

Disability in time and place

**English Heritage Disability History Web Content
Simon Jarrett
2012**

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Section 1

The Medieval period 1050-1485

Disability in the medieval period 1050-1500 – religious care, self help and duty

Disability was pervasive in medieval England. It could come with birth, be acquired through the onset of diseases such as leprosy, or arise from years of backbreaking work. The 'lepre', the 'blynde', the 'dumbe', the 'deaff', the 'natural fool', the 'creple', the 'lame' and the 'lunatick' were a highly visible presence in everyday life.

Provision and support for people with disabilities came not from the state but from the Church. We see over this period the emergence of a nationwide network of hospitals based in or near monasteries, nunneries and other religious establishments. Formed from the Christian duty of shelter to pilgrims and strangers, they evolved slowly into the hospitals caring for the sick and infirm which we recognise from a modern perspective. Some were special buildings - there was an extraordinary profusion of leper houses between the 11th and 14th centuries, and also hospitals which catered for blindness and physical disability, some of them specifically for blind, leprous or disabled monks and nuns. In the late 14th century England's first mental institution emerged from the Bethlehem hospital, later to become known as 'Bedlam', in the City of London. Almshouses, providing long term support and accommodation for the disabled and aged infirm, grew from the hospital movement at the same time.

Attitudes to disability were mixed. It could be seen as a punishment for sin or a consequence of being born under the influence of Saturn, a bad planet. But disabled people, particularly lepers, were also seen as suffering purgatory (the place of temporary suffering where sins were cleansed between earth and heaven) on earth rather than after death. They would therefore attain a place in heaven earlier than others. This made them closer to God than the rest of society. Care for the sick and the disabled was based on the Church teaching of the seven 'comfortable works'. These involved feeding, clothing and housing the poor, visiting them when in prison or sick, drink for the thirsty and burial. There were also seven 'spiritual works' which included counsel and comfort for the sick. Adherence to these works, especially if accompanied by the prayers of the disabled themselves, could speed a person's journey through purgatory to paradise.

Disabled people were not passive recipients of care. In 1297 the residents of the leper house in the Norfolk village of West Somerton mutinied against the embezzling prior and his men, looting and demolishing the buildings and killing the guard dog. Most people lived outside specialist buildings, in their communities, working if they could, supported by family, friends and sometimes the municipality if they could not. If they had no such support, they resorted to begging on the street. Pilgrimages were made, on foot, to holy sites such as the shrine of Thomas Becket in Canterbury, in search of a cure, or at least relief.

The people, towns and cities of the medieval period pioneered the use of specialist buildings and professional organisation in response to disability. Although only a small number of the buildings remain, their legacy is recognisable in the development of public services that unfolded over the following 500 years.

Disability in medieval hospitals and almshouses

The word hospital derives from the Latin 'hospes' meaning both host and guest, and is rooted in the Christian obligation to shelter any stranger, particularly passing pilgrims. Gradually rules were introduced in religious establishments which expected the passing poor to spend one night only, but the sick were allowed to stay until they recovered, creating the early version of the hospital as we understand it today. There was also a long tradition of religious orders caring for their own sick or disabled brothers and sisters. In the seventh century the monastery of Whitby, Yorkshire is described as having a building 'to which they used to take those who were infirm, or who seemed to be at the point of death'. 700 years later the hospital of St Mary Magdalene in Ripon, Yorkshire was accommodating blind priests.

The first hospital to see its role as the long term care of those deemed too ill or disabled to function in mainstream society was St John Canterbury in Kent. Established in the late 11th century by Lanfranc, the Archbishop of Canterbury, the hospital gave 24 hour care and supervision to men and women 'oppressed by various kinds of infirmities'. Just down the road, in Harbledown, he established a parallel institution for lepers. By the later Middle Ages both London and York had some 35 hospitals, Norwich 15, Exeter 10 and Canterbury 9. While some were large – such as St Mark Bristol - many were small, a few little more than cottages.

Basic layout of the larger, purpose-built hospitals was quite consistent. A large 'infirmery hall' would accommodate the sick and the infirm in lines of beds to each side with a chapel in full view of all patients – the care of the soul was just as important as the care of the body. Men and women were segregated, as at the hospital of St Nicholas Salisbury, with its two chapels linked to two infirmaries housing the two sexes. Treating those with long term disabilities was just as common as short term or acute illness. St James's Hospital in Chichester cared for 'six cripples, two people without legs and two idiots' while Chatham hospital in Kent looked after blind and epileptic nuns and monks. Specialism increased, In 1351 St Mary within Cripplegate in London, known as 'Elsyng Spital' after its founder Elsyng, an influential London merchant, catered for 100 blind, paralytic and disabled priests.

From hospitals developed the idea of the almshouse (sometimes also referred to as Maison Dieu), built to provide long term shelter for the disabled and aged infirm. Founded and supported with donations from kings, church dignitaries, nobles and merchants keen to ease their passage to heaven with good works, the almshouse became a common feature of towns and cities. Some trade guilds built almshouses for their members who could no longer sustain life in their own home. Rules were strict and there was an unrelenting regime of prayer and devotion, but diet was generally good, surroundings pleasant with gardens a common feature. There were gifts and feasts on special days. Places were sought after – the almshouse was an escape from the poverty and danger that disability and infirmity could bring. As leprosy began to recede in the late 14th century, many former leper houses were used as almshouses.

Numerous outstanding examples of medieval almshouses can be found across England. They include St Mary's in Chichester, St John's in Lichfield, the Maison Dieu in Ospringe, Kent (founded by Henry III), Gaywood Road almshouses, King's Lynn and the Guild of the Holy Cross almshouses in Stratford-upon-Avon.

The time of Leprosy – 11th century to 14th century

The disabling consequences of leprosy were ever more visible in communities, rural and urban, rich and poor, across England as the disease became endemic in the medieval period. The response would change both the landscape of the country and the mindset of its people.

Leprosy, known today as Hansen's disease, had entered England by the fourth century and was endemic by 1050. In its extreme form it can cause loss of fingers and toes, gangrene, blindness, collapse of the nose, ulcerations, lesions and weakening of the skeletal frame. Reaction to the disease in English society was complicated. It could be seen as a punishment for sin but it was also believed that the suffering of lepers was similar to the suffering of Christ, thus placing them closer to God than other people. Enduring purgatory on earth, they would ascend directly to heaven when they died. Those who cared for them or made charitable donations could, through these good works, accelerate their own journey to heaven and reduce their time in purgatory.

At least 320 religious houses and hospitals for the care of lepers (known as leper or lazaret houses) were established in England between the close of the eleventh century and 1350. Many have disappeared, destroyed during the dissolution of the monasteries in the 1530s or simply decayed. However some remain, including the oldest, St Nicholas Harbledown, Canterbury (1070s), St Mary Magdalen, Stourbridge, near Cambridge, St Mary Magdalene in Sprowston, Norwich, and the hospital of St Mary the Virgin, Ilford. Others survive as ruins or archaeological sites.

Leper houses were usually built on the edge of towns and cities or, if they were in rural areas, near to crossroads or major travel routes. They needed to retain contact with society to beg alms, trade and offer services such as prayers for the souls of benefactors. There was high demand for places and 'leprous brothers and sisters' were often accepted fully into the monastic order of the house. Care from monks and nuns centred as much on the person's spiritual needs as their physical problems. Most houses had their own chapel and rituals of prayer and singing went on throughout the day. The emphasis was on cleanliness and wholesome food – clothes were washed twice each week and a varied diet was supplied when possible, often from the home's own fields and livestock. The therapeutic effect of horticultural work and the beauty of nature was recognised – many houses had their own fragrant gardens of flowers and healing herbs with residents participating in their upkeep.

Many lepers retained their contacts with their family and friends, being allowed to make visits home and to receive visitors. Attitudes began to change in the 14th century, particularly after the horrors of the Black Death (1347-1350), as fear of contagion led to greater restriction and isolation. At the same time abusive and corrupt practices increased. However by this time leprosy was in retreat – possibly due to greater immunity in the population - and many houses fell into disuse or were put to new uses, such as St Mary Magdalene, Ripon and St Margaret and St Sepulchre, Gloucester, which became almshouses for the sick and disabled poor. The impact of leprosy lived on – it had brought about an institutional response to disability in the form of buildings and methods of care which would strongly influence future generations.

From Bethlehem to Bedlam – England’s first mental institution

In the 13th century Simon FitzMary rose from modest origins to become the Sheriff of London – twice. He was said to have had a veneration for the Virgin Mary and the Star of Bethlehem, formed during his participation in the crusades. Becoming a wealthy political figure he donated a piece of land in the Bishopsgate ward of the City of London to the Bishop of Bethlehem for the creation of a charitable hospital. In 1247 the Priory of St Mary of Bethlehem was founded, devoted to healing sick paupers. The small establishment became known as Bethlehem Hospital which Londoners later abbreviated to ‘Bethlem’, often pronounced ‘Bedlam’.

Built on the site now covered by Liverpool Street station in the City of London, the hospital was compact, covering just two acres. Single-storied and centred around a courtyard, in the middle of which stood a chapel, it had around a dozen ‘cells’ for patients, a kitchen, staff accommodation and an exercise yard. It was to remain on this site for over 400 years until a move to Moorfields, also in the City of London, in 1676.

At some point the monks began to accept patients whose symptoms were mental illness rather than physical disability or disease. There is a claim that the residents of a building called the Stone House at Charing Cross were transferred in the 1370s to Bethlem. It is certainly true that by 1403 ‘lunatic’ patients formed a majority of Bethlem’s clients - and thus was born England’s first, and perhaps most infamous, mental institution.

In 1346, as the hospital struggled to survive, the City of London agreed to take it under their protection. Its subsequent specialisation in ‘madness’ – although in fact those who were admitted also included people with learning disabilities, ‘falling sickness’ (epilepsy) and dementia - gave it a future. Those who became patients were usually the poor and marginalised, sometimes viewed as dangerous, who lacked friends or family to support them. The hospital regime was a mixture of the punitive and religiously inspired devotion. Chains, manacles, locks and stocks appear in the hospital inventory from this time - the shock of corporal punishment was believed to induce recovery in some cases – and isolation was seen as a means of enabling a person to ‘come to their senses’. At the same time attendance on and compassion towards people afflicted by madness was a religious imperative.

The long association of Bethlem in the public mind with scandal and abuse – which was in fact periodic rather than permanent - began in 1403, when the hospital treasurer, Peter Taverner (known as Peter the Porter) was found guilty of embezzlement and theft of hospital property. While the vast majority of mentally ill people remained outside institutions in this period and for the next 400 years, the notion of the specialist long term institution had been born. The image of what such an institution stood for, in the form of ‘Bedlam’, had now been planted in the English imagination.

Disability in the medieval English community

While the medieval period saw the growth of the first disability institutions in England – leper houses, hospitals and almshouses – only a small proportion of the disabled population lived in such buildings. The rest – the blind, the deaf, the ‘lame’ the ‘crippled’ – took their place in their communities. Those who could work did so. Those who could not were supported by their family, neighbours and their local communities. Those who lacked such support took their chance on the streets relying on the charity of others – ‘impotent beggars’ competing with the ‘sturdy vagabonds’ who begged on the streets of the towns and cities and the byways of the countryside.

From the 13th century the King held rights and duties over ‘natural fools or idiots’ - people we would recognise today as learning disabled. He would have custody over their property and assets but also a duty to ensure they were properly cared for. Special ‘inquisitions’ were held by officials in front of county juries, to determine a person’s mental status. From these we gain some insight into the lives of people with disabilities in this period. A Cambridgeshire woman called Emma de Beston is examined in July 1383 and asked a series of questions. She is able to say that she is in Ely when asked where she is, but cannot name the days of the week, her son or two of the three husbands she claims to have had. She does not know how many shillings there are in forty pence. Appearing also to have the ‘face and countenance of an idiot’ she is deemed to have insufficient intelligence or memory to manage herself, her lands or her goods.

Many lepers chose to live outside institutions, or could not gain places in them. Groups of them lived in small informal settlements just outside or even sometimes within towns. Some remained in their homes, cared for by their families and visited by monks and clergy. A native of King’s Lynn observed that the many lepers in the streets reminded her of Christ, ‘with hys wovndys bleeding’. Governments and municipalities, fearful of a rebellious underclass and wary of ‘wild’ lepers (as opposed to the more ‘docile’ sort who lived in leper houses) issued edicts to try to control the problem. Permits for begging were strictly controlled and in 1367 the London authorities tried to impose a blanket ban on lepers entering the city.

Many disabled people, including the deaf, blind and ‘crippled’ travelled as pilgrims to the holy sites of patron saints of disability and diseases, or to healing springs and fountains. These included the shrine of Thomas Beckett at Canterbury, the Benedictine Abbey of Bury St Edmunds and the ‘lepers’ well’ in Lyme Regis, Dorset.

Recognising a disability was not always a straightforward matter. In 1380 two London men were set in the pillory for pretending that they were mutes, ‘making a horrible noise like unto a roaring’ to deceive people into giving them money. Some beggars were accused of mutilating themselves or their children to excite compassion from passers-by. That such events occurred, and rumours circulated, is a strong indication of the large numbers of disabled people on the streets of medieval England, soliciting the support and help of their fellow citizens.

Section 2

Disability from 1485-1660

Disability from 1485-1660

Closing hospitals and naturally entertaining fools

The great changes which occurred in English society in the 16th century had a marked effect on the lives of people with disabilities. Henry VIII's 'Dissolution of the Monasteries', an assault on the monasteries and other buildings of the religious orders, after his split from the Roman Church, caught up in its wake many hospitals and places of care which were run by religious brethren. As these disappeared, so did the systems of care that went with them. For many disabled people, this meant destitution and life on the streets. A petition to Henry in 1538, calling for the refoundation of the hospitals that had been closed down, complained of 'the miserable people lyeing in the streete, offending every clene person passing by the way.'

The immediate effect of Henry's dissolution of the monasteries was misery for many of those who had been cared for in religious buildings and a 30 year gap in which little new building took place. The long term effect was a fundamental shift in society's view of its obligation to disabled people. This was now more a civic duty than a religious matter. Rich benefactors were no longer trying to save their souls, but to increase their public esteem. New hospitals were built in London, and some of the old ones were refounded. But these were now more public buildings, funded by parish collections, taxes and donations. Towards the end of the sixteenth century new almshouses and hospitals sprang up. A series of Poor Law Acts enforced vicious punishments, including whipping and branding, for 'sturdy vagabonds' who were seen as idle by choice. But the 'impotent poor' were seen differently. 'The person naturally disabled, either in wit or member, as an idiot, lunatic, blind, lame etc., not being able to work...all these... are to be provided for by the overseers of necessary relief and are to have allowances ... according to...their maladies and needs.'

