Study of programs for homebound handicapped individuals : Letter from Secretary, Department of Health, Education, and Welfare transmitting a report on a study of programs for homebound handicapped individuals, with recommendations, pursuant to Public Law 565, 83d Congress.

84th Congress, 1st Session - - - - - House Document No. 98

STUDY OF PROGRAMS FOR HOMEBOUND HANDICAPPED INDIVIDUALS

LETTER

FROM

SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

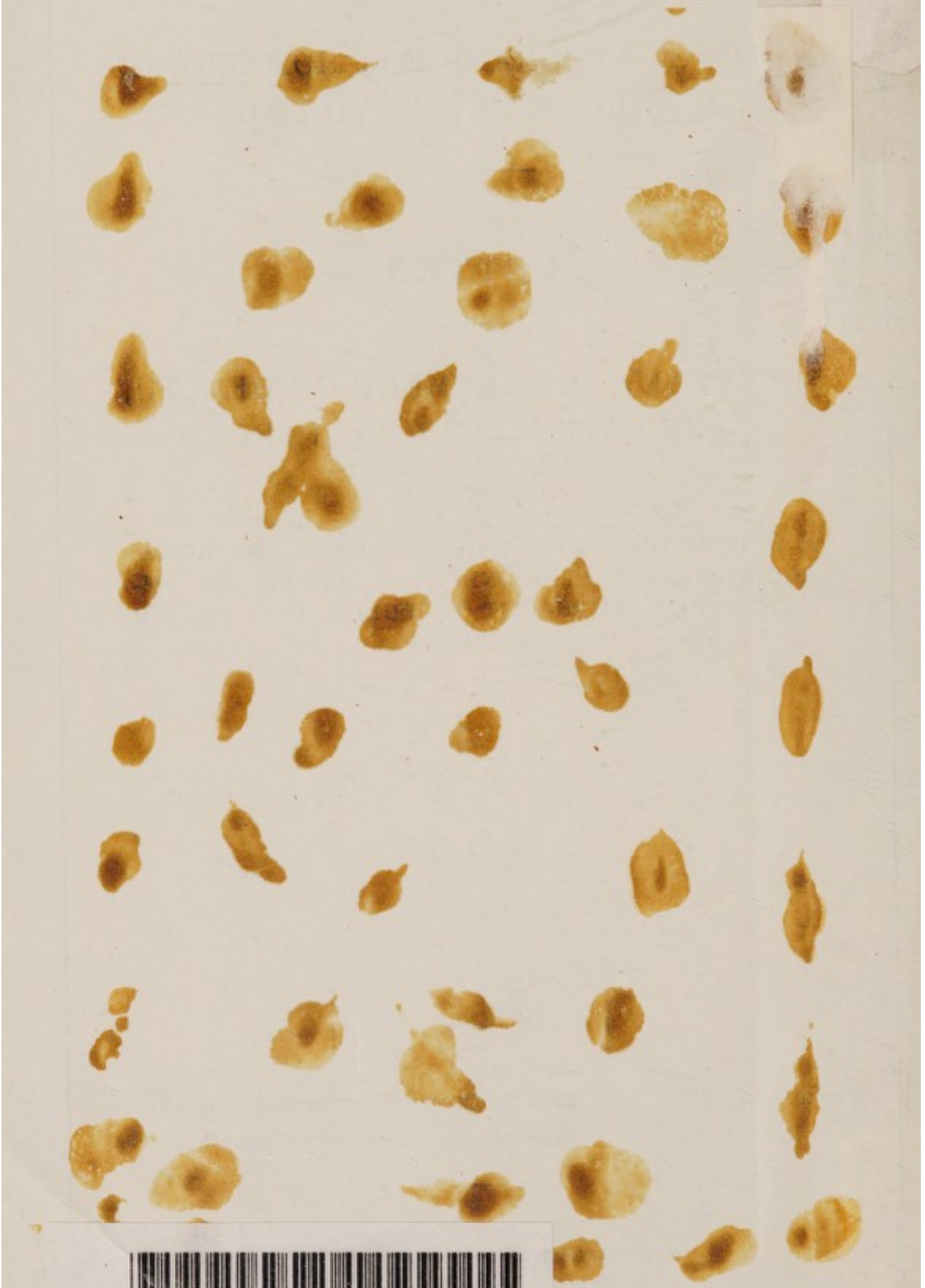
TRANSMITTING

A REPORT ON A STUDY OF PROGRAMS FOR HOMEBOUND HANDICAPPED INDIVIDUALS, WITH RECOMMENDATIONS, PURSUANT TO PUBLIC LAW 565, 83D CONGRESS

FEBRUARY 7, 1955.—Referred to the Committee on Education and Labor

FEBRUARY 25, 1955.—Ordered to be printed with illustrations

UNITED STATES
GOVERNMENT PRINTING OFFICE
0134 WASHINGTON : 1955



LETTER OF SUBMITTAL

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE,
Washington, February 3, 1955.

Hon. SAM RAYBURN,
Speaker of the House of Representatives,
House of Representatives, Washington, D. C.

DEAR MR. SPEAKER: I have the honor to submit herewith a report on a study of programs for homebound handicapped individuals, with recommendations, in accordance with Public Law 565, 83d Congress (section 7, Homebound Physically Handicapped Individuals).

Sincerely yours,

OVETA CULP HOBBY,
Secretary.

Report of a

STUDY OF PROGRAMS FOR HOMEBOUND PHYSICALLY HANDICAPPED INDIVIDUALS

This study has been prepared at the direction of the
Secretary of Health, Education, and Welfare
by
THE OFFICE OF VOCATIONAL REHABILITATION
in collaboration with
THE SOCIAL SECURITY ADMINISTRATION
THE OFFICE OF EDUCATION
THE PUBLIC HEALTH SERVICE
AMERICAN PRINTING HOUSE FOR THE BLIND
and with the cooperation of other public and private agencies
and groups, pursuant to section 7,
Public Law 565, 83d Congress, Second Session

PANEL OF ADVISERS

Miss M. Roberta Townsend, executive secretary, National Association on Sheltered Workshops and Homebound Programs, New York, N. Y.

Mr. Arthur Hill, United Cerebral Palsy Association, Inc., New York, N. Y.

Mrs. Elizabeth Wagner, the National Society for Crippled Children and Adults, New York, N. Y.

Dr. Dean Roberts, director, Commission on Chronic Illness, Baltimore, Md.

CONSULTANT

Mr. Eugene J. Taylor, assistant professor, department of physical medicine and rehabilitation, New York University-Bellevue Medical Center, New York, N. Y.

The following agencies and organizations were invited to participate in this study and to contribute data, views, and suggestions:

PUBLIC AGENCIES

Department of Labor:
- Bureau of Labor Standards
- Bureau of Employment Security
- Wage and Hour and Public Contracts Divisions

Department of Agriculture:
- Farmers Home Administration
- Federal Extension Service

Department of Commerce: Office of Small Businesses

Veterans' Administration:
- Department of Veterans' Benefits
- Department of Medicine and Surgery

President's Committee on Employment of the Physically Handicapped

Selective Service, national headquarters

State vocational rehabilitation agencies (88) including agencies for the vocational rehabilitation of the blind

VOLUNTARY AND PRIVATE ORGANIZATIONS

Adult Education Association of the United States of America

Alabama Society for Crippled Children and Adults

American Association for Health, Physical Education and Recreation

American Cancer Society

American Congress of Physical Medicine and Rehabilitation

American Council on Education

American Farm Bureau Federation

American Federation of Labor

American Federation of the Physically Handicapped

American Foundation for the Blind

American Hearing Society

American Heart Association

American Legion

American Library Association

American Medical Assocation

American National Red Cross

American Occupational Therapy Association

American Physical Therapy Association

American Veterans' Committee

American Veterans of World War II

American Vocational Association

Arkansas Enterprises for the Blind, Inc.

Arthritis and Rheumatism Foundation

Association for the Aid of Crippled Children

Baruch Center of Physical Medicine and Rehabilitation

Bay State Medical Rehabilitation Clinic

Bay State Rehabilitation Center of Western Massachusetts

Blinded Veterans' Association, Inc.

Buffalo Association for the Blind

VOLUNTARY AND PRIVATE ORGANIZATIONS—continued

California Institute of Physical Medicine and Rehabilitation
Catholic War Veterans of the United States of America
Chicago Lighthouse for the Blind
The Cleveland Rehabilitation Center
Commission on Chronic Illness
Council of Jewish Federations and Welfare Funds
Crossroads Rehabilitation Center
Crotched Mountain Foundation
Curative Workshop of Green Bay
Curative Workshop of Milwaukee
The Curative Workshop of Racine
Dade County Society for Crippled Children
Davison Technical School, Inc.
Delaware Curative Workshop
Disabled American Veterans
The Easter Seal Rehabilitation Center
Epilepsy Association of New York
Equitable Life Assurance Society of the United States
Essex County Service for the Chronically Ill
Family Service Association of America
Florida Council for the Blind
General Conference of Seventh Day Adventists
George Washington University
Gonzales Warm Springs Foundation for Crippled Children
Goodwill Industries of America
Grand Rapids Rehabilitation League
The Hartford County Rehabilitation Workshop
Hogg Foundation for Mental Hygiene
Illinois Association for the Crippled
Indiana Society for Crippled Children
Indiana University
Industrial Home for the Blind
Industrial Home and Division for the Blind
Institute of Physical Medicine and Rehabilitation
International Council for Exceptional Children
Iowa Society for Crippled Children and the Disabled
Jewish Occupational Council
Jewish War Veterans of the United States of America
Kansas Rehabilitation Center for Adult Blind
Kentucky Society for Crippled Children
Kessler Institute for Rehabilitation
Lake Tomahawk State Camp
Liberty Mutual Insurance Co.
Life Insurance Association of America
May T. Morrison Center for Rehabilitation
Board of Hospitals and Homes of the Methodist Church
Metropolitan Atlanta Association for Colored Blind
Metropolitan Life Insurance Co.
Minneapolis Curative Workshop
Minneapolis Society for the Blind
Miriam Convalescent Rehabilitation Center
Mobility, Inc.
Muscular Dystrophy Association
National Association for Mental Health, Inc.
National Association for Retarded Children
National Association on Sheltered Workshops and Homebound Programs
National Catholic Welfare Conference
National Committee on Sheltered Workshops and Homebound Programs
National Conference of Catholic Charities
National CIO Community Services Committee
National Epilepsy League
National Farmers Union
National Foundation for Infantile Paralysis
National Grange
National Health Council
National Home Study Council
National Industries for the Blind
National League for Nursing
National Lutheran Council
National Multiple Sclerosis Society
National Recreation Association
National Rehabilitation Association
National Rehabilitation Commission
National Social Welfare Assembly
National Society for Crippled Children and Adults
National Tuberculosis Association
National University Extension Association
New York Association for the Blind
New York State Rehabilitation Hospital
The Occupational Therapy Workshop
The Ohio Citizens' Council for Health and Welfare
Ohio State University Rehabilitation Center
Oakland Orientation Center for the Blind
Oklahoma Agricultural and Mechanical College—The Rehabilitation Center
Orthopedic Appliance & Limb Manufacturers Association
Paralyzed Veterans of America
Pennsylvania Working Home for Blind Men
Philadelphia Society for Crippled Children and Adults
Portland Rehabilitation Center
Board of Pensions of the Presbyterian Church of the United States of America
Rehabilitation Center, Louisville, Ky.
Rehabilitation Center of Hawaii

VOLUNTARY AND PRIVATE ORGANIZATIONS—continued

Rehabilitation Center for the Physically Handicapped, Stamford, Conn.
The Rehabilitation Institute, Kansas City, Mo.
Rehabilitation Institute, Detroit, Mich.
Rehabilitation Institute of Chicago
Research Council for Economic Security
Rochester Rehabilitation Center
Saranac Lake Rehabilitation Guild
Selective Service System
Shut-in Society
Sieberling Health Center
St. Paul Rehabilitation Center
Springfield Rehabilitation Center, Massachusetts
Tuskegee Rehabilitation Center
United Cerebral Palsy Association
United Foundation
United Mine Workers of America
University of Buffalo Chronic Disease Research Institute
Veterans of Foreign Wars of the United States
Visiting Nurse Association of New York
Volunteers of America
We, the Handicapped
Western Society for Physical Rehabilitation
Wisconsin Neurological Foundation
Woodrow Wilson Rehabilitation Center

CONTENTS

and training handicapped homebound persons, particularly in rural areas; and, third, to ascertain whether additional or supplementary programs or services are necessary to provide adequate general ameliorative services and vocational training services.

The scope of the study was directly and unavoidably limited by certain important considerations. Of these, time was unquestionably the most limiting, since all facets of services referred to in the act could not possibly be examined authoritatively without instituting and completing new surveys. This was not feasible within the 6 month period provided in the new law. A further limitation was the dearth of organized data regarding services to, and needs of, homebound persons; this was true at National, State and local levels for the homebound as a group, with the result that intensive investigation and analysis was impossible.

To obtain relevant data, major reliance was placed upon the information available from (1) Federal agencies and national private and voluntary organizations; (2) State agencies, public and private; and (3) local organizations. In all, some 250 public and private agencies were contacted to obtain data. (The nongovernmental organizations are listed in appendix I.)

The study emphasized the specific types of services referred to in the act—teaching, training and vocational. The programs identified and studied are described more fully in part V.

DEFINITIONS

The terms "homebound" and "shut-in," while having a general connotation, are easier to comprehend than to define. For purposes of this study, a homebound person is defined as one whose physical or mental condition prevents him from leaving his home regularly for education, training, rehabilitation services, employment or in pursuit of other activities. Individuals confined to the home temporarily because of illness or disability, as well as those residing in institutions, are not included.

Generally the homebound are among the most severely disabled group. However, it is not necessarily the type or severity of disability which determines whether an individual is homebound. Frequently it is a combination of the disability and circumstances. The ability of an individual to adjust emotionally to his disability often is important in determining whether or not he becomes homebound. Geographical factors are also important. The availability of a wheelchair or transportation services may enable one severely disabled person to leave his home, while the lack of such facilities leaves another homebound.

This is illustrated in multitudes of individual situations throughout the country. The following item, "School's Ban on Lame Boy Spurs Plans," reported in the Washington Daily News of October 12, 1954, indicates the important role that "circumstances" can play in making a person homebound.

> The case of an unfortunate crippled boy who was banned from the District's health school * * * because he weighs 100 pounds has started a chain reaction in public school planning here.
>
> His case may lead to new standards—including weight—for admission to a new centralized health school now in the planning stage.

The 100-pound crippled boy suffers from muscular dystrophy and has been confined to a wheelchair since last April. He has been a student at the * * * school for the past 4 years.

On September 4 his parents were notified he couldn't come back, on account of his weight. They were told the driver of the school station wagon couldn't lift him now.

His father protested and on October 11 the ban was lifted.

"We assigned him to a school bus with an attendant who can lift the boy," school budget officer explained.

(The budget officer) also reported the incident has inspired him to ask (the Superintendent) to name a study committee to set up standards for admission of handicapped children to the new school.

"It will also include high-school students," said (the budget officer). "We might have to equip our buses with a sort of lifting apparatus to get them in and out."

PART II

EXTENT OF THE PROBLEM

SUMMARY

No study, nationwide in scope, has ever been undertaken to provide the new basic data necessary to properly assess the size and characteristics of the homebound population in the United States. Data related to the subject are fragmentary and, in many instances, limited to a single locality.

The homebound population is estimated to number in the neighborhood of 1 million persons. This includes persons of all ages who have been confined to their homes for at least 1 year. It excludes persons in institutions. The lack of comprehensive information, however, is such that this estimate could vary by as much as 25 percent in either direction.

Without recourse to statistics on the homebound, it is apparent to authorities studying health, vital statistics, and other aspects of national life that scientific and social progress in this country, as illustrated by the development of the antibiotics, vastly improved surgery, more and better hospital services and other advances, has saved the lives of many thousands of persons. Only a few decades ago these people, with the same illnesses and injuries, would have died; today they survive—but often with such severe residual physical disabilities that they become homebound.

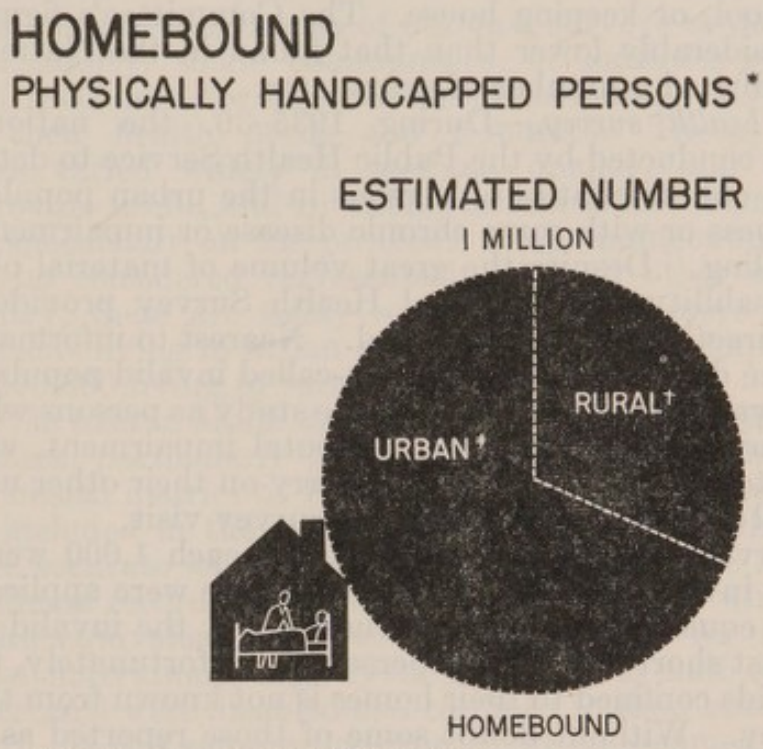
The conditions, then, which produce severe disability and restrict people to their homes promise to increase in proportion to the success which our society achieves in saving and lengthening the lives of the American people.

Statistically, it appears that there currently are about a million homebound handicapped persons in the United States. This is based on analysis of a variety of studies in the field of illness and disability, which are described in the following pages. For purposes of this statistical review, all age groups have been included; persons in institutions have been excluded;[1] and only those who have been confined to their homes for a period of 1 year or more are classified as homebound.

On the latter point, it is recognized that many disabled persons who, at any given time, have been homebound for less than a year are in fact homebound to the same extent as those so restricted for a year or more. It has been suggested, for example, that in estimating

[1] It is estimated that in 1950 there were about 1¼ million persons residing in mental hospitals; tuberculosis hospitals and other special hospitals; nursing, rest, and convalescent homes; homes for the aged and dependent; and homes and schools for the mentally and physically handicapped. It is not known how many of these were bedfast or otherwise unable to leave the institution because of physical or mental disabilities. However, for the most part they represent persons with long-term disabilities. Generally, these individuals would require the same types of services as the disabled living in their own homes. However, the problems of providing services are frequently vastly different as between an institutional setting where the "homebound" can ofttimes be provided services in a group and the instances where the homebound in their own homes are widely scattered in a rural area.

the number of homebound requiring medical services, data relating to the number of persons confined to their homes for 3 months or more might be used. This would, of course, substantially increase the estimate. With this in mind, the estimate of 1 million homebound may be considered conservative.



None of the following studies was made with the particular objective of determining the number of homebound disabled individuals in a population group. Moreover, a span of about 25 years is covered from the oldest to the most recent study described. They vary widely in scope, detail, emphasis, and in techniques employed. The study results, as would be expected, reflect these differences.

National surveys

In the past 25 years only 3 studies have been made which yield data sufficiently broad in scope that one may reasonably make rough national estimates of illness and the extent of disability from them. The significant findings of each of these studies which provide some information on the extent of the homebound problem are outlined below.

Committee on the costs of medical care.—The first of the national studies was conducted by the Committee on the Costs of Medical Care during the years 1928–31.[2] While this wide-scale survey provided a wealth of information on the incidence of illness and the use and costs of medical services, no data were obtained on disabled

[2] Between February 1928 and June 1931, the Committee on the Costs of Medical Care conducted a study of illness and the receipt and costs of medical care in families in representative communities throughout the United States. The sample included 130 communities in 17 States and the District of Columbia, and covered all sizes and types of communities. White families of two or more persons at all income levels were selected for survey, usually by house-to-house canvass, and were visited at 2-month intervals during 12 consecutive months. The final tabulations related to 39,185 individuals in 8,758 white families. The Public Health Service cooperated in the tabulation and analysis of the data. Source of data: Unpublished data obtained from the Public Health Service.

persons who were homebound. Of interest, however, was the finding that in the population surveyed by the Committee about 3 persons in each 1,000 were reported as disabled throughout the study year, excluding those in institutions. Disability, according to the study, meant that because of some physical or mental condition, an individual was unable to carry on his usual duties, such as working, going to school, or keeping house. The Committee's figure of 3 per 1,000 is considerably lower than that found in the National Health Survey, conducted a number of years later.

National health survey.—During 1935–36, the national health survey [3] was conducted by the Public Health Service to determine the number and characteristics of persons in the urban population, with disabling illness or with some chronic disease or impairment, whether or not disabling. Despite the great volume of material obtained relating to disability, the National Health Survey provided no data pertaining directly to the homebound. Nearest to information of this kind were the data obtained on the so-called invalid population of the Nation. Invalids were described by the study as persons who, because of disease, accident, or physical or mental impairment, were unable to work, go to school, keep house, or carry on their other usual activities for a full 12 months preceding the survey visit.

In the surveyed population, 11.7 out of each 1,000 were reported to be in this invalid group.[4] If this same rate were applicable today, and applied equally to urban and rural areas, the invalid population might fall just short of 2 million persons. Unfortunately, the proportion of invalids confined to their homes is not known from the national health survey. Without doubt some of those reported as "invalids" were able to engage in activities outside the home.

Disability surveys, February 1949 and September 1950.—Since the time of the national health survey, only one known attempt has been made to determine the extent of disability in the United States. In February 1949 and in September 1950, the Census Bureau's current population survey obtained data on the prevalence and duration of disability.[5] Survey findings related to the civilian noninstitutional population 14 to 64 years of age. While the survey results did not provide guides for estimating the homebound population, the September 1950 study did provide data on the number of persons who had been disabled for a year or longer. On the day of the survey in September 1950, nearly 2 million persons 14 to 64 years of age and not in institutions had been disabled for at least a full year.[6] Of

[3] During the winter of 1935–36, the Public Health Service conducted an inquiry into the state of the Nation's health by means of a house-to-house canvass in 83 cities in 18 States. The 83 cities were selected so as to be representative in general of cities in the United States according to region and size. A total of 2,502,391 individuals in 703,092 households were included in the sample. An additional 36,801 households, including 140,418 persons were surveyed in 23 rural counties in 3 States. Data from the rural sample, however, were not included in the tabulations on invalidism. Source of data: Britten, Rollo H.; Collins, Selwyn D., and Fitzgerald, James S. The National Health Survey: Some General Findings as to Disease, Accidents, and Impairments in Urban Areas. Public Health Reports, March 15, 1940, Reprint No. 2143, 27 pages. (See pp. 16–17.)

[4] Persons in institutions for the care of physical or mental diseases were not directly enumerated in the survey, although the family was asked to report such persons. Reports obtained were so incomplete that the data are considered to relate to the noninstitutional population only.

[5] Each month the Bureau of the Census conducts a current population survey that provides, on a sample basis, national statistics on employment and unemployment. Although designed primarily to produce current statistics on the labor force, it is frequently used for making special surveys for a wide variety of purposes. In February 1949 and in September 1950, as a joint project of the Social Security Administration, the Public Health Service, and the Office of Vocational Rehabilitation, questions on disability were added to the survey schedule. As used in the study, disabled persons are those who, on the day of the survey, were unable to do their regular work or other duties because of disease or injury, as well as those who had a long-term physical or mental condition that allowed them to work only occasionally or not at all.

[6] Unpublished data. Office of Vocational Rehabilitation.

these, about 800,000 reported that they were unable to work. (This excludes persons reported as keeping house, unemployed, or retired from active work.) Without doubt, many in the group were homebound; others, although unable to work, were able to carry on some activity outside their homes.

Community surveys

While there has been a dearth of national surveys to determine the extent of disability, single communities, or localities—increasingly conscious of their need for information of this kind—have proceeded to survey their health needs and resources. These community studies have varied widely in method, quality, and scope. All, however, provide useful and revealing information. Some give data which bear specifically on the problems of the homebound. If their results can be considered representative for all other communities in the country, there are today some 600,000 or more homebound disabled persons living in urban communities and perhaps somewhat more than 300,000 living in rural areas.

Illness in the eastern health district of Baltimore.—In 1938, a special study of illness, particularly of the chronic diseases, was started in the eastern health district of Baltimore.[7] Monthly visits were made to families included in the sample in order that their illness records might be as accurate as possible. At the close of the first year of the study, illness records had been obtained for 1,796 white families, including the equivalent of 5,699 persons studies for a full year. Among these individuals, slightly more than one-half of 1 percent (0.56 of 1 percent) were disabled and confined to their homes throughout the year. If this same proportion could be assumed to apply to all urban communities in the country, some 400,000 men, women, and children were disabled and confined to their homes throughout 1939. Assuming that the same figure holds true today, an estimated 600,000 disabled homebound live in our urban communities.

The New Haven survey.—In 1947, a study of the prevalence of chronic diseases in New Haven, Conn., was conducted by the department of public health of Yale University in cooperation with the city department of health.[8] Although the sample was small (802 households including 2,804 persons) certain results of the study were fairly close to those from the Baltimore eastern health district study made 10 years earlier.

In the New Haven study, persons with chronic disease were grouped according to whether they were bedfast, confined to home, ambulant with limited activity, or ambulant with unlimited activity. Those found to be bedfast (but not in institutions) or confined to their homes represented one-half of 1 percent of the city's population (compared with 0.56 of 1 percent in the eastern health district of

[7] In June 1938, this special study was initiated among a sample of white families in the eastern health district of Baltimore, Md., by the Public Health Service and the Milbank Memorial Fund in cooperation with the Johns Hopkins School of Hygiene and the Baltimore City Health Department. The population in the district was considered as fairly representative of the localities in the city in which the wage-earning population live. Source of data: Downes, Jean; and Collins, Selwyn D., A Study of Illness Among Families in the Eastern Health District of Baltimore, The Milbank Memorial Fund Quarterly, vol. 28, No. 1, January 1940, pp. 5-26.

[8] In November 1947, stimulated by the New Haven Committee on Care of the Chronically Ill (Health Division of the Council of Social Agencies), a chronic disease survey of New Haven was undertaken as a class project in statistics by the department of health of Yale University. Students acted as interviewers in a house-to-house canvass of a representative sample of households in the city. Source of data: Gerber, Joseph Hanford, Community Planning for the Chronically Ill. A dissertation presented to the faculty of the School of Medicine, Yale University, in candidacy for the degree of doctor of public health, 1948. (Available in the office of vocational rehabilitation.)

Baltimore). This figure, if applicable to today's urban population, would give a total of about 500,000 disabled homebound living in urban communities.

The Hunterdon County health survey.—In 1952 a study of the prevalence of chronic illness and the needs for care was initiated in Hunterdon County, N. J., an agricultural area with a population of 43,000.[9] Cosponsors of the project are the commission on chronic illness and the Hunterdon Medical Center, with financial assistance from the Commonwealth Fund.

As one of the initial steps in the survey, a house-to-house interviewing of a sample of 4,000 families (including 13,000 persons or about one-third of the population) was undertaken to identify the chronically ill, and the nature, extent, and duration of disability. The results of the survey are not yet complete. Preliminary information, however, indicates that just under 1 percent of the persons studied had been prevented by some disabling condition from going out of doors for a full year prior to the date of the interview. If these results are applicable to the entire rural population in this country, they imply a rural homebound population in the neighborhood of 300,000 persons.

Other local studies

In the main, community or local health surveys (other than those described briefly above) have been limited to certain population groups, as the aged, the recipients of public assistance, or persons known to social agencies. Consequently, while their results are informative and useful for local study and planning, they usually shed little light on the situation nationally. However, mention of findings from certain of these studies does appear warranted to illustrate community initiative and recognition of health problems

Old age in Rhode Island.—In 1953 the Rhode Island Governor's Commission To Study Problems of the Aged conducted a survey of the characteristics of the State's aged population.[10] At the time, 89 out of each 1,000 persons in the State were 65 years of age or older; the national rate was 81 per 1,000. About 4,500 of the aged—6 percent of the total aged population of 75,000—reported that they were entirely limited in physical activity. They were bedridden or chairbound, and needed almost complete help in such things as dressing, bathing, or eating. (If this same percentage could be applied to the group aged 65 and older in our national population, about 800,000 of these older people are completely limited in their physical activity and generally could be considered as homebound.) An additional 20,000—30 percent of the State's aged—reported partial limitation of activity. Although able to take care of their personal needs, they could get around very little outside their own homes. These figures did not include 3,500 aged residing in institutions.

Cleveland, Ohio, study of sheltered employment.—The Welfare Federation of Cleveland, in 1950, undertook a survey of the needs and resources for sheltered employment throughout Cuyahoga County.[11] Through questionnaires sent to public and private agencies serving the handicapped, data were obtained on disabled clients for whom

[9] Chronic Illness News Letter, vol. 3, No. 5, June-July 1952. Unpublished tabulations provided by the Hunterdon Medical Center.

[10] Old Age in Rhode Island: Report of the Governor's Commission To Study Problems of the Aged. Providence, July 1953, 143 pages. (See pp. 5, 25, and 27.)

[11] Welfare Federation of Cleveland, Study of Sheltered Employment Needs and Resources. September 1950. 55 pages and appendix.

sheltered employment was needed. The study thus was limited to persons of working age.

Reports were obtained concerning 3,059 handicapped individuals. Of these, 446, or 14.5 percent, were classed as bedbound or homebound and in need of home employment. An additional 151 (5 percent), although ambulatory, were considered by agency staffworkers as incapable of traveling to and from work, and consequently, also in need of home industry. Most of these 597 disabled persons were 50 years of age or older; about 1 in 5 were at least 70 years of age. Indications from the study were that women are in greater need of homebound industry than men.

Mississippi study.—In 1953, at the request of the Recess Education Committee of the Mississippi State Legislature, a survey was made to determine the number of severely handicapped in the State who could benefit from the services of a comprehensive rehabilitation center.[12] Agencies participating in the survey were the vocational rehabilitation division of the State department of education, the State department of public welfare, and the crippled children's services. Data obtained represented, for the most part, four groups of the handicapped:

1. Persons known to the vocational rehabilitation division, obtained from a statewide study.
2. Recipients of aid to dependent children in 33 counties. These counties represented about 40 percent of the State's population.
3. Recipients of aid to unemployables in 33 counties.
4. Rejected applicants for aid to unemployables in 33 counties.

A total of 1,134 persons were identified through the study as severely disabled. The study further concluded that, had the entire State been covered by the aid to dependent children and aid to unemployables survey, probably double this number would have been identified.

All of these 1,134 persons were 16 years of age or older. Seventy (6 percent) were found to be bedridden; 161 (14 percent) were chairfast; and 81 (7 percent) were able to walk only with the assistance of another person.

Study of disability assistance cases, Champaign and Sangamon Counties, Ill.—In 1952–53, a group of students of the School of Social Work of the University of Illinois undertook an analysis of disability assistance records in Champaign and Sangamon Counties.[13] Their purpose was to determine the social and, to a limited extent, medical characteristics of persons receiving aid under the disability assistance program, and of persons who were "denied" such aid. A total of 68 active cases and 70 "denied" cases, recorded from the beginning of the program in 1950 through November 1952, were read.

In about 40 percent of the active cases, the recipients were homebound; of this group, about two-thirds were either bedfast or chairfast. Of the recipients who were not homebound, almost one-third needed some help from another person in getting around.

As a group, the "denied" applicants were more mobile than the recipients. Only 9 percent were homebound, and only 2 percent were not homebound but needed the help of another person in getting about.

---

[12] Supplemental Report to the Mississippi State Legislature by the Recess Education Committee, Jackson, Miss., April 1953, 27 pages.

[13] University of Illinois, School of Social Work. Disabled and Dependent: A Study of Disability Assistance in Champaign and Sangamon Counties, Ill., 1950–52, 25 pages. Processed. (Available in Office of Vocational Rehabilitation.)

PART III

CHARACTERISTICS OF THE HOMEBOUND

SUMMARY

Few studies have given more than an indication of the numbers of homebound individuals. From the very inadequate information available, it would appear that (1) practically every type of incapacitating disease and injury is present among the homebound group; (2) the predominant causes, numerically, would seem to be heart conditions, nervous and mental diseases, and arthritis, rheumatism and allied conditions; and (3) a majority of the homebound handicapped population are in the upper age groups.

To know and understand the problems of the homebound, to plan effectively for needed services, and to translate plans into action programs, facts should be at hand on the characteristics of this group of the severely disabled. Data should be available, for example, on age, sex, economic status, living arrangements, past employment, type of disability, medical or rehabilitation services received, and other social or medical characteristics.

The findings of a number of studies which provide some data on the characteristics of the homebound are described below.

National Health Survey.—The National Health Survey of 1935–36, as described previously, obtained data on the "invalid" population at that time. Nearly two-thirds of the invalid group were 45 years of age or older; a relatively small number (only 5.6 percent were under age 15). (See appendix II, table A.)

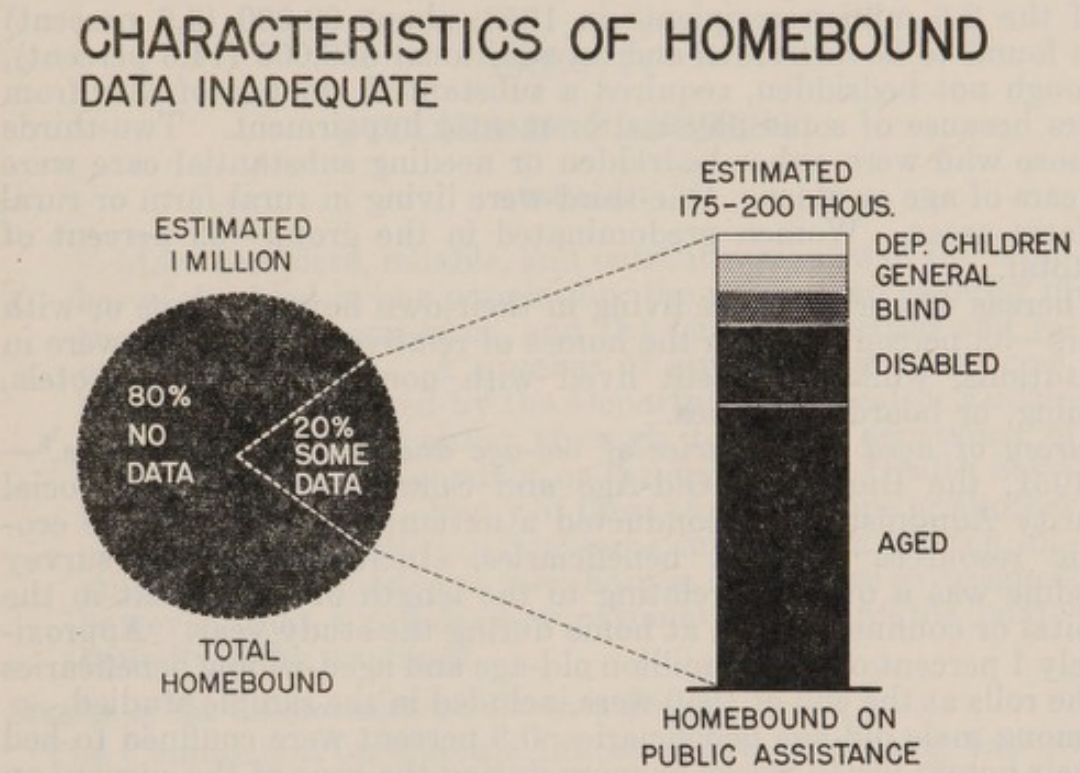
The five leading causes of disability, in this invalid group were: cardiovascular-renal diseases, nervous and mental diseases, rheumatism and allied conditions, permanent results of accidents, and tuberculosis. (See appendix II, table B.)

Public assistance: Recipients of aid to the permanently and totally disabled.—Amendments to the Social Security Act in October 1950 provided for Federal participation in assistance payments to needy persons who are permanently and totally disabled. By the middle of 1951, when 31 States were participating in the program, about 100,000 individuals were receiving such aid. To obtain information on the social and medical characteristics of these persons, a sample study covering 30 States and representing 93,000 persons was undertaken by the Bureau of Public Assistance, Social Security Administration, in June 1951.[1]

Of the 93,000 persons receiving aid to the permanently and totally disabled in mid-1951, about 1 in 5 were found to be housebound.

[1] Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Characteristics of Recipients of Aid to the Permanently and Totally Disabled, mid-1951, Washington, D. C., April 1953, 99 pages (Public Assistance Rept. No. 22.)

These included almost 6 percent who were bedridden; about the same percent who were chairfast; and nearly 9 percent who were unable to get around in their homes.



There are no recent facts to show whether, in terms of the current program load of 210,000 cases, the housebound ratio of 1 in 5 recipients is still the same as in 1951 or has changed. A large share of the increase in the total load is accounted for by increased numbers aided in the 30 States which were included in the 1951 study, rather than by the addition of caseloads from States which have adopted the program since that time. If the ratio still holds, there would be some 40,000 housebound among persons now receiving aid to the permanently and totally disabled.

In 1951 about one-half of the housebound recipients were 55 years of age or older. (See appendix II, table C.) The five most frequent major impairments for the housebound group were cerebral paralysis, arthritis, hypertension with heart disease, mental deficiency, and arteriosclerotic heart disease. The 4 major impairments that were among the first 10 in frequency for housebound recipients but were not common to more mobile recipients were cerebral spastic (infantile) paralysis, late effects of poliomyelitis, multiple sclerosis, and malignant neoplasms, in that order. The majority of the housebound, and practically all of the bedridden or chairfast, required personal services in their daily activities—in eating, dressing, bodily hygiene, or ambulating. About one-half of those able to move about in their homes needed such personal services. (See appendix II, table D.)

