groups and their contributions.

Disability: Context and Historiography

Like many other concepts, disability should be thought of as fluid and ever-changing according to historical and cultural influences. Until the mid-nineteenth century, children with varying degrees of ‘mental deficiency’ were confined to the ‘madhouse’ or asylums with no training, education, or hope for the future. Reform began in 1845 with the Lunacy Act,

which gradually improved standards in asylums, and efforts were made to separate different degrees of ‘mental deficiency’. ‘Mental defectives’ were categorised into only two groups: those born incapacitated and those who were once sane. Later, the Idiots Act of 1886 made the distinction between ‘idiots’ and ‘imbeciles’:¹ ‘imbeciles’ were explained to have greater reasoning abilities than ‘idiots’.

The Elementary Education Acts of 1870 and 1880 introduced compulsory schooling for all children. Whilst the ‘mentally defective’ were not excluded from the new system,² neither were they specifically included. Subsequently, children with low intelligence attended ordinary schools as they were not considered severe enough to be incarcerated in asylums. Instead these children were declared to be ‘feeble-minded’ and in need of extra provision outside of the main schooling system, yet few received the necessary extra help.

Eventually, in 1896 the National Association for Promoting the Welfare of the Feeble-minded was established and was to have a profound impact on the future care of those deemed to be ‘mentally deficient’. The formation of this group would later prompt the 1908 Royal Commission for the Care and Control of the Feeble Minded. This reinforced interest in the subject of ‘mental deficiency’ and the need for a solution to the perceived problem. The 1908 Royal Commission recommended the establishment of a Board of Control to specifically handle the care and control of ‘mental defectives’ at a local level.

In 1913 a bill was passed to repeal and replace the 1886 Idiots Act. The Mental Deficiency Act, as it was called, followed the recommendations of the 1908 Royal Commission and set up a Board of Control for Lunacy and Mental Deficiency to govern four classes of people: ‘idiots’, ‘imbeciles’, ‘feeble-minded’ persons, and ‘moral imbeciles’ (the latter term would later be amended to ‘moral defectives’ by the Mental Deficiency

¹ Section 17 of the Idiots Act 1886 specifically dealt with the clarification of definitions. For a complete duplicate copy of the Idiots Act 1886, see S.G. Lushington, *Archibald's Lunacy* (London: Shaws and Sons, 1895), pp. 811-821.

² Section 74 of the Elementary Education Act 1870 detailed byelaws pertaining to the attendance of children at school, aged between 5 and 13. This was later developed by Section 2 of the Elementary Education Act 1880.

(Amendment) Act of 1927). The Board of Control effectively removed the discussion of ‘mental deficiency’ from the House of Commons and placed it within the remit of local authorities. Consequently, many services and provisions were disproportionate and fractured throughout the country.³ Under the original Mental Deficiency Act those deemed to be ‘idiots’ or ‘imbeciles’ were ordered to be the responsibility of health authorities due to their ‘ineducability’. The ‘feeble-minded’ and ‘moral imbeciles’ remained under the control of the education authorities. This was also reinforced by the Education Act of 1921, which stated that ‘idiots’ and ‘imbeciles’ should remain outside the remit of the education authorities. Yet, the biggest problem remained how to ascertain which group a child belonged to.

It is partly because of definitional problems that the history of disability has attracted such longstanding interest in the academic sphere. It is my hope that this dissertation will contribute to this growing scholarship by illuminating the lives of those with disabilities and those who cared for them in mid-twentieth century Britain. Despite the pioneering work done by the APBC in the mid-twentieth century, the academic discussion of this group and its place in society remains limited. As Jaeger and Bowman have put it:

Disability is a personal experience. It is a social experience. It is a profound influence on an individual’s life with both positive and negative aspects. For all of the personal and social ramifications of disability, however, the roles of disability in the lives of persons with disabilities are still insufficiently understood both by people with disabilities and by the rest of society⁴

In 1945, Dr Sophia Weitzman was appointed by the government to write the official history of education. Her work included extensive discussions of ‘mentally handicapped’ children.

³ This remained the case and a major bone of contention for the APBC, until the Mental Deficiency Act of 1913 was repealed and replaced with the 1959 Mental Health Act.

⁴ P.T. Jaeger and C.A. Bowman, *Understanding Disability: Inclusion, Access, Diversity and Civil Rights* (Connecticut: Praeger Publishers, 2005), p. viii.

Yet her work remained unpublished at the time of her death in 1965. In 1976 Nigel Middleton, a colleague of Weitzman, included some of her work in his book *A Place for Everyone*⁵ — though little mention was made of ‘handicapped’ children. It has been suggested that this was illustrative of the academic lack of interest in the subject of disability in the 1970s. Similarly, the majority of studies on the British disability movement have concentrated on the legislative process of change and the governmental agencies involved. Few have mentioned the inspiration driving these changes. Prominent groups such as the Union of Physically Impaired Against Segregation (UPIAS), for instance, have been celebrated as being the forerunners and inspiration for the British disability movement of the 1970s and 1980s. Tom Shakespeare, for instance, has accredited UPIAS with the early concepts of the social model of disability. Expanding upon this, in 1983 the phrase ‘social model of disability’ was coined by disabled scholar and disability rights activist, Mike Oliver. Many have incorrectly ascribed the founding of the concept to UPIAS/Oliver as well, despite the fact that the ideas behind the concept gradually gained traction in the 1950s and 1960s.⁶ UPIAS may have been the catalyst (and the intellectual and political heart) for the disability movement of the late twentieth century, but to deny the inspirational work of the APBC in the preceding decades would be unwise and limited in scope. Arguably, the influential members of the British disability movement were given the opportunity and ability to communicate their opinions through the pioneering work of the APBC.

⁵ N. Middleton, *A Place for Everyone: A History of State Education from the Eighteenth Century to the 1970s* (London: Gollancz, 1976).

⁶ Oliver described himself as one of the “originators of recent discussions about disability models” and claimed “parental rights” to the distinction between social and medical constructs of disability in M. Oliver, ‘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* (1990). Oliver fails to acknowledge earlier discussions of similar ideas in the 1950s and 1960s. This is also supported in T. Shakespeare, and N. Watson, ‘The Social Model of Disability: An Outdated Ideology?’, in *Exploring Theories and Expanding Methodologies: Where We Are and Where We Need to go (Research in Social Science and Disability, Volume 2)*, eds. S.N. Barnartt and B.M. Altman (Bingley: Emerald Group Publishing Limited, 2001), pp. 9-28. This has been perpetuated by R. Lang, ‘The Development and Critique of the Social Model of Disability’, *Leonard Cheshire Disability and Inclusive Development Centre (Working Paper)* 3 (2007), pp. 1-36; C. Barnes, ‘Understanding the Social Model of Disability: Past, Present and Future’, in *Routledge Handbook of Disability Studies*, eds. N. Watson, A. Roulstone and C. Thomas (Abingdon: Routledge, 2012), pp. 12-29.

Numerous scholars (particularly those with disabilities themselves) have also discussed aspects of the concept of disability. Amongst the most notable examples are Tom Shakespeare⁷, Laura Hershey⁸ and Lennard Davis.⁹ Recently, a growing number of authors from fields such as medical humanities, social policy, law, sociology and literature have contributed to our understanding of intellectual disabilities and those deemed to be affected by them.¹⁰ Prominent works include that of D.G. Pritchard, who discussed legislation, such as the Education Act of 1944, which affected ‘mentally deficient’ children and the official categories of ‘handicap’.¹¹

Most recently the academic community has witnessed an increase in publications interested in social and institutional history. Other authors such as Joanna Ryan and Frank Thomas focused on the treatment of those in large ‘subnormality’ hospitals. Ryan and Thomas critically engage with the idea of segregation, its efficacy in controlling the ‘mentally deficient’, and the government’s approach to the matter.¹² In doing so, the authors provide a comprehensive overview of the problems of institutionalisation in the twentieth century and more recently. This was expanded by Pamela Dale’s prominent work on the mental health field prior to 1948. Dale addressed the historical imbalance of accounts of medical care in

⁷ See T. Shakespeare, *Disability Rights and Wrongs* (Abingdon: Routledge, 2006); T. Shakespeare (ed), *The Disability Reader: Social Science Perspectives* (London: Continuum, 1998); Shakespeare and Watson, ‘The Social Model of Disability’, in *Exploring Theories and Expanding Methodologies*, eds. Barnartt and Altman.

⁸ See L. Hershey, ‘Rights, Realities, and Issues of Women with Disabilities’, in, *Sisterhood Is Forever: The Women’s Anthology for a New Millennium*, ed. R. Morgan (Washington: Washington Square Press, 2003), pp. 233-243; and Laura Hershey’s blog can be found at <http://www.laurahershey.com> (Accessed on 27/09/2015).

⁹ See L. Davis, *Enforcing Normalcy: Disability, Deafness and the Body* (London: Verso, 1995); L. Davis, *Enabling Acts: The Hidden Story of How the Americans with Disabilities Act Gave the Largest US Minority Its Rights* (Boston: Beacon Press, 2015); L. Davis, *The End of Normal: Identity in a Biocultural Era* (Michigan: University of Michigan Press, 2013); L. Davis (ed), *Disability Studies Reader* (London: Routledge, 2013); L. Davis, B. Hughes and D. Goodley (eds), *Disability and Social Theory: New Developments and Directions* (London: Palgrave, 2012).

¹⁰ See P. McDonagh, *Idiocy: A Cultural History (Representations: Health, Disability, Culture & Society)* (Liverpool: Liverpool University Press, 2008); C.F. Goodey, *A History of Intelligence and “Intellectual Disability”*: *The Shaping of Psychology in Early Modern Europe* (Surrey: Ashgate Publishing Ltd, 2011); T. Koch, ‘Disability and Difference: Balancing Social and Physical Constructions,’ *Journal of Medical Ethics* 27 (2001), pp. 370-376; P. Louhiala, *Preventing Intellectual Disability: Ethical and Clinical Issues* (Cambridge: Cambridge University Press, 2004); I. Marini and M. Stebnicki (eds), *The Psychological and Social Impact of Illness and Disability* (New York: Springer Publishing, 2012).

¹¹ D.G. Pritchard, *Education and the Handicapped, 1860-1960* (London and New York: Routledge and Kegan Paul, 1963).

¹² J. Ryan and F. Thomas, *The Politics of Mental Handicap* (London: Penguin Books, 1980).

institutions, in comparison to those of educational resources in such facilities. Included in Dale's work are individual cases, making the text an important contribution to the history of segregation.¹³ Dale's text built upon Mark Jackson's study of the scientific morality of institutional care.¹⁴ In the interwar years, control of the 'mentally deficient' remained problematic and at forefront of discussions into the care of the 'handicapped'. Jackson's work in this field continued with his *Borderland of Imbecility*, published in 2000¹⁵ and is widely regarded as an important text on the subject. Jackson explored the emergence of institutions, in the early twentieth century, designed to cater for the newly medicalised presentation of the 'feble-minded' and the perceived social problem this posed. Jackson is one of several authors who have successfully addressed the history of mental illness and disability within the context of the social history of medicine. David Wright and Anne Digby are amongst these authors to examine the social history of disability. Many regard Wright and Digby's *From Idiocy to Mental Deficiency*¹⁶ as the most comprehensive text on the subject. The collection of nine essays discusses a range of topics, from the middle ages to the emergence of the NHS. Overall, they succinctly address a previously neglected area of social and medical history and provide invaluable historical depth to the subject. Wright has also provided further research into the history of psychiatry and those defined as 'insane' in *Mental Disability in Victorian England*¹⁷ and *Outside the Walls of the Asylum*.¹⁸ The latter is an important academic text in the understanding of the medical treatment of 'mental deficiency' problems and the history of

¹³ P. Dale, 'Special Education at Starcross before 1948', *History of Education* 36 (2007), pp. 17-44. See P. Dale and J. Melling, *Mental Illness and Learning Disability Since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London and New York: Routledge, 2006).

¹⁴ M. Jackson, 'Institutional Provision for the Feeble-minded in Edwardian England: Sandlebridge and the Scientific Morality of Permanent Care', in *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* eds. D. Wright and A. Digby (London: Routledge, 1996), pp. 161-183.

¹⁵ M. Jackson, *The Borderland of Imbecility: Medicine Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester: Manchester University Press, 2000).

¹⁶ D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency: Historical Perspectives of People With Learning Disabilities* (London: Routledge, 1996).

¹⁷ D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001).

¹⁸ P. Bartlett and D. Wright, *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999).

community care. In the text, Wright and Bartlett are able to discuss and combine the two main themes of the history of psychiatry: asylums and developments in the familial home.

Whilst historical analyses of disability may have been slow to emerge, there is an increasing understanding of their importance; and disability now features within many avenues of historical inquiry. Mark Jackson, Paul Jaeger and Cynthia Bowman are some of the scholars¹⁹ who have insisted on retrieving the history of disability for current debates in the history of medicine.²⁰ Other notable works include Joyce Goodman's article 'Reflections on Researching an Archive of Disability'²¹ and Goodman critically discusses the process of research into 'mental deficiency' and the handling of individual cases. Whilst Sue Wheatcroft provided a good explanation of pre- and post-WW2 provisions for 'handicapped' children, including physically segregating measures in 'The Impact of World War Two on the 'Handicapped' Children of England', although her focus is primarily on children with physical 'handicaps'.²² Importantly, Steve Humphries and Pamela Gordon were some of the first authors to allow individuals with disabilities to define their own experiences by including personal accounts and photographs in their *Out of Sight: the Experience of Disability*.²³ Other texts to provide personal experiences, as opposed to official histories, of

¹⁹ Others who have studied the interaction of disability and medical history include (but are not limited to): K. Cudlick, 'Disability History and the History of Medicine: Rival Siblings or Conjoined Twins?', *Keynote Address, Social History of Medicine Conference, Glasgow*, (2008); J. Andrews, 'The Social History of Medicine in the 1990s', *Social History of Medicine* 3, 3 (1990), pp. 515-518; A. Borsay, 'History and Disability Studies: Evolving Perspectives', in *Routledge Handbook of Disability Studies*. Watson, Roulstone and Thomas; and B. Linker, 'On the Borderland of Medical and Disability History: A Survey of the Fields', *Bulletin of the History of Medicine* 87, 4 (2013), pp. 499-535.

²⁰ See, for example, Mark Jackson's BBC Radio 4 programmes on the history of disabilities, 'From Rags to Rights', aired in 2000; M. Jackson, *The Routledge History of Disease* (London: Routledge, 2015); M. Jackson, *The History of Medicine: A Beginner's Guide* (London: Oneworld Publications, 2014); M. Jackson, *The Oxford Handbook of the History of Medicine* (Oxford: Oxford University Press, 2011); M. Jackson, *Health and the Modern Home* (New York: Routledge, 2007); Jaeger and Bowman, *Understanding Disability*; P.T. Jaeger and C.A. Bowman, *Disability Matters: Legal and Pedagogical Issues of Disability in Education* (London and Connecticut: Bergin and Garvey, 2002); P.T. Jaeger and C.A. Bowman (eds), *A Guide to High School Success for Students with Disabilities* (London and Connecticut: Greenwood Press, 2004).

²¹ J. Goodman, 'Reflections on Researching an Archive of Disability: Sandlebridge, 1902-1935', *Educational Review* 55, 1 (2003), pp. 47-44.

²² S. Wheatcroft, 'The Impact of World War Two on the 'Handicapped' Children of England,' *PhD Thesis, University of Leeds* (2009).

²³ S. Humphries and P. Gordon, *Out of Sight: the Experience of Disability 1900-1950* (Plymouth: Plymouth Northcote House, 1992).

disabilities include *Forgotten Lives* edited by Dorothy Atkinson, Mark Jackson and Jan Walmsley.²⁴ The volume examines how an understanding of past approaches to the ‘mentally deficient’ can help explain current attitudes towards those with learning disabilities. Further contribution to the relationship between the past and the present can be found in the balance of personal testimonies and narratives provided by Ann Borsay’s *Disability and Social Policy in Britain since 1750*.²⁵ Borsay comprehensively examines the experiences of those with mental and physical impairments following the Industrial revolution, placing disability histories within context and suggesting. Furthermore, Borsay suggests that such individuals faced inequalities due to their inability to function within the new, industrialised society. Finally, Mathew Thomson has also provided a valuable contribution to the subject, particularly by connecting it with eugenics in his *The Problem of Mental Deficiency*.²⁶ Thomson explained the ‘problem of mental deficiency’ in the early twentieth century cannot be fully explained by eugenic ideas alone. Instead, Thomson suggested that the adjustment to democracy must also be included. Whilst this is an important corrective to the understanding of the early ‘problem of mental deficiency’, it does not address the legacy of eugenic thought in the mid-twentieth century. Subsequently, the relationship between ‘mental deficiency’, the aftermath of eugenic ideas, and how parent reformers overcame these obstacles to implement change remains largely neglected. To this end, this dissertation aims to build upon the growing historical literature into personal testimonies of disability by including the narratives of several parents of ‘backward’ children, taken from *Parents’ Voice*. Building upon Thomson’s text, the proceeding section will address the British eugenics movement and how it was able to influence the understanding of ‘mental deficiency’.

²⁴ D. Atkinson, M. Jackson and J. Walmsley (eds), *Forgotten Lives: Exploring the History of Learning Disability* (Kidderminster: British Institute of Learning Disability, 1997).

²⁵ A. Borsay, *Disability and Social Policy in Britain since 1750: A History of Exclusion* (Basingstoke: Palgrave, 2005).

²⁶ See M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Clarendon Press, 1998).

Eugenics: Context and Historiography

Whilst eugenic principles have been practised since antiquity, the modern history of eugenics began in the UK in the late nineteenth century. Coined by Francis Galton in the 1880s,²⁷ the term ‘eugenics’ was used to define “the study of all agencies under human control which can improve or impair the racial quality of future generations.”²⁸ During the early twentieth century eugenic concepts of ‘unworthy life’ became popular. Positive and negative eugenic ideas rapidly traversed national borders and spread globally; eugenic notions of health, well-being, heredity and morality were adopted across the political spectrum. Eugenicists, among others, began to question the rationality of caring for ‘weak’ members of society and looked for legitimate ways to control the spread of ‘mental deficiency’ and other unwanted social evils. To give the movement credence, eugenicists drew on a long lineage of ideas concerning the inheritability of physical, mental and moral characteristics. Eugenic tools utilised by many governments included, but were not limited to, identifying and classifying individuals, pedigree charts, IQ tests, and the growing knowledge of heredity. Studies of heredity and the causes of ‘mental deficiency’ were heavily influential in their suggestions for the care and control of this population. Fears emerged about medical intervention and special services subverting the natural order of existence and ultimately leading to national decline.²⁹ Amongst those considered to be ‘unfit’ were the blind, deaf, criminal, insane, homosexuals, sexually wayward women, alcoholics, the pauper underclass, racial and ethnic groups and the

²⁷ The term was originally used in F. Galton, *Inquiries into Human Faculty and its Development* (London: J.M. Dent & Co., 1883).

²⁸ Galton gave four lectures to the Sociological Society in 1904 and 1905 titled: ‘Eugenics: Its Scope and Aims’; ‘Restrictions in Marriage’; ‘Studies in National Eugenics’; and ‘Eugenics as a Factor in Religion’. The aforementioned definition of eugenics appears in the Minutes of the University of London referencing the lectures.

²⁹ For more information see D. Mackenzie, ‘Eugenics in Britain’, *Social Studies of Science* 6, 3-4 (1976), pp. 499-532.

‘mentally deficient’. Coercive or restrictive measures to control these groups included sterilisation, marriage laws, birth control, segregation, abortion and euthanasia.

However, whilst eugenic ideas were discussed globally each nation tailored their implementation of eugenic concepts, according to their own specific cultural ideas, certain characteristics remained central to each movement.³⁰ In Britain, the debate revolved around the pauper underclass, identifiable by their low intelligence and high fertility rates.³¹ The ‘feeble-minded’ became the epitome of this class. Early eugenic concepts focused on the physical and mental well-being of individuals. Deviations from this standard produced concerns about degeneration, something particularly evident in the case of ‘mental deficiency’. ‘Mentally defective’ individuals were perceived to be undermining and tainting the majority of society. As a result, these persons became the target of negative eugenic campaigns such as euthanasia and sterilisation.³²

By the turn of the twentieth century, eugenic advocates had made significant progress in Britain. Notable British advocates of eugenics in politics, economics and academics included (but were not limited to) future Prime Minister Winston Churchill, liberal

³⁰ Much has been written about the various eugenics movements across the world. A selection of culturally specific works include: A. McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Oxford: Oxford University Press, 1990); E. Black, *War Against the Weak: Eugenics and America's Campaign to Create a Master Race* (New York: Thunder's Mouth Press, 1994); C. Cogdell, *Eugenic Design: Streamlining America in the 1930s* (Philadelphia: University of Pennsylvania Press, 2004); P.A. Lombardo (ed), *A Century of Eugenics in America: From the Indiana Experiment to the Human Genome Era* (Bloomington: Indiana University Press, 2011); E.A. Carlson, *The Unfit: A History of a Bad Idea* (New York: Cold Spring Harbor Laboratory Press, 2001); M. Largent, *Breeding Contempt: The History of Forced Sterilization in the United States* (New Brunswick: Rutgers University Press, 2008); D. Wyndham, *Eugenics in Australia: Striving for National Fitness* (London: Galton Institute, 2003); F. Dikotter, *Imperfect Conceptions: Medical Knowledge, Birth Defects, and Eugenics in China* (New York: Columbia University Press, 1998); C. Campbell, *Race and Empire: Eugenics in Colonial Kenya* (Manchester: Manchester University Press, 2007); S.G. Salgirli, ‘Eugenics for the Doctors: Medicine and Social Control in 1930s Turkey’, *Journal of the History of Medicine and Allied Sciences* 66, 3 (2011), pp. 281-312; M. Turda and P.J. Weindling (eds), *Blood and Homeland: Eugenics and Racial Nationalism in Southeast and Central Europe 1900-1940* (Budapest: Central European University Press, 2006); and M. Turda (ed), *The History of East-Central European Eugenics, 1900-1945* (London: Bloomsbury, 2015).

³¹ The dissertation continues to discuss the historiography of British eugenics movement further on. However, other influential works on the British eugenic movement include: G.J. Baker, ‘Christianity and Eugenics: The Place of Religion in the British Eugenics Education Society and the American Eugenics Society, c.1907-1940’, *Social History of Medicine* 27, 2 (2014), pp. 281-302; D.B. Paul, *Controlling Human Heredity: 1865 to the Present* (New Jersey: Humanities Press, 1995); L. Farrell, *The Origins and Growth of the English Eugenics Movement, 1865-1925* (New York: Garland Publishing, 1985); and C. Hanson, *Eugenics, Literature and Culture in Post-War Britain* (Abingdon: Routledge, 2013).

³² See G.R. Searle, *Eugenics and Politics in Britain, 1900-1914* (Leyden: Noordhoff Publishing, 1976).

economists John Maynard Keynes and William Beveridge, authors H.G. Wells and George Bernard Shaw, and prominent academics such as Karl Pearson and Havelock Ellis. As noted above, the 1896 National Association for the Care and Control of the Feeble-minded was established to work in favour of the physical segregation of the ‘mentally defective’ and ‘feeble-minded’. To ascertain who was eligible for permanent segregation, eugenicists aimed to evaluate and classify human populations. They began to utilise these testing methods and census-style data to determine the mental ability of the nation. Following this, fears of the supposed degenerate underclass became a part of wider discourses on national health. Many doctors discussed the symptoms of ‘mental deficiency’ as the stigmata of degeneration, indicating what they believed to be the distinctly pathological nature of ‘feeble-mindedness’. Often clinical observations of ‘feeble-mindedness’ and ‘mental deficiency’ were marred by the personal conclusions, which in turn later influenced the quality of care afforded to those individuals.

In 1907, the Eugenics Education Society (EES) was founded. Amongst other things, it campaigned for restrictions to be placed on the ‘feeble-minded’ to further prevent national decline.³³ In 1908, one prominent member of the EES, Sir James Crichton-Browne, gave evidence to the Royal Commission for the Care and Control of the Feeble-minded. Crichton-Browne suggested the compulsory sterilisation of individuals with intellectual impairments labelling them as “our social rubbish.”³⁴ In 1909, a memo was sent to the Prime Minister, Herbert Henry Asquith, by Winston Churchill, who wrote:

The unnatural and increasingly rapid growth of the Feeble-Minded and Insane classes, coupled as it is with a steady restriction among all the thrifty, energetic and superior

³³ For more information see L.A. Farrell, *The Origins and Growth of the English Eugenics Movement, 1865-1925* (Michigan: University Microfilms, 1973).

³⁴ J. Crichton-Browne quoted in V. Brignell, ‘The Eugenics Movement Britain wants to Forget’, *New Statesman* (09/12/2010) <http://www.newstatesman.com/society/2010/12/british-eugenics-disabled> (Accessed on 27/03/2013).

stocks, constitutes a national and race danger which it is impossible to exaggerate. I am convinced that the multiplication of the Feeble-Minded, which is proceeding now at an artificial rate, unchecked by any of the old restraints of nature, and actually fostered by civilised conditions, is a terrible danger to the race.³⁵

The British eugenics movement promoted the hereditary aspect of ‘mental deficiency’, and the use of coercive disciplinary methods to curtail the spread of socially detrimental groups, such as the criminal, mentally ill, disabled, prostitutes and the poor. This was strengthened by the passing of the 1913 Mental Deficiency Act which resulted in the institutionalisation of thousands of individuals.³⁶ Whilst many scholars theorised about the precise cause and treatment of ‘mental deficiency’, little consensus existed. Due to the lack of comprehensive understanding and growing social concerns, many more individuals were automatically incarcerated to limit the threat they posed. Many believed that institutionalisation was best for the ‘mentally defective’ individuals and society.

Eugenic momentum continued to increase during the interwar period.³⁷ Notable support within the government came from Labour MP Will Crooks, who suggested that individuals with disabilities were “like human vermin [who] crawl about doing absolutely nothing, except polluting and corrupting everything they touch.”³⁸ Governments globally recognised the science behind eugenics and the practicality of the presuppositions; eugenic ideals frequently underlined significant policies and programmes. Yet, it is worth remarking that British eugenicists failed to make any significant progress towards legislating for permanent control of the ‘feeble-minded’ and ‘mentally deficient’. Eugenic movements often

³⁵ W. Churchill quoted in M. Gilbert ‘Churchill and Eugenics’, *The Churchill Centre* (31/05/2009) <http://www.winstonchurchill.org/support/the-churchill-centre/publications/finest-hour-online/594-churchill-and-eugenics> (Accessed on 21/03/2013).

³⁶ See E.J. Larson, ‘The Rhetoric of Eugenics: Expert Authority and the Mental Deficiency Bill’, *The British Journal for the History of Science* 24, 1 (1991), pp. 45–60.

³⁷ For more information see D. Barrett and C. Kurzman, ‘Globalizing Social Movement Theory: The Case of Eugenics’, *Theory and Society* 33, 5 (2004), pp. 487–527 and J. Harwood, ‘Editor's Introduction: Genetics, Eugenics and Evolution’, *The British Journal for the History of Science* 22, 3 (1989), pp. 257–265.

³⁸ W. Crooks quoted in Brignell, ‘The Eugenics Movement Britain wants to Forget’.

adhered to specific moral and cultural prescriptive norms; negative eugenic measures were generally considered incompatible with British traditions and morals. In 1931 attempts were made to pass a Bill allowing the compulsory sterilisation of those deemed to be ‘mentally defective’. The motion was denied and legislation authorising the compulsory sterilisation of the ‘mentally defective’ was defeated.³⁹

In 1934, the report of the Departmental Committee on Sterilisation once more raised the idea of voluntary sterilisation for ‘mentally defective’ women. The Labour MP, Archibald Church, described the Bill as necessary for those “who are in every way a burden to their parents, a misery to themselves and in my opinion a menace to the social life of the community.”⁴⁰ Again, the Bill was rejected, although these defeats did little to limit the influence of social and physically isolating eugenic measures, such as segregation and stigma.

Following the atrocities committed in Nazi Germany and an increasing understanding of genetics, there was a growing distrust of eugenics by the mid-twentieth century.⁴¹ Many began to realise that disability, and all it encompassed, was not as straightforward as previously assumed. Despite this, in the 1950s the segregation of these individuals increased in the UK. The creation of the National Health Service in 1948 was heavily influenced by the 1942 report on Social Insurance and Allied Services (commonly known as the Beveridge Report). Written by a noted progressive, liberal reformer and a member of the Eugenics Society, William Beveridge, the newly created NHS often reflected the early tropes of the British eugenics movement.⁴² To quote Beveridge:

³⁹ More information can be found in D. King and R. Hansen, ‘Experts at Work: State Autonomy, Social Learning and Eugenic Sterilization in 1930s Britain’, *British Journal of Political Science* 29, 1 (1999), pp. 77–107.

⁴⁰ W. Crooks quoted in Brignell, ‘The Eugenics Movement Britain wants to Forget’.

⁴¹ See D. Kevles, ‘Eugenics and Human Rights’, *British Medical Journal* 319, 7207 (1999), pp. 435–438.

⁴² For more information see: C. Hanson, *Eugenics, Literature in Post-War Britain* (Abingdon: Routledge, 2013); and D. Sewell, ‘How Eugenics Poisoned the Welfare State’, *The Spectator* (2009) <http://www.spectator.co.uk/features/5571423/how-eugenics-poisoned-the-welfare-state/> (Accessed on 30/05/2015).

Those men who through general defects are unable to fill such a whole place in industry, are to be recognised as unemployable. They must become the acknowledged dependents of the state, removed from free industry and maintained adequately in public institutions, but with a complete and permanent loss of all citizen rights including not only the franchise, but civil freedom and fatherhood.⁴³

Concerns of national degeneration linked to ‘mentally defective’ individuals were resilient in many scientific and political communities. WW2 may have highlighted the intrinsic flaws of eugenics,⁴⁴ but ideas of inferiority and shame continued to pervade social and political consciousness until the 1970s.⁴⁵ The legacy of the British eugenics movement, in conjunction with the failure of the welfare state to adequately resolve social issues of ignorance, disease, squalor, and poverty, resulted in ‘mentally defective’ individuals being abandoned and left to the care of their relatives. Many families feared the socially damning consequences attached to seeking help and opted to care for their ‘deficient’ offspring quietly, and away from judgemental and uncaring eyes. In essence the British eugenics movement was able to turn what were once the pitiable *victims* of society into its *villains*.

However, this dissertation does not intend to suggest that eugenically biased policies, nor eugenicists, were still active in the 1940s and 1950s. Instead this dissertation examines the aftermath of said eugenic attitudes and how they were able to have an effect on the public

⁴³ W. Beveridge, *Unemployment: A Problem of Industry* (London: Longmans, Green and Co., 1910), p. 196.

⁴⁴ See J. Glad, *Future Human Evolution: Eugenics in the Twenty-First Century* (Michigan: Hermitage, 2008).

⁴⁵ For more information see E. Ramsden, ‘Confronting the Stigma of Eugenics: Genetics, Demography and the Problems of Population’, *Social Studies of Science* 39, 6 (2009), pp. 853–884.

perception of disability after 1945.⁴⁶ Whilst eugenic policies were openly condemned in Britain, eugenic ideas of inferiority and degeneration remained ingrained in the social consciousness in the mid-twentieth century. The legacy of eugenic thoughts helped to create a climate of fear and shame surrounding mental impairments and those afflicted with them. In turn, this often resulted in poor services and amenities available to those with learning disabilities in the mid-twentieth century. It is this culture of eugenically influenced presuppositions that will be discussed in relation to Judy Fryd and the APBC's efforts to reform social and political biases. Much has been written about the eugenics movement in Britain, this dissertation is, therefore, unable to fully recount the intricacies of the idea of eugenics and individual movements. Influential works such as Pauline Mazumdar's *Eugenics, Human Genetics and Human Failings*⁴⁷ and Daniel Kevles' *In the Name of Eugenics*⁴⁸ give a comprehensive overview of eugenic ideals in Britain.⁴⁹ Dan Stone has expanded on the commonly accepted view of the British eugenics movement predominantly driven by class prejudice. Stone has added that race and class were inseparable in the works of British

⁴⁶ For more information on the overall context of the 1950s see: J. Black, *Modern British History Since 1900* (Basingstoke: Macmillan, 2000); R. Quinault, 'Britain 1950', *History Today* 51, 4 (2001); T. Gourvish and A. O'Day (eds), *Britain Since 1945* (Basingstoke: Macmillan, 1991); A. Marwick, *British Society Since 1945: The Penguin Social History of Britain* (London: Penguin, 2003); D. Gladstone, *The Twentieth Century Welfare State* (New York: St Martin's Press, 1999); R. McKibbin, *Classes and Cultures: England 1918-1951* (Oxford: Oxford University Press, 2000); P. Johnson (ed), *Twentieth-Century Britain: Economic, Social, and Cultural Change* (London: Longman, 1994); D. Kynaston, *Austerity Britain 1945-1951* (London: Bloomsbury, 2008); K.O. Morgan, *Labour in Power, 1945-1951* (Oxford: Oxford University Press, 1985); I. Zweiniger-Barcielowska, 'Rationing, Austerity, and the Conservative Party Recovery after 1945', *The Historical Journal* 37, 1 (1994), pp. 173-197; D. Kynaston, *Family Britain 1951-1957* (London: Bloomsbury, 2009); A.F. Havighurst, *Britain in Transition: The Twentieth Century* (Chicago: University of Chicago Press, 1962); N.A. Barr, *The Economics of the Welfare State* (California: Stanford University Press, 1993); A. Booth, *British Economic Development Since 1945* (Manchester: Manchester University Press, 1995); and C. Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002), pp. 53-55.

⁴⁷ P. Mazumdar, *Eugenics Human Genetics and Human Failings: The Eugenics Society, its Source and its Critics in Britain* (London: Routledge, 1992).

⁴⁸ D. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (Massachusetts: Harvard University Press, 1985).

⁴⁹ Previous works on the particulars of the British eugenic movement include: T. Young, *The Eugenics Movement and the Eugenic Idea in Britain, 1900-1914: A Historical Study* (London: University of London, 1980); G. Tordjman, 'The Scientific Origins of the British Eugenics Movement, 1859-1914' *MA Thesis, McGill University* (1990).

eugenicists.⁵⁰ In Britain, eugenicists aimed not only to promote class, race, personal characteristics or professional achievement, but also the ‘fulfilment of parental obligation’. Whilst class related fears were certainly central to some eugenic arguments, they were by no means the only reason for the success of eugenic ideas in Edwardian Britain. The successes of the eugenicists were not measured in legislative terms but rather in the manner in which eugenic “ideas of degeneration, decay, struggle and selection pervaded social and cultural life in this period.”⁵¹

Adding to the understanding of disability from a slightly different historical perspective are, therefore, disability scholars with an interest in eugenics.⁵² These academics have unveiled the complex issues surrounding the social and political attitudes towards those with disabilities. These scholars include Anne Digby and David Wright, Mark Jackson and Mathew Thomson. Others such as Andrzej Pekalski have argued against the use of eugenic programmes, stating that they can cause a loss of genetic diversity within the population. Pekalski argued that eugenic ideals of ridding the population of certain conditions and illnesses would result in a population unprepared for future evolution.⁵³ Richard Lynn has

⁵⁰ D. Stone, *Breeding Superman: Nietzsche, Rave and Eugenics in Edwardian and Interwar Britain* (Liverpool: Liverpool University Press, 2002), pp. 99-103.

⁵¹ *Ibid.*, p. 100.

⁵² See M. Jarman, *Eugenic Anatomies: Disability Disruption in Modernist American Literature* (Chicago: University of Illinois Press, 2006); D.M. Turner and K. Stagg (eds), *Social Histories of Disability and Deformity* (London: Routledge, 2006); M. Priestley (ed), *Disability and the Life Course: Global Perspectives* (Cambridge: Cambridge University Press, 2001); S.L. Snyder and D.T. Mitchell, *Cultural Locations of Disability* (Chicago: University of Chicago Press, 2006); M. Tankard Reist, *Defiant Birth: Women Who Resist Medical Eugenics* (Melbourne: Spinifex Press, 2006); S.K. Wheeler, ‘The Enfreakment of Language: Disability, Eugenics and Rhetoric’ *PhD Thesis, Texas A and M University* (2014); D. Pfeiffer, ‘Eugenics and Disability Discrimination’ in R.P. Marinelli and A.E. Dell Orto (eds), *The Psychological and Social Impact of Disability* (New York: Springer Publishing, 1999), pp. 12-31; S. Selden, ‘Eugenics and the Social Construction of Merit, Race and Disability’, *Journal of Curriculum Studies* 32, 2 (2000), pp. 235-252; C. Kliewer and S. Drake, ‘Disability, Eugenics and the Current Ideology of Segregation: A Modern Moral Tale’, *Disability and Society* 13, 1 (1998), pp. 95-111; D. Pfeiffer, ‘Eugenics and Disability Discrimination’, *Disability and Society* 9, 4 (1994), pp. 481-499; J.D. Smith, ‘Thoughts on the Changing Meaning of Disability: New Eugenics or New Wholeness?’, *Remedial and Special Education* 20 (1999), pp. 131-133; B. Baker, ‘The Hunt for Disability: the New Eugenics and the Normalisation of Schoolchildren’, *Teachers College Record* 104, 4 (2002), pp. 663-703; T. Shakespeare, ‘Choices and Rights: Eugenics, Genetics and Disability Equality’, *Disability and Society* 13, 5 (1995), pp. 665-681; and T. Shakespeare and A. Kerr, *Genetic Politics: From Eugenics to Genome* (Cheltenham: New Clarion Press, 2002).

⁵³ A. Pekalski, ‘Effect of Eugenics on The Evolution of Populations’, *The European Physical Journal B - Condensed Matter and Complex Systems* 17, 2 (2000), pp. 329-332

also explored this subject in *Dysgenics: Genetic Deterioration in Modern Populations*.⁵⁴ However, Lynn did not discard eugenic notions of measuring intelligence and efficacy, instead he focused on the impact of such ideas on modern disabled communities. Equally, eugenic measures such as sterilisation for the ‘mentally deficient’ and the effect this concept had in Britain have been examined by Randall Hansen and Desmond King. Critically, Hansen and King examined the “permanence of ideas” and how the concepts such as sterilisation were able to impact individuals outside of their original eugenic meaning.⁵⁵ Whilst there are many academic texts concerning the relationship between eugenic ideologies/ policies and disabilities, the eugenic legacy of ideas in relation to disability in mid-twentieth century Britain has seldom been discussed. This dissertation remains committed to study them together, in order to suggest the need for a more comprehensive understanding of the APBC’s campaigns for social acceptance of those stigmatised as ‘disabled’ in 1950s Britain. As one scholar put it, “It is at these fertile points of intersection that disability histories thrive, revealing new tensions, insights, and understandings into a range of long-standing historical inquiries into health, education, welfare, and institutionalisation.”⁵⁶

The introduction now turns to the other crucial area of context: namely, the formation of the APBC, and in particular the work and life of its founder and most influential member, Judy Fryd.

Judy Fryd, the APBC and Mencap

For the history of the disability movement in Britain, an important date is 1946, when Judy Fryd, a mother of a ‘mentally deficient’ child, defied social shame and decided to seek help for her daughter. Fundamentally, she believed that children with learning disabilities were a

⁵⁴ R. Lynn, *Dysgenics: Genetic Deterioration in Modern Populations* (London: Praeger Publishers, 2011).

⁵⁵ R. Hansen and D. King, ‘Eugenic Ideas, Political Interests and Policy Variance: Immigration and Sterilisation Policy in Britain and the U.S’, *World Politics* 53, 2 (2000), pp. 237-263.

⁵⁶ D. Earl, ‘A Group of Parents Came Together: Parent Advocacy Groups for Children with Intellectual Disabilities in Post-World War 2 Australia’, *Health and History* 13, 2 (2013), pp. 84-103.

marginalised group and, along with their families, were excluded from the benefits of society. The response she received from other parents was overwhelming. Less than a year later the APBC was created in London by a small group of socially conscious and politically motivated reformers, including Fryd. The founding members of the APBC were compelled by their civic duty to convince the authorities to improve provisions and challenge (the intrinsic) prejudice towards this marginalised section of the community. They worked assiduously for the betterment of social and political conditions for those deemed to be ‘mentally defective’ or ‘backward’. The advent of the APBC fundamentally altered the understanding of intellectual impairments in Britain and further afield.

Judy Fryd was born Caroline Joyce Manning on the 31st of October, 1909 in Hornsey, London. She was the daughter of Carrie Aldridge and Harry Smith Manning, a Post Office sorter. After attending Mitchenden School in Southgate, Fryd studied economics and political science at Ruskin College, Oxford. It was during her time at Oxford that she met fellow student John Herbert Francis Fryd (1911/12–1981), who would later become the general secretary of the Trade Union Federation, the chairman of the Hertfordshire branch of the APBC, elected to Hertfordshire County Council, member of the editorial committee of *Parents’ Voice*, and a member of the National Council for the National Union of Journalists. The pair married on the 29th of August, 1936 and moved to Leeds. In 1938, Judy gave birth to the eldest of their four children, Felicity. Whilst Felicity was never formally diagnosed as anything other than ‘mentally deficient’, Fryd later proposed it was likely she had some degree of autism. Their second daughter, Patricia, followed in 1940, and after relocating to Harpenden, Hertfordshire, their family was completed by the arrival of twins Peter and Linda in 1941. From an early age, Fryd was interested in politics and joined the Labour Youth League in her teenage years. As she explained in 1996: “Before Felicity came along, my career was always going to be politics [...] I just didn't realise it was the mentally

handicapped corner I would be fighting.”⁵⁷ In 1991, at the annual conference in Brighton she received a certificate of merit from the Labour Party for her outstanding voluntary membership to the party in the St Albans constituency. Additionally, she received a certificate of recognition and appreciation for services to the community by Harpenden Local Council. An example of her community work can still be seen by the Harpenden Local History Society, which she helped establish in 1973. She was also honoured by the Association of Women Clerks and Secretaries for her thirty-four years of membership and for her work during this time for the Women’s Co-Operative Guild. In 1996 David Cohen described Fryd thus:

For an 86-year-old, Mrs Fryd is remarkably lively. She is small but not frail, with curly silver hair that defies gravity, a ready laugh and charismatic eyes that betray a keenly tuned intellect. Her memory, she confessed, is no longer a reliable continuum, but all the important events are perfectly recalled, at worst shuffled around, yielding a slightly impressionistic tour of her life.⁵⁸

In her personal life, Fryd was an accomplished piano player, an active member of the Harpenden choral society and a keen artist. Felicity would often accompany Fryd’s piano playing with twirling and pitch-perfect singing. Felicity died in 1993 at the age of 55 from pneumonia. When asked if she felt that Felicity had lived a happy life, Fryd responded:

I think [...] that she was happy at the beginning and the end, but the middle must have been terrible. I remember the devastation she felt the first time she realised she was different. It was when her siblings started school and, unlike her, they weren’t sent home on their very first day. She realised then for the first time that there was

⁵⁷ D. Cohen, ‘Judy Fryd: They Told Me My Child Had No Mind’, *The Telegraph* (23/08/1996) <http://www.independent.co.uk/life-style/they-told-me-my-child-had-no-mind-1310998.html> (Accessed on 07/03/2013).

⁵⁸ Ibid.

something wrong with her and not others. Seeing her crushed little face as she began to piece it together ... that was the moment that broke my heart.⁵⁹

Seven years later, on the 20th of October 2000, Fryd herself passed away in the Field House Nursing Home in Harpenden aged 90. She was cremated at the Garside Crematorium, Watford seven days later. Despite her remarkable public achievements, Fryd lived a modest life. She was survived by a son, two daughters and granddaughter Elly, born in 1969.

In her obituary, Judy Fryd was described as a woman who would not take no for an answer and one of the great unsung heroines of the twentieth century. Whilst she may have been reserved in private, in public she was a persuasive campaigner. For her efforts she was awarded both an MBE and CBE, and honoured as one of ten eminent Britons in 2009.⁶⁰ When the Judy Fryd commemorative stamp was released in October 2009, Mark Goldring, the serving chief executive of Mencap remarked: “The Judy Fryd stamp is a great tribute to an outstanding individual who changed the attitudes of society towards people with learning disabilities forever. Thanks to Judy’s devotion to campaigning, people with learning disabilities now have a voice in society.”⁶¹ Her story is one of courage and that of an individual challenging social stereotypes and prejudices. As noted in her obituary: “It is in no small degree thanks to Judy Fryd that so many people who would previously have been condemned to permanent institutional incarceration are now able to [...] lead full and independent lives, protected by laws against discrimination.”⁶²

⁵⁹ Ibid.

⁶⁰ See image in Illustration 1.

⁶¹ M. Goldring, ‘Mencap founder to appear on first class stamp,’ *Local Mencap; Liverpool* <http://www.mencapliverpool.org.uk/mencap-founder-to-appear-on-first-class-stamp/> (Accessed on 06/12/2013).

⁶² ‘Obituary: Judy Fryd’, *The Telegraph* (23/10/2000) <http://www.telegraph.co.uk/news/obituaries/1371367/Judy-Fryd.html> (Accessed on 04/03/2013).

By the age of 3, Felicity (known by her family as Filly)⁶³ had begun to exhibit signs of learning difficulties; Felicity was quickly described as ‘backward’ and the family sought help. She would later be diagnosed as autistic.⁶⁴ As Fryd noted:

It was not until Felicity was nearly three that my husband, John, and I began to worry that something was not quite right [...] she was saying words like “mummy” and could sing nursery rhymes beautifully, but she was not using language to communicate the way her peers were. So I took her to a local Child Guidance Clinic to be assessed. The supervisor tried to give her an IQ test, but Felicity didn’t take any notice – she wandered round the room picking things up and he didn’t know what to do, so he told me to come back in three months. When I returned, he showed her a tray with little things on it, waited until she was looking away, took one item off and asked: “What’s missing?” I knew the phrase “missing” didn’t mean a thing to her, so I added: “He wants you to tell him what he’s taken away dear.” He gave me a withering stare and announced sternly: “Mother is not to interfere.” Felicity knew he wanted something, so she took a little chair and put it next to a box on the tray and said: “It’s a table”. I thought that was an intelligent thing to do, but no, she didn’t get any marks for that. He gave her an IQ of 43 and wrote her off.⁶⁵

The reaction to Felicity’s condition, both from medical professionals and from her peers, was the incentive that led to Fryd’s campaign for disability rights. But her engagement with the authorities would raise two major concerns and frustrations: she was unable to get any reliable information on Felicity’s condition, and when Felicity was crudely assessed the doctors failed to acknowledge her intelligence. As Fryd recalled: “I had taught her the

⁶³ Ibid.

⁶⁴ The term ‘autistic’ had appeared in medical journals as early as 1912. Swiss psychiatrist, Paul Eugen Bleuler (1857-1939) associated the term ‘autism’ to describe the symptoms of a group of schizophrenics in ‘Dementia Praecox; or, The Group of Schizophrenias’ (1911). Yet, it did not become a popular or accepted term in the English language until Fryd introduced the concept as a better explanation than ‘Juvenile Schizophrenia’ for Felicity’s condition in *Parents’ Voice Magazine* in 1958.

⁶⁵ Quoted in Cohen, ‘Judy Fryd: They Told Me My Child Had No Mind’.

alphabet and to count, so I realised that Felicity had learning ability as well as disability and that there was something that could be developed if we could only get her educated.”⁶⁶

Eventually, Fryd managed to find Felicity a place in a local primary school; this in itself was a rarity as children with conditions such as Felicity’s were often declared to be ‘ineducable’. However, Felicity was quickly expelled from the school for her challenging and disruptive behaviour. Following this, at age 6 Felicity was sent to a boarding school for ‘special’ children in Surrey on a month trial. Within twenty-four hours of her arrival, the Fryd family received a telegram declaring that Felicity was unsuitable and needed immediate removal from the establishment. Fryd recounted:

When we got that telegram, John and I sobbed in each other’s arms. Our hopes rested on that school. When we went to fetch her, I heard a tale of woe about how wicked she’d been. They had tried to introduce her to the other children but when they put their arms out to shake hands, she took it as an invitation to swing them round. Every one of them was a Down’s syndrome child, whom Felicity had never seen and she was probably frightened. The staff tried to stop her and she apparently bit one of them and, well, that was that.⁶⁷

In early 1944, Fryd believed that parents of so-called ‘backward’ children were marginalised, prejudiced against and stigmatised. These parents were often advised by medical professionals to ‘forget about that baby, go home and have another one’. Fryd in particular had the aforementioned sentiment relayed to her with the addition that Felicity was “a child with no mind”, to which she responded: “What a phrase to conjure. Testimony to how cruel and inaccurate the medical profession can be.”⁶⁸ For many parents, their only option was to suffer in silence and hide their condemned ‘backward’ children from society.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Ibid.

Angered by the lack of support and public understanding, Fryd refused to suffer in silence. In 1946, she penned a letter to *Nursery World Magazine* under the pseudonym 'Cinderella' asking if other parents faced similar challenges whilst educating their assumed 'backward' children at home. Hundreds of responses were received, prompting Fryd to reply: "It would seem that the idea of forming an Association of Parents of Backward Children fulfils a great need. The letters I have received make heart-breaking reading."⁶⁹ Within months more than a thousand parents formed the core of the APBC.

Fryd noted that the subject of disability was increasingly discussed in the public sphere and media. Films such as the *Snake Pit* (1948)⁷⁰ raised the question of mental illness and began to challenge public perceptions. Disability was no longer viewed as "too depressing"⁷¹ for the post-WW2 British society. Fryd followed this "hopeful sign"⁷² and requested research and information by sending questionnaires to every County Council in the country. Whilst she received no replies, Fryd was directed by one County Medical Officer towards other societies such as the National Provisional Council for Mental Health (later renamed to the National Association of Mental Health, 1946). Yet, none of these organisations contained the statistics and in-depth information she deemed necessary to create a change in the lives of children with learning disabilities. Consequently, Fryd spent the ensuing two years educating herself in matters of psychology, 'mental deficiency', educational methods and aetiology.

Fryd also wanted to bring together mothers like her so that they could share their experiences. However, Fryd understood that their task would not be an easy one. Paramount

⁶⁹ 'Cinderella', *Nursery World Magazine* (02/01/1947) <http://www.nurseryworld.co.uk/news/723229/Lots-give/> (Accessed on 11/03/2013).

⁷⁰ The film focuses upon the plight of its schizophrenic protagonist and her journey through recovery in a mental institution. The reception of the film led to changes in American Mental Institutions in 1949.

⁷¹ 'Association of Parents of Backward Children', *Newsletter* 2, 4 (Aug, 1949), in *National Association of Parents of Backward Children Nov 1948-Mar 1953*, SA/NBT/F.9/7, The Wellcome Library, London. Hereafter abbreviated to 'APBC', *Newsletter* 2, 4 (Aug, 1949).

⁷² *Ibid.*

to their success was the public's acceptance of 'mentally defective' children, first as children. It was in this task that Fryd believed a parents' association would be pioneering, "in accepting our role as parents of backward children and getting the public to accept us and our children, we had a special part to play."⁷³ To advance her campaign Fryd requested help from doctors, mental health professionals, superintendents, teachers and reformers to give the APBC credibility. Gradually, the APBC received publicity and grew in numbers and contacts. Once the APBC's campaign was advertised nationally⁷⁴ there was no end to the public support. By the beginning of 1949, the APBC was flourishing and had sufficient means to expand its membership and influence.⁷⁵ It is with a bittersweet irony that in 1950, and just as Fryd's newly formed APBC was beginning to thrive, Felicity entered the first of many institutions which she would stay at throughout her life.

The first 'mental hospital' Felicity entered in was populated by supposedly 'psychotic people', whose problems were very different from her own. Felicity's fellow inmates were mostly elderly ladies and the girl "didn't like them, so she would push them over."⁷⁶ At the age of 12 Felicity was being home tutored and had developed some disturbed behaviour. As Fryd recalled

By now she had three younger siblings but she never played with the other children, [...] instead, she used to run wildly or when she was miserable, sit on the compost heap and howl. There was no restraining her. Even if it was pouring with rain and I had shut all the doors, she would break a window and disappear out of the house. Usually I'd find her in the neighbour's garden, where she used to open

⁷³ J. Fryd, 'Era of the Handicapped' in 'The Parents' Voice', *Newsletter* 8, 3 (Aug, 1957) in *Parents Voice: National Society for Mentally Handicapped Children 1:38, 1950-1988*, Main Library/Store 208369/7, The University of Manchester Library, Manchester. Hereafter abbreviated to 'The Parents' Voice', *Newsletter* 8, 3 (Aug, 1957).

⁷⁴ Public awareness to Fryd's campaign was raised by articles appearing in journals such as *Childhood and Youth* and newspapers such as the *London Evening Standard*, the *Eastern Daily Press* and the *Co-Operative News*.

⁷⁵ 'APBC', *Newsletter* 2, 7 (Feb, 1950).

⁷⁶ *Ibid.*

the chicken run and let all their chickens out. Sometimes she would open the window upstairs and walk precariously along the ledge and I would have to coax her back in. And she wouldn't sleep. She used to howl and hammer on her bedroom door at three in the morning until we let her out to play.⁷⁷

Fryd would later campaign against the use of institutions in favour of better-equipped schools. Unfortunately for Felicity, these changes were implemented too late to make an impact upon her life.

In the December 1949 greetings to the members of the APBC, Fryd highlighted APBC's main tenets: with adequate education, research and understanding, 'mental defectiveness' did not have to mean a life of isolation and sadness. The APBC newsletters attempted to encourage parents of the immeasurable benefits of becoming actively involved in their local branch. Fryd fundamentally believed that society's approach to the 'mentally defective' should be no different than that towards any other person. Individuals should be treated with the same due care, respect and diligence as any other minority was afforded, although this was often not the case. Members were required to establish and finance their own provisions for their children causing many to suffer financially. The state supply of provisions posed a large problem to the country as capital development was directly against the contemporary post-war economic plans for the country. Whilst the APBC believed that the 'mentally defective' were entitled to a share of these provisions, social and economic opinions did not always support this.

Owing to the lack of governmental assistance, parents began to communicate with one another and established groups and classes. The idea of uniting parents and children to achieve proper education and training facilities rapidly gained popularity. In the early days of the APBC, a great emphasis was placed on uniting families and children by hosting parties,

⁷⁷ Cohen, 'Judy Fryd: They Told Me My Child Had No Mind'.

outings, and treats etc. Despite the importance of this, Fryd suggested that eventually parents were required to stop thinking of their own situation and think of the problem of tomorrow and every day to follow. Dudley Drown (Chairman of the APBC, 1954) assured parents that it was important not just to think of their own 'backward' child but also of those who are yet to be born and to "prevent those young parents from having to face the headaches and heartaches that had been our lot."⁷⁸ Fryd concurred: "All that we can do to lighten the darkness which surrounds this subject, we should do with a whole heart, for the sake of our own children and those yet to be born."⁷⁹

Much of what was achieved by the APBC in the 1950s did not benefit the members' children, either because they had grown too old, had already been placed in an institution, or because progress was too slow. Despite this, Fryd believed this should not discourage parents from continuing to fight for better provisions and facilities for others. This proactive approach helped to relieve frustrations and tensions incurred in the day-to-day dealing with their own 'backward' child. Variations in parental commitment on learning that their child may never benefit from their efforts were most noticeably seen by branch activity. After initially becoming a member of the local branch many parents were enthusiastic, proactively involved and willing to travel many miles. After some months, some parents' dedication wavered and their attendance became less frequent. However, the vast majority of members soon returned to the branch having missed the social interaction with like-minded persons and infectious enthusiasm. This process was expedited by the inclusion of regular branch bulletins with positive news of local successes. Members were rewarded for their work by Christmas and summer parties where children were able to shed their unhappy and isolated lives. Moreover, parents were encouraged to see their child having fun with their own friends.

⁷⁸ 'The Parents' Voice', *Newsletter* 4, 4 (Oct, 1953).

⁷⁹ 'The Parents' Voice', *Newsletter* 5, 2 (April, 1954).

Summer camps were often run and financially supported by the branches.⁸⁰ Fryd felt that “in doing these things together the parents lost the sense of isolation and frustration which the possession of a handicapped child imposes.”⁸¹ The desire for shared experiences and the need to remove the feeling of difference and embarrassment was described further:

Mothers and fathers, when they are told that their child is mentally handicapped, are plunged into a bottomless pit of despair. Apart from the eternal grief and disappointment, the shattering of plans and dreams, they lose confidence in themselves, in their abilities; they feel outcast from society.⁸²

In this respect, branches were fundamental to relieving parents of their isolated and restricted lives by facilitating social outings, lectures, meetings, day trips and so on. Branches were used to widen the sphere of influence at the important local levels. The strength and success of local groups were pivotal to the APBC’s success and the reform of attitude.

However, the APBC was not solely concerned with the care of *children*. Fryd also advocated for the rights and financial support for those believed to be ‘backward’ and over the age of 16. Fryd believed that all people, regardless of age or capabilities were entitled to equal opportunities in life, particularly education and health care. This goal was one the APBC continued to strive towards, and one which Fryd would expound frequently in her capacity as the author of the quarterly newsletters. The APBC set out to connect members, not just geographically, but also in terms of experiences, skills and intellectual levels. By February 1950, it was obvious that the rise in membership called for “placing this organisation on a more democratic and business like footing.”⁸³ Thus, in June 1950 it was decided that a constitution was to be drawn and the Association became officially known as

⁸⁰ For an image of children enjoying themselves on holiday, see Illustration 2.

⁸¹ ‘The Parents’ Voice’, *Newsletter* 4, 1 (Jan, 1953).

⁸² ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

⁸³ *Ibid.*

the National Association of Parents of Backward Children and *Parents' Voice* (the new name of the quarterly journal) begun on a more formal basis than the hand typed newsletters. To begin with Fryd was editor, secretary, treasurer, case worker, public relations officer, and the distributor of the quarterly newsletter. This changed in 1950 with the central organisation of the Association.⁸⁴ It was commented: "We come forward as responsible and self-reliant citizens who believe in co-operating for our mutual benefit both through voluntary organisation and through the statutory bodies under our system of democratic government."⁸⁵

In October 1954 Fryd engaged with the article 'Mental Deficiency, a Misnomer', written by J.M. Crawford.⁸⁶ Crawford believed that society was unable to understand 'mental deficiency' because vague terms such as 'backward' were being used. Crawford explained that the general public were beginning to understand the concept of mental illness as a distinct condition from bodily illness; mental illness was beginning to be viewed as a symptom of a wide variety of abnormal conditions. Crawford and Fryd believed that there were enough obstacles in the path of equality, terminology should not be an unnecessary one; simultaneously they called for the amendment of the out-dated Mental Deficiency Act.⁸⁷

Included in the distribution of the July 1954 edition of *Parents' Voice* was a ballot paper for members to cast their vote regarding a name change. However, it is pertinent to note that the main driving force for the suggested name change was not the objection to the term 'backward', but rather 'parents'. Senior members of the APBC did not wish to discourage members from joining the Association on the basis that they did not have a 'backward' child. In January 1955, the Association published the results of the referendum regarding the possibility of a name change; 994 members were for the proposal, 866 were

⁸⁴ It is worth noting that the Association became officially known as the National Association of Parents of Backward Children (NAPBC) at this point also. This dissertation will use 'APBC' for continuity and only refer to the NAPBC when referring to policy documents or convention notes etc.

⁸⁵ 'The Parents' Voice', *Newsletter* 2, 1 (Jan, 1951).

⁸⁶ 'The Parents' Voice', *Newsletter* 6, 1 (Jan 1955).

⁸⁷ J.C. Davies, 'The Way Ahead' in 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953), p. 3.

against. The APBC then officially ratified and changed its name to The National Association for Mentally Handicapped Children during the Special Convention to be called for Rules Revision in London on the 14th of May, 1955. Steps were also made to register as a Company Limited by Guarantee.⁸⁸ Later the name would be shortened to Mencap in 1969.⁸⁹

The APBC was not afraid to challenge the stigmatising attitudes of British society and defy the longstanding governmental interpretations of eugenic practices. Fryd repeatedly tackled governmental inquiries such as the Law and Administration of Mental Deficiency and urged the Ministry of Health (hereafter MoH) to conduct more comprehensive research into ‘mental deficiency’, regardless of age or ‘grade’.⁹⁰ Dudley Drown spoke of Fryd’s work: “the way of the pioneer is hard, but with your support and your faith in our just cause we shall ultimately realise our ambition to provide, through our own efforts, security and an assured future for our children and those yet unborn.”⁹¹ The APBC’s aims were realistic and attainable; it did not seek to establish itself as an elaborate, elitist organisation and its membership consisted of all echelons of society. The APBC sought to keep fees and costs low in order to include parents from “lower income groups”,⁹² thus showing that Fryd was willing to overcome class distinctions in order to achieve her goals. Members responded by donating money and offering services wherever possible. It is worth noting all contributions to *Parents’ Voice* and the quarterly newsletters were done so voluntarily and without fee.

Whilst the work of the APBC was inspiring and progressive, it was by no means the only organisation that dealt with individuals with disabilities.⁹³ It was Fryd’s determination to remove the stigmatising attitudes she faced which set the APBC apart from its

⁸⁸ ‘The Parents’ Voice’, *Newsletter* 4, 7 (Spring 1955).

⁸⁹ The term ‘Mencap’ was first used in August 1957 by the Torbay branch which started an Adult Working Group named ‘the Mencap Centre’.

⁹⁰ Fryd believed that the current information stating that “1 in 700 births is a “Mongol” and the Central Council for the Welfare of “spastics” estimates that in this category alone there are 10,000 under 16!” was insufficient and did nothing to explain the care, treatment or education of such children, let alone the status of those over the age of 16. ‘APBC’, *Newsletter* 2, 5 (Oct 1949).

⁹¹ D. Drown, ‘Where are we Going?’ in ‘The Parents’ Voice’, *Newsletter* 4, 4 (Oct, 1953, p. 3).

⁹² ‘APBC’, *Newsletter* 1, 12 (Nov 1948).

⁹³ Most prominently The National Association for Mental Health (1946) was established.

contemporaries, such as the NAMH. Fryd believed that in order to implement changes to the lives and rights of those with learning disabilities, access to information was vital to all persons regardless of class, age, status or capabilities. However, Fryd did not believe that her Association alone could change how those with mental disabilities were treated by the society at large. Instead she opted to affiliate herself and the APBC with as many professional bodies and groups interested in the subject. Through these affiliations, Fryd believed that the APBC would be able to achieve a greater readership and thus a bigger influence. This approach was largely successful and the APBC were soon able to influence governmental, societal and medical decisions on a national level.

