"Dumping grounds for… human waste": containing problem populations in post-war British public health policy, 1945-74

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Addressing the Tory faithful in Bedford on 20 July 1957, Prime Minister Harold Macmillan epitomised post-war affluence, social security and political consensus by stating that 'most of our people have never had it so good'.[1] Macmillan was speaking beyond the Tory faithful to 'one nation' which had come together to reject Labour and elect the Tories on a promise of sustaining this liberal social democracy, however pragmatic their commitment.[2] 'Our people' in 'one nation' were defined by a nuclear family built on secure manual employment for the male breadwinner, female domesticity with responsibility for child care, and adherence to social norms of respectability, deference and gratitude when utilising welfare services and consumer goods.[3] They constituted the upstanding public of the British social and political imagination, and the state apparatus reflected these assumptions accordingly.

Six years after Macmillan's speech Fred Philp, the Secretary of Family Services Units (FSU), a leading voluntary social work organisation, similarly celebrated post-war successes for 'our people' – the Great British public – but pondered how these had exposed the issue of 'problem families':

> Nowadays, general prosperity, full employment and the extensions of the social services which are part of the "Welfare State" have removed many of the grosser problems and in doing so have shown up more clearly the failure of certain families to meet the community's minimum expectations of social behaviour, parental responsibility and domestic management.[4]

Contained in Macmillan's statement and Philp's commentary were two contentions which defined being and belonging in post-war Britain: the majority benefited, but a minority did not; and that some families were not 'our people'. Philp's 'Problem families' were not 'our people' but a separate population to be studied, diagnosed and managed by the state on their behalf in the public interest. Crucially, 'problem families' were not just a separate population but definitely a *problem* population; lacking any self-identification or common characteristics beyond the labels imposed upon them by the state of being a financial burden and a drain on the resources of society. This was a purposeful strategy of dehumanisation and stigma pursued by the state, constructing an imagined problem public which was realised through myriad private encounters by the burgeoning apparatus of the state.[5]

Moreover, a focus on the family focused the attention of the state and its services on targets for intervention rather than the anonymous class of the poor. Although the years 1945 to 1974 may have been the 'golden age' of the welfare state, 'social citizenship' and prosperity, the existence of 'problem families' served as a reminder of the endurance of exclusion, marginality and conditionality.[6] Public health policies and practices were a key instrument in delineating 'our people' from problem populations and subjecting them to a range of interventions, and, for the most problematic, pursuing a strategy of containment. Sociologist Zygmunt Bauman terms this containment of 'problem populations' by the modern state as creating 'dumping grounds… for human waste'.[7] The subject of this chapter is to reconstruct the pivotal role of post-war public health services in the creation of 'dumping grounds' for the 'human waste' of 'problem families'

Mrs DLT[8] was not one of 'our people', nor had she had it 'so good'. She was the mother to a so-called 'problem family'. In early 1955 the 35-year-old mother-of-five was sharing a condemned terraced house in Ipswich with her cohabitee and her two youngest children. Her three older children from her previous former marriage were boarded with their grandmother at the suggestion of the town's Children's Department in a suburb of the city; having been taken into care when their mother first moved into a single room with her cohabitee. Her GP felt that her diagnosed neurasthenia 'is aggravated by her living conditions which are, to say the least, appalling'. Her earlier spell in summer 1954 at St Clements Mental Hospital found her 'in a shocking state of neglect', 'very hysterical' and 'agitated' until being subjected to a course of electro-convulsive therapy according to the Deputy Medical Superintendent. The Deputy Medical Officer of Health (MOH) for Ipswich, Dr Joan Ball, felt that things went 'from bad to worse' for Mrs DLT since living with her cohabitee – whom all the officials noted met Mrs DLT in a pub – despite experiencing her previous married life with regular 'quarrels and blows'. Dr Ball wrote constructively that Mrs DLT's cohabitee had 'regular employment' as a millhand but she was dissatisfied that he spent a considerable amount of time off work helping at home, leaving them in poverty and disregarding his tacit duty as breadwinner. Her cohabitee was considered a 'quiet, timid, anxious and rather dull man' by the Director of Family Psychiatry at Ipswich Hospital, Dr John Gwilym Howells, 'more stable' than Mrs DLT and far more 'satisfactory' than her ex-husband in regards to household 'friction'. Despite this Dr Howells – 'one of the leading psychiatrists of the 20th century' according to his obituary in *The Times*[9] – concluded that: 'Her neurosis springs from her experiences as a child and [this] anxiety expresses itself over her physical state'.[10]

