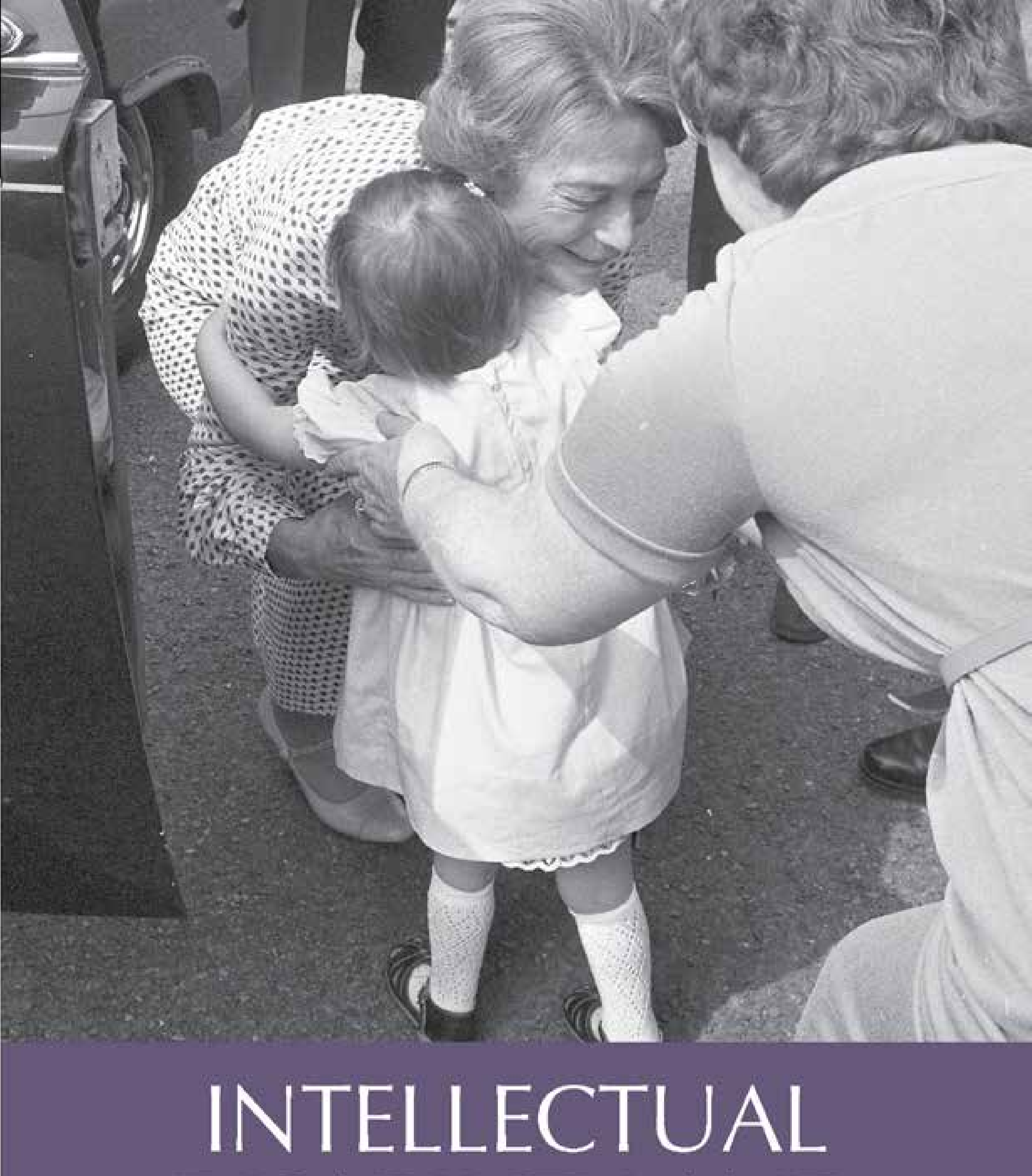

INTELLECTUAL DISABILITY AND IRELAND, 1947–1996

TOWARDS A FULL LIFE?

DAVID KILGANNON

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LIVERPOOL UNIVERSITY PRESS

First published 2023 by
Liverpool University Press
4 Cambridge Street
Liverpool
L69 7ZU

British Library Cataloguing-in-Publication data
A British Library CIP record is available

ISBN 978-1-83764-441-4
eISBN 978-1-83764-456-8

Typeset by Carnegie Book Production, Lancaster

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Illustrations

Acknowledgements

This book would not exist but for the help of some truly wonderful people. It draws from my PhD thesis, which was supported by a Wellcome Trust Doctoral Studentship (Grant Number 108597/z/15/2). The Trust's support allowed me to pursue a postgraduate education; I remain deeply grateful for this opportunity and their generosity. This book also rests on the guidance provided by my former supervisors, Sarah-Anne Buckley and Kevin O'Sullivan. Although I continue to fear their suggested edits, the experience of working with them has left me a better scholar and person; I count myself lucky for being able to benefit from their kindness, intellectual generosity, and mentorship. The guidance and support of Caitríona Clear and Carole Holohan has also been central to the creation of this book, and I'm very thankful for their unstinting help.

This research is indebted to those who helped in accessing a range of disability-related materials. Thanks to all the team at the National Archives of Ireland, who put up with more of my questions than anyone should have to endure. Thanks are also due to the teams at the Dr Steevens' library (for their assistance and for latterly introducing me to the Lenus archive), the University College Dublin Archives, the Royal College of Surgeons of Ireland Archive, as well as Noelle Dowling in the Dublin Diocesan Archive, Patricia Sweeney in the RTÉ Archive, and Harriet Wheelock in the Royal College of Physicians of Ireland Archive. The Nursing and Midwifery Board of Ireland kindly gave me access to their organisation's records, which are held in UCD. I'm also grateful to the HSE which allowed me to examine the patient registers of St John's Hospital and St Columba's Psychiatric Hospital, stored in the National Archives. Particular thanks are also due to Peter Molloy from the Department of Finance, who truly went above and beyond to help me view the disability-related records at the Department's headquarters in Merrion Street. I'm also grateful to the organisations and individuals who assisted me throughout the research process: sharing information, highlighting helpful sources, and encouraging me in this research. Voluntary efforts on behalf of those with intellectual disabilities remain invaluable and are an inspiration.

Being able to share problems can become vital during any long-term research project, and I benefited from my interactions with the fantastic researchers working in the University of Galway, who include Jamie Canavan, Maria Cullen, Lorraine Grimes, Olivia Martin, Jane O'Brien, Bernadette O'Connell, and Tríona Waters. Good colleagues are a treasure, and I've been particularly lucky in those I've worked with in recent years. Thank you for sharing in the highs of the writing process and, perhaps more importantly, thank you for buoying me when the finish line seemed far away. In this regard, special thanks are due to Gareth Millward, who has always been a stellar source of advice and support. I'm grateful to Laura Kelly, without whose help I wouldn't have pursued postgraduate research. I have also been lucky to benefit from Catherine Cox's knowledge and guidance since the completion of my MA under her supervision.

I owe a debt of gratitude to many people who have offered me their guidance at various stages of this project, a group that includes Monika Baár, Rebecca Anne Barr, Gearóid Barry, Thomas Bray, Ciara Breathnach, Emma Burns, Fiachra Byrne, Susan Carton, Jennifer Crane, Claire Cunnington, Clíona de Bhailís, Lindsey Earner-Byrne, Bernie Flatley, Kieran Fitzpatrick, Eilionóir Flynn, Joanna Forde, Alison Forrestal, Elizabeth Grubgeld, Louise Hide, Myra Irvine, Annie Killoran, Catherine Kudlick, Christine Linehan, Kimberly LoPrete, Hannah Mawdsley, Alice Mauger, Caroline McGregor, Donna McNamara, Ida Milne, Muireann O'Cinneide, Pat O'Donohoe, Andrew Power, Susan Schweik, Mary Staines, Paul van Trigt, and Jacqueline 'Jax' Wilson. Thanks to Christabel Scaife at Liverpool University Press for believing in this book and for her expert shepherding in bringing it into the world. Sarah Davison in Carnegie Book Production provided invaluable support and advice throughout. I am also grateful to the editors of the Reappraisals in Irish History series, Enda Delaney, Maria Luddy, and Ciaran O'Neill, and to the anonymous reviewers who improved the manuscript through their thought-provoking feedback. It goes without saying, but all errors remain my own.

Last, but by no means least, there is my family. My aunt Monica was the inspiration for this project. My brother Seán provided perspective and humour at crucial stages throughout the writing process; I would be lost without him. This book would not exist without my parents, Maeve and Mick, to whom I owe the greatest debt. I cannot thank you both enough.

A Note on Language

In this study, the term ‘intellectual disability’ denotes a broad range of conditions that have been associated with forms of cognitive and/or functional impairment. This is in light of its prevalence in Ireland; ‘learning disability’ and ‘developmental disability’ remain the dominant nomenclature in the UK and US respectively. Alongside such terminology, this book also uses the ‘intellectually disabled person’ formulation over a ‘person with intellectual disabilities’. This distinction has been subject to much debate within disability studies. In a contemporary context, the person-centred approach (which describes someone as being ‘with a disability’) is clearly preferable as it acknowledges the individual before any impairment.[1] Notwithstanding this, the following chapters do not employ a person-centred (people-first) framing. Instead, it remains predisposed to use the disabled-person formulation, as this foregrounds disability as a broader societal construction that was imposed on an individual rather than a chosen moniker of identity.[2] It also aligns with the framing across statutory policy documents and voluntary sector publications throughout the period under consideration.

Additionally, this research also presents terms that are problematic and, in many instances, clearly offensive, including ‘mental deficient’, ‘feeble-minded’, ‘subnormal’, and ‘retard’. The use of this reductive language is not intended to offend the reader, to present these terms as unproblematic (or, indeed, accurate), or to condone the limited conception of the individual that they convey. These terms are present throughout this work to accurately represent the linguistic discourse around intellectual disability, which in

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[1] Romel W. Mackelprang, ‘Disability Controversies: Past, Present and Future’, in Roland Meinert and Francis Yuen (eds), *Controversies and Disputes in Disability and Rehabilitation* (London, 2014), p. 21; Jim Sinclair, ‘Why I Dislike “Person First” Language’, *Autonomy, the Critical Journal of Interdisciplinary Autism Studies* 1.2 (2013), pp. 1–2.

[2] Michael Oliver, ‘The Structuring of Disabled Identities’, in Michael Oliver, *The Politics of Disablement* (Basingstoke, 1990), pp. 60–77.

itself grants an insight into how 'mentally handicapped' individuals were discussed and understood throughout the mid-to-late twentieth century.[3] All are included with an awareness of their historically contingent and problematic nature.

To speak of the intellectually disabled is to discuss an innately heterodox grouping of individuals, with varied medical diagnoses, capabilities, and limitations, which can necessitate describing them through this period's frequently vague terminology. The Commission on Mental Handicap outlined this very difficulty in 1965, declaring that 'It is virtually impossible to produce any definition [of intellectual disability] which will be universally acceptable.'[4] Given the scale of this challenge for a panel of contemporary observers, it would be unwise to do more than underline this study's careful use of these inherently ambiguous and obviously outdated terms when discussing developments throughout the mid-to-late twentieth century.

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[3] Robert L. Schalock, 'The Evolving Understanding of the Construct of Intellectual Disability', *Journal of Intellectual and Developmental Disabilities* 36.4 (2011), pp. 227–37; Robert L. Schalock et al., 'The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability', *Intellectual and Developmental Disabilities* 45.2 (2007), p. 116.

[4] Commission of Inquiry on Mental Handicap, *Commission on Mental Handicap: Report 1965* (Dublin, 1965), p. 18.

Abbreviations

APFMBC	Association of Parents and Friends of Mentally Backward Children
CBR	Community-Based Residence
DIG	Disablement Income Group (UK)
DPMA	Disabled Persons' Maintenance Allowance
EEC	European Economic Community
ERI	Economic Research Institute
ESF	European Social Fund
HSE	Health Service Executive
ICA	Irish Countrywomen's Association
IPA	Institute of Public Administration
IYDP	International Year of Disabled Persons, 1981
MENCAP	Royal Society for Mentally Handicapped Children and Adults (UK)
NAMHI	National Association for the Mentally Handicapped of Ireland
NARC	National Association of Retarded Children (US)
NHS	National Health Service (UK)
RMS	Resident Medical Superintendent
RTÉ	Radió Teilifís Éireann
UPIAS	Union of the Physically Impaired Against Segregation (UK)
WAMH	Wicklow Association for the Mentally Handicapped
WHO	World Health Organisation

Introduction

> The broad problem of the mentally handicapped is so wide and so difficult as to merit a paper devoted to itself solely.
>
> *The Problem of the Mentally Handicapped* (1960)[1]

Dr Cooney could not explain it. In 1963 the chief medical advisor to the Daughters of Charity of St Vincent de Paul published a short guide to intellectual disability services. *A Service for the Mentally Handicapped* began with the public's growing interest in 'mental handicap' issues, a trend that appeared to surprise the booklet's author. A recent government white paper, the creation of a statutory commission, and increased activity among voluntary organisations were all evidence of this newfound attention to intellectual disability across the Republic of Ireland.[2] Public interest had 'never been at such a high level as it is just now', Cooney emphasised, before recalling (with a hint of nostalgia) how his work had previously been an 'unfashionable field'.[3] This short guidebook captured an unmistakable sense of change in Ireland's disability services, as it outlined the new approaches that were emerging across residential institutions and community-based services. Yet Cooney did not try to explain what was driving these developments. Since the foundation of the Department of Health in 1947 there had been a number of significant changes for the

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[1] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 3.

[2] This book explores developments in the country known as Éire from 1937 to 1949, and the Republic of Ireland thereafter. Use of the terms 'Ireland' and 'Irish' refers to this political entity rather than the island as a whole.

[3] Dr John G. Cooney (1926–2018) was a medical director to the Daughters of Charity and an associate director of St Patrick's Psychiatric Hospital in Dublin. An advocate for the intellectually disabled, he was conferred with the papal knighthood of St Gregory in 1984 in recognition of his work at the St Vincent's residential centre in Cabra. J. G. Cooney, *A Service for the Mentally Handicapped* (Dublin, 1963), p. 1, Royal College of Physicians of Ireland Archive (hereafter RCPIA), CSFH 1/4/4.

'mentally handicapped', which included the creation of a disability-specific welfare payment, more than a doubling of beds in residential facilities, the establishment of 'special schools' in the community, the opening of disability-specific occupational training workshops, and the foundation of voluntary 'parents and friends' groups across the country. Given the speed (and scale) of these changes, it was perhaps unsurprising that the doctor did not try to explain what had happened to his previously 'unfashionable field'.

Irish developments broadly reflected international trends, as across the Anglophone world there were sizeable changes to the lives of the intellectually disabled throughout the mid-to-late twentieth century, a post-war shift in services and attitudes that was termed the 'remaking of mental retardation' in the United States.[4] Although this transformation shared some common features across geographical boundaries, such as increased public candour or the propagation of parents' groups, these trends did not emerge uniformly. British disability organisations were formed to address perceived shortcomings in the welfare state, for instance, while in the US voluntary groups drew inspiration from their proximity to the civil rights movement.[5] Dr Cooney acknowledged the importance of broader social context when it came to disability provision in Ireland, noting how 'services for the subnormal in Éire have evolved out of cultural, religious and economic conditions peculiar to this country'.[6] Irish residential institutions, for example, commonly repurposed an older building, with the unfortunate side effect that some continued to resemble 'the typical workhouse', staffed by religious congregants who operated 'in accordance with the principles of canon law'.[7] In other words, the state's social context had helped to shape its disability services.[8]

This book is about changes to the lives of the intellectually disabled in Ireland during the mid-to-late twentieth century, from the foundation of the Department of Health in 1947 to the 1996 *Strategy for Equality* report. It explores the evolution of disability policy and provision at a time when responses to the intellectually disabled as a group were changing

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[4] James Trent, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkeley, 1994), pp. 225–69.

[5] Sheena Rolph, *Reclaiming the Past: The Role of Local Mencap Societies in the Development of Community Care in East Anglia, 1946–80* (Milton Keynes, 2002), p. 42; Fred Pelka, *What We Have Done: An Oral History of the Disability Rights Movement* (Boston, 2012), p. 106; Doris Zames Fleischer and Freida Zames, *The Disability Rights Movement: From Charity to Confrontation* (Philadelphia, 2008), p. 48.

[6] Cooney, *A Service for the Mentally Handicapped*, p. 2.

[7] Ibid., p. 7.

[8] For a discussion of this dynamic in healthcare more broadly, see Dorothy Porter, 'Introduction', in Dorothy Porter (ed.), *The History of Public Health and the Modern State* (Amsterdam, 1994), pp. 20–4.

internationally, and it uses their treatment as a lens through which to understand the shifting relationship between the state and the voluntary sector. It probes the ideals articulated within statutory policy, as the state's approach moved from seeking 'protection and care for these afflicted persons' in 1947 to one that aimed for a childhood or an adult life that was as normal as possible by the mid-1990s.[9] It also addresses the impact of a nationwide network of disability services, exploring how they emerged, how they changed, and how they were maintained. In doing so, it argues that there was a distinctive response in Ireland, one that can be best understood as a product of the state's broader context. The way in which intellectual disability was discussed on paper versus the lived reality for the 'mentally handicapped' exposes deficiencies in statutory health policy but also calls into question the role of charity, as voluntary organisations became vital service providers by addressing pressing local needs. Focusing on the ways in which Irish disability policy and services reframed international thinking to better reflect national concerns and established approaches, this book shows how the state and the voluntary sector together forged the disability services landscape. Moreover, by investigating how services evolved over time, it suggests how treatment of the intellectually disabled can help us to better appreciate the development of Irish social policy going into the late twentieth century.

Defining Intellectual Disability

Defining intellectual disability remains a challenge, which is unsurprising given that the term has prompted 'shifting concepts, diverging associations and wide-ranging terminologies and diagnostic categories' throughout history.[10] Irina Metzler and C. F. Goodey have demonstrated the contested nature of the concept throughout the medieval and early modern periods, while a succession of nineteenth-century physicians offered their own distinct (and sometimes contradictory) taxonomies.[11] Internationally,

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[9] 'Memorandum for the Government', 13 August 1947, National Archives of Ireland (hereafter NAI), Department of the Taoiseach (hereafter DT) S14129A, p. 1; Commission on the Status of People with Disabilities, *A Strategy for Equality* (Dublin, 1996), pp. 5–8.

[10] Patrick McDonagh, *Idiocy: A Cultural History* (Liverpool, 2008), p. 8.

[11] Irina Metzler, *Fools and Idiots? Intellectual Disability in the Middle Ages* (Manchester, 2016); C. F. Goodey, *A History of Intelligence and 'Intellectual Disability': The Shaping of Psychology in Early Modern Europe* (Abingdon, 2011). For some examples of this trend, see John Haslam, *A letter to the right honourable the Lord Chancellor on the nature and interpretation of unsoundness of mind and imbecility of intellect* (London, 1823); W. R. Scott, *Remarks, theoretical and practical, on the education of Idiots and Children of*

scholarship on disability policy has grown exponentially over the past thirty years, with 'disability studies' emerging from this research to explore the political, social, and theoretical implications associated with the concept.[12] Notwithstanding these efforts, defining intellectual disability remains difficult given the classification's personal and broader social implications.[13] Indicative of this, a former resident at a Brothers of Charity facility in Cork retroactively challenged his diagnosis as a 'mentally handicapped child' when he gave evidence to the Commission to Inquire into Child Abuse (the Ryan Commission) during the early 2000s; he emphasised the stigmatising nature of this designation and explained that, in fact, 'I believe I am quite intelligent. I can pick up things, 99% of things.'[14]

Traditionally, disability had been defined in medical terms. The World Health Organisation (WHO) framed it in terms of impairment in 1980; a disability was 'any loss or abnormality of psychological, physiological, or anatomical structure or function', which could lead to a functional limitation. These functional limitations could then become a handicap, or a barrier to a person's full participation in society.[15] This medical approach has received sustained criticism from disability studies scholars, who highlight how it fails to account for the role of society and its attendant framing of disability as an abnormality or 'a deficit located within individuals that

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weak intellect (London, 1846); Samuel Gridley Howe, *Report made to the legislature of Massachusetts upon Idiocy* (Boston, 1848); John Langdon Down, *On some of the mental affections of childhood and youth* (London, 1887).

[12] For a discussion of the growth in disability-related scholarship within history, see Catherine Kudlick, 'Social History of Medicine and Disability History', in Michael Rembis, Catherine Kudlick and Kim E. Nielsen (eds), *The Oxford Handbook of Disability History* (Oxford, 2018), pp. 105–24; Beth 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; Catherine Kudlick, 'Disability History: Why We Need Another "Other"', *The American Historical Review* 108.3 (2003), pp. 763–93; Philip M. Ferguson and Emily Nussbaum, 'Disability Studies: What is it and What Difference does it Make?', *Research and Practice for Persons with Severe Disabilities* 37.2 (2012), pp. 70–80; Dan Goodley, *Disability Studies: An Interdisciplinary Introduction* (New York, 2016), pp. 2–5; David Johnstone, *An Introduction to Disability Studies* (Abingdon, 2012), p. 1.

[13] Rachel Cooper, 'Shifting Boundaries between the Normal and the Pathological: The Case of Mild Intellectual Disability', *History of Psychiatry* 25.2 (2014), pp. 171–86; Barbara M. Altman, 'Disability Definitions, Models, Classification Schemes and Applications', in Gary L. Albrecht, Katherine D. Seelman and Michael Bury (eds), *Handbook of Disability Studies* (Thousand Oaks, 2001), p. 97.

[14] *Report of the Commission to Inquire into Child Abuse* [Ryan Report] (Dublin, 2009), 2(5), p. 200.

[15] World Health Organization, *International Classification of Impairments, Disabilities, and Handicaps: A Manual of Classification relating to the Consequences of Disease* (Geneva, 1980), pp. 47, 182.

requires rehabilitation to correct the physiological defect or amend the social deficiency'.[16] This model also remains rooted in medical power, as a doctor retains the ability to assign the category of 'disabled' to an individual.[17]

The stigmatisation that arises from a medicalised understanding of disability ('the medical model') has contributed towards the development of the argument that disability instead emerges as a result of a discriminatory society ('the social model').[18] Originally articulated by the UK Union of the Physically Impaired Against Segregation (UPIAS) in 1975, this approach drew a distinction between an individual's biological impairment and their designation as disabled, while it defined the idea as a failure arising from a 'restriction of activity caused by a contemporary social organisation'.[19] This approach contested any understanding of disability as a static category, or as a term that could be detached from its wider social context. It also sought to go beyond the idea that the 'handicapped' were 'depersonalised objects of institutional action', and instead attempted to support a deeper exploration of their lived experiences.[20]

Although the social model marked a seminal recalibration for disability policy, the idea remains problematic within historical research as the concept is a political tool for spotlighting contemporary societal inaction rather than a comprehensive analytic framework.[21] It has also become linked to a broader narrative around the emergence of modern capitalism. Vic Finkelstein,

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[16] Colin Barnes, 'Rehabilitation for Disabled People: A "Sick" Joke', *Scandinavian Journal of Disability Research* 5.1 (2003), p. 9; Paul K. Longmore and Lauri Umansky, 'Introduction', in Paul K. Longmore and Lauri Umansky (eds), *The New Disability History: American Perspectives* (New York, 2001), p. 7.

[17] Judith Lorber, 'Deviance as Performance: The Case of Illness', in Eliot Freidson and Judith Lorber (eds), *Medical Men and their Work* (Chicago, 1972), pp. 414–15; Goodey, *A History of Intelligence and 'Intellectual Disability'*, p. 207.

[18] Lennard Davis, 'Introduction: The Need for Disability Studies', in Lennard Davis (ed.), *The Disability Studies Reader: Second Edition* (New York, 1997), p. 3; Nick Watson, Alan Roulstone and Carol Thomas, 'The Changing Terrain of Disability Studies', in Nick Watson, Alan Roulstone and Carol Thomas (eds), *Routledge Handbook of Disability Studies* (Abingdon, 2013), p. 3; Paul K. Longmore, *Why I Burned My Book and Other Essays on Disability* (Philadelphia, 2003), p. 20; Goodley, *Disability Studies*, p. 11.

[19] Union of the Physically Impaired Against Segregation, *Fundamental Principles of Disability* (London, 1976), p. 14.

[20] Elizabeth Bredberg, 'Writing Disability History: Problems, Perspectives and Sources', *Disability and Society* 14.2 (1999), p. 191. See the reading lists in Kudlick, 'Disability History: Why We Need Another "Other"', pp. 763–93.

[21] Colin Barnes, 'Understanding the Social Model of Disability: Past, Present and Future', in Watson, Roulstone and Thomas (eds), *Routledge Handbook of Disability Studies*, p. 12; Heli Leppälä, 'Welfare or Workfare? The Principle of Activation in the Finnish Post-War Disability Policy, Early 1940s to Late 1980s', *Journal of Social History* 49.4 (2016), p. 960.

for example, argued that segregated institutional services for the disabled were established in response to the emergence of ‘industry with production lines geared to able bodied norms’.[22] Anne Borsay has challenged the deterministic nature of this argument and underlined how it denied agency to the disabled, while also failing to account for the role of other factors that might equally affect an individual’s marginalisation from the labour market.[23] While indispensable to contemporary disability policy, the social model can therefore become overly simplistic when used to account for the complexities associated with historical change. Instead, an understanding of the role played by wider society in the creation of a ‘disabled person’, while not a wholesale endorsement of the social model, can be used to effectively move beyond a purely medical understanding of disability as impairment.

Ultimately, it is necessary to ground discussions of intellectual disability within a particular context. A medicalised definition of greater than average difficulty in learning, below average intelligence, and diminished adaptive functioning offers a broad rubric of features to potentially identify those with (what would now be termed) intellectual disability during the mid-twentieth century. This study remains flexible in its approach, cognisant that ‘disability’ is a mutable concept, one that refers to a ‘culturally and historically specific phenomenon’ that was nonetheless subject to considerable change over time.[24] Throughout, complexity is revealed by critical engagement with the approach adopted by statutory policymakers, voluntary organisations, and advocacy groups, aware that their response to intellectual disability was grounded in a subjective understanding of who they considered to be ‘mentally handicapped’ at any given time. The social model necessarily challenges a framing of disability as a medically diagnosed deviance from the ‘normal’, while it underlines the inadequacy of wider society to sufficiently adapt and engage at an individual level.[25] By exploring contemporary definitions of intellectual disability, we can try to understand the evolution of this category over time and, in doing so, provide a fuller account of how policies and services developed for this constituency.

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[22] Vic Finkelstein, *Attitudes and Disabled People* (New York, 1980), p. 7. See also Colin Barnes, ‘Disability, Discrimination and Disabled People’, in Mark Bendall and Brian Howman (eds), *Decoding Discrimination* (Chester, 2006), p. 148.

[23] Anne Borsay, *Disability and Social Policy in Britain since 1750* (Basingstoke, 2004), pp. 12–13.

[24] Tom Shakespeare, ‘The Social Model of Disability’, in Lennard Davis (ed.), *The Disability Studies Reader* (Abingdon, 2017), p. 195; Suzanne Quin and Bairbre Redmond, ‘Disability and Social Policy’, in Suzanne Quin (ed.), *Contemporary Irish Social Policy* (Dublin, 2005), p. 139.

[25] Henri-Jacques Stiker, *A History of Disability* (Ann Arbour, 2019), p. 192; Finkelstein, *Attitudes and Disabled People*, p. 7.

Irish History and Irish Disability

In Ireland the category of intellectual disability has existed in some form since the early modern period, when Brehon (Gaelic) law distinguished between cases of congenital disability and temporary incapacity.[26] Yet despite the presence of this group throughout history, there has been limited engagement with them in historiography. The topic has likely suffered due to the long-standing emphasis on political history in Ireland.[27] Indeed, when the 'mentally handicapped' have entered the historical narrative they have tended to do so sideways, in discussions of parents' rights,[28] the history of psychiatric care,[29] or the role of religious congregations in Irish society.[30] These offer a range of insights into various aspects of disability provision, but disability services, their policy background, and their service users are not a focus in their own right. Alongside this research, there have also been a number of studies that address institutions that housed the intellectually disabled.[31] Usually a commissioned history, or produced in collaboration with

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[26] F. Kelly, 'Medicine and Early Irish Law', *Irish Journal of Medical Science* 170.1 (2001), p. 76; Commission of Inquiry on Mental Handicap, *Commission of Inquiry on Mental Handicap: Report 1965* (Dublin, 1965), p. 10; Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland* (Newbridge, 2016), p. 18; Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Dublin, 1986), pp. 14–15.

[27] Eugenio F. Biagini and Mary E. Daly, 'Editors' Introduction' in Eugenio F. Biagini and Mary E. Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), p. 2. See the dominance of political issues in survey histories of the twentieth century, including Roy Foster, *Luck and the Irish: A Brief History of Change 1970–2000* (London, 2007); Diarmaid Ferriter, *The Transformation of Ireland 1900–2000* (London, 2004); Dermot Keogh, *Twentieth Century Ireland: Revolution and State-building* (Dublin, 1994); Joseph Lee, *Ireland 1912–1985: Politics and Society* (Cambridge, 1989).

[28] Mary E. Daly, '"The primary and natural educator"? The Role of Parents in the Education of their Children in Independent Ireland', *Éire-Ireland* 44.1/2 (2009), pp. 194–217.

[29] B. D. Kelly, 'Intellectual Disability, Mental Illness and Offending Behaviour: Forensic Cases from Early Twentieth Century Ireland', *Irish Journal of Medical Sciences* 179 (2010), pp. 409–16; B. D. Kelly, 'Searching for the Patient's Voice in the Irish Asylums', *Medical Humanities* 42 (2016), pp. 87–91; Damien Brennan, *Irish Insanity, 1800–2000* (Abingdon, 2013).

[30] John Sweeney, 'Attitudes of Catholic Religious Orders towards Children and Adults with an Intellectual Disability in Postcolonial Ireland', *Nursing Inquiry* 17.2 (2010), pp. 95–110; Joseph Robins, *From Rejection to Integration: A Centenary of Service by the Daughters of Charity to Persons with a Mental Handicap* (Dublin, 1992).

[31] See Pat O'Donohoe, *150 Years of Stewarts Care: The Pathway to the Present* (Dublin, 2019); Donnacha Seán Lucey, Gerard Fealy and Martin McNamara, *Equal Citizens: Sunbeam House, 1874–2014* (Bray, 2014); Harold O'Sullivan, *The House on the Ridge of the Weir: The Story of the Brothers and the Community of Saint John of God, St. Mary's, Drumcar* (Louth, 1998); Robins, *From Rejection to Integration*; Anna Day, *Turn of the Tide: The Story of Peamount* (Dublin, 1987); Mary Purcell, *A Time for Sowing: The*

a centre's management, these works contain a wealth of information about these institutions. Yet, by their nature, such studies can encounter issues when discussing developments beyond their boundary walls.[32] Collectively, they point to a need to understand the 'system' of disability provision, in order to appreciate the interaction between different services and the way in which this shaped the experiences of the intellectually disabled.

This 'system' has been explored through other approaches, among which two works warrant particular discussion. Andrew Power, Janet Lord, and Allison DeFranco's *Active Citizenship and Disability: Implementing the Personalisation of Support* (2013) provides an overview of policy and provision changes for the intellectually disabled since the nineteenth century, outlining major legislative reforms, the evolving role of institutions, and changing societal attitudes. Although useful in its discussion of these trends, it offers a relatively brief overview of Irish developments within a multi-nation comparative framework.[33] Annie Ryan's undeniably pioneering *Walls of Silence* (1999) is a more sustained engagement, which addresses intellectual disability through a text that combines elements of memoir and popular history. Blending the personal and the historical, *Walls of Silence* discusses Ryan's own engagement with the state's disability services alongside a history of their development since the early nineteenth century. This approach is clearly flagged from the outset: the preface states that 'if my son had been provided with a service, this book would have been very different'.[34] This book follows in Ryan's path-breaking footsteps by addressing a similar range of issues, including institutional accommodation, parental activism, and community-based services. Alongside these works, this study has also drawn from a rich body of scholarship on intellectual disability in Ireland produced by researchers from social work, geography, sociology, English literature, and disability policy.[35] These studies have discussed features within the state's

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History of St. John of God Brothers in Ireland, a Centenary Record 1879–1979 (Dublin, 1980).

[32] For instance, Brendan Kelly has underlined the 'sharply limited generalisability' of his research into 'handicapped' inpatients at the Central Mental Hospital. Kelly, 'Intellectual Disability, Mental Illness and Offending Behaviour', pp. 415–16.

[33] Andrew Power, Janet Lord and Allison DeFranco, *Active Citizenship and Disability: Implementing the Personalisation of Support* (Cambridge, 2014), pp. 343–438.

[34] Annie Ryan, *Walls of Silence: Ireland's Policy towards People with a Mental Disability* (Kilkenny, 1999), p. i.

[35] See Elizabeth Grubgeld, *Disability and Life Writing in Post-Independence Ireland* (Cham, 2020); Pauline Conroy, *A Bit Different: Disability in Ireland* (Dublin, 2018); Andrew Power, *Landscapes of Care: Comparative Perspectives on Family Caregiving* (London, 2016); Owen Doody, Eamonn Slevin and Laurence Taggart, 'Intellectual Disability Nursing in Ireland: Identifying its Development and Future', *Journal of Intellectual Disabilities* 16.1 (2012), pp. 7–16; Andrew Power and Kate Kerry, 'When Care is Left to Roam: Carers' Experiences of Grassroots Non-profit Services in

disability services landscape, such as the dominance of voluntary organisations in comparison with services in other countries.[36] Yet the absence of archival research arguably limits their ability to explain *why* Irish provision was different throughout the twentieth century. This book tries to begin to address this question.

In doing so, it draws on a range of international research that explores intellectual disability during the twentieth century. James Trent's *Inventing the Feeble Mind* (1994) and *Mental Retardation in America* (edited with Steven Noll, 2004) establish how responses to the intellectually disabled both emerged from, and were reflective of, a distinct national context.[37] In a similar manner, Sheena Rolph's *Reclaiming the Past* (2002) demonstrated how voluntary disability groups emerged to address gaps in UK statutory services. These broader narratives have been supplemented by research from the 'new disability history'. Well established in the United States, prominent works in this vein include P. K. Longmore and Lauri Umansky's *The New Disability History: American Perspectives* (2001), Longmore's *Why I Burned my Book and Other Essays on Disability* (2003), and David Turner and Kevin Stagg's *Social Histories of Disability and Deformity* (2006). Developed alongside disability studies, the 'new disability history' adopted the social model and commonly framed the experiences of the disabled in terms of stigma and isolation. Although they preceded the emergence of the new disability history, work in the UK by Jan Walmsley, Sheena Rolph, and Dorothy Atkinson addressed a broadly similar range of concerns in foregrounding the need to understand the experiences of the disabled at an individual level, while also calling for an explicit effort to move beyond institutional-based approaches when examining the history of impairment.[38]

Ireland', *Health and Place* 17.2 (2011), pp. 422–9; Suzanne Quin (ed.), *Contemporary Irish Social Policy* (Dublin, 2005); Caroline Skehill, *History of the Present of Child Protection and Welfare: Social Work in Ireland* (New York, 2004); Shane Kilcommins, Ian O'Donnell, Eoin O'Sullivan and Barry Vaughan, *Crime, Punishment and the Search for Order in Ireland* (Dublin, 2004); Suzanne Quinn and Bairbre Redmond (eds), *Disability and Social Policy in Ireland* (Dublin, 2003); Gabriel Kiely, Suzanne Quin, Anne O'Donnell and Patricia Kennedy (eds), *Irish Social Policy in Context* (Dublin, 1999).

[36] For an example of these Irish features see the discussion of regulations in Conroy, *A Bit Different*, pp. 206–24.

[37] James Trent, *Inventing the Feeble Mind: A History of Intellectual Disability in the United States* (Oxford, 2016); Steven Noll and James Trent (eds), *Mental Retardation in America: A Historical Reader* (New York, 2004).

[38] See Jan Walmsley and Dorothy Atkinson, 'Oral History and the History of Learning Disability', in Joanna Burnet, Robert Perks, Paul Thompson and Jan Walmsley (eds), *Oral History, Health and Welfare* (London, 2000), pp. 181–204; Jan Walmsley, 'Women and the Mental Deficiency Act of 1913: Citizenship, Sexuality and Regulation', *British Journal of Learning Disabilities* 28.2 (2000), pp. 65–70; Dorothy Atkinson and Jan

Each of these studies has shown that it is possible to create histories of intellectual disability that extend beyond a study of institutions or medical professionals. Yet such an effort is not without its own challenges in an Irish context.

Irish Disability History

Douglas Baynton is often quoted for his declaration that 'disability is everywhere in history, once you begin looking for it'.[39] Like other health-related topics that attracted statutory scrutiny, intellectual disability was subject to an 'outpouring' of publications from both the state and voluntary sector going into the late twentieth century.[40] The inaccessibility of certain sources has prompted drawing from this wide array of materials, as there are multiple obstacles that impede a researcher's 'view' of the intellectually disabled in Ireland.[41] Specialist residential institutions, for instance, received statutory funding throughout the period 1947–96. However, the vast majority of these were not public facilities and therefore had no legislative obligation to maintain records; they remained independent voluntary providers of a service that was 'similar or ancillary to a service which the health authority may provide'.[42] In this book, the role of these institutions is investigated without recourse to the facilities themselves and is instead explored through a combination of policy documents, local histories, media coverage, and official inquiries, which grants an insight into the evolving role played by these institutions, both on paper and in reality.

There are also challenges in accessing some public records. The 1986 National Archives Act provides for the annual accession of departmental records to the National Archives of Ireland after thirty years ('the thirty-year

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Walmsley, 'History from Inside: Towards an Inclusive History of Learning Disability', *Scandinavian Journal of Disability Research* 12.4 (2010), pp. 273–86; Sheena Rolph and Dorothy Atkinson, 'Emotion in Narrating the History of Learning Disability', *Oral History* 38.2 (2010), pp. 43–52; Sheena Rolph and Dorothy Atkinson, 'Maureen Oswin and the "Forgotten Children" of the Long-stay Wards: Research as Resistance', in Duncan Mitchell, Rohhss Chapman, Nigel Ingham, Sue Ledger and Rannveig Traustadottir (eds), *Exploring Experiences of Advocacy by People with Learning Disabilities: Testimonies of Resistance* (Basingstoke, 2006), pp. 153–72.

[39] Douglas C. Baynton, 'Disability and the Justification of Inequality in American History', in Paul K. Longmore and Lauri Umansky (eds), *The New Disability History: American Perspectives* (New York, 2001), p. 52.

[40] Virginia Berridge, 'Researching Contemporary History: AIDS', *History Workshop* 38 (1994), p. 228.

[41] Ibid.

[42] Government of Ireland, Health Act 1953, 26.

rule').[43] During the research for this book there remained significant gaps in health-related records at the National Archives, with most central registry records only going up to 1962.[44] Department of Health officials facilitated a private viewing of a select number of disability-specific records, which were supplemented by (previously inaccessible) health-related records held at the Department of Finance. In light of these gaps, the Department of Health's activities from 1962 to 1996 have been explored through various health-related materials, including policy documents, health authority meeting minutes, and contemporaneous reports. The scope of these sources allows us to appreciate the policies that were adopted by the state, as well as the potential alternatives under consideration at a given time, showing the 'window' of measures that were regarded as plausible responses throughout this period.

Alongside the evolving shape of policy, this book also addresses changes in provision, which gives an opportunity to explore the extent to which statutory goals were being met in the lives of the intellectually disabled. To do this, the following chapters draw from various materials, which include accounts from activists, documents from voluntary organisations, contemporary social sciences research, and programmes by the national broadcaster Raidió Teilifís Éireann (RTÉ). This grants an insight into many of the services developed at a grassroots level during this period, including 'special schools', community-based accommodation, and occupational workshops.

This book's focus, on the structural mechanisms that shaped the lived experiences of the 'mentally handicapped', is at the expense of an exploration that addresses the subjective lived experiences of some from this broad constituency. This work has instead prioritised an understanding of the broader policy and provision landscape that surrounded the intellectually disabled as a group throughout the mid-to-late twentieth century, contending that an understanding of this wider context remains important for understanding changes to their lives. B. J. Gleeson has argued that any such 'statist' approach risks portraying the disabled as the passive recipients of statutory support.[45] Although Gleeson's warning remains apt, it is clear that this was not the case in Ireland, as the intellectually disabled and their advocates played a clear and significant role in advancing policy change and, in many cases, directly supplied disability services in the vacuum left by statutory inaction.[46]

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[43] Ibid.

[44] A minority of these records go as far as 1970. Helen Hewson (Keeper, NAI), email message to author, 18 April 2017.

[45] B. J. Gleeson, 'Disability Studies: A Historical Materialist View', *Disability and Society* 12.2 (2010), p. 190.

[46] Jurgen De Wispelaere and Judy Walsh, 'Disability Rights in Ireland: Chronicle of a Missed Opportunity', *Irish Political Studies* 22 (2007), pp. 517–43.

Chapter Outline

What follows is an effort to explore how policies and services for the intellectually disabled evolved, what drove these shifts, and their effect. To do this, subsequent chapters delve into some of the major policy and provision changes in Ireland across the period 1947–96. Chapter 1 sets the scene for this by exploring legislative reform efforts in the early Department of Health, accounting for the limited statutory support available to this constituency by the mid-1960s. Specifically, it uses the repeated failure to introduce a 'Mental Deficiency' Act, alongside the creation of a disability-specific welfare payment (the Disabled Persons' Maintenance Allowance, DPMA), to explore the approach to social policy in mid-century Ireland and its impact on the intellectually disabled. The following chapter then broadens the scope to look at the effect of this approach in terms of institutional accommodation. Addressing a period that was marked by sizeable infrastructural expansion, it unpicks the limited measures taken by the Department of Health, as specialist services expanded along a predetermined model that struggled to meet public demand, while significant 'handicap populations' remained in inappropriate settings such as county homes and district psychiatric hospitals.

Chapter 3 addresses the emergence of day-educational facilities, investigating the development of 'special schools', and later 'mainstreamed' classrooms within the national school system. Beginning with the first 'special schools', before looking at the role played by education policy, it concludes with the experiences of pupils in some of these classrooms. In doing so, it demonstrates the challenges faced by voluntary disability organisations, while statutory inaction was shown to present opportunities and challenges for the children who attended these facilities. The emergence of community-based residences (CBRs), small-scale housing based in the community, is the focus of the fourth chapter. Examining the disjuncture between statutory disability policy and the provision of these services, it reveals the increasingly receptive character of disability policy in Ireland from the early 1970s, alongside the maintenance of a mixed economy of care in practice.

Chapter 5 returns to the issue of residential accommodation following the Commission on Mental Handicap in 1965, exploring the statutory approach towards institutional services during the ascendancy of 'care in the community' in policy. It uses a range of sources to gain an insight into life across specialist institutions and psychiatric hospital wards, considering why the state maintained its established approach to these services and the impact of this continuity. The sixth chapter turns to an area in which policy goals and their practical implementation appeared to align – occupational workshop programmes. Rooting the emergence of 'handicap workshops' in a broader chronology, it highlights the links between disability-specific services and a range of established facilities, while also showing how their development replicated key patterns seen across other disability services. Concluding with the experiences of 'trainees' reveals how, despite significant changes to the orientation of statutory disability policy, the lived experiences of the disabled could remain notably consistent over time. The seventh chapter then looks at the evolution of statutory policy going into the late twentieth century, before assessing the impact of changes throughout the period under review.

Rather than a comprehensive study, this book addresses a handful of the developments that impacted on the 'mentally handicapped', looking at the application of statutory policy changes to identify how life changed for this group of citizens.[47] It argues that responses to the intellectually disabled were reflective of an 'Irish' approach, as the trends associated with the international 'remaking of mental retardation' were reshaped to align with the state's social policy outlook. In doing so, it offers a complex picture of change and continuity for the intellectually disabled and their families. The growing prominence of international ideas in disability policy reveals how Ireland was becoming increasingly open to new ways of addressing the 'problem of the mentally handicapped'.[48] At the same time, new proposals were all too often implemented within established structures. This book demonstrates how, in the face of immense change internationally, a particular response to the intellectually disabled emerged in Ireland, one that reflected an established approach to social policy and asked much of both families and the voluntary sector.

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[47] It therefore does not address changes in Irish society, a fascinating topic that warrants further scrutiny.

[48] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960).

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Changing Times? Legislative Reform, 1947–65

On 19 August 1947 the minister for the (newly created) departments of Health and Social Welfare tabled a bill to his cabinet colleagues. Stressing the need for 'care and protection of mentally deficient persons', Dr James Ryan's proposals were the first statutory measures to specifically address the intellectually disabled since the foundation of the state.[1] The bill justified its introduction – due to there being 'no legislation in the country at present' – before it detailed a sweeping array of measures, all of which were considered 'urgently necessary' to support the 'mentally deficient' across residential care and in the wider community. Alongside an ambitious blueprint for the state, it also included a variety of new obligations for parents and local authorities, measures that called for a vast array of changes.[2]

This bill appeared to herald a radical new dawn in policy and provision for the intellectually disabled, reflecting the priorities of a government that had become increasingly engaged with health and welfare issues.[3] By the mid-1950s, however, this push for specific legislation had been largely abandoned, the sole exception being the introduction of a payment

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[1] The failure to introduce disability-specific legislation in Ireland extends back to the 1913 Mental Deficiency Act, which was not enacted due to opposition from mental hospital boards. Fiachra Byrne and Catherine Cox, '"Straightening Crooked Souls": Psychology and Children in Custody in 1950s and 1960s Ireland', in Lynsey Black, Louise Brangan and Deirdre Healy (eds), *Histories of Punishment and Social Control in Ireland: Perspectives from a Periphery* (Bingley, 2022), p. 42; Greta Jones, 'Eugenics in Ireland: The Belfast Eugenics Society, 1911–15', *Irish Historical Studies* 28.109 (1992), p. 88; Joseph Robins, *Fools and the Mad: A History of the Insane in Ireland* (Dublin, 1986), p. 170.

[2] 'Memorandum for the Government', 13 August 1947, National Archives of Ireland (hereafter NAI), Department of the Taoiseach (hereafter DT) S14129A.

[3] Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900–1970* (Dublin, 1987), p. 165.

to support those with a long-term impairment – the Disabled Persons' Maintenance Allowance (DPMA). By 1960 further attempts to introduce disability-specific legislation were considered unimportant, while five years later such measures were deemed unnecessary.[4] Indeed, the dual efforts to introduce a 'Mental Deficiency' Act reveal how the Department of Health's universalist aspirations began to falter going into the 1950s. This narrowed the scope of proposed disability legislation, a curtailment that in turn instigated a (limited) expansion of the state's welfare provision.[5] This resulted in *some* support for the 'mentally handicapped', through a system that was both challenging to navigate and maintained clear links to stigmatising antecedents. By 1965 an intellectually disabled person could access a welfare payment to support their life in the wider community. When compared against the comprehensive package of measures tabled in 1947, however, the partial nature of this reform becomes readily apparent.

'Urgently necessary' Legislation: The 'Mental Deficiency' Bills, 1947 and 1953

> appropriate legislative measures should be taken for the protection and care of these afflicted persons.
>
> Mental Deficiency Bill (1947)[6]

The 1947 'Mental Deficiency' bill matched a mood of reforming zeal across the post-war health system. Recently divorced from the concerns of local government, the new Department of Health had embarked on an ambitious reform programme, with plans to address multiple areas of long-standing concern.[7] Writing to a colleague in New York, the Chief Medical Officer Dr James Deeny discussed some of these projects. Each reform effort was much needed, he emphasised, although the CMO admitted that the scale of this challenge was 'rapidly turning my few remaining hairs a dreary

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[4] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 4; Commission of Inquiry on Mental Handicap, *Commission on Mental Handicap: Report 1965* (Dublin, 1965), p. xxiv.

[5] For a discussion of this dynamic, see Dorothy Porter, 'Introduction', in Dorothy Porter (ed.), *The History of Public Health and the Modern State* (Amsterdam, 1994), p. 24.

[6] 'Memorandum for the Government', 13 August 1947, NAI DT S14129A.

[7] Lindsey Earner-Byrne, *Mother and Child: Maternity and Child Welfare in Dublin, 1922–60* (Manchester, 2007), p. 126; Tom Feeney, *Seán MacEntee: A Political Life* (Dublin, 2009), p. 157.

white'.[8] The department was engaged in an ambitious effort to reform Ireland's health system, with the ultimate goal of providing a 'comprehensive service available to the whole population'.[9]

This innovation only emerged following the prolonged stasis imposed by the Second World War, during which the state's healthcare infrastructure had declined, with the hospital capital funding programme (the Irish Hospitals' Sweepstake) suspended throughout the conflict.[10] This clearly impacted on patients throughout the 'Emergency' years (1939–45): deaths from tuberculosis (TB) alone increased by 35% from 1938 to 1942.[11] These wartime conditions likely acted as a seedbed for post-war reform efforts, with ailing services encouraging a growing 'willingness to contemplate different and better ways of doing things'.[12] Indeed, the public's anticipation of reform was directly articulated at the 1945 Inter-Departmental Committee on Social Services, which acknowledged that government departments were now 'entering an era in which there will be an increased demand for … [the] development and expansion' of their role.[13] Expectations were manifested in the creation of the departments of Health and Social Welfare in 1947, after which there was an increasingly active statutory approach to public health and welfare issues.[14] This was visible throughout the 1947 Health Act, for instance, which included a range of measures to minimise infectious diseases and empower local health officials. Alongside increased intervention, the state also assumed a greater role in funding these services from the exchequer, reducing the cost to local authorities and allowing for greater parity in

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[8] Letter, Dr James Deeny to Dr Hugh Smith (Rockefeller Foundation, New York), 21 May 1947, Royal College of Surgeons of Ireland Archive (hereafter RCSIA), Deeny Papers (hereafter DP), 1/1/4/1/63.

[9] Ibid. The scale of this effort was clearly reflected in the responses provided by visiting health officials to Ireland. See the letters to Deeny from UK, US, and Australian health officials in RCSIA DP 4/1/4.

[10] An era titled 'the Emergency' in (nominally) neutral Ireland, after the 1939 Emergency Powers Act. Bryce Evans, *Ireland during the Second World War: Farewell to Plato's Cave* (Manchester, 2014), pp. 1, 71.

[11] Greta Jones, *'Captain of All These Men of Death': The History of Tuberculosis in Nineteenth and Twentieth Century Ireland* (Amsterdam, 2001), p. 199.

[12] Barrington, *Health, Medicine and Politics in Ireland*, p. 165; Evans, *Ireland during the Second World War*, p. 177.

[13] Inter-departmental Committee on Social Services, *Report of the Inter-departmental Committee on Social Services appointed by the Minister for Finance on 15 May 1945* (Dublin, 1945), University College Dublin Archive (hereafter UCDA), Seán MacEntee Papers P67/261, pp. 1–2.

[14] Miriam Wiley, 'Financing the Irish Health Services: From Local to Centralised Funding and Beyond', in Joseph Robins (ed.), *Reflections on Health: Commemorating Fifty Years of the Department of Health 1947–1997* (Dublin, 1997), pp. 210–31; John Curry, *Irish Social Services* (Dublin, 2003), p. 28.

provision across the country.[15] If the ‘Emergency’ years had imposed inertia, the post-war government demonstrated an awareness of the need to accelerate peacetime reforms and, in doing so, begin moving towards a health service that was ‘commensurate with modern requirement’.[16]

These efforts were catalysed by contemporaneous reforms to services in the UK, which included the creation of the National Health Service (NHS) in 1948, as well as the introduction of popular welfare measures like the Family Allowances Act (1945) and the Industrial Injuries Act (1946).[17] These reforms created a significant (and growing) disparity in health and welfare provision across the island’s two jurisdictions, as well as between the state and its nearest neighbour.[18] Cornelius Lucey had foreseen this problem as early as 1943 when he warned that, should the proposals for a British welfare state succeed, Ireland would be compelled to ‘provide something just as good, if not better’.[19] This pressure for reform arguably became more acute over time, as emigrants experienced the benefits associated with new British services.[20] This dynamic was apparent in Donall Mac Amhlaigh’s memoir *An Irish Navvy* (1964). In Ireland statutory services retained a (stigmatised) association with the Poor Law, but Mac Amhlaigh explained how the experience in Britain was fundamentally different, as officials there ‘give you to understand that you are a person and not a beggar’.[21] Alongside such individual encounters, the UK’s expansive blueprint for reform, William Beveridge’s *Social Insurance and Allied Services* (1942), found a receptive audience among mid-century civil servants, clerics, and academics in Ireland,

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[15] Adrian Kelly, ‘Catholic Action and the Development of the Irish Welfare State in the 1930s and 1940s’, *Archivium Hibernicum* 53 (January 1999), p. 108; Brendan Hensey, ‘The Health Services and their Administration’, *Administration: Journal of the IPA* 30.2/3 (1982), p. 147; Andrew McCarthy, ‘Aspects of Local Health in Ireland in the 1950s’, in Dermot Keogh, Finbarr O’Shea and Carmel Quinlan (eds), *The Lost Decade: Ireland in the 1950s* (Cork, 2004), p. 118.

[16] Seán MacEntee, qtd. in Earner-Byrne, *Mother and Child*, p. 120.

[17] Tony Farmar, *Patients, Potions and Physicians: A Social History of Medicine in Ireland, 1654–2004* (Dublin, 2004), p. 170; Barrington, *Health, Medicine and Politics in Ireland*, p. 188.

[18] Diarmaid Ferriter, *The Transformation of Ireland, 1900–2000* (London, 2005), p. 450.

[19] Cornelius Lucey, ‘The Beveridge Report and Eire’, *Studies: An Irish Quarterly Review* 32.125 (1943), p. 36. Cornelius Lucey (1902–82) was chair of Philosophy and Political Theory at St Patrick’s College, Maynooth, and became the Bishop of Cork in 1952. Co-founder of the sociology journal *Christus Rex*, Lucey was a conservative theologian who clashed with many over issues of Catholic orthodoxy during the 1950s.

[20] Enda Delaney, *Demography, State and Society: Irish Migration to Britain, 1921–1971* (Liverpool, 2000), p. 163.

[21] Dónall Mac Amhlaigh, *An Irish Navvy: The Diary of an Exile*, trans. Valentin Iremonger (Cork, 2003 [1964]), p. 65.

a popularity that was credited as a key impetus for the introduction of the children's allowance scheme in 1944.[22]

The 1947 'Mental Deficiency' bill was part of this wide-ranging post-war reform effort. It aimed to provide a legislative basis for the intellectually disabled, as heretofore the 'duty of providing for the care and welfare of mentally deficient persons … [was] not placed on any authority'.[23] This had resulted in 'higher grades of mental defectives' being raised without appropriate education or training, which left many of them 'likely to be exploited for manual labour of the heaviest kind', whereas 'lower grades' faced potential admission to institutions such as psychiatric hospitals or county homes.[24] The memorandum concluded that legislation was therefore 'urgently necessary'. To address the needs of this group, the bill proposed a broad range of measures, which included requiring parents to provide for the vocational training of their children, compelling local authorities to establish sheltered employment programmes, placing the responsibility for disability issues on regional mental hospital authorities, establishing a system of periodic visitation for those outside institutional care, and creating a new welfare payment. It was a comprehensive package of proposals, which addressed both those in residential institutions and the community. If enacted, the bill would have prompted the creation of multiple new services, while it would have significantly expanded statutory oversight, beyond even the scope of the 1913 Mental Deficiency Act.[25] The Minister for Health consulted with his counterparts in Education, Justice, and Finance before presenting these proposals, none of whom objected. It was then approved by the cabinet on the same day.[26]

The bill's broad scope becomes understandable when positioned alongside other legislation that was being advanced by the Department of Health in the late 1940s. The 'Mental Deficiency' bill was an ambitious set of proposals, among a range of similarly wide-ranging health reforms, which included the Tuberculosis Act (1945) and the Health Act (1947), reform efforts that only accelerated following the foundation of a separate Department of

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[22] Séamus Ó' Cinnéide, 'Ireland in a European Welfare State?', in Séamus Ó' Cinnéide (ed.), *Social Europe: European Community Social Policy and Ireland* (Dublin, 1993), p. 118; Bryan Fanning, *The Quest for Modern Ireland: The Battle for Ideas, 1912–1986* (Dublin, 2008), p. 148; Adrian Kelly, 'Social Security in Independent Ireland 1922–52', PhD thesis, St Patrick's College Maynooth, 1995, p. 229.

[23] 'Memorandum for the Government', 13 August 1947, NAI DT S12573/A.

[24] Ibid.

[25] Mathew Thomson, 'Family, Community and State: The Micro-politics of Mental Deficiency', in Anne Digby and David Wright (eds), *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (Abingdon, 2002), p. 207.

[26] 'Memorandum for the Government', 13 August 1947, NAI DT S12573/A; 'Cabinet Meeting Agenda', 19 August 1947, NAI DT S14129/A.

Health and the recruitment of dynamic reformers such as James Deeny.[27] The scale of this ambition should not be understated. In September 1947, a month after Minister Ryan's presentation of the 'Mental Deficiency' bill, the White Paper *Outline of Proposals for the Improvement of the Health Services* was published, which laid out a trajectory that would have culminated in an Irish version of the NHS.[28] The 'Mental Deficiency' bill contained a similarly ambitious menu of proposals, with clear obligations for parents, local authorities, and the state. In doing so, it offers a tantalising platform for counterfactual speculation, particularly given that a comparably broad piece of legislation did not emerge again until the 2005 Disability Act.[29] Of course, whether the bill could have changed the disability services landscape remains unknowable, but it provides a window into the scope of the reform efforts under consideration by the early Department of Health, an ambition that found a ready vehicle in its attempts to curb infectious diseases and expand the state's hospital infrastructure.[30]

By the late 1940s the rise of Clann na Poblachta typified a growing political volatility, one that contributed to the fall of the Fianna Fáil government in February 1948.[31] The party had by then been in power since 1932, but the election was called before the introduction of the 'Mental Deficiency' bill to Dáil Éireann, the Irish parliament.[32] That year's campaign was marked by a notable consensus from the main political parties, which agreed on the need to reform the state's health and welfare services, with a range of proposals included in their party platforms.[33] Despite efforts to form a minority Fianna Fáil government, the election concluded with the creation of the state's first inter-party coalition, which included Fine Gael, Clann na Poblachta, Clann na Talmhan, Labour, National Labour, and an independent

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[27] John Horgan, *Noël Browne: Passionate Outsider* (Dublin, 2000), p. 37; Barrington, *Health, Medicine and Politics in Ireland*, p. 155.

[28] Department of Health, *Outline of Proposals for the Improvement of the Health Services* (Dublin, 1947), pp. 1–5; Barrington, *Health, Medicine and Politics in Ireland*, p. 188; Earner-Byrne, *Mother and Child*, p. 126; Brendan Hensey, *The Health Services of Ireland* (Dublin, 1979), p. 19.

[29] Jurgen De Wispelaere and Judy Walsh, 'Disability Rights in Ireland: Chronicle of a Missed Opportunity', *Irish Political Studies* 22.4 (2007), p. 517; Andrew Power, 'It's the System Working for the System: Carers' Experiences of Learning Disability Services in Ireland', *Health and Social Care in the Community* 17.1 (2008), p. 93.

[30] Feeney, *Seán MacEntee*, p. 157; Damien Brennan, *Irish Insanity: 1800–2000* (Abingdon, 2013), p. 119.

[31] Gary Murphy, *In Search of the Promised Land: The Politics of Post-war Ireland* (Cork, 2009), pp. 29–30.

[32] Terence Brown, *Ireland: A Social and Cultural History, 1922–1985* (London, 1985), p. 209.

[33] Murphy, *In Search of the Promised Land*, p. 151.

TD (Teachta Dála, member of parliament).[34] Over the following three years (1948–51) this government compounded the impulse for reform through its commitment to increasingly 'radical health and welfare policies'.[35] Yet this did not include an attempt to produce 'mental deficiency' legislation. Regardless of common aspirations, finding consensus among a diverse group (which encompassed the parliament's ideological range) in the state's fractious first attempt at coalition government remained an obstacle to many reform proposals.[36] Dr Noël Browne's desire to curb TB also likely contributed to the marginalisation of disability-related reforms.[37] Browne, the coalition's Minister for Health, was a passionate advocate for greater statutory investment in TB services, having lost both of his parents to the disease. Recent legislation, such as the Tuberculosis (Establishment of Sanatoria) Act in 1945, empowered the newly installed minister, giving him the ability to acquire land and build treatment facilities without requiring local authority support, while it also allowed for the provision of universal treatment irrespective of means.[38] These tools became vital to Browne's expansive efforts against the disease throughout his tenure, which included the construction of multiple sanatoria and the effective liquidation of the Hospitals' Sweepstake fund.[39]

The coalition's ability to introduce health-related reforms was also influenced by the furore instigated by the 'Mother and Child' controversy, or as Joseph Lee labelled it, 'the great cause célèbre of Irish politics'.[40] This scandal, described as the 'most picked-over event in the history of the state', occurred due to a conflict between Browne and members of the medical profession who, allied with the hierarchy of the Catholic Church, objected to the provision of universal healthcare to mothers and children under a proposed statutory programme.[41] The scheme was designed to be

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[34] Joseph Lee, *Ireland, 1912–1985: Politics and Society* (Cambridge, 1989), p. 299.

[35] Mary E. Daly, *Social and Economic History of Ireland since 1800* (Dublin, 1981), p. 182.

[36] Dermot Keogh, *Twentieth Century Ireland: Nation and State* (Dublin, 1994), p. 190; David McCullagh, *A Makeshift Majority: The First Inter-party Government, 1948–51* (Dublin, 1998), p. 198.

[37] Chris Macey, *Rehab News: 50th Commemorative Edition 1949–1999* (Longford, 1999), p. 4.

[38] Jones, *'Captain of All These Men of Death'*, p. 219; Barrington, *Health, Medicine and Politics in Ireland*, p. 189; Fred Powell, *The Political Economy of the Irish Welfare State: Church, State and Capital* (Bristol, 2017), pp. 141–2.

[39] Mary E. Daly, 'The Curse of the Irish Hospitals' Sweepstake: A Hospital System, not a Health System', *Working Papers in History and Policy* 2 (2012), p. 6.

[40] Catherine Cox, 'Health and Welfare 1750–2000', in Eugenio F. Biagini and Mary E. Daly (eds), *The Cambridge Social History of Modern Ireland* (Cambridge, 2017), p. 274; Lee, *Ireland, 1912–1985: Politics and Society*, p. 313.

[41] Fanning, *The Quest for Modern Ireland*, p. 161; Eamonn McKee, 'Church–State Relations and the Development of Irish Health Policy: The Mother-and-Child Scheme, 1944–53', *Irish Historical Studies* 25.98 (1986), p. 191.

limited in scope, providing universal healthcare to women and children only, and was titled the 'Mother and Child' scheme by James Deeny because 'no one could oppose [it] … with a name like that'.[42] Notwithstanding an (intentionally) bland title, a political conflagration quickly emerged over this expansion of the state's role, fuelled by a volatile combination of threats to doctors' professional interests, perceived snubs to the Catholic hierarchy, disunity among the coalition parties, and Browne's intransigence in the face of concerted opposition.[43] The scheme was attacked as fundamentally unworkable by the Irish Medical Association, for example, which decried the proposals as 'socialist conceptions … tainted with Marxian ideas, entirely alien to our traditions'.[44] The underlying basis for the scheme lay in the department's recent reform proposals, with the idea of free maternal and infant care included in the foundational White Paper *Outline of Proposals for the Improvement of the Health Services* (1947). In other words it was a spectacularly consequential failure for a Department of Health proposal, which contributed to the government's eventual collapse in 1951. It was therefore unsurprising that the scandal instigated a 'chilling' effect when it came to further political engagement in health-related reforms.[45]

By contrast, Ruth Barrington has argued that the impact of the controversy has been overstated in Irish historiography. In particular, she points to how Fianna Fáil interpreted its election victory in 1951 'as a mandate to reform the health services'.[46] Although it is true that health reform efforts continued into the 1950s, developments occurred along a specific (and already well-established) trajectory. The White Paper *Proposals for Improved and Extended Health Services* (1952) articulated what was politically possible during the early 1950s. Given that proposals for universal maternal and infant healthcare had caused such controversy, a national health system was now off the table. Instead, the White Paper proposed expanding the mixed economy of care through increased public access to hospital facilities, which

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[42] Dr James Deeny, qtd in McCullagh, *A Makeshift Majority*, p. 198.

[43] Brian Fallon stressed the challenges created by Browne's approach, describing his 'almost Robespierre-like conviction of his own rectitude' throughout the period. Brian Fallon, 'Reflecting on Ireland in the 1950s', in Dermot Keogh, Finbarr O'Shea and Carmel Quinlan (eds), *The Lost Decade: Ireland in the 1950s* (Cork, 2004), p. 36.