Not quite half (43 percent) of the housebound recipients were living in their own homes, alone or with others. About one-third (35 percent) lived in the homes of relatives—sons, daughters, parents, and others. Fifteen percent were in institutions, while 7 percent were living with nonrelatives or in hotels, rooming, or boarding houses.

Public assistance: Recipients of old-age assistance.—In 1953, the Bureau of Public Assistance, Social Security Administration, made a

study of the characteristics of recipients of old-age assistance. At that time, some 2.5 million persons were receiving this type of aid. Although the report of the study has not yet been released, preliminary data have been provided by the Bureau of Public Assistance.

Of the 2.5 million recipients in 1953, about 92,000 (3.6 percent) were found to be bedridden and an additional 368,000 (14.3 percent), although not bedridden, required a substantial amount of care from others because of some physical or mental impairment. Two-thirds of those who were either bedridden or needing substantial care were 75 years of age or older. One-third were living in rural farm or rural nonfarm areas. Women predominated in the group—62 percent of the total.

Whereas 40 percent were living in their own homes—alone or with others—33 percent lived in the homes of relatives; 21 percent were in institutions, while 6 percent lived with nonrelatives or in hotels, rooming, or boarding houses.

Survey of aged beneficiaries of old-age and survivors insurance.[2]—In 1951, the Bureau of Old-Age and Survivors Insurance, Social Security Administration, conducted a nationwide survey of the economic resources of aged beneficiaries. Included on the survey Schedule was a question relating to the length of time spent in the hospital or confined to bed at home during the study year. Approximately 1 percent of the 2¼ million old-age and aged-widow beneficaries on the rolls at the end of 1950 were included in the sample studied.

Among male old-age beneficiaries, 0.8 percent were confined to bed in their homes for 40 weeks or more during the year of the survey; an additional 0.6 percent reported a combined hospital-home bed stay of this length of time. Among women beneficiaries, the proportions were only slightly higher—1.0 percent reported that they were confined to bed at home for 40 weeks or more during the year, and 0.7 percent reported a combined hospital-home bed stay of this duration.

While women who were 80 years of age or older represented only 5 percent of all aged-women beneficiaries studied, this group of the extremely aged accounted for nearly 21 percent of those confined to bed at home for at least 40 weeks during the year. About 9 percent of the male beneficiaries studied were 80 years of age or older; 19 percent of those in bed at home for 40 weeks or more were in this octogenarian group.

Hunterdon County health survey.—The Hunterdon County health survey has been briefly described in the previous section of this report. (See pt. II, p. 9.) Although the final results of the survey are not yet available, some preliminary information on homebound individuals has been provided by the Hunterdon Medical Center. Of all persons included in the study, just under one-half of 1 percent were found to have been "kept indoors" for at least a full year because of a physical or mental handicap. Three-fourths of this group of long-term homebound persons were women. The majority (4 out of 5) were 65 years of age or older, and a relatively large number (nearly 2 out of 5) were at least 80 years of age.

The most frequently reported causes of disability in this homebound group were diseases of the heart, strokes, and other conditions or diseases affecting the central nervous system, arthritis, and impairments due to accidents.

[2] Data collected by the Bureau of Old-Age and Survivors Insurance, to be analyzed by the Division of Research and Statistics, Social Security Administration, Department of Health, Education, and Welfare.

PART IV

STUDIES IN PROGRESS

SUMMARY

More complete, reliable, and current measures of the number of disabled in our population, the nature and severity of their disabling conditions, and the services received and required are needed. A number of studies, now in process, have been encouraged by the Department of Health, Education, and Welfare, either through technical assistance in study planning and conduct or through Public Health Service research grants. Many of these studies, in one or another of their phases, will provide some information on the disabled who are confined to their homes. None are so designed, however, that a satisfactory national picture of the homebound will be produced.

Studies of the Commission on Chronic Illness

The Commission on Chronic Illness is now sponsoring two studies of the chronic-illness problem. Planning for these studies started in 1950 as a result of a strongly felt need among leaders in the chronic-illness field for a "definitive study of a population group to determine quantitatively the amounts and kinds of chronic illness." Need for knowledge of the relationship between urban-rural residence and chronic illness led to the commission's decision to conduct at least two surveys—one in a rural community and one in a highly industrialized, heavily populated urban area. Hunterdon County, in western New Jersey, was chosen as the site of the rural study. At the invitation of the subcommittee on chronic illness of the Commission on Medical Care of the Maryland State Planning Commission, Baltimore was selected as the locale for the urban study.

Hunterdon County health survey.—Reference has already been made to preliminary information from the Hunterdon County study (pt. II, p. 9).[1] Cosponsors of the project, it will be recalled, are the Commission on Chronic Illness and the Hunterdon Medical Center, under the direction of Dr. Ray Trussell, with major financial support coming from the commonwealth fund. Technical assistance in study planning, as well as a small research grant, has come from the Public Health Service of the Department of Health, Education, and Welfare. The National Opinion Research Center, an affiliate of the University of Chicago, and the New Jersey Department of Health, are responsible for major portions of the fieldwork and tabulation of study results.

[1] Commission on Chronic Illness. Chronic Illness News Letter. Rural-Urban Studies of Needs of the Chronically Ill, vol. 3, No. 5, June-July 1952; and Chronic Illness News Letter, vol. 5, No. 9, November 1954.

The Hunterdon County study is a five-part project designed to measure the needs of various types of long-term patients for care, rehabilitation, and other services. The five steps in the project are:

1. Questionnaires delivered to every household in the county to obtain facts on overall community health needs.
2. Interviewing a sample of 4,000 families—about one-third of the population. (Data used in pt. II, p. 9 of this report were obtained from this phase of the survey.)
3. Checking medical records of patients identified in step 2.
4. Diagnosis and evaluation, by a team including a physician, nurse, social worker, and vocational rehabilitation counselor, of the services needed and rehabilitation potential of about 1,000 long-term patients.
5. Multiple screening tests for several chronic diseases, given to a sample of 8,000 persons.

Step 4, in particular, will provide more definitive information on the nature and extent of the homebound problem than has yet been available from any survey. As part of the evaluation procedure, the mobility "status" of a patient is to be determined, including the bed status, ability to move about, walk, climb stairs, travel, or attend to personal safety. Tabulation of schedule information from this phase of the study is the responsibility of the National Opinion Research Center.

The Baltimore chronic illness study.[2]—In Baltimore, Md., plans for the urban counterpart of the Hunterdon County health survey were crystallized in 1952. Many groups and individuals have contributed to the study. The Department of Health, Education, and Welfare has furnished technical aid in study plans and also, through the Public Health Service, a research grant.

The Baltimore study involves four major phases:

1. An interview by trained interviewers to obtain information about illness and disability, in approximately 4,000 households, including about 12,000 people and representing a random sample of the population of the city.
2. A clinical evaluation of a subsample of about 1,000 persons. This evaluation consists of a review of existing medical information obtained from hospitals and private physicians; a complete diagnostic examination, including all indicated laboratory tests, at a special clinic established for the purpose at Johns Hopkins Hospital; and, for a special group, an evaluation of the social, nursing, and rehabilitation needs by a team, including a physician, nurse, social worker, and vocational counselor.
3. A series of simple screening tests to all members in the 4,000 households who were not included in step 2 and who were over 16 years of age.
4. The provision of rehabilitation services for those persons in step 2 identified as having a rehabilitation potential. The Maryland State Division of Vocational Rehabilitation has assumed the responsibility for this step in order to give a practical test to the process of estimating rehabilitation potential.

In December 1952, the Commission on Chronic Illness contracted with the Bureau of the Census for that agency to carry out most of

[2] Commission on Chronic Illness. Chronic Illness Newsletter, Progress Report on the Baltimore Chronic Illness Study, vol. 5, No. 9, November 1954.

the functions of step 1. This interviewing phase of the study started in September 1953 and was completed 1 year later. Tabulations of the data obtained are now in process. Step 2, the clinical-evaluation phase, is currently underway. As in the Hunterdon County survey, the information from the evaluation procedure is expected to provide specific data on the problem of homebound disabled individuals.

The Kansas City project

The Kansas City study is a 3-year project designed to identify the disabled in the metropolitan Kansas City area, and to determine the costs and benefits to the community of a comprehensive rehabilitation program. Fact-gathering will include information as to the number and needs of the bedridden and the homebound.

The project had its beginning in 1952 when a group of civic-minded citizens learned about the report of the Task Force on the Handicapped,[3] which resulted from a year of study by a special committee of the Office of Defense Mobilization.

Recommendation 17 of this task force report urged that a demonstration be launched as soon as possible, preferably in a labor-shortage area, to aid the community in establishing a program for identifying, rehabilitating, and employing disabled persons. It was upon this recommendation that the Kansas City citizens acted and upon which their project is based. Funds for the project are coming from Community Studies, Inc. (a nonprofit research group which studies various civic problems in the Kansas City area); the Public Health Service and the Office of Vocational Rehabilitation of the Department of Health, Education, and Welfare; the Kansas and Missouri State vocational rehabilitation programs; the Rehabilitation Institute; and various other local agencies.

The Department of Health, Education, and Welfare has participated actively in the project, not only through grants, but also by providing technical assistance from the Public Health Service and the Office of Vocational Rehabilitation in developing survey plans.

The project will consist of four phases. In the first phase—the community survey—personal interviews will be obtained from a representative sample of approximately 14,000 households located in the 4 counties which comprise the Kansas City metropolitan area (both Kansas and Missouri).

In this first phase, some indication will be obtained of the number and needs of bedfast and housebound disabled persons in the area. This part of the study is being carried out by the Bureau of the Census under contract to Community Studies, Inc.

In the second phase, the disabled persons found in the survey will be given an opportunity for special study by an evaluation team composed of a physician, a social worker, a public health nurse, a psychologist, a physical therapist, an occupational therapist, a speech therapist, a hearing specialist, a vocational rehabilitation counselor, and an employment-placement specialist. The team will determine the extent of disability and will prescribe treatment and training for those who can benefit from such services. More definitive information regarding homebound persons will be discovered during this phase.

---

[3] Report of the Task Force on the Handicapped to the Chairman, Manpower Policy Committee, Office of Defense Mobilization, Washington, D. C., January 25, 1952, p. 46.

In the third phase, those found able to benefit from rehabilitation will be given the opportunity to receive the services they need.

The fourth phase will consist of a followup of two groups: (1) Persons who receive rehabilitation services, and (2) persons who have not yet received such services. The purpose of the followup is to compare costs of restoring handicapped persons to maximum social and economic usefulness with the costs of maintaining the handicapped in their disabled condition.

The Kansas City project will include all age groups, all types of rehabilitation services and goals, and the homebound along with those who are ambulatory and able to travel.

The California current morbidity project

In 1950, the California Department of Public Health, aided by a research grant from the Public Health Service, Department of Health, Education, and Welfare, initiated a two-phase morbidity research program.[4]

The first phase of the project involved an intensive survey program in the city of San Jose, Calif., and a nearby rural area, to evaluate and pretest alternate methods of measuring current morbidity. This phase included two major steps: (1) an investigation of methods of using data on illness and disability from population surveys based on household sampling methods; and (2) investigation of methods of using data arising from operating programs (as the California disability insurance program, the California Physicians Service, and the Permanente Health Plan). The household sample survey in San Jose, conducted through contract with the Bureau of the Census, was started in February 1952 and continued through June 1952. During this period, additional morbidity data were obtained from hospitals, the local health department, State agencies, and other organizations.

The second phase of the program involved the application of appropriate methods of measuring morbidity on a statewide basis. Findings from the San Jose test were utilized in developing plans for this phase. In May 1954, the statewide survey got underway. The survey will continue for 1 year and will include interviews among 12,000 households. The Bureau of the Census was responsible for the design of the sample and is acting as the data collecting agent under a contract with the State health department. The survey will cover both chronic and acute diseases, as well as injuries, and will determine not only the nature and amount of illness in California but also time lost from work and the amount of medical and hospital care received. It is anticipated that the findings from this phase of the program will provide some information on the problem of the disabled homebound in California.

New York homebound project

Early in 1954, a joint project for the rehabilitation of potentially employable homebound adults was undertaken by the New York State Division of Vocational Rehabilitation and the New York University-Bellevue Medical Center's department of physical medicine and rehabilitation.[5]

---

[4] U. S. Department of Health, Education, and Welfare. Public Health Service. Sources of Morbidity Data. Listing No. 1, 1953, and Listing No. 2, 1954. (See Listing A-16.)

[5] Memorandum of October 29, 1954, from Dr. Edith L. Kristeller, Leo L. Stein, and Harry Katz to Dr. George G. Deaver, preliminary report—The Rehabilitation of Potentially Employable Homebound Adults. (Available in Office of Vocational Rehabilitation.)

The purpose of the study is to test the hypothesis that a rehabilitation team can assist a significant proportion of potentially employable homebound adults to improve functioning ability, thereby releasing them from their homebound status or enabling them to become more efficient at home.

The study consists of a team evaluation of 100 applicants for homebound employment, taken in order of application, who are determined eligible and feasible for rehabilitation service by the New York State Division of Vocational Rehabilitation. Before evaluation, consent to allow a patient to undergo the evaluation process and prescribed rehabilitation procedures must have been obtained from the applicant's doctor.

The rehabilitation team consists of a physician with various consultants from different specialties where indicated, a psychologist, an occupational therapist, a physical therapist, a social worker, and rehabilitation counselors. After the patient is seen by the team and the consultants, one of the following steps may be taken:

1. (*a*) Homebound employment is recommended without further consideration, or (*b*) certain equipment and services are suggested and obtained which are designed to make the individual a more efficient worker at home.
2. It is recommended that he be aided and encouraged to leave the home for training or employment purposes without inpatient services.
3. Further rehabilitation procedures are recommended, and the patient is presented to the center's inpatient evaluation clinic for admittance to the rehabilitation service.

Almost half (9 cases) have been found potentially nonhomebound. In several instances, a period of more than 90 days of physical restoration services will be necessary to bring this about. The 20 cases include 1 quadraplegic, 7 paraplegics, 2 persons with hip fractures, and 2 with other orthopedic disabilities; 1 schizophrenic and 7 with chronic diseases, including 3 cardiacs and 2 arthritics. The average age when accepted for service by the division of vocational rehabilitation was 44 years.

New York homebound children study[6]

Late in 1952, the children's division of the Institute of Physical Medicine and Rehabilitation of the New York University-Bellevue Medical Center (a joint program of the institute and the Association for the Aid of Crippled Children), in cooperation with the New York City Health Department, initiated a team evaluation of homebound handicapped school-age children in New York City. At that time 800 children with orthopedic handicaps and 300 children with rheumatic fever or heart disease were receiving home instruction from teachers provided by the New York City Board of Education.

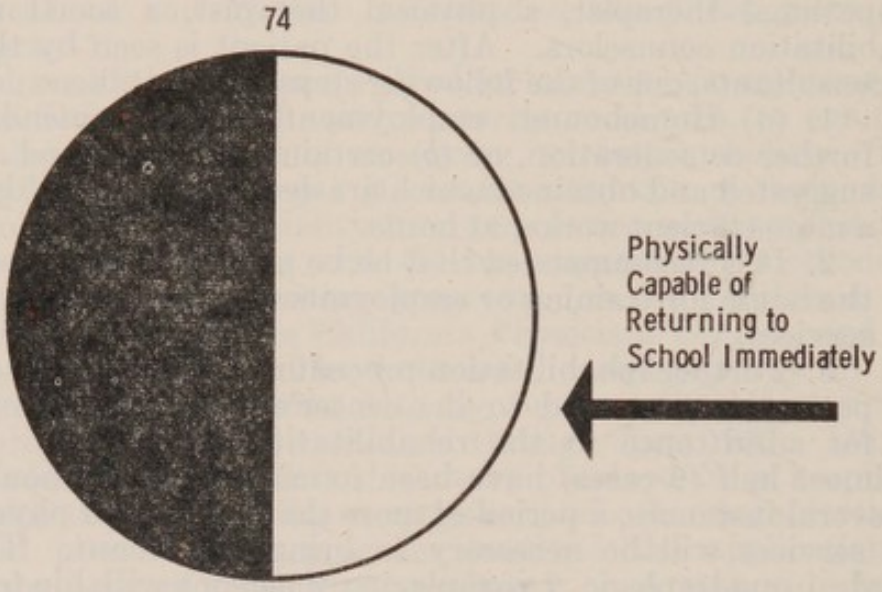
Permission for evaluation as well as abstracts of medical records were obtained from each child's physician or the hospital clinic where the child was under care. In certain instances, some social data were provided by the hospital, the home teacher, or other agencies interested in the family. Medical social workers discussed proposed evaluations

[6] Wallace, Helen M., M. D.; Siffert, Robert S., M. D.; Deaver, George, M. D.; and Pingitore, Eufelia, M. D., the Homebound Child, unpublished report from the Bureau for Handicapped Children of the New York City Department of Health, and the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center.

with children and parents, analyzed home and family situations, and secured the permission of the family to have the child evaluated. The findings and recommendations of the evaluation team, which consisted of an orthopedic surgeon, a psychiatrist, a pediatrician, and a medical social worker, were sent to the child's private physician or hospital.

Seventy-four orthopedically handicapped school-age children have been evaluated by the team. Perhaps the most outstanding observation from analysis of the evaluation data was the recommendation that one-half of these children were considered by the team as physically capable of returning to school immediately.

HOMEBOUND CHILDREN STUDY*

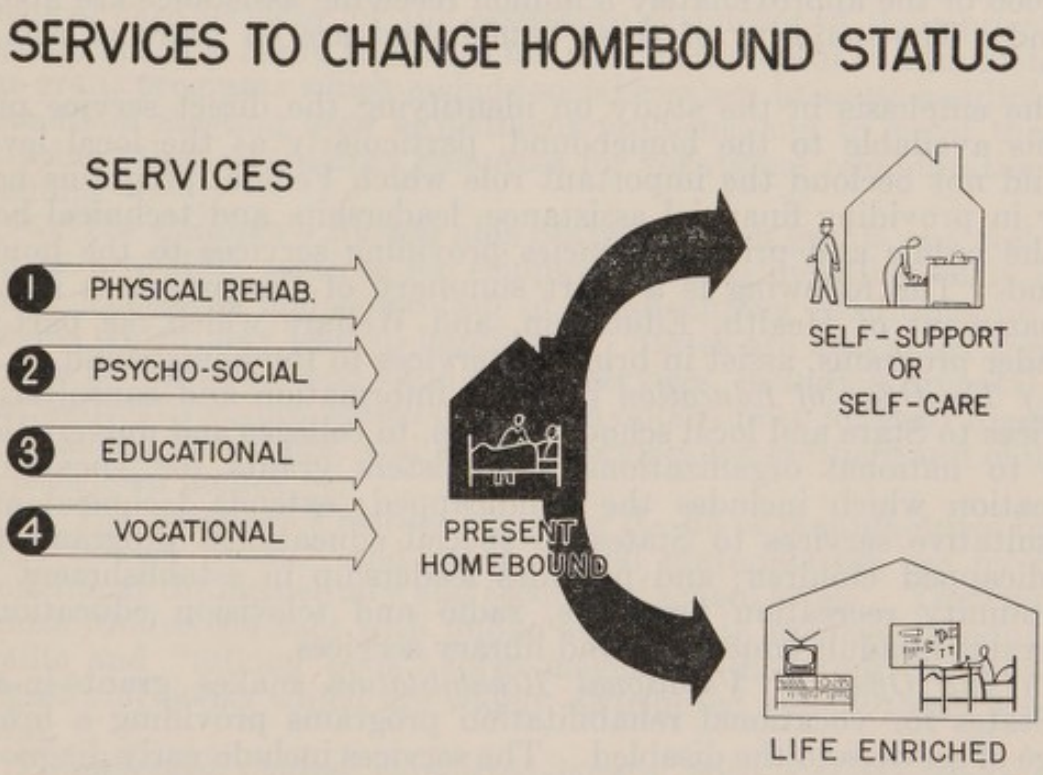


* Unpublished report in 1952 from the Bureau for Handicapped Children of the N.Y. City Dept. of Health & the Institute of Physical Medicine & Rehab. of the N.Y. University-Bellevue Medical Center.

PART V

NATURE AND EXTENT OF EXISTING SERVICES FOR THE HOMEBOUND

Although the study was directed toward a review of a variety of programs for the homebound, it was found that these fall into four major types: (1) physical rehabilitation in the functional activities of daily living; (2) psychosocial services; (3) general and special education, recreation and the worthwhile use of leisure time, and general ameliorative services; (4) vocational services, such as training and employment; and (5) combinations of all four.



The study relates primarily to a review of programs providing services to the homebound and does not include, in any detail, the programs which have among their objectives the prevention of accidents, diseases, and other disabling conditions which cause individuals to become homebound. In this category are the safety programs conducted by governmental and private groups and by industry and labor, and the health and medical research programs carried on or sponsored by the Federal and State Governments, the national voluntary groups, labor organizations, and the colleges and universities. Very important in this area are the programs of the National Institutes of Health of the Public Health Service, particularly the research work being carried on or sponsored through grants by the Institutes for Heart, Cancer, Mental Health, Arthritis and Rheumatism, and Neurological Diseases and Blindness, and the research activities

sponsored by such national organizations as the National Foundation for Infantile Paralysis, American Heart Association, American Cancer Society, and the Muscular Dystrophy Association.

The provision of financial assistance for homebound individuals has been excluded, although the importance of income maintenance is recognized. The primary programs in this regard are the Federal old-age and survivors insurance program and the Federal-State public assistance programs under the Bureau of Public Assistance in the Department of Health, Education, and Welfare, and the State general assistance programs. Needy homebound persons are included among those being aided under each of the four public assistance titles—"Old-Age Assistance," "Aid to the Blind," "Aid to Dependent Children," and "Aid to the Permanently and Totally Disabled." Although no study has been made to specifically identify the number of homebound persons receiving public assistance, recent data accumulated in the process of identifying the characteristics of the persons being aided by this program indicate that approximately 175,000 to 200,000 of the approximately 5 million receiving assistance are homebound. The majority of these homebound are 65 years of age or over.

The emphasis in the study on identifying the direct service programs available to the homebound, particularly at the local level, should not becloud the important role which Federal programs now play in providing financial assistance, leadership, and technical help to the public and private agencies providing services to the homebound. The following is a short summary of the programs in the Department of Health, Education, and Welfare which, as part of broader programs, assist in bringing services to the homebound.

(1) *The Office of Education* provides information and consultative services to State and local school systems, to colleges and universities, and to national organizations; administers grants for vocational education which includes the handicapped; extends technical and consultative services to States on special educational programs for handicapped children; and provides leadership in establishment of community recreation programs, radio and television educational programs in adult education, and library services.

(2) *The Office of Vocational Rehabilitation* makes grants-in-aid to States for vocational rehabilitation programs providing a broad range of services to the disabled. The services include early diagnosis of disabling conditions as a result of the medical examination provided applicants; the provision of the necessary medical services and treatment to reduce or overcome the disabling condition; vocational training for employment in his own home, in a sheltered workshop or in private industry; and when required, placement in a job. The disabled are also aided by grants to States and other nonprofit organizations and agencies for the development of rehabilitation centers for specialized services to the handicapped, for the development of sheltered workshops, for special research and demonstration projects, and for projects for training technical personnel.

(3) *The Public Health Service* assists States through grants, consultation, and technical aid in the prevention and control of communicable diseases and chronic diseases including heart disease, cancer, tuberculosis, mental diseases, arthritis, and rheumatism, and administers grants for general health purposes. The services to the

homebound include diagnostic clinics, laboratory services, casework services, health education, home visiting, and nursing services, and include individual and family referral to other community agencies. The Public Health Service also carries on a broad program of research on the incidence and prevalence of disease, and causes, prevention, and treatment of acute and chronic illnesses, including studies of the physical, mental and emotional problems associated with disease and disablement, and provides grants to individuals and institutions for the training of technical personnel; and administers a program for grants-in-aid to States for planning and constructing general and special hospital facilities, including rehabilitation centers and chronic disease hospitals.

(4) *The Bureau of Public Assistance* administers grant-in-aid programs to the States providing financial assistance to needy persons included under the titles of the Social Security Act relating to old-age assistance, aid to dependent children, aid to the blind, and aid to the permanently and totally disabled. Almost all States include some medical care services for the assistance recipients in their programs. Grants are also made to States for part of the costs of administering the grant programs which include social services to assist handicapped persons in meeting their adjustment problems and to assist them in utilizing other community resources for vocational rehabilitation and training.

(5) *The Children's Bureau* aids States through grants and technical aid in providing services for crippled children including early diagnosis, treatment and correction of handicapping conditions or conditions which may lead to handicaps. States are also aided through grants for maternal and child-health services, including prenatal care and well-baby clinics, which provide an opportunity for early diagnosis of disabling conditions, and nursing services for mothers and children in their own homes.

(6) *The American Printing House for the Blind* manufactures braille and "talking books," and other special materials for use by blind students at the elementary and secondary school levels. The Printing House (under contract with public and private agencies) produces in braille and "talking book" form magazines including the Reader's Digest and books which are widely distributed among those who are blind.

(7) *Gallaudet College*, supported largely with Federal funds, contributes toward the rehabilitation of homebound deaf persons through certain research activities, the training of all kinds of professional workers for the deaf, recruitment of missionaries and clerics for the deaf, and technical publications, including general sponsorship of the American Annals of the Deaf, oldest educational journal in America.

(8) *The Committee on Aging*, composed of representatives from those units of the Department which provide services for older persons, assists individuals and organizations serving older persons by serving as a clearinghouse of information on all aspects of aging, providing technical advice and consultation and by evaluation of program activities both within and without the Federal Government.

A number of other Federal programs have an important impact on services for the disabled. Particularly significant is the President's Committee on Employment of the Physically Handicapped which provides leadership for the national observance of Employ the Physi-

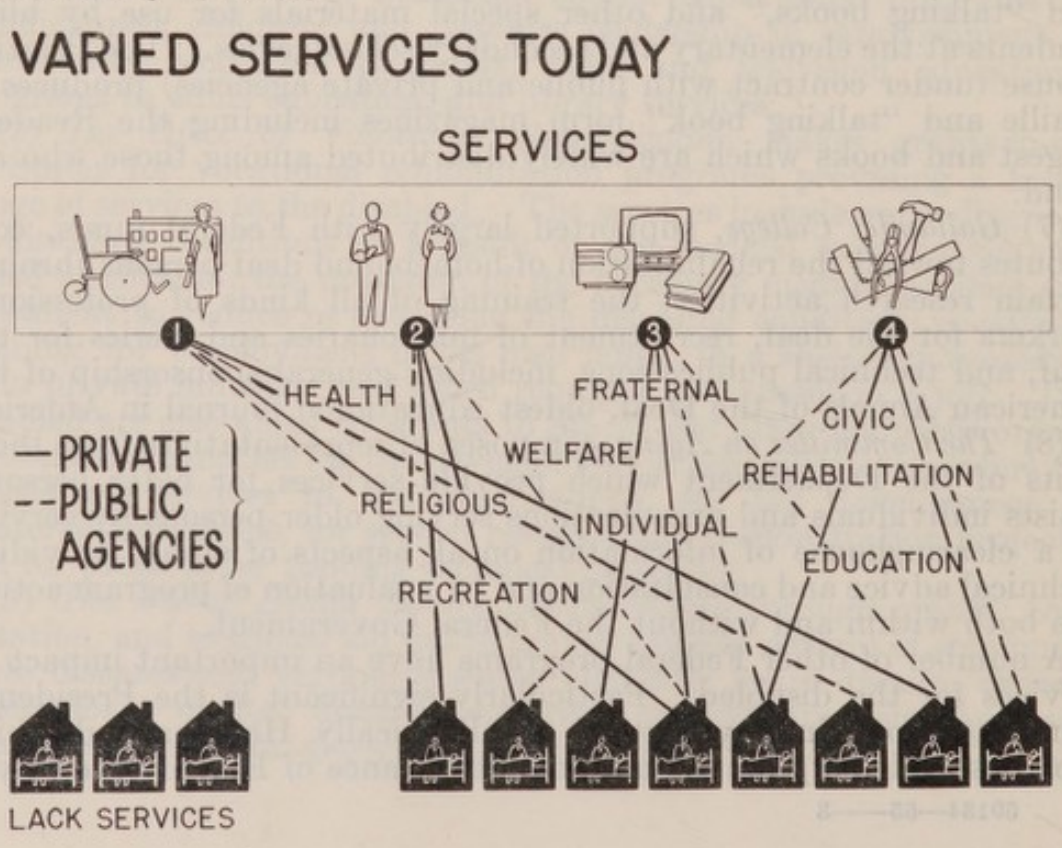
cally Handicapped Week, and carries on a continuing program of public information and education for the employment of handicapped citizens. The Committee cooperates with all groups interested in the employment of the handicapped, including Government agencies, private groups, and individuals.

Highly important also are certain of the programs of the Department of Labor including the activities of the Wage and Hour and Public Contracts Divisions, which administer the minimum wage and overtime provisions, the Fair Labor Standards Act, and the Public Contracts Act for covered workers including handicapped workers. The specific activities are described in appendix III.

The United States Employment Service provides selective placement services for the handicapped and provides a resource for those homebound persons who can be restored to the labor force.

The activities of the Division for the Blind of the Library of Congress in preparing and distributing the "talking book machines", "talking books" and other publications in braille are a direct and extensive service to homebound blind persons.

In addition to the Federal programs serving the disabled homebound generally, are those which provide services for special groups of the homebound. The largest and most comprehensive of these programs are the medical and vocational training services provided by the Veterans' Administration to eligible disabled veterans. Disabled civilian employees of the Federal Government and employees covered by the Longshoremen's and Harbor Workers' Act are aided by the medical and hospital care and rehabilitation services provided by the Bureau of Employees' Compensation of the Department of Labor. The Bureau of Indian Affairs through its educational, and health and welfare services assists Indians who are under the jurisdiction of the Department of the Interior. (The medical care services are to be transferred to the Department of Health, Education, and Welfare July 1, 1955.)



The following sections indicate the major types of services which have been developed to assist the homebound, give an approximation of the extent to which such services are available, and wherever possible, indicate the availability of services in rural areas.

Physical Rehabilitation Services

SUMMARY

Any planned program of services for the homebound should constantly emphasize those services which might permit the individual to leave his home or become significantly more self-sufficient within his home.

For many homebound persons this means physical rehabilitation in the functional activities of daily living. Such services can be given either within the home or by transporting the homebound individual to an appropriate hospital or rehabilitation center. These services are best effected when given by a rehabilitation "team" in which a variety of professions and disciplines pool and concentrate their skills upon the multiple problems of the disabled person.

Currently there are too few rehabilitation centers and too few hospitals which are equipped to meet this need. Available services are not well distributed geographically to reach all homebound persons, particularly those in rural areas. Public and voluntary agencies lack sufficient funds to send many known homebound persons to existing facilities for evaluation and rehabilitation or to bring such services to them within their homes. There is a serious shortage of trained rehabilitation personnel.

Some improvement can be expected as a result of the enactment of Public Law 565 by the 83d Congress to expand the State-Federal vocational rehabilitation program, and the enactment of Public Law 482, 83d Congress, to provide Federal grants-in-aid for the construction of rehabilitation facilities.

Many individuals are homebound today not because they are beyond help, but because help is beyond them. It is not simply a case of the necessary funds being out of reach, although this problem is all too familiar among the homebound. It is equally—and perhaps predominantly—a lack of understanding of what modern methods of physical rehabilitation can contribute in freeing the person from confinement to the home or making life in the home more active and enjoyable.

Because no adequate studies of sufficient scope have been carried out, it is impossible to project what portion of the previously estimated 1 million homebound handicapped persons might have potential for benefiting from such rehabilitation procedures. A number of research projects are underway to attempt to develop more definitive data on this question. What information is available, however, supports the contention of many rehabilitation authorities that a significantly large number of homebound persons could, with proper

services, respond to the point where they could leave their homes; many others could become much more self-sufficient within their homes.

Physical rehabilitation in the functional activities of daily living

The key principle in rehabilitation is consideration of the individual as a whole person, to the end that his total needs—medical, psychological, emotional, social, and vocational—may be met. In physical rehabilitation of the severely disabled, the starting point may often be the physical retraining of the individual in the functional activities of daily living.

Dr. Howard A. Rusk in 1951 wrote:

> Although we have in this Nation the world's finest institutions and programs for definitive medical care of our chronically disabled and aged, with but few exceptions there are no programs equipped to provide the patient who has a physical disability with the necessary retraining in the physical skills essential in performing the activities inherent in daily living. The physician in the past has thought too much about the physiological and clinical aspects of the patient's disability and too little about the physical retraining in skills necessary for carrying out the basic activities of daily living. Except in a few isolated instances, the physically handicapped person must be retrained to walk and to travel, to care for his daily needs, to use normal methods of transportation, to use ordinary toilet facilities, to apply and remove his own prosthetic appliances, and to communicate either orally or in writing. Too frequently, these basic skills are overlooked. The patient is given numerous medical, psychological, and vocational services in preparation for employment or self-care, but retraining in the activities of daily living is overlooked—with the result that the patient, being unable to walk or travel and care for himself, is also unable to utilize effectively the other medical, psychological, social, and vocational services he has received for richer and fuller living. Retraining in the basic activities of daily living is primary; it is simply a matter of "first things first," for daily-activity skills are the basis for all subsequent activities.[1]

As retraining in the physical activities of daily living is the "foundation of rehabilitation," this section of the study is devoted to outlining the extent of such services, including those given in an institution, such as a hospital or a rehabilitation center, and those performed within the patient's home.

The exclusion in this discussion of other types of medical services, particularly the care of the patient in his own home by the physician, which is the basic pattern for medical service in this Nation, should not be construed as implying that such services are not basic and fundamental to the maintenance of the health of the homebound individual or efforts to rehabilitate him. A great many other studies have been and are constantly being done under a variety of auspices on various aspects of medical care. Therefore this section of the report is directed only to physical rehabilitation.

Services provided outside the home.—In preparation for the National Conference on Care of the Long-Term Patient held March 18–20, 1954, a group of authorities on rehabilitation were asked to study rehabilitation in the care of ambulatory and homebound patients with long-term illnesses." [2] In the introduction to its report, this group stated:

> Some of these patients are homebound, but it should be recalled that this is rarely, if ever, an absolute restriction. The mobility of these patients * * *

[1] Rusk, Howard A., M. D. "Foreward" Physical Rehabilitation for Daily Living, by Edith Buchwald, p. vi. New York: McGraw-Hill Book Company, 1952.

[2] National Conference on Care of the Long-Term Patient, study group reports, committee I, The Patient at Home, Rehabilitation, p. 1 (mimeographed).

varies greatly, depending upon the physical and psychological status of the patient and the availability of appropriate personnel and devices to aid in achieving mobility.

However, after considering the limited availability of rehabilitation services in hospitals and rehabilitation centers, and the shortages of trained personnel, the same committee also stated:

> The overall trend is toward better services for the disabled through rehabilitation centers but that trend has a long way to go before every handicapped person will have near at hand a good rehabilitation center staffed with an expert team which can skillfully bring to bear on his problem the best knowledge that has been developed.[3]

Rehabilitation services in hospitals.—Rehabilitation services in hospitals are increasing and this increase undoubtedly will be hastened by the enactment in 1954 of two new Federal laws. Public Law 565, 83d Congress, provides for expanding the services of the Federal-State vocational-rehabilitation program and authorizes grants for training, demonstration projects and research. Public Law 482, 83d Congress, amends the Hospital Survey and Construction Act provisions of the Public Health Service Act to provide Federal grants to stimulate construction of rehabilitation facilities.

It is generally agreed that more and better rehabilitation services are especially needed in our general hospitals. The more than 20 million persons who are admitted to hospitals in this Nation annually have excellent medical care, but many are discharged with disabilities which cause them to become homebound—a burden to themselves, their families and society. Experience has shown that when comprehensive, well-integrated rehabilitation services are provided by hospitals, a substantial percentage of those who would otherwise be homebound or would live in institutions can be returned to useful, productive work or can achieve a significant degree of independence within the home.[4]

A 1950 survey of the Commission on Chronic Illness of 2,600 hospitals listed 65 hospitals as having "organized rehabilitation services." [5] Throughout the reports of the study groups of the National Conference on Care of the Long-Term Patient held in March 1954, are repeated references to the need for the extension and improvement of rehabilitation services in large general hospitals, small general hospitals, and chronic-disease centers.