To broaden their scope of influence the APBC made links between parent groups abroad who were also interested. Many took inspiration from the APBC, opting to follow in their pioneering footsteps. As well as being represented in Scotland⁹⁴ and Wales, the APBC were also linked to the Association of Parents of Children in Need of Special Care in Northern Ireland. The Northern Irish counterpart was occupied with the same concerns and attitudes as the APBC, and found the latter hugely influential and informative. However, it was not just in the British Isles that the APBC can be considered influential. By the end of 1950, thousands of parents of ‘mentally backward’ children met up in Minneapolis with a view to organising a group. The purposes of the group were remarkably similar to those of the APBC. Like the APBC, the American Parents Association affiliated themselves with professionals to give their organisation credence. Various American states also had similar

⁹⁴ The Scottish Association of Parents of Mentally Handicapped Children (later known as Scottish Association of Parents of Handicapped Children).

parent groups.⁹⁵ The National Association for Retarded Children was established in Cincinnati, Ohio and the Greater Detroit Parents' Association for Mentally Retarded Children. The APBC had particularly close links with the New Jersey Parents' Group for Retarded Children who had an interest in challenging the American department of education's lack of responsibility for 'mentally retarded' children. The New Jersey association also produced a journal called *Parents' Voice*. Editor of *Children Limited* journal of the National Association for Retarded Children in the USA, Eugene Gramm, commented "all of us watch with admiration and a sense of pride (since we are all part of one mighty parents' movement the world over) as we read and learn of your many advances and the general progress you are making in England. Every achievement you realise there helps every retarded child everywhere."⁹⁶

Similarly, in Canada the Association for the Advancement of Retarded Children was formed in British Columbia, Canada, 1952. The Manitoba Association for Retarded Children was established in Winnipeg, Canada soon after. By the mid-1950s reports were received of parent groups further afield in Norway (The Association for the Help of the Mentally Deficient in Oslo) and South Africa (the Association for the Help of Retarded Children). Parents in Israel had also begun to organise themselves into parents' groups. In Japan, a sister society to the APBC launched (the Japanese Society for the Welfare of Mentally Handicapped Children). The director of the group was studying in England and undoubtedly took inspiration from the APBC. In Australia, the Sub-Normal Children's Welfare Association in New South Wales; the Victorian Helping Hand for Sub-Normal Children; the

⁹⁵ More has been written about the history of mental impairments in the USA by J.W. Trent Jr, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkeley and Los Angeles: University of California Press, 1994); J.W. Trent Jr and S. Noll (eds), *Mental Retardation in America: A Historical Reader* (New York and London: New York University Press, 2004); P.L. Tyor and L.V. Bell, *Caring for the Retarded in America: A History* (Santa Barbara: Praeger Publishers, 1984); S. Noll, *Feeble-Minded in Our Midst: Institutions for the Mentally Retarded in the South, 1900-1940* (Chapel Hill: University of North Carolina Press, 1995); and P.M. Ferguson, *Abandoned to Their Fate: Social Policy and Practice toward Severely Retarded People in America, 1820-1920* (Philadelphia: Temple University Press, 1994).

⁹⁶ E. Gramm, 'Letter from America' in 'The Parents' Voice', *Newsletter* 6, 1 (Jan, 1955), p. 3.

Mentally Retarded Children's Welfare Association; the Retarded Children's Educational Society; Slow Learning Children's Group; and the Tasmanian Association for the Welfare of Retarded Children were established — all were centrally organised by the Australian Council of Organisations for Subnormal Children.⁹⁷

From its inception the APBC pioneered services for those with learning disabilities, beginning with the Association's first short-stay residential care home, Orchard Dene, established near Liverpool in 1952. In 1958, the ground-breaking Brooklands experiment was commissioned and supervised by Jack Tizard,⁹⁸ which established that educating children with learning disabilities in a home-like environment was superior to a hospital setting. After two years the children in the former situation were shown to have made marked improvements in verbal, social and emotional skills. The success of the study earned national recognition and paved the way for the 1959 Mental Health Act which complemented the shift away from hospital based care for people with mental disabilities. By the 1960s Mencap had opened their first hostel and training workshop for individuals with learning difficulties in Slough, Berkshire. Following this, in 1966 the Association established Gateway clubs with a view to offering sports and leisure opportunities for those who had been previously denied them. Regardless, parents of 'backward' children were still faced with the need to find and pay for special education privately. Moreover, even if parents were able to secure these services, their children were not deemed to be 'school children' and were thus not entitled to certain facilities.

Unhappy with the *status quo* Fryd began to lobby for change, which ultimately and successfully was reflected in the 1970 Education (Handicapped Children) Act. This Act

⁹⁷ More has been written about Australian parent groups by Earl, 'A Group of Parents Came Together', pp. 84-103. Megan Jane Edwards has written more broadly on the subject of 'mental deficiency' in Australia in M.J. Edwards, *Deficiency and Disorder: A Cultural History of Mental Deficiency in New South Wales, 1880-1920* (New South Wales: University of New South Wales, 2000).

⁹⁸ For further explanation of the Brooklands Experiment, see J. Tizard, *Community Services for the Mentally Handicapped* (Oxford: Oxford University Press, 1964), pp. 86-137.

ensured that for the first time in British history, all children regardless of abilities (or rather disabilities) were the responsibility of the education authority. This altogether dismissed the notion that individuals with learning disabilities were ‘ineducable’ and guaranteed that every child with such conditions was entitled to an education.⁹⁹ To further this agenda, Mencap initiated a series of programmes designed to increase the quality of life afforded to those with disabilities. These measures included the Pathway Employment Service in 1975. During the 1980s, Mencap ensured that the Further and Higher Education Act included those with learning disabilities and that the first community-based accommodation and homes were established. By 1985, Mencap’s services had been extended to include those with profound and multiple learning difficulties. Mencap also advocated for a new national survey of people with learning disabilities, which was eventually achieved in the late 1980s.

As vice president for 20 years, Judy Fryd was pivotal to the public success of the APBC/Mencap. During this time she ensured that all disabled people had the right to freedom from discrimination. This freedom was ultimately safeguarded by the Disability Discrimination Act of 1995 which aimed to end the discrimination faced by individuals with disabilities and guarantee their civil rights. This was quickly followed by the Golden Lane Housing Project in 1998 which supported persons with learning disabilities to buy or rent their own homes.

By the new millennium, Mencap had launched ‘Equal Chances’ in 2004. Following this, in 2005 the government published the report ‘Improving the Life Chances of Disabled People’ which laid out plans to improve the standard and quality of life for disabled children and adults by 2025. In 2008, the society launched a new font called FSme designed in cooperation with people with learning disabilities for easy legibility. The United Nations Conventions on the Rights of Persons with Disabilities reaffirmed that individuals with

⁹⁹ For a more comprehensive account of the impact of government legislation upon disability see: A. Roulstone and S. Prideaux, *Understanding Disability Policy: Understanding Welfare: Social Issues, Policy and Practice* (Bristol: The Policy Press, University of Bristol, 2012).

disabilities have the same human and civil rights as non-disabled people; this was eventually ratified by the British government in 2009.

Today Mencap is considered to be the largest and leading voice of learning disabilities in the UK and has achieved a revolution in attitudes towards those concerned. At its height it boasted having the Queen Mother as its Patron, a turnover of £200 million, over 50,000 parent members, a permanent staff of 6,000, and 20,000 volunteers.¹⁰⁰ Moreover, individuals with learning disabilities serve on the Mencap board of trustees and one third of its national assembly is comprised of people with learning difficulties. The influential and ground-breaking *Parents' Voice* was essential in shaping the new climate of opinion regarding the perception of disability. Fryd fulfilled the demanding position of editor of the journal for twenty-five years with an unwavering devotion and skill.

Aims and Structure

Whilst the history of the APBC is remarkable, for the most part discussions of its revolutionary work tend to be chronological and confined to commemorative texts. The overlooked quarterly newsletters and the APBC's journal (*Parents' Voice*) extensively detailed every aspect of the Association's activities. These sources identified the APBC's key areas of concern in the mid-twentieth century, and have been used in this dissertation to provide its structure. The work of the APBC can be broadly divided into four main areas: social exclusion, physical isolation, research, and education reform. The chapters are organised accordingly, and each begins with a thorough discussion of the contextual framework in which the campaigns should be placed, before assessing the activities of the APBC.

¹⁰⁰ 'About Us' <http://www.mencap.org.uk/about-us> (Accessed on 06/03/2013).

The first chapter examines the eugenic use of stigma as a socially isolating tool. To engage with the concept of stigma and the impact this had on those with disabilities in the mid-twentieth century, Erving Goffman's definition of stigma is employed. Stigma permeated all factions of political and social spheres in the 1950s and dictated the availability of provisions for the 'mentally deficient'. The APBC believed overcoming ideas of shame and fear were central to the inclusion of those with mental impairments.

The next chapter in this dissertation recovers why residential care was regarded by so many as the most appropriate solution to the perceived problem posed by 'mental deficiency'. In the 1940s and 1950s families were often told by medical professionals that they should put their 'backward' children in institutions, as they were be unable to benefit from life experiences. However, like the majority of society, institutions often regarded their wards as second-class citizens devoid of the need for care, attention and education. 'Mentally defective' children particularly suffered in institutions and concerns began to increase about the suitability of large, impersonal facilities.

Following this, the third chapter discusses the APBC's desire to combat the inherent discrimination in the scientific and medical fields. The discussion of research related to 'mental deficiency' will concentrate on Fryd's duty bound belief to advance and disseminate research to all who desired it, regardless of social standing. Fryd believed that increased understanding and knowledge of 'mental deficiency' would ultimately lead parents to make their own informed decisions. Additionally, she called for greater research to be conducted into the abilities of the 'mentally deficient'; refusing to accept that nothing could be done for these individuals.

Finally, the fourth chapter examines the results of Fryd's call for greater provisions for 'mentally deficient' children, namely in the form of educational provisions. Fryd refused to allow 'backward' children to have their fate sealed as socially worthless by the denial to

basic education. Prior to the 1950s, society's negative approach to 'backward' children was essentially self-prophesising. After 20 years of lobbying the APBC realised one of their fundamental aims in the 1970 Education (Handicapped Children) Act. This task was not easy and begun far earlier than many acknowledge.

The chronological framework of this dissertation encompasses the period between 1946, when the APBC was formed, and 1960. The decision to finish the dissertation in 1960 has been made on several grounds. Firstly, there is a notable change in the APBC newsletters; matters become more formal and lose the detailed personal stories that were prevalent in the preceding decade. Moreover, after a decade of lobbying, the 1959 Mental Health Act installed a greater degree of equality for those with learning disabilities, suggesting that understanding of this previously marginalised group had considerably improved. Within a relatively small time frame substantial and practical change had begun, largely in part thanks to the work of parental reformers. Lastly, the decision to conclude the dissertation in 1960 reflects the coining of the term 'genetic engineering' in 1965 which created a shift away from out-dated eugenic presuppositions. Journals such as the *Annals of Eugenics* changed to the *Annals of Human Genetics* in 1954 and the *Eugenics Review* subsequently ended in 1968. The Eugenics Society ceased its propaganda activities and became an educational charity in 1963. Later, the name would also be changed to the Galton Institute.

Disclaimer on the Language

Historically the subject of disability has been confused by the multitude of terms used to describe the topic. The language used in historical analyses continues to be hotly contested on the grounds of suitability. In this dissertation eugenic terms such as 'feeble-minded', 'mental deficiency', 'spastic', 'Mongol' and 'backward' have been included. This is not to cause offence; rather the aim is to accurately portray the historical context being discussed. These

terms were considered to be factual and scientifically valid and alluded to the threat posed by the perceived problem of 'mental deficiency'.

Chapter One

Prejudice and Stigma: The Social Isolation of ‘Mental Defectives’

“Here and there one finds those afflicted, imperfect bodies, living in a harsh and unfriendly world which rejects them.”¹

David Wright and Anne Digby have argued that the social history of disability in Britain is the most controversial subsection in the wider topic of social policy. In part, the controversial nature of the subject has resulted in it remaining largely neglected and underdeveloped in the field of medical history. The historical roots of stigmatising attitudes also remain relatively underdeveloped and misunderstood. In their study on disability, Paul Jaeger and Cynthia Bowman concluded that the lack of understanding of many disabling conditions resulted in those with disabilities having no real place within society. Jaeger and Bowman believed that this ultimately led to many stories of experiencing disability to be lost, even as they occurred.² According to David Wright and Anne Digby: “Historically, the social marginality of people with learning disabilities has been mirrored by their academic marginality.”³ Whilst many improvements have been made, relatively few texts specifically focus on the roots of isolation and stigmatising attitudes in comparison to other areas of social history. However, in the 1960s and 1970s, a new social history emerged promoting ‘history from below’. This allowed for a number of social groups to be considered for historical discussion, which at the same time accelerated the attainment of equality. Regardless of this progress, those with learning disabilities and their roles within British society were still largely neglected by the

¹ ‘Association of Parents of Backward Children’, *Newsletter* 2, 1 (Jan, 1949), in *National Association of Parents of Backward Children Nov 1948-Mar 1953*, SA/NBT/F.9/7, The Wellcome Library, London. Hereafter abbreviated to ‘APBC’, *Newsletter* 2, 1 (Jan, 1949).

² P.T. Jaeger and C.A. Bowman, *Understanding Disability: Inclusion, Access, Diversity and Civil Rights* (Connecticut: Praeger Publishers, 2005), p. xiv.

³ D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency: Historical Perspectives of People With Learning Disabilities* (London: Routledge, 1996), p. 2.

medical scholarship. It was not until the British disability movement that scholars, medical practitioners and authorities began to question their own attitudes and approaches to those with disabilities and how these altered the quality of life afforded to those with disabilities.

Eugenic Influence: Stigma

Western society places an emphasis on intellectual well-being and health. Those who are unable to literally and metaphorically live up to society's standards were often devalued and dismissed. During the period between the early to mid-twentieth century, this assumption resulted in social isolation and a lack of critical scholarship analysing the social reaction to disability. Those with disabling conditions were perceived to be undermining and contaminating society and were often subjected to stigmatisation. Moreover, most views about disability in mid-twentieth century Britain were heavily influenced by eugenic ideas. Primarily, the eugenic movement was concerned with the science of heredity. In particular, British eugenicists examined methods of curtailing the reproduction of the 'feebleminded' and those with mental disabilities. Eugenic narratives about disability tended to operate within a specific social and intellectual framework, such as the one provided by social Darwinism and the idea of the survival of the fittest.⁴ These concepts were used to legitimise the inherent social and economic imbalances as well as social behaviour. Victorian social commentators, for instance, suggested that social inequality served as a reminder of the

⁴ For further information see: M. Hawkins, *Social Darwinism in European and American Thought 1860-1945: Nature as Model and Nature as Threat* (Cambridge: Cambridge University Press, 1997); P. Crook, *Darwin's Coat-Tails: Essays on Social Darwinism* (New York: Peter Lang Publishing, 2007); G. Jones, *Social Darwinism and English Thought: The Interaction Between Biological and Social Theory* (Hertfordshire: Harvester Press, 1980); A.P. Thakur, *The Legacy of Social Darwinism* (New Delhi: Global Vision Publishing, 2005); H. Spencer, *The Principles of Biology: Volume 1* (London: William and Norgate, 1864); G. Claeys, 'The "Survival of the Fittest" and the Origins of Social Darwinism', *Journal of the History of Ideas* 61, 2 (2000), pp. 223-240; D.B. Paul, 'Darwin, Social Darwinism and Eugenics' in M.J.S. Hodge and G. Radick, *The Cambridge Companion to Darwin* (Cambridge: Cambridge University Press, 2006); and M. Ruse, *The Cambridge Encyclopaedia of Darwin and Evolutionary Thought* (Cambridge: Cambridge University Press, 2013).

society's upper echelons' dominance over the 'savage', 'primitive', and 'feeble-minded' members of the community.

By the late 1920s, however, it became apparent that the new science of genetics⁵ was unable to establish the legitimacy of eugenics. British eugenic policies relied heavily on discrimination and socially embedded fears to pervade political and social systems. The British eugenics movement helped to determine the value society placed on those with disabilities. The stigmatisation of those deemed to be 'backward' or 'mentally deficient' was largely derived from the society's fears of the unknown and the misunderstood. In particular, women and those with disabling conditions were demonised. Those with 'Mongolism' often exhibited very physical characteristics and mannerisms, including over enthusiasm and exaggerated levels of affection. The latter mannerism particularly emphasised their differences in the era of starched conservative Victorianism. This difference was implicit in the language used to define disability with terms such as 'Mongol',⁶ 'defective' and 'backward'. Progressive eugenicists in America produced myths about the rapid reproduction of the 'feeble-minded' in society. These ideas were also strongly influential in the British eugenics movement. Consequently, families in the mid-twentieth century were often afraid of the social stigma attached to their 'backward' children, and as a result they were reluctant to seek help or to send them to specialised schools.

The most widely accepted understanding of stigma has been offered by the renowned sociologist Erving Goffman. In his 1963 text *Stigma: Notes on the Management of Spoiled Identity*, Goffman defined stigma as "the situation of the individual who is disqualified from

⁵ In 1866 Gregor Johann Mendel developed his theory of Inheritance based on pea plants. This was built upon, and eventually led to the Mendelian model of heredity articulated by American evolutionary biologist Thomas Hunt Morgan. By 1925 this model was widely accepted as being the new science of genetics. Eugenicists also used theories of inheritance, as developed by Mendel, as a basis for altering the population through positive and negative biological interference.

⁶ The term 'Mongol' in connection to 'mentally deficient' individuals can be traced back to J.L. Down, 'Observations on an Ethnic Classification of Idiots', *London Hospital Clinical Report* 21 (1866), pp. 695-697.

full social acceptance.”⁷ Goffman noted that on meeting new individuals we automatically predetermine their “social identity”.⁸ The negative differences that we presume in our subconsciousness to exist within these supposed social identities ultimately create stigma. In this respect, stigma can be viewed as a failing or a shortcoming. Therefore, it is our perception of the negative characteristic of the individual which creates stigma, not the trait itself. In order for stigma to exist, a relationship between the presumption and attribute must be present. Goffman went on to mention the reactions of those he declared as ‘normal’ in contrast to those ‘stigmatised’. Those in the ‘normal’ category hold the belief that those excluded from their category were not quite human. From this assumption, those in the ‘normal’ group enact various forms of discrimination which essentially reduce the quality of life afforded to those stigmatised/or with stigma.

Goffman’s ideas were further elaborated by the scholarship on disability. Scholars such as Erik Parens and Adrienne Asch⁹ have proposed that discrimination of those with disabilities is derived from one group failing to understand that ‘others’ with disabilities live differently than themselves, thus disregarding that these lives can be full and rich in their own right. Many families dealing with disabilities suffer from the effects of discrimination; most prominent of the associated effects is isolation. Members of the general public are sometimes wary of befriending individuals or families of a person with disabilities for fear of being stigmatised by association. Consequently, people often take no action whatsoever and distance themselves from disability; thus emphasising feelings of social isolation and stigmatisation. Stigma, it can be surmised, has its roots in ‘difference’. The pain inflicted by stigmatising attitudes is linked to pity, fear, and disapproval of the difference in physicality,

⁷ E. Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New York: Simon and Schuster, 1963), p. 50.

⁸ For Goffman, ‘social identity’ differs from social status in the respect that social identity is primarily comprised of evaluated attributes rather than social position.

⁹ E. Parens and A. Asch, ‘The Disability Rights Critique of Prenatal Genetic Testing Reflections and Recommendations’, *The Hastings Centre Report* 29, 5 (1999), pp. 1-22.

personality, gender, age, sexuality or ethnicity. Wright and Digby have succinctly explained that many of us question our own lives when faced with disability.¹⁰ However, it is not our questioning which spoils the life experiences of those with disabilities, but rather the projection of expectations on said individuals which alters their ability to function.

Stephen Franzoi, for instance, has proposed a definition of stigma as the attribute that serves to discredit a person or person's ability in the eyes of other people.¹¹ It has been suggested there are primitive urges to form groups for safety and protection or a socio-psychological coupling rooted in the need to reproduce. In the establishing of said groups, distinct social structures become evident. Group identities are formed to distinguish one group from another. This identity is often based on a specific set of moral values which dictate the 'norms' and behaviour of the group. These rules can later manifest themselves as stigmatising attitudes with the capability to denounce an individual for not conforming to the normative prescription. Irrespective of the reason, denying companionship should be considered cruel, inhumane and a form of punishment. Often social 'rules' are utilised by members of the group to create peer pressure. This social phenomenon is used to compel members of society to a set of values which they would ordinarily reject. This phenomenon is evident in various eugenic and political movements in the late nineteenth and early twentieth centuries. Once a part of the mechanistic 'in-group' it is hard for an individual to extricate him or herself, or change the established set of values. In this sense, the group socialisation process becomes a self-perpetuating circle of control.¹² Discrimination and stigma serve to separate socially and to exclude individuals from the benefits of society.

Discrimination often begins early in an individual's life. For many, pregnancy holds a common expectation of the 'perfect baby'. However, this expectation is frequently shattered

¹⁰ D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001), p. 3

¹¹ S.L. Franzoi, *Social Psychology* (London: Brown and Benchmark, 1996).

¹² For a more comprehensive explanation see T. Mason, C. Carlisle, C. Watkins and E. Whitehead (eds), *Stigma and Social Exclusion in Healthcare* (London: Routledge, 2001), pp. 1-8.

when the child is revealed to have an abnormality or a birth defect. Many expecting mothers suffer from the ‘paradigm of perfection’ in which they place hopes and expectations on the unborn child, only to have these shattered after giving birth to a child with disabilities.¹³ This change in perceptions conjures up imagery of weakness, vulnerability and pity. This realisation of imperfection involves a series of emotions in parents which ultimately necessitates a process of readjustment where personal and social beliefs must be recalculated. Pertinent to the paradigm of perfection is the loss of the image of a ‘perfect child’. This holds particular importance for many parents as children are often considered to be an extension and embodiment of their parents. Using this basis, it is possible to understand why many parents viewed abnormalities and disabilities as a genetic corruption.¹⁴ This led to feelings of guilt, shame and embarrassment as the parents’ egotistic self-image was assaulted. The range of feelings exhibited by parents when responding to the birth of a child with disabilities ranged from revulsion to ambivalence to pity. Parents may react by denying, concealing, diminishing the disability, shunning social interaction or conversely by educating themselves on the nuances of the defect in order to legitimise it. Cliff Cunningham mentions the story of a mother of a three year old child with Down syndrome. The mother of the child is quoted as saying: “I used to think of her as a stranger [...] like someone from a different country [...] not one of us.”¹⁵

The impact of stigmatisation on a person can vary in form and intensity from individual to individual. At a personal level, the effect of social isolation and stigma can be distressing.

¹³ For further information on the ‘paradigm of perfection’ see M. Tankard Reist, *Defiant Birth: Women Who Resist Medical Eugenics* (Melbourne: Spinifex Press, 2006); J. Bourke, *What it Means to Be Human* (Berkeley: Counterpoint Press, 2011); and G.H. Landsman, *Reconstructing Motherhood and Disability in the Age of “Perfect” Babies* (New York: Routledge, 2009).

¹⁴ T. Mason, C. Carlisle, C. Watkins and E. Whitehead (eds), *Stigma and Social Exclusion in Healthcare* (London: Routledge, 2001), p. 53.

¹⁵ C. Cunningham, *Down Syndrome: An Introduction for Parents and Carers* (London: Souvenir Press, 1982), p. 7.

Medical versus Social Debate

Until the 1990s disability was perceived to be mainly a medical condition, derived from a failure of the endocrinal, physiological or psychological systems. Disability, in its many forms, was believed to have infringed on the affected individual's ability to cope with the necessities of life. This medical construction deemed that disability presupposed a limitation of functioning and flourishing. To be sure, some disabling conditions undeniably involved a limitation of functioning abilities; however, not all medical conditions resulted in disability and not all socially debilitating situations derived from a medical condition. As Jonathan Glover explains, being an ethnic minority in a racist society may be socially disabling, but the person's skin colour in itself is not a disabling condition. This dichotomy became known as the debate between the medical and social models of disability.¹⁶ For many scholars, social constructs as opposed to medical conditions are believed to impose greater limitations on the individual. This theory proposes that whilst an individual may have a medical condition preventing him or her from being able to walk, it is society's approach to those who cannot walk which limits their life experiences. It is therefore possible to surmise that creating an accepting and understanding environment in which an individual with disabilities can flourish is vital to the quality of life afforded to those with both mental and physical disabilities. Whilst modern society supposedly encourages and welcomes diversities of all kinds, disability is often excluded from such discourses. Consequently, the British disability movement pushed for improved anti-discrimination legislation to ensure that individual human potential is not impeded.¹⁷

¹⁶ J. Glover, *Choosing Children: the Ethical Dilemmas of Genetic Intervention (Genes, Disability and Design)* (Oxford: Oxford University Press, 2006), pp. 12-13.

¹⁷ In 1982 the Committee on the Restrictions Against Disabled People produced convincing reports on the need for anti-discrimination legislation. By the mid-1980s several groups began to lobby for such legislation under the title Voluntary Organisations For Anti-Discrimination Legislation.

Central to the social model of disability is the notion that visible medical conditions produce a negative social reaction from others. This creates shared experiences for persons with disabilities. Often the experience includes struggle, facing discrimination and learning to live differently from what has been considered ‘normal’ by the majority of society. In his 1995 *Enforcing Normalcy*, Lennard Davis, for instance, describes disability as an interruption of the culturally constructed ‘normality’.¹⁸ Nancy Eiesland has further suggested that disability was not necessarily a medical issue, but rather a social construct. According to her: “People with disabilities are distinguished not because of [...] shared physical, psychological or emotional traits, but because “temporarily able-bodied” persons single us out for differential treatment.”¹⁹ Eiesland also suggested that charities often inadvertently heightened the differences between individuals with disabilities and those without by grouping together the experiences of those with disabilities.²⁰ If allowed to personally define their own experiences and needs, society would realise that disabled persons were by no means incomplete. For Eiesland, social inclusion did not derive from charitable giving, but rather by overcoming social barriers and attitudes.

Adding to this discussion, Jonathan Glover looked at the effect of stigmatising attitudes on disability using the example of Martha’s Vineyard in America in the late nineteenth and early twentieth centuries. During this period the Duke’s County Island in Massachusetts witnessed an abnormally high ratio of deaf to hearing residents. To accommodate for this imbalance, the hearing community adapted and learnt sign language. Subsequently, oral communication and sign language became entwined, resulting in

¹⁸ L. Davis, *Enforcing Normalcy: Disability, Deafness and the Body* (London: Verso, 1995), p. 129.

¹⁹ N. Eiesland quoted in M. Edmonds, *A Theological Diagnosis: A New Direction on Genetic Therapy, ‘Disability’ and the Ethics of Healing* (Oxford: Oxford University Press, 2011), p. 18.

²⁰ These ideas are also referred to as the tragedy/charity model of disability. The charity model of disability depicts those with disabilities as deserving of pity, charity and as a victim of their own circumstance. The charity model of disability essentially declares individuals with disabilities as unable to help themselves and in need of care and protection from others. It is largely due to this reason that many persons with disabilities reject the charity model of disability as being dis-enabling and reducing their autonomy and equal/human rights.

differences between hearing individuals and persons with hearing impairments being minimised. Consequently, the socially stigmatising attitudes were minimised. Glover quotes one man's recollection of the phenomenon: "oh, those people weren't handicapped. They were just deaf."²¹ In Glover's words, "When the stigma of separateness and the communication barrier were both removed in Martha's Vineyard, deafness became insignificant as a disability. So it was not seen as a disability and this too made it less disabling."²² Those with hearing impairments in Martha's Vineyard were able to overcome their physical and mental differences and eliminate the associated isolation.

In 1947 the World Health Organisation declared that the definition of health was "complete physical, mental and social well-being and not merely the absence of disease or infirmity."²³ However, the acceptance of a specific ethnic group, behaviour type or particular disability is largely dependent on the cultural heritage of society. This heritage may be influenced by pivotal historical and social events. In early 1950s Britain, Judy Fryd and others connected with the APBC expressed ideas of the social impact of disability, long before it was academically fashionable during the 1970s and 1980s.²⁴ For example, in January 1952, whilst discussing the employment opportunities for adolescent 'mental defectives' in Liverpool, Fryd remarked:

²¹ Glover, *Choosing Children*, p. 7.

²² Ibid.

²³ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

²⁴ Academic popularity for the phrase 'social model of disability' began in 1983 after it was coined by disabled scholar and disability rights activist, Mike Oliver. Though, the ideas themselves are widely thought of as beginning to gain traction in the 1960s. Groups such as UPIAS explicitly expressed their views that society's reactions directly impacted the individual and access to the community. The social model of disability was later expanded and developed by academics globally in the late twentieth century. See M. Oliver, *The Politics of Disablement* (London: Macmillan, 1990); M. Oliver (ed), *Social Work, Disabled people and Disabling Environments* (London: Jessica Kingsley, 1991); and M. Oliver, *Understanding Disability, from Theory to Practice* (London: Macmillan, 1996).

It has to be remembered that the child is handicapped not only by his disability, but its psychological effect upon his personality and disposition [...] the influence of the home has a marked bearing on the working life of the child.²⁵

In early 1954, geneticist Lionel Penrose spoke to the Friends of the Fountain Hospital in Tooting, London.²⁶ The nature of the disability problem was described by Penrose as a social problem rather than a medical one. Fryd summarised his opinions thus: “Before medical science is called in, the first indicators of something wrong were of a social nature – a failure of the usual response to social intercourse or a failure of physical activity.”²⁷ Penrose stated his aim had always been to raise the profile of ‘backward’ children to remove the social stigma attached to the condition. He felt that the APBC was a great instrument to achieve this work. Further on, Penrose continued to speak of the social implications of ‘mental deficiency’ and explained that in what he termed ‘primitive’ countries only the most severely afflicted were recognised as ‘backward’. Whereas in more advanced countries there were more distinctions between ‘normal’, ‘backward’ and ‘grossly backward’. However, Penrose thought it important to assert that no separate race of ‘defective’ people existed but rather these distinctions had been arbitrarily created on the basis of social convenience. And Fryd quoted at length from Penrose’s speech:

²⁵ ‘The Parents’ Voice’, *Newsletter* 3, 1 (Jan, 1952) in *Parents Voice: National Society for Mentally Handicapped Children 1:38, 1950-1988*, Main Library/Store 208369/7, The University of Manchester Library, Manchester. Hereafter abbreviated to ‘The Parents’ Voice’, *Newsletter* 3, 1 (Jan, 1952).

²⁶ The Fountain Fever Hospital was originally opened in 1893 during Scarlet Fever resurgence. It was constructed within nine weeks and consisted of eight wooden bungalow-style huts with four hundred beds in each block. Later, the hospital was closed and the buildings were fireproofed in 1903 after a fire in Colney Hatch Asylum. In 1912 the hospital was reopened as a facility for ‘unimprovable imbeciles’ and the lowest grade of ‘mentally deficient’ children. The number of beds had been increased to 666 in nineteen blocks. In 1917 a school was started to help educate the children who could benefit from such services. Despite damages incurred during WW2, in 1948 the hospital joined the NHS and became known as the Fountain Hospital. In 1963 the temporary huts designed to last for ten years were eventually demolished and the site was taken over by St George’s Hospital.

²⁷ ‘The Parents’ Voice’, *Newsletter* 7, 3 (Aug, 1956).

It was necessary that all those people should be regarded as part of the same population. Many cases of backwardness were not medical problems, but problems for society; we had not so much to fit them into the community, but to fit the community to them and meet their needs. This was easier in times of full employment than when there was a great deal of unemployment. It was not merely a question of training backward people, but getting society to accept them and their work.²⁸

Fifty years later, the debate to replace the functional/medical model of disability with a social construction continues.²⁹ Although scholars such as Glover declared it unhelpful and unproductive, he ultimately stated that the entire argument should be abandoned. For many persons with disabilities, both the functional *and* social models of disability are applicable to some extent. Glover suggested instead that charting personal experiences and the effects these have had on modern notions of disability would be more productive.³⁰

Medical Views

The differences between ‘them and us’ in the 1940s and 1950s were exacerbated by persons with disabling conditions being unable to define their own experiences. The APBC newsletters allude to the frustration many parents felt at the time. The APBC felt that children with learning disabilities were overlooked and neglected. Many felt they were being punished for having a ‘backward’ child. The combination of the poor economic relief and the socially stigmatising attitudes often led to the emotional and physical abandonment of ‘backward’ children. Here’s what Judy Fryd noted in October 1953:

²⁸ ‘The Parents’ Voice’, *Newsletter* 5, 1 (Jan, 1954).

²⁹ For further reading see D. Goodley, ‘Learning Difficulties, the Social Model of Disability and Impairment: Challenging Epistemologies’, *Disability and Society* 16, 2 (2001), pp. 207-231; G.L. Engel, ‘The Need for a New Medical Model: A Challenge for Biomedicine’, *Science New Series* 196, 4286 (1977), pp. 129-136; S. Brisenden, ‘Independent Living and the Medical Model of Disability’, *Disability, Handicap and Society* 1, 2 (1986), pp. 173-178; and Oliver, *The Politics of Disablement*.

³⁰ Glover, *Choosing Children*, p. 23. Tom Shakespeare and Nicholas Watson have also discussed this idea in T. Shakespeare, and N. Watson, ‘The Social Model of Disability: An Outdated Ideology?’, in *Exploring Theories and Expanding Methodologies: Where We Are and Where We Need to go (Research in Social Science and Disability, Volume 2)*, eds. S.N. Barnartt and B.M. Altman (Bingley: Emerald Group Publishing Limited, 2001), pp. 9-28.

Few people ever thought about these children, except as a joke, or when some sensational case arose. “Those places,” the Institutions for the Mentally Defective, were left to stew in their own juice [...] Special Schools were despised by the public as “Silly Schools” and their transport was the “Looney Bus.” Parents fought against sending their children to Special Schools because of the social stigma.³¹

Fryd fought earnestly to avoid this by improving coping systems for the parents and provide better provisions for the child. She believed that families should not be punished because of their different social expectations, and that they should be judged on an individual basis. As she put it:

They [the children] were conceived in hope and born in travail like other children, and are valued and loved by their parents just as highly, in spite of all the exhortations to “put them in a home and forget them”, “don’t waste money on them”, etc. (It is a mistake to judge all parents by the minority of the feckless ones who receive the lion’s share of “statutory supervision”).³²

As a whole, society encouraged disability to be hidden from public areas, although, by the mid-twentieth century Fryd believed that the subject of disability was no longer “too depressing” for the general public. To this effect, Fryd and the APBC began to challenge the concept of disability as it existed in the general consciousness. Commenting on a public gathering of children with various disabilities in 1950, Fryd wrote: “The children were cheerful and friendly and I don’t think anyone was depressed by seeing them all together. One little boy with a severe case of hydrocephalus, was simply bubbling over with joy of living and won all hearts.”³³

³¹ ‘The Parents’ Voice’, *Newsletter* 4, 4 (Oct, 1953).

³² ‘APBC’, *Newsletter* 2, 8 (April, 1950).

³³ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

However, the bias often expressed by esteemed professionals and the public frequently led parents and their ‘backward’ children to retreat from society and live isolated, and restricted lives. Often parents were reliant on publications such as *The Brain Injured Child – A Booklet for Parents*, produced by the Sunfield Children’s Home in Clent, Worcester.³⁴ These publications were often considered to provide the best approach to disability for many parents. However, these pamphlets often expressed the opinions of society who frequently struggled to find a place for the ‘duller’ members of the community. Statements made by those in positions of authority included: “children who were born to idiots or imbeciles should be put to death in order to make room in Institutions etc. for patients who were likely to benefit from treatment.”³⁵ The author of the aforementioned pamphlet continues along these lines:

Personally, I reject this so-called solution because I also reject the proposition that “nothing can be done” to help improve these children. I have never seen much development in my own little girl who six years ago was tossed aside by the Authorities as beyond help, that I shall never again believe any hopeless diagnosis of a young child. Furthermore, I believe that the economic system exists to help individual men, women and children to enjoy their life on this earth, and that every person born has inalienable right to any benefits which civilisation can devise to be shared among us all.³⁶

Whilst there was a growing acknowledgement that ‘backward’ children required specialised care and attention, the special needs of parents were often neglected. The majority of parents had no experience with the alleged ‘backwardness’ of their children. Judy Fryd believed that parents needed the sympathy and understanding of the community around them, that they

³⁴ Established in the 1930s by Friedrich Geuter and Michael Wilson as a residential special school based on the teaching principles of Rudolph Steiner. Sunfield continues to operate as an independent residential school and learning community for those aged between 9-16 with complex learning and behavioural needs.

³⁵ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

³⁶ *Ibid.*

should be freed from stigma and shame. As she put it: “[parents have] the right to be treated as intelligent human beings, and to be told the truth about their children in an intelligent manner and at the psychologically best moment.”³⁷ Fryd believed that before parents were able to convince others of their plight it was important they themselves comprehensively understood and accepted their child’s situation. This was a task often made difficult for some by the manner in which they received the initial news. Parents reported how they were only told of their child’s diagnosis once an important decision was to be made — frequently in an overly abrupt and heartless manner. For many this shaped the attitude they felt towards their child; some parents were told that nothing could be done for their child and thus did not seek further help. According to Fryd:

It is necessary that a too hopeless or fatalistic attitude should be avoided. There is much that a mother can do to help develop his capacities to their limit, but if she is told “he will never be any good; better put him in a Home and forget him” she may feel no incentive to try her best.³⁸

If a more sympathetic and understanding approach could be adopted by the medical profession then Fryd believed much could be done to improve the standard of living. In *The Mentally Retarded Child*, Abraham Levinson wrote of a doctor’s refusal to prescribe glasses to a ‘mentally defective’ child, on the grounds that the child would never read or write in his opinion.³⁹

Parents wanted more than a simple diagnosis; they needed medical advice. Many wanted to know why their child was ‘backward’, whether or not education/training facilities were available, and if their child could benefit from them. For many parents the first

³⁷ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

³⁸ ‘The Parents’ Voice’, *Newsletter* 4, 2 (April, 1953).

³⁹ A. Levinson, *The Mentally Retarded Child: A Guide for Parents* (New York: The John Day Company, 1952), p. 73.

questions they asked were “why should this happen to us? What can be done about it? Could there have been some mistake?”⁴⁰ Some parents asked these questions as they refused to accept their child’s condition. However, others were genuinely confused and spent considerable amounts of time and money going to unorthodox means in the search for answers where others had failed them. During an APBC meeting of members from Ipswich, Colchester and Cambridge, Fryd spoke of the psychological problems faced by parents after discovering that something was different about their child. She remarked:

Mothers were sometimes chided for going round from Doctor to Doctor “in search of a reprise”, as one Doctor phrased it. He did not understand what we were really after, which is, first, a PROPER DIAGNOSIS. Available treatment should be given where necessary to all children, irrespective of parents’ means or social position, under the Health Scheme. It was sometimes withheld because the child was considered “not worth spending money on”.⁴¹

At the Annual General Meeting of the National Society of Children’s Nurseries in 1956, Dr Simon Yudkin (Consultant Paediatrician at the Whittington Hospital, London) described the contemporary situation facing individuals with ‘mental deficiency’ and their families as being a “citadel where superstition is reigning, supported largely by ignorance.”⁴² Eventually, most parents realised that no magical cure for ‘mental deficiency’ existed. At one of the APBC meetings, held in autumn 1955, it was asserted: “Knowledge is power, and in their search for truth parents gradually lose feelings of helplessness and are able to cope with their problems and enjoy their children more.”⁴³ Moreover, it was suggested that ‘mentally deficient’ children should be treated in the same manner as their ‘normal’ brothers and sisters to allow maximum enjoyment for the family. Whilst some allowances were necessary to manage the

⁴⁰ ‘The Parents’ Voice’, *Newsletter* 5, 2 (April, 1954).

⁴¹ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

⁴² *Ibid.*

⁴³ ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

‘deficiency’, smothering the child with pity was ill-advised and detrimental to the mental health and development of all involved. Parents were unable to effectively and realistically help their child until they had fully accepted the diagnosis of ‘mentally defective’.

The vast majority of those involved with the APBC agreed that doctors should deliver the diagnosis of ‘mentally deficient’ as soon as possible. However, there was considerably less agreement about what the doctors’ next suggestion should be. Kenneth Sunderland Holt (MD, DCH, MRCP, and Lecturer in Child Health at the University of Sheffield) had been researching the subject of ‘mental deficiency’ and the effect it had on families for two years (1955-1957). Holt focused on three main areas: the role of the family doctor; available help and training for the ‘defective’ child; and available help for parents. For Holt, the role of the doctor was comprised of two main demands when dealing with a ‘mentally deficient’ child: to make the initial diagnosis of ‘mentally defective’ as soon as possible; and to subsequently advise parents about the forthcoming necessities and provide guidance where needed.

During a discussion prompted by the APBC’s proposals to the MoH in March 1958, the issue of the diagnostic system was raised. Members continually pressed for diagnostic centres to relieve the uncertainty surrounding the child’s condition, and many stated that they were unable to obtain a definitive answer from their physician:

We realise that firm diagnosis may not be possible in the first months of life, but surely it need not be delayed until the child is about to go to school [...] we feel that in many cases, family doctors are (understandably) reluctant to pronounce so severe a sentence on the basis of their own meagre experience.⁴⁴

It was argued that diagnostic centres would be better equipped to dispense education, advice, diagnoses, and ultimately offer treatment courses earlier. Furthermore, it was suggested that

⁴⁴ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

doctors would be more likely to refer children and babies sooner for diagnosis if a specialist facility was available and easily accessible. Centres would also allow for professionals to be better trained to discuss the diagnosis and child's future with parents:

It is a common story that parents first notice something unusual in a child, only to have their well-founded fears pooh-poohed by the doctor [...] Not only would they have a more sympathetic understanding of the human problem involved (in centres) [...] but they would have more information on the actual community services which are at the disposal of the children and of their families. It goes without saying that the personnel of these centres will need careful selection.⁴⁵

Regardless of the condition, Holt felt that in order for medical professionals to be able to make an early diagnosis they must be knowledgeable of normal developmental problems so that deviations from this standard could be recognised. When diagnosing a child as 'deficient' it was suggested that a full examination of the child should be conducted to determine any possible causes and avenues for treatment. Holt found that this was not commonplace: "I have been very surprised at the lateness of diagnosis in some cases and also by the number of children who have never been fully examined."⁴⁶

Upon diagnosis, it was felt the physician had a duty to tell parents immediately of his concerns as nothing was to be gained by delaying this. Frequent consultation appointments should be made available to the family to alleviate fears and concerns. It was determined that the advice a doctor could, and should give, fell into three categories: medical, social and educational. The latter should also include methods of training. Holt recognised that some doctors may be able to advise parents on all three areas, others would need to refer to specialists. This service was critical as many parents had not seen a 'mentally defective' child

⁴⁵ Ibid.

⁴⁶ K.S. Holt, 'Mentally Retarded Children and Their Families', in 'The Parents' Voice', *Newsletter* 8, 1 (Feb, 1957), pp. 14-15.

before having their own. Many parents were left confused, distressed, and felt excluded from society. Furthermore, standard methods of training and education were not applicable to ‘mentally deficient’ children, causing bitterness and frustration for all involved. It was important that doctors taught parents to recognise signs of improvement and the progress of abilities to avoid these feelings. Making these observations allowed parents to ensure that their child’s development was not stagnating.

In early 1958, the APBC sent a memorandum to the Mental Health group of the Society of Medical Officers of Health. The memorandum declared that for some time the APBC had been aware of gaps and shortcomings in the services for the ‘mentally deficient’. The memorandum was composed by asking the Association’s 14,000 members what problems/flaws they had encountered in the NHS, whilst obtaining advice and treatment for their ‘backward’ child. To gather this information a questionnaire was circulated to members and much of the data returned was concerned with medical professionals’ handling of the initial diagnosis and advice.⁴⁷ The Medical Officers of Health were understood to be of utmost importance in the diagnosis and delivery process. Therefore, the resulting memorandum was circulated to this group first. The memorandum recognised provisions were highly dependent on locality and it was important to rectify this imbalance to ensure an informed, balanced and all-round service. As Fryd explained:

A child who is born, for example, with a congenital amputation of a limb is treated with the utmost care and consideration, and no trouble is too great which might help him to overcome his handicap; whereas the child whose handicap is a mental one is often handled with an astonishing unawareness of what the situation means to the child himself and the whole of his family.⁴⁸

⁴⁷ For an example of the questionnaire, see Illustration 3.

⁴⁸ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

However, it is important to note that not all physicians were ill-informed or uncaring in their attitudes towards ‘mental deficiency’. Dr Coleman Kenton (Medical Director of NAMH) also reasoned that: “Backward children have virtues as well as disadvantages; the parents recognised this and were only too willing to give them the love and care they needed.”⁴⁹

Dr Alfred Torrie (the Consultant Psychiatrist for Napsbury Hospital, Hertfordshire, and former medical director of the NAMH) discussed the prejudice and stigma directed at this marginalised group in ‘One Talent Child’ in March 1958. Torrie asserted that in most cases the stigma surrounding disability was derived from the fear of the unknown:

The man in the street has a great deal of fear, suspicion and ignorance concerning mental handicap. The physically handicapped child has a far greater appeal – his handicap is obvious and he excites our compassion – he pulls at our purse strings as well as our heart strings. But when the defect is hidden, people generally pass by on the other side.⁵⁰

Many thought that little could be done for the ‘one talent’ child except residential care. Despite this, professionals and academics increasingly accepted that if greater attention was paid to health, welfare and behaviour then a degree of learning could be achieved. It was suggested that improvements in IQ could be made by up to 20 or 30 points. Torrie declared this a considerable gain when the average IQ was 50. From this, Torrie suggested this increase was attributable to greater social awareness and attention paid to the ‘one talent’ child: “That gave us a clue that these people were not only intellectually handicapped, but they were emotionally bound, ‘frozen’, as well.”⁵¹

⁴⁹ ‘The Parents’ Voice’, *Newsletter* 3, 3 (July, 1952).

⁵⁰ A. Torrie, ‘One Talent Child’, in ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958), pp. 27-29.

⁵¹ *Ibid.*

Ultimately, Torrie dispelled the myth of ‘backwardness’ caused by genetics and insisted that improved understanding would help remove the stigma surrounding the situation:

How are we going to overcome the sense of stigma which attaches to mental deficiency? If our children had been born deaf, or spastic, or something like that, we would not feel it a disgrace. But with backwardness people start thinking about “heredity”. They say “there’s nothing like that in MY family – it must be something in my partner’s family” and this can create great division in the marriage.⁵²

Torrie concluded by offering words of advice to parents, encouraging them to write and face the problem of ‘mental deficiency’ together:

You know our children aren’t OUR children. We are trustees and stewards. They come from God, and he has as much care in their growth and development as we have. One of our duties is to make sure that we, as parents, are in fellowship, in harmony in saying that this is something that has come TO US that we must face it together, bear it together in God and under God – and in that way, something richer and rarer can come to us than ever before.⁵³

J.M. Crawford (MD, D.P.M, Physician Superintendent of Botleys Park Hospital, Chertsey) expanded on the misunderstandings and misconceptions surrounding ‘mental deficiency’. In her editorial Fryd included extracts from Crawford’s speech published in *Mental Health* (The journal of the NAMH). In his speech, Crawford explained that many people did not fully comprehend how ‘mentally deficient’ people realistically behaved. Thus:

⁵² Ibid.

⁵³ Ibid.

[They] evidently had the most extraordinarily wrong ideas about them. I could not blame them for this because, although I have been working in mental deficiency practice for fifteen years, I have never been clear in my own mind about the term “mental defective” [...] what is this thing called mental deficiency? Is it an illness? If so, psychological or both? [...] How can the public have anything more than a hazy idea of a condition so all-embracing and so vague from either the legal, the clinical or aetiological view-point?⁵⁴

Essentially, Crawford felt that the general public were beginning to understand mental illnesses, and grasped that an illness of the mind could exist in the same manner as an illness of the body. However, Crawford felt it pertinent to note that all of his patients were certified under the Mental Deficiency Act as they were not insane. If they were, then they would have been detained in a ‘mental deficiency’ hospital, either voluntarily or under the Lunacy Act. Crawford explained how ‘mental deficiency’ had come to be known as one symptom of a wide variety of conditions which interplayed with normal functioning and growth of the brain. However, this did not necessarily denote a failure to learn but rather an inability to interact in the home and community in the same manner as other people. Crawford argued:

We speak of mental deficiency as if it were something definite – a person is either mentally defective or not mentally defective. But the same person can be mentally defective, or not mentally defective, depending on the view point we take and the kind of conditions we make.⁵⁵

Whilst Crawford found it encouraging that more was known about ‘mental deficiency’, he still believed that few people fully comprehended the variety of persons who were grouped together in the ‘mentally defective’ population. Crawford stated: “fewer still realise how

⁵⁴ J.M. Crawford, ‘Mental Deficiency – A Misnomer?’ in ‘The Parents’ Voice’, *Newsletter* 5, 4 (Oct, 1954), pp. 7-8.

⁵⁵ *Ibid.*

many of them are detained there for, to me at least, a more important reason than mental defect, that is, lack of brains.”⁵⁶ Crawford explained that the ‘unintelligent simpleton’ was generally a docile and likeable person who responded well to education providing it recognised their limitations. These limitations, Crawford believed, were derived from a ‘lack of brains’, yet a simple daily routine could be taught. For Crawford, the term ‘mentally deficient’ was misapplied to persons with an IQ above and below the ‘unintelligent simpleton’. Below the line defined by Crawford, was a diverse pathology of twenty-five conditions of physical origins. Crawford felt that a physical classification of ‘mental handicap’ was beneficial for many; Crawford specifically exemplified the ‘Spastic’ child.

Due to the advanced understanding of physical origin of disability, ‘Spastic’ centres for children had been opened, tasked with specifically helping these children’s needs. Crawford summarised the importance of correct diagnosis for families: “She [the mother] can tell her friends about it freely and without shame. Why? – because he is a Spastic – not a ‘mental defective’”⁵⁷ Above the ‘unintelligent simpleton’ Crawford suggested that there was a much smaller group who were able to fuse with the ‘normal’ community. Crawford believed that “There [were] actually millions of people in this country [...] whose intelligence is low enough to put them at any time in danger of being certified as mentally defective only because they cannot learn, or will not learn to behave like the majority.”⁵⁸

Ultimately, Crawford concluded by claiming the Mental Deficiency Act and its name were out-dated, despite good intentions. Crawford did not specify whether he was discussing the original 1913 Mental Deficiency Act or the amendments made in 1927. Yet, it is reasonable to assume he was referencing the former based on his discussion of terminology and the 1913 Act’s emphasis on the subject. The Act attempted to manage the vast majority of individuals with varying conditions and degrees of disability and was often considered to

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Ibid.

be one of the legislative successes of the British eugenics movement.⁵⁹ Crawford felt that if these persons were named in more detailed, and easily understandable terms, then the public would be better able to accept and comprehend why these individuals required admission to hospitals in the first instance. Crawford expressed his exasperation at the contemporary confusion over terminology: “But no – He’s a mental defective; she’s mentally deficient. ‘What does it mean?’ They say, ‘Nobody in my family’s ever been mental.’”⁶⁰

Crawford accepted that for some the subject of terminology may be trivial but without it the correct research, education, training and healthcare provisions would be difficult to ascertain for each individual. Therefore, “The task we have before us to help this vast range of patients, from the physically disabled to the socially maladjusted, is difficult enough without this very real handicap – the misuse, the mishandling and the misunderstanding of the term ‘mental deficiency’.”⁶¹

The report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Commission) 1957, proposed that much of the existing stigma arose out of the terminology used to describe persons with ‘mental defects’; the example of ‘asylum’ was given. Many of the Royal Commission’s proposals were based on the successes of non-residential training and the growing tolerance of the ‘mentally defective’. It was stressed that the needs of ‘mental defectives’ were chronic but should not be constant if addressed properly. It was stated:

If community care was to work public opinion must accept it, which meant abandoning some of the controls and restrictions of present procedures, “we should develop a new outlook towards mental defectives not as hopeless outcasts, as has so often been the case hitherto, but more as we consider, for instance, blind people.”⁶²

⁵⁹ C. Chitty, *Eugenics, Race and Intelligence in Education* (London: Continuum, 2007), p. 61.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² ‘The Parents’ Voice’, *Newsletter* 8, 4 (Nov, 1957).

However, Christopher Mayhew (MP for Woolwich East) believed it was not the word itself which generated prejudicial thoughts but rather: “it is our attitude to mental illness which puts the stigma on the word asylum.”⁶³ Mayhew felt that the Royal Commission’s recommendation to change the terminology referring to ‘mentally deficient’ persons would hold no yield if public attitudes did not change also; the same stigma would be applied to the new terms as to the old. To quote Mayhew: “I think therefore, that we should realise that if we want to destroy the stigma of mental illness we must advise in all the fields mentioned.”⁶⁴ Mayhew suggested it was irresponsible to place the blame for this stigma on the authorities and public; he believed that the press had a responsibility to help overcome this stigma. Mayhew asserted: “There is seldom a sensible, constructive article in the Press.”⁶⁵

Restricted Lives

Those born with physical and mental abnormalities often pursue contact with others with similar afflictions. This is certainly true for parents of ‘backward’ children in Britain and elsewhere. In forming the APBC, parents were able to give a voice to the children which society had abandoned and neglected. There were many benefits to grouping together, including but not limited to: peer acceptance, improved understanding of certain conditions, additional coping mechanisms and strong responses in the face of adversity. Examples of the isolation felt by many can be seen in the ‘Advertisements’ section of the newsletter. Often mothers would post advertisements such as: “mother wishes to correspond with another with

⁶³ ‘The Parents’ Voice’, *Newsletter* 8, 3 (Aug, 1957).

⁶⁴ Ibid.

⁶⁵ Ibid.

Spastic child about three.”⁶⁶ The APBC were pivotal to the creation of this shared culture centred on disability.

For many parents the initial shock of having a ‘backward’ child was caused by the medical practitioners’ response. Additionally, many new mothers had little experience of people with ‘mental deficiency’, as they were generally hidden away from society. Mildred Firth published a letter in the *Daily Herald* in 1954 explaining her situation in the hope that a greater awareness of ‘mental deficiency’ would be achieved. Firth clarified: “When I was a child I often said to my mother, “I want a baby who will never grow up.” Now I have such a child.”⁶⁷ Further on, Firth wrote about her 8 year old daughter, Rae, who was born a month premature; 10 days later Firth was called in to see the specialist who had assisted with the birth. Firth noted her reaction to receiving her child’s diagnosis: “what a different person went into that room from the one who came out.”⁶⁸ The specialist described that Rae was never going to be like other children and all she could do was to go home, love the child, and prepare for the turbulent years ahead. Firth’s reaction was as follows: “My brains nearly snapped. I felt frantic. Why should this happen to me? I felt bitter towards the Specialist. I felt sure he had made a mistake. Now I realise how grateful I ought have been for telling me. Few doctors have courage enough.”⁶⁹

Rae had proved to be a good child; she walked at the age of 2 and spoke by the age of 4. Firth asserted that despite her initial fears, watching her grow and develop had been a pleasure for all the family. At age 4 and a half a place was found for Rae at an occupation centre where she was taken daily by bus. Firth was extremely pleased with the progress Rae had made at the centre and was glad she was happy; Rae had learned to talk properly, sing, dance, and sew. Firth wished that other children were as lucky as her daughter and

⁶⁶ ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

⁶⁷ ‘The Parents’ Voice’, *Newsletter* 5, 3 (July, 1954).

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

established a branch of the APBC in Doncaster to help ensure that as much was being done for these children as possible.

Throughout the early years of the APBC, Fryd often included personal accounts detailing the stories, struggles and successes from the APBC members. In the late 1940s and early 1950s, these accounts told the story of isolation, exclusion, and professional and social prejudice. The story of 'Mrs G.D.' was published in January 1949 as testimony to the loneliness felt by some mothers; this was often worsened by the attitudes of medical professionals. Mrs G.D.'s husband was in the RAF and due to be drafted abroad, she often felt physicians were uninterested in hers or her baby's well-being despite her uncertainties. To quote Mrs G.D.:

I was living in the country, very lonely and secluded with no help and an active baby of 15 months. In 1942 food was very poor - - there were no extra rations for expectant mothers and I was worried frequently by hungry feelings. The war news was bad and getting worse. I couldn't find a hospital to take me, I couldn't find anyone to take my young son. At my visits to the antenatal clinics my baby was frequently turned, sometimes very forcibly. (I entirely disagree with this practice unless absolutely necessary at the end of the pregnancy, as the child turned back immediately when I lay down!) [...] The friend of a nurse in charge of delivery [told] me I "couldn't be in labour" and leaving me to it until I rang for her when the baby was actually arriving. M was born with a caul and covered with dry skin like a paper bag. The cord was large and did not heal quickly. His muscles were flaccid, chest small, abdomen distended, and fontanelles large. He is a "Mongol" and suffers very severely with chilblains.⁷⁰

For many, however, matters did not improve following the end of WW2. In October 1949, Fryd recounted the story of 'Mr and Mrs B.' who took their child to the London Hospital where he was born after discovering that something was not quite right with their son. The

⁷⁰ 'APBC', *Newsletter* 2, 1 (Jan, 1949).

family were told by physicians that they were “wasting [their] time because he was a blind mental defective.”⁷¹ This crude diagnosis was later confirmed by another doctor. When the child was 6 years old, his parents took him to see an osteopath who quickly discovered seven bones out of alignment, including the atlas and axis. The osteopath was able to rearrange and return the seven bones to their rightful places and the child was able to (for the first time) hear, walk unaided and gain partial sight within a few months. Fryd believed that without the parent’s continued search for answers, the authorities would have denounced their child as ‘ineducable’ and thought no more about him. Whilst the story of the child seemingly finding a cure for his ‘backwardness’ was rare, unfortunately the account of neglect and prejudice by medical professionals was all too familiar. It was commented:

There may be among backward children some whose condition is aggravated by bodily ill-health, and anything which is done to improve their physique will probably improve their mental alertness and responsiveness. This will be all to the good, especially as the mother, watching this day to day improvement, will lose some of her tension and be able to help the child more.⁷²

Another mother, ‘Mrs T.’, recounted her family physician’s rude attitude after declaring the child ‘ineducable’. The diagnosis was based on the inability to say two hundred words. Mrs T. appealed the diagnosis in the quest to obtain more help for her ‘backward’ child. However, the doctor from the MoE who paid a house visit was far more interested in Mrs T.’s other two children. The doctor declared: “[do] not spend any money on J. but to keep it for the other two as they looked brainy children!”⁷³ Regardless, of this flagrant disregard for her child, Mrs T. showed defiance in the face of adversity and vowed to continue her search for the best provisions for her child: “My husband and I disagree with this — we intend to spend our

⁷¹ ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

⁷² ‘The Parents’ Voice’, *Newsletter* 4, 2 (April, 1953).

⁷³ ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

savings on J. If the others are clever they must work their way up in the world.”⁷⁴ However, caring for a ‘backward’ child was tiring and many parents often felt frustrated, confused and helpless.

Publishing these stories, alongside success stories, allowed parents to shed the feelings of isolation and justified their range of emotions. Another story was that of ‘Mrs O.’ who vacationed in Cornwall for a month with her ‘backward’ child. Mrs O. told of how her child went missing for the majority of the penultimate day of the holiday. Naturally, she expressed feelings of worry over her child going without food for the day, and the frustration of being unable to keep him in the home without support, as he tired and got bored easily. Mrs O. spoke of her confusion when her child returned and was visibly distressed and talked of ‘being lost with no mummy’. To quote Mrs O., “I am acting more like a keeper than a Mother. It’s so difficult to keep him in.”⁷⁵

Jessie Thomas (CBE and pro-active campaigner for equal rights for persons with disabilities) commented on the matter: “the parents of handicapped children were themselves handicapped [by the situation], and deserved all the help and consideration we could give them.”⁷⁶ For Fryd it became obvious that social acceptance for the whole family was necessary. Following the birth of a ‘backward’ child and the decision to care for them in the family home, the community often tarred the entire family. The same prejudice was used to isolate individuals and socially exclude the family, often through fear and misunderstanding. This was supported by Pearl S. Buck’s *The Backward Child Steps Forward*. Buck, an American author, civil rights activist and humanitarian,⁷⁷ declared that one of the biggest tasks facing parents was to convince others that having a 'backward' child was nothing to be ashamed of.

⁷⁴ Ibid.

⁷⁵ ‘APBC’, *Newsletter* 2, 1 (Jan, 1949).

⁷⁶ ‘APBC’, *Newsletter* 2, 8 (April, 1950).

⁷⁷ More about Pearl S. Buck can be found in P. Conn, *Pearl S. Buck: A Cultural Biography* (Cambridge: Cambridge University Press, 1998).

Since 1946 many parents had come into the open with their problem, in a manner which was previously unheard of. For Fryd, Buck was hugely influential in this process, particularly her literature such as *The Child Who Never Grows*.⁷⁸ Buck unashamedly detailed her own mental anguish as she realised firstly her child was ‘mentally handicapped’, secondly, she would not be cured and finally, that eventually she needed to put her child in an institution. Buck’s honest and unabashed attitude helped many to overcome the associated stigma. Fryd wrote to Buck to thank her for her work; in turn, Buck informed Fryd that she was in contact with similar associations in the United States.

It was with the aim to unite parents of ‘backward’ children and to dispel the associated isolation and restricted lives that the APBC was established. As Fryd noted: “The formation of the Parents’ Association has helped to break down the curse of isolation felt by parents trying to shoulder their burdens alone. It has also proved a definite asset to the Local Health Authority in the ascertainment of cases living in the community.”⁷⁹ And, many parents admitted that: “our greatest need was close contact with one another, and to put behind us that nightmare of isolation which the realisation of our children’s condition thrust upon us.”⁸⁰ Not surprisingly then, bringing families together for mutual help and advice was often regarded as the APBC’s biggest success: “In helping them to discard the sense of isolation and social frustration, the parents have been helped to enjoy their [...] children more, to face their personal problems with courage and hope, knowing that others are doing the same.”⁸¹

This principle was also expressed by Reginald L. Crawl (Chairman of Southgate and District Society for Mentally Handicapped Children.)⁸² Crawl invoked the Christian principle

⁷⁸ P.S. Buck, *The Child Who Never Grows* (New York: The John Day Company, 1950).

⁷⁹ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

⁸⁰ ‘The Parents’ Voice’, *Newsletter* 4, 4 (Oct, 1953).

⁸¹ ‘The Parents’ Voice’, *Newsletter* 1, 1 (Oct, 1950).

⁸² R.L. Crawl, ‘Love in Action: The Motive that Lies Behind the Edmonton “Settlers’ Club”’, in ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958), pp. 19-20.

of “thou shall love thy neighbour”⁸³ and believed that the subject where this could have the most beneficial effects was in the field of ‘mental deficiency’. For him, “In recent years the problem of mental deficiency has been brought into the light of day. Those afflicted in this way have always been with us, but from a misguided sense of shame their parents or guardians have kept them away from contact with other people.”⁸⁴ Moreover, he suggested that a sense of shame felt by parents need no longer apply as these families shed the shackles of stigma and become more visible in society. Owing to the increased contact, the general public had a growing understanding that there were few differences in how individuals with physical differences should be treated compared to those with ‘mental defects’. It was hoped that eventually this improved understanding would lead to better provisions for the latter category.⁸⁵

In a speech given on the 25th of May, 1957, Aneurin Bevan (Minister of Health 1945-1951) stated the treatment of the ‘mentally deficient’ should be a source of community guilt; the focus should be placed on utilising an individual’s difference to build self-esteem and not to demolish any sense of self-worth. To quote Bevan:

What we have to do is not to look for those things in a child which distinguish him from all other children, but to look for those things which make him identical with other children. We should disregard the differences in our relationship with the child, but we should take great heed of their differences in our therapy and our healing. Our main purpose should be established self-confidence in the child. Where he achieved that, wonderful things followed [...] The nation most deserving of the respect of others, and of its own self-respect, is that which gives to the sick child the same privileged place in the nation as he has in his own family. Our community ought to

⁸³ Mark 12:31, *The Good News Bible* (London: The Bible Societies/Collins, 1976), p. 64.

