The Wadham Journal

Issue 1, Michaelmas 2016

The Disability Issue

Sharing the fascinating work of Wadham graduates with the MCR, alumni, and the wider College community

This Journal was made possible by the generosity and kindness of The Wadham Society
CONTENTS

2
Letter from the editors
Annabella Massey DPhil Oriental Studies
Margarita Vaysman DPhil Medieval and Modern Languages

3–6
‘Mental Defectives’: the British eugenics movement and the social construction of mental disability
Helen Hillman MA Cultural History

7–13
A critique of disability-adjusted life years in public health policy
Lindsay Lee Msc Applied Statistics

14–18
Sensory impairment and the Victorian census
Ben Szreter MSc Economic and Social History
Letter from the editors

This issue of *The Wadham Journal* celebrates the efforts of the Wadham College community to raise the profile of issues relating to disability in academic discourse, and to contribute to the increased inclusion of, and provision for, students with disabilities in the Wadham community and in the wider University.

In 2014 and 2015, and with the support of Oxford’s Faculty of Law, Wadham students organised and took part in the Herbert Smith Freehills Oxford Disability Mooting Championship. And as part of the extensive ‘Let’s get disability on the list!’ campaign, Wadham students hosted and presented at the OUSU Disability, Sex and Relationships Workshop and the ‘Disabilities in our Disciplines’ symposium. Aiming to raise awareness of how disability features in academic research and life, this campaign was established by Wadham students and spearheaded by Marie Tidball (2011, Criminology). Wadham also recently created the Oxford Wadham Graduate Scholarship for Disabled Students, the first funding opportunity of its kind for disabled graduate students in Oxford.

To showcase undergraduate and graduate research that has been carried out in parallel with this surge of activist and academic work regarding disability, this issue of *The Wadham Journal* presents papers by three Wadham students, past and present. Helen Hillman (2011, History) explores the history of British eugenics and the effect this has had on present-day attitudes towards people with mental disabilities. Lindsay Lee (2014, Applied Statistics) offers a critique of the problematic disability-adjusted life year (DALY) metric in public health policy. Finally, using newly digitised census data, Benjamin Szreter (2012, History) writes about the impact of the industrial revolution on people with visual and hearing impairments in Victorian England and Wales between 1851 and 1901. All three papers have undergone a rigorous peer review process by Wadham’s Research Associates, Dr John Miles and Dr Tyler Shendruk.

Since 2010, the UK government have been making devastating cuts to welfare support for disabled people. In light of this sustained assault on the rights of disabled people and their ability to live independently, there is undeniably a pressing need today to keep the subject of disability visible in both the public and the academic mind. The Editors would like to thank the Wadham community for their sustained interest and engagement in initiatives such as these.

We hope you enjoy this edition, and please feel free to contact the Editors if you would like your work to be considered for the next issue of *The Wadham Journal*.

WJ Disability Issue Editors,

**Annabella Massey**, DPhil Oriental Studies
(annabella.massey@wadh.ox.ac.uk)

**Margarita Vaysman**, DPhil Medieval and Modern Languages
(margarita.vaysman@wadh.ox.ac.uk)
‘Mental defectives’: The British Eugenics Movement and the Social Construction of Mental Disability
Helen Hillman, MA Cultural History

“A STATE CHARGE”
Here, then is an additional motive to be careful in the choice of partner in marriage. No person can be indifferent about having selfish or benevolent, stupid or intelligent children.¹

This photo and quotation come from a leaflet published in 1929 by the British Eugenics Society. The picture, taken by a ‘staff photographer’, highlights the intimate relationship between movements for eugenics, condemned and largely ignored in British history today, and birth control, largely celebrated. The image of an adolescent with mental and physical disabilities and the caption underneath provide an insight into the social debates with which both movements intersected. In this image, disability is linked to contemporary social evils - stupidity, selfishness and dependence upon the state, while the boy’s visible happiness reflects the tone of humanitarianism in representations of sterilization as a form of care for the disabled. It is this connection between mental disability and sexual responsibility which this article explores through a focus on the Voluntary Sterilization Campaign of the early 1930s. Specifically, it will look at understandings of the ‘mentally deficient’ individual as posing a social, largely sexual, problem, and the debates about reproductive rights and care with which this intersected before exploring the historiographical context of such studies.