The study group on large general hospitals stated among its recommendations that a general hospital should—

> Establish a rehabilitation service for both inpatients and outpatients and actively promote the concept of early rehabilitation.[6]

Similarly the study group on small general hospitals recommended—

> That the hospitals should provide, as far as possible, nurses, physical therapists, occupational theratists * * *.[7]

The study group on chronic-disease hospitals stated:

> The chronic-disease hospital should place much emphasis on rehabilitation, not only the dramatic forms in which handicapped patients become productive

[3] Ibid, p. 7.
[4] Switzer, Mary E., and Rusk, Howard A., M. D., Doing Something for the Disabled, Public Affairs Pamphlet No. 197, pp. 18–21. New York: Public Affairs Committee, 1953.
[5] Chronic Illness Newsletter, 2:2–3 (October 1951).
[6] National Conference on Care of the Long-Term Patient, Study Group Reports, Committee II, The Patient in an Institution, Large General Hospitals, p. 21 (mimeographed).
[7] Ibid., Small General Hospitals, p. 3.

workers, but also in the less favorable situations where emphasis on self-help programs improves the morale of the patient and reduces the services required from the staff.[8]

Rehabilitation centers.—The increased interest in rehabilitation centers during the last few years has been termed "one of the most significant advances in rehabilitation since the end of the Second World War." [9] Much of this is the result of the great emphasis placed on the role of comprehensive rehabilitation services in military hospitals during the war, followed by the influence and example of the successful physical medicine and rehabilitation service of the Veterans' Administration hospitals, and the growing need for such services resulting from the marked increase in chronic disability associated with an aging population. A particular contribution to the immediate postwar acceleration of interest in rehabilitation centers was the report in 1946 of the Baruch Committee on Physical Medicine and Rehabilitation, A Community Rehabilitation Service and Center (Functional Plan).[10]

In 1952 the President's Commission on the Health Needs of the Nation stated:

> Probably one of the greatest difficulties in getting more of the chronically disabled patients out of the hospital and other medical facilities is the lack of places to send them for further rehabilitation. This is particularly true of those who are very severely disabled. Recent surveys have indicated that existing facilities are generally being used at maximum capacity, with at least some rehabilitation centers having waiting lists for new admissions. All told, there are less than a dozen comprehensive rehabilitation centers in existence; they meet only a small fraction of the Nation's needs. Here too, once the demand is tapped, it turns out to be enormous. If we are to provide vitally needed rehabilitation services, particularly to the more severely disabled of our population; if we are to make full use of our greater fund of knowledge in this field; if we are to do a total job of rehabilitation—many more well-equipped, well-staffed rehabilitation centers will become a vital necessity.[11]

While definite standards for rehabilitation centers have not been formally established, the activities of the National Conference on Rehabilitation Centers indicates that such standards are gradually emerging. The Office of Vocational Rehabilitation is currently using the definition which appears in Public Law 482, 83d Congress, which is as follows:

> The term "rehabilitation facility" means a facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision, and in the case of which—
>
> (1) the major portion of such evaluation and services is furnished within the facility; and
>
> (2) either (A) the facility is operated in connection with a hospital, or (B) all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

The extensive study of the characteristics of 40 rehabilitation centers, mentioned above, found that they range from comprehensive institutions with sizable staffs, associated with medical centers of great universities, to small curative workshops with one or two

---

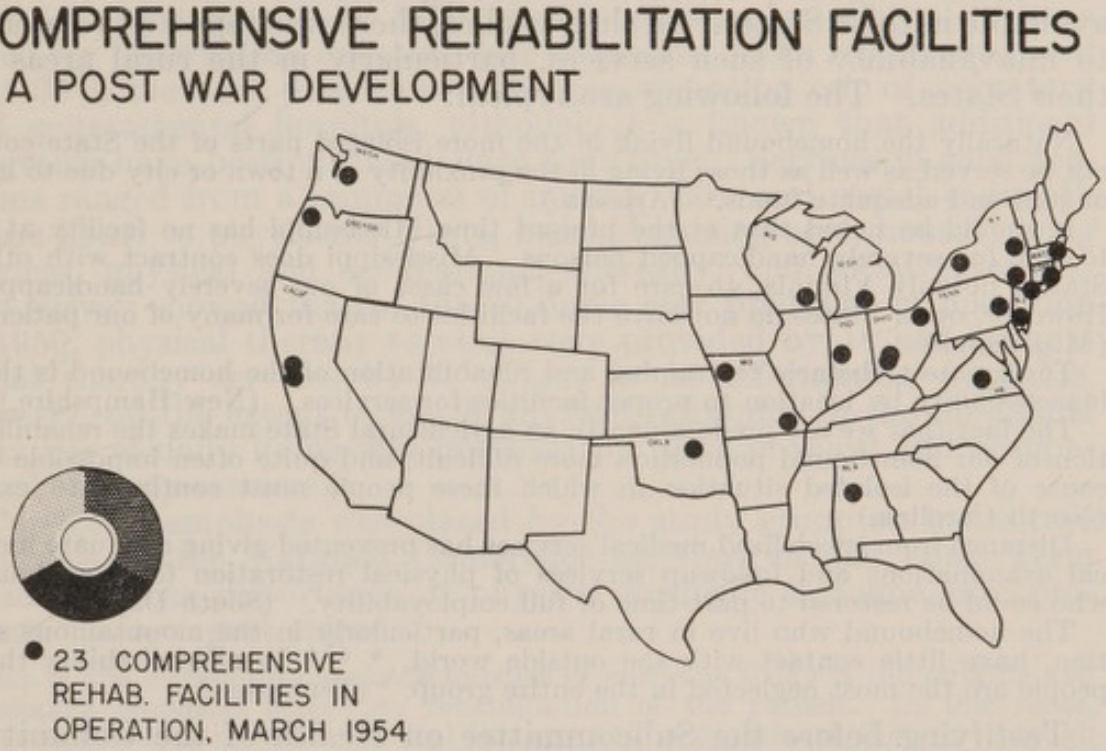
[8] Ibid., Chronic-disease hospitals, p. 9.

[9] Redkey, Henry, Rehabilitation Centers in the United States, Chicago, The National Society for Crippled Children and Adults, 1953.

[10] The Baruch Committee on Physical Medicine Report on a Community Rehabilitation Service and Center (Functional Plan), New York: The Baruch Committee on Physical Medicine, 1946.

[11] Building America's Health; America's Health Status, Needs and Resources, vol. 2, Report of the President's Commission on the Health Needs of the Nation, p. 32. Washington: Government Printing Office, 1953.

therapists serving outpatients.[12] Some have heavy medical emphasis and resemble specialized hospitals; others are primarily vocationally oriented and have a minimum of medical services. Most serve outpatients only; not more than eight have facilities for the care of inpatients. Many have waiting lists for services. Among the persons they serve are many homebound individuals, some of whom can be rehabilitated to the point of leaving the home; others acquire increased self-sufficiency within the home.



Services in rural areas.—Providing homebound persons in rural areas with physical rehabilitation services in hospitals or rehabilitation centers is particularly difficult, since practically all such available facilities are concentrated in urban areas. This makes the homebound person in the rural area and those serving him less likely to be aware of his rehabilitation potentials, and less familiar with available facilities and resources. There is a significant increase in the costs of such services for those in rural areas, both through increased transportation costs and the fact that the patient must usually be admitted as an inpatient, whereas he might be served as an outpatient if the services were near the patient's home.

The development of regional hospitalization plans, whereby smaller satellite hospitals in the surrounding rural areas call upon the major teaching hospital in the area for consultation, teaching and other services to improve the quality and scope of their own activities, holds possibilities for extending and improving services in physical medicine and rehabilitation as well as in other medical specialties. Illustrative is the department of physical medicine and rehabilitation, University of Buffalo, which works with 12 affiliated hospitals outside the city of Buffalo.

Similarly, the physical medicine and rehabilitation services at the new Mayo Memorial Building, University of Minnesota Medical

[12] Henry Redkey, op. cit.

School, Minneapolis, and at the Mayo Clinic, Rochester, serve as the "centers" for a series of smaller satellite physical medicine and rehabilitation programs in Duluth, St. Paul, Minneapolis, Mankato, Winona, and Virginia. Patients are evaluated in these smaller centers, which provide the needed services when they are able to do so, but refer the more difficult cases requiring highly specialized services to the centers.

In the preparation of this report, the State directors of vocational rehabilitation were questioned concerning services to the homebound available in their States. In their replies, there was repeated reference to unavailability of such services, particularly in the rural areas of their States. The following are typical:

> Naturally the homebound living in the more isolated parts of the State could not be served as well as those living in the proximity of a town or city due to lack of staff and adequate funds. (Arizona.)
>
> It should be noted that at the present time Mississippi has no facility at all to care for severely handicapped persons. Mississippi does contract with other States, notably Virginia, to care for a few cases of our severely handicapped. However, other States do not have the facilities to care for many of our patients. (Mississippi.)
>
> The greatest obstacle to training and rehabilitation of the homebound is their inaccessibility by location to proper facilities for services. (New Hampshire.)
>
> The fact that we are predominantly an agricultural State makes the rehabilitation of our homebound population more difficult, and quite often impossible because of the isolated situation in which these people must continue to exist. (North Carolina.)
>
> Distance from specialized medical services has prevented giving adequate medical examinations and followup services of physical restoration for homebound who could be restored to part-time or full employability. (South Dakota.)
>
> The homebound who live in rural areas, particularly in the mountainous section, have little contact with the outside world. * * * In all probability these people are the most neglected in the entire group. (Tennessee.)

Testifying before the Subcommittee on Health of the Committee on Labor and Public Welfare, United States Senate, on April 6, 1954, F. Ray Power, director, West Virginia Division of Vocational Rehabilitation, aptly summed up the situation when he said:

> A major problem now facing the States is to secure appropriate rehabilitation-center services and to get such services at a price which rehabilitation divisions are able to pay * * *.[13]

Services given in the home.—The medical care of the sick within their own homes by physicians in private practice has been the traditional pattern for medical care in this Nation and it appears that the primary burden for the care of the sick in their homes is and will continue to be the responsibility of the physician in private practice. The impact of the industrial revolution on social structure, with the increased urbanization and industrialization, the rise in chronic illness, the aging of the population, the high costs of institutional care and hospital construction, and an ever-growing awareness of the effects of prolonged institutionalization of personality, have contributed to an increasing interest in the possibilities of providing care to patients within their own homes.

Similarly, the recognition of the fact that the physical rehabilitation of the disabled homebound frequently requires specialized skills such as physical therapy, occupational therapy, and speech and hearing therapy which are not within the scope of services provided by the

[13] President's Health Recommendations and Related Measures; hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare, U. S. Senate, 83d Cong.; 2d sess., pt. I, p. 454.

physician has contributed to the development of voluntary and public agencies designed to meet the needs of these patients.

It is not the purpose of this section of this report to discuss the medical aspects per se of those services which may be brought into the home of the patient to assist in his rehabilitation but rather to deal with those services of a medical nature which are particularly concerned with the physical rehabilitation of the homebound in the functional activities of daily living.

Home medical care programs.—In a survey of general hospitals with 50 or more beds in 1950, the Commission on Chronic Illness asked for information on home care programs. The replies indicated that 30 home care programs were then operating out of voluntary and governmental hospitals, although it is known that additional programs have been initiated since that time. Services in such programs ranged from a minimum of nursing care and social casework in the home to physicians' visits, bedside nursing care, housekeeping services, physical and occupational thereapy, and social casework. The survey showed that of the 30 home care programs in operation in 1950, physical therapy services were provided by 14 and occupational therapy services by 7. There is no information available, however, on the extent to which physical retraining in the functional activities of daily living was provided by these physical and occupational therapy services.[14]

Particular emphasis was placed by the study group on home care programs of the National Conference on Care of the Long Term Patient on the importance of physical medicine in home care programs.[15] Its report stated:

> One of the distinguishing characteristics of medicine today is the striking and developing emphasis placed on rehabilitation of the patient. In this sense, physical medicine includes physical therapy and occupational therapy through which are furnished the more frequent therapeutic measures of rehabilitation * * *. The importance of this approach is manifest when it is realized that a total program of planning for the patient must be made by the physician and his coworkers on the medical care team with the objective of attaining limitation of disability and maximum rehabilitation.

Nursing services for the homebound.—The 1953 Census of Nurses in Public Health Work shows 22,214 staff public health nurses employed by State and local official agencies, voluntary agencies, and boards of education.[16] This group of workers probably has more direct and continuous contact with homebound persons than any other professional group.

Using the generally accepted ratio of 1 public health nurse to 5,000 population for general public health work (exclusive of nursing care of the sick), 9 States fall within the ratio of one nurse to each 5,000 population. Ratios in the other States vary from 1 nurse to 3,225 population to 1 to 18,791 population. There is an even greater unevenness of coverage when distribution is broken down by counties and cities within the States. For example, in the rural areas of 671 counties, and in 8 cities of 10,000 population or more there were no nurses engaged in full time public health work in 1953.

---

[14] Perrott, G. St. J.; Smith, Lucille M.; Pennell, Maryland Y.; and Altenderfer, Marion E., Care of the Long Term Patient: Source Book on Size and Characteristics of the Problem. Public Health Service Publication No. 344, Washington: Government Printing Office, 1954.

[15] Op. cit., p. 18.

[16] Glacomo, Rosalie, The 1953 Census of Nurses in Public Health Work, Nursing Outlook, vol. 1, November 1953.

In general "public health nurses, including school nurses and those in other specialties in public health nursing, work as members of a health team to further community health. They provide nursing care and treatment, health counseling, and organize families and community groups for health purposes. Their activities include work in the home, clinic, office, school, and health center. In all phases of the work emphasis is placed on the prevention of disease, promotion of health, and rehabilitative measures." [17]

There are no official estimates available of the total number of patients receiving services within their homes from all types of public health nurses. A study of 994 nursing organizations in 1951 by the Commission on Chronic Illness and the National League for Nursing showed that, of the 106 cities in the United States with populations of 100,000 or over, 74 had a separate visiting nurse association and 17 had such services combined with another agency. Data on patient visits from visiting nurse associations in 50 cities of 100,000 population or more and 79 smaller cities showed that visiting nurse associations in these 129 cities made over 300,000 visits in a 1-month period. It is significant that almost 53 percent of these visits were to chronically ill patients.[18]

There is no information available, however, as to what percentage of these chronically ill patients were "homebound" or what percentage of the services they received could be classified as supportive care of the handicapped. In the survey referred to above, of 46 organizations reporting, 33 stated their services included physical therapy and 3 occupational therapy.

In a special study of the Instructive Visiting Nurse Association of Baltimore City in 1953, of 525 patients seen in a 4-week period, almost half were 65 years of age or more, one-third spent most of their time in bed, and one-fifth could not walk or could walk only with assistance.

Voluntary and official public health nursing agencies have reported increased chronic caseloads and increased requests for bedside nursing and that the "need for such services in rural areas is especially urgent." [19]

Home nursing care provided by these organizations frequently includes many of the rehabilitative techniques designed to permit the patient to leave the home or improve his functional ability within the home, such as prevention of deformity, maintenance of range of motion of joints, functional activities of daily living for self-care and independence, maintenance of good posture, bladder and bowel control, and emotional support of the patient and the family. One of the most important functions of the public health nurse for the homebound person is the referral of such patients to vocational rehabilitation agencies, rehabilitation services in hospitals, and rehabilitation centers for evaluation and further help.

Authorities in public health nursing state that additional services of this type could be provided by the well-trained public health nurse working under the supervision of consultants in physical therapy and occupational therapy, but, because of financial limitations, many

[17] American Nurses' Association, Public Health Nurses Section, Statement of Functions for Public Health Nurses in Staff Positions Employed by Departments of Health, Board of Education and Voluntary Agencies, the American Journal of Nursing, vol. 54, July 1954.

[18] Perrott, Smith, Pennell and Altenderfer, op. cit., pp. 41–46.

[19] Letter, Ruth Fisher, director, Department of Public Health Nursing, National League for Nursing, to Mary E. Switzer, Director, Office of Vocational Rehabilitation, November 9, 1954.

agencies are unable to employ such consultant services on their own staffs, or to receive such consultant services from other organizations.

Homemaker services.—Originally established for the care of children in their own homes during the illness of the mother, homemaker services for the homebound adult have been developing slowly, particularly in urban areas, over the past decade. The Study Group on Homemaker Service of the National Conference on Care of the Long Term Patient in March 1954, reported that—

> As far as can be ascertained, 99 agencies in 64 cities in 30 States are providing homemaker services or some program with a similar purpose * * * A few States have experimented with the service in rural areas, e. g., North Carolina, Colorado, and Maryland.[20]

In mid-1953 this study group sent questionnaires to these 99 agencies. Of the group, 62 replied and 50 stated they provided services for the chronically ill and/or aged. Services specifically for the chronically ill and/or aged were reported by 9; services to individuals who live alone by 32.

Practically all reported their services included cleaning, cooking, marketing, laundry, mending, and the care of children; many reported services included such personal services as food preparation and serving, bed changing, combing, and brushing hair, and care of the bedpan. Short-term service only was provided by 26 agencies, indefinite long-term service by 2, and both types by 22.

Forty-two of the agencies reported a total of 397 homemakers employed in June 1953, of whom 307 were full time and 90 part time. Heart and circulatory disorders were the major cause of disability in almost one-third of the persons served; arthritis in 10 percent; cancer in 8 percent; and amputations, crippling conditions, and paralysis in another 8 percent.

Home services provided by rehabilitation centers.—Most of the physical therapy and occupational therapy provided within the home are made available in connection with general home medical care programs, or under the auspices of local visiting nurse services or public health nursing programs. There are, however, some rehabilitation centers which extend their physical retraining services into the home. Illustrative are the functional retraining services provided by the Curative Workshop of Milwaukee, one of the first services of its kind, which started in 1919.

The home service department of the Curative Workshop of Milwaukee accepts physicians' referrals for the treatment of homebound patients having any physical condition for which occupational therapy is indicated. In the calendar year ending September 30, 1954, a total of 185 homebound children and adults were provided 3,300 such treatments. The largest number of diagnoses in order of frequency of referrals were cerebral vascular accidents, multiple sclerosis, fractures, arthritis, poliomyelitis, amputations, paraplegia, postsurgical paralysis and rheumatic heart disease.

Mobile therapy units.—One method developed in recent years to bring services to the homebound, particularly in rural areas and small communities, is the use of mobile or itinerant therapy units. Complete figures on the volume or types of services rendered through this technique are not available, but one large organization, the National Society for Crippled Children and Adults, reported in 1953 that 33

[20] Op. cit., Study Group on Homemaker Service, p. 2.

such programs were operated by its affiliates. Services include the mobile speech and hearing clinic of the North Dakota chapter, and the mobile therapy unit of the Florida Society for Crippled Children. The former provides such specific services as testing for speech disorders and hearing defects, referrals, and consultations; in the latter, an occupational and physical therapist provided instruction to the parents of handicapped children in procedures for carrying out certain treatments at home.

Although such mobile units are now used primarily with children, adaptation of the method for increasing rehabilitation services for homebound adults is being given consideration. Similar mobile units to furnish home treatment for patients with arthritis have been established by the State and local affiliates of the Arthritis and Rheumatism Foundation, for example, in Arizona, northern California, Michigan, the District of Columbia, and elsewhere.[21] Mobile units both for arthritics and for crippled children have been developed more extensively in Canada than in this Nation.

In its recently published report to the members-elect of the 1955 General Assembly of the State of Vermont, the Vermont Commission on the Chronically Ill and Aged recommended the establishment of one modern rehabilitation center in Vermont and further recommended that—

> A modern rehabilitation center, wherever located, should be organized and equipped to make periodic visits to those general hospitals where there are smaller counterparts of the major center. The personnel of this traveling clinic would act as consultants in specialized fields and would advise on special problem cases. Progressively this team could help to formulate wider rehabilitation services in the local hospitals as the efficacy of the service became demonstrated.[22]

Self-help devices.—The growing use of mechanical devices to reduce the amount of energy an individual must expend has particular implications for persons with physical disability, many of whom have lost all or a part of their ability to perform the functional activities of daily living. Recognizing these implications, professional workers, the families and friends of the disabled, and the disabled themselves, have produced more and more "self-help" devices within recent years, designed to assist the disabled in performing some functional activities in daily living which could not be performed without mechanical assistance. With a grant from the National Foundation for Infantile Paralysis, the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York City, has been engaged for the past 5 years in the evaluation and clinical testing of such devices, the development of new devices, and the dissemination of information concerning self-help devices to professional workers in rehabilitation and to the public.[23]

In cooperation with the New York Chapter, Arthritis and Rheumatism Foundation, the Institute of Physical Medicine and Rehabilitation has published a special publication on Self-Help Devices for the Arthritic.[24]

Home management aids.—Of considerable value to many homebound persons is the research and development work done by various groups

[21] Mobile Physiotherapy Units, Chronic Illness Newsletter, vol. 3, No. 6, pp. 2-3. August-September 1952.
[22] Summary of the Interim Study Made by the Commission on the Chronically Ill and Aged to the Members-Elect of the 1955 General Assembly of the State of Vermont, p. 25.
[23] Rusk, Howard A., M. D., and Taylor, Eugene J., Living With a Disability, New York: Doubleday and Co., 1953.
[24] Lowman, Edward W., M. D., Self-Help Devices for the Arthritic, Rehabilitation Monograph VI, New York: The Institute of Physical Medicine and Rehabilitation, 1954.

to assist disabled homemakers in the design of home layouts, use of home appliances, and performance of household tasks despite limited physical capacities.

The American Heart Association and its State and local affiliates have prepared materials in their "Heart Kitchen" or "Heart of the Home" program to apply the industrial principles of work simplification to homemaking and are making this information available to cardiac housewives through various techniques.[25] For example, through a grant from the Michigan Heart Association, Michigan State College now provides consultant services to 55 Michigan home demonstration agents in teaching work simplification to cardiac homemakers.[26]

With the assistance of the Disabled Homemakers Research Fund, established by several of the Nation's leading public utility companies, the Institute of Physical Medicine and Rehabilitation, New York City, has been conducting a research project to evaluate individual capabilities and limitations, experiment with equipment suitable for specific disabilities, and adapt standard household devices for use by disabled homemakers, particularly those with orthopedic and neurological disorders.[27]

In collaboration with national and local voluntary and public organizations, the University of Connecticut and the Office of Vocational Rehabilitation pioneered in an exploratory study workshop on time and motion economy principles as applied to household tasks for the benefit of the severely disabled housewife.[28]

The National Society for Crippled Children and Adults has long been concerned with the architectural design of homes as well as public buildings to permit improved functional living by the physically handicapped.[29] More has been done in Great Britain in planning specially adapted housing for the handicapped than in this Nation.[30]

Equipment loan services.—During the past few years there has been a substantial expansion by voluntary services of equipment loan services, from which the homebound individual can borrow or rent equipment such as wheelchairs, walkers, braces, and simple physical and occupational therapy equipment without cost or at a small fee. A number of such programs under a variety of auspices are in operation in cities and several have been started on a county- or statewide basis. This valuable service, while it has originated principally in cities, now reaches the homebound and other disabled persons in some rural areas.

Services for homebound children.—Numerous agencies have devoted their attention and resources to homebound crippled children. These include the Federal-State crippled children's programs, voluntary groups such as the National Foundation for Infantile Paralysis, United Cerebral Palsy Association and the National Society for Crippled Children and Adults, local and national foundations, and civic and

[25] American Heart Association, The Heart of the Home, New York: American Heart Association, 1950.
[26] Kuttanen, Ruth C., Heart of the Home Program: The Extension Approach. An unpublished address before the annual meeting of Staff Conference of Heart Associations, Chicago, Ill., March 30, 1954.
[27] Rusk and Taylor, op. cit., pp. 114–159.
[28] Handicapped Homemakers, U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation, Washington, D. C., May 1954.
[29] A Brief Checklist of Available Publications Relating to Architectural Planning for the Physically Handicapped, Architectural Planning Bulletin 2. November 1953, Chicago: The National Society for Crippled Children and Adults.
[30] Ministry of Local Government and Planning, Housing for Special Purposes: Supplement to the Housing Manual, 1949. New York: British Information Service, 1951. Scotland Department of Health, Housing of Special Groups: Older People, One-Person and Two-Person Households, Large Households, Disabled People, Higher-Income Group Households, Occupational Groups, New York: British Information Service, 1952.

fraternal groups. As a result, the quality and scope of services available to homebound children is far greater than for homebound adults.

Under the State programs for crippled children, aided by Federal grants under the Social Security Act, some 238,000 children received physicians' services in 1952. In addition many of these children received a variety of auxiliary services by nurses, physical-therapists, occupational therapists, medical social workers, nutritionists and speech therapists, as well as foster home care and orthopedic and prosthetic appliances.

Thousands of other crippled children received similar services through the resources of their own parents or with the assistance of the local and State affiliates of the national voluntary agencies, local voluntary agencies, schools, civic and fraternal organizations, foundations, hospitals and a variety of other sources. In many instances, the same child received services from several sources.

No estimate is available concerning the number of children, served by both official and voluntary groups, who might be classified as "homebound." Nor, and of greater importance, is any estimate available as to how many of these children might have become "homebound" had they not been provided with such services. Because of the variety of services needed by a crippled child and the variety of sources from which such children receive assistance, it is not practical or desirable to attempt to isolate either the homebound child or any one particular service which he might receive from the total pattern of services and make evaluations either quantitatively or qualitatively.

In the evaluation of the total pattern of such service being rendered by both official and voluntary agencies, the most important factors are these:

1. The volume of services rendered by both groups is increasing. The increase in the number of children receiving services from the Federal-State crippled children's program from 1950 to 1952 was 11 percent.

2. Despite this increase, there are still many children who are in need of service. Of the children receiving services from the Federal-State crippled children's program in 1952, two-fifths were seen for the first time.

3. The scope and variety of services rendered is increasing. In the early days of both the State-Federal crippled children's program and of voluntary endeavor, services were limited almost entirely to orthopedic and plastic conditions, but now a much wider range of crippling conditions is receiving attention and there is greater emphasis on physical rehabilitation in the functional activities of daily living. In the State-Federal crippled children's program in 1952, over 21 percent of the children receiving physician's services had crippling conditions resulting from congenital malformations; 19 percent had their bones or organs of movement affected; over 12 percent had residual effects of poliomyelitis; about 9 percent had defects of the eye or ear; and another 9 percent had cerebral palsy.

In commenting on this aspect of services to crippled children, the study group on long-term care of exceptional children of the National Conference on Care of the Long-Term Patient stated:

> We do know that in some parts of the country fairly adequate facilities have been developed by official and voluntary agencies and private resources. Such

development, however, has not been consistent for the Nation as a whole. It is the consensus of this study group that Federal-State crippled children's services should be broadened, by legislation if necessary, to provide for all diagnostic groups of physically handicapped children and to provide long-term care for children whose disabling conditions cannot be removed or appreciably alleviated.[31]

Services for homebound veterans.—The vocational and educational aspects of services for homebound veterans are discussed in another section of this report. There are no special medical or functional physical rehabilitation services provided especially for homebound veterans. However, it can be assumed that some homebound veterans are included among the substantial number with service-connected disabilities who receive social services from Veterans' Administration social workers and medical care in their own homes at Veterans' Administration expense through contract physicians. It is believed that homebound veterans are adequately provided physical rehabilitation services in the functional activities of daily living as a result of the availability of the Physical Medicine and Rehabilitation Services in Veterans' Administration hospitals, which are geographically distributed throughout the Nation.

Home nursing service is provided as an extension of the hometown medical program. Veterans' Administration has contracts with 474 community public health nursing services to continue rehabilitative care of eligible patients in their homes. Physical therapy treatment is included among the home services available from 126 of these contract agencies, and occupational therapy from 27.

Analysis of the data on the 932 patients provided contract home nursing services during fiscal year 1954 shows these patients had a wide variety of illnesses. However, the majority of diagnoses fell in the extended disabling illness category—tuberculosis, heart disease, multiple sclerosis, arthritis, paraplegia, and malignant neoplasma.

Information is not available on the number of patients who were homebound. It is significant that during the course of the year, 348 of the 932 patients no longer needed nursing service. Some were well enough to go to clinics; in other instances the family had learned to give needed care; 148 patients were rehospitalized for further treatment. Nursing care was continued into the next fiscal year for 279 patients.

Any veteran patient may be referred to the same community public health nursing services for rehabilitative care. However, terms of payment for those patients who are not eligible for outpatient care from the Veterans' Administration are arranged on an individual basis between the family and the agency.

Factors limiting services.—The three major factors impeding the development of adequate physical rehabilitation services in the functional activities of daily living for the homebound have been declared to be—

1. Lack of sufficient facilities to which such persons may be referred for evaluation and services.
2. Lack of sufficient funds by public and voluntary agencies for referral of such persons to existing facilities or to bring services to them within their homes.
3. Lack of sufficient trained personnel to staff existing facilities and program and needed new services.[32]

[31] Op. cit., Study Group on Long-Term Care of Exceptional Children, p. 5.
[32] Rusk, Howard A., M. D., interview with study staff, November 30, 1954.

The first two of these factors have been discussed previously in this report and attention has been called to the enactment by the 83d Congress in 1954 of Public Law 565 and of Public Law 482 designed to increase the number of persons served under the State-Federal vocational rehabilitation program and to stimulate the construction of rehabilitation facilities. The implications of this legislation on services for the homebound is discussed later in this report.

Personnel shortages.—There has been universal recognition by authorities in rehabilitation that the lack of trained rehabilitation personnel has been a major deterrent to the more rapid expansion of services. The study group on rehabilitation, National Conference on Care of the Long-Term Patient in March 1954 reported:

> Although there has been a substantial increase in the number of qualified specialists in physical medicine and rehabilitation during the past few years the number of trained physicians in this newest of the medical specialties is still far from being sufficient to meet even the most urgent needs of the nation * * *. There is also a great need for increasing professional understanding of the problem of the rehabilitation phase of the management of the long-term patient by both general practitioners and specialists other than the physical medicine and rehabilitation specialist * * *. There are also acute shortages among the paramedical workers who make up the rehabilitation team—physical therapists, occupational therapists, medical social workers, orthopedic or rehabilitation nurses, prosthetic specialists, vocational counselors, and speech and hearing therapists.[33]

In a recent report it was stated that—

> There are 350,000 practicing nurses and an immediate need for 50,000 more; 6,000 physical therapists and a need for 2,500; 4,000 occupational therapists and a need for 2,900; 3,300 medical social workers and a need for 1,000; and 1,200 vocational rehabilitation counselors and a need for an additional 5,000. The immediate need for personnel expressed in terms of proportional increase then, is 14 percent for nurses, 41 percent for physical therapists, 72 percent for occupational therapists, 30 percent for medical social workers and 41 percent for vocational rehabilitation counselors.[34]

In its report in 1952, the Task Force on the Handicapped placed particular emphasis on personnel needs in rehabilitation and said:

> This training need exists on two levels:
>
> 1. Recruitment and graduate training of more physicians, physical therapists, occupational therapists, psychologists, vocational rehabilitation specialists, vocational counselors, and employment specialists in the specialized skills and techniques of rehabilitation and vocational placement of the handicapped.
>
> 2. Further specialty and in-service training of personnel now working in this field, both for higher levels of skills and for the development of the team approach in which the skills and disciplines of the various members of the team are brought to focus upon the particular problem of any given individual.[35]

Included among the recommendations of the Task Force on the Handicapped was the following:

> *Recommendation No. 18.*—It is recommended that the Health Resources Advisory Committee of the Office of Defense Mobilization be requested to develop a a national plan for the recruitment of additional students in the medical and allied fields most urgently needed in rehabilitation, and that such a plan be capable of implementation by the professional associations, private and governmental agencies, and others concerned.[36]

---

[33] Op. cit., p. 31.
[34] Report of the Division on Professional Education to the Advisory Committees on Education and Research, National Foundation for Infantile Paralysis, New York. November 10, 1954, p. 11 (mimeographed).
[35] Op. cit., p. 26.
[36] Op. cit., p. 47.

Since this recommendation was made, the following significant actions have taken place:

1. A program of support of training of personnel in a number of professional fields contributing to rehabilitation services has been initiated by the Office of Vocational Rehabilitation, under authority of the broadened Vocational Rehabilitation Act of 1954, and grants have been made to universities to enable them to expand and improve such training. Traineeships are being awarded to promising individuals to enable them to secure necessary training.

2. The National Institutes of Health of the Public Health Service has increased its support of training of physicians in rehabilitation.[37]

3. Conferences of governmental and voluntary agencies on manpower shortages of medical social workers, occupational therapists, and physical therapists, called by the National Foundation for Infantile Paralysis were held in 1952.[38] [39] [40]

4. The grants program of the National Foundation for Infantile Paralysis to increase the number of trained personnel in rehabilitation and its scholarship programs for basic training of rehabilitation personnel have been increased.[41]

5. A basic scholarship program in physical and occupational therapy has been started by the United Cerebral Palsy Association.[42]

6. The scholarship training programs of the National Society for Crippled Children and Adults for rehabilitation counselors, physical therapists, occupational therapists, speech pathologists, and personnel working in the field of cerebral palsy cosponsored with Alpha Gamma Delta, Alpha Chi Omega, Kappa Delta Phi, and the American Speech and Hearing Association have been increased.

7. A recruitment program for all types of health personnel including rehabilitation workers has been initiated by the National Health Council.[43]

8. The Health Resources Advisory Committee of the Office of Defense Mobilization has recently (December 1954) established a subcommittee to undertake the study of personnel shortages in rehabilitation recommended by the Task Force on the Handicapped.

Psychosocial Services

SUMMARY

Any constructive program of services for the homebound physically handicapped should take full account of the need for individual motivation and social opportunity, since these factors frequently determine whether other available services

[37] According to the statement of Dr. Pearce Bailey, Director of the National Institute of Neurological Diseases and Blindness, National Institutes of Health, Public Health Service, Department of Health, Education, and Welfare, at the hearing of the House Committee on Interstate and Foreign Commerce, October 7, 1953, 83d Cong., 1st sess., on the Causes, Control, and Remedies of the Principal Diseases of Mankind, pt. 4, p. 965, 20 trainees are currently being assisted in securing advanced training in the clinical and rehabilitative aspects of neurological and sensory disorders. "An additional 20 highly qualified individuals could be placed [in advanced training] immediately [if funds were available]."

[38] U. S. Department of Health, Education, and Welfare, Public Health Service, Health Manpower Source Book, sec. 3, Medical Social Workers, PHS publication, No. 263, August 1953.

[39] Potential Increase of Occupational Therapists Based on Data Supplied by Twenty-Five Occupational Therapy Schools (corrected), January 1953, mimeographed.

[40] Report of a Survey of Physical Therapy Schools, January 1953, mimeographed.

[41] Report of the Division of Professional Education to the Advisory Committees on Education and Research, National Foundation for Infantile Paralysis, op. cit.

[42] Press release, United Cerebral Palsy, May 11, 1954, mimeographed.

[43] Promoting Health Careers; A National Report to Alert High Schools, Public Health Reports 69:10:945, October 1954.

produce real benefit to the homebound. The success of any program of rehabilitation and other services is directly and markedly influenced by the degree of cooperation and understanding on the part of the handicapped person himself. Paralleling this is the question of the whole social milieu of the individual—the physical setting of the home, attitude of family members, economic circumstances, and the like.

Thus there is a very real need for incorporating into a coordinated program of services for the homebound (1) adequate provisions for psychological and social services, and (2) research to understand more fully the needs of the homebound both as individuals and as a group.

The degree of success of physical rehabilitation measures, described in the preceding section is usually influenced, or even controlled, by the degree of individual motivation and social opportunity on the part of the handicapped person.[44] From studies available it appears that, while a physical disability may be the most readily recognized cause for a person being homebound, psychological and social factors frequently lessen or increase the handicapping effects of the disability.

The role of emotional maladjustment in contributing to unemployability of individuals with marked physical disabilities is seen in the study of 200 ambulatory cerebral-palsied adults in New York City.[45] While almost three-fourths of the cases interviewed presented a picture of emotional maladjustment, some 20 percent of the cases were judged severe enough to preclude the possibility of job placement. This judgment was based upon the presence of such factors as: (1) Unrealistic attitudes, (2) intense feelings of insecurity, (3) extreme immaturity, (4) excessive fears, (5) strong feelings of inferiority, (6) low frustration tolerance, (7) problems in interpersonal relationships, and (8) lack of motivation. To all intents and purposes, these emotional problems, rather than the physical disability, precluded employment. Social casework and even psychiatric help appeared to be indicated at an early stage.

The effect of psychological and social factors upon an individual's degree of helplessness is perhaps most clearly evident in cardiovascular disease. The experience of the Altro Health and Rehabilitation Service is particularly pertinent.[46] This institution has demonstrated that, through a program not only of medical care but also of careful assessment, by trained caseworkers, of the personality, interpersonal relationships, emotional needs, and economic stresses of the individual, a large number of individuals, disabled because of serious heart disease, can be successfully rehabilitated. Success in such a program, however, depends upon the integrated services that are provided by the cardiologist, the caseworker, and the psychiatrist.

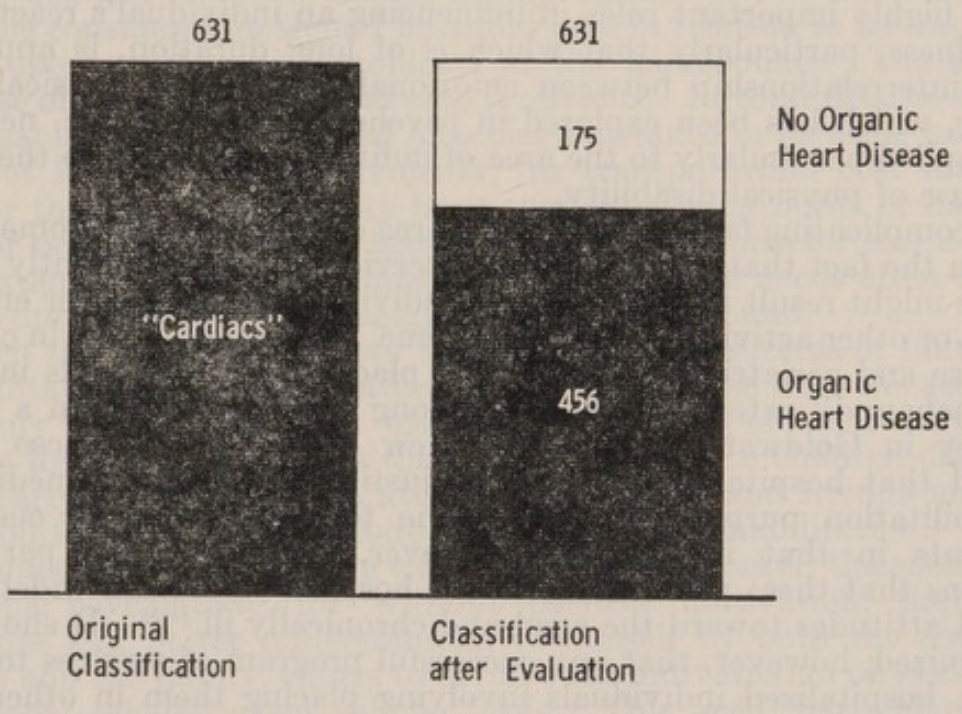
Similarly, because of difficulties in properly evaluating the physical work capacity of the cardiac, it has been reported that "much of the limitation imposed upon the rheumatic child, the hypertensive patient, and the arteriosclerotic cardiac does not make his life more comfortable, nor does it prolong it. The limitation succeeds only in setting the cardiac patient apart from the rest of his fellow men and frightening

[44] McCoy, Georgia F., and Rusk, Howard A., An Evaluation of Rehabilitation, Institute of Physical Medicine and Rehabilitation, Monograph I, 1953, p. 65.
[45] Glick, Selma J., Vocational, Educational, and Recreational Needs of the Cerebral Palsied Adult, United Cerebral Palsy of New York City, 1953, 57 pp.
[46] Jezer, Abraham; Black, B. S., et al., Workshop Experience With the "Disabled" Cardiac, British Journal of Physical Medicine, January 1954, pp. 1–6.

him unnecessarily. The limitations succeed in creating inner conflicts, stresses, and strains which defeat the purpose for which the limitations were meant. Instead of the physician transferring fear and anxiety to the sick one and to his family, a more optimistic attitude will be amply rewarded with a happier and longerlived patient.[47]

This point has been reemphasized by the work of Dr. Goldwater and his coworkers in a study of 631 cardiacs at the New York University-Bellevue Adult Cardiac Clinic.[48] They found 175, or approximately 28 percent, of these individuals had no organic heart disease and that the misdiagnoses had resulted in unemployment, anxiety, emotional disturbances, and the like.