⁸⁴ Crawl, ‘Love in Action’, in ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958), pp. 19-20.

⁸⁵ *Ibid.*

suffer deeply from a sense of guilt if it known that there is a large amount of suffering going on which ought to be arranged.⁸⁶

Highlighting the injustices and hidden lives of those with mental disabilities and their families was pivotal to securing better provisions and quality of life for all involved. Fryd felt society was receptive to individual accounts of disability and set out to capitalise on the opportunity to increase understanding.

An article authored by a certain Mrs Hamm was published in *The Spastics Quarterly Journal* in June 1954. Entitled ‘The Crippled Child’ the article was particularly useful for parents who wanted to gain a bigger picture of the task facing them and what had been achieved already. Hamm stated that relatively few years ago parents of a ‘backward’ child had little option other than to deal with the matter privately and alone. However, parents in the mid-1950s had a greatly improved medical profession at their disposal and many localities had increased facilities.⁸⁷ Hamm suggested that these changes were largely thanks to the work of parents. She described the progress using the simile of a pebble dropped into a lake and creating ripples. The first ripple was the parent’s responsibility and acceptance: “The responsibility for his care will always be primarily theirs; and it is they who, with *knowledge* and *understanding* can do most for him.”⁸⁸ It was asserted that the basis of the life afforded to the child rested on the manner in which parents accepted his diagnosis and their responsibility. Three categories of responsibility were explained: acceptance with resentment; positive acceptance; and to accept it with courage and determination to do the best possible by the child. In the process of acceptance, Hamm suggested that parents should seek knowledge from specialists to gain the most in-depth knowledge and understanding of their child’s condition, and obtain information on training and the experience of others. The

⁸⁶ ‘Parliament Debates Commission Report’ in ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958), pp. 20-22.

⁸⁷ Mrs William Hamm, ‘Parents: Set an Honest Goal’ in ‘The Parents’ Voice’, *Newsletter* 5, 4 (Oct, 1954), pp. 9-10.

⁸⁸ *Ibid.*

second ripple was described by Hamm as the understanding of other family members (such as siblings) and the understanding that they too must be able to lead a 'normal' life. Each family was different; whilst some siblings benefitted from having a 'backward' child in the family; others were unable to live harmoniously with such a child. Particularly during teenage years, some siblings were embarrassed to bring friends or potential spouses to the home which the 'backward' child was present. According to Hamm:

Too often has a child who is helpless received such a disproportionate share of attention and also of the family's means that a feeling of neglect and inferior importance has resulted. Conversely, too lavish attention on a normal child, at the expense of one who is not, can bring the same unhappy results to the handicapped child. This is likewise true when one parent devotes attention and efforts so exclusively to the handicapped child that the other parents' interest is not considered. The honest goal is to strive for as nearly normal life as possible not only for the child, but for all who surround him.⁸⁹

The third ripple concerned the child itself; progressive and attainable goals should be set to foster the child's abilities. Underestimating the child's capabilities or conversely expecting too much from the child may be detrimental and should be avoided. This final ripple was where parents were able to project their influence, whether through organisations or more individual outlets to establish better services and facilities. Due to this last ripple, Hamm supposed that each year authorities' horizons widened and a greater sense of responsibility for the care and education of the 'mentally deficient' was accepted.

The APBC understood that the decades of neglect inflicted on 'mental deficiency' would not be remedied overnight. Members were reminded of their duty to ensure that the authorities were no longer dormant on the matter. According to Fryd, "There was also the

⁸⁹ Ibid.

necessity to meet the ignorance and well meaning stupidity of the public towards our children. We have to release the tendon within ourselves, and then the public will release towards us.”⁹⁰ The first purpose of the APBC was to unite parents for their mutual benefit and reassurance; this was believed to be the Association’s most important aim. The second purpose was to raise funds for pilot schemes and training centres. Finally, the third purpose of the APBC was to apply pressure on the government and authorities to implement their powers to provide education, training facilities and communal care for all ‘backward’ children. It was felt that the third purpose was most successfully achieved by realising the second purpose, proving that members were responsible, able and willing to help their children themselves, thus prompting the authorities to provide benefits on a national level. The supply of provisions was not compulsory which meant that with the absence of public pressure many LHAs did not value the need for these facilities, nor think it was a worthwhile use of expenditure.

Despite these problems, Fryd insisted that “where there’s a will, there’s a way.”⁹¹ Fryd believed that for too long the burden of ‘backwardness’ had lain solely on the shoulders of the individual family; the community had neglected its responsibilities to these individuals and their families. Improvements made in the 1950s in social welfare spotlighted the inadequacy of provisions for ‘mental deficiency’ and it was hoped that this would be remedied. However, these changes were neither quick nor sufficient according to the APBC, and Fryd restated the need for the Association to be proactive in order to attain respect and suitable change. She continued on to explain that parents needed to demonstrate that they did not wish to surrender their responsibility to the authorities, but instead needed extra and appropriate support:

⁹⁰ Ibid.

⁹¹ ‘The Parents’ Voice’, *Newsletter* 6, 3 (Summer, 1955).

With the efforts made by our smaller groups, round Occupation Centres and Special Schools, to provide extra amenities for the children, can be taken as proof that we do not desire to relinquish our responsibility for the children we have brought into the world, we are still prepared to make what sacrifices are necessary, although we do not feel called upon to relieve the State of responsibilities to a greater extent than parents in a more fortunate position are expected to do.⁹²

Parents of ‘backward’ children were encouraged to come into the open with their child as responsible and self-reliant citizens who wanted cooperation between individuals, the APBC and the governing authorities for the mutual benefit of all parties involved. Members were reminded that they were integral to the APBC’s success and the future well-being and happiness of all ‘backward’ persons.

In October 1952, the story of ‘Colin’ was published in *Parents’ Voice* to serve as an example of the benefits of joining the APBC. It was described as: “this is a story which may make you cry; but it will almost certainly fill you with great pride in the wonderful spirit of motherhood.”⁹³ Colin was an 18 year old boy born in a small house in a small provincial area to poor parents. His father was a disabled WW1 pensioner and made a small living from boot repairing; his mother was a stay at home parent to Colin and his five ‘bonny’ sisters. Colin had two older brothers, unfortunately both were deceased; the explanation of a street accident was given as one cause, the other was unspecified. Whilst Colin was born happy and healthy he soon developed fits, resulting in one paralysed arm and Colin unable to feed himself. Furthermore, Colin was incapable of verbal communication, although was able to walk to an extent until the age of 6, upon which he was no longer able. Consequently, his mother was forced to resort to carrying him on buses and trains to attend out-patient clinics where such

⁹² Ibid.

⁹³ ‘The Parents’ Voice’, *Newsletter* 3, 4 (Oct, 1952).

cases were dealt with. However, eventually Colin became too heavy for his mother to carry and these trips were halted:

No one could do anything to treat her boy, nor hold out any hope for him. She was advised as so many of us have been, to “put him into a Home and forget him.” It is a decision most of these parents may have to make, and each must have to give his own answer, according to his own circumstances, temperament and opinions.⁹⁴

Yet, Colin’s parents made the difficult decision to keep him at home:

For year after year, Colin’s mother struggled on, feeding, washing and tending to her growing boy. For grow he did at an alarming rate; probably due to a defect or injury to the pituitary gland, Colin grew so fast that no ordinary clothes, not even the large men’s sizes, would fit him, and his mother had to design and make garments from the strongest cloth she could obtain, usually “black-out” curtaining.⁹⁵

When Colin was 15 years old his mother read about the APBC in a newspaper and joined the Association immediately. Upon learning of his case, Fryd tried hard to obtain practical help for the mother and Colin. She wrote to the LHA to draw attention to Colin’s case and asked whether some treatment for the glandular imbalance could be administered. To which a response to the effect of “this boy was an idiot, was incontinent, and removal to an Institution was desirable.”⁹⁶ Fryd suggested that Colin’s parents may qualify for the Guardianship Scheme whereby the child was placed under the LHA and boarded out to either his parents, or other suitable and willing guardians. In this circumstance a small weekly allowance was granted; although due to the amount of food Colin consumed he was a great expense to his parents and this sum was insufficient.

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ Ibid.

This suggestion garnered a visit to Colin's home from the LHA with a consent form. However, his parents were horrified to discover that compliance with the Guardianship Scheme required them to sign their rights away to caring for Colin and he would subsequently be sent to an institution. As a consequence the parents refused to sign the form; upon hearing this, Fryd sent a letter to the Board of Control alerting them to this clause and suggesting that "it was a bar to needy parents who might be willing and able to co-operate in the Guardianship Scheme and were well able to care for the child at home, thus relieving pressure on Hospital beds."⁹⁷ Fryd strongly felt that separate forms of Guardianship Allowance and the child's removal to an institution needed to be issued.

In 1948 one of the APBC's aims was realised in the National Assistance Act, which declared that all 'handicapped' persons over the age of 16 were entitled to a regular weekly allowance if they were incapable of employment. For Colin this meant he was entitled to 15/- per week, which his mother was able to collect. However this was not enough to cover Colin's growing demands for new, specialised furniture due to his size and because he kept getting sick from being on the floor. Subsequently, Fryd visited the National Assistance Board and placed the facts of his case in their hands. Within a short time a gentleman from the Board visited Colin at home and advised that an allowance increase should be granted; arrangements for new furniture for Colin were also made including a bed and chair. Despite these advances Colin's health continued to be a concern for all; other than a single success at getting himself upstairs Colin made no progress and had frequent bilious attacks. To cope, Colin's sister quit her job to help with Colin's care; she would often sing to him. However, Colin's mother soon wrote to Fryd. Colin had sadly passed away:

Colin took to his bed on November 7th and his sister and I have looked after him all the time. He passed away on February 11th. We did all in our power and all the doctor

⁹⁷ Ibid.

told us to try, but it was useless. He lived on nothing but water from December 5th. The doctors tried hard to persuade me to put him away, but I stuck it out, and I am glad I did. The end was hard, he suffered very much, but we saw him go in his own little corner he knew so well, but as I prayed to God to relieve him of his pain, I promised him I would not cry for him but would give him up to Him. We all loved him very dearly; I always spoke of him as my baby, and for all that he was so big, everybody spoke of him as little Colin. I would like to add that the Mental Visitor had been kindness itself. He even helped me wash, change and make his bed.⁹⁸

In closing her letter the mother simply stated “I will never forget your kindness.”⁹⁹ Whilst this story was sad in its ending Fryd believed it was one of struggle and courage in overcoming adversity. Ultimately, it was the story of a mother’s unwavering and unconditional love for her ‘backward’ child. Thus for Fryd:

Colin’s story is ended but the inspiration of his mother’s devotion lives on in this Association. The love and happiness those children give, in spite of their difficulties, is a more precious gift than the capacity to earn money [...] These children are human beings [...] without love, our civilisation will fall, as Rome fell and as Nazi Germany perished. Give these children their place in the sun, and we shall find true greatness.

“Blessed are the poor in spirit for theirs is the kingdom of Heaven;
Blessed are they that mourn; for they shall be comforted.
Blessed are the meek; for they shall inherit the earth.”¹⁰⁰

Colin’s story was not unique, however. Fryd believed that sharing these personal stories was important for two reasons: firstly, it demonstrated to other members they were not alone in their struggles. Secondly, for those reading *Parents’ Voice* without a ‘backward’ child it brought these families into the open and thus the problem of ‘mental deficiency’ was no longer hidden.

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Ibid.

Publicity

The weight of public opinion can often affect changes in law, government and social policy. However, mass opinion can have both positive and negative consequences; public opinion can shift to public outrage, resulting in stigmatisation. Crimes committed by ‘mentally defective’ persons were often highly publicised. Subsequently, others with similar afflictions were presumed to be deviants as well. This was not uncommon in the mid-twentieth century.

An article titled ‘These Men are Dangerous; Prevention and Vengeance Needed’ appeared in the November 1957 edition of *Parents’ Voice*. The article discussed various newspaper accounts of sensational cases of sex and violence in presumed connection to the ‘mentally defective’. This often created public outcry and was the “fatalistically easy”¹⁰¹ option for the media to take in the APBC’s opinion. Fryd commented on the recent spate of lurid accounts of police searches for ‘mental defectives’ in relation to crimes committed against children. Dr Donald Johnson (MP for Carlisle) raised this concern in the HoC and warned that this statement should not be issued unless founded on fact. Johnson found that there was no legal or moral justification for raising suspicion without valid reason. Suggesting much of the public and press believed those who committed a crime, especially those against children, must be ‘mentally deficient’ whether certifiable or not. This trope echoes sentiments of the early British eugenics movement where criminality and ‘mental deficiency’ were synonymous. Fryd felt it was important to assert that “This is not to say that all mentally disordered people are potential child murderers. Mental illness takes many forms, and the vast majority who are affected are absolutely harmless individuals who are temporarily finding life a bit too much for them.”¹⁰²

¹⁰¹ ‘The Parents’ Voice’, *Newsletter* 8, 4 (Nov, 1957).

¹⁰² *Ibid.*

Further on, Fryd wrote of the many ‘mental defectives’, and in particular ‘Mongols’, who did not mature sexually and therefore, posed little threat of these attacks against children. Fryd accepted there may be overlap between ‘mental deficiency’ and mental illness. She suggested that persons who committed these violent and heinous crimes would, in all likelihood, be medically regarded as psychopaths. Yet, it was noted that psychopathy was not uncommon and not all psychopaths posed a danger to themselves or others. However, ignoring these individuals when searching for a perpetrator would be unwise. Fryd proposed that less attention should be paid to sensational tabloid headlines and greater focus should be placed on improving awareness and understanding:

The community should turn its thoughts away from the salacious, lip-licking, vengeful mood of some recent “letters to the editor” and even “ex cathedra” pronouncements from people in high positions, and should consider how to prevent this form of mental illness early enough and thoroughly enough to prevent tragedies from occurring.¹⁰³

By July 1954, Fryd suggested the press’ initial reluctance to publish non-sensationalised stories of ‘mental deficiency’ was gradually disappearing. Fryd believed there was a tremendous amount of goodwill towards the Association, largely derived from the parent’s courage to come into the open with their children and problems. In addition, Fryd did not feel this was a sentimental concern but instead many people were genuinely interested in helping ‘backward’ children and their families. The growing tolerance towards ‘backward children’ demonstrated the necessity of ceasing to shamefully hide ‘backward’ children and alerting the general public to the existence of a problem which many had never known was real. Greater understanding and acceptance of conditions such as epilepsy, blindness, and deafness were

¹⁰³ Ibid.

encouraging to the APBC, and strengthened the hope that with greater publicity and awareness perhaps ‘mental deficiency’ would be accepted and understood also.

Fundamentally, the APBC understood that in order to achieve their aims they needed to teach the general public about ‘mental deficiency’ and all that it entailed. Whilst this task was daunting, the APBC encouraged members to help embark on a large-scale publicity campaign. Gaining mass opinion in favour of those deemed to be ‘backward’ proved to be the single greatest factor working against associations and campaigners such as Fryd. Garnering mass support was the key to obtaining widespread understanding and improved provisions and equality for the ‘mentally defective’. Central to the attainment of equality were those who were willing to face these stigmatising and prejudicial attitudes with a steely determination. Fryd declared:

May those who serve these children reap a just reward for their devotion [...] and may all those who have the power to make or mar these children’s future bear in mind these words:- “IN AS MUCH AS YE HAVE DONE IT UNTO ONE OF THE LEAST OF THESE MY BRETHREN, YE HAVE DONE IT UNTO ME.”¹⁰⁴

Ideally, members were to canvas every authority at every level in the country to gain their support. It was estimated that there were over 135,000 ‘mentally deficient’ persons in the UK. This figure was rapidly changing in the 1950s; for many an indication of the scale of the problem of ‘mental deficiency’ and the need for more attention to be raised. Ellis (APBC Chairman in the 1950s) was particularly concerned with parents who did not take their responsibility and duties seriously:

I am aware of parents in high places who could make a greater contribution to the welfare of the nation’s mentally handicapped children. But they do not come forward.

¹⁰⁴ ‘APBC’, *Newsletter* 2, 6 (Dec, 1949).

They will not identify themselves with the problem. I ask these parents to search their consciences, I ask them to come out into the open – to come forward with their talents for the benefit of all mentally handicapped children [...] I give it to you that publicity should be a major project of the Society. It may be undramatic, but I tell you it will produce ultimately the biggest dividend for our children. And we should always be guided in doing these things that will achieve the maximum amount of good for the maximum number of children [...] Every individual member should be a torch-bearer, seeking to spread the gospel to the public.¹⁰⁵

It was declared that for any real change to happen members must be vigorous in their campaigns and bring their plight to the fore. However, the APBC recognised that change would not and could not occur overnight. The problems of ‘mental deficiency’ had been enduring for over fifty years and changing the accepted public opinion would be neither easy, nor quick. Fryd commented: “Prejudice does exist, but it is ignorance that creates it. Knowledge and personal contact with the people affected by this tragedy, will drive prejudice and thoughtless behaviour away.”¹⁰⁶ Understanding was impeded by misconceptions of why these negative opinions existed, why change was so slow to occur, and why the authorities were willing to offload ‘backward’ children in church halls and worse. Ellis explained his position on the matter: “Bluntly I will tell you the answer. Those in authority represent public opinion. And the decisions of authority must always reflect public opinion.”¹⁰⁷ However, it is worth noting that by 1955 it was established that there were two parents of ‘backward’ children sitting in the HoC in favour of the Association and its work. Parents of ‘backward’ children were also represented on various County Councils, Borough Councils, and County Health Committees. Having parents of ‘backward’ children in these positions was hugely valuable and influential to the Association’s work. In post-WW2 Britain an emphasis was

¹⁰⁵ ‘The Parents’ Voice’, *Newsletter* 7, 2 (May, 1956).

¹⁰⁶ ‘The Parents’ Voice’, *Newsletter* 9, 3 (Autumn, 1958).

¹⁰⁷ ‘The Parents’ Voice’, *Newsletter* 7, 2 (May, 1956).

placed on children's health, welfare and education. Yet, this progressive attitude did not apply to 'backward' children. Further on, Ellis wrote:

The picture was vastly different in the mental field – it was still surrounded by a man-made curtain of silence. True, in well-informed and progressive sectors of public opinion a few chinks were appearing in that curtain. Our newspapers, which were very sensitive to public opinion had more than once drawn attention to the inadequacies of Britain's Mental Services.¹⁰⁸

Regardless of goodwill, Ellis believed that until everyone was aware of the injustices faced by 'backward' children and their families, then governmental changes would be slow. Ellis declared: "there are fifty million people in Britain, but only a handful of them know about mental deficiency. The whole problem is shrouded in stigma."¹⁰⁹ Fundamentally, the APBC attempted to correct the widespread misconception that disability was the direct result of the parents' failing; a notion perpetuated by the eugenics movement since the beginning of the twentieth century. Stigma regarding 'mental defect' was derived from the common notion that 'backwardness' was a direct result of 'bad stock' and this justified shunning and socially isolating parents and individuals. As Fryd noted: "Many people used to think that all, or most backward children come from "bad stock", and that the parents themselves were to be despised and shunned. Now, we are approached as equals by the authorities and have been received in the House of Commons."¹¹⁰

Negative eugenic ideas continued to be widespread in the public consciousness during the 1950s. Despite the growing understanding, public opinion concentrated on the negative associations with 'mental deficiency'. This often made it realistically impossible for those with 'mental defects' to live successfully in the community. Members frequently reported

¹⁰⁸ Ibid.

¹⁰⁹ 'The Parents' Voice', *Newsletter* 7, 1 (Feb, 1956).

¹¹⁰ 'The Parents' Voice', *Newsletter* 4, 4 (Oct, 1953).

negative attitudes in their day-to-day lives. In April 1953, a mother from the South-west Essex branch reported the following quote from a lady she encountered whilst making house to house collections: “[I] do not agree with backward children.”¹¹¹ The APBC stalls and demonstrations were also peppered with negative responses from the general public. Fryd discussed the reaction to a stall in Stratford:

Some would view the facts and figures whilst pretending to look at a neighbouring stall; others would stand at a distance but as soon as our eyes met would hurry off, as though they had been caught peeping through a bathroom keyhole. One woman approached said indignantly, “I haven’t a backward child – all mine are normal!”¹¹²

This behaviour was echoed at a stall in Cornwall; some people shuddered at the words ‘mentally handicapped’ and scurried away, some giggled, and others looked in fearfully as though looking at a ‘freak show’ at a funfair. One individual was heard shouting “Have you seen the looney stall?”¹¹³ which drew quite a crowd. Questions such as “I suppose you just keep them quiet and amuse them?”¹¹⁴ indicated that relatively few people understood how much could be done for ‘backward’ children. Whilst these stalls often initiated a negative reaction from some, their value to the APBC was immeasurable as they piqued curiosity and made people question. To quote Ellis: “We have to convince the people [...] that our tragedy could quite easily come to some of the people who are now doing the objecting.”¹¹⁵ For many people the general appearance of those with ‘mental defects’ dictated the response invoked; those with highly visible symptoms of their conditions, such as ‘Mongolism’, were disregarded instantaneously by the general public.

¹¹¹ ‘The Parents’ Voice’, *Newsletter* 4, 2 (April, 1953).

¹¹² ‘The Parents’ Voice’, *Newsletter* 4, 4 (Oct, 1953).

¹¹³ ‘The Parents’ Voice’, *Newsletter* 8, 4 (Nov, 1957).

¹¹⁴ *Ibid.*

¹¹⁵ ‘The Parents’ Voice’, *Newsletter* 8, 1 (Feb, 1957).

The effects of this approach towards ‘mental defects’ were prominent in the ‘Advertisements’ section of *Parents’ Voice*. Mothers seeking help or temporary care for their ‘backward’ child would often include phrases such as ‘not unattractive’ in their adverts in an attempt to secure help. To quote Fryd: “Many little girls and boys who are obviously Mongols are also very pretty and charming.”¹¹⁶ This emphatically troubled the APBC and many felt that much could be done if public awareness and understanding was improved. Fryd commented that “People still despised and feared the mentally dull, and confused backwardness with ‘insanity’, we [have] got to teach the public to accept the handicapped and help them to adjust to life in the community.”¹¹⁷

Irene Mervyn Pike (DBE, MP for Melton) asserted that ‘mental disorder’ was one of the most tragic and expensive conditions: “when it struck one human being, it affected the whole family.”¹¹⁸ This was particularly true of the associated stigma and prejudicial attitudes towards ‘mental defectives’ and their families. It was hoped improved public awareness would alleviate struggles facing these individuals and families. Additionally, improved understanding would help facilitate the raising of funds for this vital area of provisions and research, whether done through donations or raised taxes. By 1957, many in the APBC believed that continuing to concentrate on improving governmental understanding was akin to preaching to the choir. Many proposed that the Association’s focus should be shifted to the County and Local Authorities. The cost of change was estimated to be £40 million; this obviously posed a problem which could not be solved without the cooperation of the whole nation.

By November 1957, the press increasingly published positive reports of the APBC’s activities and stories of individuals with ‘mental deficiency’. Articles appeared in: *Midwives’ Chronicle and Nursing Notes*; *She*; *Rehabilitation*; the *Hospital and Social Services Journal*;

¹¹⁶ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

¹¹⁷ ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957).

¹¹⁸ ‘The Parents’ Voice’, *Newsletter* 8, 3 (Aug, 1957).

the Boy (Journal of the National Association of Boys Clubs which dealt with youth clubs for the ‘mentally handicapped’); and a number of Trade Union Journals including the Confederation of Health Services for Employees’ Training and Employment of Mental Handicap.

The BBC’s *Week’s Good Cause Appeal* on the 29th of September, 1957 was given by Reverend David Sheppard and led to over £4000 being donated to the APBC. Sheppard began thus:

Good evening. Is your child normal? What a question! But is he? Lying upstairs asleep like my other ordinary child, tired after a happy day’s playing? Or is he thinking of school work tomorrow, or perhaps grown up, taking a normal place in life? Is your child normal? Then count your blessings, for tonight tens of thousands of little children have been put to bed who will never grow up.¹¹⁹

Sheppard continued on to explain that ‘backward’ children were unlikely to go to school, get married or have a family, he stated “always they will be prisoners of a crippled brain.”¹²⁰ Sheppard estimated that there were 150,000 of these children that he termed ‘Peter Pans’ (due to never growing up) in England and Wales in 1958. Sheppard also discussed how ‘mental deficiency’ crossed all social, political, economic and eugenic boundaries:

Like all children, these are God’s children. And they are born to families high and low, rich and poor. Some of them will struggle on the edge of a normal life, often being hurt by the unkindness of others who have never bothered to think about this problem; some will never even leave their cots.¹²¹

¹¹⁹ D. Sheppard, ‘Is Your Child Normal?’, in ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958), p. 5.

¹²⁰ Ibid.

¹²¹ Ibid.

It was explained that despite the struggles, the parents of such children loved them with a fierce devotion and needed the support, help and prayers of the community. Sheppard discussed the ever increasing APBC and their achievements: “At last the parents of these children feel that they are no longer struggling alone, and they can do something practical to help one another.”¹²² Sheppard urged the listeners to learn more about ‘mental deficiency’ and what they could do to help; they could support the APBC by donating money to what he deemed a very worthy cause. As a result over £4000 was raised for the APBC; this type of publicity was invaluable both in economic terms and gaining awareness.

Ultimately, the media coverage of ‘mental deficiency’ in the press was fickle; either they discussed sensationalised and often misinformed cases, or failed to discuss the matter at all. Fryd believed the reason for this was because editors were misguided about what the public wanted to read about. She felt this was the APBC’s duty to rectify. She declared: “We must produce the information, the ideas and the people to carry it out, because it is neither fair, nor a practical contribution to sit back and wait for “them” to “do something”. If we really mean business it is up to us - ALL of us.”¹²³ To support this, Fryd recounted a frustrated letter from a mother who stressed the need for greater media and public presence: “The newspapers always have plenty of space for horses and harrowing stories of little doggies and pussy cats, and readers will pour out floods of tears and even money for such a cause, but in our suffering children and their families there could hardly be less interest.”¹²⁴

By the late 1950s small changes were beginning to be seen. Founding members believed the authorities were starting to see these individuals and their families as equals. To aid this, the formation of the All-Party Standing Committee of backbench MPs met regularly to discuss the problems posed by ‘mental deficiency’. The close cooperation and involvement of the general public and government officials was important for the advancement of the

¹²² Ibid.

¹²³ ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957).

¹²⁴ Ibid.

APBC's work. To this effect, the APBC had approached various heads of religious groups to become its patrons and help spread awareness and understanding. The Archbishop of Canterbury had agreed to become a patron alongside Cardinal Griffin, the Archbishop of Westminster and the head of the Roman Catholic Church in England. Letters of good wishes, support and encouragement were received from the Archbishops of Canterbury and Westminster, Chief Rabbi, the Minister of Health, Lord Mayor of London, President of the NAMH, Chairman of the Board of Control, Editor of the *British Medical Journal* and members of London County Council. The Archbishop of Canterbury wrote: "The care of mentally handicapped children is a weight upon the conscience of us all."¹²⁵

By late 1958, Fryd suggested that there was a growing feeling in the UK that the 'mentally handicapped' should no longer be regarded as second-class citizens. Prominent physician and author of various works on 'mental deficiency', Jack Tizard, declared 'mental defectives' should no longer be thought of as a separate "sub-human" category.¹²⁶ To combat the segregation of the 'mentally handicapped' from the majority of society the APBC continuously proposed new plans, ideas, and methods to bring 'backward' children and their families into the community and to promote a "greater degree of happiness and justice into the lives of these little ones "who cannot speak for themselves."¹²⁷

Short-Stay Care: Orchard Dene

In November 1956 the story of a family vacationing in Lyme Regis, Dorset was recounted. The family, including the Chairman of the Batley branch in Yorkshire, Charles Brooke, took their 'mentally deficient' 16 year old son to the seaside for a holiday. Upon arrival the family were told by the proprietors of the boarding house in which they were staying that they would

¹²⁵ 'The Parents' Voice', *Newsletter* 7, 2 (May, 1956).

¹²⁶ 'The Parents' Voice', *Newsletter* 9, 2 (Summer, 1958).

¹²⁷ 'The Parents' Voice', *Newsletter* 3, 2 (Jan, 1952).

have to leave because complaints had been lodged against his son. Brooke had informed the proprietors of his son's condition when making the booking months prior, yet it was not until the family had travelled 250 miles to the coast and were eating their evening meal that the landlady felt it an appropriate time to ask the family to leave. Fryd commented on the matter in disbelief:

One marvels at the mentality of people who can deliberately ruin the holiday of such an unfortunate family, and for no good reason. As though "mental deficiency" were contagious or dangerous? Unfortunately, the kind of mental health that persecutes the afflicted IS contagious and dangerous.¹²⁸

Similar cases were reported on the east coast; only one family was allowed to remain at the premises after a courageous manager objected to the complaint and instead insisted on the complainant's departure. However, this case was by no means the standard and the vast majority of families were unable to vacation or take a break with their 'mentally defective' child. As a result many branches called for the establishing of a holiday home so that parents could either send their children somewhere for a short-stay where they would be properly cared for, or have somewhere where the family could vacation together, but support would still be available to permit parents a break. Many felt that this need was urgent and pressed the Association to begin work on the matter immediately. The APBC took its lead from the Fountain Hospital which had established a seaside annexe for the children who resided at the facility and their families. The Friends of the Fountain Hospital group had managed to raise over £1000 in a single year (1950) by dedicating one quarter of all money donated to the fund and had begun negotiations for a property by early 1951. By January 1952, the Fountain had purchased a home in Hastings capable of accommodating up to 40 patients at a time. This

¹²⁸ 'The Parents' Voice', *Newsletter* 7, 4 (Nov, 1956).

inspired the APBC and many members felt that if the Friends of the Fountain could achieve this in a short time frame then there was no reason that they too could not follow. The Essex and East London branch of the APBC began to discuss the idea of obtaining a holiday hostel for parents and their ‘backward’ children and established a fund; similar ideas were also discussed and started in the East Midlands.

The idea of a holiday home was so popular that in early 1951 the Association made the decision to begin a fund for a short-stay home. Primarily the home was intended for holidays and to temporarily relieve mothers of their duties in emergencies throughout the year. The need for such a home was confirmed by the Surrey County Council in the same year when repeated urgent advertisements were placed for homes for ‘backward’ children between the ages of 5 and 15 during the school holidays. Hospitals frequently reported that they were inundated with short-stay requests and generally had to refuse them. Slowly the authorities across the country began to recognise the need for such a home. Many children were cared for during term-time in boarding schools or under the Guardianship Scheme but had nowhere to reside in the holidays. This was especially true for orphaned, abandoned or forgotten children where in most cases it was impossible for friends or relatives to look after the child. Advertisements read: “Anyone who feels able to offer a permanent holiday home to any of these children is invited to write [...] indicating whether they would accommodate a boy or girl and the age of the child desired.”¹²⁹

During her correspondence with Dorothy Riddick of the National Birthday Trust, Fryd explained the need for a short-stay home to relieve mothers of their stressful and isolated duties for a short while. Fryd believed that the health and well-being of families of ‘backward’ children was of equal importance to the child’s. This kind of support was currently neglected by organisations and authorities. The ability to take a break from normal

¹²⁹ ‘The Parents’ Voice’, *Newsletter* 2, 1 (Jan, 1951).

routines and have a holiday was taken for granted by the general public, and most did not consider those who were denied this luxury due to the trials of taking their ‘backward’ child with them. If more short-stay care facilities were provided and utilised, the APBC supposed that families would be better able and willing to care for their child at home, thus relieving the pressure on the government for residential facilities. It was surmised: “In terms of cash alone, this would be a great saving to the communal purse – to say nothing of the gain in human happiness.”¹³⁰ Despite this, provisions for this facility varied greatly between authorities; some authorities were described as only providing this service grudgingly or not at all.

Moreover, some parents explained that they were completely unaware that such a service existed until they joined the APBC, not to mention those that did not know the service was free on application to their LA. Consequently, the APBC felt strongly that better publicity of this service and others was needed. Short-stay care was generally offered in ‘mental deficiency’ hospitals, yet there often was not enough room in institutions for this due to the pressure from the government to keep beds full. Vacancies only arose when a resident was released on license. These beds had to be kept vacant in case the resident needed to return to the facility. For this reason, it was likely that physical shortages led some LAs to be unwilling or unable to grant short-stay care. To remedy this, the APBC drew attention to the paediatric departments of large general hospitals with vacant beds. Severely ‘mentally handicapped’ and bedridden children could, and should, be cared for in such establishments on a short-term basis according to the Association. Whilst these beds were usually full in the winter, during the summer vacancies arose which coincided with the greatest demand for short-stay care. Again, this service was possible without the need for new legislation and formality if the hospital consented; it was believed that if hospitals were approached in the

¹³⁰ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

correct manner then they would pose no objections. Furthermore, if large teaching hospitals consented to this proposal it would serve as a double purpose: trainees would have greater contact with ‘mentally defective’ persons which in turn would increase knowledge and understanding and perhaps prompt some to take up the field.

Throughout the early 1950s repeated appeals were made for the short-stay home fund and the need for such a facility was continuously stressed to the readers of *Parents’ Voice*. Members were reminded that if the short-stay home fund appeal was to become anything a considerable amount of funds needed to be raised if the Association was to be able to take up the option of a property. Readers and members were asked to give all that they could spare and to encourage others to do so as well. These repeated appeals were successful and many branch delegates reported considerable sums had been raised for the fund by the summer of 1951. However, it should be noted that it was not just members who raised money for this cause, in October 1951 Fryd reported that a performance was being put on by the London Jewish community to raise funds for the appeal, once more demonstrating that ‘mental deficiency’ crossed all social, economic and religious barriers and concerned all equally. Progress in the short-stay home appeal was relatively quick.

By the summer of 1951, the APBC was able to begin considering suitable properties for the home. A small sub-committee was appointed to handle the cause and the Merseyside branch in particular was congratulated for raising attention to potentially suitable properties in their locality. By the autumn of 1951, a large property near Rainhill, Liverpool had been found and deemed appropriate for the purpose of a short-stay home. The property acquired was named Orchard Dene and was previously used as a children’s home and included a considerable amount of useful equipment. The NAMH were approached to help run the home with the assistance of the LAs providing the APBC were able to raise the capital needed for running the facility. The NAMH were to be responsible for the management of the property,

but the appointment of Trustees was to be equally appointed by both the NAMH and the APBC; the Committee met monthly to assess the property and future needs. Orchard Dene was the first of its kind in the country and the APBC wished to merge as much experience as possible in the administration of the home. The NAMH were included in the APBC's short-stay home scheme because they had considerable experience in running voluntary homes, although this would be the first short-stay home that the NAMH were involved in. The NAMH also felt that: "However good a mother might be, if she had one of these backward children at home year after year, she was bound to break down under the strain."¹³¹ Fryd spoke of the scheme: "Not only does it represent a private effort on the part of the members of this Association and their friends; it is also the forerunner of an ENTIRELY NEW SOCIAL SERVICE."¹³²

The negotiations for the property were conducted quickly, efficiently and virtually completed by January 1952. Once more the Merseyside branch was thanked for its assistance in helping bring the scheme to fruition; the branch had been instrumental in finding the property, liaising with the LAs, raising awareness and funds. In total the branch had raised £1200 of the needed £4000 for the short-stay home. Davies in particular was impressed with the work of the branch and prompted other branches to rival their work, claiming that any who were able would undoubtedly have the first claim to the next short-stay home. Whilst Davies' use of 'next' is optimistic and promising, Fryd later recounted his encouragement of competition and reasserted that the Association must remain a united movement and pursue multipurpose activities together. Fryd stated: "We must avoid jealousy of each other, and of other branches, and remember only the welfare of the children."¹³³ Regardless of the in-house rivalries, the Association's and indeed the country's first short-stay home, Orchard Dene, was opened in 1952. Fryd commented: "By opening our own Home at Orchard Dene we

¹³¹ 'The Parents' Voice', *Newsletter* 3, 3 (July, 1952).

¹³² 'The Parents' Voice', *Newsletter* 2, 4 (Oct, 1951).

¹³³ 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953).

encouraged the Authorities to bring into being this new social service for our children.”¹³⁴ This suggested that the Association’s concept of showing the way and providing the will was not only correct, but also effective as a means of founding new and improved provisions for ‘backward’ children.

Fryd believed the realisation of a short-stay home to be a dream come true. Few could believe when the idea was first pioneered in 1949 that it would become a reality in the space of three short years, and solely from their own efforts. The fact that parents had initiated and realised this scheme was a particular source of pride for the Association considering they were the ones who would benefit. The money for Orchard Dene was raised as follows (correct at the time of July 1952): £400 raised by the Merseyside branch; £600 loaned by a member of the APBC, Mr Holmes; a charity show at Friends of the Fountain totalled £840; £300 from the Middlesex branch; and £1,580 from the BBC’s *Week’s Good Cause Appeal*. Additionally, it was agreed during the Annual Convention in May 1952 that the National Council would later borrow up to £2,500 to ensure the purchase and repairs of Orchard Dene. The facility was to cost £3,500 of which a £350 deposit needed to be paid. In total £4,100 was raised in a year and Orchard Dene was purchased; repairs and alterations began immediately. Various surveyors donated their time and talents to the project and a good rate was given by the construction company demonstrating public awareness of the need for such a facility was increasing. Despite this, more funds were needed for the necessary alterations and equipment; all donations of toys and clothing were welcomed as some of the children came from poor backgrounds. Parents were urged to offer their help to take the children for walks and occupy them. Fryd spoke of the acquisition of Orchard Dene thus:

[Orchard Dene] has involved a great deal of work for a number of members, and has aroused great interest in the Association. Not the least important result is the

¹³⁴ ‘The Parents’ Voice’, *Newsletter* 3, 4 (Oct, 1952).

recognition of this provision as a necessary part of the Health Service as announced by the Minister of Health in Circular No. 5/52 issued on January 21st to all Local Health Authorities and Hospital Boards.¹³⁵

In addition to the strain placed on families, short-stay homes relieved the pressure placed on institutions and hospitals. LHAs were given powers under the MoH circular to facilitate a child's stay at Orchard Dene for up to 6 weeks during a domestic emergency. Parents who wished to utilise this scheme were advised to apply to their County Medical Officer quoting the MoH circular 5/52. Those who wished to send their child to Orchard Dene privately needed to apply to the Residential Services Department with details of the child's home circumstances. The issuing of a circular by the MoH for LHAs to provide short-stay care for families in need demonstrates that the APBC were proactive and successful, to a degree, in changing legislation and political attitudes.

Orchard Dene was officially opened on the 16th of May, 1952 at 3pm with the opening ceremony performed by the Earl of Derby.¹³⁶ Over 100 members and distinguished visitors assembled on the lawn of Orchard Dene for its opening. Davies (current Chairman of the APBC) handed the key to Councillor G.W. Prout (Chairman of Liverpool City Council Health Committee) and asked him to perform the official opening ceremony. Prout was said to be proud to be offered the honour and Fryd noted, "He and his Committee were acutely aware of the problems of parents of backward children. There were over 100,000 "mentally defective" persons in the country, of whom about half were in Institutions and the rest were at home. In Liverpool alone there were 14,000."¹³⁷

When commenting on the pressures borne by mothers caring for their 'backward' children at home, Prout stated that he and his Committee were anxious to help in any way

¹³⁵ 'The Parents' Voice', *Newsletter* 3, 2 (April, 1952).

¹³⁶ For images of Orchard Dene see Illustration 4.

¹³⁷ 'The Parents' Voice', *Newsletter* 3, 3 (July, 1952).

possible and encouraged others to adopt the same attitude: “There was still room for voluntary effort in the Welfare State, this home was a valuable contribution.”¹³⁸ The July issue was dedicated to “the first big practical achievement of the Association – the opening of the first Short-Stay Home at Orchard Dene, Rainhill, Lancs.”¹³⁹ The administration of Orchard Dene was explained to the readers as follows:

Orchard Dene is vested in the N.A.P.B.C. and four Trustees have been appointed. The Residential Services Department of the National Association for Mental Health has undertaken to run and maintain the Home, and a small Management and Welfare Committee of both Associations will attend to extra amenities and Services for the children and form a link with local organisations which might help the Home.¹⁴⁰

It was explained that with the correct staff and equipment up to 12 children could be accommodated at Orchard Dene. However, Orchard Dene still required some equipment in the first 4 months after it opened before it could be used to full capacity. Appeals were made to the branches for money, equipment and clothing donations to accommodate this. Money was also needed to repay the interest-free loan given by Mr Holmes. The cost of maintenance was 4 2/3 guinees per week; this was a standard cost of private and public homes and institutions throughout the country and could not be reduced.

The first children arrived at Orchard Dene on the 1st of June, 1952, and the uptake of the service was good in the first few months. In the first 13 weeks since opening, Orchard Dene accommodated 40 children, and therefore 40 families were provided with a much needed brief respite. Caroline Evans (Residential Services Department of the NAMH) commented: “Parents have had a well-earned holiday with contented mind knowing that their child was under proper care; in other cases the child has been cared for while the mother was

¹³⁸ Ibid.

¹³⁹ Ibid.

¹⁴⁰ Ibid.

in hospital.”¹⁴¹ However, essential equipment such as tables, chairs, linoleum and funds were still needed. Members were reminded that caring for 20 children was full-time and arduous work. Telephone calls were limited to between 3:30pm and 7:30pm so as to not disturb the staff during the busy periods. Similarly, appointments with the management, whilst always welcomed, were to be made on an arranged basis only. This option was taken by many parents and many met with the Matron to hear and see first-hand the service offered by Orchard Dene. The facility was not only utilised in the summer months but also during the colder seasons. In December 1952 it was recorded that there were 17 patients in residence being funded by various LHAs.

By 1954, Orchard Dene had received a new laundry and isolation room for the special problems imposed by many of the children. Despite this, other alterations were needed to the sum of £1,600 (to be raised by donation/bank loan.) The General Secretary of the NAMH, Mary Appleby, wrote an article titled ‘The Miracle of Orchard Dene’ in November 1956. Appleby praised the Association for their work: “How richly justified have been the vision and courage of the pioneers who made the project possible.”¹⁴² It was initially believed that the children who would attend Orchard Dene would be mostly ‘high grade’ patients. However, it was soon discovered that this was not necessarily the case and more specialised equipment and care was required. On occasion Orchard Dene had to be closed due to the rapid spread of infections amongst ‘helpless’ children, or because there were not enough residents to make opening fiscally worthwhile. Despite this, there were very few complaints made about the overall service offered at Orchard Dene. Those that were made were impartially investigated and remedied where applicable.

Whilst Orchard Dene was expensive to obtain and maintain, especially when considering the cost of alterations and specialised equipment needed, Fryd did not believe

¹⁴¹ C. Evans, ‘News About Orchard Dene’ in ‘The Parents’ Voice’, *Newsletter* 3, 4 (Oct, 1952), p. 6.

¹⁴² M. Appleby, ‘The Miracle of Orchard Dene’, in ‘The Parents’ Voice’, *Newsletter* 7, 4 (Nov, 1956), pp. 5-6.

that its value could be measured in monetary terms: “The value of such a House cannot be measured in pounds, shillings and pence where the health, both mental and physical, of a mother is at stake.”¹⁴³ However, not all LAs had adopted the MoH circular and many parents were either unaware or unable to use this scheme. Members were urged to find out whether or not their LA had adopted the circular and if not members were pressed to persuade their Local Health Committee to do so. MP for North Ealing, John Barter, questioned whether or not short-stay facilities were being fully utilised by LAs, and if not to what extent. The Senior Secretary to the MoH, Miss Hornsby-Smith replied:

During 1954, 1,300 “mental defectives” were received for short-term care in hospitals and 461 elsewhere. Ninety local health authorities in England and Wales have power in schemes approved under Section 28 of the National Health Service Act and no specific amendment of schemes is needed to enable them to secure removal to a hospital.¹⁴⁴

However, no information was provided for LAs who had yet to utilise the short-stay facilities. The average cost to bring the idea of Orchard Dene to fruition was £4,950. However, the poor attendance of children due to many authorities not making full use of the facility resulted in the NAMH making a loss of £1,500 on running costs in the first year. It was hoped that a better use of the MoH’s circular would improve this situation. Mr Belford, of the Essex branch, wrote to Fryd to complain of some LAs approach to the circular. Belford explained that a mother in his district was forced to wait three weeks when suffering from appendicitis before the LAs approved her application for short-stay care and she was able to have her operation.

¹⁴³ ‘The Parents’ Voice’, *Newsletter* 5, 3 (July, 1954).

¹⁴⁴ ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

Consequently, the APBC pressed for better implementation of the MoH's circular and for it to be made compulsory for LAs to act where needed. Furthermore, some LAs imposed a means test on parents applying for short-stay care for their child which defeated the purpose of the circular. By the autumn of 1955, Orchard Dene was considered such a success that the Middlesex and Leeds branches were opening their own short-stay homes. Furthermore, short-stay homes were announced as a normal part of the National Health Service in the UK. Following the APBC's efforts to make the circular compulsory it was reported that over 250 families made use of the service and their children attended Orchard Dene in the year 1956/57. This was approximately 4 children per week admitted to the facility. The increase in administrative work from Orchard Dene helped the Association to achieve their second milestone: the opening of a central London office and a full-time paid secretary. In this respect Orchard Dene helped the APBC to "grow like a snowball."¹⁴⁵

The need for short-stay homes was made evident by the success of Orchard Dene and similar homes were established by parents' associations in Australia and New Zealand. In addition, Ella Stewart in Scotland donated Graigrowine Castle to the Scottish parent's association upon learning of the struggles of the children. The castle was to be used as a short-stay home, demonstrating that the APBC were not just influential and pioneering in the UK, but also globally. Other societies interested in the care of 'mentally defective' children followed the APBC initiative in opening a short-stay home. The 'Invalid Children's Aid Society' in Worthing opened their own short-stay facility for children with cerebral palsy in 1954. The facility was intended to accommodate boys between the ages of 7 and 14, and girls aged from 7 to 16; however, the facility excluded children with 'mental deficiency', epilepsy or blindness. By the late 1950s, the success of Orchard Dene had travelled across the Atlantic to New York, America. The 'Centre for Retarded Children' in Pomona, New York had

¹⁴⁵ 'The Parents' Voice', *Newsletter* 6, 2 (Spring, 1955).

established its own short-stay home modelled after Orchard Dene. The home was designed to provide care for up to 6 weeks for children aged between 5 and 13 with an IQ between 30 and 65; it was the first of its kind in the US. It opened on the 7th of July, 1958 and was well received.¹⁴⁶ Whilst eugenic ideas of stigma and isolation were socially adopted and carried out by the general public, the permanent physical segregation of those deemed to be ‘socially undesirable’ remained in the remit of politicians. The idea of physical exclusion for the ‘mentally deficient’ is discussed in the following chapter.

¹⁴⁶ ‘The Parents’ Voice’, *Newsletter* 7, 4 (Nov, 1956)

Chapter Two

Hidden Lives: The Physical Exclusion of ‘Backward’ Children

“We are all faced with the problem of what is to become of our children [...] the trouble is, that the parents without money have no real choice – for them, its institution or nothing.”¹

Whilst the social dimensions of exclusion are now being subjected to a more comprehensive, scholarly debate,² the history of institutionalising ‘mentally subnormal’ individuals in the nineteenth and twentieth centuries is not comprehensively developed. Roy Porter has argued that there is an academic lack of interest in the segregation of ‘idiots’, ‘lunatics’ and ‘imbeciles’ stemming from a disinterest in the subject matter as a whole. According to Porter, “madness continues to exercise its magic, but mindlessness holds no mystique.”³ On his part, David Wright asserted that the majority of scholarly works on the topic of exclusion analysed it within the great chain of ideas from the Age of Enlightenment. Wright suggested that approaching the matter from a theoretical perspective, and placing medical discussions of ‘idiocy’ and ‘lunacy’ in classic literature, resulted in tracing a linear progression of medical ‘discoveries’ to the present day.⁴ However, there has been a shift away from these broad

¹ ‘Association of Parents of Backward Children’, *Newsletter* 2, 10 (Jun, 1950), in *National Association of Parents of Backward Children Nov 1948-Mar 1953*, SA/NBT/F.9/7, The Wellcome Library, London. Hereafter abbreviated to ‘APBC’, *Newsletter* 2, 10 (Jun, 1950).

² J. Hills, J. Le Grand and D. Piachaud (eds), *Understanding Social Exclusion*, (Oxford: Oxford University Press, 2002); T. Burchardt, J. Le Grand and D. Piachaud, ‘Social Exclusion in Britain 1991-1995’, *Social Policy and Administration* 33, 3 (1999), pp. 227-244; D. Abrahams, J. Christian and D. Gordon (eds), *Multidisciplinary Handbook of Social Exclusion Research*, (Chichester: John Wiley & Sons, 2007).

³ R. Porter quoted in L. Carlson, *The Faces of Intellectual Disability: Philosophical Reflections* (Indiana: Indiana University Press, 2010), p. 18.

⁴ D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum, 1847-1901* (Oxford: Oxford University Press, 2001), p. 27

global histories towards a more detailed historical discussion.⁵ As a whole, previous academic discussions of institutions have tended to focus on praising or reprimanding the institution and the individuals involved. However, these approaches often do not account for the personal experiences of those with learning difficulties and their families in the matter of rejection.

In the early modern period ‘mental deficiency’ was considered to be a domestic issue. According to Peter Rushton, the family was the centre of the state-enforced system of care. ‘Fools’ were cared for by their family and community,⁶ and the institutionalisation of village ‘fools’ or ‘idiots’ was believed to be an inappropriate solution. State intervention only occurred after other care systems had failed, been exhausted, or if said care systems caused the poverty of the family. As a whole, English parishes only cared for a small minority of individuals with ‘mental defects’; overall, care was subsidised in neighbouring homes. Jonathan Andrews et al. have discussed how a small portion of ‘idiots’ were sent to surrounding counties for care, nursing, and lodging.⁷ However, this measure was used as a last resort, the majority of counties and parishes favoured a community based care programme. The community based care systems socially included ‘idiots’ by eliminating their physical differences: “Being dressed like ordinary people [...] the old village fools seemed at once to disappear from the villages without having really left them.”⁸

⁵ J. Hamlett, L. Hoskins and R. Preston (eds), *Residential Institutions in Britain, 1725-1970* (Abingdon: Routledge, 2013); M. Jackson, ‘Institutional Provision for the Feeble-minded in Edwardian England: Sandlebridge and the Scientific Morality of Permanent Care’, in *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* eds. D. Wright and A. Digby (London: Routledge, 1996), pp. 161-183; D. Atkinson, M. Jackson and J. Walmsley (eds), *Forgotten Lives: Exploring the History of Learning Disability* (Kidderminster: British Institute of Learning Disability, 1997); A. Borsay, *Disability and Social Policy in Britain since 1750: A History of Exclusion* (Basingstoke: Palgrave, 2005).

⁶ For a complete discussion see: P. Rushton, *Approaches to the Sociological Study of the Organization of Family Structures in the UK, 1800 to Present: a Critical Analysis* (Manchester: University of Manchester Press, 1975) and P. Rushton, ‘Lunatics and Idiots: Mental Disability, the Community, and the Poor Law in North-East England, 1600-1800’, *Medical History* 32 (1988), pp. 34-50.

⁷ J. Andrews, A. Briggs, R. Porter, P. Tucker and K. Waddington, *The History of Bethlem* (Abingdon: Routledge, 1997).

⁸ D. Wright and A. Digby (eds), *From Idiocy to Mental Deficiency: Historical Perspectives of People With Learning Disabilities* (London: Routledge, 1996), p. 6.

The use of certain words has helped to understand the position afforded to those with mental health issues in modern society,⁹ yet cannot fully explain the feelings of those with learning disabilities as society changed. The early modern period referred to those with learning disabilities as ‘fools’, suggesting a harmless component of the community. However, within two centuries, attitudes towards mental health problems had degenerated at an alarming rate. After the thirteenth century a legal distinction between ‘idiocy’ and ‘lunacy’ was introduced. ‘Idiots’ were deemed to be ‘natural fools’: inherent with a permanent lack of understanding, whereas ‘lunacy’ was attributed to a post-natal event causing a lack of mental capacity, denouncing the individual as a ‘person of unsound mind’. Generally speaking children and adolescents tended to be considered as ‘idiots’, whereas ‘mentally infirm’ adults were labelled as ‘lunatics’. By the seventeenth and eighteenth centuries, intermediate categories such as ‘criminal lunatic’ had been introduced in the judicial system with the ability to deprive individuals of equality on a legal basis. Regardless, most legal decisions supported the family’s claim of ‘idiocy’ or validated the popular opinion of the individual as such, and denied any freedom or equality. Medical texts in the eighteenth century referenced ‘idiots’ and ‘imbeciles’; ‘imbeciles’ were considered to have more reasoning ability than ‘idiots’. This negative attitude towards those with learning disabilities was often a by-product of industrialisation and of their perceived lack of capability in the industrial environment.¹⁰

By the nineteenth century, the Lunacy Act of 1890 defined an insane person as an ‘idiot’, ‘lunatic’ or person of unsound mind.¹¹ The Act emphasised a shift towards legal intervention in cases of ‘mental impairment’. Furthermore the role of medicine was

⁹ For more information on the role of linguistics in understanding disability, see: J.C. Wilson and C. Lewiecki-Wilson (eds), *Embodied Rhetorics: Disability in Language and Culture* (Illinois: Southern Illinois University Press, 2001).

¹⁰ The industrial revolution in Britain occurred in the late eighteenth to early nineteenth centuries. During this period manufacturing evolved from hand processes to faster and more economic machinery. Affected industries included iron production, the textile industry, and chemical manufacturing, which used steam power, machine tools and introduced a new factory system. It was often believed that those with ‘mental deficiencies’ were incapable of understanding the new systems and machinery and would not be able to function quickly enough to operate them.

¹¹ It was not until the twentieth century that the legal definition of ‘lunacy’ would exclude mental impairments.

superseded by legal rules and judicial, rather than medical, sanctions were imposed. Indicating that irrespective of ability or disability, those with mental health problems were viewed as a burden on the State. Generally, a premium was placed on ‘idiots’ rather than ‘lunatics’, as they were perceived to be capable of basic labour.

The descriptive language was furthered in the early twentieth century to include the borrowed American terms, ‘feeble-minded’ and ‘mentally defective’. ‘Idiots’, ‘imbeciles’ and ‘morons’ were grouped together by the eugenic term ‘feeble-minded’ and considered to have an IQ fewer than 70 (between 0-24, 25-49 and 50-69 respectively).¹² By the mid-twentieth century, derogatory attitudes were widespread and terms such as ‘mental sub-normality’ permeated legislation.¹³ These descriptions were used to define and enhance differences between those deemed to be ‘mentally subnormal’ and ‘normal’. In the process these terms often socially isolated individuals and assisted their physical segregation in legal terms. Eventually, the terms ‘mental impairment’ and ‘learning disability’ were introduced to medically describe those with neurobehavioral disorders affecting their ability to learn in a conventional manner. These late twentieth century terms were designed to accurately describe various conditions without inferring any social bias. Despite this advance, much of British society remains unclear on the differences between mental illness, the concepts of ‘idiocy’ and ‘imbecility’ and the related connotations.

Roots of Exclusion

The roots of exclusion can be traced back to antiquity. However, the developments since the early modern period have been the most influential to the current understanding of

¹² American terms were prevalent in Britain during the period due to the volume of works produced on ‘mental deficiency’ by American academics. Influential American eugenicists include, but are not limited to, Henry H. Goddard, Charles Davenport, Henry Laughlin and Madison Grant.

¹³ Previously The Idiots Act of 1886 made the legal distinction between ‘idiots’ and ‘imbeciles’. This was expanded upon in The Mental Deficiency Act of 1913, which made provisions for the institutional treatment of people deemed to be ‘feeble-minded’ and ‘morally defective’.

segregation. For scholars, such as Richard Neugebauer, during the medieval and early modern eras, naturalistic tests were increasingly used in place of demonological criteria to ascertain the nature of disability.¹⁴ For instance, naturalistic tests were used to ascertain the level of mental impairment in English court hearings involving ownership of property and the Crown's incompetency jurisdiction. However, the late seventeenth century saw the increase of 'idiots' excluded and sent to workhouses.

By the nineteenth century, the social and political discussion of voluntary labour camps for 'mentally deficient' persons was raised. The idea of segregating 'idiots' from the respectable working classes gained popularity. One suggested measure was the removal of 'idiots' in the cities to rural towns. Once there, 'idiots' could be utilised for farm labour with 'firm discipline'. The distancing of 'idiots' from the community resulted in a growing social negativity towards this marginal group. As social fears increased, closer medical, educational, and social attention was paid to those denounced as 'idiots', 'lunatics' and 'imbeciles'. Yet, this increased attention did little to improve the overall understanding of their conditions. One example of this includes how babies born deaf or dumb were legally assumed to be 'idiots' despite unimpaired mental faculties.

In 1912 the EES organised the first International Eugenics Congress in London. During the Congress, British eugenicists proposed legislation for the care and control of the 'feble-minded'. Suggested measures included the compulsory segregation of those deemed to be 'mentally deficient' after intelligence testing. One of the founders of the EES, Sybil Neville-Rolfe, welcomed the passing of the Mental Deficiency Act of 1913. The Act established the Board of Control for Lunacy and Mental Deficiency to administer the care and management for those deemed to be 'idiots', 'imbeciles', 'feble-minded' or 'moral imbeciles'. Under the Act, approximately sixty-five thousand 'mentally deficient' people

¹⁴ R. Neugebauer, 'A Doctor's Dilemma: The Case of William Harvey's Mentally Retarded Nephew', *Psychological Medicine* 19 (1989), pp. 569-572.

were excluded to Colonies or Institutions.¹⁵ Rolfe concluded that the Act was a “practical example of the value of a biological approach to social problems.”¹⁶

Alongside advocating for legislative changes, the Eugenics Society strove to disseminate information to the general public about human biology and racial responsibility. As a whole, the British eugenics movement promoted mass education for biologically fit members of society. Individual responsibility for healthy sexual and reproductive conduct which would benefit the State was promoted. Conversely, British eugenicists proposed the segregation (and to an extent, the sterilisation) of those declared as ‘feeble-minded’ or ‘backward’. However, Francis Galton initially promoted eugenics’ ability to provide a humane alternative to social problems. Galton rejected notions of infanticide and other cruelties inherent in natural selection. Contemporary British eugenicists understood the need to provide humanitarian alternatives to antiquated solutions; physical segregation appeared to be a socially acceptable substitute. For instance, prominent Quaker and expert on mental illness, Daniel Hack Tuke stated in 1882:

There may be times when, desiring to see the ‘survival of the fittest’, we may be tempted to wish that idiots and imbeciles were stamped out of society. But [...] there is a compensation for the continued existence of so pitiable a population in our midst in [...] that our sympathies are called forth on their behalf [...] those who are strong should help the weak.¹⁷

Eugenic fears of the pauper underclass and their rapid reproduction were a part of the larger discussion of national health. Socially and physically segregating policies and coercive

¹⁵ For more information on the Mental Deficiency Act of 1913 see: J. Woodhouse, ‘Eugenics and the Feeble-Minded: the Parliamentary Debates of 1912-14’, *History of Education* 11, 2 (1982), pp. 127-137; W.H. Gattie, T.H. Holt-Hughes, ‘Notes on the Mental Deficiency Act, 1913’, *The Law Quarterly Review* 30 (1914), p. 201 and J. Walmsley, ‘Women and the Mental Deficiency Act of 1913: Citizenship, Sexuality and Regulation’, *British Journal of Learning Disabilities* 28 (2000), pp. 65-70.

¹⁶ Quoted in A. Richardson, *Love and Eugenics in the Late Nineteenth Century: Rational Reproduction and the New Woman* (Oxford: Oxford University Press, 2003), p. 30.

¹⁷ D.H. Tuke, *Chapters in the History of the Insane in the British Isles* (London: K. Paul, 1882), p. 318.

disciplinary measures were considered necessary to achieve eugenic ideals. Eugenists in the late nineteenth century emphasised the benefits of eugenic practices to limit the reproduction of socially undesirable groups. In doing this, the risk of diseases and the cost of caring for the ‘feeble-minded’ would lessen. To gain credibility, the British eugenics movement drew upon a long genealogy of eugenic ideas and practices from ancient civilisations in Greece and Rome. Traditionally, the Greeks and Romans dispelled weak children and adults from their communities; ancient societies were known to kill the weaker members of their communities.¹⁸ Eugenists claimed authority by reiterating this ancient lineage.

Undeniably, the rise in social fears and increase in institutionalisation was accelerated by the age of industrialisation and urbanisation in the nineteenth century. The transition from anonymity in community based care systems to state incarceration led to an increase in historical documentation and a greater social impact of the ‘mentally deficient’. An example of the growing concern with mental health issues can be seen by the growth of segregating facilities. In 1827 there were 9 ‘idiot’ and ‘lunatic’ asylums, with an average of 116 patients in England. By 1870 there were 51 similar institutions. They employed a total of 251 medical practitioners with approximately 550 inmates in each.¹⁹ This growth in statistics seems to be better attributed to rising social anxieties than the actual increase in ‘idiots’ and ‘lunatics’. Nonetheless, within institutions and asylums, ‘idiots’, ‘lunatics’ and ‘imbeciles’ were rarely the focus of concern. Various categories of mental impairment were grouped together irrespective of their vast differences. Impairments included: deaf, dumb, ‘idiocy’, epilepsy, weak intellect, mentally infirm, and mental and senile imbecility. No specialised care was paid to the members of the aforementioned groups. Conversely, focus was directed to the effects of said groups on the sane in asylums and institutions. To exaggerate this neglect, few

¹⁸ For a more comprehensive discussion of ancient eugenic practices see: in P. Mazumdar, *Eugenics Human Genetics and Human Failings: The Eugenics Society, its Source and its Critics in Britain* (London: Routledge, 1992); A. Spektorowski and L. Ireni-Saban, *Politics of Eugenics: Productionism, Population and National Welfare* (Abingdon: Routledge, 2013).

¹⁹ Figures from Wright, *Mental Disability in Victorian England*, p. 197.

institutions were equipped for the vast intake of ‘idiots’, ‘imbeciles’ and ‘lunatics’ that they received.²⁰ The confusion about the varying nuances of disability, and the lack of a suitable typology resulted in many sent to inappropriate institutions. Amongst these were workhouses which offered no medical benefits; they were a cost effective alternative.