Firstly, the term ‘mental defective’ was used to describe those seen as mentally disabled. Mental disability is distinct from mental illness and physical disability, despite overlap. This was recognised in the 1930s, with ‘ lunacy’ and physical ‘ deformity’ being seen as separate issues, even if the ‘mentally deficient’ showed signs of mental illness or also had physical ailments. The Voluntary Sterilization Movement was a campaign led by the British Eugenics Society which began in the 1920s and which focused on ‘mental deficiency’. In light of the perceived heredity nature of mental disability, operations to sterilize individuals were suggested. This was argued as a solution to the problems of caring for the mentally disabled in future generations. It was put forward alongside an existing argument for the separation of the mentally disabled into their own communities: ‘the colony solution’. The campaign was by no means unique to Britain by the 1930s, being paralleled in the USA and Europe, and the most infamous case, of course, being that of Nazi eugenics. The ‘mentally defective’ individual was cast first and foremost as a social problem, a threat to society’s moral as well as physical health.

Arguments about ‘mental deficiency’ revolved around images of uncontrolled sexuality and disturbed domesticity. The category of ‘high grade’ or ‘moral defectives’ evidenced this. The minutes of the British Medical Association’s Committee on Mental Deficiency in 1930 outlined an established scale or series of ‘grades’ of ‘mental defective’; ‘idiots’, ‘imbeciles’, ‘feeble minded’, ‘moral defectives’. Constituting the ‘highest grade’, ‘moral defectives’ were the most likely to be ‘at large’ in the community, and least likely also to have physical disabilities. This category associated ‘mental deficiency’ with social failings; ‘this lessening of mental capacity comprises a lessening of both his general intelligence and his social acceptability’. Gender and class prejudice were implicit here, it being believed in the 1930s that the ‘feeble-minded’ tended to be working-class with loose sexual morals; ‘English experience indicates that, in spite of great care, feeble-minded girls when not in institutions sometimes give birth to illegitimate children.’

From the Edwardian period, the British birth control movement and Eugenics Society were both wrangling to give the practice of contraception scientific or moral respectability. At the Church of England’s Lambeth Conference in 1930 birth control was addressed: ‘In those cases where there is such a clearly felt moral obligation to limit or avoid parenthood, and where there is a morally sound reason for avoiding complete abstinence, the Conference agrees that other methods may be used, provided that this is done in the light of the same Christian principles.’ Clearly, the birth control debate brought the tension between conceptions of sexual morality and arguments for healthy children into public debate. Indeed, this subject throws up many questions about how to view the place of eugenic debates alongside more accepted histories of birth control and welfare. The consequences of increased birth control and new attitudes to sexual pleasure included debates on eugenic sterilization just as much as the freedom of ‘sexual liberation’. Feminist historians have begun to explore this connection; for instance, Carey arguing that western birth control movements ‘were primarily eugenic, rather than

---

2. SA/ BMA/C.2 Mental Deficiency Committee, p 1.
feminist... in the interwar years birth control and eugenics were so intertwined as to be synonymous'.

Moreover, the welfare rhetoric of a ‘voluntary’ measure masked a range of issues over consent which studies like this bring to light. The position of the Eugenics Society towards care was summed up by Leonard in 1928: ‘to have to shut up any one is of course very distasteful to us all, for we all advocate freedom. But can we call the Feeble Minded person “free”, even when he is at liberty?’: In The Problem of Mental Deficiency Thomson integrates social and political analyses of the campaign, arguing that the movement became so potent yet ultimately failed in Britain due to its specific context within the development of modern democracy. He draws out the tension between rights and responsibilities in a society which at once sought to exclude the ‘unfit citizen’, yet privileged the language of individual liberty. Indeed, recent works of medical history have developed this theme in their discussion of consent. These historians have drawn attention to the challenges presented by the policing of the sexuality of the mentally-disabled even in more recent periods, when care aims to give the disabled individual as much control over their body as is possible.

It is hardly surprising that over the last three decades, the Voluntary Sterilization Movement and ‘mental deficiency’ have been increasingly addressed by social historians. This originally took the form of legislative or institutional studies. Yet, historians of disability have begun to tackle debate about and the treatment of the mentally disabled through other sources in an attempt to get to a wider sense of social experience. There has been an attempt to place disability within its social context, to see the ways in which institutions intersected with people’s lives in specific areas at specific times. In particular, the articles in Stagg and Turner’s volume explore the relationships between the disabled and others in the world around them, teasing out the sorts of stigma which affected them.