For some life could be very different. In Henry VIII's court 'natural fools', people we would recognise today as having learning disabilities, occupied a privileged position. With a 'keeper' or carer to look after their needs, they were seen as an important source of natural wisdom and humour, an antidote to the poisonous manoeuvrings and treachery which characterised much of court life. The 'natural fool' Will Somer and 'Jane the Fool' appear at the heart of paintings of Henry and his family in this period.

There remained only one institution for mentally ill people – the small Bethlem Hospital in London. Seized by Henry during the Dissolution, control passed from the religious order which had run it for 300 years to the Corporation of London in 1547. For the first time a medically qualified superintendent was employed. This did not prevent the financial abuse and neglect which dogged the hospital for so many years of its history, but it did start to embed the idea that mental illness was a matter for medical treatment. However, the vast majority of mentally ill people lived in their communities, most of them cared for by family and friends. Treatment was a heady mix of religious, psychological, astrological and traditional remedies.

Most other disabled people lived in their communities, with their families. They married and had families. They worked, unless their disabilities were so extensive as to make work impossible. In Norwich in 1570 a 70 year old blind baker was still at work, aided by his wife. Life could be very hard indeed, but the idea of segregation or separation was barely considered.

Hospitals and Almshouses – disability in the Tudor institution

In 1485, at the beginning of the Tudor period, institutional care of disabled people was still largely in the hands of religious orders, in the 'spytals' (hospitals) and almshouses run by orders of monks and nuns. While some remained well managed and honestly administered, there were growing concerns about neglect, abuse, building decay and corruption. 'I heare that the masters of your hospitals be so fat that the pore be kept leane and bare enough,' wrote one critic. In 1533 the momentous event of Henry VIII's divorce precipitated a split from the Roman Catholic Church and the creation of the Church of England. Over the next twelve years the process of confiscation of the land, property and assets of the old church, known as 'the Dissolution', took place. Many hospitals, being religious institutions, were plundered and 'dissolved'. This was to have far reaching implications for disabled people.

Hospitals were targeted more by accident than design, caught up in the programme of hostility and plunder against anything which carried the imprint of the 'old religion'. Henry and his ministers appear not to have foreseen that this would lead to destitution for many sick and disabled people. Leading hospitals closed down, among them St Leonards in York, St John Redcliffe in Bristol, Burton Lazars in Leicestershire and in London St Giles Holborn and St Bartholomew's. Bury St Edmunds lost five hospitals, including its leper house, York lost thirteen. The Maison Dieu (almshouse) in Dover became an ale house. As these institutions closed those who lived in them were forced out. Many were left destitute. The King's attention was drawn to 'those miserable creatures which do now daylye dy in the streets for lack of their due porsion'.

There was a public reaction as the 'impotent poor' fought to survive on the streets. There was fear of the significant rise in 'sturdy vagabonds' but also concern for those seen as unable to fend for themselves: 'the pore impotent creatures (had) some relyfe of thyr scrapes, where as nowe they have nothings. Then they had hospitals, and almshouses to be lodged in, but nowe they lye and starve in the stretes'.

At last Henry and his government were pressed into action by the petitions of citizens. In London St Bartholomew's and St Thomas's hospitals were reformed and, with the Royal Bethlem asylum, passed to the control of the Corporation of London. Two new hospitals, Christ's for orphaned children and Bridewell for the 'correction' of 'habitual idlers' opened. These were now public hospitals, funded through donations, parish collections and taxes on companies. Their job was to implement public policy. Surviving hospitals and almshouses often passed to the control of civic authorities.

After the upheaval of the Dissolution, new almshouses and hospitals slowly began to be built again. John Port commissioned the Etwall Hospital in Derbyshire in 1557. Robert Dudley, Earl of Leicester built a Maison Dieu in Warwick in 1571. In 1596 John Whitgift, Archbishop of Canterbury under Elizabeth I, founded the Hospital of the Holy Trinity in Croydon. Coningsby hospital in Hereford was built in 1614 for 'eleven poore ould servitors that have been souldiers, mariners, or serving men'. Hospitals and almshouses were back, but they had become something different – public institutions to look after those seen as not being able to look after themselves. Those who funded them aimed to increase their public image rather than perform good work to ease their passage to heaven. If disabled people were seen as needing support, public duty rather than religion was now the driving factor.

The King's fools – disability in the Tudor court

'As please your Grace' said William Somer the King's fool to Henry VIII, 'you have so many frauditers, so many conveyers and so many deceivers to get up your money, that they get all to themselves.' He should have said 'auditors, surveyors and receivers' and was telling his monarch through this joke that he was being defrauded and exploited by those around him. Few in the Tudor court would have dared speak such an uncomfortable truth to Henry but Somer's humorous banter was much loved by the King. As a fool, he had licence to speak the truth in ways that others could not.

Yet, although well paid, well fed and well clothed in return for his work in Henry's court, Will Somer did not lead the same life as other courtiers. In 1551, some years after Henry's death, a payment of 40s was made to William Seyton, 'whom his Majesty hath appointed to keep William Somer'. Somer needed a 'keeper', a person who would look after and care for him, and was clearly understood not to be able to care for himself. He was, in the language of the period a 'natural fool', a person we would recognise today as having a learning disability.

Henry's previous fool Sexton, known by the nickname Patch (meaning 'fool') was also considered a 'natural' who needed help and support in his life. He had been 'given' to Henry VIII, along with Hampton Court Palace, by Cardinal Thomas Wolsey the Lord Chancellor, who was desperately trying to win back Henry's favour as allegations of treason were made against him. It was recorded that it took six tall yeomen to transport the clearly distressed Sexton to the court. A succession of 'keepers' or carers were paid to look after him and given funds for his needs, such as food, laundry, shoes and 'posset ale'. Clothing was provided for him, rather than purchased by him with his own money. However, like other 'natural fools' in Henry's court, Sexton did not wear the harlequin's motley and cap with bells familiar to us from images of court jesters of this period. He wore high quality cloth and silk doublets and coats, the clothes of a favoured retainer.

Another prominent 'natural fool' of the sixteenth century was 'Jane the fool', who appears to have been the 'woman fool' successively of Anne Boleyn, Henry's second queen; Princess Mary, his daughter; and, from 1543/4, Katherine Parr, his sixth and last queen. Court records show that Jane was expensively clothed at the court's expense and there were eight payments at 4d a time for 'shaving of Jane [the] fool's head'.

Paintings from this time show the prominent positions occupied by 'natural fools' in the royal family. A 1545 painting shows Henry VIII with his 'ideal family' - his long-dead favourite wife Jane Seymour, his son Edward and his daughters Mary and Elizabeth. Will Somer and what is thought to be Jane the fool appear on either side of the painting, flanking the family. Another intimate family portrait shows Somer between Henry and his three children.

These fascinating glimpses of 'natural fools' in the Tudor Court show people with learning disabilities occupying valued and significant roles in the lives of the Tudor elite. Their perceived lack of guile, their directness and their humour were recognised as assets and woven into the fabric of court life. Perceived as closer to God and closer to the truth than other people, they occupied a unique and surprising position.

'This section is based on the research of the historian Dr Suzannah Lipscomb, which she has kindly permitted English Heritage to use. Dr Lipscomb is senior lecturer and convenor for history at the New College of the Humanities, London.'

<http://suzannahlipscomb.com/>

Mental illness in the 16th and 17th centuries

During his dissolution of religious orders Henry VIII seized the Bethlem Hospital in London, England's only asylum for the mentally ill. However, shortly before he died in 1547 he transferred its control to the Corporation of London, making it a civic, rather than religious, institution. In 1574, the City Aldermen, struggling to keep it running, handed its management to the Bridewell, a hospital established for the management of the 'idle poor'. The Bethlem at this time could only admit a maximum of 40 people, and was often only half full. The new governors had a strict admission policy, accepting only those people who were 'raving and furious and capable of cure, or if not yet are likely to do mischief to themselves or others'.

In 1619 Helkiah Crook became the first medically qualified 'keeper'. He was a controversial character who had accused the previous keeper of irregularities and who was constantly at odds with the Royal College of Physicians. His appointment indicated that, at an elite level, treatment of mental illness was starting to be seen as a medical skill rather than a matter for lay people using traditional methods. Sadly his medical qualification was all that distinguished him from previous keepers. A Royal Commission in 1632 found that he had been falsifying accounts and stealing donations while neglecting food and basic comforts for his patients. He was dismissed in 1633. His influence, however, was long-lasting. The medicalisation of Bethlem's mental health care was now accepted as the norm. The hospital would, from now on, always be run by a medical officer with a team of medical staff.

It was only the handful of people living in Bethlem who were receiving any sort of institutional care in the 16th and early 17th centuries. In a population of five million this meant that large numbers of mentally ill people remained in their communities, usually cared for by their family. Some were on the streets – mentally ill beggars were nicknamed 'Tom o'Bedlams'. In the eyes of the law they lacked the capacity to reason, and a Court of Wards would allocate responsibility for management of their affairs. On the whole they were not exploited through this system. King James I (1603-1625) instructed the court that 'lunatics be freely committed to their best and nearest friends, that can receive no benefit by their death.' The care of the mentally ill was a domestic matter.

Tudor England had a vibrant medical marketplace from which illness, including mental illness, could be treated. Most could not afford the services of a physician or surgeon, but there was an array of other practitioners – bone setters, 'wise women', 'cunning men', herbalists, astrologers – offering treatments. Mental illness could be seen both as a natural and supernatural event, a sickness or something caused by devils or astronomical events. People had no difficulty holding these different explanations simultaneously. Richard Napier was a clergyman, medical practitioner and astrologer who treated thousands of patients worried about their mental health between 1597 and 1634. Servants, beggars, butchers, university dons, lawyers and nobility flocked to his practice in the hamlet of Great Linford in Buckinghamshire. Their symptoms included suicidal thoughts and self-harm, refusal to pray, inability to feel pious, sexual urges, visions, weeping, 'too much talk' and 'hatred of spouse'. Using religious, psychological, astrological and traditional healing remedies, Napier

treated them all. Response to mental illness at this time could be as much about listening and humane intervention as incarceration in a building or ill-treatment.

Marriage, work, family and war – the daily life of people with disabilities in the 16th and 17th centuries

When Thomas Bone married Sara Earle in St Botolph, Aldgate, London in 1618 it was an unusual occasion. Thomas, a blacksmith, was a ‘dumbe person’ and indicated his willingness to marry Sara by making ‘the best signes he could, to show that he was willing to be maried’. Permission had been given for the ceremony to go ahead after the Lord Chief Justice had agreed that a marriage could be solemnised without the vows being spoken by one of the parties. Thomas Bone therefore gives us the first known English wedding conducted in sign language.

25 years later, in 1643, another deaf man made his mark on history. As the Civil War reached Lichfield in Staffordshire, John Dyott, nicknamed ‘dumb Dyott’, was part of the Royalist forces defending the town against an assault by Oliver Cromwell’s parliamentary forces. From the battlements of the central cathedral spire a bullet fired by Dyott killed the commanding officer of the parliamentary army, Lord Brooke. Dyott was led back into the town to a hero’s reception from the people of Lichfield.

In the crowded and unhealthy cities of Elizabethan England, disabling conditions were very common. The city of Norwich conducted a ‘census of the poor’ in 1570. Information was gathered about the lives of 1,400 of the poorest people in the city. Among them were 63 disabled men and women who had ‘lameness’ or ‘crookedness’ of the arms or legs, missing limbs, blindness or deafness. Their lives were surprising. Although poor, many were in work. The women were spinners or knitters, some of the ‘lame’ men were labourers. William Mordewe, a blind baker, was still working at the age of 70, aided by his young wife Helen. Almost all of the disabled men, and most of the disabled women, were married to non-disabled people, and many had children. Their marriages were stable and long lasting, (although two disabled women were identified as ‘harlots’). Disabled people, though often poor, were very much part of family life and work and lived in the heart of their communities.

People we would recognise today as having learning disabilities also lived in their communities rather than in institutions. Known as ‘natural fools’, innocents’ or ‘ideots’, the expectation was that they would live with their families and work if possible. If the families were struggling through ill health or extreme poverty then parish relief might be paid. When Alice Stock, in the parish of St Botolph Bishopsgate, London, became aged and lame, she received 6d a fortnight to care for her ‘foolish girle’ Martha. If family care broke down or parents died, then ‘keepers’ or ‘nurses’ in the local community would be paid to care for people. John Shusock of Wapping, London, was paid 2s 6d per week from 1649-53 to ‘keep’ the ‘innocent’ Thomas Walker, with extra payments for ‘clothing and other necessaries’.

Attitudes to disabled soldiers changed over this period. Horrified at the sight of wounded men left to die on the streets, senior officers agitated for hospitals, sick pay and pensions for those discharged with disabilities. A small hospital for ‘maimed soldiers’ was founded in Berkshire in 1599, the precursor to much grander efforts in Chelsea, Greenwich and elsewhere in the later 17th century. In Elizabeth’s reign acts were passed to provide pensions for soldiers and sailors who had ‘lost their limbs or

disabled their bodies'. The 'Chatham Chest', established in 1590 to pay pensions to disabled seamen, has been described as the world's first occupational health scheme.

Section 3

Disability from 1660-1832

The Long Eighteenth Century

Disability from 1660 to 1832: hospitals, schools, madhouses and Billies in bowls

In what is sometimes called the long eighteenth century, from the restoration of Charles II to the Great Reform Act of 1832, important shifts took place in the understanding of disability. English society continued the move to a less religiously-dominated outlook that had begun in the Tudor period. While the idea that disability and madness had some sort of God-given or astrological cause did not disappear entirely, it diminished in importance and there were new explanations.

Madness came to be seen more as a loss of reason than some sort of possession of the soul and so, with the right treatment, reason could be restored. Disability was seen more as a misfortune than a divine message. It was therefore worthy of charity, a part of the Christian and civic duty to ease the suffering of the poor. Disabled people generally saw themselves as part of their communities, who would marry, work and support themselves if they could, and were entitled to the help of the better off if that proved impossible. For the most part support for people with disabilities was seen not as the duty of the state but as the charitable duty of the individual. The parish might step in with poor relief but for this to happen disability was not sufficient in itself – you had to be destitute as well. As a disabled person you belonged to society, but you were subject to its potential for harshness and brutality like everyone else.