STUDY OF "CARDIACS"*



* Goldwater, Bronstein and Kresky's "Study of 175 'Cardiacs' Without Heart Disease," Journal of the A.M.A., 148, 1952, pp. 89-92.

Emotional factors play a large part in the extent to which disabled individuals will cooperate in the treatment process. This was clearly pointed out in the recent Galveston conference on medical and psychological teamwork in the care of the chronically ill.[49] Typical of the discussion at this conference is the statement by Wright that—

> the problem of the patient who does not follow through the plan of treatment may * * * have its roots in self-devaluating feelings. Not only may he fear the physical implications of his illness, but he may fear even more the stigma of being worthless, a burden, unmanly, etc.[50]

The role of cooperation in the treatment process as it relates to personality integration has been emphasized by Dr. Karl Menninger.[51]

[47] Jezer, Abraham, Work Capacity of the Cardiac, Medical Clinics of North America, May 1953, pp. 3, 37, 16.
[48] Goldwater, L. J.; Bronstein, L. H.; and Kresky, B., Study of 175 "Cardiacs" Without Heart Disease, Journal of the American Medical Association, 148, 1952, pp. 89–92.
[49] Harrower, Molly (ed.), Medical and Psychological Teamwork in the Care of the Chronically Ill, Texas Reports on Biology and Medicine; 12, 3, pp. 561–794.
[50] Op. cit., p. 612.
[51] Garrett, J. F. (ed.), Psychological Aspects of Physical Disability, Office of Vocational Rehabilitation, Washington, D. C., Government Printing Office, 1952, pp. 8–17.

He indicates that the disabled person must not only adjust to the physical limitations and changes imposed by his disability, but also make a profound psychological adjustment involving his image of himself, his worth, and his place in society. The fact of physical dependency, he points out, must be accepted, not denied or yielded to, by the disabled person before he can make a realistic adjustment to his disability. Menninger also indicates that this acceptance is the basis for the personal motivation for improvement which is essential to successful rehabilitation.

The number of physically impaired individuals who are homebound due primarily to psychological and social factors has nowhere been explored in the literature either of psychology or chronic illness. The need for more information about such factors as motivation, level of aspiration, tolerance for frustration, and the like, which undoubtedly have highly important roles in influencing an individual's reaction to all illness, particularly that which is of long duration, is apparent. The interrelationship between emotional factors and physical well-being, which has been explored in psychosomatic medicine, needs to be applied particularly to the area of individuals confined to the home because of physical disability.

A complicating factor in the whole area of services to the homebound lies in the fact that, while improved services to those presently in the home might result in more of these individuals finding either employment or other activities outside the home, improved services in chronic disease and geriatric hospitals might place more individuals into the "homebound" category. A study along this line is seen in a recent survey in Goldwater Hospital in New York City.[52] Dacso et al. found that hospitalization was not justifiable either for medical or rehabilitation purposes in almost the total group of 95 custodial patients in that institution. However, "for the most part, the reasons that these patients are in the hospital stem from widely held social attitudes toward the aged and chronically ill." [53] It should be recognized, however, that any successful program of services to these older, hospitalized individuals involving placing them in other than a hospital setting probably would increase the number of homebound individuals proportionately.

Because social opportunity has such a direct effect on the results finally achieved by physical rehabilitation services, it is important to remember that rehabilitation must be completed in the home and in the community. Still to be explored is the problem of how programs in rehabilitation centers or hospital rehabilitation programs may be integrated with the social setting of the individual at home. This is made apparent in the study of rehabilitation centers in the United States in 1952.[54] Although there were a comparatively large number of such "centers," only a very few had any type of social service or psychological program. The study is particularly striking in pointing out the paucity of services in the psychosocial area. This lack of integration and coordination between the services of the rehabilitation facility on the one hand and the patient's home on the other can result in "a waste of the community's money as well as the still more serious waste of human courage and effort." [55]

---

[52] Dacso, M. M.; Novey, J.; and Kristeller, E. L., Survey of 95 Custodial Patients in a Municipal Hospital, Institute of Physical Medicine and Rehabilitation, 1954, Rehabilitation Monograph VII, 52 pages.
[53] Op. cit., p. 40.
[54] Redkey, H., op. cit.
[55] McCoy, Georgia F., and Rusk, op. cit., p. 65.

One of the most obvious social needs of the disabled individual is a physical setting which permits maximum activity of the individual within the limits of his disability. Such things as the availability of living quarters at ground level or housing close to public transportation often determine whether the disabled person will become a "shut-in"—perhaps the prisoner of a flight of stairs—or will be able to participate in the life of the community at least to some degree. Because most houses are designed for the able-bodied, a disabled individual very often needs help in seeking better living arrangements, particularly if he has no family upon whom he can depend.

Inadequate income is an important consideration for anyone, but one which often has special significance to the disabled person because of his special needs, which to him are basic. As stated earlier in this report, the subject of adequate income for the homebound was not included among the "programs of services" studied. Yet this consideration should be noted here in relation to its impingement upon psychosocial problems of the homebound. The added expense of restorative medical care is obvious. Beyond this, however, the disabled person may need financial assistance in securing housing to meet his physical requirements; his transportation cost may be greater than average; he may have special clothing needs or have to pay for services which other people are able to perform for themselves. The extent of his ability to meet his basic financial needs often determines the extent to which the individual is homebound.

Often the intangible factors which account for success or failure in rehabilitation are social in nature and generally arise from the attitude not only of the individual toward himself, but of his family and friends toward him. This is the great problem with children disabled from early childhood. The attitudes of parents and friends may be so debilitating as to preclude any effort at rehabilitation. Such situations call for cooperative work by the social worker, the counselor, and the psychiatrist, for without positive motivation, improved attitudes and better understanding of himself by both the disabled person and the family, efforts to involve the individual in physical and vocational rehabilitation will be futile. This need, particularly for client motivation, has been set forth in the recent California experiment in cooperative relations.[56]

The success of this program to rehabilitate disabled parents receiving assistance under the aid to needy children program in California revolved around the capacity of counselors to develop client motivation. The project indicated that motivation for rehabilitation services can take place only when a positive drive to become independent is substituted for the negative desire to stay dependent. It was felt that the answer to the problem of motivation does not lie in the ability of a caseworker to motivate a client, but in the client's being helped to reorient his own motivating values.

No adequate analysis and evaluation of the psychosocial and related factors which cause a person to remain homebound—or, conversely, which must be overcome to enable the person to leave the confines of home—has ever been made. Some additional information was provided by a study of home instruction students, made by the New York Division of Vocational Rehabilitation.[57]

[56] Rehabilitation of Disabled Parents in the Aid to Needy Children Program, California State Department of Education, 23, 6, 1954, 80 pages.

[57] Martin, Marion, The Home Instruction Student, Division of Vocational Rehabilitation, New York, 1952, 9 pages.

In this study a group of 246 students on home instruction in New York City were contacted by the New York Division of Vocational Rehabilitation and offered services. These students were under the care of private physicians and it did not appear from the study that any special physical restorative services were provided after the beginning of the study. Through the provision of counseling and vocational training, 174 of the group successfully adjusted or were in the process of adjusting to the community. Thirty-one individuals were provided with vocational training and placed in employment, 16 were placed without further training, 16 were attending universities, 11 were attending either State institutes or receiving special art instruction, and 15 were enrolled in a variety of private schools in the community. Sixteen of those in the study returned to high school or regular classes for the first time; 29 remained on home instruction.

The study, among other things, points to the relationship of psychological and social factors to the rehabilitation process and demonstrates the need for comprehensive evaluation of clients' strengths and weaknesses, in an integrated program of rehabilitation and related services.

Educational and Ameliorative Services

SUMMARY

The educational services available to homebound persons today represent, in contrast to the picture 20 or 30 years ago, substantial progress.

The needs today, however, still so far overshadow available services that the lack of adequate educational services is still one of the principal gaps to be filled in assuring adequate services to the homebound.

While educational services must be brought into the home for many children and adults, every effort should first be made to restore the mobility of the individual and permit him to attend school, in every possible case.

Electronic and other devices are coming into wider use as a supplement to the work of the home teacher, along with educational radio and television.

Educational opportunities for the homebound adult have increased in recent years through the growth of extension courses of colleges and universities, correspondence courses, and other private study plans.

In general, it appears evident that the homebound in rural sections receive less educational services than those in cities, and in some cases none at all.

Talking machines and talking books are being widely distributed to the blind. In some places, machines which project books on the ceiling for those who are bedfast are provided. Mobile libraries reach the homebound in some areas, although the lack of State and local appropriations for library services is reported in some places to restrict or eliminate this type of service.

The availability of recreational services varies all the way from extensive to none at all, with a general picture of too few

recreational services reaching the homebound in any satisfactory amount. They are largely provided by voluntary efforts, particularly under the auspices of church and fraternal groups. "Friendly visitor" programs, making use of voluntary workers under the direction of public and private welfare and other agencies, are expanding.

It is now generally accepted that each State has a responsibility to make available free public schools to all its children and youth. As a part of the total educational program, special education has developed in the States and in local communities as a service to those children and youth who have exceptional educational needs. Homebound handicapped individuals may receive services from school systems through general education which includes programs for exceptional children. The following pages concern programs for physically handicapped homebound individuals under (1) education of exceptional children; (2) roles and activities for the adult homebound; (3) adult education; (4) television as a teaching service; (5) library services; and (6) recreational services.

1. Education of exceptional children

The education of the homebound is one aspect of existing programs in the various States commonly referred to as "education of exceptional children" or "special education." Although much is yet to be done by State and local school systems, tremendous strides have been made within the last half century, and particularly within the last decade.

The steady development of programs of special education (including the homebound) has been aided by leadership from educational agencies of the Federal, State, and local governments.

The United States Office of Education, Department of Health, Education, and Welfare, through its Section on Exceptional Children and Youth, provides information, consultative service, and prepares publications concerning the education of all types of physically handicapped, mentally limited, mentally gifted, and emotionally disturbed children. Since 1930, it has given leadership and motivation to many new State and local programs of special education, and to national organizations concerned with the education of the handicapped. Major studies have been made of State legislation, qualification and preparation of teachers of exceptional children, and on problems and practices in the education of such children as the mentally retarded, socially and emotionally maladjusted, visually and auditorily handicapped, orthopedically involved, cardiopathic, and children handicapped by other physical or neurological problems.

State departments of education, within the last 25 or 30 years, and particularly within the last 10 years, have assumed leadership in providing for the education of various types of exceptional children, including the homebound. This is shown through marked increase in: (1) State legislation affecting the education of exceptional children; (2) appropriations to assist local school systems develop and extend special education; (3) employment by State departments of education of personnel to work with exceptional children; and (4) the setting of professional standards for teachers.

Before 1900, schools for handicapped children were mainly residential and served the deaf, blind, and mentally retarded. In the

early decades of this century, most of the efforts of local school systems were in a few communities, usually urban, but the program is now reaching into the rural areas of the States.

Today, on the basis of facts and estimates, we have 700,000 children (a sizable segment of them in the homebound category) who are in special classes and schools, or receive help from educational specialists, home or hospital teachers. Even though the exact number of children enrolled in local programs for the homebound is not specifically known, the numbers are increasing year by year. In 1952, 47 of the 48 States reported home instruction. While these figures indicate progress, it is estimated that there are at least 4 million children and youth (half of whom are physically handicapped) in the United States who have need for a special type of school program.

Enrollment in home instruction.—It is conservatively estimated that one per 1,000 now may be receiving home instruction in several of the States (not all), but more information should be secured before it could be concluded that this is the number for whom home instruction is the best educational service.

Statistics on enrollment in home instruction (of 1953–54) have been collected from a few States and are presented below. It is to be noted that these figures represent the total number of boys and girls reported for the *year* and do *not* show average enrollments for a given date. Furthermore, these figures come from States with very good programs in special education and programs which have been in existence for a number of years, and they are *not* necessarily typical of the country as a whole.

Enrollment in home instruction for a few States, 1953–54

	Public school			Home instruction		
	Total	Elementary	Secondary	Total	Elementary	Secondary
Connecticut [1]	340,373	224,764	115,609	893	544	349
Illinois	1,307,468	989,275	318,193	1,548	1,227	321
Missouri [2]	710,126	555,761	154,365	535	----------	----------
New Jersey	811,664	----------	----------	[3] 1,645	----------	----------
New York	2,174,285	----------	----------	2,782	1,373	1,409
State	----------	----------	----------	1,301	725	576
City	----------	----------	----------	1,481	648	833
Oklahoma	473,173	307,393	165,780	334	276	58
Tennessee	716,295	575,024	141,271	1,530	1,194	336
Virginia	695,277	521,938	173,339	955	785	[4] 167

[1] Connecticut divides elementary and secondary as New York City does: Elementary—kindergarten through 6th grade; secondary—7th through 12th grades.
[2] Missouri figures for public-school enrollment are estimates. Official figures not available at this date.
[3] New Jersey figures include individual bedside instruction in hospitals.
[4] 3 adults.

State programs.—Forty-six States have some kind of legislation through which they can aid local school districts in providing for handicapped children. Under some of these laws, home instruction is specified. Under others, services to the homebound are available even though not specifically mentioned in the law. State appropriations for the education of exceptional children range from several thousand dollars in some States to several million dollars in other States.

Forty-four States now have one or more persons employed in the State department of education to give consultative service to local school systems as they develop and improve services for the handi-

capped. Several of the States employ specialists who work with children who are crippled or who have special health problems. In these States, considerable attention is given not only to children in special day-school classes, but also to those who are on home instruction, or in hospitals. A further major development in behalf of exceptional children is the establishment of standards for teachers. Thirty-two States now have special certification requirements for teachers of at least one type of exceptional child.

The specific objectives of the educational program for these homebound children are the same as for all children. A well-adjusted program emphasizes the pupil's assets and liabilities; teaches him to understand and appreciate the contributions of others; and teaches him to assume civic and economic responsibility insofar as he can. In these programs of home instruction, academic skills are blended with those social understandings and abilities commensurate with the age and maturity of the child.

Many education programs for homebound children in this country are thought of as developmental and many of the children return either to other special educational services, or to the usual classes. In some of the forward-looking programs, extensive use is made of activities which not only help social competencies and understandings, but also develop the use of arts, crafts, radio, television, library resources, and vocational skills as part of the school experience of children and youth.

With full use of educational resources available for the child within the home and community, the later task of furnishing ameliorative and vocational training at the adult level is lessened. For the homebound pupil who is not preparing for vocational training, these opportunities for learning are valuable in adjusting to the everyday demands of normal living. When the child is not able to run or jump, and perhaps not able to engage in activities which call for laughing and yelling (as he would if he were on a baseball diamond), it is important that this "course of study" include enterprises which engage his interest, stimulate his learning, and contribute to his whole development.

Programs to supplement home teacher services.—A variety of means, in addition to home teaching, are being used to bring educational programs to the home. The home-to-school telephone is used by local schools in many States as a supplement to the work of the teachers. Telephone teaching is being carried on in 30 States, with California 1 of the more recent converts. In 23 States which have programs for special education for handicapped children, this method has been approved for partial or full State aid.[58]

The provision of these services usually is a responsibility of the local public school system, but in some instances they are provided by voluntary organizations, primarily State and local affiliates of the National Society for Crippled Children and Adults. In Cleveland, for example, 83 children are served by the Cleveland society.

A "Magic Box" is bringing both instruction and companionship to shut-in youngsters in Washington State. Janie has been attending her second-grade class at Bellevue Elementary School since last December by the use of speaker-microphone equipment. Dr. Ross Hamilton, State director of education for handicapped children, is enthusiastic about the benefits which can be realized from the use of

[58] Martin, Mary Frances, A Modern Miracle, CTA Journal, May 1954, California Teachers Association.

speaker-microphone equipment. He points out that use of the equipment can stretch school funds earmarked for aid to the handicapped. Visiting teachers can spend more time where they are especially needed and make fewer and shorter visits in other cases.[59]

The regular classroom teacher can also serve the homebound pupil. Since 1940 the Des Moines schools have successfully used the school-to-home telephone service. Pupils from grades 4 through 12, who, for physical reasons, are to be absent permanently or for at least 1 semester are eligible for this service. For example, Jean is a little elementary-school girl who has rheumatic fever. She must have lots of rest for several weeks before rejoining her classmates at school. Jean was worried about this because her class was just beginning to study Spanish. She knew if she did not get started with her class, she would never catch up.

Jean's worry was ended when the bedside teacher made plans for keeping her in close contact with her classroom work by use of a tape recorder. Recordings were made in the classroom and taken to Jean, and Jean in turn made recordings which were taken back to her class. In addition to work in her regular subjects, Jean has kept up in Spanish and will soon be able to return to school and fit right in with her group.[60]

While the above devices have been of great value in teaching homebound children and youth, it should be remembered that all such mechanical devices should be used as an adjunct for the teacher, not as a substitute for one.

2. Roles and activities for the adult homebound

Insufficient as are services for homebound children, those for homebound adults are even more so. This fact obtains even though a majority of the homebound are in the upper age brackets.

As pointed out earlier in this study, the number of older homebound persons is almost certain to increase—first, because of the striking increase in the number of older people, and second, because medical science is adding years to the lives of many who are already old and, often, infirm. Preventive services may be expected to hold down the number of homebound people but can hardly be expected to offset the factors working in the opposite direction.

Many services for the adult homebound today are directed toward preserving or restoring residual function in order that the individual may care for himself to the greatest possible extent. This is important because it helps to preserve the dignity and independence of the individual, releases family members for other activity, and lessens the need for custodial facilities in the community.

Another primary emphasis has been on training homebound adults for gainful employment, largely in their own homes. Many programs of this nature are described in this study. To the extent that such opportunities can be provided, they enhance the benefits derived from mere restoration for self-care.

Despite the successes reported by existing programs, it must be recognized that the majority of the older adult homebound are not candidates for any significant degree of paid employment. Some are

[59] A Magic Box for Janie, Washington Education, May 1953, Washington Education Association, Seattle, Wash.

[60] Van Meter, Ruby F., Teaching the Homebound Child, NEA Journal, March 1954, Washington, D. C.

so severely disabled that they will never recover any function. Only the simplest forms of activity will relieve the monotony of their existence and the task of caring for them imposed upon their families.

The preponderance, however, must be seen as a part of the growing number of older persons who have completed their responsibilities in family rearing and in gainful employment and for whom new activities and roles must be found. There are today 14 million Americans 65 years of age or over of whom perhaps 3 million have some gainful employment. The majority of the adult homebound are among the 11 million retired to other forms of activity. It does not seem reasonable, therefore, to assume that many of the most severely handicapped among these 11 million are going to find places in the employed work force. At the same time, efforts at restoration for self-care will probably achieve minimal results until the individual has some purpose beyond that of merely caring for himself. It is now recognized that inactivity and lack of purpose are factors in premature physical and mental deterioration.

To what, then, may the adult homebound look for meaningful experiences in their later lives? The question, indeed, faces millions of persons whose years are being extended beyond the completion of traditional adult roles. The total situation has emerged upon us quite suddenly and represents one of the major challenges to contemporary and future society.

While relatively little current experience is available, there are indications that satisfying and useful roles are being found by many older people in the fine arts and artcrafts pursued for their own sake; in continuing education, in voluntary community services; in recreational reading, radio, and television; and in mere conversation with other persons.

Reports and evaluations of programs for ambulatory older adults and of individual experience in these areas are just beginning to appear. There is urgent need for inventory and evaluation of current experience in the total field and with reference to the homebound. A few examples of current activities are set forth in the following sections which deal with both children and adults.

3. Adult education

At least 5 million adults are attending public-school programs for adult education. These programs are primarily of class nature, although they also include individual instruction available to help persons. The programs include the federally aided vocational education (Smith-Hughes and George-Barden Acts) with programs in agriculture, homemaking, trade, and industrial education and distributive occupations. Vocational education, however, is a part of the total adult educational program. Enrollment in these programs includes significant numbers in such areas as Americanization, elementary education, secondary education, fine arts, practical arts and crafts, health and physical education, personal improvement, recreation, and safety education.

Extension divisions of universities and university evening colleges often serve more people than are served in the regular full-time day program for young adults. Extension programs are carried on all over the State and include vocational training.

4. Television as a teaching service

Dr. David D. Henry, president-elect of the University of Illinois in an address to the college division of the National Council of Teachers of English, described television as "a boon to the homebound of all ages." Dr. Henry not only included wholesome entertainment in that statement but also planned sequential education. In New York City the results of teaching elementary school subjects to homebound children over the last 3 years with the aid of television already show a greater teaching efficiency for the visiting teacher. She can now cover 6 and even 8 times as many children with a less number of visits personally made to the homes, and, at the same time, show better learning on the part of pupils who actually attend school by television. The reason for this lies in the fact that television produces actual classroom situations and with vicarious participation questions are answered and superior results achieved.

Television courses for elementary school homebound children are also carried on in Detroit, Pittsburgh, St. Louis, Cincinnati, Chicago, Los Angeles, San Diego, Houston, Philadelphia, Baltimore, and Washington, D. C. These courses have become so popular that they are also received in classes for those pupils attending schools, as supplementary lessons. Pittsburgh and San Diego both provide television courses on the high-school level which reach homebound youngsters, as well as those continuing their education after a workday.

Adult education is now supplied by regular telecourses in a wide variety of subject matter fields from over 65 colleges and universities. Most of these courses may be taken for credit toward a degree on successful accomplishment of examination. They are in subjects like history, economics, philosophy, psychology, anthropology, political science, mathematics, foreign languages, English literature and composition and in many vocational subjects as well. Universities cooperating in this nationwide project are Columbia, Harvard, Princeton, Johns Hopkins, American University, University of North Carolina, University of Alabama, Tulane, Houston, University of Texas, University of Southern California, Stanford University, University of Washington, Washington University at St. Louis, Western Reserve University, Ohio State University, Northwestern, Michigan State College, Pennsylvania State University, University of Michigan, University of Kansas, University of Iowa, and many others. The regular commercial television stations provide as well today many-course series which though not credited are extremely valuable for supplementary viewing and listening in many fields of interest.

5. Library services

Libraries can play a significant role in the education and training of handicapped children, youth, and adults. These educational agencies have organized collections of books, periodicals, and other materials which can be used by the handicapped in learning new skills, in obtaining guidance about new or altered careers, and in building up morale. These resources are also at the disposal of specialists in the field of vocational rehabilitation.

Public libraries consider that all ages fall within their scope—children, youth, and adults. The modern library, moreover, does not limit its activities to those persons who are able to come to its four

walls. Many of the large public libraries in cities have extension departments which serve persons in hospitals, special schools, other institutions, and the homebound. Some of this activity is carried on through either deposits of library materials in the institutions themselves or the regularly scheduled visits of bookmobiles. Talking books for the blind and machines which project books on the ceiling for the bedridden are available from some libraries.

County public libraries in many cases are in a position to assist the work of vocational rehabilitation in rural areas. A large number of this type of libraries operate bookmobiles which carry books throughout the countryside, to points far removed from cities. These traveling units bring library resources within easy access of farmhouses, village homes, rural schools, and other county institutions.

Experience has shown that the significance of the service extends beyond the mere delivery of books. The visit of the librarian gives the homebound individual an outside social contact and the satisfaction of having something done for him as a person. In Cleveland, where a bookmobile program is well developed, the homebound adult often acquires real community status. The periodic discussions with the traveling librarian and the books supplied by the librarian place the individual in the role of an important and informed person. Not infrequently, neighbors gather in the home of the person being served in order to participate in the discussions.

Furthermore, all States have library extension agencies maintained by State funds to further the development of library facilities and to render at least a limited service to persons without ready access to local public libraries.

One of the promising newer services is the "projected books" program, in which libraries supply projectors and filmed books to bedfast or chairfast invalids. Reports from Oklahoma and Michigan libraries indicate that requests for the service continue to exceed the expanding supply of equipment. An important feature of the Michigan program is that Lions clubs are purchasing most of the delivery and pickup service. The secondary values: the community contacts for the homebound individual, the relief of the libraries of the delivery costs, and provision of an opportunity to club members for useful community service, may approach the importance of the primary value.

In some States, the meagerness of the State appropriations curtails severely the effectiveness of the library extension program. The common purpose of these States, however, is to provide all educational programs with the necessary library facilities.

School and college libraries are often of considerable help in home study and training. The Service to Libraries Section of the Office of Education, Department of Health, Education, and Welfare, is available for advice in planning for the use of library facilities.

6. Recreational services

The variety of recreational services which are being provided for the homebound range from simple visiting by neighbors or fellow members of a church to relieve the monotony faced by the shut-in, to organized, relatively comprehensive programs which include a regular schedule of visits, plus a variety of other recreational services. The variety is indicated by a summary made by the National Recreation Association for purposes of this study, showing some of the types

of programs developed for shut-ins. The Recreation Department in Jamestown, N. Y., for example, is reported as having organized a good radio program for shut-ins. Each week the local station carries a simple radio program which includes as much local color as possbile—the singing of a birthday song for those whose friends or relatives have sent in their names, sometimes a simple instruction for a craft or a game, always on a very informal and free basis, with a cheerful poem or a song and things of that sort. Its effective use depends, of course, upon good promotion both by the local newspapers and the recreation department; so far it has been very successful.

In Chicago, a voluntary service has been in operation for 3 years training older adults in art and craft skills in order that they, in turn, may transmit the skills to homebound persons in institutions or in their own homes.

Ths use of local newspapers to carry a weekly column of similar material of interst to the homebound is also suggested. Weekly or monthly newsletters that go out to the shut-ins are also reported as frequent devices to give the homebound news about other people who are shut in. A lending service which includes portable radios, television, books, games, magazines, and certain craft tools is also reported as a possibility, but for such a service, there must be some type of organization to handle and distribute the materials. The National Recreation Association, describing the ways in which community recreation programs for the homebound generally get organized, has noted the following story about the shut-in program in Jeanette, Pa., as reported in the newsletter of the Pennsylvania Recreation Society for April 1953:

> One day a civic-minded gentleman walked into the office of the recreation director with an idea. "Can't something be done to bring a little joy into the life of my neighbor who is a cripple?" Immediately plans were formulated to procure a committee to undertake this activity; the response was terrific. The committee first formed consisted of the mayor, recreation commission, superintendent of schools and other spirited citizens. Each has his own specific duties, such as procuring a birthday cake, a bouquet of flowers, which are presented to the shut-in on his or her birthday, the committee as a whole visits the shut-in on this day.
>
> Shortly after the first meeting of the committee was held, the Beta Tri-Hy-Y Club of the high school consisting of 40 teen-agers (girls) came to offer their services and further the cause of this most worthwhile project.
>
> In addition to the birthday visit of the committee, these teen-age girls make a weekly visit to spend an hour or so, reading or performing some other phase of recreation. The committee is now having church services of the different religions recorded on tape, so that now in addition to recreation, religion may be brought into the lives of our shut-ins. The clergy of our community have met this phase of it with great enthusiasm and cooperation.
>
> The club started out with 16 members; since the first visit it has increased to 25, with 1 or 2 applications coming in each day. The present program was not enough, many of the neighbors of semishut-ins and temporary shut-ins ask the questions, "Why can't recreation also be brought to these people?" So now the committee is hard at work devising a mobile recreation unit to carry recreation to those who cannot come to it. Much of the success is also owed to the local florists and bakeries who have so generously donated flowers and cakes.
>
> Future plans call for a monthly bulletin to be put out by the shut-ins themselves, which will include birthday dates, favorite poems, and stories, carol singing at Christmastime, free movies, television and radio programs.
>
> Let us urge this type of program to all communities, big or small, rich or poor, it doesn't cost much and the joy of doing good for those who can't do for themselves more than pays for the little work that has to be done to keep the program rolling.
>
> The following steps are recommended to get such a program started:
>
> 1. Get a list of shut-ins from the clergy and welfare office.

2. Contact the shut-ins by letter explaining the purpose of the club, making them feel that they will conduct it, enclose an application blank which will include such questions as, "What is your favorite flower, hobby, etc.?" Try to give them what they want. Let them suggest names for it.
3. Get a committee of interested citizens to help get the program started. The more working on it the better the program.
4. Use teen-age clubs, for readers, particularly for the blind.
5. Plan to have committees visit each member on his or her birthday, with the teen-agers visiting once a week. Young people have such enthusiasm that the shut-ins enjoy their company.
6. Send cheerful cards periodically, especially on holidays.
7. Raise funds and provide for birthday cakes and flowers.

The following are brief descriptions of some of the other organized recreational services which are being provided the homebound. These are intended as examples of the types of services being provided rather than as an inventory of existing programs.

1. *"Friendly visitor."*—An increasing number of communities are organizing programs for visiting individuals who are shut in and lonely. Generally, these people have at least one need in common—someone to take a personal interest in them on a regular basis.

These programs are usually operated under volunteer auspices, although they sometimes are assisted by a public agency.

As the number of homebound and socially isolated older persons increases, pastors are finding it difficult or impossible to meet the demands for home calls. Some churches and synagogues that can afford it are adding assistant pastors or lay workers to their staffs or are organizing visitor services to cope with this growing situation.

The American Red Cross Gray Ladies are also developing a visiting program. The Greenwich, Conn., chapter initiated such a program in 1949 at the request of the Department of Welfare.[61]

Characteristic of these programs is the emphasis on training the volunteers to recognize the many needs of the homebound and, in cases where the volunteer worker herself cannot meet the need, to bring it to the attention of the professional workers in the agency with which she is associated. Most of the emphasis for organizing the "friendly visitor" programs is coming from the increased interest in programs for older individuals. However, an interesting service that has been functioning for a relatively long time to meet the needs of children is the Handicapped Children's Home Service in New York City. This agency was organized in 1939 to bring constructive recreation to invalid, convalescent, or handicapped children in their own homes. The service visitor goes to the child's home once a week, taking handicraft materials, books, toys, games, etc. A major part of the work of the service is done by volunteers from churches, schools, and volunteer organizations. The visitors make written reports of their visits and attend biweekly meetings at some of which doctors or social workers discuss special aspects of the recreation program; at others there are lessons in handicrafts and the use of play materials. From time to time the services use a small mimeographed magazine depicting materials created by the children and news items concerning their activities.

2. *Girl Scouts of the U. S. A. and Boy Scouts of America.*—Both of these organizations carry on extensive activities for handicapped children. They have made special efforts to assure that these children are given the maximum opportunity to participate in Scout activities.

[61] Windows for the Homebound, Mrs. John W. Sheppard. Nursing Outlook, February 1954.

The Girl Scouts of the U. S. A. has recently issued a guide for its leaders "Working with the Handicapped." Prepared in cooperation with outstanding authorities and specialists concerned with the disabled, the guide presents in summary form special information needed by adults who work with "exceptional children."

The Boy Scouts of America has long been active in bringing its programs to the physically handicapped. In 1942, this organization published a "Directory of Scouting among Physically Handicapped Boys" which showed a total of 230 groups comprised entirely of physically handicapped boys. Many of these units are in hospitals and institutions. In an article "Gamest Kids in the Country" Jerome Ellison reports that 15,000 of the active Scout membership are crippled or blind.[62] While many are not "homebound" in the narrow sense of the term, others are shut-in. Mr. Ellison notes that "several cities, including Oklahoma City, Van Nuys and Oakland, Calif., have organized radio troops for shut-in Scouts. A neighborhood Scout acts as 'buddy' to help each shut-in."

3. *Volunteer Film Association, St. Louis.*—A unique volunteer group which has brought education and entertainment to several thousand homebound persons in institutions or their own homes each month since 1939 is the Volunteer Film Association. Using its own motion picture projectors, the volunteers of this organization secure films, preview them, maintain the films and equipment, transport the films to institutions and individual homes and show them for the homebound.

4. *Activity centers.*—A promising recent development in providing new activities and social contacts for older adults is the activity center with its varied program of arts and crafts; poetry, drama, and discussion groups; organization of opportunity for volunteer service; sports and games; lounges; and social events. There are perhaps 20 or 25 such centers in the country today, pioneered by Hudson and Sirovitch Centers in New York City and Little House in Menlo Park, Calif. Hundreds, if not thousands, of clubs for older people are providing similar opportunities on a weekly or monthly basis.

Homebound individuals are benefited in two ways by these programs. In the first place, some of the homebound living within short distances of the centers find that they can get to them and become direct participants. Thus, they are removed from the homebound class. Second, when members of activity center groups become homebound they frequently become objects of attention and service by the friends they have made in the centers.

Thus, it would appear that more communities could well develop activity centers and that, as the functions of the centers evolve, specific effort should be made to extend services to the homebound. As suggested earlier, those who render the services may well be older people finding new, useful roles for themselves and preventing their own deterioration.

[62] Gamest Kids in the Country, Jerome Ellison, Saturday Evening Post, 1953.

Vocational Training and Employment

SUMMARY

Although both public and private agencies are engaged in programs to provide vocational training and employment for the homebound, the availability of these services varies widely from State to State and locality to locality.

State vocational-rehabilitation agencies serve those disabled homebound persons who are eligible under the law, to the extent the resources and obligations of the agencies will permit. The Veterans' Administration provides a variety of training and employment benefits for eligible disabled veterans who are homebound. Private organizations also furnish some of the vocational services needed by the homebound, with blind agencies being especially active.

The method of training most commonly used are home teaching and tutorial aid, correspondence courses, and instruction in sheltered workshops and other rehabilitation facilities. Training provided by State rehabilitation agencies is, for the most part, to assist the homebound to establish small businesses.

The Federal Government, and most of the States, have laws which control in varying degrees the operation of homebound industries.

From the fragmentary data available, it appears that somewhere in the neighborhood of 10,000 homebound handicapped persons presently are employed by an industrial concern or sponsoring organization in some form of homebound industry or craft. (This excludes those in independent, self-employment.) Rough estimates have been made that approximately 100,000 could become employed in the home or in sheltered workshops.

Of the many types of services which are provided today for the homebound, one of the most sought and least widely available is service in vocational training and in securing suitable employment. Although, as mentioned earlier, a high proportion of homebound are of advanced years, with many no longer interested in employment, there still remain many thousands of homebound persons who could perform work for pay and who would welcome the opportunity. In this section of the report, some information is provided on the types of training and employment now provided, the prospects for expanding these and developing others, and some of the obstacles to be overcome.

Although most of this section of the study and report deals with training and employment in the home and in sheltered workshops, it should be noted and emphasized that the first consideration should be efforts to restore the individual to the point where he may get and hold a job in regular competitive employment, and that plans for homebound employment should be developed only when there is no other reasonable prospect for the homebound person.

Vocational training services

The State-Federal program of vocational rehabilitation is legally constituted as a public agency to provide vocational training and

other services to physically handicapped persons, including the severely disabled and homebound, for whom such services may reasonably be expected to result in remunerative employment. State vocational rehabilitation agencies report that the training services furnished for the homebound are generally considered as part of their regular operations. These services are provided on an individualized basis with self-employment generally the objective.

During recent years an increasing interest has been manifested in meeting the problems of the homebound through the provision of vocational training and other services. This interest has been very evident among the State rehabilitation agencies. One of the most comprehensive reviews of the subject was prepared by a group of State vocational rehabilitation representatives participating in the Fifth Annual Workshop on Guidance, Training, and Placement, held in Washington, D. C., in 1952.[63]

There remains, however, a great variation among the States, and among localities within the States, in the amount of training being provided for the homebound. There are many reasons for this—

Lack of special rehabilitation centers and sheltered workshops to begin the rehabilitation process.

Extreme shortages of professional staff with competency in the specialized work of planning and carrying out training for the seriously disabled at home.

The high cost, in both time and money, of supervisory visits to individuals in widely scattered places, and particularly in rural sections.

The unreliability of training plans for home manufacture of products when there is no reliable system for continued marketing.

These and other factors raise, for the State rehabilitation official, the perennial question: How best to invest the available resources of funds and staff to the advantage of the greatest number of handicapped persons who need services. With the need constantly outstripping the resources, States frequently are forced to the decision to serve only a few homebound handicapped persons in order to apportion the funds and staff among all the handicapped—homebound and nonhomebound.

In addition to questions of individual physical abilities, aptitudes, home space, and facilities, etc., suitable training plans for the homebound must be geared to the actual employment opportunities which exist in the community.

In some States vocational training and employment opportunities exist in home industries and homecrafts through the facilities of voluntary and private nonprofit agencies. In other States, however, such organized programs of home employment have not been developed and self-employment activities offer the only substantial employment objectives for the homebound.

The experience of the United Mine Workers of America, Welfare and Retirement Fund, in developing rehabilitation services for disabled miners who are beneficiaries of the fund, has highlighted some of the difficulties inherent in training and employment of the homebound.[64]

[63] Rehabilitation Programs for the Homebound, pt. III, Report of Proceedings, Fifth Annual Workshop on Guidance, Training, and Placement, Office of Vocational Rehabilitation, Federal Security Agency, Washington, D. C., June 1952.

[64] Communication from the United Mine Workers, Welfare and Retirement Fund, to the Study on Homebound Physically Handicapped Individuals, January 17, 1955.

Our severely disabled (miners) who are homebound, coming from rural areas with one industry, are difficult cases for rehabilitation because: (1) local job opportunities which can be handled by a homebound person are extremely limited and, in most instances, nonexistent; (2) isolation, coupled with lack of marketing facilities and transportation difficulties, serve as a real barrier to the development of potential productivity—even though individuals may have an opportunity to gain particular skills through outside training; (3) programs developed to date for homebound in coal-mining States have not been utilized to any extent among our beneficiaries, which leads us to believe that State agency personnel concerned recognize the difficulties herein indicated.