Some of this work has been carried out in relation to the eugenics movement. Morris maps the evolution of eugenic thought, showing the incoherence of definitions and solutions offered for ‘mental deficiency’, and emphasising the importance of regionally-differentiated interpretations. Myres focuses even more locally on what certification as ‘mentally deficient’ meant for the individual in a case-study of a family who challenged the categorisation of their son. These studies imply the fluidity of concepts of mental disability, while bringing in themes of identity and relationships: individual, familial, regional. They make imaginative use of the sources available, intertwining social and legal sources to get closer to experience. They move away from studies of disability which privilege a policy focus on ‘curing’. This is an especial problem within the interwar period, which, in the context of the history of disability, has traditionally been studied

---

2. L. Darwin, What is eugenics?
6. S. Morris, ‘“Human Dregs at the bottom of our national vats”’, pp. 142-60.
for the advances made in prosthetics and the treatment of mental disorders such as shell shock. Indeed, ‘mental deficiency is an ideal subject for such a reorientation for it was more obviously a problem of care than cure’.6

Disability history itself is still, however, a fledgling discipline. The move from disability studies to disability history is still being made, and the disability rights movement and critical disability studies are still fighting for social equality today. It was in the 1980s that Kudlick called for disability to become a category of historical analysis alongside gender, class and race. Indeed, in 2003, she stated its importance to wider society, pointing out that ‘hierarchy depends on the threat of disability always lurking as the ultimate living catastrophe’,7 and highlighting that most people will experience being disabled, however temporarily, in their lives. The debate about ‘social’ versus ‘medical’ models of disability has dominated its history. It has been established that the realities of social exclusion are a potent disabling factor, as proven in studies of ‘otherness’. This certainly rings true in the study of ‘mental deficiency’ and ‘idiocy’ throughout history. Yet more recently, historians like Harris and Thomson have pointed out the problems inherent in too sharply differentiated a distinction. As Harris argues, ‘one serious and worrying dimension’ of the social model is the claim that ‘once the social dimensions of disability have been resolved no seriously “disabling” features remain.’8 In fact biological differences need to be acknowledged as physical as well as social realities.

The imaginative power of ‘the body’ becomes evident when studying the Voluntary Sterilisation Movement. The mapping of social anxieties onto the bodies of ‘disabled’ individuals was clear in debates about the ‘mental defective’. Moreover, the wellbeing of the social body, reflected metonymically in an ideal of the healthy individual body, was placed above the rights of individuals over their own bodies. Exploring this construction of the ‘mental defective’ in this way promises new insight. It is fertile ground for uncovering the ‘disabled’ experience. Not only this but it also helps to understand debates on reproductive and sexual autonomy, care and individual liberty: debates which themselves contributed to the attitudes now entrenched in our own society.

Helen Hillman completed a BA in History at Wadham in 2014. She is currently studying for an MA in Cultural History at Queen Mary, University of London while working part time delivering therapies to people who have sustained traumatic brain injuries. Her current research focuses on ‘Thalidomide Babies’ in Europe in the mid-20th century, the press coverage they received and the emergence of subsequent support networks. She is also part of a lottery funded project exploring sites of historical significance for disabled and deaf people in London.

---

A critique of disability-adjusted life years in public health policy

Lindsay Lee, Master of Public Policy

Introduction

It is commonly accepted that there is a scarce supply of resources that can be devoted to public health initiatives; therefore, a system of prioritisation is needed to determine which health issues should be given which resources. Since the mid-1990s, the most widely accepted metric to evaluate the cost, efficiency and effectiveness of health care interventions has been the disability-adjusted life year (DALY). This metric, which combines mortality and morbidity into one measure of quality of life, has been officially endorsed by the World Health Organisation [14] and is used by public health researchers and officials internationally to set health priorities. However, using DALYs as the primary measure of health policy effectiveness is wrought with practical and ethical implications that stem from the model’s assumptions about disabled people. Policies created on the basis of DALY calculations are at risk of not truly understanding the experiences or needs of disabled people. A more valid metric that utilises the social model of disability needs to be developed in order to effectively and justly evaluate public health interventions.