Important social and cultural changes were taking place. London, a booming, rapidly expanding global city, wanted to show off its wealth and power. A massive building programme took place after the Great Fire of 1666 including grand new hospital buildings, established with the wealth of traders and merchants. The first hospital to benefit was the Royal Bethlehem asylum which moved to a commanding new building in Moorgate. Provision for disabled soldiers and sailors followed soon after with the Royal Chelsea and Greenwich hospitals. Some reacted against what they saw as these ostentatious displays of wealth and a voluntary asylum movement sprang up, based on a belief that the disabled and the mentally ill could flourish in healthy, clean institutional settings. Quakers in York created the York Retreat, their own modest, gentle, asylum regime. Alongside all this emerged that unique English institution the private madhouse, ordinary houses catering mainly for the mentally distressed of ‘the better sort’. A belief in civic order and progress spawned many new institutions. The charity school movement for education of poor children was followed at the end of the century by the first specialist schools for ‘deaf and dumb’ and blind children.

Despite all this, most people with any sort of disability continued to live in their own homes and communities, at all levels of society. They included disabled beggars (Billies in bowls), distinguished deaf portrait artists and ‘Peter the Wild Boy’ or (as Daniel Defoe called him) ‘the young forester’, plucked naked from the forests of Hanover to the court of George I at St James. He caused a sensation, at least for a year. In a population of around nine million people at the end of the eighteenth century, probably less than 10,000 lived in some sort of institution. Imperceptibly though, the notion of the institution as the ‘right place’ for people who are ‘different’ had begun to insinuate itself into the public consciousness. A steadily increasing range of specialist buildings was in place. As a new era beckoned, life for many people with disabilities was about to become very different indeed.

The rise of the hospital for disabled people

From the small centres of religious care and refuge of the medieval period, hospitals by the late seventeenth century had come to be seen as something far grander. They existed to be charitable and to protect public health – but also to express new ideas of public order and progress, particularly in the rapidly expanding capital of London. This had implications for the disabled people of England.

Following the great fire of 1666 a London hospital rebuilding programme was launched to display the city's wealth and prestige. Surprisingly, this was led by the poor relation of the five London hospitals – the much discredited Royal Bethlehem, or Bethlem, London's 'asylum for the mad'. Though the old building was undamaged by the fire, the Governors had concluded by 1674 that it was 'too weak and ruinous' and too small to meet demand. By 1676 a new building had been constructed in Moorfields, designed by the eminent scientist and architect Robert Hooke. Light and airy with landscaped gardens sweeping from the front entrance, it was designed to inspire awe and admiration and could house 120 people. One Londoner wrote '*so brave, so neat, so sweet it does appear / makes one half-mad to be a lodger there*'.

The Bethlem's example inspired others. Charles II was keen to emulate Louis XIV's great *Hôtel des Invalides* military hospital in Paris and work began on Christopher Wren's Chelsea Hospital in 1682. By 1691 this building for disabled and aged soldiers was complete, followed in 1694 by the Royal Hospital at Greenwich for disabled and aged navy veterans. These were the prelude to a century of naval hospital building - Haslar (1762), Plymouth (1762), Deal (1795) and Great Yarmouth (1811). In 1721 Guy's Hospital in London opened its doors, built for the incurably sick and chronic lunatics.

Some reacted against what they saw as the 'vain magnificence' and merchant-wealth extravagance of these buildings. A lively charitable movement began which sought to pursue the social aims of supporting the sick and disabled poor above the grandeur of buildings. In 1712 the charitable Bethel Hospital for lunatics was built in Committee Street (later Bethel Street), Norwich. In London, as often in the history of Bethlem, it was not so much the building as those that ran it that caused distress to its residents. By 1750 the acquisitive Monroe family of 'mad doctors' was in charge. With paying visits from the curious public, restraints and purges it was once again in public disrepute. St Lukes, a rival, charitable asylum for pauper lunatics was built nearby in Old Street, London, with a magnificent classical frontage. Run by the eccentric physician William Battie it advocated (but did not always achieve) a system of non-restraint, occupation, fresh air and good food and rejected the Bethlem-type regime.

Other voluntary hospitals sprang up. Small scale asylums housing around 100 people were built in Manchester (1766), Newcastle (1767) York (1777) and Liverpool (1792). Voluntary did not always mean good, however, and York became notorious for corruption and abuse. In 1796, the Quaker community, led by William Tuke, chose to establish their own asylum, the York Retreat in Bootham. 'Medical' treatment was replaced by 'moral' means – kindness, reason and humanity in a family atmosphere, with no restraint. The Retreat became famous around the world. In England the foundations were in place for the era of the asylum and the institution.

The age of the madhouse - home of the well-attired ploughman

A unique feature of English society in the eighteenth century was the private madhouse. Madness was coming to be seen as the loss of a person's reason, rather than a defect of their soul or their body. It could be restored through 'moral treatment'; gentle discipline, order and well-intentioned manipulation. And what better place to do this than in the orderly, well managed institution of a small private madhouse, with its family atmosphere and controlled environment?

Rarely purpose-built, by the end of the century there were around 45 of these officially licensed private dwellings adapted for the accommodation of 'the mad' around the country. They catered largely for better off residents, particularly the smaller houses which charged the highest fees and accommodated only five or six people. There were a few larger houses which housed some 'pauper lunatics' paid for by the parish. In such establishments living areas for paupers and private patients were strictly segregated and of widely differing quality.

From the 1790s at the very select Ticehurst House in Ticehurst, Sussex patients could bring their own servants, some lodging in their own dwelling in the grounds of the large house. A pack of beagles was kept so that gentleman patients could enjoy the hunt. Work was very important for the restoration of reason. At the Greatford Hall madhouse in Greatford, Lincolnshire run by Dr Frederick Willis, famous for treating George III, 'the unprepared traveller.... was astonished to find almost all the surrounding ploughmen, gardeners, threshers, thatchers and other labourers attired in black coats, black silk breeches and stockings, and the head of each *bien poudrée, frisée et araignée* (well powdered, curled and styled). These were the doctor's patients'. Many homes advertised their extensive gardens, or pleasure grounds, which were often walled to prevent wandering. The better houses might have a bowling green, a small library and indoor games like bagatelle.

Behind the high ideals and optimism, there was disquiet about treatment in these private institutions and standards varied widely. In 1763 *The Gentleman's* magazine condemned the 'many unlawful arbitrary and cruel acts' which went on in madhouses. At Lainston House near Winchester private patients resided in the mansion but paupers were kept in converted stables and outbuildings. The home was closed in 1847 for mistreatment of its paupers, who had been left chained in cold and filthy conditions. In 1846 there was a public enquiry into ill treatment and corruption at Haydock Lodge, Winwick in Lancashire. By 1851 it was shut down.

The proprietors, known as mad doctors, were a varied group and not necessarily medically qualified. They had little social or professional status and included clergymen, quack doctors and family dynasties. Medical qualification bore little relation to quality of care. This depended more on the charitable instincts and motives of the proprietor, like those who ran the more reputable institutions such as Brislington House in Somerset and Laverstock House near Salisbury. From 1774 the Regulation of Madhouses Act introduced a licensing system, following public concern that some non-lunatics were being unlawfully detained at the whim of their spouses or families. With the growth of state-managed county asylums in the nineteenth century the private madhouse declined, although several survived in some form through to the 20th century.

Specialist education for children with disabilities – ‘the happiest effect’

Although a thriving charity schools movement providing education for the children of the poor took off in the first half of the eighteenth century, it did not include children with disabilities. Those from better off families could enjoy private tutoring or take their chance in mainstream school, but the disabled children of the poor were unlikely to receive an education.

In Gloucestershire Thomas Arrowsmith, (1771- c1830) who was born deaf, was taken aged 4 or 5 by his mother to the local village school where she demanded that he be educated. Despite the misgivings of the teacher he was admitted and did well. He then became a pupil in England’s first special educational provision for the deaf – Braidwood’s Academy for the Deaf and Dumb in Grove House, Hackney, on the eastern edge of London. Thomas went on to become a well-known painter, studying and exhibiting at the Royal Academy, the first of a number of distinguished graduates of the Braidwood Academy.

Thomas Braidwood (1715-1806) set up the academy in London in 1783, having run a successful school in Edinburgh since 1760. He used a form of sign language known as the combined system (later known as the Braidwoodian system), which was the forerunner of British Sign Language. He had dreamed of setting up a public school for poor deaf children. However it was one of his pupils, John Creasy (c1774-1855), who inspired and persuaded his local Reverend to raise money to build the London Asylum for the Deaf and Dumb in Bermondsey in 1792. This was the first ever public school for the deaf in England. A former pupil, William Hunter (1785-1861), later became Britain’s first deaf teacher of the deaf. This had, said the head teacher ‘the happiest effect’ of a deaf teacher communicating with deaf pupils in their own manner.

Meanwhile a young man from Liverpool, Edward Rushton (1756-1814) survived a sinking on a slaver ship heading for Dominica. Outraged at the brutal treatment of the slaves on the ship, he was charged with mutiny after remonstrating with the captain. He tried to assist the slaves with food and water. Many of them had caught the highly contagious ophthalmia and he contracted the disease himself, losing the sight in one eye and becoming virtually blind in the other. On his return he became a poet, anti-slavery campaigner, newspaper editor and general supporter of radical causes. However his most lasting legacy was the Liverpool School for the Indigent Blind, in London Road, which opened in 1791. It was the first specialist school for the blind in the country, second in the world only to Paris. Pupils were taught music, weaving, basket making, spinning and other trades to equip them for economic survival and independence after school. The school survives today (in a new location) as the Liverpool Royal School for the Blind. Inspired by Rushton, blind schools were built in Bristol (1793), London (1799) and Norwich (1805).

It was inspirational blind and deaf people like John Creasy, William Hunter and Edward Rushton who fought for the idea that young deaf and blind people had the right to an education. Through their actions they showed just what that education could achieve.

The lives of people with disabilities in eighteenth century England

While buildings for people with disabilities increased over this period, the vast majority of disabled people lived their lives in family homes or on the streets and in the workplaces of their communities. They lived at all levels of society, from the meanest dens of vagabonds to the circles of the elite and the royal court.

Disability could often mean destitution, as most people's livelihoods depended on the ability to do hard physical work. The numbers of disabled beggars on the London streets was remarkable - urban pedestrians were warned in 1716 to beware of crossing Lincoln's Inn at night, for fear they would be knocked down with the crutches of beggars. The halt, the blind, the lame were everywhere, as were the unusual methods they used to make themselves mobile – 'Billies in bowls', 'go cart' and 'sledge-beggars' formed a whole sub-section of the vagrant community. Legless 'Philip in the tub' roamed the streets seated in a hollowed out wooden tub, propelling himself with two small wooden blocks, selling ballads at weddings. The Foundling Hospital in Bloomsbury, London and other institutions taught blind children to play a musical instrument and a blind violinist beggar was a common daily sight. In desperation some people turned to whatever way they could find to survive – the prostitute Elizabeth 'Betty' Steel (1764-1795) was, in 1787, the first deaf person transported to Australia – she had assaulted and robbed her (deaf) client in a pub in notorious Black Boy Alley, Holborn, London.

However, many did not live lives of destitution. Often, people with learning disabilities – categorised as 'idiots' in this period – held down jobs and lived within networks of family and friends. In 1780 a young learning disabled man, Thomas Baggot, who collected animal skins for making leather at Newgate market in the City of London, was saved from the hangman's noose when his employer, work mates and family all gave (contradictory) evidence that he had not participated in the anti-catholic Gordon riots, despite others testifying that he had.

In the golden age of portrait painting at the end of the 18th century three remarkable deaf miniaturists, Richard Crosse (1742-1810), Sampson Towgood Roch (1759-1847) and Charles Shirreff (1750-1831) flourished as high society artists in London and Bath. Crosse became court painter in enamel to George III. Lord Nelson (1758-1805), with one arm and sightless in one eye, led the British fleet and the deaf artist Joshua Reynolds (1723-1792) was the first president of the Royal Academy. Disability reached into the royal court at St James. Duncan Campbell (1680-1730), presented to George I in 1720, was a deaf and dumb man who worked as a 'professional predictor', or clairvoyant, communicating with his clients by writing, gestures or finger spelling. 'All his visitors come to him full of expectations', reported the Tatler, 'and pay his own rate for the interpretations they put on his shrugs and nods.'

In 1726 'Peter the Wild Boy' (now believed to have had the genetic condition 'Pitt Hopkins') was brought to the court of George I at St James. He had been found, aged about 12, in the forests of Hanover naked and unable to speak. His behaviour caused a sensation at court – he was an inveterate pickpocket and was rumoured to have taken the Lord Chamberlain's staff and put on his hat before the King. He fascinated public and intellectuals alike, who debated whether nature or learning makes a person human. He was adopted by the royal household but within a year interest waned. He

lived till his death in his 70s supported by families at two farms, Haxters End and Broadway, near Berkhamstead in Hertfordshire. He is buried in nearby Northchurch. The only words he ever learned to say were 'Peter' and 'King George'.

Section 4
Disability from 1832-1914

The age of the asylum, and the ‘brave poor things’: disability in the 19th century

If any period can be called the age of the building for people with disabilities it is the nineteenth century. The appearance of England was changing dramatically as the industrial revolution gained pace and new towns, factories, railways and mills ate into the rural landscape. Alongside these changes came other new and strange sights.

Outside the towns and cities, there were the high walls and the towering chimneys of the county pauper lunatic asylum. ‘From any of the great main lines of railway which run through the shire’ proclaimed *The Builder* magazine in 1892, ‘a traveller will be sure to spy, in some comparatively secluded position, a great group of buildings, which by their modern air ...their tall chimney stacks and ... their bulky water tower, seem to belong rather to the busy towns than to country seclusion.’ This was the image of these new asylums that the 19th century person saw; something distant, something to marvel at, but not a place where they would ever want to live.