[44] Eamonn McKee and Lindsey Earner-Byrne have also emphasised the role of medical resistance to the programme. Lindsey Earner-Byrne, 'Managing Motherhood: Negotiating a Maternity Service for Catholic Mothers in Dublin, 1930–1954', *Social History of Medicine* 19.2 (2006), p. 272; Earner-Byrne, *Mother and Child*, pp. 140–4; McKee, 'Church–State Relations and the Development of Irish Health Policy', p. 191.

[45] Finola Kennedy, *Family, Economy and Government in Ireland* (Dublin, 1989), p. 134; Fanning, *The Quest for Modern Ireland*, p. 161.

[46] Barrington, *Health, Medicine and Politics in Ireland*, p. 223; Daly, 'The Curse of the Irish Hospitals' Sweepstakes', p. 5.

was then legislated for in the 1953 Health Act.[47] By the late 1950s, this resulted in approximately 85% of the population being entitled to free or subsidised treatment in an acute hospital, facilities that were in many cases operated by voluntary organisations.[48] Reforms continued throughout the 1950s, but instead of increasing the state's remit, there was a formal effort to cooperate with existing service providers. This was expansion through a consolidation of the status quo.

This approach was reflected in the discussion of health-related legislation. James Ryan dismissed the idea that earlier governments had ever sought to create 'a complete scheme of state medicine', and instead positioned his department in a limited role; it would not go 'further than is necessary to provide the specialised services'.[49] Among its range of provisions, Section 65 of the 1953 Health Act went on to have a long-standing impact on the lives of the intellectually disabled. It acknowledged the role played by voluntary organisations in the health system, and allowed statutory authorities to financially support any service that was 'similar or ancillary to a service which the health authority may provide'.[50] Section 65 paved the way for the financing of a range of voluntary disability initiatives through grants from the Department of Health, a mechanism that went on to play a key role in the funding of intellectual disability services for the remainder of the twentieth century.[51]

An emphasis on established practices was apparent in Fianna Fáil's second attempt to produce disability-specific legislation, which followed its return to government in 1951 and was (again) tabled by Minister for Health James Ryan.[52] At a first glance this 1953 iteration of the 'Mental Deficiency' bill appears to be even broader than its expansive predecessor, its stated aim being to 'provide for the care, supervision and training of mentally defective persons', a goal that expands on the 1947 version's effort to provide 'care

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[47] Bryan Fanning, 'The Construction of Irish Social Policy' (2004), p. 2, https://researchrepository.ucd.ie/bitstream/10197/7640/1/Administration2003.pdf (accessed 20 November 2022).

[48] Ibid., p. 6.

[49] Barrington, *Health, Medicine and Politics in Ireland*, p. 223; Daly, 'The Curse of the Irish Hospitals' Sweepstakes', p. 6; Mary E. Daly, *Sixties Ireland: Reshaping the Economy, State and Society, 1957–1973* (Cambridge, 2016), p. 232.

[50] Government of Ireland, Health Act 1953, 26.

[51] The Department of Health only began to move away from this mechanism following the *Enhancing the Partnership* report in 1997, which highlighted some of the concerns raised by direct funding. Department of Health, *Enhancing the Partnership: Report of the Working Group on the implementation of the Health Strategy in relation to persons with a Mental Handicap* (Dublin, 1997), pp. 43–8; Andrew Power, *Landscapes of Care: Comparative Perspectives on Family Caregiving* (Abingdon, 2016), p. 172; Brian Harvey, *Evolution of Health Services and Health Policy in Ireland* (Dublin, 2007), p. 7.

[52] 'Memorandum for the Government', 4 December 1953, NAI DT S14129/B.

and protection'.[53] However, the 1953 bill was a significant curtailment when compared with its predecessor, which had recommended a wide range of powers for both the Department of Health and local authorities.[54] In the 1953 version these reforms were untenable, due to the limited number of places in institutional facilities nationwide and the lack of a trained body of staff to determine who qualified as intellectually disabled. Yet rather than providing a means to expand institutions or train staff, the new bill instead offered a limited selection of measures from its predecessor. Some proposals, such as the provision of specialised education services or the periodic inspection of the disabled in their homes, simply disappeared. In their place there was an overt focus on 'care and training'. This aim, the bill concluded, must be 'provided for in institutions administered by religious communities'. In contrast to its predecessor, the 1953 bill gave local authorities 'the power to arrange for the supervision, training and employment of mental defectives who are not resident in institutions', but placed no obligation on them to provide any community-based services.[55] Religious communities were expected to play a key role, with the state relegated to granting financial support in recognition of their efforts.

Like the Health Act, the 'Mental Deficiency' bill adopted a cautious approach, rooting itself in the long-standing reliance on voluntary organisations to provide large swathes of the state's health and welfare services.[56] The bill clearly built upon this established relationship, proposing that new services for the 'mentally deficient' would emerge through growing activity by individual religious congregations, rather than through statutory expansion.[57] The bill's conservatism is apparent given that many of its provisions simply gave a legislative basis to existing practices in areas such as institutional accommodation, where religious congregations already played a key role in providing the vast majority of residential places.

From 1947 to 1953 the broad range of reforms advanced in the original 'Mental Deficiency' bill were pared back, as the wide-ranging ambitions of the new Department of Health encountered resistance to expanding the state's role in the health system. Financial concerns likely played a part in this, as competing priorities (such as the new TB programme) consumed limited resources throughout the early 1950s; measures such as the expansion of sanatoria infrastructure, the introduction of mass radiography, and

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[53] 'Proposed Mental Deficiency Bill', 13 August 1947, NAI TAOIS-S12573-B.

[54] 'Memorandum for the Government', 4 December 1953, NAI TAOIS-S14129/B.

[55] Ibid.

[56] Donnacha Seán Lucey and Virginia Crossman, 'Introduction', in Donnacha Seán Lucey and Virginia Crossman (eds), *Healthcare in Ireland and Britain from 1850: Voluntary, Regional and Comparative Perspectives* (London, 2014), pp. 1–5.

[57] 'Memorandum for the Government', 4 December 1953, NAI TAOIS-S14129/B.

the rollout of the BCG (Bacillus Calmette-Guérin) vaccine compounded pressure on the department's (already stretched) budget.[58] On top of financial constraints, the ideological ramifications of the 'Mother and Child' controversy fostered caution towards any perception of statutory overreach. The result was a distinctive policy approach throughout the early 1950s, described by Tom Feeney as a mixture of 'severe economic impositions with tentatively applied social reform'.[59] This had obvious implications for the intellectually disabled where, in a short period, the legislative response went from being a pressing concern that called for increased statutory provision across multiple areas, to something that should only be addressed through a select number of Church-run institutional services.[60]

Regardless of its abridgement, the 1953 bill was also not presented to the Dáil. Indeed, in the period from 1953 to 1957 the plan to introduce specific proposals appears to have been abandoned entirely. Questioned on the absence of a 'Mental Deficiency' Act in May 1957, Minister for Health Seán MacEntee queried whether such a measure was even feasible: 'I understand that there are formidable constitutional difficulties in the way of the enactment of effective legislation.'[61] MacEntee did not go on to detail these difficulties, nor were any challenges referred to in the memoranda for the 1947 or 1953 bills. By the publication of the government's White Paper *The Problem of the Mentally Handicapped* (1960), it had become departmental policy that 'In present circumstances the existing code provides a sufficient basis for such services as might be needed.'[62] The possibility of a disability Act definitively disappeared in 1965, when the Commission on Mental Handicap recommended that, excluding a few exceptions, the intellectually disabled should continue to be addressed 'under … general legislation'.[63]

Despite the abandonment of both 'Mental Deficiency' bills, each proposal marked the horizon of possibility for statutory action at that time, with the creation of a variety of new services in 1947 giving way to limited cooperation with the voluntary sector in 1953. By the mid-1950s, financial pressures, a minister (Seán MacEntee) who was predisposed to limit the state's role, and residual caution in the wake of past controversy had coalesced to curb

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[58] Anne Mac Lellan, 'Alone among Neutrals: Ireland's Unique Experience of Tuberculosis during the Second World War', in David Durnin and Ian Miller (eds), *Medicine, Health and Irish Experiences of Conflict, 1914–45* (Manchester, 2017), p. 71; Stephen Bance, 'Crippled, Maimed, Lamed, Shattered and Broken: Polio in Ireland, 1942–1970', PhD thesis, University College Dublin, 2017, p. 55.

[59] Feeney, *Seán MacEntee*, p. 172.

[60] John Cooney, *John Charles McQuaid: Ruler of Catholic Ireland* (Dublin, 1999), p. 262.

[61] Seán MacEntee, *Dáil Debates* 161, 28 May 1957, col. 1948.

[62] Department of Health, *The Problem of the Mentally Handicapped*, p. 4.

[63] Commission of Inquiry on Mental Handicap, *Report 1965*, p. xxiv.

the department's reforming zeal. This resulted in legislation, such as the 1953 Health Act, that reflected a well-established social policy approach, with a limited role for the state alongside a voluntary sector that could receive statutory funding.[64] Yet one element from the 1947 bill proved persistent and re-emerged in the early 1950s, that of a financial allowance to support the 'mentally deficient persons maintained at home' who were unable to provide for themselves.[65] This idea was introduced in 1954 as part of the broader Disabled Persons' Maintenance Allowance (DPMA) scheme; a clear innovation in statutory disability policy, but one that remained stymied by structural flaws embedded in a vestigial corner of the welfare system.[66]

'Assistance to the citizen who needs it': The Disabled Persons' Maintenance Allowance

> [The applicant] by reason of injury, disease, congenital deformity, or physical or mental illness or defect, which has continued or may reasonably be expected to continue for at least one year from its outset, is … substantially handicapped in undertaking work.
>
> *Disabled Persons' (Maintenance Allowance) Regulations* (1954)[67]

The welfare system in Ireland was different. At least that was the conclusion of Peter Kaim-Caudle's report for the Economic Research Institute in 1964. Professor Kaim-Caudle repeatedly stressed the impact of cultural features on Irish welfare provision, suggesting that 'the extensive work of the religious orders, the long tradition of almsgiving and the great and apparent need of some sections of the population' had combined to limit the emergence of a broader social security infrastructure.[68] In practice, this meant that many Irish services retained links to their Poor Law antecedents, while it also fostered a public that continued to regard these

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[64] Power, *Landscapes of Care*, p. 172.

[65] 'Memorandum for the Government', 13 August 1947, NAI DT S14129A.

[66] Nicholas Acheson, Arthur Williamson, Brian Harvey and Jimmy Kearney, *Two Paths, One Purpose: Voluntary Action in Ireland, North and South* (Dublin, 2004), p. 119; Harvey, *Evolution of Health Services*, p. 7.

[67] *Disabled Persons (Maintenance Allowances) Regulations 1954* (S.I. 207).

[68] Peter Kaim-Caudle, *Social Security in Ireland and Western Europe* (Dublin, 1964), pp. 10, 25. Peter Kaim-Caudle (1916–2010) was a Professor of Social Policy at Durham University.

payments as 'at best a necessary evil'.[69] The inadequacy of welfare rates was one obvious distinction between Ireland and its European neighbours, Kaim-Caudle emphasised, with the result that it was 'extremely difficult to understand how thousands of people can manage to exist on [payments such as] Unemployment Assistance at all. They have to rely on help from some quarters – neighbours, emigrants' remittances, family, religious orders, food centres or charities.'[70] His study underlined how national context had shaped the emergence of welfare services in Ireland, resulting in provision that was notably more limited when compared against British analogues. Yet despite a range of obvious deficiencies, Kaim-Caudle's research (arguably) failed to acknowledge a handful of innovations in the Irish social welfare system. Among these was the Disabled Persons' Maintenance Allowance; an allowance that was introduced in the mid-1950s to support those with an impairment that affected their ability to provide for themselves, a payment that did not have a counterpart in post-war Britain.[71]

The sole surviving remnant from the 1947 bill's expansive range of proposals, the DPMA was an attempt to financially support the (physically or intellectually) disabled person who was living in the wider community. Its introduction gives an insight into the way in which political dynamics shaped the development of services, producing a payment that represented a clear intervention in the lives of the disabled, but one that was equally reflective of established forms of provision and the clientelistic approach that characterised the era's politics. For the recipient, the DPMA was an independent source of income that supported them to remain in their community and financially contribute towards their household. Like other social welfare payments, it rose throughout the latter decades of the century, while it was praised as a key support in maintaining many who lived outside residential care.[72] Parliamentary deputies were clear that the payment had a limited function – it was not supposed to supplant the caring role of the recipient's family or the work carried out by voluntary sector organisations. The allowance was therefore based in the Department of Health, rather than

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[69] Ibid., p. 25.

[70] Ibid., p. 24.

[71] Gareth Millward, 'Invalid Definitions, Invalid Responses: Disability and the Welfare State, 1965–95', PhD thesis, London School of Hygiene and Tropical Medicine, 2014, p. 106; Jameel Hampton, *Disability and the Welfare State in Britain: Changes in Perception and Policy 1948–79* (Bristol, 2016), pp. 72–3; John Dixon and Mark Hyde, 'A Global Perspective on Social Security Programmes for Disabled People', *Disability and Society* 15.5 (2000), p. 275.

[72] Harold O'Sullivan, *The House on the Ridge of the Weir: The Story of the Brothers and the Community of Saint John of God, St. Mary's, Drumcar* (Louth, 1998), p. 105; Jean Tubridy, *Pegged Down: Experiences of People in Ireland with Significant Physical Disabilities* (Dublin, 1996), p. 116.

Social Welfare, which meant that it could be means-tested by local health authorities.[73] However, this decision also positioned the allowance within a limited and stigmatising corner of the state's welfare services that retained ties to the much maligned nineteenth-century Poor Laws.[74]

The idea of a disability-specific welfare payment first arose in the 1947 'Mental Deficiency' bill, which called for the introduction of an allowance to support the intellectually disabled outside institutional care.[75] A specialised welfare allowance due to temporary incapacity also appeared in the 1947 Health Act, which proposed a payment for those who were 'prevented from making reasonable and proper provision for his own maintenance'.[76] This was introduced after campaigning by the TB advocacy group the Post Sanatorium League, which sought to supplement the incomes of sanatoria patients undergoing the (then prolonged) confinement associated with their treatment.[77] By 1950 there were calls from groups such as the Infantile Paralysis Fellowship to expand this temporary payment to those suffering from diseases that caused a permanent physical incapacity, such as poliomyelitis.[78] In 1952 Fianna Fáil introduced the Social Welfare Act, a wide-ranging piece of legislation that 'integrated and improved the existing social insurance scheme and provided a national Social Welfare system under the Department of Social Welfare'.[79] Contemporaneously, it was framed as the apogee of the state's welfare system; during a Dáil debate Minister Ryan argued that, with the Act's introduction, 'the structure of social services in this country might be regarded as having taken final form'.[80] Notably, this view has also been reflected in historical analyses, many of which conclude with the Social Welfare Act.[81]

Yet despite its scope, parliamentary debates continued to see dissatisfaction with social security provision throughout the early 1950s. In the UK, post-war welfare measures were predicated on labour-force participation,

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[73] 'History of the Scheme', 5 November 1953 NAI Department of Finance (hereafter FIN) S72-7-53.

[74] Kaim-Caudle, *Social Security in Ireland and Western Europe*, p. 25; Séamus Ó Cinnéide, *A Law for the Poor: A Study of Home Assistance in Ireland* (Dublin, 1970), pp. 1–3.

[75] Mel Cousins, *The Irish Social Welfare System: Law and Social Policy* (Dublin, 1995), p. 19.

[76] Government of Ireland, Health Act 1947, Section 44.

[77] Jones, *'Captain of All These Men of Death'*, pp. 201–2; Helen Bynum, *Spitting Blood: The History of Tuberculosis* (Oxford, 2012), pp. 128–60.

[78] 'To Aid Paralysis Victims', *Irish Independent*, 20 March 1950, p. 3.

[79] Kelly, 'Social Security in Independent Ireland', p. 247; Cousins, *The Irish Social Welfare System*, p. 20.

[80] James Ryan, *Dáil Debates* 143, 2 December 1953, col. 1394.

[81] See Sophia Carey, *Social Security in Ireland, 1939–1952: The Limits to Solidarity* (Dublin, 2007); Kelly, 'Social Security in Independent Ireland'; Mel Cousins, *The Birth of Social Welfare in Ireland, 1922–52* (Dublin, 2003).

which tacitly excluded the majority of the disabled.[82] There was a similar stress on employment in the Social Welfare Act, which supported those who had been employed and had paid an appropriate number of social insurance contributions ('stamps'). During Dáil debates, however, deputies repeatedly highlighted a need to introduce measures that supported those who had never (or could never) take up remunerative employment. During a health committee meeting in May 1952, James Hickey gave a detailed account of a physically disabled young man who lived with his brother. The Labour deputy conceded that 'from the moral point of view' there was a duty for family members to support such a relative, but argued that the state also had a responsibility to protect those unable to earn a wage themselves, reminding his audience that 'it is the duty of the state under the constitution to give some assistance to the citizen who needs it'.[83] This view appeared to transcend political affiliation – Fianna Fáil's Eugene Gilbride called for a similar expansion to the social welfare system. Such a bill, he emphasised, would be popular 'no matter what the cost, [and] will have the wholehearted support of every member of this house'.[84] This contrasted sharply with developments in the UK, where there was little progress in statutory welfare for the disabled throughout the 1950s.[85] In the Dáil, deputies commonly framed their concerns in terms of Christian charity, arguing that the state had a moral obligation to support those in need. Fianna Fáil's Seán Flanagan typified this, describing the needs of 'unfortunate people … who are deformed from birth', before outlining the state's responsibility to support those who were not voluntarily out-of-work but instead 'unemployed by the force of God's providence'.[86]

This overt desire for a disability-specific allowance likely arose due to the re-entrenchment of the Department of Health's role during the early 1950s, when statutory-operated residential facilities were clearly off the table and these services expanded solely through voluntary activity. In practice, this meant that a limited number of institutions struggled to meet a (seemingly) insurmountable level of public demand. This presented a problem for mid-century politicians. Sociological research has highlighted how the state's political culture remained 'localistic, clientelistic and intensely responsive' throughout the twentieth century, with politics gravitating towards local concerns and operating through personal interaction with representatives, cultural features that were supported by the maintenance of multi-seat

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[82] Millward, 'Invalid Definitions, Invalid Responses', p. 99; Hampton, *Disability and the Welfare State in Britain*, p. 55.

[83] James Hickey, *Dáil Debates* 131, 7 May 1952, col. 1258.

[84] Eugene Gilbride, *Dáil Debates* 130, 27 March 1952, col. 805.

[85] Millward, 'Invalid Definitions, Invalid Responses', p. 99.

[86] Seán Flanagan, *Dáil Debates* 130, 27 March 1952, col. 760.

constituencies and a relatively high representative ratio.[87] Clientelist political structures depended on the development of personal relationships between public representatives and their electorate, alongside the idea that political power conferred influence in terms of access to services.[88] The contours of this dynamic were first outlined by Basil Chubb in 1963, when he stated that many politicians appeared to serve their constituencies by 'going about persecuting civil servants' in pursuit of services, with public representatives viewing their role as that of a mediator between the organs of the state and their constituency.[89] In a country characterised by this dynamic, where individuals commonly sought out their 'local politicians seeking remedy for their specific problems', the lack of residential accommodation presented a clear problem for any public representative who failed to secure a placement for a family with a disabled relative.[90] A disability-specific allowance represented a potential 'solution' in that it supported the continuation of community-based care for the intellectually disabled, without resorting to already overstretched residential institutions.

Minister Ryan first acknowledged his plan to address 'people who are disabled almost from birth' through the Department of Health in May 1952.[91] This was also included in the White Paper *Proposals for Improved and Extended Health Services* (1952), which detailed plans for an allowance that addressed 'cases of persons over 16 years of age who are without means and unable by reason of chronic illness or disability to provide for their own maintenance'.[92] This was legislated for in the 1953 Health Act, while disability was given a broad definition in the 1954 Disabled Persons' (Maintenance Allowances) Regulations as anyone who was unable to work 'by reason of injury, disease, congenital deformity, or physical or mental illness or defect, which has continued or may reasonably be expected to continue for at least one year from its outset'.[93] The allowance's initial rate

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[87] Elaine Byrne, *Political Corruption in Ireland, 1922–2010: A Crooked Harp?* (Manchester, 2013), pp. 36–68; Neil Collins and Mary O'Shea, 'Clientelism: Facilitating Rights and Favours', in Mary Adshead and Michelle Millar (eds), *Public Administration and Public Policy in Ireland* (London, 2003), pp. 88–107; Nigel Boyle, 'FÁS and Active Labour Market Policy 1985–2004', *Studies in Public Policy* 17 (2005), p. 22.

[88] Eimear O'Leary, 'The Constituency Orientation of Modern TDs', *Irish Political Studies* 26.3 (2011), pp. 329–43.

[89] Basil Chubb, 'Going about Persecuting Civil Servants: The Role of the Irish Parliamentary Representative', *Political Studies* 103 (1963), p. 272.

[90] Power, *Landscapes of Care*, p. 131.

[91] James Ryan, *Dáil Debates* 131, 7 May 1952, col. 1259.

[92] Department of Health, *Proposals for Improved and Extended Health Services* (Dublin, 1952), p. 16.

[93] Lee, *Ireland, 1912–1985: Politics and Society*, p. 321; The allowance was to be paid to to 'persons over 16 years of age who are unable to provide for their own maintenance'.

was set at a maximum of £1 per week, to be administered by the local health authority.[94]

The payment attracted praise from politicians across the political spectrum, with many Deputies highlighting its role in supporting vulnerable groups such as the 'mentally deficient' to remain in their local community. Seán McBride, leader of the centre-left Clann Na Poblachta, described it as 'one of the most useful provisions' of the wide-ranging Health Act, while Labour deputy Thomas Kyne noted that his party's support for the bill was predicated on the allowance.[95] Many deputies also stressed the role of the DPMA in alleviating demand for institutional care. Ultimately, Fianna Fáil's Seán McCarthy argued, this payment would be a cost-saving measure, as he reminded his colleagues that 'it would cost much more if those people were removed from the home to an institution'.[96] Initially, the only criticism of the allowance was its parsimony. Deputies emphasised that its maximum rate of £1 a week was insufficient, although this was broadly in line with comparable social welfare payments, such as the old-age pension rate of £1 1s 6d in 1952.[97]

Yet, notwithstanding the warm reception it attracted from TDs, the DPMA's implementation was notably haphazard in practice, marked by limited planning and prolonged bureaucratic struggle. Operationally, the Department of Health lacked even basic data about the scheme's potential cost, while its introduction through local health authorities ensured the perpetuation of the punitive approach to welfare inherited from the Poor Law.[98] The allowance was first discussed at a Dáil health committee meeting in July 1953, when Minister Ryan explained that his department lacked even basic information about the potential number of eligible recipients nationwide. This uncertainty should prompt caution, he warned, as the allowance 'may be a costly scheme: I should not care even to mention a sum … It will cost a fairly big amount, and, for that reason, we do not want to be too flaithiúlach for a start off.'[99] In fact, departmental correspondence makes clear the near total blindness of both the departments of Health and Finance when it came to the scheme's 'fairly big' cost. Pádraig O'Cinnéide, First Secretary of the

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Government of Ireland, Health Act 1953, Section 50; Disabled Persons (Maintenance Allowances) Regulations 1954 (S.I. 207), Section 4.

[94] Disabled Persons (Maintenance Allowances) Regulations 1954 (S.I. 207), Section 4.

[95] 'New Plan to Aid Disabled', *The Irish Times*, 15 July 1953, p. 1.

[96] Seán McCarthy, *Dáil Debates* 156, 11 April 1956, col. 236.

[97] Government of Ireland, Social Welfare Act 1952, Section 77; National Health Council, 'Meeting Minutes: 10 September 1954', pp. 1–10.

[98] Ó Cinnéide, *A Law for the Poor*, p. 1.

[99] James Ryan, *Dáil Debates* 140, 14 July 1953, col. 1136; The word flaithiúlach translates as 'generous', but it is commonly used in Hiberno-English to indicate profligacy. Terence Patrick Dolan, *A Dictionary of Hiberno-English* (Dublin, 2006), p. 94.

Department of Health, explained in a letter to the Department of Finance that it was 'not at present possible to be more precise than to place the possible total number of disabled in this country at somewhere between 50,000 and 90,000 persons over 16 years old and under 70'.[100] Other documents draw even this range into question, as it was acknowledged that health officials had only 'very nebulous estimates … [which were] based on little more than sheer guesswork'.[101] This lack of information likely fostered resistance among conservative members of the cabinet, including the Minister for Finance Seán MacEntee, who described the proposed scheme (provisionally costed at £500,000 a year) as 'one for which I can hold no hope of approval'.[102] Indeed, from the DPMA's appearance in 1953, the Department of Finance continually sought to exclude the payment from the Health Act.[103]

This was reflected in the prolonged bureaucratic struggle that emerged between the departments of Health and Finance over the allowance. The January 1953 draft of the Health bill prompted MacEntee to write to Dr Ryan. He advocated fiscal caution, requesting that the allowance be deferred until a halcyon day when 'national output increases, prices and costs are stabilised and conditions generally become more favourable'.[104] The allowances section was then changed to an optional service that the local authorities *could* choose to provide at a cabinet meeting on 3 February 1953, before the Minister for Health made the payment mandatory at the report stage that July.[105] Indeed, as late as December, following the introduction of the Health Act, Department of Finance officials continued to wonder whether the DPMA could be delayed 'at least until some of the more important services have been introduced first'.[106] Of course, conflict between Finance and other government departments was far from new.[107]

Regardless of these qualms, the Department of Health continued to press for the introduction of the DPMA, with the minister pointing to its importance as a support for families with a disabled relative who lived in the community.[108] Following the introduction of the 1954 Disabled Persons (Maintenance Allowance) Regulations, the scheme became operational from February 1955.[109] Almost immediately, there were problems. The allowance

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[100] Pádraig O'Cinnéide (First Secretary, Department of Health) to Owen Redmond (First Secretary, Department of Finance), October 1953, NAI FIN S72-7-53.

[101] 'Memorandum', 7 November 1953, NAI FIN S72-7-53.

[102] 'History of the Scheme', 5 November 1953, NAI FIN S72-7-53.

[103] Ibid.

[104] Ibid.

[105] 'Memorandum to C.S. Almond', 8 December 1953, NAI FIN S72-7-53.

[106] Ibid.

[107] See Ronan Fanning, *The Irish Department of Finance 1922–58* (Dublin, 1978).

[108] James Ryan, *Dáil Debates* 140, 14 July 1953, col. 1136.

[109] '200 Disabled Draw New Allowance', *The Irish Times*, 4 February 1955, p. 7.

Table 1.1: DPMA applications received and refused, 1957–8.

Year ending:	Applications received	Applications refused	Percentage refused
31/3/57	6,132	3,416	55.7%
31/3/58	4,678	2,579	55.1%
30/9/58	2,175	1,069	49.1%

Source: Seán MacEntee, *Dáil Debates* 175, 27 May 1959, col. 607.

was administered through the local authorities, who contributed 50% of the scheme's cost.[110] The administration of any payment through local authorities tended to attract controversy, with varying practices across different counties.[111] Again and again, there were complaints about the punitive approach adopted across multiple local authorities. Fianna Faíl's Neil Blaney explained in the Dáil that 'the good intentions [underlying the allowance were] … being nullified or being watered down' in practice.[112] Blaney's concerns were echoed by many, while DPMA statistics lend some credence to their claims. By April 1955 Dublin Corporation had received 2,002 applications for the allowance. Of these, 415 (20.7%) had been approved, while 845 (42.2%) had been refused, with the remainder awaiting consideration.[113] This trend, whereby a significant proportion of applications were rejected, was broadly replicated across the country. In the same period, Mayo County Council received 910 applications, of which 23 (2.5%) were approved and 88 (9.7%) were rejected, with the other 799 (87%) awaiting consideration.[114] This high rejection rate continued beyond the allowance's first year. In the period from April 1956 to March 1957, 55.8% (3,416) of applications were rejected nationwide.[115] Aside from this rejection rate, contention also arose over how local authorities administered the DPMA

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[110] 'History of the Scheme', 5 November 1953, NAI FIN S72-7-53.

[111] In Cork ambiguity prompted the county manager to grant DPMA to households that were already in receipt of payments from the Department of Social Welfare, including old-age pensions or Widows and Orphans pensions. However, once he realised that he was the only county manager in the state with this approach, the payment was withdrawn. 'Discussion at Cork Corporation Meeting', *Cork Examiner*, 15 June 1955, p. 6.

[112] He condemned their 'miserly and niggardly treatment' of needy applicants. Neil Blaney, *Dáil Debates* 151, 16 June 1955, col. 1494.

[113] 'Dáil Query on Aid for the Disabled', *Irish Press*, 5 May 1953, p. 8.

[114] 'North Mayo Dáil Questions', *Ballina Herald*, 2 April 1955, p. 3.

[115] Seán MacEntee, *Dáil Debates* 175, 27 May 1959, col. 607.

in conjunction with other welfare schemes, as many new recipients of the DPMA found that they now received a reduced rate of other payments such as public assistance, the net effect being that they were left financially worse off than before.[116]

Public assistance was a renamed version of home assistance, itself a direct successor to the 'outdoor relief' offered under the Poor Law.[117] Administered by the local health authorities, in the majority of cases it was intended for short-term emergency relief, but it could be extended beyond a month 'in cases of permanent infirmity of mind or body … provided that every such case shall be reviewed by the board every three months'.[118] In their administration, public assistance payments were also contentious due to the varying practices between different local authorities and the fundamentally opaque criteria for eligibility.[119] This ambiguity was inherent to the payment, as the legislation vaguely tasked each local authority to provide 'such public assistance as shall appear to them to be necessary or proper in each particular case'.[120] These guidelines prompted calls for the standardisation of these payments and the implementation of 'a certain code for the application of home assistance', as Dáil deputies repeatedly complained that the varying approaches of local authorities produced starkly different results across the country.[121] Another key problem with public assistance payments lay in their stigmatised association with the Poor Law. During a debate on the Health Act in April 1953, Fianna Fáil deputy Liam Cunningham detailed how a public assistance payment was the only form of state support available to the disabled person who remained outside institutional care. Yet he noted how many eligible recipients simply refused to apply for the allowance; it remained 'very distasteful to Irish people as it smacked too much of the British regime'.[122] Deputies had repeatedly highlighted failures in the administration of payments (such as home assistance) by local authorities, and now detailed similar complaints when it came to the DPMA. Yet there was a wilful naivety to their approach, as politicians should have expected difficulties from the local authorities; they were known to administer welfare payments in a strict manner, which was unsurprising when half of the

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[116] 'Mr. O'Higgins Stresses the Importance of Specialist Services in Local Areas', *The Irish Times*, 16 June 1955, p. 6.

[117] Government of Ireland, Public Assistance Act 1939; Cousins, *The Irish Social Welfare System*, p. 16.

[118] Ministry of Local Government, *Rules and Regulations for the Administration of Home Assistance* (Dublin, 1924), p. 3.

[119] Ó Cinnéide, *A Law for the Poor*, p. 4.

[120] Government of Ireland, Public Assistance Act 1939, Section 19.

[121] Michael Kennedy, *Dáil Debates* 123, 26 October 1950, col. 309.

[122] Liam Cunningham, *Dáil Debates* 138, 16 April 1953, col. 250; Stephen Coughlan, *Dáil Debates* 214, 11 March 1965, col. 1800.

payment came from the local rates budget.[123] Thus, while this new allowance was an extension of the Department of Health, this expansion occurred in an advantageous manner, as local authorities could be blamed for any failures in its administration.

Efforts to improve the DPMA's administration had a limited impact throughout the 1950s. Aware of the potential adjustment to public assistance rates, the First Secretary of the Department of Social Welfare wrote to local authorities in November 1954 and asked that they 'exercise their discretion in a manner favourable to recipients'.[124] This appeal appeared to have little effect, with the same problem highlighted again in the *Report of the Department of Health 1955–6*, which noted that it was 'evident that some public assistance authorities reduced by a considerable amount the weekly rate of home assistance paid to persons who [also] qualified for [a] Disabled persons [*sic*] allowance'.[125] The prevalence of this practice prompted the introduction of the Home Assistance Order in 1955, which mandated that authorities disregard the first ten shillings of the DPMA when calculating an applicant's means for home assistance.[126] Nonetheless, complaints persisted. Labour deputy John O'Leary outlined some of these issues in June 1955, commenting that 'since these allowances were brought into operation in my county, I have never got as many letters expressing dissatisfaction. The County Councils are sending out from their offices a typed letter to nearly every applicant saying that he or she is not entitled to the allowance.'[127]

Similar concerns continued into the 1960s. At the Select Committee on Health Services (1962), multiple groups raised concerns about the DPMA and the deleterious effect of its administration for applicants.[128] Some local health authorities called for an increase to the allowance to bring it in line with other non-contributory schemes, such as blind or non-contributory old-age pensions, while others sought a set of national guidelines for assessing income levels, or the creation of a national appeals board to address contested applications; in other words they sought to standardise the payment and remove ambiguity over an applicant's eligibility.[129] Indeed, even

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[123] Cousins, *The Irish Social Welfare System*, p. 20.

[124] Letter, First Secretary of the Department of Social Welfare to Public Assistance Authorities, 8 November 1954, NAI FIN S72-7-53.

[125] Department of Health, *Report of the Department of Health 1955–6* (Dublin, 1956), p. 30.

[126] Home Assistance Order (S.I. 85), 1955.

[127] John O'Leary, *Dáil Debates* 151, 21 June 1955, col. 1550.

[128] Barrington, *Health, Medicine and Politics in Ireland*, p. 257.

[129] These recommendations were eventually introduced in 1996, when the payment was transferred to the Department of Social Welfare. *Select Committee on Health Services: Submissions* (Dublin, 1962), Submission Two, p. 2; *Select Committee on Health Services*, Appendix One, p. 206; *Select Committee on Health Services*, Submission Four, p. 12.

the Department of Health acknowledged that, when it came to the DPMA, it received ‘a fairly substantial volume of complaints’.[130]

By 1960 approximately 16,000 people were in receipt of the DPMA. Among them, an estimated 3,500 (22%) were thought to be congenitally intellectually disabled.[131] Discussions surrounding the allowance’s role in the lives of the ‘mentally deficient’ invariably framed the scheme as a vital adjunct to institutional care, particularly given the demand for places in these facilities. Fine Gael’s Joseph McLoughlin noted that the DPMA supported families with the ‘great expense and inconvenience’ associated with caring for a disabled relative. The scheme should expand further, he argued, as otherwise there would be an increased demand for beds in congregate facilities.[132] Yet although the allowance was described as a vital support that allowed a community-based life for the disabled, it was introduced into a welfare system that remained structurally predisposed to limit its scope. The local health authorities, which administered the scheme and bore half of its cost, applied the scheme’s eligibility criteria in a limited manner to curb the expense for local ratepayers, resulting in the rejection of the majority of applicants or the reduction of an applicant’s other welfare payments. To an extent, this was the point. Using the local authorities as scapegoats, TDs could rely on them to introduce the payment in a limited fashion (as they were paying half of the bill) and then blame them for being miserly in their approach.

During the drafting process for what would become the Green Paper *Towards a Full Life* in 1981, Department of Health officials started to question the seemingly illogical differences between the DPMA and the blind pension scheme, which was administered by the Department of Social Welfare. Not only did these schemes have different maximum rates (£38.60 for the blind, £36.45 for the DPMA), but they were available at different ages (18 for the blind, 16 for the DPMA) and were administered by different government departments. In the end officials concluded that the schemes should not be amalgamated into one allowance, mainly due to the estimated cost (£2.4 million a year) of bringing DPMA payments in line with blind pensions, but also because ‘the Department of Health adopts the line that this [ambiguity around the payment] is to their advantage in that it allows

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[130] The committee eventually collapsed due to disagreements between the government and the opposition. Department of Health, *Select Committee on Health Services: Memo from Department of Health Describing the Irish Health Service* (Dublin, 1962), p. 99; Cousins, *The Irish Social Welfare System*, pp. 5–20.

[131] Letter, to the Secretary-General of the Department of Finance, 25 July 1960, NAI FIN S72-7-53; Commission of Inquiry on Mental Handicap, *Report 1965*, p. 33.

[132] Joseph McLoughlin, *Dáil Debates* 195, 10 May 1962, col. 681.

flexibility'.[133] Indeed, there were clear differences between a Department of Health administered payment and its equivalents in the Department of Social Welfare. In 1994, when plans were (finally) announced to move the payment from the Department of Health, the columnist Padraig O'Morain noted the transition as a positive development, as 'say what you like about the Department of Social Welfare but it has clear published rules for things and if you fit in with the rules you get the allowance'.[134] Viewed as a reflection of the 'economic, political, ideological and cultural structures and conflicts in Irish society', the DPMA shows the state's need to do 'something' for vulnerable groups such as the intellectually disabled during the mid-century, a desire that manifested in a financial allowance that provoked instances of praise and criticism.[135] Although a step forward, the payment obviously failed to meet the needs of many 'mentally handicapped' applicants, a failure that was often explained away given the state's inability to excessively intervene in the 'family sphere'.

'Surely the obligation was on them': Limits to Intervention

> it is gravely wrong to take from individuals what they can accomplish by their own initiative and industry and give it to the community, so also it is an injustice and at the same time a grave evil and disturbance of the right order to assign to a greater and higher association what lesser and subordinate organisations can do.
>
> Pope Pius XI, *Quadragesimo Anno* (1931)[136]

Specifically, limitations on statutory intervention were rooted in an understanding of the rights of the family. Article Forty-One of *Bunreacht na hÉireann* outlined an expansive role for the family, acknowledging that the state recognised it as 'the natural primary and fundamental unit group of society and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law'.[137] Similar language was absent from its predecessor, the 1922 Constitution of the Irish Free State,

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[133] 'On merging of DPMA and Blind Pension Schemes', NAI TAOIS 2014-72-10.

[134] Padraig O'Morain, 'Disabled Persons' Maintenance Allowance', *The Irish Times*, 1 February 1994, p. 12.

[135] Cousins, *The Irish Social Welfare System*, p. 10.

[136] Pius XI, *Quadragesimo Anno* (Rome, 1931).

[137] Article 41, *Bunreacht na hÉireann* (Dublin, 2015 [1937]), p. 162.

and has been linked to Taoiseach Éamon de Valera's consultations with the Catholic Archbishop of Dublin, John Charles McQuaid.[138] Indeed, Catholic social policy framed the family in broadly similar terms during the mid-1930s, presenting it as the basic unit of social welfare and suggesting that the state should only intervene in this 'family sphere' at a point when its internal resources were exhausted.[139] Throughout the mid-century, recourse to this social thinking on the family presented a rhetorical bulwark against failures in statutory provision for vulnerable groups, justifying inactivity by the state as a necessary deference to the family's primacy in the lives of the intellectually disabled.

Ruth Barrington suggested that opposition to statutory intervention in Ireland arose from an indigenous effort to apply papal teachings to contemporary social issues.[140] Central to this effort were the concepts of 'subsidiarity' and 'familialism'. First articulated in Pope Pius XI's encyclical *Quadragesimo Anno* (1931), subsidiarity sought to outline the structure of an ideal society.[141] Produced in the midst of totalitarianism, it argued that the state should refrain from providing direct support wherever possible, but could facilitate smaller (subsidiary) organisations (such as voluntary organisations or families) to carry out some tasks.[142] In the *Manual of Social Ethics* (1956) textbook, Fr James Kavanagh outlined a subsidiarist framework; the voluntary sector was the key driver across a range of services, while the organs of the state 'should not supplant them when they can partly do

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[138] Caitriona Beaumont, 'Women, Citizenship and Catholicism in the Irish Free State, 1922–1948', *Women's History Review* 6.4 (1997), pp. 563–7.

[139] See Linda Connolly, 'Locating the Irish Family: Towards a Plurality of Family Forms', in Linda Connolly (ed.), *The 'Irish' Family* (Abingdon, 2015), p. 21; Thomas Mohr, 'Embedding the Family in the Irish Constitution', in Niamh Howlin and Kevin Costello (eds), *Law and the Family in Ireland: 1800–1950* (London, 2017), p. 214; Pauline Conroy, 'From the Fifties to the Nineties: Social Policy Comes out of the Shadows', in Gabriel Kiely, Suzanne Quin, Anne O'Donnell and Patricia Kennedy (eds), *Irish Social Policy in Context* (Dublin, 1999), p. 3; Eugene McLaughlin, 'Ireland: Catholic Corporatism', in Allan Cochrane and John Clarke (eds), *Comparing Welfare States: Britain in International Context* (Milton Keynes, 1993), p. 210.

[140] Barrington, *Health, Medicine and Politics in Ireland*, pp. 143–4.

[141] The encyclical's title translated literally is 'In the fortieth year', and the document is commonly regarded as a review of the major societal trends since the publication of Pope Leo XIII's *Rerum Novarum* in 1891. John Pollard, *The Papacy in the Age of Totalitarianism 1914–58* (Oxford, 2016), p. 244; Ciara Meehan, *A Just Society for Ireland? 1964–87* (Basingstoke, 2013), p. 8; Louise Fuller, *Irish Catholicism since 1950: The Undoing of a Culture* (Dublin, 2003), p. 69; Peter Murray and Maria Feeny, *Church, State and Social Science in Ireland: Knowledge Institutions and the Rebalancing of Power 1937–73* (Oxford, 2016), p. 18.

[142] See Susannah Riordan, '"A Political Blackthorn": Seán Macentee, the Dignan Plan and the Principle of Ministerial Responsibility', *Irish Economic and Social History* 27.1 (2000), pp. 44–62.

things but should supplement their efforts'.[143] In policy terms this meant favouring smaller services over wider provision, while state intervention was 'regarded as merely a first-aid measure'.[144] This clearly aligned with legislative measures such as Section 65 of the 1953 Health Act, which allowed the Department of Health to financially support voluntary organisations to provide their services on behalf of the state. Subsidiarity also aligned with the idea of 'familialism', which prioritised the family unit and framed it as essential for the correct functioning of the state. It viewed the state's role in terms of the family, as it suggested that 'by natural and divine law, the father of the family was bound to maintain his home for himself, his wife and his family'. Mel Cousins found familialist thinking in social welfare debates throughout the mid-twentieth century, where it served to limit the growth of the state. In practice, familialism meant that the state should not try to supplant a (presumed to be male) head of household, 'but should assist him so that he could better meet these obligations.'[145]

Of course, subsidiarity and familialism are both general principles and do not offer an explicit framework for how the state should function at a granular level, only the goals that it should aspire towards. This ambiguity is inherent to much of *Quadragesimo Anno*, as the encyclical 'carefully avoids details and specific applications' of its ideas.[146] Tony Fahey challenged the idea that the Catholic Church shaped the development of welfare services in Ireland, arguing that the hierarchy's concern was much more 'intermittent and unsystematic than is often believed'.[147] Indeed, the Church's position evolved across the mid-twentieth century, so that by the early 1960s the hierarchy 'was more likely to demand rather than decry state intervention' when it came to issues of welfare and poverty.[148] Yet while the Church's role might be overstated, the reappropriation of its social thinking by contemporary politicians was significant. Fianna Fáil was in government for the majority of the period 1947–65, and subsidiarist-inflected ideas are an

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[143] James Kavanagh, *Manual of Social Ethics* (Dublin, 1956), p. 54.

[144] Jerome O'Leary, 'Social Topics', *Christus Rex* VIII.1 (1954), p. 61.

[145] Cousins, *The Birth of Social Welfare in Ireland*, p. 199.

[146] Donal Dorr, *Option for the Poor: A Hundred Years of Vatican Social Teaching* (New York, 1983), p. 80.

[147] Tony Fahey, 'The Catholic Church and Social Policy', in Seán Healy and Brigid Reynolds (eds), *Social Policy in Ireland. Principles, Practice and Problems* (Dublin, 1998), p. 153.

[148] Carole Holohan, 'The Second Vatican Council, Poverty, and Irish Mentalities', *History of European Ideas* 46.7 (2020), pp. 1009–26; Carole Holohan, 'Conceptualising and Responding to Poverty in the Republic of Ireland in the 1960s: A Case Study of Dublin', *Social History* 41.1 (2016), p. 45; John Henry Whyte, *Church and State in Modern Ireland, 1923–1979* (Dublin, 1984), p. 333.

obvious element in the thinking of some of its senior politicians.[149] In a 1961 radio broadcast, Seán MacEntee, who served as Minister for Health from 1957 to 1965, described the party's welfare policy as:

> To foster the spirit of independence and self-reliance in our people. In our social policy we reject all excesses of paternalism, believing that to the best of his ability a man should provide for his own needs. We also recognise however, that there are many who are unable to fulfil this obligation; and these, we hold, must be helped to the extent that our resources will allow.[150]

The application of subsidiarist thinking was particularly apparent in the 1953 'Mental Deficiency' bill, produced in the aftermath of the 'Mother and Child' controversy. Rather than an expansive menu of statutory services, it recommended support for 'mental handicap' institutions, which were (in all but one case) operated by Catholic religious orders.[151] These facilities were owned and managed by religious communities, which would receive statutory funding to carry out their role. This was not statutory care, however, but voluntary services that received departmental funding in recognition of their charitable work. Mary E. Daly characterised the 1953 Health Act as a compromise that operated along this ideological tightrope – between the imperatives of Catholic social teaching and the need to expand health services – a balance that was inextricably tied to the legislation's introduction in the aftermath of a (perceived) public clash between the Catholic Church and the state.[152]

This limited statutory engagement brought clear risks for groups such as the intellectually disabled, who could fall between the gaps in (limited) state services. The death of Veronica L in June 1961 illustrates the impact of these social policy trends on an individual with an intellectual disability.[153] Veronica lived in a flat in Dublin's inner city, which she shared with her mother.[154] Certified as 'mentally deficient', she had received a maximum rate

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[149] There were two breaks in Fianna Fáil governments during the mid-century, for the coalition governments of 1948–51 and 1954–57.

[150] Seán MacEntee, qtd in Feeney, *Seán MacEntee*, p. 210.

[151] 'Memorandum for the Government', 4 December 1953, NAI DT S14129/B; 'Proposed Mental Deficiency Bill', 13 August 1947, NAI TAOIS S12573-B.

[152] Daly, *Sixties Ireland*, p. 232; Government of Ireland, Health Act 1953, Section 65; John Curry, *Irish Social Services* (Dublin, 2003), pp. 200–1; Power, *Landscapes of Care*, p. 136.

[153] Given the personal and upsetting nature of this case, Veronica's surname is not given.

[154] 'Woman of 32 Died of Slow Starvation: Had Disability Allowance', *The Irish Times*, 21 July 1961, p. 11. A more in-depth discussion of Veronica's life, death and coroner's court inquest is contained in David Kilgannon, 'The Death of Veronica L: Intellectual

DPMA (of £1 2s 6d) from the Dublin Health Authority since 1954.[155] At her inquest, the city coroner Dr D. A. MacErlean attributed the young woman's death to a prolonged period of starvation, noting that her 4 foot 10 inch (1.47 m) frame weighed approximately 56 pounds (25.4 kg).[156] Newspaper coverage of the inquest detailed the conditions in Veronica's flat, where there 'was no bed, no cooking utensils, no plates, no cups, no gas and only cold water'.[157] This was confirmed by Garda Sergeant E. P. Murray, who described it as being 'in a filthy condition', while hospital staff noted that Veronica was 'filthy and grossly emaciated … wearing the remnants of two garments, both of which were in shreds'.[158] One witness to the coronial proceedings was the Inquiry Officer from the Dublin Health Authority, who managed her DPMA payment. The officer's testimony to the court described the (virtually non-existent) oversight regime associated with the DPMA, despite this being an allowance that supported vulnerable applicants who had long-term disabilities. The officer noted that she was never allowed into the flat, and instead met Veronica and her mother out on 'the landing' every three months. When questioned further as to why she did not enter the flat, or raise any concerns about Veronica's weight loss, the Inquiry Officer clarified that the general welfare and living conditions of the recipient were simply not her concern: 'the officer's job was merely to check that people receiving [the] allowance were alive'.[159]

The shocking circumstances surrounding this death prompted a discussion of Veronica's case in the Dáil. Fine Gael's Patrick Byrne, from her constituency in inner-city Dublin, raised various questions with the Minister for Health, Seán MacEntee, asking whether the rate of DPMA could be increased or whether the powers of Inquiry Officers could be expanded to investigate the living conditions of the intellectually disabled in the community. In his reply, the minister presented a subsidiarist argument to justify failures by both the Department of Health and the local health authorities in Dublin. First, he rejected many of Byrne's suggestions out of hand, stating that he would not increase the DPMA and that 'any extension

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Disability and Statutory Welfare in Mid Twentieth-century Ireland', *Irish Historical Studies* 45.167 (2021), pp. 81–100.

[155] 'Woman Recluse Died of Slow Starvation', *Irish Press*, 21 July 1961, p. 7.

[156] 'Woman of 32 Died of Slow Starvation', p. 11; Deposition: Dr Cyril Comer, Meath Hospital, 20 July 1961, NAI Coroner's Court Records (hereafter CC), Dublin/1961/118 Veronica L; Deposition: Dr Maurice Hickey, Department of Forensic Science, University College Dublin, 20 July 1961, NAI CC, Dublin/1961/118 Veronica L.

[157] 'Woman Recluse Died of Slow Starvation', p. 7.

[158] 'Woman of 32 Died of Slow Starvation', p. 11.

[159] 'Woman Recluse Died of Slow Starvation', p. 7; Deposition: Inquiry Officer (name on file), 20 July 1961, NAI CC, Dublin/1961/118 Veronica L.

of the range of enquiry [of Inquiry Officers] would be inappropriate'.[160] This prompted critical reactions from both Fine Gael, the main opposition party, and a range of independent TDs. Yet, following this criticism, MacEntee would not concede that there were any failures in the state's support of Veronica, and instead stressed the role of family members in ensuring her welfare. He argued that the state could not, and indeed should not, be expected to address such matters. When it came to the care of the intellectually disabled, he reminded the Dáil that:

> This unfortunate person had a mother, sisters and other relatives. I think the responsibility lay on them to look after her, the community having come to her assistance to the extent of the Disability allowance paid to her … the assumption upon which all our statutes is based, and on which the Constitution is based, is that there is regard to be had of the principles of family responsibility without which we cannot have any communal life at all.[161]

In other words, subsidiarist thinking was used to excuse the death from starvation of a vulnerable woman who was known to her local health authority. For the minister, Veronica's welfare remained a family responsibility, rooted in the expansive territory provided to them under the Constitution. Her receipt of a disability allowance therefore marked the limit of statutory involvement, unless and until the family explicitly ceded her care to the public authorities.[162] Although singular and tragic, Veronica's death provides a striking insight into the limited role occupied by the state throughout this period. Given these extreme circumstances, which included a probable case of prolonged neglect of an adult who was already known to her local health services, MacEntee's intransigence sent a clear message about the role played by the state – a lack of engagement that left the lion's share of responsibility with parents and relatives.[163] Of course, where the individual had a family that was in a position to support a disabled person, this did not pose an issue. In other cases, however, there could be potentially fatal consequences.

In broad terms Irish social policy was oriented towards increased statutory engagement across health and welfare services during the mid-twentieth century.[164] The foundation of a separate department, alongside the Health

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[160] Seán MacEntee, *Dáil Debates* 191, 26 July 1961, col. 1866.

[161] Seán MacEntee, *Dáil Debates* 191, 26 July 1961, col. 1867.

[162] Ibid.

[163] See Kilgannon, 'The Death of Veronica L', pp. 81–100.

[164] Maev-Ann Wren, *Unhealthy State: Anatomy of a Sick Society* (Dublin, 2003), p. 136;

Acts of 1947 and 1953, acknowledged a growing role for the state in the provision of health services. Where health policy operated successfully, as with the praise associated with the introduction of the DPMA, this could be attributed to statutory action and foresight. However, where there was any failure, a subsidiarist argument could be deployed – presenting the issue as simply beyond the state's responsibility, an inevitable result of its need to respect the role of the voluntary sector or the family in Irish life. This benefited the state by limiting costs and keeping service-provision for the intellectually disabled in the realm of charity, rather than entitlement, a dynamic that had clear implications for the disabled person's access to a range of services, including institutional facilities, community accommodation, and day centres. With the Health Act 1953, this reliance on the voluntary sector was formally enshrined in policy. Thus, the Department of Health placed the burden on voluntary organisations to drive the provision of new services for the 'mentally handicapped'. This had clear implications for the state's disability policy and for the development of a range of services across the country, while it remained an influential feature across the disability services' landscape into the twenty-first century.[165]

Conclusion

In its final report, the Commission on Mental Handicap saw little need for specific legislation; any 'Mental Deficiency' Act was simply unnecessary, particularly when this group's needs were already being met via 'general legislation'.[166] Although the idea reappeared periodically, this recommendation held until the introduction of the Disability Act in 2005.[167] This prolonged statutory inaction grants a particular significance to the flurry of reform efforts advanced during the mid-century, when a wide range of reform measures came under consideration. The twin 'Mental Deficiency' bills show the influence of broader trends on this policymaking process, as expansive post-Emergency proposals gave way to a 'necessarily elastic cooperation' between Church and state in the provision of a select number of services just a few years later.[168] Each bill provides a window into

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Cousins, *The Birth of Social Welfare in Ireland*, p. 177; Whyte, *Church and State in Modern Ireland*, pp. 126–7.

[165] Power, *Landscapes of Care*, p. 136.

[166] Their report did acknowledge the need to address a select number of issues via legislation, including guardianship and sheltered employment. Commission of Inquiry on Mental Handicap, *Report 1965*, p. xxiv.

[167] De Wispelaere and Walsh, 'Disability Rights in Ireland', p. 517.

[168] Fanning, *The Quest for Modern Ireland*, p. 143.

what was considered a viable statutory response at that time, while the failure to implement either plan underscores the challenges associated with health reform efforts throughout the financially challenging and ideologically fraught post-war years. The impact of political events, such as the controversy that engulfed the 'Mother and Child' scheme, is also apparent, as the department's reforming zeal clearly deflated in the face of broader pressures going into the early 1950s.

The DPMA, the sole surviving reform measure, was framed as an altruistic expansion of the social welfare system beyond a contribution-based framework.[169] Yet in its implementation, the scheme revealed some of the challenges associated with moving welfare provision beyond the residual vestiges of the Poor Law, while the payment represented (at best) a tentative expansion of the state into the lives of vulnerable groups. Later developments, such as the introduction of the Domiciliary Care Allowance in 1978, continued to reflect a similar statutory trepidation around excessive intervention, with payments that offered limited financial support (£35 a month) to parents who cared for their severely disabled children in the family home.[170] The appearance of subsidiarist-inflected thinking in policy debates shows how the evolution towards greater statutory intervention remained uncertain. At least partly attributable to the appearance of senior political figures in successive cabinets,[171] subsidiarity was a useful rhetorical trope to deflect failures by the state. In the case of Veronica, recourse to blaming her ageing caregiver (and her relatives for failing to seek an institutional placement) provided a ready scapegoat, which simply ignored the limited actions taken by the state when it came to the care of an obviously vulnerable adult who was already known to her local health authorities. For the Minister for Health, the only instance when the state would assume the disabled person's care was in an institutional setting. As we will see in the next chapter, this was a feeble argument and one that posed an entirely different set of challenges for both the intellectually disabled and their families.

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[169] Joseph Lenehan, *Dáil Debates* 207, 5 February 1964, col. 428.

[170] Pauline Conroy, 'Income Maintenance and Social Protection', in *Disability, Exclusion and Poverty: Papers from the National Conference* (Dublin, 1994), p. 91; Mel Cousins, 'Social Security Support for Informal Caring in the Republic of Ireland', *International Social Security Review* 47.2 (1994), pp. 37–50.

[171] During the debate on Veronica L in 1961, for instance, Seán MacEntee was 71 and had served in the cabinet for over twenty years.

2

Institutional Accommodation, 1947–65

On 21 May 1956 the International Hospital Federation embarked on a ten-day, 170-person study tour of Ireland.[1] John Dodd, the honorary secretary of the British Hospital Contributory Schemes Association, provided a detailed account of the group's journey across the country. Dodd was clearly impressed as he outlined their hectic itinerary, which included visits to a wide variety of hospitals, sanatoria, residential institutions, and geriatric services. The scale of this new Irish infrastructure was particularly notable, he stressed, as many of the facilities they visited were 'so amazing that Americans in the party said that America could not afford to build so ample accommodation' for its patients.[2] This praise was understandable given the extent of post-war construction efforts, which had precipitated a period of 'substantial and at times even spectacular' expansion in the state's healthcare infrastructure.[3] When it came to hospitals it resulted in a national network of 7.2 inpatient beds per 1,000 people in 1960, a capacity higher than either Northern Ireland (5.5) or England and Wales (4.3).[4] Added to this, there were new county-level dispensary facilities, sizeable growth in tuberculosis sanatoria, and plans for a regional network of specialist cancer services.[5] Within this already considerable expansion programme, the Irish Hospitals' Trust also acknowledged its goal of providing 'further beds for

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[1] International Hospital Federation, *Report of the Study Tour of Hospitals in Ireland, May 21st–31st 1956* (London, 1956), p. 3.

[2] John Dodd, *Éire Hospitals and Health Services* (Bristol, 1957), p. 6.

[3] Department of Health, *Health Progress 1947–1953* (Dublin, 1953), p. 3; Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900–1970* (Dublin, 1987), p. 137; Hospitals' Commission, *Seventh General Report 1945–7* (Dublin, 1948), p. 22; Noël Browne, *Against the Tide* (Dublin, 1986), pp. 113–14; Greta Jones, '*Captain of All These Men of Death': The History of Tuberculosis in Nineteenth and Twentieth Century Ireland* (Amsterdam, 2001), p. 219.

[4] Consultative Council on General Hospital Services, *Outline of the Future Hospital System: Report of the Consultative Council on General Hospital Services* [Fitzgerald Report] (Dublin, 1968), p. 49.

[5] Department of Health, *Health Progress 1947–1953*, p. 3.

mental defectives'; a target that fuelled a sizeable increase in places within specialist institutions nationwide, which more than tripled from approximately 800 in 1939 to 2,620 by 1960.[6]

This expansion coincided with broad shifts to the social policy philosophies surrounding public health and welfare services.[7] Geoffrey Finlayson and Martin Gorsky, for instance, have both framed the mid-twentieth century as a pivotal period of change for the state and the voluntary sector in health provision; a shift that was marked by increased statutory engagement in many countries, exemplified by the creation of the UK National Health Service (NHS) in 1948.[8] This was also a significant period for the health system in Ireland, although it did not result in a comparable level of statutory expansion. The Health Acts of 1947 and 1953 gave a larger remit to the Department of Health and increased public access to hospital-based services.[9] Yet voluntary organisations retained a significant role, perpetuating their long-standing engagement with the state.[10] Examining intellectually disabled populations across three forms of residential institution – county homes, district mental hospitals, and specialist centres – reveals the impact of the state's limited approach throughout the mid-century, as residential services remained characterised by instances of deficient care and the maintenance of established practices. This contradicted the Department of Health's (stated) aspiration to address the needs of this group, while it perpetuated a network of services that could fail the intellectually disabled and their families.[11]

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[6] Irish Hospitals' Trust, *Ireland's Hospitals 1930–1955* (Dublin, 1956), p. 27; Barrington, *Health, Medicine and Politics in Ireland*, p. 165; Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 5.

[7] Chris Renwick, *Bread for All: The Origins of the Welfare State* (London, 2018), pp. 1–5; Stein Kuhnle and Anne Sander, 'The Emergence of the Western Welfare State', in Francis G. Castles, Stephan Leibfried, Jane Lewis, Herbert Obinger and Christopher Pierson (eds), *The Oxford Handbook of the Welfare State* (Oxford, 2012), pp. 61–80; Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (London, 1997), pp. 640–3.

[8] Martin Gorsky, 'Voluntarism in English Health and Welfare', in Donnacha Sean Lucey and Virginia Crossman (eds), *Healthcare in Ireland and Britain from 1850: Voluntary, Regional and Comparative Perspectives* (Abingdon, 2014), p. 57; Geoffrey Finlayson, *Citizen, State and Social Welfare in Britain* (Oxford, 1994), p. 275.

[9] Mary E. Daly, *Sixties Ireland: Reshaping the Economy, State and Society, 1957–73* (Cambridge, 2016), p. 232.

[10] Mary E. Daly, '"An atmosphere of sturdy independence": The State and Dublin Hospitals in the 1930s', in Elizabeth Malcolm and Greta Jones (eds), *Medicine, Disease and the State in Ireland 1650–1940* (Cork, 1999), p. 235; John Sweeney, 'Attitudes of Catholic Religious Orders towards Children and Adults with an Intellectual Disability in Post-colonial Ireland', *Nursing Inquiry* 17.2 (2010), pp. 95–110.

[11] Seán MacEntee, 'Memorandum: Local Government and Public Health (Delegation of Ministerial Functions) Order', 22 March 1944, University College Dublin Archives (hereafter UCDA), MacEntee Papers P67/253.

‘Housing a miscellaneous population’: County Homes

> The other children were in a dayroom which looked equally unkempt and neglected, a ‘bad’ low-grade (female) mental defective was eating bread which was being shared by the toddlers from the floor which was far from clean … Altogether, it was a very distressing sight … [The matron] pointed out that the care of invalid children and low-grade defectives was very time absorbing, [and] that there were fewer unmarried mothers now in institutions than in the past to assist.
>
> Margaret Reidy, Inspection of Tipperary North County Home (1958)[12]

Writing to a health official in 1949, the RMS of a psychiatric hospital in Waterford resisted pressure to admit a young ‘mental defective child’ to his institution. Could the boy be placed elsewhere, he asked, reminding the official that ‘there was always an idiot ward in the county home’.[13] The doctor’s statement was supported by statistics: an estimated 1,100 ‘mental defectives’ continued to live across the county home system in 1965, a long-established resident population that the Department of Health was clearly aware of but did little to address.[14] County Homes were the ageing remnants of the Victorian workhouse system, facilities that had traditionally served as ‘safety-net’ institutions for those in chronic need, housing a whole ‘range of human infirmity and deprivation’ since their foundation in the mid-nineteenth century.[15] Admission to the Poor Law workhouse operated under the Poor Relief (Ireland) Act 1838 and the *General Order for Regulating the Management of Workhouses and the Duties of Workhouse Officers* (1849), which stipulated that necessitous applicants could enter these facilities to receive ‘indoor relief’ (food and accommodation).[16] The requirement to

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[12] Margaret Reidy, qtd in Mother and Baby Home Commission, *Final Report of the Commission of Investigation into Mother and Baby Homes* (Dublin, 2021), chapter ten, p. 35.

[13] RMS Waterford, ‘Letter’, qtd in Annie Ryan, *Walls of Silence: Ireland’s Policy towards People with a Mental Disability* (Kilkenny, 1999), pp. 22–3.

[14] Commission of Inquiry on Mental Handicap, *Commission on Mental Handicap: Report 1965* (Dublin, 1965), p. 111.

[15] Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Dublin, 1986), p. 202.

[16] Virginia Crossman, *Poverty and the Poor Law in Ireland, 1850–1914* (Liverpool, 2013), p. 111; Bairbre Redmond and Anna Jennings, ‘Social Work and Intellectual Disability: A Historical Overview’, in Noreen Kearney and Caroline Skehill (eds), *Social Work in Ireland: Historical Perspectives* (Dublin, 2005), p. 108.

admit all those in need meant that they commonly operated on the principle of deterrence, with living conditions that were intentionally inferior to those outside the institution.[17]

Regardless, the intellectually disabled entered workhouses in considerable numbers throughout the nineteenth century; a return from 1878 estimated that there were 1,655 'idiots, [and] imbeciles' housed in Poor Law facilities across the country.[18] Following the foundation of the Irish Free State, these publicly maligned institutions were renamed 'county homes'.[19] Aside from this change, these county-level facilities inherited 'residual and insurmountable' problems from their Poor Law predecessors, including a physically ailing infrastructure and a heterogeneous population of residents unwanted by other institutions; a grouping that commonly included the aged, the infirm, the sick, unmarried mothers, the physically disabled, epileptics, and the intellectually disabled.[20] Indeed, the 1927 Commission on the Relief of the Sick and Destitute Poor demonstrated the continuity of life in workhouses under an Irish government, as these institutions continued to operate under a system 'redolent of the poor law'.[21] The county home in Sligo, St John's, has the only complete set of post-independence county home records held by the National Archives of Ireland.[22] Its registers commonly list terms such as 'mental infirmity' or 'mental deficiency' when accounting for a resident's arrival, grouped under the broad rubric of 'Lunatics, insane persons and idiots'.[23] Records from 1970–72, for instance, include five admissions in this category during April 1970 alone.[24]

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[17] Donnacha Seán Lucey, *The End of the Irish Poor Law? Welfare and Healthcare Reform in Revolutionary and Independent Ireland* (Manchester, 2015), p. 27; John Curry, *Irish Social Services* (Dublin, 2003), p. 12.

[18] *Return of Average Number of Pauper Children, Idiots, Imbeciles and Harmless Lunatics in Union Workhouses in Ireland* (London, 1878), p. 5, http://www.dippam.ac.uk/eppi/documents/16614/eppi_pages/442444 (accessed 12 April 2018).