Dr Howell's plan for the rehabilitation of Mrs DLT was typical for 'problem families': birth control; children attend nursery; treatment for neurosis as an outpatient; rest and recuperation at a holiday home or rehabilitation centre; and rehousing. The problem was individual and behavioural, and the package of interventions reflected this judgment. Moreover, as Pat Starkey notes, 'problem family' meant 'problem mother' and contained the gendered assumptions of family intervention.[11] Ultimately, it was Dr Reginald Leader, the town's MOH who held the final sway as he funded Mrs DLT's two-month stint at Brentwood Recuperative Centre for 'problem families' – a large converted residential villa in Marple, a rural commuting village near the City of Manchester, in mid-1955. The 'negotiations'[12] – as Leader put it – to implement this process were conducted in the city's 'problem family' committee chaired by the town's Children's Officer,[13] euphemistically known as the Coordinating Committee following a joint government circular in 1950.[14] Part of this included securing Mrs DLT an undesirable older council property at the outer periphery of the town boundary following a successful period of rehabilitation at Brentwood. There she would be taught all the necessary skills needed to run her home – unlike a prior unsuccessful stint at a holiday home in Chingford, a London suburb, in 1952. Then the Deputy MOH noted that the 'relapse to their very low standard of living at that time was rapid'. Despite Leader reporting in late 1955 that the 'prognosis for this unfortunate family is doubtful', he felt that 'the advice and help… received at the Brentwood Centre has been of great help to [Mrs DLT] through all these dreadful vicissitudes'.[15]

The case file on Mrs DLT concludes with this remark. Her case was indicative, but not typical, of 'problem families' subject to the surveillance of Coordinating Committees across Britain and of those referred to Brentwood from the 1940s to the 1970s. Several

commentators have identified how discursive and professional struggles between different welfare professionals underpinned competing 'problem family' definitions.[16] John Welshman goes so far to say: 'In many respects, the numerous reports published about "problem families" tell us little of value about the families themselves and rather more about professional rivalries and connections.'[17] MOsH, as the custodian of local public health were at the centre of this contest, being reduced to what Charles Webster terms 'a dispirited rump'[18] from the height of their interwar powers following the creation of the National Health Service (NHS) in 1948. It was their concomitant 'lack of firm philosophy', according to Jane Lewis, which meant post-war public health services increasingly became defined solely by their activities.[19] However, our knowledge of these activities in relation to 'problem families' is shaped primarily by the extensive commentaries of MOsH themselves. These have also informed the historiography, which focuses on the most vocal proponents, typically with membership of the Eugenics Society.[20] Atypically, Howells' views on 'problem families' are far more visible than those of Ipswich's MOH.[21] Yet neither reflects how Mrs DLT was materially treated not as one of 'our people', but as 'human waste': a constituent member of a problem population from which 'our people' needed to be protected.

There remains, then, a startling disparity in understanding post-war public health services between what officials thought, believed and articulated; what they documented of their activities as the head of a local authority service; and how they treated 'problem families' both individually and collectively as a problem population to be contained *and* controlled. In short, 'problem family' case files expose how individuals were treated materially rather than discursively by post-war public health officials.

Understanding this treatment of families clearly applies at the individual, seemingly private level, largely out of the public eye beyond its function serving a larger discourse shaped by lurid depictions, sensationalist press coverage, or the moral panic of mass evacuation during the Second World War which gave rise to the 'problem family' label itself in 1943.[22] Such discursive constructions and subsequent representations of the 'problem family' undoubtedly helped to define and delineate them against 'our people' through such visibility. Much of this was redolent of the enduring notion of a class apart from society, an underclass, rooted in Victorian anxieties of the urban poor.[23] Yet beneath these performative dimensions of recreating the undeserving poor at popular, political and policy levels were a 'phalanx' of officials whose task was to realise them in time and place.[24] Their actions spoke louder than words.

At an individual level, Mrs DLT's case exemplifies this stigmatised dehumanisation; but she was far from alone. Her private story documented as the life of another by officials is illustrative of the everyday process of being handled by the state as part of this problem population. It's telling through the documents of officialdom only begin to hint at the affective consequences of such experiences. However, the collective, material treatment of an undeserving, unrespectable, backward problem population of failed families, out of step with modernising society fit for the public and out of social and physical *place*, was as much a part of 'building a modern, rational, post-imperial nation' as other facets of reconstructing everyday life through mundane experiences in post-war Britain.[25]

Although each of the five solutions suggested in the case of Mrs DLT could be studied, this chapter considers the intersection between public health and housing through the lens of 'problem families'. This assessment is developed in three ways. Firstly, through a

critical reappraisal of the political, economic and social basis of the post-war settlement; historiographical perspectives on public health and housing services; and notions of modernity, belonging and place influenced by Zygmunt Bauman. Secondly, by examining historiographical and contemporary approaches to the 'problem family'; the centrality of public health services; and emergent discrepancies between material and discursive approaches exposed through individual histories. Thirdly, in considering five interfaces between public health and housing which delimited problem populations from 'our people': homeless families; housing hierarchies; intermediate welfare accommodation; slum clearance; and peripheralisation.