Then there were the monotonous, forbidding facades of the workhouse. After the 1834 Poor Law Act 350 of these were constructed at an average distance of 20 miles from each other. There had been workhouses previously, but of a more humane design and offering some assistance to the destitute disabled as well as services for the local parish. From 1834, the new workhouses were designed to punish the ‘workshy’. Soon many of them were not housing the able bodied poor, who avoided them if they could, but the disabled and the mentally ill. With their spartan conditions and punitive work regimes, they were, intentionally, a miserable environment.

Why was there this great migration from the community into specialist buildings? At the beginning of the 19th century a few hundred people lived in nine small charitable asylums. By 1900 more than 100,000 ‘idiots and lunatics’ were living in 120 county pauper asylums, average intake almost 1,000. A further 10,000 were in workhouses.

The workhouse was seen as a regime which would root out ‘shirkers and scroungers’. No one should be given financial relief in their own home as this would make them lazy. Relief would only be given to the truly destitute, and that in a workhouse which they would be only too happy to leave. They did not foresee the impact this would have on the disabled and mentally ill population. The asylum, by contrast, was seen as a haven of peace, tranquillity and ‘moral treatment’ which would enable patients to recover. A new class of medical professional, the ‘alienist’ (later to be known as psychiatrist) claimed that interventions in the asylum would cure and restore. But by the end of the century the ‘therapeutic optimism’ of the alienists had changed to pessimism. Most people were deemed ‘incurable’ and never left the asylum, now seen as a building of containment for ‘chronic’ and dangerous cases.

Even as these great shifts took place many disabled people somehow remained in their communities. Accompanying the growth of asylums and other buildings was a rise in special educational provision and an explosion in charitable organisations and activity aimed at people with disabilities. While some begged on the streets others prospered. The blind Henry Fawcett became postmaster general in 1880. Young disabled people formed a self-help group. In the style of the time, they called themselves the Guild of the Brave Poor Things, their coat of arms a sword crossed with a crutch. The battle for respect and acceptance continued.

A parallel world – the growth of the asylum

The asylum age arrived with a bang in the 19th century. Until then it had been accepted in English society that people with disabilities or illness who needed care and support got it from family, friends and community. Now reformers claimed that an asylum would be a safe place where ‘lunatics’ could be cured and ‘idiots’ taught.

Beginning with nine voluntary institutions, the asylum movement rolled across the nineteenth century English landscape like an avalanche gathering pace. The ‘mentally unsound’ were moved in ever greater numbers from their communities to these proliferating institutions. From 1808 parliament authorised publicly funded asylums for ‘pauper lunatics’, and 20 were built. From 1845 it became compulsory for counties to build asylums, and a Lunacy Commission was set up to monitor them. New buildings sprang up at breakneck pace. By the end of the century there were as many as 120 asylums in England and Wales housing more than 100,000 people.

There were three main types of asylum. The ‘conglomerate’, a hodgepodge of miscellaneous structures (Suffolk County Asylum), the ‘corridor’ type, with wards connected by corridors up to a quarter of a mile long, (Colney Hatch in Middlesex) and later the ‘pavilion’ type, with rows of female and male blocks each housing 150-200 patients (Leavesden near Watford). Styles ranged from classical Greek to Gothic.

Entering through the large gates past the porter in his lodge, the visitor’s eye would be caught by the looming water tower at the centre of the grounds and the chapel. Clustered around the tower were the kitchens, laundries, workshops, recreation hall and administration block. On either side were the wards, with the sexes rigorously separated. Each ward housed up to 100 people. As many as 50 patients slept in one dormitory, their beds close together. They had day rooms for relaxation and large communal dining halls. Male and female attendants, as strictly segregated as their patients, worked and lived their lives on the site, often for generations.

Asylums were a self-contained world. In their rural settings, their grounds were designed by some of the finest landscape gardeners. High walls prevented escape. The grounds contained farms, orchards, workshops, bowling greens, croquet lawns and cricket pitches. Walled gardens with shelters where patients could safely exercise, known as ‘airing courts’, led off the wards. There was always a cemetery. Some asylums even had their own railway stations, with a branch line into the grounds. The five asylums known as the ‘Epsom cluster’ in Surrey had their own light railway and rolling stock. There would often be an asylum fire brigade, with its own fire engine.

The number of people certified as ‘insane’ soared. The asylum created demand for its own services. Less and less people ever left, and more and more arrived. In 1806 the average asylum housed 115 patients. By 1900 the average was over 1,000. Earlier optimism that people could be cured disappeared. The asylum became simply a place of confinement. New wings and stories were constantly added until eventually a second or even third County Asylum had to be built in many areas. In London there were eleven. In 1866 the physician Sir George Paget hailed the asylum as ‘the most blessed manifestation of true civilization the world can present’. 130 years later one historian described them as ‘museums for the collection of the unwanted’. The strange parallel world of the asylum has always stirred strong emotions.

Daily life in the asylum

In 1854 most of the 298 'lunatic and idiot' patients of the Norfolk County Asylum assembled in the grounds. It was time for drill. Responding to barked commands from nursing staff, they marched around the 30 acres surrounding the asylum. 'Great control is gained over the patients', commented a lunacy commission inspector, 'and the task of taking a vast number ...for air and exercise becomes comparatively easy.'

The asylum day was long, rigorously organised and highly controlled. At the Liverpool Asylum the bedroom doors of patients were unlocked at 6.00am. Patients were washed, their hair brushed and the state of their skin examined. At 9.00am, following breakfast, they were to be taken to the 'airing courts' and gardens while the wards were cleaned. At the Buckinghamshire County Asylum the focus was on work, preferably out of doors. For the men it was gardening and husbandry, for the women 'occupations suited to their ability' such as light hoeing and sorting potatoes. At the first Middlesex Asylum in Hanwell, London, patients were encouraged to keep small allotments to aid recovery. On the adjacent canal, produce from the asylum gardens was loaded onto barges at the 'asylum dock' and shipped to the London markets to generate income. Asylum diet was better than in many working households, with fish or meat and vegetables for lunch, and bread and cheese supplemented by beer, cocoa and tea. Bedtime was at 8.00pm, with long rows of beds two feet and six inches apart.

In 1851, the year of the Great Exhibition, Prince Albert opened the second Middlesex County Pauper Lunatic Asylum in Colney Hatch, north of London. With its Italian style, six miles of corridors and capacity for 1,000 people it was the very model of modern asylum design. It had its own gasworks, brewery, farm and even an aviary breeding canaries. Its catchment area was north and east London. Within 15 years 2,000 people were living there, including many from the large, impoverished Jewish community in London's East End. A kosher kitchen was installed and a Jewish cook employed. An interpreting attendant was recruited for the many Yiddish speakers. Craft workshops were managed by local artisans. Patients' boots and clothing and staff uniforms were made on site in tailoring workshops. There was also bookbinding, carpentry and mat making. 150 women worked in the laundry. Patients kept canaries as pets and cats roamed the estate, used as vermin hunters. Within 50 years Colney Hatch had become effectively a small, overcrowded, enclosed town, with all the bustle and drama of the multicultural London streets that supplied it with its patients.

Life had its own daily and seasonal rhythms. At the Buckinghamshire Asylum the chaplain would perform the Church of England service every Sunday, Christmas Day and Easter. There were Christmas parties and patient dances. Institutions even marked their own histories – the Sussex asylum celebrated its fourth anniversary with a grand ball in 1863. Momentous national events were celebrated. The coronation of George V, Victoria's grandson, took place on 22nd June 1911. World War I was just three years away. At the Western Counties Idiot Asylum at Starcross, near Exeter, the day began with the inmates performing a 'Trooping the Colour' spectacle. After a day of celebration, as night drew in, the buildings of the asylum were illuminated and a flag drill was performed, accompanied by the fifes and drums of the asylum Boys Band.

The asylum movement was in robust health, and had a further 70 years of life in it yet.

‘Asylums in everything but...’ - the changing face of the workhouse

The workhouse at the dawn of the nineteenth century was a very different place to the later institution that would come to occupy such a strong place in popular memory. Although shunned and dreaded by many it was a gateway to various means of support for the disabled and destitute. It was seen as a sort of all-purpose parish institution combining emergency ward, orphanage, geriatric ward and home of last resort. Used for parish business and meetings, it also housed the parish fire engine and morgue. Most had a ‘shell’ (a form of stretcher) to collect accident victims, and dispensaries to treat disabled and sick residents. Living arrangements, if spartan, were relatively informal, with able-bodied and disabled people living together. They could be built on a domestic scale, like the parish workhouse in Aldenham, Hertfordshire, or with considerable style, like Gressenhall in Norfolk and the Harrogate workhouse – the so-called ‘pauper palaces’.

The nature of the workhouse changed suddenly and rapidly with the introduction of the Poor Law Amendment Act in 1834. The idea of this new legislation was that from now the ‘idle’ able-bodied would be made to work in the workhouse. The system would be deliberately harsh with minimum comfort (chairs were to be made backless, to avoid ease of sitting), basic diet and separation of the sexes. Husbands and wives would live apart, as would parents and children. The theory was to punish the workshy so that only the truly destitute or incapable would accept relief. In the five years after the act some 350 new workhouses were constructed, at a distance of roughly 20 miles from each other. A further 200 were built before the end of the century. The architects George Gilbert Scott and William Moffatt criss-crossed the country on horseback in the 1840s, picking up workhouse commissions. Their designs, based on standard model plans, excluded any sort of extravagance, were sited on the edges of towns to avoid offence to the citizens and aimed for a standard below the average labourer’s cottage, so as not to be too attractive to the destitute. Segregation was strict, diet meagre, work punitive.

The consequence was that soon many workhouses were housing not the able-bodied poor but the old, the sick, the mentally ill and those with physical or learning disabilities deemed unable to work. In 1835 the Birmingham workhouse established purpose-built wards for ‘insane’ residents. The Leicester workhouse segregated ‘idiots and lunatics’, providing specialised nursing attendants. By 1837 more than 8,000 ‘idiots and lunatics’ were under the care of parishes. Workhouse staff struggled to care for them. In 1854 the master of the Southwell workhouse, Nottinghamshire, complained about a suicidal lunatic resident. The only way they could control the ‘poor creature’, he claimed, was to beat him around the toes and the head with a stick.

In 1856 the Lunacy Commission commented that the huge insane wards in some workhouses were asylums ‘in everything but the attendance and appliances which insure...proper treatment’. But the asylum building programme of the period was intended only for those who could be cured or who were disruptive. This excluded ‘harmless and incurable idiots’, 10,000 of whom remained in the workhouse. Gruel, bread and cheese formed the diet, with soup or meat and potatoes once a week. Water was the only drink (with tea a privilege for the elderly). Women made sacks or worked in the kitchen and laundry. Men chopped wood or ground corn. Renamed as public assistance institutions, the last few workhouses would linger on until 1948.

The daily life of disabled people in Victorian England – community, school and charity

‘Some boys laugh at poor cripples when they see them in the street’, observed a religious advice pamphlet for children in 1848. ‘Sometimes we meet a man with only one eye, or one arm, or one leg, or who has a humpback. How ought we to feel when we see them? We ought to pity them.’ The writer had a sting in the tail for the jeering boys. While cripples might be made ‘bright and beautiful’ by God on judgement day, wicked able-bodied children who laughed at them could be ‘burned in a fire that will never be put out.’ These were the ambivalent Victorian attitudes towards disability - a combination of fear, pity, discomfort and an idea of divine judgement.

The pull of the asylum and the workhouse was strong, but many thousands of people with disabilities remained in their communities. The social investigator Henry Mayhew described the disabled beggars of the London streets in 1862, including the ‘idiotic looking youth...shaking in every limb’ or the ‘crab-like man without legs strapped to a board (who) walks upon his hands’. Some prospered. James ‘deaf’ Burke (also known as ‘the deaf un’) rose from poverty to become a world champion prize fighter. Henry Fawcett, blinded as a young man, became Postmaster-General in 1880, introducing the parcel post and the postal order.

Educational provision for children and young people with disabilities grew rapidly. Literacy and education began to be seen as equally important as traditional vocational training. In 1838 the London Society for Teaching the Blind to Read was formed. In 1866 the Worcester College for the Blind (‘for the blind sons of gentlemen’) became the world’s first further education provision for disabled people. In the 1890s local authorities were empowered to set up day schools for blind, deaf, ‘defective’ and epileptic children. By 1899 there were 43 such schools in London alone, teaching 2,000 children – life in the asylum was not the inevitable route for everyone.

The Victorian era also saw a huge explosion in charitable activity. By the end of the century there were hundreds of organisations providing community or institutional services to disabled people. In 1868 the British and Foreign Blind Association was formed by Dr Thomas Armitage, initially to promote the use of Braille. It was to become the Royal National Institute for the Blind. There were charitable bodies for the blind, the ‘deaf and dumb’, ‘lunatics’, ‘idiots’, ‘epileptics’ and ‘the deformed’. They offered education (The Association for the Oral Instruction of the Dumb), work (Liverpool Workshops and Home Teaching Society for the Blind), hospital treatment (National Hospital for the paralysed and epileptic) and many other services.

Many disabled people simply soldiered on purposefully in their communities. In 1894 the first branch of the Guild of the Brave Poor Things (motto ‘*Happy in my lot*’) was formed, a self help group for people with physical disabilities. They described themselves as a group to ‘make life sweet for the blind and crippled folk of all ages’. Conveying a sense of pride and solidarity, they used popular military imagery of the period to create positive feelings about their disabilities, referring to themselves as ‘a great army of suffering ones’. Their annual report in 1902 described how they ‘go out daily into a battle-field, where pain is the enemy to be met and overcome.’ Outside the walls of the nineteenth century asylum, the daily battles for survival, fame or simple respect were fought in the towns and cities of England.

Section 5

Disability from 1914-1945

War, segregation and the struggle of daily life – disability from 1914-1945

‘What are we going to do? Every defective man, woman and child is a burden. Every defective is an extra body for the nation to feed and clothe, but produces little or nothing in return.’ So wrote, in 1930, Julian Huxley, public intellectual, secretary of the London Zoological Society and chairman of the Eugenics Society. He was not alone. Many public figures embraced the idea of eugenics, the need to ‘manage the human stock’ and avoid, as birth control pioneer Marie Stopes called it, ‘race suicide’. The aim – which appealed to the political left and right - was to strengthen the human race, eliminating physical and mental defects to build a better society. Human perfectibility was very much part of the currency of early 20th century thought.