[19] Government of Ireland, Local Government (Temporary Provisions) Act 1923.

[20] Lucey, *The End of the Irish Poor Law?*, pp. 152–61; Department of Health, *First Report of the Department of Health* (Dublin, 1949), p. 62; Paul Michael Garrett, 'Excavating the Past: Mother and Baby Homes in the Republic of Ireland', *The British Journal of Social Work* 47.2 (2017), pp. 358–74.

[21] *Report of the Commission on Relief of the Sick and Destitute Poor including the Insane Poor* (Dublin, 1927), p. 62; Brendan Hensey, *The Health Services of Ireland* (Dublin, 1979), p. 22.

[22] Brian Donnelly, 'Hospital Records in the National Archives of Ireland', *Journal of the Irish Society for Archives* (Winter 2008), p. 2.

[23] Indoor Register, April 1960–March 1962, p. 20, National Archives of Ireland (hereafter NAI) BR/97/40/B/25; Indoor Register, April 1968–March 1970, p. 52, NAI BR/97/40/B/29; Indoor Register 1970–72, p. 1, NAI BR/97/40/B/30.

[24] Ibid.

Yet by 1950 it was already well established that county homes were not suitable as accommodation for the intellectually disabled. The *Second General Report of the Hospitals Commission* (1937) clearly stressed the need to transfer 'mental defective populations' elsewhere. This was important, as other institutions 'succeed[ed] in having a considerable number of these cases better cared for' than was possible within the mixed population of a county facility.[25] During an inspection of the Tipperary North County Home in 1958, for instance, an inspector found children lying in cots unsupervised. These included 'two invalids' who had spina bifida and hydrocephaly. They were lying on bare mackintoshes, and it appeared to the inspector 'that quite a time had elapsed from when they were given care last'.[26] Alongside this lack of care staff and specialised support, there were also concerns around the physical conditions in some homes, which rendered them unsafe as housing for vulnerable populations. The *First Report of the Department of Health* (1949) revealed the 'far from satisfactory' living conditions in these centres, while that same year the Interdepartmental Committee on County Homes raised extensive concerns about daily life in these centres.[27] It detailed how residents:

> often seem such a part of their environment that it is difficult to decide whether they looked as they did because they lived in the county homes or whether the county homes take the tone and appearance of inmates … [most] look apathetic and listless … [they] seem to lack interest in their surroundings. They sit in the day room motionless and often silently waiting for the next meal or for bedtime.[28]

This internal report was not published, but even the 1951 White Paper raised a range of concerns about life in these facilities; it criticised accommodation that was often 'cheerless and badly furnished', while they also commonly had unappetising food, a lack of furniture, and poor lighting.[29] During her visit to Stranorlar County Home in February 1949, the inspector Alice Litster encountered three suspected cases of 'mental deficiency'. Two of these children resided in 'the hut', a long wooden outbuilding in the yard, where the room was 'stuffy and

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[25] Ryan, *Walls of Silence*, p. 29.

[26] Mother and Baby Home Commission, *Final Report of the Commission*, chapter ten, p. 35.

[27] Department of Health, *First Report of the Department of Health*, pp. 62–6.

[28] Interdepartmental Committee, 'Report of the Interdepartmental Committee appointed to examine the question of the Reconstruction and Replacement of the county homes' (Dublin, 1951), p. 1, NAI Department of the Taoiseach (hereafter DT) 3/S14472 B.

[29] Department of Health, *White Paper on the Reconstruction and Improvement of County Homes* (Dublin, 1951), p. 10.

unpleasant' with a 'strong odour of humanity'. In the same facility other children had scabies, some couldn't walk, one had a prolapsed rectum and there were multiple 'not healthy looking children'.[30] Understandably, the 1951 White Paper concluded that, when it came to the intellectually disabled, 'every effort should be made to remove [them]' from these facilities.[31] Yet reform efforts remained limited; identical complaints (about unsuitable conditions and the need to move the intellectually disabled elsewhere) persisted into the mid-1960s.[32] During a Lions Club address in 1964, Lt. Col. Joseph Adams, honorary secretary of the National Association of the Mentally Handicapped of Ireland (NAMHI), condemned the state for continuing to house the intellectually disabled in county homes. These centres could not (and should not) house the 'mentally handicapped', Adams argued, as they lacked specialist support and maintained a mixed population of residents, which made them clearly 'unsuitable to … [the] requirements' of the disabled.[33] This was obviously the case at facilities across the country. Visiting Thomastown County Home in Kilkenny in 1960, Margaret Reidy saw a 'mentally defective' boy who she recalled from a previous visit. He remained on a waiting list for admission to a specialist institution, but had deteriorated considerably, so much so that he was now 'distressing to look at'. Despite this boy, Reidy nonetheless concluded that children were being 'adequately cared for' at the facility.[34]

Just as legislative reforms foundered in the face of competing priorities, breaking an established practice remained a challenge within a health system that was already undergoing significant change across many other areas.[35] Indeed, the Department of Health's emphasis on certain services, such as TB sanatoria and acute hospitals, arguably precluded addressing other issues of concern, including the care provided in county homes.[36] The general public

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[30] Mother and Baby Home Commission, *Final Report of the Commission*, chapter twenty-nine, p. 21.

[31] These descriptions of a 'typical' county home were removed due to concerns in the Department of Finance about negative press coverage. Shane Kilcommins, *Crime, Punishment, and the Search for Order in Ireland* (Dublin, 2004), p. 79; Department of Health, *The Reconstruction and Improvement of County Homes* (Dublin, 1951), pp. 9–10, 13.

[32] 'County Home System Archaic, Says Doctor', *Irish Independent*, 13 September 1963, p. 12; 'The State's Role in National Development', *Irish Press*, 1 March 1966, p. 8.

[33] 'The Mentally Handicapped', *Irish Press*, 8 October 1964, p. 10.

[34] Mother and Baby Home Commission, *Final Report of the Commission*, chapter thirty, p. 17.

[35] Mairéad Considine and Fiona Dukelow, *Irish Social Policy: A Critical Introduction* (Dublin, 2009), p. 219; Lindsey Earner-Byrne, *Mother and Child: Maternity and Child Welfare in Dublin, 1922–60* (Manchester, 2007), pp. 120–44; Barrington, *Health, Medicine and Politics in Ireland*, p. 137; Mary E. Daly, *Sixties Ireland: Reshaping the Economy, State and Society, 1957–1973* (Cambridge, 2016), p. 232.

[36] National Health Council, *Report of the National Health Council for the Year Ended 31st March 1971* (Dublin, 1971), p. 8.

were well aware of the limited care and poor physical conditions available in many of these facilities. In the 1920s local officials had openly criticised and called for the closure of ailing county homes, the former workhouse in Tralee was openly derided as a 'struggling and miserable place'.[37] This rhetoric continued throughout the early decades of political independence, with seemingly little optimism that these centres could ever be reformed.[38] Fundamentally, the Poor Law workhouse remained the institutional provider of 'last resort', used only due to a lack of alternatives.[39]

From the 1950s changes were noted at some county homes, with capital budgets allocated for the improvement of residents' living conditions.[40] This reform effort was compounded by Minister MacEntee's plan to renovate these facilities, with plans to create 'geriatric homes for elderly people in bright surroundings … where they would not be regarded as paupers'.[41] Yet this 'reform' process remained slow.[42] Notwithstanding these plans, in 1965 the Commission on Mental Handicap repeated a well-established plea when it called on the Department of Health to remove the intellectually disabled, except in cases of elderly residents 'who have been in such homes for a long time and whose removal at this stage would create undue upset'.[43] The local county home was an obviously undesirable option, as it offered limited care in poor conditions. Nonetheless, these facilities continued to serve a purpose by admitting all those in need, which included some 'mental defectives'. The persistence of this practice hints at broader problems around both the capacity of specialist residential accommodation to meet demand and the absence of support for the intellectually disabled in the wider community during the mid-twentieth century. Although admission to a county home was based on necessity, it was not assured that the 'mentally deficient' would remain in these mixed facilities for very long. If behavioural issues were a concern, placement in the local psychiatric hospital was another possibility.

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[37] Kate Breen, qtd. in Lucey, *The End of the Irish Poor Law?*, p. 157.

[38] During a Dáil debate in 1970, for instance, Noël Browne openly dismissed the idea of ever changing the county home network, arguing that the Victorian-era roots of these centres meant that 'they were intended to be punitive, soul-destroying, demoralising institutions … to humiliate and degrade anybody going into them'. Browne raised these concerns during a debate on the 1970 Prisons Act. Noël Browne, *Dáil Debates* 247, 26 May 1970.

[39] Crossman, *Poverty and the Poor Law in Ireland*, p. 30; Gerard Fealy, *A History of Apprenticeship Nurse Training in Ireland* (Abingdon, 2006), p. 11.

[40] Mother and Baby Home Commission, *Final Report of the Commission*, chapter ten, pp. 18–19.

[41] 'Government Plans Geriatric Homes', *Cork Examiner*, 26 February 1964, p. 5.

[42] This was unsurprising given the challenge associated with renovating a nationwide network of institutions and the lack of places available to house groups such as those with disabilities elsewhere.

[43] Commission of Inquiry on Mental Handicap, *Report 1965*, p. xviii.

‘Those whom nobody wants to take’: Psychiatric Institutions

> The uphill struggle to modernise these hospitals, to relieve overcrowding and to achieve a satisfactory standard continues, but there is still a long way to go before our services can be regarded as adequate.
>
> Dr Vincent Dolphin (1960)[44]

The Commission on Mental Handicap (1965) acknowledged the role played by district mental hospitals in accommodating the intellectually disabled who presented with challenging behaviour, noting how they commonly housed ‘those whom nobody wants to take, but whose needs are very great’.[45] *The Problem of the Mentally Handicapped* (1960) estimated that there were at least 2,000 ‘mental defectives’ across the mental hospital network nationwide, which meant that the intellectually disabled occupied more than 10% of the state’s psychiatric inpatient beds.[46] As with county homes, this practice emerged in the early nineteenth century during the creation of these institutions.[47] Following a visit to Ballinasloe Asylum in Galway in 1833, an assistant commissioner for Whateley’s Commission (The Royal Commission on the Poorer Classes in Ireland) opposed the foundation of further ‘lunatic’ asylums in Ireland. It was a futile effort, the Commissioner argued; the state should abandon these projects as they were not being used to house the mentally ill, instead officials were engaged in ‘erecting palaces for the permanent accommodation of slavering and worthless idiots’.[48] Indeed, the Victorian-era asylum clearly struggled in the face of requests to admit ‘incurable patients’.[49] Catherine Cox demonstrated that hospital committees were concerned by the impact of the admission of those with long-term needs

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[44] Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1960* (Dublin, 1961), p. 10.

[45] Ibid., p. 15.

[46] Department of Health, *The Problem of the Mentally Handicapped*, p. 5; Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1960*, p. 14; Dermot Walsh, ‘Delivery of Psychiatric Care to Those Mentally Ill in Ireland: Proposals for Change’, *Journal of the Statistical and Social Inquiry Society of Ireland* 25.5 (1988), p. 153.

[47] Sweeney, ‘Attitudes of Catholic Religious Orders’, p. 105; Damien Brennan, ‘A Theoretical Exploration of Institution-based Mental Health Care in Ireland’, in Pauline M. Prior (ed.), *Asylums, Mental Health Care and the Irish: 1800–2010* (Dublin, 2012), p. 287; Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland* (Newbridge, 2016), p. 126.

[48] Robins, *Fools and the Mad*, p. 159.

[49] Brennan, ‘A Theoretical Exploration of Institution-based Mental Health Care’, p. 287; Mark Finnane, *Insanity and the Insane in Post-famine Ireland* (London, 1981), p. 34.

to asylums; a contemporary observer described how this practice had precipitated a change at some facilities, which had become 'domiciles for incurable lunatics to the exclusion and serious detriment of acute cases'.[50] These patterns continued into the early twentieth century. The 1927 Commission discussed the practice of 'handicap' admissions as one of the many roles played by the (newly renamed) district mental hospitals, where beyond the treatment of acute mental illness they also housed those 'who have been medically certified as either dangerous lunatics or idiots'.[51]

Yet, unlike county homes, the need to reform psychiatric institutions was acted upon as a matter of concern by the new Department of Health.[52] The first substantive attempt at reform in the twentieth century was the 1945 Mental Treatment Act. This legislation replaced the 1867 Dangerous Lunatics Act and initiated a range of reforms to the state's mental hospitals, including changes in terminology ('patient' instead of 'inmate'), expanding outpatient provision, and creating a voluntary admissions process.[53] It also introduced a shift in power. Previously, a committal had involved magistrates (later peace commissioners) who authorised a doctor's certificate of admission. Under the new legislation, admission was on foot of a clinical decision alone.[54] This consolidated medical authority in the hospital, as doctors alone now determined who resided in the facility.

Notwithstanding this, clear limits remained to medical influence in the facility, as 'handicap admissions' continued throughout the mid-century. This was due to the long-standing use of the 'asylum' as housing for challenging individuals who could not be accommodated elsewhere. In his memoir *Music and Madness* (2008) Dr Ivor Browne, former chief psychiatrist of the Eastern Health Board, described the mid-century 'mental hospital' as an environment that was not simply a curative institution for those with acute psychiatric illnesses, but also a form of long-term sheltered housing for a heterogeneous population of 'those for whom society had no place [and] are dumped to get them out of sight – the aged, the mentally retarded, the

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[50] Catherine Cox, *Negotiating Insanity in the Southeast of Ireland, 1820–1900* (Manchester, 2012), pp. 174–5.

[51] *Commission on Relief of the Sick and Destitute Poor*, p. 101.

[52] Tom Feeney, *Seán MacEntee: A Political Life* (Dublin, 2009), p. 157.

[53] Elizabeth Malcolm, '"Ireland's crowded madhouses": The Institutional Confinement of the Insane in Nineteenth and Twentieth-century Ireland', in Roy Porter and David Wright (eds), *The Confinement of the Insane: International Perspectives, 1800–1965* (Cambridge, 2003), p. 328; Brendan Hensey, *The Health Services of Ireland* (Dublin, 1979), p. 25; Brendan Kelly, 'Mental Health Law in Ireland, 1945 to 2001: Reformation and Renewal', *Medico-Legal Journal* 76.65 (2008), p. 66.

[54] Patricia Casey and Ciaran Craven (eds), *Psychiatry and the Law* (Dublin, 1999), p. 458; Brendan D. Kelly, 'The Mental Treatment Act 1945 in Ireland: An Historical Enquiry', *History of Psychiatry* 19.1 (2008), pp. 47–67.

epileptic, the disturbed'.[55] Clearly, Victorian-era admission practices had persisted well into the following century. Indeed, while anecdotal, there is varied evidence of psychiatric hospitals being used to house potentially 'troublesome' individuals away from wider society. A nurse who worked at the St Columba's hospital in Sligo during the mid-1960s admitted that 'it was no secret that many that went to St. Columba's were social cases – an old person or someone the family couldn't get on with'.[56] Similarly, Dr Maurice Guéret recalled how his grandfather, the RMS of the Central Mental Hospital in Dundrum, was compelled to admit the notorious abortion provider Mary Anne 'Mamie' Cadden in the 1950s, despite the (clinically inconvenient) fact that 'she had no mental illness' to speak of.[57] Although the hospital was increasingly framed as a medicalised environment that housed the mentally ill, these centres clearly retained their long-standing ancillary role as accommodation for a miscellaneous collection of 'the poor, the eccentric, the socially troublesome, the vulnerable and the unwanted'.[58]

Reliance on psychiatric accommodation was augmented by public demand, particularly when an intellectually disabled person presented with behavioural issues. Hospital committee minutes note the reluctance of governing boards to admit 'mental defectives' to their institutions but justify their inclusion due to the lack of alternative forms of secure accommodation. In June 1948 the Grangegorman and Portrane Mental Hospital Board discussed the twelve patients under the age of 16 in their facility, explaining that 'all these cases are suffering from Mental Deficiency of varying grades, from idiocy to imbecility'.[59] Committee minutes from Grangegorman in 1949 similarly emphasised how the hospital offered secure institutional accommodation for vulnerable disabled children, with the result that:

> There are six mental defectives seven years of age or under and nine between the ages of 8 and 15 … All are suffering from low-grade mental deficiency, some with epilepsy, some with complete lack of control of natural habits and some extremely mischievous and restless. These little patients had to be admitted because it was represented that there was no alternative accommodation and no means of managing them in their home. The only way in which these children could be

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[55] Ivor Browne, *Music and Madness: A Personal Journey* (Cork, 2008), p. 139.

[56] A. Jamie Saris, 'Mad Kings, Paper Houses, and an Asylum in Rural Ireland', *American Anthropologist* 98.3 (1996), p. 548.

[57] Brendan D. Kelly, 'Searching for the Patient's Voice in the Irish Asylums', *Medical Humanities* 42.2 (January 2016), p. 89.

[58] Eilís Ward, 'Foreword', in Hanna Greally, *Bird's Nest Soup* (Cork, 2008 [1971]), p. xiv.

[59] Grangegorman Hospital Joint Committee, 'Meeting Minutes: 17 June 1948', p. 314.

> treated in this Hospital was by scattering them through the adult wards.[60]

In 1956 alone, fifteen children under the age of 10, and thirty-three between the ages of 10 and 14, were committed to district mental hospitals in Ireland – the majority likely due to a congenital cognitive impairment.[61] Assessing these trends, Fiachra Byrne has suggested that Grangegorman Mental Hospital in Dublin served as a form of emergency accommodation for parents, utilised when home care was no longer possible for a child with behavioural issues; the hospital was an emergency 'salve to conflicts within families'.[62]

It remains challenging to give specific examples of 'handicap admissions' to the psychiatric system.[63] Notwithstanding this, the unusually detailed record of one young boy in Limerick demonstrates the role played by the psychiatric hospital as a venue for the intellectually disabled person with 'challenging' behaviour. 'Gerry' was a 7-year-old 'mute child' when admitted to Limerick District Mental Hospital in 1946.[64] The hospital RMS sought the National Inspector of Mental Hospitals' advice about the boy's care and, in doing so, provided a history of the child's previous accommodation. He originally entered his local county home in Limerick, before being sent to the St Vincent's home in Dublin, operated by the Daughters of Charity of St Vincent de Paul. He soon returned to the county home in Limerick, following complaints about his 'mischievous' behaviour in St Vincent's. In the county home Gerry found himself in further trouble; one report described him as 'violent and bites and spits when restrained and [repeatedly] attempted to get through windows'.[65] It was this behaviour that prompted his admission to the local psychiatric hospital. The RMS was obviously concerned for this young boy. In his letter to the Inspector

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[60] John Dunne, qtd. in Grangegorman Hospital Joint Committee, 'Meeting Minutes: 20 October 1949', p. 258.

[61] Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1956* (Dublin, 1957), p. 63; Fiachra Byrne, 'Madness and Mental Illness in Ireland: Discourses, People and Practices: 1900–60', PhD thesis, University College Dublin, 2011, p. 250.

[62] Byrne, 'Madness and Mental Illness in Ireland', p. 252.

[63] Further discussion of these issues is available in B. D. Kelly, 'Intellectual Disability, Mental Illness and Offending Behaviour: Forensic Cases from Early Twentieth Century Ireland', *Irish Journal of Medical Science* 179 (2010), p. 409.

[64] A pseudonym has been used, but one that retains this boy's initial so that others can trace the discussion of these records. RMS Limerick to Inspector of Mental Hospitals (Joseph Kearney), 8 November 1946. Previously filed under NAI HLTH L50/2 Vol. 2. Viewed by private appointment at the Records Management Unit (hereafter NMU), Department of Health, Hawkins House, 5 April 2017.

[65] Ibid.

of Mental Hospitals, he detailed efforts to send Gerry elsewhere, including an attempt 'to have him admitted to the stuart [*sic*] institute and also to St. Augustine's colony Blackrock, but both were unable to receive him'.[66] The Inspector's response was disheartening. The boy's situation appeared to be quite unexceptional, as he simply recommended that the RMS continue to contact specialist institutions but that, until sent elsewhere, Gerry should be accommodated on an appropriate ward within the hospital. While this was understood as an obviously undesirable practice, the lack of urgency in this singular exchange underscores the prevalence of 'handicap' admissions to psychiatric institutions throughout this period.[67] For a child such as Gerry, described as too 'troublesome' for either a county home or a specialist institutional place, there were simply no other options.

Similar practices occurred across the country, when doctors highlighted their obligation to admit (often significant numbers of) the 'mentally handicapped' into facilities that were ill-equipped to care for them. The RMS of St Brigid's Hospital in Ballinasloe, Dr John O'Shea, underlined that it 'was not a hospital for mental defectives'. Nonetheless, he stated that it housed 145 intellectually disabled residents in 1961, who once admitted 'remain permanently in the hospital, keeping up the population. Recently we had to accept a three and a half year old.'[68] Several hospitals tried to formalise their practice of admitting the intellectually disabled, with proposals to establish disability-specific 'handicap' wards. The idea was discussed in 1956 at St Ita's Hospital in North Dublin, while in the early 1960s Youghal Mental Hospital proposed taking young men who 'could not be handled or treated any longer' at the Brothers of Charity centre in Lota. This effort to 'free up' beds in a specialist institution would result in the young men from Lota entering a psychiatric facility that already housed twenty intellectually disabled children, the youngest of whom was six and a half.[69] At a 1959 meeting of the National Health Council, the An Bord Altranais (Irish Nursing Board) representative outlined his experience as a psychiatric nurse and emphasised to the council how 'he was appalled at the lack of accommodation for the treatment of such children, across the country, with the results [*sic*] that in the institution in which he worked he was aware of ten children who were mixing with adult mental patients'.[70]

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[66] Ibid.

[67] Ryan, *Walls of Silence*, p. 41.

[68] John Shea, qtd in 'Scarcity of Doctors for Mental Hospital', *Leitrim Observer*, 10 June 1961, p. 1.

[69] Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1956*, p. 34; 'Proposed Transfer of Mental Defectives from Lota', *Cork Examiner*, 29 May 1962, p. 6.

[70] The National Health Council was a consultative group that advised the Minister for Health. National Health Council, 'Meeting Minutes: 20 March 1959', p. 3.

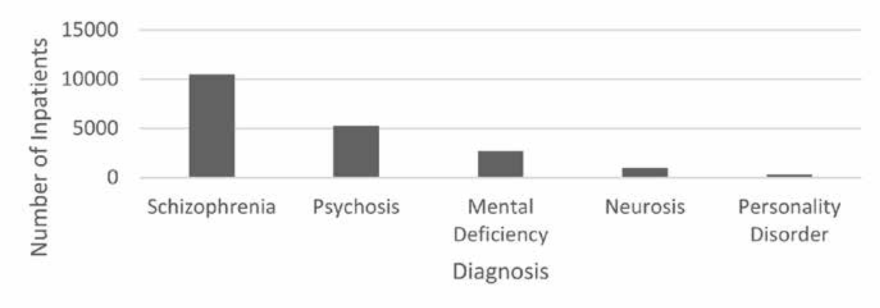

Figure 2.1: Population of the Irish psychiatric hospital system, 1963.
Source: Dermot Walsh, *The 1963 Irish Psychiatric Hospital Census* (Dublin, 1971), p. 5.

St Columba's Hospital in Sligo is the only psychiatric institution that has a complete set of admissions registers in the National Archives, covering the period from its opening in 1855 to the late twentieth century.[71] Registers from the late 1940s onwards, although periodically blank, frequently note the admission of 'mentally deficient' patients. There are cases where the intellectually disabled arrived at St Columba's before moving on to a specialist institution. 'John', for example, was admitted to the hospital in August 1948 as a 'congenital mental defective' before his transfer to St Augustine's, the St John of God centre in Blackrock, Dublin.[72] By contrast 'Peter', described on the admission register as 'was never right in his mind', spent the remainder of his life in the institution.[73] Of course, we cannot speak definitively about the resident population in any mid-century psychiatric hospital, due to the evolving nature of diagnostic practices and inconsistencies in their records.[74] Yet the relatively comprehensive registers maintained at St Columba's reveal the periodic admission of patients due to 'mental deficiency', or an analogous term, throughout the latter decades of the twentieth century. Often the intellectually disabled constituted a considerable proportion of the hospital's overall admissions in a given period.[75]

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[71] Donnelly, 'Hospital Records in the National Archives of Ireland', p. 1.

[72] Pseudonyms have been used for these registers, but ones that retain the same initials so that others can trace the discussion of these records. 'Register of Admissions', p. 6, NAI SL 1184/3/4.

[73] Peter died from pneumonia, three years after his admission. 'Register of Admissions', p. 16, NAI SL 1184/3/4.

[74] Kelly, 'Intellectual Disability, Mental Illness and Offending Behaviour', p. 409.

[75] For example, during the first three months of 1950 the hospital admitted seven patients under this rubric alone, representing 14% of admissions to the facility. 'Register of Admissions', pp. 23–4, NAI SL 1184/3/4.

The Department of Health was well aware of these 'handicap admissions' to psychiatric institutions. The National Inspector of Mental Hospitals repeatedly highlighted the scale of this population in his annual reports, while the need to reform these institutions was listed as a department priority from 1947.[76] Yet this practice, and the poor living conditions available within the psychiatric system, remained a concern throughout the mid-century.[77] An inspection of St Senan's in Enniscorthy described cramped living conditions that 'extended to every department' of the hospital, while in Ardee the 'overcrowding was evident on both sides of this institution … in some dormitories it was necessary to include an extra row of beds each night which had to be removed each morning'.[78] These concerns were vividly outlined in Ivor Browne's memoir. He recounted his first visit to Grangegorman (St Brendan's) in 1959, which was then the largest psychiatric hospital in the state. At that time, he noted, 'many of the wards … had upwards of a hundred patients in them'.[79] Understandably, this fostered less than ideal conditions for both staff and patients. Browne detailed how, on the evening of his first visit, 'there were crowds of patients all jostling each other, some of the women with their dresses pulled up over their heads and here and there a nurse, struggling amid the chaos. There was a cacophony of sound and I felt as though I was lost in some kind of hell.'[80]

Nationwide, the psychiatric inpatient population peaked at 21,075 patients in 1958, equivalent to 0.7% of the state's total population.[81] The sizeable numbers housed in these facilities had an obvious impact on the treatment available to constituencies such as the intellectually disabled. In 1962 Browne, by then a senior medical officer, was transferred to Portrane (St Ita's) Hospital in North Dublin. There he encountered the grim marginalisation of the intellectually disabled in a psychiatric facility, as:

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[76] Feeney, *Seán MacEntee*, p. 157.

[77] Damien Brennan, *Irish Insanity, 1800–2000* (Abingdon, 2013), p. 99; Cox, *Negotiating Insanity*, p. 174; Finnane, *Insanity and the Insane*, p. 54.

[78] Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1951* (Dublin, 1952), p. 25; Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1952* (Dublin, 1953), p. 23; Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1954* (Dublin, 1955), p. 22.

[79] Browne, *Music and Madness*, p. 67.

[80] Ibid.

[81] Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1959* (Dublin, 1960), p. 20; Dermot Walsh and Antoinette Daly, *Mental Illness in Ireland 1750–2002: Reflections on the Rise and Fall of Institutional Care* (Dublin, 2004), p. 33. Although this began to decline during the 1960s, reliance on psychiatric 'mental hospital' beds remained high in Ireland by comparison with broader European norms into the 1970s. Daly, *Sixties Ireland*, p. 248.

> St. Ita's [was] even more depressing than St. Brendan's, with the long, sombre corridors leading to large wards full of forlorn human beings … There were old dilapidated huts where the most disabled of the mentally retarded were housed. These were known as the wet and dirty wards, full of small, gnome-like creatures in long black coats sitting and standing around on floors impregnated with years of urine.[82]

This blatantly unsafe and insanitary accommodation, which was originally built as temporary housing for builders at the hospital during the early twentieth century, remained in use until the early 1980s.[83] Browne acknowledged that this deficient care was not consistent across all psychiatric institutions in the state; he described St Loman's in Palmerstown, for example, as a 'small, clean, well run hospital with a buoyant, optimistic atmosphere'.[84] Yet official reports suggest that St Loman's was largely aberrant across the broader field of psychiatric services. A 1959 memorandum for John Brady, the assistant secretary at the Department of Health, warned of the effect of overcrowding on vulnerable patients in psychiatric institutions, describing how systemic deficiencies were 'keeping patients at … a low level of animal existence and actively destroying any bit of individuality, confidence or self-respect they may have left'.[85] Officials also bemoaned how, regardless of the successes at an individual institution such as St Loman's, there was 'no way of achieving coordination or organisation' across the psychiatric facilities in the state.[86] Thus, while St Loman's in Dublin could be described as a great success and a model for others, just 43 miles away the psychiatric hospital in Mullingar (also called St Lomans) served as an exemplar of the 'ferocious institutionalised cruelty of the Irish mental hospital'.[87] In a report to the Dublin Health Authority in 1966, Browne outlined a system that could provide only basic physical care to its intellectually disabled patients, in institutions that were characterised by 'therapeutic inactivity, a low state of morale and an atmosphere not generally conducive to recovery' for the acutely mentally ill, to say nothing of the impact on long-term resident populations.[88]

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[82] Browne, *Music and Madness*, p. 103.

[83] Eddie Barrett, 'Huts House Hospital Patients', *RTÉ News*, 1 August 1978, RTÉ Archive Online, https://www.rte.ie/archives/2018/0720/979942-hunger-strike-for-portrane-patients (accessed 12 September 2018); Helen Connolly, 'The Scandal of the Mental Hospitals', *Magill*, 31 October 1980.

[84] Browne, *Music and Madness*, p. 105.

[85] Ciara Meehan, *A Just Society for Ireland? 1964–1987* (Basingstoke, 2013), pp. 46–7.

[86] Inspector of Mental Hospitals, qtd in Christine Linehan et al., *Moving Ahead: Mapping the National Disability Policy Landscape* (Dublin, 2014), p. 2.

[87] Ward, 'Foreword', in Greally, *Bird's Nest Soup*, p. xiv.

[88] Ivor W. Browne, 'Psychiatric Services', in John O'Regan, *Report of the Chief Medical*

In 1965 the Commission on Mental Handicap characterised housing the intellectually disabled in psychiatric hospitals as a 'very undesirable' practice, due to the mixed populations in these facilities and their lack of specialist therapeutic services. Yet the report acknowledged that there were few alternatives to this form of accommodation, and concluded that 'it seems inevitable that a number of [the] mentally handicapped must be accommodated in district mental hospitals for several years to come'.[89] This pessimism was rooted in reality, as large numbers of the intellectually disabled made up a significant proportion of those resident in 'mental hospitals' nationwide. In 1956 alone there were 2,241 'handicap admissions' across the country, which represented 10.6% of all inpatient beds.[90] The undesirable nature of these practices was made abundantly clear on multiple occasions over nearly two decades. In 1948 the National Inspector of Mental Hospitals succinctly warned that 'mental hospitals were not suitable places for mental defectives'.[91] This was obviously true, as their overcrowding, poor physical condition, and lack of ancillary support combined to foster therapeutic inactivity and a disheartening environment for residents, who were rarely (if ever) discharged from the hospital.[92] For families, the local county home or district psychiatric hospital was an obviously undesirable destination for their 'mentally handicapped' relatives. Yet these admissions persisted due to the limited places available in specialist residential facilities.

Specialist Institutions

> The inadequacy of existing places in institutions for the accommodation of the mentally handicapped is well recognised.
>
> *The Problem of the Mentally Handicapped* (1960)[93]

Admission to a specialist facility remained an ideal for many families with an intellectually disabled relative during the mid-twentieth century. Harold O'Sullivan provided a typical relative's account when he described the religious brothers at the St Augustine's centre in Blackrock, Dublin.

Officer for the Year 1966 (Dublin, 1967), p. 132.

[89] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 111.

[90] Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1956*, 'Appendix X', p. 22.

[91] Ryan, *Walls of Silence*, p. 42.

[92] 'Scarcity of Doctors for Mental Hospital', *Leitrim Observer*, 10 June 1961, p. 1.

[93] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 5.

Brother Fachtna Walsh, he explained, was exemplary in giving the most 'tender, nursing care … to our son Sean, [which] will not be forgotten; the memory of him, old and frail, trailing Sean along the infirmary corridors with the end of his habit will stay fresh with us'.[94] O'Sullivan's comments typified the laudatory praise for 'mental handicap' institutions operated by Catholic religious orders throughout the middle decades of the twentieth century. These orders also occupied a dominant position in the provision of these residential disability services as – in all but one case – they owned and operated the state's specialist institutions for the intellectually disabled.[95]

The first facility for the 'mentally handicapped' was exceptional, however, as it was founded without the involvement of a religious order. Stewart's Institute for Idiotic and Imbecile Children and Middle Class Lunatics opened in the Dublin suburb of Lucan in 1869, before moving to nearby Palmerstown in the early 1870s.[96] Founded by Dr Henry Hutchinson Stewart and Dr George Kidd, the institution was an Irish analogue to the institutional philanthropy visible across Victorian Britain, with a clear focus on education and training.[97] Notwithstanding this focus, Cardinal Paul Cullen, the Primate of Ireland, prohibited Catholic attendance at Stewart's due to it being 'evidently founded on proselytising principles'.[98] Cullen's prohibition was announced at a time when Stewart's was the sole example of specialist residential care for the 'mentally deficient' on the island.[99] The attendance of Catholics at this Protestant-operated facility remained a concern into the mid-twentieth century; the Archbishop of Dublin, John Charles McQuaid,

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[94] Harold O'Sullivan was president of the Irish Congress of Trade Unions. Mary Purcell, *A Time for Sowing: The St. John of God Brothers in Ireland: A Centenary Record, 1879–1979* (Dublin, 1980), p. 115.

[95] Sweeney, 'Attitudes of Catholic Religious Orders', p. 99; Tom Inglis, *Moral Monopoly: The Rise and Fall of the Catholic Church in Modern Ireland* (Dublin, 1998), p. 211; Bryan Fanning, *The Quest for Modern Ireland: The Battle of Ideas, 1912–1986* (Dublin, 2008), p. 139; James Smith, *Ireland's Magdalen Laundries and the Nation's Architecture of Containment* (Manchester, 2008), p. 47; Robbie Gilligan, 'Residential Care in Ireland', in Mark E. Courtney and Dorota Iwaniec (eds), *Residential Care of Children: Comparative Perspectives* (Oxford, 2009), p. 3; Louise Fuller, *Irish Catholicism since 1950: The Undoing of a Culture* (Dublin, 2003), p. 11.

[96] Alice Mauger, *The Cost of Insanity in Nineteenth-Century Ireland: Public, Voluntary and Private Asylum Care* (London, 2017), p. 7.

[97] Martin Gorsky, *Patterns of Philanthropy, Charity and Society in Nineteenth Century Bristol* (Woodbridge, 1999), p. 113; Keir Waddington, 'Health and Medicine', in Chris Williams (ed.), *A Companion to Nineteenth Century Britain* (Oxford, 2004), pp. 421–2; Pat O'Donohoe, *150 Years of Stewarts Care: The Pathway to the Present* (Dublin, 2019), p. 167.

[98] O'Donohoe, *150 Years of Stewarts Care*, p. 25.

[99] Bairbre Redmond and Anna Jennings, 'Social Work and Intellectual Disability: A Historical Perspective', in Noreen Kearney and Caroline Skehill (eds), *Social Work in Ireland: Historical Perspectives* (Dublin, 2005), p. 108.

Table 2.1: Specialist residential institutions for the intellectually disabled, 1932–47.

Institution	Managing authority	Date of foundation	Gender of residents	1932	1939	1947
Stewart's Institute, Palmerstown	Private philanthropy	1869	Male and female	120	120	120
St Vincent's, Cabra	Daughters of Charity of St Vincent de Paul	1926 [1892]*	Male (3–9) and female	360	500	480
St. Augustine's, Blackrock	Hospitaller Order of St John of God	1931	Male	20	180	238
House of Our Lady of Good Counsel, Lota	Brothers of Charity	1939	Male			90
St Teresa's, Stamullen	Hospitaller Order of St John of God	1942	Male			60
St Joseph's, Clonsilla	Daughters of Charity of St Vincent de Paul	1943	Female			42
Total				500	800	1030

* St Vincent's was originally founded as a children's home in 1892, before transitioning to provide disability care from 1926.

Source: Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 11.

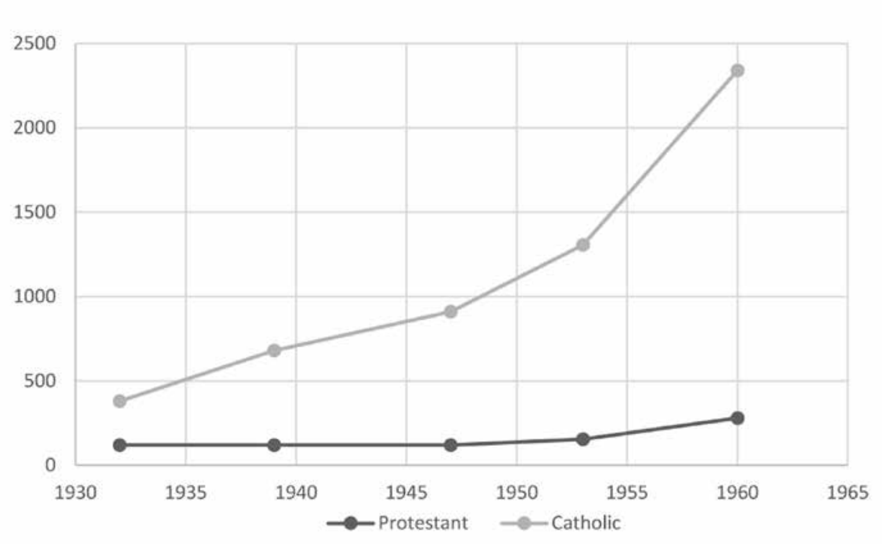

Figure 2.2: Capacity of specialist residential institutions, 1932–60.

Source: Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 11.

continued to recommend that Catholic children be sent elsewhere. The Archbishop even went so far as to ask for a report from James O'Keefe, the local parish priest in Chapelizod, which detailed the religious instruction available to any potential Catholic resident at the centre in Palmerstown.[100] O'Keefe's report collected information about the minutiae of religious practices for the Catholics resident in Stewart's, including their Mass attendance and access to confession. This level of interest was particularly notable in the 1950s as, by then, Stewart's had become an aberration, with Catholic religious orders dominating the provision of institutional services.

The role of Catholic religious orders in residential disability services was first discussed at the 1889 Inquiry into the Blind, Deaf and Dumb, which explored a potential role for these congregations in operating specialist residential institutions. It concluded that the orders had a 'machinery peculiarly favourable for making the institutions successful', as they could provide congregants to operate and staff facilities.[101] These financial

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[100] Letter, Fr John Brady (parish priest, Ballyconnell, Co. Cavan) to Archbishop John Charles McQuaid, 13 June 1953, Dublin Diocesan Archive (hereafter DDA) L64/6/1; Fr James O'Keefe, 'Report on Stewart's Hospital', 23 February 1955, DDA L64/7/2.

[101] *Report of the Royal Commission on the blind, the deaf and dumb of the United Kingdom* (London, 1889), p. cxiii.

advantages were stressed by Archbishop of Dublin, William Walsh, who extolled the willingness of orders to operate centres and said that the Church's human 'resources in this respect are practically unlimited'.[102] By the mid-twentieth century Catholic religious orders played a key role in operating residential disability services, managing 680 (85%) of the state's 800 institutional beds in 1939.[103] This dominance only compounded over time, as the number of places managed by religious congregations had increased to 2,340 by 1960.[104]

Reliance on religious congregations brought with it economic advantages. Caitríona Clear has suggested that a central factor in the ubiquity of nuns across a range of social services during the nineteenth century was their financial 'value' to the authorities; fundamentally it remained important that they 'did not cost very much, in proportion to the amount of work which they performed'.[105] Maev-Ann Wren similarly stressed how religious congregants remained valuable in the Irish health service during the late twentieth century, as they 'worked for little material gain, ploughing their salaries back into their orders or employing institutions'.[106] A similar pattern emerges from intellectual disability services, where religious staff often worked long hours to deliver services. When the Brothers of Charity centre at Kilcornan House in Galway lost a religious brother, for instance, the order had to hire on average 2.5 lay staff, or approximately 100 hours of lay employment a week, to make up for his departure.[107] Discussing the heavy workload at the St John of God congregation, Mary Purcell framed their long working hours as a natural corollary of religious life, explaining that 'the luxury of a forty hour week or even a seventy hour week is not for them'.[108] The scale of this labour was likely exacerbated by the staffing ratios across many institutions, as orders appear to have admitted considerable numbers of residents in proportion to their staff. At St Mary's in Westmeath, for instance, three religious sisters cared for the centre's forty residents, while the Brothers of Charity had between six and nine brothers to care for more than one hundred boys at their facility in Galway.[109]

Alongside financial benefits, this residential network was also ideologically

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[102] Ibid.

[103] Department of Health, *The Problem of the Mentally Handicapped*, p. 11.

[104] Ibid.

[105] Caitríona Clear, *Nuns in Nineteenth-century Ireland* (Dublin, 1987), p. 164.

[106] Maev-Ann Wren, *Unhealthy State: Anatomy of a Sick Society* (Dublin, 2003), p. 125.

[107] Kevin McCoy, *Report of Dr Kevin McCoy on the Western Health Board Inquiry into Brothers of Charity Services in Galway* [McCoy Report] (Galway, 2007), p. 59.

[108] Purcell, *A Time for Sowing*, p. 132.

[109] Sisters of Charity of Jesus and Mary, *A Vision Unfolds: Sisters of Charity of Jesus and Mary, 1952–2002: St Mary's, South Hill, Delvin, Co. Westmeath, Ireland* (Delvin, 2003), p. 7; McCoy Report, p. 28.

advantageous. Funding religious orders to provide institutional services clearly aligned with a subsidiarist model, in that the state was supporting a smaller (subsidiary) organisation to carry out a public function, while it remained the overall director of resources.[110] This approach was enacted during a particularly receptive political and social climate in the mid-century when, as John Henry Whyte has argued, the state sought to institutionalise 'the identity project of Irish nationalism'.[111] After the political tensions associated with the state's first decades, Whyte suggests that the 1950s were characterised by a concerted effort to create a vision of Ireland that was distinct from Britain, a process of de-anglicisation that was enacted by emphasising indigenous features, such as the prominent position of the Catholic Church in Irish life.[112] Emblematic of this was the wide-scale dedication of public institutions to Catholic saints throughout the 1950s, when psychiatric hospitals such as Grangegorman (St Brendan's) and Ballinasloe (St Brigid's) were renamed.[113] This broader cultural push towards a distinct Irish identity prompted some politicians to frame the work of religious orders as evidence of the state's innate Christian values. Fine Gael's Timothy Manley was typical when he described the Brothers of Charity at Lota, Cork, as living exemplars of Christian virtue, detailing how it was a 'revelation to go into these institutions and see the spirit of devotion, self-sacrifice and loyalty which the brothers display towards the children'.[114] It is also noteworthy that politicians discussed these congregations in similarly high terms in their private correspondence. Dr Noël Browne, former Minister for Health in the first inter-party government, repeatedly emphasised his personal esteem for the religious orders involved in disability care. During his first visit to St Mary's, the Brothers of St John of God centre in Louth, Browne described how:

> I watched unknown to him, a brother sitting on in a ward full of distressingly afflictive mental defective children. He seemed to me, in that setting, to be the very moving reality of the words 'Suffer the little children to come unto me and forbid them not' [Matthew 19:14]. The sharp memory of that apparently slight episode … [is] among remembered seemingly small incidents that have helped me, more often than not, to unravel and accept events which would not,

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110 Pope Pius XI, *Quadragesimo Anno* (Rome, 1931).

111 Gerard Delanty and Patrick O'Mahony, *Rethinking Irish History: Nationalism, Identity and Ideology* (Basingstoke, 1998), p. 157.

112 John Henry Whyte, *Church and State in Modern Ireland 1923–70* (Dublin, 1984), p. 158.

113 Kelly, *Hearing Voices*, p. 37.

114 Timothy Manley, *Dáil Debates* 167, 29 April 1959, col. 1015.

> otherwise, be readily comprehensible. These memories have been, on reflection, of no small significance in my life.[115]

Browne's esteem is notable, particularly given that his own chequered history with the Catholic Church had effectively ended his ministerial career. If he held these religious congregations in such high regard, it is reasonable to assume that they were largely respected across the political establishment. This sentiment was also shared among the general public, as a 1963–64 sociological survey of popular opinion in Dublin found that over 90% of participants agreed with the statement that 'The Church is the greatest force for good in Ireland today'.[116] In light of this, any expansions to religious-run institutions aligned the Department of Health with both Catholic social thinking and wider public attitudes, while contributing to the broader drive to distinguish Ireland from the UK.

Unsurprisingly, this combination of economic and ideological advantages meant that religious-order-operated institutions encountered 'no shortage of champions … [among] senior civil servants' throughout the mid-century.[117] Indeed, documents from the Department of Health present a bureaucracy that had a singular focus: providing further institutional places via religious-order-run institutions. During the negotiations surrounding the development of a disability facility in Bohola in Mayo, for instance, the Department of Health consistently emphasised the need to secure the services of a religious order so as to operate any new facility for the intellectually disabled.[118] Eventually, this focus became such a sticking point that the American philanthropist involved with the project ended up abandoning the effort altogether.[119] The post-war years had enlarged the department's remit, but this did not extend to the direct provision of state-operated residential institutions for vulnerable groups such as the intellectually disabled. A memorandum in August 1953 noted the Minister for Health's approval of an additional 1,300 institutional beds for the 'mentally deficient'. It implicitly assumed, however, that these new beds would be provided in institutions operated by religious orders, noting that 'the introduction of new bodies or communities willing to undertake this work would be desirable'.[120] At a

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[115] Noël Browne, qtd in Purcell, *A Time for Sowing*, p. 93.

[116] Mary Kenny, *Goodbye to Catholic Ireland: A Social, Personal and Cultural History from the Fall of Parnell to the Realm of Mary Robinson* (London, 1997), p. 258.

[117] Fanning, *The Quest for Modern Ireland*, p. 139.

[118] 'Minutes of meeting in connection with Bohola', 17 August 1967, National Archives Ireland 2000/6/645.

[119] Ibid. The benefactor, Paul O'Dwyer, eventually donated the premises to the Cheshire Foundation, who opened a respite facility in 1976.

[120] Memorandum, 'To Secretary' [August 1953], NAI H39/25.

further meeting in November, three ways of providing 'accommodation for mental defectives' were presented. They were:

1 By institutions run wholly by religious orders

2 By institutions controlled by religious orders with a lay staff

3 By institutions operated by local authorities[121]

The third option was never discussed at the meeting. Instead, the overwhelming focus was on efforts to expand religious-order-run institutions, without resorting to the hiring of lay staff. The meeting included a detailed discussion of the department's challenges in this regard, while at another meeting proceedings lingered on the 'reluctance of male orders to undertake further schemes'.[122] Indeed, a consistently poor response from various orders pointed to a limited appetite for expansion among religious congregations. The state was pursuing the orders, not the other way around. This dynamic was made clear on numerous occasions, when religious congregations simply rejected any plans to develop new services or expand their existing provision. In June 1952 Reverend Brother Quilligan, Provincial of the Hospitaller Brothers of St John of God, met with officials. Quilligan noted that he was already aware of 'adverse comment from Rome on account of … [the order] having no activities in Ireland but the care of Mental and Mental Defective patients'. He then expressed a willingness to establish a general hospital, stating that 'it is quite usual for his order to operate general hospitals on the continent', but would not consider further disability-specific services.[123] A meeting with Brother Bilfrid, Provincial of the Brothers of Charity, produced a similar result in November 1953, when Bilfrid noted the need to introduce lay staff if the order's existing centres in Galway and Cork were to expand any further.[124]

In the Magdalene Asylums religious congregations commonly sought committals. James Smith has detailed how, in many instances, an order's Mother Superior 'wrote directly to the court or to the relevant registrar communicating the institution's willingness to accept the … [woman] in

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[121] Memorandum, 'Provision of Extra Accommodation for Mental Defectives', 12 November 1953, NAI H39/25.

[122] Meeting, 'Minutes: Increased Accommodation for Mentally Defective Boys', 4 November 1953, NAI H39/25.

[123] Meeting, 'Minutes: Mental Defective Institutions under the care of the Hospitaller Brothers of St. John of God', 26 September 1952, NAI H39/25.

[124] Meeting, 'Minutes: Increased Accommodation for Mentally Defective Boys', 4 November 1953, NAI H39/25.

question'.[125] Similarly, the Ryan Commission (Commission to Inquire into Child Abuse) found that religious congregations actively engaged with statutory authorities to admit children to industrial school facilities and to expand these services.[126] By contrast, the Department of Health had to pursue new religious orders to become involved in operating disability-specific institutions. This included plans for the Inspector of Mental Hospitals, Dr Vincent Dolphin, to visit congregations including the La Sagesse Order in Liverpool, the Order of the Sisters of the Sacred Heart of Jesus and Mary, and the Augustinian nuns, all to 'enquire into their capacity for undertaking the care of mental defectives and the possible location of an institution which they might set up'.[127] For the Department of Health, the solution to the 'problem' of accommodation for the intellectually disabled was to be found in care provided by these personnel.

This approach had a range of implications, not least the fact that the religious orders were clearly the potent partner in this relationship. This dominance was particularly apparent during the detailed negotiations between the department and the Sisters of La Sagesse from Liverpool. Their centre was opened outside Sligo town in 1955, with plans to eventually house 143 female residents.[128] In November 1956 the Mother Provincial, Sister Joseph Du Carmel, produced a series of letters that criticised the actions of the Department of Health, while repeatedly underlining her willingness to simply abandon the Irish project altogether. Du Carmel began by rhetorically dismissing rumours of another disability centre being planned for the West of Ireland, contending that the idea was implausible when (due to delays) the department could not seem to 'find funds to go ahead with our building'. She also reminded officials that the order had hoped to locate on the east coast 'to be nearer to England', but that their Cregg House facility was established in Sligo (on the west coast) at the department's request.[129] She then outlined the order's need for further funding and an end to delays in their building programme. Internal Department of Health memoranda noted that Du Carmel refused to contribute any funds to this expansion programme, an action that was attributed to the order's already 'heavy commitments in England'. Du Carmel was a religious philanthropist, who was threatening to cease providing her charitable services if grant funding

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[125] Smith, *Ireland's Magdalen Laundries*, p. 65.

[126] *Report of the Commission to Inquire into Child Abuse* [Ryan Report] (Dublin, 2009), 1(4), pp. 27–9.

[127] Ibid.

[128] Memorandum, 'Tenders for building works at the home and school of the Immaculate Conception, Cregg House, Sligo', NAI H26/22/1.

[129] Letter, Sister Joseph Du Carmel to Mr Herlihy (Department of Health), 24 November 1956, NAI H26/22/1.

from the Department of Health did not come quickly. Yet, while nominally a private charitable initiative, this centre was one that the Department of Health had picked and purchased a site for, funded a building, and provided annual grants to support.[130]

This produced an uneven power dynamic, which was apparent when the Department of Health quickly acceded to Du Carmel's request for increased funding; an official noted the need to support the sisters due to the fear that 'the order might pull out if there is nosign [*sic*] of any progress on the scheme'.[131] The department's approach was understandable, particularly in a period when waiting lists were long and religious orders were already a key provider of a range of health and welfare services. The reluctance of religious orders to operate these centres is more difficult to explain. In some cases, orders may simply have been overstretched in being asked to operate multiple centres across the country.[132] The Hospitaller Order of St John of God, for instance, ran four residential centres that cared for 427 children in 1953.[133] In other cases, reluctance among orders might have emanated from the range of fields that they were already engaged in, which encompassed a wide variety of health and educational services.[134] Put simply, other roles (such as educating children or operating acute hospitals) could be more appealing to some religious congregations.

The need for renovations may also have deterred some orders from disability-related projects. Many residential facilities were not designed for the purpose, with congregations repurposing an existing building such as a workhouse (St Vincent's) or a former estate mansion (Kilcornan House, Celbridge House, Drumcar House). When the St John of God Brothers moved into Drumcar House in Louth, for example, they encountered a once stately Georgian property that was now 'in a dilapidated condition, many rooms were without windows or doors, and, lacking both a hot water or central heating system'.[135] Conditions were similarly difficult in the early years of Kilcornan House, when the brothers and residents lived in the 'most cramped conditions' in the crumbling shell of the former 'big house' of the Redington family estate.[136] Religious congregations, shaped by their

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[130] Memorandum, 'Tenders for building works at the home and school of the Immaculate Conception, Cregg House, Sligo', NAI H26/22/1.

[131] Memorandum, 'Development of Cregg House Mental Defective Home, Sligo' [1956], NAI H26/22/1.

[132] Department of Health, *The Problem of the Mentally Handicapped*, p. 11.

[133] Ibid.

[134] Inglis, *Moral Monopoly*, p. 9.

[135] Harold O'Sullivan, *The House on the Ridge of the Weir: The Story of the Brothers and the Community of Saint John of God, St. Mary's, Drumcar* (Louth, 1998), p. 35.

[136] McCoy Report, p. 28.

Table 2.2: Specialist residential institutions for the intellectually disabled, 1947–60.

Institution	Managing authority	Gender of residents	1947	1953	1960
Stewart's Institute, Palmerstown	Private philanthropy	Male and female	120	154	280
St Vincent's, Cabra	Daughters of Charity of St Vincent de Paul	Male (3–9) and female	480	532	480
St Augustine's, Blackrock	Hospitaller Order of St John of God	Male	238	220	220
House of Our Lady of Good Counsel, Lota	Brothers of Charity	Male	90	135	260
St Teresa's, Stamullen	Hospitaller Order of St John of God	Male	60	60	
St Joseph's, Clonsilla	Daughters of Charity	Female	42	45	270
House of the Immaculate Conception, Cregg House	La Sagesse Order	Female			25
St Mary's, Delvin	Sisters of Charity of Jesus and Mary	Female			40
St Teresa's, Blackrock	Daughters of Charity	Female			100
St Philomena's, Stillorgan	Daughters of Charity	Female		30	35
House of the Holy Angels, Chapelizod	Daughters of Charity	Female		110	235
St Joseph's, Kilcornan	Brothers of Charity	Male		27	100
St Raphael's, Celbridge	Hospitaller Order of St John of God	Male		32	200
St Mary's, Drumcar	Hospitaller Order of St John of God	Male		115	340
Total			1030	1460	2620

Source: Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 11.

Figure 2.3: Kilcornan House, home of the Redington family, Clarinbridge, Co. Galway, c. 1900.

Courtesy of the National Library of Ireland.

vows of obedience, proved to be remarkably adaptable and resourceful when faced with these challenging conditions. Sister Desmond from the Sisters of Charity of Jesus and Mary recalled how, on the opening of St Mary's in Delvin, the order's Superior 'Mother Joseph sold some of the numerous trees [around the house] to be able to get the fire escape installed and buy beds [for residents]'.[137] In Lota, the Brothers of Charity also carried out a wide array of tasks in the institution throughout the mid-century; an early lay staff member recalled how they 'repaired clothes, made underwear, hand-washed clothes and … patched sheets'.[138]

While designs varied across these institutions, isolation was a feature in multiple facilities.[139] Kilcornan House in Clarinbridge, Galway, for example, was surrounded by forest and was more than a kilometre away from the

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[137] Sister Desmond, qtd in Sisters of Charity of Jesus and Mary, *A Vision Unfolds*, p. 33.

[138] M. T. E. O'Connor, 'From Community to Institutions, from Institutions to Community: Planned Progress to Independence', MSoc thesis, UCC, 1991, p. 207.

[139] Terence Dooley, *The Decline of the 'Big House' in Ireland: A Study of Irish Landed Families* (Dublin, 2001), p. 25.

Figure 2.4: Our Lady of Good Counsel, Lota, Glanmire, Co. Cork, March 1955. Note the pavilion-style accommodation units in the left and centre middle ground.

Courtesy of the National Library of Ireland.

nearest public road.[140] This was partially a result of using former 'big houses', which tended to be located in secluded areas.[141] This isolation was underlined, however, by the development of purpose-built 'pavilion' accommodation.[142] These were detached, single-storey buildings that housed a centre's residents in large, dormitory-style units. St Mary's in Drumcar constructed four pavilion units to house 350 residents, while in Lota three pavilions each housed sixty.[143] Predictably, given the collective nature of this accommodation, one of the frequent complaints from former pavilion residents was an acute lack of privacy in sleeping and during daily activities such as showering.[144] This communal style of accommodation also had a long-term impact on some. Mary Therese (Betty) O'Connor worked as a social worker in Lota from the early 1960s. She highlighted the challenges that surrounded the discharge of residents into the community, as the centre's emphasis on communal practices meant that a proportion of young men would always struggle outside the daily 'routine group life of an all-male institution'.[145] In Lota, for instance, residents were divided by age in each pavilion unit, with often limited access to other residents. This created a self-contained world within an already marginalised institution. Some former residents fondly remembered these centres, describing the 'good times … like the football … gymnastics and things … Even the plays, [the] things we did.'[146] Yet it is noteworthy that most of these recreational activities occurred within the institution itself among fellow residents. At Cregg House in Sligo, for instance, residents engaged in a range of activities that, with the exception of trips to the cinema, were all conducted within the facility.[147] In essence, these institutions could function as a largely autonomous world.[148]

This did not appear to be an issue during the mid-century, however, when the scale of these residential facilities was the central concern. In 1958 the aggregate waiting list across all 'mental deficiency' institutions was 1,242. This was a considerable number in itself, representing 47% of institutional beds.[149] In reality, however, the number waiting for admission to a specialist institution was probably significantly larger. Brother Vincent, provincial

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[140] McCoy Report, p. 55.

[141] Dooley, *The Decline of the 'Big House' in Ireland*, p. 25.

[142] James Trent, *Inventing the Feeble Mind: A History of Intellectual Disability in the United States* (Oxford, 2016), pp. 88–9.

[143] O'Sullivan, *The House on the Ridge of the Weir*, p. 39; Ryan Report 2(5), p. 197.

[144] McCoy Report, p. 46.

[145] O'Connor, 'From Community to Institution, from Institutions to Community', p. 218.

[146] Conall, qtd in Ryan Report 2(5), p. 233.

[147] 'Inspection Report: Cregg House', 17 June 1966, UCDA An Bord Altranais Papers P220/415, p. 1.

[148] O'Connor 'From Community to Institutions, from Institutions to Community', p. 218.

[149] Michael Kennedy, *Dáil Debates* 171, 3 December 1958, col. 1429.

of the Hospitaller Order of the Brothers of St John of God, noted in the late 1950s that his order's waiting list represented only a small fraction of those who sought a placement, commenting that it was customary to delete any name off the list that had been there for over two years, or where the person had gone over the age of 16.[150] Thus, these (already large) lists likely represented only a fraction of those who sought an institutional placement at any given time. The scarcity of beds in residential institutions remained a concern throughout this period. *The Problem of the Mentally Handicapped* (1960) acknowledged that the inadequacy of existing institutional facilities was a 'well recognised' issue; despite a doubling of places over the 1950s, demand continued to grow and 'the solution … is not yet in sight'.[151] In 1962 the Select Committee on Health received a report from the Medical Officers of Health that highlighted the need for reform. Due to an 'overwhelming' level of public demand, institutions could only offer admission to most children after a waiting period of several years. That year, for example, St Vincent's in Cabra began to admit residents who had first applied to the residential centre in 1956, a delay that was described as broadly typical across the county.[152]

Alongside issues of scale, oversight was a further concern. Under the 1953 Health Act, 'Section 65' grants operated through a 'grant in aid' rather than a contractual model. This meant that a residential centre partially financed a proportion of its expenditure itself, either through public fundraising or a parental contribution.[153] This had implications for these services, which remained private charitable initiatives that received some financial support from the state, rather than a statutory-funded service that was operated through a voluntary organisation.[154] This meant that the Department of Health had limited engagement with a religious order, beyond the provision of financial support, and viewed the management of the centre as outside its purview.[155] Indicative of this, the institutions were not subject

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[150] National Health Council, 'Meeting Minutes: 13 November 1959', p. 6.

[151] Department of Health, *The Problem of the Mentally Handicapped*, p. 8.

[152] Society of Medical Officers of Health, 'Submission 60: Submission by Society of Medical Officers of Health', in *Select Committee on Health Services: Submissions* (Dublin, 1962), pp. 188–9.

[153] Ryan, *Walls of Silence*, p. 115. Stewarts in Dublin relied upon a variety of funding sources, which in the early 1950s included a countrywide network of voluntary collectors. O'Donohoe, *150 Years of Stewarts Care*, p. 182.

[154] Andrew Power, Janet Lord and Allison DeFranco, *Active Citizenship and Disability: Implementing the Personalisation of Support* (Cambridge, 2014), p. 354; Andrew Power and Kate Kenny, 'When Care is Left to Roam: Carers' Experiences of Grassroots Non-profit Services in Ireland', *Health and Place* 17.2 (2011), p. 424.

[155] Carole Holohan, *In Plain Sight: Responding to the Ferns, Ryan, Murphy and Cloyne Reports* (Dublin, 2011), p. 32.

to inspection under any existing oversight regime, such as the Inspector of Mental Hospitals or the Inspector of Reformatory and Industrial Schools.[156] In the case of institutional disability facilities, capital projects were sent to the Department of Health, but the internal administration of the institution was managed privately by the orders themselves, which were answerable to their superior in the religious hierarchy.[157]

In this context, accountability meant the presentation of evidence that 'grant aid was spent properly'.[158] The McCoy Inquiry, which investigated complaints of abuse at Kilcornan House in Galway, found this approach reflected across the institution itself, which operated like a private religious congregation rather than a large-scale institutional facility; this was seen in the centre's limited record-keeping, for instance, with no clear consensus around 'how records were kept. Files were maintained at different locations for different purposes.'[159] The approach adopted by the institutions themselves was matched by a lack of appetite from the state to expand its oversight of these facilities. At the Brothers of Charity facility in Lota, Cork, the Department of Health did not conduct an inspection between its foundation in 1939 and 1990.[160] Indeed, the only evidence of oversight at that centre in this fifty-one year period was a visitation report from the order's central congregation, which did not discuss residents and instead focused on the 'religious life' in the community.[161] Exploring the operation of institutions across the state, the Mother and Baby Home Commission found no evidence that institutions for the intellectually disabled were inspected by the Department of Health or by local health authorities. Ultimately, it concluded that 'little is known about the conditions within' these centres in this period.[162]

This relationship meant that the Department of Health could claim that it was not responsible for the service provided to the 'mentally handicapped' in these residential facilities. By offering a financial contribution to a

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[156] A formal inspection programme for institutions that housed intellectually disabled children was introduced in 2013. Eoin O'Sullivan, '"This otherwise delicate subject": Child Sexual Abuse in Early 20th Century Ireland', in Paul O'Mahony (ed.). *Criminal Justice in Ireland* (Dublin, 2002), p. 196; Mother and Baby Commission, *Second Interim Report of the Mother and Baby Home Commission* (Dublin, 2016), p. 7.

[157] J. G. Cooney, *A Service for the Mentally Handicapped* (Dublin, 1963), p. 7. The exception to this was Stewart's Institute in Palmerstown. Yet, here as well the managing committee had only limited engagement with the Department of Health throughout the mid-century. O'Donohoe, *150 Years of Stewarts Care*, p. 171.

[158] Nicholas Acheson, Arthur Williamson, Brian Harvey and Jimmy Kearney, *Two Paths, One Purpose: Voluntary Action in Ireland, North and South* (Dublin, 2004), p. 187.

[159] McCoy Report, p. 67.

[160] Ryan Report 2(5), p. 201.

[161] Ibid., p. 202.

[162] Mother and Baby Home Commission, *Final Report of the Commission*, chapter two, p. 33.

voluntary provider, which then operated the centre, the department played a determinative role in the life of these institutions. It could have withheld payments from any centre, for any reason, an action that would have precipitated their closure, as these facilities relied upon statutory support for the majority of their funding.[163] However, by supporting a congregation to provide a charitable service, the Department of Health created a 'buffer zone' around this care; it remained a charitable service that received some statutory funding rather than being a de facto state service. If the care proved deficient, this was not a statutory failing, but a lapse by an individual religious order. Looking at the industrial school system, Mary Raftery and Eoin O'Sullivan underlined how the public never appreciated the degree of statutory involvement in services staffed by religious orders, arguing that in the public imagination they were 'provided from the financial resources of the Church itself, with the Irish state playing only a marginal and miserly role'.[164] While this was not the case, by maintaining a subsidiarist model the Department of Health ensured an ideological advantageous relationship with Catholic religious orders, and expanded a service that was cheaper to operate than one staffed by lay people, while it also grounded the discussion of these services in terms of religious beneficence and charity. This meant that there was no obligation on the department to ensure parity of provision, or to oversee the operation of these centres, which were framed as private philanthropic initiatives that were simply worthy of financial support from the state.