We feel strongly that severely disabled individuals who are homebound should be given an opportunity to break with their environment and be placed in a rehabilitation center or facility where they may be exposed to the best available medical and related services which conceivably might improve their physical and psychological condition. Subsequently, they need exposure to training opportunities which may enable them to leave their environment and find employment under more favorable circumstances. Such steps will require more ingenuity on part of local counselors, increased per-case cost for rehabilitation measures, and better coordination of services, on the part of local counselors and outside agencies offering employment opportunities.

We have found many so-called homebound cases in the course of our operations who were able to increase their bleak and bedfast existence through medical and psychological rehabilitation. With careful guidance and supervision they were also able to develop job skills far beyond those initially prescribed for them when they started their physical and psychological rehabilitation. Subsequently, determined efforts to resettle such cases or to rearrange their environment to the end that they found a job suited to their capacities has often resulted.

Home study through correspondence is one method of vocational training which has demonstrated its effectiveness in assisting the disabled homebound to acquire new knowledge and skills. The National Home Study Council reports that numerous severely handicapped persons have completed correspondence courses and become successfully employed in small-business activities such as radio repair, watch repair, dress designing, drafting, bookkeeping, accounting, and artwork. Others have developed skills in typewriting, reweaving, hosiery mending, and various types of art and craft activities. Correspondence training has been utilized by State rehabilitation agencies especially for the homebound living in isolated areas, although it has proven equally effective in urban centers. One correspondence school, the Davison Technical School of Detroit, has developed a series of commercial and drafting courses which are used exclusively for rehabilitation training. Studies which they have conducted indicate that approximately 80 percent of their students successfully complete the courses undertaken.

Films and other audiovisual aids are being used for home instruction more every year. As indicated previously, television is a new medium in home study and has many possibilities for encouraging students to complete their work on schedule and in a shorter time than usual. Although it is not known how many of the disabled homebound have benefited already, these special devices certainly offer opportunities for extending more adequate training services to many of the homebound, particularly those in rural areas.

No form of home instruction can supplant the home teacher who is equipped through special training and experience to meet the individual needs of the homebound. Regularly scheduled visits to the home provide the means for establishing the type of personal relationship with the teacher which is conducive to the homebound individual's good morale. His accomplishments are recognized and his efforts to advance as far as possible are encouraged. Continued

family interest and community cooperation are maintained. In addition, the home teacher may distribute training supplies and instructional materials, pick up finished products and transport them to marketing outlets.

Most State agencies serving the blind employ home teachers, many of whom themselves are blind. Their services are extended to three general categories of blinded individuals: (1) the newly blinded who are provided with certain personal adjustment services, (2) the older age group who are trained in the worthwile use of leisure time, and (3) those homebound blind individuals who may engage in some type of productive activity. For this latter group, the home teachers provide vocational training in such activities as hand and power sewing, crocheting, knitting, weaving, assembly of leather goods, basketry, hammered metalwork, and rubber-mat making. Instruction is also given in the development of communicative skills through the reading and writing of braille and the use of "talking books" for the blind.

State rehabilitation agencies make less use of home teachers and private tutors for the sighted disabled than for the blind. This is due in part to the more highly organized nature and greater number of industrial homework programs carried on by public and private agencies serving the blind. In general, home teaching for industrial homework and crafts for the sighted is available only in those States which have developed statewide home employment programs or in local areas where voluntary agencies are providing this type of service.

For those who are expected to remain permanently confined to their homes, the training is generally in some phase of arts and crafts, home-industry, or small-business type of enterprise which can be successfully managed and operated in the home. For others who have been homebound but for whom the causes might be removed or alleviated, vocational training might be provided in any of the trades or professions which are considered feasible. Following a thorough rehabilitation diagnosis, such training might be given concurrently with physical restoration and other services aimed at removing homebound restrictions.

From examination of the policies and procedures followed by public and private agencies in accepting homebound individuals for rehabilitation services and in determining their feasibility for training, there appears to be rather general agreement that the acceptance of trainees for homebound services should be based upon the following criteria: (1) the extent of the disability is so severe as to prevent entry into the usual school facilities established for community use and entry into regular channels of employment; (2) the prognosis is such that a reasonable period of productive activity can be expected; (3) the condition is such that it will not be aggravated by engaging in some form of work activity; (4) the condition is static and of a longtime nature as opposed to acute or temporary disabilities which might follow some accidents and illnesses; and (5) the condition does not have an element of contagion.

Although the above are generally accepted as basic criteria, the actual provision of training services to the homebound is dependent upon many other factors. The feasibility of serving a particular homebound individual may depend to a large extent upon the ability of the agency, through its own organization or through other available

resources, to provide the total services necessary for successfully carrying on a home enterprise. Such services would include provisions for marketing and merchandizing in addition to training staff and the financial ability to adequately provide a continuing program of closely supervised activity including the marketing of products.

Sheltered workshops.—Sheltered workshops were established as early as 1840 but it has only been since the turn of the century that they have risen to prominence. Early in their development they were considered primarily as employment and training facilities.

As a greater understanding was reached concerning the characteristics of severely handicapped persons and the many factors which affect their efforts to attain the highest degree of employment potential of which they are capable, organizations sponsoring the operation of sheltered workshops began to recognize the need for increasing the scope of services provided by the workshops. Today the sheltered workshop may provide, in addition to remunerative employment, such other services as medical consultation and supervision, physical and occupational therapy, personal and social adjustment, vocational evaluation, testing and counseling, prevocational and vocational training, and selective placement.

The sheltered workshop has proven that it is a vital link in the chain of the rehabilitation process, particularly as a means of bridging the gap for a severely handicapped person who cannot immediately enter the competitive labor market or participate in other than special training programs. However, there are many individuals who, because of the severity of their physical condition and other factors, have found it impossible to travel to and from the workshop. Pioneering efforts by many sheltered workshops have demonstrated the social, vocational, and moral values to be drived from an industrial homework program which is geared in with the regular workshop activities.[65]

Vocational rehabilitation services for homebound veterans.—The Veterans' Administration provides vocational rehabilitation services to veterans having disabilities connected with service in World War II or subsequent service covered by law. Under this program, special provision has been made for training homebound veterans. Since 1943, when instruction in the home became effective, approximately 2,000 veterans have undertaken training in their homes.

The philosophy underlying this special type of service is expressed in the Veterans' Administration's general policy concerning the vocational rehabilitation of seriously handicapped veterans:

> It will be the policy of the Veterans' Administration to discover and apply ways and means by which a seriously handicapped veteran may overcome the effects of his disability and become employable in an occupation which is suitable with regard to his aptitudes, abilities, interests and other personal characteristics whenever, considering his circumstances and with due regard to his disability, there is sound reason to believe that the values to be realized from employment in such an occupation will be sufficient to constitute an incentive to continue employment in the occupation.

Training in the home may be provided for a veteran whose disability prevents him from availing himself of instruction at a facility where training customarily is obtained. Great care is exercised in assisting

[65] The need for adequate services of a vocational nature for the homebound has been recognized on an international level as well as in our own country. See the report of the 37th session of the International Labor Conference, Geneva, 1954, sec. VIII, Sheltered Employment, Comments and Conclusions.

the homebound veteran in the selection of a suitable employment objective and in making the arrangements for his training. Before such training is resorted to, assurance is obtained through medical sources that the limitations imposed by the disability cannot be reduced through medical treatment to such an extent that the veteran would be enabled to avail himself of instruction at the usual places of training. In this program the Veterans' Administration has not utilized industrial contract homework or extensive handicraft production arrangements but rather has emphasized the teaching of professions and trades in combination with instruction in the operation of small business enterprises. The variety and difficulty of the occupations involved is illustrated by the list of occupations for which veterans have trained in their homes. (See pt. A, appendix III.)

Medical supplies, medical treatment and special equipment of various types are furnished as necessary. Equipment may include specially constructed items such as workbenches and chairs, as well as complete sets of occupational tools and in some instances power tools and other production equipment. For most veterans who are homebound, the Veterans' Administration has provided prosthetic appliances and sometimes have furnished other physical aids to aid them in performing the activities of daily living. These include wheelchairs, braces, crutches, and similar items which facilitate vocational rehabilitation wherever pursued.

The individual training program for the homebound veteran calls for the trainee to develop gradually a market for his products or services and to supply that market so that in effect upon completion of the training program he is employed. A correspondence course is sometimes prescribed in connection with training under an individual instructor where the correspondence course will provide needed therapy and pertinent technical information. This practice is followed particularly if the instructor, although familiar with the occupation, is not regularly engaged in teaching.

For purposes of this study the Vocational Rehabilitation and Education Office of the Veterans' Administration has provided information on the numbers of disabled veterans reported as receiving vocational rehabilitation training in the home as of selected months subsequent to October 1951. (See pt. B, appendix III for tabular presentation of "Disabled Veterans' Training in Their Home," including definitions of the disablement categories indicated.) The steady decline in numbers of veterans receiving home instruction conforms somewhat to the decline in the total number of disabled veterans in training of all types. The number participating since 1951 reached a high of 163 in April 1952 and a low of 83 in October 1953. There has been little change since July 1953.

Veterans who require regular aid and attendance because of being bedridden or otherwise unable to care for daily needs receive a special amount of compensation. On June 30, 1954, 1,708 veterans were receiving additional compensation for aid and attendance needed because of service-connected disabilities.

Another factor which contributes to the reduction in potential homebound load is the provision made by Congress for furnishing automobiles to certain veterans, including those who have lost the use of the lower extremities. Veterans so disabled also may receive Government grants toward the purchase of special housing, designed

for easy access and use by those in wheelchairs, and sometimes having special exercise rooms to aid in maintaining physical fitness. Thus the relatively small number of veterans who have engaged in home training may be attributed partly to the comprehensive rehabilitation services and benefits, which have the effect of helping to restore ability to leave the home to enter training and employment.

By far the majority of the veterans who require training in their homes had sustained orthopedic disabilities. For example, in July 1954 out of a total of 87 veterans only 7 had major disabilities other than orthopedic. The number of veterans in other disablement categories is practically negligible, which indicates that the mobility factor is the primary reason for the disabled veteran's homebound condition and necessity for selecting home employment as a vocational objective.

A number of seriously disabled veterans who would ordinarily be considered homebound have been trained in management aspects of farming, with the actual labor operations being carried out by other members of the family or by hired hands. Some of the trainees get around their farms to supervise operations in jeeps, and some operate moving farm machinery. The kinds and sizes of farming enterprises are carefully considered in the light of the veterans' limitations and available assistance and although the eventual return from the farming project may not be as large as in cases of less disabled persons, it is sufficient to provide motivation to continue farming and to make a reasonable contribution to family living expenses.

Major types of home employment programs.—Programs providing employment opportunities for homebound workers are operating in two broad fields—those providing industrial homework opportunities and those assisting the homebound to set up small businesses.

The industrial homework programs may be further described according to the nature of the arrangements for marketing the products of the homeworkers. Under one type—"contract" work—the production is on the basis of a contract with the agency serving the homebound for the production of a stipulated number of a given article or articles at a set price. The specifications for the product and materials used in their production are generally supplied by the employer. The other major type is the "homecraft" program where the product is produced by the homebound worker on arrangement with the public or nonprofit agency. The materials may be supplied by the agency, but the product is disposed of through retail or wholesale outlets, including door-to-door sales, operated or arranged for by the agency serving the homebound worker.

Some programs utilize both "contract" and "homecraft" work. For purposes of this study, the term "industrial homework program" is used as it is defined by the National Association of Sheltered Workshops and Homebound Programs.[66]

> An industrial homework program for the physically handicapped is a service to be rendered by an accredited agency, designed and developed with the intention of adhering to health and labor laws, to offer regular work training and remunerative work opportunities to those eligible disabled persons who cannot for physical, pshychological or geographic reasons leave their homes to travel to and from a place of business.

[66] Sheltered Workshops and Homebound Programs—A Handbook on Their Establishment and Standards of Operation, p. 6. National Committee on Sheltered Workshops and Homebound Programs, 15 West 16th Street, New York, N. Y., 1952.

This definition has also been adopted by the American Foundation for the Blind and the National Industries for the Blind.

The term "small business enterprise" is used to mean an independent, profitmaking activity carried on in the home and in which there is no direct affiliation with an organized industrial homework program.

Federal laws affecting industrial homework.—Two Federal laws affect industrial homework, specifically, the Walsh-Healey Act of 1936 and the Fair Labor Standards Act of 1938, as amended. Under the Walsh-Healey Act, industrial homework is prohibited in all Government contracts of more than $10,000, except for homeworkers of sheltered workshops. The Fair Labor Standards Act, commonly called the Federal wage and hour law, provides that every employee who is engaged in interstate commerce or the production of goods for interstate commerce, including any closely related process or occupation directly essential to such production, be paid at least 75 cents an hour for the first 40 hours worked in any workweek, and not less than time and one-half the regular rate of pay for all hours worked over 40 in any workweek, unless an exemption applies. If, by reason of disability, the homeworker is unable to earn the required 75-cent hourly minimum wage, a subminimum wage certificate may be issued. The act does not specify any place of work; thus the worker may be employed in a factory, a workshop or at home. (See appendix IV for a more detailed description.)

Early administration of the act disclosed persistent, widespread, and flagrant violation of the minimum wage and overtime compensation provisions of the act among industrial homeworkers, particularly in those industries where industrial homework constituted a substantial part of the industry's economy.

To meet this situation, industrial homework was restricted by regulations in seven industries—embroideries, knitted outerwear, gloves and mittens, jewelry, women's apparel, handkerchiefs, and buttons and buckles. Homework in these industries may be performed only by persons (1) who are unable to adjust to factory work because of age or physical or mental disability, or (2) who must remain at home to care for an invalid in the home. Industrial homework certificates usually for a term of 1 year and renewable, are issued to homeworkers in the seven restricted industries by the regional directors of the wage and hour and public contracts divisions of the Department of Labor. Homework certificates are not required for homeworkers of sheltered workshops.

State laws affecting industrial homework.—In addition to the Federal legislation, 20 States have enacted industrial homework laws. In 9 of these 20 States, the laws provide machinery for the ultimate elimination of homework; 8 States have established some form of minimum wage and 9 have some maximum hour provisions; 10 States have laws which set a minimum age at which children may engage in homework; in 2 States, New York and Rhode Island, the use of industrial homework contractors and distributors is prohibited, while California and New York limit the homeworker to 1 employer in certain industries. (See appendix V for a more detailed analysis of State legislation.)

Extent of home employment in the United States.—No national data are available on the total number of homeworkers or the number of

disabled in home employment. Such information as is available, however, particularly from statistics collected by the wage and hour and public contracts divisions of the United States Department of Labor indicates that the number of homebound disabled workers who are gainfully employed is relatively small. The tangible information includes data in the two general areas of (1) industrial homework and (2) small business enterprises.

1. Industrial homework

Such data as are available concerning home employment generally arises out of the operations of the State and Federal laws relating to homework from the relatively few public and private agencies which are providing employment for the homebound.

(*a*) *Individual homeworkers certified by the United States Department of Labor.*—The Department of Labor issued homework certificates to about 2,500 disabled workers in the year ending June 30, 1954, for employment in the 7 restricted industries above.[67] (See table A, appendix VI).

The majority of these homeworkers were employed in the gloves and mittens industry and the embroideries industry. The women's apparel and knitted outerwear industries were third and fourth respectively in the numbers employed while the button and buckles, and handkerchiefs industries followed in that order.

Employment in the seven restricted industries is concentrated in a few areas. (See table B, appendix VI.) New York State, with an estimated 1,600 homeworker certificates, has about twice the number of certified homeworkers than all the other States combined. Five other States in addition to New York—Massachusetts, Pennsylvania, Georgia, Illinois and Tennessee—granted more than 100 homeworker certificates. On the other hand, 16 States issued no homeworker certificates during fiscal year 1954 and 5 States granted only a single certificate.

(*b*) *Homeworkers employed by nonprofit sheltered workshops certified by the United States Department of Labor.*—The regulations of the Federal Department of Labor pursuant to the Fair Labor Standards Act require that sheltered workshops (nonprofit charitable organizations providing remunerative employment in which handicapped persons are placed for training or employment) must obtain a sheltered workshop certificate authorizing subminimum workshop rates if the handicapped persons placed in the workshop are engaged in covered work and are unable to earn the applicable minimum wage.

For the year ending June 30, 1954, the Department of Labor issued certificates to 40 sheltered workshops which, at the time of application for a certificate, were providing home employment for about 1,000 disabled workers. (See appendix VII for listing.) Because of turnover, the total does not represent the number of different workers employed during the year. Moreover, the workshops are required to list only homebound workers who are performing covered work and who are unable to earn the statutory 75-cent minimum wage. However, because most workshops

[67] This includes 1,920 workers identified as disabled in the 7 industries exclusive of the glove and mitten industry in New York. Of the 1,254 total homeworkers employed in the glove and mitten industry in New York it is estimated that 600 are disabled.

listed all homebound workers in reporting to the Department of Labor it is felt that the available data represent a comprehensive coverage of homebound workers in certified workshops.

(c) *Individual homeworkers certified by State departments of labor.*—An effort was made to obtain the number of homebound workers in those States having industrial homework laws and/or regulations by contacting the State departments of labor. However, the information obtained from these agencies does not distinguish the physically handicapped homebound from other homeworkers except in a few situations. Rhode Island, for example, reported that as of November 1954 there were 140 persons holding homework certificates. Of these, 27 persons were 60 years of age or over. Of the remaining 113 persons under the age of 60, 13 were physically handicapped for reasons other than age. On the other hand, Massachusetts reports approximately 3,800 licenses for industrial homework but no data on the number of physically handicapped. In a like manner, New Jersey reports approximately 150 concerns distributing homework to about 1,000 workers, with about one-half of these engaged in operations related to the clothing industry, but without figures on the number of workers who are physically handicapped.

(d) *Homeworkers employed by sheltered workshops and other home employment programs not covered by the Federal wage and hour law.*—Sheltered workshops and home employment programs operated by various State instrumentalities are exempt from the wage and hour law as are those workshops whose homeworkers do not produce articles which move in interstate commerce. The number of homebound physically handicapped persons employed through these programs is not known. However, figures available from some of the larger programs indicate that the number is relatively small and probably would include fewer than 3,000 persons.

Most of the State-operated programs may be classified in the general category of homecraft programs.

Among the larger programs are those operated by the Alabama Vocational Rehabilitation Service, the Wisconsin Vocational Rehabilitation Division, and a number of State agencies serving the blind, including the New Jersey Commission for the Blind, the Iowa Commission for the Blind, the Michigan State Department of Social Welfare, the New York Commission for the Blind, and the Washington State Department of Public Assistance.

While practically all industrial homework is confined to urban areas, there has been some effort on the part of homecraft programs to extend their services to rural areas. The Wisconsin Homecrafters, for example, with a caseload of approximately 500 report that about 42 percent or 210 homebound persons were living in rural areas. The program covers 37 of the 71 counties in Wisconsin.

The Alabama Vocational Rehabilitation Service operates a homecraft program which is currently serving approximately 285 persons in 32 of the 67 counties of the State. There is no breakdown of these persons by urban and rural areas but it was reported that they include homebound workers in the sparsely settled sections of the State as well as in the cities and towns.

In Pennsylvania an industrial homework pilot study is now underway to determine the feasibility of establishing a statewide industrial homework program for the blind. Planning for this demonstration project began in 1951 when representatives of the State council for the blind and a private statewide agency, the Pennsylvania Association for the Blind, undertook a cooperative study of home employment opportunities for the blind. This resulted in an estimate that 1,500 blind persons were potentially available for home employment. In October 1953 an agreement was executed between the Pennsylvania Association for the Blind and the State council for the blind for the initiation of a pilot study in the tricounty area of Berks, Lebanon, and Schuylkill Counties which covers both urban and rural territories. It is too early to adequately evaluate the results of this study, particularly since the first homeworker did not begin producing salable merchandise until May 15, 1954. However, it was reported that a preliminary analysis as of November 1954 indicates (1) the geographical area of study should be expanded, (2) the length of the study should be extended, (3) the study should be refinanced, including working capital, (4) a planned coordinated sales program should be developed, (5) product and sales research must be carried on and (6) provision should be made for additional full-time personnel. (See appendix VIII for an outline of the study.)

2. Small business enterprises.

Another major type of employment in which homebound persons are successfully engaged is the small-business enterprise. Many States have few or no sheltered employment facilities and no industrial homework or homecraft programs on an organized basis. In such situations the only opportunity for the homebound individual to attain some degree of self-sufficiency is through self-employment.

Each year, State rehabilitation agencies have trained and assisted a substantial number of homebound persons in the establishment of small-business enterprises. Although the exact number is unknown, the available data indicate considerable activity in this area.

The Office of Vocational Rehabilitation recently analyzed the records of 5,022 disabled persons rehabilitated in nonagricultural employment during the fiscal year ended June 1951.[68] All types of disabilities were represented among this group and no effort was made to distinguish between homebound and nonhomebound individuals. It is significant, however, that 1,942 persons were provided with training services and, of this number, 429 (22.1 percent) were trained by tutors, 148 (7.6 percent) by correspondence and 74 (3.8 percent) by sheltered workshops. All others received their training through such facilities as trade schools, colleges, and business establishments. The fact that 651, or nearly 34 percent of those trained, received their training under sheltered conditions would indicate that a substantial number of the 651 were either homebound or otherwise severely handicapped. Some homebound individuals would also be included in the number of self-employed not receiving training. This group was provided with such other services as physical restoration, occupational tools and equipment, and counseling.

[68] The Self-Employed in the State-Federal Vocational Rehabilitation Program, to be published by the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare.

For the homebound living in rural areas or in areas not accessible to organized home industry programs, the only form of productive activity available is self-employment. As a result, State rehabilitation agencies have placed considerable emphasis on the establishment of the homebound in small-business enterprises. In Texas, for example, the State agency has developed a method of utilizing local advisory committees consisting of representatives from business, civic organizations, church groups and other interested citizens. These committees work with the rehabilitation counselor in planning for small-business enterprises and carrying out the plans. Other State rehabilitation agencies also have developed somewhat similar plans for stimulating community interest and participation.

Although the development of a home business can be an excellent solution to the vocational problems of a homebound individual, the unfortunate fact is that the mortality rate for most small businesses is very high, whether operated by the able-bodied or the handicapped. In recognition of this fact, a Committee for the Severely Disabled, consisting of representatives from State rehabilitation agencies participating in the guidance, training and placement workshops sponsored by the Office of Vocational Rehabilitation during 1949 and 1950, prepared a Catalog of Small Business Enterprises for the Severely Disabled. This publication, first printed in March 1951, has now been revised and will be available for distribution at an early date. Included in the catalog are criteria for determining the feasibility of small-business enterprises and descriptions of selected enterprises which are being operated successfully. (See appendix IX.)

The United States Department of Commerce and the Small Business Administration have published a number of materials which may be helpful to individuals in establishing a small home business. One publication of particular interest is entitled "Home Businesses" (December 1950) and includes a list of organizations which serve as marketing outlets and a bibliography of other sources of information. This bulletin has now been revised and will be available for distribution at an early date. Another very helpful bulletin, Handicrafts and Home Products for Profit, is in the process of publication and will be available soon.

Current employment picture—Summary

When it is considered that approximately 2,500 disabled homeworkers have been issued certificates in the 7 restricted industries, approximately 3,000 are working for employers in the nonrestricted industries, approximately 1,200 are employed by nonprofit sheltered workshops certified by the United States Department of Labor and approximately 3,000 are employed by sheltered workshops and other home employment programs not covered by the Federal wage and hour law, it would appear that about 10,000 disabled homebound persons are currently employed by an industrial concern or sponsoring organization in some form of home industries or home crafts. This figure does not include those who are engaged in independent, self-employment activities for which no reliable data are available.

Although it is not known how many homebound persons might become gainfully employed in the home or a sheltered workshop, the number has been estimated to be approximately 100,000 persons. It will be seen readily that the problem of remunerative employment for large numbers of the disabled homebound has yet to be solved.

Urban-rural distribution of home employment programs

Organized programs providing homebound employment under supervised conditions appear to be concentrated in urban areas. Very few examples were found of programs serving the homebound disabled living outside the metropolitan areas of the larger cities. This was particularly true of the "contract" type of industrial homework programs. The "homecraft" programs to some extent are able to reach the disabled in the less populated areas. Goodwill Industries is hoping to develop a program of small "feeder" workshops associated with larger workshops which because of their location in small towns will be able to provide the training and supervision needed by the homebound workers living in the more rural areas.

Characteristics of home employment programs

A review of types of work being provided by home employment programs, wages paid, and some of the other aspects of the programs indicate:

(1) *Workers on industrial homework programs are engaged in a variety of activities.*—In general, "contract" industrial work is such as to require relatively few skills and is repetitive in nature. Craftwork, on the other hand, requires a higher degree of ability and aptitude due to the variety of handcraft activities that the homebound individual may undertake and the artistic nature of the work. Both types of homework require little or no equipment.

The most comprehensive information available on the types of work being done is supplied by the sheltered workshops conducting home employment programs in applying for certificates from the Department of Labor. The information for 40 such workshops is shown in appendix VII. Sewing, crocheting, typing, and hand assembly of small items are among the activities most frequently indicated.

Similar findings were made in a survey of 37 nonprofit agencies made by the National Committee on Sheltered Workshops and Homebound Programs conducted in 1952, which found that 15 agencies were carrying on home-employment programs.[69] (Five of these 15 were also on the Department of Labor list of sheltered workshops cited above.) Programs were being conducted in "contract" industrial homework, homecraft work, and in home-service activities. One program offered employment in all 3, and 4 provided work in both homecraft and "contract" industrial work. The eight programs conducting "contract" homework programs mentioned most frequently hand assembly, sewing, addressing, knitting, and chair-seating activities. One of the agencies reported that it found small hand assemblies and packaging provided the best industrial homework for sedentary homebound workers. Among the most frequently mentioned activities in the homecraft programs were needlecraft, leathercraft, weaving, and rugmaking. The home-service activities included phone soliciting and addressing envelopes.

Another recent survey of public and private agencies providing employment for the disabled identified 17 programs which were providing services to a substantial number of persons.[70] Eleven programs indicated activities of a homecraft nature; the most frequently men-

[69] From the unpublished study by the National Committee on Sheltered Workshops and Homebound Programs, 15 West 16th Street, New York, N. Y. (1952).

[70] Clarke, Margaret, Occupational Therapist, Montefiore Hospital, New York, N. Y. Unpublished study, 1953.

tioned activities are needlecraft (10); weaving (7); leathercraft, jewelry, woodwork (5); rugmaking, basketry, and metalcraft (4). Nine programs provided "contract" work with assembly being the most frequently mentioned activity. Two programs specified typing and packaging, with embroidery, knitting, and chair caning also mentioned. The "home service" activities included cooking, mending, bookbinding, radio spot checking, and photodeveloping.

(2) *There is little uniformity in the method by which the homeworker's remuneration is determined. Workers' earnings in some instances are relatively low.*—The survey mentioned above found that only 1 of the 17 programs conducting a home-employment program paid salaries to its clients. The others paid piece rates. Methods of calculating the amount of payment included: (1) Sale price of item minus cost of materials; (2) sale price of item minus 10 percent; (3) sale price of item minus outlet's deduction; and (4) workers furnished their own materials and sold articles to the program at their own prices.

The survey of the national committee cited above found that 7 of the agencies conducting homework programs complied with the wage-and-hour law by either paying the legal minimum of 75 cents per hour or having special work certificates for those earning less than the minimum. The other programs reported no wage rates for their homebound clients but rather pay on the basis of articles produced.

No comprehensive information is available on the weekly earnings of those engaged in homework. Their earnings in some instances, however, are relatively low due to the severity of their disability and accompanying limitations which prevent their earning the minimum wage of 75 cents an hour and working the usual 40 hours a week. In addition, work that can be done in the home is usually of a type for which pay is poor.

Some inkling of the extent of earnings of those employed on homework programs may be gained from the following data:

(*a*) The Wisconsin Vocational Rehabilitation Division reports that 76 homebound individuals were closed as rehabilitated during fiscal year 1954 in some type of homecraft. Of these 76 persons, 27 were making $11 or more per week at time of closure with 11 earning $20 or more per week and 1 person making as much as $50 per week. Twenty-four persons were earning between $5 and $10 per week and 25 were earning less than $5 per week. Seventeen of the 76 had never worked before, 25 had had substantial employment experience, and 34 had worked only part time.

(*b*) The Pennsylvania branch of the Shut-In Society indicates that their annual payroll is $74,000, with wages being drawn by 200 physically handicapped persons of whom 150 are homeworkers and 50 sheltered workshop employees. During 1953 the society found that 68 percent of its homeworkers earned up to $300 annually; 17 percent earned $300 to $500; 7 percent, $500 to $700; 4 percent, $700 to $1,000; and 4 percent earned over $1,000.

(*c*) The New Jersey Commission for the Blind reports that in its homecraft program during the past fiscal year an average of 114 blind persons per month were served, with average earnings of $34.62.

(*d*) The reports from a number of organizations give data on the total wages or remuneration paid to homeworkers over the

period of a year. While this information cannot be used to derive "average" earnings for a worker, because many more different workers are employed during a year than are on the program at any one time, nevertheless they are useful in indicating the extent to which workers are being aided. Thus, the Chicago metropolitan unit, Illinois Association for the Crippled, reported payment of $56,313 to 435 workers in the fiscal year 1953–54; the Connecticut affiliate of the National Society for Crippled Children and Adults reported a total sales last year of $4,153 for 37 homebound adults living in 25 towns throughout the State; the Iowa society's program included 85 homebound adults with sales of $4,048; the Michigan society, 645 homebound adults with sales of $5,525; the Oregon society, 405 homebound adults with sales of $11,506 and an overhead cost of $6,300 to the society; and the Philadelphia society, 20 homebound adults with sales of $12,018. Several societies also employ homebound adults in the making of paper Easter lilies which are used as a part of the organization's fund campaign. In New Hampshire last year 150 homebound adults earned $22,259 in such a project.

(3) *Part of the administrative and other overhead costs of employment programs for homebound workers are frequently met from sources other than from sale of product.*—The objective of agencies engaged in the operation of home-employment programs is to make homebound persons as economically self-sufficient as possible. However, the costs inherent in managing and supervising a production program carried on in many widely scattered homes, of providing training to the workers, of transporting "raw" materials to the home and then picking up the finished products, frequently cannot be included in the price if the article produced is to be competitive with that of private industry. Part of these and other administrative costs are often met from outside sources—from community contributions and from local or State funds.

Patterns of program operations providing vocational training and employment for the homebound

Programs providing training and employment opportunities for the homebound differ with the type of sponsoring organization and the objectives established for such programs. Although not all the agencies providing vocational services to homebound persons could be contacted in this study, some information has been gathered concerning certain organized programs serving rather substantial numbers of the homebound. Appendix X lists these programs by States. The list does not include State rehabilitation agencies except where they have developed organized programs of home employment other than small-business enterprises and other forms of self-employment. The numbers of employed homebound are shown where these data were provided. The significant conclusions which may be drawn from this information are:

(1) Except for the State agencies for the blind, organized programs of home employment were found in only about one-half of the States.

(2) Many home-employment programs are extensions of sheltered workshops while others serve primarily as sales outlets for craft products.

(3) Most programs serve small numbers of the homebound and their activities are largely limited to urban areas.

(4) More public and private agencies are providing vocational services for the homebound blind than for other disability groups.

(5) The National Society for Crippled Children and Adults, Inc., and the National Industries for the Blind, through their local affiliates, are the most frequently mentioned private nonprofit agencies with organized homebound programs.

The following is a description of the patterns of operation of a few selected programs presently providing vocational training and employment to homebound individuals.

New Jersey State Commission for the Blind.—The home-industries program of the New Jersey State Commission for the Blind is an example of the type of services provided by a public agency for the blind. The program was organized in 1912 and has grown to a point where approximately 400 blind workers located throughout the State are now consigning articles to the home-industries department. At the present time, approximately 50 percent of the homebound workers are production workers whose work meets necessary standards of quality and who can be counted upon to fill quotas as needed. The program is coordinated with the State vocational rehabilitation services. (See appendix XI for a more detailed description.)

Homecraft service of Wisconsin Division.—The Wisconsin homecraft program is a unique example of a statewide organization providing training and employment in arts and crafts to the homebound. It is operated by the State vocational rehabilitation division under the State board of vocational and adult education. (See appendix XI for a more detailed description.)

Homecraft services are being extended to eligible persons in approximately 37 of the 71 counties in Wisconsin. In these counties, homecrafters are receiving regular craft-training services. In addition, some limited instruction is being given to isolated trainees in the counties by a homecraft teacher-trainer. Approximately 500 individuals are being carried on the active caseload at the present time and of this number about 42 percent, or 210 persons, reside in rural areas.

Responsibility for the marketing of the items produced is assumed by the Wisconsin Association of the Disabled which has its own store in Milwaukee, space in a department store in Madison which it staffs, and special sales throughout the State from time to time.

Homecraft service of the Minnesota Rehabilitation Division.—The Minnesota homecraft program, like that in Wisconsin, is operated by the State rehabilitation agency. It differs from the Wisconsin program, however, in a number of respects. While both programs are concerned primarily with the manufacture of craft articles, the Minnesota program also engages in some industrial contract work. Both programs have cooperative arrangements with private, nonprofit agencies for the marketing of finished products, but in Minnesota a private agency has been established for the express purpose of providing sales outlets. It is called the Minnesota Homecrafters, Inc., and is administered with the aid of advisory committees composed of citizens interested in the homebound disabled. The Minnesota program extends services only to the residents of Minneapolis, St. Paul, Duluth, and the Iron Range area of the State.

The homecraft program in Minnesota originated in May 1939 when the Division of Vocational Rehabilitation served as a sponsor for a WPA project for the homebound. The United States Office of Education through the Office of Vocational Rehabilitation made funds available for this project on an experimental basis. With the termination of WPA in February 1943, the project was incorporated as part of the regular vocational rehabilitation program with additional State funds. (See appendix XI for a more detailed description of the program.)

Home industries program of Alabama.—This program is operated by the State vocational rehabilitation service under the Alabama State Board of Vocational Education. It is relatively new as compared with the Minnesota and Wisconsin programs but illustrates the development of an organized home industry service to meet the needs of homebound individuals in a predominantly rural State.

The program has the objective of providing a statewide service although, at present, individuals in only 32 of the 67 counties are receiving limited training in crafts and other occupations. There is a caseload of approximately 285 clients with a backlog of several hundred presently known by the agency to need such services.

The Alabama Rehabilitation Service has employed a consultant on home industries and four supervisors to assist in the development of the program. Although still in the planning stage, the State agency hopes to have three centers in the State where concentrated efforts can be directed to solving the problems already identified. In each of these centers a person will be placed in charge to supervise receiving, storing, and shipping materials as well as inspecting the products made by the homebound worker and finding marketing outlets.

Homecraft program of California Vocational Rehabilitation Bureau in Los Angeles.—This program was inaugurated in September 1953. Several nonprofit corporations have been established, primarily for marketing purposes. The homebound workers are members of the cooperative which markets the particular product he produces. Wage scales are figured on a piecework basis which enables the producer to earn a minimum of $1.25 per hour.

The largest cooperative so far is the one raising and marketing parakeets. This cooperative now has 70 breeders, 2 woodworkers, 2 metalworkers, and 2 trainers. The wood and metal workers make such things as parakeet cages and novelty toys.

Other cooperatives (1) produce and market knit goods, particularly stoles and baby wear; (2) produce and market ceramics, especially ceramic jewelry, silk screen television circuits, and doll dress material; (3) operate telephone answering services, including such types of telephone work as an employment service for baby sitters and domestics; and (4) operate advertising projects, including letter shops and the like.

All of these cooperatives are under the umbrella of an overall corporation. Each nonprofit cooperative is permitted to appoint one member to the board of this corporation which also includes a number of influential businessmen in Los Angeles.

Industrial homebound program of the Federation of the Handicapped, New York City.—This program is an example of the work carried on by a private, nonprofit agency in a large urban center. The services it provides to the homebound include vocational training, employ-

ment, counseling and guidance, medical consultations, education and social and recreational activities. It includes transportation to the agency for specific purposes such as recreation, training and counseling, and delivery and pickup of work supplies. Currently services are provided to a total of 161 homebound persons. Of this number 37 are employed by the federation in tying, slip stitching ties, and making costume jewelry.

The Federation of the Handicapped contracts for the work with the manufacturer or business firm. The prospective employee is transported to the federation for training. Following the training program the work is picked up from the manufacturer, allocated and delivered to the homeworker. On a prearranged date it is picked up from the worker, checked and then delivered to the manufacturer or disposed of according to the terms of the contract with the firm. The homebound person is an employee of the federation and is covered for workmen's compensation and unemployment insurance.

Home service program of the Brooklyn Bureau of Social Services and Children's Aid Society, Brooklyn, N. Y.—This agency provides a multiservice program of assistance to the physically handicapped residents of Brooklyn including the severely handicapped and homebound. It is another example of the services which are available in some urban areas through the facilities of a private, nonprofit agency. Although the primary purpose of the homebound program is vocational training and employment in home industries, other ameliorative services are also provided such as social study and evaluation, counseling, therapeutic recreation, and guide and home services for blind women. (See appendix XI for a more detailed description.)

In the area of industrial homework the bureau is limited by the New York State Department of Labor to 75 homework licenses. Because of this limitation and because work suitable for the homebound is difficult to obtain, the agency makes financial need a criterion for acceptance of an applicant for homework. The agency maintains contact with various manufacturers and secures contract orders for work which is largely of a mechanical assembly nature.

Home service to approximately 60 blind women is provided by a home teacher who is herself blind and travels with the aid of a guide. Recreation services are greatly varied but primarily consist of participation in such activities as music, drama, hobby work, and useful classes involving braille combined with drama. The bureau also employs a person who serves as a guide for blind women going to and from hospital and dental clinics.

The National Society for Crippled Children and Adults.—The National Society for Crippled Children and Adults, Inc., has made a significant contribution to the development of additional work opportunities for homebound individuals by making available specialized treatment and educational and employment services.