There was an uneasy tension between two ways of thinking about disability, as the legacy of the Victorian asylum came up against the new realities of the twentieth century. On the one hand there was the threat to the ‘health of the nation’ from anyone considered disabled or ‘deficient’. This called for isolation and segregation. On the other hand, almost two million newly disabled British ex-servicemen had come home from the battlefronts of World War I. The presence of these young heroes, who had sacrificed their bodies for the nation, demanded a different way of thinking.

This sudden influx of disabled people had a profound impact on society. There were improved prosthetic limbs and advances in plastic surgery. Exercise and fitness approaches to repair both physical and mental damage were introduced. Employers were urged to accommodate disabled workers into their factories and businesses and a network of sheltered employment initiatives sprang up, including the British Legion poppy factory in south London. New housing was built for disabled ex-servicemen, ranging from single cottages to entire special villages.

However these changes did not always spread to the civilian disabled population. For the ‘mentally deficient’ – people we would recognise today as having learning disabilities – a new network of ‘colonies’ was established. These were self-contained small worlds set in rural areas. As well as the 60 person ‘villas’ which housed the large numbers of men, women and children who lived there, there were farms, laundries, bakeries, recreation halls, chapels and mortuaries. Segregation by sex, age and ability was strict and separation from the outside world was the main aim.

Between 1900 and 1945 up to half a million children had some sort of physical disability or sensory impairment. Many of them were from the working class, the diseases and problems of poverty and the absence of immunisation contributing to the high prevalence of disability. Life both at home and at school could be difficult. Many families lacked resources for specialist equipment or treatment. Education became a right, but school regimes for ‘crippled’, blind and deaf children could be harsh and punitive. However, some pioneered new approaches. These included progressive ‘Sunshine Homes’ for blind children and the phenomenon of the ‘open air’ school, believed to improve the health of disabled children. Many children were trained for low-skilled work, in the belief that they would be lucky to secure any sort of job at all.

Another war came in 1939. An urgent shortage of manpower arose. The Ministry of Labour launched a recruitment drive amongst those previously considered unemployable. Life for people with disabilities was about to change again.

War and its impact on disability

The human toll of World War I was appalling. Not only had almost one million British servicemen been killed, but almost two million had become disabled as a result of their wounds. The challenge to society was immense. There was an impact on a whole range of disability issues: rehabilitation, housing, employment, rights and entitlement.

Queen Mary's Hospital in Roehampton, London, became in 1915 the main English limb-fitting hospital for ex-servicemen. More than 40,000 lost one or more limbs during the conflict. Swamped by demand, the number of beds increased throughout the war. The Disabled Society, a war charity, agitated for lighter artificial limbs: light aluminium replaced heavy wooden legs and arms. Queens Hospital, Sidcup, in Kent, was a centre for facial surgery under the pioneering plastic surgeon Sir Harold Gillies. The artist Francis Derwent-Wood worked there and applied his skills with burned patients to make masks concealing areas that surgery could not restore.

Rehabilitation through exercise and sport became important. At the Croydon Union Workhouse Infirmary (later the Mayday Hospital) in Surrey, Colonel Deane established his gymnastic exercise centre for rehabilitation of disabled ex-servicemen. At St Dunstan's, a large property in 15 acres of Regents Park, central London, 1,833 blinded ex-servicemen passed through, recuperating, learning skills and exercising. A grateful public visited and 'made a fuss' of the men, accompanying them to theatres and concerts. The Star and Garter home for disabled soldiers and sailors opened in 1916 in Richmond, Surrey with a sister home in Sandgate on the Kent coast. Rehabilitative work training included a poultry farm known as No-Man's Land.

Work and housing were particular concerns. The 'King's National Roll' was a 1919 scheme encouraging firms to employ disabled ex-servicemen, but its success rate was low. In 1927 a training school for war-disabled taxi drivers was set up in London. However, for the most part, disabled people remained on the margins of economic activity. Most work opportunities were sheltered. Disabled men trained as limb fitters at Roehampton. The British Legion opened its poppy factory in Richmond, Surrey.

A network of ex-servicemen's villages were built, providing sheltered employment as well as family housing. These included Haig Homes in Welwyn Garden City, Westfield War Memorial Village in Lancaster and the Enham Village Settlement near Andover in Hampshire. There was also specialist housing. In 1920 twelve cottages were funded from public donation in Sprowston, near Norwich for disabled members of the Royal Norfolk Regiment. In 1927 the Prince of Wales opened the North Memorial Homes in Leicester, 35 homes for disabled ex-servicemen.

Some of the developments for ex-servicemen also benefited the civilian disabled population. The new artificial limbs became available to more civilians, specialist medical facilities for disabled miners were introduced in the 1920s and rehabilitation for industrial injuries was considered in the 1930s. Many felt, however, that resources were not evenly shared, (although in fact pensions for disabled servicemen were limited and their unemployment levels remained high). At a 1920 conference on care of 'crippled' children it was claimed that provision for the war disabled had caused 'an appalling amount of suffering' among other disabled people.

‘Mental deficiency’ between the wars – life in the colony

In November 1917, as the Great War raged on, Leslie Scott, the chairman of the Central Association for the Care of the Mentally Defective, turned his mind to the looming problems of the peace. ‘There are’, he wrote, ‘large numbers of low-grade, even imbecile defectives, now in remunerative work who will assuredly leave their work when there is any displacement of labour, and we are anxious to make plans for their protection.’ Clearly the country’s need for manpower, with so many fighting on the front, had changed the perception of the ‘mentally deficient’ from people incapable of work to useful members of the workforce. However, this was about to change again, as soldiers returned from the front with an expectation of employment.

The 1913 Mental Deficiency Act had set up a new ‘Board of Control’ and specified that ‘Mental Defectives’ should either be closely supervised in the community or maintained in a new type of institution, the ‘mental deficiency colony’, providing permanent settlement for both children and adults in an isolated ‘scattered village’ environment. These ideas of separation and control derived from the fashionable ‘science’ of eugenics of the period. Proponents of eugenics argued that ‘defective’ members of the population would cause a general deterioration of the racial stock unless kept strictly controlled, segregated and, if possible, sterilised. People we would recognise today as having learning disabilities were ‘graded’. At the bottom were the ‘idiots’ (the profoundly disabled) and ‘imbeciles’ (the ‘medium grade’). Then there were two types of the ‘feeble-minded’ - those who were mildly disabled yet able to contribute to their own support, but also the so-called ‘moral defectives’, who ‘cannot distinguish right from wrong and represent a grave danger to the community’.

A network of colonies was established across the country. Each was a small, self-contained world. Between 900 and 1,500 people would live in the typical colony, in detached ‘villas’ housing up to 60 people, grouped around a central administrative block. This block always formed a barrier between male and female villas, as separation of the sexes was deemed essential, except in the case of the lowest grade ‘idiots’. Children and adults lived separately and there would also be a special villa for ‘difficult cases’ – those whose behaviours were regarded as needing control. The villas for ‘idiots’ and for ‘difficult cases’ would be as far from the hospital approaches as possible, to avoid offence to visitors. Villas housing the ‘better class of working patients’ were allowed to be furthest from the administrative block, with their own cooking and heating facilities. Patients slept in multiple rows in large dormitories.

As well as the villas there would be a children’s school, workshops for the adults, kitchens, bakery, laundry, recreation hall (seating up to 750 patients and doubling as a chapel), staff quarters, playing fields (particularly for the males) and a small mortuary. No one need ever leave. Many colonies had their own farms with market gardens, stables, poultry, pigs, herds of cows and greenhouses. As well as nurses they employed farm bailiffs, firemen, engineers and, of course, gatekeepers. Most patients worked (unpaid) in the laundries and workshops or on the farm. The ‘idiots’ stayed in their villas, but these had verandas, so that they could be out in the fresh air even in bad weather. The children attended school, where they would learn useful occupational skills for their future life as an adult in the colony. In 1939 another war came, and some ‘colonists’ left to work, or even fight. But the colonies would live on until the 1990s.

The right to education – the growth of the ‘special’ school for children with disabilities

The early 20th century saw a significant shift towards specialist education for disabled children. The 1918 Education Act made schooling for all disabled children mandatory, building on an 1893 act which had made local authorities responsible for schooling for blind and deaf children. Although a small number of children attended mainstream school, by 1921 there were more than 300 institutions for blind, deaf, ‘crippled’, tubercular and epileptic children. It was often thought better for children to be away from their families, so for many the experience of education was residential.

The Royal National Institute for the Blind (RNIB) set up a network of ‘Sunshine Homes’ which pioneered liberal and progressive teaching and care methods. The first was in Chorleywood, Hertfordshire in 1918 and had an intake of 25 blind infants. The Chailey Heritage Craft School in Sussex was founded in 1903 under the banner of the ‘Guild of the Brave Poor Things’, a self-help group for young disabled people. The school offered disabled children from deprived city areas craft training in a countryside setting, with the aim of ensuring independence in adulthood.

However, there was often a focus on low-skilled work training rather than full education, and many educational regimes could be harsh and highly disciplinarian. Parental visits were discouraged and letters home censored. A group of blind boys made a night time ‘escape’ from the Mount School for the Blind and Deaf in Stoke on Trent in 1915 because they wished to contribute to the war effort by working on a farm. When they returned they were placed with the deaf children as a punishment, (they struggled to communicate because of lack of facial context with each other), and were forced to hand in their trousers each night to prevent further escapes.

Such harshness meant that relations between staff and pupils were often combative. Pupils at the Manchester Road School for the Blind in Sheffield went on a two day strike after a pupil was severely disciplined for something he had not done. Deaf children were often required to learn to lipread rather than use sign language, which was usually their preferred method of communication. At the Yorkshire Residential Institute for the Deaf in Doncaster pupils signed subversively to maintain a secret, independent life, out of the sight of staff. The sexes were rigorously separated but boys and girls found ways to communicate. Pupils from the Halliwick Home for Crippled Girls in Edmonton, North London, would slip crumpled notes to the choirboys on their weekly visits to church.

From Germany, the ‘open-air school’ came to England. Disabled children studied in a regime of outdoor classrooms, afternoon rest and improved diet. Even in winter they took afternoon naps outside wrapped in blankets. The first school was opened by London County Council at Bostall Woods, Woolwich in 1907. Away from unhealthy, crowded home environments, there were improvements in children’s health. By 1939 there were 150 open air schools, providing for almost 20,000 children.

The acquisition of the right to education was a great gain for children with disabilities and special schools mushroomed across the country. Yet in practice it could prove a mixed blessing. For some it could be progressive and highly innovative. For others, it was a brutal experience.

Everyday life and work – disabled people in the community in the early 20th century

Although the number of disabled people in institutions grew in the first half of the 20th century, the majority remained in their communities. However, it was a difficult time, with growing governmental supervision based on a fear of the spread of ‘feble-mindedness’. This was associated with people with physical, mental and sensory disabilities.

People classified as ‘mentally deficient’, if not placed in an institution, were submitted to close control in the community. The Central Association for Mental Welfare, a voluntary organisation, would identify people believed to be deficient and visit those under statutory supervision. This work was carried out by teams of volunteers and officials on behalf of the government’s Board of Control in Victoria Street, London.

One woman recalled the visiting Mr Grey. ‘Grey! ...Ooh I hated him! He wouldn’t let anybody live. He did a lot of damage, picking up people what didn’t deserve to be picked up.’ Enthusiastic local branches identified large numbers of ‘deficient people’ for supervision – 351 in Buckinghamshire and 930 in Somerset in 1925. A particular concern was the prevention of sexual relationships and marriage. In Rotherham in 1926 Mabel M, a ‘defective’ and her boyfriend Thomas L, a coal miner, applied for a marriage license. Mabel M’s mother was opposed to the marriage. ‘No certificate is to be issued,’ ruled the Board of Control.

Physical disability and sensory impairment were rife, particularly amongst working class children, in this period. The problems of poverty – poor housing, sanitation, health care and diet – allied with a lack of immunisation took their toll. Compulsory physical examinations in schools from 1907 made the extent of the problem clear. Between the 1900s and 1950s an estimated half a million boys and girls had disabilities, often caused by diseases such as polio and tuberculosis.

Loneliness, teasing and bullying could be a feature of daily life. ‘I had no friends in the village. I used to go around more on a level with the dogs because I had to cross my legs over...and use them like a shovel to get about,’ recalled a Doncaster man of his life in the 1920s. There were so-called ‘cripple parlours’, well-intentioned clubs for disabled children, but they could attract the derision of able-bodied children. Others had happier memories. For one man in Rotherham ‘my brothers and (sister) stuck by me in our village when I were little.’

Some protested about their status and treatment. In 1920 and 1933 blind workers marched to London from all over Britain to hold mass demonstrations against low wages and poor working conditions. A culture of low expectations in schools for deaf, blind and ‘crippled’ children led many into low-skilled, repetitive jobs in sheltered workshops, if they were able to get any employment at all. Once again war changed everything. In 1941 the Ministry of Labour, faced with acute shortages, recruited more than 300,000 previously ‘unemployable’ disabled people into the workforce. **‘Cripples Can Do Vital War Work’** read a Northumbrian woman with cerebral palsy in a newspaper headline. Within months she was working at a Royal Ordnance Factory. ‘It was a wonderful feeling.... I revelled in being my own mistress at last.’

Section 6

Disability from 1945 to the present day

Disability since 1945 – war is over, and now the fight begins

As the Second World War ended in 1945 the true extent of its horrors began to emerge. Among these was the mass killing of disabled people in Germany. The appetite had lessened for the ‘eugenicist’ theories that had circulated in the pre-war period advocating the isolation and sterilisation of disabled people. In England, a legacy of the war was 300,000 disabled servicemen and women and civilians. Public concern shifted to those who had sacrificed their bodies for their country.

The Disability Employment Act of 1944 promised sheltered employment, reserved occupations and employment quotas for disabled people. Rehabilitation practices that had developed during the war, aimed at restoring the fitness, mobility, daily living skills and morale of disabled servicemen and women, spread to the rest of the disabled population. The new National Health Service took over and extended rehabilitation centres and services, including workers disabled by industrial accidents.

Attitudes changed. Disabled people were not prepared to remain passive and, beginning with a ‘silent reproach’ march of disabled ex-servicemen in 1951, a social movement developed. A host of campaigning disability charity groups formed in the 1940s and ’50s. Through the 1960s and 70s, inspired by the civil rights movement in America, direct action groups of disabled people campaigned against discrimination, poor access and inequality. A ‘social’ rather than a ‘medical’ model of disability was put forward. In 1995 a Disability Discrimination Act was passed.