Defining DALY

The concept of the disability-adjusted life year arose in 1993 from the Global Burden of Disease and Injury study, which was a collaboration between the World Bank, WHO and Harvard School of Public Health. The DALY was designed to be objective, to include morbidity into discussions of global health policy, and to be used in cost-effectiveness analysis [14].

One DALY is equivalent to the loss of one healthy year of life, either through premature death or disability. A DALY is by definition something that public health officials seek to minimise. The basic equation is

\[ DALY = YLL + YLD, \]

where DALY is disability-adjusted life years, YLL is the number of years of life lost due to premature death, and YLD is the years of healthy life lost due to disability. This equation can be applied to an individual or a population [14].
In its simplest form, YLL is calculated by subtracting the age of death from life expectancy. The WHO has also supported the use of age discounting and time discounting, whereby life years at different ages and at different points in the future, respectively, are given unequal value [14]. This discounting was controversial; however, the latest iteration of DALY calculations completed by the Global Burden of Disease project did not include discounting, so we will not include it in our discussion here [8].

YLD calculations are in many ways less straightforward than YLL calculations. The basic equation for YLD for an individual is

\[ YLD = DW \times L, \]

where DW is the disability weight, between 0 and 1, given to different conditions, and L is the duration of the disability. Death has a disability weight of 1, and perfect health has a weight of 0 [14]. Until the most recent calculation of DALYs by the Global Burden of Disease project, these disability weights were determined by a panel of health experts using the “person trade-off method” (PTO) [10]. Under this scheme, respondents were asked to choose to use a set of resources to either, for example, extend the life by 1 year of 1000 perfectly healthy people or extend the life by 1 year of 1500 people with a certain type of disability. The number of disabled people in the comparison is altered until the participant feels the two choices are equivalent. Since disability is assumed to be undesirable, it is expected that the participant will decide it takes a higher number of disabled people to be equivalent to the set number of healthy people [7]. These answers were statistically compiled, and disability weights were then assigned for a myriad of different physical and mental health conditions [10].

The most recent iteration of DALY calculations from the 2010 Global Burden of Disease study were completed using a different kind of survey of a wider variety of participants. A web survey was released along with household surveys in Bangladesh, Indonesia, Peru, Tanzania and the USA. The data was primarily collected via paired comparison questions: the participants were presented with two different health states and were asked to determine, in their opinion, which person was healthier. This data was then compiled, and the disability weights were assigned [10].

Criticism of DALY

Experts in public health, policy and economics have been critical of DALYs since they were first proposed [1; 2; 5]. As with most mathematical models, many of the critiques stem from the assumptions the model makes. Here the validity of equating time lived to quality of life and the development of the disability weights are questioned.
Equating time lived to quality of life

At its core, a DALY is a unit of time. It attempts to equate the amount of valuable time lost when one dies and when one lives with a disability [14]. The assumption underlying DALY calculations is that individuals will automatically be willing to trade years of life lived for an increased quality of life. But studies have shown that even severely ill and disabled people are most often unwilling to trade better quality of life for actual years lived [9]. Therefore, using time as the unit of measure to unify the extremely varied and complicated consequences of morbidity and early mortality takes DALYs out of the realm of reality and into an overly simplistic world, separate from the actual decision-making processes that dictate real individuals’ actions and preferences.

Person trade-off method

The disability weights are the most complicated part of the DALY calculation, and the most fraught with practical and ethical issues. For most of their history, disability weights were calculated using the person trade-off method, as described above, which has many problems. Firstly, the questions posed to the PTO panelists automatically presuppose that living with a disability is inherently worse than living without a disability. The relationships between disabled and non-disabled populations that the questions posit influence the panelist to accept the assumption that disabled populations are automatically less deserving of health resources than the non-disabled. The purpose of the PTO exercise is just to determine how much less deserving they are. It has also been reported that in practice, if a panelists asserted that prolonging the life of 1000 healthy people is equally valuable to prolonging the life of 1000 disabled people, it was considered unreasonable by the officials collecting the data [2].