By the end of the nineteenth century, social education, familial wealth and medical suitability became considered factors in the placing of ‘mental defectives’. Subsequently, there was a growth of medicalised Georgian and Victorian institutions such as the Earlswood Asylum. In this setting the budding new psychiatric profession was born, able to flourish and advance rapidly. Georgian and Victorian institutions were inspired by the psychiatric profession to suitably care for the particular nuances of disability. However, they were equally driven by the developing trend of eugenics and safeguarding the health of society.²¹ This dichotomy of approaches often led to poor conditions and treatment in institutions and asylums.

Many contemporary scholars theorised about the course and treatment of ‘mental deficiency’; yet little consensus existed. This lack of understanding, combined with the societal fears of ‘backwardness’, resulted in many individuals automatically institutionalised to curtail the perceived threat. During the process of institutionalisation very few of the acknowledged associated medical conditions of ‘backwardness’ were treated. Subsequently, many ‘backward’ children died in infancy or early adult life. Generally, authorities believed that ‘mentally deficient’ persons were unable to benefit from life experiences and education, and thus suited living in large institutions which were often devoid of any individuality or stimulation.

²⁰ However, there were exemptions to this. An example is the London Institutions of Caterham, Leavesden, and Darenth which built specific ‘imbecile wards’.

²¹ For more in-depth information on the history of institutions see: R Porter and D Wright (eds), *The Confinement of the Insane: International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003); J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914* (Abingdon: Routledge, 1999); and J. Andrews, ‘The Rise of the Asylum in Britain’ in D. Brunton, *Medicine Transformed: Health, Disease and Society in Europe 1800-1930* (Manchester: Manchester University Press, 2004)

One notable advocate for the segregated treatment of the ‘feeble-minded’ was John Langdon Down, after whom Down syndrome is named for his work in classifying the condition. Down utilised his esteemed academic position as an author to promote the advantages of separated institutionalised education and care for ‘idiot’ children. Down asserted: “in but few homes [...] is it possible to have appliance for physical and intellectual training adopted for the duration of the feeble in mind.”²² Langdon Down supported the separation of ‘idiot’ institutions from ‘lunatic’ asylums to promote specialised medical practice and knowledge in the former. Additionally, Langdon Down did not believe that ‘idiot’ children should be segregated with ‘feeble-minded’ adults. Langdon Down held that ‘idiot’ children should be separated according to individual academic ability. Regardless, Langdon Down was the minority amongst those who discussed the care and education for the ‘mentally defective’. The majority of professionals were unconcerned with the nuances of ‘backwardness’ or the best course of treatment. In the late nineteenth and early twentieth centuries, authoritative interest in ‘mental defects’ ended after the segregation of ‘idiots’ and ‘lunatics’. It was this approach which effectively confirmed the physical isolation and social seclusion of those with mental impairments in the nineteenth and twentieth centuries. Essentially, those with learning disabilities became social and physical pariahs.

Irrespective of the initial widespread support for the exclusion of those with learning disabilities, institutions were thought to have created their own problem populations. ‘Feeble-minded’ patients were viewed as inherently troublesome; they were often chronic patients with no curative value. By the late nineteenth century, the optimism of early advocates had been replaced with pessimism. Pressurised by the demand for the classification of the ‘feeble-minded’, many Victorian institution Superintendents discharged the ‘weak-minded’ on the basis that they posed little threat to society. However, this was later believed

²² Quoted in Wright, *Mental Disability in Victorian England*, p. 159.

to have contributed to the alarming increase in Victorian crime. Eugenic advocates and social commentators asserted that these individuals contributed to the degeneration of the population, and alternatives were sought to curtail the problem of 'mental deficiency'. These attitudes permeated the social consciousness until the mid to late twentieth century. Despite the efforts of the APBC to change legislation in the 1950s, individuals with mental disabilities continued to suffer from the legacy of early institutionalisation and the eugenics movement in Britain until the 1980s due to ingrained eugenic ideals.

Sterilisation: A Desirable Alternative?

Proposals for eugenic legislation in Britain spanned from marriage to prostitution, immigration to emigration, and quality and quantity of the population. Specifically, the British eugenics movement focused on the questions of pauperism, inheritance, criminality and various social ills. For eugenicists, the answer to Britain's imperial problems was rational reproduction and the restriction of the lower classes. By the beginning of the twentieth century, eugenic movements often became entwined with public health and social welfare, and aimed at improving the national vitality. Eugenics may have suffered scientific criticism in the 1930s and the disabling effects of post-WW2, but the ideals generated in the inter-war period continued into the scientific, medical and social movements of the later twentieth century. There was a renewed interest in the autonomy of the individual. These ideals were noticeably evident in the societal and medical reaction to disability in post-WW2 Britain.

Yet, this is not to suggest that there was no political overlap between countries; sterilisation proved to be both a fundamental and controversial subject in global eugenic debates.²³

Eugenic ideals promoted the hereditary aspects of ‘feeble-mindedness’ and encouraged the on-going “custodial care for ‘those feeble-minded persons who were a danger to the community, especially women of child-bearing age’.”²⁴ By the 1930s, institutionalised inmates were amongst the most sterilised persons permitted by legislation in the USA, Canada, Scandinavian States, Mexico, Germany, Japan, Hungary, Yugoslavia, Czechoslovakia, Latvia, Cuba, and Turkey. By the early twentieth century many nations considered the sterilisation, segregation and even euthanasia of the disabled, poor, prostitutes, and the mentally and criminally ill to be a humanitarian effort for the betterment of society.²⁵ In the USA, the eugenics movement in the twentieth century resulted in thirty-three (of the then forty-eight) states beginning programmes of forced sterilisation of those with Down syndrome and other mental afflictions.²⁶

²³ The subject of sterilisation has been globally discussed by various authors from several disciplines. For further information see: H. Bruinius, *Better for all the World: The Secret History of Forced Sterilisation and America's Quest for Racial Purity* (New York: Knopf, 2006); J. Areen, ‘Limiting Procreation’ in R.M. Veatch (ed), *Medical Ethics* (Massachusetts: Jones and Bartlett Publishers, 1989), pp. 103-135; R. Hansen and D. King, *Sterilized by the State: Eugenics, Race and the Population Scare in Twentieth Century North America* (Cambridge: Cambridge University Press, 2013); A. Frank, *Margaret Sanger's Eugenic Legacy: The Control of Female Fertility* (North Carolina: McFarland & Company, 2005); E. Dyck, *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (Toronto: University of Toronto Press, 2013); I. Dowbiggin, *The Sterilization Movement and Global Fertility in the Twentieth Century* (Oxford: Oxford University Press, 2008); E. Bratlinger, *Sterilization of People with Mental Disabilities: Issues Perspectives and Cases* (Connecticut: Greenwood Publishing, 1995); S.M. Brady, ‘Sterilization of Girls and Women with Intellectual Disabilities: Past and Present Justifications’, *Violence Against Women* 27, 4 (2001), pp. 432-461; R. Cepko, ‘Involuntary Sterilization of Mentally Disabled Women’, *Berkeley Journal of Gender, Law & Justice* 8, 1 (2013), pp. 122-165; E. Tilley, Elizabeth, S. Earle, J. Walmsley and D. Atkinson. ‘The Silence is Roaring: Sterilization, Reproductive Rights and Women with Intellectual Disabilities’, *Disability and Society*, 27, 3 (2012), pp. 413–426.

²⁴ M.A. Field and V.A. Sanchez, *Equal Treatment for People with Mental Retardation: Having and Raising Children* (Massachusetts: Harvard University Press, 2001), p. 10.

²⁵ This would remain the case until the late twentieth century, despite the disillusionment with eugenics in the 1950s and 1960s. Eventually, the rights of the individual, regardless of the impact upon the State were considered to be more important. This is evidenced by the ‘right to be homeless’ and not forced into custodial care.

²⁶ A comparison between UK and USA policies of sterilisation can be found in R. Hansen and D. King, ‘Eugenic Ideas, Political Interests and Policy Variance: Immigration and Sterilization Policy in Britain and the U.S.’, *World Politics* 53, 2 (2001), pp. 237-263.

However, not all countries with eugenic programmes subjected their state wards to the process of sterilisation; the UK and the Soviet Union are both examples of this. Nevertheless, British eugenicists were attracted to the economic benefits of sterilisation in contrast to the costs of physical segregation. For the majority of the twentieth century sterilisation was globally viewed as the social service paradigm for curtailing the reproduction and spread of ‘mental defectives’. However, it is pertinent to note that British legislation allowing the sterilisation of those deemed to be ‘mentally defective’ was never passed. The majority of the English public and politicians believed the proposed Feeble-minded Control Bill in May, 1912 which promulgated the compulsory sterilisation of ‘mental defectives’ to be an infringement of individual rights. Moreover, the British eugenics movement took the form of a class war, as opposed to race. For this reason, utilising sterilisation methods to achieve eugenic goals of cleansing society from its undesirables was unrealistic and unattainable. Regardless, the social and physical isolation of ‘mentally defective’ persons was commonly considered acceptable and for the betterment of society.

Mathew Thomson has examined the British society’s willingness to institutionalise the ‘mentally deficient’. British eugenicists, he argued, called for the sterilisation of the criminal, poor, and the unemployed but their demands went largely ignored. Yet, they were able to gain widespread support from society in the case of segregating ‘mental defectives’. Thomson has argued that community care and institutionalisation had much closer links than has been previously assumed and that social policy was a “complex, multilevel and interactive process.”²⁷ ‘Mentally deficient’ members of society were viewed as a group in need of protection, rather than freedom. Ultimately, Thomson believes that policies of segregation were successful in 1913, but the sterilisation bill of the 1930s failed because it challenged human rights and social responsibility about citizenship in democratic Britain.

²⁷ M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c. 1870-1959* (Oxford: Clarendon Press, 1998), p. 3.

Euthanasia: A Merciful Death?

The late nineteenth century and the interwar period saw the rise of the pauper underclass with their alleged low intelligence, and high fertility rates that came to characterise all Britain's social ills; the 'feeble-minded' were the epitome of this class. For the first time, the principles of science were applied to social problems. As Dora F. Kerr noted in her 1898 *The Conversion of Mrs Grundy* "with the power to control the birth-rate, comes the ideal of quality rather than quantity."²⁸ Ultimately, the introduction of eugenic ideas would permanently alter the role of the disabled in society. The handicapped would no longer be viewed as a subject of ethnological curiosity; instead the 'feeble-minded' became the victims of a dark global movement of forced segregation, sterilisation and finally euthanasia.

The most comprehensive annihilation of those with 'mental deficiencies' occurred during the Third Reich. The road to euthanasia in Germany began in 1933 with the Law for the Prevention of Offspring with Hereditary Diseases Act. This Act legalised the involuntary sterilisation for "any person suffering from a hereditary disease [...] if his offspring will suffer from severe hereditary physical or mental damage."²⁹ These persons included the 'feeble-minded', the schizophrenic, the epileptic, the blind and deaf among many others. Between 1939 and 1945 it is estimated that over 400,000 individuals were forcibly sterilised in Nazi Germany alone. The situation deteriorated in 1939. Midwives and physicians were issued with a decree from the Ministry of Interior requiring them to report infants (and children up to the age of 3) with various mentally and physically disabling conditions. This programme became known as 'Aktion T4'. Children were transferred to various children's wards where physicians systematically murdered an estimated 5,000 children considered to

²⁸ D.F. Kerr, 'The Conversion of Mrs Grundy', quoted in Richardson, *Love and Eugenics*, p. xiv.

²⁹ Quoted in H. Friedlander, *The Origins of Nazi Genocide: From Euthanasia to the Final Solution* (North Carolina: University of North Carolina Press, 1997), p. 26.

be 'mentally defective'. Dependent on the doctor, children were subjected to starvation, and lethal doses of medications or painkillers. In late 1939, the policy was extended to 'mentally defective' adults in institutions; over 70,000 individuals perished. The programme was eventually halted by Hitler's orders in 1941 from concern about its impact on the Nazi regime's image. Despite the official termination of the policy in 1941, unauthorised killings continued to occur in extermination facilities in psychiatric hospitals in Germany and Austria. It has been suggested these illegal killings totalled over 200,000.

Despite the growing recognition of the 'mentally defective' as a misunderstood and vulnerable faction of society, those involved in 'Aktion T4' were acquitted of their crimes or given minimal prison sentences. The court believed that the perpetrators did not recognise the immorality and illegality of their crimes at the time of their occurrence. This ruling indicated the general public and judicial system was apathetic, and at times sympathetic, to the actions of these men and women. It was expected for the defendants to make excuses for their actions. Controversially, the presiding judge also attempted to pardon their heinous crimes as a reflection of the contemporary society. Unfortunately, attitudes towards the euthanasia of the 'mentally defective' had changed relatively little in many countries in the two succeeding decades after the fall of Nazism. Comparatively, displaying overt signs of anti-Semitism was condemned and viewed as an infringement of human rights, yet, negative approaches to those with mental disabilities was considered a cultural norm and acceptable.

The Nazi regime was not the first to express ideas of euthanizing and sterilising the mentally ill and 'defective' in society, and nor were they the last. Whilst understanding and tolerance of those with mental 'defects' continuously increased in the mid-twentieth century, the legacy of eugenic thinking continued to pervade many minds. In late 1958, Fryd discussed the attitudes of some Anglican Bishops. Some believed that certain members of

society should be “mercifully put to sleep.”³⁰ Whilst the Anglican Bishop was not explicitly named, it is reasonable to assume that Fryd may have been discussing the ideas of Bishop Ernest William Barnes of Birmingham. Bishop Barnes was a prominent member of the Eugenics Society and vocal advocate of euthanasia for the ‘mentally deficient’.³¹ To quote Barnes: “Many are beginning to think that medically controlled euthanasia for defective infants should be an element in our social policy.”³² Euthanasia was officially and overtly rejected in the UK. Yet, opinions such as these were often voiced by those who did not wish to incur the cost of caring for ‘weaker’ members of society, who would be unable to return the expenditure. Additionally, some individuals felt that spending resources on the ‘weak’ was a waste as many would be unable to appreciate it.

In the spring of 1955, Fryd discussed the proposals of Alderman W.L. Dingley, the Chairman of the Mental Health Committee of the Association Hospital Management Committee. Dingley gave evidence and made suggestions to the 1957 Royal Commission; this was highly publicised and partly published in *The Times*.³³ Dingley appeared to advocate the legislation of euthanasia for ‘mentally defective’ babies. The APBC responded that these sentiments were “stupid and unchristian.”³⁴ Fryd continued to explain that the causes of ‘mental deficiency’ were now understood as being many and diverse:

Even if every “defective” alive today were to be killed, it would not prevent the birth of others to take their place [...] it is impossible to make a reliable diagnosis, much less a certain prognosis, on a very young baby – though more may be pointers to the

³⁰ ‘The Parents’ Voice’, *Newsletter* 9, 3 (Autumn, 1958) in *Parents Voice: National Society for Mentally Handicapped Children 1:38, 1950-1988*, Main Library/Store 208369/7, The University of Manchester Library, Manchester. Hereafter abbreviated to ‘The Parents’ Voice’, *Newsletter* 9, 3 (Autumn, 1958).

³¹ For a more comprehensive discussion of E.W. Barnes see: P.T. Merricks, ‘God and the Gene: E.W. Barnes on Eugenics and Religion’, *Politics, Religion and Ideology* 13, 3 (2012), pp. 353-374.

³² E.W. Barnes ‘Too many people, Sterilize the Unfit, Euthanize Defective Infants, and Family Planning’, *The Daily Express Tuesday* (29/11/1949) (Accessed on 11/09/2015).

³³ ‘Euthanasia of Babies ‘In Certain Cases.’’ *The Times* (16/02/1955) <http://goo.gl/savWE6> (Accessed on 15/09/2015).

³⁴ ‘The Parents’ Voice’, *Newsletter* 6, 2 (Spring, 1955).

fact that a child may need special care. Often those who “look want” turn out to be highly intelligent, and live useful and fruitful lives, whereas many “picture book” babies prove to be seriously handicapped in later life.³⁵

The APBC tackled the popularity of euthanasia in a constructive manner. The first essential task was research. Increased knowledge of the causes of ‘deficiency’ could possibly prevent babies from being born ‘defective’ in the first instance. Widespread euthanasia would ultimately hinder research and understanding. Fryd declared: “Alderman Dingley’s proposal would undermine what incentive exists to prevent these tragedies.”³⁶ Secondly, it was suggested that the correct training of ‘mental defectives’ would prevent them from becoming burdens on their families or the state. Fryd proposed that if the progress being made in these facilities was better known, it would support the APBC’s campaign to triple the amount of said facilities. Improved research and education techniques had dramatically improved the educability of many ‘defectives’: “Visit any special school or occupation centre and see what can be done with unpromising children.”³⁷ Ultimately, the APBC believed that if individuals with ‘mental deficiencies’ were treated equally and provided with suitable opportunities for their needs, the gross suggestion of euthanasia would fail to gain popularity and cease to be mentioned.

During the National Convention in the summer of 1955, Alderman Dingley caused great surprise by attending and addressing the parents about his recent comments. He was applauded by many for his courage in doing so. Dingley elaborated on his previous ideas put forward to the Royal Commission, for which he was criticised in the press. However, this criticism was explained to be borne from “mainly a failure to read what his proposal actually

³⁵ Ibid. Felicity was described as a ‘picture book’ baby by Fryd herself, but spent the majority of her life in institutions due to her disruptive and difficult behaviour. See D. Cohen, ‘Judy Fryd: They Told Me My Child Had No Mind’, *The Telegraph* (23/08/1996) <http://www.independent.co.uk/life-style/they-told-me-my-child-had-no-mind-1310998.html> (Accessed on 07/03/2013).

³⁶ Ibid.

³⁷ Ibid.

was.”³⁸ Fryd’s explanation continued: “He believed that some children were too hopelessly handicapped that it should be possible (not, he emphasised, compulsory) for the parents to appeal to a panel of people, both lay and medical, for “euthanasia” or merciful death for their child.”³⁹ Dingley suggested the motivation for his proposal was because the current system was impossibly cruel, in his opinion. Dingley believed that the problem of ‘mental deficiency’ and the parents’ predicament was colossal in nature and events such as ‘Flag days’ were insufficient. The scale of the problem, he insisted, was evident by the lack of hospital beds, facilities and research. He emphasised the message received by parents: “You have given birth to a defective child, and you shall bear the whole burden of care until it grows older; and when you have grown to love it, we will take it away from you and put it into an Institution.”⁴⁰

Dingley did not wish to force his policy on any parent, but felt that a degree of control would be maintained over the policy and an extra amendment should be: “Thou shall do no medical hurt to another.”⁴¹ In response to Dingley’s clarification, Fryd once more asserted that efforts would be better focused on research. Greater knowledge, it was believed, would help parents to overcome their fears and feelings of helplessness and inadequacy. Sydney Irving (MP for Dartford) stated in his first speech to Parliament: “Britain can’t afford to neglect this problem.”⁴² Irving suggested that progress on the problem of ‘mental deficiency’ did not lay in the realms of euthanasia, but rather in the vigour with which causes and treatment research was sought. He implored the Minister of Education to insist that the Government leave no avenue of research untouched due to a lack of expenditure. At the end of his speech, Dingley was told that whilst the Association had not failed to understand his proposal or motives, many still fundamentally disagreed with his concepts. Regardless, all

³⁸ ‘The Parents’ Voice’, *Newsletter* 6, 3 (Summer, 1955).

³⁹ *Ibid.*

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

⁴² ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

attending the convention were grateful for Dingley joining them and comprehensively explaining, and dispelling any misunderstanding about his proposals. It was surmised: “Too often parents had been “brushed off” by those whom they consulted, who felt that parents could not understand or should not be bothered with technicalities.”⁴³

In late 1954, the Kent branch’s journal *The Watchman* published the article titled ‘What must we do now?’ The article declared that the APBC had become a powerful association capable of achieving its goals. The question became ‘what must our next step be?’, and to answer this the branch felt it appropriate to first address the aims of the APBC, namely:

We should hold that this Britain of ours should direct its Medical Service to give its best to prevent the birth of mentally handicapped children. And so long as medical science fails in this task (and fail it may for generations to come) then for so long should the nation accept as a bounden duty the care of all the mentally handicapped.⁴⁴

The idea that parents wished to eradicate ‘mental deficiency’ from society altogether is an interesting one, and one which starkly contrasts the many stories of families living happy and enriched lives because of their ‘backward’ child, not in spite of them. This notion also contrasts the idea of embracing differences and disability and encouraging understanding and acceptance. Instead the branch suggested these individuals must be tolerated until the underlying causes of their conditions, and thus these future persons, could be eradicated from society. This sentiment echoed early eugenic ideas of removing the ‘weak’ from society by breeding methods. However, the branch asserted the need for greater public awareness of ‘mental disability’. Their charter was as follows:

⁴³ ‘The Parents’ Voice’, *Newsletter* 6, 3 (Summer, 1955).

⁴⁴ ‘What Must We Do Now?’ in ‘The Parents’ Voice’, *Newsletter* 6, 1 (Jan, 1955), pp. 4-5.

To those of us who have these children, it asks no more than common humanity, but of the Nation it asks for more – it calls for a change of heart. In the spirit of the Good Samaritan, a Christian Nation should have compassion on their children, when ill in body as well as mind, and should take them to its heart. Every mother should dwell long on the struggle that there, but for the Grace of God, pray one of hers. Few people, whether they have a mentally handicapped child or not, can contemplate the treatment of these children and their souls without shame.⁴⁵

The Policy of Physical Exclusion in the Twentieth Century

Because of the lack of support for sterilisation/euthanasia ideas, institutionalisation had become an integral part of public policy in the USA, as in the UK. In the USA, thirty-one states opened institutions for those specifically declared to be ‘feble-minded’, mentally ill, epileptics and ‘retarded’, and the American process of institutionalisation rapidly expanded. According to Martha Field and Valerie Sanchez, in 1900 there were 9,334 persons in American institutions declared as ‘mentally retarded’. This figure increased to 68,035 by 1930.⁴⁶ In England the figures were similar. The results of the 1947 MoH report, Annual Report on the Lunacy, Mental Treatment and Mental Deficiency Acts were given: the number of ‘mental defectives’ under statutory care in 1946 was 101,805, this increased to 130,321 by 1947. In 1947 there were 54,229 ‘mentally defective’ persons residing in institutions, of which 7,592 were under the age of 16. 3,474 young persons under the age of 16 attended occupation centres daily. Finally, the total number of children reported to the authorities as ‘ineducable’ or in need of supervision upon leaving school was totalled to be 3,799.⁴⁷

⁴⁵ Ibid.

⁴⁶ Field and Sanchez, *Equal Treatment for People with Mental Retardation*, p. 10.

⁴⁷ Figures from ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

However, Fryd was keen to assert that these figures were by no means comprehensive. She believed many ‘defective’ individuals were not reported as needing supervision until they had committed an act of juvenile delinquency. Moreover, the MoH report failed to account for those who were privately educated, and not reported to the authorities as ‘ineducable’. Children under 5, few of which were institutionalised or admitted to occupation centres, were also excluded from the report. Regardless, these figures were able to express the rapid increase in institutionalisation in both the UK and the USA. In the USA a growth of 86.3%⁴⁸ was documented in institutionalisation over thirty years. This is approximately a growth of 2.9% annually. Comparatively, the English rate of institutionalisation rose 1.5% per annum. Whilst there were similarities between the English and American processes of institutionalisation, it is pertinent to note that there were also several important differences. Most prominent of these is the legalisation of forced sterilisation in American institutions.

Parents were often unaware of their legal rights concerning their child and institutionalisation. Authorities made little attempt to inform parents, often due to a lack of facilities and understaffing. The APBC provided alternative methods of informing parents of their rights. In July 1953, the APBC set out their latest policy aims which included advice for parents on the matter of the law, delinquency, and their ‘backward’ child. The APBC policy stated:

No child or adolescent ascertained as E.S.N. or Ineducable should be brought to trial in an ordinary court until the Mental Health Department of the Local Health Authority had been notified. A medical officer from this department should attend in person to give his opinion and advice.⁴⁹

⁴⁸ Estimation of growth based upon figures supplied in Field and Sanchez, *Equal Treatment for People with Mental Retardation*, p. 10.

⁴⁹ ‘The Parents’ Voice’, *Newsletter* 4, 3 (July, 1953).

In cases where the offender had a degree of insight, and punishment was deemed necessary, the penalty should not be a prison sentence or exclusion to a ‘colony’, but rather a hostel with available psychiatric treatment. The policy suggested that the legal variations in terminology were unnecessary, confusing, and often misapplied. Arguments for clearer legal definitions were made. “Moral delinquent”, it was argued, should be replaced by the term “socially inadequate” and all other groups referred collectively as “mentally defective”.⁵⁰

In January 1951, the APBC provided a lecture entitled ‘Your Child and the Law’. The lecture highlighted the distressing lack of accommodation and staff available for ‘mentally defective’ persons. Long-term residential care was organised by the Regional Hospital Boards. In Monmouthshire, Scotland, it was established that children were admitted to ‘mental deficiency’ hospitals by the age of 2 and a half where necessary. However, the term ‘mentally deficient’ was not applied to the child until school age when proper assessments could be made. Hospital Boards were only able to absorb approximately 11% of cases per week, this resulted in many persons completely or partially lacking in provisions. Dr John F. Galloway, the Medical Office Administrator for Wolverhampton, declared: “Nowhere are the evils of divided responsibility more evident than in the care of mental defectives.”⁵¹ Galloway continued to explain that roughly 7% of patients admitted to mental hospitals (and he presumed that this figure would also apply to ‘mental deficiency’ hospitals) became chronic or long-stay patients. However, finding suitable guardianship for individuals with ‘mental deficiency’ remained one of the biggest issues in the care for the 93% of persons not confined in ‘mental deficiency’ hospitals. Members were encouraged to provide suitable guardianship where possible to avoid unnecessary institutionalisation. Some members felt that provisions were inadequate and private facilities were the only available option. Private facilities for ‘ineducable’ children were not, however, available for the Education authorities

⁵⁰ Ibid.

⁵¹ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

to utilise. Subsequently, parents who intended to send their child to such facilities were required to pay fees in the range of £200-£400⁵² per annum.

Fryd believed that it was important to insist that in the decision of whether or not to institutionalise a child (and if so, where) there was no definitively correct option:

There is no rule of thumb which can be applied to all cases; from time to time individuals are heard to say that “all these children should be away in Institutions” or alternatively that “the best of Institutions is no substitute for a good home” and parents often are terrified of doing the wrong thing, or of incurring social displeasure by taking a decision which others consider unwise. It is most important that no pressure should be brought on parents either way, either directly or by implication.⁵³

Despite the alarming increase in institutionalisation, by the mid-twentieth century institutionalisation and the process of separation had altered. Like Langdon Down, the APBC recognised the importance of segregating adult patients from ‘backward’ children. Exceptional cases of ‘high grade’ adults acting as helpers for the staff were occasionally permissible. The NAPBC policy stated: “Children admitted to Mental Deficiency Institutions should be regarded as a separate problem and adequate training comparable to that provided in the community should be available for such patients as can derive benefit from it.”⁵⁴ Automatically institutionalising ‘maladjusted’ or ‘deranged’ children was considered to be an inappropriate response. Instead, the expert opinion of a child psychologist with a special interest in the problem of ‘mental deficiency’ and childhood psychosis should be consulted. Placing ‘maladjusted’ children in institutions was aggravated by the problem of vacancies filled by juvenile delinquents who were not considered to be ‘mentally deficient’. Fryd was keen to mention that some ‘backward’ children adjusted well to institutionalisation.

⁵² Approximately £4,000 to £8,000 in today’s currency.

⁵³ ‘The Parents’ Voice’, *Newsletter* 8, 1 (Feb, 1957).

⁵⁴ ‘The Parents’ Voice’, *Newsletter* 4, 3 (July, 1953).

Reiterating the need for parents to assess the specific needs of their child and the suitability of residential care on an individual basis, Fryd wrote:

Some children settle happily in institutions. Others are better in a place where more individual attention can be given. Others again would be far better living in their own homes and attending schools daily. We believe that there should be a real freedom of choice in the matter – the criterion should be, what suits this particular child and his family, not the length of the parents’ pocket or the generosity or otherwise of the local authority.⁵⁵

Fryd believed that it was the Association’s duty and responsibility to reassure parents and eliminate the fear surrounding the subject of residential care. To help with this, the Association organised regular visits to institutions. During visits parents were greeted by a number of MPs able to provide support, and meet with other parents in a similar situation. It was hoped this would lead to a greater understanding of the complexities of institutions, and ultimately result in better facilities and amenities. One member spoke about his 17 year old daughter’s expectations in an institution. G.R. Henderson’s (Newcastle branch Secretary) daughter was admitted to Northgate and District Hospital. Henderson declared it clean and bright with sympathetic and understanding nurses who suited his daughter’s good disposition. Overall, the patients at Northgate seemed happy, at ease and had a sense of camaraderie with no fear of being restrained. For Henderson, “the staff who do so much for the welfare of these charges, must sometimes wonder whether the patients’ relatives, when they come to visit, really understand and appreciate all that is done for the welfare of the patients.”⁵⁶

Despite this, Henderson explained that his daughter was unhappy at her new home; she was homesick and unable to relax. Henderson stressed the importance of allowing their

⁵⁵ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

⁵⁶ ‘The Parents’ Voice’, *Newsletter* 6, 2 (Spring, 1955).

daughter a little time to process the change in her surroundings. After a week their daughter had been assigned a buddy (another patient) to help look after her and she seemed a little happier. Their daughter's days were filled with occupational therapy classes, and other patients had learned to accept her and became friendly towards her. Following their initial visit, Henderson noted that on progressive visits their daughter was happier each time and less lonely than she was at home; she was no longer bored from having no one to play with. Henderson concluded: "We no longer worry about our girl. We know she is in good hands surrounded by kindness and love, and we are grateful to the staff and patients who have done, and are doing, everything they can for her."⁵⁷

The Consultant Psychiatrist, Medical Superintendent of Northgate, and the President of Ashington and District Society for Mentally Handicapped Children, C. Guy Millman (MRCS, LRCP) also spoke of this 'happy hospital'. Northgate was described to be the most northern 'mental deficiency' hospital in the country. Like all others, Northgate was overcrowded and understaffed; yet, it had more staff than most hospitals. Regardless, the majority of visitors remarked that the hospital was a happy one. Millman attributed this positive atmosphere to the shared knowledge from all parties involved. Organisations such as the APBC and Friends of the Hospital, helped to raise money for the hospital. As a result of the goodwill experienced, members without a 'backward' child and concerned professionals were quickly drawn to the Association (many were friends of staff members).

Stories and examples of good institutions featured prominently in the quarterly editions of *Parents' Voice*. One unnamed mother communicated her experiences of the Hill House Hospital in Rye, Sussex. The parents and individuals connected to the facility felt it was much more than a hospital. The mother felt that the term 'home' was more suitable as everyone appeared to be a part of a big, happy family. She explained how there were no set

⁵⁷ Ibid.

rules or times for visitation. No locked doors and no restrictions were placed on where visitors could go; questions were welcomed, encouraged and fully and honestly answered, parents were treated as friends by staff, and each child received individual care and attention. In the three months since the author's son had been admitted, he had progressed greatly. Previously he was unable to help himself in any way, but within three months he was able to make an effort to walk. Other children who were similarly 'helpless' on admittance had learnt to walk, feed themselves, and some even made progress in terms of speech and conversation. The mother discussed the nurse's clear ambition: "That each child will be able to go back and take his place among family and friends, without being a burden to everybody."⁵⁸ She further commented: out of the 366 patients residing in Hill House (over 4 years) only 20 had been discharged. This was attributed not to a lack of suitable skills provided, but rather because the patients themselves did not want to leave; they had finally found a place where they fit into the world in their own way. However, large, impersonal institutions were still considered to be an inappropriate solution to the problem of 'mental deficiency'. The Fountain Hospital's Annual Report of 1951 stated that "If a defective child is to learn to live in the community when he grows up, as so many could do today under the existing welfare services, he must not be isolated in large Institutions, but be given the maximum of supervised contact with the world."⁵⁹ However, this liberal opinion was not dismissive of the shortcomings and failings of institutions either. Fryd suggested that focusing on single aspects presented an inaccurate portrayal of institutional life, and those who were a part of the system. In May 1949, she discussed the Royal Eastern Counties Institution (RECI) in Colchester, suggesting that it was a "very good place for research, and the best place in the country for Brain Injuries."⁶⁰ Tellingly, Lionel Penrose had conducted one the earliest attempts to research the genetics of 'mental deficiency' at the RECI. Fryd proposed institutions were neither positive nor

⁵⁸ 'The Parents' Voice', *Newsletter* 7, 1 (Feb, 1956).

⁵⁹ 'Opening of Osbourne House' in 'The Parents' Voice', *Newsletter* 4, 1 (Jan, 1953), p. 4.

⁶⁰ 'APBC', *Newsletter* 2, 3 (May, 1949).

negative, but rather fell within a scale of acceptability. Fryd refused to automatically equate institutionalisation with the socially damning consequences with which it would later be conflated. Fundamentally, she believed this approach was neither practical nor helpful for parents with few options. For many the dichotomy between the lack of realistic alternatives and the waning trust in institutionalisation posed a dilemma. As Fryd explained:

So far as the parents are concerned, we are all faced with the problem of what is to become of our children, and we each have to make up our own minds after weighing the pros and cons. The trouble is, that the parents without money have no real choice – for them, its institution or nothing. The more fortunate can choose a small home if they think it is the best place for their particular child.⁶¹

It is worth noting in June 1950 after exhausting all other possibilities, Fryd allowed her daughter to be sent to a series of institutions at the age of twelve. Fryd did not wish to condemn institutions or the parents who chose to send their children to them. The APBC were keen to dispel the myth that children were institutionalised because their parents did not love or want them. The media often wrongly portrayed reformers as comprehensively dismissing the use of institutions. Published articles referencing her name had often been embellished to make it appear as though she frowned on institutionalisation. “The material which I submitted [to the *Sunday People*],” she noted, “has been “hotted up” with colourful phrases and sensational headlines.”⁶² Eager to explain why she had submitted material to the magazine initially, Fryd continued:

The purpose of them [the articles] was to bring home to the 5 million readers of that paper the suffering that exists among parents of backward children. Such are the ways

⁶¹ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

⁶² *Ibid.* Unfortunately, I have been unable to locate a copy of the original article discussed by Fryd due to a lack of specific details.

of the Press that some sacrifice of personal dignity is inevitable, but if our object is achieved it will have been worth it.⁶³

As a result of the vilification in the media, Fryd was quick to correct the torrent of misquoted information. She reaffirmed that institutions could be both a positive and negative experience. Presenting an unnecessarily negative view of institutions created unrest amongst the lower echelons of society who were given little other practical choice than institutionalisation: “Many parents at present favoured Institutional care because of the lack of community services and uncertainty regarding the future.”⁶⁴ For many parents, institutionalisation was the only realistic option available to them once their child reached puberty. Adolescent ‘defectives’ were often harder to cope with in the family home.⁶⁵ Other reasons families wished to find residential care for their child included: if the mother was unable to cope; if the child would benefit from the company of others like them; and if a child was deemed ‘ineducable’ but no occupation centre was available. If LEAs had no place for ‘normal’ children in the area they could opt to pay for private facilities. However, this option was inapplicable to ‘ineducable’ children, resulting in parents having little option than to institutionalise their child for the sake of its education. Parents found it reassuring that state-run institutions could not expel their child, having gained a place, unlike privately run facilities, occupation centres or special schools.

Additionally, many institutions were able to offer occupation and training for their residents. School departments within institutions worked in a similar manner to many occupation centres and special schools; this was necessary as there were often many ‘high

⁶³ Ibid.

⁶⁴ ‘The Parents’ Voice’, *Newsletter* 5, 1 (Jan, 1954).

⁶⁵ Fryd provided a good example of parents altering their opinions on institutionalisation in J.P. Frank, *My Son’s Story* (London: Sidgwick & Jackson: 1952). John Frank, a Professor of Law and his wife, Lorraine’s first-born son Petey was diagnosed with Cortical Atrophy and predicted to be ‘backward’, have no future and die young. The Frank’s struggled with Petey’s diagnosis and the subsequent demands of his condition. Initially reluctant to institutionalise their son, Petey’s parents came to the realisation that placing him in residential care would be the best option for themselves, Petey and their second child on the way. Fryd considered this to be an informative and illuminating document for parents in a similar situation.

grade' patients in institutions. Matters were similar in the US. The editor of *Children Limited Journal* of the Association for Retarded Children, USA, Eugene Gramm echoed the idea of inevitability in matters of residential care:

Overshadowing all this is the prospect [...] before all parents of a mentally deficient child, that unless death intervenes, the day MUST come when we shall for all time surrender our child to the care of strangers in a mental deficiency colony. We yield to some in our admiration and gratitude for the loving care that the doctors, nurses and even other patients give to the children. We, for our part, will prepare ourselves and our children for the inevitable. Till the day comes, we will care for and guard them even more devotedly than we do for their more fortunate brothers and sisters, we will teach them to love and respect [...] and to be ready in due course, to take their place as cheerful, even useful members of the colony where, sheltered from the harder world, they will live out their lives.⁶⁶

Whilst Gramm presented an optimistic view of institutional life, unfortunately this was not always the reality of 'mental deficiency' hospitals in the UK and the USA. Many parents feared the commonly presented negative opinions of institutions were grounded in fact. Fryd frequently suggested improvements needed in individual institutions, and the system itself. The APBC urged the improvement of institutions to be multifunctional and provide educational, healthcare and practical facilities for residents. It prompted Fryd to declare: "We did not want Institutions; we wanted Schools."⁶⁷ Many reformers believed that institutions were most effective when they did not permanently segregate individuals, but rather taught them how to participate with the community.

It would be unfair to claim that all institutions operated and treated their wards in the same manner. Some were able to offer older children employment and occupation

⁶⁶ E. Gramm, 'A Letter From America' in 'The Parents' Voice', *Newsletter* 6, 1 (Jan, 1955), p. 3.

⁶⁷ 'The Parents' Voice', *Newsletter* 2, 1 (Jan, 1951).

opportunities. The majority of training was divided into basic trades such as brush making and boot repairing. Industrial centres existed in some facilities and provided more in-depth and useful training schemes. Generally only trades considered to be too slow for modern factory work were taught. A. de Raadt spoke of his experience in teaching ‘backward’ children in a letter called ‘An Industrial School’. Raadt was frequently asked “how can you teach Backward Children? [...] what could you teach them?”⁶⁸ This attitude continued to pervade the social consciousness of many despite the advancements made in medical and scientific communities. Raadt felt it was important that the general public, and particularly teachers in his opinion, understood the differences between the occupation centre child⁶⁹ and the child which required institutional care:

Some of the children come from broken homes, some have been found the type of child that easily runs into danger or trouble, so it is for their own safety that they should be looked after in an institution [...] And of course, there is the group of children who need nursing day and night, and how many mothers really could cope with that sort of thing without help?⁷⁰

Raadt suggested most of the children in institutions belonged to one of the aforementioned categories. His assessment failed to account for children which the authorities had failed to make any adequate provisions for whatsoever. These children were given little other choice than institution. He continued on to describe the behaviours of such children and proposed possible courses of treatment: “They are a difficult bunch of children, restless, sometimes

⁶⁸ ‘The Parents’ Voice’, *Newsletter* 5, 1 (Jan, 1954).

⁶⁹ Whilst similar, occupation centres should not be confused with the history of occupational therapy. Occupation centres acted as a combination of medical care and educational training. More has been written on the subject in ‘Chapter Four, Occupation Centres: A Suitable Substitute?’ of this dissertation.

⁷⁰ *Ibid.*

wild, often tearful and homesick and very often maladjusted. What on earth could we do about that? The answer is: keeping little hands and minds busy.”⁷¹

Raadt spoke of the children’s daily routine in a typical institution and suggested that this was a good example to follow. The day typically began with a hymn and Morning Prayer. After which a discussion of the weather took place and it was decided who was going to serve the milk that morning. This was usually followed by playtime, including running around, bouncing balls and shouting excitedly. During this time arguments and quarrels were settled. Following this, a short break was taken and a cup of Bournvita was served. The morning session was finished with various activities including a choice of: painting, modelling, colouring, drawing, story time, speech rhymes, apparatus to work with, bead threading (for the younger children), puppet making or papier-mâché (for the older children), number/arithmetic or spelling work (for the more ambitious children), or a request for a toy could be made providing arguments did not ensue and the toy was not broken. After lunch, the afternoon session resumed with simple handcrafts which the children took to enthusiastically, and music and games were played as an important feature. Raadt commented on the importance of activities and games in the children’s routine and how the children benefitted from the experience:

The children learn to co-operate with each other, tolerate each other. Their senses are trained, they have learned to observe things, to take notice of happenings [...] Is it not wonderful for our children to have that feeling of achievement, of being useful, of being wanted? Teaching the backward child may be difficult and tedious, but it is a privilege to those who dare venture into it, for there is much affection and gratitude to be received.⁷²

⁷¹ Ibid.

⁷² ‘The Parents’ Voice’, *Newsletter* 5, 1 (Jan, 1954).

Raadt's recounts of institutional life were particularly useful and illuminating for parents considering the decision. Raadt's use of 'our children' implied a sense of community and allayed many fears of uncaring institution workers.

In November 1957, the Association published a section entitled 'How to Improve the Mental Deficiency Hospitals' exploring the tentative suggestions proposed by the Friends of Leybourne Grange, Kent. The main function of institutions was deemed to be to provide shelter and accommodation for 'mentally defective' individuals who cannot live in the community. In addition to providing shelter, it was felt important to prevent patients' mental deterioration, and to provide medical attention for the variety of commonly associated illnesses. Special training should be provided to the very few patients thought to be able to return to the community; this should be facilitated by two clearly defined sets of staff of similar rank – those responsible for medical and nursing duties and those responsible for non-medical duties. In particular medical staff in 'mental deficiency' hospitals needed strengthening. Psychiatric⁷³ and occupational therapy⁷⁴ services had proven to be beneficial when extended. Ideally, many called for remedial therapies, including speech therapy, to be provided by institutions. It was suggested that a large improvement could be made in 'mental deficiency' hospitals if the responsibilities of trained nursing staff was restricted exclusively to nursing duties. It was felt this would help attract more professionals to the field. Career values and financial prospects should also be improved to attract dedicated and qualified persons to the field and accommodate for the often difficult and unrewarding work. Non-medical staff should be responsible for the supervision of a trained, university graduate

⁷³ For a history of the psychiatric profession see: P. Bartlett and D. Wright, *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: The Athlone Press, 1999); E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (London: John Wiley & Sons, 1997); M.S. Micale and R. Porter (eds), *Discovering the History of Psychiatry* (Oxford: Oxford University Press, 1994); W.F. Bynum, R. Porter and M. Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry* (London: Routledge, 2004), and E.R Wallace and J. Gach (eds), *History of Psychiatry and Medical Psychology* (New York: Springer, 2008).

⁷⁴ For a detailed history of occupational therapy see: J. Creek and L. Lougher (eds), *Occupational Therapy and Mental Health* (Amsterdam: Elsevier, 2008), and K. Diasio Serrett (ed), *Philosophical and Historical Roots of Occupational Therapy* (Philadelphia: Haworth Press, 1985).

standard sociologist. Included in the non-medical staff sector, should be professionals in management, catering, diet, clothing and specially qualified staff for teaching and training. These staff members would ideally work closely with LEAs and LHAs in the close supervision and occupation of all patients. Lastly, the duty of keeping parents involved and informed in their child's care would fall to an almoner in larger hospitals. The APBC understood that some 'mentally defective' individuals would require residential care. Yet, this should not hinder the individuals' possibility to make every effort to return to the community with the necessary skills for employment.

As a result many institutions in Britain began to operate as large special needs schools or training centres. In several institutions efforts were made to include patients (both long-stay and daily attendees) into the community by hosting employment workshops where individuals could learn needed skills for the job market. Occupational activities for patients (particularly 'high grade' patients) allowed for both routine and development of practical skills. To nurture this, greater financial reward, maximum permissible freedom, and special leisure facilities, and longer working hours were suggested. Though, these workshops were not an unmitigated success; issues with transporting individuals to the facility arose, and some parents of daily attendees objected to their child mixing with certified patients. Eventually, the scheme at Leavesden Hospital, Hertfordshire was dropped on economic grounds. Despite this initial set back, Fryd was keen to explain that the scheme was not unviable. However, greater consideration was needed. Dr Neil O'Connor of the Social Psychiatric Unit, Institute of Psychiatry at the Mandalay Hospital, London, declared: "We must not only train defectives to live with us, but we must train ourselves to live with them."⁷⁵

⁷⁵ 'The Parents' Voice', *Newsletter* 9, 1 (March, 1958).

The subject of patients' treatment in institutions was also a common discussion for the national press.⁷⁶ Participating in this discussion were representatives from the MoH who explained how many people did not understand that a wide variety of persons in institutions were governed by different Parliamentary acts, such as the Lunacy and Mental Treatment Acts 1890-1930, and the Mental Deficiency Acts 1913-1938. The APBC believed that one of the major tasks facing them was to get the general public (specifically those without a 'backward' child or ties to one) to closely look at 'mental deficiency' hospitals. If this were to happen, it was felt by all that the public would not hesitate to pay for the necessary improvements to be made: "a real impact can be made in public opinion for the benefit of our forgotten children."⁷⁷ This was later furthered to justify the level of expenditure needed for practical change. Ultimately, for the necessary improvements to be made in the mental health sector a vast increase in expenditure was needed. Fryd believed that the majority of this could be found in the general public if they understood the challenges facing this marginalised group. Fryd exclaimed:

Let the Minister be bold, and make the mental health services a national responsibility. Let us have the equivalent of a military operation to tackle this problem [...] For it is not beyond the wit and resources of this great nation to solve the problem [...] The less a child could give itself, the more other people had to give it. It was an act of wisdom, and not charity.⁷⁸

⁷⁶ Examples include: 'Study Of Hospitals And Laboratories', *The Times* (28/01/1954) <http://goo.gl/zHL9Bb> (Accessed on 15/09/2015); 'Obstacle To Mental Treatment', *The Times* (03/02/1955) <http://goo.gl/Srij7X> (Accessed on 15/09/2015); 'Food In Mental Hospitals', *The Times* (10/06/1955) <http://goo.gl/UVRWtA> (Accessed on 15/09/2015); and 'Care Of Mental Sick', *The Times* (16/05/1952) <http://goo.gl/v4n4ya> (Accessed on 15/09/2015).

⁷⁷ 'The Parents' Voice', *Newsletter* 7, 4 (Nov, 1956).

⁷⁸ 'The Parents' Voice', *Newsletter* 7, 1 (Feb, 1956).

Fryd expanded on this idea in March 1958, to include a change to the extent: “such a change of heart that the public can accept the ‘one talent child’ as first, foremost and fully a HUMAN BEING, with human rights and needs.”⁷⁹

In his foreword to the 1955 report to the MoH, Robert Turton (Minister of Health 1955-1957) expressed his view that the main priorities facing the government were: to bring existing hospitals up to a satisfactory standard and provide new premises as far as possible; to ensure that mental health services received an appropriate share of resources, suitable for the necessary alterations to be made; and finally, to tackle the problem of making adequate provisions for the care of the elderly. Turton believed that the problems regarding mental health services were among the most difficult facing the MoH. Parents, who thought that it may be likely that their child may need a place in an institution in later life, were advised to join the waiting list as soon as possible in the hope of securing a place in the future. In the cases of emergencies (such as the death of parents), queue jumping was a possibility, but the situation would need to be vitally urgent. Even still, many institutions had long waiting lists of urgent cases. Waiting lists often had disastrous consequences for both the child and family of those placed on them. Many believed that the waiting lists were a direct result of overcrowding and understaffing. Whilst new schemes for more beds were continuously being devised, under-staffing accounted for 1,273 beds in 3 hospitals unoccupied. Subsequently, Turton proposed that improved clinical and social treatment facilities were needed. Turton found it remarkable that the MoH’s latest report contained more than one page entirely dedicated to the mental health services. Despite Turton’s optimism, the report was 124 pages in total length, leaving the consideration of the mental health services still very much a minority. Fryd countered: “it is up to this Society to disabuse them of this notion.”⁸⁰

⁷⁹ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

⁸⁰ ‘The Parents’ Voice’, *Newsletter* 8, 1 (Feb, 1957).

Certification and Admission

The MoH was the central authority for the administering of the Mental Deficiency Acts to those to whom it applied. The definition of ‘mental deficiency’ given in the 1927 Act was as follows: “A condition of incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury.”⁸¹ Under these Acts, it was the MoH’s responsibility to provide institutional accommodation for ‘mentally defective’ persons; this was typically administered by the Hospital Management Committees. The Board of Control acted independently of the MoH, had quasi-judicial powers and duties including the admission and discharging of patients, periodic review of cases, visitation and inspection of institutions. In order for an individual to be treated under the Mental Deficiency Acts by their LHA, two medical practitioners (one approved by the Board of Control/LA) were required to provide certificates for the consideration of a magistrate. Upon this, a magistrate had the opportunity to grant an order for the ‘mentally deficient’ person to be sent to an institution, on the grounds that said person needed more care or training than could be provided in the familial home. Alternatively, the order may be granted if the home situation was insufficient or unsatisfactory causing the individual to be unstable in temperament or conduct. In extreme cases (where there was no time for the aforementioned formalities) a ‘mentally defective’ individual could be removed to a ‘place of safety’ under Section 15 of the amended NHS Act. The aforementioned individual would be detained in the ‘safe place’ until the necessary formalities could be conducted. Alternatively, a child could be sent to an institution if a court deemed it so, or if a parent decided that it would be the most suitable course of action. In the case of the former, a criminal court could make an Order for a person charged to reside in an institution based on the opinion of one medical professional. In the latter case, a parent/guardian could make provision for their child to relocate to an institution

⁸¹ ‘Should Children be “Certified”?’ in ‘The Parents’ Voice’, *Newsletter* 6, 1 (Jan, 1955), pp. 7-8.

under Section III of the Mental Deficiency Act without recourse to the LHA. In this circumstance two signatures were required, one certified by the LHA or MoH. In the case of the ‘deficient’ or ‘feebleminded’ under the age of 21, but not considered to be ‘imbecilic’ (though ‘backward’ enough to require care and supervision for the protection of themselves and others), the signature of a magistrate was also required. Many parents posed the following question, regarding the matter of certification and admission:

Is it necessary to “certify” children as mentally deficient at all – especially in view of the cases one knows, or hears about, or mistaken diagnosis of physically handicapped children as defectives? Should the “Section 3” procedure be adopted in all cases? What about children whose parents unnecessarily refuse to let them enter Institutions when their own interests and those of the community who require it? In these cases who is to be the arbiter of the child’s fate?⁸²

Additionally, parents were concerned about the authorities’ right to remove their child from their care. Similarly, parents were confused about whether or not they had, or should have, a right of appeal against this. Cases were reviewed at the end of the first and second years of institutionalisation, and then again after five years and upon reaching the age of 21. During these reviews, the Medical Superintendent and a representative of the Board of Control were present. Notably, a parental presence was lacking and many argued this did not ensure all factors of the individuals’ life were represented. The option of placing a ‘mentally defective’ person on license, meaning the individual was released to their home, parent or guardian for a period of time, whilst still being under the responsibility of the MoH/institution, was increasingly used. Many parents were sceptical that after admittance to an institution their child would actually be released if suitable. The following question was posed: “Is it safe for us to assume therefore that certification does not, in the opinion of this Association, constitute

⁸² Ibid.

a danger to the future liberty of patients who may recover to an extent, or whom home conditions have improved to an extent to permit discharge?”⁸³

Questions were raised about the usefulness of magistrates in making these decisions and whether or not they adequately represented the lay perspective. At the Annual Convention in Liverpool, 1952 it was decided that the hospital management committees of ‘mental deficiency’ hospitals should be encouraged to include representation of parents or guardians of patients on their boards.

The need for a change in certification was further explained by the Association in August 1957. ‘Backward’ children could be certified and removed to an institution without their families’ consent if the authorities believed the child to be ‘in need of care and protection’ under the Children and Young Persons Acts. The Royal Commission proposed children in this category to be dealt with according to the Children Act of 1948. This allowed LAs to take charge of the child, assume parental rights and arrange suitable care or alternative measures where necessary. Children who were neglected or cruelly treated and those whose family life had broken down would also be protected under this system. The family retained the statutory right of appeal in Quarter Sessions, or had the right to a review of the circumstances by the Mental Health Review Tribunal, but this would not occur more frequently than once a year. Many parents were unaware that residential care for their child could be obtained without the need for certification. Under Section III of the Mental Deficiency Act a child could be admitted to an institution or Approved Home on the application of the parents and the consenting signatures of two physicians (providing a vacant bed was available in the area.) Parents may also apply for a child to be admitted at short notice on the grounds of ‘neglect’ in domestic emergency. Despite this, waiting lists for

⁸³ Ibid.

facilities were extremely long and heavily dependent on home circumstances in matters of priority. The APBC explained:

Orders are made for an indefinite period, but must be reviewed at the end the first and second years, and at intervals of five years, and when the age of 21 is reached. On these occasions, parents wishing to apply for discharge may submit independent medical evidence and also state which means of care and supervision are available.⁸⁴

An example of this in action was the Fountain Hospital; all of the patients at the Fountain were admitted by this process, as opposed to judicial authority, and many felt that this system allowed for more informed, reassured and actively involved parents. Moreover, the APBC felt that a proper and comprehensive review of each patient should be made upon admittance to an institution:

On admission to a Mental Deficiency Institution the patient should properly spend some time in an observation ward. There should be adequate facilities for medical, surgical and psychological diagnosis by appropriate specialists. Cases should be graded according to age, sex and degree of backwardness.⁸⁵

It was felt that parents should be granted regular visiting hours when a doctor was available to answer any questions the parents may have. Fryd urged parents to report instances where this was not the case, or where they were discouraged from visiting or enquiring about their child to the Regional Hospital Board. Some LAs offered extra help for parents wishing to visit their child at an institution, but without sufficient means to do so.⁸⁶ Whilst matters of certification and admission to 'mental deficiency' hospitals were outside of the remit of the Royal Commission of 1957, this did not prohibit the discussion of the subject. The

⁸⁴ 'The Parents' Voice', *Newsletter* 2, 4 (Oct, 1951).

⁸⁵ 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953).

⁸⁶ 'The Parents' Voice', *Newsletter* 2, 4 (Oct, 1951).

Commission were asked their opinion on whether parents or Superintendents should have the right to discharge a child. The APBC provided their opinion on the subject: cases were to be judged on an individual basis and the best interests of the child should always be considered. To ensure this, an independent court of arbitration that could consider both viewpoints was proposed. Moreover, Section III of the Mental Deficiency Act⁸⁷ was considered important and believed that it should be used more widely in the process of admission to institutions:

A voluntary system is urged of admission to Mental Deficiency Institutions, comparable to that now in operation under the Mental Treatment Acts. However, until legislation is altered greater use should be made of Section III of the Mental Deficiency Acts, particularly in the case of young children.⁸⁸

The APBC once more reiterated that a child could not be removed from the home and sent to an institution without the written consent of its parents or guardians, regardless of how 'defective' the child was perceived to be.

Following the proposals to the Royal Commission, the government accepted the need to change admission to 'mental deficiency' hospitals to an informal basis.⁸⁹ This would dramatically alter the relationship between authorities and 'mentally defective' individuals and their families. Chiefly, the process of entering a 'mental deficiency' hospital should be: "just like going into hospital for any other illness or disability. It will end the stigma."⁹⁰ However, this did not mean that individuals would be free to leave the hospital at their own choosing. Those who were a danger to themselves, or the public (in the opinion of the authorities) would still require certification. Despite this, the Royal Commission recognised the vast majority of cases in 'mental deficiency' hospitals were not violent, and arrangements

⁸⁷ For more information see <http://goo.gl/XW8Np9> (Accessed on 15/09/2015).

⁸⁸ 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953).

⁸⁹ More about this can be found in C. Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002), pp. 53-55.

⁹⁰ 'The Parents' Voice', *Newsletter* 9, 1 (March, 1958).

for more appropriate forms of care should be made to counter automatic detainment. This did not mean that voluntary admission was flawless. The example of voluntary patients who wished to leave the facility before adequate care and treatment had been provided was yet to be resolved. Regardless, the APBC considered the recommendations of changing the law on certification to be: “A triumph for the more enlightened attitude which has been brought about through years of campaigning.”⁹¹

Despite the lack of new legislation Fryd believed that improvements could be made to the contemporary system; namely in the form of Review Tribunals. Review Tribunals were established on a regional basis to allow patients and families the opportunity for independent investigation into the justification for confinement. Ideally the panel consisted of both medical and non-medical personnel, appointed by the Lord Chancellor in consultation with the MoH. Moreover, the chairman and regional chairman of each tribunal should be legally qualified individuals in one respect or another. Review Tribunals were better equipped to assess patients than the current Board of Control (which was felt should be abolished alongside certification.) Ultimately, the power of discharge should be held by ‘patient’s’ family, a medical Superintendent (or another suitable physician), any member of the Hospital Management Committee or Board of Governors, the Mental Health Review Tribunal or the MoH.

Parents were often confused about their rights and the question ‘can my child be certified without my consent?’ was frequently posed to the Association. No child could be removed to an institution from their familial home without the parents’ consent, with the exception of the child being presented to the court as a delinquent or if the child was assessed as ‘in need of care and protection’ under the Children’s Act of 1948. These examples were also true of ‘normal’ children. However, ‘mentally defective’ children were incarcerated in an

⁹¹ Ibid.

institution by default. It was noted: “Under Section 15 of the Mental Deficiency Act, a child may be removed to a “place of safety” without consent if he is “neglected, abandoned, or without visible means of support, or cruelly treated.”⁹² By March 1958, Derek Walker-Smith (QC, and Minister of Health 1957-1960) announced that voluntary admission to ‘mental deficiency’ hospitals was to become standard practice. This decision was heavily influenced by the recommendations of the Royal Commission, composed in connection with the APBC:

We consider compulsion and detention quite unnecessary for a large number, probably the great majority, of these patients at present cared for in mental deficiency hospitals, most of them who are childlike and prepared to accept whatever arrangements are made for them.⁹³

A circular was issued to hospital authorities, instructing, “To admit Mental Deficients on an informal basis in the future. – To review all patients already in hospitals and recommend bringing the existing compulsory power of detention to an end whenever the patients can suitably remain in hospital on an informal basis.”⁹⁴ Hospital authorities were informed that it was their responsibility to ascertain the number of ‘mental defects’ in any given area. Supervision of their welfare and overseeing the process of admittance also fell under their remit. Prioritising facilities was to be based on a strict medical and social basis. These changes to the admission process only applied to ‘mental deficiency’ hospitals, not the ‘mentally ill’ in hospitals. Patients in the latter category were already admitted on a voluntary basis. Whilst changes were made to the admission process, changing certification was not possible without altering the existing legislation.

⁹² ‘The Parents’ Voice’, *Newsletter* 2, 4 (Oct, 1951).

⁹³ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

⁹⁴ *Ibid.*

Outdated Buildings

In May 1956, Robert Turton addressed the members of the APBC. Turton praised the medical staff in institutions and agreed that the general approach appeared to be “Victorian buildings, Elizabethan spirit.”⁹⁵ He was keen to mention that many improvements had been made and would continue to be made in institutions. Turton also remarked the APBC was having a direct effect on the changes being made in the field. The Minister praised the Association for their work and declared the progress they had made since their inception to be impressive.⁹⁶

However, the problem of out-dated buildings remained, and there was little the Association could do about the situation. Fryd felt that many authorities were unwilling to move on from the opinions expressed in the seventeenth and eighteenth centuries; many continued to think ‘any old thing will do for those duds’. Many of the ‘mental deficiency’ and mental hospitals dated back to either the seventeenth or eighteenth centuries. Most did not have modern fire alarm systems or modern lifts fitted; an unsafe and dangerous situation. Adding to the deterioration of out-dated institutions was the continuously increasing demand for them, creating overcrowding and understaffing. A 1954 report of the NHS stated:

The staffing of mental and mental deficiency hospitals continued to cause anxiety especially as the number of student nurses again showed a reduction during the year (males by 122; females by 68). The Ministry is endeavouring to overcome these difficulties by schemes for Nursing Cadets for part-timers and by more economical use of existing staff.⁹⁷

By 1957, the imbalance between male/female professionals had been tackled. Since the beginning of the year there was an increase of 19% nursing staff in mental hospitals. In ‘mental deficiency’ hospitals this broke down to an increase of male nurses by 22%, and

⁹⁵ ‘The Parents’ Voice’, *Newsletter* 7, 2 (May, 1956).

⁹⁶ *Ibid.*

⁹⁷ ‘Parliamentary Progress’ in ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955), pp. 4-5.

female nurses by 24%. This was a much welcomed reversal of the previous downward trend of female nursing personnel; suggesting that the government's campaigns and incentives were effective. In January 1955, Fryd called for:

Nursing recruits should learn that mental nursing is no less a vocation than general nursing, and that the mental ward, no less than the general ward [...] Parents of prospective nurses should ponder long and deeply before they say a word to dissuade their own child from adopting mental nursing as a profession.⁹⁸

The problem of out-dated buildings was addressed by E.M. Gleadle-Richards in March 1958. Gleadle-Richards confirmed that the MoH planned (subject to Parliamentary approval) to increase the expenditure on the hospital service from £18 million to £20 million in 1958, and £22 million in 1959-1960. Hospital boards were advised by the Ministry of their individual allocation for modernisation of hospitals. Suggested improvements to be made included out-patients departments and admission units attached to a greater number of hospitals. Despite this, the vast majority of the proposed increased expenditure was still allocated to the construction of twenty general hospitals, as opposed to mental or 'mental deficiency' hospitals.

However, some felt that the money and resources continued to be spent on institutions, despite the growing understanding that for many they were an inappropriate solution to the problems faced. A large colony for 'mentally retarded' persons was sanctioned in Southport at the cost of approximately £3,000,000 in the 1950s; money which could have been, arguably, spent building suitable schools and training facilities for those on waiting lists. When asked if parents would prefer to send their 'backward' child to an institution, or keep the child at home if appropriate help was provided, the majority opted for the latter

⁹⁸ 'The Parents' Voice', *Newsletter* 6, 1 (Jan, 1955).

choice. Despite this, for many parents the latter option was unattainable, as adequate care services and provisions were unavailable under the MoH's control of the LHAs. Members were encouraged to become a 'friend' of their local hospital to bring these issues to the fore and monitor the progress being made.

Parents described specific methods in which they were included: social gatherings and parties attended by parents and children; an 'adoption' scheme which gave an immeasurable amount of pleasure to children who had previously never received a visitor; presentations of toys, bicycles and games to the children; establishing a zoo and aquarium for the enjoyment and instruction of the children; regular coach outings for families and children; and finally, the proposed seaside vacation home. The Fountain Hospital and its Friends group were frequently used as a good example of a 'mental deficiency' hospital and the extent to which parents could and indeed should be involved in their child's care. Parents were also strongly advised to become members of the Hospital Management Committee (where available) as this would increase their position of influence.