Consensus, Settlement and 'Our People'

The notion of a post-war settlement for 'our people' is built on political consensus, economic prosperity and social security provided by the welfare state. It marks a so-called 'golden age' from its creation under the 1945-51 Labour Governments, retention under subsequent changes in power, and fragmentation with the economic crisis induced by the oil shocks of 1973-74.[26] Party political consensus remains contested in generations of historiography.[27] Whilst scholarship on partisan debates in the Labour and Conservative Parties shows considerable ideological tension and pragmatism in power,[28] the convergent views of Charles Webster and Tim Bale that a status quo was arrived upon by 'default' through different routes and the limits of governmental reach, captures the extent of assent.[29] Richard Toye reminds us to look for 'pertinent silences' to identify genuine political agreement for the unchallenged assumptions of consensus.[30] Political consensus was dependent upon economic prosperity premised on policies securing full employment,

growing consumption and rising living standards. [31] Burgeoning secondary analysis of post-war social science surveys has shown that insecurity, poverty and squalor persisted despite prosperity.[32] Feminist and Marxist critiques have also exposed the class and intersectional imperatives which delineated experiences of prosperity for those not considered 'our people'.[33] Social security was the last component of settlement, with portions of the welfare state historiography teleologically celebrating the 1945-51 'moment' in consolidating centuries of progress followed by an analysis of its rise and decline until the 1973-74 oil shocks and ending with a crescendo against emergent neoliberalism under the 1979 Thatcher Governments.[34] This 1945 'moment' is heralded as arising through collective working-class wartime struggle realised at the ballot box.[35] However, pre-war welfare services perpetuated cultures of paternalism, principles of less eligibility, and deterrence redolent of the Poor Laws despite rhetorical commitments to universalism.[36] Consequently, Macmillan was right to herald the post-war settlement marking change for a majority of 'our people', but a minority subject to differential treatment. As a result, definitions of 'our people' shaped by political, economic, and social expectations constrained the lived relations of citizenship as a process, not a condition. As David Vincent notes: 'Properly understood, a poor citizen is a contradiction in terms'.[37] It was the role of state services to enforce the settlement by managing such problem populations.

Public health services are emblematic of continuity across the 1945 'moment' of the post-war settlement and insulated 'our people' from those without. Whilst recent scholarship has pointed to the multiplicity of publics and malleable ways of knowing their health,[38] as noted above, public health services continued to be defined by what they did. The head of services – the MOH – was significant. They were, in many respects, omnicompetent public servants[39] who incrementally accumulated duties until their interwar

height, although these were not evenly disposed by politically and geographically diverse local authorities.[40] The nationalisation of hospital services under the NHS and the emergence of personal social services left MOsH marginalised and seeking a purpose.[41] MOsH developed strategies to stake their claim,[42] as their health function was overlooked by central government.[43] Suffused with either membership or a 'fashionable' interest in eugenics from the interwar years, MOsH increasingly turned their attention to the problem of the 'problem family' which perplexed the functional complexity of the welfare state.[44] A social substratum disproportionately responsible for health and social problems, 'problem families' represented a reinvented concern with the inter-war 'social problem group' as part of a much longer underclass discourse, as Welshman has eloquently articulated.[45] Crucially, and unlike the 'social problem group', 'problem families' were more than a discursive concern as they were identified, subject to intervention and their lives impacted by the actions of post-war public health services. A focus on the family as a unit, rather than the poor as a class, reinvented and legitimised residualised public health services.

Whilst much of the historiography of the 'problem family' has focused on competing departmental claims with statutory and voluntary personal social services over definitions and interventions, less had been said of public health's changing relationships with other services, particularly housing. Becky Taylor and Ben Rogaly's detailed work has examined the 'unsatisfactory households' subcommittee for Norwich – the local variant of a 'problem family' Coordinating Committee – but fails to situate it in its policy context.[46] My earlier work on 'problem families' in Sheffield similarly privileges the local at the expense of the national framework.[47] Housing has rightly been considered a 'square peg in a round hole' or a 'wobbly pillar' of the welfare state, with a limited supply and an economic desire to secure rents sustaining managerial concerns over access, affordability and conditionality by housing

departments.[48] It was not until after the collapse of the post-war settlement – and unintentionally – that housing became a right.[49] Much of the literature focuses on the massified dimensions of post-war local authority housing[50] although the significance of place and experiences of rehoused tenants have been elaborated.[51] However, the public health role in housing relates not to allocation and management of services, but to residualised powers originating before 1945 in designating slum clearance areas, individual homes unfit for human habitation, and the certification of priority tenancies on medical grounds.[52] The creeping advance of the bulldozer and the swelling numbers of people clamouring for improved living conditions ensured that housing continued to be a national political issue throughout the era.[53] Given its scarcity, the political attention and additional resources available, public health departments also competed with housing in shaping the living arrangements for 'our people' and ensuring that problem populations were separated and contained.