In this way, the Department of Health relinquished most of its responsibility towards a nationwide network of residential institutions, including facilities that it had helped to both establish and finance.[165] The public discourse surrounding these centres framed them in terms of charity, describing how religious staff worked 'with that community spirit, working for no personal reward and no personal recognition whatever, in the service of God and Christianity, providing comfort for these children'.[166] It remains undeniable that many staff in these facilities worked incredibly hard in often challenging conditions to care for their residents. Yet the development of these services through the voluntary sector adds a charitable veneer that can obscure how they operated in practice.[167] These were state-sponsored

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[163] Ryan, *Walls of Silence*, p. 115.

[164] Mary Raftery and Eoin O'Sullivan, *Suffer the Little Children: The Inside Story of Ireland's Industrial Schools* (Dublin, 1999), p. 89.

[165] Memorandum, 'Tenders for building works at the home and school of the Immaculate Conception, Cregg House, Sligo', NAI H26/22/1.

[166] Timothy Manley, *Dáil Debates* 167, 29 April 1958, col. 1015.

[167] Eoin O'Sullivan and Ian O'Donnell, *Coercive Confinement in Post-Independence Ireland: Patients, Prisoners and Penitents* (Manchester, 2014), p. 1.

facilities that received capital grants from both the Irish Hospitals' Trust and the Department of Health, support that was on top of the 'Section 65' payments provided to support these services and any payments they received from local county councils. St Mary's in Drumcar, for instance, received £461,415 in capital grants from the Irish Hospitals' Trust between 1946 and 1969.[168] Beyond this financial support, however, the state and its authorities were absent, with each centre operating as a fundamentally private charitable enterprise, where 'the internal administration of each house … [was] controlled by the sister [or brother] in charge, who is responsible to her [or his] religious superior'.[169] By adhering to this, the Department of Health focused on the benefits of extensive cooperation with the Catholic Church and the financial bottom line, twin concerns that produced a system that the state had no substantial role in (other than funding) and that could only ever address a fraction of public demand.

Conclusion

As part of their ten-day tour, the International Hospital Federation visited the Brothers of Charity's residential facility in Lota, Cork. John Dodd's account emphasised the improvements across the centre, including how the main building had been 'completely renovated, enlarged and equipped', while he noted that the religious brothers 'did some fine work' in a confined environment.[170] His account elides any potential questions or concerns with the centre, such as its admissions system, staffing levels, or the potential for overcrowding given the high levels of demand. Instead, the delegation appeared determined to highlight the 'amazing' nature of Irish progress in the development of the state's healthcare infrastructure.[171]

The 'mentally deficient' were acknowledged as a concern for the Department of Health from the late 1940s.[172] Yet there were limited efforts to address their being admitted to clearly inappropriate accommodation in county homes and district psychiatric hospitals, while specialist institutions continued to develop overwhelmingly through one approach – collaboration

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[168] Irish Hospitals Trust, *Irish Hospitals 1956–71* (Dublin, 1971), pp. 71, 75.

[169] Cooney, *A Service for the Mentally Handicapped*, p. 1.

[170] Dodd, *Éire Hospitals and Health Services*, p. 115.

[171] There was plenty to praise, as the Department of Health brought rapid and sizeable change to many areas of the health system. Ibid., p. 6; International Hospital Federation, *Report of the Study Tour of Hospitals in Ireland, May 21st–31st 1956* (London, 1956), p. 1; Barrington, *Health, Medicine and Politics in Ireland*, p. 165.

[172] See 'Memorandum for the Government', 13 August 1947, NAI DT S14129A.

with Catholic religious orders.[173] Trying to put new wine in old bottles, this obviously did not serve those in need of residential accommodation, while this failure was underlined by its appearance during a period that was marked by infrastructure projects and expansion across the health system. Dr James Deeny, the Department of Health's chief medical advisor, argued that a range of reform proposals were 'financially handicapped' throughout the economically challenging early 1950s.[174] Ambitious reforms were simply not sustainable in the face of these challenges, he suggested, as health officials were compelled to divert their limited resources towards areas such as epidemic diseases and hospital infrastructure.[175] Financial concerns likely played a part in the continued accommodation of the intellectually disabled in county homes and psychiatric wards, while it also helps to account for what had become, by the late 1950s, a quixotic effort to expand the religious-order-run institution model.

Fundamentally, the department's approach was cautious and shaped by precedent. Like a losing gambler, officials continued to bet that, if just one more religious order set up a residential centre, then the perennial 'problem of the mentally handicapped' would *finally* be solved. Expanding the state's network of specialist accommodation centres occurred through investment in congregations that already operated a facility, or the enticement of a new order to replicate the same model in a new location. Having begun to establish a network of state-funded, religious-owned institutions, the department continued to invest in this particular form of care. Yet even at the apex of these efforts, specialist residential institutions catered for only a small fraction of public demand, a deficiency that continued to fuel admissions to 'alternative' forms of accommodation, which included beds in obviously unsuitable county homes and 'mental hospitals' across the country. Attempts to reproduce the religious-order institutional model were unsurprising, given that it offered an enticing combination of financial and ideological advantages for a cash-strapped and ideologically chastened Department of Health in the mid-1950s. Congregants, willing to work for little pay in challenging conditions, were simply too useful for a mid-century civil servant who faced an already tight budget. There were clear limits to this approach, however, as increasingly active efforts were required to engage a religious congregation. This model of care also meant that the department effectively surrendered oversight of these facilities but retained a range of

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[173] Mary E. Daly, 'The Curse of the Irish Hospitals' Sweepstake: A Hospital System, not a Health System', *Working Papers in History and Policy* 2 (2012), pp. 1–15.

[174] Eamonn McKee, 'Church–State Relations and the Development of Irish Health Policy: The Mother and Child Scheme 1944–53', *Irish Historical Studies* 25.98 (1986), p. 162.

[175] Barrington, *Health, Medicine and Politics in Ireland*, pp. 248–9; Earner-Byrne, *Mother and Child*, p. 162; Fitzgerald Report, p. 49.

financial obligations. The state paid the majority of the bill, but had little control over the nature of the services that it was paying for, as individual orders retained latitude to determine who they admitted, the care they received, and when they were discharged.

This approach was a product of the dominant social policy philosophy at play in mid-century Ireland, which favoured a mixed economy of care that included statutory and voluntary involvement.[176] Successive governments reflected this thinking by acknowledging a (limited) role for the state, a position that was best summarised by Minister James Ryan's assertion that the state would act but would not 'go further than is necessary to provide the specialised services'.[177] The Department of Health could be relied upon to do the right thing, once every other provider had been tried first. A mid-century parent with an intellectually disabled child therefore faced a distinctly unenviable range of options: the uncertainty of obtaining a place in an oversubscribed specialist institution, the challenges of home care, or accommodation in a mixed facility such as the local district mental hospital.[178] Families were not passive in the face of these challenges, however, as from the mid-1950s 'parents and friends' organisations emerged across the country. These groups began as forums for mutual support, but soon began to directly address deficiencies in statutory provision, with their first 'response' emerging in terms of education and schools.

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[176] Sarah-Anne Buckley, *The Cruelty Man: Child Welfare, the NSPCC and the State in Ireland, 1889–1956* (Manchester, 2015), p. 200.

[177] Barrington, *Health, Medicine and Politics in Ireland*, p. 223.

[178] Noël Browne, *Dáil Debates* 163, 26 June 1957, col. 48.

3

'Special' Education, 1947–84

His anger was obvious. Speaking at the NUI Graduates' Association in November 1955, Sean Brosnahan condemned the state's national schools. The former president of the Irish National Teachers' Organisation (INTO) surveyed a range of deficiencies across a system that was failing a vast array of pupils, a neglect exemplified by the absence of support for 'subnormal and backward' children.[1] The intellectually disabled were not only stymied by persistent overcrowding in classrooms, Brosnahan explained, but also by an inspection regime that continued to operate as if they 'were a figment of the imagination'. The Department of Education seemed largely indifferent to this issue, as 'the very existence of these children does not seem to have impinged itself greatly upon the official mind'. They were being left to the wayside, 'written off as a bad debt … they do not count; they are not destined to become leaders of society, in other words, they are [the] educationally expendable'.[2]

These deficiencies began to recede during the latter decades of the century, as specialist classrooms were established across the country. By 1984 the *Towards a Full Life* Green Paper could extol the range of educational facilities available to a 'mentally handicapped' child, as approximately 5,600 attended segregated 'special schools' while there were a further 1,800 'mainstream' places available in disability-specific classrooms based in primary schools.[3] This provision was accompanied by a new awareness of

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[1] Various terms, including 'backward', 'deficient', and 'slow', were used to describe a broad group of children with additional educational needs during the mid-twentieth century. Differentiating the intellectually disabled from this wider group presents obvious and significant challenges. This chapter considers the intellectually disabled to have been a group within this broader collection of 'backward' children, although not all 'backward children' would be considered intellectually disabled. Sean Brosnahan, 'The Sins of our Primary Education', NUI Graduates' Association, 26 November 1955, in *An Múinteoir Náisiúnta*, December 1955.

[2] Ibid.

[3] Department of Health and Social Welfare, *Towards a Full Life: Green Paper on Services for Disabled People* (Dublin, 1984), p. 46.

intellectual disability in policy, as documents such as the 1980 *White Paper on Educational Development* stressed the importance of designated services.[4] Clearly, a lot had changed since Brosnahan's lecture. Beyond Ireland, the propagation of 'special classrooms' has been attributed to a range of factors, including growing statutory engagement, court decisions, and advocacy efforts from parents.[5] In the UK the 1944 Education Act and the 1945 Education (Scotland) Act are commonly cited as evidence of an increased statutory engagement to ensure the education of all citizens, regardless of whether a child's disability ranged from a 'trifling to total'.[6] While the influence of this legislation can be overstated, its scope was progressively widened over time, so that by the 1970 Education (Handicapped Child) Act the UK government committed to ensuring the availability of a tailored education to all children.[7] There were similar developments in the US, as the Education for all Handicapped Children Act 1975 provided a legal recourse for parental activists.[8]

By contrast, Irish 'special' educational facilities emerged through 'bottom-up' activism by voluntary organisations and concerned groups of parents. Three strands – the foundation of the first 'special schools' in the 1950s, the role of policy in the emergence of 'mainstream' provision in the 1970s, and the experiences of pupils within these services – show how disability-specific educational services developed in line with the state's

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[4] Department of Education, *White Paper on Educational Development* (Dublin, 1980), p. 29.

[5] See Robert L. Osgood, *The History of Special Education: A Struggle for Equality in American Public Schools* (Westport, CT, 2008), pp. 99–103; David Wright, *Downs: The History of a Disability* (Oxford, 2011), pp. 150–1; John T. Hall, *Social Devaluation and Special Education* (London, 1997), pp. 33-6.

[6] Adrian Wooldridge, *Measuring the Mind: Education and Psychology in England, c. 1860–1990* (Cambridge, 1990), p. 338; Colin Barnes, *Disabled People in Britain and Discrimination: A Case for Anti-discrimination Legislation* (London, 1991), p. 29; Sonali Shah and Mark Priestley, *Disability and Social Change: Private Lives and Public Policies* (Bristol. 2011), p. 94.

[7] Bonnie Evans reflected this when she discussed the impact of the 1970 Act on autism provision in the UK, positing that this development 'paved the way for autism to be regarded as a unique impairment … leading to a transformation in the way that schools managed their intake and organised their classes'. Bonnie Evans, *The Metamorphosis of Autism: A History of Child Development in Britain* (Manchester, 2017), pp. 16, 252; Anne Borsay, *Disability and Social Policy in Britain since 1750: A History of Exclusion* (Basingstoke, 2005), p. 111; David S. Petrie, 'The Development of Special Education in Scotland since 1950', in W. B. Dockrell, W. R. Dunn and A. Milne, *Special Education in Scotland* (Edinburgh, 1978), pp. 8–11; Felicity Armstrong, 'Disability, Education and Social Change in England since 1960', *History of Education* 36.4–5 (2007), pp. 551-4.

[8] Wright, *Downs: The History of a Disability*, pp. 150–1; James Trent, *Inventing the Feeble Mind: A History of Intellectual Disability in the United States* (Oxford, 2016), p. 267.

established approach to social policy. Histories of the education system commonly discuss the expansion of ‘special’ provision over time, which can foster an unduly teleological narrative of progression. Exploring the role played by voluntary efforts, we can better understand how these services were created through a combination of activism, relentless fundraising, and clear innovation.

The Emergence of ‘Special Schools’, 1947–65

> May we respectfully point out that to expect a teacher dealing with mental defectives to handle more than fifteen to twenty children in a class is to render her work fruitless, besides undermining her health.
>
> Sister Margaret Morris, St Vincent’s (1948)[9]

In 1955, when Seán Brosnahan discussed the lack of services for the ‘educationally expendable’ child, specialist schooling was available to only a small minority of the intellectually disabled – those resident in a ‘mental handicap’ institution. Training was a foundational goal for most of these centres, which aimed to (eventually) discharge their residents into the wider community.[10] Throughout the late-nineteenth century education was a part of life in Stewarts in Palmerstown. Its AGM commonly included a report from the centre’s school, which described ‘the curriculum being taught, the ability levels of the pupils and the number attending’.[11] By the late 1940s St Vincent’s, the Daughters of Charity centre in Cabra, also oversaw an established pedagogical programme, with sisters from the order attending training courses at the National Association for Mental Health in London and the Jordanhill College of Education in Glasgow. This influenced the daily routine in their classrooms, which included work on ‘language and storytelling … handiwork, crafts, art, eurythmics, physical education and a health programme’; efforts that resulted in their centre being recognised as a

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[9] Letter, Sister Margaret Morris (Superior, St Vincent’s) to Seán Moran (Departmental Inspector for Special Education), qtd in Joseph Robins, *From Rejection to Integration: A Centenary of Service by the Daughters of Charity to Persons with a Mental Handicap* (Dublin, 1992), p. 59.

[10] Alice Mauger, *The Cost of Insanity in Nineteenth-Century Ireland: Public, Voluntary and Private Asylum Care* (London, 2018), p. 7; Robins, *From Rejection to Integration*, pp. 34–49; Pat O’Donohoe, *150 Years of Stewarts Care: The Pathway to the Present* (Dublin, 2019), p. 167.

[11] O’Donohoe, *150 Years of Stewarts Care*, p. 167.

national (primary) school by the Department of Education in 1947.[12] Yet their capacity was often limited. In 1960, there were 260 young men at the Brothers of Charity centre in Lota, but only 49 (18.8%) attended the centre's school.[13]

Indeed, only a minority of the intellectually disabled could access these residential institutions at all, as spaces remained highly sought after. Considerable waiting lists meant that there were conceivably thousands of 'mentally deficient' children who resided with their families and were unable to access forms of educational support. Undoubtedly, some of those with an intellectual disability stayed away from formal education altogether. The School Attendance Act 1926 included an exception where a child could be considered medically exempt, while attendance figures remained patchy into the 1950s, lingering at approximately 88%.[14] For other children, the alternative was to attend a 'normal' classroom in a local school. Questioned in 1959, the Minister for Education Kevin Boland admitted that his department had no idea whether intellectually disabled children attended local national schools.[15] Yet some of those with a 'mental handicap' probably did go to their local primary school, as anecdotal evidence pointed to the presence of 'deficient pupils' in classrooms across the country.[16] Labour deputy Martin O'Sullivan explained how a 'backward child' could attend their local school. Rather than learn, he suggested, they passed

> from class to class. The teacher cannot hold the child down to second class until he be 12 or 13 or 14 years of age. The teacher, being an ordinary humane individual, will, for the sake of the child's feelings,

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[12] Eurythmics was a progenitor of aerobics, involving rhythmical physical movements to music. Robins, *From Rejection to Integration*, p. 38; Claire Sweeney, 'St. Vincent's Cabra: Opening the Door to Education for Children with Special Needs', in Jacinta Prunty and Louise Sullivan (eds), *The Daughters of Charity of St. Vincent De Paul in Ireland: The Early Years* (Dublin, 2014), p. 166. St Vincent's received its school status in 1947, while the Brothers of Charity in Lota became a school in 1955. Designation also allowed a reduced pupil–teacher ratio of 15:1, compared to the mid-century average of 34:1. Robins, *From Rejection to Integration*, p. 59; *Report of the Commission to Inquire into Child Abuse* [Ryan Report] (Dublin, 2009), 2(5), p. 197; John Coolahan, *Irish Education: Its History and Structure* (Dublin, 1981), p. 171.

[13] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 11; Department of Education, *Statistical Report of the Department of Education 1960–61* (Dublin, 1961), p. 101.

[14] Tony Fahey, 'State, Family and Compulsory Schooling in Ireland', *The Economic and Social Review* 23.4 (1992), p. 379; Government of Ireland, School Attendance Act 1926.

[15] Kevin Boland, *Dáil Debates* 176, 21 July 1959.

[16] Alfred Byrne, *Dáil Debates* 136, 5 February 1953; Declan Costello, *Dáil Debates* 176, 21 July 1959; 'Discussion on Dr. Clifford's Paper', in Louis S. Clifford, 'Investigation into the Incidence of Mental Deficiency amongst Dublin School Children', *Journal of the Statistical and Social Inquiry Society of Ireland* 16.3 (1939/1940), pp. 43–8.

> pass the child upwards in class and, at 14, he is sent out knowing little or nothing.[17]

Similar practices were also acknowledged by Dr Louis Clifford, who conducted a survey on 'mental deficiency' among Dublin schoolchildren for the Statistical and Social Inquiry Society of Ireland in 1939. Teachers were reluctant to retain a potentially disabled child in their classroom for an extended period, he argued, especially when 'lack of promotion … [was] generally regarded by inspectors as a reflection on the teacher'. Holding back pupils also brought implications for a school's inspection rating and a teacher's salary increments.[18] Given this incentive to 'move on' a potentially disabled pupil, as well as the persistent overcrowding in classrooms, it was conceivable that some of the intellectually disabled passed through the primary education system during the mid-century. Of course, this only applied to children who could successfully integrate into these (often crowded) environments. In other cases, intellectually disabled children were simply dismissed. The independent TD Alfred Byrne described how he frequently observed a group of children outside their local school. Their exclusion, he explained, was because of the teacher's reluctance to admit any 'backward' pupils in to the classroom.[19] For parents of the intellectually disabled there were limited options. This dilemma was captured in a 1955 letter to the *Sunday Independent* newspaper. Written by a 'distressed parent', it discussed the demand for institutional places nationwide, which caused an extended waiting period and placed families in a 'difficult position' as they struggled to care for children in the family home. Schools were reluctant to help by enrolling a known 'deficient child', which left families (and particularly mothers) in a 'pitiable plight' due to the absence of support.[20]

Internationally, lack of services for the intellectually disabled prompted the formation of voluntary parents' organisations throughout the post-war period. In the UK Judy Fryd, whose daughter Felicity had an intellectual disability, published an advertisement in the magazine *Nursery World* in 1946, calling for interested parties to come together and form a parents' organisation. Her respondents went on to found the National Association of Parents of Backward Children.[21] In the United States regional organi-

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[17] Martin O'Sullivan, *Dáil Debates* 106, 20 May 1947.

[18] Thomas O'Donoghue, Judith Harford and Teresa O'Doherty, *Teacher Preparation in Ireland: History, Policy and Future Directions* (Bingley, 2017), p. 118.

[19] Alfred Byrne, *Dáil Debates* 97, 15 May 1945.

[20] 'The Voice of the People on a Tragic Problem', *Sunday Independent*, 24 July 1955, p. 5.

[21] The organisation underwent several name changes during its first decades. It began as the National Association of Parents of Backward Children in 1946; it then became The National Society for Mentally Handicapped Children in 1955. From 1969 it was known

sations emerged along a similar pattern. An advertisement in a New Jersey newspaper in 1947 preceded the foundation of the New Jersey Parents' Group for Retarded Children, while a similar appeal prompted the foundation of the Association for the Help of Retarded Children in New York City in 1949.[22] The first organisation in Canada met in Toronto in 1948. Meanwhile, parents in New Zealand formed their own group in 1949 and an August 1950 public meeting instigated the formation of the Mentally Retarded Children's Society in Australia.[23] These organisations aimed to provide a supportive environment to parents of 'mentally backward' children, offering a space for collective discussion, where members could share the challenges associated with home-based care.[24]

In the US, the development of these groups has been presented as both a progressive 'outgrowth of the more general expansion of civic and community organisations' as well as a conservative trend that reinforced a 'stifling set of values: nuclear family, domesticity and togetherness'.[25] In the UK, their emergence has been tied to the propagation of 'expert citizens' in public policy debates.[26] Despite the varied nature of these explanations, a handful

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as Mencap and in 1986 it became the Royal Mencap Society. Sheena Rolph, *Reclaiming the Past: The Role of Local Mencap Societies in the Development of Community Care in East Anglia, 1946–80* (Milton Keynes, 2002), p. 27; Matthew Hilton, Nick Crowson, Jean-François Mouhot and James McKay, *A Historical Guide to NGOs in Britain: Charities, Civil Society and the Voluntary Sector since 1945* (New York, 2012), p. 50; Mencap, *History of Mencap*, https://www.mencap.org.uk/about-us/mencaps-history (accessed 22 July 2017).

[22] Kim E. Nielsen, *A Disability History of the United States* (Boston, 2012), p. 142; Katherine Castle, '"Nice, average Americans": Post-war Parents' Groups and the Defence of the Normal Family', in Steven Noll and James W. Trent Jr (eds), *Mental Retardation in America: A Historical Reader* (New York, 2004), p. 351.

[23] Rose Blackmore, 'Developmental Challenges', in Francis J. Turner (ed.), *Encyclopaedia of Canadian Social Work* (Ontario, 2009), p. 101. The Australian group later became known as Orana. Ian Lewis, *Making a Difference: Sixty Years of Service to the People of South Australia, 1950–2010* (Netley, 2010), p. 5; Wright, *Downs: The History of a Disability*, p. 148.

[24] Kathleen W. Jones, 'Education for Children with Mental Retardation: Parent Activism, Public Policy and Family Ideology in the 1950s', in Steven Noll and James W. Trent Jr. (eds), *Mental Retardation in America: A Historical Reader* (New York, 2004), p. 331; Rolph, *Reclaiming the Past*, pp. 1–5.

[25] Castle, '"Nice, average Americans"', p. 353; Jones, 'Education for children with mental retardation', p. 341.

[26] These figures were a part of the increased professionalisation of mid-century British society, as a growing voluntary sector drew on experts' specialist knowledge (their cultural capital) to cater for specific groups or interests. Hilton et al., *A Historical Guide to NGOs in Britain*, p. 23; Matthew Hilton, James McKay, Nicholas Crowson and Jean-François Mouhot, 'The Big Society: Civic Participation and the State in Modern Britain', *History and Policy* (June 2010), p. 7; Henrik P. Bang, 'Among Everyday Makers and Expert Citizens', in Janet Newman (ed.) *Remaking Governance* (Bristol, 2005),

of features prompted the emergence of these 'parents and friends' organisations. Prominent among them was a repudiation of eugenics-based shame and stigma in the aftermath of the Second World War. Although the Nazi involuntary euthanasia programme (Aktion T4) was not decisive in ending eugenics-based policies worldwide, its scale encouraged parents to discuss the needs of their children in a more public manner.[27] An American GI put it bluntly when he explained that parents of the disabled were no longer willing 'to take shit from anybody', regardless of their child's diagnosis.[28]

This shift towards candour was augmented by an emergent public discourse. Bestselling memoirs such as Pearl S. Buck's *The Child Who Never Grew* (1950), John Frank's *My Son's Story* (1952), and Dale Evans Rogers' *Angel Unaware* (1953) all discussed 'retarded' children in a positive light. In doing so, they legitimised parents' efforts to form public organisations and to campaign for improved services.[29] These memoirs, produced by a Pulitzer prize winner, a professor of constitutional law, and a Hollywood actress respectively, also implicitly underlined how an intellectual disability could occur in any family and in doing so implicitly challenged eugenics-related stigma. Alongside these broader cultural shifts, post-war parental organisations also encountered a particularly supportive environment in which to grow these efforts, as an expanding voluntary sector and a buoyant economy supported the emergence of specialist associations.[30]

Ireland's economic malaise throughout the mid-century might therefore help to account for the state's relatively late entry to this trend. The first Irish parents' organisation, the Association for Parents and Friends of Mentally Backward Children (APFMBC), was founded in November 1955.

p. 160; Matthew Hilton, James McKay and Jean-François Mouhot, *The Politics of Expertise: How NGOs Shaped Modern Britain* (Oxford, 2013), p. 10.

[27] Dagmar Herzog, *Unlearning Eugenics: Sexuality, Reproduction, and Disability in Post-Nazi Europe* (Madison, WI, 2018), pp. 1-–15; Suzanne E. Evans, *Forgotten Crimes: The Holocaust and People with Disabilities* (Chicago, 2004), pp. 16–21; Ivan Brown, 'When is Life Unworthy of Living? Lessons from the Systematic Killing of Children with Disabilities in Nazi Germany', in Roy Hanes, Ivan Brown and Nancy E. Hansen (eds), *The Routledge History of Disability* (Abingdon, 2018), pp. 422–4.

[28] Wright, *Downs: The History of a Disability*, p. 107; Allison Carey, *On the Margins of Citizenship: Intellectual Disability and Civil Rights in Twentieth Century America* (Philadelphia, 2009), p. 108; Tim Stainton, 'Equal Citizens? The Discourse of Liberty and Rights in the History of Learning Disabilities', in Lindsay Brigham, Dorothy Atkinson, Mark Jackson, Sheena Rolph, and Jan Walmsley (eds), *Crossing Boundaries: Change and Continuity in the History of Learning Disability* (Kidderminster, 2000), pp. 87–101.

[29] Pamela Abbott and Roger Sapsford, *Community Care for Mentally Handicapped Children* (Milton Keynes, 1988), p. 48; Pearl S. Buck, *The Child Who Never Grew: A Memoir* (New York, 2012 [1950]), p. 2.

[30] Hilton et al., *A Historical Guide to NGOs in Britain*, pp. 12–33.

It started with Patricia 'Patsy' Farrell, who placed a classified advertisement in the *Irish Times* newspaper in June 1955.[31] It sought interested parties to form an association for parents of handicapped children, an effort that was prompted by the lack of school facilities for her son Brian in Westmeath. Interviewed in the late 1990s, Farrell detailed her ambition for the group: as with parents' organisations in the UK, she wanted the APFMBC to bring parents of the intellectually disabled together to discuss their common challenges; for Farrell, 'great consolation' was possible through an exchange of experiences.[32] After multiple meetings across Dublin, the organisation was formally founded in November at an event that attracted over 200 attendees.[33] Dr Barbara Stokes, the association's first medical director, accounted for this rapid growth by highlighting the lack of support available to families with an intellectually disabled relative. Following a medical diagnosis, parents were usually advised to seek an institutional admission for their child, but were otherwise left to manage in the family home. Yet given public demand, a residential placement could conceivably take years. Stokes explained how the APFMBC sought to address this 'gap' period, by providing a forum where parents could discuss the issues associated with caring for their 'mentally handicapped' child in the wider community.[34] The association began to hold regular discussion sessions and hosted lectures with speakers such as Carlo Pietzner from the Camphill 'curative school' in Northern Ireland, meeting each month in the Country Women's Club in St Stephen's Green.[35]

In the UK, Judy Fryd's organisation was founded in 1946 to provide a forum for discussion; the association only began to consider opening its own services from 1951.[36] By contrast, the Irish APFMBC began to plan their own services from early in 1956, mere months after the group's foundation. Patricia Farrell instigated this organisation because of her personal challenges in caring for Brian, but also because of the absence of educational facilities

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[31] Patricia Farrell, 'Personal', *The Irish Times*, 2 June 1955, p. 10.

[32] Annie Ryan, *Walls of Silence: Ireland's Policy towards People with Mental Disability* (Kilkenny, 1999), p. 75; 'Welfare of Mentally Retarded Children', *Cork Examiner*, 19 October 1957, p. 6.

[33] Mary E. Daly, '"The primary and natural educator"? The Role of Parents in the Education of their Children in Independent Ireland', *Éire-Ireland* 44.1/2 (2009), p. 212; Commission of Inquiry on Mental Handicap, *Commission on Mental Handicap: Report 1965* (Dublin, 1965), p. 11; 'Association to Aid Backward Children', *Irish Press*, 11 November 1955, p. 7.

[34] St Michael's House, *History of Saint Michael's House*, http://www.smh.ie/?q=node/145 (accessed 12 May 2016); Association of Parents and Friends of Mentally Handicapped Children, *St. Michael's House: Annual Report 1975* (Dublin, 1976), p. 1.

[35] 'To Aid Handicapped Children', *Irish Press*, 26 November 1955, p. 2.

[36] Rubahanna Amannah Choudhury, 'The Forgotten Children: The Association of Parents of Backward Children and the Legacy of Eugenics in Britain, 1946–1960', PhD thesis, Oxford Brookes University, 2015, p. 259.

for her son in Westmeath; where, outside of placement in a specialist institution, the only alternative was admission to the local county home or district mental hospital. Awaiting a residential placement, there were few other supports. It was therefore understandable that the APFMBC proposed the idea of a 'special day school' for the intellectually disabled in early 1956, which could help to educate 'backward children' and simultaneously provide respite to family carers during the school day.[37]

Yet, as with residential services, 'special schools' were predicated on a foundation of voluntary action.[38] The Department of Education's approach was rooted in practices inherited from the nineteenth century, when the Victorian-era state had allowed the emergence of denominational state-funded primary schools.[39] There was little appetite to assert statutory control over this following political independence in 1922.[40] Indeed, successive Education Ministers closely adhered to a limited role in acting as a conduit for the statutory funding of schools that were owned and operated by religious bodies.[41] During the mid-1950s Minister for Education Richard Mulcahy (1948–51; 1954–7) commended his remit as the funder and coordinator of voluntary-operated schools. This structure was ideal, Mulcahy suggested, with his department responsible for coordinating grassroots efforts in local communities rather than providing the schools directly. In this environment the Minister for Education was not a catalyst for reform, but a 'plumber who would make the satisfactory connections' to expand the school system.[42]

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[37] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 11; Bernard Farber, *Mental Retardation: Its Social Context and Social Consequences* (Boston, 1968), p. 147; 'Failure to Tackle Problem of the Retarded Child', *The Irish Times*, 11 April 1958, p. 1; 'Welfare of Mentally Retarded Children', *Cork Examiner*, 19 October 1957, p. 6; Constance O'Connell, 'The Many Causes of Juvenile Delinquency in this Country', *Kerryman*, 5 December 1959, p. 12; 'Permanent Body to Study Juvenile Delinquency Urged', *The Irish Times*, 14 November 1958, p. 4.

[38] Donald Akenson, *A Mirror to Kathleen's Face: Education in Independent Ireland 1922–60* (Abingdon, 2012), p. 117.

[39] Antonia McManus, *The Irish Hedge School and its Books, 1695–1831* (Dublin, 2004), pp. 1–3; Donald Akenson, *The Irish Education Experiment: The National System of Education in the Nineteenth Century* (Abingdon, 2012), p. 46.

[40] Indeed, there was an overt desire to maintain the denominational status quo, exemplified by a 1919 education bill from the provisional government that openly endorsed existing practices and declared that the 'Dáil will support the bishops in setting up and maintaining a national system of education'. Séamus Ó Buachalla, *Education Policy in 20th Century Ireland* (Dublin, 1988), p. 54.

[41] Coolahan, *Irish Education*, p. 185; Michael Shevlin, 'Historical Overview of Development in Special Education in Ireland', in Brendan Walsh (ed.), *Essays in the History of Irish Education* (London, 2016), pp. 183–7; John Henry Whyte, *Church and State in Modern Ireland 1923–1979* (Dublin, 1984), p. 337.

[42] Tom Inglis, *Moral Monopoly: The Rise and Fall of the Catholic Church in Modern Ireland* (Dublin, 1998), p. 57; Séan Healy and Brigid Reynolds, *Social Policy in Ireland:*

This was despite the adoption of a new constitution in 1937, *Bunreacht Na hÉireann*, which required the state to ensure that all children received a minimum level of education.[43]

The voluntary management of schools in Ireland contrasted with trends in the UK, where the 1943 White Paper *Educational Reconstruction* laid out a broad plan for increased statutory engagement.[44] The limited role occupied by the Department of Education persisted in light of the state's broader social context. On an ideological level the advantages of a subsidiarist approach were obvious, in that religious bodies continued to operate the majority of schools, with services functioning through an 'institutional monopoly' between the Church and state.[45] For the Catholic Church, which operated the vast majority of the state's primary schools, its role in the education system remained significant, with the hierarchy retaining a 'keen sensitivity' to any potential curtailment of this role.[46] There were also obvious advantages for the state in that a proportion of costs were addressed through local fundraising, while it also aligned with an established approach to infrastructure projects. Sean O'Connor served as an assistant secretary in the Department of Education during the mid-1960s. He described an innate conservatism in its operating practices, as school organising committees were commonly 'requested to submit evidence that the Catholic bishop of the diocese did not oppose the[ir] venture' before the department agreed to support a school project.[47] There were a lot of reasons to favour this status quo, but in doing so the state perpetuated a system where local engagement remained critical and where facilities remained 'fundamentally private institutions in basic structure' until formally opened.[48]

This brought clear risks for the intellectually disabled child, who could easily fall between the gaps in existing provision. Religious orders exhibited little appetite to expand their engagement during the 1950s. Yet without these congregations the Department of Education was not going to directly provide a school for a necessitous group such as the intellectually disabled. There was no legislative basis for such an action, while an expansion of the department's role risked alienating the Catholic Church and would

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Principles, Practice and Problems (Dublin, 1989), pp. 383–5; Patrick Clancy, 'Education in the Republic of Ireland: The Project of Modernity?', in Patrick Clancy (ed.), *Irish Society: Sociological Perspectives* (Dublin, 1995), p. 474.

[43] Article Forty-One, *Bunreacht na hÉireann* (Dublin, 2012 [1934]), p. 166.

[44] Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London, 2001), pp. 65–8.

[45] Inglis, *Moral Monopoly*, p. 57.

[46] Whyte, *Church and State in Modern Ireland*, p. 19.

[47] Sean O'Connor, *A Troubled Sky: Reflections on the Irish Educational Scene* (Dublin, 1986), p. 21.

[48] Freda Donoghue, *Defining the Nonprofit Sector: Ireland* (Baltimore, MD, 1998), p. 14.

deviate from long-established patterns. These were considerable barriers for a department that had remained solicitous to the Catholic hierarchy throughout the mid-century.[49] In this environment, the status quo remained in place, with religious bodies the predominant organiser and manager of the primary school system. The result was an education system where over 90% of national schools were operated under Catholic management into the twenty-first century.[50]

This approach did attract some criticism during the 1950s. The lack of disability-specific classrooms was identified as a key concern at the 1952 INTO teachers' union conference, for example, where the problem was described as 'one of the most trying, most difficult and most significant issues in Irish Education'.[51] At their 1955 meeting, the Franciscan educator Fr Peter Dempsey condemned the department's failure to act in the face of repeated calls for action, reminding officials of their constitutional obligation and that 'the school existed for the child, not the child for the school'.[52] The issue was also a persistent concern among teachers, who repeatedly highlighted how such children could not succeed within an 'ordinary' classroom environment, but were left with little option due to the lack of appropriate alternatives.[53]

Relatives of the 'mentally handicapped' were not the first group to encounter this challenge. In the 1950s there was a variety of school initiatives established by voluntary parents' organisations for children with physical disabilities. The Irish Association for Cerebral Palsy opened its school in 1950. The group's founder, Dr Robert Collis, had repeatedly criticised the Department of Education for its inaction in failing to provide a specialist facility to educate those with physical limitations; he justified the group's efforts as it was 'impossible to teach … [children with cerebral palsy] in ordinary schools'.[54] Similarly, the Central Remedial Clinic (CRC), whose

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[49] O'Connor, *A Troubled Sky*, p. 21.

[50] Colin Barr and Daithí Ó Corráin, 'Catholicism in Ireland, 1880–2015: Rise, Ascendancy and Retreat', in Thomas Bartlett (ed.), *Cambridge History of Ireland: Volume Four* (Cambridge, 2018), p. 75; Noel Woods and Triona Dooney, *Irish Education for the Twenty-First Century* (Dublin, 1999), p. 206; Irish National Teachers' Organisation, *A Plan for Education* (Dublin, 1947), p. 7; Niall Murray, '90% of Primary Schools are Catholic', *Irish Examiner*, 2 April 2011, https://www.irishexaminer.com/ireland/education/90-of-primary-schools-are-catholic-150202.html (accessed 2 November 2018); Joe Moran, 'From Catholic Church Dominance to Social Partnership Promise and Now Economic Crisis, Little Changes in Irish Social Policy', *Irish Journal of Public Policy* 1.2 (2010), pp. 7–21.

[51] 'Backward Children are "Neglected, Ignored"', *Irish Examiner*, 17 April 1952, p. 4.

[52] 'School Exists for Child', *The Irish Times*, 18 June 1955, p. 10.

[53] Barney Boland, 'Dublin Letter: Behind Closed Doors', *Nationalist and Leinster Times*, 3 December 1955, p. 15.

[54] Robert Collis, 'Letter to the Editor: Cerebral Palsy', *The Irish Times*, 7 January 1950,

early work revolved around the rehabilitation of children with poliomyelitis, opened a school at the organisation's headquarters in Goatstown, South Dublin, in 1956.[55]

These 'mixed' schools diverged from the tacitly denominational structure of the Irish education system.[56] This approach also went against a swathe of contemporary Catholic doctrine, including Pope Pius XI's encyclical *Divini Illius Magistri* (1929) and the decrees of the 1929 Synod of Maynooth, both of which emphasised the importance of a religious-influenced education for Catholic children.[57] The need for segregated services was also stressed by the Catholic hierarchy in their approach to most 'mixed' school programmes.[58] This was reflected by figures such as the Archbishop of Dublin, John Charles McQuaid, who condemned 'mixed' school programmes. However, he did not seek to develop a Catholic alternative for 'mentally handicapped' children.[59] This contrasted against McQuaid's earlier efforts to inhibit the non-denominational provision of both tuberculosis and maternal health services.[60]

The Archbishop's (uncharacteristic) docility when faced with a 'mixed' school for the intellectually disabled possibly reflected the fact that 'mentally handicapped' children were poorly served by existing services. When asked about the CRC's classroom, for instance, he had refused to endorse the project as it educated both Catholic and Protestant children together; instead he hoped for a school that functioned 'on a denominational basis, to be attended in the classes for Catholics only by Catholics, to have Catholic teachers for Catholic children and the Parish Priest as manager'.[61] McQuaid

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p. 8.

[55] Valerie Goulding, 'Fundraising Appeal: The Central Remedial Clinic', Dublin Diocesan Archive (hereafter DDA), Central Remedial Clinic Papers (hereafter CRC), L9/3.

[56] Antonia McManus, 'The Irish Hedge School and Social Change', in Karin Fischer and Deirdre Raftery (eds), *Educating Ireland: Schooling and Social Change 1700–2000* (Kildare, 2014), pp. 2–3; Akenson, *The Irish Education Experiment*, p. 384; Ó Buachalla, *Education Policy in 20th Century Ireland*, p. 322.

[57] Pope Pius XI, *Divini Illius Magistri* (1929); E. Brian Titley, *Church, State and the Control of Schooling in Ireland, 1900–44* (Dublin, 1983), p. 121.

[58] Daly, '"The primary and natural educator"?', p. 212; Lindsey Earner-Byrne, 'Managing Motherhood: Negotiating a Maternity Service for Catholic Mothers in Dublin, 1930–1954', *Social History of Medicine* 19.2 (2006), p. 267; Anne MacLellan, '"That preventable and curable disease": Dr. Dorothy Price and the Eradication of TB in Ireland 1930–60', PhD thesis, UCD, 2011, p. 108.

[59] Letter, Archbishop John Charles McQuaid to Fr Ryan, 17 August 1956, DDA Association of Parents and Friends of Mentally Handicapped Children Papers (hereafter APFMHC), L9/10/3.

[60] See the discussion in Earner-Byrne, 'Managing Motherhood'.

[61] Letter annotation, Fr Ryan (parish priest, Dundrum) to Fr Mangan (secretary to Archbishop McQuaid) 15 December 1955, DDA CRC L9/10/1.

likely opposed the CRC project as there was a Catholic school available at the Baldoyle Orthopaedic Hospital, operated by the Sisters of Charity.[62] Yet when asked about the development of the APFMBC's 'special' day school for the intellectually disabled, McQuaid was notably more sanguine, declaring that he would allow this (non-denominational) initiative to function.[63] It appears that the Archbishop was willing to save his opprobrium when denominational provision was obviously failing to meet the needs of families. Of course, the Archbishop was a single person, albeit an influential one. He was also notable for consistently lionising the 'strong and saving influence of the genuinely Catholic School', which made it all the more noteworthy that he was willing to countenance a service that broke with the denominational character of the broader education system.[64]

The APFMBC opened its first 'special day school' for the intellectually disabled, St Michael's House, in 1957. The school underlined its unique position in its pedagogical approach, which was influenced by the philosophy of Rudolf Steiner, who taught educators to view 'childhood as an integrated spiritual and physical process that could inform the teacher of what to teach'.[65] Based in Ranelagh, the school was initially staffed by a teacher who trained in Germany, Sheila McCabe-Reay, alongside a rotating team of volunteers, who catered for a group of ten children. It continued to expand throughout its early years, and by 1965 it had 61 pupils drawn from across South Dublin.[66] St Michael's House became a prototype for community-based 'special schools' and its opening was a pivotal moment in the history of intellectual disability in the state.[67] The emergence of these facilities explicitly challenged ideas around the educational ability of the 'mentally handicapped' child, while they also provided an outlet that supported home carers (usually mothers) during the school day.

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[62] Anne qtd in Nuala Harnett (ed.), *Polio and Us; Personal Stories of Polio Survivors in Ireland* (Dublin, 2007), p. 24

[63] Letter, Archbishop McQuaid to Bishop Cornelius Lucey, 4 October 1957, DDA National Association of the Mentally Handicapped of Ireland Papers, L84/2/3.

[64] John Cooney, *John Charles McQuaid: Ruler of Catholic Ireland* (Dublin, 1999), p. 248.

[65] Christopher Clouder, 'Preface', in Christopher Clouder (ed.), *Rudolf Steiner Education: An Introductory Reader* (London, 2003), p. 23.

[66] Described in the letter as 'Randolph [*sic*] Steiner'. Unsigned Note, DDA APFMHC L102/1/1; 'First Day Centre is Opened by Mrs. O'Kelly', *Cork Examiner*, 11 April 1957, p. 9; Department of Education, *Statistical Report of the Department of Education 1965–66* (Dublin, 1966), p. 14.

[67] Pauline Conroy, *A Bit Different: Disability in Ireland* (Dublin, 2018), p. xi; Andrew Power, *Landscapes of Care: Comparative Perspectives on Family Caregiving* (London, 2012), p. 134; Ryan, *Walls of Silence*, p. 74.

In the UK, early 'special schools' were supported by a range of additional statutory supports, which were outlined in a teacher's letter to the *Parents' Voice* magazine in October 1951. The 'mentally handicapped' attended

> 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.[68]

Although these measures were not always realised in practice, they existed on paper to encourage the development of disability-specific facilities.[69] By contrast, the Irish Department of Education often presented stipulations to 'parents and friends' organisations which sought to open new specialised facilities. The stress was on voluntary groups to meet the state's standards, with seemingly little consideration of what differentiated a 'special school' from any other national school. This intransigence even extended to efforts by religious orders. Brother Burcet, from the Congregation of Christian Brothers, tried to establish a specialist programme for the 'backward' boys at the Artane Industrial School in Dublin during the late 1950s. Burcet, the school's principal from 1956 to 1969, outlined the 'resistance' he encountered from Department of Education officials, so much so that he concluded that 'the physical welfare of the children was the primary concern of the Department [of Education]'.[70] Similarly, when a 'parents and friends' association tried to establish a 'special school' in their area the Department of Education usually required that they meet a number of minimum standards before they could be considered for funding. First, they had to ensure that all pupils were 'educable deficients', which they defined as having an IQ (intelligence quotient) score between 50 and 70 while under the age of 18.[71] Secondly, groups had to retain a school site that was separate from existing national schools and secure 'suitable [*sic*] qualified teachers'.[72] Beyond the (considerable) financial challenge associated with having children assessed or securing a suitable site, retaining an appropriately trained teacher

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[68] 'Letter' in *The Parents' Voice* 2.4 (October 1951), qtd in Choudhury, 'The Forgotten Children', p. 266.

[69] Evans, *The Metamorphosis of Autism*, p. 16.

[70] Ryan Report 4(1), p. 15.

[71] This result was verified through an assessment by an educational psychologist.

[72] Letter, Department of Education, 5 December 1966, qtd in Caoilte Breatnach and Elske Breatnach (eds), *A Caring World: Cion is Cúram, Working with Intellectual Disability in Galway: A History of the Galway Association* (2012), p. 11.

was another high bar; qualifications in 'mental handicap education' were not even available in Ireland until 1960, when St Patrick's College in Dublin launched the first course on this topic.[73] This meant that, until 1961, all suitably qualified teachers had to train abroad. The final stipulation was around pupil–teacher ratios. The department acknowledged that the intellectually disabled required additional attention and greater assistance than their counterparts in other schools. Schools for the disabled were therefore entitled to a reduced pupil–teacher ratio of 15:1 in the early 1960s, versus the mainstream equivalent of 34:1.[74] Although this pupil–teacher ratio was lower, the department sometimes raised concerns about the scale of 'special school' projects. In a letter to the Galway Association for Mentally Handicapped Children, for instance, the Department of Education stipulated that 'there should be sufficient children available, or a reasonable prospect of there being available, to sustain a four teacher school i.e. a minimum of sixty-one pupils'.[75] By contrast, in the nearby town of Tuam the local association was allowed to establish a one-teacher school.[76]

To be clear, the department's conditions were not significantly different from those required of a 'normal' school project in this period, which also had to independently procure a site, ensure a body of pupils, and secure a qualified teacher.[77] Yet it is notable that statutory authorities appeared to grant minimal concessions to these early 'special school' projects, initiatives that were fundamentally different from a local school building campaign, which could more easily secure pupils and financing from within a limited geographical area. Remembering his father's involvement with the Galway Association for Mentally Handicapped Children (later Ability West), the broadcaster Sean O'Rourke recalled how there was 'endless time [spent] on an old coinbox phone in our hall, talking to people … organising meetings, sorting problems, setting up branches'.[78] The scale of effort required from activists in these groups likely limited the emergence of facilities throughout the mid-century, with only thirteen 'special schools' in operation by 1965.[79]

Indeed, meeting the department's conditions was not even the end of this process. If satisfied, the Department of Education would agree to pay

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[73] Coolahan, *Irish Education*, p. 142.

[74] Robins, *From Rejection to Integration*, p. 59; Ryan Report 2(5), p. 197; Coolahan, *Irish Education*, p. 171.

[75] Letter, Department of Education, 5 December 1966, qtd in Breatnach and Breatnach (eds), *A Caring World*, pp. 11–12.

[76] Ibid.

[77] Coolahan, *Irish Education*, p. 142.

[78] Sean O'Rouke, 'Kevin O'Rourke', in Breatnach and Breatnach (eds), *A Caring World*, p. 129.

[79] Department of Education, *Statistical Report of the Department of Education 1965–6* (Dublin, 1966), p. 8.

staff salaries, two-thirds of the school's construction costs, and most of its current expenditure.[80] This left a fundraising 'gap', which had to be made up by the school itself. Again, this challenge was shared by education initiatives nationwide. In his study of St Joseph's College in Manorhamilton, Leitrim, Proinnsíos Ó Duigneáin outlined the range of costs that were left in the hands of the school's organising committee, from agreeing a rate of pay for the building's caretaker to the '£850 spent on new toilets, window repairs and painting'.[81] Yet a school like St Joseph's, which was established for all children in a local area, could effectively raise funds in a manner that was impossible for an equivalent 'special school', which necessarily drew its pupils from a much broader geographical area.

The (sometimes prohibitive) costs faced by parents' organisations meant that fundraising was a key part of a group's work.[82] To address this, voluntary groups commonly embarked on an eclectic range of initiatives. Seán Conneally, from the Galway Association for Mentally Handicapped Children, detailed his group's varied revenue-generating efforts throughout the early 1960s, in response to a Department of Education that had

> agreed to pay five-sixths of the cost of a site and a wooden structure and equipment for the school and pay the salary of a teacher, if there were more than twelve children on the rolls … [we then embarked on fundraising] The first £100 raised by the Association was at a jumble sale at the Columban hall. The ladies held coffee mornings in their houses … a flag-day … the selling of Christmas cards, the running of a raffle for a Connemara pony … an old-time dance held in the Oslo Hotel, a sherry reception and dinner.[83]

In most cases schools lacked the financial support of a religious order, or the geographical concentration of parents in a local area, with the result that they did whatever they could to raise much needed funds. This became a notable feature across voluntary disability services nationally, a trend that was so well established by 1962 that Minister for Health Seán MacEntee could commend the 'freedom of action' taken by local organisations across

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[80] Coolahan, *Irish Education*, p. 142.

[81] Proinnsíos Ó Duigneáin, *A Right not a Privilege: St. Joseph's College Manorhamilton and Educational Initiatives, 1930–1970* (Leitrim, 2013), p. 116.

[82] See the emphasis on fundraising activities in Western Care's Annual Reports throughout the late 1970s. See also the emphasis on fundraising in the accounts of Denis Crowe, Lizzy Kelly, Brigid Brophy and Mary Devane in Breatnach and Breatnach (eds), *A Caring World.*

[83] Seán Conneally, qtd in Breatnach and Breatnach, *A Caring World*, p. 12.

the country.[84] In reality, what MacEntee was praising was a makeshift collection of ad hoc measures driven by the need to establish services, as groups tried everything from bake sales, public collections, raffles, and film screenings to raise funds.[85]

The emergence of 'special schools' in the community marked the start of a significant trend for disability organisations across the anglophone world.[86] The idea of an 'ineducable' child was beginning to recede into the background. Writing in her organisation's newsletter in 1950, Judy Fryd emphasised the state's responsibility to provide appropriate services; it was 'what they pay rates and taxes for – namely, education suitable for their special needs in schools specially built for the purpose'.[87] In Ireland the development of 'special schools' was different, as the international trend of 'special education' was germinating within a distinctive national context. It is true that more facilities became available to the intellectually disabled over time, as the number of places in 'special schools' grew year on year.[88] Yet the character of this development process remains significant, as new facilities in the community required considerable voluntary engagement in the face of an intransigent status quo, which presented a sizeable roadblock in the way of each new 'special school'. On the ground, this was reflected in the limited number of these facilities, with only thirteen in operation by the mid-1960s.[89] However, limited statutory engagement equally established a dynamic around these services, with the voluntary sector retaining considerable autonomy to shape the nature of this 'special education'.

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[84] Seán MacEntee, 'Address at Opening of St. Michael's House in Finglas', 6 April 1962, UCDA p67/672.

[85] 'Day Centre Opened by Mrs. O'Kelly', *Irish Press*, 11 April 1957, p. 4.

[86] Choudhury, 'The Forgotten Children', p. 217.

[87] Ibid.

[88] See Patrick McDonnell, 'Education Policy', in Suzanne Quinn and Bairbre Redmond (eds), *Disability and Social Policy in Ireland* (Dublin, 2003), pp. 28–44; Patrick McDonnell, 'Developments in Special Education in Ireland: Deep Structures and Policy Making', *International Journal of Inclusive Education* 7.3 (2003), pp. 259–69; Andrew Loxley, Aidan Seery and John Walsh, 'Investment in Education and the Tests of Time', *Irish Educational Studies* 33.2 (2014), pp. 173–5.

[89] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 66.

Towards Integration? 'Mainstream' Education, 1965–84

> The history of special provision for Mentally Handicapped persons in Ireland can be seen as an evolution from custodial care for a selected few … to the sophisticated differentiation of needs at which we have arrived today.
>
> *Education and Training of Severely and Profoundly Mentally Handicapped Children in Ireland* (1983)[90]

The 1960s was marked by significant changes across the Irish education system, including the introduction of free tuition for post-primary schools and the expansion of the school transport scheme.[91] These changes reflected a newfound imperative to expand public access to schools, fuelled by a buoyant economy and a growing awareness of the long-term benefits associated with an educated workforce.[92] Yet this wide-ranging reform across the education system was late to encompass the intellectually disabled.

Instead this period was marked by continuities for those with an intellectual disability. Nationwide, 'special schools' grew from a group of thirteen facilities in 1965 to a service that was attended by approximately 5,600 children in 1984.[93] However this expansion occurred along broadly similar lines to the very first iterations of this service, and still required considerable

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[90] Departments of Education, Health, and Social Welfare: Working Party, *Report on the Education and Training of Severely and Profoundly Mentally Handicapped Children* (Dublin, 1983), p. 18.

[91] Whyte, *Church and State in Modern Ireland*, p. 338; Coolahan, *Irish Education*, p. 138.

[92] Sheelagh Drudy and Kathleen Lynch, *Schools and Society in Ireland* (Dublin, 1993), p. 122; Maresa Duignan and Thomas Walsh, *Insights on Quality: A National Review of Policy, Practice and Research relating to Quality in Early Childhood Care and Education in Ireland 1990–2004* (Dublin, 2004), p. 6; John Walsh, *The Politics of Expansion: The Transformation of Education Policy in the Republic of Ireland* (Manchester, 2009), p. 74; T. K. Whittaker, 'Capital Formation, Saving and Economic Progress', *Journal of the Statistical and Social Inquiry Society of Ireland* 19 (1955–56), pp. 185–8; Memorandum, T. Ó Raifeartaigh to T. K. Whitaker, 'Education post-war planning', 8 November 1961, NAI DT S12891 D/1/62; Department of Education, *Investment in Education* (Dublin, 1966), p. 374. See the discussions on disability services during the 1960s in Coolahan, *Irish Education*, p. 186; Séamas Holland, *Rutland Street: The Story of an Educational Experiment for Disadvantaged Children in Dublin* (Amsterdam, 2014), p. 88; Bairbre Redmond and Anna Jennings, 'Social Work and Intellectual Disability: A Historical Perspective', in Noreen Kearney and Caroline Skehill (eds), *Social Work in Ireland: Historical Perspectives* (Dublin, 2005), p. 111.

[93] Department of Health and Social Welfare, *Towards a Full Life*, p. 46. The continued need for parental advocacy around access to education for the disabled is exemplified in the case of Sinnott v Minister for Education (2001), which is discussed further in Thomas Murray, *Contesting Economic and Social Rights in Ireland: Constitution, State*

action by local groups to bring each project to fruition, regardless of the aims articulated by the Department of Education. This brought benefits for the Department of Education and created challenges for both the intellectually disabled and their families. Yet the persistence of a subsidiarist approach also gave space to voluntary groups, allowing them to play a determinative role in shaping their own disability-specific educational services.

An example of this was in 'mainstreaming', where an intellectually disabled child attended a specialist classroom that was physically based in a 'normal' primary school, an approach that was used across 157 schools by 1985.[94] Researchers have accounted for mainstreaming through the shift towards integrated services internationally, arguing that 'growing demands for equality for all, threatened segregation philosophies and gave birth to the belief that the handicapped individual had the right to experience the same opportunities as their mainstream peers, in as unrestricted an environment as possible'.[95] This was true, to a point. In the United States the Education for all Handicapped Children Act 1975 obliged schools in receipt of federal funds to educate all children, including the physically and intellectually disabled. Building upon already acknowledged standards, the Act intended 'that all handicapped children have available to them … a free appropriate public education'.[96] Bolstered by this legislation, parents were now supported in seeking tailored accommodation for their children within 'normal' school settings.[97]

The UK witnessed a similar drive towards integration. Groups such as the Union of the Physically Impaired against Segregation (UPIAS) had

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and Society, 1848–2016 (Cambridge, 2016), pp. 261–3; Department of Education, *Statistical Report of the Department of Education 1983–4* (Dublin, 1984), p. 29.

[94] Department of Education, *Statistical Report of the Department of Education 1984–5* (Dublin, 1985), pp. 32, 2.

[95] Marina Hughes, 'A Study of Policy Documents Illustrating the Development of Thinking and the Provision of Educational Services for Children with a Mental Handicap/General Learning Disability from 1960–1998', MEd thesis, NUI Maynooth, 1999, p. 20.

[96] In particular, the standards established in Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania (1972) and Mills v. Board of Education in District of Columbia (1972). Margaret A. Winzer, *The History of Special Education: From Isolation to Integration* (Washington, DC, 1993), pp. 381–2; Paul T. Hill, 'The Federal Role in Education', in Diane Ravitch (ed.), *Brookings Papers on Education Policy: 2000* (Washington, DC, 2000), p. 23; Jeffrey J. Zettel and Joseph Ballard, 'The Education for All Handicapped Children Act of 1975 PL94-142: Its History, Origins and Concepts', *The Journal of Education* 161.3 (1979), p. 5.

[97] Hill, 'The Federal Role in Education', p. 24; Barbara K. Keogh, 'Celebrating PL94-142: The Education of all Handicapped Children Act of 1975', *Issues in Teacher Education* 16.2 (2007), pp. 65–9; William H. Clune and Mark H. Van Pelt, 'A Political Method of Evaluating the Education for all Handicapped Children Act of 1975 and the Several Gaps of Gap Analysis', in Katharine T. Bartlett and Judith Welch Wegner (eds), *Children with Special Needs* (New Brunswick, 1987), pp. 9–12.

argued against specialist services throughout the 1970s, arguing that an intransigent society 'excludes them from the mainstream of social activities' through disability-specific provision.[98] This thinking was put into action following the *Report of the Committee of Enquiry into the Education of Handicapped Children and Young People* (1978), the Warnock Report. It called for educational support that was targeted towards a broad group of those with 'special educational needs', advocating the removal of categories of disability ('mildly disabled', 'severely disabled'), with 'mainstream' provision recommended wherever possible.[99] The implementation of this report's (varied) body of recommendations was sometimes questionable, as educational statistics failed to show a sizeable transition to mainstream provision by the late 1980s.[100] Instead, its significance lay in its influence on thinking within the sector.[101]

Alongside international trends, there were also national catalysts that spurred the emergence of 'mainstream' provision in Ireland, including the role played by remedial teachers. On foot of the *Investment in Education* report (1966), the Department of Education began to financially support the introduction of support teachers into the national school system.[102] Desmond Swan has highlighted how these staff, tasked with providing additional educational support for 'slow' pupils, helped to blur the distinction between students who required additional educational support and those with a congenital intellectual disability. In this way, growing provision for the 'remedial pupil' provided a means by which the intellectually disabled child could enter their local primary school.[103] The development

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[98] UPIAS, qtd in David Johnstone, *Introduction to Disability Studies* (London, 2001), p. 14.

[99] Committee of Enquiry, *Report of the Committee of Enquiry into the Education of Handicapped Children and Young People* (London, 1978), p. 4; Colin Barnes, *Disabled People in Britain: A Case for Anti-discrimination Legislation* (London, 1991), p. 32; Peter Mittler, 'Warnock and Swann: Similarities and Differences', in Gajendra K. Verma (ed.), *Education for All: A Landmark in Pluralism* (London, 1989), pp. 192–3.

[100] Ted Cole, *Apart or a Part? Integration and the Growth of British Special Education* (Milton Keynes, 1989), p. 132.

[101] Betty Dowling, the principal of a 'special school' in Scotland, saw the report as heralding a new era of integration, as at the time she had expected that 'they would [now] close all special schools'. Angela Turner, 'From Institutions to Community Care? Learning Disability in Glasgow from c.1945', PhD thesis, University of Strathclyde, 2009, p. 391.

[102] Denise Frawley, 'Combating Educational Disadvantage through Early Years and Primary School Investment', *Irish Educational Studies* 33 (2014), p. 155.

[103] Department of Education, *Investment in Education*, p. 346; Con Power, 'White Paper on Educational Development', *Journal of the Statistical and Social Inquiry Society of Ireland* 24.3 (1980/1981), pp. 84–8; Desmond Swan, 'From Exclusion to Inclusion', *Frontline Magazine*, 23 September 2000, https://frontline-ireland.com/from-exclusion-to-inclusion/ (accessed 12 September 2017).

of integrated classrooms was also supported by the removal of examinations from national schools, with the abolition of the primary certificate in 1967.[104] The same year, the introduction of free tuition in secondary schools also reduced the reliance on local authority scholarship examinations for pupils at the end of primary school. This meant that, by the late 1960s, it was possible to complete a primary school education without undertaking any formal examinations. This encouraged parents to initially seek a placement for their child in a local national school, while retaining the option of transferring to a 'special school' if necessary.

'Mainstreamed' classrooms emerged on an ad hoc basis, requiring groups of parents to actively arrange for the placement of their children in one of these designated classrooms.[105] This dynamic placed much of the burden on parents to develop appropriate services for their children. 'Mainstream' classrooms had an obvious advantage in that they avoided the costs associated with a new school building, with the result that they were particularly popular in rural areas that could not sustain the pupil numbers required for a separate 'special school'.[106] A disjuncture between the availability of these services nationwide and their niche role in policy demonstrates the limited role played by the Department of Education in their development. The Department of Health, for instance, foregrounded the importance of segregated services for educating the 'handicapped child'. The Commission on Mental Handicap instigated this trend in 1965, with a lengthy discussion of why an integrated education was undesirable. Such efforts resulted in 'educationally unsound' classrooms, while they were equally unfair to the teacher who 'suffers from lack of contact with other teachers [of the disabled]', while the initiative also risked pupils being 'subject to ridicule from their more able fellows'.[107] Mainstreaming was an option, but only as a last resort when separate provision was not possible. For the Commission, specialist schools were obviously preferable as they offered appropriate support for teachers, classified pupils by ability, and provided 'general vocational training' to older children.[108] The preference for segregated

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[104] In place since 1943, the certificate consisted of exams in Irish, English and arithmetic. Thomas Walsh, '100 Years of Primary Curriculum Development and Implementation in Ireland: A Tale of a Swinging Pendulum', *Irish Educational Studies* 35.1 (2016), p. 7; Martin Brown, Gerry McNamara and Joe O'Hara, 'Teacher Accountability in Education: The Irish Experiment', in Brendan Walsh (ed.), *Essays in the History of Irish Education* (London, 2016), p. 371.

[105] Irish National Teachers' Organisation, *Accommodating Difference: An INTO Policy Document on the Integration of Children with Disabilities into Mainstream National Schools* (Dublin, 1993), p. xii.

[106] Shevlin, 'Historical Overview of Development in Special Education in Ireland', p. 192.

[107] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 73.

[108] Ibid., p. 74.

services persisted in health policy into the early 1980s, when the *Services for the Mentally Handicapped* report described how 'special schools' were superior to any integrated alternative.[109] This preference was likely shaped by the competing remits held by the departments of Health and Education. Mainstreaming efforts, operated in a 'normal' school, were managed by the Department of Education alone, while 'special schools' remained the joint purview of both.[110] This may have influenced the Department of Health's scepticism. In 1980 more than one hundred mainstream classrooms were in operation across the country. Yet health policies continued to frame the concept as a fundamentally untested experiment, something that should be regarded with caution, since 'if such a tendency were to become an accepted part of our policy, it would require some, perhaps radical, changes in our approach to the provision of education services'.[111] Inevitably, the report instead suggested measures that would maintain the Department of Health's engagement, such as the placement of teachers in health-funded 'handicap day-centres'.[112]

The Department of Education lacked a similar imperative to condemn mainstreaming, and (eventually) came to endorse these services, but only after this approach was in widespread use in schools across the country. The National Economic and Social Council's *Major Issues in Planning Services for Mentally and Physically Handicapped Persons* report (1980) acknowledged the value of mainstream provision. Like the Warnock Report in the UK, it stressed the need for a broader range of support services beyond specialist centres. It also criticised the medicalised focus of many disability services and highlighted how some of the needs of the intellectually disabled could be better addressed in mainstream schools; akin to the US Education for all Handicapped Children Act, the report favoured a 'continuum of graduated provision to complement "ordinary education"'.[113] Similar thinking was visible in the 1980 *White Paper on Education Development*. A significant piece of policymaking, it included a broad range of information, including an analysis of existing staff training and the use of specialised curricula.[114] The White Paper proposed that mainstream services should cater for the majority of the intellectually disabled. Specialist centres had a role, but most support could now be provided within the wider education system, where provision would operate along a continuum – from additional in-class remedial help

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[109] Department of Health, *Services for the Mentally Handicapped* (Dublin, 1980), p. 41.

[110] Coolahan, *Irish Education*, p. 163.

[111] Department of Health, *Services for the Mentally Handicapped*, p. 41.

[112] Ibid., p. 42.

[113] National Economic and Social Council, *Major Issues in Planning Services for Mentally and Physically Handicapped Persons* (Dublin, 1980), pp. 58, 81.