Even the Fountain Hospital (which was regarded by many as the archetype of a great institution and a model for all others) had drab and out-dated buildings. Originally established as a temporary field hospital for tuberculosis and other infectious diseases patients in the 1890s, the Fountain was consequently run down, lacking in facilities, and overcrowded. Regardless, the Fountain was brightly decorated and had flowers throughout. Many institutions made no effort whatsoever, and all institutions were overcrowded, understaffed, and in desperate need of renovation.

The Friends of Leybourne Grange asserted that the majority of buildings used for 'mental deficiency' hospitals were out-dated. Proposals were made to replace the old asylums and work houses with villas. Each villa should hold no more than fifteen patients, under the care of two 'home parents' residing in the villa. Parents would ideally be occupational and

speech therapists and should take charge of the patients' general occupation, leisure activities and exercise routines. Incentives such as travel assistance and frequent holidays should be provided to attract suitable employees, if necessary. To an extent Fryd agreed with the proposals suggested by Leybourne Friends, proffering:

The present day policy of building large Institutions for the mentally deficient is to be deprecated. 1,500 patients should be considered as the absolute maximum number. Larger communities inevitably become more like a hospital and the patients become institutionalised that is increasingly difficult for them to adapt themselves to a life in the community when allowed out on license.⁹⁹

However, the suggestion of villas was agreed to be impractical and economically unviable by the government and Fryd. In the meantime, the Friends suggested that improvements with institutions could be made (aside from staffing and buildings) including clothing, feeding, occupation and visitation rights. Uniforms should be abolished to allow patients maximum individuality and free expression. An expert buyer for modern and suitable clothes would ideally be employed. General repair and replacement of clothing should be the duty of others, not the nursing staff. The Friends believed that simple changes to relative's visitation rights could produce a marked difference. Provisions for more and improved privacy between families were considered paramount. An almoner should be available to answer any questions on visitation days and when patients were first admitted to the facility to dispel any parental fears.¹⁰⁰ Whilst food was generally considered to be adequate in quantity, doubts were raised over the quality and variety provided; suggesting more fresh fruit, vegetables and dairy produce could be supplied. Canned food was considered to be unsuitable and advised to be banned. Likewise, central kitchens for entire facilities which generally led to poor standards

⁹⁹ 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953).

¹⁰⁰ 'How to Improve the Mental Deficiency Hospitals' in 'The Parents' Voice', *Newsletter* 8, 4 (Nov, 1957), pp. 9-10.

of food quality should be eradicated. Fryd wrote in 1956 about what she termed ‘Britain’s disgrace’: “The idea dies hard that mental patients do not care what they eat or how it is served.”¹⁰¹

In the 1955 report to the MoH, Turton focussed attention to the issue of feeding and diet in ‘mental deficiency’ hospitals. Compared to general hospitals, the diet, variety, and quality found in mental and ‘mental deficiency’ hospitals was below standard and lacking. Moreover, the portions were often too small, lacking in protein and vitamin C, and the gaps between meals were too long. In many instances light, soft and special diets were poorly planned and delivered. Subsequently, the allocation of governmental expenditure for food in ‘mental deficiency’ hospitals compared to general hospitals remained grossly different. In some areas the former was merely allocated 14/- per week, per patient. This meagre ration was inexcusable in Fryd’s opinion, she stated: “[It] cannot possibly provide a properly balanced, nutritious, and satisfying diet, even allowing for wholesale prices and some small-scale farming and market gardening.”¹⁰²

The MoH dictated greater improvement to be made in two stages concerning dietary arrangements: firstly, recipes were to be altered and amended immediately to improve nutrition standards, including greater issues per head of milk, fresh fruit and vegetables (other than potatoes), meat, and other protein rich foods. Secondly, a wider variety of dishes was recommended, with special attention to be paid to light and soft diets. A substantial meal during tea or supper was considered necessary and evening meals were encouraged to be served later, whenever possible. The MoH urged a review of kitchen staff and facilities to be made with special attention to be paid to kitchen planning in all modernisation schemes.

Whilst new and improved institutions were needed, many believed that other services were just as vital. The need for local guidance counselling for parents and their children was

¹⁰¹ ‘The Parents’ Voice’, *Newsletter* 7, 1 (Feb, 1956).

¹⁰² ‘The Parents’ Voice’, *Newsletter* 8, 1 (Feb, 1957).

strongly urged; the Family Counselling Service established by Middlesex County Council was cited as a good example. Several ‘mental deficiency’ hospitals ran out-patient clinics to provide advice to parents and their children, but did not offer in-patient services. An unnamed member of the APBC suggested that these services could be developed into a comprehensive service by including medical, civic, and educational services, more authoritative personnel, general practitioners, religious ministers, and others who had regular contact with the public. These suggestions were taken seriously and a sub-committee was established. The service was designed to tackle problems faced by families and set up an Almoner Service to visit local ‘mentally defective’ children, proffer advice and help to obtain aid when necessary.

Fryd suggested that even if members’ own children were spared these deplorable conditions, it was vital that they help in urging a nationwide inquiry to help those who were suffering. Furthermore, Fryd refused to allow the public to turn its back on these issues any longer:

There is absolutely no excuse for cruel and thoughtless neglect of elementary hygiene and comfort such as described by these M.P.s [...] One family in every hundred has a mentally handicapped child. Forty-per-cent of all our hospital patients are in mental or mentally deficient hospitals. The public must realise that “the Mental Million” allocated by the Minister of Health for expansion of the mental health services is grossly inadequate.¹⁰³

The Royal Commission welcomed the idea of replacing the “high-walled, bleak mental institutions”¹⁰⁴ with clinics or homes for 40-100 patients. The Commission lobbied for medical students studying ‘mental retardation’ in addition to ‘mental instability’; this would result in more qualified persons to staff the clinics. The newly proposed clinics/homes would

¹⁰³ ‘The Parents’ Voice’, *Newsletter* 7, 1 (Feb, 1956).

¹⁰⁴ ‘The Parents’ Voice’, *Newsletter* 8, 4 (Nov, 1957).

ideally continue with training for patients over the age of 16. However, the Commission did not believe that the responsibility of the government and facilities such as clinics/homes ended with those under their care. Instead, the Commission reported that vulnerable persons who did not require residential state care, but for whom “the conditions of the ordinary world were getting too much for them”,¹⁰⁵ should remain a priority and duty of care for the State.

Hostels: An Interim Solution

In October 1954, Lord Percy, the Chairman of the Royal Commission, addressed the Commission thus: “Has it ever occurred to you that if all, or most, of the high grade patients were kept at home or discharged to hostels, medical research might be hindered and the Institutions population would be confined almost entirely to low grade cases.”¹⁰⁶ However, Fryd responded that the presence of hostels would actually aid research. Many undiagnosed, or misdiagnosed, cases of ‘mental deficiency’ were grouped together in institutions, devoid of proper care and attention. Hostels would allow individuals to express the abilities that they did possess. Moreover, Fryd asserted that persons with disabilities had human rights and should not be treated as tools for research.¹⁰⁷ Ultimately, Fryd believed that information on both ‘high and low grade’ cases, and a comparative study could be obtained if proper diagnostic systems were established and the State did not rely on institutionalisation.

¹⁰⁵ Ibid.

¹⁰⁶ ‘The Parents’ Voice’, *Newsletter* 5, 4 (Oct, 1954).

¹⁰⁷ The twentieth century witnessed non-therapeutic research on non-consenting individuals in institutions and hospitals across Europe and the USA. Following the end of WW2, several international organisations supported the ban of non-therapeutic research on the mentally incompetent. This included the Nuremburg code of 1947: “the voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint nor coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.” Further to this, the World Medical Association Declaration of Helsinki: Recommendation Guiding Physicians in Biomedical Research Involving Human Subjects, June 1964 and the Convention on the Rights of Persons with Disabilities made similar proclamations. For more information see J. Laing, ‘Information Technology and Biometric Databases: Eugenics and Other Threats to Disability Rights’, *Journal of Legal Technology Risk Management* 3, 1 (2008), pp. 9-34.

This was further antagonised by the MoH's reluctance to supply the agreed "Guardianship Allowance"¹⁰⁸ for parents who wanted to look after and educate their 'backward' child at home. In practice the supply of Guardianship Allowance was provided on the contingency that parents would relinquish a degree of control and send their child to an institution. This negated the desire to keep their child at home and the primary need for Guardianship Allowance. In November 1948, Fryd explained the difficult situation to the readers of the APBC newsletters: "Parents wishing to care for their children at home, but whose means are not sufficient, are entitled to apply to the County Health Committee for a Guardianship Allowance. In certain localities this involves signing a form of consent for the child to be sent to an Institution."¹⁰⁹

The unwillingness to provide provisions for families who did not wish to segregate their child from society suggests that it was not merely 'backward' individuals who were discriminated against, but rather the family as a whole. Despite some regional differences, overall eugenic ideals were heavily prevalent in the social and political treatment of the 'mentally defective'. These attitudes were directly reflected in the accessibility and availability of resources for children with 'mental defects'. Despite this, Fryd was not dissuaded by the negative attitudes and she responded with defiance: "We have asked officials at the Board of Control to have the position standardised [...] This has not been done, but we intend to return to the fray."¹¹⁰

For many parents the biggest and most frightening question facing them was their child's future. Numerous 'heart-breaking' letters were received at the APBC headquarters from mothers, widows or deserted women who were struggling to raise their 'backward' child. As one letter stated: "Who will love my child when I am gone? I know there are

¹⁰⁸ The 'Guardianship Allowance' was a part of The Family Allowances Act of 1945, which was the first law to provide child benefit in the United Kingdom. Family allowances had been one of the items proposed by the Beveridge Report in 1942.

¹⁰⁹ 'APBC', *Newsletter* 1, 12 (Nov, 1948).

¹¹⁰ *Ibid.*

Institutions where I could send him, but where will he get the love and care I have always given him and without which he will pine and die?”¹¹¹

In principle hostels were a suitable idea of rehabilitation for older, ‘high grade’ patients. The APBC believed that the present system of friendly supervision or Guardianship on release from an institution was often inadequate. The NAPBC policy of 1953 confirmed that “The mentally defective person should never be obliged to remain permanently in an Institution because of adverse Home Conditions, or because of the death of a parent or guardian.”¹¹² It was felt that many patients would benefit from a greater degree of supervision from the LHAs, in full co-operation with the Employment Exchange and the family physician to place the patient in suitable employment and ensure a smooth transition to community life. Hostels would allow for this heightened degree of supervision and primarily cater for the following types of patients: patients who were to be given a trial in the community on license, where they could reside in a halfway hostel to allow for social rehabilitation; patients who were capable of gainful employment but still required supervision during their leisure time; and finally, patients who were able to live in the community with a certain degree of independence, but were left homeless due to the death of a parent or guardian. Proposals were made to the MoH and many agreed in principle. The APBC suggested that Regional Hospital Boards should be responsible for and provide these provisions for children and young adults who required minimal supervision. Halfway hostels would relieve the pressure on waiting lists for institutions and simultaneously be suitable for ‘high grade’ patients, thus allowing vacancies to be made for patients in institutions who were unable to thrive in a hostel or the community.

Harry Hynd (MP for Accrington) addressed the HoC about the problem of institutional accommodation. Hynd proposed many APBC ideas including hostels for ‘high

¹¹¹ Ibid.

¹¹² ‘The Parents’ Voice’, *Newsletter* 4, 3 (July, 1953).

grade' adults. Plans for a halfway hostel were discussed, but Chairman of the APBC, Drown, declared: "Such schemes will require imagination, energy, and expenditure of much time and money – things which sometimes seem sadly lacking."¹¹³ Implementing hostels as an additional and alternative measure to institutions required a great deal of capital expenditure. Many believed this should be facilitated by government grants and by repurposing and adjusting old 'mental deficiency' hospitals. The Manchester branch was able to take over two hostels from the NAMH for individuals on license who were being helped to find employment and assisted in returning to community life. The APBC hoped that the opportunity would arise for the Association to take over more hostels in this manner; this would later become one of the National Association's main aims and objectives.¹¹⁴ Ultimately, it was declared that the Association and authorities could not afford to be complacent in the issue of hostels. The MoH applauded the existing experimentations with hostels by the APBC, but claimed that the report of the Royal Commission was necessary before a definitive answer could be given to their proposals.¹¹⁵

The End of Institutionalisation: the Advent of the British Disability Movement

Understanding of the appalling conditions in institutions began to receive media attention in the mid-1950s. In April 1951, the Annual Convention of the APBC established the following point to be discussed and rectified: "That representations be made for notifications of sickness to be sent in all cases to parents of patients in Hospitals or Institutions,"¹¹⁶ suggesting previously parents were not informed about the health status of their child, and presumably given no option on the course of treatment or subsequent care. Understandably, this generated widespread fears amongst parents of 'backward' children and left them feeling

¹¹³ 'The Parents' Voice', *Newsletter* 4, 4 (Oct, 1953).

¹¹⁴ 'The Parents' Voice', *Newsletter* 7, 4 (Nov, 1956).

¹¹⁵ 'Minister of Health States Facts' in 'The Parents' Voice', *Newsletter* 7, 2 (May, 1956), pp. 4-5.

¹¹⁶ 'The Parents' Voice', *Newsletter* 2, 2 (April, 1951).

powerless and marginalised. Fryd believed the deplorable conditions and attitudes towards this vulnerable group in society were a national disgrace and was keen to reassure parents that well-run institutions did exist. By 1957, the use of the word ‘institution’ appears to have been replaced with ‘mental deficiency’ hospital or home in *Parents’ Voice*.¹¹⁷

By the 1960s the failings of institutionalisation and physical segregation were uncovered. The complete disregard for health and wellbeing, poor living conditions and inadequate education facilities were among the many inherent flaws. Fundamentally, institutions challenged the parental desire to keep children close in spite of their shortcomings. For many they exacerbated the loss of familial support systems and provided no reasonable alternative. Fryd, for instance, believed that:

It was all very well for people to say “send them into institutions,” but these are the very children whose parents are most loathe to part with them [...] the instinct is to keep these children at home, because parents cannot conceive that they would be understood, tolerated or loved in other surroundings and by other people.¹¹⁸

Consequently, many parents were reluctant to send their children to what were perceived to be impersonal, failing institutions. Ultimately, institutions failed because parents condemned their use and stopped sending their children to them, not as a result of government legislation. As the age of institutionalisation was declining, increasing numbers of parents of ‘backward’ children demanded “SCHOOLS not HOMES.”¹¹⁹ Many officials continued to think patients in institutions were permanently incapable of functioning within the community. Authorities were reluctant to provide adequate resources to ensure the effective maintenance of large institutions for those considered to be a drain on society and the struggling economy.

¹¹⁷ The terms institutions, ‘mental deficiency’ hospital and colonies were used interchangeably to refer to residential care for ‘mentally defective’ individuals, usually run by the State (though private residential facilities also existed).

¹¹⁸ ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

¹¹⁹ ‘APBC’, *Newsletter* 2, 8 (April, 1950).

Institutions were frequently understaffed, in high demand and overcrowded. Problems arose in the distribution of education and healthcare of those who had been institutionalised. Ultimately, facilities and care systems diminished, and contributed to the widespread abuse and neglect now commonly associated and recognised in institutions.¹²⁰

During the 1950s and 1960s, institutionalisation was accepted as having created more social problems than it intended to solve. Social seclusion created feelings of dehumanisation which facilitated, and to a degree necessitated, their physical segregation. In this respect, the process of institutionalisation accentuated differences between ‘normal’ and ‘mentally deficient’ individuals. Essentially, institutionalisation was self-prophesising; society segregated individuals perceived to be different, but it was the process of social exclusion, leading to institutionalisation, which made them different in reality. In evidence of this, Cliff Cunningham claimed that researchers in the 1950s alleged that ‘Mongol’ children lost their genial personalities by adolescence. Cunningham asserted this was not a reflection of their personalities but rather of their social treatment. Nevertheless, this ‘lack of spark’ led to the widespread confinement of adolescent ‘Mongols’ which caused the ‘loss of spark’; social exclusion was a self-rationalising catch-22.¹²¹ In the case of physical segregation arbitrary rules (both social and judicial) were created to justify and conceal the abuse and widespread neglect of those deemed to be ‘backward’ in the mid-twentieth century.

Due to the unpopularity of institutionalisation, the transition to supported community living in the 1960s was facilitated. The implementation of ‘care in the community’ systems, equality for those with disabilities, and specialised education reform, all ensured the improvement of the quality of life afforded to those with physical and mental disabilities. Yet, it was not until the 1970s that institutions began to, or were given warning to close. In

¹²⁰ See HMSO, 1972 for a report on the abuse committed by staff in learning disability hospitals; HMSO, 1992 for a report on the allegations of abuse by nurses of mentally disordered offenders; and the Beverly Allitt Report, HMSO, 1994 for details of wrongful deaths of patients by medical practitioners.

¹²¹ C. Cunningham, *Down Syndrome: An Introduction for Parents and Carers* (London: Souvenir Press, 1982), p. 27.

nations such as America, where the sterilisation of ‘defectives’ was legal in institutions, such practices continued until the late 1970s.¹²² This created an expansive global controversy over whether or not continued healthcare intervention in cases of mental health was an appropriate use of resources. Debates focused on the ethicality of intervention when it specifically contradicted the wishes of the patient and/or family.

During the late twentieth century increasing access to the benefits of society for those with disabilities was granted. Individuals with disabilities were no longer confined to the social margins. However, the theoretical end of isolation in the 1950s did not dictate the immediate beginning of inclusion. In the 1960s reformers, educators, parents and some professionals advocated for the inclusion of individuals with disabilities in to the community. This became known as the principle of ‘normalisation’ and gained worldwide attention. Normalisation aimed to “make available to [...] mentally retarded people patterns of life and conditions of everyday living which are as close to regular circumstances and ways of society as possible.”¹²³

It was not until the advent of the British disability movement in the 1970s and 1980s that persons with disabilities were eventually included into society. The disability movement shifted focus from welfare to the attainment of equal opportunities and rights for persons with disabilities. It also allowed individuals to define their own experiences and limitations. Moreover, persons with disabilities confirmed that barriers of access to social participation originated in societal prejudice. Groups such as the Liberation Network of People with Disabilities, the Disability Alliance, the Disablement Income Group (DIG) and UPIAS were established and became the political and intellectual heart of the British disability movement

¹²² A.M. Stern, ‘Sterilized in the Name of Public Health: Race, Immigration and Reproductive Control in Modern California’, *American Journal of Public Health* 95, 7 (2005), pp. 1128–1138.

¹²³ Field and Sanchez, *Equal Treatment for People with Mental Retardation*, p. 12.

in the 1980s.¹²⁴ DIG was formed in 1966 and campaigned for improved benefits for persons with disabilities. However, unlike UPIAS, DIG did not directly address the conditions in institutions or hospitals. Moreover, DIG did not campaign for persons with disabilities to comprehensively have control over their own lives, as UPIAS went on to. The frustration caused by DIG's failure to address these crucial aspects in the lives of persons with disabilities prompted the establishing of UPIAS and the Disability Alliance. Formed in 1974, the Disability Alliance was predominantly reformist in approach, offering an alternative solution to many problems faced by those with disabling conditions. The Disability Alliance, chaired by the academic Peter Townsend, sought to establish a comprehensive income scheme and to unite individuals and disability groups with non-disabled scholars and professionals for the mutual benefit of all. Fundamentally, the Disability Alliance believed that financial restrictions were pivotal to the segregation and isolation of persons with disabilities.

In contrast, UPIAS was more Marxist in approach and comprehensively argued to increase the quality of life and combat the inherent injustices facing those with disabilities. UPIAS explicitly set out to establish a vast base level organisation of persons with disabilities; directly contrasting many previous societies which aimed to include non-disabled academics and professionals. UPIAS and DIG believed that disability had been used as a form of social oppression and that widespread psychological beliefs of superiority over individuals with disabling conditions still existed. UPIAS was established to combat the social exclusion and stigma felt by those with disabilities. UPIAS originated when resident, Paul Hunt, of the Le Court Cheshire Home near Liss, Hampshire published a letter in the *Guardian* newspaper on the 20th of September, 1972. Hunt called for representatives of those with disabilities in institutions to speak out against the injustices that occurred; Hunt himself

¹²⁴ For further information see J. Campbell, M. Oliver, *Disability Politics: Understanding Our Past, Changing Our Future* (Abingdon: Routledge, 1996)

had spent the majority of his life in an institution. After researching independent living, inclusive education and welfare benefits, Hunt edited *Stigma: The Experience of Disability*; a collection of essays written by those with various disabilities. For the first time, this text highlighted the social isolation, physical segregation and prejudice those with disabilities experienced from a personal perspective.

In December 1974, the aims of UPIAS were set forth. Demands were made for the substitution of segregation with the comprehensive social inclusion for people with impairments. Including the opportunity to live independently, to participate in productive work and to have full control over their lives.¹²⁵ UPIAS utilised the personal experiences and perspectives to define the barriers faced by those with learning disabilities. Suggesting simple improvements could make substantial changes to the quality of life afforded to those with impairments, UPIAS defined the challenges faced by those with disabilities, thus “We find ourselves isolated and excluded by things such as flights of steps, inadequate public and personal transport, unsuitable housing, rigid work routines in factories and offices, and a lack of up-to-date aids and equipment.”¹²⁶

Ultimately, groups such as UPIAS in the early 1970s aimed for the liberation of people with disabilities. This was sought through the abolition of socially isolating systems and legislation. In 1968, the Declaration of General and Specific Rights of the Mentally Retarded was drafted by the United Nations General Assembly. Countries such as the UK and the USA adopted the declaration or vowed one similar. The core features were:

- The basic right to live [in and] to participate in all aspects of community life.

¹²⁵ UPIAS (1976) Aims, Paragraph 1 www.disability-studies.leeds.ac.uk/files/library/UPIAS-UPIAS.pdf (Accessed on 01/04/2014).

¹²⁶ Ibid.

- For those individuals who required institutional care, the right to live in circumstances as close to normal living as possible.¹²⁷

It is now acknowledged that for many, community integration is more appropriate than living in large, impersonal institutions. Families and individuals often operate better with societal support and resources. As Marcia Rioux stated in her 1994 *Disability is not Measles*, the definition of true equality for those with disabilities was “[to] incorporate the premise that all human beings – in spite of their differences – are entitled to be considered and respected as equals and have the right to participate in the social and economic life of society.”¹²⁸

The concepts of access and rights have been at the heart of the disability movement since its inception. Equal access to physical places, intellectual content, and social systems has been a central issue for those who campaigned for equality. Within this, access to modern communication and information technologies are seen as increasingly important to everyday life. Many campaigners have called for the adaptation of technological systems to accommodate for the various needs of those with disabilities. Measures such as modified housing, public transportation, support with shopping, and respite care all made it easier for individuals with disabilities and their families to function in the community.

¹²⁷ Field and Sanchez, *Equal Treatment for People with Mental Retardation*, p. 10.

¹²⁸ M.H. Rioux, M. Bach and Roeher Institute, *Disability is Not Measles: New Research Paradigms in Disability* (Toronto: The Roeher Institute, 1994), pp. 85-86.

Chapter Three

Causes and Treatment of ‘Mental Deficiency’

“Mental deficiency is a symptom and not a cause.”¹

The National Health Services Act of 1946 (hereafter NHS Act) declared medical provisions and education uniformed throughout the United Kingdom. Thus:

It shall be the duty of the Minister of Health [...] to promote the establishment [...] of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness and for that purpose to provide or secure the effective provision of services.²

The Report of the Inter-Departmental Committee on Social Insurance and Allied Services, known commonly as the Beveridge Report, was heavily influential in the formulation of the NHS Act. Author of the report, William Beveridge (1879-1963), was a social reformer and prominent eugenicist.³ Links between Beveridge’s eugenic beliefs and the construction of the welfare state have been made, suggesting that the early days of the NHS were inherently biased against the ‘mentally defective’.⁴ As such the language used in the NHS Act is exemplary of the era in which it was fashioned and the extent of the influence of the British eugenics movement on governmental practice. Terms such as ‘mental defectives’ and

¹ ‘Association of Parents of Backward Children’, *Newsletter* 2, 3 (May, 1949), in *National Association of Parents of Backward Children Nov 1948-Mar 1953*, SA/NBT/F.9/7, The Wellcome Library, London. Hereafter abbreviated to ‘APBC’, *Newsletter* 2, 3 (May, 1949).

² ‘National Health Service Act, 1946. 9 and 10 GEO. 6. CH. 81’ http://old.post-gazette.com/pg/pdf/201004/2010_national-health-service-book_01.pdf (Accessed on 22/07/2013).

³ C. Hanson, *Eugenics, Literature in Post-War Britain* (Abingdon: Routledge, 2013), p. 1.

⁴ For further reading see: D. Sewell, ‘How Eugenics Poisoned the Welfare State’, *The Spectator* (2009) <http://www.spectator.co.uk/features/5571423/how-eugenics-poisoned-the-welfare-state/> (Accessed on 30/05/2015); and J. Freedland, ‘Eugenics: the Skeleton that Rattles the Loudest in the Left’s Closet’, *The Guardian*, (2012) <http://www.theguardian.com/commentisfree/2012/feb/17/eugenics-skeleton-rattles-loudest-closet-left> (Accessed on 30/05/2015).

‘persons of unsound mind’ all feature prominently and suggest that individuals with learning disabilities were considered as little else other than their ‘defect’. Moreover, for many parents during the 1940s and 1950s, the MoH failed to provide a comprehensive service with adequate provision of medical care.

The NHS Act established a new organisation and administration of the medical profession. The NHS Act placed the ownership of hospitals and many medical facilities under the control of the MoH. Under the new legislation, physicians were responsible to the LHA and required to enter onto a comprehensive list of medical practitioners in England and Wales. As a consequence, stricter restrictions were placed on physicians. Despite many heralding the new NHS Act as forward-looking, a number of medical practitioners viewed it as a loss of control and freedom; physicians were initially reluctant to renounce their independence.⁵ As a result, doctors frequently disregarded the guidelines of the NHS Act and acted in accordance with their own principles, proffering advice often tainted by longstanding social and eugenic biases. When, in 1956, the Carnegie United Kingdom Trust vowed to investigate the problem of families with ‘mentally deficient’ children, it spoke of research to improve the quality of life afforded to these families and declared them to be “problems which the Welfare State has not succeeded in resolving.”⁶

In 1953, the MoH ascertained that 5,168 children and adults were ‘mentally deficient’ in England and Wales and “subject to be dealt with.”⁷ 3,408 of these ‘mental defectives’ were admitted to hospitals or placed under Guardianship. 1,347 patients in ‘mental deficiency’ hospitals were discharged in 1953, and 834 persons died. This was a death rate of 13.4% per thousand. The 1954 report of the NHS provided statistics and suggested that there were more

⁵ To counteract this, the National Health Services (Amendment) Act of 1948 would later give practitioners a degree of their independence back.

⁶ ‘The Parents’ Voice’, *Newsletter* 7, 2 (May, 1956) in *Parents Voice: National Society for Mentally Handicapped Children 1:38, 1950-1988*, Main Library/Store 208369/7, The University of Manchester Library, Manchester. Hereafter abbreviated to ‘The Parents’ Voice’, *Newsletter* 7, 2 (May, 1956).

⁷ ‘The Parents’ Voice’, *Newsletter* 6, 2 (Spring, 1955).

‘mental defectives’ under state care at the end of the year than there was at the beginning. The following figures were provided: 76,987 ‘mentally deficient’ persons under state care compared to 75,810 at the beginning of 1954. Yet, 7,000 individuals were still on waiting lists for a hospital vacancy. 987 extra beds were being utilised by ‘mental deficiency’ hospitals; bringing the total to 52,240 patients. Overcrowding was established to be at a rate of 12%; staff limitations accounted for 1,336 hospital beds being vacant, compared to 1,750 the previous year. Planned/progressing building schemes proposed a further 5,550 beds in ‘mental deficiency’ hospitals; although it was unclear how these beds would be staffed. The NHS report declared:

The staffing of mental and mental deficiency hospitals continued to cause anxiety especially as the number of student nurses again showed a reduction during the year (under by 122 [males]; females by 68). The Ministry is endeavouring to overcome these difficulties by schemes for Nursing Cadets for part-timers and by economical use of existing staff.⁸

The MoH also published a report on the scale of the problem of ‘mental defectives’ in the spring of 1955. The report suggested that there were 60,065 ‘mentally deficient’ persons in hospitals, institutions, or ‘on license’. However, 8,442 people were considered to be urgent and 2,306 were believed to be children under the age of 16. The overcrowding in ‘mental deficiency’ hospitals was estimated to have risen to 12.4% within a year. A further 74,794 ‘mental defectives’ were declared to be living in the community.

The MoH continued to collect data from hospitals and centres in research projects. The Ministry’s own Advisory Committee on Mental Health and Medical Research Council were also considered to be an important aspect in the research field. The MoH particularly sponsored research into projects studying the effects of diseases on mothers during early

⁸ ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

pregnancy. This was supported by the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency in 1957. The Royal Commission was particularly significant as it demonstrated that the government were beginning to understand the plight of those with disabilities.

Such changes determined Fryd to declare that “The commission, the Minister of Health and the Government have conceded the justice of our case and propose to delegate the implementation of our Report to the Local Authorities.”⁹ In turn the APBC’s work in the sphere of ‘mental deficiency’ was altered by the Royal Commission’s report. The Association’s aims now became threefold: to press the need for urgency on parliament; convince LAs to produce the funds necessary to implement the suggestions of the report; and to educate the general public concerning the recommendations of the Royal Commission in the hope of raising funds for improved services and provisions.

The APBC estimated that there were, in fact, approximately 135,000 ‘mentally defective’ persons in the UK in need of help. 25,000 of these were children of school age who did not attend any form of schooling or training. 20,000 were between the ages of 16 and 21 claiming National Assistance funds; many of whom were capable of working if provided with adequate care, training and supervision. Finally, the APBC asserted that over 10,000 toddlers may be considered ‘backward’ but were still officially undiagnosed or suffering from an untreated physical handicap such as hearing problems. It was suggested that improved research may have prevented these cases from developing into educational problems if diagnosed and treated early enough.¹⁰

⁹ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

¹⁰ Figures are approximations based on research conducted by the APBC (correct as of Spring, 1955).

Eugenic Fallacies: Heredity and Genetics

During the 1950s, many medical professionals frequently delivered advice in accordance to eugenic ideals. In response, Fryd attempted to provide a brief explanation of Mendelianism to the readers of the APBC newsletters,¹¹ suggesting that “It would help to solve the problem of those dull, apathetic types who are said to come of “weak stock”.¹² By solving the issue of ‘weak stock’, Fryd believed that those with genuine disabling conditions would have better access to medical aid. Fryd’s use of the term ‘stock’ is particularly illuminating, as it reflects the pervasive influence of arguments about eugenic motherhood.

Whilst Fryd fought tirelessly against the barriers facing individuals with disabilities, she was not untouched by the far reaching influence of the British eugenics movement. In October 1949, Fryd echoed the tropes of eugenic thinking while explaining heredity to the readers of the APBC quarterly newsletter:

The parents and other members of the family show a similar type of poor physique and mentality [...] the offspring tend to de-generate because they are receiving defective genes from both sides of the family. They can and do produce many children and constitute the biggest social problem. [...] They also, for obvious reasons, claim the lion’s share of the attention of psychiatric social workers and others, which explains why these worthy people tend to take such a dim view of parents.¹³

Further on, Fryd recounted H.G. Wells’s idea of justice from *First and Last Things*. According to Wells:

¹¹ For Fryd’s complete explanation of Mendelian heredity see Illustration 5.

¹² ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

¹³ ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

We are part of one being and body, each unique yet sharing a common nature and variety of imperfections and working together (albeit more or less darkly and ignorantly) for a common end. We are strong and weak together in one brotherhood [...] and the real justification of democracy lies in the fact that none of us are altogether strong nor altogether weak; for everyone there is an aspect wherein he is seen to be weak; for everyone there is a strength though it may only be a little peculiar strength, or an undeveloped potentiality.¹⁴

Wells' words were obviously considered important by Fryd, as they were included in the first pages of the 'New Year Greetings' and thoughts to be considered for the year 1952. However, Fryd's inclusion of Well's ideas could perhaps be considered controversial. Wells' advocacy of eugenic policies is well documented; alongside Aldous Huxley, Wells worked to promote his own view of social Darwinism.¹⁵ For Wells, sterilisation, euthanasia and birth control of what he deemed to be inferior people were a legitimate solution to the problem posed. Influenced by his affair with prominent eugenicist Margaret Sanger,¹⁶ Wells believed that evolution alone could not be relied upon to ensure the survival of the fittest. Sanger challenged the view that every individual, regardless of race, sex, mental capacity, religion, colour or creed had intrinsic value and a right to dignity. Consequently, Wells proffered the suggestion that lower echelons of society needed to be controlled and manipulated by the respectable and ruling elite. This involved opiate induced mercy killings in Wells' opinion for those with transmissible diseases, alcoholics and the 'mentally defective'.

There was a distinct lack of consensus among professionals in the mid-twentieth century as to whether or not 'mental deficiency' was inheritable. Fryd accepted this argument

¹⁴ H.G. Wells, *First and Last Things: A Confession of Faith and Rule of Life*, 1908 (London: The Floating Press, 2012), p. 176. Quoted by J. Fryd in 'The Parents' Voice', *Newsletter* 3, 1 (Jan, 1952).

¹⁵ See J. Partington, 'H.G. Wells' Eugenic Thinking of the 1930s and 1940s', *Utopian Studies* 14, 1 (2003), pp. 74-81.

¹⁶ Margaret Sanger wrote extensively about birth control, sex education and race. Her works included: M. Sanger, *Woman and the New Race* (Connecticut: Truth Publishing, 1920); M. Sanger, *The Pivot of Civilization* (New York: Brentano's Publishing, 1922); M. Sanger, *Family Limitation* (Michigan: Michigan State University, 1917).

and suggested that without comprehensive family charts, specific hereditary defects were hard to trace. she surmised that professionals should insist upon documenting family histories in spite of the difficulties faced “for both research and personal reproductive reasons.”¹⁷ This suggests that Fryd was fully aware of the eugenic arguments which lay behind pedigree charts. Family histories acted as both research and persuasion tools for eugenicists; ‘defective’ families as well as ‘talented’ families were chronicled and used as examples. Fryd particularly emphasised the impact of the environment on ‘mental deficiency’ and called for further investigation into injury sustained at the time of birth and infectious diseases. In this, she challenged the eugenic claim that disability was a form of ‘deviance’. In particular, she was concerned with this medical fallacy and the effects it had on disability, believing that by increasing public knowledge of matters such as heredity, causation and aetiology, society would become less dependent on doctors and better able to assess their children’s abilities and needs.¹⁸

Prior to the 1980s, most of the information about mental ‘backwardness’, particularly in the USA, was written by or for medical practitioners presumably due to practicality.¹⁹ In addition, many parents with ‘backward’ children had very little access to knowledge regarding the care, treatment and prevention of ‘mental deficiency’. The limited literature that was available to the general public often did not explain the cause of ‘mental deficiency’ and focused on the symptoms and signs for classification which did little to practically help parents in the day-to-day care of their child. Consequently, parents were largely reliant on

¹⁷ ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

¹⁸ It is important to note that the British Medical Association did not officially support the eugenic movement and did not allow eugenic thinking to become a part of the British Medical Curriculum. Moreover, it is important to mention that not all doctors supported eugenic policies.

¹⁹ Examples include: N. Howard Jones, ‘On the Diagnostic Term “Down's disease”’, *Medical History* 23, 1 (1979) pp. 102-104; H.J. Grossman, *Manual on Terminology and Classification in Mental Retardation* (Michigan: American Association on Mental Deficiency, 1977); N.R. Ellis, *Handbook of Mental Deficiency: Psychological Theory and Research* (California: L. Erlbaum Associates, 1979); L.T. Hilliard, *Mental Deficiency* (Minnesota: Little, Brown, 1965); P.J. Mittler (ed), *Research to Practice in Mental Retardation: Care and Intervention* (Michigan: University Park Press, 1977); B.C. Moore and S.C. Moore, *Mental Retardation: Causes and Prevention* (Michigan: Charles E. Merrill, 1977); and P.J. Mittler (ed), *Research to Practice in Mental Retardation: Biomedical Aspects* (California: University Park Press, 1977).

their local medical professionals for advice when making decisions for the future of their ‘backward’ child. Too often doctors denounced children as ‘deficient’ and made no further effort to attain better healthcare resources and educational opportunities for the family.

Subsequently, Fryd felt that parents were cautious of medical practitioners and their apparent displays of bias. She was alarmed by the biased information given by doctors and set out to correct the imbalance as much as possible; this is made evident by the various lectures, articles and speeches recreated in the quarterly newsletters of the APBC. It was Fryd’s belief that accessible information about education, cause, and treatment of ‘backwardness’ would lead to better informed parents. In turn, these parents would no longer be reliant on doctors and could better control their families’ lives. As a consequence, Fryd hoped that this would force the medical profession and government to reassess their standards and ethics when advising families dealing with ‘mental deficiency’.

Fryd believed that parents and healthcare professionals required greater education on mentally disabling conditions. In order for ‘backward’ children to be able to access suitable facilities, Fryd asserted that parents needed a working knowledge of their child’s abilities and disabilities; this was often influenced by those in the medical profession. In 1955, the aims and objectives of the APBC were set out as follows:

To work for and promote the study of and research into mental health and mental disorders and defects and to obtain and make records of and disseminate information concerning the same [...] to foster mutual help and co-operation between parents, relatives and friends of the mentally handicapped and teachers and members of the medical and nursing professionals, and all entrusted with the care of the mentally handicapped.²⁰

²⁰ ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

Much of the general public in the 1950s did not necessarily understand that mental illness and ‘deficiency’ were two different conditions and not synonymous. The former implied a ‘normal’ mind suffering a breakdown of sorts, whereas the latter suggested a malformed mind from pregnancy or birth. Fryd believed that many parents were worried about two questions: first, “does the diagnosis of mental deficiency imply lack of intelligence, or should it be of early traumatic dementia implying loss of intelligence?”; and second, “What are the differences between the brain injured child and the hereditary type of mentally defective child?”²¹ Fryd later commented in August 1956: “Parents could not tolerate the fatalism, the lack of curiosity about this problem which to them is equivalent to a matter of life and death.”²²

To better educate herself and the readers of the APBC newsletters, Fryd actively sought the guidance of esteemed physicians and academics. Fryd’s affiliation with medical professionals and scholars appeared regularly in the quarterly newsletters. In her capacity as editor, Fryd believed it was her duty and obligation to distribute knowledge on as many aetiological theories as possible. The quarterly newsletter often served as the most efficient vessel for this work, through local lectures, talks and outings were also arranged by individual branches of the Association. Fryd reproduced information and knowledge she acquired to the readers and members of the APBC. Dr Lise Gellner, Professor Lionel Penrose, Dr Mary Pantin and their respective works featured prominently in *Parents’ Voice*.

The APBC was particularly indebted to the many professionals who gave them credence to fulfil their research promise. For instance, the death of Dr Flora Innes, who researched the effects of special diets on ‘mentally defective’ children and worked closely with the Middlesex branch, in the Autumn of 1952 was strongly felt by all who knew her: “we feel her loss so deeply because for many of us she was the first member of the medical

²¹ ‘APBC’, *Newsletter* 1, 12 (Nov, 1948).

²² ‘The Parents’ Voice’, *Newsletter* 7, 3 (Aug, 1956).

profession to hold out any hope for the future of our mentally handicapped children [...] she has outsoared the shadow of our night.”²³ Fryd also conveyed information about various lectures, articles and scholarly texts to her audience. Once more battling the ingrained eugenic barriers, crossing social divides and distributing free knowledge to all those who desired it, yet did not necessarily have access to it.

The APBC was frequently told “research is not the foundation of a lay organisation.”²⁴ Whilst this was not a new sentiment, Fryd felt that as the APBC was uniquely comprised predominantly of parents of a ‘backward’ child, these families could yield a mass of new, valuable information. This information could be analysed, codified and had the potential to reveal important factors. During their engagement with the research community, many parents were told “we should not bother our heads over things we could not possibly understand.”²⁵ Irrespective of this, parents continued to ask questions and the APBC sought to answer them in as much detail as possible.

Research Methods

It was decided that scientific research could generally be divided into three main categories: firstly ‘pure’ research. Secondly, research conducted to ascertain what something is made of, what it does and what happens to the item when certain things are done to it. This second category was also called ‘purposive’ research as an explanation was sought for a phenomenon or the cause of a particular condition. And, finally, ‘detective’ research. In this case evidence was sought to support a theory or corroborate a hypothesis.

To simplify the matter Fryd summarised the APBC’s research aims into three categories also. Firstly, the Association was interested in the search for a cause of ‘mental

²³ ‘The Parents’ Voice’, *Newsletter* 3, 4 (Oct, 1952).

²⁴ ‘The Parents’ Voice’, *Newsletter* 7, 3 (Aug, 1956).

²⁵ ‘The Parents’ Voice’, *Newsletter* 10, 2 (Dec, 1959).

deficiency’; this task involved finding the underlying cause of a great number of conditions. Impaired mental abilities were understood to be simply one symptom of various physical and organic disabilities involving the brain and nervous system. Secondly, the APBC sought answers for the prevention or remedial treatments of various physical conditions. Lastly, the search for methods of training and education were considered vital. Individuals with ‘defects’ may be helped to overcome their impaired faculties and develop their abilities to the fullest by the correct education and training programmes.²⁶

The APBC continued to study the causes and possible treatments of ‘mental deficiency’ throughout the 1950s. Methods of investigation notably improved as the Association’s membership and influence grew. This included improved access to facilities and professionals affiliated. Despite the objections of many, the APBC did not relinquish their research objectives. During the late 1950s the APBC financed a major research project intended to help all parents of ‘backward’ children. The project aimed to study the training methods applied to ‘mentally deficient’ children in occupation centres over the duration of three years. The project leader was announced as Dr Jack Tizard (a psychiatrist on the Medical Research Council for the social psychiatry research unit at Maudsley Hospital, London) who asserted that the term ‘occupation centre’ itself implied a place where children could pass time, rather than receive proper training based on scientific methods.²⁷

²⁶ Ibid.

²⁷ Jack Tizard (1919-1979) was born and raised in New Zealand. Between 1940 and 1945 he joined the New Zealand Expeditionary Force as part of the Medical Corps. Upon his return in 1945, Tizard was made assistant lecturer in educational psychology at the University of New Zealand. In 1946 he accepted an ex-serviceman’s grant to travel to Oxford and study. Tizard later became a lecturer in psychology at the University of St Andrews in 1947, but soon left in 1948 to join the Medical Research Council for research into social psychiatry at Maudsley Hospital, London. He remained in this post until 1964. During this appointment, Tizard was interested in the suitability of industrial employment and social independence for individuals with mild ‘mental deficiency’. Tizard was critical of existing services in the 1950s and suggested practical models for development. In 1951 Tizard was awarded a PhD; in 1964 he became lecturer of child development at London University Institute of Education. He remained in this post until 1971. Tizard’s work on social psychiatry was particularly influential to social policy and made a considerable impact on the Royal Commission into the Laws Relating to Mental Illness and Mental Deficiency. Today, Jack Tizard’s legacy and contributions to the lives of those with learning disabilities is honoured by the many schools in his namesake. For further information see ‘Obituary: Jack Tizard’, *The Lancet* 2, 8139 (1979), p. 427 and D.M.G. Beasley, ‘Jack Tizard Memorial Lecture’, *Australia and New Zealand Journal of Developmental Disabilities* 10, 3 (1984), pp. 127-133.

Fundamentally, the project envisioned creating new and improved training methods which would allow children to reach their full potential. It was recognised that training methods suitable to each child's specific needs were necessary and would stimulate them to successive degrees of intellectual attainment. Tizard suggested: "methods of teaching do not appear to have changed during the last half century or longer."²⁸ The research observation unit was established at the Fountain Hospital in London and cost approximately £2,000 per annum.

The APBC explored many avenues of inquiry into 'mental deficiency'. The comprehensive attitude towards research is evident within the quarterly publications of the APBC. The transmission of information through the newsletters was a two-way process. The APBC reproduced articles and research believed to be beneficial to members; additionally, concerned parents asked for more information on certain conditions that they felt would be applicable to their circumstances. Glutamic acid and its effect as a 'brain food' were of particular interest to many parents with a 'backward' child. Glutamic acid was described to be a non-essential amino acid found in food and could be built up and used by the body and brain. However, glutamic acid was not determined to be essential for normal growth and many felt it should not be considered to be a 'brain food'. In fact:

It was the ability of the brain to "metabolise" Glutamic Acid that led Doctors in America about ten years ago to try it in the treatment of the milder forms of epilepsy called "petit mal". They claimed that in many cases, as well as reducing the number of seizures, glutamic acid surprisingly increased the mental and physical alertness of patients, and at once saw the possibilities of it being used in the treatment of backward children.²⁹

²⁸ 'The Parents' Voice', *Newsletter* 8, 3 (Aug, 1957).

²⁹ 'Is Glutamic Acid a "Brain Food"?' in 'The Parents' Voice', *Newsletter* 2, 2 (April, 1951), p. 5.

Following this, many professionals, in both the UK and the USA, began a series of investigations on laboratory animals and human patients with a variety of conditions. In the early 1940s a lot of publicity was generated in the USA about the positive effects of glutamic acid on the intelligence quotient of ‘mentally defective’ children, in particular ‘Mongols’. Medical professionals with ‘backward’ children were particular proponents of the positive use of glutamic acid. One contributor claimed, for instance, that the addition of glutamic acid to the diet had lessened their child’s attacks. However, Fryd believed that some of this improvement should be accredited to the excellent schools and clinics in the USA. Eventually, widespread use of glutamic acid waned as many found that it caused severe indigestion in many patients. Regardless, many members with ‘Mongol’ children continued to test glutamic acid. Despite the premature publicity, researchers repeating the experiment were unable to recreate the same results. It was noted:

It is very difficult to conduct a fair and accurate experiment on this type of child. The usual practice is to put a group of children on a course of Glutamic Acid and then to assess their progress both by close observation of trained staff and by various intelligence tests at intervals of say, a month. At the same time, a comparable group of children living under the same environmental conditions, but receiving no Glutamic Acid, are observed and tested as ‘controls’.³⁰

Having conducted investigations under these conditions, it was found that there was no comparative improvement in the intelligence quotient of the group receiving glutamic acid. It was commented that both groups often improved enormously throughout the course of the experiment: “it can be understood that the extra attention focused on a group of children leading the otherwise routine life of say an Institution can itself stimulate the child’s

³⁰ Ibid.

interest.”³¹ As such it was understood that an increase in attention, resources and education hugely benefitted the quality of life afforded to ‘mentally deficient’ individuals. After studying the available research Fryd concluded that the effects of glutamic acid on the brain and nervous system were yet to be determined. She stated:

Reports on its efficacy in the treatment of epilepsy and ‘mental deficiency’ are conflicting and disappointing, and although individual parents claim that it has been of benefit to their particular child, there seems to be no justification for the general use of Glutamic Acid in attempting to increase intelligence.³²

Glutamic acid was not the only supplement that interested parents. Concerns about a number of chemicals taken in through the diet of an expecting mother were raised. Others questioned the effects of atomic fallout and the chemicals in cow’s milk and tap water. It was discovered that any nutritional defect in high quantity could lead to ‘mental deficiency’; the lack of oxygen was used as an example.³³ Vitamin deficiencies had been discovered as a cause of a large proportion of ‘malformed’ or stillborn babies. However, it was unlikely that women in the UK would be subject to a vitamin deficiency virulent enough to create problems for the unborn child. Whilst ‘mental deficiency’ appeared to be a relatively rare side-effect of any trouble during pregnancy, it did suggest that this new territory of research needed further study.

The slow development of research in the ‘mental deficiency’ field was aided by the lack of physicians at Registrar level. It was felt that improvement could be made, if co-

³¹ Ibid.

³² Ibid.

³³ For further information see: C.E. Bloch, ‘Effects of Deficiency in Vitamins in Infancy: Caries of the Teeth and Vitamins’, *The American Journal of Diseases of Children* 42, 2 (1931), pp. 263-278; B. Pasamanick and A.M. Lilienfeld, ‘Association of Maternal and Fetal Factors with Development of Mental Deficiency: Abnormalities in the Prenatal and Paranatal Periods’, *Journal of American Medical Association* 159, 3 (1955) pp. 155-160; and H.E. Himwich, ‘Cerebral Metabolism in Mongolian Idiocy and Phenyl pyruvic Oligophrenia’, *Archives of Neurology and Psychology* 44, 6 (1940), pp. 1213-1218.

operation between teaching hospitals and medical schools was strengthened to encourage young doctors to embark on training in the mental and ‘mental deficiency’ fields. Furthermore, it was the APBC’s belief that trainees in the medical and nursing professions should be guaranteed employment for the duration of their training to encourage more to take up the fight of ‘mental deficiency’.

Ellis, the APBC’s Chairman in the 1950s, compared the mental health field to other medical areas and stated the former had been neglected in terms of research, professionals and funding. It was determined that since 1948, £44,000 had been approved by the government to spend on mental health issues. Yet, at the time of the report (August 1956) only £27,000 had currently been expended, despite approximately 40 out of 100 hospital beds for mental patients. For many reformers, this was an unacceptable and insufficient amount to be spent on such a vital subject. Ellis commented:

We should be ever grateful to the band of pioneers who are now giving their time to this vital work. In research, men are more important than money – although if the money were there, I am convinced that more medical men would be attracted to this field. It is my view that as the mental problems as a whole is dragged out into the open, more and more attention would be focused on research. In fact I am optimistic enough to say that I feel we are on the threshold of a great advance of activity in this field.³⁴

Ellis believed that the APBC had a responsibility to encourage medical men and women to devote their talents to this worthwhile cause. However, it was understood that qualified research workers would be unavailable if there was no financial reward. Likewise, there would be little point in raising funds if there were no medical professionals and researchers to utilise the money. While many young men and women qualified as doctors every year

³⁴ ‘The Parents’ Voice’, *Newsletter* 7, 2 (May, 1956).

relatively few gravitated towards the ‘mental deficiency’ field. Many reformers believed that this could be remedied by greater publicity for opportunities and rewards of the work.

In Fryd’s opinion ‘mental deficiency’ research was an inherently flawed field. In addition to financial, staffing and resource problems, the lack of machinery resulted in specialists and research workers being largely unaware of the work. Subsequently, research conducted in other medical research fields which may have had a significant impact on the knowledge of ‘mental deficiency’ was often unconnected and therefore lost. According to Fryd:

We are told “knowledge about mental handicap is as likely to come through research in other fields of medicine as through mental deficiency research in particular.” True – BUT ONLY IF THE BEARING THIS KNOWLEDGE HAS ON MENTAL DEFICIENCY IS NOTICED BY SOMEONE INTERESTED IN MENTAL FUNCTION. Vital clues are probably being missed because the facts are locked up in some laboratory or treatise quite removed from the problem.³⁵

Improved research was able to draw attention to physical causes of ‘mental deficiency’ (such as ‘Cretinism’ and thyroid problems) and enable preventative action to be taken. Other predisposing conditions were continuously being discovered and solutions formulated. This issue was advanced by Louis Minski, whose findings were later published in *Deafness, Mutism and Mental Deficiency in Children*.³⁶ However, Fryd recognised that ‘backward’ children fortunate enough to be diagnosed as deaf and successfully treated were in the minority. Many deaf children remained undiagnosed and devoid of any educational help, thus increasing their ‘defect’.

³⁵ Ibid.

³⁶ L. Minski, *Deafness, Mutism and Mental Deficiency in Children* (London: Heinemann, 1957).

Psychiatrist and geneticist Lionel Sharples Penrose (1898 –1972) wrote extensively about the history, causes, treatment and future lines of inquiry of ‘backwardness’. His insight and knowledge was of immeasurable value to the APBC and its members, and his works were frequently reproduced in the quarterly newsletters. Moreover, Penrose often directly addressed the APBC to share his recent findings and advance the progress of knowledge. Equally important, Penrose conducted one of the earliest attempts to comprehensively address the genetic basis of ‘mental deficiency’ in his ‘Colchester Survey’ of 1938. This survey revealed that families of relatives with severe learning impairments were usually unaffected, but those who were, were generally affected to a similar degree as the initial patient. However, relatives of individuals with mild ‘mental deficiency’ tended to be afflicted with equally mild or borderline forms of disability. Penrose continued his work into the genetic causes of ‘mental deficiency’ after his appointment to the chair of Galton Professor of Eugenics at University College London, a post which he held from 1945 to his retirement in 1965; he succeeded prominent eugenicists Karl Pearson and Ronald Aylmer Fisher. It is pertinent to note that whilst Penrose was interested in genetics, he should not be thought of as a proponent of eugenics. Penrose was always dissatisfied with the term ‘eugenics’ and changed the title of the Galton Laboratory’s journal from *Annals of Eugenics* to *Annals of Human Genetics* in 1954. Furthermore, he eventually succeeded in 1963 in changing the title of his chair to the Galton Professorship in Human Genetics. From this position Penrose was able to change his department’s focus from broad enquiry into the particular genetic causes of various forms of ‘mental deficiency’.

After his retirement in 1965, Penrose established the Kennedy-Galton Centre; a laboratory and clinic in the grounds of Harperbury Hospital, Hertfordshire.³⁷ He worked within this large residential community for individuals with various learning disabilities until

³⁷ C.A. Clarke, ‘Obituary: Lionel Sharples Penrose (1898-1972)’, *Journal of Medical Genetics* 9 (1972), p. 253.

his death in 1972. The following information on the care and treatment of ‘handicapped children’ is taken from Penrose’s address to the APBC in the spring of 1956. Penrose stated that the problem of ‘mental deficiency’ was complex, difficult to understand and may take years to fully comprehend, let alone solve. Penrose suggested that there were two aspects to the care and treatment of ‘backward’ children. The first he believed was to attack the problem from the outside. The method began in France over a century ago and was continuously developing.³⁸ The process began with knowledge of a child’s abilities, some of which may have been impeded. Secondly, an attempt was made to increase said abilities with the aim of finding enough skill for a useful and profitable occupation. Penrose stated that this process was not dissimilar to the method of training and education being utilised. Penrose noted:

It is interesting to know that the development of the methods of training which are now in use, and have been for many years, originally started by transferring people who had first been training deaf or dumb or blind children, and then began to get interested in the problems of children with whom it was not the sense which was wrong, but the interpretation.³⁹

The second aspect of the care and treatment of ‘mentally deficient’ children particularly appealed to Penrose; assessing the subject from a medical standpoint and tackling it from the inside out. A prime example of this successful approach was the case of the ‘cretin’ child who suffered from thyroid problems. The child’s condition and mental growth could be helped by the addition of the missing thyroid secretion to their system; thyroxin was

³⁸ The first documented approach to educating the ‘mentally deficient’ was in France 1799. A medical doctor named Jean-Marc Itard developed a skills based program for a local boy. This was developed by Edouard Seguin with a systematic program to educate the ‘mentally deficient’ at Salpêtrière Hospital in Paris. See: J.M.G. Itard, *An Historical Account of the Discovery and Education of a Savage Man: Or, the First Developments, Physical and Moral, of the Young Savage Caught in the Woods Near Aveyron in the Year 1798* (Paris, 1802); E. Seguin, *Traitement Moral, Hygiène et éducation des idiots et des autres enfants arriérés* (Paris: Bailliere, 1846); E. Seguin, *Idiocy: and its Treatment by the Physiological Method* (New York: W. Wood & Co., 1866).

³⁹ ‘Professor Penrose’s Address: Care and Treatment of Handicapped Children’ in ‘The Parents’ Voice’, *Newsletter 7*, 2 (May, 1956), pp. 5-7.

established as improving the child's mental faculties. Penrose was keen to note that not all conditions which appeared to be the same were in fact the same. Cases where the child was not deficient in the thyroid secretion, but rather was unable to utilise the secretion effectively were provided. In this instance, additional thyroxin would not help the child and other methods must be discovered.

Penrose also explained how knowledge was continuously advancing and becoming more specific and founded on fact. He referenced the previous assumption that if a child had a smaller than average head, then they would likely be 'mentally deficient' and required an operation to help the growth of the brain. This was obviously crude, unnecessary and did not succeed in improving mental faculties. Yet, thanks to medical improvements it was understood that there were certain cases of 'brain injury', which led to 'mental deficiency', which could be successfully operated on and the damaged part of the brain could be removed. For Penrose, the most interesting work being conducted in the medical field was on the supply of substances to the body which were not created internally. Penrose mentioned the 1933 discovery of phenylketonuria which resulted in 'mental deficiency' if untreated. Phenylketonuria was particularly important to the study of 'mental deficiency' and initiated a change in many approaches to causes and treatment. It was discovered that children with the condition were unable to digest food in the correct manner. Subsequently, a special diet was required. Whilst this had not made any improvement to mental ability, investigations continued to be conducted in both the UK and the USA. From this, it was discovered that lactose from dairy sources also had a negative effect on the condition. If a substitute was found early enough, then it was believed that improvement in mental ability was possible. However, many were cautious of such assertions because it was possible that it was the increased attention paid to the child which produced a positive result. The condition emphasised the importance of studying and identifying biochemical, and not simply

neurological factors. Previously it had been presumed that ‘mental deficiency’ was a result of heredity or the nervous system. This view of ‘mental deficiency’ assumed that the condition was singular, incurable and disreputable.⁴⁰

Penrose maintained that vitamin deficiency could account for ‘mental defects’; particularly if the mother’s diet was lacking during pregnancy, which could cause physical abnormalities. Experiments were conducted on rabbits; the results of which determined that a deficiency of vitamin A led to hydrocephalic offspring.⁴¹ Support for this in humans was found in an unspecified 1952 case in the USA. It was also noted that this case was rare. Whilst vitamin deficiency in the mid-twentieth century may have been uncommon, it was useful as a possible theory if individuals were unable to absorb and utilise vitamins correctly. For many years it had been suspected that hormone treatment was an important factor in the case of ‘Mongolism’. Many professionals believed it was a matter of determining which hormone would be the correct treatment course; early treatment was strongly urged. Penrose’s position on ‘mentally deficiency’ and the impact it had on their families was that society should:

[N]ot regard the mentally defective children as helpless or outcasts, or unprofitable for **study** [sic]. This attitude has changed in recent years to a more optimistic viewpoint, and people realise that this is a thing which is ripe for medical investigations, and that has removed a stigma from such cases and also from their relatives. The “defectives”, as they used to be called (and perhaps we shall get rid of that word!) will be welcomed back to the community. After all nobody is without

⁴⁰ Ibid.

⁴¹ Various studies were produced attempting to corroborate these results to differing degrees of success. For further reading see: R.H. Rigdon, ‘Effect of Vitamin A Deficiency on Plasmodium Lophurae Infection in Ducks’, *Journal of Infectious Disease*, 79, 3 (1946), pp. 272-277; J.W. Millen and D.H.M. Woollam, ‘The Effect of the Duration of Vitamin-A Deficiency in Female Rabbits Upon the Incidence of Hydrocephalus in Their Young’, *Journal of Neurology, Neurosurgery and Psychiatry* 19 (1956), pp. 17-20; J.W. Millen, D.H.M. Woollam and G.E. Lamming, ‘Hydrocephalus Associated with Deficiency of Vitamin A’, *The Lancet* 262, 6798 (1953), pp. 1234-1236; J.W. Millen and D.H.M. Woollam, ‘Influence of Cortisone on Teratogenic Effects of Hypovitaminosis-A’, *British Medical Journal* 2, 5038 (1957), pp. 196-197; and Z.A. Leitner, ‘Congenital Hydrocephalus and Vitamin A Deficiency’, *British Medical Journal* 1, 4868 (1954), p. 987.

some degree of mental defect – even the most brilliant members of society have their blind spots and their disabilities. It is a matter of degree not kind, and if I may paraphrase George Orwell, “we are all defective, but some of us more defective than others.”⁴²

However, the APBC and Fryd knew that in order for significant change to be made, awareness and involvement was needed on a governmental level. Conferences were arranged for the benefit of improving research on ‘mental deficiency’. Sir Frederick Messer (MP for Tottenham South) was well known for his work on hospitals and the ‘mentally handicapped’ and presided over a conference in May, 1954 for the Defence of Children in Westminster, London. The conference had a committee consisting of medical professionals, ministers of religion, teachers, social workers, and others interested in advancing the care of children. Later, Fryd reported on a parliamentary debate of the Royal Commission report.

The debate focused on Mr Walter Elliot (MP for Glasgow Kelvingrove) who stated that there was a greater need for research. He endorsed his claim by declaring that much of the current research concentrated on the physical formation and impact of ‘mental deficiency’ on the body. In Elliot’s opinion works rarely focused on the results of physical changes on the mind. Elliot surmised that barely 2% of research expenditure in the country was being applied to these ‘mental questions’. Elliot likened the case of mental health to that of leprosy. Individuals with leprosy were subjected to conditions similar to those being thrust on the ‘mentally defective’; namely stigmatisation, exclusion, convict conditions, and treated as “the scourge of the human race.”⁴³ However, Elliot believed that as with the case of leprosy, improved research and knowledge could greatly improve the services available to this marginalised group. He felt that the task of research was beyond the realms of the Department of Health and certainly LAs. Ultimately, he suggested that due to the scale of the

⁴² ‘Professor Penrose’s Address: Care and Treatment of Handicapped Children’ in ‘The Parents’ Voice’, *Newsletter* 7, 2 (May, 1956), pp. 5-7.

⁴³ ‘The Parents’ Voice’, *Newsletter* 8, 3 (Aug, 1957).

research required the task should be entrusted to the Local President of the Medical Research Council:⁴⁴

We believe that for a proper solution to the problem the full facts must be known, and we therefore can call upon the *Government* to set up an OFFICIAL COMMISSION OF INQUIRY to investigate the numbers of the different types of handicapped children and the provision made for their welfare.⁴⁵

In October 1954, the APBC's aims were realised when a memorandum submitted by the Association's Parliamentary Committee was heard by the Royal Commission. It was once more reiterated that research was a long and often unrewarding task. One research worker explained that they would often devote a great deal of time and expenditure to disproving a theory, rather than investigating new avenues of thought. Fryd reasserted that research should not be thought of as a magic wand. She explained how some members had a tendency to believe, or rather hope, that research would uncover a 'cure' to eradicate their child's condition and make them 'normal' like other children. Ellis too reiterated the same point:

Research is no magic wand. It may be that victories can be achieved, but for the children already born will be limited. It may prove that greater achievements will be won in preventing this tragedy of mental handicap. But whatever that future holds, this Society must always be out there in front, giving the medical man every encouragement at our disposal.⁴⁶

Despite the enormous task facing the APBC, Ellis believed that research was critically important for the members and the general public. He concluded: "Let us not turn away

⁴⁴ For further information on Walter Elliot's opinions see 'Mental Illness and Mental Deficiency (Report)' *House of Commons Debate* 573 (1957), pp. 35-103
<http://hansard.millbanksystems.com/commons/1957/jul/08/mental-illness-and-mental-deficiency> (Accessed on 30/05/2015).

⁴⁵ 'The Parents' Voice', *Newsletter* 5, 3 (July, 1954).