During the past year the national society through some of its State and local affiliates operated 43 sheltered workshops and homebound programs. In some instances, the local societies cooperate with other agencies in the community and provide only specific services which are otherwise unavailable, such as the marketing services for the Wisconsin homecrafters. In other instances they have taken the leadership and sponsored a comprehensive program of services to the homebound, as illustrated by the Chicago metropolitan unit of the Illinois

Association for the Crippled which provides home employment to persons between the ages of 18 and 60 who are so physically disabled that they cannot travel to and from a place of employment.

The agency conducts a home employment program which provides training and supervision by competent instructors and transportation of material to and from the home. Subcontracts from industry are obtained for such work as typing, packaging, and light assembly. During the last fiscal year (September 1953–August 1954) 435 persons were provided with employment on 39 industrial contracts. Sixty homebound typists participated in the preparation of the Easter Seal Society's campaign letters. Other services to the homebound include case finding, social service, occupational therapy, physical therapy, speech therapy, craft teaching, and a pool or lending library of equipment for physically handicapped persons. (See appendix XI for a more detailed description.)

Goodwill Industries of America.—This national organization is carrying on a program of home employment through some of its over 100 local affiliates. During recent years 12 of these local agencies have had some experience in extending their sheltered workshop activities to include the homebound. Although only a few of the programs are currently providing substantial homebound services, there is a growing conviction on the part of Goodwill Industries that they should do more to resolve the problems of the homebound, as expressed in a statement of policy for operating homebound programs in Goodwill Industries, by P. F. Trevethan, executive secretary of Goodwill Industries of America in October 1954:

> * * * the future success of our whole sheltered workshop program is going to be conditioned by the kind and degree of service we are able to render to severely disabled and handicapped persons including homebound persons. We must be thinking and planning for those who are on the bottom of the list—those who need our services most. Reasonably adequate facilities and programs are available for the less severely disabled and we have been able to render a reasonably good service to them. The task now before us is to accept the difficult assignment of extending our services to the very last person in need of our help. * * *

An example of a local Goodwill Industries affiliate which is presently operating a homebound program is the Goodwill Industries of Dayton, Ohio, which is providing remunerative employment to 36 homebound persons. The homework is divided into two classifications—industrial and craft. At present there is a limited amount of industrial subcontract work which the driver delivers to the home and, upon completion of the work, picks up and delivers to the plant. Homebound people doing this industrial homework are paid weekly as are the regular sheltered workshop employees.

Some of the homebound workers are engaged in such craft activities as weaving, crocheting, knitting and sewing. Upon the completion of this work, Goodwill Industries pays them for the articles they have finished and assumes responsibility for merchandising this craft material. The agency reports there is a heavy demand for additional home service work which they are unable to meet.

Pennsylvania branch, Shut-In Society.—The Pennsylvania branch of the Shut-In Society is an example of a private, nonprofit agency which over a period of many years has developed an industrial type of work program for "shut-ins." The origin of its home employment service differs from most in that work opportunities did not grow out of a sheltered workshop situation. On the other hand, the experi-

ences that the society had with its home industry program demonstrated the need for a facility to which homeworkers could advance if and when their circumstances warranted it. As a result, a sheltered workshop was started and many "shut-ins" who would otherwise still be homebound have now been graduated from their homes and some have even been able to develop their work capacities to the point that they can take outside employment. (See appendix XI for a more detailed description.)

Factors which limit employment opportunities for the homebound.—An analysis of the services presently being provided the homebound by the State-Federal program of vocational rehabilitation reveals that employment opportunities are very limited, particularly for the rural segment of our population. Factors which have contributed to these limitations include: (1) inadequate funds for paying the high cost involved in rehabilitating each homebound person; (2) the lack of trained professional personnel, including rehabilitation counselors, teachers of arts and crafts, and specialists in marketing and merchandizing; (3) lack of special rehabilitation facilities, such as sheltered workshops and rehabilitation centers, where treatment, training, and sheltered employment may be provided; (4) the lack of marketing outlets and merchandizing facilities for articles produced under sheltered conditions; and (5) the problem of frequent and regular supervision occasioned by the need for covering a large geographical area for a comparatively small number of persons.

(1) *Inadequate funds.*—The cost of providing services to an individual in his home is much higher than making the same services available to a group of individuals in a central setting. The lack of adequate funds was one of the most frequently mentioned factors by both public and private agencies in commenting upon the limited services presently available for the homebound. For example, the Connecticut rehabilitation agency for the blind reports that "the factors currently limiting these services are primarily lack of funds to implement the staff to give broader and more varied services to the homebound." The Colorado rehabilitation agency indicates that "agencies involved in the business are short of funds and staff." The Council of Jewish Federations and Welfare Funds, Inc., summarizes this problem by stating:

> * * * the volume and variety of services required by severely handicapped persons in their own homes is so great and the available services so limited that it can hardly be said their needs are being met. This limitation derives not only from limited funds and lack of public support. It is also influenced by the fact that it is very costly to deliver traditional forms of service on a completely individualized basis into people's homes over a very extended period of time.

(2) *Lack of trained personnel.*—The lack of trained and well qualified personnel who are equipped to carry on a program of instruction and supervision in the area of highly specialized services to the homebound is a problem which goes hand-in-hand with the lack of sufficient funds. Typical responses from State rehabilitation agencies include the following:

> * * * the requirement of additional adequately trained staff is most important (Iowa); the greatest obstacle to effective service in this area appears to be the lack of trained and experienced personnel for instructing [the homebound] in suitable skills and for locating markets for their products (Maine); to date we have not been able to find any capable personnel (Maryland); and the great factor is the lack of sufficient personnel (New Hampshire).

(3) *Lack of special rehabilitation facilities.*—It has been indicated previously that special rehabilitation facilities can often provide the treatment necessary for removing or alleviating an individual's disability which may be causing his homebound condition. The Oklahoma rehabilitation agency which sponsors the Okmulgee Rehabilitation Center reports "in the past 6 years we have learned through the services of a rehabilitation center, that persons who were considered homebound and not feasible for rehabilitation 6 years ago are now being rehabilitated into competitive employment." However, there are few facilities in the country today which can provide the special training, treatment or sheltered employment services needed by the severely handicapped. For example, the Mississippi rehabilitation agency reports that their State "has no facility at all to care for severely handicapped persons." Many other States are in a similar position with little or nothing in the way of comprehensive treatment and training centers or sheltered workshops. The New Jersey rehabilitation agency reports that "the problem of providing adequate services to the homebound in New Jersey is intensified by the lack of appropriate facilities and personnel." In Delaware "the lack of employment opportunities and a sheltered workshop have precluded [the State rehabilitation agency] from doing as much as we would like to with these cases."

(4) *Lack of marketing outlets.*—One of the most serious problems in the establishment of a program of home industries is the development of a satisfactory method of marketing the products of the homeworkers. This problem is present in both programs of industrial contract work and home crafts whether they are sponsored by public or private agencies. State rehabilitation agencies have found it particularly difficult to develop an organized program of home industries because of the lack of marketing outlets and their inability to use Federal funds for operating such a program. The Vocational Rehabilitation Act does not authorize the use of Federal grants for this purpose. As a result, very few State rehabilitation agencies have succeeded in developing organized home industry programs and then only with the assistance of cooperating private agencies which assume the responsibility for marketing the products of the homeworkers.

Industrial homework programs often experience difficulty in obtaining sufficient quantities of contract work to maintain a regular production schedule. In New Jersey, for example, industrial plants are licensed to distribute homework but the State rehabilitation agency reports that "this activity is extremely limited since comparatively few concerns are inclined to distribute work of this character; and, in addition, the concerns which are engaged in this type activity must maintain a legal ratio of three inplant workers for every homeworker. Here again, this activity is nonexistent in many rural regions."

The problems of marketing and low wages are described in the following statement by Mr. Stanwood L. Hanson, assistant vice president, Liberty Mutual Insurance Co.:

> Many of our sheltered workshops have not yet solved the problem of paying the workers a living wage. This is because they have either not been able to compete with other industries successfully or because they have not been able to get contracts to do from private industries that contain a sufficient profit to pay their people a good living wage. As this is still the major problem for sheltered workshops to answer it is even a more difficult problem to answer in homebound

programs. From my observations this has all had the effect of confining homebound programs to small individual efforts that have been done more generally in the larger communities.

The problem of marketing is even more evident in programs which depend upon both contract work and home crafts. The Minnesota Homecrafters program, one of the largest in this area, reports as follows: "We feel that one of the biggest needs in order to extend services to the homebound is adequate provision for merchandising their products or for providing subcontract work to be done in the home." This statement is typical of reports received from many of the programs currently providing home employment.

In a recent study of 17 vocational rehabilitation programs for the homebound, Miss Margaret Clarke, occupational therapist, Montefiore Hospital, New York, found that the most frequently mentioned problem in program operations was finding outlets for the clients' products. Eleven of the fifteen programs reported this to be a major source of difficulty. Other problems encountered included (*a*) meeting quality demands of outlets, (*b*) cost and time involved in setting up displays, (*c*) mishandling of consigned merchandise by merchants, (*d*) tendency for customers to purchase articles on a sentimental rather than a competitive basis, (*e*) excessive expense, and (*f*) inability of the programs to obtain a self-sustaining status.

(5) *Problems of providing vocational services and supervision to homebound persons living in rural areas.*—The problem of serving homebound persons living in rural areas is complicated by many factors involving such things as unavailability of facilities, distance between homes and transportation difficulties, high cost of providing services to isolated areas, and the lack of employment opportunities. In fact, all of the factors limiting the availability of services to the homebound which have previously been mentioned are particularly true for those living in rural areas. However, while many of these problems have been solved by agencies operating programs in urban centers, few agencies have attempted to provide the same type of services and supervision to the homebound in rural areas. As a result, services are meager, as indicated in the following statements from State directors of rehabilitation agencies:

The geographical location of many of the homebound makes it expensive and time consuming to serve them. These people are not concentrated in cities or small towns in Alabama. They seem to be spread out in the sparsely settled sections of the State (Alabama).

Limiting factors—lack of transportation in our rural areas necessitating the expenditure of more time to visit the clients who reside in rural counties. This in turn limits the number of visits and the extent of services available to our homebound clients (Delaware).

Limiting factors in providing services are * * * the way they are scattered in the population (Florida).

The only private agencies in Kansas are located in our three largest cities and, therefore, do not serve the rural areas. It is obvious that little service is given the homebound of Kansas (Kansas).

In South Dakota the most important factor is distance (South Dakota).

PART VI

RECENT DEVELOPMENTS WHICH SHOULD INCREASE SERVICES AVAILABLE FOR THE HOMEBOUND

The recent broadening of the scope of some of the Federal health and welfare programs and increased interest in the homebound by some voluntary organizations hold promise of bringing to many more of the homebound the services now available to relatively few. The more important of the developments are:

(1) The 1954 amendments to the Vocational Rehabilitation Act (Public Law 565, 83d Cong., Aug. 3, 1954). This act introduced a new three-part financial structure for the Federal-State program and broadened the range and scope of services which the Federal Government could assist financially. Furthermore, it authorized a year-to-year increase in the appropriation for the program, reaching an authorization of $65 million for grants to States for rehabilitating handicapped individuals for the fiscal year 1958. Such a Federal appropriation would enable the States to rehabilitate some 200,000 individuals a year, assuming the States made the required matching funds available. (This compares with the appropriation of $27 million in fiscal year 1955 for grants to States and an estimated 67,600 persons rehabilitated during the year.) The increase planned during the next few years will enable the States to provide services for many more of the homebound than has hitherto been possible.

In this connection, it is interesting to note that 6 of the first 30 applications submitted by States to extend or expand their programs are designed to improve services for the homebound.

The changed financing system not only provides for an increase in the current basic program but also encourages the States to extend and improve their vocational rehabilitation programs and enables the Federal Government to make grants to States and public and other nonprofit organizations for part of the costs of projects for research, demonstrations, training and for special facilities and services. The newly provided system of grants to States for extension and improvement projects, under which the Federal Government may pay up to 75 percent of their cost for a maximum of 3 years, will enable many States to institute new programs for the homebound or to expand their current programs. Moreover, States and nonprofit groups will, for the first time, be able to obtain aid in expanding and improving existing rehabilitation centers and workshops—facilities which are the keystone of any well-rounded program to remove the homebound limitations from as many as possible of the handicapped. Similarly, an expansion of the home industries and small business enterprises programs for the homebound can be expected as a result of the broadened Federal program. Important also are the provisions in the act which enable the Federal Government to pay part of the cost of training persons providing vocational rehabilitation. Acute shortages of trained personnel were mentioned frequently by the agencies

working with the homebound as a major factor limiting their activities.

(2) Enactment of the Medical Facilities Survey and Construction Act (Public Law 482, 83d Cong., July 12, 1954) which amends the hospital survey and construction provisions of the Public Health Service Act. Under this legislation grants to States are authorized to enable them to construct various types of medical facilities including rehabilitation centers for the disabled. An appropriation of $10 million annually for each of the fiscal years 1955–57 is authorized for rehabilitation facilities. The actual appropriation for this purpose for fiscal 1955 was $4 million.

(3) Addition, in 1950, of title XIV to the Social Security Act providing for Federal grants to States for aid to the permanently and totally disabled under the public assistance program. In addition, provisions in title X of the Social Security Act, the aid to the blind program, require States to exclude up to $50 a month in earned income in computing the assistance grants of blind persons.

The provision of financial assistance for the disabled under the assistance program is enabling many homebound persons to obtain at least a minimum of necessary services. Forty-two States are now participating in the Federal-State program for aid to the permanently and totally disabled with an estimated combined Federal-State expenditure in 1954 of $141,300,000. The exemption provision in the aid to the blind programs should give an incentive to homebound who are blind, since if they are able to engage in remunerative activity they may earn up to $50 a month without any change being made in their assistance grant. How many homebound have benefited from this provision is not known.

The disability assistance programs have, through the payment of assistance grants to eligible persons, at least assured a minimum level of living to needy disabled. Receipt of a monthly payment has lessened one aspect of the burden on families in caring for a severely disabled member. A report of an individual's recent medical examination is required before his eligibility for the APTD program can be established. Many of the homebound individuals who made application have not had the benefit of a complete medical examination for many years; in fact, some have reported that they had never been seen by a doctor before the examination relative to establishing their eligibility for public assistance.

The provision of recommended medical treatment is a responsibility assumed by States or localities that varies according to their resources and facilities. Some States meet the costs of needed medical care. Although medical care services are not available for all recipients of APTD, many persons known to the assistance agencies through the APTD programs do receive needed services either through other public resources or by referral from the public assistance agency to a private resource.

A team of experts is a part of most States' APTD program. It usually consists of a physician, a qualified social worker, and often a representative of the State vocational rehabilitation agency. This group evaluates the medical and social reports of applicants for the disability assistance program by considering the applicant's capacities and potentialities, and reaching a joint recommendation on his eligibility for assistance. Homebound persons are identified by the team,

and recommendations geared to their particular individual needs can be made.

The term "permanence" in this program applies to the physical or mental impairment, disease or loss, while totality refers to the inability of the individual to engage in a useful occupation as a result of his current impairment. Thus, the hope is always present that many persons who are found eligible will be able, through medical treatment, rehabilitation, or other services to overcome the total effects of the disability. The expert consideration that can be given by an evaluation team at the State level materially enhances the opportunity for each applicant to have a plan recommended for him that will lead toward greater independence. For some the most that can be hoped for is improved facility in self-care, but for others it can mean eventual economic independence.

(4) The 1954 amendments to title II of the Social Security Act protect the old-age and survivors insurance rights (or social-security rights) of persons who have sufficient work covered by social security and who become totally disabled. In addition to protecting the level of benefits at retirement, the new act also provides for the State agencies (in the majority of States, the vocational rehabilitation agencies) to act as agents of the Social Security Administration in determining the existence of disability. In all States, disabled persons who come to the social-security offices will be referred to the vocational rehabilitation agencies. This will make possible earlier treatment and rehabilitation services and thereby help reduce the number of people who will become homebound.

(5) The research and training programs of the Public Health Service, particularly those of the National Institutes of Health, are among the more important services related to preventing persons from becoming homebound which the Federal Government is carrying on. Noteworthy in fiscal year 1952 was the activation of two new institutes—the National Institute for Neurological Diseases and Blindness, and the National Institute of Arthritis and Metabolic Diseases.

(6) The problems occasioned by the increasing numbers of older persons in our population are receiving increased attention at all levels of government and by both public and private agencies. The fact that the large number of the disabled homebound are apparently over age 60 makes the work being done in this area of particular interest. At the Federal level a "Committee on Aging" made up of representatives from the constituents of the Department of Health, Education, and Welfare provides a means for joint development of the agency programs to better utilize their resources in this area. The bimonthly publication Aging published by this Committee reports on the developments with regard to programs being developed throughout the country to meet the needs of the "aged."

The large variety of programs related to the health, employment, and recreation of the older persons which is coming to the attention of this Committee attests to the great interest in this area. Among the most significant developments are the activities being undertaken by the States in establishing commissions to deal with various aspects of the problems associated with "aging." To date 19 States have established such organizations. (See appendix XI for list.)

(7) There is an increased interest by both public and private organizations in the growing incidence of chronic diseases. The

decline in the incidence of communicable diseases in itself would have shifted the emphasis to the development of health programs related to heart disease, neurological diseases, cancer, and other diseases.

The "aging" of our population with the resultant increase in the number of chronically disabled persons, and proportionately, the number of homebound persons, has emphasized the need for rapid program development. The Public Health Service is in the forefront in stimulating the development of State and local health programs dealing with the chronic diseases. The increasing activities, moreover, by such organizations as the American Heart Association, American Cancer Society, and the Muscular Dystrophy Association are having their effect in increasing State and local programs to bring aid to those suffering from these diseases, many of whom are "homebound."

(8) Efforts to provide adequate education for "exceptional children" and particularly those who require instruction in their own homes, are having a growing influence in the educational field.

PART VII

SUMMARY

RÉSUMÉ

Origin of the study

The Vocational Rehabilitation Amendments of 1954, Public Law 565, included the following provisions:

HOMEBOUND PHYSICALLY HANDICAPPED INDIVIDUALS

SEC. 7. The Secretary of Health, Education, and Welfare shall make a thorough study of existing programs for teaching and training handicapped persons, commonly known as shut-ins, whose disabilities confine them to their homes or beds, for the purpose of ascertaining whether additional or supplementary programs or services are necessary, particularly in rural areas, in order to provide adequate general, ameliorative and vocational training for such handicapped persons. The Secretary shall report to the Congress not later than 6 months after the date of enactment of this act the results of such study, together with such recommendations as may be desirable.

Scope and method of the study

Pursuant to the provisions of the new act, this study was directed toward three principal objectives: First, to assess the extent of the problem; second, to review and study existing programs for teaching and training homebound persons, particularly in rural areas; and third, to ascertain whether additional or supplementary programs or services are necessary to provide adequate ameliorative services and vocational training services.

The scope of the study was directly and unavoidably limited by several important considerations. Of these, time was unquestionably the most limiting, since all facets of services referred to in the act could not possibly be examined authoritatively without instituting and completing new studies, surveys, and personal on-site visits. This was not feasible within the 6 months' period provided in the law. A further limitation was the dearth of organized data regarding services to, and the needs and characteristics of, homebound persons; this was true at National, State, and community levels for the homebound as a group, with the result that intensive investigation and analysis of all dimensions of the problem were impossible.

To obtain relevant data, major reliance was placed upon published literature and information available from (1) Federal agencies and national private and voluntary organizations; (2) State agencies, public and private; (3) local organizations; and (4) a panel of technical advisers. In all, some 250 public and private agencies were contacted to obtain data and information.

The study was directed to a review of programs providing physical rehabilitation, psychosocial, education (general, recreational, and ameliorative), and vocational training and employment services to the homebound. Programs of income maintenance, though important, were not included.

Definitions

For purposes of this study, a homebound person is defined as one whose physical or mental condition prevents him from leaving his home regularly for education, training, recreation, rehabilitation services, employment, or in pursuit of other activities.

Findings

The following are the major findings of this study:

1. There are approximately 1 million Americans confined to their homes for 1 year or more duration by serious disabilities in combination with a variety of circumstances. This estimate is based on a review of existing studies of disabilities and illnesses, most of which contain fragmentary information about the homebound. Excluded from the estimate are the approximately 1,250,000 severely disabled confined to institutions; also those confined to their homes for a period of less than 1 year. If individuals disabled for 3 months or more were included in the estimate, the number of persons confined to their homes because of disability might approach as much as 4 million. The majority of the homebound appear to be in the upper age groups. The major disabling conditions causing persons to become homebound are cardiovascular conditions, nervous and mental conditions, and arthritis, rheumatism, and allied conditions. It is conservatively estimated that about 175,000 to 200,000 homebound disabled persons are receiving some form of public assistance.

2. The study concerned itself with four broad groups of services: physical rehabilitation; psychosocial; educational and ameliorative; and vocational training and employment. The specific findings with regard to each are:

(*a*) *Physical rehabilitation.*—Physical rehabilitation services in the functional activities of daily living are essential for many homebound persons if they are to leave their homes or become more self-sufficient. If provided in the early stages of disablement, such services may also prevent many individuals from ever becoming homebound. Physical rehabilitation services can be provided either within the home or by transporting the homebound individual to a hospital or rehabilitation center, for a temporary period of time, where such services are available. The rehabilitation center provides a rehabilitation "team," in which a variety of professions and disciplines, including medical and paramedical, concentrate their skills in an integrated manner upon the multiple problems of the disabled person.

Currently there are not sufficient rehabilitation services available in hospitals, in rehabilitation centers or through organized home-care programs to meet existing needs, nor are available services well distributed geographically.

Public and voluntary agencies lack sufficient funds to refer many known homebound persons to existing facilities for evaluation and rehabilitation or to bring such services to them within their homes.

The lack of sufficient trained rehabilitation personnel to staff existing centers and programs also discourages the development of new ones.

Increased services, facilities, and personnel can be expected to some degree in the future as a result of the enactment in 1954 of Public Law 565 expanding the scope and services of the State-Federal vocational rehabilitation program, and through Public Law 482, 83d Congress,

the Medical Facilities Survey and Construction Act, which authorizes Federal grants-in-aid for the construction of rehabilitation facilities.

(*b*) *Psychosocial services.*—The individual's motivations and social factors, such as the physical setting of the home, activities of family members, and economic circumstances are important factors in carrying out a rehabilitation program for the homebound individual. The available data indicate a need for a total coordinated evaluation and service program for the homebound and a research program to more fully understand the psychological and social situations and needs of homebound persons.

(*c*) *Educational programs and ameliorative services.*—Although substantial progress is being made in providing special schools and classes and specialists' services for disabled children, only about 700,000 of the estimated 4 million children and youth who need special services are obtaining them.

The number of children who are homebound or who are receiving instruction in the home is not known. It is known, however, that local programs for homebound children have increased within recent years. In 1952, 47 of the 48 States reported home instruction programs. The extent of such services, however, varies widely and many of the homebound children, particularly in some rural areas, receive little or no educational services.

A statistical survey of special education programs for exceptional children for the school year 1952–53, made by the Office of Education, found that, even among what might be termed the readily accessible handicapped school population, fewer than 40 percent in need of the special educational services covered in the survey were receiving such services. The situation was even less favorable in some localities. It would appear, moreover, least favorable for the disabled children in rural areas because of the cost and difficulties involved in providing home teachers to the widely scattered children in need of the home services.

A sizable number of State and local educational authorities are utilizing means other than the home teacher to bring educational services to homebound children. One of the most interesting of these is the home-to-school telephone system pioneered in Iowa and now used to some extent in 30 States. In 23 States which have programs for special education for handicapped children, this method has been approved for partial or full State aid.

Correspondence courses, particularly at the secondary education and higher levels, are being used by some homebound. A number of colleges and universities as well as private organizations offer courses, both academic and vocational in nature.

Educational television and radio are becoming increasingly important factors for the homebound. Television courses for elementary school homebound children are now provided in many of our larger cities. A few are giving such courses on the high school level. Telecourses in a wide variety of subject matter fields are being supplied by over 65 colleges and universities. In addition, the regular commercial stations provide many educational programs.

Library services in many areas are available to the homebound through mobile libraries. Talking Books are widely available for the blind. Machines which project books on the ceiling for the bedridden are available from some libraries.

A variety of recreational services are being provided the homebound. However, relatively few organized programs were identified by the study. Some areas are making effective use of volunteer workers through Friendly Visitor programs. Church groups are providing important leadership in helping the homebound lead a more constructive life.

(*d*) *Vocational training and employment.*—Home employment programs, except for the blind, are largely local in nature and, in the main, are operated by private agencies. Some of the larger voluntary organizations in this field are the National Society for Crippled Children and Adults, Goodwill Industries of America, Inc. and the Shut-In Society. Public and private agencies for the blind generally have extended their services to include more of the homebound in rural areas. In this connection, the National Industries for the Blind, Inc., has made an outstanding contribution by assisting its local affiliates with the development of marketing outlets and methods of production.

Homebound persons are currently engaged in two major types of employment—industrial homework, including "contract" work and homecraft, and small business enterprises. "Contract" work programs are few in number and are mostly limited to large urban centers with a concentration of industrial concerns. Most "contract" homework has developed by extending sheltered workshop activities into the home. Necessary restrictions imposed on homework by some State laws have prevented or delayed expansion in this area.

More homecraft programs than "contract" programs appear to be in operation. All have a heavy backlog of persons known to need the service but who cannot be served.

Few States have developed organized programs, on a statewide basis, for providing the homebound with vocational training and employment services. Those which do have organized programs do not cover the entire State, concentrating their services instead in predominantly urban areas. Exceptions to this are illustrated by the homecraft programs in Alabama, Minnesota, New Jersey, and Wisconsin. Generally, however, those homebound individuals living in rural areas have had little opportunity to participate in any type of remunerative employment except those few who could be transported to a sheltered workshop or similar facility.

State vocational rehabilitation agencies which have the legal responsibility of serving the severely handicapped have been unable to adequately meet and solve the vocational problems of the homebound. They have been successful in training and placing many homebound persons in small business enterprises but, here again, this type of activity is confined primarily to urban areas where the products or services of the self-employed individual can be made available to a substantial population group.

Factors which have limited the availability of services to the homebound include (1) the lack of funds to meet the high costs involved in rehabilitating each homebound person; (2) the lack of trained professional personnel, including rehabilitation counselors, teachers of arts and crafts, and specialists in marketing and merchandising; (3) the lack of sheltered workshops, adjustment centers, and other special rehabilitation facilities; (4) the difficulties of opening up marketing outlets and merchandising facilities for articles produced under shel-

tered conditions without special trained staff to do this; and (5) the problem of frequent and regular supervision occasioned by the need for covering a large geographical area for a comparatively small number of persons.

3. Although services for the homebound, particularly in rural areas, are inadequate, there are some indications that recent developments may be bringing greater recognition of their problems and, in some fields, additional services. The gradual expansion of the grant-in-aid programs of public assistance to the permanently and totally disabled is serving to identify many of the homebound and is resulting in the rehabilitation of some through the use of the available medical and other rehabilitation techniques. Similarly, the provisions of the 1954 Social Security Act amendments for preserving the benefits of workers in covered employment, under the old-age and survivors insurance system who become seriously disabled, will bring thousands of severely disabled persons to the early attention of State rehabilitation agencies and thus should help greatly in reducing the numbers of persons who become homebound. The increased attention being given to the problems of "aging" is focusing attention on the needs of the older persons.

All of these developments increase the *possibilities* of providing additional services for the homebound. Whether these actually occur, however, is dependent mainly on recognition of the problem in the community. Since a sizable proportion of the special services for the homebound currently are being furnished by private organizations, with extensive use of volunteer workers, the services of these groups will need to be expanded.

GENERAL OBSERVATIONS

Several clear impressions emerge from this study. The first is that individuals are homebound not only because of the nature or severity of their disabilities but often because of circumstances. These circumstances may be within the individual or within his environment. The same disability may cause a person to be homebound in one situation but not in another. Although these circumstances are many and varied, they might for convenience be grouped as follows:

(*a*) Geographical factors frequently are important in causing a person to be "shut-in." In rural areas, lack of transportation, distance from the home to treatment centers, schools, rehabilitation facilities, and other factors may intervene to keep the individual at home.

(*b*) The lack of rehabilitation centers, workshops, special educational classes for adults and children of school age, and the acute shortage of trained personnel to provide needed services force many people into homebound status. This situation is not confined to rural areas; it exists in many cities and is also reflected in several States.

(*c*) The psychological components of disability, although not always apparent to the observer, are often causative factors in confining an individual to his home. Failure to remove or reduce these conditions may prevent the individual from undertaking appropriate treatment or services to eliminate or reduce the handicapping effects of the physical disability.

A second impression is the potential of many of these individuals to substantially improve their lives if the services they require are provided through a well-conceived and integrated plan of action.

A third impression is that prevention of disablement and the handicapping effects of disablement are both vitally important in dealing with the problems and needs of the homebound population. The provision of appropriate medical and paramedical services and physical rehabilitation services in the functional activities of daily living may prevent many severely disabled individuals from becoming confined to their homes or to public institutions. Special classes for handicapped children may often prevent these individuals from becoming homebound when they reach adult years.

Officials of public and voluntary agencies in direct contact with the homebound share a conviction based on observation that many persons now confined to their homes could become more active and self-sufficient within the home and all could find a new and more satisfying way of life. Some could also perform useful work for pay in sheltered employment or in performing work in the home.

This study has also revealed that a wide variety of services are being furnished to homebound persons in various situations and localities, with less variety and less volume reaching those who live in rural areas. Scattered throughout the country are many sympathetic and enterprising individuals, public and private organizations—often unpublicized—who are active in developing new ways of organizing services to improve the well-being of the homebound. Many of the public programs, in the process of providing their particular services to the population generally or to physically handicapped persons generally, serve the homebound at the same time. In many instances the resources, human and material, to provide the needed services are already present and available to some degree. What appears to be needed is community leadership, technical know-how and encouragement in mobilizing and integrating these resources in terms of the needs of the homebound.

The requirements of a homebound person are highly individualized; many persons require only 1 or 2 or perhaps 3 kinds of services; others may be found in need of a complicated series of types of aid from a large number of public and private programs.

For these reasons, it is apparent that, while there are many phases in which the Federal Government does play a useful role, many aspects of the problems of the homebound can only be dealt with successfully by the local community. Civic interest, spiritual comfort and strength, fraternal and neighborly associations, family understanding and unity—these and many other facets in the life of the homebound person are close to the home and the affairs of the immediate community, and are best dealt with there. Integrating and focusing the available services of both public and voluntary groups, and developing the full use of volunteers in reaching the homebound, are by their very nature community functions.

The basic pattern of service to people which runs through the programs of the Department of Health, Education, and Welfare are nowhere better highlighted than in this study of homebound handicapped people. Among other things, the importance of *preventing* conditions which cause individuals to become homebound, and of constructive action to *eliminate* or *reduce* the effects of such condi-

tions when they occur, have been evident throughout the report. As knowledge and understanding of the characteristics of the homebound and their needs are increased, these programs, with adequate financial support, can be more directly oriented toward meeting the needs of homebound disabled individuals and in providing technical and consultative assistance to the States and communities, so that maximum use may be made of existing programs.

While the variety of existing services to the homebound is striking, it should not be inferred that all homebound handicapped persons need services, or that those who need services are receiving them, or that those receiving services are receiving all of the services they require.

One gap between need and available services for the homebound exists in the general fields of adult education and recreation. While these activities, important to many homebound handicapped persons, lend themselves to an organized program in the community, too few such programs are operated on a scale which reaches substantial numbers of homebound individuals regularly or effectively. Such media as radio, television, visual and electronic aids, mobile libraries, and other developments offer possibilities which have been only partially explored.

This observation takes on increased significance when one considers that the major portion of our homebound handicapped persons appear to be in the older age group. They are among the older adults who, in modern, technological society, represent a new social group. Organized adult educational and recreational activities afford a fruitful means for older adults to find new roles that will yield a sense of purpose and usefulness.

Throughout this study it has been abundantly clear that we, as a Nation, have too little organized information about our homebound handicapped population as a group, or what their needs are, or how these needs might best be met. Thus this report, in assembling and evaluating known data on the subject, is an important first step in overcoming the deficiencies in information and provides a basis for a much better understanding of the homebound. Although limited in scope by time and other factors, it should also serve to encourage States and communities to gather necessary data and bring additional services to their own homebound population.

The National Government can be of greater service to the homebound by exercising leadership in encouraging State, local, and nongovernmental agencies and the public generally to understand more thoroughly the needs and characteristics of their own homebound handicapped populations and by providing support to such agencies in planning and carrying out constructive action programs.

CONCLUSIONS AND RECOMMENDATIONS

1. The services being provided to homebound handicapped individuals at present are varied in type and amount, according to the degrees of interest and support manifested by local and State agencies and by the public generally. In general, the amount of services provided to the homebound in rural areas is markedly less than in urban areas. In both rural and urban localities, it is found that some home-

bound individuals are not receiving services; others are greatly in need of additional services beyond those already being provided.

2. Many aspects of the problems of the homebound must be dealt with at the community level. The needs of the homebound persons are highly individualized; just what services the person needs must be determined "on the spot." This has been revealed convincingly by the preliminary results of studies of chronic disease and disability currently underway in Hunterdon County, N. J., Kansas City, and Baltimore.

3. One major gap between need and available services for the homebound appears in the general fields of adult education and recreation. Although such programs lend themselves to organized activity, few such programs were found to exist.

4. Many homebound individuals are reached regularly through the basic pattern of service to people which runs through the programs administered by the Department of Health, Education, and Welfare. The National Government can further contribute to improving the well-being of homebound handicapped individuals by—

(*a*) Directing additional emphasis to the needs of the homebound in the operation of existing programs of health, education, and welfare, particularly as our understanding of their special needs and characteristics is increased.

(*b*) In the field of vocational rehabilitation, making use of legislative authority (enacted by the 83d Congress at the request of the President) for grants for special projects and extension and improvement activities to strengthen services to, and increase knowledge of, the homebound.

(*c*) Increasing technical and consultative assistance to States and communities, particularly in special education for the handicapped and in the strengthening of medical home care programs.

(*d*) Furnishing in connection with the above, information and counsel to State, local, and nongovernmental agencies, and the public, which will assist them to more thoroughly understand the needs and characteristics of their homebound handicapped population.

5. The President, in the budget message and his health message to the Congress on January 31, 1955, recommended measures designed to improve the health and well-being of our people, including the homebound disabled. Of special significance for the homebound, among the President's proposals, are, first amendments to the Social Security Act to (1) authorize separate matching of State and local expenditures for providing medical care for public assistance recipients; (2) minimize the need for public assistance in the States by providing staff services which might help needy individuals to attain self-support or self-care; (3) strengthen and expand services to crippled children, and second, amendments to the Public Health Service Act to authorize grants for extension and improvement of public health services and for special projects. The latter broadening of the grant structure provides the flexibility needed to permit a special focus at this time on problems of the homebound.

The findings of this study lend support to the President's recommendations as they affect the needs of the homebound population.

6. Although many national, State, and local studies and investigations have been made of disability and illness, they provide very little

specific information on the homebound as a group. Basic data on the numbers, characteristics and needs of the homebound are urgently needed along with experience in methods of organizing and providing services efficiently and successfully.

The Federal Government should explore the feasibility of augmenting our knowledge of the homebound problem and of developing procedures for bringing services to more individuals who need them, along the following lines:

(*a*) First, the inclusion in the current population survey program of the Bureau of the Census, Department of Commerce, of inquiries to obtain simple basic data on the numbers of homebound persons.

(*b*) Second, provision of necessary legislative authority to the Department of Health, Education, and Welfare to provide Federal financial support and technical assistance to States and nongovernmental agencies to carry out adequate demonstrations in this field. Authority for various phases of such demonstrations is now available in connection with several of the programs administered by the Department, but is not adequate for coordinated projects to support all necessary elements of such demonstrations for the homebound. Demonstrations would be for the purpose of—

(1) Establishing methods and techniques, for use of other States and communities in understanding the size, essential characteristics and needs of the homebound population.

(2) Developing effective and economical methods for coordinating available resources to provide the services needed to achieve the highest possible level of useful activity for each homebound individual.

(3) Furnishing data on which reliable national estimates may be projected.

APPENDIXES

APPENDIX I

Nongovernmental Organizations Contacted

Malcolm S. Knowles, administrative coordinator, Adult Education Association of the United States of America, 743 North Wabash Avenue, Chicago 11, Ill.
W. H. Harrison, executive secretary, Alabama Society for Crippled Children and Adults, 472 South Lawrence Street, Montgomery, Ala.
Carl A. Troester, Jr., executive secretary, American Association for Health, Physical Education and Recreation, 1201 16th Street NW., Washington, D. C.
Mefford R. Runyon, executive vice president, American Cancer Society, 47 Beaver Street, New York 4, N. Y.
Dr. William Benham Snow, president, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Ill.
Dr. Francis J. Brown, staff associate, American Council on Education, 1785 Massachusetts Avenue NW., Washington, D. C.
Kenneth Ingwalson, American Farm Bureau Federation, 423 13th Street NW., Washington, D. C.
Louis G. Hines, special representative, American Federation of Labor, 901 Massachusetts Avenue NW., Washington 1, D. C.
Paul A. Strachan, president, American Federation of the Physically Handicapped 1370 National Press Building, Washington 4, D. C.
M. Robert Barnett, executive director, American Foundation for the Blind, 15 West 16th Street, New York 11, N. Y.
Dr. Herschel Nisonger, president, American Hearing Society, 817 14th Street NW., Washington 5, D. C.
Rome A. Betts, executive director, American Heart Association, 1775 Broadway, New York 17, N. Y.
Henry H. Dudley, national adjutant, American Legion, 700 North Pennsylvania Street, Indianapolis 6, Ind.
T. D. Kraabel, director, National Rehabilitation Commission, American Legion, 1608 K Street NW., Washington 6, D. C.
David H. Clift, executive secretary, American Library Association, 50 East Huron Street, Chicago 11, Ill.
Dr. George F. Lull, secretary-general manager, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.
E. Roland Harriman, chairman, American National Red Cross, 17th and D Streets NW., Washington 13, D. C.
Marjorie Fish, American Occupational Therapy Association, 33 West 42d Street, New York, N. Y.
Mildred Elson, executive secretary, American Physical Therapy Association, 1790 Broadway, New York 19, N. Y.
Jess E. Weiss, director of veterans' affairs, American Veterans Committee, 1751 New Hampshire Avenue NW., Washington 9, D. C.
Rufus Wilson, national commander, American Veterans of World War II, 1710 Rhode Island Avenue NW., Washington 6, D. C.
Dr. M. D. Mobley, executive secretary, American Vocational Association, 1010 Vermont Avenue NW., Washington, D. C.
Roy Kumpe, director, Arkansas Enterprises for the Blind, Inc., Welfare Building, Little Rock, Ark.
Thomas Freeman, executive director, Dr. Russell Cecil, medical director, Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 19, N. Y.
Leonard W. Mayo, director, Association for the Aid of Crippled Children, 345 East 46th Street, New York, N. Y.
Dr. Herbert W. Park, Baruch Center of Physical Medicine and Rehabilitation, Medical College of Virginia, Richmond, Va.
Bay State Medical Rehabilitation Clinic, 255 Charles Street, Boston, Mass.