The attention of public health leaders and services on the residual management of problem populations was not new to post-war Britain. Gareth Stedman-Jones's classic *Outcast London* on the impact of slum clearance exposing a residuum to the attention of elites readily points to continuities cemented by other pre-war studies.[54] The common dimension is the force of modernity in defining and shaping conditions of citizenship and spaces of existence. The modernisation revolution in post-war Britain brought the state into inescapable proximity to, and responsibility for, redundant problem populations. Bauman terms these surplus people 'human waste'. They could no longer be relegated; they had to be regulated. Whilst domestic scholarship has focused on material benefits and their disbursement, studies of other Western nations including France,[55] Canada,[56] and Australia,[57] have shown that the state must be foregrounded in understanding the

modernising forces of nationalised welfare regimes after 1945. It is a question of returning histories of the state to histories of welfare. Here Bauman sees marginality as the contradictory counterpart of modernity, with the 'thoroughly modern art of rational action' in building a consolidating order in turn contributing to the creation of surplus and redundant people and places.[58] In short, the state forces necessary to establish social order for 'our people', represented by the welfare settlement, create marginal and contained spaces for problem populations; or, as Bauman terms them: 'dumping grounds… for human waste'. There is, here, synergy with Marxist perspectives viewing 'problem families' as a housing lumpenproletariat produced by state policies to contain the reserve army of labour.[59] This chapter vindicates such perspectives, but suggests that modernity is as much a social democratic process as a neoliberal one. In the final analysis, what they contend is that there are discursive and material limits to modernity which entail the exclusion of certain categories of citizens, to which the welfare state – and public health services – are instrumental in managing.

The social landscape of post-war Britain as understood by the contours of settlement and consensus, health and housing services, and the tension involved in bounding the frontiers of modernity is a picture of continuity despite the 1945 'moment'. The material, as well as discursive, characterisation this entailed delineated 'our people' as entitled citizens and served to marginalise or exclude those without. 'Problem families' were not the only problem population. In terms of health and housing, there is an extensive literature on the role welfare services played in marginalising other groups such as Commonwealth migrants,[60] and travellers.[61] Each constituted a discrete category for services which required different forms of identification and intervention. Constraints of space mean that the remaining focus of the chapter will be on the material treatment of 'problem families' by

public health services, but similar dimensions of the management of what Bauman terms 'human waste' are applicable to other undesirable population categories.

'Problem families'

'Problem families' have been interrogated primarily as a discursive construct. John Macnicol's pathfinding work has shown how the term was an administrative artefact which represented contacts with state agencies, conflating inter-generational transmission of poverty with continuity, attributing a single cause to a range of behaviours, and based on service resource allocation.[62] John Welshman, Pat Starkey, and Tom Bray have extended this analysis to show how disputes over definitions underpinned tensions between statutory and voluntary services, especially social work and public health.[63] Becky Taylor and Ben Rogaly have moved beyond discursive approaches to examine how notional pathologies captured different aspects of poverty.[64] Using case files Selina Todd has contradicted this established view by suggesting they show evidence of officials mediating eugenicist and pathologising explanations of poverty.[65] Elsewhere, using nearly 2,000 case files, I have shown that although interpretations were mediated by street-level officials, pathological and condemnatory approaches remained.[66] Further, I have shown the overlap between academic and administrative classifications through a case study of Sheffield.[67] What much of the historiography suggests is that the term 'problem family' was a behavioural signifier which differentiated the actions of a pathological problem population from that of 'our people' through the kaleidoscopic prism of a spectrum of welfare state services.

The 'problem family' historiography focuses on discrete use of the term from the 1940s when it first emerged from anxieties about unruly children being evacuated in the

Second World War through to the 1970s when it faded from fashion due to connotations of stigma, and was substituted with the more social scientific 'cycle of deprivation' label. The opening definition given by Philp epitomises key aspects given by contemporaries: a 'problem family' was exposed by material progress to be socially, parentally, and domestically incompetent. Yet the bounds of acceptability for competence were disputed, giving rise to extensive debates over how to establish a normative definition on which much of the historiography draws.[68] The final publication of the Eugenics Society Problem Families Committee – dominated by public health professionals – concluded in 1952 that:

> The answer to the question of what proportion of families in the country as a whole are problem families thus depends not only on how we define the problem family but also on how we define the normal family with which we compare the problem family.[69]

Knowing the borderline between 'our people' and others was far from established, although social scientist Barbara Wootton noted at the time that the only common characteristic of families were 'the financial ones': namely poverty.[70] Despite this uncertainty, families were identified as a 'problem family' and subject to targeted interventions and differential treatment than 'our people'. Social work academic Elizabeth Irvine captured this tension by noting: 'Problem families are easy to recognise and describe, but surprisingly hard to define'. Although she then proceeded to offer a number of signifiers to remove doubt: 'Unemployment, pawn tickets, rent arrears, debts, child neglect, undernourishment, mental deficiency, mental illness, drunkenness and squalor, coals or worse in the bath – all are

characteristic, and none are indispensable'.[71] Whilst an agreed definition proved elusive, officials and street-level workers alike knew a 'problem family' when they saw one.