The idea of the social model changed the disability agenda. The discussion was now about people’s rights. How could disabled people be as much a part of society as everyone else? Questions of access became critical. How could disabled people negotiate the complex environments of rapidly urbanising England without adjustments and adaptations being made? Dropped kerbs, accessible toilets and accessible buildings became key issues. At first there was a ‘micro-approach’, building separate disabled facilities. This changed, and architects and planners began to embrace the ideas of ‘universal design’ – buildings and landscapes which enable every person to use every part of them.

Great changes took place in the arena of sport. Under the leadership of the inspirational refugee neurosurgeon Ludwig Guttmann, war-injured paralysed patients at Stoke Mandeville Hospital in Buckinghamshire began to compete against each other as part of their rehabilitation. In 1948 a wheelchair archery competition took place on the lawns of the hospital against other wheelchair users. It was the birth of the Paralympic Games. Today these are the second biggest sporting event on earth, featuring elite disabled athletes who have become sporting icons in their own right.

Finally, the era of the asylum came to an end. A series of scandals revealed neglect and abuse, causing rising public concern. From 1981 the Jay Report promoted a ‘care in the community’ programme which signalled the end of the long stay hospital, and tens of thousands of people with learning disabilities and mental health needs returned to life within mainstream communities. The Victorian ideal of safe institutional ‘asylum’ in rural settings had ended unhappily. Today new visions of equality, inclusion and universal access have replaced it. Their long-term impact will be seen with time.

Back to the community – disability equality, rights and inclusion

In 1951 800 people took part in a ‘silent reproach’ march to Downing Street. They were members of the British Limbless Ex-Servicemen’s Association. In 1946 the National Cripples Journal had lambasted the government’s promise of ‘security from cradle to grave’, claiming that it did nothing for ‘the civilian cripple, who is incapable of earning a living’. There was a new militancy in the air. If there was going to be a bold new society fit for all, disabled people must be a part of that ‘all’.

A host of new campaigning organisations sprang up, at first led by parents and families. In 1946 The National Association for Mental Health and the National Association of Parents of Backward Children formed, later becoming MIND and Mencap respectively. The Leonard Cheshire Foundation, British Epilepsy Association, the Spastics Society, (now Scope) and hundreds of others soon followed.

In parliament disabled MPs led the struggle. Two wounded World War I veterans, the double amputee Jack Brunel-Cohen, (Liverpool Fairfield), and the blinded Ian Fraser, (Morecambe and Lonsdale, Lancaster), fought for disabled servicemen’s rights. The deaf MP Jack Ashley (Stoke on Trent South) campaigned for the rights of disabled people generally. In the 1970s and 1980s campaigning organisations of disabled people themselves, rather than their families, came to the fore – the Union of the Physically Impaired against Segregation (UPIAS), the Mental Patients Union (MPU) and, for people with learning disabilities, People First.

New thinking emerged. In 1968 the American academic Wolf Wolfensburger denounced asylums and long- stay hospitals as abusive institutions which dehumanised people through their design and their routines. From the 1970s disabled campaigners, such as the sociologist Michael Oliver and disability studies pioneer Vic Finkelstein at the Open University advocated the social model of disability, in which disabled people control their own lives, challenging non-disabled society.

Post-war, long-stay hospitals for people with learning disabilities and mental illness seemed neglected and forgotten. From the 1960s abuse scandals erupted onto newspaper front pages triggering enquiries at Ely Hospital, Cardiff, Farleigh Hospital in Flax Bourton, Somerset and Coldharbour in Sherborne, Dorset. A famous television documentary ‘Silent Minority’ exposed further scandals at St Lawrence’s in Caterham, Surrey and Borocourt in Reading, Berkshire. Public disquiet became overwhelming. The 1981 Care in the Community Green Paper signalled the end of the asylum. Over the following two decades tens of thousands of people moved from hospitals back to the community. A new era of residential and group homes, day care facilities and independent living within mainstream communities began.

Thinking continues to move on. In the new century notions of empowerment and self direction, where disabled people acquire a personal budget to buy support, rather than ‘receiving’ care, have come to the fore. The idea of specialist homes and buildings is challenged – there should be ‘universal design’ for ‘universal buildings’. We find ourselves at the end of the asylum period, an era which only represents 140 years of disability history and which never involved all people with disabilities. But for how long will the shadow of Bedlam continue to be cast? How will life change for people with disabilities in the future?

Disability, rehabilitation and work

The treatment of seriously injured, burned and disabled soldiers and civilians during the second world war had been predicated on restoring them to participation in the war effort or, if that was not fully possible, to at least reduce dependence on assistance for the rest of their lives. An important element of this approach was that disability was no longer seen as an obstacle to employment at any level. The most famous example of this thinking was the acceptance of Douglas Bader as an RAF pilot, despite his having lost both legs in a flying accident in 1931.

New approaches brought new ideas in the concept of rehabilitation. Medical and surgical interventions came to be seen as the first part of a process which then focused on restoration of fitness and mobility, relearning daily living skills and combating depression through purposeful activity, including work. The physiotherapy profession grew enormously. There were significant advances in the design and manufacture of artificial and prosthetic limbs, particularly at Roehampton Hospital, south London.

By 1945 a network of convalescent and rehabilitation centres for disabled servicemen and women had grown up around the country. Rehabilitative ideas were applied to the civilian disabled population. In 1946 the Egham Industrial Rehabilitation Centre in Surrey opened to civilians. It offered 'vocational guidance and purposeful training', particularly in building work, shoe repair and retail distribution. Roffey Park in Sussex specialised in supporting workers with mental health issues. St Dunstons in Regents Park, London continued its rehabilitative work with blind servicemen as did the RNIB with the rest of the blind population. The National Health Service, created in 1948, had taken over most rehabilitation services by 1951. Amongst these was the Miners' Rehabilitation Service, which included centres at Berry Hill Hall near Mansfield and the Hermitage in Chester le Street, Durham. In the 1960s the Daily Living Research Unit at Mary Marlborough Lodge, based at the Nuffield Orthopaedic Hospital in Oxford, pioneered new rehabilitative techniques in daily living skills and new designs in wheelchairs and appliances.

Work was seen as crucial, both for rehabilitation purposes and to reduce dependence on the state and in an era of labour shortages. Following the Disabled Persons Employment Act of 1944 a network of factories was established – at first known as 'British Factories' and later renamed Remploy. The first factory was set up in Salford in 1946. By 1953 there were 90, employing 6,000 disabled people. Products included woodwork, leatherwork, mats and brushes – in Bristol and Halifax stump socks were manufactured for amputees. Veterans worked in the Thermega electric blanket factory in Ashted, Surrey. Outside these sheltered work settings a registration scheme was set up requiring employers to take a fixed percentage of disabled workers. Certain occupations – lift operator and car park attendant – were reserved for disabled people.

Later in the century there was a move from sheltered work settings as doubts arose about their effectiveness. There was a drive for inclusion in mainstream employment, in line with the idea of full participation in mainstream life. High profile disabled people such as the politician David Blunkett, the scientist Stephen Hawking and the athlete Tanni Grey-Thompson have reached the top of their professions. Yet unemployment amongst people with disabilities remains an issue. The quest for equality and inclusion goes on.

Nowhere out of bounds – disability access and adaptation

From 1945 the urbanisation of the English landscape progressed rapidly. With 300,000 war-disabled people added to the existing disabled population, issues of mobility and access in towns and cities became paramount. If the idea was that disabled people should work and participate in society, how could they do this amidst the complex buildings, difficult entrances and exits, steps, stairs, kerbs, busy roads and transport systems of the modern urban environment?

At this time most buildings were not designed with disabled people in mind. When a young man called Selwyn Goldsmith (1932-2011) became disabled through polio in 1956, the year that he completed his architecture training, he devoted the rest of his life to overcoming what he called ‘architectural disability’. He fought the ‘institutional discrimination’ of buildings which placed impediments in the way of disabled people who wished to use them. This meant not just people using wheelchairs – it meant blind people, deaf people, the ambulant disabled, indeed anybody who had difficulty in negotiating buildings. His ‘Designing for the Disabled’ (1963) was the first guidance for architects on disability access and quickly became an indispensable ‘bible’ and teaching aid for architects and local authority planners.

In 1964 Goldsmith selected Norwich as a representative English city, and lived there for three years. He interviewed 284 disabled people, asking which types of buildings should be made easier for disabled people to use. The highest priority by far was public toilets. The other buildings mentioned – restaurants, local shops, churches – reflected the desire of disabled people simply to lead the ordinary lives that other people led. From this came England’s first unisex, disabled-access public toilet (on Castle Hill in Norwich), fifteen ramped kerbs around the city – a feature now standard around the world – and a revised edition of ‘Design for the Disabled’.

Disabled people took the fight to the streets. In the 1990s DAN (Direct Action Network) demonstrated against inaccessible public transport and buildings. Government regulation consistently increased the onus on building owners to ensure that all public buildings were accessible and contained suitable facilities. This culminated in the Disability Discrimination Act (1995) which placed a duty on owners to take measures to make buildings accessible.

A ‘doctrinal leap’ then took place, moving away from adding special facilities to a ‘normal’ building to the concept of ‘universal design’ which saw any person with any disability as entitled to use every part of a building. The Richard Attenborough Centre for Disability and the Arts in Leicester provides an example of a complex but accessible multi-story public space. Architectural competitions now include accessibility as a key component for any award. The winner of the 2011 Stirling Prize was the Evelyn Grace Academy in south London, a multi-level mainstream school on a cramped inner-city site – fully accessible throughout.

The impulse of much design is now not just about people being able to get into buildings, it is about them being able to get anywhere. In 2004 new design and landscaping features made the Tower of London, a world heritage site, accessible. Boscombe in Bournemouth has England’s first disabled access beach-huts. Nowhere should be out of bounds. Goldsmith’s fight against ‘architectural disability’ lives on.

Caption. *'I wish when I use buildings to do so in the same way as others, to be integrated rather than segregated, to be treated as a normal and not as a peculiar person.'* Selwyn Goldsmith, 1997

Disability and sport - the birth of the Paralympics, from rehabilitation to world class performance

It all began in 1944 with a competitive 'dressing exercise' on what was known as Ward X at Stoke Mandeville hospital, Buckinghamshire. The war-injured, paralysed young men on the ward raced each other to get up from their beds, dress and into their wheelchairs.

Twelve spinal units had been set up around the country during the Second World War. However it was Stoke Mandeville's director Ludwig Guttman, a German Jewish neurosurgeon and refugee from Nazism, who made the first significant breakthrough in the rehabilitation of people with spinal paralysis. Previously such people had been seen as 'hopeless cases'. Guttman introduced not only an improved medical regime, but a rehabilitation system designed to restore hope and a sense of purpose to the young people whose minds as well as bodies had been damaged by their injuries. Sport played an important part in this, making use of the competitive instincts of the young men and women who had led active lives before their disabling injuries.

Competitive activity at Stoke Mandeville developed through darts, skittle and snooker competitions in local pubs to ball throwing, wheelchair polo, wheelchair netball and archery. On the 29th July 1948 – the opening day of the Olympic Games in London – an archery competition took place on the lawns of the hospital against a team from the Star and Garter residential home for war-disabled people in Richmond, Surrey. There were 16 competitors, including two women. Guttman predicted that one day it would become the disabled person's equivalent of the Olympics.

In 1950 the games were named the Stoke Mandeville Festival of Sport and 10,000 people watched a wheelchair netball match at the Empress Hall in west London. People with disabilities caused by industrial accidents, many of them miners from the north of England, began to take part. In 1952 the games became international and by 1966 in Rome 400 disabled athletes from 22 countries were participating.

In 2001 Philip Craven became the president of the International Paralympics Committee. Paralysed aged 16 in a rock climbing accident he subsequently became one of the finest wheelchair basketball players in the world. He was motivated not by the desire for medical rehabilitation but by a hunger to become a world class elite player. Led by him, the formidable Great Britain wheelchair basketball team became world champions in 1973. Under Craven the transformation of the Paralympics, away from the idea of medical rehabilitation and towards the idea of world-class performance by elite athletes, gathered pace.

Today the Paralympics are the second biggest sporting event in the world. At the 2012 London games 4,200 disabled athletes participated in twenty sports in a stunning range of fully accessible, 'universal design' venues. The games are no longer just about the rehabilitation of paralysed people; they are a great international sporting event in their own right. Other famous sporting venues have opened up to disability sports, including Wimbledon where wheelchair tennis is now played. Guttman's dream in 1948, in a quiet corner of Buckinghamshire, has been realised in a way even he might not have imagined.

Section 7

**Mainstream society or separate
community?**

Mainstream society or separate community?

Buildings have often occupied a controversial place in the history of people with disabilities. Some viewed the asylums of the 19th century as places of safety for vulnerable people. Others, at the time and since, have seen them as places of incarceration to exclude people from society – ‘convenient places for inconvenient people’ as one historian has described them. ‘Madhouses’ could be seen by the public in the 18th century both as places of humanity and recuperation for people suffering mental illness and as abusive institutions for locking away unwanted family members.

Today the debate about separation or inclusion goes on. Do some disabled children need separate special schools or should all children be part of mainstream education? Do people with disabilities need to use specially adapted buildings, such as day centres, or should all buildings be fully accessible and integrated so that there is no need for separation? Should people with disabilities have the opportunity to work in sheltered work settings, or should it be the norm that everyone can work in mainstream, open employment?

The special village community

The 20th century has seen a very distinctive example of separate living, where people with disabilities have lived in a specially created, self-sustaining community, apart from the rest of society - the special village. These are sometimes known as ‘intentional communities’ – meaning that people only live in them if they choose to do so, and have expressed a considered wish to live there. They see themselves as distinct from institutions, such as asylums, because they are structured on family and community life. Inhabitants live simple lifestyles, in a self-enclosed, self-supporting community. They belong to the tradition of the commune, which has existed in English society since the radical religious sects, such as the Diggers, of the mid-seventeenth century. Communes flourished again briefly during the ‘hippy revolution’ of the 1960s and 70s. Internationally the Kibbutz in Israel and the Anabaptist communities of North America (Amish, Moravian and Hutterite), which originated in 17th century Germany, exemplify the separate, self-sustaining community.

Enham Alamein – a village fit for heroes?