Bay State Rehabilitation Center of Western Massachusetts, Springfield, Mass.
Irvin P. Schloss, executive director, Blinded Veterans Association, Inc., 3408 Wisconsin Avenue NW., Washington 16, D. C.
Penelope W. Crane, executive director, Buffalo Association for the Blind, 864 Delaware Avenue, Buffalo, N. Y.
California Institute of Physical Medicine and Rehabilitation, 2600 Alameda Street, Vallejo, Calif.
Thomas J. Cuite, national commander, Catholic War Veterans of the United States of America, 1012 14th Street NW., Washington 5, D. C.
A. L. Severson, executive director, Chicago Lighthouse for the Blind, 3323 West Cermak Road, Chicago, Ill.
The Cleveland Rehabilitation Center, 2239 East 55th Street, Cleveland, Ohio
Dr. Dean W. Roberts, director, Commission on Chronic Illness, 615 North Wolfe Street, Baltimore, Md.
Morris Zeldritch, director of social planning, Council of Jewish Federations and Welfare Funds, 165 West 46th Street, New York 36, N. Y.
Crossroads Rehabilitation Center, 3001 North New Jersey Street, Indianapolis 5, Ind.
Harry A. Gregg, treasurer, Crotched Mountain Foundation, Manchester, N. H.
Curative Workshop of Green Bay, 1001 Cherry Street, Green Bay, Wis.
Curative Workshop of Milwaukee, 750 North 18th Street, Milwaukee, Wis.
The Curative Workshop of Racine, 2335 Northwestern Avenue, Racine, Wis.
Mrs. Ezelle B. Kerrigan, executive director, Dade County Society for Crippled Children, 159 Northeast 51st Street, Miami, Fla.
Dr. Harold J. Davison, president, Davison Technical School, Inc., Woodward at Grant Avenue (H. P.), Detroit 3, Mich.
Delaware Curative Workshop, 16th and Washington Streets, Wilmington, Del.
Vivian D. Corbly, national adjutant, Disabled American Veterans, 1423 East McMillan Street, Cincinnati 6, Ohio.
Charles E. Caniff, executive director, The Easter Seal Rehabilitation Center, 3114 East Chandler Avenue, Evansville 14, Ind.
Dr. Harry Sands, Epilepsy Association of New York, 129 East 52d Street, New York 22, N. Y.
Dr. H. E. Ungerleider, medical director, research, Equitable Life Assurance Society of the United States, 393 Seventh Avenue, New York 1, N. Y.
Mrs. T. F. Delaney, director, Essex County Service for the Chronically Ill, 1004 Broad Street, Newark, N. J.
Clark W. Blackburn, general director, Family Service Association of America, 192 Lexington Avenue, New York 16, N. Y.
E. B. Hall, superintendent, Adjustment Training Center, Florida Council for the Blind, Holly Hill, Daytona Beach, Fla.
Carl Guenther, elder, General Conference of Seventh-Day Adventists, 6840 Eastern Avenue, Tacoma Park 12, Md.
Leonard Small, coordinator, rehabilitation counseling, George Washington University, Medical Integration and Rehabilitation Unit, 22d and Pennsylvania Avenue NW., Washington, D. C.
Roy C. House, administrator, Gonzales Warm Springs Foundation for Crippled Children, Gonzales, Tex.
Percy J. Trevethan, executive secretary, Goodwill Industries of America, 1222 New Hampshire Avenue NW., Washington, D. C.
Gerrit H. Wiegerink, executive director, Grand Rapids Rehabilitation League, 555 Houseman Building, Grand Rapids 2, Mich.
The Hartford County Rehabilitation Workshop, 680 Franklin Avenue, Hartford, Conn.
Dr. Robert L. Sutherland, Hogg Foundation for Mental Hygiene, University of Texas, Austin, Tex.
Charles H. Moody, executive secretary, Illinois Association for the Crippled, 816 East Edwards Street, Springfield, Ill.
Glenn R. Reynolds, director of rehabilitation, Indiana Society for Crippled Children, 6055 College Avenue, Indianapolis, Ind.
Genevieve Weeks, assistant professor, Division of Social Services, Indiana University, 122 East Michigan Street, Indianapolis, Ind.
Peter J. Salmon, executive director, Industrial Home for the Blind, 520 Gates Avenue, Brooklyn, N. Y.
R. M. Dickinson, superintendent, Industrial Home and Division for the Blind, 1900 South Marshall Boulevard, Chicago 23, Ill.
Institute of Physical Medicine and Rehabilitation, 619 North Glen Oak Avenue, Peoria, Ill.

Harley Z. Wooden, executive secretary, International Council for Exceptional Children, 1201 16th Street NW., Washington, D. C.
Harold Hymans, executive director, Iowa Society for Crippled Children and the Disabled, 2920 30th Street, Des Moines, Iowa.
Roland Baxt, executive director, Jewish Occupational Council, 1841 Broadway, New York 23, N. Y.
Ben Kaufman, executive director, Jewish War Veterans of the U. S. A., 1712 New Hampshire Avenue NW., Washington, D. C.
William Dauterman, director, Kansas Rehabilitation Center for Adult Blind, Topeka, Kans.
Edwin Powell, Jr., Curative Workshop, Kentucky Society for Crippled Children, 840 South Third Street, Louisville 3, Ky.
Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, N. J.
Lake Tomahawk State Camp, Lake Tomahawk, Wis.
Stanwood L. Hanson, assistant vice president, Liberty Mutual Insurance Co., 175 Berkeley Street, Boston 17, Mass.
Louis Dawson, president, Life Insurance Association of America, 488 Madison Avenue, New York 22, N. Y.
May T. Morrison Center for Rehabilitation, 1680 Mission Street, San Francisco, Calif.
Karl P. Meister, executive secretary, Board of Hospitals and Homes of the Methodist Church, 740 Rush Street, Chicago 11, Ill.
P. J. Woods, executive director, Metropolitan Atlanta Association for Colored Blind, 293 Sunset Avenue NW., Atlanta, Ga.
Edward A. Lew, actuary and statistician, Metropolitan Life Insurance Co., 1 Madison Avenue, New York 10, N. Y.
Minneapolis Curative Workshop, 2515 Nicollet Avenue, Minneapolis, Minn.
Byron M. Smith, executive secretary, Minneapolis Society for the Blind, 1936 Lyndale Avenue, South Minneapolis 5, Minn.
Miriam Convalescent Rehabilitation Center, 501 Bacon Street, Webster Groves, Mo.
Mobility Inc., 10 Heatherbloom Road, White Plains, N. Y.
William Mazer, president, Muscular Dystrophy Association, 39 Broadway, New York 6, N. Y.
Robert M. Heininger, executive director, National Association for Mental Health, Inc., 1790 Broadway, New York 19, N. Y.
National Association for Retarded Children, 129 East 52d Street, New York 22, N. Y.
M. Roberta Townsend, National Association on Sheltered Workshops and Homebound Programs, 15 West 16th Street, New York 11, N. Y.
The Right Reverend Howard Carroll, executive secretary, National Catholic Welfare Conference, 1312 Massachusetts Avenue NW., Washington 5, D. C.
M. Roberta Townsend, chairman, National Committee on Sheltered Workshops and Homebound Programs, 22 West 17th Street, New York 11, N. Y.
Rev. John J. Lennon, assistant secretary, National Conference of Catholic Charities, 1346 Connecticut Avenue, Washington 6, D. C.
Leo Perlis, national director, National CIO Community Services Committee, 1776 Broadway, New York 19, N. Y.
Ben H. Gray, national director, National Epilepsy League, 130 North Wells Street, Chicago 6, Ill.
James G. Patton, president, National Farmers Union, 1417 California Street, Denver 2, Colo.
Basil O'Connor, president, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.
Herschel D. Newson, master, National Grange, 744 Jackson Place, Washington 6, D. C.
Philip E. Ryan, executive director, National Health Council, 1790 Broadway, New York 19, N. Y.
Dr. Homer Kempfer, National Home Study Council, 1420 New York Avenue NW., Washington, D. C.
Chester C. Kleber, general manager, National Industries for the Blind, 15 West 16th Street, New York, N. Y.
Anna Fillmore, R. N., general director, National League for Nursing, 2 Park Avenue, New York 16, N. Y.
Dr. C. E. Krumbholz, executive secretary, division of welfare, National Lutheran Council, 231 Madison Avenue, New York 16, N. Y.
Sylvia Lawry, executive secretary, National Multiple Sclerosis Society, 270 Park Avenue, Suite 7G, New York 17, N. Y.

Joseph Prendergast, executive director, National Recreation Association, 315 Fourth Avenue, New York 10, N. Y.
E. B. Whitten, executive director, National Rehabilitation Association, 1025 Vermont Avenue NW., Washington 5, D. C.
T. D. Kraabel, director, National Rehabilitation Commission, American Legion, 1608 K Street NW., Washington 6, D. C.
Robert E. Bondy, director, National Social Welfare Assembly, 345 East 46th Street, New York 17, N. Y.
Lawrence J. Linck, executive director, National Society for Crippled Children and Adults, 11 South LaSalle Street, Chicago 3, Ill.
Dr. James E. Perkins, managing director, National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.
Dr. W. S. Bittner, National University Extension Association, Bloomington, Ind.
Philip S. Platt, executive director, New York Association for the Blind, 111 East 59th Street, New York 22, N. Y.
Susan S. Barnes, director, The Occupational Therapy Workshop, 608 North Spring Avenue, St. Louis, Mo.
Gene Wallace, rehabilitation coordinator, The Ohio Citizens' Council for Health and Welfare, 167 East State Street, Columbus 15, Ohio.
Dr. Austin J. Canning, director, New York State Rehabilitation Hospital, West Haverstraw, N. Y.
Kenneth W. Hamilton, Ohio State University Rehabilitation Center, Ohio State University, Columbus, Ohio
Allen G. Jenkins, administrator, Oakland Orientation Center for the Blind, 3601 Telegraph Avenue, Oakland, Calif.
Oklahoma A. and M. College, The Rehabilitation Center, Okmulgee, Okla.
Glenn E. Jackson, executive director, Orthopedic Appliance & Limb Manufacturers Association, 411 Association Building, 1145 19th Street NW., Washington 6, D. C.
Robert Frost, president, Paralyzed Veterans of America, 101 Hay Avenue, Nutley 10, N. J.
Earl Barrett, superintendent, Pennsylvania Working Home for Blind Men, 36th Street and Lancaster Avenue, Philadelphia, Pa.
Philadelphia Society for Crippled Children and Adults, 2000 South College Avenue, Philadelphia, Pa.
Portland Rehabilitation Center, 1615 Southwest 14th Avenue, Portland, Oreg.
John Park Lee, director, Division of Welfare Agencies, Board of Pensions of the Presbyterian Church of the U. S. A., Witherspoon Building, Philadelphia 7, Pa.
Rehabilitation Center, 418 Martin Brown Building, Louisville 2, Ky.
Rehabilitation Center of Hawaii, 226 North Kuakini Street, Honolulu 17, Hawaii.
Rehabilitation Center for the Physically Handicapped, 20 Wall Street, Stamford, Conn.
The Rehabilitation Institute, 3600 Troost Street, Kansas City, Mo.
Dr. C. Robert Dean, director, Rehabilitation Institute, 8811 Hamilton Avenue, Detroit 2, Mich.
Rehabilitation Institute of Chicago, 401 East Ohio Street, Chicago, Ill.
Gerhardt Hirschfeld, director, Research Council for Economic Security, 111 West Jackson Boulevard, Chicago 4, Ill.
Rochester Rehabilitation Center, 233 Alexander Street, Rochester, N. Y.
Saranac Lake Rehabilitation Guild, 5 Franklin Avenue, Saranac Lake, N. Y.
Maj. Gen. Lewis B. Hershey, Director, Selective Service System, national headquarters, Washington, D. C.
Mrs. Jessie V. Leslie, secretary, Shut-In Society, 221 Lexington Avenue, New York 16, N. Y.
Dr. Keith Keeler, medical director, rehabilitation, Sieberling Health Center, Akron, Ohio.
St. Paul Rehabilitation Center, 319 Eagle Street, St. Paul 2, Minn.
Virginia Greenwood, executive director, Springfield Rehabilitation Center, 1400 State Street, Springfield, Mass.
Tuskegee Rehabilitation Center, John A. Andrew Memorial Hospital, Tuskegee, Ala.
Karl K. Van Meter, executive director, United Cerebral Palsy Association, 50 West 57th Street, New York 19, N. Y.
Russell W. Richmond, executive secretary, United Foundation, 90 North Prospect Street, Akron 4, Ohio.
Kenneth E. Pohlmann, United Mine Workers of America, Welfare and Retirement Fund, 907 15th Street NW., Washington, D. C.
Chronic Disease Research Institute, University of Buffalo, Department of Physical Medicine, Buffalo, N. Y.

Julian Dickenson, adjutant general, Veterans of Foreign Wars of the United States, Broadway and 34th Street, Kansas City 11, Mo.
Miriam Randall, executive director, Visiting Nurse Association of New York, 107 East 70th Street, New York, N. Y.
Gen. Charles Brandon Booth, commander in chief, Volunteers of America, 340 West 85th Street, New York 24, N. Y.
Harry Smythson, We, the Handicapped, 15327 San Juan Drive, Detroit 38, Mich.
E. J. Desjardins, manager, Western Society for Physical Rehabilitation, 900 West 27th Avenue, Vancouver, British Columbia, Canada.
Wisconsin Neurological Foundation, 1 West Main Street, Madison 3, Wis.
Frank O. Birdsall, supervisor, Woodrow Wilson Rehabilitation Center, Fishersville, Va.

APPENDIX II

TABLE A.—*Invalids* [1] *per 1,000 population and percentage distribution by age group, 1935–36 (national health survey)*

Age group	Number per 1,000 persons	Percentage distribution	Age group	Number per 1,000 persons	Percentage distribution
All ages	11.7	100.0	35 to 44	10.8	14.6
			45 to 54	16.2	16.8
Under 5	1.6	1.0	55 to 64	28.5	17.9
5 to 14	3.1	4.6	65 to 74	55.0	19.2
15 to 24	4.6	7.1	75 to 84	76.1	9.1
25 to 34	5.7	8.0	85 and over	101.0	1.9

[1] Persons disabled for the entire 12 months immediately preceding the date of interview.

Source: Britten, Rollo H.; Collins, Selwyn D.; and Fitzgerald, James S. The National Health Survey, Some General Findings as to Disease, Accidents, and Impairments in Urban Areas. Public Health Report, Mar. 15, 1940, reprint No. 2143, 27 pp. (See p. 16.)

TABLE B.—*Invalids* [1] *per 100,000 population by sole or primary diagnosis, 1935–36 (national health survey)*

Sole or primary diagnosis	Number per 100,000 persons
All diagnoses	1,173
Cardiovascular-renal diseases	284
With permanent crippling effects	(94)
Nervous and mental diseases	216
Rheumatism and allied diseases	119
Permanent results of accidents	103
Senility and other ill-defined diseases	68
Tuberculosis (all forms)	61
Blindness and diseases of the eye	42
Chronic diseases of the digestive system, not elsewhere classified	31
Diabetes mellitus	28
Chronic results of communicable disease	23
Infantile paralysis	(14)
Asthma	23
Cancer and other tumors	23
Chronic diseases of respiratory system, not elsewhere classified	19
Diseases of female genital organs	16
Diseases of gall bladder and liver	13
Ulcers of stomach and duodenum	13
Hernia	12
Congenital and early infancy causes	12
Diseases of bladder, urethra, urinary passages, and male genital organs	11
Deafness and diseases of ear	11
Anemia	10
Chronic diseases of skin and cellular tissue	8.1
Chronic bronchitis	7.4
Diseases of bones, joints, and organs of locomotion	6.8
Diseases of thyroid gland	6.7
Varicose veins	5.1

[1] Persons disabled for the entire 12 months immediately preceding the date of interview.

Source: Britten, Rollo H.; Collins, Selwyn D.; and Fitzgerald, James S. The National Health Survey: Some General Findings as to Disease, Accidents, and Impairments in Urban Areas. Public Health Reports, Mar. 15, 1940, reprint No. 2143, 27 pp. (See p. 17.)

TABLE C.—*Mobility status of recipients of aid to the permanently and totally disabled, by age group, 30 States, mid-1951*

Mobility status	Recipients	Percentage distribution			
		All ages	Under 35	35 to 54	55 and over
Total recipients	93,359	100	9.9	36.4	53.7
Household, total [1]	19,350	100	12.3	37.6	50.1
Bedridden	5,313	100	13.0	36.8	50.2
Chairfast	5,829	100	14.2	38.2	47.6
Other [2]	8,208	100	10.5	37.8	51.7
All other recipients [3]	73,973	100	9.3	36.1	54.6

[1] Represents 20.7 percent of all recipients of aid to the permanently and totally disabled.
[2] Capable of moving about within their homes but not outside.
[3] Capable of activity outside home or usual residence.

Source: Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance; Characteristics of Recipients of Aid to the Permanently and Totally Disabled, Mid-1951. Washington, D. C., April 1953. Derived from table 8, p. 21.

TABLE D.—*Mobility status of recipients of aid to the permanently and totally disabled, by personal services needed in essentials of daily living, 30 States, mid-1951*

Personal services needed	All recipients	Mobility status							
		Housebound				Capable of activity outside home or usual residence			
		Total	Bedridden	Chairfast	Other	Total	With help of another person	With help of a device	By self
Total:									
Number of recipients [1]	93,359	19,350	5,313	5,829	8,208	73,973	7,272	7,198	59,503
Percent [2]	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Need for personal services, total [3]	28.2	75.4	93.0	92.1	52.3	15.9	79.2	28.2	6.6
In eating	5.9	23.6	46.0	24.7	8.4	1.2	7.6	.9	.5
In dressing	15.9	55.2	75.7	74.3	28.3	5.6	29.2	10.8	2.1
In toilet functions	8.9	37.3	74.0	44.2	8.6	1.5	8.3	2.9	.5
In other bodily hygiene functions	9.2	34.0	49.7	40.2	19.4	2.7	12.1	5.9	1.2
In ambulating	11.0	36.5	29.4	64.4	21.4	4.3	34.5	8.3	.2
In activities affecting personal safety	15.4	35.3	36.4	41.6	30.2	10.2	53.8	14.2	4.4
No need for these services	71.8	24.6	7.0	7.9	47.7	84.1	20.8	71.8	93.4

[1] Includes a few recipients whose mobility status was not reported and a few for whom data as to need for personal services were not reported.
[2] Based on data excluding those recipients for whom mobility status and need for personal services were not reported.
[3] Less than sum of entries for each type of service because some recipients needed more than one type.

Source: Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance, Characteristics of Recipients of Aid to the Permanently and Totally Disabled, Mid-1951. Washington, D. C., April 1953. Table 11, p. 25.

APPENDIX III

PART A

Occupations of disabled veterans who have entered training in their homes [1]

Professional, technical, and managerial work:
- Accountant, general
- Accountant, junior
- Accountant, tax
- Photographer retoucher (air brush)
- Cloth designer
- Photographer, portrait
- Radio operator
- Manager, retail variety (self-proprietorship)
- Draftsman, mechanical
- Poster artist
- Photographer, commercial
- Draftsman, architectural
- Manager, service establishment (letterpress service)
- Editorial writer
- Memorial designer
- Signwriter, hand
- Commercial artist
- Teacher, music
- Jeweler, creative

Clerical and sales work:
- Bookkeeper
- Accounting clerk
- Insurance broker
- Circulation clerk (telephone salesman and solicitor)
- Salesman, insurance
- Typist

Mechanical work:
- Cabinetmaker
- Watch repairman
- Radio repairman
- Darkroom man

Mechanical work—Continued
- Radio-TV repairman
- Watchmaker, jeweler
- Toymaker, wood
- Bookbinder
- Motorboat mechanic (outboard motors)
- Book finisher
- Shoe repairman
- Electric appliance serviceman
- Seamstress
- Gunsmith and locksmith (key maker)
- Clockmaker
- Gun repairman and stock refinisher
- Book repairer
- Stonecutter, jeweler
- Upholsterer
- Furniture finisher
- Monograming machine operator
- Tailor
- Leather stamper
- Saw filer, machine
- Leathercrafter
- Weaver
- Hand raised stamper
- Modelmaker
- Craftsman, ceramics
- Luggage repairman
- Craftsman, textile
- Handpress printer
- Silversmith
- Sheet-metal worker (ornamental)
- Rod builder and reel repairman
- Fly tier and fishing rod and reel repairman

[1] Information provided by the Office of Vocational Rehabilitation and Education of the Veterans' Administration, Washington, D. C.

PART B

Disabled veterans training in their homes [1]

Year and month	Total	Disablement category							
		Blinded	Other visual	Hearing	Orthopedic	Tuberculous	Cardiovascular	Neuropsychiatric	Other
October 1951	147	5	0	2	121	0	3	3	13
January 1952	158	2	0	0	131	4	3	5	13
April	163	5	1	1	137	0	1	6	12
July	136	2	0	0	119	2	0	3	10
October	104	2	0	0	89	0	3	2	8
January 1953	110	1	0	0	94	2	4	1	8
April	107	2	0	0	95	0	2	2	6
July	88	3	0	0	73	0	1	1	10
October	83	3	0	0	70	0	1	1	8
January 1954	87	1	0	0	76	0	1	2	7
April	86	2	0	0	75	0	0	1	8
July	87	1	0	0	80	0	0	0	6

[1] Information provided by the Office of Vocational Rehabilitation and Education, Veterans' Administration, Washington, D. C.

DEFINITION OF DISABLEMENT CATEGORIES

Blinded.—A case which has been classified as "blinded" with reference to the major disablement. For purpose of this record, a blinded veteran is one whose central visual acuity is 20/200 or less in the better eye, with corrective lenses, or whose central vision acuity is more than 20/200 but who has a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees in the better eye.

Other visual impairment.—A case which has been classified as a visual loss with reference to the major disablement but which does not fall within the category of blindness as defined above.

Deafened.—Veterans having no residual hearing which is usable either with or without a hearing aid.

Hard of hearing.—Veterans having residual hearing either with or without a hearing aid, but who have suffered a hearing loss to the extent of 30 decibels or more for frequencies within the speech range (512–1024–2048–4096) in the better ear, and all borderline cases with a prognosis of progressive hearing loss.

Orthopedic impairments.—Veterans who have serious disabilities of the skeletal system (not including the skin) involving an amputation or a partial or total functional loss of muscles, bones, joints, and/or related structures, which result in marked lack of strength or severe limitation of motion.

Tuberculosis.—Veterans who have pulmonary tuberculosis except those who are classified as "apparently cured."

Cardiovascular.—Veterans who have serious cardiovascular diseases that primarily affect the heart and/or the arteries and veins, especially those with moderate to marked limitation of physical activity and for whom less than ordinary physical activity causes discomfort (class III, American Heart Association) and those unable to carry on any physical activity without discomfort (class IV, American Heart Association).

Neuropsychiatric disorders.—Veterans who are suffering from the effects of a psychosis, severe neurosis, or convulsive disorder.

All other.—A case in which the major disablement does not fall under one of the above categories.

APPENDIX IV

Federal Legislation [1]

The Fair Labor Standards Act, as amended, requires that every employee who is engaged in interstate commerce or in the production of goods for interstate commerce or in any closely related process or occupation directly essential thereto be compensated at a rate of not less than 75 cents for the first 40 hours worked in any workweek and time and one-half his regular rate of pay for all hours worked in excess of 40 in any workweek unless specifically exempt from one or both requirements by some provision of the act.

HANDICAPPED WORKERS

Persons whose earning capacity is impaired by age or physical or mental deficiency or injury and who, by reason thereof, are unable to earn the statutory minimum wage may be issued certificates permitting them to be paid wages less than the 75-cent hourly minimum. The following conditions must be met in order to obtain certification of handicapped workers at subminimum rates:

1. The handicap must be related to the job.
2. If employed at piece rates, the handicapped worker must be paid at piece rates at least as high as are paid nonhandicapped workers in the vicinity for essentially similar quantity and quality of work.
3. If employed at time rates, the handicapped worker must be paid commensurate with his productivity at the going rates in the vicinity for the type of work being performed.
4. Where overtime hours are worked, the handicapped workers must be paid in accordance with the overtime compensation provisions of the act.

[1] Information provided by Wage and Hour and Public Contracts Division, U. S. Department of Labor.

Certificating procedure relative to the several categories of handicapped workers coming within the purview of the Fair Labor Standards Act and/or the Walsh-Healey Public Contracts Act is as follows:

1. Disabled veterans placed for on-the-job training in covered work by the Veterans' Administration under Public Law 16, amended, and Public Law 894, who by reason of their disabilities are unable to earn the applicable minimum, may be issued subminimum rate certificates by the authorized Veterans' Administration training officers for a training period not to exceed 90 days. Extension of the training certificate may be granted by the appropriate regional director of the divisions upon the recommendation of the veterans training officer.

2. Handicapped persons placed for on-the-job training in covered work by a State vocational rehabilitation agency under Public Law 113, amended, who, by reason of their disabilities, are unable to earn the applicable minimum wage, may be issued subminimum rate certificates by the regional directors of the Divisions for part or all of the training period. Application for a certificate is made to the appropriate regional director by the vocational rehabilitation training officer.

3. Sheltered workshops (nonprofit charitable organizations providing remunerative employment), in which handicapped persons are placed for training or for employment, must obtain a sheltered workshop certificate from the Divisions' regional directors authorizing subminimum workshop rates if the handicapped persons placed in the workshop are engaged in covered work and are unable to earn the applicable minimum.

4. Handicapped workers employed in industry on covered work, but not under either Public Law 16 or 113, and who are unable to earn the applicable minimum, may be issued handicapped worker's certificates by the regional directors of the Divisions, authorizing employment at subminimum rates.

In the absence of a certificate an employer is obligated to pay the handicapped employee not less than the statutory minimum wage.

INDUSTRIAL HOMEWORK

In its minimum wage and overtime requirements the Fair Labor Standards Act makes no distinction between factory workers and homeworkers. The act, as amended, however, authorizes the Administrator to make such regulations and orders, regulating, restricting, or prohibiting industrial homework as are necessary or appropriate to prevent the circumvention or evasion of and to safeguard the minimum wage rate prescribed in the act. Homework is currently restricted by regulation in seven industries—button and buckles, embroidery, gloves and mittens, handkerchiefs, jewelry, knitted outerwear and women's apparel. Each homeworker employed in any of these industries must hold an industrial homeworker certificate issued by the Divisions. No fee is charged for such a certificate. Certificates are issued only to (1) persons who by reason of age, or mental or physical disability, or injury are unable to adjust to factory work or (2) who must remain at home to care for an invalid. Homebound workers of sheltered workshops are not required to hold industrial homeworker certificates.

The Wage and Hour and Public Contracts Divisions require that employers provide homework handbooks to each of their homeworkers for record-keeping purposes. These handbooks are furnished by the Divisions to the employer. This requirement applies to all homeworkers covered by the act, whether in restricted or nonrestricted industry.

Employment of children under 16 years of age in manufacturing occupations is prohibited under the Fair Labor Standards Act.

Except for homebound workers of sheltered workshops industrial homework is not permitted on Government contracts, which are subject to the Walsh-Healy Public Contracts Act.

APPENDIX V

STATE REQUIREMENTS IN INDUSTRIAL HOMEWORK—1954 [1]

Twenty States have industrial homework laws or other regulations, exercising governmental control over the process of industrial homework. Principally the regulations are through statutes adopted by the legislative body, but some

[1] Information on State homework laws and regulations from the Bureau of Labor Standards, U. S. Department of Labor.

States also utilize administrative orders, issued by the chief labor official under authority given him by the legislature. Three States—Colorado, Oregon, and Utah—rely on administrative orders issued under the enforcement powers of minimum wage authority and apply to women and minors only. In all but these three, most provisions of the laws apply to all persons. The States which have industrial homework laws and/or regulations are:

California	Michigan	Rhode Island
Colorado	Missouri	Tennessee
Connecticut	New Jersey	Texas
Illinois	New York	Utah
Indiana	Ohio	West Virginia
Maryland	Oregon	Wisconsin
Massachusetts	Pennsylvania	

INDUSTRIAL HOMEWORK PROHIBITED, RESTRICTED, OR SUBJECT TO RESTRICTION

In 9 of the 20 States, the laws provide machinery for the ultimate elimination of homework: California, Connecticut, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, Texas, Wisconsin. In these States the laws grant authority to the State labor department, to prohibit homework, industry by industry, or they prohibit all distribution of homework except by special permission of such department. Usually older persons or those physically handicapped, who would be subject to undue hardship if deprived of homework, are exempted from the prohibition. Under these laws such homework as is permitted is regulated. Homework has been prohibited under authority of these laws in a number of industries. For instance administrative orders are in effect in California in the garment industry, and in New York for men's and boys' outer clothing, men's and boys' neckwear, artificial flower and feather, and glove industries. In addition to authority to prohibit homework, most of these nine laws contain outright prohibitions against homework on specific articles.

In most of the remaining 11 States, which are regulatory in their approach, homework on specified articles or in certain industries is prohibited, but authority is not given for further prohibitions. A few of the 11 regulate only conditions under which the work is carried on, such as sanitary conditions or licensing.

The homework specifically prohibited by both the prohibitory and regulatory laws consists primarily of work on articles which are injurious to the health and welfare of the homeworker or to the general public. An enumeration of the articles included children's and infants' wear, dolls, toys, tobacco, medical supplies, explosives, fireworks, drugs and poisons, articles of food or drink, and the like.

SYSTEM OF LICENSING OR PERMITS TO EMPLOYERS AND EMPLOYEES

Most of the States where homework is regulated require both employers and workers to obtain permits before engaging in the process. Employers, and in some States, their subcontractors or distributors, must have permits or licenses, which are issued annually. Minimum license fees range from $25 to $200. Graduated renewal fees are set up in some States according to the number of workers employed; maximum amounts range from $25 to $300. The permit or license may require the employer to maintain a factory where similar work is done, and to have held a license prior to a given date. In Wisconsin an annual health license, the fee for which is $3, is required for each home where homework is done. Workers' certificates, where required, must usually be obtained annually, and are issued without fee, except in Texas, where a small fee may be charged. The certificate issued to a homeworker permits him to engage in homework. Both permits and certificates are issued usually on prerequisite conditions, such as compliance with sanitation and health standards, and minimum age qualifications. Permits and certificates are revocable for cause.

RECORDS

The industrial-homework laws and/or regulations in 15 out of 20 States require some form of recordkeeping. Practically all of the 15 States require an employer to keep a record of the names and addresses of his homeworkers, wages paid to them, as well as rates of pay and the articles manufactured by them; agents or contractors to whom he has furnished work and all persons from whom he has received homework materials. The homeworkers in some States are required to keep certain work records.

SETTING OF MINIMUM WAGES AND OF MAXIMUM HOURS

Of the 20 States which have homework laws or regulations, 8 have some form of minimum wage, and 9 have some maximum hours provisions. Industrial homeworkers are required to be paid at not less than factory or plant rates for essentially similar work—at least in certain industries—in California, Connecticut, Illinois, Massachusetts, New Jersey, New York, Rhode Island, and Wisconsin. In New York and California the homeworker is not permitted to do factory work while holding a homeworker's certificate. In Massachusetts a homeworker's certificate may not be issued to a person regularly employed. Working time for homeworkers in California, Connecticut, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and Wisconsin is regulated by laws applicable to factory workers similarly engaged.

LIMITATION OF CHILD LABOR

One-half the States which have homework laws expressly set a minimum age at which children may engage in homework. Strict controls were adopted in the early laws because of the former prevalence of child labor in the homework system. The usual minimum age is 16 years, which is in effect in Connecticut, Illinois, Massachusetts, New Jersey, New York, Pennsylvania, and Rhode Island. Industrial homeworkers must be at least 15 years of age in Texas; 15 in California if the work is done during school hours, 14 if outside school hours or 12 during vacations. In Wisconsin the minimum age for such work is 18 years.

REGULATIONS OF WORKING CONDITIONS

The regulation of conditions of work pertains to health and safety specifications. The home in which the work is to be done must be free from communicable disease, and must meet prescribed standards of sanitation and cleanliness in 12 States. In 2 States the workroom must be separate from the family living and sleeping quarters, and in 3 States the work must contain a prescribed amount of cubic air space for each homeworker and must be sufficiently lighted, heated, and ventilated.

MISCELLANEOUS REQUIREMENTS

In 2 States, New York and Rhode Island, the laws prohibit the use of industrial homework contractors and distributors, while California and New York limit the homeworker to 1 employer in certain industries. In eight States the employer is required to label homework materials or articles produced. New York industrial homework orders require an employer to show that he was an employer of homeworkers as of a specified antecedent date and held a valid license at that time.

State industrial homework requirements, 1954

	California	Colorado	Connecticut	Illinois	Indiana	Maryland	Massachusetts	Michigan	Missouri	New Jersey
States having comprehensive laws authorizing prohibition of industrial homework	X	----	X	----	----	----	X	----	----	X
Prohibits outright certain types of industrial homework	X	----	----	X	----	----	X	----	----	X
Requires employer's license or permit	X	----	X	X	X	X	X	X	----	X
Fee for employer's license or permit	----	----	X	X	----	----	X	----	----	X
Requires homeworker's certificate or license	X	----	X	X	----	X	X	----	----	X
Requires some form of recordkeeping	X	----	X	X	----	X	X	X	X	X
Contains some form of minimum wage standard	X	----	X	X	----	----	X	----	----	X
Contains some form of maximum hours provision	X	----	X	X	----	----	X	----	----	X
Sets a minimum age for child labor	X	----	X	X	----	----	X	----	----	X
Prohibits use of industrial homework contractors and distributors	----	----	----	----	----	----	----	----	----	----
Requires labels to be affixed to materials or articles	X	----	----	----	----	X	X	----	----	X
Homework requirements in minimum wage orders only; apply to women and minors only	----	X	----	----	----	----	----	----	----	----

State industrial homework requirements, 1954—Continued

	New York	Ohio	Oregon	Pennsylvania	Rhode Island	Tennessee	Texas	Utah	West Virginia	Wisconsin
States having comprehensive laws authorizing prohibition of industrial homework	X			X	X		X			X
Prohibits outright certain types of industrial homework	X			X					X	
Requires employer's license or permit	X		X	X	X		X		X	X
Fee for employer's license or permit	X			X	X		X		X	X
Requires homeworker's certificate or license	X			X	X		X		X	
Requires some form of recordkeeping	X	X		X	X	X	X			X
Contains some form of minimum wage standard	X				X					X
Contains some form of maximum hours provision	X			X	X					X
Sets a minimum age for child labor	X			X	X		X			X
Prohibits use of industrial homework contractors and distributors	X				X					
Requires labels to be affixed to materials or articles				X	X				X	X
Homework requirements in minimum wage orders only; apply to women and minors only			X					X		

Appendix VI

TABLE A.—*Action taken on application for homeworker certificates by wage order industry, fiscal year 1954, Wage and Hour and Public Contract Divisions, U. S. Department of Labor*

	Total, all wage order industries	Wage order industry						
		Knitted outerwear	Jewelry	Women's apparel	Gloves and mittens	Buttons and buckles	Handkerchiefs	Embroideries
Total number of applications acted upon [1]	3,671	644	233	937	64	70	59	1,664
I. Number of certificates granted, total	2,297	594	193	858	59	68	47	1,478
A. Homeworkers prior to specified date, total	1,286	176	24	213	15	26	19	813
1. Handicapped by age	338	73	7	59	2	9	8	180
2. Disability other than age	781	92	13	129	13	13	10	511
3. Invalid at home	167	11	4	25	0	4	1	122
4. Other	0	0	0	0	0	0	0	0
B. Not a homeworker prior to specified date but involving unusual hardship, total	2,011	418	169	645	44	42	28	665
1. Handicapped by age	413	154	28	82	9	6	4	130
2. Disability other than age	1,139	204	95	427	25	30	21	337
3. Invalid at home	424	59	39	133	8	6	3	176
4. Other	35	1	7	3	2	0	0	22
II. Number of applications denied or withdrawn, total	374	50	40	79	5	2	12	186
Not a homeworker prior to specified date	303	44	37	70	5	2	10	135
All other	71	6	3	9	0	0	2	51

[1] Includes only actions reported to the national office during the year. Does not include 1,254 certificates granted by the New York State Department of Labor in the gloves and mittens industry, although these certificates are approved by the divisions.