[114] Department of Education, *White Paper on Educational Development* (Dublin, 1980).

to separate 'special' services. Mainstreaming was now possible, it suggested, as curriculum reform and ongoing staff development meant that 'integration of the handicapped is not as daunting now as it would have been even ten years ago'.[115]

Of course, these proposals were not applicable to every child with an intellectual disability. The 1983 *Working Party Report on the Education and Training of Severely and Profoundly Mentally Handicapped Children in Ireland* was produced jointly by the ministers for Education, Health, and Social Welfare, and was obviously oriented towards a segregated approach. It envisaged medically staffed specialist care units as the standard service for these children, arguing that their needs were too demanding for an educational setting. However, the report did acknowledge a need for greater input from teachers for 'severely disabled' children, an engagement that was warranted due to there being no 'justification for excluding this population from access to [their] accumulated expertise of teaching'.[116] The final significant policy document, in a period marked by the production of multiple policy documents and proposals, was the Department of Health's 1984 Green Paper *Towards a Full Life*. It (finally) emphasised that, wherever possible, the intellectually disabled should receive their education in mainstream institutions. On the whole, the Green Paper seemed to regard educational services for the intellectually disabled as a notable success, given that 35,000 children received some form of remedial support in their schools ('it can be assumed that a proportion of these children are disabled'), 5,600 attended specialist schools, and a further 1,800 attended specialist classes within the national school system.[117]

This policy reorientation, from specialist provision to 'mainstreaming', was significant, as the goals articulated in this period are echoed in later legislation such as the Education for Persons with Special Educational Needs Act 2004.[118] Yet these policy shifts were not pioneering forays by the state, but instead represented a statutory acknowledgement of practices that were already in use in schools nationwide. The Department of Education only came to reluctantly support mainstreaming by the late 1970s, at which stage it was an already well-established practice. By the academic year 1978/79,

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[115] Ibid., 4.6; This was compounded in the *Programme for Action in Education 1984–87*, which presented a vision where 'special schools … become resource and reference centres for teachers and pupils in special classes throughout their area'. Department of Education, *Programme for Action in Education 1984–87* (Dublin, 1984), 4.1.

[116] Departments of Education, Health, and Social Welfare, *Education and Training of Severely and Profoundly Mentally Handicapped Children*, pp. 40, 45.

[117] Department of Health and Social Welfare, *Towards a Full Life*, pp. 45–6.

[118] Government of Ireland, Education for Persons with Special Educational Needs Act 2004.

for instance, the approach was in use in 133 classrooms nationwide.[119] Yet the department's first policy on this issue was only published in the previous year, in Circular 23/77 (Criteria for the Admission of Pupils to Special Classes in National Schools).[120] It is inconceivable that 133 classrooms were created in a single year. Instead, education policy retroactively endorsed what was happening in practice at schools across the country. This fostered a dynamic in which voluntary groups had a lot of responsibility, but also a considerable degree of autonomy to shape the nature of their services.

The 'Special' Classroom

> So she would have, she would have really struggled in mainstream school … Yeah. Looking back it's hard you know: I'd weigh it up sometimes and I'd say, was it the right decision? I think for us, it was, it was right.
>
> A parent whose child attended a 'special school'[121]

Some statutory proposals were implicitly oriented towards specialist provision for the intellectually disabled, emphasising the pedagogical benefits associated with a 'special school'.[122] This preference was shared by many parents, as the desire for a specialist education likely compounded demand for residential services throughout the mid-century.[123] Inevitably, this influenced the demographics in some institutional facilities, as a proportion of their resident population consisted of individuals who did not require long-term care. For instance, in 1980 it was assessed that 50% of 5- to 14-year-olds in residential centres could be effectively educated outside their institution.[124] The *Services for the Mentally Handicapped* report acknowledged the scale of public demand for 'special' education, explaining how it continued to create issues around overcrowding and inappropriate admissions to residential care. However, given the dispersed nature of community-based facilities, some

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[119] Department of Education, *Statistical Report of the Department of Education 1978–79* (Dublin, 1979), p. 16.

[120] Department of Education, *Criteria for the Admission of Pupils to Special Classes in National Schools* (1977), 23.

[121] Oral history interview, qtd in David Loughnane, 'The Provision of Disability Services in Limerick, 1930–1990', MA thesis, Mary Immaculate College Limerick, 2013, p. 81.

[122] For instance, Commission of Inquiry on Mental Handicap, *Report 1965*, p. 73.

[123] Ryan Report 3(13), p. 237.

[124] This figure rises to 71% among those classified as 'moderately' disabled. Department of Health, *Services for the Mentally Handicapped*, p. 25.

parents (understandably) sought these institutional placements to ensure that their child received an education.[125]

In the UK the 'obligations of citizenship' were stressed by Conservative governments throughout the latter decades of the century.[126] This idea foregrounded the 'duty to work', Anne Borsay suggested, which filtered down into a focus on practical work skills in many 'handicap classrooms'.[127] Speaking in 1975, Margaret Thatcher implicitly reflected this thinking when she discussed a review of educational facilities for the intellectually disabled, which had to consider 'arrangements to prepare them for entry into employment'.[128] In practice, this meant that the education of the intellectually disabled increasingly prioritised their participation in the workforce. Sometimes, this focus came at the expense of their literacy and numeracy. In effect, the disabled person's education was structured around a preconceived notion of their capabilities and potential future occupation.[129] Admission to a special classroom could therefore impact on the broader trajectory of an individual's life.[130] For example, in one special school in Glasgow this approach translated into a focus on the essential skills needed for the world of work, where even religious studies could be used 'if bible stories … illustrate the importance of "honesty at work" and the need to avoid petty pilfering'.[131]

In Ireland, teachers of the intellectually disabled were given scope to tailor their classes under *Curaclam na Bunscoile*, the primary school curriculum. Introduced in 1971, the programme was praised for its flexible approach to learning, as well as the 'child-centred, heuristic and discovery learning methodologies' that it encouraged in the Irish education system.[132] When it came to intellectual disability, the curriculum allowed multiple changes

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[125] Ibid., p. 41.

[126] Borsay, *Disability and Social Policy in Britain*, p. 4.

[127] Ibid., p. 4. See also the discussion of work as a 'social good' in John Welshman, 'Organisation, Structures and Community Care, 1948–71: From Control to Care?', in John Welshman and Jan Walmsley (eds), *Community Care in Perspective: Care, Control and Citizenship* (Basingstoke, 2006), p. 73.

[128] Margaret Thatcher, qtd in Len Barton, 'The Politics of Special Educational Needs', in Len Barton and Mike Oliver (eds), *Disability Studies: Past, Present and Future* (Leeds, 1997), p. 145.

[129] Borsay, *Disability and Social Policy in Britain*, pp. 115–16.

[130] Thomas S. Popkewitz, Miguel A. Pereyra and Barry M. Franklin, 'History, the Problem of Knowledge and the New Cultural History of Schooling', in Thomas S. Popkewitz, Barry M. Franklin and Miguel A. Pereyra (eds), *Cultural History and Education: Critical Essays on Knowledge and Schooling* (New York, 2001), p. 12.

[131] Angela Turner, 'Educating, Training and Social Competence: Special Education in Glasgow since 1945', in Anne Borsay and Pamela Dale (eds), *Disabled Children: Contested Caring, 1850–1979* (Abingdon, 2012), p. 163.

[132] Duignan and Walsh, *Insights on Quality*, p. 8.

in a 'handicap classroom'. For those classified as moderately intellectually disabled, for example, there was an exemption from the obligation to learn Irish and pupils could complete an abridged version of the general curriculum.[133] This flexibility was supposed to support teachers by giving them time to address the particular needs of their pupils. In 'special classrooms' this commonly translated into a focus on social and language skills. Liam Lawlor, a former Principal of the Catherine McAuley school in Limerick, described how classes commonly incorporated social training into their day, as:

> You would have a certain theme for the week … let's say, the railway station and everything then would be developed around that railway station for the week or for a fortnight. Your language development in the mornings, your written work would be … focused on that.[134]

For Lawlor this focus on social skills was an inevitable part of daily life at a 'special school', and this skills training was incorporated into the pupils' academic work.[135] Yet some former 'special school' pupils have raised doubts about the quality of their education at some of these facilities. During the McCoy investigation into the Brothers of Charity centre in Galway, for instance, respondents were highly critical of the standards at their school in Clarinbridge. The investigation found a set curriculum that was 'very basic, covering reading, writing and sums', while only a minority recalled the appearance of subjects such as art, history, and geography. Alongside a limited academic programme, there was an emphasis on the mastery of ancillary skills that could be used in future employment, with students receiving vocational training in 'practical areas' such as horticulture, woodwork, and painting.[136] The McCoy Report underlined how 'most' of its interviewees remained dissatisfied with this education, as they felt it 'was not commensurate with their needs or abilities'.[137]

The primary school curriculum was supposed to help teachers in 'special classrooms', as it allowed them to develop bespoke programmes that addressed their pupils' needs.[138] Yet a focus on manual tasks at some facilities

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[133] Coolahan, *Irish Education*, p. 152.

[134] Liam Lawlor, qtd in Loughnane, 'The Provision of Disability Services in Limerick', p. 82; Maureen Keane, 'A Special School', *Irish Farmers Journal*, 11 December 1965, p. 27.

[135] Loughnane, 'The Provision of Disability Services in Limerick', pp. 82–3.

[136] Kevin McCoy, *Report of Dr Kevin McCoy on Western Health Board Inquiry into Brothers of Charity Services in Galway* [McCoy Report] (Galway, 2007), pp. 48–9.

[137] Ibid., p. 48.

[138] Coolahan, *Irish Education*, p. 152.

mirrors Maurice Roche's broader critique of education in the twentieth century, when he argued that schools had 'both intentionally and latently been oriented to the advanced industrial and capitalist economy for the production and reproduction of variously skilled labour forces'.[139] In other words, the education of some of the intellectually disabled was being overtly tailored to aid their employment prospects in the future. This thinking was a part of daily life at their schools. At the Brothers of Charity in Cork, for instance, academic subjects were taught alongside industrial-style work such as basket weaving and rug making.[140] Although this manual skills-training was described as developmentally significant, these activities could come at the expense of more formal academic development. This left some former pupils at a disadvantage later in life in terms of their possible occupations. One respondent, who believed he had been inappropriately placed in a residential centre, described to the Ryan Commission how 'I believe I am quite intelligent … I have done a lot of study into science, into space travel and stuff like that … but I do not think I had the education to have been able to follow it up'.[141] Indeed, the dangers associated with this bespoke classroom approach were compounded by the inspection regimes that surrounded some of these facilities. In 1959 the Department of Education assigned its first Inspector for 'Special Education'.[142] Yet when it came to the Brothers of Charity school in Lota, the Ryan Commission found little evidence of *any* routine inspection at the school. Instead, it remained the responsibility of the Brothers of Charity to assess 'the quality of care they provided and the suitability of the staff'.[143]

It remains possible that the statutory neglect of Lota's school was an exceptional case. Yet the state's approach to educational provision risked the emergence of a range of different 'special' facilities, especially in light of the sector's 'private complexion'.[144] Páid McGee served as the Director of Special Education at St Patrick's teacher-training college in Drumcondra. Speaking in 2003, he reflected on the limited role played by statutory officials. The department had to 'allow itself to be persuaded of the need' for a new school or classroom, McGee explained, but otherwise had little

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[139] Maurice Roche, 'Citizenship, Social Theory and Social Change', *Theory and Society* 16.3 (1987), p. 365.

[140] M. T. E. O'Connor, 'From Community to Institution, from Institution to Community: Planned Progress to Independence', MSoc thesis, University College Cork, 1991, p. 321.

[141] Ryan Report 2(5), p. 200.

[142] Coolahan, *Irish Education*, p. 185.

[143] Ryan Report 2(5), pp. 201, 234. See also the Brothers of Charity's report: Ann-Marie Dooley Groake, *Community Integration: A Comparative Study of Past Pupils of a Special School and an Ordinary School* (Galway, 1985).

[144] Páid McGee, 'Reflections on Irish Special Education over Four Decades', *REACH: Journal of Special Needs Education in Ireland* 17.2 (2004), p. 67.

engagement with these services beyond allocating their funding.[145] Equally, there was no formal framework for interaction between ‘special schools’ on either a local or regional basis.[146] In this environment a teacher had sizeable latitude about how to best meet their students’ needs, but also could operate with a potentially questionable level of oversight and support.[147] It is clear that many pioneering ‘special schools’ used the scope within *Curaclam* to develop bespoke programmes that helped to equip their pupils for daily life in the community. However, in other cases it remains plausible that a focus on manual skills, such as rug weaving, could end up being used to fill the school day. Indeed, some schools could act as a form of occupational training facility for children, one that offered a basic level of formal education and a preview of the practical tasks that the ‘mentally handicapped’ could expect if employed outside the centre.

Notwithstanding these concerns, ‘special classrooms’ benefited from a growing range of supports during the late twentieth century, as teachers’ unions and parents’ organisations successfully lobbied for additional assistance.[148] When it came to additional training, for instance, teachers who completed the ‘Diploma for teachers of mentally and physically handicapped children’ received an annual allowance.[149] ‘Special schools’ were also supported with lower pupil–teacher ratios. In 1984 there were 494 teachers in specialist schools for the intellectually disabled, teaching a total of 5,035. This gives an average pupil–teacher ratio of 10:1, a third of the contemporaneous rate of 30:1 across the national school system.[150] Considered in the round, it was a significant shift from the statutory neglect outlined by Brosnahan in 1955.

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[145] Ibid., p. 67. As late as 2020, research continued to acknowledge how this sector ‘often appeared to be fragmented and lacking coordination’. Neil Kenny, Selina McCoy and Georgiana Mihut, ‘Special Education Reforms in Ireland: Changing Systems, Changing Schools’, *International Journal of Inclusive Education* (2020), p. 2.

[146] Patrick E. O’Keeffe, ‘Local Education Boards: Implications for Special Education Policy and Provision’, *REACH: Journal of Special Needs Education in Ireland* 9.1 (1995), p. 15.

[147] Teachers could interact with colleagues through professional associations like the Irish Association of Teachers in Special Education, but this would have been on a voluntary basis.

[148] See Association of Secondary Teachers of Ireland, *From School to Work: Issues in Education and Employment for the Disabled* (Dublin, 1981).

[149] Irish National Teachers’ Organisation, *The Professional Development of Teachers: Issues in In-service Education* (Dublin, 1993), p. 68.

[150] *Statistical Report of the Department of Education 1983/4*, p. 29; Coolahan, *Irish Education*, p. 171; Irish National Teachers’ Organisation, *Accommodating Difference*, p. 4.

Conclusion

By the early 1980s accessing a tailored education was easier than ever.[151] In 1984 the Department of Education detailed some of its expenditure on services for the 'mentally handicapped', which included £111,082 on new 'special courses' of teacher-training for those educating the more than 8,000 children attending designated classrooms for the physically and intellectually disabled.[152] Such resources were a considerable shift from the mid-century, when a Dáil deputy had complained about the groups of 'backward children' he encountered outside Dublin schools.[153] These services were accompanied by increased attention to the needs of the disabled in education policy, as the department now acknowledged the importance of specialist provision for a range of children.[154]

Yet this expansion in statutory policy was a recent development, as the majority of new measures were introduced after 1980. The Department of Education's approach remained cautious, simultaneously aware of the need for integration and 'the practicalities of segregation'.[155] Clearly, proposals emerged in response to grassroots efforts, which were being spearheaded by local 'parents and friends' organisations, with education policy trailing these practices on the ground. 'Special schools' were an understandable goal for groups of concerned parents. Left to decide between the (distant) prospect of a residential placement or the unsupportive environment of a primary school, local organisations sought to provide an alternative that could support children to remain in the community. These efforts were praised, as Dáil deputies, teachers' unions, and newspaper columnists stressed the need for these services. Yet no matter how valuable in the lives of the disabled, it remained incumbent upon voluntary groups to manifest new facilities on the ground.

In this environment, voluntary action remained critical. The Department of Education was obviously content to rely on its long-established approach to school building, leaving it in the hands of 'parents and friends' organisations to drive the provision of these new services. For them, this process was economically advantageous, with a proportion of overall costs met through

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[151] Geraldine Scanlon and Alison Doyle, 'Whose Right(s) is it Anyway? A Review of Policy and Practice(s) in Inclusive Education in Ireland', in Brendan Walsh (ed.), *Education Policy in Ireland since 1922* (Cham, 2022), pp. 305–40.

[152] *Statistical Report of the Department of Education 1983/4*, p. 29.

[153] Alfred Byrne, *Dáil Debates* 97, 15 May 1945; Department of Education, *Statistical Report of the Department of Education 1984–5* (Dublin, 1985), pp. 32, 2. See also Irish National Teachers' Organisation, *Providing Education for Pupils with Severe and Profound Handicap* (Dublin, 1996).

[154] See Association of Secondary Teachers of Ireland, *From School to Work* (1981).

[155] Brian Mac Giolla Phádraig, 'Towards Inclusion: The Development of Provision for Children with Special Educational Needs in Ireland from 1991 to 2004', *Irish Educational Studies* 26.3 (2007), p. 291.

fundraising, while it also maintained an established deference to religious bodies in education, and left any potential problems with their local organising committees. These were considerable advantages for a department that had remained cautious in its approach throughout the mid-century.[156] For families with a disabled child, however, it made the road to a 'special classroom' long and challenging, demanding considerable dedication and fundraising efforts. Yet by its inaction, the Department of Education granted these groups some latitude. If the buyer determined the service, then the Department of Education had forfeited its prerogative by only stepping in once most of the organisational work was complete.

Given the challenges associated with establishing 'special classrooms', it was notable that there were more than 8,000 children with (physical and intellectual) disabilities attending day school facilities across the country in 1984.[157] Reflecting on her engagement with St Michael's House in Dublin, Dr Barbara Stokes admitted that there was a cavalier attitude among the group's committee; they 'rushed in where many feared to tread'.[158] Yet by rushing in, organisations such as the APFMBC demonstrated what was possible for the intellectually disabled and encouraged replication of their methods. An RTÉ television profile of St Michael's House sparked the interest of journalist Johnny Mee. He published a letter in the *Connacht Telegraph* newspaper, which led to a meeting that instigated the foundation of the Mayo Association of Parents and Friends of Mentally Handicapped Children (later Western Care).[159] Organisations continued to emerge in this fashion into the late twentieth century, in many cases establishing 'special' classrooms that were vital for intellectually disabled children, while also supporting their families. Through these efforts voluntary organisations addressed an obvious deficiency in statutory provision and demonstrated the ability of the 'handicapped' child. Over time, these approaches were recognised in statutory policy. This was not always the case, however, as some disability policies emerged before services became widely available, as occurred in the case of community-based accommodation programmes.

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[156] O'Connor, *A Troubled Sky*, p. 21.

[157] Department of Health, *Statistical Report of the Department of Education, 1984*, p. 14.

[158] Dr Barbara Maive Stokes (1922–2009) was a paediatrician and disability campaigner. A lifelong advocate for the Intellectually Disabled, she became the medical director of St Michael's House in the mid-1950s, and also served in roles at Stewart's Hospital, the National Health Council, the Medico-Social Research Board and the National Association for the Mentally Handicapped of Ireland. Barbara Stokes, qtd in St Michael's House, *History of Saint Michael's House*, http://www.smh.ie/?q=node/145 (accessed 12 May 2016).

[159] Johnny Mee, 'Breaking New Ground', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 6; Western Care, *Western Care Association: For People in Mayo with Mental Handicap* (Castlebar, 1982).

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Life in the Neighbourhood: Community Housing, 1965–84

Paddy Joe made it clear, he would not return to an institution. During his interview for the current affairs programme *Today Tonight*, he stressed the benefits of a life in the community over his childhood at Kilcornan House, the Brothers of Charity centre near Clarinbridge in Galway. The town was obviously better, he explained, as 'you can have your own freedom … [and] you can go where you want to go'. Following visits to physically ailing institutions, and interviews with exhausted families 'in a constant state of crisis awaiting residential care', journalist Hilary Orpen came to the same conclusion. She praised the approach in Paddy Joe's community-based accommodation, deeming it the ideal way to support an intellectually disabled person in the early 1980s; such programmes should expand further, she recommended, as they provided residents with the best 'opportunity to … [have] a rich and fulfilling life'.[1]

Orpen's assessment mirrored a growing focus on 'care in the community' in statutory policy. Beginning with the Commission on Mental Handicap's report in 1965, a preference for smaller accommodation schemes over congregate facilities was consolidated throughout the 1970s, culminating in the approach adopted across the *Services for the Mentally Handicapped* report (1980) and the *Towards a Full Life* Green Paper (1984), both of which called for the use of so-called 'handicap hostels' wherever possible.[2] Yet this prominence in successive policy documents did not translate into a broad expansion in the number of community-based residences (CBRs) available nationwide, with these facilities able to house less than 3% of the intellectually disabled into the mid-1980s.[3] On paper, CBRs were an

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[1] Hilary Orpen, *Today Tonight*, 13 August 1982, RTÉ Archive.

[2] Department of Health and Social Welfare, *Towards a Full Life: Green Paper on Services for Disabled People* (Dublin, 1984), p. 95.

[3] Ann Kelleher, Denise Kavanagh and Margaret McCarthy, *Home Together: A Study of*

obvious priority and a model for the future of disability provision, while in reality they remained an aspirational dream for most, with nearly ten times more 'handicap admissions' to psychiatric care than the number of beds in community facilities.[4] Yet although limited in number, the distinctive development process for these centres played a role in shaping public perception, resulting in community-based accommodation that obviously diverged from their international counterparts.

'When they can be usefully integrated': Community Housing on Paper

> The successful development of community-based hostels/ homes for small groups of mentally handicapped adults has shown that the large residential centre is no longer the only accommodation option for many mentally handicapped people.
>
> *Towards a Full Life* (1984)[5]

Before 1965, the Department of Health had focused (almost exclusively) on expanding congregate accommodation for the intellectually disabled. This was visible in internal memoranda, which discussed at length how to grow existing institutional services in collaboration with voluntary providers such as religious orders.[6] It was also present in policy documents such as *The Problem of the Mentally Handicapped* (1960), whose headings – existing facilities, institutional accommodation available, further accommodation now in prospect, the difficulty of staffing established institutions, problems in connection with new institutions – make clear its range of concerns. This institutional focus began to shift from 1965, after the Commission on Mental Handicap suggested that the state required a broader range of services, an expansion that was warranted given that 'mental handicap' represented 'one of our gravest problems in the fields of health and education'.[7] At 195

Community-based Residences in Ireland for People with Mental Handicap (Dublin, 1990), p. 199.

[4] Based upon the total number of CBR places versus the 'mental handicap' population in psychiatric institutions during the early 1980s. Ibid., p.186; Dermot Walsh and Aileen O'Hara, *Activities of Irish Psychiatric Hospitals and Units, 1981* (Dublin, 1983), p. 12.

[5] Department of Health and Social Welfare, *Towards a Full Life*, p. 95.

[6] See 'Provision of Extra Accommodation for Mental Defectives', 12 November 1953, NAI H39/25.

[7] Commission of Inquiry on Mental Handicap, *Commission on Mental Handicap: Report 1965* (Dublin, 1965), p. xiii.

pages, including 96 recommendations, the Commission's report exemplified the period's proclivity for exhaustive social policy research into areas that had 'been neglected or individuals who had been traditionally ignored'.[8] Its wide-ranging scope can also be, at least partly, attributed to its extended gestation. By 1965 the Commission had sat for four years, received 38 written submissions, held 102 committee sessions, convened 32 general meetings ('most of which occupied a whole day'), visited disability institutions across Northern Ireland and the Netherlands, and inspected every day centre and residential facility in the state, at a final cost of £10,260.[9]

This research process prompted the Commission to foreground the need for a range of different measures. *The Problem of the Mentally Handicapped* had discussed community-based services, such as day centres, as a 'welcome and valuable development' that helped families engaged in home-based care, but focused the majority of its attention on the lack of places in large-scale institutions.[10] The Commission similarly acknowledged the importance of congregate accommodation facilities; these centres already housed large populations of the intellectually disabled, they were 'desirable in certain circumstances … essential in others'.[11] However, in line with developments elsewhere, the report called for a variety of community-based services, articulating a vision that placed institutional care alongside a broader range of supports. The 'mentally handicapped person' should have access to a continuum of measures, from additional classroom instruction in a 'normal' national school to long-term institutional care.[12] Placement in a specialist facility was not always necessary, it suggested, and in some cases community-based support could instead assist the 'mentally handicapped' person to live successfully outside of a residential environment.[13] This wide-ranging vision attracted praise from Dr John McKenna of University College Dublin, who deemed the final report 'one of the most significant social documents produced in Ireland in the last few decades', while Minister for Health Seán MacEntee assured the 25-person Commission that their

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[8] Counterparts included the 1963 Commission on Itinerancy and the 1967 Commission on Mental Illness.

[9] Commission of Inquiry on Mental Handicap, *Report 1965*, pp. 179–81.

[10] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), pp. 1–10.

[11] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 104.

[12] Ibid., pp. xv–xviii.

[13] Andrew Power, *Landscapes of Care: Comparative Perspectives on Family Caregiving* (Abingdon, 2010), p. 133; Department of Health, *Services for the Mentally Handicapped* (Dublin, 1980), p. 40; Department of Health, *Report of the Working Party on General Nursing* [Tierney Report] (Dublin, 1980), p. 20; National Economic and Social Council, *Community Care Services: An Overview* (Dublin, 1987), p. ix.

recommendations were 'invaluable … to the task of planning, organising and implementing a comprehensive countrywide scheme for ameliorating the lot of all our Mentally Handicapped citizens'.[14]

The Commission's report was the first policy document to demarcate a significant role for community-based services in the lives of the intellectually disabled. Although it never prompted the publication of a government White Paper, its conclusions nonetheless marked the start of a shift towards the community in statutory policy. Less than a decade later, the Working Party on Training and Employing the Handicapped (1974) called for increased investment to limit the state's dependence on institutional facilities.[15] A variety of policy documents agreed on this point, concluding that Ireland relied excessively on congregate care and that there was a need to invest in alternative measures.[16] This 'community turn' was justified in a variety of ways. The Working Party report, for instance, emphasised the need for local services because of the rights of the intellectually disabled; they should not be denied 'the satisfaction derived from being a useful member' of wider society.[17] By contrast, the Task Force on Child Care Services (1980) argued that a residential placement was inherently harmful; it should always be a last-resort measure, as life in an institution was in itself a 'form of deprivation'.[18] The Working Party on General Nursing (1980) discussed this shift to community-based accommodation, acknowledging that this change had occurred over a relatively short period of time. Where residential care was required, it was now the 'policy … to provide modern centres planned in small units allowing for family size groupings'; this approach aimed to offer 'a normal domestic-type living environment' that was in contrast to the 'institutional services of the past'.[19]

This ascendancy in statutory policy can be, at least partly, understood

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[14] 'White Paper on Plans for Handicapped Soon', *The Irish Times*, 24 November 1965, p. 8; Seán MacEntee, 'Speech at dinner for the Commission on Mental Handicap', 3 April 1965, UCDA, MacEntee Papers P67 729, p. 5.

[15] Department of Health: Working Party, *Training and Employing the Handicapped* (Dublin, 1974), p. 28.

[16] Department of Health, *Services for the Mentally Handicapped*, p. 40; Department of Health, *Working Party on General Nursing*, p. 20; National Economic and Social Council, *Community Care Services: An Overview*, p. ix; Department of Health and Social Welfare, *Towards a Full Life*, p. 95.

[17] Department of Health, *Training and Employing the Handicapped*, p. i.

[18] Task Force on Child Care Services, *Task Force on Child Care Services: Final Report 1980* (Dublin, 1980), p. 294.

[19] Department of Health, *Working Party on General Nursing*, p. 22. A similar preference was also visible across the health boards, which transitioned away from a focus on congregate facilities. See North-Western Health Board, *Annual Report 1978* (Sligo, 1979), p. 15; Similar discussions occurred across other health board areas; see Western Health Board, 'Meeting Minutes', 7 July 1975, p. 18; Charlotte Damery, 'Barrymore

as a response to international trends.[20] In particular, the twin concepts of deinstitutionalisation and normalisation offered a compelling conceptual framework to militate against further expanding large-scale facilities. Deinstitutionalisation was part of a broad international movement that sought 'least restrictive' environments for former institutional residents, such as ex-psychiatric hospital patients, during the latter decades of the twentieth century.[21] In general terms, it aimed to reduce the need for segregative services wherever possible and to encourage the provision of bespoke facilities in local communities. In doing so, deinstitutionalisation tried to align the daily lives of service-users as closely as possible to broader societal and cultural norms.[22] This was prompted by a growing awareness of the damage that could occur through a prolonged period spent within a congregate facility. Seminal texts such as Erving Goffman's *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates* (1961) demonstrated how, even if operated well, an institutional environment inexorably shaped the behaviour of its residents and thereby impaired their ability to successfully reintegrate into wider society on discharge.[23] This thinking became influential from the mid-1960s and contributed towards a notable decline in congregate services across the anglophone world.[24]

House: A Bridge to the Community', *Contacts: The Journal of the Eastern Health Board* 1.3 (1975), p. 1.

[20] David L. Braddock and Susan L. Parish, 'An Institutional History of Disability', in Gary L. Albrecht, Katherine D. Seelman and Michael Bury (eds), *Handbook of Disability Studies* (Thousand Oaks, CA, 2001), p. 46.

[21] Dave Earl, 'Australian Histories of Intellectual Disabilities', in Roy Hanes, Ivan Brown and Nancy E. Hansen (eds), *The Routledge History of Disability* (Abingdon, 2018), p. 315.

[22] Kent Ericsson and Jim Mansell, 'Introduction: towards Deinstitutionalization', in Kent Ericsson and Jim Mansell (eds), *Deinstitutionalization and Community Living: Intellectual Disability Services in Britain, Scandinavia and the USA* (New York, 2013), p. 1; Julie Beadle-Brown, Jim Mansell and Agnes Kozma, 'Deinstitutionalization in Intellectual Disabilities', *Current Opinion in Psychiatry* 20.5 (2007), p. 437; David Braddock, Eric Emerson, David Felce and Roger Stancliffe, 'Living Circumstances of Children and Adults with Mental Retardation or Developmental Disabilities in the United States, Canada, England and Wales, and Australia', *Mental Retardation and Developmental Disabilities Research Reviews* 7.2 (2001), p. 115; Eric Emerson and Chris Hatton, 'Deinstitutionalization in the UK and Ireland: Outcomes for Service Users', *Journal of Intellectual and Developmental Disability* 21.1 (1996), p. 17; David Braddock, 'Deinstitutionalization of the Retarded: Trends in Public Policy', *Psychiatric Services* 32.9 (1981), pp. 607–15.

[23] Erving Goffman, *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates* (New York, 1961); Greg Smith, *Erving Goffman* (Abingdon, 2007), p. 78.

[24] John Burnham, 'Deinstitutionalisation and the Great Sociocultural Shift to Consumer Culture', in Despo Kritsotaki, Vicky Long and Matthew Smith (eds), *Deinstitutionalisation and After: Post-War Psychiatry in the Western World* (New

In terms of the disabled, normalisation also influenced Irish policy thinking. First articulated in Denmark's 1959 Mental Retardation Act, it held that the disabled should have the same community-based lives as their non-disabled peers.[25] Disability theorist Bengt Nirje refined this principle, holding that normalisation encouraged the 'mentally retarded [to] obtain an existence as close to normal as possible'. This was not, he later clarified, an attempt to impose 'normalcy', but was instead an effort to ensure that 'mentally handicapped people are entitled to the same rights and opportunities as are available to others in their society'.[26] Arising from human rights principles, normalisation's starting point was to 'view the mentally handicapped as people with intrinsic value who have been devalued by society'.[27] This idea challenged a medicalised understanding of disability as a limitation or defect and instead explored the role played by societal barriers in the creation of a 'handicapped' person, spotlighting the broader failure to appropriately facilitate an individual's specific needs, thereby mirroring the approach and critique associated with the social model of disability.[28] In practice the idea sought that disability services, wherever possible, should mimic the developmental stages in a life cycle, from attendance at school as a child to the attainment of greater autonomy as an adult.[29]

York, 2016), p. 40; Eric Emerson and Chris Hatton, 'Deinstitutionalisation', *Learning Disability Review* 10.1 (2005), p. 36.

[25] Pamela Block, 'Bank-Mikkelsen, Niels Erik', in Gary L. Albrecht, Sharon L. Snyder and David T. Mitchell (eds), *Encyclopaedia of Disability* (Thousand Oaks, 2005), p. 2031; Eric Emerson, 'What is Normalisation?', in Hilary Brown and Helen Smith (eds), *Normalisation: A Reader* (Abingdon, 2012), p. 5; Jan Tøssebro, Inge S. Bonfils, Antti Teittinen, Magnus Tideman, Rannveig Traustadóttir and Hannu T. Vesala, 'Normalization Fifty Years Beyond – Current Trends in the Nordic Countries', *Journal of Policy and Practice in Intellectual Disabilities* 9.2 (2012), pp. 134–5.

[26] Bengt Nirje, 'The Normalisation Principle and its Human Management Implications', in Robert Kugel and Wolf Wolfensberger (eds), *Changing Patterns in Residential Services for the Mentally Retarded* (Washington, DC, 1969), p. 179; Burt Perrin and Bengt Nirje, 'Setting the Record Straight: A Critique of Some Frequent Misconceptions of the Normalization Principle', *Australia and New Zealand Journal of Developmental Disabilities* 11.2 (1985), p. 69.

[27] Anne Boucherat, 'Normalisation in Mental Handicap – Acceptance without Questions?', *Bulletin of the Royal College of Psychiatrists* 11 (December 1987), p. 423. See also Wolf Wolfensberger, *Normalization: The Principle of Normalization in Human Services* (Toronto, 1973), p. 28.

[28] Joseph Berg, Ann Clarke and Alan Clarke, 'The Changing Outlook', in Ann Clarke, Alan Clarke and Joseph Berg (eds), *Mental Deficiency: The Changing Outlook* (London, 1985), p. 4; Union of the Physically Impaired Against Segregation, *Fundamental Principles of Disability* (London, 1976), p. 14.

[29] Sarah Irwin, 'Repositioning Disability and the Life Course: A Social Claiming Perspective', in Mark Priestly (ed.), *Disability and the Lifecourse: Global Perspectives* (Cambridge, 2001), p. 15; Guðrún Stefánsdóttir, 'People with Intellectual Disabilities in Iceland in the Twentieth Century: Sterilisation, Social Role Valorisation and "Normal

Of course, both deinstitutionalisation and normalisation were broad concepts, with varying levels of application (and efficacy).[30] Yet it is clear that these concepts quickly became a part of policy discussions in Ireland, both among voluntary organisations and in the Department of Health. Awareness of normalisation among health officials can be traced through the growing appearance of these terms in statutory policy documents. For example, deinstitutionalisation was cited as a goal for services across the 1984 Green Paper on disability and the *Planning for the Future* study group on psychiatric services.[31] Although these terms only appear explicitly during the early 1980s, these ideas were being discussed within disability services much earlier. In the mid-1970s, the Eastern Health Board's *Contacts* magazine profiled community-based disability services in Denmark. Eileen Larkin's wide-ranging article emphasised how Danish services tried to avoid the segregation of the disabled and instead replicated a 'normal' life-experience, with disused school buildings converted into centres where 'handicapped people … can go out to work during the day'.[32] Although the article never uses the terms normalisation or deinstitutionalisation, Larkin was clearly grappling with their implications in practice and how Danish facilities used them to achieve a 'normal' life for the intellectually disabled outside of a residential setting.[33] These efforts were presented as a novel (if vaguely bizarre) attempt to integrate the 'mentally handicapped' into wider society. Nonetheless, Danish facilities were clearly presented as innovators. For even the casual reader, it was obvious that the future of disability services in Ireland was going to be found through similar forms of community-based support.

There was also pressure from disability organisations to incorporate these ideas, where there were often direct links between Irish groups and international experts. In October 1973, for instance, Niels Erik Banks-Mikkelsen, National Director of State Services for the Mentally Retarded in Denmark (and the inventor of the term normalisation), spoke at a seminar hosted by the Mayo Association of Parents and Friends of Mentally Handicapped Children (later Western Care) in Castlebar. Throughout his lecture Banks-Mikkelsen

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Life"', in Jan Walmsley and Simon Jarrett (eds), *Intellectual Disability in the Twentieth Century: Transnational Perspectives on People, Policy and Practice* (Bristol, 2019), p. 131.

[30] Emerson, 'What is Normalisation?', pp. 1–5.

[31] Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland* (Newbridge, 2016), pp. 224–9; Damien Brennan, *Irish Insanity, 1800–2000* (Abingdon, 2013), p. 101; Andrew Power, Janet Lord and Allison DeFranco, *Active Citizenship and Disability: Implementing the Personalisation of Support* (Cambridge, 2013), p. 421.

[32] Eileen Larkin, 'In Denmark the Community Cares', *Contacts: The Journal of the Eastern Health Board* 1.7 (1975), p. 4.

[33] Ibid.

emphasised how Danish state services had 'achieved world-wide recognition as a model of excellence and comprehensiveness' through their use of normalisation as a guiding principle.[34] His recommendations influenced the approach adopted by his audience, as the Mayo Association went on to highlight the dangers associated with segregated 'handicap' facilities and stressed the importance of provision that was based in local communities. Four years later at their 1977 Annual General Meeting, the association's manager Geoffrey Salisbury emphasised the salience of the group's community-based approach, noting their efforts to integrate the intellectually disabled into local social activities and to provide services that matched a 'normal' life-experience in the wider community.[35] In 1978 Salisbury elaborated further on this point, explaining how the group aimed to treat 'the handicapped as normally as their handicap allows them to be treated'.[36] This approach was shared by other voluntary groups. Seán Conneally worked as a psychologist with the Galway County Association for Mentally Handicapped Children (later Ability West) in the early 1980s. He recalled their work in the community, and how they were 'trying to have services as normalised as possible … It was all about normalisation and the whole principle of people with learning disability actually being a participating member of the community.'[37]

This idea, that the intellectually disabled were entitled to live in the same way as everyone else, might have appealed to some at a conceptual level. Mary Loftus, secretary of the Ballina branch of the Mayo Association, emphasised how the group's focus on community services attracted her during the late 1960s, as their efforts meant that disabled children could 'be treated as normal people in the community with the same hopes and dreams as everybody'.[38] Community-based housing may also have gained support from parents' groups as a means of postponing (or even preventing) admission to institutional care. This became increasingly significant from the mid-1960s onwards, as demand for residential places continued, while the number of available beds remained limited. In 1966 there were 871 people on residential waiting lists nationwide, seeking admission to a network

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[34] 'Mental Handicap Seminar at Castlebar', *Western People*, 13 October 1973, p. 23; 'Specialist Needs to Aid Handicapped', *Connacht Tribune*, 24 June 1977, p. 17.

[35] 'Co-operation between Community and Western Care of "Vital Importance"', *Mayo News*, 5 February 1977, p. 13. See also Western Care, *Annual Report 1978* (Castlebar, 1979), p. 6.

[36] Geoffrey Salisbury, *Western Care News: 1978* (Castlebar, 1979), p. 3.

[37] Seán Conneally, qtd in Caoilte Breatnach and Elske Breatnach (eds), *A Caring World: Cion is Cúram, Working with Intellectual Disability in Galway: A History of the Galway Association* (2012), p. 54.

[38] Mary Loftus, 'Ballina Branch and North Mayo', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 51.

of institutions that had a total of 3,534 beds.[39] Like its antecedents, however, this waiting list likely represented only a small fraction of those who applied, while there were an additional 3,646 'handicap admissions' spread across the district mental hospital and county home system.[40] Placement in a specialist institution therefore represented a distant prospect for the vast majority, with residential centres only able to cater for a fraction of those who sought care at a given time. Arguably, this hope became increasingly distant into the latter decades of the century, as institutions that were founded to educate children transitioned to provide long-term residential care for those who had little prospect of being discharged into the community. The disability campaigner Annie Ryan highlighted these issues during the late 1970s when she decried discussions of institutional waiting lists. It was a pointless exercise, she explained, as the lack of discharges from these centres meant that 'you are, in effect, waiting for someone to die' for a bed to become available.[41]

Alongside demand for places in specialist facilities, this period was also marked by a growing awareness of failures in institutional facilities. Writing in 1986, Anne Borsay linked the emergence of British 'care in the community' initiatives to a growing public awareness of the ways in which a long-term residential centre could fail its residents.[42] Pauline Morris's *Put Away: A Sociological Study of Institutions for the Mentally Retarded* (1969) exemplified this body of research.[43] An assessment of 35 centres for the 'mentally retarded' across the UK, it revealed institutions that had inflexible daily routines, where residents lived in physically rundown communal wards, conforming to child/parent dependency relationships with staff.[44] The 1969 inquiry into failures at Ely Hospital near Cardiff provided a similar insight into failures within an institutional facility that housed large numbers of the intellectually disabled. In this case, claims of abuse aired by a former staff member were substantiated in a report that outlined a regime of 'cruel ill treatment … [characterised by] generally inhumane and threatening behaviour towards patients'.[45] Public exposés were augmented by academic research that questioned the need for residential services altogether. F. Joan Todd's *Social Work with the Mentally Subnormal* (1967) discussed the dangers of housing an intellectually

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[39] Donogh O'Malley, *Dáil Debates* 222, 28 April 1966, col. 1032.

[40] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 108.

[41] Frank McDonald, 'Mother Fasts to Aid Mentally Ill', *Irish Press*, 2 August 1978, p. 7.

[42] Anne Borsay, *Disabled People in the Community: A Study of Housing, Health and Welfare Services* (London, 1986), p. 1.

[43] The report's full title was *Report of the Committee of Inquiry into Allegations of Ill–Treatment of Patients and other irregularities at the Ely Hospital, Cardiff.*

[44] Pauline Morris, *Put Away: A Sociological Study of Institutions for the Mentally Retarded* (London, 1969), pp. 76–99, 164–88.

[45] Michael Pantelides (cited as XY), in *Report of the Committee of Inquiry into … Ely Hospital, Cardiff* (London, 1969), Section 1–2.

disabled person in any institution for any period of time. Such regimented accommodation should be avoided, the book warned social workers, as these services could ‘be as damaging as, or more so than, the original conditions’ in the family home.[46] Central to Todd’s analysis was how an institutional regime inhibited the intellectually disabled, who when resident in a facility had ‘less initiative and participation in decisions concerning their future than is found in other settings’.[47] This mirrored trends in the United States, where books such as Burton Blatt and Fred Kaplan’s *Christmas in Purgatory: A Photographic Essay on Mental Retardation* (1966) highlighted the ‘serious imperfections of institutions for the mentally retarded’.[48] Using an early form of hidden camera, this investigative exposé provided a harrowing insight into daily life in residential institutions where the ‘mentally retarded’ lived in overcrowded, dirty, and often physically unsafe wards.[49]

During the mid-century there had been an overt emphasis on expanding institutions wherever possible, with the Department of Health actively pursuing the growth of congregate services in collaboration with voluntary service providers. By contrast, the mid-1960s introduced an unmistakable note of scepticism, as policy documents began to acknowledge the potential dangers associated with residential care. The Commission on Mental Handicap, for instance, reminded readers that:

> institutional life can be disabling in its effects, emotionally, physically, and socially. It is now realised that the condition of many patients in institutions derives to a greater degree from their environment and

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[46] F. Joan Todd, *Social Work with the Mentally Subnormal* (London, 1967), p. 47.

[47] Ibid., p. 48.

[48] Burton Blatt and Fred Kaplan, *Christmas in Purgatory: A Photographic Essay on Mental Retardation* (New York, 1974 [1966]), p. 121; Allison C. Carey and Lucy Gu, ‘Walking the Line between the Past and the Future: Parents’ Resistance and Commitment to Institutionalisation’, in Liat Ben-Moshe, Chris Chapman and Allison C. Carey (eds), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (New York, 2014), p. 108; Kim Nielsen, *A Disability History of the United States* (Boston, 2012), p. 145; Steven J. Taylor, ‘Christmas in Purgatory: A Retrospective Look’, *Mental Retardation* 44.2 (2006), p. 145.

[49] Burton Blatt, ‘Introduction’, in Blatt and Kaplan, *Christmas in Purgatory*, p. vi. Such exposés were matched by a willingness to highlight failures within individual institutions, as when Senator Robert Kennedy deemed the Willowbrook State School in Staten Island a deplorable ‘snake pit’ where residents lived in ‘filth and dirt, their clothing in rags, in rooms less comfortable and cheerful than the cages in which we put animals in a zoo’. Robert Kennedy, qtd in Arie Rimmerman, *Disability and Community Living Policies* (Cambridge, 2017), p. 68; These criticisms persisted into the 1970s: television journalist Geraldo Rivera broadcast an investigation into similar failures within the facility in 1972; see Helen Starogiannis and Darryl B. Hill, ‘Sex and Gender in an American State School (1951–1987): The Willowbrook Class’, *Sexuality and Disability* 26 (2008), pp. 83–103.

> the way they are treated than from the illness which caused their admission.[50]

Instead, the goal was to help the intellectually disabled 'to overcome their disabilities and to become independent … members of society', an aim that could be met through the use of community-based services.[51] Institutions were not regarded as deficient in their care, but time spent in this environment was regarded as nonetheless impairing in its effect. This nuanced perspective had to emerge due to the nature of the state's residential infrastructure. There was a balancing act for health officials between praising a model that was predominantly provided through Catholic religious orders on the one hand, and discussing why there was a need for new community-based measures on the other. This challenge was apparent at the opening of the Holy Family 'special school' in Renmore, Galway, in 1965, when a representative of the Minister for Health noted the department's gratitude to the religious orders that operated congregate disability institutions; they 'for so many years, virtually alone … carried the burden of caring for the mentally handicapped'. Yet the same representative also acknowledged the need to develop new services based within local communities.[52]

CBRs also had a financial advantage. In the UK, the emergence of 'care in the community' has been linked to the 'ever rising' expenses associated with residential services.[53] Going into the latter decades of the century, there was a growing awareness of the expenses associated with congregate facilities. A 1971 report by the Irish Hospitals' Trust, for instance, discussed a range of 'very substantial capital expenditure' that was required to renovate

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[50] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 104.

[51] Ibid., p. 50. The Commission on Mental Handicap was not alone in emphasising the need to limit recourse to institutional services; an identical statement was also included in the *Report of the Commission on Mental Illness* (1966), while the 1970 *Report on Industrial and Reformatory Schools* (the Kennedy Report) stressed how institutional admissions should be regarded as a last resort measure, used only in the absence of an alternative. Commission of Inquiry on Mental Illness, *Commission on Mental Illness: Report 1966* (Dublin, 1966), p. xxii; Committee on Reformatory and Industrial Schools, *Reformatory and Industrial Schools System: Report 1970* [Kennedy Report] (Dublin, 1970), p. 6; Caroline Skehill, *History of the Present of Child Protection and Welfare Social Work in Ireland* (New York, 2004), p. 67.

[52] 'Holy Family School for Mildly Retarded Boys', *Connacht Sentinel*, 14 September 1965, p. 2.

[53] John Welshman, 'Rhetoric and Reality: Community Care in England and Wales, 1948–74', in Peter Bartlett and David Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community, 1750–2000* (London, 1999), pp. 205–8; Borsay, *Disabled People in the Community*, p. 1; Pamela Abbott and Robert Sapsford, *'Community Care' for Mentally Handicapped Children: The Origins and Consequences of a Social Policy* (Milton Keynes, 1987), p. 43.

existing disability institutions across the state.[54] Working from a different angle, the *Towards Better Health Care* report (1970), a multi-volume study of the Irish health system by the management consultants McKinsey and Company, recommended the creation of community care teams. These were groups of staff who would provide 'financial and personal support' to a variety of groups, including the 'handicapped, the aged and the needy' across each health board area. The report acknowledged that the creation of these teams represented a new cost for the authorities, but stressed that these supports would ultimately limit reliance on institutional care facilities and thereby produce a net economic benefit.[55]

This financial dimension was crucial to an analysis by the Department of Finance official James Fitzharris. His 1981 report compared residential centres with CBRs, underlining the differences between these two forms of accommodation, as on average a CBR placement cost 'between half and three quarters' of its institutional equivalent.[56] At the Brothers of Charity's CBR in Galway, for example, residential places cost an average of £4,060 per year, while the per resident rate at Kilcornan House was £8,736. The report disregarded the rehabilitative benefits associated with a community-based life and instead justified the department's preference for CBRs on financial grounds alone.[57] It was noteworthy that health officials were also cognisant of this financial dimension. In a 1976 letter to Joan Collier, from the Irish Countrywomen's Association in Meath, a Department of Health official outlined some of the future approaches to the intellectually disabled in Ireland, explaining that 'the majority of the Mentally Handicapped, given proper support services, should be able to live with their families or perhaps in hostel-type accommodation in the community'. This community-based approach was preferable, the official noted, for both 'humanitarian and economic reasons'.[58] The financial benefits of CBRs were clear, and if these services could also benefit their residents so much the better. This economic

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[54] Irish Hospitals' Trust, *Irish Hospitals 1956–71* (Dublin, 1971), p. 90.

[55] McKinsey and Company, *Towards Better Health Care: Management in the Health Boards: Volume One* (Dublin, 1970), 2–9.

[56] The report does not delve into the potential greater dependency of institutional residents versus their peers in community-based services. James Fitzharris, 'Cost of Hostels and Day Care Centres for the Mentally Handicapped' (Department of Finance: Analysis Section, October 1981), p. 1. A similar regional-focused analysis is available in Ann R. Broekhoven-Kyne, 'Comparative Cost of Care for Mentally Handicapped Persons in Galway', MA thesis, University College Galway, 1990.

[57] Fitzharris, 'Cost of Hostels and Day Care Centres', pp. 34–5, 1.

[58] Letter, G. Johnston (Department of Health) to Joan Collier (ICA Guild, Dunsany, Meath), 16 December 1976, National Library of Ireland, Irish Countrywomen's Association Papers, 39,526.

dimension goes some way towards accounting for the 'fervent conversion' to community-based accommodation seen across the era's statutory proposals.[59]

Health policies are complex, shaped by the often vexed process of bureaucratic decision making and bound to a pluralistic range of interests.[60] The rapid ascendancy of CBRs in statutory policy must be considered in light of this myriad of influences. Indeed, the rapid shift in statutory policy can be attributed to a varied range of developments, from the Department of Health's effort to reduce costs to the growing influence of international thinking. These features also went on to influence the emergence of community-based residences in practice, as facilities were established by disability organisations across the country.

'A welcome improvement for all concerned': Community Housing in Practice

> The clients were not shunted off to some remote part of the country, but to residences in the very heart of tourist thronged Salthill.
>
> Kevin Whelan, Galway County Association for Mentally Handicapped Children[61]

For the intellectually disabled, the transition from a residential institution to a CBR brought sizeable changes to their daily lives. Usually based in a housing estate, these facilities were supposed to approximate 'ordinary homes' in the community, while they tried to bring residents into daily contact with neighbours and wider society.[62] This was a shift from the typical experience at a congregate facility. Erving Goffman described how 'block treatment' and rigid daily routines were characteristic features in an institutional setting, noting how these practices appeared to shape residents' behaviour over time.[63] Set daily routines were also a part of life in centres

[59] Annie Ryan, *Walls of Silence: Ireland's Policy Towards People with a Mental Disability* (Kilkenny, 1999), p. 106.

[60] Dorothy Porter (ed.), *The History of Public Health and the Modern State* (Amsterdam, 1994), p. 24.

[61] Kevin Whelan, qtd in Breatnach and Breatnach (eds), *A Caring World*, p. 61.

[62] Mary Purcell, *A Time for Sowing: The St. John of Gods Brothers in Ireland: A Centenary Record 1879–1979* (Dublin, 1980), p. 120.

[63] Goffman, *Asylums*, p. xii; Jan Walmsley, 'Ideology, Ideas and Care in the Community 1971–2001', in John Welshman and Jan Walmsley (eds), *Community Care in Perspective: Care, Control and Citizenship* (Basingstoke, 2007), p. 42.

for the intellectually disabled in Ireland, as they commonly focused on the fulfilment of basic physical needs and the maintenance of an orderly environment. At Kilcornan House in Galway, for example, former residents recalled their unchanging days, where they slept in large dormitories and carried out activities communally into the mid-1970s.[64] Similar practices also persisted on the 'handicap wards' of psychiatric hospitals. At St Senan's in Enniscorthy, for instance, the intellectually disabled dressed from a central supply of clothes. Their breakfast arrived from the hospital kitchen at exactly 8:15 each morning, with tea served from pots that already had 'milk and sugar added', while there was no need for cutlery as 'the bread is already buttered'.[65]

Community housing was different. During an interview in 1986 a CBR resident underlined the everyday nature of their routines; it was a life where 'You just get along with one another or fight like cats and dogs – we have our ups and downs like everybody else.'[66] These services aimed to ensure that residents had a 'normal' life, which included adopting a more flexible approach to their daily activities and moving away from institutional-style practices. St Patrick's Hostel in Upton, Cork, was a CBR operated by the Rosminian Fathers. In the house residents had flexibility within their daily routines, as well as being tasked with buying their own clothes and 'personal requisites' (such as toiletries) from a budget. Along with this flexibility there were also increased responsibilities, including daily household tasks for each resident, which commonly included washing dishes, setting the table, cleaning communal areas, and maintaining their rooms.[67] Discussing its new CBR in Newport, Mayo, the 1979 edition of Western Care's newsletter explained how this service would operate. It was supposed to mirror a family environment as much as possible, which meant 'allowing for individual needs and moods of good and bad "form"'.[68] Each CBR had a member of staff, titled a 'houseparent', who was usually addressed by their first name. They lived on-site, where they supervised residents and assisted in preparing meals, a role that was clearly different from religious staff or shift-based workers in a congregated setting.[69]

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[64] Kevin McCoy, *Report of Dr. Kevin McCoy on Western Health Board Inquiry into Brothers of Charity Services in Galway* [McCoy Report] (Galway, 2007), p. 46.

[65] Peter Kieran, 'Eighteen Plus: An Examination of the Life Experiences of Adult Moderately Mentally Handicapped Persons in the South East of Ireland', MSoc thesis, University College Cork, 1982, pp. 4–5, 85.

[66] Jodie Walsh, *Let's Make Friends* (London, 1986), p. 22.

[67] Kieran, 'Eighteen Plus', p. 4.

[68] 'Newport Residential Home and Day Centre', *Western Care News 1979* (Castlebar, 1980), p. 2.

[69] *Seven Days: Mentally Handicapped Children*, 10 March 1979, RTÉ Archive.

Like 'special schools', CBRs were pioneered by voluntary organisations, with early facilities provided by voluntary groups including the Hospitaller Order of St John of God and the Brothers of Charity. Described as 'chalet villages', these initial projects were clusters of domestic-scale houses constructed beside existing residential institutions. St Augustine's in Blackrock, Dublin, established six chalets in December 1965, with the aim of relieving overcrowding in the main house and taking 'the atmosphere of the institution out of … [residents'] lives'.[70] A similar initiative opened at Kilcornan House in 1974, described as a 'village complex'. Based beside the main house, it consisted of thirteen individual bungalows that were grouped around a pathway. Journalist Hilary Orpen underlined the solitude associated with this complex, describing the houses, which were designed to reflect a cul-de-sac in an estate, as a site of 'luxurious isolation' for their residents.[71] This was an initial step away from large-scale provision. Yet these were not community-based facilities, as those resident in the 'village complex' commonly remained in the centre and had limited interaction with the local area.[72]

The implications of the state's approach was readily apparent across disability services by the late 1950s, when Department of Health officials had struggled to engage new religious orders to provide further institutional facilities. Yet the Department of Health adhered to this dynamic into the late twentieth century, as it continued to encourage voluntary groups to establish new community-based services such as CBRs. At the 1972 AGM of the KARE organisation in Kildare, Minister for Health Erskine Childers implored his audience to expand KARE's (then nascent) community accommodation programme. There were many advantages to a community-based approach, Childers emphasised, including how these services could limit the number of institutional admissions, and 'the more people [that] can be kept in the community, the better will be the future for them'.[73] Voluntary organisations were clearly expected to play a role in the development of new community-based facilities, with the state providing funding to support their efforts.[74]

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[70] '"Village" for Retarded Needs Help', *Irish Independent*, 20 September 1966, p. 9.

[71] Hilary Orpen, *Today Tonight*, 13 August 1982, RTÉ Archive.

[72] McCoy Report, p. 29.

[73] Qtd in Vicki Weller, *An Extraordinary Voluntary Commitment: 25 Years of KARE* (Kildare, 1992), p. 30.

[74] Bryan Fanning, 'Communitarianism, Social Capital and Subsidiarity', in Bryan Fanning, Patricia Kennedy, Gabriel Kiely and Suzanne Quin (eds), *Theorising Irish Social Policy* (Dublin, 2004), p. 44. This dynamic extended beyond services for the intellectually disabled. On children's homes, for example, the Minister for Education Richard Burke (1973–76) also adhered to the established approach and warned that 'the state should not interfere … any more than is necessary' with these services, which

In practice this meant that local activism remained critical to the emergence of most new CBR facilities; a dynamic that replicated many of the challenges associated with the development of other disability services, including the lack of overall coordination in the availability of residential facilities and the logistical challenges encountered by new 'special schools'. Voluntary organisations developed the first community-based services, in many cases as a means of relieving overcrowding in their residential facilities. By the mid-1980s, the Hospitaller Order of St John of God had ten CBRs in the north-east, while the Brothers of Charity founded residences across the west coast, with houses in Connemara, Ballinasloe, Castlerea, Gort, and Roscommon Town.[75] Non-denominational parents' organisations also established their own accommodation programmes.[76] Yet despite the overwhelming preference for CBRs in statutory policy, the number of available beds in these facilities remained limited. In 1981 the Department of Health estimated that approximately 1,531 of those resident in institutional facilities could live outside of a congregate environment, which represented 45% of the total population of 3,393 residential places nationwide.[77] However, despite the large numbers of the intellectually disabled who could avail of this accommodation, CBRs could then accommodate only a fraction, as they had 376 places. Even by the end of the 1980s, when the varied benefits associated with these centres were well established and they occupied a central role in statutory policy, CBRs could house just 2.25% of the intellectually disabled nationwide.[78]

To an extent, the transition away from congregate care was always going to be a slow process. In practical terms, CBRs were challenging to set up; houses had to be dispersed within a local area rather than clustered together, which called for additional planning. These services

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in practice meant maintaining the state's established reliance on voluntary service providers. Diarmaid Ferriter, *Ambiguous Republic: Ireland in the 1970s* (London, 2012), p. 376.

[75] Harold O'Sullivan, *The House on the Ridge of the Weir: The Story of the Brothers and the Community of Saint John of God, St. Mary's, Drumcar* (Louth, 1998), p. 115; McCoy Report, p. 29; Mary Therese O'Connor, 'From Community to Institution, from Institution to Community: Planned Progress to Independence', MSoc thesis, University College Cork, 1991, p. 268; Hilary Orpen, *Today Tonight*, 13 August 1982, RTÉ Archive.

[76] Cróna Esler, 'Helping Children who Cannot Help Themselves', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 36; Breatnach and Breatnach (eds), *A Caring World*, p. 61; KARE, 'Newsletter 1985' (Kildare, 1985), NAI TAOIS 2015-77-153.

[77] Department of Health, *Services for the Mentally Handicapped*, p. 26; Department of Health: Planning Unit, *Statistical Information Relevant to the Health Services, 1981* (Dublin, 1981), p. 36.

[78] Kelleher et al., *Home Together*, p. 199.

were also resource-intensive. For example, to move residents out of a single pavilion unit at the Brothers of Charity centre in Lota required multiple separate houses in the community, each of which had to be purchased and furnished along the lines of a standard domestic dwelling. Lack of resources undoubtedly played a part in limiting the emergence of CBRs among some voluntary groups, as even established service providers incurred significant costs in opening these facilities. For instance, Hospitaller Order of St John of God operated St Augustine's in Blackrock. It funded much of this community housing programme through voluntary largesse. Dun Laoghaire Soroptimist Club furnished one of the first houses, while the nearby confectionery manufacturer Rowntree-Mackintosh donated a minibus.[79] The St Augustine's 'parents and friends' group also carried out fundraising to equip a playground, an effort that was supplemented by a local youth club.[80] Notwithstanding this support, the order still incurred a debt of £13,000 for the new buildings, of which 'very little … [had] been cleared' by 1966.[81]

Every bit of help was welcome, as Annie Ryan detailed a handful of the projected expenses associated with the Eastern Health Board's Cheeverstown facility in Dublin, which gives some insight into the potential costs associated with establishing one of these centres for a voluntary organisation. Each bungalow was expected to have

> well-appointed kitchens with cooker, microwave, dishwasher, liquidiser, and food processor. The living areas will be provided with modern television, stereo and video equipment … Special chairs will be provided for some of the handicapped at a cost of £999 each … Each person will be allocated £150 for the purchase of clothes and shoes.[82]

Although no expense was decisive in and of itself, the range of costs associated with a new CBR presented an obvious impediment for some. 'Section 65' payments, or later direct funding from the Department of Health, operated through a 'grant in aid' structure, which meant that the state *could* choose to support a voluntary service. Yet there were a range of costs associated with a CBR before a centre could admit its first residents. Aside from the possibility of receiving a capital funding grant, this left a considerable fundraising hurdle in the hands of the voluntary sector.

Additionally, statutory payments were commonly delivered via a block grant, with little direction as to how it should be allocated or any guarantee that

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[79] Purcell, *A Time for Sowing*, p. 120.

[80] Ibid.

[81] '"Village" for Retarded Needs Help', *Irish Press*, 20 September 1966, p. 9.

[82] Ryan, *Walls of Silence*, p. 119.

the organisation would receive a comparable level of support in the following year.[83] This (seemingly) arbitrary structure discouraged criticism of the state, out of fear that an organisation might lose its funding. Groups were also (understandably) reluctant to find new ways to stretch their grants to establish new services, as their payment could be reduced in the next year. Tom Fallon underlined the challenging nature of Western Care's finances into the mid-1980s, a precarity that made its development of a range of community-based housing all the more remarkable. He acknowledged how the organisation 'always had financial fears, all along the line' and that 'there were months when the money wasn't in the kitty to pay my wages'.[84] A survey in 1984 found that half of all CBRs received some form of financial support from the Department of Health, while 27% also received funds from their local health board. Yet despite these payments, a significant number continued to rely on a makeshift array of funding measures, which included fundraising (26%), subscriptions (10%), and resident fees (42%).[85] These practices persisted as groups retained a variety of expenses, even when they were in receipt of statutory funding. In 1975, for example, the Wicklow Association for the Mentally Handicapped (WAMH) obtained a grant to develop an accommodation programme based at Newcastle Hospital in Greystones. The Eastern Health Board approved its plan, noting that the board would cover the cost of 'heat, light and food' in this new facility. However, all other expenses (including staffing and insurance) had to be met via fundraising.[86] A parent from Ballinasloe in east Galway described a consistent 'gap' in statutory funding, which was addressed through local fundraising efforts. The health authorities

> gave you £100 [and presumed] that should keep you quiet for a number of years. It wasn't their job – they had no concept of what it was like to have a member of your family that couldn't get a service. Getting a service meant that [the] branch here spent a lot of time fundraising and when we had children from the area going to Athlone, we almost [entirely] paid for it through fundraising. That's the way it was.[87]

The efforts of Western Care in Mayo demonstrated the scale of these challenges for a local organisation. By 1987 it had established eleven

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[83] Power, *Landscapes of Care*, p. 130.

[84] Tom Fallon, 'Talk about Small Beginnings!', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 15.

[85] Kelleher et al., *Home Together*, p. 21.

[86] Eastern Health Board, 'Meeting Minutes', 6 February 1975, p. 28.

[87] Unnamed parent, qtd in Breathnach and Breatnach (eds), *A Caring World*, p. 19. See also the consistent emphasis on fundraising in Western Care's annual newsletter *Western Care News*. Ryan, *Walls of Silence*, p. 121; Fallon, 'Talk about Small Beginnings!', p. 15.

'group-homes', each of which had been financed through a parish-based network of programmes. One of the first homes, St Rita's in Claremorris, cost £28,750 and was paid for by 90 local fundraisers.[88]

While voluntary organisations remained crucial to the delivery of these new facilities, their efforts were supported by the creation of the health boards. Founded under the 1970 Health Act, these eight regional authorities assumed control over services that had been previously managed by the local authorities (whether the county or city council) under the 1947 Health Act.[89] Annie Ryan argued that the health boards were usually an impediment to intellectual disability organisations; she suggested that it was 'much more difficult to persuade your local health board to part with money than … your local county men'.[90] While this may have been the perception, in many cases health boards were amenable to supporting the development of CBRs.[91] Action by the health boards can be attributed to two factors. First, despite having a broad remit, they shared many features with their antecedent local authorities, including the fact that their membership was similarly dominated by local councillors.[92] Health boards were therefore susceptible to the same forms of lobbying. Secondly, the new health authorities encountered long-standing issues around public demand for oversubscribed residential institutions. In this environment, CBRs appeared to offer a 'solution' to an entrenched problem by diverting the intellectually disabled who could not live at home into community-based facilities, bypassing the extended waiting lists for a congregate facility. Yet support from the eight health boards was notable, as strictly speaking intellectual disability services were not a part of their remit at all. During a meeting of the Western Health Board in January 1972, its members began to discuss 'mental handicap' issues in their area. However, they were soon informed by an official that this was not a part of their purview; disability services were provided by voluntary groups that dealt 'directly with the Department of Health'.[93] Undeterred, local voluntary organisations often continued to lobby their local health boards for

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[88] Western Care Association, *Western Care Association: For People in Mayo with Mental Handicap* (Mayo, 1982), p. 136; Tom O'Dea, 'Proud of Our Achievements', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 111.