An early example of an English village community is Enham-Alamein, near Andover in Hampshire. Built in 1918 as the Enham Village Centre, this was the first specially created village for the care and support of disabled servicemen returning from World War I. It was aimed at men unable to return to their former trades because of their disabling injuries and focused on supporting them to regain independence and earn a living wage. Crucially, servicemen were able to move in to the cluster of houses with their families, creating a genuine community. Those who lived in the village were known as ‘settlers’. In its rural setting, the village contained craft workshops, a poultry farm and facilities for book and shoe repairs, furniture making and upholstery. With its own woodworking factory and market garden, it aimed for as high a level of economic independence as possible. Fulfilling industrial orders for the World War II war effort, including the manufacture of gliders, brought Enham to its highest level of self-sustainability.

After World War II Enham, with a new generation of disabled war veterans to house, was boosted by a financial gift expressing the ‘gratitude of the Egyptian people’ in commemoration of the battle of El Alamein. Renamed Enham Alamein, the village saw new purpose-built cottages and flats added in the 1940s and 1950s. New industries, such as candle making, were introduced. Enham Alamein survives today as a community providing housing and work training for people with disabilities.

Camphill Communities – seeking the ‘hidden and eternal soul’

The origin of the Camphill communities is extraordinary. The first Camphill School was founded in Aberdeen in 1940 by a group of German and Austrian Jewish refugees from Nazism. Led by the inspirational paediatrician Karl Konig, a Christian convert, they wanted to create a new form of ‘healing environment’ for the education and upbringing of children with special needs. Following the teachings of the social reformer and educational philosopher Rudolf Steiner, they rejected the fashionable idea of the time that some children were ineducable. They wanted to create a community where children with disabilities and (unpaid) staff would live together and share their lives to foster mutual help and understanding. They believed that there was ‘in each human being a hidden and eternal soul’ that had to be reached.

Simplicity and naturalness

The movement flourished and the first English community was built at Botton Village in North Yorkshire in 1956. Today there are 22 communities in England, for both children and adults. Influenced by the Moravian Christian communities of North America, ‘villagers’ (also known as ‘Camphillers’) live as ‘co-workers’ in non-hierarchical communities. Family-sized groups live together in small houses. Mostly in rural settings, the communities produce high-quality hand crafted goods and foods, as well as sustaining themselves with their own produce. Some villages have their own gift shops and cafes. Their cooperative businesses include agriculture, horticulture, cheese-making, pottery and woodcraft. Simplicity, naturalness, tranquility and respect for the ‘natural rhythms’ of life are key. Villagers come together in a central village hall to celebrate Christian festivals, changes in the seasons and the rhythms of the farming year. Buildings are simple, with as many natural materials as possible used. Camphill is now an international movement, operating in 23 countries.

Social refugees?

Towards the end of his life, Karl Konig recalled what it was that brought together this unlikely alliance of exiled European Jewish intellectuals and British children with disabilities. Why did they come together in their own special community, outside mainstream society?

‘The handicapped children, at that time, were in a similar position to ours. They were refugees from a society which did not want to accept them as part of their community. We were political, these children social, refugees.’

Section 8

The shifting borderlands of disability

The shifting borderlands of disability

It may seem that recognising and defining a disability is a straightforward matter. However disability is an idea whose meaning has shifted continuously over the centuries. Those who have been defined, or defined themselves, as disabled have varied significantly over time. The implications of having a disability have also changed markedly over time, and will no doubt continue to do so.

Some types of disability have effectively disappeared from our society, or can now be treated as a disease or illness without disabling consequences. Leprosy for example is no longer prevalent in English society. Polio, which caused widespread disability in England for much of the 20th century, has now been eradicated through vaccination. Ophthalmia, which caused the blindness that affected Edward Rushton (founder of the first English Blind School in Liverpool in 1791), is now treatable.

While some disabilities or disabling conditions have disappeared, other new ones have been identified. Autism, for example, was only identified after the Second World War. Sometimes political and social attitudes can shape what is recognised as a disability – in the first half of the 20th century the idea of the ‘moral imbecile’ was invented. Some disabled activists argue that disability is just a political idea anyway – in their opinion the problem is society’s attitude towards people who are considered different. The shifting borderlands of disability can be a complicated matter.

Leprosy – a disappearing disability

Today leprosy is not considered a disabling condition. Known as Hansen’s Disease it is still prevalent in some parts of the world. However with treatment it is no longer highly infectious and its disabling consequences can be avoided. With treatment, segregation is not necessary. When leprosy reached its peak in England in the medieval period, it was the single biggest disabling condition. As a result it caused the first big institutional response to disability – more than 300 ‘leper houses’ or ‘lazar houses’ were built across the country. At the end of the 14th century leprosy began to recede. It is not known why but one theory is that it was supplanted by the plague. The leper houses were no longer needed. Some fell into disuse, but others changed their purpose. St Johns Hospital in Canterbury, for example, became an almshouse. In this way leper houses laid the foundations for future institutional responses to disability such as almshouses, the madhouse, the workhouse and the asylum.

Nowhere reflects the shifting borderlands of disability better than the 12th century Leper Hospital of St Mary Magdalene in Sprowston, near Norwich. Built for male lepers, it became a home for ‘poor, aged and sick men’ after the retreat of leprosy at the end of the 14th century. Today the building still stands, and is used for employment and personal development activities by people with learning disabilities. The lepers for whom the building was constructed are no longer a disabled group in our society. The people with learning disabilities who now use the building would not have been seen as a disabled group needing special provision in the medieval period, they would simply have lived and worked in their families and communities. Each age has its own idea of disability.

Autism – a newly identified disability

The condition of autism was only identified towards the end of the Second World War by a psychiatrist and a psychologist working independently of each other, the American Leo Kanner (1894-1981) and the Austrian Hans Asperger (1906-1980) (after whom Asperger's syndrome was named). The relatively recent identification of this disorder raises interesting questions for historians of disability. Has autism always been with us, or is it a recent phenomenon? There are of course no historic buildings associated with autism, given that it was not even a named disability in the past. But some historians and psychiatrists have looked at case records to find evidence of autism in the past. In 1799, for example, a five year old boy at the Bethlem hospital was described in a case study. He never engaged in play with other children or became attached to them, but played in an absorbed, isolated way with toy soldiers. This is possibly the first formally recorded clinical case of autism in England.

Others have examined the life and work of some famous historical figures, and speculated that they may have had the characteristics of autism. For example the great scientist **Sir Isaac Newton** (1642-1727) was described as having a rigorously logical mind, an inability to form intimate friendships and numerous eccentric behaviours. **John Howard** (c1726-1790), the great 18th century penal reformer, travelled 60,000 miles over 17 years visiting prisons in Britain and Europe, meticulously recording and reporting everything he saw. His solitary lifestyle, intense focus on one special interest and extreme obsession with punctuality have led to speculation that he may have had Asperger's syndrome. **Lewis Carroll** (1832-1898) (the pen name of the Reverend Charles Lutwidge Dodgson) the author of *Alice's Adventures in Wonderland* (1865) was known to have had difficulty with social interaction, narrow obsessive interests, odd speech and 'compulsive orderliness'. However the application of modern diagnostic criteria to historical figures can only be speculation. What we do know is that when Newton, Howard and Carroll were alive they may have been seen as eccentric but were not seen as having any sort of disability or condition. They were simply valued for their extraordinary talents.

The idea of moral deficiency – a socially created disability

The Mental Deficiency Act of 1913 invented a whole new category of disabled person – the 'moral imbecile'. At this time proponents of the idea of eugenics were arguing that 'defective' members of the population would cause a general deterioration of the racial stock unless kept strictly controlled, segregated and, if possible, sterilised. They meant not only those who had an intellectual or physical disability, but also those they believed represented a 'moral threat' to society. These were to be found, the eugenicists believed, only in the 'lower orders' of society and could include habitual petty criminals, alcoholics, prostitutes and unmarried mothers. The meaning of 'moral imbecile' was never made entirely clear, even when in 1927 it was changed to 'moral defective'. It was broadly taken to mean someone who appeared not to know the difference between right and wrong and, more broadly, people whose behaviour appeared to be against the moral values of mainstream society. Thus many people with no sort of intellectual deficit found themselves living in the new network of mental deficiency colonies which were built across the country, many living there until they died or not emerging until their old age.

The category of 'moral defective' survived until 1959. Disability in this case was nothing to do with the shape of a person's body or their intellectual capacity. It was about how a person thought and behaved. Once more the boundaries had shifted. They will move again. 'Disability' is not a fixed idea – it changes over time and place.

Glossary

Glossary

Access/accessibility – The features of a building or area such as ramps, sliding doors, toilets etc which ensure that it can be used by people with disabilities

Airing Court – a walled garden area leading off from nineteenth century asylum wards where patients were allowed to exercise and ‘take the air’ without risk of ‘escape’. Often contained shelters and ornamental features.

Alienist – the early 19th century word for the medical professional who would later become known as a psychiatrist

Alms – charitable donations of food or money to the poor or those considered unable to look after themselves

Almshouse – homes built, from the medieval period onwards, to shelter elderly, disabled or other people considered unable to look after themselves. (Sometimes known as Maison Dieu)

Ambulant disabled – people who have a disability but are able to walk and do not use a wheelchair

Architectural disability – The effect of forms of architecture considered by disabled activists to prevent or hinder use by disabled people

Asperger’s syndrome – a form of autism which particularly affects communication and interaction with others, and the anxiety levels caused by communication. People with Asperger’s syndrome are often of average or above-average intelligence.

Asylum – Form of institution particularly for mentally ill or learning disabled people which creates a fully segregated environment set apart from mainstream society. Began as charitable institutions in England in late 18th century, built and provided by the state from 1815.

Attendant – 19th and early 20th century term for staff working with patients in asylums and workhouses

Autism – a lifelong developmental disability that affects how a person communicates with and relates to other people, and how they make sense of the world around them

Autistic Spectrum Condition/Disorder – Because autism can manifest itself in many different ways and has many different forms the full range of conditions are known as a spectrum. Therefore people can be described as being ‘on the autistic spectrum’ or having an autistic spectrum disorder or condition.

Bagatelle – A game in which small balls are propelled into numbered holes on a board, with pins as obstructions. The forerunner of pinball.

Bedlam/Bethlem - popular names used by the public for the Royal Bethlehem Hospital in London, the first English institution for people with mental illness.

Beggar – a destitute person seeking money or help from members of the public.

Billies in Bowls – an 18th century slang expression to describe disabled people who moved themselves around by sitting in a small wooden bowl and propelling themselves with two small wooden blocks.

Blynde – early English word for blind

Board of Control (for lunacy and mental deficiency) – government body established under the Mental Deficiency Act 1913 to replace the Lunacy Commission, and to oversee the treatment of mentally ill people and people with learning disabilities.

Braidwoodian system – a form of sign language (also known as the combined system) introduced by Thomas Braidwood, who set up the first academy for the deaf and dumb in London in 1783. The forerunner of British Sign Language.

Bridewell – originally a type of hospital, first established in the 16th century for the improvement of the ‘idle poor’. Eventually became houses of correction for beggars and petty criminals.

British Sign Language (BSL) – the sign language used in the United Kingdom and the preferred language of many deaf people in the UK.

Care in the community – a system of care and support for people with disabilities and people with mental illness based on the belief that people should live in their communities rather than in separate institutions. The Care in the Community green paper of 1981 signalled the end of the asylum era.

Charitable asylum – an asylum established as an independent charity through the voluntary efforts of members of the public. Popular at the end of the 18th and beginning of the 19th centuries before state asylums became the norm.

Chronic lunatic – 19th century term for a person with mental illness who is perceived as unlikely to recover from their illness.

City of London – The original walled city, (known today as the square mile) around which the greater conurbation of London later grew. Had its own system of government and was politically influential particularly from the medieval period to the 18th century.

Colony – a type of asylum institution established by the 1913 Mental Deficiency Act where both adults and children with learning disabilities lived in a ‘village’ arrangement of a number of ‘villas’ each housing up to 60 people.

Combined system - a form of sign language (also known as the Braidwoodian system) introduced by Thomas Braidwood, who set up the first academy for the deaf and dumb in London in 1783. The forerunner of British Sign Language.

Comfortable works – Church teaching of the medieval period which encouraged people to perform charitable works, supporting and giving alms to poor and disabled people as a means of speeding their passage to heaven.

Conglomerate asylum – a form of asylum consisting of miscellaneous structures, without any real unity of style and often composed of buildings of widely varying ages.

Corridor asylum – a form of asylum consisting of a series of connecting corridors with wards and other rooms opening off them.

County lunatic asylum – asylums built by counties across England to house ‘pauper lunatics and idiots’, meaning mentally ill and learning disabled people unable to meet the costs of their own care. From 1845 it was compulsory for counties to build such asylums, and many built more than one.

Court of Wards – a court established in the Tudor period which allocated responsibility for the affairs of ‘lunatics’ and ‘natural fools’.

Cripple/creple – a term used to describe physically disabled people until the second half of the 20th century, (creple is its early English form, used in the medieval period). Now used pejoratively or abusively.

Crooked/crookedness – an early English term to describe people seen as misshapen in their bodily form

Daily living skills – the skills seen as necessary to be able to live an independent life, such as cooking, eating, budgeting, shopping and travelling. Restoration of daily living skills is often the focus of rehabilitation programmes.

Deaff – early English word for deaf

Defective – term used in the early 20th century to describe a person who would be described today as having a learning disability

Deficient – see mental deficiency

Degeneration/degenerate – a theory propounded by eugenicists in the late 19th and 20th centuries. They believed that breeding by people with disabilities, mentally ill people or people seen as ‘feckless’ or ‘idle’, particularly those from the poorer classes, would cause general racial deterioration in a society.

Disabled access – the design features or adaptations of a building such as ramps, doors, toilets etc which mean that people with disabilities can enter and make use of it.

Dissolution – the period largely between 1533 and 1545 when England under Henry VIII broke with the church in Rome and ‘dissolved’ or plundered and shut down many religious buildings, including those which cared for the sick and the disabled.

Dumbe – early English word for a person unable to speak (modern equivalent is *dumb*). From the medieval period till the 18th century it could signify that a person was deaf as well as unable to speak.

Empowerment – the idea that people with disabilities should be in a position to have power and control over their own lives.

Epilepsy – a neurological disorder which can cause loss of consciousness or convulsions. Originally known as ‘falling sickness’.