⁴⁶ 'The Parents' Voice', *Newsletter* 7, 1 (May, 1956).

because the challenge is of such magnitude [...] we seek a better world for those who are in no position to seek it themselves. And none of us should slow our efforts until that prize has been won.”⁴⁷

‘Mongolism’/Down syndrome

One particular research area which simultaneously helped the APBC to grow in membership and social/professional influence was the subject of ‘Mongolian idiocy’ or Down syndrome.⁴⁸

Whilst Fryd’s own child did not suffer from ‘Mongolism’, she recognised the need for better understanding of the condition, for without it effective treatment was unattainable. It is for this reason that Fryd devoted much of her time to this cause and why ‘Mongolism’ played such a vital role in the growth of the APBC.

Originally described by Jean Etienne Dominique Esquirol⁴⁹ in 1838 and Edouard Seguin⁵⁰ in 1844, the condition of ‘Mongolism’ had a highly influential role in the deluge of ideas unleashed by the popularisation of eugenics. By the early twentieth century, ‘Mongolism’ was considered a form of ‘mental deficiency’ and a focus of growing eugenic and aetiological concern. The unclear causal factors and symptoms continued to generate

⁴⁷ Ibid.

⁴⁸ The history of ‘Mongolism’/Down syndrome has been extensively written on by various authors. See: R.M. Stewart, ‘The Problem of the Mongol’, *Proceedings of the Royal Society of Medicine, Section of Psychiatry*, January XIX (1926); D. Wright, *Downs: The History of a Disability* (Oxford: Oxford University Press, 2011); L. Zihni, ‘Sutherland’s Syphilis Hypothesis of Down’s Syndrome’, *Journal of the History of the Neurosciences* 4 (1995), pp. 133-137; S.L. Einfield & R. Brown, ‘Down Syndrome – New Prospects for an Ancient Disorder’, *Journal of the American Medical Association* 303, 24 (2010), pp. 2525-2526; J.A. Rondal, J. Perera and L. Nadek (eds), *Down Syndrome: A Review of Current Knowledge* (New Jersey: Wiley-Blackwell, 1999); A. Yong, *Theology and Down Syndrome: Reimagining Disability in Late Modernity* (Texas: Baylor University Press, 2007); O.C. Ward, *John Langdon Down: A Caring Pioneer (Eponymists in Medicine)* (London: Royal Society of Medicine Press, 1998); O.C. Ward, ‘John Langdon Down: The Man and the Message’, *Down Syndrome Research and Practice* 6, 1 (1999), pp. 19-24; O.C. Ward, *John Langdon Down, 1828–1896* (London: Royal Society of Medicine Press, 1998); G.E.W. Wolstenholme & R. Porter (eds), *Mongolism: in commemoration of Dr. John Langdon Haydon Down* (London: J & A Churchill, 1967); M. Jackson, ‘Changing Depictions of Disease; Race, Representation and the History of “Mongolism”’, in W. Ernst and B. Harris (eds), *Race, Science and Medicine, 1700-1960; Studies in the Social History of Medicine* (London: Routledge, 1999), pp. 167-188.

⁴⁹ Ideas regarding ‘Mongolism’ were published in J.E.D. Esquirol, *Des Maladies Meantales Considerées sous les Rapports Medical, Hygienique et Medico-Legal* (Brussels: T.B. Bircher, 1838).

⁵⁰ Seguin, *Traitement Moral, Hygiène*

greater interest than many other conditions. Heavily influenced by the study of ethnology and phrenology,⁵¹ acclaimed Victorian alienist and astute clinical observer, John Langdon Down⁵² set about assigning the patients under his care at the Royal Earlswood Asylum for Idiots to racial groups; he begun by carrying out autopsies on patients who had died at Earlswood, measuring the diameter of their heads and identifying specific facial features. This was the research foundation on which Langdon Down based his infamous ethnic classification of ‘Mongolism’.⁵³ From this work, Langdon Down postulated that ‘Mongolian idiocy’ occurred in more than 10% of the patients presented to him. Langdon Down classified ideas of ‘Mongolism’ in the context of anthropological debates over race and theories of degeneration. He stated, “The boy’s aspect is such that it is difficult to realise that he is the child of Europeans, but so frequently are these characters presented that there can be no doubt that these ethnic features are the result of degeneracy.”⁵⁴ Langdon Down noted that the condition appeared to be a combination of physical and mental characteristics but little else was known about causation. Whilst Langdon Down’s ethnic classification was eventually discredited, including by Langdon Down himself, his initial, widely published description of the condition led to the recognition of such individuals as a distinct group aside from the ‘feebleminded’.⁵⁵ The impact of Langdon Down’s classification of the syndrome was by no

⁵¹ For a comprehensive explanation of phrenology and its implications upon mental health see: J.P. Browne, *Phrenology: and its Application to Education, Insanity and Prison Discipline* (London: Bickers and Son, 1869); J.G. Spurzheim, *Phrenology: Or, the Doctrine of the Mental Phenomena* (New York: Harper and Brothers Publishers, 1846).

⁵² There have been many biographies written about the Langdon-Down family, most notably: O.C. Ward, *John Langdon Down: A Caring Pioneer (Eponymists in Medicine)* (London: Royal Society of Medicine Press, 1998); Ward, ‘John Langdon Down’; O.C. Ward, *John Langdon Down, 1828–1896* (London: Royal Society of Medicine Press, 1998); O.C. Ward, *Dr John Langdon Down and Normansfield* (Middlesex: The Langdon Down Centre Trust, 2009); and G.E.W. Wolstenholme and R. Porter (eds), *Mongolism: in Commemoration of Dr. John Langdon Haydon Down* (London: J and A Churchill, 1967).

⁵³ Langdon Down published his ethnic observations in the *London Hospital Reports* (1862), the *Journal of Medical Science* (1863), and again alongside the transcripts of his Lettsomian Lectures at the Medical Society of London (1887).

⁵⁴ J. Langdon Down, ‘Observations on an Ethnic Classification of Idiots’, *London Hospital Reports* 3 (1866), pp. 259-262.

⁵⁵ *Ibid.*

means immediate. It was not until the turn of the century that ‘Mongolism’ became a widely used description for the condition.

However, in his original ethnic classification of ‘Mongolian idiocy’ Langdon Down did not condemn individuals with the condition to a life devoid of content and worthiness. He suggested that with the correct training and attention the condition could be improved. In 1876, Langdon Down published a little-known book called *Education and Treatment of the Feeble in Mind*,⁵⁶ in which he described the optimum conditions for the care of the disabled. He advocated the use of special diets, sensory stimulation, social activities and physical exercise. In order to establish such a routine, Langdon Down commissioned the roles of occupational therapists, specialist teachers, carers and speech therapists. Moreover, Langdon Down was particularly concerned with the social exclusion of ‘feeble-minded’ children. To counteract this, Langdon Down suggested that institutions would be better equipped to provide the necessary care and training. He also emphasised that children of lower levels of intellect would flourish better among others of similar abilities; in effect removing the stress of competition.

Since Langdon Down’s original classification of ‘Mongolism’, the official medical discourse had widely disagreed to its cause.⁵⁷ Theories regarding race degeneration, maternal age, exhaustion of the womb, and gland and ovarian disorders surfaced; no conjecture was too absurd. P.M.G. Russell stated “Indeed, one fact seems to stand out from the prodigious literature on Mongolism – that no single aetiological factor can stand the test of being applied to all cases.”⁵⁸ Langdon Down initially asserted that the condition was caused by complications during pregnancy due to disease: “They are always congenital idiots and never

⁵⁶ J. Langdon Down, *The Education and Training of the Feeble in Mind* (London: HK. Lewis, 1876).

⁵⁷ For an overview of causation theories see M. Engler, ‘The Causation of Mongolism and its Prognosis’, *Proceedings of the Royal Society of Medicine, Section of Psychiatry* 38 (1945), pp. 211-216.

⁵⁸ P.M.G. Russell, ‘Mongolism in Twins’, *The Lancet* 221, 5720 (1933), pp. 802-803.

result from accidents after uterine life. They are, for the most part instances of degeneracy arising from tuberculosis in the parents.”⁵⁹

A vast array of authors speculated about the causation of ‘Mongolism’. Amongst these were esteemed scholars such as Francis Crookshank,⁶⁰ Clemens Benda, Lionel Penrose, P.M.G. Russell, and Cedric Carter. The prevalence of the condition in all races and economic classes made it an enigma for many physicians, academics and researchers. By the early twentieth century, theoretical and racial premises of ‘Mongolism’ had been discredited by most scholars in the field. John Langdon Down’s ethnic classification of ‘idiocy’ was believed to be severely lacking and limited the term ‘idiot’ to the lowest ‘grades’ of ‘mental deficiency’. Moreover, Langdon Down’s classification of ‘Mongol’ had become synonymous with ‘idiot’ and denied the possibility for any mental development. This misnomer had been debunked by many physicians, including by Langdon Down himself in his original publication.⁶¹ It was observed that ‘Mongolism’ could produce a high functioning individual as well as a ‘Mongolian idiot’.⁶² Most prominent of the new wave thinkers to propose alternate ideas to Langdon Down’s was Lionel Penrose. During the 1930s, Penrose debunked Langdon Down’s ethnic and eugenic theories and reformulated the classification of ‘Mongolian idiocy’ using statistical investigations and improved medical knowledge.⁶³ Despite this, little progress was made in determining the causation since John Langdon Down’s original identification in the 1860s.

⁵⁹ Langdon Down, ‘Observations on an Ethnic Classification of Idiots’.

⁶⁰ See F.G. Crookshank, *Mongol in Our Midst A Study of Man and His Three Faces* (London: Dutton, 1924); and H. Armstrong, ‘The Etiology of Mongolism: With a Case of Mongol Twin’, *The British Medical Journal* 1 (1928), pp. 1106-1107.

⁶¹ For more information see D. Kevles, “Mongolian Idiocy”: Race and its Rejection in the Understanding of a Mental Disease’, in S. Noll and J. Trent (eds), *Mental Retardation in America: A Historical Reader* (New York: New York University Press, 2004), pp. 120-129.

⁶² Patrick McDonagh is one of many authors to assess the use and implications of ‘idiot’ in P. McDonagh, *Idiocy: A Cultural History (Representations: Health, Disability, Culture and Society)* (Liverpool: Liverpool University Press, 2008).

⁶³ Penrose’s findings are expressed in his paper: L. Penrose, ‘The Incidence of Mongolism in the General Population’, *Journal of Mental Science* 95 (1949), pp. 685-688.

The APBC and ‘Mongolism’

In May 1957, Dr Gerald O’Gorman (Physician Superintendent of the Borocourt Hospital, Reading) stated his belief that the unknown cause of ‘Mongolism’ was “an insult to medical science.”⁶⁴ It was understood that ‘Mongols’ were found in every race which prompted greater calls for international research. However, Fryd felt that it was hardly necessary to mention that so-called ‘Mongol’ children were not a genetic anomaly related to Asiatic ancestors; this theory had long been disproven.⁶⁵ Fryd believed that the causal factor was largely ignored by doctors who showed no interest in diagnosing or treating individuals with learning disabilities. She therefore declared that doctors did not care what treatment and care should be facilitated, but rather, whether or not any provisions should be made at all. Working on the belief that the current approach was unjust and overly presumptuous, Fryd challenged the infallibility of medical knowledge and set out to provide new facts about ‘Mongolism’.⁶⁶

Whilst understanding was rapidly improving in the mid-twentieth century, there was a lack of general consensus about the hereditary aspect or cause of ‘Mongolian idiocy’ and how it could be treated and prevented. The numerous aetiological theories are informative of why ‘Mongolism’ was a cause of concern for eugenicists and parents alike; many parents were left with unanswered questions and very little understanding of this condition. Many existing aetiological theories regarding ‘Mongolism’ were largely unproven and considered dubious by medical experts.

This is particularly illustrative of the dispersed approach towards determining the cause of ‘Mongolism’ and the limitations in knowledge that existed. Dr R.M. Stewart declared “it has recently been said that knowledge advances much more slowly than the

⁶⁴ ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957).

⁶⁵ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

⁶⁶ Later, this idea would become engrained in the NAPBC Constitution with the pledge “To encourage more research into causes and treatment of mental handicap.” ‘APBC’, *Newsletter* 2, 10 (June, 1950).

writings of papers, and this is particularly true of [this] subject.”⁶⁷ Fryd felt this was especially accurate and as a result strived to popularise the research conducted into ‘Mongolism’. For instance, in November 1948, she discussed Dr Clemens Benda’s book *Mongolism and Cretinism*, in which it was asserted “this condition is probably caused by some factor in the health of the mother early in the pregnancy. We have certain “hunches” as to what this factor may be.”⁶⁸

During a formal meeting of the APBC, Dr Mary Pantin also spoke of recent research conducted into the occurrence of ‘mental deficiency’ and ‘Mongolism’. She concluded that “15% of the population were mentally backward. 3 in every thousand births were Mongol – these constituted 10% of the “Mentally Defective”.”⁶⁹ Dr Pantin also surmised that the majority of ‘Mongols’ were born to women over the age of 36 and were generally the last to be born.⁷⁰ Pantin reiterated the arguments of other physicians and researchers, concluding that conditions during pregnancy and the health of the mother were believed to affect the general health of the unborn child. Pantin argued that undernourishment, German measles, congenital heart disease, alcoholism, and venereal disease poisoned the whole body and certainly affected the developing foetus. It had long been known that there was a connection between illness during pregnancy and ‘defective’ babies. The discovery of the effects of German measles during pregnancy had come as a great surprise and had opened new possibilities for understanding the causes of ‘backwardness’.

Australian ophthalmologist, Dr Norman Gregg, discovered in the early 1940s that there was a connection with German measles during pregnancy and the likelihood of physical and mental defects in new-borns. Largely in part to this discovery, professionals and

⁶⁷ R.M. Stewart, ‘The Problem of the Mongol’, *Proceedings of the Royal Society of Medicine, Section of Psychiatry* 19 (1926), pp. 11-25.

⁶⁸ ‘APBC’, *Newsletter* 1, 12 (Nov, 1948).

⁶⁹ ‘APBC’, *Newsletter* 2, 3 (May, 1949).

⁷⁰ This idea was initially discussed in G.E. Shuttleworth, ‘Mongolian Imbecility’, *British Medical Journal* 2 (1909), pp. 661-665.

authorities began to investigate the possibility of other influences on pregnancy. Regardless, much of this new investigative work focused on other illnesses, rather than stress and trauma. To combat this risk, mothers with German measles were injected with a substance extracted from human blood called Gamma Globulin which prevented attacks and protected the unborn foetus.⁷¹ It was expected that this research would take between 10 and 20 years to come to fruition. Regardless, enough was currently known to understand that preventative measures were necessary. Cyril Burt surmised: “Scientists have never yet waited for absolute certainty, and we had to judge risks and try to avoid them though they might not be absolute certainties.”⁷²

Contemporary research alluded to the fact that the condition was directly caused by the arrested development of the foetus, most likely between the sixth and eighth week of pregnancy. Despite this increased knowledge, it was still not understood why this arrested development occurred, simply that a crucial stage of development was missed. In previous years, research had determined that maternal age was a factor, as many ‘Mongol’ children were born to middle-aged women. However, Fryd believed that this was ‘putting the horse before the cart’ as a great number of young mothers also had ‘Mongol’ children and so other causes should be researched. According to Fryd: “So far, medical science has been unable to find any means (whether by diet, drugs, homeopathy, massage, manipulation or operation) of enabling the child to become normal.”⁷³

In her understanding of ‘Mongolism’, Fryd was particularly influenced by Penrose who was considered to be the leading authority in Britain on ‘mental deficiency’, and ‘Mongolism’ in particular. Specifically, he analysed the chromosomal disorder previously known as ‘Mongolian idiocy’, which he termed as ‘Down’s anomaly’. He published several

⁷¹ Today, Rubella (previously known as German measles) is prevented with the use of live, disabled virus vaccines and immunisation of children at a young age. This immunisation program has had varying degrees of success, with countries such as Cuba declaring the disease eliminated in the 1990s.

⁷² ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957).

⁷³ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

works, including the seminal 1949 text *The Biology of Mental Defect*⁷⁴ and the much praised *Handbook for Parents*. In a 1949 lecture to the Friends of the Fountain Hospital and members of the APBC, Penrose explained to the audience what he believed to be the most recent updated aetiological theories regarding the underlying cause of ‘Mongolism’.⁷⁵ He asserted that it was less likely that the number of ‘Mongols’ was increasing, but more probable that improved medical and welfare conditions resulted in less premature deaths. Penrose continued that “something went wrong in the 8th to 12th week of embryonic life.”⁷⁶ The use of ‘something went wrong’ is particularly telling of the ambiguity surrounding causation. Ultimately, Penrose believed that the endocrine glands were of particular importance in determining the cause of ‘Mongolian idiocy’. To substantiate this claim, Penrose analysed the secretions of the pituitary glands with a view to eventually reproducing them synthetically in the hopes of curing the symptoms of ‘Mongolism’. Penrose declared that definitive answers in the case of ‘Mongolism’ were extremely elusive and believed that a more hopeful approach was to treat the expecting mother with preventative means once the underlying cause had been discovered. However, this too was overly optimistic.

The uncertainty intrigued and scared researchers and parents equally. The most compelling research on the condition was being conducted in the UK and the USA. The increase in research and medical knowledge created a greater number of empirical facts to influence causation and aetiology theories. Similarly to Penrose, Fryd explained that experiments were also conducted in the USA into pituitary deficiencies. Patients with ‘Mongolism’ were given complete physical, bio-chemical and x-ray examinations before commencing various programmes of treatment. Dr M.A. Halperin of Hudson County, New Jersey, suggested that:

⁷⁴ L. Penrose, *The Biology of Mental Defect* (London: Sidgewick, 1949).

⁷⁵ ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

⁷⁶ *Ibid.*

Both Mongolism and Cretinism are caused by glandular deficiencies. In Cretinism there is a definite thyroid deficiency which, in turn, upsets the secretions of the pituitary; whereas in Mongolism [...] a deficiency of the pituitary hormone upsets the balance of the thyroid. The pituitary is the “master” gland which stimulates all others.⁷⁷

Ideas of thyroid deficiencies and glandular malfunctions intrigued Fryd as they hinted at a possible cure for ‘Mongolism’. Readers often wrote letters to Fryd detailing the effects of glandular and vitamin treatment courses. Physicians often prescribed courses of treatment based on these findings. In May 1949, Fryd published an extract from a letter sent by a mother in the Western hemisphere regarding the usage of vitamin and glandular supplements. To quote:

She [Mrs B.] is a great believer in the efficacy of certain vitamins, particularly Bi (sic) which she calls the “behaviour vitamin”. The whole family take it daily in the form of Betalin Complex of Lilly, in syrup form, and, says Mrs B., it certainly makes for good-tempered children and Mothers! The little Mongol boy also has a daily teaspoonful of “PHYTIN” or “FITINA” granules. This is a nerve food which stimulates the metabolism and increases the appetite. Periodically, about every three months, he has injections of High Potency Ostelin Ampoules. This is to ward off colds and build up resistance to disease. M. [the ‘Mongol’ son] has only been in bed five days during his five years of life.⁷⁸

Halperin elaborated on the potential causes of glandular deficiencies. Much like Penrose, his terminology suggests the trepidation of medical professionals to conclusively diagnose the exact cause of ‘Mongolian idiocy’. Halperin conveyed that the following states were the most likely cause of children born with glandular deficiencies: emotional stress of the mother;

⁷⁷ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

⁷⁸ ‘APBC’, *Newsletter* 2, 3 (May, 1949).

menopause; long intervals between pregnancies; German measles during early pregnancy; womb exhaustion; and the glandular imbalance of the mother.⁷⁹

One suggested treatment explained by Halperin involved implanting a calf's pituitary gland into the abdominal wall of a 'Mongol' child. The gland remained active for approximately two months and needed to be regularly supplemented with pituitary extract injections. Halperin concluded "the treatment is considered beneficial in promoting bone growth and the development of sexual characteristics."⁸⁰ This course of treatment was contrary to eugenic aims and suggested a growing shift away from eugenic ideas, for the advancement of sexual characteristics was incongruent with the extensive sterilisation programmes in the USA. However, ultimately, Halperin noted that chemists and endocrinologists had failed to produce what he deemed to be a "satisfactory fraction of the pituitary gland."⁸¹ This posed a particular problem when estimating the success of glandular treatment courses.

Whilst these ideas may have been presented in a new manner using medical terminology, the actual content and concepts were largely the same as what had been previously presented.⁸² The notion of hormonal and glandular imbalance was not innovative as an explanation. Yet, it gained popularity as a theory due to the possibility of treatment and solution that it alluded to. In spite of the renewed hope of a potential cure, glandular extracts had not yet been proven to be of any practical use in the treatment of 'Mongolian idiocy'. Regardless of this and perhaps owing to a lack of alternative, glandular treatments were not excluded entirely as a possibility. In March 1958, Fryd amalgamated the latest knowledge and research into one, easily understandable article and relayed the fears and worries of many

⁷⁹ 'APBC', *Newsletter* 2, 10 (June, 1950).

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

⁸² Other contemporary authors who had discussed notions of hormonal and endocrine imbalances as the cause of 'Mongolism' included: C.E. Benda, 'Endocrine Aspects of Mongolism', *The Journal of Clinical Endocrinology and Metabolism* 2, 12 (1942) pp. 737-748; and E.N. Warner, 'A Survey of Mongolism, with a Review of 100 Cases', *Canada's Medical Association Journal* 33, 5 (1935), pp. 495-500.

mothers of ‘Mongol’ children in her article ‘The Mongol Child’. She begins by quoting one mother: “They say my baby is a Mongol – what does it mean? Is there anything I can do about it?”⁸³ She continued:

So many parents feel that the information available seems to err in opposite directions and either it is couched in rather brutal terms of a medical textbook, or it glosses over the problem in a rather over-sentimental fashion. In either case, it treats Mongol children as though they were all exactly alike.⁸⁴

These fears and concerns were common in many letters received by the APBC. Another example of the frustration and confusion was expressed by one mother’s concerns over how frequently a ‘Mongol’ child should be taken to different doctors in the hope of finding a cure. Whilst this particular mother had given up the practice of visiting numerous doctors, she still wondered whether it was her duty to do so; believing she was failing her child by not engaging in this routine. For many, the confusion and lack of clear directive concerning ‘Mongolism’ was alarming. Parents were reassured that if a miracle cure was found for ‘Mongolism’ they need not worry about missing this key bit of research as it would surely make headlines across the world.

Fryd suggested that it was important to convey that ‘Mongol’ children were vastly different from child to child. ‘Mongolism’ varied in severity from individual to individual and not all children were affected by the same mental and physical characteristics. Whilst medical knowledge was continuously improving, ‘old wives’ tales’ persisted to influence many opinions. Some asserted that ‘Mongolism’ was caused by the mother trying to get rid of the baby or ‘drawing back’ at the time of conception because the baby was unwanted. Other causes such as venereal disease and immorality had also been linked to the condition.

⁸³ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

⁸⁴ *Ibid.*

However, Fryd was quick to assert: “there is nothing whatever in these suggestions. Nearly all these babies were longed for and eagerly awaited and were born to most respectable families.”⁸⁵ These displays of love and care whilst awaiting the arrival of the child often continued after the child was born. With the love and care of the familial home, many ‘Mongols’ learnt enough skills to have a degree of independence to go to the shops on their own and be ‘normal’ enough in their limitations to live successfully within the community. Fryd concluded that whether or not one agreed with the complete statement, it was hard to deny that ‘Mongol’ children had a lot to reciprocate in exchange for love, comfort and support. As one mother put it in a letter to Fryd:

It need not be regarded as a tragedy [...] one mother thanks God for her “Mongol” child, because the other members of the family though superior in intelligence, were subnormal in human relationships! The “Mongol” though subnormal in intelligence had taught them all a great deal about human relationships.⁸⁶

However, a common characteristic shared by all ‘Mongol’ children was a limitation in terms of intellectual prowess. Again, this limitation varied from child to child, and some were able to flourish in certain areas, while others excelled in different subjects. Take for example this statement made by the followers of Rudolph Steiner, the Austrian philosopher and pedagogue:

[We] believe that the Mongol children have been specifically sent by God to teach people how to love one another, and to teach us that intellectual attainments are by no means the most important things in life [...] It is not just a simple matter of grading either. Some of them who are quite right in their actions and understanding cannot talk at all. Some can talk after a fashion but are very backward. Some can talk well

⁸⁵ Ibid.

⁸⁶ ‘The Parents’ Voice’, *Newsletter* 4, 2 (April, 1953).

and have a sensible conversation. It is usual for Mongols to be excluded from education and passed over to the Health Committee for training in Occupation Centres. Some Mongols, however, have got on reasonably well in a Special School for the Educationally Subnormal. Much depends not only on the child's own personality and capabilities, but on the availability of school places and the willingness of teachers and headmasters.⁸⁷

However, not all professionals in the field were willing to help educate 'backward' children. Many parents were advised by professionals, family, and friends to put their 'Mongol' baby into an institution at the earliest possible stage. This was necessary for some families, due to poor maternal health, inadequate home circumstances, among other reasons. Yet, the majority of parents objected to this and preferred to keep their child at home and seek education possibilities. Ultimately, it was felt that all efforts and decisions should be made in the best interest of the individual and the family.

The 'Mongol' Questionnaire

The lack of support from the authorities and waiting lists for schools, centres and 'mental deficiency' hospitals were seen as directly contradicting the best interests of those involved. The needs of 'Mongol' children, aside from medical aid, were not so different from 'normal' children: love, respect, comfortable environment, food, clothing, and education suitable to their capabilities. However, the parents of 'Mongol' children often had special requirements. These included expert advice on care, and training and avoiding the common milestones in a child's progression to evade expecting too much or too little from the child.

Fryd believed that these assertions were worth further exploration and devised a 'Mongol questionnaire' to gather research from mothers of 'Mongol' children about the

⁸⁷ 'The Parents' Voice', *Newsletter* 9, 1 (March, 1958).

gestation period.⁸⁸ Included in the questionnaire were inquiries into the condition of the mother during pregnancy to ascertain whether or not these factors contributed to the occurrence of a ‘Mongol’ child. Fryd proffered her personal view that the cause of ‘Mongolism’ could be found by further investigation into the psychological and physiological state of the mother during pregnancy. Subsequently, she mentioned that any abnormalities of the mother during the gestation period should be recorded in the ‘Mongol questionnaire’. Questions about vitamin, glandular and endocrine deficiencies were also posed when constructing the ‘Mongol questionnaire’. Fryd believed that establishing the precise cause of ‘Mongolism’ was crucially important. To counter the uncertainty surrounding the condition Fryd compiled the questionnaire to ascertain the significant factors relating to the pregnancy and history of ‘Mongol’ children. Fryd went on to mention that the questionnaire was drawn up for easy reference and research purposes. She began by circulating the aforementioned questionnaire; she described the purpose of the questionnaire as being “to try and discover the cause [...] in order to be able to suggest a possible course of treatment, either educational or medical (surgical).”⁸⁹

Fryd followed the most persuasive contemporary trend towards ‘Mongolism’ being a result of the interplay between both environment and heredity when constructing the questionnaire. Parents were asked for all details of pregnancy, maternal and paternal temperance, details of illness and any drugs or special diets to be recorded.⁹⁰ Fryd’s interjection into the sphere of medical research was largely unpopular in the medical and scientific communities. Many doctors previously associated with the APBC were quick to end their affiliations. This did little to dispel Fryd’s determination. During correspondence

⁸⁸ For an example of the questions included in the ‘Mongol questionnaire’ please see the image in Illustration 6. The discussion of said questionnaire is based upon the text in this image and Fryd’s dialogue in the quarterly newsletters of the APBC.

⁸⁹ ‘Judy Fryd’, Correspondence Between the National Birthday Trust and the APBC (Feb, 1950) in *NAPBC 1948-1953*.

⁹⁰ Unfortunately, I was unable to locate any of the returned questionnaires during the process of my research. Discussions of the results have been based upon discussions and correspondence by Fryd and Moncrieff.

with the APBC, the secretary of the National Birthday Trust, Doreen Riddick commented: “Medical people raise their eyebrows at the idea of a mere mother questioning their diagnosis and methods! But are forced to admit that the last word has not been said yet.”⁹¹

Despite the ambiguity surrounding ‘backwardness’, Fryd initially struggled to convince other, supposed likeminded individuals of the need for better research and reform. Correspondence between Fryd and Riddick is exemplary of this. In her letters to Fryd regarding the ‘Mongol questionnaire’, Riddick explained “the main problem is that the causes of backwardness in children have been brought about by many varied factors, inherent abnormality, birth injury, lack of oxygen, etc., and unless each child is examined by a Specialist, and indeed the *same* Specialist, material gathered over a large sample in this way would not be of use in a scientific investigation.”⁹² Riddick herself was a devoted advocate for improved maternity services; yet her approach to the research being conducted by the APBC was less than supportive. Fryd frequently encountered these half-hearted approaches to her campaigns; further prompting her to fight for social and political change.

However, it was not merely physicians and professionals who opposed Fryd’s questionnaire. Many parents were reluctant to detail their family history through fear of discovering that their ‘Mongol’ child was a result of their genes. This demonstrates eugenic uses of the concept of stigma were still heavily prevalent. Entire families were often shunned and isolated by the community if they had a ‘mentally defective’ child. Fryd responded to these anxieties by promising anonymity and assurances of importance: “Some of the questions are very personal, but it is hoped that members will cooperate fully, in the knowledge that they are helping possibly to prevent their tragedy happening to future

⁹¹ ‘Judy Fryd’, Correspondence Between the National Birthday Trust and the APBC (Feb, 1950) in *NAPBC 1948-1953*.

⁹² ‘Doreen V. Riddick’, Correspondence Between the National Birthday Trust and the APBC (Jan, 1950) in *NAPBC 1948-1953*.

generations of parents.”⁹³ The use of the term ‘tragedy’ is particularly illuminating to the social and political limitations placed upon the ‘backward’ individual and their family.

Regardless of the initial negativity, as a whole the questionnaire was well received and Fryd was able to compile representative case histories to pass on to the renowned paediatrician, Sir Alan Aird Moncrieff of The Fountain Hospital.⁹⁴ As a result of the ‘Mongol’ questionnaire, it was determined that the majority of members of the Association had a child who was considered to be a ‘Mongol’. Parents were encouraged to keep records of their children’s abilities as well as disabilities by professionals as this was an important research tool. This information was used by professionals to assess the best educational methods and capabilities and disabilities of ‘backward’ children.

As demonstrated here, for Fryd, associating the APBC with leading professionals in the fields of child health and ‘mental deficiency’ was vital. Moncrieff’s assistance with compiling and assessing the information gathered from the ‘Mongol questionnaire’ helped Fryd to confirm previous theories that one in seven hundred children born was a ‘Mongol’ and that the risk steadily increased with maternal age. Owing to the success of the first ‘Mongol’ questionnaire, in the summer of 1958, the results of the second ‘Mongol’ questionnaire were published in *Parents’ Voice*. Due to the growing support and awareness of the Association, and the diminishing social stigma, a good result was received. The follow up questionnaire was designed to gather feedback on the mental health of the entire family, but in particular the mental state of brothers and sisters of ‘Mongols’. The questionnaire contained the same questions for both ‘mental defectives’ and their siblings. There were 1,309 completed questionnaires returned: 765 were directly related to the ‘Mongol’

⁹³ ‘APBC’, *Newsletter* 2, 3 (May, 1949).

⁹⁴ A limited selection of Moncrieff’s works include: A. Moncrieff, *A Textbook on the Nursing and Diseases of Sick Children for Nurses, and Welfare Workers* (London: Waverley Book Company Ltd, 1930); A. Moncrieff, ‘Safe Milk and the Young Child’, *The Lancet* 241, 6250 (1943), p. 757; A. Moncrieff, ‘Social and Preventive Medicine’, *The Lancet* 243, 6280 (1944), p. 67; and A. Moncrieff, ‘Tests for Respiratory Efficiency the So-Called Dead Space’, *The Lancet* 221, 5723 (1933), pp. 956-961.

themselves; 390 questionnaires related to other 'mental handicaps'; and finally 154 were returned with information of 'normal' brothers and sisters. Whilst this result was certainly an improvement on the first 'Mongol' questionnaire,⁹⁵ it was hoped that the remaining 2,000 questionnaires which had been dispatched would be returned, preferably with details of siblings.

Owing to the successes of the first two questionnaires, the APBC discovered that members could be used as a valuable research tool. Subsequently, the APBC continued to question members about the care and help they received from the LAs during the 1950s, in the form of mini questionnaires. The responses received confirmed the APBC's suspicions; current methods of providing information and help to parents of a 'backward' child were disproportionate and inadequate in the early years. The questionnaire composed by Dr Denis H. Stott and the APBC included inquiries into health and education. Stott suggested twenty-two lines of inquiry in addition to the Association's questions. The questionnaire began: "Would any mother who suffered from shin trouble of any sort during pregnancy before the birth of her mentally defective child, please get in touch?"⁹⁶

As before, members were urged to complete the questionnaire in as much detail as possible; questions primarily focused on education and medical research. It was hoped that the APBC's Research Committee would also be able to utilise the members' response to direct further research lines of inquiry. The results of these mini questionnaires were often prepared and presented to the appropriate governing bodies, such as Parliament Deputations or the Royal Commission. In the summer of 1955, it was noted that there was a good response to Stott's questionnaire. Members of the APBC without a 'backward' child were also encouraged to complete the questionnaire; this information was used to assess the impact of 'backwardness'.

⁹⁵ Exact figures for the first 'Mongol' questionnaire are not given, but Fryd repeatedly mentioned the greater response to the second 'Mongol' questionnaire.

⁹⁶ 'The Parents' Voice', *Newsletter* 4, 2 (April, 1953).

By May 1956, it was remarked that over one thousand responses to the questionnaire had been received from members about their 'backward' children; approximately half of the questionnaires related to 'Mongol' children. It was remarked that a greater number of responses about 'normal' children or siblings of a 'mentally deficient' child were received than had been hoped for. The Association believed that largely thanks to the completed questionnaires, they were on the cusp of some very important discoveries. Despite this, the need for an additional 4,000 completed questionnaires was urged to confirm the preliminary results. The questionnaire's results highlighted troubles during early pregnancy which required further investigation, and relatively few cases of 'high grade deficiency' were caused by heredity.

Stott was particularly revered by the APBC and frequently updated its members with the most recent and relevant information. Whilst a considerable amount of work had already been conducted on the field of mental health, Stott stated that it was astounding how relatively little information there was compared to other medical and scientific fields. He believed that many potential researchers were discouraged by 'old wives tales'. In May 1957, he described how academic teaching was often based on folklore, such as the effect the mother's thoughts and mentality had on the foetus during pregnancy. Other examples included how, for many years, it had been assumed that the foetus was completely protected during pregnancy, and thus the gestation period had been largely ignored. Many still believed that every individual was born with a specific amount of intelligence. This misguided viewpoint often led to a dichotomy of opinions regarding whether or not social environment had any effect on intelligence and if so, to what extent could an improvement be made.

Various attempts had been made to comprehensively answer this question, including tests performed on identical twins raised in different environments.⁹⁷

These experiments proved that environment and heredity were extensively entwined and ascertaining the effect of each individually was futile and ultimately unhelpful. Stott suggested that the subject of prenatal life was far more important and useful to understanding the subject of ‘mental deficiency’. In his opinion, too many academics had failed to address this area sufficiently and did not fully comprehend the impact of ‘congenital defects’. The latter term recognised the impact of both environmental and hereditary factors. However, Stott believed that by debunking and discarding the many preposterous tales that “we may have thrown the baby out with the bathwater.”⁹⁸

Stott was a psychologist by profession and aware of the connection between mental stresses and physical defects. Consequently, Stott conducted an investigation about a wide range of emotional factors during pregnancy, including paternal illness, serious incidents and accidents, and harassment and distress. Stott concluded that these events occurred more frequently in the cases of mothers with a ‘mentally defective’ child than those who had a ‘normal’ child. The case histories of a control group of children were used to ensure that the study was as accurate as possible. Stott discovered the same level of trauma, stresses and illnesses, but deemed these children to be lucky as they only suffered from physical effects, and not mental conditions. Stott concluded that 1 in 3 women who suffered some trauma or distress during pregnancy had a ‘mentally defective’ child, whereas, similar conditions or illnesses were only found in 1 in 10 healthy pregnancies. Fundamentally, Stott firmly

⁹⁷ Perhaps most infamous of these was the work conducted by SS Officer and Physician in Auschwitz Concentration Camp, Josef Mengele. Mengele held a particular interest in the subject of twins and subjected inmates at the concentration camps to human experimentation. For a fuller explanation of Mengele and human experiments conducted in the Third Reich see P. Weindling, *Victims and Survivors of Nazi Human Experiments: Science and Suffering in the Holocaust* (London: Bloomsbury, 2015).

⁹⁸ ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957).

believed that a big leap in research was made when the initial core group of mothers of the APBC were willing to ‘put their cards on the table’ and aid, encourage and advance research.

Stott utilised a candid approach to produce new theories about pregnancy and early life of ‘backward’ children. He personally thanked the mothers for their honest and comprehensive information: “It will be a consolation to know that through their mentally handicapped children they have been able to play a part in what may prove to be a decisive contribution to science.”⁹⁹ Irrespective, many challenges still faced reformers; general practitioners and society were either misinformed or not greatly concerned with the subject of ‘mental deficiency’.

It was not until 1958 that the ‘Mongol’ question would receive a scientific answer. The discovery of karyotype techniques in the 1950s made it possible to identify chromosomal abnormalities in ‘Mongoloid’ individuals. Jérôme Lejeune discovered that ‘Mongolism’ resulted from an extra chromosome and, as a result, the condition became formally known as ‘Trisomy 21’.¹⁰⁰

⁹⁹ ‘The Parents’ Voice’, *Newsletter* 8, 4 (Nov, 1957).

¹⁰⁰ See J. Lejeune, ‘Mongolism: Premier Exemple d’Aberration Autosominque Humaine’, *Annual Genetic* 1 (1959), pp. 41-49; J. Lejeune, M. Gauthier and R. Turpin, ‘Etudes des Chromosomes Somatiques de Neuf Enfants Mongoliens’, *Comptes Rendus l’Académie des Sciences* 248 (1959), pp. 1721-1722. However, terminology surrounding the condition remains a complicated and debated issue; the assumption and emphasis on Lejeune as the principal figure in the discovery of ‘trisomy 21’ has been challenged by his former colleague, Marthe Gauthier. Peter Harper has further commented on this and emphasised the role of Lejeune’s team rather than the previously accepted notion that Lejeune worked alone. See M. Gauthier, ‘Cinquante ans de la Trisomy 21. Retour sur une Découverte’, *Medicine/Sciences* 25, 3 (2009), pp. 311-315; and Peter Harper has recently translated Gauthier’s paper and provided a commentary in P. Harper, ‘Fiftieth Anniversary of Trisomy 21: Returning to a Discovery’, *Human Genetics* 126 (2009), pp. 317-324; P. Harper, *A Short History of Medical Genetics* (Oxford: Oxford University Press, 2008), pp. 151-158. Despite the change in understanding, commonly the condition was still referred to as ‘Mongolian idiocy’. Noting the ‘misleading connotations’ of such a description, grandson of John Langdon Down and Physician Superintendent of Normansfield Hospital, Norman Langdon-Down and seventeen other geneticists penned a letter *The Lancet* in 1961, petitioning for a name change suggesting the term ‘Mongolian idiocy’ was inappropriate, a misnomer, and embarrassing. In 1965 the WHO officially dropped pejorative references to ‘Mongolian idiocy’ and used the term Down syndrome instead. In 1992 the *Index Medicus* changed from Down’s Syndrome to Down Syndrome. Despite this, in the same year over a hundred authors continued to use the former; no authoritative body has officially pronounced on the matter. Instead the historical validity of the term appears to be reason enough for its continued usage.

‘Brain Injury’ and Other ‘Mental Defects’

Whilst ‘Mongolism’ played a vital role in the development of the APBC, other mental impairments and their causes were of equal importance to the Association. These conditions were broadly termed ‘brain injury’. Dr Gordon Sidney Claridge, prominent psychologist and eminent author on schizotypy,¹⁰¹ was concerned with the comparatively inadequate amount of research being conducted in the mental health field. Claridge stated that for those involved, the subject of training was probably the most important factor in their lives. He was keen to note that training ‘mentally deficient’ children required great patience. Preliminary research on the subject of training had suggested that much more could be done for these children; achievable targets were believed to be critical to their progress. Claridge called for more research into organic factors, such as brain damage. Claridge felt that the old viewpoint that these individuals were ‘unfortunate creatures’ needed to be relinquished.¹⁰²

By the mid-1950s a selected minority of researchers began to recognise the benefits of discovering improved methods of training to improve so-called ‘backward’ individuals’ self-confidence and mental faculties. Dr Alfred Highfield began a series of articles in conjunction with experts on the subject, designed to inform readers of the positions of ‘mentally deficient’ persons in the UK and abroad. Highfield hoped that this series of articles would highlight the need for more in-depth research into training methods, and specifically research which would complement the existing medical research. It was suggested that it should not be simply accepted that ‘backward’ persons had damaged brains, but instead the reasons for these broken/incomplete connections needed to be investigated. Ultimately, Highfield believed that

¹⁰¹ Schizotypy is a psychological theory which argues that there is a continuum between normal and abnormal psychological traits, ranging from normal dissociative to psychosis and schizophrenia. See G. Claridge, *Schizotypy: Implications for Illness and Health* (Oxford: Oxford University Press, 1997).

¹⁰² ‘The Parents’ Voice’, *Newsletter* 7, 4 (Nov, 1956).

the goal of research should be to engage the brain which he felt was “unwilling to work for its own recovery.”¹⁰³

In the summer of 1955, James McClure Smellie (Professor of Paediatric and Child Health at the Birmingham’s Children Hospital) spoke of the effects of ‘brain injury’ on a child’s physical and mental health at the APBC National Convention. Smellie told of the latest research into ‘brain injury’ and explained the workings of the brain itself. He deduced that the brain was an extremely fragile organ made up of twelve nerve cells upon which the correct functioning of other body parts were dependent. Within the first few months of intra-uterine life it was believed that the central nervous system pervaded every tissue of the body. Disturbances in growth during the gestation period such as German measles, or x-ray treatment during the early months, could adversely affect the baby’s character or create a pause in growth. Smellie believed that great advances had been made in the standard of care given to mothers and their babies in the UK and the level was at an all-time high. Procedures such as blood tests were given to all expectant mothers to identify anomalies, and blood pressure readings were taken in the hopes of discovering other problems. Additionally, advances had been made in provisions for care of premature babies. It was established that the first five minutes of a baby’s life were the most critical; deprivation of oxygen in this time window could have serious and long-lasting effects. However, the complete growth of the brain and nervous system took years to occur; by three years old the brain had doubled its weight. A varied and balanced diet was considered vital to the correct development of the brain, and it was understood that certain conditions prevented the growth of the brain, such as meningitis, encephalitis, and German measles, to name but a few. Professionals were beginning to understand that early diagnosis of such conditions was vital and that with

¹⁰³ ‘The Parents’ Voice’, *Newsletter* 7, 1 (Feb, 1956).

modern medicine more favourable outcomes could be hoped for. Smellie declared that if detected early enough certain brain affecting conditions could be completely cured.

However, ‘mental deficiency’ could be caused by an endocrine or thyroid gland dysfunction; proposing that ‘mental disorder’ could be caused by defects in other areas of the body. Physical defects were commonly associated with mental disorders. Examples of this include skull shape and size; a small skull was believed to prevent the development of the brain, however, exploratory surgery soon discovered that it was in fact the poor development of the brain itself which prevented the correct growth of the skull. Similarly, a large skull was discovered to be a result of too much fluid on the brain; blood typically produced a quarter of a pint of cerebral fluid which circulated through the nervous system, brain and back into the bloodstream approximately two or three times a day. However, when this fluid was retained by the brain, hydrocephalus was created.

Whilst many advances had been made in the medical and scientific fields, Smellie declared that there were still sizeable gaps in the subject of ‘mental deficiency’. It is possible to surmise that medical and scientific professionals were beginning to understand that eugenic methods of heredity to explain conditions were tired, out-dated, and often incorrect; the new age of medical and social discovery had begun. Smellie dispelled many myths and misunderstandings previously believed to be fact: “Perhaps in the past it had been just a little too easy to incriminate family or genetic factors because we could not find another cause. The hereditary factor certainly did not apply in most cases of gross mental defect, which could appear in any family.”¹⁰⁴

¹⁰⁴ ‘The Parents’ Voice’, *Newsletter* 6, 3 (Summer, 1955).

Lise Gellner's Lecture on the Brain

Another academic quoted in the APBC's newsletters was Dr Lise Gellner and her lecture at Bowes Road School, Arnos Grove, London entitled 'The Brain, it's functioning in Health and Disease'. Gellner conveyed her knowledge of the brain during the course of the lecture. In turn, Fryd relayed this information to the readers of the APBC newsletters that ordinarily would not have the latest information on medical advances available to them. This is further example of Fryd's campaign for education and her quest for new knowledge. Gellner provided a brief history of medical sciences and how these helped to form public and medical opinions of those with 'mental deficiencies'. According to Gellner, medical science in medieval times was inhibited by the church and their refusal to allow post-mortem examinations. Consequently, physicians had to resort to prescribing medication and making diagnoses based on the visible symptoms of the disease; often referred to as 'symptomatic diagnoses'.¹⁰⁵ Gellner illustrated that due to many different conditions presenting with the same symptoms, diagnoses were often ineffective unless the source of the symptoms was considered. Furthermore, Gellner questioned why previous physicians had not disputed the causal factors behind 'mental deficiency' in greater depth. In her opinion, the complexities of the functioning of the brain were the reason that causation was largely neglected. Unlike other internal organs (such as the lungs, heart or bowel) the mechanisms of the brain were virtually impossible to understand in a living person. The functioning of organs was established through animal experiments and observations. However, this was of little help in the case of the brain and its relationship to mental faculties in humans.

Gellner explained that since the 1920s vast improvements had been made in the exploration of the brain. She highlighted the importance of WW1 and WW2; these periods of

¹⁰⁵ For a more detailed discussion of 'symptomatic diagnosis' see: M. Nicolson, 'The Art of Diagnosis: Medicine and the Five Senses', in W.F. Bynum and R. Porter (eds), *Companion Encyclopaedia of the History of Medicine 2* (London: Routledge, 1993), pp. 801-25; S.J. Reiser, 'The Science of Diagnosis: Diagnostic Technology', in Bynum and Porter, *Companion Encyclopaedia of the History of Medicine*, pp. 826-51.

conflict led to valuable discoveries about head injuries and certain functions of the brain.¹⁰⁶ Moreover, the connections between the brain and mental processes were improved by pathology tests performed on infants who had died soon after birth. Comprehensive animal experiments on conditional animal reflexes, and modern methods of brain surgery and x-ray investigations of the skull, were also critically important. Moreover, the structure of the brain was comprised of a large number of ganglions or collected nerve cells. These ganglions formed pathways to the glands, muscles and supposed cortical centres of intellect and judgement. Gellner believed that ‘mental deficiency’ could be caused by a lesion in these specific centres during birth. Regardless of this new wealth of information, little had been done to gather the knowledge into a single, cohesive theory.

Diagnosis and treatment of ‘mental deficiency’ was still heavily reliant on symptoms; Gellner asserted that doctors “set little store by symptomatical treatment.”¹⁰⁷ Yet, as aforementioned, doctors were reluctant to investigate the cause of the condition. As a result, patients with ‘mental deficiency’ were often referred to osteopaths, chiropractors and ‘quacks’ to attempt to guarantee treatment. It was suggested that physicians essentially abandoned their patients with various forms of ‘mental deficiency’ and such treatment was sanctioned by the government and tolerated by the vast majority of society. Fryd summarised Gellner’s approach thus: “such people never really attack the cause of the disability and never really overcome the mental handicap.”¹⁰⁸ Fryd inferred that even those commissioned to improve the lives of the ‘mentally deficient’ were unable to see the individual without the disability. This tenet remains problematic for reformers of mental illness to the present, and is

¹⁰⁶ For a more comprehensive account of the history of neurology see F. Clifford Rose, *History of British Neurology* (London: Imperial College Press, 2012).

¹⁰⁷ ‘APBC’, *Newsletter* 2, 6 (Dec, 1949).

¹⁰⁸ *Ibid.*

discussed in works by prominent disability scholars such as Tom Shakespeare and Cliff Cunningham.¹⁰⁹

Gellner, like Fryd was a mother of a ‘brain-injured’ child and a staunch advocate and campaigner for equal rights for ‘mentally deficient’ children. By October 1950, Gellner, a medical consultant and trained teacher, was appointed to the official Research chair of the NAPBC¹¹⁰ by the National Council; she would later become a member of the NAPBC National Council also. She often travelled to the USA to obtain the most up-to-date research to relay to the members of the APBC and was put forward to represent the APBC at the International Congress on Mental Deficiency before its cancellation in 1951. Gellner featured prominently in the APBC newsletters in her research role during the late 1940s/early 1950s before her relocation to Ohio State University as a Fellow in April, 1952. Her research work at Ohio State University focused on a project entitled ‘Diagnosis and Education of the Brain Injured Child’ at Columbus State School.

Gellner’s experiences when dealing with her ‘brain-injured’ son, Michael, closely echoed Fryd’s own story. Gellner was advised to put her son into an institution and not to “waste money on him.”¹¹¹ This recurrent theme and repetition of phrasing hints at the social inadequacies and ineptitude which reformers fervently campaigned against. The majority of campaigners were parents (more specifically mothers) with children with varying degrees of learning difficulties. Regardless of the maternal pursuit for equality, mothers themselves were denied equality in matters of caring for their ‘mentally defective’ children as evidenced by the NHS act:

¹⁰⁹ C. Cunningham, *Down Syndrome: An Introduction for Parents and Carers* (London: Souvenir Press, 1982); T. Shakespeare, *Disability Rights and Wrongs* (Abingdon: Routledge, 2006); T. Shakespeare (ed), *The Disability Reader: Social Science Perspectives* (London: Continuum, 1998).

¹¹⁰ A post later filled by Sir Cyril Burt upon her relocation to the USA.

¹¹¹ ‘APBC’, *Newsletter* 2, 6 (Dec, 1949).

A patient detained in any such institution or under such care as aforesaid shall be discharged on a direction in writing given under his hand by the appropriate relative [...] In this section the “appropriate relative” means husband or wife, or if there is no husband or wife, [...] the father, or if there is no father, or if he is incapable as aforesaid, the mother, or if there is no mother, or if she is incapable as aforesaid, then any one of the next of kin.¹¹²

This demonstrates that in reality women themselves possessed little power of attorney for their children, be it the institutionalisation or release of said child in the early 1950s. However, much like Fryd, Gellner refused to abandon her son in an institution; instead she too opted to educate herself and studied her son’s specific condition and ‘mental deficiency’ as a whole. From her extensive examinations she deduced that in some exceptional cases ‘mental deficiency’ was a result of hereditary or pre-natal incapacity of the cortical nerve cells to develop correctly. However, Gellner believed that in the majority of cases ‘mental deficiency’ was an outcome of a circumstantial lesion caused by a haemorrhage during birth. Unlike many researchers, Gellner’s hypothesis did not rely on repeated knowledge from the 1860s. Gellner made fresh observations culminating in a rejuvenated approach towards ‘mental deficiency’. This suggests that substantial medical advances in the 1940s were aided by those with a vested personal interest.

After deducing the exact cause for her son’s symptoms of ‘mental deficiency’ she was able to teach her supposed ‘ineducable’ son to write within two months. She utilised her own special technique, specifically catered for the remaining unimpaired pathways. Cautiously, Fryd relayed to the readers that it would be unwise to publicly propose a singular method suitable for all children without a prior examination and diagnosis of each child. For Gellner: “the method outlined should not be applied indiscriminately to all children who were unable

¹¹² ‘National Health Service Act, 1946. 9 and 10 GEO. 6. CH. 81’ http://old.post-gazette.com/pg/pdf/201004/2010_national-health-service-book_01.pdf (Accessed on 22/07/2013).

to talk.”¹¹³ This highlights that Gellner and by proxy, Fryd, understood the particular nuances and variations available under the banner of ‘mental deficiency’; detail often overlooked and abandoned by authorities, physicians and society. Fryd furthered this by declaring: “I would stress that expert diagnosis should be sought before trying out this, or any other educational or medical treatment which may be mentioned in the Newsletter.”¹¹⁴ Whilst Fryd was frequently at odds with the differential diagnoses of ‘backward’ by doctors, she had no misgivings about the important role of physicians in attaining better resources for ‘defective’ children. Fryd postulated that given the successful treatment courses on ‘brain injured’ adolescents, the potential for success with children in their early years was immeasurable. Fryd warned the readers of the APBC newsletters:

How extremely careful one must be in making statements regarding the future development of the brain injured child, it cannot be urged too strongly that such differential diagnosis and the introduction of these methods (which are achieving success even when begun at 12 years plus) would save many children in this country from the Mental Deficiency Colonies.¹¹⁵

Fryd discussed the variations between the many forms of ‘mental deficiency’ in December 1958. In Fryd’s ten years’ experience she found that there was one group of parents who did not feel that their children were intellectually deficient, but instead that they failed to express themselves correctly. This resulted in the derangement of expression often association with this type of child (what would later be known as Autism.) Fryd summarised parents’ attitudes with the quote “MY CHILD ISN’T MENTAL – he’s only a bit awkward.”¹¹⁶ She personally understood the fears expressed by these parents, as she too had an ‘other worldly’ child, her

¹¹³ ‘APBC’, *Newsletter* 2, 6 (Dec, 1949).

¹¹⁴ Ibid.

¹¹⁵ ‘APBC’, *Newsletter* 1, 12 (Nov, 1948).

¹¹⁶ ‘The Parents’ Voice’, *Newsletter* 9, 4 (Dec, 1958).

daughter Felicity, who was not intellectually stunted, but rather lacking in emotional expression. Another parent commented about her similar situation: “In many ways she is quite clever, she understands everything that is said to her, but she just won’t talk.”¹¹⁷

Fears were accentuated by many believing that these parents were unable or refused to accept the truth about their children. However, many professionals believed that this area of ‘mental deficiency’ had not been fully researched and parents felt that labelling these children as ‘mentally deficient’ was an ill-informed assumption. Dr Michael Creak of the Institute of Child Health at Great Ormand Street Hospital, London, described these children as ‘juvenile schizophrenics’ in the *Journal of Mental Science*; a description many felt was far more appropriate. Yet, the medical profession had currently denied the idea that this subgroup of children were suffering from a mental illness rather than simply ‘mentally deficient’.

Gellner’s works continued to influence and instruct the APBC’s research aims. Yet, Gellner was by no means the only academic to write on the subject of ‘brain injury’. However, in Fryd’s opinion she was one of the few professionals who approached the matter of ‘backwardness’ with a practical and rejuvenated approach. This resulted in new and innovative research as detailed above. Irene Gairdner, prominent member and General Secretary of the British Epilepsy Association (founded in 1950), also wrote about the child affected by ‘brain injury’. Gairdner specifically focused on the needs of the ‘child with fits’, or epilepsy. Gairdner believed that many supposed ‘backward’ children were actually epileptic; the brain damage as a result of oxygen deprivation during fits caused ‘backwardness’ and thus further fits. However, determining the cause of seizures was incredibly difficult; the most common type of seizure was known as ‘idiopathic epilepsy’ or ‘no known origin’. Gairdner declared that whatever the cause of epilepsy, the problems and treatment should be the same.

¹¹⁷ Ibid.

During the mid-twentieth century, treatment, medication and diagnosis methods were continuously improving. The APBC stated it was of the utmost importance that parents sought out the best neurological and psychological care at the earliest opportunity to prevent 'backwardness'. Upon determining the form of epilepsy, it was understood that physicians and parents would be able to better consider the benefits of surgery, medication and education for each individual. Parents were reassured of their duty to ensure that medical professionals were performing their responsibilities to the fullest extent. Comprehensive union and co-operation was urged between the family and physician; the smallest of details, whether good or bad, should be conveyed to the doctor even in the seemingly helpless cases.

As mentioned above, many advances had been made in the medical and scientific fields, specifically, those in relation to 'mental deficiency'. The Deputy Physician Superintendent of the Fountain Hospital, Dr Brian H. Kirkman, spoke of the specialist research occurring at the hospital in May 1956. Kirkman outlined a number of cases where the cause of 'mental deficiency' had not only been discovered, but also a course of treatment had been established.¹¹⁸ These included: 'cretinism' – caused by thyroid malfunction; 'jaundice of the new born' – caused by the 'Rhesus factor'; an incompatibility of blood groups; biochemical anomalies – caused by phenylketonuria and insufficient diet; 'brain injury' – caused by syphilis or meningitis. Additionally, the researchers at the Fountain Hospital were able to eliminate several social factors by the correct nutrition of expectant mothers and proper management of childbirth. Whilst research facilities, such as the Fountain Hospital, were making advances, there were still many areas which required further investigation. Kirkman suggested that the outcome for research was optimistic on the proviso that a pragmatic and practical approach was taken. It was estimated that 3% of the population were 'mentally deficient' and this matter should remain an active interest for professionals in

¹¹⁸ For more examples of Kirkman's work on the causation of 'mental deficiency' see B.H. Kirkman, 'Rubella as a Cause of Mental Deficiency', *The Lancet* 266, 6900 (1955), pp. 1113-1115.

the field. Kirkman concluded that the APBC would be most effective if they could help to remove the barrier between ‘mental deficiency’ and medical research. To succeed in this, the APBC established their own journal intended for academics interested in ‘mental deficiency’.

The Journal of Mental Deficiency Research

By the autumn of 1958 considerable ground had been made on the understanding of ‘mental deficiency’, its causes and treatment. Fryd asserted that the most common mistake many made was that ‘mental deficiency’ was one subject, separate from other aspects of health, education and welfare. In order for this misunderstanding to be rectified, Fryd felt that it was “time to give a decent burial to the Kallikak family.”¹¹⁹ It was generally understood in academic circles that heredity was only a small factor in the cause of ‘mental deficiency’, despite the longstanding assumption, and the legacy of the eugenics movement suggesting that it was a major contributor. Neil O’Connor (MA, PhD) discussed this issue in his article ‘The Problem of Severe Mental Handicap’.¹²⁰ O’Connor spoke of how ‘educationally subnormal’ individuals should be considered to be a new separate category from the broader definition of ‘mental deficiency’. It was suggested by G.O. Lewis that 25% of all ascertainable defects were ‘gross defects’.¹²¹ Individuals with ‘gross mental defects’ were assumed to have an IQ lower than 50; ‘educationally subnormal’ individuals were believed to have an IQ between 50 and 75. Following the extensive research carried out by Beate Fliess Hermelin and O’Connor, the average IQ of ‘imbeciles’ was established as 33.¹²² This suggested that many declared to be ‘mentally deficient’ were, in fact, more educationally

¹¹⁹ ‘The Parents’ Voice’, *Newsletter* 9, 3 (Autumn, 1958).

¹²⁰ N. O’Connor, ‘The Problem of Severe Mental Handicap’ in ‘The Parents’ Voice’, *Newsletter* 7, 4 (Nov, 1956), p. 12.

¹²¹ *Ibid.*

¹²² For a more comprehensive understanding of O’Connor and Hermelin’s work see: N. O’Connor and B. Fliess Hermelin, ‘The Role and Concept Learning of Imbeciles’, *Journal of Intellectual Disability Research* 2 (1958) pp. 21–28; B. Fliess Hermelin and N. O’Connor, ‘Reading Ability of Severely Subnormal Children’, *Journal of Intellectual Disability Research* 4 (1960), pp. 144–147; and B. Fliess Hermelin and N. O’Connor, ‘Recognition of Shapes by Normal and Subnormal Children’, *British Journal of Psychology* 52 (1960), pp. 281–284.

capable than had previously been thought. Without improved understanding and support, it was suggested that few realistic gains could be made for persons with learning difficulties and their families:

In helping many of them [mental defectives] to gain independence, and thus relieve their families, and the State of much burdensome custodial care and that intensive research into causes and treatment of mental handicap would give more lasting results than the drastic measures advocated in some circles.¹²³

In order to advance their research activities, in April 1954, the APBC established a Research Sub-Committee, specifically designed to advance the existing knowledge on ‘mental deficiency’. Sir Cyril Burt, Emeritus Professor of University of London and esteemed author of the standard textbook *The Backward Child*, was offered the Chairmanship of the Committee, which he gratefully accepted. In April 1954, Fryd published a review of Burt’s *The Causes and Treatment of Backwardness*.¹²⁴

Burt’s article charted the problems of ‘backwardness’ from its origins, through studies and methods of investigation, environmental influences, and personality attributes. Burt described the changes in trends of thought about the problem of ‘mental deficiency’ as new research and knowledge was gained. Ultimately, Burt was able to provide practical conclusions about the contemporary methods of educating, training, and caring for ‘backward’ children. However, Burt was by no means the only professional to affiliate himself with the Research Sub-Committee; a number of other leading experts in the educational and medical fields had agreed to participate and serve on the Committee. Numerous projects were conceived, including a journal for ‘mental deficiency’ research findings and questionnaires involving members to gather more exhaustive research. The

¹²³ ‘The Parents’ Voice’, *Newsletter* 2, 3 (July, 1951).

¹²⁴ C. Burt, *The Causes and Treatment of Backwardness* (London: University of London Press, 1954).

Research Sub-Committee allowed the APBC to be at the forefront of research and a driving force for further exploration.

The work of the Research Sub-Committee was critically important, but it was by no means quick. In July 1954, it was remarked “[the activities of the Committee] were naturally less spectacular being a long term task both in Medical and Educational fields.”¹²⁵ Whilst the APBC were constitutionally bound to further research, funds were continuously low during the 1950s and contributions were desperately needed. During the mid-1950s the Medical Research Council were only able to spare 2/- from every £1 donated to ‘mental research’. In August 1957, the first meeting of the Association’s Research Fellowship was reported on. Consideration was placed in two broad subjects: the needs of ‘backward’ children and detailed recommendation for the authorities. The former consisted of: a list of the needs of ‘backward’ children; the need to exert pressure on a national level over a sustained period of time; the importance of early diagnosis and research into causation; and the need for more and better special schools, occupation centres, adult training centres, halfway hostels and hospital accommodation. Additionally, increased help for mothers was sought, including available short-stay care facilities for emergency situations. The latter subject focused on the need for expert and sympathetic help for parents; particularly mothers upon discovering that their child was ‘mentally defective’.

To aid this and uphold the objectives set out at the very beginning of the APBC: “to encourage research into causes and treatment of mental handicap”¹²⁶ it was decided in April 1954, that if enough funds were available, a *Journal of Mental Deficiency* should be established.¹²⁷ It was believed that this resource would be a valuable asset to all professionals and interested bodies. However, due to financial restraints, the idea of a journal specifically

¹²⁵ ‘The Parents’ Voice’, *Newsletter* 5, 3 (July, 1954).

¹²⁶ ‘The Parents’ Voice’, *Newsletter* 1, 1 (Oct, 1950).