[89] Department of Health, *Comhairle na nOspidéal and the Regional Health Boards* (Dublin, 1972), p. 10.

[90] Ryan, *Walls of Silence*, p. 79.

[91] 'Improved Facilities for Mentally Handicapped', *Munster Express*, 20 June 1975, p. 1. See also the discussion of normalisation in John Loughlin, 'Chairman's Report', in North-Western Health Board, *North Western Health Board: Annual Report 1979* (Sligo, 1980), p. 17.

[92] Ferriter, *Ambiguous Republic*, p. 600.

[93] Western Health Board, 'Meeting Minutes', 3 January 1972, p. 7.

funding.[94] Just two months after the Western Health Board was informed that disability services were the Department of Health's responsibility, for example, it received a request from Western Care for a grant to convert a disused building in Foxford into an occupational day centre.[95]

Health boards remained clear in their preference for the provision of these services through the voluntary sector wherever possible.[96] In some cases, this prompted them to become a considerable funder of services that were provided through the voluntary sector. By 1980 the North-Western Health Board had given a total of £467,000 to more than 120 voluntary organisations in its area, which included grants to a range of services including 'day-care' centres, work programmes, and respite care.[97] The Department of Health itself acknowledged that this approach lacked overall coordination; an official described how community-based housing had 'been left largely to voluntary agencies to pioneer and attempt to develop', which had led to disparities in the availability of facilities across the country.[98] The finance official James Fitzharris commended the state's limited engagement with CBRs, praising how they had emerged 'more or less spontaneously with little central guidance'.[99] This dynamic had obvious financial benefits for the state, in that voluntary organisations were often a crucial catalyst in the development of a new CBR facility. Yet the cultural environment of the 1970s was notably different from that of the 1950s, as the state could no longer rely upon the considerable human resources associated with Catholic religious orders to operate these services.[100] Instead, most community-based housing projects emerged as adjuncts to existing residential services or were the product of fundraising efforts by 'parents and friends' organisations across the country. In policy terms CBRs were viewed as a 'large part of the answer to the considerable social problems … of handicapped persons',

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[94] Ryan, *Walls of Silence*, p. 122.

[95] Western Health Board, 'Meeting Minutes', March 1972, p. 2. Other health boards also received comparable requests from voluntary organisations. In the Eastern Health Board, for instance, see Eastern Health Board, 'Meeting Minutes', 2 September 1971, p. 128; Eastern Health Board, 'Meeting Minutes', 20 July 1972, p. 205.

[96] Western Health Board, 'Meeting Minutes', 1 February 1977, p. 3; Western Health Board, 'Meeting Minutes', 3 June 1975, p. 5.

[97] Eastern Health Board, 'Meeting Minutes', 1 February 1973, p. 48; North-Western Health Board, *Review of Activities: 1st April 1971 to 31st March 1981* (Sligo, 1981), p. 21; North-Western Health Board, *Annual Report 1979* (Sligo, 1980), p. 18.

[98] Department of Health, *The Future of Personal Social Services in Health Boards: A Policy Document* [Garland Report] (Dublin, 1983), p. 8; Western Health Board, 'Meeting Minutes', 28 March 1978, p. 3; P. W. Flanagan, 'Memo: FAO Barry Murphy', 28 March 1984, Department of Finance records, S72/16/82.

[99] Fitzharris, 'Cost of Hostels and Day Care Centres', p. 47.

[100] Tom Inglis, *Moral Monopoly: The Rise and Fall of the Catholic Church* (Dublin, 2004), pp. 212–13.

but realising this putative solution on the ground was a long and challenging process for the organisations involved.[101] Where there was a total absence of voluntary action, combined with an obvious and pressing need for some form of provision, health boards were willing to engage in a (limited) number of accommodation programmes. A 1990 Health Research Board study nonetheless underlined the continued dominance of the voluntary sector in these services, as in its sample of 96 community residences, 92 (95.8%) were operated by a voluntary provider.[102]

This dynamic placed a considerable burden on voluntary organisations. At the same time, it contributed towards a distinctive development process for community accommodation in Ireland, as these facilities were established with notably little controversy compared with their analogues in the UK and US. Generally, large congregate institutions had been located in physically isolated locations. The Sisters of La Sagesse were encouraged by health officials to develop their residential centre on the coastal peninsula of Rosses Point outside Sligo town, for instance, while the Redington family estate in Galway provided the Brothers of Charity with a former 'big house' set in the countryside.[103] Of course, isolation was a common feature across a variety of facilities. Indeed, some centres for children were considered so remote that, in the face of falling vocations, ministers openly questioned whether they could get lay people to staff them.[104] By contrast, community accommodation brought the disabled into close contact with their neighbours – in some cases for the very first time. In the UK, this proximity was controversial, as some of the general public were afraid when it came to the intellectually disabled. Psychiatrist T. L. Pilkington explained that these concerns were driven by public confusion about the nature of a 'mental handicap' versus mental illnesses such as schizophrenia, with the result that 'even a friendly mongol may be regarded as potentially dangerous'.[105]

Compounding this fear, medical thinking continued to articulate concerns about the potential risks posed by the 'mentally deficient'. The eleventh edition of the textbook *Tredgold's Mental Retardation* (1970) still contained residual eugenics-inflected concerns when it came to the intellectually disabled, such as when it warned that 'some subnormal girls have comparatively strong direct sex drives … the self-gratification aspects of their need

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[101] Department of Health, *Services for the Mentally Handicapped*, p. 4.

[102] Ibid., pp. 19–21.

[103] 'Development of Cregg House Mental Defective Home, Sligo' [1956], NAI H26/22/1; McCoy Report, p. 28.

[104] Bruton discussed this issue in terms of children's homes. Letter, John Bruton to Liam Cosgrave, 10 February 1976, NAI DT 2007/116/98.

[105] T. L. Pilkington, 'Public and Professional Attitudes to Mental Handicap', *Public Health* 87.3 (1971), p. 63.

can also drive [these] girls into sexual promiscuity'.[106] These ideas were rooted in eugenicist-inflected fears from the early decades of the twentieth century, when proponents had framed the 'mentally deficient' as inherently sexually promiscuous, a vice that would (inevitably) precipitate a decline in the nation's citizenry.[107] A survey in 1972 highlighted the persistence of these ideas among the British public, such as the fact that it was 'still widely believed that mentally handicapped people are uncontrollable and perverted in their sexual appetites'.[108] Such thinking clearly impacted on efforts to provide community-based accommodation in the UK.[109]

There were similar issues across the Atlantic, where concerns around proposed CBR housing projects ossified into unambiguous public opposition. David Wright described how

> unseemly battles erupted in town hall meetings across North America … as concerned parents (of non-Down's syndrome children) expressed their anxiety about the 'appropriateness' of locating group homes in their residential community and the possible dangers that Down's syndrome adults might pose to their children.[110]

Other accounts describe similar 'mob scenes' at local authority meetings across the US, where neighbours stressed the emotional burden associated with their proximity to a CBR, explaining how there was 'a very real psychological cost of living in an atmosphere that is not normal'.[111] This resistance was commonly framed in terms of the physical dangers associated with living

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[106] A. F. Tredgold, R. F. Tredgold and K. Sodding, *Tredgold's Mental Retardation: Eleventh Edition* (London, 1970), p. 91.

[107] Philippa Levine and Alison Bashford, 'Eugenics and the Modern World', in Alison Bashford and Philippa Levine (eds), *The Oxford Handbook of the History of Eugenics* (Oxford, 2010), pp. 3–7; Sharon L. Snyder and David T. Mitchell, *Cultural Locations of Disability* (Chicago, 2010), p. 26; Michael Rembis, 'Disability and the History of Eugenics', in Michael Rembis, Catherine J. Kudlick and Kim Nielsen (eds), *The Oxford Handbook of Disability History* (Oxford, 2018), pp. 85–8; Douglas C. Baynton, *Defectives in the Land: Disability and Immigration in the Age of Eugenics* (Chicago, 2016), p. 4.

[108] Alan Shearer, 'A Report on Public and Professional Attitudes towards the Sexual and Emotional Attitudes of Handicapped People', qtd in Pamela Abbott and Roger Sapsford (eds), *Community Care for Mentally Handicapped Children* (Milton Keynes, 1987), p. 51.

[109] Colin Barnes and Mike Oliver, 'Disability Rights: Rhetoric and Reality in the UK', *Disability and Society* 10.1 (1995), pp. 111–16; Brendan Gleeson, *Geographies of Disability* (London, 1999), p. 156.

[110] David Wright, *Downs: The History of a Disability* (Oxford, 2011), p. 140.

[111] J. Deutch, qtd in Cynthia Okolo and Samuel Guskin, 'Community Attitudes toward Community Placement of Mentally Retarded Persons', *International Review of Research in Mental Retardation* 12 (1984), p. 26.

adjacent to such a facility. Yet contemporaneous research also acknowledged how adverse public reactions were shaped by 'NIMBY' (not in my back yard) fears about a potential decline in local property values.[112]

Regardless of its basis, public resistance had an obvious effect, both in terms of limiting the emergence of community-based facilities in certain areas and in shaping residents' experiences once in this accommodation. Karen Morgan worked as a disability nurse in the UK in the 1980s, a role that she described as being like a 'public relations officer', as she would 'untangle' concerns and work to 'alleviate the … fears' among the neighbours of community housing facilities. Given this broader environment, it was unsurprising that both British and American CBRs reported a frequently poor level of interaction between their centres and the wider community.[113]

The emergence of CBRs in Ireland is notable, as opposition to these projects appears to have been limited.[114] This was not because the Irish public was inherently better informed when it came to intellectual disability; research such as the Psychological Society's *A Place to Live* (1982) acknowledged how plentiful 'misconceptions and confusions' about the needs of people with disabilities remained in Ireland. However, these ideas did not appear to translate into outright opposition to schemes in the community.[115] A report in 1990 found that more than 95% of community accommodation schemes encountered no formal resistance during the building process, while a majority of sites (60%) reported that they had visits from their neighbours, while a third also had involvement from local volunteers.[116] The absence of eugenicist-based thinking begins to account for this. The fears associated with the disabled in the UK and US were rooted in conceptions of the

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[112] Robert N. Hornick, *The Girls and Boys of Belchertown: A Social History of the Belchertown State School for the Feeble-minded* (Amherst, MA, 2012), p. 177; Gleeson, *Geographies of Disability*, p. 202.

[113] Karen Morgan, 'Through My Eyes: One Nursing Student's View', in Alan Parrish (ed.), *Mental Handicap: The Essentials of Nursing* (London, 1987), p. 7; Alan Barr, 'New Dog – New Tricks? Some Principles and Implications for Community Social Work', in Gerald Smale and William Bennett (eds), *Pictures of Practice: Community Social Work in Scotland* (London, 1989), p. 163.

[114] *Towards a Full Life* acknowledged that there was 'some opposition from local residents in certain areas'. Yet the scale of this was likely relatively limited, as there was little discussion of public resistance in the press or in other policy documents. Department of Health and Social Welfare, *Towards a Full Life*, p. 87.

[115] Psychological Society of Ireland, *A Place to Live: Services for People who are Mentally Handicapped* (Dublin, 1982), p. 3.

[116] Kelleher et al., *Home Together*, p. 28. Newspaper coverage also welcomed the provision of disability-specific accommodation; see Bob McDonald, '£70,000 Handicapped Plan', *Connacht Sentinel*, 10 October 1978, p. 3; 'Handicap Hostel', *Connacht Tribune*, 20 June 1975, p. 30; 'Provision of Hostels for Retarded', *Cork Examiner*, 19 November 1971, p. 11.

intellectually disabled as inherently degenerate and therefore dangerous. In contrast to the broader anglophone world, however, eugenicist ideas largely failed to thrive in Ireland, a trend that Greta Jones attributed to an overarching Catholic suspicion of intervention in the family, the state's lack of urbanisation, and the political turmoil that occurred throughout the early decades of the century.[117] Without an understanding of the intellectually disabled as people who were dangerous, and thereby warranted fear, a comparable level of public resistance to community-based accommodation simply could not be sustained. Catherine Kennedy worked as a houseparent at the first community-based home established by Stewart's in Palmerstown. The public might have been apprehensive about the facility, but the CBR had its own unique way of breaking down boundaries. She explained how, in the early 1970s:

> there was a several year wait in order to get a telephone installed … and as we were the only house in the cul-de-sac with a telephone this became an agent to breaking down barriers. Neighbours called in to use the phone and could see how normal the living situation was.[118]

Alongside this engagement with neighbours, the development process for a CBR in Ireland served to dissipate potential resistance, as most services emerged slowly through grassroots efforts by local voluntary organisations. In contrast to the bureaucratic, 'top-down' process described by David Wright in the United States, Irish voluntary organisations necessarily had to establish their facilities over time and clearly relied upon local support. KARE in Kildare, for instance, spent nearly a decade establishing its first residential programme, from the initial idea to being able to welcome residents.[119] This helped to alleviate potential fears among the public, as a centre's neighbours were given ample opportunity to voice their concerns. However, it also gave the voluntary groups involved extensive space to engage with the local community. This meant that an area became aware of their local facility well in advance of its opening, as each required years of preparation and fundraising. Even in cases where an existing service provider managed to establish a CBR relatively quickly, as occurred with Brothers of Charity's first residence in Cork city, they engaged in efforts to work with the local community and address any potential issues among their new

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[117] Greta Jones, 'Eugenics in Ireland: The Belfast Eugenics Society, 1911–15', *Irish Historical Studies* 28.109 (1992), p. 95.

[118] Catherine Kennedy, qtd in Pat O'Donohoe, *150 Years of Stewarts Care: The Pathway to the Present* (Dublin, 2019), p. 206.

[119] Weller, *An Extraordinary Voluntary Commitment*, p. 33.

neighbours. The social worker Mary Therese 'Betty' O'Connor noted that the order's CBR sites were all carefully chosen; they tried to avoid 'newer and more transitional estates' that had busy younger families and instead sought to place their CBRs in more 'established' areas that had an older population, as these communities were more likely to have time and be in a position to interact with the centre. She also noted that all potential CBR programmes were first 'tested' by asking the opinions of prominent figures from the local community such as clergy, doctors, teachers, and councillors. Following this, the order then began to raise the idea in the local community. Regardless of this planning, O'Connor still had work to do in reassuring a CBR's neighbours that the young men from her facility would behave well in public; she was confident, but still had to say that they would not 'look in windows … urinate on the street … masturbate in living areas … [or] create noise at mass'.[120]

Alongside an extended development process, Ireland's relatively low level of urbanisation likely contributed towards a broader candour when it came to intellectual disability, as research in the UK had highlighted an urban/rural divide in the experiences of the 'mentally handicapped'. Looking at the work of MENCAP societies, Sheena Rolph described how an urban upbringing potentially allowed for the concealment of a child's disability, which facilitated feelings of shame. This approach was simply less tenable in a rural setting, where hiding a child (or their disability) was more difficult.[121] A similar dynamic was visible in Ireland, where the role played by the wider community was emphasised among those raising children with disabilities. Based in Dublin, Mrs O'Brien, the mother of a disabled son, put the support of her local community to the forefront when she was interviewed for the RTÉ current affairs programme *Seven Days* in 1970. O'Brien made clear the importance of her social links in the wider community, and how local people were well aware of the need for understanding around her 'handicapped Tony'. She described how:

> I have very good neighbours here, they didn't take any notice of what Tony done. Tony was doing very odd things [as a child]. He'd go to people's doors and drink the milk out of the bottles and people never approached me over it. They were very very kind, the people. They'd

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[120] Mary Therese O'Connor, 'Living with the Neighbouring Community' (Cork, June 1986), in O'Connor, 'From Community to Institution, from Institution to Community', pp. 366–7. See also Cork Polio and General After-Care Association, *Report and Recommendations of Special Committee on Hostel Accommodation for the Mentally Handicapped of the Association on Attaining the Age of 18 Years* (Cork, 1973 [1971]).

[121] Sheena Rolph, *Reclaiming the Past: The Role of Local Mencap Societies in the Development of Community Care in East Anglia, 1946–80* (Milton Keynes, 2002), p. 58.

> help him, if they saw him doing something wrong they'd stop him, you know that way.[122]

Guidance literature similarly emphasised the importance of interaction with the wider community and assured readers that the public were welcoming towards an intellectually disabled child. A NAMHI booklet by Dr Noreen Buckley encouraged all new parents to go out into their local area as soon as possible, as they would find out that 'people are kind, sympathetic and interested, give them a chance to show their interest and also their help'.[123]

There was some variation in the way CBRs operated.[124] In theory, they were supposed to provide residents with 'the opportunity to interact and form relationships with other community members'.[125] Internationally, institutional features persisted in some community-based housing initiatives, leading to CBRs that were physically located in the community but isolated from their neighbours.[126] Roy McConkey criticised Irish facilities along similar lines in the late 1980s, dismissing them as 'special sorts of rather small institutions which are located in areas of residential housing'.[127] Yet many community-based housing projects reported a high level of interaction between centres and their neighbours, which resulted in residents who had 'increased their level of adaptive behaviour, decreased their level of maladaptive behaviour, engaged in more purposeful activities, [and] had a more varied lifestyle'.[128] However, other research was more circumspect. Denis Healy, a psychologist with the Brothers of Charity in Renmore, explored the experiences of residents at a CBR facility in Gort, a small town in South Galway. He found that, while they did engage in social activities in the town, residents tended

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[122] *Seven Days: Mentally Handicapped Children*, 10 March 1970, RTÉ Archive.

[123] Noreen Buckley, *What Can I Do to Help My Child? Practical Advice on the Home Care of the Mentally Handicapped* (Dublin, 1975), p. 2.

[124] Sean Conneally, Grainne Boyle and Frances Smyth, 'An Evaluation of the Use of Small Group Homes for Adults with a Severe and Profound Mental Handicap', *Mental Handicap Research* 5.2 (1992), pp. 160–8.

[125] Robert Bogdan and S. J. Taylor, 'Conclusion: The Next Wave', in S. J. Taylor, D. Biklen and J. Knoll (eds), *Community Integration for People with Severe Disabilities* (New York, 1987), p. 210.

[126] Hilary Brown and Helen Smith, *Normalisation: A Reader for the Nineties* (London, 1992), p. xvi; Deborah S. Metzel, 'Historical Social Geography', in Steven Noll and James Trent (eds), *Mental Retardation in America: A Historical Reader* (New York, 2004), p. 440.

[127] Roy McConkey, *Who Cares? Community Involvement with Mental Handicap* (London, 1987), p. 19. See also Roy McConkey, Marlene Sinclair and Dympna Walsh-Gallagher, 'Social Inclusion of People with Intellectual Disability: The Impact of Place of Residence', *Irish Journal of Psychological Medicine* 22.1 (2005), pp. 10–14.

[128] Sean Conneally et al., 'An Evaluation of the Use of Small Group Homes', p. 160.

to do so mainly in groups and with the participation of a houseparent. The degree of their interaction with the wider community was therefore predicated on the approach adopted in each individual CBR and, indeed, by each individual member of staff.[129] At the same time, contemporaneous sociological research highlighted that, although the public accepted the need for community-based facilities as an idea, they remained decidedly uncomfortable when it came to interacting with a 'mentally handicapped' person on an individual basis. In 1981 the Irish Committee for the UN's International Year of Disabled Persons (IYDP) collaborated with the Health Education Bureau to produce a survey on interaction with the intellectually disabled. Its results were not promising. Through interviews with the public, the survey found that over 60% of people 'never or only rarely interacted' with a disabled person. Even more strikingly, a quarter of respondents said that they would feel 'uncomfortable or embarrassed when in the company of a disabled person' in a public setting.[130]

A complementary survey, also conducted by the National Committee for the IYDP, interviewed disabled people who lived in community-based accommodation and attended day centres in Dublin city. They found that only half of respondents had someone they would describe as a friend who did not have a disability, even though these respondents lived in CBRs, where community interaction was supposed to be a central part of their daily lives. In practical terms, these respondents also spent a significant proportion of their day in the wider community, including travelling to and from occupational day centres on public transport.[131] There was an obvious asymmetry between the residents' visibility in society and the extent to which this prompted meaningful interaction with others.[132] In common with the disabled who remained in their family home, surveys also found that a proportion of community housing residents were not involved with local clubs or societies and instead engaged in recreation in their dwelling; a survey in 1982 found that 'as many as 34% occupied their spare time mainly by lying on their bed, sleeping or doing housework'.[133]

In 1990 Betty O'Connor worried about the intellectually disabled who lived in community housing. If they struggled to make friends in an institution, do they now 'hole up after work with their TV'? She questioned

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[129] Denis Healy, 'Normalisation in Action', *Journal of the British Institute of Mental Handicap* 13.2 (1985), pp. 55–7.

[130] National Youth Policy Committee, *National Youth Policy Committee: Final Report 1984* (Dublin, 1984), pp. 166–7.

[131] Ibid., p. 167.

[132] Kieran, 'Eighteen Plus', p. 151.

[133] Michael Mulcahy and Jodie Walsh, 'Service Requirements of Adult Mentally Handicapped Persons Living in the Community', *Irish Medical Journal* 75.1 (1982), p. 2.

whether the shift towards community services was a beneficial one, or whether it had forced these residents to 'change our type of institution for another smaller one'.[134] In practice, daily life in a CBR contrasted sharply against its institutional equivalents, with increased freedom, privacy, and responsibility for residents. However, admission to one of these facilities represented a distant hope for the vast majority, as the 376 beds available in the early 1980s paled in comparison to the more than 5,000 housed in residential institutions, to say nothing of the population of more than 14,000 of the 'mentally handicapped' based in local communities across the country.[135] These new services emerged mainly through the voluntary sector, a dynamic that accounts for why these services could simultaneously occupy a prominent position in statutory policy, while being available to only a small minority. However, it also meant that they could emerge in a way that diverged from broader anglophone trends, with the result that Irish facilities met with a different reception from their neighbours.

Conclusion

In 1980 a government memorandum presented community-based housing as evidence of a newfound attitude to intellectual disability in Ireland. The shift away from congregated services mirrored a move away from 'fatalistic' forms of thinking when it came to the 'mentally handicapped'. These old attitudes had now been abandoned, it suggested, a change that was evident in the new community-based services that recognised the abilities of the intellectually disabled.[136] For a minority, this argument was true. Daily life in a CBR was far removed from the communal practices and set routines of a congregated institution, while it fulfilled many of the core goals associated with normalisation by locating the intellectually disabled in the wider community, with daily routines that approximated those of their neighbours.[137] The 'normal' nature of this life was stressed by one resident, who emphasised how CBRs were 'the same as if you were living with your own family'.[138]

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[134] O'Connor, 'From Community to Institution, from Institution to Community', p. 294. See also Máire Leane, *Community Living: A Quality of Life Study of Adults with Mental Handicap Returned to Community Living* (Cork, 1992).

[135] Department of Health, *Services for the Mentally Handicapped*, p. 26; Planning Unit, *Statistical information ... 1982*, p. 37.

[136] 'Report on services for the Mentally Handicapped', 30 April 1980, p. 1, NAI PRIV/2010/53/192.

[137] Nirje, 'The Normalisation Principle', p. 179.

[138] Walsh, *Let's Make Friends*, p. 22.

What the memorandum neglected to discuss, however, was how new community-based services could only ever cater to a fraction of a much broader population; as late as 1990, it was estimated that just 2.25% of those with an intellectual disability could avail themselves of a place in a community-based facility.[139] The ascendancy of CBRs on paper occurred in response to a range of developments across the disability services landscape, but this shift in thinking remained stymied by the Department of Health's continued delivery of services through a mixed economy of care, an approach that left the responsibility overwhelmingly in the hands of the voluntary sector without adequate statutory support and funding. In the UK, Alan Barr acknowledged an attachment to the idea of community-based provision, but argued that this impulse 'often has more to do with the aura that it creates, the sense of wellbeing or belonging, than to do with any specifically measurable features'.[140] Irish policy similarly oriented itself towards the community, but struggled to bring 'care in the community' into practice nationwide. It is a testament to the voluntary groups engaged in disability services that, despite the scale of this task, they managed to create a range of community-based housing projects across the country.

Aside from the obvious advantages for the state, the continuation of a mixed economy of care also maintained a network of different providers, resulting in a services landscape that operated as a 'patchwork of largely autonomous agencies, each responsible for services within [their] geographical areas'.[141] Statutory disability policy had fundamentally changed, but this shift was not matched by a comparably brave commitment to ensure that new policy goals were being met on the ground in a uniform way. In many instances, this was clearly not a concern, as innovative CBRs sought to integrate their residents into the local community. Yet this was not always the case, as disparities (between policy aims and practice on the ground) were already apparent in some centres, to say nothing about the uneven distribution of these facilities across the country. The opening of these services also represented another break from international trends, as CBRs created by voluntary organisations were often embedded in the local community and thereby failed to attract the concerted opposition seen elsewhere. In theory, specialist institutions would 'feed' their residents into new community-based services over time. In 1984 this remained a pipedream, with community housing able to accommodate less than 10% of those in institutional facilities.[142]

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[139] Kelleher et al., *Home Together*, p. 199.

[140] Alan Barr, qtd in Turner, 'From Institutions to Community Care?', p. 246.

[141] Roy McConkey and Patrick McGinley, *Concepts and Controversies in Services for People with Mental Handicap* (Dublin, 1988), p. 16.

[142] Kelleher et al., *Home Together*, p. 186.

This chapter opened with Paddy Joe, who was reluctant to leave his new life in the community. He was clearly one of a lucky few. For others, more established forms of residential care remained the only option.

5

No Longer Acceptable? Institutional Accommodation, 1965–84

In May 1975 delegates met at a hotel in Waterford. Over three days they grappled with an enormous task, namely: ‘To obtain a preliminary overall view of the state of the health services, to direct attention to the major problems which beset them, and to identify the key issues requiring further investigation and attention.’[1] During their (necessarily) wide-ranging discussions the seminar touched on a vast array of issues, from the correct operation of an accident and emergency department at night to the challenge of attracting dentists to work in rural areas.[2] Within their varied array of issues, the meeting eventually came to discuss institutional provision for the intellectually disabled. Delegates were clear when highlighting gaps across existing services, such as the acute absence of beds for disabled ‘disturbed children’. They also highlighted delays in assessment and stressed the need for a greater range of community-based support. All in all, their tone was a notable shift from the uncomplicated praise that institutional facilities had attracted throughout the mid-twentieth century.

Indeed, although large-scale centres continued to expand their capacity, they progressively lost their dominant position in statutory policy, going from an obvious ideal for most of the intellectually disabled to a necessary measure that was required by only a minority.[3] In 1984 *Towards a Full Life* outlined the ‘no longer acceptable’ forms of residential care, which now included those that ‘protected’ the intellectually disabled from wider society through placement in ‘large institutions with few facilities sited away from centres of

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[1] Department of Health, *A Review of Irish Health Services: Seminar Proceedings, Held in Waterford, 15–17 May 1975* (Dublin, 1975), p. 1.

[2] Ibid., pp. 50, 69.

[3] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), pp. 4–5; Department of Health and Social Welfare, *Towards a Full Life: Green Paper on Services for Disabled People* (Dublin, 1984), p. 94.

population and amenities'.[4] Clearly, large-scale residential institutions were becoming a 'last-resort' measure, a terminal option used only in the absence of a community-based alternative.[5] Yet despite a shrinking remit, congregate facilities continued to house more than 7,000 residents into the early 1980s.[6]

Two forms of residential accommodation – specialist institutions and the district mental hospital system – reveal how little changed for the 'mentally handicapped' in congregate facilities. This period was marked by a variety of significant developments, including the introduction of lay staff to religious-owned specialist facilities and the promulgation of psychotropic medication in 'mental hospitals'. Yet mid-century approaches survived, and were consolidated upon, into the latter decades of the century. Limited access to services and the abuse of residents demonstrate the perpetuation of a subsidiarist-inflected approach when it came to specialist facilities, with the continued absence of statutory engagement maintaining these primarily state-funded institutions in the realm of charity. There was similar continuity in psychiatric facilities, where 'handicap admissions' persisted along an established pattern, despite seismic changes to inpatient psychiatric care. In other words, deficient care in 1984 had its roots in well-established approaches.

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[4] Department of Health and Social Welfare, *Towards a Full Life*, p. 94. For a discussion of this trend internationally, see Allison Carey, *On the Margins of Citizenship: Intellectual Disability and Civil Rights in Twentieth Century America* (Philadelphia, 2009), pp. 179–85; John Burnham, 'Deinstitutionalisation and the Great Sociocultural Shift to Consumer Culture', in Despo Kritsotaki, Vicky Long and Matthew Smith (eds), *Deinstitutionalisation and After: Post-war Psychiatry in the Western World* (Abingdon, 2016), pp. 39–41.

[5] See the discussions in Psychological Society of Ireland, *A Place to Live: Services for People who are Mentally Handicapped* (Dublin, 1982), p. 4; Eastern Health Board, *Planning Mental Handicap Services: Report of the Mental Handicap Committee* (Dublin, 1981), p. 6; Department of Health, *Task Force on Child Care Services: Final Report to the Minister for Health* (Dublin, 1980), pp. 294, 298; Department of Health, *Report of the Working Party on General Nursing* [Tierney Report] (Dublin, 1980), p. 20; Department of Health, *General Survey of the Work on the Superintendent Public Health Nurse and of the Practice of Public Health Nursing* (Dublin, 1983), pp. 100–1; National Economic and Social Council, *Community Care Services: An Overview* (Dublin, 1987), p. ix; Western Health Board, *Review of Activities: 1st April 1971 to 31st March 1981* (Galway, 1981), p. 12.

[6] Department of Health: Planning Unit, *Statistical Information Relevant to the Health Services 1982* (Dublin, 1983), p. 37; Dermot Walsh and Aileen O'Hare, *Activities of Irish Psychiatric Hospitals and Units, 1981* (Dublin, 1983), p. 12.

‘There would always be a need’: Specialist Institutions

Access to services

> In a document published this year entitled *Services for the Mentally Handicapped* the number of places needed for the Mentally Handicapped at 1977 levels is estimated at 6,330, representing a shortfall of places specifically designed for the Mentally Handicapped of almost 2,000.
>
> John Boland, *Dáil Debates* (1980)[7]

Specialist institutions housed considerable numbers of the intellectually disabled into the late twentieth century, with more than 5,000 beds in the early 1980s.[8] Yet despite their scale, and despite successive expansion programmes throughout the 1970s, facilities continued to struggle in the face of public demand. In a submission to the government in 1979, Annie Ryan underlined the need for further residential services in Ireland, positing that a ‘substantial’ number of the intellectually disabled across the country were not suitable for home care but equally could not secure a place in a residential institution.[9] Her claims were bolstered by health board statistics, which pointed to often sizeable populations of the intellectually disabled who remained on waiting lists for long periods of time. In 1981 the Eastern Health Board’s Mental Handicap Services committee estimated that there were over 1,000 awaiting a residential placement in the counties of Dublin, Kildare, and Wicklow alone.[10] In many cases the gap between the capacity of local institutions and the need for places remained considerable. To take an example – given the department’s own estimates, institutional services in the north-east needed to house approximately 582 long-stay residents in 1980. By 1984, however, the only institution in that region was St Mary’s in Drumcar, which had 310 beds.[11] The Department of Health was obviously aware of this deficiency, as successive reports highlighted the fact that even new projects were failing to meet the department’s targets. Minister for Health Barry Desmond bemoaned the piecemeal nature of expansion efforts in 1984, acknowledging that they did too little to assuage the need

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[7] John Boland, *Dáil Debates* 323 (2), 16 October 1980.

[8] Department of Health, *Statistical Information Relevant to the Health Services 1982*, p. 37.

[9] Annie Ryan, ‘Memo for the attention of Dáil deputies’, May 1979, NAI 2009/135/154.

[10] Eastern Health Board, *Planning Mental Handicap Services*, p. 18.

[11] P. W. Flanagan, ‘Memo: FAO Barry Murphy’, 28 March 1984, Department of Finance records, S72/16/82.

for places. A project in Swinford in County Mayo, for instance, had 140 beds planned. Yet if internal targets were followed, Desmond noted that the state needed approximately 800 beds to cater for local requirements across Mayo and Roscommon alone.[12] In 1984 the Swinford project was the only building programme under consideration in either county, meaning that the Department of Health had fallen short of its own target by 660 beds (82.5%). Fundamentally, this remained an issue of scale, with the institutional network chronically inadequate for the numbers who required long-term care.

Demand for residential places was augmented by deficient discharge policies in the institutions themselves. Most specialist residential centres were originally established to house children, and had aimed to train their residents so that they could eventually return to life in the local community.[13] This was reflected in the operational practices across these centres, which commonly set an upper age limit for entry, with many specifying that they would admit children between the ages of 6 and 12.[14] In Scotland discharges from residential institutions remained an aspiration that went (largely) unfulfilled, as centres commonly released around 2.5% of their population each year.[15] It remains difficult to compare this with Irish practices. However, lack of discharges from residential institutions was a frequent topic of complaint in the Dáil and among the regional health boards.[16] At a Western Health Board meeting in 1972, for instance, speakers explained that beds for young children remained severely restricted due to a 'lack of turnover' across many facilities. Once admitted, residents appeared to remain in residential care for the rest of their lives.[17] This was also reflected in the ageing of the resident population at institutions across the country, as the vast majority of centres (designed to accommodate children) housed increasing numbers of adult residents during the latter decades of the century. In 1976, 64% of those at the Sisters of La Sagesse centre in Sligo were over the age of 18, as were 73% at Our Lady of Good Counsel in

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[12] Barry Desmond, 'Memo: Department of Finance', 19 February 1984, Department of Finance records, S72/16/82.

[13] See the discussion in Pat O'Donohoe, *150 Years of Stewarts Care: The Pathway to the Present* (Dublin, 2019), p. 167; Alice Mauger, *The Cost of Insanity in Nineteenth-Century Ireland: Public, Voluntary and Private Asylum Care* (Abingdon, 2017), p. 7; Joseph Robins, *From Rejection to Integration: A Centenary of Service of Daughters of Charity to Persons with a Mental Handicap* (Dublin, 1992), pp. 15–26.

[14] Department of Health: Working Party, *Training and Employing the Mentally Handicapped*, 'Appendix B', pp. 70–1.

[15] Angela Turner, 'From Institutions to Community Care? Learning Disability in Glasgow from c.1945', PhD thesis, University of Strathclyde, 2009, p. 76.

[16] See John F. O'Connell, *Dáil Debates* 302 (3), 30 November 1977; Thomas J. Fitzpatrick, *Dáil Debates* 328 (4), 1 April 1981.

[17] Western Health Board, 'Meeting Minutes: 3 January 1972', p. 7.

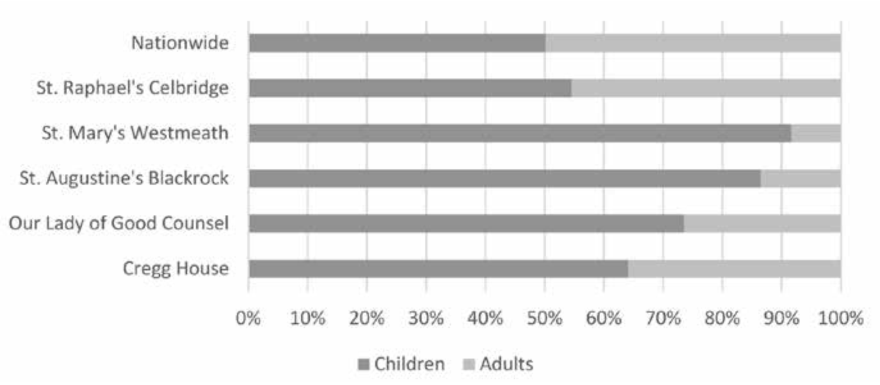

Figure 5.1: Age profile of residents in specialist institutions, 1976.

Source: Richard Barry, *Dáil Debates* 293, 28 October 1976, col. 674.

Cork, 86% of St Augustine's population in Dublin, and 91% of those in St Mary's in Westmeath. Indeed, nationwide, specialist residential institutions accommodated an equal proportion of children and adults in 1976.[18]

Although newspaper coverage anecdotally discussed discharges from residential institutions due to 'difficult' or 'disturbed behaviour', this research has found no evidence of a set policy.[19] Indeed, staff at some of these centres resisted the idea of a blanket approach, arguing that, given the lack of community-based provision in some areas, long-term residential care remained essential. Ann Byrne, principal social worker for the Brothers of Charity at Kilcornan, discussed her alarm over the idea of a set discharge age in the *Irish Social Worker* magazine in 1983. Such a policy should be strenuously avoided, she argued, given that 'some of these young adults have had little or no contact with their family during their stay in residential care and parents have been given no specific help or guidelines as to how to cope'.[20]

These trends contributed towards a shift in the 'average' applicant for institutional care.[21] During a meeting between the Department of Health and the Brothers of Charity, the provincial Brother Alfred outlined how their resident population was evolving, as he explained that 'persons seeking

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[18] Richard Barry, *Dáil Debates* 293, 28 October 1976, col. 674.

[19] See 'Handicapped Children in Psychiatric Centres', *Irish Independent*, 10 November 1977, p. 28.

[20] Ann Byrne, 'Trends in Mental Handicap', *Irish Social Worker*, October–December 1983, p. 4.

[21] O'Donohoe, *150 Years of Stewarts Care*, p. 194.

entry tend to be more severely mentally handicapped than heretofore'.[22] This suggests that, with a growing network of community-based services available nationwide and their lengthy waiting lists for admission, institutional care was increasingly viewed as a 'last-resort' measure, used by those with a more 'severe' form of disability.[23] Viewed as the panacea during the 1950s, these centres were increasingly sought by those unsuitable for alternative forms of support in the community. This was directly reflected at the Kilcornan facility in Galway, for instance, where newer admissions during the 1980s 'had higher degrees of disability, were more dependent and required more care and attention and in many cases had complex challenging behaviour'.[24] Living in a community-based residence, or attending an occupational facility while remaining in the family home, was becoming preferable for many families as against (potentially indefinite) admission to residential care. This was reflected in the discourse surrounding these facilities, in which they were no longer described as an ideal but were instead discussed as a form of care that should only be used when necessary. By 1975 they were framed as an emergency measure, the Department of Health stressed, to be utilised only when there was a risk that 'the disturbed mentally handicapped child … may destroy the family'.[25] This view was also reflected among health officials, who emphasised that residential services 'should only be considered as a last resort'.[26]

These trends manifested at institutions across the state, which increasingly accommodated those diagnosed with a 'severe handicap'.[27] The impact of some of these broader trends was visible on living conditions in St Mary's in Drumcar, Louth. Purchased in 1946 by the Hospitaller Order of St John of God, this initially 'dilapidated house on a windswept ridge' first opened for 'mentally handicapped' children during the late 1940s. Like other facilities, over time the average age of residents at St Mary's began to climb, as children remained at the centre into adulthood. In the early 1970s one-third of St Mary's residents were over 18; by 1984 80%

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[22] 'Report on the Meeting with the Brothers of Charity in Clarinbridge', June 1980, NAI TSCH/PRIV/2010/53/192, p. 2.

[23] See 'Eileen Molloy' in Caoilte Breatnach and Elske Breatnach (eds), *A Caring World: Cion is Cúram, Working with Intellectual Disability in Galway: A History of the Galway Association* (2012), p. 119.

[24] Kevin McCoy, *Report of Dr. Kevin McCoy on Western Health Board Inquiry into Brothers of Charity Services in Galway* [McCoy Report] (Galway, 2007), p. 29.

[25] Department of Health, *A Review of the Irish Health Service: Seminar Proceedings*, p. 61

[26] Letter, G. Johnston (Health) to Joan Collier (Dunsany, Meath) 16 December 1976, National Library of Ireland (hereafter NLI), Irish Countrywomen's Association Papers (hereafter ICA), MS 39/526.

[27] O'Donohoe, *150 Years of Stewarts Care*, p. 194; McCoy Report, p. 29.

were over the age of 16.[28] The age profile of the centre's residents was a concern during a 1981 inspection by An Bord Altranais (the Irish Nursing Board), when it was noted that 'It should be remembered … St. Mary's Drumcar was a children's centre, and that it has, through the absence of adult accommodation elsewhere become "silted-up" with grown up men and some young adults', a problem that was 'compounded by the absence of additional facilities to meet the change in usage'.[29] The Department of Health acknowledged that most new residents arriving at St Mary's were categorised as 'severe' or 'profoundly' disabled, which fostered increasingly challenging conditions in the facility. The Hospitaller Order of St John of God outlined that some residents now exhibited 'disturbance disorders', which commonly manifested in acts of physical violence such as 'nose biting, biting of ears and facial disfigurement'.[30] This was exacerbated by deficient living conditions, the order stressed in its submission to the Department of Health, as residents continued to live in 'long sparse pavilion units which were designed for children'. They argued that overcrowding and a lack of privacy 'stimulates [the] disturbed behaviour', while 'the inadequacies of the accommodation … [were] increasingly intolerable' for staff and residents alike. Given these challenges, the St John of God congregation sought urgent funding to provide more staff for the institution. It was hoped that this would help to limit the risk of physical harm to residents in the facility.[31]

The challenging conditions in St. Mary's, and the broader issues around access to services, were inextricably linked to the maintenance of a subsidiarist-inflected operating structure. Demand for residential places remained considerable into the early 1980s.[32] Given this, it was notable that there were some efforts to establish residential services operated by local health boards, including the Cheeverstown facility in Dublin and the Áras Attracta complex in Mayo.[33] This was an expansion of the state's role, as previously residential provision had been managed solely by voluntary sector organisations in receipt of statutory funding. Yet this development operated along established lines in that the state only 'stepped in' to provide a service that was not available through other means. In the case of Áras Attracta, for instance,

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[28] Harold O'Sullivan, *The House on the Ridge of the Weir: The Story of the Brothers and the Community of Saint John of God, St. Mary's, Drumcar* (Louth, 1998), pp. vii, 59.

[29] Ibid., p. 71.

[30] P. W. Flanagan, 'Memorandum: FAO Barry Murphy', 28 March 1984, Department of Finance records, S72/16/82.

[31] Afterwards, the Department of Finance noted that the new staff members would be approved, on the condition that the Department of Health found equivalent savings elsewhere. Ibid.

[32] See the discussion in John Boland, *Dáil Debates* 323 (2), 16 October 1980.

[33] Western Health Board, 'Meeting Minutes: 1 February 1977', p. 3; Eastern Health Board, 'Meeting Minutes: 7 July 1983', p. 70.

it took a considerable length of time for the facility to become operational; the centre was first proposed in 1977, but did not open until 1988. Despite this delay there was an obvious and pressing need for the centre's beds throughout the intervening period, as approximately a third of its residents were taken from wards in the local psychiatric hospital, St Mary's.[34] This was a limited and (given the delay) likely reluctant statutory response in the face of an overwhelming level of public demand, rather than a wholesale expansion of the state's role.

Indeed, this issue continued to be framed in terms of voluntary sector activity. At a speech to the KARE organisation in Kildare in May 1983, for instance, Minister for Finance Alan Dukes acknowledged that more places in residential institutions were needed across the country. Yet this was not described as a failure by the state, but was framed as a (further) task for the voluntary sector, which were urged to do more to alleviate this 'considerable and growing demand for places'.[35] This framing continued to throw responsibility back on to the voluntary sector, while it consolidated the development of services in what the Department of Health itself acknowledged as a largely 'haphazard, unplanned and uncoordinated fashion' across the country.[36] It also allowed the Minister for Finance to blame lack of action from voluntary organisations rather than rooting this failure in the limited actions taken by either the Department of Health or the regional health boards. The persistence of this dynamic meant that most residential institutions continued to function as private charitable services in receipt of statutory support, with the result that government bodies could complain about a 'silted-up' resident population but could do little to reform practices within these facilities.

'I couldn't comprehend what was going on': Abuse of Residents

> Witnesses with intellectual disabilities repeatedly commented on the fact that 'nobody explained anything' … they did not understand what they were supposed to do and at times why they were being punished or abused.
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> *Report of the Commission to Inquire into Child Abuse* (2009)[37]

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[34] Brendan Corish, *Dáil Debates* 296 (5), 2 February 1977; Review Group, *Áras Attracta Swinford Review Group Report* (Dublin, 2016), p. 2.

[35] Alan Dukes, 'Address: KARE AGM', 2 May 1983, Department of Finance records, S72/16/82, p. 6.

[36] Department of Health, *The Future of Personal Social Services in Health Boards: A Policy Document* (Dublin, 1983), p. 8.

[37] *Report of the Commission to Inquire into Child Abuse* [Ryan Report] (Dublin, 2009), 3, p. 248.

Over the past twenty-five years, multiple exposés have outlined failures in the safeguarding of the intellectually disabled while resident in institutional care facilities.[38] Given the paucity of records, the death of many residents, and the risks associated with potentially re-traumatising now elderly cognitively impaired individuals, assessing the scale of this abuse poses obvious and significant issues.[39] Yet it remains possible to examine how abusive practices occurred, and could persist, in these congregated settings. Looking at Lota, the Brothers of Charity facility in Cork, reveals how failures in the care of the intellectually disabled continued due to deficient oversight regimes, a failure that was compounded by a lack of engagement from either the regional health boards or the Department of Health. Indeed, despite sizeable changes to the nature of institutional care during the late twentieth century, including the introduction of lay staff to religious-run institutions, these centres continued to operate as private charitable facilities in receipt of statutory funding.[40]

The operating practices in individual institutions played a part, in that predatory adults had access to large groups of vulnerable children. A complainant to the Ryan Commission (the commission to inquire into child abuse) underlined his vulnerability when he was a child in residential care at Lota in Cork. He detailed his contemporaneous rationalisation of a prolonged period of sexual coercion by a paedophile member of staff. He explained the need to obey all adults in Lota, and how 'what was happening between the brother and myself I thought were the rules of the school. I was told when I went to the school first, that the brothers were to be obeyed at all times and anything they ask you to do you were to do it.'[41] Alan, who also resided at

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[38] See Maeve O'Rourke, 'Ireland's "Historical" Abuse Inquiries and the Secrecy of Records and Archives', in Lynsey Black, Louise Brangan and Deirdre Healy (eds), *Histories of Punishment and Social Control in Ireland: Perspectives from a Periphery* (Bingley, 2022), pp. 107–38; Carole Holohan, *In Plain Sight: Responding to the Ferns, Ryan, Murphy and Cloyne Reports* (Dublin, 2011), p. 17; Harry Ferguson, 'Abused and Looked-after Children as "Moral Dirt": Child Abuse and Institutional Care in Historical Perspective', *Journal of Social Policy* 36 (January 2007), p. 123; Paul Michael Garrett, 'A "catastrophic, inept, self-serving" Church? Re-examining Three Reports on Child Abuse in the Republic of Ireland', *Journal of Progressive Human Services* 25 (2003), pp. 43–65.

[39] Notwithstanding this, the Dublin Rape Crisis Centre's wide-ranging *SAVI Report* has called for a comprehensive study of violence and abuse towards those with intellectual disabilities in Ireland, with an emphasis on studying these patterns within an institutional context. Hannah McGee, Rebecca Garavan, Mairéad de Barra, Joanne Byrne and Ronán Conroy, *Sexual Abuse and Violence in Ireland (SAVI) Report* (Dublin, 2002), p. 263.

[40] Andrew Power, Janet E. Lord and Allison S. DeFranco, *Active Citizenship and Disability: Implementing the Personalisation of Support* (New York, 2013), p. 354.

[41] 'Garda statement of complainant', qtd in Ryan Report 2(5), p. 222.

Lota during the early 1960s, framed his molestation in broadly similar terms, stating, 'We had three or four maybe more than six foot men who were all dressed in black. I was only a little fella and I couldn't comprehend what was going on.'[42] Interviewed for Mary Raftery's pioneering investigative documentary series *States of Fear* in 1999, Alan remained convinced that other members of staff were aware of his treatment, suggesting that they 'would probably have covered it up, and pretended it didn't really happen'.[43] Although this accusation is plausible, the physical architecture of the centre would have inadvertently served to perpetuate abusive practices. Introduced during the mid-century, the pavilion system effectively split the resident population at Lota into autonomous groups, who remained together for their daily activities.[44] This isolated the institution's residents into smaller units within an already segregated residential facility. Staff also determined the recreation of those in their unit, which gave adults (both lay and religious) an opportunity to isolate potential victims.[45] Alan, for instance, recalled being molested while on a nature walk organised by a religious brother.[46]

In terms of oversight, these centres continued to operate as private charitable services. This meant that the religious hierarchy occupied a crucial role in safeguarding residents, as a parent or relative had to direct their concerns to a figure either within (or affiliated to) the religious congregation. This was an obviously problematic practice given that residents lived in these centres as a privilege, not a right. Beyond this problematic structure, there are examples where the order failed in this role. An example was the case of James Redmond/Brother Eunan (Brother Guthrie in the Ryan Report). Redmond was a serial paedophile, who worked in the residential centre at Lota from 1952 to 1984 and served as principal of its 'special school' from 1955 to 1974.[47] As noted earlier, oversight at Lota operated through the religious hierarchy. It was therefore notable that concerns about Redmond actually preceded his arrival and that the religious hierarchy were aware that he could pose a risk to children. He first arrived at Lota in 1952 after a period spent teaching in a suburb of Liverpool, during which a 'serious situation' had occurred that involved a schoolboy.[48] This ambiguously described event prompted Redmond's transfer to Lota, where the hierarchy of the Brothers

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[42] Mary Raftery, *States of Fear: Episode Two*, 4 May 1999, RTÉ Archive.

[43] Alan, interviewed on *States of Fear: Episode Two*, 4 May 1999, RTÉ Archive.

[44] Ryan Report 2(5), p. 197.

[45] Anne-Marie McAlinden, *'Grooming' and the Sexual Abuse of Children: Institutional, Internet, and Familial Dimensions* (Oxford, 2012), pp. 1–12.

[46] Alan, interviewed on *States of Fear: Episode Two*, 4 May 1999, RTÉ Archive.

[47] Ryan Report 2(5), p. 212.

[48] Letter, Father Harvey to Father Gordon, 31 July 1951, in Ryan Report 2(5), p. 213.

of Charity hoped that 'the matter [would] fizzle out'.[49] While in the centre, he was estimated to have abused more than one hundred boys, holding cycling trips as a pretext to 'groom' them in smaller groups without the presence of other staff members.[50] To give some idea of the scale of these practices, in 1971 alone he took 56 boys on a total of 37 different trips, which included camping, day excursions, and weekends to youth hostels.[51] Extant evidence suggests that the patterns at Lota were not an aberration. By 2007, for example, there were 27 allegations of sexual abuse of residents at the Brothers of Charity centre at Kilcornan House in Galway.[52]

Deficient oversight structures within the institution were compounded by the lack of information and engagement from the state. The Department of Health's guidelines on the abuse of children illustrates the dearth of information available to a contemporary professional. These guidelines were first issued in 1977 and termed acts of abuse as 'non-accidental injury' of children.[53] This document, and its 1983 descendant *Guidelines on Procedures for the Identification, Investigation and Management of Non-accidental Injury to Children*, made only fleeting references to cases of sexual abuse and instead focused on physical injuries such as fractures, lacerations, scalds, and bruises.[54] A collaboration between doctors at Crumlin and Harcourt Street hospitals, these documents were clearly oriented towards medical personnel working in an assessment setting, such as a doctor's practice or a hospital's accident and emergency department. Despite this limited frame of reference, however, these were the only major set of guidelines going into the 1990s.[55] The voluntary groups involved in operating residential services commonly produced their own policy documents and guidelines in this period, including the Hospitaller Order of St John of God's *Relationships and Sexual Development* (1995) and the Brothers of Charity's *Guidelines for the Investigation and Management of Alleged Incidences of Non-Accidental*

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[49] Ibid., p. 214.

[50] Ryan Report 2(5), pp. 212–13; McAlinden, *'Grooming' and the Sexual Abuse of Children*, pp. 1–12.

[51] 'Cycling Activities 1971', in Mary Therese O'Connor, 'From Community to Institutions, from Institutions to Community: Planned Progress to Independence', MSoc thesis, UCC, 1991, p. 359.

[52] McCoy Report, p. 70.

[53] Department of Health, *Memorandum on Non-accidental Injury to Children* (Dublin, 1977); Ferguson, 'Abused and Looked-after Children as Moral Dirt', p. 129.

[54] Department of Health, *Non-accidental Injury to Children: Guidelines on Procedures for the Identification, Investigation and Management of Non-accidental Injury to Children* (Dublin, 1983), p. 21.

[55] Helen Buckley, Caroline Skehill and Eoin O'Sullivan, *Child Protection Practices in Ireland: A Case Study* (Cork, 1997), p. 13; McCoy Report, p. 114.

Injury and Sexual Abuse (1993).[56] Before this, it is unknown how each institution would respond to a potential instance of abuse. Records seen by Brian McDonald from the *Irish Independent* note instances when younger residents were being touched by older boys at Lota. Yet there were no follow-up entries to suggest that any actions were taken to address this issue or to prevent further harm.[57] Similarly, the McCoy Inquiry concluded that the Kilcornan centre in Galway operated in an ad hoc fashion, without any clear standards, into the mid-1990s.[58]

Alongside a lack of information, the state also sought to retain its established 'hands-off' approach to disability institutions, maintaining that these (state-funded) centres were private facilities. The maintenance of this charitable façade supported the Department of Health by distancing it from any failures (such as overcrowding or lack of places). Yet it also rendered disability institutions immune to changes during a period of wide-ranging reform across the health system. Emblematic of this was the fact that 'handicap institutions' were not incorporated into the remit of the regional health boards. These eight health authorities were given vast scope under the 1970 Health Act, charged with 'the administration of the health service in the state'.[59] However, this did not encompass residential institutions for the intellectually disabled, as these centres continued to deal with the Department of Health on an individual basis.[60] This was a bizarre exception to the health board's remit, and one that contradicted the broader drive towards the regionalisation of health services during the early 1970s.[61] It also did not suit the regional health boards, which continued to discuss these issues on a regular basis.[62] By maintaining this approach, the Department of Health could continue to present these institutions as charitable initiatives that merited state funding, rather than de facto state services operated by voluntary organisations. Viewing disability services as being within

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[56] McGee et al., *SAVI Report*, p. 258.

[57] Brian McDonald, 'Mice, Beetles, Flooding and Abuse – the Terrifying Conditions Endured at Lota', *Irish Independent*, 15 August 2011.

[58] McCoy Report, pp. 33–4, 114.

[59] Government of Ireland, Health Act 1970, Article Four.

[60] This approach remained in place into the mid-1990s, when the *Enhancing the Partnership* Report (1996) called for the transfer of this function from the Department of Health to the health boards. *Enhancing the Partnership: Report of the Working Group on the Implementation of the Health Strategy in Relation to Persons with a Mental Handicap* (Dublin, 1996). See the discussion on this issue in Western Health Board, 'Meeting Minutes: 3 January 1972', p. 7; Annie Ryan, *Walls of Silence: Ireland's Policy Towards People with a Mental Disability* (Kilkenny, 1999), p. 115.

[61] Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900–1970* (Dublin, 1987), p. 279.

[62] See John McLoughlin, 'Chairman's Report', in *North-Western Health Board: Annual Report 1979* (Sligo, 1980), p. 2.

the realm of charity clearly remained important, as on multiple occasions politicians explicitly rejected the idea of expanding statutory oversight over these services. In the early 1970s, for instance, the management consultants McKinsey and Company produced the *Towards Better Health Care* report, a comprehensive blueprint for the future of the Irish health system.[63] Among its suggestions was the creation of a specialist national director for 'mental handicap' services. This office was warranted, the report suggested, as it could integrate disability services under one authority and help to ensure parity of provision nationwide.[64] However, the idea was dismissed out of hand at the Dáil's all-party committee on healthcare; statutory oversight was deemed unnecessary given that services for the intellectually disabled were being 'provided mainly in voluntary institutions'.[65]

Clearly, this placed parents in a vulnerable position, as their children were not entitled to a residential place in a voluntary-operated facility. The experience of Margaret and her son Kenneth, who resided at the residential centre in Lota, illustrates the impact of this approach in practice. Kenneth was 6 years old when admitted to the Brothers of Charity residential facility. He had brain damage and an estimated mental age of between 6 and 18 months. He was incontinent and prone to bouts of 'unpredictable behaviour'. During his time in the institution he suffered from a series of unexplained illnesses, which included repeated bouts of diarrhoea, blisters on his groin, and recurrent eye and dental problems. Although any child can become ill while in residential care, Margaret felt that she was discouraged from visiting and that staff regarded her 'as a troublemaker'. She also felt that she 'never got a proper answer' from staff at Lota to account for this varied range of illnesses and, in desperation, felt compelled to get Kenneth referred to a consultant through her own GP. Alongside these medical issues, Margaret also felt that she was given little information about her son's care when resident in the facility. By 1984 these concerns were so pronounced that she felt compelled to remove Kenneth from Lota.[66] Although a singular case, it illustrates the vulnerable position parents were placed in by the charitable orientation of this service. With her questions unanswered, and lacking a statutory reporting mechanism, Margaret was left with little option but to withdraw her son from the institution altogether.

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[63] John Curry, *Irish Social Services* (Dublin, 1980), p. 150.

[64] McKinsey and Company, *Towards Better Health Care: Volume IV* (Dublin, 1971), p. ii.

[65] All-Party Committee on Health Services, *Briefing for Members on the Structure and Administration of Health Boards* (Dublin, 1972), p. 8.

[66] Alison O'Connor, 'Vaccine Case Resulted in 2.75 Million Pounds Award', *The Irish Times*, 7 July 1997; Brian McDonald, 'Long Battle for Access to Lota Records', *Irish Independent*, 16 August 2011; Brian McDonald, 'Mother Tells of Guilt at Putting Son in Hands of Religious Order', *Irish Independent*, 16 August 2011.

During the mid-century the subsidiarist approach to services emerged due to a combination of its economic, ideological, and practical advantages for the state. Into the late twentieth century these factors began to shift, but mid-century practices remained largely intact. In economic terms, the Department of Health could no longer rely on care by religious orders being inherently cheaper, as the number of religious congregants began to decline. Tom Inglis has charted this drop, a trend that accelerated during the broader societal changes of the 1960s and the cultural reforms that emanated from the Second Vatican Council (1962–5).[67] The late twentieth century witnessed a dramatic reduction, with a 58% fall in the number of religious brothers and a 55% reduction among religious sisters between 1970 and 1995.[68] This cultural shift had clear implications for the major 'mental handicap' institutions which, with the exception of Stewart's Institute in Palmerstown, were staffed and managed by religious orders. John Bruton, parliamentary secretary to the Minister for Education, advised Taoiseach Liam Cosgrave about the effect of the transition to lay staff across a range of state-funded services in 1976.[69] The decline of religious congregants posed an obvious economic problem, Bruton noted, given that lay recruits were unlikely to 'be satisfied with the conditions of service (including the absence of salary scale) under which the religious have worked'.[70] Clearly, politicians and civil servants were aware of the economic advantages associated with institutions staffed by religious orders. Yet as congregants departed and these benefits began to decline, there was no discernible shift in the state's approach. Similarly, the ideological advantages associated with operating disability provision through a religious community also began to recede in this period, as care delivered by religious orders slowly became care provided by lay staff in a service that was managed by a religious community.

This left the practical advantage – that a service operated through a voluntary provider functioned under a charitable façade that placed it at a distance from the state. The maintenance of this structure had profound implications for both the nature of these services and for their perception among the general public. For one, it kept institutional provision largely within the realm of charity rather than rights, with admissions decided on a case-by-case basis through engagement between the service provider and the disabled person's family. There was no entitlement to a place, with

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[67] Louise Fuller, *Irish Catholicism since 1950: The Undoing of a Culture* (Dublin, 2002), p. 141.

[68] Tom Inglis, *Moral Monopoly: The Rise and Fall of the Catholic Church in Modern Ireland* (Dublin, 1998), p. 212.

[69] John Bruton to Liam Cosgrave, 'Memorandum: 10 February 1976', NAI DT 2007/116/98.

[70] Ibid.

residential centres presented as private charities that could admit (or reject) any applicant. It also meant that the Department of Health had limited insight into their day-to-day operations.[71] It could be argued that, as these centres were predominantly state-funded and provided long-term care to a vulnerable population, the Department of Health had a responsibility towards residents *in loco parentis*. However, a 2004 memorandum from the department explicitly rejected this responsibility, and clarified that health officials had always regarded these institutions as 'privately operated establishments to which a person would not have been sent by the state or where the state acted *in loco parentis*'.[72] While this may have been the Department of Health's position, it was based on a tenuous reading of how these services operated. Parents might have sought an institutional admission without explicit statutory engagement or contact with a health official. To this extent, an admission could be regarded as a private arrangement. Yet in many cases, members of the public sought help from their local politicians to secure a residential placement, a dynamic that was reflected in the consistent complaints from Dáil deputies about the paucity of residential places across the country.[73] The Department of Health's position also ignored the fact that the state financially supported religious congregations to care for these residents, as well as the fact that facilities provoked frequent complaints in the Dáil. Thus, while nominally voluntary bodies, in the absence of a comparable network of state-run institutions these voluntary facilities (with their statutory support) were the de facto statutory service, which the Department of Health could have closed at any stage by simply withdrawing the annual capitation grant.

Of course, incidents of abuse and violence were not determined by the operating structure of the institutions themselves. Similar failures occurred in a secular context in the UK and were discussed during the enquiries into Ely Hospital (1969) and South Ockendon Hospital (1974).[74] Yet while

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[71] Their principal oversight tool remained the 1908 Children Act, which was in place until the late 1990s. Sarah-Anne Buckley has outlined the significance of this legislation for child protection in the community during the early decades of the century. The Act had limited applicability for those within institutional care, however, as it did not confer 'any power of intervention' in cases where the child was at risk from someone who was not their parent or appointed guardian. The 1908 Act was superseded by the Children Act in 1997. Helen Buckley, Caroline Skehill and Eoin O'Sullivan, *Child Protection Practices in Ireland* (Dublin, 1997), p. 1; Sarah-Anne Buckley, *The Cruelty Man: Child Welfare, the NSPCC and the State in Ireland 1889–1956* (Manchester, 2013), pp. 22–3; Catriona Crowe, 'The Ferns Report: Vindicating the Abused Child', Éire-Ireland 43.1/2 (2008), p. 59.

[72] Mother and Baby Home Commission, *Second Interim Report* (Dublin, 2016), p. 8.

[73] See Daniel Desmond, *Dáil Debates* 156, 11 April 1956.

[74] See Claire Hilton, *Improving Psychiatric Care for Older People: Barbara Robb's*

incidents of abuse could occur anywhere, Irish residential institutions for the 'mentally handicapped' were structurally predisposed to allow deficient care to continue for an extended period, which tragically prolonged instances of physical and sexual abuse. Mid-century operating structures, which placed little responsibility on the state and allowed individual facilities to shape the nature of their own services, created a residential care system that lacked the basic checks and balances to prevent harm. This meant that, where care failed, it could do so in a disastrous fashion over an extended period. Just as the DPMA had relied upon families to ensure the care of their 'handicapped relative', the state similarly depended upon a facility's management to police the standard of care in its service. This approach was exemplified by the absence of statutory inspections at Lota by either the Department of Health or the Southern Health Board, from the centre's foundation in 1939 to 1990.[75] In effect, residential institutions could operate in a form of bureaucratic limbo, with little statutory intervention other than their annual funding. The fact that the department maintained this dynamic, and actively discouraged reform or engagement from the regional health boards, underscores the entrenchment of this approach during a period that was otherwise marked by reform across multiple areas of the health system.

For those in congregate facilities, this meant that there were limited changes to their 'lived experiences' into the late twentieth century. The growing presence of lay staff was more than offset by continuities with the mid-century.[76] Potentially, an increase in the department's engagement, or the inauguration of a system of inspections, could have prompted a change to the operating practices in some of these residential centres. Yet the prism of charity clearly remained critical, allowing services to operate in an autonomous manner, while the state effectively outsourced the majority of residential care to them. Established practices remained hard to break, a dynamic that was also reflected in the persistence of 'handicap admissions' to psychiatric institutions.

Campaign 1965–1975 (London, 2017), p. 215; Ian Butler and Mark Drakeford, *Scandal, Social Policy and Social Welfare* (Bristol, 2005), p. 114; Committee of Inquiry, *Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other Irregularities at the Ely Hospital, Cardiff* (London, 1969); Committee of Inquiry, *Report of the Committee of Inquiry into South Ockendon Hospital* (London, 1974).

[75] Ryan Report 2(5), p. 201.

[76] Barrington, *Health, Medicine and Politics in Ireland*, p. 271.