Eugenics – a movement prevalent in the later half of the 19th century and first half of the 20th century. Based on the writings of Francis Galton, eugenicists believed in the sterilisation or even euthanasia of disabled people and others such as the mentally ill or ‘morally degenerate’ to prevent what they described as racial deterioration. They believed that degeneration was due to genetic inheritance.

Falling sickness - early English term for Epilepsy

Feeble minded – a term used in the late 19th and early 20th centuries to describe people who would be described as having moderate or mild learning disabilities today or, as it was also known at the time, ‘high grade mental deficiency’.

Fool/foolish – early English word usually used to denote a person we would recognise as having a learning disability today. Could sometimes be used to denote a mentally ill person also. Also described people in the role of jester, but distinction was made between ‘artificial fools’, people pretending to be foolish, and ‘natural fools’, people born ‘foolish’.

Freak – term used particularly between 1850 and 1914 to describe human performers in the popular Freak Shows and Circuses (also known as Human Zoos) of the period, who were exhibited because of their unusual bodily shapes or ‘deformities’

Furious - used in the 18th and 19th centuries to describe mentally ill people who are in a state of agitation or who are perceived to be potentially violent

Go Cart – an 18th century slang expression to describe a disabled beggar who used a wooden box on wheels to move around

Gordon Riots – serious riots which took place in London in June 1780 to protest at the relaxation of anti-Catholic laws which had taken place two years earlier. Mainly targeted Catholic businesses and properties.

Hansen’s disease – the modern medical term for leprosy.

Idiocy/Idiot – when classification systems were introduced in the 19th century idiot was used to denote the lowest rank of intelligence and functional ability, similar to what we would define as a profound learning disability today. In earlier English used to describe ‘dull witted’ people who could be seen as broadly equivalent to what we would define as learning disability, but could be used in a wider sense to describe the labouring classes and the peasantry. Today used pejoratively or abusively.

Imbecile - when classification systems were introduced in the 19th century imbecile was used to denote the medium rank of intelligence and functional ability amongst people with learning disabilities, between 'idiot' and 'moron'. Similar to what we would define as a severe learning disability today. In the 19th century could also be used to describe a person with mental illness. Today used pejoratively or abusively.

Impotent – in its early English sense referred to people considered unable to look after themselves for reasons of age, infirmity or disability. The 'impotent poor' were distinguished from the 'able bodied' poor in poor law legislation.

Inaccessible – describes a building or area that a disabled person is unable to get into or use because its design prevents them from doing so.

Incurable – term used to describe mentally ill or learning disabled people whose condition is perceived to be permanent and who are therefore unable to 'recover'.

Indigent blind – used in the 18th century to describe needy or poor blind people. The first charitable blind schools were for the 'indigent blind'.

Industrial rehabilitation – rehabilitation for people injured or disabled in industrial accidents.

Innocent – Early English word for a 'natural fool', broadly a person we would recognise as having a learning disability today.

Insane – general term, still in use but not as widely as in the past, to denote mental illness. Tends to be associated with criminal or highly irrational behaviour rather than lower level illness.

Institution – a building used specifically for the separate care or treatment of specific groups of people, separated from mainstream society, and, usually, highly regulated in its operations

Keeper – in the 16th and 17th centuries referred to any male carer, and did not imply any qualification.

Lame/lameness – early English term meaning restricted use of one or more limbs. Applied to restricted use of arms as well as legs.

Lazar House – medieval term for a specialist institution housing lepers (now known as people with Hansen's disease) derived from the name of the Biblical character Lazarus.

Learning disability – the current terminology in use to describe the condition previously known as mental handicap, mental deficiency and many other terms. Technically defined as 'a significant intellectual impairment and deficits in social functioning or adaptive behaviour (basic everyday skills) which are present from childhood (*Learning Disabilities the Fundamental Facts – The Foundation for People with Learning Disabilities 2001*).

Leper House/hospital – medieval institution to house and care for people with leprosy (known today as Hansen’s disease).

Lepre/lepra – medieval terms for leper and leprosy respectively.

Leprosy/leper – respectively, terms for the disease known today as Hansen’s disease, and those who have the disease. Highly prevalent disabling condition in England and the rest of Europe in the medieval period.

Lesions – general term for abnormalities in tissues of an organism, often caused by injury or disease. A common consequence of leprosy.

Lunacy commission – a public body established by the Lunacy Act of 1845 to oversee the welfare of people with mental illness (‘lunatics’) and people with learning disabilities (‘idiots’). One of their roles was to monitor and inspect asylums.

Lunatic/lunatick – early term to describe broadly the term mentally ill used today. Current usage is pejorative or abusive.

Maison Dieu – literally ‘Godly house’, an alternative term for an almshouse.

Mad doctor – 18th century term to describe the proprietor or superintendent of a ‘Madhouse’. Mad doctors were not necessarily medically qualified.

Madhouse – a type of institution which began at the end of the 17th century and was particularly prevalent in the 18th century. Private houses which cared for and treated people with mental illness. Mostly treated private patients with independent means, but some also provided for ‘pauper’ patients paid for by Parishes.

Mainstream education – Generally available public education aimed at all children.

Mariners – early English word for sailors

Mental deficiency – a term used mainly in the first part of the 20th century and broadly having the same meaning as the current term learning disability

Mental handicap - a term used mainly in the second half of the 20th century and broadly having the same meaning as the current term learning disability

Mental health – the state of a person’s mental well being.

Mental illness – the generally accepted current terminology for people who are seen as having some sort of disorder or ‘abnormality’ of the mind which affects their behaviour or ability to function. In the past often referred to as lunacy.

Metropolitan Asylums Board – established in 1867 under the Metropolitan Poor Act to care for London’s ‘sick poor’. Established about 40 institutions, including fever hospitals and three large purpose built institutions for ‘harmless and incurable lunatics’ known as ‘idiot asylums’. Duties passed to London County Council in 1930.

Mobility – a person’s ability to move around. Mobility aids and adaptations, such as wheelchairs, crutches and grab rails, and mobility vehicles such as scooters and adapted cars, are designed to assist people with restricted mobility.

Mongol – the term used by John Langdon Down, the 19th century physician, to describe people known today as having Down’s syndrome. Derived from a belief (since discredited) that their facial features suggested some sort of ancient racial link to Mongolian people.

Moral deficiency/morally deficient – a category of people defined in the early 20th century broadly similar to moral imbecility, whose perceived ‘deficiencies’ were seen as linked to genetic inheritance.

Moral imbecility/moral imbecile – a category influenced by the ideas of Eugenics in the early 20th century. It labelled as a type of ‘feeble-mindedness’ those people who were believed not to be able to distinguish right from wrong. Drawn exclusively from the poorer classes this category might include people who would be seen today as having mild learning disabilities. However it could also include people such as prostitutes, mothers of illegitimate children and criminals.

Moral management/treatment – a method of treatment for people living in madhouses or lunatic asylums which rejected physical restraint and harsh treatment in favour of gentle discipline, order and therapeutic intervention. Pioneered by the Quaker York Retreat and taken up in some public asylums, in particular by John Connolly at Hanwell Asylum in the 19th century.

Moron - when classification systems were introduced in the 19th century moron was used to denote the higher rank of intelligence and functional ability amongst people with learning disabilities, above ‘idiot’ and ‘imbecile’. Similar to what we would define as a moderate learning disability today. Today used pejoratively or abusively.

Natural – shortened term for a natural fool

Natural Fool – used from the medieval period until its usage died out in the eighteenth century, to describe a person born with a lifelong mental impairment. Used to make a distinction from ‘lunatics’, seen as people suffering a temporary impairment due to mental illness. Also distinguished from ‘artificial fool’, someone pretending to be a fool, such as a court jester.

Nurse – in the 16th and 17th centuries referred to any woman carer, and did not imply any sort of qualification.

Open air school – a type of school introduced to England from Germany in the early 20th century, where pupils spent much of their time learning outdoors. It was believed that fresh air would be beneficial to ‘delicate’ and disabled children.

Ophthalmia – an infection causing inflammation of the eye, previously a major cause of blindness but now treatable.

Paralympics – major international multi-sport event in which athletes with physical disabilities compete. Originated in England in 1948 as an event for disabled war veterans, and now, after the Olympics, the second largest sporting event in the world.

Paralytic – Early English word for paralysed.

Parish – a district for the purposes of local government, of particular importance from the medieval period through to the 19th century. Replaced by local authority boundaries. Originally defined by the area served by a church and priest.

Pauper – a person who does not have the means to support themselves, or who is in receipt of poor relief.

Pavilion asylum – a form of asylum characterised by parallel rows of uniform blocks each housing between 150 and 200 patients. The parallel rows separated male and female patients.

Physiotherapy – a healthcare profession which seeks to repair or improve impairments and disabilities through the promotion of mobility, functional ability and quality of life by physical intervention.

Polio – (Poliomyelitis), infectious viral disease affecting the central nervous system which can cause temporary or permanent paralysis. First identified in the 19th century there were major epidemics across Europe throughout the 20th century. A common childhood disease and cause of disability in England until its eradication through a vaccination programme which began in the 1960s.

Poor Law – Legislation designed to define English society's obligations and duties to the destitute, aged, sick or disabled people who were judged unable to look after themselves. Also contained punitive measures aimed at able-bodied poor people deemed 'idle' or unwilling to work. Began with a 1531 law under Henry VIII and culminated in the Poor Law Amendment Act of 1834.

Poor relief – from the 16th century, the use of parish or state funds to support destitute, sick, aged or disabled people, as stipulated by the Poor Law. Could be given as cash (outdoor relief) to allow people to achieve a level of subsistence needed for survival, or in kind (indoor relief), such as a place in a workhouse. After the 1834 Poor Law Amendment Act indoor relief was favoured over outdoor relief.

Prosthetics – the use of artificial replacements for missing body parts, particularly limbs.

Psychiatrist – a specially qualified doctor whose speciality is the study and treatment of mental illness

Psychologist – a specialist who studies the human mind and its functions, particularly those affecting human behaviour in given contexts

Public assistance institution – the term used in the 20th century to describe a workhouse.

Purges – the practice popular in early medicine, particularly in the 18th century, of removing blood or other fluids from a patient. Derived from the idea that the health of a person depends on the balance of four ‘humours’, and that purging can restore balance when it has gone out of alignment.

Purgatory – in medieval belief a place of temporary suffering where people’s earthly sins are cleansed before they ascend to heaven.

Quack doctor – a person pretending to have medical skills and promoting the sale of unproven or fraudulent medical remedies.

Quakers – a religious movement originating in England in the 17th century, based on a belief in a direct relationship between individual believers and God. Quakers became prominent in social reform movements in the 18th centuries, including the establishment of humane asylums practising ‘moral treatment.’

Raving – Early English word used to describe people experiencing episodes of mental illness where they appear to have no control of their emotions and to be talking nonsensically.

Relief – see poor relief.

Reserved occupations – an idea introduced in legislation after the Second World War where certain jobs, such as lift attendants or car park attendants, were reserved solely for people who have some sort of disability. Intended to boost employment of people with disabilities.

Restraint – the practice of using manacles, straitjackets or other physically coercive methods to control people seen as out of control, disruptive or dangerous.

Retreat – an early word to describe an isolated therapeutic environment, separate from the pressures of mainstream society, where people who have experienced mental illness can undergo healing and recovery (e.g. The York Retreat).

Rehabilitation – a process of medical and other interventions to enable people who have become disabled through accident or injury, or who have experienced mental illness, to recover skills and functions they have lost, to aid their recovery and reintegration into society.

Self direction – the idea that disabled people should be given funds with which to purchase and control their own support and care arrangements.

Sheltered work – work for disabled people taking place in specialist work settings separate from mainstream workplaces.

Sledge beggar – an 18th century expression to describe a disabled beggar who used a wooden sledge, pulled by a dog or another person, to move around.

Social model – the social model of disability argues that while physical, intellectual or social variations can cause individual limitations or impairments, it is society's failure to take account of these differences and include people that causes disability. The idea developed between the 1960 and 1980s in opposition to the 'medical model' of disability.

Spastic – the word originally used to describe a person with cerebral palsy, but now only used in a pejorative or abusive sense.

Special education – the provision of separate education in schools specifically established for children with disabilities (and other difficulties such as behaviour).

Spinal paralysis – injury or damage to the spine causing the loss of the use of two limbs (paraplegic), or all four limbs (quadriplegic).

Spital, Spytall – early English word for a hospital.

Sterilisation – surgical procedure to make men or women infertile. Advocated by the Eugenics movement for people viewed as mentally and sometimes physically or morally degenerate or deficient.

Sturdy – Early English word meaning 'able-bodied' as in 'sturdy vagabond', meaning a beggar who has no disability or sickness preventing them from working.

Tom o'Bedlam – 16th and 17th century expression to describe a mentally ill beggar.

Trade Guild – associations of craftsmen in a particular trade, originating in the medieval period. Their purpose was both to protect and regulate their own trade and to care for their own members, e.g. through the provision of almshouses.

Tubercular – having tuberculosis, an infectious disease of the lungs.

Ulcerations – open sores on the body, one of the symptoms of leprosy in the medieval period.

Universal design – architectural approach which seeks to ensure that buildings are fully accessible in all parts to anyone with any sort of disability.

Vagabond – Early English word for a beggar, tending to denote those who were perceived as 'idle', dangerous or criminal, as opposed to impotent beggars who were incapacitated in some way and not seen as dangerous.

Villa – used to describe the separate ward buildings housing up to 60 people in Pavilion design asylums, particularly mental deficiency colonies.

Water Tower – the high towers often at the centre of 19th century asylums, and visible from a distance, which supplied water to asylum staff and patients. They became an iconic symbol of the separateness of the asylum.

Wheelchair polo – a form of the game of Polo, which is usually played by riders on horses striking a ball with long mallets. Played instead in wheelchairs using shortened mallets. First played at Stoke Mandeville hospital.

Wild Boy – term used to describe a number of young men and boys who were ‘discovered’ or emerged from remote European forest areas during the eighteenth century. They were without language and were perceived as animal-like in their behaviours. They were of great interest to philosophers, doctors and intellectuals who were trying to define what constituted a human, and whether language was innate or learnt. Retrospectively it is considered that most probably had a learning disability or other condition and had been abandoned by their families.

Workhouse – an institution to house and put to work the destitute poor. Many destitute sick, aged and disabled people also lived in them. After the 1834 Poor Law Amendment Act workhouses who were deliberately designed as punitive institutions to discourage people from ‘idleness’.

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