¹²⁷ The title *British Journal of Mental Retardation* was also considered, though eventually discarded in favour of the *Journal of Mental Deficiency*.

for ‘mental deficiency’ research was deferred by the National Council. Initially, it was intended for the journal to be funded by the Association’s research fund; it was hoped that it would soon be self-sufficient. It was not until February 1957, that the APBC were fiscally stable enough to once more consider the project. In addition to the issue of finance the Association believed that the journal content and audience was of utmost importance and required extensive consideration. It was agreed by all that Professor Lionel Penrose should serve as Chairman of the Editorial Board due to his expertise. The Research Council decided that articles would consist of reports on new research and experiments concerning ‘mental deficiency’ of all variations. These articles would comprehensively address the matter of ‘mental deficiency’ from medical, psychological, educational, and sociological perspectives. Ultimately, the primary audience was the academic and professional communities. It was hoped that it may be of interest to APBC members and the lay public, despite the technical terminology. Fryd believed that the journal would be a gift to the medical and scientific spheres and to those in the education field. To gauge the possible reception and help compose the structure of the journal, the Research Committee consulted with various senior staff of ‘mental deficiency’ hospitals, university medical scientists, and university educationalists, the Education Research Foundation, the MoH and the MoE. Everybody agreed that the journal would serve a vital role and help fill a serious gap in the current academic sphere; namely that it would be able to co-ordinate and unify all the various fields of experimentation and research.

Five months ahead of schedule, it was decided that the journal would be published quarterly, with the first edition out in November 1957. Generous donations in response to the ‘Chairman’s Appeal’ resulted in enough donations and subscriptions to fully cover the first year’s costs; the fund remained open and it was hoped that the money for the complete project would be raised.

The first edition had an intended circulation of one thousand copies, with the hope to expand soon after. Whilst the readership was not expected to be large, those who did read it were intended to be influential. Fryd, for one, hoped, that “Societies will recognise that this Journal is a valuable gift to the professions.”

Articles which appeared in the first issue included: ‘The Relationship between Incentive Personality Type and Improvement in Performance’;¹²⁸ ‘Some Observations on Leucocytes in Mongolism’;¹²⁹ ‘A Survey of Mental Deficiency Problems in America’;¹³⁰ and ‘Phenylketonuria’.¹³¹ It was felt that these articles would help to fill a long-felt gap in knowledge; this was reaffirmed when the first publication was well received in both the UK and further abroad by eminent professionals.

In March 1958, Dr Alfred Highfield (who succeeded Burt to the Chairman of the Research Committee) proclaimed the *Journal of Mental Deficiency* to be a great contribution to all doctors and academics that were focused on the ‘mentally defective’. “This Journal,” Highfield suggested, “was not conceived as a popular magazine to “sell” mental deficiency research to the man in the street. Its aim is to publish only the best of critical work on mental deficiency, and its articles will be largely technical”.¹³² And he continued:

Few of us are sanguine of early results or that substantial benefits will accrue to our own child. But we are all conscious of the truth, that what has befallen our own handicapped child might have been avoided if earlier suggestions had devoted more

¹²⁸ G.S. Claridge and N. O’Connor, ‘The Relationship Between Incentive, Personality Type and Improvement Performance of Imbeciles’, *Journal of Intellectual Disability Research* 1, 1 (1957), pp. 16-25.

¹²⁹ U. Mittwoch, ‘Some Observations on the Leucocytes in Mongolism’, *Journal of Intellectual Disability Research* 1, 1 (1957), pp. 26-32.

¹³⁰ D.H.H. Thomas, ‘A Survey of Mental Deficiency Problems in the United States of America’, *Journal of Intellectual Disability Research* 1, 1 (1957), pp. 33-52.

¹³¹ D. Yi-Yung Hsia, R.S. Paine and K.W. Driscoll, ‘Phenylketonuria: Detection of the Heterozygous Carrier’, *Journal of Intellectual Disability Research* 11 (1957), pp. 53-65.

¹³² ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

of their resources to research. It is a measure of the sincerity of our movement that we are determined to hand down a better record to our descendants.¹³³

The first edition was accepted as a legitimate medical publication; 250 orders were placed from 16 countries. These orders included 30 from the USA, 70 from influential and respected medical libraries, 40 from hospitals, and 30 from LAs. This exemplifies the magnitude of the perceived problem of ‘mental deficiency’ in the UK and worldwide. It also serves to illustrate the influence the APBC was beginning to have. Fryd was elated:

[The journal] is rapidly becoming the internationally accepted medium for the publication of scientific research into mental defect, and there is continual increase in subscriptions from all parts of the world. We were proud to see it discussed recently in an American periodical as a “scientific magazine sponsored and financed by the N.S.M.H.C., as an unconditional gift to those working on behalf of its members’ children.”¹³⁴

Promising sales figures inspired the APBC’s leaders to believe that within 2 or 3 years the *Journal of Mental Deficiency* would become an authoritative and influential global publication on the subject and research. This was substantiated in the summer of 1958, when the second edition of the journal was much longer in terms of content due to a rise in submissions; the Association took this as a sign of growing confidence in its credentials. Calls for a third edition began early by the academic communities. However, the editors of the journal believed it would be beneficial to combine aspects of *Parents’ Voice* with the scholarly publication; namely helpful educational and care advice. The third edition attempted to target and attract the public and professionals alike, and specifically address the needs of those interested in the sociological aspects of ‘mental deficiency’.

¹³³ Ibid.

¹³⁴ ‘The Parents’ Voice’, *Newsletter* 9, 4 (Dec, 1958).

Today, the journal continues to publish under the revised name of *Journal of Intellectual Disability Research* on behalf of Mencap and the International Association for the Scientific Study of Intellectual and Developmental Disabilities. It covers a broad range of subjects including (but not limited to): genetics, ethics, biology, psychiatry, education, medicine, psychology, philosophy, sociology and legal matters.

Chapter Four

Disability and the Reform of the British Education System

“All so-called “defective” children should be properly diagnosed with a view to finding out HOW – not WHETHER – they should be educated.”¹

As discussed in previous chapters, too often ‘backward’ children were denounced as ‘ineducable’ and essentially abandoned by the authorities. What limited support that was provided by the state generally took the form of very basic training. However, through the APBC newsletters, Fryd encouraged parents to seek education for their children, and not just training. “Not all the classes, groups, lectures, or pamphlets,” Fryd argued, “can take the place of what the parents really want for their children, and what they pay rates and taxes for – namely, education, suitable for their special needs in schools specially built for the purpose.”²

Parents of ‘backward’ children often felt embittered with the government and resented paying for inaccessible education and healthcare provisions. Subsequently, families with ‘mentally deficient’ children felt isolated and neglected by the State. Boldly, Fryd challenged society’s willing acceptance of this and advocated for the reform of the education system to provide support and provisions for all. During her years as editor of the newsletters and *Parents’ Voice*, Fryd witnessed the transition of the education system from predominantly exclusionary to full equality for children with learning difficulties.³ In this chapter, I discuss

¹ ‘Association of Parents of Backward Children’, *Newsletter 2*, 8 (April, 1950), in *National Association of Parents of Backward Children Nov 1948-Mar 1953*, SA/NBT/F.9/7, The Wellcome Library, London. Hereafter abbreviated to ‘APBC’, *Newsletter 2*, 7 (Feb, 1950).

² ‘APBC’, *Newsletter 2*, 8 (April, 1950).

³ For a comprehensive understanding of education reform in the UK see The OECD Project, *Implementing Inclusive Education Policies* (Paris: OECD Publications, 1997); D. Wardle, *English Popular Education 1780-1975* (Cambridge: Cambridge University Press, 1976); A. Pollard, *Changing English Primary Schools: The Impact of the Education Reform Act at Key Stage One* (Virginia: Cassell Educational Ltd, 1994); G. Sherington, *English Education, Social Change, and War, 1911-20* (Manchester: Manchester University Press, 1981); and E. Green, *Education for a New Society* (Wisconsin: Routledge, 1947).

how disability influenced the reform of the British education system during the 1950s and 1960s.

Intelligence Tests and the 'Ineducable' Child

In November 1948 Fryd stated that one of the primary objectives of the APBC was to “put our children on the map.”⁴ ‘Backward’ children were often excluded from the education system, and thus, the government allowed them to be forgotten and isolated from society. To determine a child’s educability, intelligence tests were used. IQ or intelligence tests were originally developed by Alfred Binet (1857-1911). Binet was a French psychologist who published over two hundred books on what would now be considered experimental, educational, social and differential psychology.⁵ After working and monitoring his daughters’ developments (Margueritte and Armande, born 1885 and 1887, respectively), Binet refined his concept of intelligence, understanding of attention span, and the power of suggestibility in intellectual development. Following this, Binet developed and published intelligence scales in 1905, 1908 and 1911 known as the Binet-Simon scale after himself and his collaborator, Theodore Simon (1872-1961). This scale quickly gained popularity due to the practical utility that it evoked. In principle, the scale was designed to identify children who required extra help in school, although, arguably, the tests were eventually changed and used to exclude children from school who it was deemed would not benefit from the experience. Ultimately, the Binet-Simon scale aimed to compare a child’s mental abilities to those of their ‘normal’ peers. The scale was comprised of thirty tasks of varying degrees of difficulty; examples included following a beam of light, having a conversation with an examiner, correctly identifying body parts, and repeating and understanding simple words and sentences.

⁴ ‘APBC’, *Newsletter* 1, 12 (Nov, 1948).

⁵ R.S. Siegler, ‘The Other Alfred Binet’, *Developmental Psychology* 28, 2 (1992), pp. 179-190.

Following testing, the scale supposedly revealed the child's correct 'mental age' regardless of their actual age.

However, Binet was aware of the inherent limitations in his theory of testing children's mental abilities according to a scale based on the abilities of other children. Binet understood that intelligence was hugely diverse and further study should focus on measuring it in terms of qualitative, rather than quantitative terms. Intelligence was also explained to have been affected by environment which resulted in intelligence being continuously changing and not fixed. Despite Binet's warnings of the Binet-Simon scale's failings and shortcomings, the test gained popularity in the USA, where it was used by Henry Herbert Goddard in 1913 to test the intelligence of immigrants at Ellis Island. It later metamorphosed into what would denounce children with learning difficulties as 'ineducable'.⁶

In 1908, Henry Herbert Goddard, a prominent eugenics advocate, found that intelligence testing was able to suggest the superiority of the Caucasian population in the USA. Following his study in Europe, Goddard returned to the USA where he was able to translate the Binet-Simon scale. This was later standardised by Lewis Terman (1871-1956) using a large American sample; it became known as the Stanford-Binet scale. The primary difference between the Binet-Simon scale and Stanford-Binet scale was that the latter was no longer used to determine the educational abilities of a child in order to obtain better and more tailored resources for said child, as Binet had intended. Instead, the later scale was used for: "Curtailing the reproduction of feeble-mindedness and in the elimination of an enormous amount of crime, pauperism, and industrial inefficiency."⁷ Terman's contributions and the often abusive application of his revised version of the intelligence test have been deliberated by many scholars. The effects of the Stanford-Binet scale and the important role it played in

⁶ For a more comprehensive account of Binet's life and work see Siegler, 'The Other Alfred Binet' and S.H. White, 'Conceptual Foundations of IQ Testing', *Psychology, Public Policy, and Law* 6, 1 (2000), pp. 33-43.

⁷ L. Terman, G. Lyman, G. Ordahl, N. Galbreath and W. Talbert, *The Stanford Revision and Extensions of the Binet-Simon Scale for Measuring Intelligence* (Baltimore: Warwick and York, 1917), p. 7.

notions of intelligence and social worth have been discussed in a number of works, including Gretchen Kreuter's 'The Vanishing Genius'⁸, Harold Berlak's *Toward a New Science*⁹, Wilma Vialle's "'Termanal' Science?"¹⁰, and Alan Stoskopf's 'Echoes of a Forgotten Past'¹¹.

Binet is now regarded by many as one of the most important figures in the history of psychology, and the original Binet-Simon scale as one of the most important discoveries of the twentieth century.¹² Regardless of Binet's contributions, intelligence testing was hijacked and predominantly used to exclude people with disabilities from the benefits of society in the early to mid-twentieth century. This extended to education and healthcare resources and permeated various other aspects of community life. Pragmatic tests for 'idiocy' in the 1950s were based on establishing levels of intellect, judgement, reasoning abilities, and memory capacity. Individuals were questioned about their ability to understand their age, location, a simple literacy and numeracy test, religious affiliation, and whether the individual understood what day of the week it was. These tests would become commonplace and an acceptable method of determining whether or not a 'mentally defective' individual would be of any social worth.

However, the APBC frequently questioned the validity of intelligence tests. Dr Ann Margaret Clarke (PhD) and Dr Alan Douglas Benson Clarke (PhD, CBE) wrote: "the assumption of a fixed I.Q. throughout life is untenable."¹³ Consequently, they believed that caution should be applied before denouncing a child on the basis of a single test; this opinion

⁸ G. Kreuter, 'The Vanishing Genius: Lewis Terman and the Stanford Study', *History of Education Quarterly* 2, 1 (1962), pp. 6-18.

⁹ H. Berlak (ed), *Toward a New Science of Educational Testing and Assessment* (New York: SUNY Press, 1992).

¹⁰ M. Vialle, "'Termanal' Science? The Work of Lewis Terman Revisited', *Departments of Historical Perspective* 17, 1 (1994), pp. 32-38.

¹¹ A. Stoskopf, 'Echoes of a Forgotten Past: Eugenics, Testing, and Education Reform', *The Educational Forum* 66, 2 (2002), pp. 126-133.

¹² The journal *Science* 84 (1984) named Binet as one of the twenty most important/significant developments or discoveries of the twentieth century. For more information see J.L. Teramani, 'Science 84 Celebrates Fifth Anniversary', *Science* 226, 4674 (1984), pp. 530-531.

¹³ 'Lancet' in 'The Parents' Voice', *Newsletter* 5, 2 (April, 1954) in *Parents Voice: National Society for Mentally Handicapped Children 1:38, 1950-1988*, Main Library/Store 208369/7, The University of Manchester Library, Manchester. Hereafter abbreviated to 'The Parents' Voice', *Newsletter* 5, 2 (April, 1954), p. 10.

gathered growing momentum in the mid-twentieth century. These concerns were frequently dismissed by authorities as being “the unreasoning resistance of Doting Mamas.”¹⁴ Furthermore, intelligence tests were often applied to nervous ‘handicapped’ and ‘maladjusted’ children who did not function well with other children or attend any form of school. If children failed to reach the necessary pass mark, they were denounced as ‘ineducable’ and excluded from the education system.

In the UK, the APBC was not alone in its distrust of intelligence tests for determining a child’s educational potential, or rather the lack thereof. In January 1950, a conference for Assistant Secondary Schoolmasters was held. A number of speakers called for the complete abolition of intelligence tests; one was quoted as saying “They have a pseudo-scientific appearance of infallibility and impartiality but are comparatively useless. They put a premium on slickness to the disadvantage of the painstaking if slow worker.”¹⁵ Another speaker agreed that children of a nervous disposition were at a disadvantage and commented: “They are a fetish. I got a copy of the Test and found I could not do it myself.”¹⁶ Many believed intelligence tests were engineered to ensure that ‘mentally deficient’ children would fail. This was extended in the questions posed to the Royal Commission in October 1954. Intelligence testing was categorically denounced by the APBC. As Fryd remarked “A brain injured child [...] has a snowball’s chance in a very hot place of getting any education whatever, since it is simply assumed that the cortical cells of the brain are damaged or non-existent.”¹⁷ As Fryd noted:

Dissatisfaction is expressed by parents at the method of testing to determine whether the child is to receive education. The type of test is regarded as unreal, having regard

¹⁴ ‘APBC’, *Newsletter* 2, 7 (Feb, 1950).

¹⁵ ‘APBC’, *Newsletter* 2, 7 (Feb, 1950).

¹⁶ *Ibid.*

¹⁷ ‘Judy Fryd’, Correspondence Between the National Birthday Trust and the APBC, (Feb, 1950) in *NAPBC 1948-1953*.

to the limited experience of such children. There is a subjective element in the testing which is often not given by qualified educational psychologists, but by a Medical Officer who had taken a three weeks' course in mental testing. Too often, the children are excluded from school on the basis of only one test, which may be administered under adverse conditions. There is provision for parents to appeal against the report of "ineducability", but they are not always informed of this right. Many parents who wish to appeal find it difficult to find a second opinion from an independent examiner, and such a second opinion can be set aside by an Education Authority.¹⁸

'Backward' children were declared the problem of their own family, instead of being the responsibility of the Government or the community. This was later corroborated by the parents' concern over the use of the intelligence tests to effectively exclude their child from the community. Fryd believed the government were able to implement policies rejecting 'mentally deficient' children from the education system by rigidly categorising them into 'grades' using intelligence tests. The APBC agitated for a change in legislation to abolish intelligence tests and allow for an equal right to education. It was thus argued:

The present system of intelligence testing is far from satisfactory. The tests should in any case be given by a sympathetic person in surroundings familiar to the child. Many medical assistant officers [...] are not adequately equipped to undertake this important examination which should professionally be given by a fully qualified educational psychologist.¹⁹

By the 1960s, authorities had made the decision to abolish intelligence tests on the understanding that intelligence was an ever-changing concept. It was determined these tests should only account for one aspect of assessing a child's abilities and disabilities. Additionally, many parents raised the distressing effect of the label 'ineducable'; many

¹⁸ 'The Parents' Voice', *Newsletter* 5, 4 (Oct, 1954).

¹⁹ 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953).

described it as ‘heart-breaking’. It is worth noting that children were also denounced as ‘ineducable’ if they were noisy or disruptive to other children in an education setting. Many believed that this diagnosis could be easily removed if the child was paid more individual attention from a teacher. The term ‘ineducable’ was believed to be grossly misleading; the vast majority of children were capable of some education; new and specialised methods for educating these ‘duller’ children was simply needed.

During a teachers’ conference in 1957, the concept of ‘ineducable’ was discussed at length. The first question raised by the panel was ‘what is an ineducable child?’ It was agreed by all that it was by no means an absolute term but rather dictated by the education facilities available in the individuals’ area. Additionally, the panel felt that too much emphasis was placed on labels instead of educability. The most contentious of all the questions posed was: “Whether it was a waste of time and money to educate the feeble-minded, and available resources might not be better employed in teaching the bright child.”²⁰ This was criticised on several grounds: firstly, it was not beneficial for anyone involved to allow the ‘mentally defective’ to be ‘mentally defective’ and deny them any chance of progression. Secondly, without education and training these individuals became an unnecessary burden on the State. The final question dealt with how far intelligence was affected by learning; the panel suggested this was dependent on the understanding of the concept of ‘intelligence’ and that it should be thought of in terms of fluidity.

The vast majority of parents described the lack of provisions as cruelly inadequate. When their child was born, many parents were optimistic that provisions would be made for their child. However, this hope often ebbed away as their child was subjected to intelligence tests, denounced as ‘ineducable’ and written off by the community as useless. The APBC believed that it was their duty to continue the fight for better provisions. It is for this reason

²⁰ ‘Teachers’ Conference on Backward Children’ in ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957), pp. 10-12.

that the APBC believed that the problem of the 'ineducable' child should be separated from the 'normal' school child. Fundamentally, 'ineducable' children needed to be educated to help them become less 'hopeless'; these children had the same right to an education as every other child.

The Royal Commission recommended the abolition of the word 'ineducable'. However, many remained sceptical of the suggested improvements. The MoE Pamphlet No. 5 issued in January 1946, which declared that no action should be taken in determining a 'mentally defective' child's educational course until at least two tests were completed at intervals of time, was often cited as evidence that practical change was hard to achieve. Despite the circular, many were still subjected to intelligence tests and parents were unaware of their rights.

Parents were to be given 14 days to appeal the final decision made by writing to the MoE Special Services Department. In reality, the right of appeal was usually reserved for 'borderline' children, and even in these circumstances parents were discouraged from appealing. Evidence of this can be seen by incorrect forms handed to parents of 'ineducable' children by Sheffield LEAs which failed to mention the right of appeal. Whilst this was soon rectified, many parents had either missed the opportunity to appeal the decision or were still unaware/unsure of the process and outcome that could be hoped for. Ideally, the Association called for a series of tests over the period of a few months; if the outcomes of the tests all concurred then parents should have the right to appeal and the procedure fully explained to them by the MoE Special Services Branch. Notification to the MoE should still be made within 14 days, but more time should be allowed to secure a second opinion of the child's condition. Stories of parents' heartache at receiving the diagnosis of 'ineducable' feature prominently in the APBC newsletters; less common were the stories of parents who successfully appealed their child's diagnosis. The APBC declared that of all the children

denounced as ‘ineducable’, 1 in 10 parents decided to appeal the decision, and only 1 in 10 were successful in having the label revoked. Subsequently, once a child was declared to be ‘ineducable’ it had a 1 in 100 chance of remaining under the education authorities’ responsibilities and receiving a suitable education for their needs.

Generally, children were only referred to the LHAs upon the result of an intelligence test. Exceptions were made if a child was deemed ‘severely handicapped’ and schooling was not an option and no availability at an occupation centre existed. In order for this to occur, a distinction between ‘backward’ and ‘very very ‘backward’/severely ‘backward’ was necessary. Joseph Squire Hoyle, the Executive Officer of Leeds Mental Health Services defined the difference as follows:

The merely “backward” child is probably retarded for a variety of reasons – prolonged absence from school owing to sickness, late development owing to some emotional disturbance or too frequent movement of the family, necessitating a disjointed school career. These children are the responsibility of the Education Authority and attend schools for the educationally sub-normal which were previously referred to as Special Schools. A very large proportion of these children are, under specialised institution, able to catch up and probably become useful citizens.²¹

And Hoyle continued:

The more severely handicapped child, however, has provided *ineducable* in either an ordinary school or a school for educationally sub-normal and has permanent defect. Such children are unable to learn the three r’s but some of the higher grade although ineducable, are able to participate in lessons which provide sense and speech training, even if they never succeed in learning actually to read and to write. They may be

²¹ ‘The Parents’ Voice’, *Newsletter* 4, 4 (Oct, 1953).

taught to recognise numbers, destination indicators and the buses and sometimes to print their own names.²²

Ultimately, opinions about intelligence testing as a means of assessing a child's capabilities were divided. Whilst Fryd deplored them and rejected their use altogether, other professionals believed that the tests could be useful as an important part of a wider series of tests, and appeals allowed parents to voice their protest.

The Responsibility of the Education Authorities

During the 1950s, the MoH was in charge of the care and training of 'mental defectives'. However, Fryd proposed that the service offered was vastly inadequate and needed huge improvements. Fryd implied that the MoH had failed to address a lack of basic facilities needed for the day-to-day care of 'backward' children. She supposed this was due to the lack of coherence within the MoH's structure of how these individuals were handled. The MoH was unable to make regulations regarding the LAs exercise of their functions. This resulted in vast differences from authority to authority. It was suggested that centralising the control of LAs would produce better facilities, even if in practice the control would be on an informal consultation and advice basis. Many members felt that too little attention was paid to mental health matters by County Health Authorities. As Fryd stated:

It is apparently considered that the Mental Health Committee alone should be responsible for all the needs of the mentally handicapped; but these committees, being only a part of local Health Committees, and having to compete with all aspects of public health, have neither the resources, nor the will to shoulder the whole responsibility. That, thousands of these young people, who may be physically fit and

²² Ibid.

active, but merely backward, live their lives in idleness at home until their parents are unable to cope with the burden.²³

One parent worried that the task of the ‘mentally deficient’ was tacked on to other services of the well-organised authorities whose work was largely governed by the Lunacy Acts. Matters regarding mental health were often treated as second-class; including individuals who were frequently thought of as second-class citizens by the general public.

Unlike many in the APBC, Fryd believed all ‘backward’ children should be the responsibility of the education authorities and the MoH. Fundamentally, she believed it was the MoE’s duty to “provide education of one sort or another for every child according to his handicap.”²⁴ Understanding that not all ‘mentally handicapped’ children were the same, Fryd conveyed these nuances: “There should be free access and transference to whatever type of education is best suited to the ability and temperament of each child, without the necessity for certificates and labels.”²⁵ The situation was aggravated by the existing legislation, which explicitly declared all children’s right to education. Take, for example the Education Act of 1944, which stated:

It shall be the duty of every local education authority to secure that there shall be available for their area sufficient schools [...] schools available for an area shall not be deemed to be sufficient unless they are sufficient in number, character and equipment.²⁶

The NHS Act of 1948 also elaborated on this matter: “Local Health Authorities are empowered, and it shall be their duty, to provide training for the mental defectives who are in

²³ ‘The Parents’ Voice’, *Newsletter* 2, 3 (July, 1951).

²⁴ ‘APBC’, *Newsletter* 1, 12 (Nov, 1948).

²⁵ *Ibid.*

²⁶ ‘Education Act 1944 7 & 8 GEO. 6 CH. 31’

http://www.legislation.gov.uk/ukpga/1944/31/pdfs/ukpga_19440031_en.pdf (Accessed on 13/09/2015).

their area.”²⁷ However, education authorities were allowed to pass their responsibility onto the health authorities, which in turn could pass the responsibility to Regional Hospital Boards. Neither authority made adequate provisions for the care and training of ‘backward’ children, and in the case of health authorities there were no legal requirements to do so.

Problems arose with parents who had applied for a place in a special needs school only to be told that their child was ‘ineducable’ and should be notified to the Mental Health Committee. However, the Committee lacked any official training or local facilities to determine the diagnosis of ‘ineducable’. Subsequently, parents were once again referred elsewhere when trying to attain education for their ‘backward’ child. Essentially, the MoH and MoE sent parents on a futile pursuit, shedding responsibility from one to another. This made the attainment of a diagnosis and appropriate education course financially unrealistic and virtually impossible. In doing this, the MoH and MoE showcased the reluctance of government faculties to deal with the problem of ‘mental deficiency’. Fryd continued her tirade against the injustices of the MoH and the MoE: “[the] lack of education was the biggest bugbear. Parents could not understand why the children should be cut off from the Ministry of Education, and placed under the Health Committee.”²⁸ Decisions were often not explained to parents which removed any choice about the welfare of their child.

However, Fryd’s desire to place the education of ‘backward’ children under the responsibility of the MoE placed a great strain on local councils to provide adequate care. Consequently, ‘backward’ children were often neglected by both the MoE and the MoH. Many felt that if these children were placed under the responsibility of the MoE then they would become the tail-end of a very long queue and fail to receive the required provisions. However, Fryd countered by declaring that these children were certainly not a top priority for the MoH and were clearly failing to receive the care and attention needed. It is essential to

²⁷ ‘National Health Service Act, 1946. 9 and 10 GEO. 6. CH. 81’ http://old.post-gazette.com/pg/pdf/201004/2010_national-health-service-book_01.pdf (Accessed on 22/07/2013).

²⁸ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

note that the MoH's failings were not necessarily from a lack of interest or understanding on their behalf. The Minister of Health, Derek Walker-Smith (Minister from 1957-1960, QC, MP, Baron Broxbourne) stressed the MoH's desire to help in the problem of 'mental deficiency' which he believed had a "great human interest, great social significance, and great opportunity for service."²⁹

Walker-Smith was particularly complimentary of the APBC and their work in overcoming social prejudices and securing provisions. "Mental disorder," he said, "used to be regarded as a visitation, and it was even thought "impious" to try and remedy it, but we had a great revolution in understanding; it was now recognised as presenting a challenge to science, medicine and to the community. Your Society", he continued "is a symbol of that increased awareness and heightened sympathy. In the short space of ten years the Society had achieved National status, and had served as a better model for similar developments at home and overseas."³⁰

Walker-Smith accepted the need for a change in legislation to help with legal definitions, medical concepts and the understanding of the general public. Despite this, the APBC suggested that many improvements could be made under the existing legislation. Former Minister of Health, Robert Turton (Baron Tranmire, KBE) agreed with Walker-Smith and proposed that the terms used by legislation often obscured the facts and predetermined the child's fate: "[The terminology] so forcibly and depressingly reminds parents [...] of the affliction suffered by these children."³¹ He too congratulated the APBC on their attitude and successful gains made in "[f]inding and facing the facts are the first steps to doing something about them [...] only with a solid basis of facts can the Society present its cause fairly and successfully to a public which is increasingly willing to sympathise and help."³²

²⁹ 'The Parents' Voice', *Newsletter* 9, 2 (Summer, 1958).

³⁰ Ibid.

³¹ 'The Parents' Voice', *Newsletter* 7, 2 (May, 1956).

³² Ibid.

In his first speech to Parliament about the education of ‘mentally defective’ children, Sydney Irving (MP for Dartford) addressed the statistics of waiting lists for education and care resources. Irving deemed the situation to be a “disappointing picture throughout.”³³ He declared there to be approximately 12,000 to 13,000 children on waiting lists (provisions had been made for 7,800 in 1956, but this still left nearly 7,000 on lists without any provision); 20 County Authorities were established as having no residential special school; 21 County Borough Authorities had no day schools; and 23 County Education Authorities and 26 Borough Authorities had no child guidance clinics. Irving expounded that this was unacceptable and provisions needed to be established immediately. Fundamentally, Irving believed that the MoE should not denounce their responsibility for ‘ineducable’ children as he felt that education should always play a role in the care system. Many in the Association agreed with Irving’s statement. An increase of 8,000 school places for ‘educationally subnormal’ children had been made since the beginning of the 1950s. This brought the total to an estimated 23,000 places in educational facilities.

These concerns were also voiced by Kenneth Robinson (MP for St Pancras North and a member of the Metropolitan Regional Hospital Board) in a proposal to the HoC. Robinson declared that whilst advances had been made in recent years, the progress was insufficient; understaffing, overcrowding and unsuitable premises persisted in causing problems. He called for more capital expenditure to relieve what he called ‘human suffering’ caused by waiting lists by building new and appropriate premises, new machinery and a nationally scaled nursing cadet scheme. Sir Frederick Messer (MP for Tottenham) agreed with Robinson’s motion. He remarked:

If there was one thing which bridged both sides of the House; it was the common ground of humanity found in this debate. The problem of the “mental defective” at

³³ ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

home was not merely a problem of the patient, it was a problem of those affected by the patient [...] there is a child declared ineducable, a backward child, yet there is within it the capacity to do something. Whilst the retarded mind cannot understand the abstract, it can understand reality [...] we who are not afflicted know how it feels if we are inactive. What must it be like for a “mentally defective” person who can do something and is not allowed to do it?³⁴

The initial motion raised by Robinson was supported by fifteen more speeches and a debate in the HoC lasted over five hours. Changes were beginning to be acknowledged on a governmental level, however, many understood that changing public opinion would be more troublesome. A further debate in the HoC took place in August 1957; many of the speakers at the second debate claimed that in the past 27 years only two full and comprehensive debates on mental health had occurred in the HoC. The HoC debated the issue of so-called ‘ineducable’ children excluded from the education system and what provisions were supplied for them. For instance, Martin Redmayne (MP for Rushcliffe, Nottinghamshire) raised this issue and asked the Minister of Health whether such a drastic decision realistically benefitted children, especially ‘borderline’ cases. Furthermore, Redmayne suggested that the decision of whether or not the so-called excluded ‘ineducable’ child received institutional care was based less on his/her ability to benefit from the specialised situation and more dependent on the social and economic circumstances of the child’s upbringing. Redmayne continued to suggest that where LHAs were unable to financially help individual families willing to contribute to the cost of their child’s care, provisions should be made to financially aid groups of families attempting to establish their own occupation centres. Redmayne’s damning assessment of the inherent prejudiced and discriminatory political attitudes towards ‘backward’ children and their families encouraged APBC members, and awakened politicians to the problem which had been hidden for so long. Fryd deemed the subjective approach to

³⁴ ‘The Parents’ Voice’, *Newsletter* 5, 2 (April, 1954).

the distribution of provisions an infringement of basic human rights. She noted: “it should be incumbent upon the State to ensure that every child who can secure a vacancy in a Private Home, School or Occupation Centre should be enabled to irrespective of the means of his parent.”³⁵

Ultimately, clear and closer liaison between the two Ministries was urged to ensure that every child that could benefit from care and training would, and in a manner suitable to his or her needs. To combat the widespread neglect a ‘Joint Committee of the Special Branch of the Ministry of Education and the Board of Control Section of the Ministry of Health’ was established. In suggesting an interim solution, the APBC’s campaign to place ‘backward’ children in the most accurate and secured teaching facilities became inevitable.

However, the decision to ratify the government to place the complete responsibility of care and training for ‘backward’ children under the MoE was a divisive one. Difficulties arose when discussing the practicalities of moving the responsibility from the MoH to the MoE. 3,000 children yearly were excluded from schools, and only 182 occupation centres had been established by LHAs for approximately 5,000 children³⁶ — for Fryd this was reason enough to discuss the matter. There were a further 30,000 children in inappropriate care and training facilities (including institutions, private homes and family homes). This figure could not be substantiated as statistics from LHAs were unattainable by the APBC. A unanimous resolution on whether or not the responsibility for the care and training of ‘backward’ children should be the MoH or the MoE could not be reached.

A questionnaire was sent to the APBC branches in October 1951 to ask its members whether or not it was worth pursuing a referendum. The returned opinions were divided. The results of the referendum were published in the January 1952 issue of *Parents’ Voice*; for – 235, against – 166. Due to the marginal results, the APBC decided that no further action

³⁵ Ibid.

³⁶ Figures accurate as of July 1951.

should be taken until a clearer need was established by all. Regardless of this decision, Fryd continued to stress the need for change and was optimistic that eventually the situation would change for the better.

Moreover, some members believed it was the APBC's responsibility to secure provision for 'backward' children. The APBC had managed to secure and establish training facilities and some felt this approach was more proactive and reliable than placing their trust in the government. Regardless, the APBC did not believe that the authorities should be allowed to evade their responsibilities because voluntary organisations were achieving their goals quicker and more efficiently. Moreover, establishing facilities was expensive and technically challenging. This sentiment was echoed in Sir Frederick Messer's (MP for Tottenham) foreword to Peggy Jay's *Making our Way: The Story of Handicapped Children*.³⁷ Messer argued that the problem of 'mental deficiency' was a community burden and should be handled as such. Whether the responsibility ultimately fell to the MoH or MoE was not relevant. Yet, the Ministries' approaches to handling the matter needed careful evaluation. He suggested that in failing to correctly address this issue, 'backward' children were being denied the human right of education: "Not one of these agencies can feel satisfied whilst a single child who could benefit is denied that which is his right as a human being."³⁸

Engaging with this issue, Fryd remarked: "Some will say the country cannot afford to make this provision. Can we afford NOT to make it?"³⁹ She believed that if Britain was wealthy enough to waste millions of pounds every year on 'ephemeral pleasures, trashy novelties, and personal adornment', then it was certainly wealthy enough to dedicate time and

³⁷ P.E. Jay, *Making Our Way: The Story of Handicapped Children* (London: National Committee for the Defence of Children, 1956).

³⁸ *Ibid.* p.3.

³⁹ 'The Parents' Voice', *Newsletter* 8, 4 (Nov, 1957).

money to improving the lives of hundreds of thousands of people affected and afflicted with ‘mental handicap’.⁴⁰

Deputations to Ministries

To tackle the issue of responsibility and the lack of provisions, the APBC planned a deputation to the MoH and other interested parties. Primarily the deputation was handled by the president, Davies. On the 2nd of March, 1953, Anthony Greenwood, Ronald Bell and Joseph Grimand representing the Labour, Conservative and Liberal MPs, respectively, met with Mrs Wheeler, Mr and Mrs Drown, Mr Peacock, Mrs Maclaren-White and Fryd representing the APBC.⁴¹ The Minister of Health, Hilary Marquand (MP) presided over the proceedings where over twenty MPs were present. The APBC briefly outlined the purpose of the meeting, their aims and objectives, following which MPs asked questions for nearly an hour.

Overall, the deputation was considered to be a success and Marquand declared that a subsequent meeting would be called between MPs to consider the possibility of practical help. In support of the APBC’s proposals to the deputation, Fryd provided the following statistics: in December 1951, there were 30,881 children ascertained as ‘educationally subnormal’ in England and Wales; the total number of such children accommodated in schools was 18,726; the remaining 12,155 children were explained to be either at home or “dragging along in the back rows of ordinary schools.”⁴² In one year, 3,267 children had been ascertained as ineducable and referred to Health Committees; bringing the total number of children under the age of 16 who had been excluded as ‘ineducable’ in July 1951 to 23,691. 3,495 of these children had a place at an occupation centre, 6,416 resided in an institution and

⁴⁰ ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957).

⁴¹ The majority of the APBC members were a part of the Parliamentary Sub-Committee, with the exception of Maclaren-White who was the General Secretary and Mr Drown who was the Vice-Chairman.

⁴² ‘The Parents’ Voice’, *Newsletter* 4, 2 (April, 1953).

13,780 were left devoid of any provision. Statistics declared for 16-21 years olds in receipt of regular National Assistance Allowances were in excess of 20,000 individuals. Although, it was not known what proportion of these individuals were ‘mentally handicapped’; Fryd stated that it was reasonable to assume that the proportion was high. In total, the number of ‘mental defectives’ of all ages and ‘grades’ in England and Wales at the end of 1951 was given as 133,123, of which 37,661 were in institutions or hospitals. Fryd was able to gather these statistics from official sources; however she mentioned that reformers frequently faced difficulties when attempting to obtain statistics regarding age groups, the extent of the problem, and the amount and kinds of provisions which were available. For Fryd, gaining useful and accurate statistics was vital to improving understanding for all involved: “If once more the public could be made to realise the facts, we feel sure that the will and wherewithal to solve these problems could be found.”⁴³

Owing to the success of the first, a second deputation took place on the 7th of December, 1953. It was received by Iain Macleod, the current Minister of Health and presented by Fryd, Davies, Drown and the County Councillor John Barter of the Middlesex branch of the APBC. Davies once more explained that provisions were inadequate in number and quality. The deputation was again met with interest and appropriate understanding and empathy where necessitated.

The APBC detailed the following proposals to the MoH: a counselling service, school health services, training centres and short-stay care. Additionally, the APBC strongly believed that facilities of the School Health Service should be made available to all children of school age, irrespective of whether or not they were able to attend school. This was particularly important in the case of dental services which were commonly needed by many ‘mentally defective’ children. As Fryd wrote: “Mentally defective children are often difficult

⁴³ Ibid.

patients, and many private dentists fight shy of them.”⁴⁴ This extension of services did not require new legislation and many believed that it should be implemented immediately with no excuse for delay. Unfortunately, it was not just health and dental services which were denied to families of ‘mental defectives’. Many services were unavailable to children unless they attended full-time schooling. Mrs E.D. Durham commented that her application for Family Allowance was denied on the basis that her child did not fall under the remit of the Education Act of 1944. This was explained by the APBC to be because the child did not attend any form of schooling during his lifetime because of his supposed ‘ineducability’. The APBC appealed this loophole which denied families financial and practical assistance on the basis that their child was unable to attend school.

Many parents were confused by what financial provisions they were entitled to. Under the provision of the Family Allowances Act a child over the school leaving age of 15 could still be considered to receive financial support if receiving full-time instruction in a school or as an apprentice. In this case the child may be eligible for provisions until the 31st of July following their 16th birthday. In situations involving ‘mentally defective’ persons the APBC advised the most liberal use of the term ‘full-time instruction’ to include occupation centres, ‘mental deficiency’ hospitals and other similar facilities. However, if the child remained at home, regardless of any instruction given there, the child was not eligible to receive any Family Allowance as the terms were not satisfied. Fundamentally, Fryd believed that the Family Allowance Act should be expanded to include the year from school leaving age (15) to the year an individual was able to qualify for National Assistance (16), irrespective of whether or not full-time instruction was being received. According to Fryd: “The fact that the child is prevented by mental or physical illness from attending school cannot affect the

⁴⁴ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

position. The same is true of those in Institutions who are incapable of receiving more than mere habit training.”⁴⁵

It was believed that this would relieve the hardship placed on parents, particularly those on sickness benefits with dependents between the ages of 15 and 16 who were not eligible for either Family Allowance or National Assistance. This was particularly evident for female widowers with ‘backward’ children who were struggling to live and care for their child on their small pensions and were unable to earn more money. One widower wrote:

A backward child, especially one who does not attend any school or centre, is a heavy expense. Fares to the shops etc., small snacks when on a day’s outings, not to mention the replacement of damaged crockery and furnishings, are daily items which parents of normal children at school do not have to cater for. There is extra wear and tear on clothing and bed-linen for many of these children.⁴⁶

John Dugdale (MP for West Bromwich) agreed with the APBC’s position on the matter and decided to question the anomalies in the Family Allowances Act with the Minister of National Insurances. Dugdale and the APBC were successful in their campaign to have the financial provisions awarded to families of ‘mentally defective’ individuals assessed.

In autumn 1955, Fryd reported that children over the age of 15 who had never been able to attend school were to be given benefits under the National Insurance Act. The MoH instructed the National Insurances Regulations to be reconsidered, especially aspects which related to the Family Allowances Act being payable to children in full-time instruction (including occupation centres, special schools, and other forms of education and training) to be paid until the age of 18. The Minister also made promises to assess the provisions granted to children who were too ‘defective’ to attend any form of school or training. A reply to the

⁴⁵ ‘The Parents’ Voice’, *Newsletter* 4, 1 (Jan, 1953).

⁴⁶ ‘The Parents’ Voice’, *Newsletter* 2, 3 (July, 1951).

Private Secretary to the Ministry stated: “A child who is a child for the purposes of amending this Bill will be a child for the purposes of increases of National Insurance Benefits for children.”⁴⁷

By May 1956, it was announced that the Minister of National Insurance had permitted children with ‘mental defects’ and unable to attend any form of school or training to be eligible for the Family Allowances Act. Moreover, other National Insurance child allowances (such as sickness benefit) would be granted for children between the ages of 15 and 16. Despite these advances, inequality still existed for ‘mentally deficient’ persons; ‘normal’ children were eligible to receive allowances up to the age of 18, whereas ‘mentally defective’ children receiving National Assistance ceased at age 16. The APBC, and indeed the parents, felt much of the system was still flawed. Provisions should be based on the individual’s level of dependence, as numerical age was an unreliable factor in the care of those with ‘mental deficiencies’. If assistance was doled out based on need, rather than age, this would safeguard the individual’s health by placing their care in the hands of the County Health Authorities.

The Minister of Health made promises to review the eligibility of death grants; since ‘mentally deficient’ children did not enter employment on leaving school, they did not contribute to National Insurance and were thus ineligible for certain benefits such as death grants. The APBC called for a complete review of the provisions offered for ‘mentally deficient’ individuals, particularly those which related to education. Parents were unhappy with the term ‘ineducable’ and the claim that nothing could be done for them; parents demanded their fair share of education expenditure.

Alongside numerous deputations to the MoH, the APBC sent one to the MoE on the 18th of February, 1955, chaired by Mr Howlett (Principle Officer of the Special Branch of the MoE.) The APBC delegates in attendance were: Mrs Wheeler, Mr and Mrs Drown, Earle

⁴⁷ ‘The Parents’ Voice’, *Newsletter* 6, 4 (Autumn, 1955).

Davison, and Fryd. Others present at the meeting were: Dr P. Henderson (Principle Medical Officer); Dr A.F. Alford (Senior Medical Officer); Mr James Lumsden (Chief Inspector for Special Education); Mr M.A. Walker (Principle Secretary); and Miss Clinkard (Assistant Secretary). The purpose of the deputation was to highlight the MoE's failure to provide special education for children already ascertained as needing it. Additionally, the Association wished to bring attention to those children they believed were unfairly and unwisely excluded from the Education authorities' responsibility. A memorandum with case histories was presented to the MoE; this explained the situation, suggestions of the APBC, and how to tackle waiting lists and public understanding.

The circumstances regarding special schools were explained to be grossly inadequate in all counties and non-existent in a few, according to members. Every year the education authorities excluded approximately 3,000-4,000 children from the education system and displayed no further concern for the future, or rather lack thereof, of said children under the health authorities. The APBC plainly stated this was a failure on the following basis:

- (i) The line of demarcation of educability is not scientifically fixed; it varies from place to place and from time to time – apparently having some relationship to the amount of special school provision in a particular place at a particular time.
- (ii) The method of ascertainment is the “intelligence test”. This is a method nowadays being less and less accepted as a scientific measurement of a child's capabilities; it has already been abolished in one County for the purposes of Grammar School selection. In theory the “intelligence test” is not used by itself in assessing the educability of a child, but in practice it has been so used, as reported by our members from all over the country.
- (iii) The tests are often not administered by trained educational psychologists but by Medical Officers who have attended a three weeks' course in mental testing.

- (iv) It has been found that children have been excluded from school on the basis of ONE TEST ONLY.
- (v) Parents have reported that they had NOT BEEN INFORMED of their right of appeal to the Ministry against exclusion of their child by Local Health Authorities.⁴⁸

To help remedy these injustices the APBC composed a list of suggestions for the MoE to consider. The list was accompanied by the following stipulation:

We consider that it is a birthright of every child to receive education according to his age, ability and aptitude, and we further remind the Ministry that the parents of handicapped children are ratepayers and taxpayers even as the parents of normal children. We are aware of the difficulties, but we urge that these should be surmounted at the earliest possible moment.⁴⁹

The suggestions put forward by the APBC included: a change in terminology regarding special schools to increase public understanding and tolerance; greater encouragement for teachers to take up the field of special education (including monetary incentives); and earlier ascertainment of what education provision is needed. Before any label of 'ineducable' is applied, the child should be placed in an opportunity class, which should be smaller than special school classes, and careful attention should be paid to monitor any undiagnosed physical or mental problems.

Furthermore, it was suggested that opportunity classes should be established in mainstream schools; many children coped better in the schooling system than at home with their families. In addition to this, it was proposed that a greater number of schools for 'mentally defective' children should be established as most areas only supplied residential

⁴⁸ 'The Parents' Voice', *Newsletter* 6, 3 (Summer, 1955).

⁴⁹ *Ibid.*

homes. If day schools were provided, adequate places would be available for children who did require residential care, thus lessening the burden of waiting lists. Evening classes (run by LEAs with close liaison with LHAs) were proposed for children classed as late developers. This would facilitate the return of 'ineducable' children to the schooling system and monitor progress where applicable. The deputation to the MoE also included advice on stimulating research into the causes and treatment of 'mental deficiency' from an educational perspective.

Overall, the deputation was well received and a lively discussion took place about the Association's proposals. The APBC were congratulated on their presentation of arguments. Dr Alford spoke of the training received by medical officers before intelligence testing and reiterated that IQ should be thought of as an indicator for further investigation. The APBC delegates expressed their concerns that if this were true the need for a deputation would not exist. Despite this, the MoE attempted to reassure the members by declaring that since the end of WW2 12,000 special school places had been provided and the building programmes intended to supply an additional 8,500 places. Irrespective, the APBC pointed out that waiting lists continued to rise not decrease, and suggested that more could be done in the manner of home teaching. £750,000 was being spent on this annually, yet this was mainly for those with physical handicaps. To combat this, it was insisted that LAs should run parentcraft classes which were supported under the further education scheme.⁵⁰

To conclude, the MoE promised to assess the manner in which children were excluded from the education system. The deputation was followed up by a letter received in the autumn of 1955 from Howlett which expanded on the complaints and suggestions made at the deputation. Following the deputations to the MoH and MoE both Ministries made visits to the Fountain Hospital to assess the problem of 'mental deficiency' for themselves. In 1955,

⁵⁰ Ibid.

the Report of the Committee on Maladjusted Children, also known as the Underwood Report, was published. The Committee were appointed in 1950 by the then Minister of Education, George Tomlinson, to comprehensively assess the medical, social and educational problems relating to ‘maladjusted’ children, with particular reference to the education system. To an extent, the Underwood Report addressed the history of ‘mental deficiency’, the supply of provisions, and possible avenues of progress. Whilst much of the content of the Underwood Report was not ground-breaking, the new introduction of the term ‘maladjusted’ to describe ‘mentally deficient’ children suggested an increasing government awareness of the effects of educational and social settings on these children. Additionally, the Underwood Report was one of the first examples of the authorities extensively and proactively tackling the problems facing many families with ‘backward’ children.⁵¹

As a result of the positive feedback generated by political involvement, local branches were encouraged to send deputations to their County Councils; a task which many embarked on. The Minister of Health in 1953, Iain Macleod, encouraged the APBC to send him further memorandums of any problems which arose with the day-to-day handling of their ‘mentally handicapped’ child. His Ministry endeavoured to maintain a good relationship with the APBC, and Macleod believed that “if the same sort of relations can be established at the local level between your Branches and the County Health Authorities and Hospital Boards, much can be achieved.”⁵² Further on, Macleod explained the importance of relations at a local level, stating that changes made centrally were often ineffective if LAs chose not to comply with their suggestions. He quipped that he could not “humanise the Health Service by issuing circulars from Whitehall.”⁵³ Subsequently, the MoH requested further information from the APBC; this was gathered from members by questionnaires included in copies of *Parents’*

⁵¹ Ministry of Education ‘Report of the Committee on Maladjusted Children (the Underwood Report)’ (London: HMSO, 1955) <http://www.educationengland.org.uk/documents/underwood/underwood1955.html> (Accessed on 20/07/2015).

⁵² ‘Deputation to Minister of Health’ in ‘The Parents’ Voice’, *Newsletter* 5, 1 (Jan, 1954), pp. 6-7.

⁵³ *Ibid.*

Voice. In this respect *Parents' Voice* was an invaluable resource for the APBC and governing authorities; it was a mechanism for change.

The Royal Commission Report

After months of hard work, five members of the National Council were received by the Royal Commission on the Law Relating to Mental Deficiency and Mental Illness on the 29th of June, 1954. The Royal Commission was appointed to review the “existing machinery regarding Mentally Defective Persons, particularly in regard to consultation and admission of children to Institutions.”⁵⁴ The APBC delegates were: Dudley Drown (current Chairman), Mrs Drown, Mary Wheeler (the Policy Committee Chairman), Mrs Maclaren-White (General Secretary), Fryd and John Barter (although he was a County Councillor, he no longer served on the National Council Board.) The members of the Royal Commission were: Lord Percy of Newcastle; Mrs Edgar Adrian; Mr C. Bartlett (President of the Confederation of Health Services Employees); Mrs Bessie Braddock (JP, MP); Sir Russell Brain (President of the Royal College of Physicians); Mr Harry Braustyn Hylton-Foster (QC, MP); Mr Richard Meredith Jackson (L.I.D, Reader of Public Law at the University of Cambridge); Sir Cecil Oakes (CBE, former Clerk of East Suffolk County Council); Dr Thomas Percy Rees (Medical Superintendent of Warlingham Park Hospital; Dr David H. Thomas (Medical Superintendent of Cell Barnes Hospital, St Albans); and Dr John Greenwood Wilson (Medical Officer of Health, Cardiff.) The APBC produced a statement of evidence based on careful consideration, questionnaires and case histories. The teamwork of the National Council and members resulted in a great deal of useful information being presented to both ministerial deputations and the Royal Commission. Additionally, a copy of the Association’s National

⁵⁴ ‘Royal Commission’s Proposals: Our Children’s Charter’ in ‘The Parents’ Voice’, *Newsletter* 8, 3 (Aug, 1957), pp. 4-6.

Policy was sent to each member of the Commission. According to the memorandum submitted by the NAPBC Parliamentary Committee to the Royal Commission:

the main problem to be dealt with is the fact that larger numbers of mentally handicapped and mentally sick children are left at home in the sole care of their parents for many years, sometimes for the whole of their childhood and adolescence. [...] the situation plays house with the family life, causes the children concerned to deteriorate and finally become a life-long burden on the State, and creates social problems which are not confined to the families concerned.⁵⁵

The burden on the state was ever-increasing and the APBC urged that the measures provided were grossly inadequate to meet the demands of this marginalised group in society. In 1954, the APBC estimated:

In the absence of daily training and supervision, many of the 23,000 awaiting places in Special Schools or Occupation Centres will deteriorate and become too much of a burden to themselves and their families, or may come before Courts as delinquents or beyond control, it would be wiser to consider a potential waiting list for Institution of 23,000 children.⁵⁶

The Royal Commission report deemed it necessary to comprehensively and accurately determine what the LHAs and the Government were doing in terms of provisions. The Royal Commission suggested these figures should be put in a brochure to be widely published and distributed. It was hoped that this brochure would help LAs recognise the necessary measures needed to be undertaken for this perceived growing problem and the need to devote expenditure to its resolution. It was established that the cost of 46,000 patients in ‘mental

⁵⁵ ‘Telling the Royal Commission: Extracts from Memorandum Submitted by the N.A.P.B.C Parliamentary Committee’ in ‘The Parents’ Voice’, *Newsletter* 5, 4 (Oct, 1954), pp. 3-4.

⁵⁶ *Ibid.*

deficiency' hospitals was not less than £12 million per annum, and at least a further £6 million was needed for social services for those left in the community. Additional to this figure was the loss of economic contribution and earnings estimated to be £120,000; based on an average of £500 annually per each 'mentally defective' person. To conclude, it was proposed that the problem of 'mental deficiency' cost the nation £70 million annually. However, the distinction between 'mental deficiency' and 'mental handicap' is made here. 'Mental handicap' was believed to be a result of pre-natal illness of which 'mental deficiency' was but one outcome. The problem of 'mental handicap' as a whole, for the British Isles only, was tallied to have cost the State in excess of £1 billion per annum. However, it was suggested by Martin Redmayne (MP for Rushcliffe) that statistics regarding the number of 'mentally deficient/handicapped' individuals may be incorrect as some cases were regarded as 'too hopeless' and not included in lists of those needing provision. He declared that until a reliable and accurate figure was reached, the public would not be able to understand, and thus help, with the full-scale of the problem.

Fundamentally, the resulting Royal Commission report was largely in agreement with the deputation made by the APBC and posed to the Commission. The deputation was largely based on the NAPBC policy of 1952, and Fryd commented: "they give all that we ask for and more!"⁵⁷ Whilst the Commission did not always agree with the APBC's point of view, they diligently listened for two hours to their arguments, asked appropriate questions, and raised concerns. Fryd explained that all who attended felt that "undoubtedly when we left [they] had acquired a clear and sympathetic understanding of the problems as seen by the parents."⁵⁸ Fryd thanked the Royal Commission for hearing their case and for letting them speak on behalf of the thousands of children and young adults who could not speak for themselves. The report was debated in Parliament in the summer of 1957, and most discussions focussed

⁵⁷ 'The Parents' Voice', *Newsletter* 8, 3 (Aug, 1957).

⁵⁸ 'Telling the Royal Commission: Extracts from Memorandum Submitted by the N.A.P.B.C Parliamentary Committee' in 'The Parents' Voice', *Newsletter* 5, 4 (Oct, 1954), pp. 3-4.

on the problem of admission of the mentally ill to hospitals, the protection of civil liberties, and the winding up of the Board of Control.

Home Secretary and Lord Privy Seal, Richard Austen Butler began the discussion by noting that the “Government thought this matter of sufficient importance for a member of the Cabinet to interfere.”⁵⁹ He then suggested that the recommendations for a change in legislation were broadly welcomed and agreed with. He did not mention whether or not it would be possible to introduce new legislation in the coming Session. However, the report advised that many changes could be made without the need for legislation and the recommendations should be acted on. During the discussion, tribute was paid to the League of Friends of Hospitals (e.g. the Fountain Hospital) and other voluntary organisations. Whilst the APBC were proactive in the field, their work did not feature on any statistic report. It was agreed by all that these organisations accomplished more than any other single factor in overcoming and breaking down the prejudice attached to the subject. It was commented: “We are paying the price for isolation and separation in the past of this branch of medicine.”⁶⁰

Fryd believed that the report had helped to produce an entirely new pattern of the Mental Health Service which aimed to reduce specialised legislation for ordinary provisions which were readily available for ‘normal’ people. Legislation for these basic rights was not deemed to be necessary. Many believed that the most important aspect of the report was the encouragement of a shift towards community care. This was inspired by a growing distrust of residential care and improved public tolerance of services for the ‘mentally handicapped’. Fryd put it categorically: “There was no justification, medical, moral, or social, for the lifelong separation of the mentally handicapped from society.”⁶¹

By 1959, the Mental Health Bill had been composed based on the recommendations of the Royal Commission report. The Lunacy and Mental Treatment Acts 1890-1930 and the

⁵⁹ ‘Parliament Debate Commission Report’ in ‘The Parents’ Voice’, *Newsletter* 8, 3 (Aug, 1957), pp. 20-22.

⁶⁰ *Ibid.*

⁶¹ ‘The Parents’ Voice’, *Newsletter* 9, 2 (Summer, 1958).

Mental Deficiency Acts 1913-1918 were repealed by the Bill and replaced with a singular legal code to cover both 'mental deficiency' and mental illness. In the realising of the Mental Health Bill the Association achieved their main aims. The Bill provided for the abolition of the Board of Control and the transfer of its functions to the new Regional Tribunals. These were to consist of members of the medical and legal professions, as well as lay persons. Hospitals which was presently designated as mental or 'mental deficiency' hospitals were declared redundant. The Bill dictated there would be no designated hospitals and any hospital may receive any type of person, including a mentally ill or 'deficient' patient. Moreover, the closest member of family to the patient would possess the power of discharge under the new regulations; this was previously not applied to the 'mentally defective'. Additionally, the Bill commanded the compulsory attendance at occupation centres (excluding cases of illness or delicate children etc.) Powers were granted to LAs to provide residential training centres for the 'mentally handicapped'. Overall, the Association welcomed the new Bill and agreed for the most part. However, it too was not exempt from failings. The Bill failed to make it compulsory for LAs to provide training courses for 'mentally defective' persons that it was known would be in their district (based on a realistic estimation of the population.) Furthermore, the Bill failed to make adequate financial provisions for new buildings, equipment, and staff which were vital for the duties imposed by the Bill to be carried out. Fryd could not hide her disappointment. "It is high time," she said, "the Government and the Local Authorities stopped saying "After you Claude," "NO, after YOU, Cecil," and got down to the business of making proper provision for the mentally handicapped."⁶²

Generally speaking, the Bill attempted to ensure that 'mentally disordered' patients were to be treated no differently from any others. This included the abolition of terms such as 'mentally deficient', 'idiot', 'imbecile' and 'feebleminded' in legislature, the media, and

⁶² 'The Parents' Voice', *Newsletter* 9, 5 (March, 1959).

popular usage. This was largely welcomed by all concerned. However, some APBC members felt the Bill was not comprehensive enough. Parents were compelled to send their child to a centre or risk prosecution, yet, there was no compulsion for the LAs to provide a centre. For many this raised the question: if LAs did not act under the previous Acts, what hope was there that they would act now? Subsequently, it was urged that a duty should be imposed on LAs to provide health and education provisions for 'backward' children as they did 'normal' children. The APBC continued to exert pressure on Parliament and at local levels to ensure that no delay to the much needed reforms took place on the basis: "of elementary justice and Christian Ethics, refusal to carry out these reforms cannot be defended."⁶³

Extra Support: Home Helps

Due to the stigma caused by 'backwardness' a feeling of them/us existed between 'normal' individuals and those with a learning disability. Additionally, many 'backward' individuals were hidden away from society, widening the gap between these factions of the community. As a result of this, much of society were unaware of the problems faced by 'mentally defective' individuals and the level and type of care/training needed. Negative psychological aspects, such as behavioural disorders, often formed very early on and had detrimental effects. If those psychological issues were left unattended they frequently created problems for the child and family in later life. To counteract these problems, parents were urged to help educate their child by reading pamphlets and taking the "practical steps of talking a lot to the child about a variety of topics, even though he might not be able to respond openly; by taking him out and about and giving him the most varied experience of life."⁶⁴

In this context, Fryd stressed the need for home helps for mothers in the care of their 'mentally defective' children. Mothers became anxious when their babies did not act in the

⁶³ 'The Parents' Voice', *Newsletter* 8, 4 (Nov, 1957).

⁶⁴ 'APBC', *Newsletter* 2, 10 (Jun, 1950).

expected manner as others their age and the inevitable comments from others followed this realisation. Fryd encouraged mothers to ask for special help with the care and training of their child suitable to his/her condition. The mother should make it apparent during these appointments that there was no interest in intelligence testing, but rather in training which the mother could start at home in the child's early years. By age 5, if the child had not managed to catch up with others their age, the problem of schooling became acute. If the child's condition was restricted to mental matters (meaning the child was uninhibited physically) then it would be possible for a Head teacher to allow the child a trial in a school. This was especially true of village schools where overcrowding was not an issue. However, it was more likely that the mother would be advised to get the child tested. If the child's speech was not considered to be as advanced as it should be, a performance test would be included and on the results of these tests the child may be admitted to a special or mainstream school. Alternatively, the mother may receive the diagnosis that no parent wanted to hear: 'your child is unlikely to benefit from any schooling or training at all'.

If training was started at an early age in the family home, the child had a greater chance of succeeding in an occupation centre or special school. It was argued that training in the home helped to alleviate the feelings of frustration experienced by both the child and family:

The better the training of a backward child, the less work it makes in the home, even if it takes him six months to learn to dress himself. Much of the feelings of frustration, of wasting valuable years in the child's life waiting for a vacancy in a Hospital or Institution, would be mitigated by some such scheme of training by the parents. It is felt that this Association can do pioneer work in this country by inaugurating such a scheme. Several teachers and specialists have written to the Association offering to

give their services to help the parents and children and this seems a useful channel for their activities.⁶⁵

Isabel Laird (Chairman of the British Standing Committee of the Women's Federation for Mental Health) spoke of the necessity of training 'backward' children in the home. She encouraged mothers to be detached in their approach and appraisals and not to focus too heavily on negative aspects, but rather, to concentrate on what the child had achieved. For Laird, one of the most fundamental aspects of training in the home was to be cautious in comparing a 'backward' child to a 'normal' child of the same age. Whilst similar toys should be provided (only on a larger scale) and opportunity for self-expression given, expecting a 'backward' child to reach the same milestones as others at the same time would inevitably lead to disappointment for all. Emphasis was placed on big movements such as walking, dressing, and feeding oneself; smaller, more intricate movements like hand-weaving would follow later. Language developments should be fostered and nurtured at every stage as missing simple sounds could lead to the child being permanently mute. Laird urged parents to keep accurate records of their child's progress and to use them for comparison over five years. Many parents were encouraged by Laird's laidback and humorous approach to training 'backward' children. Parents began to share stories and training methods at weekly branch meetings (as reported by the Southern England branch in January 1951.) This helped parents to understand the benefits and necessity of helping themselves and not being reliant on the government for provisions.

In January 1951, *Parents' Voice* published an article called 'How to Train Your Child' after numerous parents had written to ask for advice and if classes could be arranged to help instruct parents. The association were approached to begin organising a class for

⁶⁵ 'The Parents' Voice', *Newsletter* 2, 1 (Jan, 1951).

parents to gather information on how to train their child. By July 1951, the APBC had successfully completed the setup of the classes. The classes were described thus:

The organisers stress that as the course has been carefully planned to cover all aspects of the mental, physical and emotional development and training of the backward child, it would not be satisfactory if odd lectures were picked out, and in teaching students have, therefore, been urged to attend the whole course.⁶⁶

The classes were designed to begin with a lecture, a break for refreshments and then a question and answer section regarding parents' personal problems. The lecture programme included: 'Your Child and the Law'; 'the Physical Training of the Defective Child'; 'Training Your Child through Play'; 'Stages in Development of the Backward Child'; 'Social Development'; 'Family Relationships'; and finally 'Practical Training in the Home'. Due to the overwhelming response received from local parents and the limited number of spaces available, the course and lectures were intended to be repeated in the winter of 1951. Fryd declared them: "Just what the parents have always needed, to help them to train and care for their own children at home."⁶⁷

To complement the lecture series, in May 1956 *Parents' Voice* published the first in a series of articles designed to help parents in the daily care and training of 'backward' children in the home. These articles were intended to be reprinted as leaflets and as widely distributed as possible. For instance, the article called 'Home Care of the Backward Child' noted that: "The biggest enemy of a backward child is idleness and boredom. Therefore a mother will have to be always on the alert for ways of rousing and maintaining the child's interest in his surroundings, and keeping him busy without fatigue or overstrain."⁶⁸ The article continued on

⁶⁶ 'The Parents' Voice', *Newsletter* 2, 3 (July, 1951).