Descents into Hell: Psychiatric Hospital Accommodation

> The old wooden buildings in which mentally handicapped patients are housed pose the biggest immediate problem in St. Ita's. These buildings are substandard and constitute a fire hazard.
>
> Dr Vincent J. Dolphin (1981)[77]

In December 1976 the Horace Plunkett Guild of the Irish Countrywomen's Association gathered in Dunsany, Meath. During their meeting, one mother tabled a resolution, which asked 'that the problem of residential accommodation for the mentally handicapped over eighteen be tackled by the government immediately'.[78] She went on to explain that her 19-year-old son lived 'very happily' in a residential facility. However, she had begun to fear that he would be discharged from this facility, as part of an effort to 'free up' places for children. She then outlined the limited support available to families. Her frustration was obvious as she asked:

> Where will the over eighteen boy go? He could go home to his parents, if they are still alive. If so, they are probably now growing old. They are older and weaker than when their child went away and the child is older and strong and is therefore more difficult to handle and take care of. The only alternative is the psychiatric hospital … Most of us are mothers. How would you like to have your child sent to a mental hospital?[79]

Her resolution was endorsed by the Guild in Dunsany, before it was included in the ICA's national platform.[80]

Unfortunately, this mother's fear remained plausible, as 'handicap admissions' to psychiatric facilities continued into the mid-1980s. This meant that often considerable populations of the intellectually disabled were housed in mental hospitals across the country. In 1971 St Conal's in Letterkenny had 132 intellectually disabled patients, which was a quarter of the hospital's beds; that same year St Loman's in Mullingar had 244

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[77] Vincent J. Dolphin, *Report of the Inspector of Mental Hospitals for the Years 1977–79* (Dublin, 1981), p. 7.

[78] Horace Plunkett Guild, 'Resolution: 16 December 1976', NLI ICA MS 39,526, p. 3.

[79] Ibid.

[80] Letter, Joan Clooney (General Secretary, ICA) to Eileen Desmond (Minister for Health), 27 January 1982, NLI ICA MS 39,530.

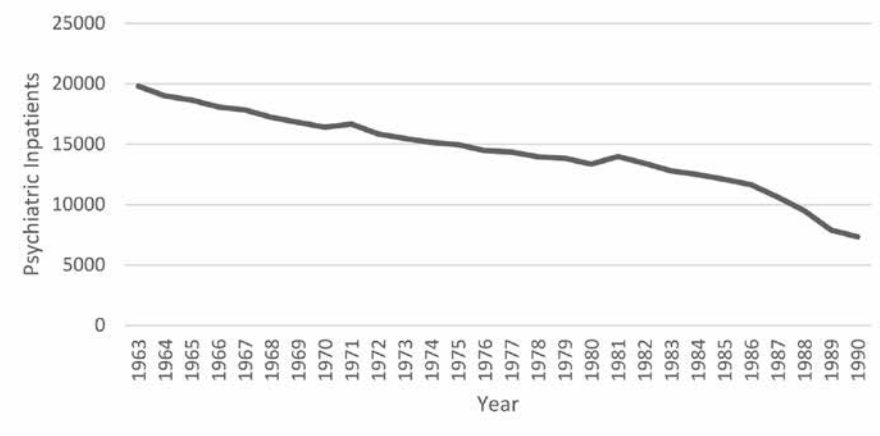

Figure 5.2: Psychiatric hospital inpatient population, 1963–90.

Source: Dermot Walsh and Antoinette Daly, *Mental Illness in Ireland 1750–2002: Reflections on the Rise and Fall of Institutional Care* (Dublin, 2004), p. 69.

'handicap admissions', which represented 26% of the institution's capacity.[81] The admission of the congenitally disabled was a feature at facilities across the country, where it was described as 'generally stable and predictable from year to year'.[82] Indeed, in 1965 there were 2,594 'handicapped' patients in hospital facilities, a figure that had only reduced to 2,170 in 1981, or 15.5% of inpatient beds nationwide.[83]

While 'handicap admissions' remained consistent, the late twentieth century was a period of decline for inpatient psychiatric institutions. Speaking in 1991, Ivor Browne, then chief psychiatrist of the Eastern Health Board, gave a teleological narrative of progress, as he described a (seemingly) inexorable decline in psychiatric inpatient populations across the region.[84] Admittedly, the shift away from large-scale institutions was striking, with the population of Grangegorman Hospital (St Brendan's) in inner-city Dublin falling from approximately 2,000 patients in the early 1960s to just

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[81] 'Call for Psychiatric Social Workers', *Donegal Democrat*, 5 November 1971, p. 14; Aileen O'Hare and Dermot Walsh, *Irish Psychiatric Hospital Census 1971* (Dublin, 1971), p. 41.

[82] Aileen O'Hare and Dermot Walsh, *Activities of Irish Psychiatric Hospitals and Units, 1973 and 1974* (Dublin, 1975), p. 14; Aileen O'Hare and Dermot Walsh, *Activities of Irish Psychiatric Hospitals and Units, 1980* (Dublin, 1983), p. 24.

[83] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 108; Dermot Walsh and Aileen O'Hare, *Activities of Irish Psychiatric Hospitals and Units, 1981* (Dublin, 1983), p. 12.

[84] Ivor Browne, '"Community Care" or "Independence?"', in *The Writings of Ivor Browne: Steps along the Road, the Evolution of a Slow Learner* (Dublin, 2013), p. 325.

over 300 by 1991.[85] Although not as stark, this trend was broadly replicated across the country, as the national inpatient psychiatric population declined from 21,720 in 1956 to 7,334 by 1990.[86] For Browne, this was evidence of progress; he declared to the Mental Health Association of Ireland that '[in] the Eastern region, the demise of the mental hospital is nearly complete'.[87] However, this fall occurred unevenly across the different patient groups housed in Irish 'mental hospitals'. There was a 48% reduction in 'organic psychosis', for instance, which was comparable to the 41% decline in schizophrenic inpatients and the 40% fall in manic-depressives. Yet there was a drop of only 16% in 'mental handicap' inpatients during the same period.[88]

Internationally, systemic changes to psychiatric care prompted this decline.[89] Principal among these was the introduction of chemically synthesised psychotropic medication, including chlorpromazine (Largactil). While not a cure for mental illnesses (such as anxiety, depression, and psychosis), this psychopharmacological intervention made it 'possible for patients to tolerate their disorders with less anxiety and agitation' through the minimisation of their physiological symptoms. In doing so, Largactil allowed for a better rapport in the hospital environment and thereby supported patients to become 'occupied and re-socialised'.[90] In Ireland, it was first trialled alongside the antipsychotic Reserpine (Serpasil) in Grangegorman in 1956. The trial's results were positive, so much so that the Chief RMS Dr John Dunne described the medication as 'now essential'.[91] The use of Largactil contributed towards a marked change in the atmosphere within psychiatric institutions. Writing in the *Irish Times*, Michael Viney explained that it had drained hospitals of their 'old disturbance and tension' by minimising distress among patients, while it also made possible a shorter inpatient stay.[92] These trends were reflected in

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[85] Browne, '"Community Care" or "Independence?"', p. 325.

[86] Brendan Kelly, 'Mental Health Law in Ireland, 1945 to 2001: Reformation and Renewal', *Medico-Legal Journal* 76.65 (2008), p. 68; Dermot Walsh and Antoinette Daly, *Mental Illness in Ireland 1750–2002: Reflections on the Rise and Fall of Institutional Care* (Dublin, 2004), p. 69.

[87] Browne, '"Community Care" or "independence?"', p. 325.

[88] Walsh and Daly, *Mental Illness in Ireland 1750–2002*, p. 75.

[89] Joan Busfield, 'Mental Illness', in Roger Cooter and John Pickstone (eds), *Medicine in the Twentieth Century* (Amsterdam, 2000), p. 639.

[90] Edward Shorter, 'Foreword', in Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland* (Newbridge, 2016), p. ix; Diana Gittins, *Madness in its Place: Narratives of Several Hospitals 1913–1997* (Abingdon, 2006), p. 211; Busfield, 'Mental Illness', p. 639; Ali Haggett, *Desperate Housewives: Neurosis and the Domestic Environment 1945–70* (Abingdon, 2015), p. 136.

[91] 'Drug Success Claim in Mental Illness', *Irish Press*, 16 November 1956, p. 8.

[92] Michael Viney, 'Mental Illness, an Inquiry II: The Opening Door', *The Irish Times*, 24 October 1963, p. 10; Mary E. Daly, *Sixties Ireland: Reshaping the Economy, State and Society, 1957–1973* (Cambridge, 2016), p. 248; Damien Brennan, 'A Theoretical

psychiatric infrastructure projects. Ardee was the last major 'mental hospital' established in the state, opened in 1933 to accommodate approximately 500 patients.[93] From the late 1950s there was a shift in approach, with an effort to locate psychiatric units as part of general hospital buildings.[94] In light of new treatments, the congregate mental hospital was becoming an anachronistic remnant of earlier approaches to psychiatric care.

This trend was also augmented by the development of community-based outpatient clinics. First used in the Adelaide Hospital in Dublin during the 1930s, this form of treatment expanded considerably from the late 1950s.[95] In 1957, for example, St Loman's in Mullingar had 3,491 outpatient attendances; by 1962 this had more than tripled to 13,340 a year.[96] Ivor Browne helped to establish a clinic in the Dublin suburb of Ballyfermot in the early 1960s. He described encounters with patients who faced a wide array of 'virtually insoluble social problems'; they were 'depressed, anxious, overwhelmed and ready to give up'.[97] Notwithstanding the severity of their issues this community-based service allowed Browne to support patients without always requiring their admission to an inpatient bed; he could simply change their 'prescriptions from one antidepressant or tranquiliser to another', while they continued to live in the wider community.[98]

In the late 1950s, psychiatric hospitals peaked at 21,720 inpatients, or 0.7% of the state's total population. Within this group, 2,241 (10.6%) were classified as 'mentally handicapped'.[99] The percentage of beds occupied by intellectually disabled patients fluctuated throughout the latter decades of the century. In 1963 the intellectually disabled occupied 14.3% of places.[100] By the 1971 census, this figure had increased to 16.8% of the hospital

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Exploration of Institutional-based Mental Health Care in Ireland', in Pauline M. Prior (ed.), *Asylums, Mental Health Care and the Irish* (Dublin, 2012), p. 311; Damien Brennan, *Irish Insanity 1800–2000* (Abingdon, 2013), p. 108; Kelly, *Hearing Voices*, p. 194.

[93] Lisa Butterly, 'Institutional Reform in Mental Healthcare in Ireland: The Establishment of the Ardee Mental Hospital, 1933, in its Historical Context', PhD thesis, Maynooth University, 2014, p. 1.

[94] Working Party on Psychiatric Nursing, *Psychiatric Nursing Services of Health Boards* (Dublin, 1972), p. 10.

[95] Kelly, *Hearing Voices*, pp. 214–15.

[96] Michael Viney, 'Mental Illness, an Inquiry II', p. 10; Ivor Browne, 'Psychiatric Services', in John O'Regan, *Report of the Chief Medical Officer for the Year 1966* (Dublin, 1967), p. 152.

[97] Ivor Browne, *Music and Madness: A Personal Journey* (Cork, 2008), p. 123.

[98] Ibid., p. 123.

[99] Vincent Dolphin, *Report of the Inspector of Mental Hospitals for the Year 1959* (Dublin, 1959), p. 32.

[100] Social Affairs Committee, *Psychiatric Services: Present Policies and Problems* (Dublin, 1978), p. 15.

population, despite remaining relatively static at 2,638 patients.[101] This decreased only slightly during the 1970s, so that the 2,170 disabled inpatients in 1981 accounted for 15.5% of beds.[102] It is clear that the intellectually disabled were a consistent minority population across a contracting network of institutions. Reports from visiting committees, and testimony provided by hospital medical staff, show that the admission of these 'handicapped' patients prompted disquiet. Nonetheless, it continued to occur due to a chronic lack of secure residential beds elsewhere. At St Finan's Hospital in Killarney, for instance, the visiting committee was informed in 1965 that its 804 patients represented 'the lowest population figure in the hospital for over 10 years'. Yet despite this reduction, the hospital's RMS Dr J. J. O'Connor still expressed concern about the need to admit certain groups, saying that 'they were still getting Mentally Handicapped people into the hospital, both children and adults'.[103]

Of course, the practice of 'handicap' admissions was nothing new in the mid-1960s. Nonetheless, during a period of decline for institutional psychiatric care more broadly, it was notable that this practice continued, and was consolidated upon, with health authorities trying to utilise their (increasingly vacant) psychiatric hospital system. Overcrowding in specialist institutions prompted the local health authority in Cork to place 'mentally defective' adults in St Raphael's psychiatric hospital in Youghal from 1967.[104] There was a need to relieve overcrowding in the local specialist facility (Lota), officials argued, and there was an already established population of the intellectually disabled at this hospital, which housed 136 'mentally handicapped' patients.[105] Regional health authorities also established specialist wards for the intellectually disabled in their 'mental hospitals'. In 1968 St Brigid's in Ballinasloe proposed an 18-bed ward for intellectually disabled children. These were highly dependent admissions, whose 'presence in the family home was causing undue hardship to the parents', but who could not secure a residential placement elsewhere.[106] This plan was presented as an imperfect solution in the face of broader challenges across an (already) overtaxed network of specialist institutions. Indeed, the chairman of the Galway-Mayo Hospital board, Senator Mark Killilea, hoped that other

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[101] Comhairle na nOspidéal, *Psychiatric Services at Consultant Level: A Discussion Document* (Dublin, 1978), p. 20.

[102] O'Hare and Walsh, *Activities of Irish Psychiatric Hospitals and Units, 1981*, p. 12.

[103] 'Killarney Hospital Problem', *Cork Examiner*, 3 September 1965, p. 18; 'Lowest Number of Patients in Ten Years', *Kerryman*, 4 September 1965, p. 7.

[104] 'Decision to Re-group Youghal Patients', *Southern Star*, 14 October 1967, p. 2.

[105] 'Youghal Patients Transfer to Macroom', *Southern Star*, 18 February 1967, p. 3.

[106] 'Hospital Unit for Retarded Children Approved', *Connacht Tribune*, 13 September 1968, p. 24.

facilities would soon 'follow the example' of St Brigid's by using vacant wards as accommodation for the disabled.[107] This 'handicap' ward in Ballinasloe opened in 1970; according to the county manager, it played a vital role in caring for dependent children who were 'very severely handicapped and need to be watched from the minute they wake in the morning'.[108]

Clearly, institutional space remained valuable. The weight of precedent, and an acute lack of alternatives, also meant that doctors were still compelled to admit the intellectually disabled.[109] The willingness of some local health authorities to make use of these wards did attract criticism. The plan to create a unit for 'mentally handicapped' boys in the grounds of St Joseph's Hospital in Limerick was opposed by the hospital's RMS Dr Niall O'Higgins. At a local health authority meeting in 1968, O'Higgins described the hospital as 'the most unsuitable site imaginable' given its proximity to those with acute psychiatric illnesses; the proposal 'should create feelings of revulsion at the very thought'.[110] In this case, the doctor's objections proved fatal to the project, with the effort abandoned in favour of developing services in conjunction with the Sisters of St Vincent de Paul.[111]

In May 1982 the Eastern Health Board's psychiatric services review committee published its grim assessment of the region's institutional services. The report acknowledged that 'mental hospitals' were still being used to house significant numbers of patients who were not acutely mentally ill, including the intellectually disabled and the elderly, while it also detailed a 'continuing and accelerating deterioration' in the region's hospital infrastructure.[112] The report went on to underline the disquiet of staff given the repeated failure to reform these services. Patients continued to reside in 'seriously deficient' living conditions, which had fostered a culture of 'learned helplessness and dependency', compounding day-to-day challenges in these facilities.[113] After outlining this myriad of failures, the committee came to the damning conclusion that reform would not occur. It explained that the remaining patients in these facilities constituted a disenfranchised forgettable minority who could be ignored; a neglect that

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[107] Ibid.

[108] 'Ballinasloe Unit for Handicapped Children Soon', *Connacht Tribune*, 24 April 1970, p. 1; 'The Mentally Handicapped', *Connacht Sentinel*, 20 July 1971, p. 10.

[109] See Pearl Finnegan's account of the admission of a small child to St Brigid's Hospital in Ballinasloe in the 1960s. 'Pearl Finnegan', in Breatnach and Breatnach (eds), *A Caring World*, pp. 144–5.

[110] 'RMS Opposes Minister's Suggestion for Retarded Boys', *Cork Examiner*, 9 November 1968, p. 11.

[111] Ibid.

[112] Eastern Health Board, *Report of the Psychiatric Services Review Committee* (Dublin, 1982), pp. 7–8.

[113] Ibid., p. 11.

was driven by the fact that there were 'few votes to be obtained behind the walls of mental institutions'.[114]

Exploring the lived experiences of patients within this institutional environment presents obvious (and significant) challenges.[115] This problem is particularly evident when it comes to Irish psychiatric institutions; there are even substantial gaps in the state's statutory reporting mechanisms during the 1960s and 1970s, as the Inspector of Mental Hospitals did not produce a public report (despite a legislative obligation to do so) between 1965 and 1979.[116] Notwithstanding these lacunae, extant records offer some insights into the bleak conditions in 'handicap wards' across the country, where significant numbers of intellectually disabled residents lived in unsuitable and unsafe environments.

Admitting the intellectually disabled to psychiatric facilities attracted criticism in the UK and the US from the mid-1960s onwards. Public concern metastasised under the weight of sociological and journalistic investigations, which highlighted the deficient living conditions and limited care available to the intellectually disabled when resident in these services. Typifying this trend was Pauline Morris's *Put Away: A Sociological Study of Institutions for the Mentally Retarded* (1969). An extensive survey, it charted the deficient lives of the intellectually disabled in large-scale institutions such as psychiatric hospitals.[117] Physical deficiencies were compounded by the absence of activities or rehabilitative training, Morris stressed, which ensured the continued dependency of residents.[118] Research was accompanied by public exposés of deficient hospitals in the UK, such as the inquiries into Ely Hospital (1969) and South Ockendon Hospital (1974), both of which received extensive coverage in the press.[119] This mirrored trends in

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[114] Ibid., p. 23.

[115] Tim Hitchcock, 'A New History from Below', *History Workshop Journal* 57 (spring 2004), pp. 294–8; Iain Hutchinson, 'Institutionalization of Mentally Impaired Children in Scotland c.1855–1914', *History of Psychiatry* 22.4 (2011), p. 430; Ann Sheridan, 'Being a Psychiatric Nurse in Ireland in the 1950s', in Gerard M. Fealy (ed.), *Care to Remember: Nursing and Midwifery in Ireland* (Cork, 2005), p. 176; A discussion of these challenges in an Irish context is contained in B. D. Kelly, 'Intellectual Disability, Mental Illness and Offending Behaviour: Forensic Cases from Early Twentieth Century Ireland', *Irish Journal of Medical Sciences* 179 (2010), p. 412; B. D. Kelly, 'Searching for the Patient's Voice in the Irish Asylums', *Medical Humanities* 42 (2016), p. 87.

[116] The absence of these reports remains a puzzling anomaly. Other researchers have suggested that it was evidence of the deliberate marginalisation of the Inspector's office during this period. Power, Lord and DeFranco, *Active Citizenship and Disability*, p. 357; Ryan, *Walls of Silence*, pp. 1–3.

[117] Pauline Morris, *Put Away: A Sociological Study of Institutions for the Mentally Retarded* (London, 1969), pp. 120–1.

[118] Ibid., p. 124.

[119] Charles Webster, *The National Health Service: A Political History* (Oxford, 2002),

the United States where investigations, such as Blatt and Kaplan's *Christmas in Purgatory* (1966) and Geraldo Rivera's exposé of the Willowbrook State School, demonstrated the failures that could occur in a congregate facility.[120]

Irish psychiatric institutions also received some public scrutiny in this period, such as in Hanna Greally's memoir *Bird's Nest Soup* (1971). A highly critical account, it detailed Greally's committal to St Loman's Hospital in Mullingar from 1943 to 1962, offering a rare glimpse into the largely occluded perspective of the psychiatric inpatient.[121] *Bird's Nest Soup* described a daily life that was characterised by poor living conditions, a lack of privacy, and inadequate food, while Greally's account implicitly underscored the 'mixed' nature of the psychiatric system, which housed the 'mentally ill but also … the poor, the eccentric, the socially troublesome, the vulnerable and the unwanted' of Irish society.[122] Alongside Greally's singular account of life in a 'mental hospital', a growing body of press coverage detailed the poor living conditions in facilities across the country. During a strike by psychiatric nurses in 1971, John Maddock from the *Evening Herald* described some of the 'harrowing reports [that were] coming in from all over the country of the experiences in the [mental] hospitals'.[123] Ivor Browne, who was then the programme manager for specialist hospital care at the Eastern Health Board, also spoke out in increasingly strong terms about these living conditions. In a 1972 report he damningly concluded that the board's institutional psychiatric services were 'substandard, antiquated and dehumanising'.[124]

These failures were brought into stark relief in November 1978, when thirteen junior doctors went on strike as part of an effort to raise publicity about their working conditions in Grangegorman Hospital (St Brendan's) in inner-city Dublin.[125] Coverage of their initial complaint was followed by a series of longer profiles of life in the hospital, which outlined a 'Dickensian world of a badly lit passage maze connecting three floors of gloomy wards'.[126] Multiple journalists encountered a panoply of

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p. 119; Butler and Drakeford, *Scandal, Social Policy and Social Welfare*, p. 114.

[120] Burton Blatt and Fred Kaplan, *'Christmas in Purgatory': A Photographic Essay on Mental Retardation* (New York, 1974 [1966]), p. 5; David J. Rothman and Sheila M. Rothman, *The Willowbrook Wars: Bringing the Mentally Disabled into the Community* (Abingdon, 2017), pp. 45–6.

[121] Kelly, *Hearing Voices*, p. 198.

[122] Hanna Greally, *Bird's Nest Soup* (Cork, 2008 [1971]), pp. 3–5; Eilís Ward, 'Foreword', in Greally, *Bird's Nest Soup*, p. xiii.

[123] John Maddock, 'Patients in Sorry Plight', *Evening Herald*, 10 November 1971, p. 1.

[124] 'Mental Hospitals to be Phased Out Plan', *Evening Herald*, 23 June 1972, p. 3.

[125] Browne, *Music and Madness*, p. 147.

[126] Michael Sharkey, 'The Grim Wards of St. Brendan's', *Irish Press*, 14 November 1978, pp. 1–3; Gerard O'Regan, 'Rat-ridden Hospital Scandal', *Irish Independent*, 10 November 1978, p. 1.

Figure 5.3: St Ita's Psychiatric Hospital, Portrane, Co. Dublin, c. 1954–7. Courtesy of the National Library of Ireland.

concerns during their visits, which included: 'black and peeling' walls, visible 'bird droppings' in the kitchens, a rodent problem (which the hospital management described as being at 'an acceptable level') alongside antiquated sanitary facilities.[127] In August 1982 the RTÉ current affairs programme *Today Tonight* filmed in St Brigid's Psychiatric Hospital in Ballinasloe, Galway. Superimposed over the programme's footage of slumped bodies, stained walls, and sparse furniture, journalist Hilary Orpen narrated her experiences from inside this institution's 'handicap' wards; she commented that 'to enter here is like a descent into hell. The dark and squalid accommodation reeks of excrement. There is no activity,

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[127] 'Haughey Agrees that Hospital may be as Bad as Doctors Say', *Irish Press*, 11 November 1978, p. 3; 'Not Good Enough', *Irish Independent*, 16 November 1978, p. 10; 'That Man Again', *Western People*, 18 November 1978, p. 10; 'A Five Year Wait?', *Irish Press*, 13 December 1978, p. 8; Helen Connolly, 'The Scandal of the Mental Hospitals', *Magill*, 31 October 1980.

no communication. The mentally handicapped sit and rack and moan. They are forgotten people, abandoned here for life.'[128]

Each of these reports was publicly available and thus offered health officials a clear insight into the (obvious and pressing) failures within these institutions. These public discussions were supported by a growing body of research by both activist groups and semi-state organisations, which enforced the need to reform deficient conditions, particularly for vulnerable populations such as the intellectually disabled. Portrane (St Ita's) in North Dublin housed the largest number of 'mentally handicapped' patients in a psychiatric facility in the state, with approximately 500 intellectually disabled residents (42%) among the hospital's population of 1,190 in 1977.[129] In 1981 two separate independent inspections of Portrane were carried out. The first was by Clare Kelly, from the Association of Parents and Friends of St Ita's. Her report detailed the scale of neglect across the 'handicap' wards, highlighting a facility that lacked even the infrastructure needed to provide basic physical care for residents.[130] In the Number 7 east ward for young 'handicapped' males, for instance, she described an overwhelming 'stench of urine' across a ward that had excrement smeared on walls, where patients' clothes were 'ill-fitting and dirty', and bedsheets were heavily stained and adorned with 'rag-like' blankets. Kelly then offered a lengthy description of the ward's bathroom:

> Scandalous. Two toilets. Behind those toilets there is a channel. Over on the right-hand side looking in at the channel it is filled with a sludge-like matter. The shore is at the end of the channel, it is blocked and uncovered. It overflows all over the floor and patients must walk in this mess to use the toilets … Nurses and other staff say nothing is ever done about this.[131]

In a ward that accommodated 35 'handicapped' patients there was a similarly dirty environment, blocked toilets, and a bathroom where 'a sink was removed from the wall and never replaced. Two iron stays are [left] sticking from the wall.'[132] These deficiencies clearly affected the residents, who were forced to live in an obviously unsuitable and insanitary environment. Kelly described how one man sat on the floor, his feet touching effluent from the

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[128] Hilary Orpen, *Today Tonight*, 13 August 1982, RTÉ Archive.

[129] Ivor Browne, *Development of Community Mental Health Services: Planned Evolution* (Dublin, 1977), p. 68.

[130] The Irish Countrywomen's Association sent this report to the Minister for Health. Clare Kelly, 'Report of Visit to St. Ita's, 11 February 1981', NLI ICA MS 39,365, n.p.

[131] Ibid.

[132] Ibid.

bathroom. Due to a lack of staff, this 'unfortunate patient' was left 'just rocking to and fro'.[133] The conditions in Portrane prompted her conclusion that talk of maintenance in the facility was 'a sick joke', as 'only a blind man could ignore so many things needing urgent attention' across the hospital.[134]

These complaints were reflected in a second inspection of St Ita's that year, this time by representatives from the nursing organisation, An Bord Altranais. They visited at Portrane's request in June, producing a final report that augmented Kelly's assessment of the centre's blatantly deficient living conditions. Policy goals were not achievable within this facility, the report concluded, given that it could not even meet basic living standards on wards. 'Handicapped children' were being neglected, the inspectors underlined, as they were denied 'the multitude of therapeutic advances' that could help to facilitate their integration into wider society.[135] By contrast, if a child had a physical impairment, they could access services at centres such as the Central Remedial Clinic or the Baldoyle Orthopaedic Hospital (operated by the Sisters of Charity), both of which were 'newly built, well equipped, interdisciplinary staffed hospitals with a nursing complement of personnel trained in the specific field of paediatric nursing'.[136] The report also noted that 'other equally handicapped but more fortunate children' could access services in their local community, including CBRs, 'special schools', and community workshops. The inspectors concluded that the children in Portrane were an unlucky minority, left in a dirty, unstimulating, and unsafe environment.[137]

Concerns around the physical conditions in Portrane recurred throughout the report. Ward 9A housed 30 'mentally handicapped patients', where there was a pervasive smell of urine. The conditions in 'ward 4, male' were 'nothing short of disgusting', while '7 east' was 'bleak, utilitarian and absolutely non-stimulating' for patients, which fostered an atmosphere of 'gloomy despondency'.[138] These physical deficiencies were framed in terms of their impact on patients, as the inspectors described a 'total and absolute air of institutionalisation in Ward 5', while in another 'non-ambulant patients … just sit in their chairs around by the walls all day, doing nothing, saying nothing but thinking who knows what'. These failures were so pervasive that the report even raised concerns about the damage to staff members in the

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[133] Ibid.

[134] Ibid.

[135] R. McGuiness, T. O'Baoill, J. Crehan and E. Lennon, 'Report on a 3 day inspection by a select committee of the psychiatric sub-committee of An Bord Altranais, carried out on the 3,4,5 June 1981', University College Dublin Archives (hereafter UCDA), An Bord Altranais Papers P 220/381, p. 9.

[136] Ibid., p. 9.

[137] Ibid., p. 9.

[138] Ibid., p. 11.

facility; it explained how, 'As presently organised, functioning and existing, the student psychiatric nurse of 1981 had nothing beneficial, good or positive to learn in a hell hole like this. The unit is an affront to the dignity of man.'[139] It bears repeating that this report was produced by a subcommittee of An Bord Altranais, the statutory body that regulated nurses and midwives in Ireland. During a subsequent meeting, Portrane's management attempted to justify their standards, with the RMS explaining that the hospital was originally an annex of Grangegorman and that historically 'it took the offal' in terms of patients.[140] This explanation was obviously unsatisfactory to the inspectors, who concluded their report with the damning summation that 'A lot of good men must have conspired over the years to do nothing, to have allowed St. Ita's to deteriorate to its present condition.'[141]

This raises an obvious question – how could a hospital deteriorate to the extent that it could shock professional inspectors and prompt such a scathing report? Journalist Helen Connolly identified budgets as a key constraint nationwide. Undoubtedly, limited finances played a role in the poor conditions in this (self-described) 'Cinderella' service.[142] In March 1980 the chief executive officer of the Southern Health Board described the need to reduce the region's psychiatric services budget. This entailed cuts to 'additional' expenses, which included 'spending on furniture, crockery, bedding, clothing, heating, lighting, medicines, medical appliances, X-ray, pathology, travelling expenses, stationery and telephones'.[143] Clearly, little was considered essential to the operation of these facilities. Although budgets provide some context for the conditions across many psychiatric institutions, the scale of these failures lay in the maintenance of established practices. Consultant psychiatrist Dermot Walsh presented 'handicap' admissions to psychiatric care as an inevitable by-product of the state's approach to the intellectually disabled. Doctors may have gained greater autonomy in psychiatric facilities during the late twentieth century, he argued, but in the absence of additional specialist beds or community-based supports, medical professionals continued to be 'called into the breach and … [were] only too willing to respond no matter how inappropriate that response has been' by admitting the intellectually disabled in to their facilities.[144] 'Mental hospitals'

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[139] Ibid., p. 11.

[140] Ibid., p. 23.

[141] Ibid., p. 23.

[142] Connolly, 'The Scandal of the Mental Hospitals'; Derek Chambers, 'When Health Means Illness: Analysing Mental Health Discourses and Practices in Ireland', in Claire Edwards and Eluska Fernández (eds), *Reframing Health and Health Policy in Ireland: A Governmental Analysis* (Manchester, 2017), p. 122.

[143] Ibid.

[144] Dermot Walsh, 'Brief Historical Review', *Irish Journal of Psychiatry* 13.1 (1992), p. 3.

remained compelled to act as the institutional provider of last resort, addressing 'gaps' across other services.

In 1907 the RMS of Grangegorman (then the Richmond Asylum) condemned the admission of 'deficient' patients as an 'ordinary asylum is not a suitable place for them in any way'.[145] It was therefore well established that the practice of 'handicap admissions' was inappropriate and should stop, but in the absence of statutory action to provide appropriate accommodation, the Victorian-era network of 'mental hospitals' remained the inevitable destination for a proportion of the intellectually disabled who could not secure a place elsewhere.[146] By 1984 the *Towards a Full Life* Green Paper was eager to look beyond these facilities; it included a full-page photograph of a CBR facility in Monaghan, under which it noted that the house now accommodated 'four former long stay mental hospital patients'.[147] Clearly, the disabled person's future was in the community. Yet the need to remove the intellectually disabled was not a new concern and had been raised for nearly a century across a multitude of government reports and proposals. Medical autonomy remained constrained by this historical practice, which meant that (with the best of intentions) doctors continued to admit the intellectually disabled into psychiatric institutions across the country, where budget cuts and an ailing physical infrastructure ensured a minimal standard of care. In this way, the Department of Health perpetuated a long-standing practice by maintaining a network of institutions whose conditions deterred all but the neediest of applicants. This kept the state in a limited role, throwing the bulk of the responsibility for 'handicap' services back on to the voluntary sector, as parents' groups worked incredibly hard to provide an alternative to the 'very bleak future' offered in these facilities.[148]

Conclusion

Within statutory disability policy, the shift away from congregate services was pronounced. The *Towards a Full Life* Green Paper foregrounded how only a minority of the intellectually disabled required admission to a residential facility at all, meaning that health authorities should focus their efforts on community services and maintaining a life that was as

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[145] Dr Norman, qtd in Kelly, *Hearing Voices*, p. 158.

[146] Aileen O'Hare and Dermot Walsh, *Activities of Irish Psychiatric Hospital and Units, 1983* (Dublin, 1984), p. 15.

[147] Department of Health and Social Welfare, *Towards a Full Life*, pp. 100–1.

[148] Tom Hughes, 'Punching Above Our Weight', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 334.

'full' as possible.[149] Yet despite changes to their role on paper, institutional services continued to house thousands during the ascendancy of 'care in the community'.[150] The maintenance of established practices across specialist institutions and psychiatric hospitals compounded a disjuncture between the increasingly progressive goals articulated in statutory disability policy and the lived experiences of some residents. The 1984 Green Paper on disability may have concluded that the underlying philosophy of congregate services was 'no longer acceptable'.[151] Yet there is little evidence that the Department of Health actively sought to reform the ways in which some institutional facilities continued to fail the intellectually disabled, which ranged from the absence of specialist support at some centres to the perpetuation of 'handicap admissions' to obviously unsuitable psychiatric hospital wards.

Indeed, when it came to specialist institutions the Department of Health maintained the status quo, with the majority of residential facilities operated by the voluntary sector, which maintained a direct funding relationship with the Department of Health. At various junctures the department had the opportunity to expand its engagement with these services, or to give the health boards a role in this relationship. The era's lack of reform on either count points to the continued importance of the charitable character of these facilities. There was a similar continuity in the 'mental hospitals', where 'handicap admissions' continued despite broader changes to the nature of institutional psychiatric care. For the concerned parent, this presented an undesirable range of options between oversubscribed specialist institutions and the deficient accommodation available in psychiatric care. In light of these choices, it is perhaps unsurprising that parents' groups became involved in providing services that helped intellectually disabled adults to remain in the wider community, an effort that included the development of day-services such as occupational workshops.

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[149] Department of Health and Social Welfare, *Towards a Full Life*, p. 3.

[150] Department of Health, *Statistical Information Relevant to the Health Services 1982*, p. 37; Walsh and O'Hare, *Activities of Irish Psychiatric Hospitals and Units, 1981*, p. 12.

[151] Department of Health and Social Welfare, *Towards a Full Life*, p. 94.

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The Opportunity to Work: Occupational Training, 1962–84

In May 1966 the documentary series *Discovery* addressed the visibility of the intellectually disabled in Irish society. Titled 'Out of the Shadows', the programme filmed at some of the new community-based services for the 'mentally handicapped', including the Cork Polio and General After-Care Association's training workshop in Montenotte. Presenter Brian Cleeve repeatedly stressed the importance of occupational training, lingering on the facility's positive impact on the lives of its trainees. Showing a group of young men busy at carpentry, he praised the Association's foresight. Rather than 'rotting to death in perfect safety', he explained, the workshop was risking the injury of attendees, but in doing so demonstrated their potential and implicitly challenged public perceptions of the 'mentally handicapped'. The programme then moved on to a former workshop trainee, now in open employment at the Cork Woollen Mills – an outcome that Cleeve deemed nothing short of miraculous.[1]

Towards a Full Life (1984) emphasised the importance of work, regarding the ability to 'make a practical contribution to society' as one of the 'primary objectives of policies and programmes for disabled people'.[2] The Green Paper was notable for its candour when discussing deficiencies in existing disability services, as it acknowledged that there remained 'many unmet or only partially met needs and expectations … stretching across the whole field of human interest'.[3] Yet the same report deemed 'occupational training' a success, noting that in 1984, 4,825 people attended community-based workshop facilities across the country; where they received training for future employment, laboured at niche craftwork, or completed subcontracted

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[1] Brian Cleeve, *Discovery: Out of the Shadows*, 23 May 1966, RTÉ Archive.

[2] Department of Health and Social Welfare, *Towards a Full Life: Green Paper on Services for Disabled People* (Dublin, 1984), p. 55.

[3] Ibid., p. 108.

tasks for larger industries, in facilities that were (at least partially) subsidised and separate from the broader labour market.[4] Indeed, when it came to occupational training, disability policy and provision appeared to align – with the widespread propagation of services that were considered vital in the lives of the 'mentally handicapped'.[5]

Commonly, these facilities were discussed in terms of international trends and changing public attitudes, with policy documents stressing that the disabled now had 'the right to work'.[6] Yet notwithstanding wider influences, their propagation can equally be understood in national terms. Workshop facilities built upon a range of established predecessors, while their rapid development during the late twentieth century owed a considerable amount to timing, as facilities drew from new sources of funding and an established network of voluntary experience. This helped to spur the emergence of training facilities, while the varying experiences of attendees underscores the continued development of services at a grassroots level across the country. Policy documents praised workshops as a modern approach to the needs of the disabled, one that was 'particularly appropriate to Irish conditions'.[7] In practice, occupational services emerged in dialogue with an array of developments across the disability services landscape.

The Importance of Labour: Antecedents to Occupational Training

> The approach to the patient should be such as to raise not only his interest but his confidence.
>
> Eamonn O'Sullivan, *Textbook of Occupational Therapy* (1955)[8]

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[4] This does not include the 3,105 who attended a workshop facility while resident in an institutional setting. The report acknowledged some issues, including the uneven distribution of facilities nationwide, but nonetheless highlighted that 'most counties now have community workshops', as well as the 'considerable progress' made in implementing the 1975 Working Party's recommendations. Department of Health and Social Welfare, *Towards a Full Life*, pp. 61, 64.

[5] Department of Health: Working Party, *Training and Employing the Handicapped* (Dublin, 1974), p. 1; Eastern Health Board, *Report on Services for the Mentally Handicapped* (Dublin, 1981), p. 31; Department of Health and Social Welfare, *Towards a Full Life*, p. 61.

[6] See Declan Costello, 'Speaking on Radion [*sic*] Eireann on behalf of the Association of Parents and Friends of Mentally Handicapped Children', 1973, UCDA Declan Costello Papers, P237/5.

[7] Department of Health and Social Welfare, *Towards a Full Life*, p. 61.

[8] Eamonn O'Sullivan, *Textbook of Occupational Therapy: With Chief Reference to Psychological Medicine* (London, 1955), p. 25.

The state's first workshop for the intellectually disabled opened to a somewhat bemused press response in September 1962.[9] Based in the coach house of the St John of God residential facility in Celbridge, Kildare, it catered for a group of 20 young men, who learned to construct corrugated cardboard mats that would protect glass bottles during transport. Although these efforts were praised by local parents, an *Irish Independent* journalist seemed to marvel at the group's audacity in thinking that 'handicapped young men … could be taught' to work.[10] Indeed, across the press coverage, journalists underscored how this workshop tried to imitate 'real' employment, with 'trainees' completing a working day and earning between two and three shillings a week. The organising committee stressed that this was a commercial environment with an emphasis on speed, while the facility also had bonuses for timekeeping, behaviour, and productivity. These measures were necessary, they emphasised, as 'you can't expect businessmen to give us work simply out of sentiment'.[11] The workshop was not a diversion for institutional residents, but instead sought to empower by introducing attendees to labour 'in a wage-earning capacity'. The idea proved popular, with the centre tripling to 60 attendees within two years.[12]

This Celbridge facility was the first iteration of an intellectual disability-specific workshop in Ireland. Yet the need for specialist occupational training centres had recurred since at least 1947.[13] That year, the 'Mental Deficiency' bill outlined the state's proposed role in preparing the 'mentally deficient' for paid employment; the present lack of support was unacceptable, as it resulted in many being 'ill fitted for suitable employment in later life', and consequently this group were 'likely to be exploited for manual labour of the heaviest kind'.[14] The Commission on Mental Handicap's wide-ranging report

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[9] During the early twentieth century, occupational activities were practised across a range of residential institutions, including Stewarts and St Vincent's. The Celbridge centre was distinct in that, wherever possible, it sought to imitate employment in the wider community and to prepare their attendees for employment outside the facility.

[10] 'Work and a Place to Work In', *Irish Independent*, 13 September 1962, p. 13.

[11] Eileen O'Brien, 'Sheltered Workshops and Hostels Urgently Needed', *The Irish Times*, 23 March 1966, p. 4.

[12] 'Aim to Help Handicapped', *Irish Press*, 25 October 1962, p. 15; 'They Help the Boys', *Nationalist and Leinster Times*, 2 November 1962, p. 7; 'Fashion to Aid Handicapped', *Irish Press*, 9 March 1963, p. 14; 'Voluntary Aid to Mentally Ill Praised', *Irish Press*, 11 June 1964, p. 7; 'Handicapped Boys to Have Workshop', *Irish Press*, 1 June 1964, p. 5.

[13] The need for training services to support the 'feeble-minded' child also arose during parliamentary debates on the mental deficiency bills in 1913. Mark Jackson, *The Borderlands of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Later Victorian and Edwardian England* (Manchester, 2000), p. 220.

[14] 'Memorandum for the Government', 13 August 1947, NAI DT S14129A; The value of occupational training also appeared in the 1960 White Paper *The Problem of the Mentally Handicapped*, which emphasised the long-term economic benefits that accrued through

also noted a 'great need' for appropriate training facilities, with workshops framed as an essential service to prepare the intellectually disabled to have a 'life in the community'.[15] Over time, the importance of occupational training was reiterated and expanded upon across multiple policy documents. In 1974 the working party report on *Training and Employing the Handicapped* foregrounded the importance of work in an individual's life and stressed the state's role in providing appropriate services, as 'no one should be denied the opportunity to work even if it requires a special effort by society to enable him to do so'.[16] In *Towards a Full Life*, vocational training facilities were a central service for the 'mentally handicapped'; training helped to ensure that they functioned at 'the maximum extent of their abilities'.[17] Throughout this period, occupational services were linked to international thinking; documents such as the UN's *Declaration on the Rights of Mentally Retarded Persons* (1971) and the *Declaration on the Rights of Disabled Persons* (1975) were cited as evidence of new responsibilities, as they declared that the intellectually disabled had 'a right to perform productive work or to engage in any other meaningful occupation'.[18]

Notwithstanding the influence of international trends, positioning Irish occupational training facilities along a broader chronology highlights continuities between disability-specific training and labour-based practices in a range of established institutions. The development of these workshops also benefited from fortunate timing, as disability-specific services emerged in the wake of community-based efforts to rehabilitate those who had been infected with infectious diseases, such as tuberculosis and poliomyelitis, during the early 1950s. These provided a foundation for the emergence of 'handicap' facilities during the early 1960s, with disability-specific occupational training largely understood as a reappropriation of their ideas around work and rehabilitation. Workshops could therefore emerge more effectively than a CBR facility, as they were viewed as a 'handicap' version of an existing service and could be readily framed in terms of these antecedents.

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training the intellectually disabled to become self-sufficient. Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), pp. 5–8.

[15] Commission of Inquiry on Mental Handicap, *Commission on Mental Handicap: Report 1965* (Dublin, 1965), p. xvii.

[16] Department of Health: Working Party, *Training and Employing the Handicapped* (Dublin, 1974), p. 1.

[17] Department of Health and Social Welfare, *Towards a Full Life*, p. 55; T. Gaffney, 'Evaluation of community workshops and special training centres for the handicapped', Analysis Section, Department of Finance records, December 1980, p. 1.

[18] UN General Assembly, *Declaration on the Rights of Mentally Retarded Persons*, 20 December 1971, A/RES/2856 (XXVI); UN General Assembly, *Declaration on the Rights of Disabled Persons*, 9 December 1975, A/RES/3447 (XXX); Department of Health and Social Welfare, *Towards a Full Life*, p. 108.

Sheltered workshops, centres that supported necessitous groups to gain skills in an environment that approximated industrial conditions, first emerged in the mid-nineteenth century, with Samuel Gridley Howe's work in Massachusetts commonly cited as the progenitor.[19] His institution, Perkins School for the Blind, prepared pupils for a semi-skilled occupation, such as weaving or knitting, that would be economically valuable in the wider community.[20] By imparting skills that were desirable to local employers, workshops could limit an attendee's economic dependency.[21] Training programmes were commonly defended on these economic grounds; a representative of the Iowa School of the Blind justified his efforts in 1854, arguing that the facility supported attendees so that they 'will be able to maintain themselves free of charge from their friends or the state'.[22] In Ireland, 'sheltered workshops' emerged for those with sensory disabilities during the late nineteenth century. There were facilities for the blind at the Richmond Asylum, while occupational training played a part at the Claremont Institution for the Deaf and Dumb, where attendees engaged in tailoring and comb-making.[23] While the first workshops for the intellectually disabled did not emerge until the mid-twentieth century, they drew from the approach adopted by these earlier initiatives in offering a service that would train attendees for paid employment in the community, which could limit their future economic dependency.[24] Occupational facilities for the intellectually disabled were defended along these very lines, as when the

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[19] Dustin Galer, *Working towards Equity: Disability Rights, Activism, and Employment in Late Twentieth Century Canada* (Toronto, 2018), p. 106; Michael Gill, 'The Myth of Transition: Contractualizing Disability in the Sheltered Workshop', *Disability and Society* 20.6 (2005), p. 617; Brad Byrom, 'A Pupil and a Patient: Hospital Schools in Progressive America', in Paul K. Longmore and Lauri Umansky (eds), *The New Disability History: American Perspectives* (New York, 2001), p. 145.

[20] Doris Zames Fleischer and Freida Zames, *The Disability Rights Movement: From Charity to Confrontation* (Philadelphia, 2012), p. 19; Fred Pelka, *What We Have Done: An Oral History of the Disability Rights Movement* (Boston, 2012), p. 574; Arnold Birenbaum and Herbert Kesse Cohen, *Community Services for the Mentally Retarded* (Totowa, 1985), p. 32.

[21] Frances A. Koestler, *The Unseen Minority: A Social History of Blindness in the United States* (New York, 2004), p. 233.

[22] Jacobus tenBroek and Floyd W. Matson, *Hope Deferred: Public Welfare and the Blind* (Oakland, CA, 1959), pp. 250–1.

[23] See Pat Lyons, *A Place in the Sun: A Brief History of the National League of the Blind of Ireland* (Dublin, 1999), pp. 9–10; Rachel Pollard, *The Avenue: A History of the Claremont Institute* (Dublin, 2006), pp. 119–32.

[24] This framing was particularly apparent in the press coverage surrounding early workshops. For example: 'Work and a Place to Work In', *Irish Independent*, 13 September 1962, p. 13; 'Aim to Help Handicapped', *Irish Press*, 25 October 1962, p. 15; 'They Help the Boys', *Nationalist and Leinster Times*, 2 November 1962, p. 7; 'Fashion to Aid Handicapped', *Irish Press*, 9 March 1963, p. 14; Eileen O'Brien, 'Sheltered Workshops and Hostels Urgently Needed', *The Irish Times*, 23 March 1966, p. 4; 'Voluntary Aid

organising committee at the St John of God centre in Celbridge stressed the economic benefits associated with training the 'mentally handicapped' young men to develop 'whatever potential for work he has'.[25]

There are also parallels with the work carried out by residents in institutional settings during the nineteenth and early twentieth century. While Poor Law workhouses were obliged to admit all those in need, labour remained a crucial part of daily life for their residents. The Board of Guardians in Thurles, for instance, tried to run an institution that was capable of 'defraying its own liabilities' through the work of residents.[26] Although Virginia Crossman has questioned the scale of these practices nationwide, it was clearly expected that those capable of work should labour in support of the institution.[27] This obligation persisted in these facilities; county home officials complained about the lack of unmarried mothers in the mid-century, for instance, an absence that was damaging as these women were expected to help in cleaning and the care of children.[28] Similar thinking also occurred across the district lunatic asylum network, where residents often engaged in work on hospital farms.[29] Typically, this labour was discussed in terms of its innately edifying quality, as when an 1862 inspection noted the value of agricultural work to an individual's mental state and how 'nothing can be more injurious to the insane than idleness'.[30] Framed as beneficial for residents, this approach also brought obvious financial advantages for the institutions involved.[31]

This trend continued in psychiatric institutions well into the twentieth century. The Inspector of Mental Hospitals' report in 1935 discussed

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to Mentally Ill Praised', *Irish Press*, 11 June 1964, p. 7; 'Handicapped Boys to Have Workshop', *Irish Press*, 1 June 1964, p. 5.

[25] 'Work and a Place to Work In', *Irish Independent*, 13 September 1962, p. 13.

[26] Virginia Crossman, *Poverty and the Poor Law in Ireland, 1850–1914* (Liverpool, 2013), p. 129.

[27] Donnacha Seán Lucey has shown how this emphasis on work persisted in Poor Law facilities into the twentieth century. Donnacha Seán Lucey, *The End of the Irish Poor Law? Welfare and Healthcare Reform in Revolutionary and Independent Ireland* (Manchester, 2015), p. 85.

[28] Mother and Baby Home Commission, *Final Report of the Commission of Investigation into Mother and Baby Homes* (Dublin, 2021), p. 33.

[29] Matthias Reiss, *Blind Workers against Charity: The National League of the Blind of Great Britain and Ireland, 1893–1970* (Basingstoke, 2015), p. 4; Crossman, *Poverty and the Poor Law in Ireland*, p. 126; Lucey, *The End of the Irish Poor Law?*, p. 41.

[30] Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (London, 1981), p. 196. Similar examples are also discussed in Catherine Cox, *Negotiating Insanity in the Southeast of Ireland, 1820–1900* (Manchester, 2012), pp. 210–13.

[31] Finnane, *Insanity and the Insane in Post-Famine Ireland*, pp. 196–7; For a discussion of the role of the hospital farm at the psychiatric hospital in Ballinasloe (St Brigid's), see Brendan Kelly, *Ada English: Patriot and Psychiatrist* (Dublin, 2014), pp. 56–9; Thomas King-Moylan, 'The District of Grangegorman', *Dublin Historical Review* 7.1 (1944–45), p. 14.

multiple institutions where 'a large number' of patients were occupied on hospital farms, while several facilities were called on to engage more residents in agricultural work and increase their tillage acreage. These were not insignificant ventures. Nationwide 1,301 acres were tilled by psychiatric institutions that year, while the state's 'mental hospitals' owned more than 4,000 acres.[32] Dr Maurice Guéret, whose grandfather Dr William Coyne was resident governor of the Central Mental Hospital in Dundrum from 1944 to 1965, tellingly recalled Coyne's role as closer to that of a business manager for a large agricultural estate than a medical professional during the mid-twentieth century; he described how his grandfather was often 'hauled before politicians on the public accounts committee to explain matters like failures of the carrot crop on the hospital farm, low prices from sales of hospital sheep, victualling rations for staff and the late delivery of spring seeds'.[33]

By the mid-twentieth century, resident labour was an established practice in these centres, justified in terms of its restorative value for the patient. Residents' work was thought to have a range of benefits, including helping workers to develop skills, exhibit their readiness for future discharge, and reduce their dependence by contributing towards their own maintenance.[34] Framed as 'occupational therapy', this hospital-based labour began to transition from generic agricultural work to assembly-style production based in 'industrial therapy units' from the 1930s.[35] First trialled by Dr Eamonn O'Sullivan in Killarney Mental Hospital, by the mid-century this therapeutic model was in use in multiple hospitals.[36] An inspection of Grangegorman in 1953 described the hospital's female therapy unit, where they had 'patients making cushion covers, afternoon tea cloths, socks, scarves and many other items', while the male unit were busy producing 'occasional tables, chairs, stools, towel rails, fire mats, cushions [and] rugs'.[37] As with

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[32] See the recommendations for Ardee, Carlow, Clonmel, Portrane, and Killarney in D. L. Kelly, *Annual Report of the Inspector of Mental Hospitals for the Year 1935* (Dublin, 1936), pp. 16–22, 44.

[33] Maurice Guéret, 'Holistic Healing', *Sunday Independent: Life Magazine*, 15 December 2013, p. 14.

[34] Jennifer Creek, 'The Thinking Therapist', in Jennifer Creek and Anne Lawson-Porter (eds), *Contemporary Issues in Occupational Therapy: Reasoning and Reflection* (Chichester, 2007), p. 5.

[35] Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland* (Newbridge, 2016), p. 179.

[36] Judith Pettigrew and Katie Robinson, 'Dr. Eamonn O'Sullivan: Psychiatrist and Forgotten Pioneer of Occupational Therapy', *Irish Journal of Psychological Medicine* (2022), pp. 1–7; Creek, 'The Thinking Therapist', p. 5.

[37] C. R. Keeble, E. O'Byrne and W. Chase, 'Inspection of Grangegorman on 7 July 1953', in Grangegorman Hospital Committee, 'Meeting Minutes', 23 July 1953, p. 167.

agricultural tasks on the hospital farm, 'industrial therapy' was framed in terms of its benefits for patients, including the ability to impart skills that could facilitate the transition into open employment in the community. O'Sullivan's *Textbook of Occupational Therapy* (1955) stressed how these units were not a diversion for the patient, or a profit-making enterprise for the institution itself, but were training facilities that helped to ensure the successful reintegration of patients into society following their discharge. This made the workshop supervisor a particularly important role, as it called for staff who had both the 'necessary technical knowledge, [and a] special attitude for imparting instruction'.[38]

These labour-based programmes remained in place within institutions into the latter decades of the century and clearly aligned with the ideas and practices that emerged in community-based 'handicap workshops'. In 1972 an inspection at Portrane (St Ita's) described the working environment in the St Benedict's industrial therapy unit, where inspectors 'saw 200 male and female patients, mainly moderately Mentally Handicapped, processing carrots for Messrs. Batchelors Ltd, in another section the members saw short-stay patients engaged in occupational therapy e.g. making rugs, mats, lampshades, paper bags etc'.[39] For the board members, these tasks were evidence of the hospital's progressive approach; they later asked whether 'this aspect [of the facility] … should be publicised' to counteract criticism of the hospital.[40] Although this work was framed as emblematic of a 'modern' approach, there are clear parallels between this 'industrial therapy' work in 1972 and earlier labour on the 'mental hospital' farm, where the patient's work was also framed as therapeutic and potentially useful for a future occupation.

It remains challenging to establish a direct epistemic link between institution-based practices and disability-specific 'handicap workshops'. Nonetheless, there are striking parallels between the discussion of work in 'handicap' facilities and the thinking within these established services. Work – whether on a hospital farm or in a factory-style industrial therapy unit – was viewed as innately beneficial for the worker, as through daily tasks residents could learn skills and thereby prepare themselves for a life in the community. 'Handicap workshops' presented themselves in broadly similar terms, with an emphasis on the inherently beneficial nature of labour in the daily lives of their attendees, while the inculcation of skills would

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[38] Eamonn O'Sullivan, *Textbook of Occupational Therapy with Chief Reference to Psychological Medicine* (London, 1955), p. 28; Judith Pettigrew, Aisling Shalvey, Bríd Dunne and Katie Robinson, 'Eamonn O'Sullivan: Twentieth-Century Irish Psychiatrist and Occupational Therapy Patron', *History of Psychiatry* 31.4 (2020), pp. 470–82.

[39] Eastern Health Board, 'Meeting Minutes', 2 November 1972, p. 309.

[40] Ibid.

help to limit any future economic dependency. Senator Seán Brosnahan, former president of the INTO teachers' union, framed disability-specific workshops in these exact terms during an RTÉ television interview in 1965; occupational training allowed the 'handicapped' attendee to 'find a place in society' through their work, he argued, while these centres also acted as a 'safeguard against [future] exploitation' by imparting skills that the intellectually disabled could use to become financially self-sufficient in the community.[41]

Alongside this alignment with existing practices, disability-specific workshops also benefited in the wake of a flurry of voluntary rehabilitation initiatives. These presented a model of what was possible in terms of community-based training while, in many cases, programmes gradually expanded to include the intellectually disabled in their remit.[42] The post-Emergency years were marked by a sizeable range of health-related reforms, which included the reopening of the Hospital Sweepstakes Fund and an ambitious infrastructural expansion programme from the newly founded Department of Health.[43] This increased engagement was particularly apparent in the Department of Health's efforts to combat tuberculosis (TB), which accelerated under Dr Noël Browne's tenure as Minister for Health (1948–51) and included a considerable expansion in sanatoria infrastructure.[44] This caused a sharp decline in the disease's mortality, with the result that thousands of patients were discharged from sanatoria annually throughout the early 1950s.[45] Former sanatoria patients faced both the challenge of securing employment after a period outside the workforce and the public stigma associated with TB.[46] To address this, the Central Committee for the Rehabilitation of the Tuberculous established training workshops, which sought to equip former TB patients with skills

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[41] Senator Seán Brosnahan, *Horizon: Care of the Mentally Handicapped*, RTÉ Archive, 15 August 1965.

[42] Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900–1970* (Dublin, 1987), p. 139; Diarmaid Ferriter, *The Transformation of Ireland* (London, 2010), p. 396; Greta Jones, *'Captain of All These Men of Death': The History of Tuberculosis in Ireland* (Amsterdam, 2001), p. 219; Anne MacLellan, 'Alone among Neutrals: Ireland's Unique Experience of Tuberculosis during the Second World War', in David Durnin and Ian Miller (eds), *Medicine, Health and Irish Experiences of Conflict, 1914–45* (Manchester, 2017), p. 74; Donnacha Seán Lucey and Virginia Crossman, 'Introduction', in Donnacha Seán Lucey and Virginia Crossman (eds), *Healthcare in Ireland and Britain from 1850: Voluntary, Regional and Comparative Perspectives* (London, 2015), p. 25.

[43] Barrington, *Health, Medicine and Politics in Ireland*, p. 137.

[44] Jones, *'Captain of All These Men of Death'*, p. 219.

[45] Ibid., pp. 217–33.

[46] Susan Kelly, 'Stigma and Silence: Oral Histories of Tuberculosis', *Oral History* 39.1 (2011), pp. 65–76; Chris Macey, *Rehab News: Celebrating 50 Years of the Rehab Group* (Longford, 1999), p. 4; Lucey and Crossman, 'Introduction', p. 25.

that would facilitate their return to work. Based on the Altro programme, organised by the Federation of Jewish Charities in New York, the first Irish workshop was opened for women in Pleasant Street, Dublin, in 1949, followed by a male equivalent in Portland Row in 1952.[47]

These centres aimed to train their attendees in a busy industrial-style environment, where they could learn skills, demonstrate their competence, and then go on to work in the wider community.[48] Like the Perkins School in Massachusetts, the focus was on semi-skilled occupations such as sewing, with the Pleasant Street workshop producing a range of pleated skirts for the department store Bolgers.[49] It aimed to provide a 'real life work situation' for its attendees, allowing them to develop their capacity for work after a period of convalescence and, in doing so, show their ability to cope in a busy industrial-style environment. In theory, once a trainee's capacity and skills were established, they could move on from the workshop into open employment.[50] Occupational services for those with poliomyelitis emerged in a similar manner. Groups such as the Central Remedial Clinic (CRC) opened workshop facilities to supplement their existing physical rehabilitation services. At the CRC, attendees completed intricate tasks such as 'jewellery making and button crafting' for outside firms, which earned a stipendiary payment and helped to demonstrate their ability to work productively.[51]

These organisations demonstrated what was possible in terms of community-based rehabilitation services, while over time these centres often grew to directly address the intellectually disabled in their remit. When TB chemotherapies such as Streptomycin made it possible to treat the disease in weeks rather than months, the need for occupational rehabilitation programmes declined rapidly. Yet rather than marking the end of these organisations, they simply expanded their scope to address a broader group of 'trainees'. With the group now renamed the Rehabilitation Institution, their former TB workshops began to widen their focus from late in 1956, when they began to admit both the mentally ill and those with physical and intellectual disabilities.[52] A comparable process also occurred in voluntary rehabilitation programmes in Cork, when the Cork Poliomyelitis Association

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[47] Macey, *Rehab News*, p. 10; Nicholas Acheson, Brian Harvey, Jimmy Kearney and Arthur Williamson, *Two Paths, One Purpose: Voluntary Action in Ireland, North and South* (Dublin, 2004), p. 89.

[48] Macey, *Rehab News*, p. 1.

[49] Ibid., p. 10.

[50] Mac Lellan, 'Alone among Neutrals', p. 72.

[51] Stephen Bance, 'Crippled, Maimed, Lamed, Shattered and Broken: Polio in Ireland, 1942–1970', PhD thesis, University College Dublin, 2017, p. 80.

[52] Macey, *Rehab News*, p. 28.

became the Cork Polio and General After-care Association in the late 1950s, a group that now addressed the intellectually disabled.[53]

Occupational training workshops were innovative to the extent that they managed to reappropriate this thinking to include the intellectually disabled, either through the creation of a new disability-specific service or through the broadening of existing training facilities to include this constituency. This also meant that workshops were readily understandable in society more broadly, as the public were already aware of the role played by rehabilitative training centres and the importance of labour in institutional settings. Together, these ideas provided a foundation for the development of disability-specific training initiatives, which began to emerge from the mid-1960s through efforts by the voluntary sector.

‘A critically hard nut to crack’: The Emergence of Sheltered Workshops

> In this country the lack of full employment presents problems in the development of sheltered workshops.
>
> *Final Report of the Commission on Mental Handicap* (1965)[54]

It was not a coincidence that the first disability-specific training centre was established at the St John of God residential centre in Celbridge, an institution that already had an active ‘parents and friends’ organisation.[55] In common with a range of other disability services, ‘occupational training’ emerged overwhelmingly through efforts by local voluntary groups, with some supplementary help from regional health boards. By and large this approach proved successful as, by the late 1980s, there was a network of 139 ‘vocational training’ centres across the country.[56]

Voluntary organisations were a vital vector for the emergence of most disability-specific occupational facilities. Parents’ groups commonly developed along the pattern first established by the APFMBC in Dublin in 1955, with a newspaper advertisement precipitating a public meeting, which

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[53] COPE Foundation, *Our History*, http://www.cope-foundation.ie/About-Us/Our-History (accessed 12 June 2018).

[54] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 100.

[55] ‘Aim to Help Handicapped’, *Irish Press*, 25 October 1962, p. 15.

[56] Barbara Murray, ‘Training of Adults with Mental Handicap in Community Workshops’, in Roy McConkey and Patrick McGinley (eds), *Concepts and Controversies in Services for People with Mental Handicap* (Dublin, 1988), p. 244.

then prompted the foundation of a local organisation to provide support and local services in a particular area.[57] Similar to chapters of MENCAP in the UK, concerned parents initially came together to share experiences and to establish services in the absence of statutory provision.[58] This contrasted with the approach in the US, where chapters of NARC (National Association for Retarded Children) commonly participated in public protests and lobbied the government for policy reform.[59] By the mid-1970s there were at least 91 of these voluntary organisations across the country, affiliated under the national umbrella organisation, the National Association for the Mentally Handicapped of Ireland (NAMHI).[60]

Irish disability groups responded to the state's disability services landscape, with the shape of Irish activism influenced by the opaque nature of statutory funding structures and the long-established role afforded to voluntary organisations in the health system. 'Section 65' payments, provided under the 1953 Health Act, remained donations to a charitable organisation that offered a service that was 'similar or ancillary to a service that a health authority may provide'.[61] Yet this payment did not establish a funding relationship between a particular voluntary organisation and the state, with no guarantee of ongoing support. This issue was at the fore of Western Care's newsletter in 1980. The association's president, Frank Turnbull, acknowledged that 'one would expect that by now the government would recognise … and take over the entire financial responsibility' for a group that was providing a range of vital services.[62] Yet this was clearly not the case, meaning that voluntary groups remained reliant on (potentially intermittent) support from the state while they continued to provide key services in their local communities. Groups

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[57] See the regional organisations discussed in 'One Group to Cater for the Mentally Handicapped', *Cork Examiner*, 10 September 1975, p. 3; 'Mental Handicap Association Now Aids 120 Children', *Tuam Herald*, 23 November 1977, p. 3; 'Helping the Handicapped Child', *Sligo Champion*, 23 February 1973, p. 14; 'Praise for Mentally Handicapped', *Longford Leader*, 5 December 1980, p. 22; 'Breakthrough for Mental Handicap Association', *Westmeath Independent*, 4 June 1982, p. 1; Vicki Weller, *An Extraordinary Voluntary Commitment: 25 Years of KARE* (Kildare, 1992), p. 10; Johnny Mee, 'Breaking New Ground', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 3.

[58] Sheena Rolph, *Reclaiming the Past: The Role of Local MENCAP Societies in the Development of Community Care in East Anglia, 1946–80* (Milton Keynes, 2002), p. 48.

[59] James Trent, *Inventing the Feeble Mind: A History of Intellectual Disability in the United States* (Oxford, 2016), p. 231; Allison Carey, *On the Margins of Citizenship: Intellectual Disability and Civil Rights in Twentieth Century America* (Philadelphia, 2009), p. 137.

[60] National Association for the Mentally Handicapped of Ireland (NAMHI), *Notes for Parents: Number Three* (Dublin, 1976).

[61] Government of Ireland, Health Act 1953, Section 65.