Another major issue with PTO is the fact that health experts were exclusively consulted to create these disability weights. The final values are a product of the experts’ own personal and professional perceptions of what living with a particular condition or disability is actually like, not based on the first-hand experiences of the disabled themselves [4]. The reasoning behind this choice has to do with what the WHO researchers sometimes offensively call the “happy slave” phenomenon: people’s self-reported quality of life tends to increase after the onset of disability after they have adapted to their new conditions. The fact that people base their personal quality of life ratings on their abilities to successfully adapt to and cope with their conditions is seen as a biasing factor instead of a phenomenon that should be incorporated into the model, as it is part of the lived experience of disabled people [3].
Current survey methods

The newest survey methods that pull participants from an international population were developed in response to critiques of the lack of diversity in the previous surveys [10]. The latest survey methods represent an improvement on the previous method, but there are still many issues. The new survey pulls from a much more diverse population than just health professionals; instead the disability weights from this iteration can be seen as the product of broad public opinion about the relative severity of various health states. However, as described in the previous section, there are often major differences between how severe others imagine a particular disability is and how severe the actual person with the disability feels it is. The researchers see the adaptation to disability as a biasing factor among the disabled population instead of viewing it as part of the complete experience of living with disability. Instead, they should view the ignorance of the general public and the stigmas they carry toward disability as the more problematic biases. The researchers do not provide a demographic breakdown of the health statuses of the people surveyed, so it is impossible to analyze how different survey answers among populations with different health statuses are. In addition, though the researchers tried to sample from a general population, participants for the web survey were recruited primarily via communication channels in the scientific community such as scientific journals and professional networks in public health [10].

Secondly, though the primary survey questions changed to simple paired comparison questions, the web survey still contained a PTO section. Participants were asked to compare a health program that prevents 1000 people from dying to a program that prevents a higher number (1500, 2000, 3000, 5000, or 10000) of people from obtaining some other non-fatal health state [10]. The framing of the question is altered, but the issues with the PTO scheme still remain.

Definition of disability

Finally, perhaps the most serious problem with the disability weights is that they do not reflect the currently accepted definition of “disability,” nor did they reflect its contemporary definition when they were first formulated [4]. The Global Burden of Disease study defines disability as “any short-term or long-term health loss.” [12] In other words, their definition of “disability” attempts to follow the “medical model,” under which disability is viewed as a purely individual, medical issue that one should seek to cure. They attempt to differentiate between health loss and overall welfare loss in their calculations [10], but separating the two is not so simple. Many of the health states numerically evaluated by DALYs have definitively social aspects. For instance, the health
state “disfigurement” is described to survey participants at various levels of severity based on how uncomfortable it makes others. Other health states like “hearing loss” are partially described via the ability of the person to communicate with others. Still other health states, like “intellectual disability” and “motor impairment” are described via the need of individuals to depend on other people to function in everyday life. The creators of these disability weights claim to just be measuring health and not overall welfare, but the definitions they formulated themselves show this is not entirely so. The two concepts inevitably interact with one another.

Modern definitions of disability take this reality into account. United Nations Convention on the Rights of Persons with Disabilities states, “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” (emphasis added by author) [11] Indeed, the WHO’s World Report on Disability emphasises that disability is “a dynamic interaction between health conditions and contextual factors, both personal and environmental.” [13] Disability is now accepted internationally to be in large part a product of the social environment, but the disability weights have no parameters that take this into account. Each disorder is considered its own, independent entity, when in reality disability is experienced in a familial, economic and societal context. The life of a double leg amputee with the resources to purchase an appropriate wheelchair, with a supportive family structure, and who lives in a city where most buildings have barrier-free access is not equivalent to the life of a double leg amputee who cannot afford assistive devices, whose family considers him or her an outcast, and who lives in a town full of physical barriers. The researchers who created disability-adjusted life years use the word “disability” without considering its meaning nor its reality for the people who live with it.

**Vision for a new metric**

While there have been critiques of the DALY system since its inception, there has not been a concerted effort to replace it with a metric that addresses its many practical and ethical issues. The public health community acknowledges the issues with DALYs but is largely complacent with their continual use. Too often DALYs are treated as evidence when policymakers attempt to create policy that is evidence-based, but the fact remains that there is no substantive, objective proof that DALY measurements of quality of life accurately reflect reality [6]. We have presented here several reasons why this is the case.

A new measure needs to be developed that agrees with the stated purpose of the
WHO, part of which being, ”[to strengthen] the scientific and ethical foundations of health policies...The aim of the work is to promote equity, quality, and efficiency.” [2, pg. 1425]. While it is beyond the scope of this paper to formulate the new metric, it is not difficult to imagine how concepts from the social model of disability could be integrated within it. The new measure should analyze the economic effects of poor health and disability beyond simple ”years lost.” It should mathematically equate the value of successful treatment of illness and successful adaptation to disability, whether it be via environment modification, assistive devices or social awareness. It should take into account the value that an entire community gains from increased economic participation of disabled people once successful treatment or adaptation occurs. Parameters for the relative severities of disabilities under this new metric should include measures of the economic and social support that the disabled community has, because these are some of the factors that truly determine disability’s consequences.