Public health leaders – typically MOsH, their Deputies and Assistants – and professionals from within the service propelled debate about how to identify and intervene in the lives of 'problem families' throughout the 'golden age' of the post-war welfare state. The core of public health service philosophy was shaped by their actions, and as a range of practitioners and professionals were exposed to conditions of poverty with advancing modernity, its omnicompetent public servants readily deployed their expertise. It is this coverage which is reflected in the historiography: opinions pieces and research reports in public health periodicals such as *The Medical Officer*, *Public Health*, the *Journal of the Royal Sanitary Institute*, *The Lancet* and the *British Medical Journal*.[72] Similarly, annual reports of MOsH after 1948 adopt a semi-standardised reporting structure mirroring the requirements of the Ministry of Health including commentaries on work undertaken as part of the 1950 joint circular noted above, but also further circulars in 1954, 1959, 1966 and 1970.[73] They also undertook and published research linked with these activities, not least a series of local case studies informing the Eugenics Society Problem Family Committee findings.[74] Whilst these sources certainly reflect the interests of public health professionals as Welshman suggests, they represent a fraction of service involvement with 'problem families'.

Drawing on 1,702 surviving case files of mothers and their young children from approximately 3,600 in total referred to the Brentwood Recuperative Centre from 1943 to 1970, the remainder of this chapter uses the experiences contained in these documentary fragments to demonstrate how public health contained a problem population during the so-called 'golden age' of post-war Britain. They created 'dumping grounds' for this 'human

waste' of the social democratic modernising mission. Brentwood was a residential rehabilitation centre which received, re-educated and rehabilitated 'problem families' from sponsoring organisations encompassing the full spectrum of the post-war mixed economy of welfare.[75] Its ethos reflected post-war reconstruction priorities where the family – and its concomitant gendered obligations of male breadwinning, female domesticity, and childhood quiescence – was its foundational building-block.[76] Indeed, as John Clarke has suggested, the family was *the* focal point for social policies, with the boundary between normality and deviancy being thrown firmly around the home.[77] Policy-makers and officials, in the view of Michael Peplar, envisaged a 'healthy flourishing of the family as an institution and as the basis of everyone's domestic life, involving life-long marriage and the production of three or four healthy children, cared for primarily by their mothers in the home.'[78] Although there was some softening of this ideal between the 1940s and the 1970s through marital partnership and companionate marriage which shifted obligations,[79] the domestication of masculinity through involvement in child-rearing and private home life,[80] and more acceptable labour market participation of mothers,[81] it is clear that when officials discussed the 'problem family' in case files and outlined courses of action, it was treated as a family which departed from this gendered ideal. The role of Brentwood was to reconcile the two; at least as far as practicable in the view of the officials concerned.

This idealisation of the family in post-war society encapsulated the Janus-faced nature of the social democratic modernising mission for 'problem families'. This was articulated by the Assistant MOH for Liverpool, Clare Oswald Stallybrass, in 1947 when he argued that: 'The problem consists in the presence, in a developed civilisation, of families, or groups of families, and I make the addition advisedly, who have stone age standards of conduct in the cities of an age of steel'.[82] On the first side of the coin, the modernising

mission produced an idealised image of the family for officials which hinged on the *expectations* of living in the 'cities of an age of steel'. This was clearly not being fulfilled by 'problem family' mothers; those with 'stone age standards of conduct'. Accordingly, a period of domestic re-education which revolved around training women to meet such gendered expectations and inculcating maternal responsibility was central. On the reverse side of the coin was the stark material realities of family poverty and working-class life throughout 'golden age' post-war Britain which did not accord with the ideal, and which officials encountered traipsing through the homes, streets, and communities in which 'problem families' lived.[83] Rather than treated as shortcomings of the welfare state, the impossibility of reconciling the two sides was attributed entirely to the 'problem family'. As Peter Boss, Area Children's Officer for West Cheshire remarked in 1959: '[W]hereas we seem to have solved the problems of poverty we have not yet solved the problems of mental health and matrimonial incompatibility: perhaps we never shall and shall have to resign ourselves to having to deal with 'problem families' for evermore'.[84] It was in dealing 'for evermore' that Brentwood became a key institution in processing 'human waste'.

The gendered of regime of Brentwood mirrored broader social changes during its existence, although institutional arrangements rested heavily on the character of key individuals, notably the Warden. From the 1940s until the 1960s mothers and all their children under seven – with frequent exceptions to secure admission – attended for a period of four weeks, although this was often extended to six at the behest of either mothers or the sponsoring authority. Mothers shared rooms with other mothers and their children, and were expected to keep them clean and tidy as part of the rehabilitation regime, as well as contributing on a rota with chores for the communal areas of the house. This domestic re-education was partnered with a schedule of walks in the countryside,

chaperoned visits to the cinema and social evenings with dancing and singing for mothers after children their children were in bed. Ultimately, Brentwood was a balance between serving the purposes of officials and giving mothers a sanctioned respite from their gendered obligations: a common format for similar residential rehabilitation regimes for mothers in Western Europe.[85] Husbands were prohibited apart from visits at weekends and remained at home to work and look after older children, although many were admitted for residential holidays themselves or taken into care. Moreover, the husband was expected to either redecorate existing housing in anticipation of the rehabilitated return of his wife and children, or make new housing ready for their arrival. This regime underwent significant changes during the 1960s with the arrival of a new warden: husbands and all children were admitted; families stayed for a minimum of three months; they lived in independent flats; and they were subject to pre-admission visits to ensure their suitability.[86]