⁶⁷ Ibid.

⁶⁸ 'The Parents' Voice', *Newsletter* 7, 2 (May, 1956).

to mention that children required plenty of fresh air, free play and outings, and at no point should the child be kept at home from the fear of others staring.

Occupation Centres: A Suitable Substitute?

In connection with this argument, it is worth looking at the developments in the education for ‘backward’ children, namely occupation centres.⁶⁹ Occupation centres were established in the early to mid-twentieth century as non-profit organisations. Specifically, occupation centres were tasked with helping ‘backward’ children and those with mental impairments learn basic education skills. Many children who attended occupation centres began so unable to walk, talk or think independently. Yet, within a short time-frame the majority were able to make progress in these respects. Voluntary women’s groups co-operated with occupation centres to establish plans for special classes. These classes were specifically designed for aphasic ‘backward’ children. Similar classes had been proposed for other particular ‘handicaps’ such as vision, hearing, special language defects and other disabilities. With the proper government support and tailored curriculums, Fryd was confident that the lives of ‘backward’ children could be greatly improved. The *Guild of Diploma Teachers’ Journal* suggested the term ‘occupation centres’ should be changed to ‘training schools’ as the work conducted in these establishments was no different to a school and to say ‘centre’ was derogatory.⁷⁰ This change was not fully implemented in the 1950s. Later, occupation centres were known as training centres. They were predominantly for children who remained with their families and not deemed worthy or capable of mainstream schooling. Although funded by the government, provisions were often not enough for the demand placed on them; many were frequently subsidised by local donations of time and money.

⁶⁹ See Illustration 7 for an image of children playing at the Maidenhead occupation centre.

⁷⁰ It is worth noting that by late 1955 many occupation centres had begun to change their names to ‘special training schools’ to better reflect the nature of their work. Similarly industrial centres for children over the age of 16 began to change their names to ‘special occupation training centres’.

By mid-1950s, the inherent flaws in occupation centres had caused Fryd to lose a degree of optimism. Owing to a lack of alternatives, many reformers remained positive. The NAMH encouraged and circulated a pamphlet for authorities and voluntary groups who wished to open an occupation centre. The advice given on location, staffing, aims, curriculum, and equipment heavily influenced many occupation centres established by local branches. In many counties, occupation centres had been established where the child could learn to be self-reliant to an extent and learn simple crafts. In some counties transport was also provided, although this was certainly not the standard. Practices in occupation centres had considerably improved since their inception, largely due to improved and more informed staff. Nurses were able to 'grade' the children and put them into suitable groups accordingly. 'Higher grade' children would often partake in classes teaching the three r's, and if significant progress could be made then the label of 'ineducable' may be revoked and the child readmitted to the Education Authorities under the Education (Miscellaneous Provisions) Act of 1948. It is pertinent to note that staffing levels, skills, and attitudes varied greatly from centre to centre. Due to understaffing in many centres, a waiting list of approximately 12,000 children for special needs schools or occupation centres still existed for 'educationally subnormal' children.

Occupation centres aimed to teach habit training, handwork, self-help, speech training, physical training, percussion instruments, music and movement amongst other things. Some occupation centres offered reading and writing for children who could benefit from such lessons. These tasks aimed to train 'backward' children in habit sense and cleanliness, encourage them to be more stable and independent, to be useful members of the family and partake in simple domestic chores and social pleasures. Ultimately, the purpose of occupation centres was to teach 'backward' children to lead happy, useful and fulfilled lives as far as their 'defect' permitted. Parents were encouraged to send their child to an occupation

centre should the opportunity arise, as the majority enjoyed learning new skills and gained self-confidence which they otherwise lacked amongst ‘normal’ people. It was remarked: “The provision may not be all that one would desire in the way of a school for their child, but if an opportunity arises to send him it is wise to accept.”⁷¹ This was corroborated by Gerald De Cruz who reported on the activities of Osbourne House for the *Fountain Magazine*: “Our 3R class seems really to be paying substantial dividends both in reading and writing. Reading lessons, often a drudgery to the normal child, are roads of high adventure to these boys. They get such a kick out of knowing that they are learning to read.”⁷² Additionally, children who regularly attended an occupation centre had access to a yearly physical examination similar to those organised by the School Health Service in mainstream schools. This, alongside many other developments, occurred after pressure was placed on the governing authorities by local branches.

The need for more occupation centres or improved facilities in existing centres was prominent in all branches. As noted by the APBC Chairman, Ellis: “We have got to get rid of the church hall mentality – not only from ourselves, but we must never slow our endeavours until the last occupation centres in a church hall is closed down. Church halls for our children in 1956 are an affront to a civilised community.”⁷³ The mentality in many counties was still very much “any old thing is good enough for the duds.”⁷⁴ However, Ellis was keen to point out that for many thousands of children a church hall occupation centre was better than no provision at all. To have only one occupation centre in each parliamentary division would still require tripling the number of centres in existence in 1956. Branches were encouraged to double their efforts if this was to be achieved. Some areas had been successful and LAs provided better facilities for occupation centres and a home tuition service for children unable

⁷¹ ‘The Parents’ Voice’, *Newsletter* 8, 1 (Feb, 1957).

⁷² ‘The Parents’ Voice’, *Newsletter* 4, 3 (July, 1953).

⁷³ ‘The Parents’ Voice’, *Newsletter* 7, 1 (Feb, 1956).

⁷⁴ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

to attend. However, Davies communicated that he was certain that at least six of the newly opened occupation centres had been a direct result of the pressure exerted by the APBC. This was expanded on by W. Barrie Atkinson, the vice Chairman and Appeals Officer for the APBC in 1954. Atkinson declared that four branches had started their own occupation centres, one of which had been taken over by the LAs, one was receiving financial help, and the remaining two were solely run and financed by parents. In addition, parents had prompted the opening of nine occupation centres, two special schools, countless nursery schools, and twenty gramophones, three televisions and two pianos had been donated to various occupation centres throughout the country. Finally, several centres had been redecorated and refurbished by the members.

In July 1953, the drawing up of the official NAPBC policy contained two sections dedicated to ‘occupation centre training’ and ‘occupation centres – qualifications and training of staff’. The first section emphatically called for LHAs to provide adequate and suitable occupation centre training. There were approximately 9,000 children suitable for an occupation centre unable to attend because of provision shortages or a lack of transport. This was particularly true of rural areas. Roughly 30 areas provided no occupation centre or other form of training; the areas which did not establish occupation centres were deemed unsatisfactory. By February 1957, it was noted that the number of occupation centres had increased from less than 100 to nearly 300. Regardless, the waiting list remained 7,800 children in need of provisions which the government admitted. In reality, the APBC believed that this number was likely to be closer to 12,000. However, some of these children may have been of a very ‘low grade’, had severe ‘handicaps’ or living in extremely remote locations. Others in this statistic may have been suffering from a mental illness rather than ‘deficiency’. Yet, the majority of the predicted 12,000 children could attend an occupation centre if permitted to do so. The policy continued to call for greater attention to be paid to planning

occupation centres. Specific focus was placed on sanitary arrangements, outdoor recreation facilities, and the means to suitably segregate children according to age, sex, and mental ability (special facilities for nursery school aged children were mentioned.)

The second section (occupation centres – qualifications and training of staff) primarily dealt with the issue of supervisors in occupation centres holding a nationally recognised diploma. It was suggested that all centre staff and home teachers should be regulated by scales laid out by the MoH. The policy explained that the only training offered for those who wished to work in occupation centres was from the NAMH; the APBC called for wider recruitment calls to be made. Ideally, it was hoped that candidates could take the recognised teacher training course and specialise in the subjects of training and teaching ‘mental defectives’. This should not be restricted by financial constraints on candidates by supplying grants (possibly under the Further Education Schemes) to enable suitable staff to take the NAMH Diploma.⁷⁵ It was suggested that bursaries for training staff should be given by the National Exchequer, as many LAs were reluctant to financially support and train staff for their area who may relocate upon achieving their qualifications. Under the Health Scheme, LAs lost powers to make monetary grants to assist parents able and willing to pay towards the cost of caring for their ‘backward’ child in a private facility. However, in a MoH circular to LHAs it was made clear that any cuts made due to the credit crunch should not be made in the provision of occupation centres and training for ‘mental defectives’. Despite this, just over a year later in August 1957, it was reported that centres receiving governmental funding were told that this would cease due to Ministerial budget cuts, irrespective of the Minister’s specific directions to not affect this important area.

By the late 1950s occupation centres were deemed to be an inappropriate solution to the problem of educating ‘backward’ children. Many occupation centres had a basic skills

⁷⁵ ‘N.A.P.B.C. Policy’ in ‘The Parents’ Voice’, *Newsletter* 4, 3 (July, 1953), pp. 4-6.

orientated education programme, devoid of the three R's – reading, writing, and arithmetic. This limited curriculum failed to help 'backward' children reach their potential. Instead their fate was determined as socially worthless by denying them access to basic education. In this respect, the government's negative approach to 'backward' children was self-fulfilling. Yet, occupation centres were by no means flawless. Whilst they were an alternative worthy of consideration; generally the poor conditions in occupation centres were tolerated by the authorities. Little effort was made to improve circumstances; many believed that occupation centres were sufficient provision for those who would not benefit from further opportunities.

Dr Isobel Wilson (Senior Commissioner of the Board of Control) spoke to the APBC in October 1950. Wilson focused on the issue of occupation centres and emphasised the need for “sensible propaganda from all those interested in removing the stigma that was so often attached to mental deficiency.”⁷⁶ Wilson continued on to explain the need to educate the public about occupation centres which were so often hidden down side streets where few people knew of their existence. Wilson felt convinced that if voluntary bodies such as the Scouts, Women's Institute, Guides and the British Legion knew of the struggle they would be willing to help. Subsequently, Wilson took every opportunity to talk of her work with occupation centres and the profound effect they had on children and their families. Many responded to Wilson by asking what they could do to help. Fryd responded:

This is yet another indication that there is a vast body of sympathisers amongst the general public who are only too eager to help our children whether they are in Institutions, attending Occupation Centres, or in the community if only we can make them aware of our problems and needs.⁷⁷

⁷⁶ 'The Parents' Voice', *Newsletter* 1, 1 (Oct, 1950).

⁷⁷ *Ibid.*

As a result, occupation centres frequently featured in the press, both locally and nationally. Interest was paid to authorities refusing to supply provisions or suitable premises.⁷⁸ A reporter from the *Huddersfield Examiner* was especially impressed by an occupation centre open day and reported: “These children [...] were becoming ‘persons’ instead of afflicted beings from whom nothing is expected and for whom all that is needed is protection.”⁷⁹

Generally speaking, the majority of attendees at occupation centres came from middle and upper class families. Due to the lack of alternatives there was a great demand for places and those who could financially contribute to the facility were favoured in the admissions process. In the mid-twentieth century there were vast class differences in the care and treatment of ‘backward’ children. The majority of amenities, such as homes, schools, and institutions were filled by those in the upper classes and privately maintained. This effectively furthered the chasm between the classes and made attaining resources even harder for working class families. Regardless of the extra financial contributions, much like institutions, occupation centres suffered from staffing and overcrowding issues. It was explained that as classes became larger in ‘normal’ schools, so-called ‘duller’ children who were entitled to an education were sent to overcrowded occupation centres. Subsequently, those in occupation centres who were considered to be the most ‘troublesome’ were excluded due to space restrictions and sent to unsuitable institutions, or home to unsupported families who were unable to cope.

Whilst institutions were certainly not faultless, comparatively occupation centres offered little education and healthcare. A number of institutions were better equipped to educate ‘backward’ children and realistically provided a better alternative despite the inherent social exclusion. However, Fryd refused to settle for social segregation to provide education for ‘backward’ children, particularly as education was not guaranteed or regulated in

⁷⁸ Particularly in the Sunday papers, the *People* and *Reynolds News* and the *Merton and Marden News*, with the latter featuring a front page article about provisions for occupation centres.

⁷⁹ ‘A Big Success’ in ‘The Parents’ Voice’, *Newsletter* 5, 3 (July, 1954), p. 13.

institutions. Fryd proposed occupation centres and institutions served well as an introduction to the tailored education that was needed. Ideally, occupation centres should have been seamlessly integrated into the education system. This would have provided suitable education resources specifically catered for the various nuances of disability. Subsequently, she championed readily accessible special needs schools. Such facilities would allow children to be appropriately educated and remain within their family structures. “What we wanted for our children,” she said, “was not “Homes” and “Centres” but SCHOOLS, in properly designed buildings.”⁸⁰

The Beginnings of Reform: Specialised Schools

The APBC’s main aim was to attain a free and fair education for so-called ‘backward’ and ‘ineducable’ children. Whilst occupation centres certainly made attempts to care for ‘backward’ children, the measures were often inadequate and disproportionate to those given to ‘normal’ children in mainstream schools. Fryd understood that readily accessible education for children with learning difficulties would not be easily achieved. To counter this, Fryd proposed special needs schools where the particular needs of ‘backward’ children could be met.⁸¹ In order for equal access to education to be a reality, a change in legislation and political attitudes was necessary. It was proposed that all ‘backward’ children should be given a placement in a special school irrespective of class or wealth. During a meeting in April 1951, the parents voiced their concern about the urgent need for special schools. Parents felt that if resources could not be dedicated to an entire special school, then special classes in mainstream schools should be facilitated. These classes could potentially help children whose only ‘handicap’ was slowness in learning. Residential special schools were reserved for

⁸⁰ ‘APBC’, *Newsletter* 2, 10 (June, 1950).

⁸¹ The history of special schools far predates the APBC; the beginnings of specialised education can be traced back to France in the late eighteenth century. For further information see: M.A. Winzer, *The History of Special Education: From Isolation to Integration* (Washington: Gallaudet University Press, 1993); and A.F. Rotatori, F.E. Obiakor and J.P. Bakken (eds), *History of Special Education* (Bingley: Emerald Group Publishing, 2011).

children with more serious physical or behavioural difficulties. If provisions such as these were established members believed that it would alleviate the pressure of 12,000 children on waiting lists for special schools, and many more 'borderline' cases not included in that figure. The issue of 'borderline' children was frequently discussed at length by the APBC. The definition of 'borderline' often changed in accordance to differences in levels, places and times according to vacancies in special schools. This made attaining provisions for 'borderline' children extremely difficult.

Whilst Fryd was undoubtedly the driving force and pioneered many legislation changes, she was by no means the only campaigner to do so. The campaign for equal rights and access to education did not start with Fryd in the mid-1940s. In April 1950, Fryd boasted the work of long-standing supporter of equal rights for disabled children and Head teacher at Peckforton Castle Residential Council School for Evacuated Physically Defective Children in Tarporley, Jessie Thomas (MBE) of Middlesex. Thomas campaigned for 30 years to convince the MoE to organise a training course for teachers of 'mentally handicapped' children. This seemingly small change was fundamental to gaining better, more tailored education for 'backward' children. Additionally, an intensive diploma course was organised by the NAMH from 1949-1950. During the course, the students were taught various eurhythmics, songs, dances and speech training exercises to help when training 'backward' children. Fryd and Thomas believed that the main aim for teachers was to banish the feelings of inadequacy and inferiority and replace it with the sense of achievement. The course also taught the attendees that physical disability was by no means the only handicap faced by those with disabilities. Social influences played a vital role on how 'backward' individuals viewed themselves and how society perceived them. Fryd and Thomas believed that education was pivotal to changing these perceptions, and demonstrating that 'backward' and supposed 'ineducable' persons possessed talents elsewhere. Thomas' work also indicated the expansive time

required to change authoritative opinion and the determinism of campaigners in the face of adversity. Thomas believed that many schools were beginning to understand and accommodate for a larger variety of 'backward' children. For many the placement of 'mentally deficient' children amongst 'normal' children in education terms was not beneficial for either party. As a consequence, specialist schools/classes were established to avoid "bitterness and frustration."⁸² Children were divided up within the education system to allow for the particular nuances of their disability. Fryd explained "the near normal children go to regular classrooms, the cerebral palsied to one for orthopaedically handicapped children, those whose major handicap is mental deficiency to a special class for retarded children."⁸³

An article published by Fyfe Robertson in *The Picture Press* in April 1949, provided a good example of the contemporary change in attitudes towards education of the 'backward' child. Robertson discussed the favouring of special needs schools such as Dr Karl Konig's Scottish Camphill School in his article 'A School Where Love is a Cure'. According to Robertson, "Some people think defective children cannot be educated. Some people think they cannot appreciate thoughtful care. But this school, which is returning many defective children to normal, or nearly normal, shows that both these beliefs are often wrong."⁸⁴ Comparatively, the Scottish education system was far more progressive than its English counterpart, which was more rigid and exclusionary.⁸⁵ The Camphill School and the pioneering work that was being conducted by Superintendent Konig particularly interested Fryd. She believed that he was a pioneer in the betterment of services for 'backward' children. Konig believed that 'backward' children were not by definition 'ineducable' but simply needed the correct education programme in order to excel. Occupation centres in

⁸² 'APBC', *Newsletter* 2, 8 (April, 1950).

⁸³ 'APBC', *Newsletter* 1, 12 (Nov, 1948).

⁸⁴ F. Robertson, 'A School Where Love is a Cure', *The Picture Press* (30/04/1949). Newspaper article in *NAPBC 1948-1953*.

⁸⁵ For more information on the Scottish education system see L. Paterson, *Scottish Education in the Twentieth Century* (Edinburgh: Edinburgh University Press, 2003).

Glasgow were attached to mainstream primary schools promoting fluidity and synchronicity to the inclusion of ‘backward’ children in education. ‘Backward’ children and their families were given access to daily coaches, allowing the children to travel to centres where they were provided with school milk, meals and medical services. Attendance at the occupation centres was not mandatory for ‘backward’ children. Yet, the free provision ensured an excellent response to the service. Whilst Fryd was increasingly sceptical of occupation centres, she was unable to deny that the Scottish approach was more advanced than the contemporary English education system. For Fryd: “What has been done in Scotland could surely be done elsewhere and we intend to press for the amendment of the Education and Health Acts to conform with this.”⁸⁶

It became increasingly obvious to reformers that the label of ‘ineducable’ should not be a life tariff. Robertson mentioned how schools such as Konig’s were employing educational and ‘love’ methods to lessen the associated conditions of ‘mental deficiency’. The generous ratio of staff to children in the Camphill School was considered important to the progress made. Konig employed 75 staff members to educate and provide care for the 180 children who attended daily; essentially this meant that the ratio of teachers to students was 1:3. Robertson explained Konig’s approach: “Camphill is not an institution, but a place for educating children who can be, more or less, educated.”⁸⁷ However, Konig was met with a degree of dissent from society which believed that this allocation of staff to children was excessive. For Robertson: “This may seem large, and some people may think that so much work and care should not be spent on defective children ‘who will be unable to make an adequate return to society’.”⁸⁸ Konig responded to this with defiance similar to Fryd’s, insisting that “To care for them [‘backward’ children] is a Christian duty.”⁸⁹

⁸⁶ ‘APBC’, *Newsletter* 1, 12 (Nov, 1948).

⁸⁷ Robertson, ‘A School Where Love is a Cure’.

⁸⁸ *Ibid.*

⁸⁹ Dr Karl Konig quoted in Robertson, ‘A School Where Love is a Cure’.

Fryd saw the successful operation of the Scottish system as a hopeful sign. Fryd added that whilst improvements could certainly be made, the Scottish curriculum was “satisfactory”⁹⁰ and saw no reason to delay the implementation of specialised schools in England.⁹¹ The increase in specialised schools confirmed the change in attitudes towards institutionalisation and occupation centres. However, special schools for educating ‘backward’ children did not necessitate the end of discrimination against the ‘mentally defective’. This solution, like many others, was fraught with problems. Funding for the building of new premises for teaching and training ‘backward’ children was scarce and many LAs wished to make economic cuts. One large school was economically more suitable and more palatable to the governing authorities. Yet, several smaller schools would be better equipped to provide intimate specialised care and education. The specialised schools which were established were unable to cope with the high demand placed on them and were often overcrowded, much like institutions and occupation centres. To tackle this, the NAPBC policy specifically dealt with provisions for ‘educationally subnormal’ children. It suggested that special classes in primary schools for ‘retarded’ children should be facilitated to discourage segregation and allow special teaching. Where possible, all ‘backward’ and particularly ‘borderline’ children should be allowed to spend time in opportunity classes before being formally excluded from the education system. For those where segregation from older children was necessitated, LAs would ideally be duty bound to provide an adequate amount of day special schools. Residential special schools should also be provided for children living in extremely scattered or isolated locations, where transport and administrative difficulties arose, or children with unsuitable home conditions. Lastly, the policy discussed the curriculum in special schools which needed drastic revision: “Too much emphasis is often placed on purely scholastic objects which will bear little relations to the life

⁹⁰ ‘APBC’, *Newsletter* 1, 12 (Nov, 1948).

⁹¹ *Ibid.*

of the child [...] upon leaving the shelter of school.”⁹² Irrespective of this, Fryd was encouraged by the beginnings of reform in the education system.

Discussion of individual special schools continued in *Parents’ Voice*. In February 1957, Fryd reproduced a talk by R.H. Leipnik, the Headmaster of Garston Manor School for ‘educationally subnormal’ children in Hertfordshire. Leipnik began with: “Every school is in its own way a Special School.”⁹³ Leipnik believed that every school supplied varied programmes of education according to age, ‘grade’, capabilities and aptitude. Yet, by name certain schools were specifically designated for ‘educationally subnormal’ children; the same label which created an unnecessary stigma. Leipnik continued on to mention that some children attending Garston Manor may have been able to attend a mainstream school had they not began on the wrong foot. For Leipnik, parents recognising and asking for their child to attend a special school was an indication of progress.

Children in special schools could be broadly classified into four main categories. The first: children unable to attend an ‘ordinary’ school because of feelings of unhappiness and frustration. These children constituted the largest proportion of the special school population and would likely remain until the age of 16. The second category of children was often thought more ‘deficient’ than they were in reality due to emotional distress during testing. This was generally a small group who, with the right conditions, may be transferred back to mainstream schools. The third category was children who required help from a psychiatrist for disturbed behaviour that may have been a result of brain disturbances. These children often had multiple ‘handicaps’ but were greatly improved with focused care and attention. The last category of children was from occupation centres provided with an opportunity to be in a special school. These children required specialist help with their specific needs. As Leipnik declared: “Education must not merely consist of reading, writing and arithmetic. It is

⁹² ‘The Parents’ Voice’, *Newsletter* 4, 3 (July, 1953).

⁹³ ‘The Parents’ Voice’, *Newsletter* 8, 1 (Feb, 1957).

a question of helping a child to adjust to living, and helping to establish him in the community. This is particularly true of the duller children.”⁹⁴

Equally important, Leipnik conveyed the damage caused by ridicule. He believed ‘community’ started in the home and expanded out to the neighbourhood. There was a tendency in some communities to group together against ‘weaker’ members: “the old idea of the “village idiot” who was the victim of a sort of half-affectionate ridicule.”⁹⁵ However, these ‘weaker’ members may only be ‘weak’ due to a physical factor such as malnutrition or ill-health causing ‘backwardness’. Equally, long periods of absence from school due to illness may cause a child to be perceived to be ‘backward’. If a special school was made available for such children, the child may be able to catch-up in a non-competitive environment and eventually re-enter mainstream schools. The sooner a child’s disabilities were recognised, the greater the chance of progress being made and confidence gained. Confidence, in Leipnik’s opinion, was the trait that ‘educationally subnormal’ children most notably lacked: “The dull child was often cruelly treated by other children in their ignorance of his condition and needs, and this unfortunately was often the result of adult attitudes, and could be corrected by adult example.”⁹⁶

The replacement of the three r’s with the three s’s was proposed: stimulation, stability and success. And Leipnik concluded his talk, suggesting that “To educate these children we must have faith in them and let them see that we have faith – and we must give their parents the reassurance that their children were going to have every chance open to them of an education suited to their individual needs.”⁹⁷ However, Garston Manor was described as a particularly progressive school. Unfortunately many parents felt that it was not the reality of the overall situation. A letter sent to *Parents’ Voice* in October 1951 claimed that special

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ Ibid.

⁹⁷ Ibid.

schools were very much thought of as the ‘Cinderellas’ of the Education Authorities. The author explained the common opinions they faced as a teacher in a special school for 19 years:

Special Schools are *privileged* schools, having the following advantages: (a) the Teachers are paid more (two increments): (b) the classes are smaller (20 instead of 30, 40 or 50): (c) there is extra money for material and apparatus: (d) there is extra attention from Doctors, Nurses and Home Visitors: (e) in every way the children get extra consideration and attention to their individual problems.⁹⁸

Regardless, this was often not the reality; staffing, like many other facilities in the ‘mental deficiency’ field, was problematic. Provisions were hard to obtain and funding even more troublesome. Large classes resulted in not enough individual attention paid to each child and waiting lists of 12,000 children still existed, despite the advances made since the end of WW2. Finally, parents felt special schools did not practically help children to obtain a job. Despite this, teachers were specially trained and recognised the importance of the work being conducted in special schools. It is also worth noting that the majority of teachers and headmasters belonged to the APBC and were equally devoted to the campaigns for better understanding and provision for ‘backward’ children as parents of such children were. To combat the stigma and misconceptions caused by the term ‘special school’, the following recommendations were made to the Royal Commission:

We recommend that the terms “special education” and “special schools” be no longer used, as these create in the public mind a feeling that they are “frills” which can be dispensed with on the grounds of economy. We suggest that the terms “education of

⁹⁸ ‘The Parents’ Voice’, *Newsletter* 2, 4 (Oct, 1951).

handicapped children” and “schools for handicapped children” be substituted, and that the Ministry should give a lead to Local Authorities regarding increased provision.⁹⁹

Next Steps: Industrial Centres

Many parents expressed concerns about what became of their child once they reached school-leaving age. Members suggested that little seemed to be done for ‘backward’ children in special schools and occupation centres to help them economically function in the community. For many ‘backward’ individuals still living at home, their only source of income was National Assistance Allowance. Individuals aged 16-18 were granted 23/-, 6d (per week); 18-21 year olds were given 27/-, 6d with rent allowances granted after the age of 18; and finally, those over 21 were given 33/-, 6d. Subsequently, these persons remained a burden on their families and were unable to financially support themselves on this income alone. Often children were transferred to occupation centres for ‘ineducable’ children upon reaching the age of 16. Whilst occupation centres taught crafts to older children, these crafts had little connection with local trades and the products did not have any significant commercial value.

As with ‘normal’ children, ‘backward’ children reaching adolescence required a different form of care. Fryd discovered that it was during this period that parents first began to think of residential care, as little other option was provided. The NAPBC policy on this matter was that “In no case should an orphan or deprived child, upon leaving a Special School, have to enter an Institution until every effort had been made to place the child in a suitable hostel or foster home, if necessary under a Guardianship Order.”¹⁰⁰

Institutions often failed to provide daily training in workshops either and so children’s chances of meeting their potential was low. This idleness and boredom regularly produced acute behavioural problems and deeply affected families of ‘backward’ children. In some

⁹⁹ ‘The Parents’ Voice’, *Newsletter* 6, 3 (Summer, 1955).

¹⁰⁰ ‘N.A.P.B.C. Policy’ in ‘The Parents’ Voice’, *Newsletter* 4, 3 (July, 1953), pp. 4-6.

areas industrial centres had been established to help with this problem; Fryd encouraged this practice and welcomed the news of other areas opening similar centres. Adult centres were important psychologically for young adults. Fryd believed that ‘mentally deficient’ persons should leave day centres at age 16 and join an adult centre where they could learn new skills, without looking after younger attendees in occupation centres. To some extent, “Failure to provide commercially valuable training and employment results in a number of social evils, the more severely handicapped have to be constantly watched over by their mothers, which imposes increasing strains as they grow older.”¹⁰¹ Not surprisingly, in July 1951, it was stressed, “There was little need to remind members of the strain imposed on mothers by the unremitting care of these children everyday over a long period of years, in addition to all the other cares complained of by the modern housewife.”¹⁰²

In March 1958, E.M. Gleadle-Richards wrote an article for *Parents’ Voice* entitled ‘They Want to Work’. Gleadle-Richards stated that industrial centres, or sheltered workshops, and residential hostels were desperately needed to make a real change to the lives of ‘mental defectives’. Gleadle-Richards declared: “The mentally handicapped and their parents every day face many and difficult problems unknown to those who do not suffer from this most widespread of all stresses.”¹⁰³ He further explained how ‘mentally handicapped’ children with an IQ above 50 were not admitted to special schools until the age of 7; this stunted many children’s development. Finally, Gleadle-Richards suggested that industrial centres were necessary to combat this delay in education and make it easier to find employment. Despite this, certain industries, such as the Civil Service, were unwilling to employ those who were not physically or mentally fit, regardless of training. Youth Employment Officers and Labour Exchange Managers frequently had no positions to offer ‘backward’ adolescents, leaving many in limbo between school and employment. Parents

¹⁰¹ ‘The Parents’ Voice’, *Newsletter* 8, 2 (May, 1957).

¹⁰² ‘The Parents’ Voice’, *Newsletter* 2, 3 (July, 1951).

¹⁰³ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

commented that ‘backward’ adolescents found it extremely frustrating and disheartening to see their ‘normal’ brothers and sisters in employment while they remained idle at home. For some, frustrations manifested themselves in petty crime and antisocial behaviour:

This enforced idleness is to be deplored, and should be avoided at all costs, as it has led many an adolescent to the magistrates’ courts; this in turn can lead to certification under the Mental Deficiency Act and their transfer and detention in a Mental Deficiency Hospital.¹⁰⁴

Ideally, services should be provided in accordance with the Disabled Persons (Employment) Act of 1944, the Employment and Training Act of 1948, and under Section 29 of the National Assistance Act of 1948. With the peace brought by the end of WW2 came an era of social security. Particularly important during this era was the establishing of the Disabled Persons (Employment) Act of 1944 which provided for any adult who was “handicapped by some form of disability.”¹⁰⁵ This Act required the MoL to form a voluntary register of handicapped persons with a view to rehabilitating them or train them to make the most of their disability so that they may partake in some form of employment, whether in industry or sheltered workshops. This Act forced the split of mutual obligation between the ‘handicapped’ element and the remainder of the community. Despite this, the Act was primarily concerned with the employability of the individual as opposed to their welfare. However, few authorities responsible for the leadership and assistance in the lives of the ‘mentally deficient’ under Section 29 of the National Assistance Act of 1948 had followed the example set by the MoL. Many felt that the obvious solution was to extend the powers of LA welfare services to the provisions for the ‘mentally handicapped’. Sheltered workshops provided an ideal solution;

¹⁰⁴ Ibid.

¹⁰⁵ ‘Disabled Persons (Employment) Act 1944 7 & 8 GEO. 6 CH. 10’
http://www.legislation.gov.uk/ukpga/1944/10%20/pdfs/ukpga_19440010_en.pdf (Accessed on 13/09/2015).

the National Assistance Board could establish industrial centres without the need for new legislation.

Whilst not specifically intended for the ‘mentally defective’ there was nothing preventing the Board from establishing these provisions for these individuals. Additionally, the Disabled Persons Employment Service could make provisions for Remploy factories which did not necessarily have to exclude the ‘mentally deficient’. Despite the possibilities, in reality neither of these provisions was supplied due to economic reasons or because it was believed that the responsibility was that of the LHAs or Mental Health Committees. Gleadle-Richards closed his article by providing the following statistics for December 1955: there were 4,317 adult occupation centres; 1,108 adults partaking in part-time training at home; and 5,763 individuals on official waiting lists. There were also considerable amounts of individuals in ‘mental deficiency’ hospitals who were stable enough to be released but had no place to go. The APBC suggested hostels but this was opposed by some LAs who refused site proposals or planning permission. LAs had a duty to help ‘mentally handicapped’ employment schemes and parents were advised to push for this: “such things take time and action now will safeguard the future.”¹⁰⁶ However, most of the statistics tended to focus on ‘ineducable’ children and teenagers; it was suggested that greater attention should be paid to the special school leaver. The NAPBC policy specifically included a section titled ‘The School Leaver’ to deal with the provisions for ‘backward’ adolescents upon reaching the age of 16. It declared that:

In such cases where the Education Authority considers supervision necessary and refers the case to the Mental Health Department, under Section 37(5) Education Act, then it is desirable to arrange a School Leavers Conference, when all the available information about the child is passed on by the Head Teacher and the School Doctor

¹⁰⁶ ‘The Parents’ Voice’, *Newsletter* 9, 1 (March, 1958).

to the Mental Health Officer and the Mental Welfare and Juvenile Employment Officer who will be responsible for the supervision of the child.¹⁰⁷

Ultimately, the policy reiterated that provision should exist to make the most of these individuals' abilities. In rural areas agricultural workshops and hostels were proposed. For young adults who were unready for employment (either because they lacked the necessary skills or because they were socially immature) they should have the opportunity for further training in an industrial training workshop, which if properly administered could be self-supporting. The policy mentioned that full use of the Disabled Persons Employment Register should be made. Current training schemes under the Register were mainly for 'normal' people who had become disabled, as opposed to those born with mental impairments. The APBC urged LHAs, LEAs and Justice Employment Departments to cooperate with a view to finding suitable employment for 'mental defectives' over 16. LHAs were approached to provide industrial centres or their equivalent in institutions or occupation centres. Sheltered workshops, agricultural hostels and training centres for those considered to be 'mentally subnormal' but still able to partake in employment. The APBC pressed for the amendment of social security legislation for sheltered workshops and 'training for employment' schemes.

The suggestions made in the NAPBC policy were supported by the report of the Royal Commission. The report recommended more hostels and training centres to be provided by LAs. The Royal Commission emphasised that for the necessary additions to be made, a great deal of capital expenditure would be required. This should be facilitated by additional governmental grants and the return of buildings used as 'mental deficiency' hospitals to LAs. Whilst this may have appeared impractical, given the overcrowding and waiting lists, once hospital rebuilding schemes commenced this should have been possible. Irrespective, these provisions were considered economically necessary and to increase the

¹⁰⁷ 'N.A.P.B.C. Policy' in 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953), pp. 4-6.

individual's well-being and sense of self-worth. It was estimated that 19 individuals with IQs of 35-50 had earned the nation £3000 per annum from factory work once taught the vital skills, as opposed to costing the State £2500. However, the issue of appropriate payment for labour in sheltered workshops often arose. The majority agreed that 'mentally deficient' individuals deserved payment for their work. Yet, some believed that it was unfair for industry to pay these workers a full wage for slower work, yet paying a half-wage had the potential to undermine other workers and cut jobs. Fryd, thus, dispelled the eugenic myth of the low economic value of 'disabled children': "Our children, though they have but a limited value as economic units, are infinitely valuable to God. They have human feelings and rights in common with all other human beings. We ask for them respect and justice."¹⁰⁸

Fryd also raised the issue of sexism in terms of provisions. Girls were not included in paid employment despite many being capable of the same, if not more, skills as their male counterparts. This was included in the Association's resolutions discussed at the 1953 Annual Convention:

While some efforts are being made to cater for mentally defective youths over 16 years of age, by instituting Industrial Centres, very little is being done to cater for girls of a similar age; efforts should be made to get Local Authorities aware of this position and ask them to institute suitable centres for girls where further training can be given.¹⁰⁹

Dr Alan Douglas Benson Clarke (PhD, CBE) and Dr Beate Fliess Hermelin charted the progression of thoughts on adult training since the 1920s in 'Adult Imbeciles: Their Abilities and Trainability'.¹¹⁰ Clarke and Hermelin questioned Alfred Frank Tredgold's 1952 edition

¹⁰⁸ 'The Parents' Voice', *Newsletter* 4, 1 (Jan, 1953).

¹⁰⁹ 'The Parents' Voice', *Newsletter* 4, 3 (July, 1953).

¹¹⁰ A.D.B. Clarke and B. Fliess Hermelin, 'Adult Imbeciles: Their Abilities and Trainability', *The Lancet* 2, 6885 (1955), pp. 337-339.

of *A Text-book of Mental Deficiency (Amentia)*¹¹¹ and Edmund Oliver Lewis' 1929 work 'Report of an Investigation into the Incidence of Mental Deficiency'.¹¹² Lewis declared:

Imbeciles are incapable not only of earning an independent livelihood but even of contributing materially to their own support...the brightest...can manage, in a somewhat irregular fashion, menial duties...but even here they would need almost continuous supervision [...] They are incapable of adapting themselves to anything out of routine to which they have been accustomed, and it is doubtful whether the work they do from an economic standpoint is worth the supervision it entails.¹¹³

Whilst these opinions were still prevalent in some communities, by the 1950s popularity was growing for the idea of training adults to learn enough skills to make them useful in the industrial sector. Articles written by Professor Herbert C. Gunzburg of Monyhull, Birmingham in the NAMH's *Mental Health* supported this.¹¹⁴ Some progressive areas had established industrial centres and arranged for men from institutions to be brought to workshops daily. These changes were widely praised. The newly opened centres were run by County Health Authorities for older 'mentally handicapped' children still under care. A variety of suitable work was vital as individuals varied and rarely had the same skills and difficulties.

Problems in finding suitable employment often arose when employers expressed their unwillingness to take on 'mentally deficient' workers, or when the kind of job offered to the individual was considered unacceptable by the person or family. This is not to suggest that all jobs offered were suitable. In some instances the jobs were far from appropriate. Fryd

¹¹¹ A.F. Tredgold (assisted by R.F. Tredgold, 8th ed), *A Text-book of Mental Deficiency (Amentia)* (Baltimore, William & Wilkins; 1952).

¹¹² E.O. Lewis, 'Report of an Investigation into the Incidence of Mental Deficiency in Six Areas, 1925-1927', *Report of the Mental Deficiency Committee, Part IV; Being a Joint Committee of the Board of Control and the Board of Education* (London: H.M.S.O; 1929).

¹¹³ Ibid.

¹¹⁴ H.C. Gunzburg, 'The Colony and the High-Grade Mental Defective', *Mental Health* 9 (1950), pp. 87-92; see also H.C. Gunzburg, 'Therapy and Social Training for the Feebleminded Youth', *British Journal of Medical Psychology* 30, 1 (1957), pp. 42-48.

provided the example of messenger jobs which required the 'mentally handicapped' individual to wander the streets unsupervised, or jobs where taking money and giving change was expected. Relatively few placements had good liaison between the Health Authorities and the Juvenile Employment Officer about the welfare of the 'mentally deficient'. In reality the Juvenile Employment Officers had little experience with the 'mentally deficient' and their problems and thus were unable to suitably place them in employment. Despite happy examples of adolescent 'mental defectives' finding employment, Fryd was eager to explain that these individuals were the lucky minority. She estimated in July 1951 that there were over 20,000 'mentally deficient' individuals under the age of 21 receiving National Assistance Allowance but physically fit enough to contribute economically and be of benefit to the nation.

Workshops in 'mental deficiency' hospitals gradually convinced many people that the residents were capable of more than had previously been believed. Authorities began to explore the idea of industrial centres with a view to finding individuals employment. Generally speaking, the training focused on manual labour, light engineering and assembly work. Progress had been made from garden work and rug making which was previously believed all that could be achieved. Residents in institutions were increasingly given opportunities and their confidence continuously increased. The Mayor of Slough called for greater provisions to help 'mentally defective' individuals into employment. Slough became a pilot area for industrial centres and local factories promised to send machinery and a trainer to each occupation centre in the district. However, not all areas were as willing, or able, to establish industrial centres. In Sheffield, the proposition by the City Council for a training centre for older boys was met with opposition from the local community and an MP. The local APBC branch reacted by sending letters from members to the local press and efforts

from Councillor Molloy (the branch Chairman) and his contacts in City Council eventually managed to get the proposal passed.

Another progressive and exemplary area was Liverpool. In 1929 a Specialist Officer was appointed to the Juvenile Employment Registry to specifically deal with ‘mentally deficient’ persons. The Specialist Officer’s duties included visiting every special school each term with a Medical Officer to assess those about to leave school. After careful consultation with the parents, Head teacher, and Medical Officer, vocational advice was given and an appropriate job selected. The job selected allowed the child the opportunity to exercise and develop their skills without placing any unnecessary strain on their physical and mental well-being. Ideally the job held the youth’s attention and had potential to lead to a career. In order to be effective in their post the Youth Employment Officer remained in contact with employers and personal officers responsible for engaging with youth workers. The job required great patience but was rewarded with fierce loyalty and punctuality from the ‘mental defectives’. The Superintendent of Liverpool’s Youth Employment Bureau, William Duncan commented:

The term “mentally defective” has been rather largely used in the public eye, the result that the educationally sub-normal may have been regarded as unbalanced and unemployable. It is often overlooked that the educationally sub-normal children may have as stable a temperament and as pleasing a disposition as other more intelligent young people.¹¹⁵

Suggesting that the incorrect use of terminology, and the stigma placed on certain words, affected the treatment afforded to those with learning disabilities. And Duncan continued:

¹¹⁵ W.M. Duncan, ‘Helping the Over Sixteens’ in ‘The Parents’ Voice’, *Newsletter* 3, 1 (Jan, 1952), p. 7.

The majority of mentally subnormal boys and girls of stable temperament who have had the benefit of education in a Special School can and do achieve considerable success when placed in selected positions [...] it is not sufficient merely to place the handicapped in employment.¹¹⁶

The Bureau encouraged the young people it had successfully placed in employment to send letters and telephone to ensure that the work was not too much mentally or physically; regular visits to the home were also made by the Bureau to ensure this. This regular contact also ensured constant medical help could be provided where necessary. Duncan writes:

Some of the Special Schools have After-Care Committees whose members visit the homes of former pupils three times a year until they reach 21. Sometimes gatherings of pupils are arranged which the Youth Employment Officer is invited and by those means the bond is further strengthened.¹¹⁷

Duncan concluded by stating that the form of vocational guidance offered by the Liverpool Youth Employment Bureau allowed most 'mentally deficient' young adults to take a valuable place in the community. This was hugely beneficial, not just for the individual and their family in terms of being self-supporting, but also as a national interest. Duncan asserted that each individual should make as large a contribution to the State as possible and if necessary every individual should be helped to do this.

Dr Jack Tizard wrote about the importance of finding suitable employment for the 'mentally deficient'. Tizard believed that many individuals were capable of simple handwork, but more research on the subject was needed to ascertain what level was feasible. Tizard discovered that research in the UK and abroad had proven that even those of a very 'low grade' were capable of some industrial work. For 'high grade' placement cases, it was felt

¹¹⁶ Ibid.

¹¹⁷ Ibid.

that Psychiatric Social Workers employed by the LHA should be utilised; many 'high grade' cases had been referred to the LHAs for supervision after leaving school. Tizard suggested that a census was needed to comprehensively understand how many individuals would be capable of partaking in some form of work. In order for this concept to be useful Tizard believed that the services of a psychologist and trained professional were needed in addition to adequate and appropriate buildings. Ideally, the facilities would need to be close to where individuals lived; otherwise transport was required, which presented another unnecessary obstacle. Overall, Tizard believed that the MoH was helpful in suggesting jobs and were sympathetic employers. The Local Chamber of Commerce and other employers' associations needed to be canvassed by consulting Local Trade Councils. Despite the assumption that Trade Unions were hostile to the project, Tizard found that this was not the case and conversely Trade Unions were sympathetic and tremendously helpful. In Northumberland, the local APBC branch had begun negotiations with the Ex-Servicemen's Employment facility with a view to securing their help to gain local employment for 'mentally deficient' children. Canvassing helped to combat the difficulties posed by local conditions; in some areas the only available forms of work were folding cardboard boxes, cutting work, simple filing jobs, and other routine work which did not require machinery. Additionally, the Leeds City Health Department took over the 'Factory in the Fields'; an establishment used to teach 'mentally deficient' young adults and ex-servicemen to repair boots, make rugs, pottery, basketry, carpentry and other skills.

One story was provided by the mother of 21 year old 'Mongol', Ronald. Ronald's mother had been a member of the APBC since the beginning and hoped her story would give others the courage and hope needed. Ronald's father was war-disabled and had been out of work for 10 years, which made his parents' struggle for provisions even harder. Regardless, at age 7, Ronald's parents were able to send him to a private school where he made good

progress. Yet, the financial constraints eventually became too much and this had to be stopped; the County Council were subsequently persuaded to provide him with a place in a special school in the nearest town. However, after 18 months, Ronald was excluded due to the complaint there were children on the waiting list from the town. Owing to his short time in education, Ronald learned to read and write (printing) and liked to spend his time writing songs. Additionally, Ronald occupied himself with meccano, going to the pictures, travelling by bus on his own, and other hobbies. However, Ronald's mother was quick to clarify: "I am not saying that he is a "wonder child" for he is not, and we were to help him by seeing that he has the right money for each purpose, and so on, but what matters is that he has the confidence to do it."¹¹⁸ Despite this, his mother was proud to note that Ronald had begun employment as a test case on a trial in a spinning mill. However, this position was not easy to obtain, Ronald's mother explained that he was subjected to a lot of running around, interviews with the MoL, National Insurance, the National Assistance Board, and the advice of the Mental Welfare People was sought before it was decided that Ronald was the best person for the job.

As discussed in this chapter, during the 1950s the APBC gained rapid popularity, indicating a change in the public opinion of 'mental defectiveness'. The APBC helped to establish a number of regional voluntary women's groups to help aid LEAs in the supply of provisions and education for 'backward' children. These groups quickly grew in numbers and an APBC sub-committee was established in April, 1950 to govern and regulate their practices. However, the input of these voluntary organisations went unrecognised by the authorities. Officials often deplored the attempts to educate 'defective' children as futile, worthless and a waste of resources. Nonetheless, Fryd ignored the government's vigour to

¹¹⁸ 'The Parents' Voice', *Newsletter* 6, 2 (Spring, 1955).

denounce 'backward' children as socially worthless and pursued further methods of education.

Ultimately, the APBC's work in the field of educational reform helped to achieve equality, irrespective of needs and disability. Unfortunately, changing legislation and putting these changes into effect was neither quick nor easy to achieve. However, after a lifetime of campaigning for reform, the aim of increasing tolerance and acceptance of children with various learning disabilities into the education system was eventually achieved in the Education (Handicapped Children) Act of 1970.

Conclusion

This dissertation aimed to examine the relationship between the eugenics movement and disability in the British context after 1950. This issue has formed the core of the dissertation, and the information used for chapters 1-4 has been mostly from primary sources. The significant aspects of the chapters have been the path from social exclusion to inclusion, the use of physical segregation, interest in disability research in the mid-twentieth century, and the eventual attainment of educational equality. One of the main components of the thesis has been to assess the extent to which parent reformists, in particular the APBC, were able to influence and instigate processes of change. To achieve this, it has been necessary to examine the campaigns and plights of the APBC and their motivator, Judy Fryd. For this, the quarterly publication of the APBC, *Parents' Voice*, in the period 1946–1960, has been evaluated in conjunction with secondary sources. Existing debates on the subject of disability has attracted the attention of academics from various disciplines. Similarly, British and American eugenics movements have been widely discussed. However, much of the current scholarship has focused on the concepts of eugenics and disability as separate entities. Whilst this has helped to expand the existing knowledge of each subject, a more specific study, which combined the two notions, was necessary in order to assess the contribution made by Fryd and the APBC towards the history of disability in Britain during the post-war period. This conclusion will assess the contribution this thesis will make to studies of both disability and eugenics.

The Legacy of Eugenics

Existing scholarship on the history of eugenics in Britain has tended to focus on legislation and idealistic goals. Additionally, many have assumed that eugenic ideals were abandoned after 1945. This study aimed to prove that eugenic stigma was far more enduring than has

previously been accepted. The introduction of personal accounts of disability in the 1950s, such as those revealed in this dissertation, into research about eugenic practices in Britain will provide a new perspective for future debates. Furthermore, as argued here, the legacy of eugenic concepts was felt by marginalised groups in Britain long after the supposed end of eugenics. This dissertation has underlined four important areas to be included in future debates on the influence of eugenics in social policy and national health in Britain. As shown, the areas in which the legacy of eugenics was most felt were: social exclusion, physical segregation, research, and educational inequality. The inclusion of these subjects in future histories of eugenics will result in broader, more comprehensive interpretations of disability in Britain and elsewhere. This dissertation has shown that eugenic beliefs in British society and the government in the mid-twentieth century were far more pervasive than previously thought. It also highlighted the personal accounts of disability from the members of the APBC. Parents of ‘backward’ children were able to accurately and candidly explain how social, political and economic limitations were enforced upon them. These accounts of the legacy of eugenics are vital to the understanding of learning disability in the mid-twentieth century.

As evidenced in chapter one, the socially isolating eugenic use of stigma continued to pervade the social consciousness into the mid-twentieth century. Furthermore, as shown in chapters 2-4, this, in turn, affected the provisions afforded to, and the social and political considerations of, those deemed to be ‘backward’. It bears repetition that the primary aim of this dissertation has been to show that presumptions of the complete abandonment of eugenic ideals in 1945 are misguided and ill-informed.

The early twentieth century was, broadly speaking, a grim period for those with mental or learning impairments. By contrast the 1950s were a period in which considerable progress was made in the lives of so-called ‘backward’ children, and their families. It is

hoped that this dissertation has extended our knowledge of the personal, social, political and economic legacy of eugenics into the post-war period, whilst reflecting on current academic debates of genetic intervention (arguably ‘neugenics’¹) on disability communities. Whilst the technologic and scientific developments in the fields of genetic engineering, enhancement and cloning may be new, the idea of altering and improving the population by means of intervention certainly is not. This argument has been put forward by Chris McChesney, who has noted that “Abortion and advancements in genetics have the potential to become, and within some communities have already become, another form of eugenics.”² The lives of those with learning disabilities are once more being compromised by the advancement of genetic technologies. Understanding the roles of disability in the past may help to avoid the same mistakes in the future. As Paul Miller and Rebecca Levine have remarked, “genetics, as currently defined, practised, and presented to the public, reinforces the stigma of disabled individuals as defective individuals.”³

For many the question of whether to welcome this power or fear its implications has been raised. On the one hand, disabilities can reduce an individual’s quality of life, and genetic intervention offers the possibility to reduce or eliminate these disorders. Conversely, the suggestion of eliminating disabilities often discounts the enriched and fulfilled lives many persons with disabilities have, and the positive affect they can have on others.

Moving forward, greater studies of the personal impact of genetic technologies are needed. This dissertation has highlighted the importance of personal accounts of disability, and the limitations placed on individuals by society. These personal narratives are vital to

¹ The term ‘neugenics’ has been used to describe prenatal diagnosis in the abortion process of disabled foetuses. See M.J. Selgelid, ‘Neugenics?’, *Monash Bioethics Review* 19, 4 (2000), pp. 9-33; M.A. Rembis, ‘(Re)Defining Disability in the ‘Genetic Age’: Behavioural Genetics, ‘New’ Eugenics and the Future of Impairment’, *Disability and Society* 24, 5 (2009), pp. 585-597; and J. Entine, ‘DNA Screening is Part of the New Eugenics – and That’s okay’, *Genetic Literacy Project* (08/07/2013) <http://www.geneticliteracyproject.org/2013/07/08/dna-screening-is-part-of-the-new-eugenics-and-thats-okay/> (Accessed on 19/10/2015).

² C. McChesney, ‘Abortion, Eugenics, and a Threat to Diversity’, *The Modern American* 2, 1 (2006), pp. 16-20.

³ R.L. Levine and P.S. Miller, ‘Avoiding Genetic Genocide: Understanding Good Intentions and Eugenics in the Complex Dialogue Between the Medical and Disability Communities’, *Genetics in Medicine* 15, 2 (2013), pp. 95-102.

understanding the impact of modern debates on social equality and the elimination of stigma from certain groups of people. Furthermore, the understanding of attitudes towards disability in the past needs further exploration. These historic attitudes are still prevalent in society and disability continues to be largely misunderstood. Improved understanding of how modern concepts of disability were partly formed by eugenic ideals may lead to a better understanding of why society continues to marginalise and discriminate against those with learning disabilities.

Disability

The subject of disability crosses various academic subjects and social barriers. This dissertation has made a contribution to the understanding of disability in a specific historical context, Britain during the post-war period. The telling of Judy Fryd and the APBC's story adds another dimension to existing narratives of disability, and it is likely that preconceived notions of change in the disability field beginning in the late 1970s and 1980s will be dispelled. Existing literature on disability has tended to focus on explaining disability as a medical and social construct. By adhering to a comparatively small, but important time period, this dissertation contributes to existing knowledge by uncovering an important pivotal point in the history of disability, whilst at the same time offering an opportunity to develop our understanding of the impact of disability on affected individuals and their struggle to overcome it and the stigma associated with it. In particular, this dissertation supports the claim made by J.C. Davies in 1956: "It is the Mrs Fryds of life that we must be grateful to – for they were the pioneers [...] and without their efforts we should never have made the very great progress we are able to show today."⁴ A decade after its inception, Fryd likened the

⁴ F. Ellis, 'National Council 1956: The Best Yet' in 'The Parents' Voice', *Newsletter* 7, 2 (May, 1956) in *Parents Voice: National Society for Mentally Handicapped Children 1:38, 1950-1988*, Main Library/Store

APBC's campaign to battles for emancipation, women's rights, and the abolition of slavery. "We set out to create nothing less than a revolution", she noted, "a revolution in thinking about mental deficiency, and in the thinking about the place of the handicapped in the community."⁵

This dissertation has also demonstrated that a revolution in attitudes is precisely what Judy Fryd started. Under her guidance, the APBC was able to flourish into a national organisation, capable of realistically and practically changing the quality of life afforded to those with learning disabilities from the 1950s to the present day. Importantly, this thesis has shown that the story of Fryd's personal conviction, and more widely of the APBC's campaigns for disability rights, should be thought of as an important corrective to the history of change in the lives of those with disabilities in the UK. By comparing the legacy of the British eugenic movement in the 1950s, and the pioneering work of the APBC, a more rounded narrative and analysis of the history of disability in Britain has been provided. Similarly, by including personal stories of prejudice, stigma and inequality, this thesis has introduced a new dimension to the overall discussion of British eugenic policies and ideals. Whilst parent groups and reformers in other countries have been touched upon, this is certainly an avenue which requires greater exploration.

This dissertation has also brought attention to the beginnings of social and political reform concerning mental and learning disabilities in the mid-twentieth century. It has dispelled many common assumptions of political change occurring as a direct result of the British disability movement in the 1970s and 1980s. Instead, examples were given of politically driven parents in the 1940s and 1950s who applied pressure on authorities at local and national levels to enact change. This dissertation has suggested that parent reformers were able to encourage greater research into 'mental deficiency'. Additionally, examples

208369/7, The University of Manchester Library, Manchester. Hereafter abbreviated to 'The Parents' Voice', *Newsletter* 7, 2 (May, 1956), p. 3.

⁵ J. Fryd, 'Era of the Handicapped' in 'The Parents' Voice', *Newsletter* 8, 3 (Aug, 1957), p. 3.

have been given of how the APBC was utilised by professionals to provide large amounts of first-hand and in-depth accounts of their children's disabilities. The APBC helped parents to overcome ideas of shame to pursue a change in the politics of disability. Tellingly, the APBC was able to prompt the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency in 1957. Subsequently, this led to the 1959 Mental Health Bill which witnessed a change in attitudes towards residential care. After nearly twenty years of lobbying, practical education equality was also achieved by the 1970 Education (Handicapped Children) Act. Finally, the issue of incarceration for 'mentally deficient' children has been addressed. It is often assumed that attitudes towards institutionalisation dramatically and instantaneously changed from unquestioned acceptance to unconditional rejection. The APBC insisted that institutions, as a whole, were neither good nor bad, but rather fell short of their acceptability of disability. Thus, parents were encouraged by Fryd and others to visit institutions and assess the suitability of the facility to their child's specific needs. This autonomous approach to their families' lives has seldom been acknowledged.

Ultimately, this dissertation has explained how this reform-driven political community helped to ensure the emancipation of persons with disabilities from the shackles of societal prejudice, and helped to obtain improved healthcare and educational resources. In doing this, this community effectively brought discussions of disability into the open and for general scrutiny. The advent of parent groups in the mid-twentieth century challenged the preconceived notion that their children were socially and economically worthless, and of no value to the community. In doing so, the APBC reimagined social possibilities for generations of individuals with learning disabilities.

To this day, the core principles of the APBC continue in the services provided by Mencap. Mencap continues to offer a wide range of services for individuals with various forms of learning disabilities to help combat inherent inequality and prejudice. Currently

Mencap have active campaigns in the following areas: health care; social care; the rights of children and young people with learning disabilities to good life; equal rights; persuading local authorities to stop the cuts reducing benefits for person with disabilities; access to short-break services for families and care providers; access to good-quality further education and training; and welfare reforms. These campaigns are reflective of the early tenets of the APBC.⁶

Contemporary Relevance

Whilst society may have a better understanding of what causes a ‘disability’, it remains largely uncomfortable with the concept. The historical study of disability is relatively new, and much of the work tends to concentrate on a particular disability. Arguably, this does little to improve the shame and prejudice that continues to surround mental and learning impairments; unfortunately those with learning disabilities continue to be an overlooked group. The terms ‘racism’, ‘sexism’ and ‘homophobia’ exist to describe the prejudice towards race, gender and sexuality. Yet no such term exists for the prejudice against disabilities. Ironically, the closest word that could be used is eugenics, which was originally used to describe the betterment of society by their exclusion. Sensational cases such as Tania Clarence who killed her three disabled children have indicated that prejudice and misunderstanding remain rife in society. Clarence was convicted of manslaughter for the smothering of her three children with type two spinal muscular atrophy.⁷ Clarence’s lawyer cited her inability to cope with raising three children with the challenging condition as a reason for her depression and acts. It is undoubtedly a sad case for all involved and perhaps a damning indictment of the services and provisions available. However, what is most

⁶ More information on the activities and goals of Mencap can be found at <https://www.mencap.org.uk>.

⁷ For more information see ‘Tania Clarence Sentenced for Children’s Manslaughter’, *BBC News* (18/11/2014) <http://www.bbc.co.uk/news/uk-england-30096820> (Accessed on 19/10/2015).

interesting is the general public's reaction to the case. Many people empathised with the mother's distress and difficult situation.⁸ However, this raises the issue of whether reactions to her crime would have been the same had the children not been disabled? This has reiterated the importance of discussions of the value of disabled lives in the community in comparison to their 'normal' counterparts. Many dismissed the severity of Clarence's crimes on the basis that her children with disabilities had reduced lifespans, despite many with the condition living to middle age.

Legislation exists in the UK to guarantee the rights of those with learning disabilities.⁹ Yet, in reality, these rights are often compromised according to political and economic status. Too often special provisions and amenities for those with learning disabilities are the first to be cut in government budgets during economic downturns. For example, people with learning disabilities still struggle to find suitable employment. Remploy, a government owned recruitment agency for persons with disabilities, was set a target of helping 7,500 people gain employment in 2014; a target which the agency failed to reach. A statement issued by Remploy explained that only 5,654 people were helped into jobs;¹⁰ and its task was made increasingly more difficult by the closure of sheltered workplaces under the Coalition government in 2013.

Additionally, many parents still face troubles obtaining a diagnosis for their child. In an article about the speed of diagnosing autism, six experts wrote to the *Times*¹¹ detailing how many parents were breaking under the pressure of having to care for their child without

⁸ See M. Scarlet, 'Viewpoint: What's Troubling Disabled People About the Tania Clarence Case', *BBC News* (19/11/2014) <http://www.bbc.co.uk/news/blogs-ouch-30111904> (Accessed 19/10/2015).

⁹ The United Nations Conventions on the Rights of Persons with Disabilities reaffirmed that individuals with disabilities have the same human and civil rights as non-disabled people; this was ratified by the British government in 2009 and in 2005 the government published the report 'Improving the Life Chances of Disabled People'. This detailed plans to improve the standard and quality of life for disabled children and adults by 2025.

¹⁰ Figures from 'Remploy Annual Report and Accounts 2013-14', *House of Commons Written Statement* (HCWS137) (18/12/2014) <http://www.parliament.uk/documents/commons-vote-office/December%202014/18%20December/32-DWP-Remploy-Annual-Accounts-2014-14.pdf> (Accessed on 19/10/2015).

¹¹ 'Letters to the Editor: Autism Campaign', *The Times* (28/08/2015) <http://www.thetimes.co.uk/tto/opinion/letters/article4541338.ece> (Accessed on 19/10/2015).

support. Exemplifying that for many, issues of diagnosis remain problematic, with the average age of a child at diagnosis being 3 and a half years old.¹² The delay in diagnosis frequently has a ripple effect, resulting in many children not receiving specialised education care when needed. Moreover, obtaining suitable education provisions for children with learning disabilities remains challenging.¹³

To conclude: the aim of this dissertation has not been to further disability campaigns or rights, but rather to cast greater academic attention upon those with mental and learning disabilities, with a view to encouraging their inclusion in discussions of disability and, more broadly, in the history of eugenics. Moreover, it is hoped that uncovering the work of Judy Fryd and the APBC in the mid-twentieth century will ensure that their remarkable achievements may receive their appropriate place within the history of post-war Britain.

¹² For more information see ‘Speed of Autism Diagnosis Must Improve, say Experts’, *BBC News* (29/08/2015) <http://www.bbc.co.uk/news/uk-34095075> (Accessed on 19/10/2015).

¹³ See J. Kent, ‘Families Face Special Educational Needs Help ‘Postcode Lottery’’, *BBC News* (15/03/2015) <http://www.bbc.co.uk/news/education-31858681> (Accessed on 19/10/2015).

NB Illustrations removed from electronic version due to possible copyright and confidentiality issues

Illustration 1:

‘Judy Fryd 1909-2000: Royal Mail first class stamp from Eminent Britons series’, in *Biography Ephemera. Box 1, A-I*, EPH722, The Wellcome Library, London.

Illustration 2:

The Parents’ Voice’, *Newsletter 7*, 1 (Feb, 1956).

Illustration 3:

‘The Parents’ Voice’, *Newsletter* 8, 3 (Aug, 1957).

Illustration 4:

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Illustration 5:

‘Is it Hereditary?’ in ‘APBC’, *Newsletter* 2, 5 (Oct, 1949).

Illustration 6:

‘Research into Possible Causes of “Mongolism”’: Questionnaire to Members of the Association of Parents of Backward Children’ in *Archives of the National Birthday Trust*, SA/NBT/J4/1, The Wellcome Library, London.

Illustration 7:

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