Calculating these new measures of health would be a large project, and would take the commitment of the World Health Organisation and various international public health institutions to sustain. However, if as a society we strive for equity, then we must develop metrics for evaluating our policy that actively reflect that value.

References


Lindsay Lee completed a Master of Public Policy in 2016 and a MSc in Applied Statistics in 2015 at Wadham as a Rhodes Scholar. She currently works combining data analysis, public policy and disability issues.
Sensory Impairment and the Victorian Census

Benjamin Szreter, MSc Economic and Social History

How did the industrial revolution have an impact upon those with sensory impairments? An analysis of the geographic position and household placement of the blind and deaf between 1851 and 1901 is made possible using newly available census data. This reveals striking disparities with the ‘non-disabled’ population and suggests that the sensory-impaired were increasingly ‘disabled’ by social and economic trends in the Victorian era.

What was the geographic and social position of the blind and deaf in Victorian England and Wales? Using census data that has been newly digitised by the University of Essex’s Integrated Census Microdata Project (I-CeM), this research focuses on how far capitalism and industrialisation – associated with nineteenth century technological developments – changed the lives of the sensory-impaired in the Victorian period.

Census taking began in the United Kingdom in 1801 largely to enumerate population totals and to ascertain the numbers of people who were working the land. By 1841, the function of the census had expanded to include more information such as name, age, sex, occupation and place of birth. From 1851, the census began asking householders to specify if any of the inhabitants of the household were blind, deaf or dumb. This was an interesting development, due to the limited number of questions asked in the mid-Victorian censuses, and is likely related to the wish of the registrar general at the time – William Farr – to enumerate the blind and deaf to stimulate philanthropy. The census was taken by local enumerators who gave each household a schedule to fill out before copying it into the Census Enumerators’ Books. National statistics were compiled from these records and they become available for public examination 100 years after that specific census was taken. The digitisation project created a huge database, which according to the researchers, “has transformed the research landscape for work in the economic, social, and demographic history of this country”.* This research is one of the first projects to utilise the newly digitised data.

The questions on disability were asked in seven censuses over sixty years, stopping after the 1911 census, but little significant use has been made of the data. This research made use of this potentially valuable source while recognising that it likely offers a lower-bound estimate of sensory disabilities. However, the margin of error on sensory impairment was fairly uniform across decades and regions, therefore allowing trends to be assessed accurately across time and space which means that the data has use for internal comparative purposes. Unfortunately, 1871 has not been successfully digitised, and in 1911, a subtle change to the question was made that inhibits comparison. In 1911, the question asked whether the individual was ‘totally’ blind or deaf rather than just whether they were blind or deaf as previously. Nonetheless, records on over 230,000 sensory-impaired individuals across five censuses between 1851 and 1901 were used and compared to ‘non-disabled’ population aggregates of millions of individuals.

Reported regional rates of blindness and deafness were calculated by using county totals for blindness and deafness and then comparing these to population totals for each

county. Figure 1 displays reported county rates of blindness mapped onto England and Wales. The darker sections show higher reported rates of impairment. There is variation from reported rates of 4 per 10,000 individuals up to 19 per 10,000 and the variation is perhaps surprising; rural counties on average have higher reported rates of impairment than urban counties. This was also true for reported rates of deafness as shown in Figure 2 where again darker shades show higher reported rates. The range of reported rates is very similar to the reported blindness rates and once more the higher reported rates are predominantly in rural counties. This apparent difference from the spatial data of higher reported sensory impairment rates in rural counties was confirmed using t-tests for comparison of means. Why do we find this perhaps surprising variation?