Brentwood was one of seven such centres in Britain run by voluntary organisations. Regimes varied from centre to centre, but a recognisable mainstay of domestic duties, leisure and supervision found at Brentwood was common throughout, although these changed gradually during the period. Many organisations which ran such centres were seeking to maintain their viability in responding to the new social concern of 'problem families' and reflected longer histories of child rescue and religious salvation. All the centres received mothers from across Britain, with London as the largest contributor, although there were clear local and regional dimensions to referrals, particularly for the centres in Scotland and Northern Ireland. The majority of mothers who passed through the doors of Brentwood were as a result from North West England where it was situated. Mrs DLT's visit during 1955 was representative of a significant minority who travelled to Marple from across the country – sometimes alone or escorted, with both young children and their

luggage in tow, and waved from the platform by their husband and welfare workers – to receive domestic instruction.[87] Welshman has previously used both case files and correspondence between mothers and key figures at Brentwood to illustrate the impact of the residential regime.[88] However, Welshman's focus remains on the Brentwood experience rather than the policy and practice regime which gripped 'problem families'. Despite methodological difficulties of survival, the privileged position of officials, the marginality and performativity of the voices of mothers and children, not to mention inconsistencies and inaccuracies of recording, case files offer a means of peering beneath the veneer of 'problem families' presented by public health officials by examining their material treatment at the hands of the state. Indicative 'problem family' cases from across England from Brentwood are used here to show how public health services contained problem populations in five ways: designating homeless families; shaping housing hierarchies; providing intermediate welfare accommodation; progressing slum clearance; and marginalising families.

Containment

The clearest continuity with pre- and post-war containment was the workhouse; or as it was relabelled reflecting new legislative provisions, part III accommodation. These 'revamped workhouse wards' were the consequence of the 1948 National Assistance Act which notionally abolished the Poor Law, removing its responsibilities for homeless families to local authority Welfare Departments.[89] In order to prevent families seeing this temporary accommodation as permanent, they remained grim and unforgiving places perpetuating less eligibility and deterrence.[90] However, many powerful urban MOsH retained both health and

welfare functions throughout the post-war period, with the development of parallel health and welfare plans complementing the 1962 hospital plan leading to widespread mergers.[91] Public health professionals were instrumental gatekeepers. Not all 'problem families' were homeless families, and not all homeless families were a 'problem'; but public health services were crucial in maintaining distinctions of deservingness which institutionalised families and insulated them from the wider population: 'our people'. Despite accommodation being temporary, and to discourage others, Mrs PR was referred from Redhill Lodge, Middlesex, in 1958 to improve her domestic standards in order to obtain a council house, having spent four years living with three of her five children.[92] Conditions were abysmal. Another former workhouse run by Middlesex County Council obtained 'national notoriety' having been 'allowed to deteriorate to a condition intolerable to the community at large' by a prospective Liberal candidate in 1961.[93] Their own development plan noted that efforts needed to be bring both sites 'nearer to the standards adopted for the newer hostels' which were designed with deterrence in mind.[94] Another in Southwark was said to be so squalid that it had dysentery 'in the walls'.[95] Indeed, in *The Grief Report* by homeless charity Shelter such hostels were termed 'dumping grounds' for the manner in which they were used by local authorities.[96] Similarly, from 1949 to 1958 Mrs JAW and her growing family were circulated around several former workhouses throughout Cornwall due to an unwillingness of district councils to house them.[97] Until 1958 the MOH in Liverpool chaired a liaison subcommittee which managed admissions and discharges from their Part III accommodation – dubbed 'the cubicles' due to their size – which was driven by a commitment to restrict access to a limited housing stock and to prevent evicted tenants from jumping the queue.[98] Homeless 'problem families' then, were contained both *within* temporary accommodation

as a public institution, and *without* by restricting the ways they could legitimately be discharged into the wider working class population.