[62] Frank Turnbull, 'President's Message', *Western Care News* (1980), p. 2.

noted the precarious nature of this approach as well as how their grant rates rose and fell on an annual basis.[63] By its nature, this funding relationship called for caution, moderation, and consensus-building. In practice it often prompted groups to develop close working relationships with politicians and statutory health authorities, as when Declan Costello served as president of St Michael's House, while Western Care had a senior manager from the local health board on its executive committee.[64]

Although voluntary groups played a key role in the development of many occupational services, regional health boards did establish some occupational training facilities. Yet as with CBRs, the health boards appeared to only act in the absence of voluntary engagement, as when the North-Western Health Board opened a workshop in the Gaeltacht area of Gweedore in North Donegal.[65] These efforts were intended to supplement, not supplant, the work of the voluntary sector. This approach replicated many of the challenges faced by 'special schools' in earlier decades, as groups had to overcome similar fundraising and planning issues. For instance, funding was a clear concern during the early years of the Galway County Association's workshop in Woodquay. The group addressed this challenge through successive fundraising efforts and by being inventive, which often involved 'securing free or cheap raw material … [including] waste ends of timber, seashells and the like' for use in the workshop.[66]

Yet by the mid-1970s individual voluntary efforts were beginning to coalesce into a national network, a trend that supported the emergence of similar types of services across the country. This occurred through the National Association for the Mentally Handicapped of Ireland (NAMHI). Founded in 1961, it was a national disability organisation that did not engage in service provision itself. Instead, it tried to bring local disability groups together at events, while also providing an outlet for regional organisations in the media and producing information materials.[67] One of NAMHI's first activities was the publication of informational booklets, which worked

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[63] See Tom Fallon, 'Talk about Small Beginnings!', in Liam MacNally (ed.), *Western Care: Celebrating Forty Years* (Castlebar, 2007), p. 15; Galway County Association for Mentally Handicapped Children, 'Annual Report 1983', qtd in Caoilte Breatnach and Elske Breatnach (eds), *A Caring World: Cion is Cúram, Working with Intellectual Disability in Galway: A History of the Galway Association* (2012), p. 55.

[64] St. Michael's House, *Annual Report 1975* (Dublin, 1976), p. 2; Western Care Association, 'Annual Report 1978', p. 1.

[65] John Loughlin, 'Chairman's Report', in *North-Western Health Board Annual Report 1979* (Sligo, 1980), p. 17.

[66] 'Big Drive on to Wipe Out £5,000 Debt', *Connacht Tribune*, 3 December 1971, qtd in Breathnach and Breathnach (eds) *A Caring World*, pp. 203–4.

[67] NAMHI, *Information Handbook on the Organisation and Work of the NAMHI* (Dublin, 1975), p. 1.

to dispel stereotypes about intellectual disability and encourage a positive outlook among parents. Typical of this was Dr Noreen Buckley's *What Can I Do to Help My Child? Practical Advice on the Home Care of the Mentally Handicapped* (c. 1975), which discussed a varied range of concerns, from infant feeding and early encounters with neighbours to long-term socialisation and institution-based care.[68] The group also created a popular series of 'mental handicap' directories, which listed intellectual disability organisations across the country and went through five editions in a decade.[69] By creating this space at national level, NAMHI aided in the replication of services such as sheltered workshops, as each individual voluntary group did not have to blindly innovate but could instead establish a facility along a pattern that had proven successful elsewhere.

In support of this, NAMHI published a 'how-to' booklet on day services in the mid-1960s. Sponsored by the Educational Building Society, it was explicitly designed for dissemination among local organisations, its stated aim being to impart the 'maximum of information and direction in the formation and management of day centres'.[70] A similar approach was adopted in publications such as Jodie Walsh's *Let's Make Friends* (1986).[71] Walsh, a member of staff at St Michael's House in Dublin, provided an account of her efforts to integrate St Michael's House attendees through efforts such as befriending programmes and outings, which were discussed in a book that was obviously oriented towards the replication of these initiatives elsewhere; it addressed the common roles fulfilled by a disability organisation, including family support, respite care, and community engagement, before outlining the series of actions that a prospective initiative had to follow. It was a comprehensive guide that discussed activities at a granular level, from how to plan a 'friendship' initiative that paired local teenagers with a disabled peer to the best way to collect feedback from respite carers.[72] The Cork Polio and General

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[68] Noreen Buckley, *What Can I Do to Help My Child? Practical Advice on the Home Care of the Mentally Handicapped* (Dublin, 1975), p. 2. These advice booklets remained a part of NAMHI's role into later decades. See Patricia Sheehan, *Developmental Speech Problems and a Guide for Parents* (Dublin, c.1981); Mary Lowry, *You and Your Down's Syndrome Baby: A Guide for Parents of Babies with Down's Syndrome* (Dublin, 1991).

[69] National Association for the Mentally Handicapped of Ireland (NAMHI), *An Outline of the Existing Services for Treatment and Care of Mentally Handicapped and Disturbed Children and Mentally Handicapped Adults in the Republic of Ireland: Fifth Edition* (Dublin, 1971).

[70] National Association for the Mentally Handicapped of Ireland (NAMHI), *Report on Day Training Centres for Mentally Handicapped Children* (Dublin, [1965?]).

[71] See also the discussion of efforts in Mary Hearne and John Dunne, *Home Sharing: An Evaluation of Family-based Respite Care: Galway County Association for Mentally Handicapped Children* (Galway, 1992), pp. 1–5.

[72] Jodie Walsh, *Let's Make Friends* (London, 1986).

After-Care Association's booklet series, *Vocational Training Programme for People with Intellectual Disability*, also had a comparable focus. Each volume addressed a form of workshop programme, with the series discussing how to establish programmes in horticulture, physical education, light engineering, woodwork, household skills, sewing, and 'social and practical academics'. Their subtitles underlined the booklets' role – these were 'step-by-step manual[s]' designed to encourage the replication of their methods by others.[73] Indeed, alongside learning from these publications, it was also clear that groups were increasingly interacting with each other, a dialogue that also encouraged the development of similar services. Journalist Johnny Mee saw an RTÉ profile of St Michael's House during the mid-1960s, for instance, which inspired him to publish a letter in the *Connacht Telegraph* newspaper. This instigated the foundation of (what would become) Western Care.[74]

The increasingly national network of voluntary organisations was particularly significant as they encountered a new challenge – what to do with the 'mentally handicapped' adult. The Association of Parents and Friends of Mentally Backward Children (APFMBC) had rapidly transitioned from family support to the provision of 'special schools' during the mid-1950s, opening St Michael's House in 1957.[75] Over time, similar efforts emerged across the country, with 5,600 pupils attending 'special classes' by the early 1980s.[76] Yet these services could only address the intellectually disabled up to the age of 18; the Department of Education held that a citizen's constitutional entitlement to a free education effectively ended at this age, regardless of whether an individual would benefit from ongoing support.[77] The lack of adult services was 'a critically hard nut to crack' for disability organisations across the country.[78] However, it also gave a clear impetus for the development of services that could address intellectually disabled adults, as disabled children would all eventually 'age out' of specialist education. Dr Barbara Stokes, the medical director of St Michael's House, emphasised the future importance of

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[73] See Cork Polio and General After-Care Association, *Vocational Training Programme for People with Intellectual Disability: Horticulture Course: Step-by-step Manual* (Cork, 1987). Other organisations produced booklets designed to help carers. For example, Barbara Doyle's *Signed Communications: A System for Teaching Sign Language to Non-verbal People*, which was produced by Western Care in 1980.

[74] Mee, 'Breaking New Ground', p. 6.

[75] 'First Day Centre is Opened by Mrs. O'Kelly', *Cork Examiner*, 11 April 1957, p. 9.

[76] Department of Health and Social Welfare, *Towards a Full Life*, p. 46.

[77] This controversial practice was upheld by the Supreme Court in *Sinnott v. Minister for Education* (2001), when the court agreed that ending state-funded education at 18 did not impinge on an individual's constitutional rights. *Sinnott v. Minister for Education* (2001), 2 IR 545, 600; Thomas Murray, *Contesting Economic and Social Rights in Ireland: Constitution, State and Society, 1848–2016* (Dublin, 2016), p. 262.

[78] *Western Care News 1978* (Castlebar, 1979), p. 6.

occupational training facilities in the early 1960s. Given the persistent difficulty associated with securing a place in a congregate residential institution, she argued, local occupational centres were a vital support alongside special schools, as the disabled should be 'able to graduate onwards [from schools to adult day services] … continuing to live at home for as long as their parents and the community could care for them'.[79]

Although CBRs and occupational workshops were both discussed as a means of relieving pressure on congregate institutions, there were significant differences in their development processes. A CBR required sizeable investment from a voluntary group, including the effective outfitting of a domestic house before the facility could function. In contrast, occupational training could open on a much more flexible basis. In Galway, a training programme was first trialled in an unused room in St Joseph's 'special school' in Newcastle in 1969, with four attendees who completed subcontracted work for local manufacturers such as Hygeia and Connacht Minerals. Unlike long-term community accommodation, training services could function in this kind of informal setting before finding a more permanent home. After nine months in St Joseph's, the workshop then moved to a designated building in Woodquay.[80] Likewise, KARE Industries was first based at a temporary location in Newbridge, before relocating to a large factory site on a local industrial estate two years later.[81] Alongside this flexibility, occupational programmes also allowed experimentation in their daily tasks. During the first weeks at the St Michael's House workshop in Dublin, attendees trialled a range of different tasks, from the production of pottery to packing and assembly work.[82]

Alongside national catalysts, the scale of workshop projects was augmented by the state's accession to the European Economic Community (EEC) in 1973. Described as a 'watershed' moment in Irish social policy, entry into the EEC encouraged the juxtaposition of indigenous disability initiatives against their European analogues.[83] Membership also gave the state access to a body of additional funding. In line with the Universal Declaration of Human Rights (UDHR), the European Social Charter (1961) affirmed the importance of the

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[79] Dr Barbara Stokes, qtd in 'How Britain Cares for her Mentally Handicapped', *The Irish Times*, 5 May 1962, p. 11; NAMHI, *Report on Day Training Centres for Mentally Handicapped Children*, pp. 1–3.

[80] Breatnach and Breatnach (eds), *A Caring World*, p. 28.

[81] Weller, *An Extraordinary Voluntary Commitment*, p. 24.

[82] St Michael's House, *St. Michael's House: Annual Report 1975* (Dublin, 1976), pp. 10–11.

[83] Gabriel Kiely, 'From Colonial Paternalism to National Parternship: An Overview of Irish Social Policy', in Gabriel Kiely, Anne O'Donnell, Patricia Kennedy and Suzanne Quin (eds), *Irish Social Policy in Context* (Dublin, 1999), p. 4; Sylda Langford, 'The Impact of the European Union on Irish Social Policy Development in Relation to Social Exclusion', in Kiely et al. (eds), *Irish Social Policy in Context*, p. 90.

right to work and obliged states to 'provide or promote appropriate vocational guidance, training or rehabilitation to those in need'.[84] To further this aim, the European Social Fund (ESF) tried to promote employment through the provision of vocational training facilities for both the physically and the intellectually disabled.[85] This became a considerable resource for disability initiatives in Ireland. At a meeting of the Midlands Health Board in 1973, the CEO acknowledged the need to do more for the disabled, but stressed how 'handicapped persons will [now] qualify for financial assistance under the European Social fund'.[86] Indeed, during its first years in Ireland, the ESF established itself as a major source of funding for the state's disability organisations. By November 1974, less than two years after accession, the ESF had paid £400,000 to disability training programmes.[87] It provided £5.85 million to the state in 1976 alone, which represented 46% of the AnCo training authority's total budget.[88] These trends continued into the 1980s, when in 1982 more than a third of ESF funding to Ireland was exclusively dedicated to the 'training of the handicapped', totalling more than £18 million.[89]

'Routine repetitive tasks': Labour and the Sheltered Workshop

> training centres and community workshops … will be providing a range of training or work opportunities, which will enable the handicapped person to undertake work best suited to his present abilities.
>
> Working Party, *Training and Employing the Handicapped* (1974)[90]

Statutory policies frequently drew a distinction between workshops that offered skills training for jobs and other community-based facilities,

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[84] Ireland ratified the charter in October 1964. Council of Europe, *European Social Charter* (ETS 35) 18 October 1961, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168006b642 (accessed 19 June 2018).

[85] Brian Shaev, 'Rescuing the European Welfare State: The Social Affairs Committee of the Early European Communities, 1953–1962', in Monika Baár and Paul Van Trigt (eds), *Marginalized Groups, Inequalities and the Post-War Welfare State: Whose Welfare?* (London, 2019), p. 16.

[86] 'EEC Benefits to Help the Handicapped', *Leinster Express*, 24 February 1973, p. 16.

[87] Miceal Ross, *State Aid to the handicapped 1960–77* (ESRI Memorandum 125) (Dublin, 1977), pp. 16–17.

[88] Ibid., pp. 16–18.

[89] Ibid., pp. 16–18; Brendan Corish, *Dáil Debates* 276, 28 November 1974, col. 471.

[90] Department of Health, *Training and Employing the Handicapped*, p. 27.

arguing that the state needed a mixture ‘from open employment to sheltered employment and activation’ to cater for the intellectually disabled.[91] It was commonly envisaged as a continuum, where the ‘workshop trainee’ could be placed in the setting that was most appropriate to their ability.[92] Yet this variety was rarely available on the ground. In 1984 there were 4,825 places available in rehabilitation facilities nationwide; of these, only 430 exclusively offered skills training that could be used to gain employment on the open labour market, with other community workshops providing training programmes alongside long-term sheltered employment.[93] This meant that only a few centres were likely to serve as a clear pipeline to paid employment, as in many ‘mixed’ facilities there was little distinction between transitory skills training in preparation for a job and long-term support.[94] Additionally, while sheltered workshops were the dominant form of provision, there was also clear variability in the nature and range of tasks carried out by attendees at these facilities. Some learned useful niche skills through fulfilling tasks. Others, however, engaged in repetitive work practices shaped by occupational training principles and the pressures associated with production. This meant that the experiences of workshop attendees differed, as facilities were fundamentally shaped by the approach adopted at a local level.

Occupational centres were expected to vary their daily tasks, and it is clear that many groups provided a range of activities to their attendees. In the early 1970s HELP Industries in Cork had 105 trainees, who worked at a mixture of ‘furniture manufacture, textile contract work, industrial strapping and twine manufacture, [and] shoe assembly’; in Limerick there was garment making, upholstery, and industrial repair training; those attending Stewart’s in Dublin could do leatherwork, basketry, rug making, and knitting; while those attending Western Care’s workshops in Mayo engaged in a variety of tasks that included ‘horticulture, woodwork and crafts’.[95] Yet the nature of this work obviously differed from centre to centre. A short-term workshop operated by St Michael’s House included ‘educational and social training’ as part of each day.[96] By contrast, at the workshop attached to the Peamount

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[91] Department of Health and Social Welfare, *Towards a Full Life*, p. 55.

[92] Department of Health, *Training and Employing the Handicapped*, p. 27.

[93] Department of Health and Social Welfare, *Towards a Full Life*, p. 61.

[94] NAMHI Working Committee, *The Crisis of Unemployment: A Report on the Crisis of Unemployment for the School Leaver with a Mild Mental Handicap* (Dublin, 1986), p. 39.

[95] NAMHI, *Trustee Plan: How It Can Help your Child* (Dublin, [1975?]), p. ii; David Loughnane, ‘The Provision of Disability Services in Limerick, 1930–1990’, MA thesis, Mary Immaculate College Limerick, 2013, p. 40; Pat O’Donohoe, *150 Years of Stewarts Care: The Pathway to the Present* (Dublin, 2019), p. 180; Western Care, *Western Care Association: For People in Mayo with Mental Handicap* (Castlebar, 1987), p. 2.

[96] St Michael’s House, *Annual Report 1975* (Dublin, 1976), p. 9.

Hospital in Dublin, attendees engaged in a distinctly more limited range of tasks, which included 'box making and packaging', while at the Sisters of Charity occupational centre, also in Dublin, there were 300 attendees involved in 'simple repetitive work i.e. folding, wrapping, packaging, assembly work'.[97]

The limited nature of these tasks aligned with some contemporary thinking on occupational training and the disabled, as even proponents of disability-specific training facilities envisaged limits to their ability in an industrial setting. The psychologist G. S. Claridge was an advocate for workshop facilities in the UK, and stressed the benefits of a service where 'the emphasis … was on training, rather than on merely occupying the defective'.[98] An individual's cognitive impairment should not (necessarily) preclude them from industrial employment, Claridge argued, as an intellectually disabled person could work successfully at a niche role in a factory; he described how 'one often comes across a worker who seems to have extremely limited intelligence but is engaged in some simple task'.[99] For Claridge, the key was to find an appropriately limited function for this worker. A similarly narrow conception of the disabled person's ability was present across a range of Irish policy documents. This began with the *Report of the Commission on Mental Handicap* (1965), which discussed how occupational training helped to 'demonstrate the capabilities of the mentally handicapped'. Yet the Commission clearly did not consider this group to be capable of a lot, as it highlighted that all industrial tasks could be 'broken down into a number of simple processes' to be carried out in a workshop setting.[100] Indeed, early drafts of the *Training and Employing the Handicapped* report (1974) failed to discuss training at any great length, but instead emphasised how workshop services could be used to occupy the intellectually disabled person during working hours. The 1970 draft, for instance, foregrounded the importance of occupational workshops, but clearly had little faith in the ability of those who would attend these centres, describing in reductive terms how:

> mental retardates are ideally suited to the performance of routine repetitive tasks, which they often perform better than average workers … retardates are more contented and dependable than average workers … the retarded worker does the job as instructed and does not develop his own method or try to find shortcuts … mentally

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[97] NAMHI, *Trustee Plan: How It Can Help your Child*, p. iii.

[98] G. S. Claridge, 'The Senior Occupation Centre and the Practical Application of Research to the Training of the Severely Subnormal', in Herbert C. Gunzburg (ed.), *Advances in the Care of the Mentally Handicapped* (London, 1973), p. 158.

[99] Ibid., p. 161.

[100] Commission of Inquiry on Mental Handicap, *Report 1965*, pp. 100, 103.

> retarded workers have a high degree of job satisfaction on routine jobs, do not actively seek promotion, and are motivated better than their counterparts.[101]

The limited tasks available in some of these workshops was also a corollary of the stress placed on productivity, which was itself a by-product of the emergence of many facilities from voluntary efforts. Some centres presented themselves as professional businesses, which just happened to be staffed by workers who had intellectual disabilities. At the Brothers of Charity's workshop in Galway, for instance, there was a clear emphasis on the 'commercial basis' of the enterprise, with an 'atmosphere … as in open employment'.[102] This need to emphasise the quality and commercial nature of these services had recurred since the opening of the first 'handicap workshop' in 1962, when a member of the parents' organisation in Celbridge had underlined its commercial character, as 'you can't expect businessmen to give us work simply out of sentiment'.[103] This outlook equally linked these facilities to earlier community-based rehabilitation programmes, which had been criticised for their 'sweatshop-like' working conditions throughout the mid-century.[104] The entrepreneurial drive evident in some workshop facilities was a natural response to their financial precarity, as facilities came to rely upon their ability to produce a profit in order to maintain their services. In Limerick, for example, the National Rehabilitation Board became such a profitable enterprise that it allowed for expansion of its work.[105]

Writing in the mid-1970s, Dr Vincent Molony, consultant psychiatrist at the Daughters of Charity, and Michael Brady, the Cherry Group workshop manager at St Vincent's, emphasised the need to maintain certain conditions in any workshop facility, stating that 'discipline must be certain and continuous', that each attendee was paid weekly in cash, and that there was an emphasis on timekeeping and grooming across the workforce.[106] Such features, they argued, were necessary to help trainees move into open employment. Yet in the workshop's daily tasks, which included 'contract packaging of pre-packaged hardware', the same attendees gained little in

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[101] Michael A. O'Foghlu, 'Interim Report: Employment of Handicapped Persons', December 1970, NAI 2007/116/231.

[102] James Fitzharris, 'Cost of Hostels and Day Care Centres for the Mentally Handicapped' (Department of Finance: Analysis Section, October 1981), p. 30.

[103] 'Work and a Place to Work In', *Irish Independent*, 13 September 1962, p. 13; 'Aim to Help Handicapped', *Irish Press*, 25 October 1962, p. 15.

[104] Macey, *Rehab News*, p. 43.

[105] During the mid-century, it produced an annual profit of approximately £15,000. Loughnane, 'The Provision of Disability Services in Limerick', p. 40.

[106] Vincent Molony and Michael Brady, *Cherry Group Sheltered Workshop: Sheltered Workshops* (Dublin, [1975?]), p. iv.

terms of skills that would prepare them for a job in the wider community.[107] Additionally, there were no clear mechanisms in place to ensure that broader policy goals, such as normalisation, were being met in occupational training facilities. This was exemplified by the dearth of educational facilities at many workshops that were supposed to act as 'training' centres. As late as 1987, only one third of workshop facilities across the country had any ancillary educational support to assist their attendees with basic literacy and numeracy, while the majority of those attending in the mid-1980s did not have a structured rehabilitation plan in place.[108] A visit in 1980 to the Brothers of Charity's workshop in Clarinbridge, Galway, showed that the centre's core focus was the production of items, not the training of its workforce. In their workshop, literacy remained a peripheral goal, taught to a 'minimum level … to assist the trainees to become socially acceptable'.[109]

From the mid-1970s doubts began to emerge about the benefits of contract work in 'handicap workshops' in the UK. Kathleen Jones's survey of eleven local authorities across England and Wales found that, despite an often prolonged 'training' period, two-thirds of attendees at workshop facilities 'did not have the basic skills which would make them immediately employable in modern industrial society'.[110] Jones highlighted that 'trainees' rarely transferred from their centre and that their work was frequently so limited that it 'provided remuneration but not enough to make it attractive to outside workers … [as well as being] dull and repetitive, providing little opportunity for moving trainees from simple tasks to more complex ones'.[111] A 1983 study similarly found a disconnect between individuals and their labour in UK workshops, where attendees carried out rote industrial-style tasks, with 'the activity … often felt to be meaningless', while interviewees described a 'sense of powerlessness' when it came to their daily lives.[112] Although many Irish workshops completed similar contract-style tasks, 'trainees' appeared to be broadly positive when it came to their work, as respondents emphasised the companionship and communal structures associated with their centres.[113] Yet it is clear that the issues described in UK research did occur in some Irish workshops. In the early 1980s Drumcar

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[107] Ibid., p. iv.

[108] Murray, 'Training of Adults with Mental Handicap', p. 252.

[109] Mr Feinneadha, 'Report: Clarinbridge Brothers of Charity visit', June 1980, p. 1, NAI PRIV/2010/53/192.

[110] Kathleen Jones, *Opening the Door: A Study of New Policies for the Mentally Handicapped* (London, 1975), p. 164.

[111] Ibid., p. 166.

[112] David Brandon and Julie Ridley, *Beginning to Listen: A Study of the Views of Residents Living in a Hostel for Mentally Handicapped People* (London, 1983), p. 18.

[113] See Murray, 'Training of Adults with Mental Handicap', p. 254; Walsh, *Let's Make Friends*, p. 21.

Park Enterprises focused on furniture manufacturing, with informal 'on the job' training of attendees. Reflecting on this approach in the late 1980s, staff members acknowledged that this had resulted in a less than ideal environment, where there was 'a low intensity and relevancy to training programmes … [while] no structured attempts had been made to increase the production rate'.[114] This sometimes questionable level of productivity also impacted on the transition of trainees into open employment. Surveying twelve facilities in the mid-1990s, A.R. Giles found that 'in general [these] workers did not proceed into the labour market'.[115]

Of course, open employment was not the goal for many workshop facilities. Yet by focusing on long-term sheltered employment, grassroots services were implicitly moving away from the vision articulated in statutory policy, where a continuum of different services were available. In the UK, the failure to transition 'handicapped trainees' into paid work contributed towards a shift in the role of these workshop facilities. Jan Walmsley has charted how centres remained open, but their focus changed from the late 1970s onwards; attendees became 'subject to a life of perpetual leisure and "education"', with the twin goals of normalisation and social role valorisation leading to the foregrounding of recreational activities as part of their daily routine.[116] Walmsley underlined the good intentions that prompted this shift in thinking, but equally acknowledged the deleterious impact of the move away from contract work. Trainees were spared the exploitative work practices that offered little in the way of actual training for a job, she argued, but they also surrendered their sole connection with the 'adult world of wages, regular working hours and productivity'.[117]

Given this change in the UK, it is noteworthy that a comparable move away from industrial-style tasks was slower to emerge in Ireland.[118] There was a conspicuous lack of reflection on this issue in policy, for instance, with multiple documents failing to question the work being carried out in disability-specific workshops. In a report for the Minister for Health, produced as part of the UN's International Year of Disabled Persons in 1981, there was no

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[114] David McEwen, Frank Joly and Mary Byrne, 'Systematic Industrial Training for Adults with a Wide Range of Mental Handicap[s]', *Irish Educational Studies* 8.1 (1989), p. 219.

[115] A. R. Giles, 'Sheltered Workshops in Ireland: Relative Efficiency of a Sample of Twelve Units', MA thesis, University of South Wales, 1996, p. 112.

[116] Jan Walmsley, 'Ideology, Ideas and Care in the Community, 1971–2001', in John Welshman and Jan Walmsley (eds), *Community Care in Perspective* (Basingstoke, 2006), p. 46.

[117] Ibid., p. 46.

[118] Christine Whyte, 'Disability and Poverty: Training and Employment Policy Implications', in Combat Poverty Agency, *Disability, Exclusion and Poverty: Papers from the National Conference* (Dublin, 1994), p. 124.

mention of any need to reform (or even oversee) existing occupational services for the intellectually disabled. Instead the report recommended equalising payments across 'handicap' workshops and AnCo rehabilitation facilities (which predominantly catered for the physically disabled), and asked for the payment of a 'living wage to each sheltered employee'.[119] Surveying this issue in 1994, Christine Whyte from the National Rehabilitation Board recognised how debates over the nature of sheltered employment had 'singularly failed' to get on the agenda in Ireland 'in any shape or form'.[120]

This failure to probe the rehabilitative value of workshops likely lay in the state's broader context, particularly its persistent challenges around unemployment.[121] An economically inclement climate arguably served to temper the expectation that a 'mentally handicapped' worker could transfer to open employment in the community, with the feasibility of employment for the disabled declining alongside contractions across the wider labour market.[122] Indeed, Irish policy persistently noted the challenges associated with transitioning the intellectually disabled into open employment. As early as 1965, the Commission on Mental Handicap noted that the 'lack of full employment' was an issue for any sheltered workshop that sought to move attendees into the workforce.[123] Unemployment increased consistently throughout the 1970s and accelerated during the 'deeply depressed' 1980s, eventually reaching a European high of 21% in 1993.[124] In this environment, the pressure to transition the disabled 'trainee' into open employment was likely less acute – with unemployment so high, how could an intellectually disabled 'trainee' be expected to find a job? This was a noted concern at the foundation of some of these occupational facilities in the mid-1960s. At the 1966 AGM of the Galway County Association for Mentally Handicapped Children, for instance, Dr Michael Mulcahy from the Brothers of Charity in Cork stressed the importance of workshop places being available across the county. Yet he equally warned his audience that 'the outlay may not be recouped' from such a facility.[125] An occupational workshop might never

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[119] National Committee for the Year of Disabled Persons, 'Second Report to the Minister for Health' (Dublin, 1981), p. 15, NAI Department of Foreign Affairs Papers 2011/49/36.

[120] Whyte, 'Disability and Poverty', p. 124.

[121] Andy Bielenberg and Raymond Ryan, *An Economic History of Ireland Since Independence* (Abingdon, 2013), p. 171.

[122] Anne Borsay discusses a similar trend in the UK. Anne Borsay, *Disability and Social Policy in Britain since 1750: A History of Exclusion* (Basingstoke, 2005), p. 137.

[123] Commission of Inquiry on Mental Handicap, *Report 1965*, p. 100.

[124] Denis O'Hearns, 'Global Restructuring and the Irish Political Economy', in Patrick Clancy (ed.), *Irish Society: Sociological Perspectives* (Dublin, 1995), p. 93; Bielenberg and Ryan, *An Economic History of Ireland*, p. 171; Joseph Lee, *Ireland, 1912–1985: Politics and Society* (Cambridge, 1989), p. 494.

[125] Dr Michael Mulcahy, qtd in Breatnach and Breatnach (eds), *A Caring World*, p. 20.

become a profit-making enterprise or a pipeline to employment, Mulcahy emphasised, but it remained important as a support for the intellectually disabled and their families.

Workshops emphasised how they were like any other employment. This was not a leisure or diversionary activity but a workplace, where 'trainees' were paid in cash for their days spent in a busy productive environment.[126] It is clear that statutory authorities had little engagement with these facilities at the local level, with most centres emerging organically through the efforts of local organisations. This meant that each centre could remain as a (relatively) autonomous initiative, with the quality and range of tasks determined by the ability and foresight of its organising committee. Undoubtedly, this freedom allowed for the emergence of a variety of innovative programmes that were both productive and fulfilling for their attendees, clearly meeting the goals ascribed to these services in statutory policy. Nonetheless, this diffuse network equally allowed for the emergence of long-term sheltered workshops that provided little beyond rote tasks, used to occupy their attendees throughout the working day.[127] Disability policy articulated a vision, which was then left in the hands of individual organisations to manifest on the ground, with the result that a wide variety of services emerged under the broad umbrella of 'occupational training'.

Conclusion

Business was booming for KARE Industries in 1984. On an industrial estate outside Newbridge, Kildare, the 6,500 square foot factory floor could accommodate 60 workers at a time, drawn from those leaving 'special schools' in the local area. The centre had established a three-year programme to integrate new workers into this busy industrial-style environment; skills training was vital, as the line progressed rapidly, while quality was also significant, as all finished products were 'carefully monitored and controlled' by floor supervisors. Previously, the centre had completed a variety of subcontracted work for Aer Lingus and Purex Industries, but it had recently embarked on the production of its own range of toiletry bags. These had proven popular, resulting in a busy assembly line. At its official opening in 1985 President Hillery praised KARE, emphasising its innovation, including the support available to new workers, the varied range of tasks carried out in the facility, as well as the 'enthusiasm and contentment' visible across its workforce. Notwithstanding this praise, factory management stressed

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[126] Cherry Group, *Sheltered Workshop*, p. iv.

[127] Ibid.

the commercial nature of their efforts. KARE's training standards were high, the workforce was skilled, and the assembly process was brisk, as a representative explained that 'demand for our own products … almost too much to cope with – with one very substantial export order keeping [us] working flat out'.[128]

KARE Industries was a singular example of this broader growth in adult day services. Hailed as an innovation during the early 1960s, the first 'handicap workshops' drew from a range of antecedents, with disability-specific training mirroring institution-based labour and emerging just as infectious disease rehabilitation programmes had begun to recede. Discussions of occupational training facilities commonly framed their role in terms of rights, as when Declan Costello contended that sheltered workshops supported 'mentally handicapped' attendees, who had the 'right to work, and to training to enable them to do so'.[129] Yet national context played an equally significant role. The influence of established practices was particularly apparent across this nationwide network of services, which borrowed from existing models, depended upon engagement from the voluntary sector, and persisted in Ireland after they were phased out elsewhere.[130] An often challenging labour market, and a limited range of other community-based support, meant that more than 4,000 intellectually disabled people continued to attend workshop-style services as late as 2007, where some received engaging training in a varied range of tasks, while others carried out tedious work unwanted by mainstream industries, including 'shrink-wrapping two-for-one offers for supermarkets, putting inserts into mail shots or making cardboard boxes'.[131]

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[128] Purex Industries manufactured the steel wool scouring product Brillo Pads. Patrick Hillery, 'Address by the President on opening of sheltered workshop in Industrial Estate Newbridge', 4 October 1985, NAI TAOIS/2015/77/153; KARE, 'Annual Report 1984' (May 1985), p. 2; KARE, *KARE Industries* (Kildare, 1985), p. 1; Weller, *An Extraordinary Voluntary Commitment*, pp. 24–5.

[129] Costello, 'Speaking on Radion [*sic*] Eireann on behalf of the Association of Parents and Friends of Mentally Handicapped Children'; Departments of Education, Health, and Social Welfare: Working Party, *The Education and Training of Severely and Profoundly Mentally Handicapped Children in Ireland* (Dublin, 1983), p. 2; Department of Health and Social Welfare, *Towards a Full Life*, p. 108; Stanley S. Herr, 'The New Clients: Legal Services for Mentally Retarded Persons', *Stanford Law Review* 31 (1978), pp. 553–611; Paul R. Friedman, 'Human and Legal Rights of Mentally Retarded Persons', *International Journal of Mental Health* 6.1 (1977), pp. 50–72.

[130] Murray, 'Training of Adults with Mental Handicap', p. 246; Walmsley, 'Ideology, Ideas and Care in the Community', p. 46.

[131] Kitty Holland, 'Sheltered Workshops at the Centre of Exploitation Claims', *The Irish Times*, 27 August 2007; Eimear McGlinchey, Philip McCallion, Eilish Burke, Rachel Carroll and Mary McCarron, 'Exploring the Issue of Employment for Adults with an Intellectual Disability in Ireland', *Journal of Applied Research in Intellectual Disability* 26 (2013), pp. 335–43.

In 1966 Brian Cleeve described occupational training as a 'miracle', one that shifted both public perceptions and the lives of the disabled.[132] Undoubtedly, many facilities had a profound impact on the lives of their attendees, giving the intellectually disabled the opportunity to enter the world of work and labour in an environment that mirrored employment in the wider community. They also played a vital role in supporting family carers and, in doing so, ensured the continued maintenance of thousands of the intellectually disabled outside of residential settings. Yet the emergence of these facilities replicated issues seen elsewhere across the disability services landscape, with the development of a wide variety of services under the banner of 'occupational training'. *Towards a Full Life* viewed these facilities as central to its vision for the intellectually disabled, as workshop services were a means to an end and could provide integrated support across the lifecourse.[133] The proposals outlined in *Towards a Full Life* were undeniably ambitious, but they would only become fully embedded in Irish disability policy during the following decade.

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[132] Brian Cleeve, *Discovery: Out of the Shadows*, 23 May 1966, RTÉ Archive.

[133] Department of Health and Social Welfare, *Towards a Full Life*, p. 21.

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'A strategy for equality': Intellectual Disability and Ireland, 1947–96

It was normal to worry. In a booklet on intellectual disability, Anne Dempsey acknowledged that any parent would be concerned about their child, but particularly when they had a 'mental handicap'. Yet she asked her readers to recognise that there was cause to be positive in the early 1980s, and that everyone could agree 'that it is better to be born handicapped today than it would have been a hundred, or even thirty, years ago'.[1] The NAMHI pamphlet *What Can I Do to Help My Child?* (1975) detailed a handful of these changes, reassuring any concerned parents that they:

> live in a good era. Here in Ireland over the last fifteen years the problem of mental handicap has been highlighted. Efforts by religious and voluntary bodies have encouraged the state to set up special schools, special care centres, day and residential schools and trainee workshops and also sheltered workshops.[2]

Statutory documents outlined the impact of these new services on the lives of the intellectually disabled and suggested that they had contributed towards a broad shift in public thinking. There was now a 'different attitude' to intellectual disability across Ireland, visible in the fact that it was accepted among the public that the 'mentally handicapped' were entitled to the 'same opportunities and benefits from life as other citizens'.[3] Clearly, a lot had changed during the mid-to-late twentieth century.

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[1] Anne Dempsey, *People Like Us: Disability, the People and the Facts* (Dublin, 1982), p. 41.

[2] Noreen Buckley, *What Can I Do to Help My Child? Practical Advice on the Home Care of the Mentally Handicapped* (Dublin, 1975), p. 7.

[3] Department of Health and Social Welfare, *Towards a Full Life: Green Paper on Services for Disabled People* (Dublin, 1984), pp. 17, 23.

'Towards a full life': The Evolution of Statutory Disability Policy, 1984–96

This transformation was particularly apparent across statutory policy, where responses to the intellectually disabled had progressively expanded over time. The 1960 *Problem of the Mentally Handicapped* White Paper had focused almost exclusively on residential accommodation, discussing existing provision and the challenges associated with growing congregate services.[4] By contrast, in 1984 a government Green Paper grappled with the enormous question of how to help the physically and intellectually disabled to 'realise their full potential and to participate to the greatest extent possible in the life of the community'.[5] The *Towards a Full Life* discussion paper was also notable for its willingness to explore deficiencies across existing services. It clearly underlined the need to move away from a reliance on large-scale institutions, which were too often 'sited away from centres of population and amenities'.[6] It also conceded that large areas of existing provision remained far from perfect; there remained 'many unmet or only partially met needs and expectations of the disabled [which spanned] … across the whole field of human interest'.[7] *Towards a Full Life* positioned itself as a statutory reflection of a much broader shift in public attitudes and grassroots services. It explored how:

> when the State was less developed and its social commitments more restricted, the task of supporting the disabled person fell almost exclusively on the family and the charitably minded. Occasionally, through exceptional courage and determination or the availability of extra resources, disabled people were able to establish an independent life for themselves. For the majority, however, survival at minimal levels of subsistence and tolerance was the reality of their lives and they were psychologically conditioned to expect no better. There is now a different attitude. There is greater public and private acceptance that the disabled are entitled, as of right, to the same opportunities and benefits from life as other citizens and that obstacles to their exercising that entitlement should be minimised if not eliminated. While progress has been made in that direction Irish society still has a considerable way to go to bring about a full life for the disabled.[8]

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[4] Department of Health, *The Problem of the Mentally Handicapped* (Dublin, 1960), p. 3.

[5] Department of Health and Social Welfare, *Towards a Full Life*, p. 21.

[6] Ibid., p. 94.

[7] Ibid., p. 108.

[8] Ibid., p. 17.

The document's wide-ranging vision aligned with a growing body of contemporary social policy research, which explored the marginalisation of certain groups from Irish society, including travellers (*Report of the Travelling People Review Body*, 1983), psychiatric patients (*Planning for the Future*, 1984), the young (*Report of the National Youth Policy Committee*, 1984), and the old (*Years Ahead – A Policy for the Elderly*, 1988). Yet despite its ambitious vision, *Towards a Full Life* recommended a limited range of measures to manifest its goals on the ground, with measures such as the creation of a nationwide database of the disabled as well as the launch of a Health Education Bureau campaign to improve wider society's understanding of disability.[9] The idea of specific legislation on disability was dismissed out of hand, for instance, with 'general agreement' preferred instead of such 'measures of compulsion'.[10] Indeed, the Green Paper explicitly acknowledged that provision would continue to be shaped at a grassroots level by individual organisations; this remained the 'main thrust in the development of services', with 140 groups affiliated to NAMHI in 1984.[11]

In terms of rights there is a similar disjuncture between the Green Paper's ambitious vision and its discussion of how to put these ideas into practice. *Towards a Full Life* aimed to ensure that the intellectually disabled had a 'full life' based in wider society wherever possible, an approach that was supported by the emergence of a 'new and more enlightened attitude' among the general public.[12] Reflecting this, its appendices included both the UN *Declaration on the Rights of Mentally Retarded Persons* (1971) and the *Declaration on the Rights of Disabled People* (1975). Yet there was limited engagement with these ideas throughout the document's main text, while the section on 'Rights of the Disabled' discussed international trends in broad terms alongside the initiatives that were carried out for the UN's International Year of Disabled Persons in 1981.[13] By the early 1980s voluntary organisations had demonstrated the valuable role played by community-based services, as the growing availability of services such as CBRs, 'special schools', and training workshops gave new opportunities to the intellectually disabled and their families. The emergence of this provision, alongside international trends such as normalisation, necessitated the expansion of statutory disability policy. Yet while long on vision, *Towards a Full Life* fell short when it came to how to manifest its ideals, instead falling back on well-established approaches.

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[9] Ibid., pp. 11, 16.

[10] Ibid., p. 112.

[11] Ibid., pp. 19–20.

[12] Ibid., p. 20.

[13] Ibid., pp. 108–9.

There is continuity between *Towards a Full Life* and the 1990 White Paper *Needs and Abilities: A Policy for the Intellectually Disabled.* Like its predecessor, *Needs and Abilities* had the vast aim of securing for 'every person with an intellectual disability … as fulfilling and normal a life as possible'.[14] It listed 61 recommendations, which ranged from the need to discontinue the use of the term 'mental handicap', to the development of multidisciplinary support teams across each health board area. Some recommendations, such as the need for regional databases or the creation of coordinating committees, mirror those included in *Towards a Full Life* six years earlier. Others are notably specific and limited in scope, particularly for a document with such wide-ranging aims. For instance, it called for the collation of information materials for parents, a role that was already being addressed by voluntary groups such as NAMHI.[15] Indeed, although the White Paper is very clear in its broad aims there is little evidence that its specific recommendations were ever enacted. For instance, it called for a deinstitutionalisation programme that, over the following five years, would transfer 250 people per year out of congregated settings. While the move away from large-scale services continued throughout the 1990s, it would take until 2011 before a similar programme was launched.[16]

Other trends also persisted, including continued growth in the number of educational and occupational facilities, alongside the ageing of the resident population in congregate facilities and the continued reliance on psychiatric hospital wards as housing for some of the intellectually disabled. By 1995 344 'mentally handicapped' patients remained at St Ita's Hospital in North Dublin, spread across 18 wards, 16 of which were locked. This was a long-term resident population; 92% of this group had been in the hospital for more than five years. Despite successive scandals, media coverage, and countless improvement efforts, the Inspector of Mental Hospitals grimly noted how 'much [remained] to be done' for those living in the facility in the mid-1990s.[17]

The Commission on the Status of People with Disabilities marked a crucial turning point for statutory disability policy, with a decisive shift towards a rights-based model.[18] Like earlier documents, the Commission's

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[14] Department of Health, *Needs and Abilities: A Policy for the Intellectually Disabled* (Dublin, 1990), p. iii.

[15] Ibid., p. 10.

[16] Christine Linehan, 'Ireland's Journey to a Person-centred Approach to Disability Support Services', in Jan Šiška and Julie Beadle-Brown (eds), *The Development, Conceptualisation and Implementation of Quality in Disability Support Services* (Prague, 2021), p. 79.

[17] Inspector of Mental Hospitals, *Report of the Inspector of Mental Hospitals for the Year Ending 31st December 1995* (Dublin, 1996), p. 33.

[18] Dónal Toolan, 'An Emerging Rights Perspective for Disabled People in Ireland: An

report, *A Strategy for Equality* (1996), had an ambitious vision for the future of the physically and intellectually disabled; its final report was 'the most comprehensive examination of the needs of people with disabilities' in the history of the state. Unlike its predecessors, however, it included 'wide-ranging, even radical' proposals to bring this vision into reality. This encompassed 402 detailed recommendations across 22 areas of concern, from constitutional change and the accessibility of buses to the visibility of the disabled across the media.[19] The scale of this vision was groundbreaking and has been credited with 'igniting the transformation agenda in Irish disability policy'.[20] The Commission's wide-ranging and comprehensive recommendations flowed from the body's membership and its approach. In contrast to previous efforts, 60% of the Commission consisted of those with a disability, their carers, or family members.[21] These included many prominent disability advocates, including Frank Mulcahy from the Irish Wheelchair Association and the parental activist (and president of NAMHI) Annie Ryan. Alongside activist membership, the Commission was also notable for its engagement with the disability sector more broadly. In 1990 *Needs and Abilities* received a total of 70 submissions; just six years later the Commission considered approximately 600 submissions, on top of 30 'listening meetings' conducted at 18 locations across the country. This fed into a final report that foregrounded the need for equality and laid the groundwork for a range of legislation throughout the following decade, including the 1998 Education Act, the 1998 Employment Equality Act, the 2001 Disability Bill and the subsequent Disability Act in 2005.[22] Among its varied range of measures, *A Strategy for Equality* instigated the creation of the National Disability Authority, an organisation that took a central role in the future development of the state's disability policy.

A Strategy for Equality represented an undeniable shift from previous statutory responses, as it foregrounded a comprehensive plan and a rights-based approach.[23] The intellectually disabled were now being

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Activist's View', in Suzanne Quinn and Barbara Redmond (eds), *Disability and Social Policy in Ireland* (Dublin, 2003), p. 177.

[19] Even more notably, an evaluation in 1999 found that over 75% of its recommendations were being implemented. Francesca Lundström, Donal McAnaney and Bevereley Webster, 'The Changing Face of Disability Legislation, Policy and Practice in Ireland', *European Journal of Social Security* 2.4 (2000), pp. 379–97.

[20] Anne Doyle, 'Disability Policy in Ireland', in Suzanne Quin and Bairbre Redmond (eds), *Disability and Social Policy in Ireland* (Dublin, 2003), p. 15; Andrew Power, Janet Lord and Allison DeFranco, *Active Citizenship and Disability: Implementing the Personalisation of Support* (Cambridge, 2014), p. 366.

[21] Department of Health, *Needs and Abilities*, p. v.

[22] Doyle, 'Disability Policy in Ireland', p. 15.

[23] See the press responses collected in the papers of Mervyn Taylor, who served as

addressed on an equal footing with wider society; they were no longer in need of special protection but were a group of heretofore 'neglected citizens'. Of course, a singular statutory report did not instigate wide-ranging changes overnight; the movement away from the established services landscape continued into the twenty-first century.[24] Yet the state's vision had obviously changed, and with this change there was a new commitment to achieving equality. Earlier approaches, which had regarded the intellectually disabled as a 'problem' (in need of a solution), were finally being set aside in favour of a detailed plan that outlined how they could (and should) be supported to live community-based lives, just like anyone else.[25]

'A good era': The 'Remaking' of Intellectual Disability in Ireland, 1947–96

The Department of Health was established just months before the needs of the 'mentally deficient' first crossed the minister's desk, when a sweeping array of proposals were considered urgently necessary to address their needs. This group remained a concern decades later, when the department again turned to consider the 'problems and needs of the great majority of the mentally handicapped'.[26] The years in between witnessed instances of both change and continuity. For some, CBR facilities gave the opportunity to reside in the wider community, while 'special' classrooms and occupational workshop facilities provided new opportunities to access a formal education and the world of work. At the same time, hundreds continued to enter clearly unsuitable psychiatric hospital wards, while parents approached their local TDs in despair about the absence of community-based support.[27] Statutory policy for the intellectually disabled was obviously 'better' in 1996 than in 1947, as the state had progressively expanded its vision for the 'handicapped'. Yet the process of enacting this change, Ireland's version of the international 'remaking of mental retardation', was far from even; there are cases where policy goals fell short in practice, while services were often predicated on a (formidable) foundation of effort from the voluntary sector. This produced 'winners' and 'losers' among the intellectually disabled across the country.

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the Minister for Equality and Law Reform (1993–94; 1994–97). National Library of Ireland, Mervyn Taylor Papers, MS 46,512/9.

[24] Power, Lord and DeFranco, *Active Citizenship and Disability*, p. 366.

[25] See the discussion in Department of Health, *The Problem of the Mentally Handicapped*, p. 1.

[26] Department of Health and Social Welfare, *Towards a Full Life*, p. 18.

[27] See the discussions of families under 'fierce pressure' in the Dáil. For example: *Dáil Debates* 328 (13), 13 May 1981.

Irish society also underwent an obvious cultural shift when it came to disability in this period, as the distant figure of 'deficient' children who were placed in far-off residential institutions gradually became the 'mentally handicapped' young people who lived in the community, attended mainstream classrooms, or were employed in local occupational facilities. This was a revolution in visibility for the disabled, a process that arguably culminated in Ireland's hosting of the Special Olympic Games in 2003.[28] Encompassing the expansion (and evolution) of congregate institutional care, the creation of a disability-specific welfare payment, as well as the emergence of 'special schools', community housing, and occupational training facilities, this was a period of considerable change for the intellectually disabled, but these developments continued to be shaped by the state's approach to social policy alongside entrenched political and administrative dynamics. In 1996 disability policy was obviously more receptive to a range of international thinking, placing ideas such as normalisation and rights-based thinking at the heart of statutory approaches.[29] However, the practical implementation of these ideas remained overwhelmingly rooted in the delivery of services through the mixed economy of care. Indeed, to an extent this approach has remained a feature across the health system, as in recent years the involvement of the Sisters of Charity in the National Children's Hospital instigated considerable public debate and controversy.[30]

Limited Interventions: Statutory Disability Policy

There was an obvious transformation across disability policy in this period, with the state's approach moving from 'care and protection' in 1947 to an acknowledgement that the 'mentally handicapped' should have a 'normal' life in 1996. Increased scrutiny, through government White Papers and inquiries such as the 1965 Commission on Mental Handicap, played a role in broadening policy thinking and helped to instigate new approaches. Yet this policy transformation was equally shaped by 'bottom-up' activism from the voluntary sector. Concerned teachers had demonstrated the viability of 'mainstreaming' in national schools before the Department of Education drafted a memo on the topic, while local parents' organisations invited

[28] Paul Horan, 'Special Olympics: An Irish Welcome', *Learning Disability Practice* 6.7 (2003), pp. 28–30.

[29] Commission on the Status of People with Disabilities, *A Strategy for Equality* (Dublin, 1996), pp. 5–8.

[30] Henry McDonald, 'Sisters of Charity Give up Role in Dublin Maternity Hospital', *The Guardian*, 29 May 2017; Miriam Lord, 'Politicians Unite on Maternity Hospital, but Nuns not on the Run', *The Irish Times*, 23 June 2021.

internationally renowned experts so as to learn more about new ideas such as normalisation and deinstitutionalisation. It is clear that disability policy was being influenced in a multiplicity of ways, as a range of actors sought a variety of means to support the intellectually disabled going into the late twentieth century, from advocating for new community-based housing facilities to repurposing disused psychiatric hospital wards. The scale of this policy change was undeniable; in 1996 an intellectually disabled person could point to a range of statutory documents that addressed their accommodation, welfare, education, and right to work.

The state had gradually oriented itself towards greater intervention in the lives of its citizens.[31] This process began with the formation of the Department of Health in 1947, an event marked by a flurry of new proposals and an obvious desire for reform among health officials.[32] Indeed, the 1947 Health Act and the White Paper *Outline of Proposals for the Improvement of the Health Services* appeared to mark the beginning of a journey towards greater statutory engagement across the health system.[33] Yet voluntary provision continued to grow alongside the state, in a manner that was broadly comparable to the 'moving frontier' in the interwar UK.[34] Accounting for the influence of national context on the policymaking process remains challenging.[35] Notwithstanding this difficulty, the formation of public policy is inextricably linked to broader technocratic values, while health policy remains bound to a varied range of national political interests.[36] Greta Jones has shown how political fears influenced the development of disability services during the early twentieth century, for instance, when fears around adverse reactions from local ratepayers stymied the introduction

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[31] For a discussion of these trends in a broader Anglophone context, see Geoffrey Finlayson, qtd. in Martin Gorsky, 'Voluntarism in English Health and Welfare', in Donnacha Sean Lucey and Virginia Crossman (eds), *Healthcare in Ireland and Britain: 1850–1970* (London, 2015), p. 57; Roger Cooter, 'Medicine and Modernity', in Mark Jackson (ed.), *The Oxford Handbook of the History of Medicine* (Oxford, 2011), pp. 100–17; John Pickstone, 'Medicine, Society and the State', in Roy Porter (ed.), *The Cambridge Illustrated History of Medicine* (Cambridge, 2001), pp. 304–8.

[32] Ruth Barrington, *Health, Medicine and Politics in Ireland, 1900–1970* (Dublin, 1987), pp. 248–9.

[33] Lindsey Earner-Byrne, *Mother and Child: Maternity and Child Welfare in Dublin 1922–60* (Manchester, 2007), p. 126; Barrington, *Health, Medicine and Politics in Ireland*, p. 188.

[34] Geoffrey Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911–1949', *Twentieth Century British History* 1.2 (1990), pp. 183–206; Sarah-Anne Buckley, *The Cruelty Man: Child Welfare, the NSPCC and the State in Ireland, 1889–1956* (Manchester, 2013), p. 201

[35] See the discussion in Earner-Byrne, *Mother and Child*, pp. 222–3.

[36] Dorothy Porter, 'Introduction', in Dorothy Porter (ed.), *The History of Public Health and the Modern State* (Amsterdam, 1994), p. 24.

of the Mental Deficiency Act in 1913.[37] This then limited the development of services for the intellectually disabled throughout the first half of the twentieth century, compounding a reliance on institutional care. Broader events continued to impact on the intellectually disabled into the mid-century, as when the political aftermath of the 'Mother and Child' controversy helped to curtail the scope of the 1953 'Mental Deficiency' bill. The influence of Catholic social principles (such as subsidiarity) must be considered when trying to account for the limited development of statutory disability services in Ireland, as this rhetoric allowed the Department of Health to perpetuate its (well-established) reliance on voluntary providers.[38] This approach remained a part of Irish social policy thinking long after its theological underpinnings had been eroded. Carole Holohan has demonstrated how Catholic clergy became increasingly vocal advocates for greater statutory intervention from the early 1960s, as documents such as the *Pastoral Constitution on the Church in the Modern World* (1965) presented a vision in which human suffering was not 'a god given unalterable fact of life but … humanly caused and built into the structures of society'.[39] Although commonly couched by politicians as a necessary opposition to paternalism, the continued salience of subsidiarist thinking further demonstrates how the dialectics of political power remain essential to understanding the histories of national public health services.[40]

When it comes to the intellectually disabled, we can see a system that aligns with this thinking, with services predominantly offered through the voluntary sector and statutory support provided under ambiguous provisions such as Disabled Person's Maintenance Allowance regulations (1954). This meant that there was no legal entitlement to most disability services, nor was there a responsibility on the health authority to provide for the intellectually disabled, ideas that had appeared in the original 1947 'Mental Deficiency' bill.[41] In terms of residential institutions, for instance, it is clear that they only ever catered for a fraction of public demand throughout this period. Similarly, a range of pioneering community-based services were created through voluntary efforts and funded via the 1953 Health Act and later through a direct funding relationship with the Department of Health.

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[37] Greta Jones, 'Eugenics in Ireland: The Belfast Eugenics Society, 1911–15', *Irish Historical Studies* 28.109 (1992), pp. 81–6.

[38] Buckley, *The Cruelty Man*, p. 201; Tom Inglis, *Moral Monopoly: The Rise and Fall of the Catholic Church* (Dublin, 2004), p. 211.

[39] Carole Holohan, 'Conceptualising and Responding to Poverty in the Republic of Ireland in the 1960s: A Case Study of Dublin', *Social History* 41.1 (2016), p. 43; Carole Holohan, 'The Second Vatican Council, Poverty, and Irish Mentalities', *History of European Ideas* 46.7 (2020), pp. 1009–26.

[40] Porter, 'Introduction', p. 24.

[41] Lee Komito, 'Irish Clientelism: A Reappraisal', *The Economic and Social Review* 15.3 (1984), p. 173; 'Memorandum for the Government', 13 August 1947, NAI DT S14129A.

The impact of this approach was profound. Policy documents increasingly articulated international best practices and the importance of 'normalising' the lives of the intellectually disabled. At the same time, these proposals had to be enacted by a varied range of groups over which the state had little formal oversight. The fact that local disability services were framed as charitable organisations despite being in receipt of state funds and, in many cases, being the only service available, reveals the limits of the state's willingness to engage and an official approach that was at best naive and at worst cynical. Successive reports and policy documents, including the *Problem of the Mentally Handicapped* (1960), the *Report of the Commission on Mental Handicap* (1965), *Services for the Mentally Handicapped* (1980), and the *Needs and Abilities* report (1990), expanded the rights of the disabled to access a range of services. Yet this was never accompanied by the creation of a statutory machinery to provide, support, or improve services, or even to ensure that new standards were being met.[42]

'A patchwork network of services': Disability Provision

Throughout this period, the Department of Health returned to the importance of voluntary-driven services versus any statutory analogues. Even in the (frequently critical) *Towards a Full Life* Green Paper there was an effort to build on this approach; it acknowledged that the government was committed to supporting the 'continuation and strengthening of … [voluntary] involvement in the future'.[43] The impact of this was visible across disability services, including institutional accommodation, schools, community housing, and day centres. At various stages, each was declared a priority, while these services continued to emerge overwhelmingly through voluntary action. Statutory services were created in only a select number of instances, with these measures provided as a supplement to the broader body of voluntary efforts.

Lack of places in specialist institutions was a perennial concern throughout this period. It can be argued that residential care was never intended to house a majority of the intellectually disabled. Nonetheless, the scale of their waiting lists, combined with the 2,170 'handicap residents' in psychiatric care during the early 1980s, points to the inadequacy of the 5,417 beds in congregate facilities to meet a reasonable proportion of public

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[42] See the discussion of local responses to disability in Enda Kenny (TD), 'Speech: Seminar on Adult Training for the Mentally Handicapped', 24 September 1981, NAI TAOIS/2011/127/192.

[43] Department of Health and Social Welfare, *Towards a Full Life*, p. 16.

demand.[44] The development of residential institutions in collaboration with religious orders exemplified a subsidiarist approach, maintaining a voluntary appearance around a service that was, to all intents and purposes, a statutory one. Until 1970 these services received grants from the Irish Hospitals' Trust and a capitation rate from the Department of Health, while discussions around their capacity and ability to expand recurred in the Dáil, at local health authority meetings, and at the National Health Council. Indeed, their proximity to the state only increased over time, as the Department of Health agreed to cover institutional care costs for the intellectually disabled (irrespective of their parents' means) from 1970.[45] Despite such a sizeable financial commitment, however, these remained putatively private voluntary initiatives, with no role for the state (other than writing cheques). This lack of oversight supported the maintenance of this approach long after the financial and ideological advantages associated with religious-delivered care had disappeared. In short, the charitable character of a service offered through a voluntary provider remained crucial, providing a scapegoat for long waiting lists and dispersed services for the Department of Health, while also maintaining a system where admission to a residential institution was viewed as a privilege, not a right. When this model became increasingly untenable, the regional health boards showed a willingness to develop services, but this was to supplement rather than supplant the existing services landscape.

The result of this was that the state funded many services that it had limited ability to control and shape.[46] It is clear that many voluntary efforts were exemplary, offering vital support to the intellectually disabled and their families through organisations that were characterised by relentless fundraising and clear innovation. Like their international analogues, parents' groups grew from a desire to gather and discuss the challenges associated with raising an intellectually disabled child. Yet organisations in Ireland almost immediately began to talk about the need to establish their own services, with an alacrity that spotlights the absence of community-based provision for the 'mentally handicapped'. Without action from the state, local disability organisations instead sought guidance from other groups (in Ireland and further afield) about how to establish 'mental handicap' services in their own area. The state's approach allowed room for this kind of innovation, giving local associations the scope to establish ground-breaking 'special schools', community-based accommodation facilities, and

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[44] Department of Health, *Statistical Information Relevant to the Health Services, 1982* (Dublin, 1983), p. 37; Dermot Walsh and Aileen O'Hare, *Activities of Irish Psychiatric Hospitals and Units, 1981* (Dublin, 1983), p. 12.

[45] Barrington, *Health, Medicine and Politics in Ireland*, p. 271.

[46] Department of Health and Social Welfare, *Towards a Full Life*, p. 94.

occupational training centres across the country. These efforts pushed the boundary of what was considered possible for the 'mentally handicapped', while providing vital services that addressed pressing needs in their local community.

At the same time, voluntary groups (by their nature) tended to address a defined geographical area. They also seemed to emerge earlier in more affluent areas. It was not a coincidence that the first 'special day school' opened in the South Dublin suburb of Ranelagh. Reliance on voluntary efforts also meant that many services could not establish quickly, often requiring years of 'flag days' and fundraising efforts before being able to offer any form of support to needy families. When a group received any statutory funding it was given with little direction or support, either through block 'Section 65' grants from the Department of Health or the partial funding offered by the Department of Education. The state's lack of oversight meant that it financially supported services that were supposed to advance specific policy goals around integration and normalisation, but could do little to ensure that provision matched up to any of these new standards.

Historical Practices?

It is a well-worn cliché that historians should be wary about applying their findings to a contemporary context.[47] In most cases the feasibility of such an effort remains dubious; there are few issues so similar that an 'answer' can be extracted from the archives.[48] Notwithstanding this, the history of intellectual disability in Ireland can offer an interesting perspective by revealing continuities between trends in 1947–96 and the disability services landscape of the twenty-first century. It can therefore enhance our understanding of the present and prompt reflection on the historically contingent nature of current practices.

A clear continuity is the position occupied by the voluntary sector. In recent years the Health Service Executive (HSE) has taken a larger role in the provision of disability services, while the 'Progressing Disability Services' plan seeks to create better links between statutory and voluntary providers.[49] Nonetheless, the mixed economy of care remains an embedded

[47] See G. R. Elton, 'Second Thoughts on History at the Universities', *History* 54.180 (1969), p. 66.

[48] John Tosh, *Why History Matters* (London, 2008), pp. 58–60.

[49] Oisín McGovern, 'HSE Communication with Families to Increase', *The Mayo News*, 16 February 2022; Martin Wall, 'St. John of God Says Transfer of Disability, Mental Health Services to HSE to go Ahead', *The Irish Times*, 16 February 2021; Michael Moran, 'HSE to Take Over at Cregg House', *The Sligo Champion*, 4 August 2013.

feature. In 2020, for instance, there were a total of 9,166 residential places for those with disabilities. Of these, 1,151 (13%) were provided directly by the HSE, with 8,015 places (87%) offered in facilities that either had a service agreement with the HSE or received grant funding from it.[50] Some voluntary groups have coalesced over time, with the largest 35 organisations receiving approximately 75% of all statutory funding.[51] This financial support is provided by the state under Sections 38 and 39 of the 2004 Health Act, which allows the HSE to 'have an arrangement with a person to provide a health or social service on behalf of the HSE' (Section 38) or states that 'the HSE can provide assistance to any person or body providing a similar service to the HSE' (Section 39), wording that is remarkably similar to Section 65 from the 1953 Health Act.[52]

Unfortunately, there are other through lines, including the reliance on inappropriate facilities for emergency accommodation. In 2017 a lack of alternative beds prompted a High Court judge to house an intellectually disabled man in a Garda (police) detention cell overnight, while there are also instances where prison cells, homeless hostels, and direct provision centres have been used.[53] In January 2018 a psychiatric unit was used to house a vulnerable disabled man, described by the President of the High Court Justice Peter Kelly as 'seriously underweight, incontinent and at risk of sepsis'.[54] Although it was deemed highly inappropriate, psychiatric care remained the accommodation of last resort, perpetuating a pattern that had recurred throughout the previous century. Fundamentally, the disability services landscape remained a 'mixed economy', made up of a variety of providers, an environment that tacitly supported a discourse around charity instead of rights for the intellectually disabled. The impact of this can be seen in the fact that disability rights were the last major group of civil rights to be recognised by the state, Ireland being the final state in Europe to ratify the UN Convention on the Rights of People with Disabilities, which it did in 2018.[55]

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[50] Health Information and Quality Authority (HIQA), *Annual Overview Report on the Inspection and Regulation of Disability Services in 2020* (Dublin, 2021), p. 58.

[51] Chris McInerney and Cian Finn, *Caring – At What Cost? Rebuilding and Refinancing the Community and Voluntary Sector* (Dublin, 2015), p. 7; Department of Health, *Value for Money and Policy Review of Disability Services in Ireland* (Dublin, 2012), p. 37.

[52] HIQA, *Annual Overview Report*, p. 58.

[53] Cormac O'Keefe, 'Use of Prisons for People with Psychiatric Illnesses in Breach of International Obligations', *The Irish Examiner*, 12 October 2021; Mary Carolan, '"Lamentable" to Send Disabled Man to Garda Station due to Lack of HSE Places', *The Irish Times*, 14 November 2017.

[54] 'Young Man with Intellectual Disability to be Discharged from Hospital into Community', *The Irish Examiner*, 23 January 2018.

[55] Pauline Conroy, *A Bit Different: Disability in Ireland* (Dublin, 2018), p. 3; Suzanne

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The experiences of the intellectually disabled have been underexplored in Irish historiography. This book set out to examine the evolution of statutory disability policy and its implementation on the ground. In addressing how life changed for the 'mentally handicapped', it looked at instances of both radical change and striking continuity, in a period when the orientation of statutory policy moved from a model based on protection and segregated care to one centred on community services and a life that was as 'normal' as possible. Parallel to this shift, other practices remained notably consistent, with 'handicap admissions' continuing into the psychiatric system and persistently lengthy waiting lists for specialist residential institutions. A focus on the intellectually disabled spotlights the uncertain development of social policy in Ireland, as the state continued to rely on a number of established approaches. The way in which intellectual disability was discussed on paper, versus the lived experiences of this constituency, reveals obvious and telling deficiencies in statutory health policy, but also calls into question the role played by charity, as new voluntary organisations necessarily emerged to address pressing needs. This book opened with Dr John Cooney's warning that services for the 'mentally subnormal' must be understood in terms of the 'cultural, religious and economic conditions peculiar to this country'.[56] It has tried to begin to outline these conditions and their impact, spotlighting the distinctive Irish response that emerged during the international 'remaking' of intellectual disability.[57]

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[56] J. G. Cooney, *A Service for the Mentally Handicapped* (Dublin, 1963), p. 2.

[57] James Trent, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkeley, 1994), pp. 225–69.

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