*Figure 1: Reported blindness rates in England and Wales 1851-1901*
Analysis of the data revealed that counties with high amounts of out-migration had higher sensory-impairment rates. This suggests that the sensory-impaired were geographically immobile and unable to follow ‘normal’ urbanisation patterns. Another reason for the variation appears to be the younger age-structure in urban counties; because the population of urban and industrial counties were growing so fast through in-migration, younger age groups were being continually inflated by the inflow of young migrants. In other words, in urban centres the relatively large proportion of the population that was young would have acted to reduce the general reported rates of blindness and deafness, compared to rural counties, which retained almost all of their elderly populations and tended to lose only the younger people. This implied lack of geographic mobility indicated by geographic variation in reported sensory impairment rates shows the inability of the blind and deaf to access socially normal phenomena such as urbanisation.

Further work analysed the domestic (or non-domestic) situation of the sensory-impaired and found that the sensory-impaired were significantly more likely to be in institutionalised poverty; in non-domestic locations designed for those without the means to live – in this period this was often in the infamous workhouse. Figure 3 shows that, throughout the period, the percentage of the sensory-impaired population in institutional poverty towers over the percentage of the ‘non-disabled’ population in institutional poverty. The smallest proportional difference is in 1851, when the sensory-
impaired population are 6.3 times more likely to be in institutional poverty. The largest difference is in 1891, when the sensory-impaired are 10.7 times more likely to be in institutional poverty. These data in general seem to indicate a significant removal from mainstream society of the blind and deaf over this period, increasingly so until 1881 before a slight decrease.

![Figure 3 - Comparison of institutional poverty rates of the sensory-impaired and 'non-disabled populations' in England and Wales 1851-1901](image)

The contemporary Thomas Armitage – who founded the organisation that would later become the Royal National Institute for the Blind – writing in 1886, stated that the blind “dislike extremely to be forced to associate with those who have become paupers through drink or other vicious habits...At present the blind will suffer almost any privations rather than enter them [workhouses].” This view incorporates conventional Victorian, conservative views which tended to attribute poverty to moral character rather than to issues such as low wages and unemployment. However, it shows that the sensory-impaired were striving to avoid institutional poverty. The blind and deaf may well have attempted to avoid workhouses but the evidence from this new research indicates that they were nevertheless frequently and disproportionately found in them and thus removed from families into institutional poverty.

It seems possible that they were also housed in ‘lunatic asylums’. Whilst by 1901 there are some ‘blind asylums’ and ‘asylums for the deaf and dumb’, the number of blind and deaf in ‘lunatic asylums’ prior to this is worrying. Although it could be that these individuals did have some sort of mental impairment along with their sensory impairment, very few of these individuals have any mental impairment mentioned in their census record. It is possible that those recording the census assumed their mental impairment was implied by their place of residence. But if this was not the case, then some blind and deaf were being housed in ‘lunatic asylums’ despite not having a mental
impairment. The real possibility of this is shown by the ‘County Lunatic Asylum’ in Whittingham, Lancashire. In this asylum in 1901 of the eight blind or deaf individuals resident, three are described only as ‘blind’, three are described only as ‘deaf and dumb’, whereas the other two are described as ‘blind insanity’ and ‘idiot deaf and dumb’. Whilst this is not proof that blind or deaf individuals were being housed in ‘lunatic asylums’, it shows that in this institution some of the sensory-impaired were being labelled along with their mental infirmities but others were not. Why would this be the case unless these individuals did not have mental infirmities? The prospect of the sensory-impaired being housed in lunatic asylums, despite a lack of mental infirmity, as late as 1901 is troubling but cannot be ruled out.

To conclude, this research uses newly-available evidence to assess the position of the blind and deaf in Victorian Britain. The findings are consistent with theories positing the disabling of the sensory-impaired coincident with the maturity of industrial capitalism in late 19th century England and Wales. This argument relates to the social model of disability which states that individuals can only be impaired, it is society which disables those with impairments. This raises the possibility that capitalism and proletarianisation – associated with technological developments – in the Victorian period disabled the visually-impaired. Between 1851 and 1881, the sensory-impaired were increasingly forced outside family living arrangements into institutional poverty, and after this point, percentages in institutional poverty remained very high relative to the non-disabled population. Indeed, some individuals may have resided in ‘lunatic asylums’. Speculation on a possible causal mechanism for this suggests factors related to increasing individualisation and the removal of the ability of communities to provide support which are both associated with proletarianisation and urbanisation. More research is needed in disability history to assess these arguments further.

Benjamin Szreter is studying for the MSc in Economic and Social History at Wadham. He completed his BA History at Wadham in 2015. His current research analyses non-European immigration into late-nineteenth century Britain.