Families discharged from temporary accommodation were not entitled to local authority housing. Instead this provided another site of containment for public health services by repurposing defunct, peripheral or undesirable locations which extended both the quantity and quality of housing hierarchies downwards. For instance, the only reason Mrs JAW – mentioned above – could leave temporary accommodation was to accept a hut on a former military base which had been taken over by squatters and then drawn into local authority health and welfare – not housing – management.[99] In Eccles, Manchester, both Mrs GW and Mrs RP were referred to Brentwood in 1953 and 1954 from a former anti-aircraft site which had similarly been occupied and drawn into local authority use under supervision of the public health department.[100] At Sheffield squatters occupying empty properties were also relocated under the jurisdiction of the MOH to a disused airfield at the edge of the city in 1949, also giving rise to the arrival of FSU.[101] As well as being peripheral, the conditions of such camps were appalling due to lack of investment. Mireside Camp, Cumberland, was another site repurposed for the local authority housing which was described in terms of such squalor – with children playing in a ditch which doubled as a path and a sewer – that the Children's Officer threatened to take every single child into care.[102] 22 were.[103] These included Mrs MW, referred to Brentwood in 1948, whose children were repeatedly removed as she moved with her husband from a neighbouring disused camp to a cottage 'literally on the fells… very isolated, with no water laid on (a stream nearby) and no transport'.[104] Mrs MW wrote from the Camp to the Warden, Doris Abraham, in Winter 1948 saying there was 'much illness in the family' and '[t]he children will never be better while they live here because the places are that damp and wet'.[105] No action was taken at either

camp, showing the significance of public health officials opting *not* to enforce powers on the unfitness of properties for human habitation. Indeed, the Clerk of Cumberland County Council was keen to contain the 'problem families' as 'if conditions became too intolerable in any of the huts the inhabitants might have to seek Part III Accommodation, which was no final solution'.[106] Central government encouraged this process of grading and extending housing hierarchies in its Central Housing Advisory Committee (CHAC) guidance, noting most local authorities were using 'requisitioned premises, huts or camps' for such purposes.[107] Containment was effected both by concentrating 'problem families' in substandard accommodation, and by physically keeping them from 'our people'.

'Problem families' could not be forever isolated from 'our people', particularly as advancing modernity raised standards, expectations, and the purview of services. Intermediate welfare accommodation and halfway houses facilitated the movement of 'problem families' from the lowest housing hierarchies into other forms of housing as they were closed. In large cities the oldest and least desirable forms of housing were used to dump the 'human waste' of 'problem families'. In 1970 the MOH for Wigan championed the redevelopment of an interwar estate of precast concrete houses which had experienced 'a period of gradual degradation of both property and tenants' following the successive dumping of 'problem families' in the post-war years.[108] Such houses were not included as part of massified housing, but for rehousing families under the jurisdiction of public health services until they were deemed domestically capable of moving; although stigmatising language was carefully negotiated.[109] In Liverpool, the Liaison Subcommittee mentioned above made singular use of an interwar tenement complex at Speke Road Gardens, although other pre-war tenement blocks were used in a similar fashion over time.[110] Southwark's intermediate accommodation at Chaucer House was the subject of a 1972 BBC

documentary where the MOH responsible noted 'the poorest of families are visited, and a close eye is kept on them' through the 'wonderful work' of health visitors.[111] The condition of the accommodation was appalling as they were left to decay as part of an ongoing policy of running them down combined with financial responsibility falling across three tiers of government. A senior civil servant was pushed to label them 'very unsatisfactory'.[112] Inside fittings were kept to a minimum, what a report termed 'adequate but… not particularly comfortable or attractive'.[113] Here, the boundary between discursive commitments and material practice were crucial, as noted in the case of Wigan. The MOH for Chesterfield Rural District Council, Dr John Graham, courted national press controversy in 1953 by advocating for the erection of substandard housing for 'problem families'. This, along with his demand for the sterilisation of the unfit prompted outrage.[114] Similar incidents occurred for MOsH throughout the post-war period.[115] As noted in the case of Mrs DLT in Ipswich which opened the chapter, such practices were widespread. The 1955 CHAC report on *Unsatisfactory tenants* similarly recommended authorities adopt different approaches to containing 'problem families'.[116] Articulating arrangements for rehabilitating problem populations served to expose their tensions and contradictions, but also demonstrate the material difficulties of living with them.

Containment strategies shifted throughout the post-war period in tandem with the advance of the bulldozers of modernity, represented by the progression of slum clearance schemes. Although a national policy its local implementation hinged on MOsH designating properties as unfit and representing areas for clearance and redevelopment.[117] Moreover, it was a process rather than an event and as noted by contemporary commentators: '[I]n many towns and cities the process of slum clearance and redevelopment has been a permanent backdrop to the lives of many thousands of citizens'.[118] The living conditions in

clearance areas, left to decay and bereft of investment by local authorities, were often appalling.[119] The MOH for Burnley noted throughout the late 1960s how difficult it was for public health services to act quickly, leading to a spiral of localised decline.[120] Consequently, even for a relatively short period, the local authority became the landlord to thousands for slum properties. Rather than see them empty and losing rental income, these were in turn used to relocate 'problem families' from both part III and intermediate accommodation without incorporating them into conventional housing hierarchies. In 1960 Mrs BW was living with her husband and three of her four children in such a property in the Everton district of Liverpool.[121] Her health visitor offered the following description in her referral report:

> The family live in an old type of house in an area scheduled for slum clearance. They have a small living room, and a pokey, dark scullery, which houses the water supply and gas cooker. Stairs from the living room lead to the only usable bedroom, the attic bedroom above being unfit for use. The property is infested with rats, and the sideboard in the living room shows "carved" evidence of attempts made by the rats to get at the family food supply. The Rodent Control Officer has been visiting, but is unable to effect a permanent cure because of the state of the surrounding property.[122]

Mrs PL with her husband and four children were evicted from a council flat in 1960 due to arrears and were, in order to save the cost of the children being admitted to care, allocated a 'pre-demolition' property in the heart of Bolton's clearance area at the behest of the

MOH.[123] Once again, CHAC gave direction to local action in advocating such policies including buying separate slum properties to be adapted for longer term housing.[124] The use of so-called deferred demolition properties designated as unfit by MOsH but reused for 'problem families' points to the tensions at the heart of modernity in separating, managing and containing problem populations in time and place.

Whilst a range of accommodation forms – temporary, hutment, intermediate and deferred demolition – characterised public health strategies to containment in the post-war period, towards the late 1960s and early 1970s these were becoming impossible to sustain through the growing massified availability of local authority housing. However, whilst there remained 'human waste' in the form of 'problem families', public health officials remained instrumental in strategies to isolate and contain such problem populations. Here, so-called 'difficult-to-let' properties in unpopular areas – typically deck access or multi-storey properties in peripheral estates or new towns – became the new way of enacting enclosure away from 'our people'.[125] Whilst public health routes through homelessness and substandard housing remained, a failure to issue medical certification for tenancies on health grounds further narrowed opportunities for 'problem families'. For instance, it took Mrs MR three years until 1963 to obtain a certification for nervous strain for priority housing from the MOH for Staffordshire whilst living with her three children at her mother's house, but she was then moved to an older property at the very edge of an interwar housing estate adjacent to a railway line and an industrial estate.[126] A different Mrs MR was similarly moved from a deferred demolition property she obtained on leaving Brentwood in 1953 with her two surviving children, having experienced stillbirth and infant mortality, to a peripheral house on an outer estate at the edge of Widnes in 1959.[127] Perhaps emblematic was the case of Mrs AC in 1963 who was living with five of her seven children in a derelict

farm building on the very edge of the peripheral Kirkby estate – one of the many outer estates built to house Liverpool's overspill population[128] – whose brutalist blocks were slowly erected around them, having being forced out of her mother's flat in Liverpool for overcrowding.[129] Her Brentwood referral was intended by the Divisional MOH for Lancashire, where Kirkby was situated, to provide training to demonstrate fitness to obtain a flat on the already notorious 'difficult-to-let' estate.[130] Although CHAC had been superseded by this stage, the state again saw utilisation and containment as preferable to the alternatives.[131] Material marginality in the form of outer houses on peripheral estates represented the climax of the post-war public health process of identifying and containing 'problem families' as a problem population.

Conclusion

Post-war political, economic, and social consensus arguably led to 'most of our people' never having it so good, but the cost of this modernity remained a conditional citizenship which entrenched marginality, inequality and poverty. 'Problem families' represented the unwanted face of modern Britain as those marked as behaviourally different, but ultimately exposing the limits of touted modernity through the persistence of poverty; the Potemkin city limits for Stallybrass's 'cities of an age of steel'. Public health services imbued with longstanding professional cultures of paternalism, less eligibility and deterrence inherited from the pre-welfare state era readily managed the problem of the 'problem family' population. Ultimately, in relation to questions of welfare, the state and access to resources, this chapter demonstrates how public health services were invoked to contain and constrain *who the public was* and *how their health* demands were administered by curtailing the

contagion of ‘human waste’. Mirroring the arguments of both Jennifer Gunn and Beatrix Hoffman in this volume, such a distinction has a significant bearing on how citizenship and public participation were shaped by technocratic as well as political distinctions in the mid-twentieth century. Intimate and local decisions taken about individual families illuminate the layered social and spatial dimensions to the practice of public health and the wider welfare state apparatus.

Whilst post-war British public health encompassed a range of powers reflecting the historical accumulation and divestment of services through changes in state organisation, this chapter has shown that housing represented an equally significant departmental domain as other historians have shown for statutory and voluntary personal social services in relation to ‘problem families’. However, such disputes impacted families beyond a discourse which considered them and their lives substandard to the accepted post-war norm, and on the material conditions of families. Public health strategies encompassing homeless families, housing hierarchies, intermediate accommodation, deferred demolition and peripheralization were all deployed to contain problem populations and offer, in Bauman’s phraseology, ‘dumping grounds… for human waste’. Whilst ‘problem families’ were far from the only problem population identified and treated in such a way, this chapter has demonstrated that histories of post-war modernity, welfare and affluence need to account for the role of the state. The role of the state, and its bastions of technocratic expertise, continued to exclude and marginalise significant sections of the population. A focus on public health services as operationalised, built through the case files of ‘problem families’ and the policies which contained them, offers an example of how the state materially treats such families as ‘human waste’.

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