TABLE B.—*Action taken on application for homeworker certificates by State, fiscal year 1954, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor*

Region and State	Total certificates granted	Homeworker prior to specified date					Not a homeworker prior to specified date but involving unusual hardship				
		Total	Handicapped by age	Disability other than age	Invalid at home	Other	Total	Handicapped by age	Disability other than age	Invalid at home	Other
United States	3,297	1,286	338	781	167	.....	2,011	413	1,139	424	35
I. Boston	185	24	2	19	3	.....	161	8	124	29	.....
Connecticut	2	1	.....	1	.....	.....	1	1	.....	.....	.....
Maine	1	.....	.....	.....	.....	.....	1	.....	.....	1	.....
Massachusetts	162	18	1	15	2	.....	144	6	111	27	.....
New Hampshire	1	.....	.....	.....	.....	.....	1	.....	1	.....	.....
Rhode Island	16	5	1	3	1	.....	11	1	9	1	.....
Vermont	3	.....	.....	.....	.....	.....	3	.....	3	.....	.....
II. New York City	1,987	931	266	532	133	.....	1,056	280	489	257	30
New Jersey	59	20	10	9	1	.....	39	14	19	5	1
New York	1,928	911	256	523	132	.....	1,017	266	470	252	29
III. Philadelphia	245	124	28	86	10	.....	121	13	94	13	1
Delaware	1	.....	.....	.....	.....	.....	1	.....	1	.....	.....
Maryland	34	20	3	16	1	.....	14	2	12	.....	.....
Pennsylvania	210	104	25	70	9	.....	106	11	81	13	1
IV. Birmingham	204	7	4	3	.....	.....	197	32	118	47	.....
Alabama	21	.....	.....	.....	.....	.....	21	4	11	6	.....
Florida	52	1	.....	1	.....	.....	51	3	27	21	.....
Georgia	131	6	4	2	.....	.....	125	25	80	20	.....
Mississippi	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
South Carolina	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
V. Cleveland	29	6	.....	6	.....	.....	23	6	12	3	2
Michigan	11	3	.....	3	.....	.....	8	1	5	1	1
Ohio	18	3	.....	3	.....	.....	15	5	7	2	1
VI. Chicago	255	121	23	89	9	.....	134	31	88	15	.....
Illinois	205	104	22	76	6	.....	101	26	66	9	.....
Indiana	9	5	.....	5	.....	.....	4	2	.....	2	.....
Minnesota [1]	1	1	.....	.....	1	.....	.....	.....	.....	.....	.....
St. Paul [1]	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Wisconsin	40	11	1	8	2	.....	29	3	22	4	.....
VII. Kansas City	37	12	1	10	1	.....	25	.....	21	4	.....
Colorado	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Iowa	7	4	1	3	.....	.....	3	.....	3	.....	.....
Kansas	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Missouri	30	8	.....	7	1	.....	22	.....	18	4	.....
Nebraska	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
North Dakota	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
South Dakota	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Wyoming	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

[1] Inspections made by employees of the State of Minnesota shown opposite "St. Paul."

TABLE B.—*Action taken on application for homeworker certificates by State, fiscal year 1954, Wage and Hour and Public Contracts Divisions, U. S. Department of Labor*—Continued

Region and State	Total certificates granted	Homeworker prior to specified date					Not a homeworker prior to specified date but involving unusua hardship				
		Total	Handicapped by age	Disability other than age	Invalid at home	Other	Total	Handicapped by age	Disability other than age	Invalid at home	Other
VIII. Dallas	99	30	3	23	4	.....	69	3	55	11	.....
Arkansas	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Louisiana	18	14	2	10	2	.....	4	.....	4	.....	.....
New Mexico	4	2	.....	2	.....	.....	2	1	.....	1	.....
Oklahoma	1	.....	.....	.....	.....	.....	1	.....	1	.....	.....
Texas	76	14	1	11	2	.....	62	2	50	10	.....
IX. San Francisco	116	25	10	11	4	.....	91	28	47	14	2
Arizona	16	5	.....	4	1	.....	11	.....	6	4	1
California	96	20	10	7	3	.....	76	26	41	9	.....
Idaho	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Montana	1	.....	.....	.....	.....	.....	1	.....	.....	.....	1
Nevada	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Oregon	3	.....	.....	.....	.....	.....	3	2	.....	1	.....
Utah	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Washington	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
X. Nashville	140	6	1	2	3	.....	134	12	91	31	.....
Kentucky	9	5	1	2	2	.....	4	1	3	.....	.....
Tennessee	131	1	.....	.....	1	.....	130	11	88	31	.....
Virginia	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
West Virginia	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
XI. San Juan	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Puerto Rico	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Virgin Islands	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
XII. Other Offices	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Alaska	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
District of Columbia	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Hawaii	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
XIII. Raleigh, N. C	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

APPENDIX VII

Sheltered workshops having homebound programs certified by the U. S. Department of Labor [1]

State	Number of homeworkers	Type of work performed
Connecticut: New Haven Goodwill Industries, Inc.	2	Telephone soliciting.
Georgia:		
Georgia Association, Workers for the Blind, Atlanta.	1	Assembling wooden baskets.
Georgia Factory for the Blind:		
Bainbridge	5	4 matmaking, 1 rugmaking.
Griffin	3	Rugmaking.
Illinois: Chicago metropolitan unit of Illinois Association for the Crippled, Inc., Chicago.[1]	153	Typing, sewing, and embroidering. Making paper flowers and assembling paper favor cups. Goggle straps, mails in envelopes, postage stamps, and placing decals on plastic cups.
Iowa: Iowa Society for Crippled Children and the Disabled, Des Moines.	[2] 12	3 typing, 9 contract.
Kansas:		
National Handicapped Foundation, Wichita.	4	Contract.
Kansas Foundation for the Blind, Wichita.	2	1 chair caning, 1 making pot holders.
Kansas Industries for the Blind, Topeka	([3])	Cotton mops.
Louisiana: Goodwill Industries of New Orleans	1	Telephone soliciting.
Massachusetts: Community Workshops, Inc., Boston.	11	Stitching complete garments, e. g., cotton hospital supplies, waitresses' uniforms, etc.
Michigan: Detroit League for the Handicapped.	20	10 engaged in hand and machine sewing for local retail sale, 6 wiring and stringing tags, 3 hand assembly eye sponges and sweatbands, 1 industrial machine sewing.
Minnesota:		
Minnesota Homecrafters, Inc.:		
Duluth [4]	317	Setting pockets in sweaters, tipping mittens and gloves, embroidering mittens and gloves.
Minneapolis (headquarters office) [4]		Embroidering ski parkas, typing and stuffing envelopes.
Missouri: Occupational Therapy Workshop, St. Louis.	28	14 typing, 14 lacing moccasins.
Nebraska: Lincoln Goodwill Industries, Lincoln.	1	Promotion.
New Hampshire:		
Crotched Mountain Foundation, Manchester.	53	Lily-making project.
New Hampshire Association for the Blind, Concord.	21	Filling preparation, stitching, woodworking, chair seating, pomander making, knitting, crocheting, weaving, fringing, basketry, tassel making, doormat making.
New Jersey: Goodwill Industries of New Jersey, Jersey City.	1	Promotion by phone.
New York:		
Albany Association of the Blind, Inc	1	Machine sewing.
Blind Work Association, Inc., Binghamton.	9	Machine sewing, crocheting mitts, hand hemming, fringing, finishing knitting bags, winding of yarn over bags, winding of yarn over wire frame—toy lambs.
Brooklyn Bureau of Social Service and Children's Aid Society, Brooklyn.	74	Assembly work, jewelry assembly work, electric assembly, hand sewing, bureau mailing service, hand crocheting.
Central Association for the Blind, Inc., Utica.	13	Weaving rugs, mats; hand hemming of tablecloths.
Elmira Association for the Blind, Elmira	1	Weaving rag rugs.
Federation of the Handicapped, New York	8	Slip stitching, typing.
Goodwill Industries of New York, Inc., New York.	5	Telephone solicitation.
Industrial Home for the Blind, Brooklyn	14	This establishment houses woodworking and handle departments, also mat department. Specific type of homework is not specified in application.

[1] Information provided by the Wage and Hour and Public Contracts Divisions, U. S. Department of Labor.

[2] Carries on only a homework program. All other workshops listed have both homework and shop programs.

[3] Not specified.

[4] Carries on only a homework program. All other workshops listed have both homework and shop programs.

Sheltered workshops having homebound programs certified by the U. S. Department of Labor [1]—Continued

State	Number of homeworkers	Type of work performed
New York—Continued		
New York Association for the Blind, occupational department, New York.	2	Knitted outerwear, gloves knitted.
Rochester Rehabilitation Center, Inc., Rochester.	1	Sewing.
Saranac Lake Rehabilitation Guild	1	This is a contract garment shop. Specific type of homework is not specified in application.
Ohio:		
Toledo Society for the Blind, Toledo	9	Weave pot holders, home sewing small items for local retail sale.
Goodwill Industries of Dayton, Dayton	3	2 fanfold and string tags, 1 sort conveyor cards.
Pennsylvania: Pennsylvania branch, Shut-In Society, Philadelphia.	180	Assemble pencil sharpeners; wire safety pins; card and pack plastic toys; hand finish finger cots, card snaps, loop and knot tags; assemble and pack plastic hangers and eyelets; hand address envelopes; cut and stack labels; make bows for greeting cards; assemble and stack bath stoppers.
Rhode Island: Community Workshop of Rhode Island, Inc.	1	Plier work, jewelry.
Texas:		
Goodwill Industries of Dallas, Dallas	6	Telephone soliciting, make quilts, fold Goodwill bags, and mate stockings.
Goodwill Industries of Fort Worth, Fort Worth.	2	Telephone soliciting and assembling badges.
Goodwill Industries of San Antonio, San Antonio.	1	(Not shown.)
Dallas County Association for the Blind, Dallas (white clients).	7	Make a variety of articles, including pot lifters, dolls, clown beanbags, and fly swatters.
Harris County Association for the Blind, Houston.	2	(Not shown.)
Travis County Association for the Blind, Austin.	2	Chair caners.
Lighthouse for the Blind of Fort Worth, Fort Worth.	1	Sews ironing-board covers.

APPENDIX VIII

Outline for Industrial Homework Pilot Study

A COOPERATIVE PROJECT OF THE PENNSYLVANIA ASSOCIATION FOR THE BLIND AND THE STATE COUNCIL FOR THE BLIND [1]

Objective

To furnish remunerative continuous employment to blind individuals which can be done in their own homes. The work to be given to those blind people who because of social, physical, or geographic handicaps in addition to blindness are unable to leave their home, but who are capable of doing quality and quantity production in their home setting and to gather data indicating the type of industrail homework program that might be set up on a statewide basis.

Definitions

1. *Home industrial group.*—Individuals who cannot unassisted and by ordinary means convey themselves regularly from their place of residence to a place of employment and who differ from those individuals in competitive employment or in sheltered workshops in that they are at a further serious disadvantage in economic competition because of other physical handicaps, because of other social situations which cannot be easily resolved, or because of the location of their residence in relation to feasible remunerative employment. However, they are capable of regular, continuous, quantity and quality production in a home environment that is adaptable for home industrial work. This group includes those individuals who:

(*a*) Have a handicap in addition to blindness that prevents them leaving home—e. g., orthopedic conditions, arthritis, vascular disturbances, etc.

[1] From a report by Mr. G. W. Dauth, director, State Council for the Blind, Department of Welfare, Commonwealth of Pennsylvania.

These conditions differ in degree of severity as compared to the therapeutic group and although these physical handicaps are present, the individual concerned can adapt himself to regular quantity production schedules.

(*b*) Have a family that is dependent on the individual to an extent where he/she must remain at home—e. g., care of children, spouse, or other relatives.

(*c*) Have a family that prevents or does not accept for various reasons the possibility of the individual leaving the home for outside employment.

(*d*) Through lack of travel ability are incapable of leaving home.

(*e*) Have residence so remote that getting to public transportation is not feasible. This would include the consideration of time, money, and danger involved in getting to and from the available transportation or employment center and, also, the situation where private means of transportation cannot be arranged.

2. *Industrial homework.*—Industrial homework is work that can be done by a blind person in his home through which he can earn regular and dependable income. This work would be furnished and supervised by an agency, marketed by the agency, lacking in complications, so that a majority of blind people can perform it sufficiently on demand to furnish regular turnover of goods and be compensated for according to regular payroll periods. This is distinct from business enterprises where the worker is a businessman in charge of an entire operation and it is distinct from therapeutic homework where the object is therapy or part time rather than steady employment.

3. *Industrial homework program.*—A service to be rendered by an accredited agency designed and developed with the intention of adhering to health and labor laws to offer regular work training and remunerative work opportunities to those eligible persons who cannot for physical, psychological, or geographical reasons leave their homes to travel to and from a place of business.

4. *A blind person.*—"Blind" means a person having visual acuity not to exceed 20/200 in the better eye with correcting lenses; or visual acuity greater than 20/200 but with a limitation in the fields of vision such that the widest diameter of the visual fields subtends an angle no greater than 20 degrees.

5. *Remunerative employment.*—Remunerative employment is that which will supply an income to the blind workers of at least $10 per week after a 3-month trial period. The remuneration may be limited by the types of work being done or the person performing the work or the environment in which it is being done. Employment on which nonhandicapped workers could expect to earn not less than $25 per week would be considered suitable.

6. *Suitable work space.*—A suitable environment for use in processing products is one where there is space that is not interfered with by ordinary processes of living in the home. It is one in which workers can continue to do work without endangering their health and without violating labor laws and one which makes it possible for goods to be carried in and out, to be processed and to be temporarily stored without damage to the product.

7. *Suitable homework job.*—A suitable job for use in the industrial homework program is one which in addition to supplying the $25 per week minimum income to normal workers, can be steadily marketed, can be economically transported, can be processed by a blind worker without help or constant supervision, can be performed by a majority of blind people, is sufficiently tidy to permit processing in an ordinary home, is reasonably continuous so as to avoid the necessity of retraining workers and will furnish steady dependable employment.

Type of product

Product must be one sufficiently simple to permit a large number of blind to perform work involved in it; easily learned; not consuming too much handling, working, or storage space; involving no great transportation problems; readily marketable; and should be repetitive enough to permit earnings of not less than $10 per week for the blind worker.

Training of workers

Training to be given.—This training shall be with particular reference to the job which the client is to perform and will be subsequent to any adjustment or pre-vocational training which might be deemed advisable prior to acceptance as a homework trainee; it shall be formal, individual training preferably in a workshop

or training center and shall include work layout, motion sequence, material handling, cleanliness, proper storage of raw and finished goods, recordkeeping by client him/her self, packaging and shipping methods, safety on and around his/her work. If conditions are such as to prevent the client from getting to a training center, training shall be given in the home. This training must be completed and evaluated before client is finally accepted for productive work.

Geographical area included in pilot study

The initial area to be covered is Berks County, Lebanon County, and Schuylkill County, excepting communities of Kelayres, McAdoo, Nuremberg, Oneida, and Sheppton in said Schuylkill County. This area is chosen because it is both metropolitan and rural and because it includes territories now served by a branch of the Pennsylvania Association for the Blind, by the central office of the Pennsylvania Association for the Blind by the State council for the blind. It is selected because the executive director of the Berks County branch who will supervise the program is also a member of the study committee with a knowledge of the work of the committee and, because experience gained in the small area can be applied when the program is expanded statewide. It is not intended that the area served will be limited to the three mentioned counties for any extended period, but that when funds, suitable types of production, markets, and sufficient, knowledge make it possible, the program may be expanded. It is not intended that the permanent headquarters of a statewide industrial homework program remain in the Berks County branch, but that it may be moved to a suitable central point or points when the program develops.

Staff to be engaged

The staff to be engaged for the building and operation of the pilot program will consist of (1) Industrial homework supervisor; (2) industrial homework instructor; (3) in-shop clerk and (4) delivery and shipping clerk.

Markets

The Pennsylvania Association for the Blind retail sales units will be used if cooperative arrangements can be made, to dispose of products and further markets will be explored by a subcommittee on product selection and marketing.

Statistical data

Factors involved in the conduct of an industrial homework program on which statistical data will be compiled as the result of the pilot study:

1. Average and model age of homeworkers.
2. Predominate sex of homeworkers.
3. Types of handicaps in addition to blindness.
4. Predominant reasons for group being "homebound."
5. Average and model age at loss of sight.
6. Group data on results of psychometric testing.
7. Overhead costs per worker.
   - (*a*) Administrative and supervisory
   - (*b*) Training
   - (*c*) Distribution costs through direct delivery
   - (*d*) Distribution costs through mail delivery
   - (*e*) In-shop handling and clerical
   - (*f*) Sales costs to dispose of finished products
8. Home environments encountered.
9. Output of workers per type article as compared to normal output.
10. Comparison of shop-trained versus home-trained workers.
11. Amount of in-shop space required for processing and storage.
12. Amount of home space required for fabrication per type article.
13. Maximum, minimum, and average income per worker from homework.
14. Amount of help required or accepted from others in the home to produce each article.
15. Loss of materials through shrinkage or spoilage.
16. Number of workers advancing to workshop or outside employment.

APPENDIX IX

EXAMPLES OF SUCCESSFUL SMALL-BUSINESS ENTERPRISES [1]

FLY TYING [2]

I. Nature of business enterprise

This business consists of the manufacture and sale of flies in various sizes and styles for sport fishing. Flies are manufactured both on an individual custom basis and on general production for sale through personal contacts, publicity, local sport centers, and contacts with fishing clubs. The product is supplied to local hardware and sporting goods stores for local distribution.

II. Capital required

One hundred dollars to one hundred and fifty dollars for equipment and initial supplies. Much of the equipment can be improvised and the other purchased from local hardware and sporting goods stores.

III. Equipment required

1. Work table.
2. Fly tying vise with bobbin, hackle plier, scissors, spools of bobbin, thread, tying wax, and shellac.
3. Assortment of feathers, chenille yarn, silk floss, tinsel, animal hair and fur, and occasionally a few other materials for makeup of the flies.
4. Assorted sizes of hooks.
5. Cellophane envelopes and display cards for mounting the individual hooks for sale.
6. A quantity of empty boxes of various sizes in which to store various sizes of feathers, hair and other supplies.

IV. Knowledge and skills required

No education is needed for the actual tying of the flies. The operator should be able to read and write sufficiently to keep up a business correspondence with supply firms and with customers. He must possess sufficient initiative to identify outlets for his products and have determination and perseverance to hold him to his bench during the fall and winter.

The operator must have a knowledge of sport fishing and the type of flies popular in various seasons, particularly suitable for the region. He should have enthusiasm for the sport and be able to talk the language. He might, in addition to fly tying, make or repair fly rods and sell subscriptions to sport magazines.

V. Specific job demands

Physical requirements:

1. Dexterous use of fingers, both hands.
2. Use of eyes for fine work at fairly close range.
3. Steady work in a sitting or propped-up position.

VI. Potential income

Probably not more than $1,000 per year, except in instances where the operator is an unusually good worker and is very good at promoting his sales. However, income is dependent largely on productive capacity and the extensiveness of the market developed for the product.

VII. Outlook

The interest in fly tying has grown considerably in recent years, partly due, no doubt, to widespread use of this activity for occupational therapy in Veterans' Administration hospitals. At present, competition is keener than in the past. Orders will go to the tyers with good quality products, starting in the fall after the fishing season closes, or even before. Some of the advantages of this type of activity are:

1. It is relatively inexpensive to start.
2. The client can be tying salable flies within a few weeks in a number of patterns, and 3 months' training should be sufficient to give him all the basic knowledge. Within a year's time he should be developing a good market.
3. It is within the capacity of many badly handicapped people.
4. The worker is his own boss and his success and earnings depend in great part upon his own push and resourcefulness in developing his market.

---

[1] These examples of successful small-business enterprises have been reported by State rehabilitation agencies. They will be included in the revised Catalog of Small-Business Enterprises which is being prepared for publication by the Office of Vocational Rehabilitation.

[2] Reported by the Maine Vocational Rehabilitation Division.

VIII. Client situation

The client participating in the above business enterprise is a 25-year-old woman with paralysis of both legs, resulting from polio. She is able to walk only with great difficulty, using a cane, and sits in a slanting position with the aid of pillows. She had no previous work experience outside of the home. However, she had developed some skills in needlework, making pot holders and place mats. Because of the need for additional income, her interest was developed in fly tying and training was provided as well as tools and materials with which she was able to begin the operation of the business.

Suggestion

The manufacture of fishing flies along with other services to fishermen, such as the raising and sale of worms, manufacture and sale of fishing rods, sale of assorted supplies for fishing purposes, have been reported with good results. This business can be developed through contact with sports stores, fishing guides and publicity.

PARAKEET RAISING [3]

I. Nature of business enterprise

The purpose of raising parakeets is to sell them, both retail and wholesale, while the birds are young—about 1 week out of the nest—in order that the buyers may make pets of these birds.

Parakeet breeders generally have their business in their back yards. The aviary consists of from 3 to 15 flights with from 20 to 30 pairs of breeding birds in a flight. The breeding of parakeets is different from the breeding of other birds since parakeets breed 12 months of the year.

The income is stable, but the amount of income depends on the number of pairs of breeders, the quality of the breeders and the construction and management of the aviary. On the average, an aviculturalist can expect a gross return of $30 from each pair of breeders, with net profit of $25. Severely handicapped persons should be able to handle 100 pairs of breeders by working 3 hours a day. The extensive breeding of parakeets is fairly new and has room to expand.

II. Requirements for establishing the business

Vocational Rehabilitation bought the client 3 portable aviaries, costing $638.50; 6 nest boxes, $24; blueprints, $1.74; and purchased short-term training in the amount of $150, for a total of $814.24 spent. The client started out with 12 pairs of birds which he purchased at $12 a pair.

Texas has no prohibitive regulations concerning parakeet raising, and no regulations prohibiting interstate shipping. Federal regulations do not permit the shipping in of foreign birds.

III. Physical activities involved

The physical activities involved in operating an aviary are such that a person in a wheelchair can perform the work. The amount of walking, standing, and lifting is in direct proportion to the arrangement of the aviary. One outstanding aviculturalist uses electrical gadgets to open doors, remove boxes, turn on heat and lights, and much of the other work that does not involve direct handling of the birds.

The aviculturalist must be able to set out food for his birds, keep water fresh, and keep the aviary and nests clean. He must have means to keep the aviary from getting too hot or too cold, for parakeets are sensitive to radical temperature changes. The greatest modification that should be made is for the safety of the birds. Trapdoors should be installed so that the severely handicapped person can prevent escape of birds.

IV. Job analysis

Practically no job skills are required, and very little salesmanship is required since there is a ready market for parakeets. Bird wagons and bird buyers pick up the birds from the homes of the individual breeders.

Very little education is required. The care of the birds and the aviary requires no special occupational skill or knowledge. There are no community factors that enter into the success of the enterprise for the reason that a parakeet breeder operates his own business, does not have to depend on local seed houses, and does not have to depend on local sales, since bird wagons and buyers purchase most of his birds. The aviary can be located several miles from town provided it is readily accessible from town.

[3] Reported by the Texas Vocational Rehabilitation Division.

V. Other pertinent factors

An aviary should not be attempted until the counselor and client have familiarized themselves with the details of aviculture. Such things as housing for the birds, types of food, methods of handling and banding, and the method of determining the sex of the birds, for example, should be observed.

A study of 400 parakeet breeders reveals that 60 percent of them are severely handicapped. Persons with disabilities such as tuberculosis, arthritis, cerebral palsy, and spine injuries requiring the use of a wheelchair could handle the business of aviculture. A semiblind individual could easily handle an aviary, but it is not a suitable enterprise for a totally blind individual.

If a client is handy as a carpenter, he can save money by building his own nest boxes and other items needed for the care of his birds.

VI. Actual client situations

The client was 21 years of age when he was set up in business, and had an eighth grade education. He was a very severe athetoid cerebral palsy. The client started with 12 pairs of birds, and at the end of the year, he was making $70 a week. He has two small flights in his backyard. His business has been successful, and he plans to expand.

VII. Evaluation

The client at the time of initial interview was desperately eager to do some type of work commensurate with his disability. He has worked hard at making his aviary a success. He is well adjusted to his disability, and all evidence points to his continued success in aviculture.

ADDRESSING MACHINE STENCIL SERVICE [4]

I. Nature of business

This business is an addressing machine stencil cutting service. Stencils are prepared for mailing list supplied by firms engaged in soliciting business by mail, advertisers, membership lists for organizations, churches, clubs. The business is conducted in the home and requires no special licenses or tax. Average earnings, $30 to $50 weekly with fairly stable year-round demand for services.

II. Requirements for establishing the business

1. Capital: $150 to $350.
2. Equipment: (*a*) typewriter; (*b*) typewriter desk and chair or table and chair; (*c*) blank stencils and small quantity of office supplies.

III. Qualifications of operator

1. Knowledge and skills: (*a*) high school education or equivalent is desirable; (*b*) ability to use typewriter; (*c*) ability to solicit business by telephone and correspondence.
2. Personal traits: (*a*) initiative and imagination; (*b*) good work habits; (*c*) industrious.

IV. Physical activity required

1. Sit in chair or wheelchair.
2. Use typewriter to cut stencils.
3. Read mailing list from master copy.
4. Speak clearly over telephone.

V. Pertinent information

This type of business can be operated in large cities or where business can be secured from a well-established firm that makes extensive use of mail in advertising or in soliciting business. It is not an appropriate business for a small community. An operating capital of from $50 to $200 is needed.

This activity could serve as a supplement to a telephone secretarial service: mimeographing, mailing service, telephone solicitation and sales.

VI. Outlook

It is believed that in a good location a disabled person can have an income from this type of business sufficient to maintain self-support. Earnings will depend upon the ability to secure a steady flow of business from well-established firms.

Some advantages of this type of activity:

1. Minimum of capital required;

[4] Reported by the Virginia Vocational Rehabilitation Division.

2. Physical requirements permit severely disabled persons to engage in self-employment and to adjust work hours and activities to meet physical demands for rest, exercise, etc.

VII. Client situation

At 24 years of age the client engaged in this business was injured in an automobile accident. As a result of spinal cord injury, she suffered a total paralysis of the lower extremities. For 17 years she was confined to her home, dividing her time between the bed and wheelchair. She is a highly intelligent person with an unusual amount of ambition and determination to become self-supporting. She is a high school graduate and learned to operate a typewriter while in school. As the result of a physical restoration program provided by rehabilitation service, her condition has improved making it possible for her to engage in crutch walking. She now has a contract for cutting addressing machine stencils for a large business firm. At present her earnings amount to $35 per week and she is self-supporting, and to a large extent supports her handicapped daughter, now age 15.

APPENDIX X

PUBLIC AND PRIVATE AGENCIES IDENTIFIED BY THE STUDY AS PROVIDING TRAINING AND EMPLOYMENT FOR THE HOMEBOUND [1]

Alabama	State division of vocational rehabilitation (285)
	Alabama Institute for Deaf and Blind
California	Local affiliates of the National Society for Crippled Children and Adults, Inc., in Los Angeles, Riverside, and San Mateo Counties (111)
	Braille Institute of America, Inc., Los Angeles
	San Francisco Association for the Blind
	State division of vocational rehabilitation, Los Angeles district
Connecticut	State agency for the blind
	State affiliate of NSCCA (37)
Delaware	State agency for the blind
Florida	State agency for the blind
	Lions Industries for the Blind, Inc., West Palm Beach
Georgia	Georgia Association for the Blind
	Georgia Factory for the Blind, Bainbridge
Idaho	State agency for the blind
Illinois	Chicago and North Shore Cook County Society of NSCCA (435)
Indiana	State agency for the blind
Iowa	State agency for the blind (115)
	State affiliate of NSCCA (85)
Kansas	State agency for the blind (14)
Maine	State agency for the blind
	Pine Tree Society of NSCCA
	Sunset Industries, Inc.
Maryland	State workshop for the blind, Baltimore
Massachusetts	State agency for the blind
	Community Workshops, Inc., Boston (11)
Michigan	State agency for the blind
	Detroit League for the Handicapped, Inc. (30)
	State affiliate of NSCCA (645)
Minnesota	State division of vocational rehabilitation, and Minnesota Homecrafters, Inc. (317)
	Minneapolis Society for the Blind, Inc.
Mississippi	State agency for the blind
Missouri	State agency for the blind
Montana	Montana Association for the Blind

[1] This list is not exhaustive and includes only those organized programs identified during the course of this study which are providing training and employment services to substantial numbers of the homebound. State vocational rehabilitation agencies are included only where they have developed an organized home industry program. The numbers of employed homebound are shown in parentheses where this data was provided.

PUBLIC AND PRIVATE AGENCIES IDENTIFIED BY THE STUDY AS PROVIDING TRAINING AND EMPLOYMENT FOR THE HOMEBOUND—Continued

New Hampshire	Local affiliates of NSCCA (150)
	including the Crotched Mountain Foundation, Manchester (65)
	New Hampshire Association for the Blind, Concord (21)
New Jersey	State agency for the blind (400)
New York	State agency for the blind (170)
	Brooklyn Bureau of Social Services and Children's Aid Society, Brooklyn (75)
	Federation of the Handicapped, New York (37)
	Saranac Lake Rehabilitation Guild, Inc., Saranac Lake
	Numerous private associations for the blind in New York and other cities throughout the State
North Carolina	State agency for the blind
Ohio	State agency for the blind
	Goodwill Industries, Dayton (36)
	Columbus Society of NSCCA (9)
	Shut-In Society of Cincinnati (50)
	Cleveland Rehabilitation Center (20)
	Private associations for the blind throughout the State
Oklahoma	State Division of Vocational Rehabilitation (130)
	Oklahoma League for the Blind
Oregon	State agency for the blind
	State Society of NSCCA (405)
Pennsylvania	State agency for the blind
	Numerous local affiliates of the Pennsylvania Association for the Blind, Inc.
	Pennsylvania branch of the Shut-In Society, Philadelphia (150)
	Philadelphia (20) and Erie Societies of NSCCA
Rhode Island	Community Workshops of Rhode Island, Inc. (16)
	Rhode Island Association for the Blind, Providence
South Carolina	State agency for the blind
Tennessee	State division of vocational rehabilitation
Texas	State agency for the blind
	Numerous county associations for the blind
Utah	State agency for the blind
Vermont	State agency for the blind
Virginia	State Society of NSCCA (7)
	State agency for the blind
Washington	State agency for the blind
Wisconsin	State Division of Vocational Rehabilitation in conjunction with State Society of NSCCA (500)
	State agency for the blind

APPENDIX XI

PATTERNS OF AGENCY OPERATION IN SERVING THE HOMEBOUND

NEW JERSEY STATE COMMISSION FOR THE BLIND [1]

I. Legal basis of program

The home industries program is provided for legally in the New Jersey public law of 1909 which established the State commission for the blind. It was first organized in 1912.

II. Finances

Salaries are paid from State appropriations. Equipment for use in headquarters or for craftworkers is provided from a fund set up by State appropriation or is provided from vocational rehabilitation funds, depending on the status of the client. Workers are paid monthly from a special fund as they complete an article and the fund is reimbursed upon the sale of that article. Raw material is pur-

[1] From a report by Arthur L. Voorhees, blind rehabilitation specialist, Office of Vocational Rehabilitation and submitted to the Fifth Annual Workshop on Guidance, Training, and Placement, sponsored by the Office of Vocational Rehabilitation, Washington, D. C., April 1952.

chased from a revolving fund which is replenished periodically through the sale of articles.

III. Personnel

Personnel of the home industries program consists of a supervisor who is directly responsible to the executive director of the commission, 2 sales clerks, a senior stock clerk, a stock clerk, a clerk-bookkeeper, a clerk and 2 helpers for the finishing department.

IV. Program services

Training is provided by six home teachers who visit the homes of blind persons throughout the State and give instruction in the production of items which may be sold through the home industries department. During the training period, material and equipment are furnished free of charge to the client at the request of the home teacher. Further training is available through the vocational rehabilitation program.

Training is given in the following areas:

Hand weaving	Leatherwork
Hand sewing	Knitting
Machine sewing	Crocheting
Basketmaking	Chair caning

Training materials and equipment are supplied at the request of the home teacher and with the approval of the home industries supervisor, regardless of the number of items an individual can make.

The home teacher, in consultation with the supervisor of home industries, determines the type and extent of training to be given a client. She also determines when training is completed.

Individual contact reports submitted to the Commission and incorporated as part of the client's case record reflect progress made.

V. Production

Consigners usually limit themselves to producing one or more items in order to achieve perfection and gain speed. Articles produced include: rugs, mats, towels, aprons, ironing-board covers, doll dresses, baskets, purses, wallets, key cases, children's sweaters, afghans, ascot scarfs, mittens, caps, capes, pot holders, baby jackets, crocheted edgings on washcloths, handkerchiefs, fringed luncheon cloths, tatted edgings.

All articles received from consigners for sale are thoroughly inspected before they are accepted and placed in stock. Substandard articles are returned to the consigner. In order to maintain perfection, patterns of simple design are selected at headquarters' office and instructions for processing are given directly to consigner by mail or telephone as the case requires. Consigners are encouraged to make new designs for inspection and acceptance.

VI. Distribution—marketing

The Department operates a craft shop, which is open to the public 6 days a week. It is located in a popular shopping area in a town of upper middle class residents.

Educational days or weeks for the blind are conducted in 25 communities or towns each year. These are organized in the following manner. The planning committee is composed of a chairman, publicity chairman, treasurer, secretary, representatives of all churches, women's organizations and clubs in the town. A representative of the home industries department is a participant in these meetings. Subcommittees headed by representatives of the planning committee plan various phases of the sale including publicity, location, the operation of a tearoom serving light luncheons for which tickets are sold, and the selection of volunteer salespersons for portions of the day or week. Blind persons from the area are employed to demonstrate their skills as an educational phase of the activity. The number of demonstrators depends on the size of the sale and space available.

Publicity for all educational sales is handled well in advance by newspaper releases which include pictures of local blind people doing their craftwork. For the larger sales, television and radio programs are arranged featuring the chairman of the day, the supervisor of home industries, and a blind person. There is also a 12-minute film, in technicolor, which is shown at preliminary meetings. It tells the story of homebound persons before and after rehabilitation.

Wholesale outlets have been developed with three organizations which purchase such items as ironing-board covers, rugs, aprons, baskets, and leather goods, in

quantity. Consigners are paid the same price for wholesale items as for retail items. Patterns sold at wholesale are different from those sold at retail and the stock is kept separate.

Prepaid orders at educational sales for the blind are taken for merchandise which is not available at the time. The customer pays full purchase price of the articles at the time of ordering. This cuts bookkeeping to a minimum and reduces parcel-post costs.

Chairs to be reseated are brought to the home industries headquarters by the customer and distributed to the homes of consigners who cane them.

WISCONSIN HOMECRAFTERS [2]

I. Legal basis of program

The Wisconsin homecraft program operates under the provision of the act of Congress known as the Vocational Rehabilitation Act and amendments thereto (Public Law 113, 78th Cong.) and Wisconsin laws relating to vocational and adult education (sec. No. 41.71).

Sections in State Statutes 41.71:

"(12) (a) The Board shall provide such services as vocational training or instruction in crafts as may be practicable for severely handicapped persons 16 years of age or over, who cannot be inducted into the regular types of remunerative employment, and who elect to take advantage of the benefits of the State services herein described. When deemed advisable and feasible, handicapped persons may be transported to a central place where classes or schools shall be provided for giving vocational training and instruction in the various crafts as will propitiate the rehabilitation of the individual.

"(b) No vocational training or craft instruction shall be rendered to a homebound handicapped person whose disability may be of a progressive nature without a certificate from the regular physician certifying that such handicapped person can carry on such work without injurious results.

"(c) The Board shall aid the homecraft clients in the disposition of the finished products and shall utilize the facilities of such agencies both public and private in such manner as may be practical in providing ways and means of disposing of the products made by such handicapped homebound persons.

"(d) When products are sold which are made by severely handicapped persons who are under the supervision of the State Board of Vocational and Adult Education, the cost of the raw material furnished such persons for use in fabricating products may be deducted from receipts which are obtained from the sale of such products. Such material-cost funds will be deposited by the State Board of Vocational and Adult Education in the general fund of the State Treasury and are appropriated therefrom to the State Board of Vocational Adult Education to be used in purchasing raw materials for severely handicapped persons who are under the supervision of the State Board of Vocational and Adult Education."

The program functions under the State plan adopted by the State board of vocational and adult education and approved by the Federal Office of Vocational Rehabilitation. Rules and regulations are issued from time to time which set forth the procedures to be followed in providing rehabilitation services for the handicapped. State funds for homecraft services are provided by statute.

II. Personnel

The homecraft staff includes a homecraft supervisor, assistant supervisor in the capacity of teacher-trainer, designer (position presently vacant), and the necessary clerical assistance. Sixteen qualified instructors are employed by the vocational schools and, under the technical supervision of the State homecraft staff, have the responsibility to render adequate and skillful instruction.

III. Program services

A. *Training.*—1. Types of training provided:

(*a*) General crafts:

Needlecraft (both hand and machine)	Jewelry making
Leathercraft	Weaving
Woodwork	Rug making
Ceramics	Toymaking
Metalcraft	

[2] From a report by Mrs. Mary F. Beyer, senior supervisor, homecraft services, Division of Vocational Rehabilitation, Madison, Wis., and submitted to the Fifth Annual Workshop on Guidance, Training, and Placement, sponsored by the Office of Vocational Rehabilitation, Washington, D. C., April 1952.

(*b*) Subdivisions of craftwork:

Acid etching
Applique
Ash-splint basketry
Batik
Beadcraft
Block cutting and printing
Bookbinding
Braiding
Brasswork
Buttonhole rugmaking
Caning of furniture
Chip carving
Copperwork
Crocheting
Dollmaking
Dry-point etching
Finger painting
Floor-loom weaving
Freehand drawing
Hooking
Knitting
Knotting
Leathercraft
Loom construction
Machine sewing
Mechanical drawing
Modeling of clay and papier mache
Needlepoint
Pewter work
Pine needle basketry
Plaster carving
Plaster-mold making
Plastics
Pottery
Quilting
Raffia basketry
Rake knitting
Reed basketry
Rush seating
Scroll-saw work
Shell work
Silk-screen process stenciling
Silverwork
Small-furniture making
Stuffed-cloth toymaking
Table-loom weaving
Tatting
Tinplate work
Tufted-rug making
Watercolor painting
Weaving with simple appliances
Willow basketry
Wood carving
Wooden-toy making
Wrought-iron work
Embroidery
Stenciling
Oil painting

(*c*) Home service occupations:

Clock and watch repairing
Tool sharpening
Repairing of radios and typewriters
Typing
Radio spot checking
Canning
Magazine and newspaper clipping service
Reweaving
Hosiery mending
Mimeographing
Furniture refinishing
Fish fly tying
Photograph developing
Painting
Retouching and tinting
Baking
Candymaking
Bookkeeping
Showcard writing
Electric appliance repairing
Millinery

2. Criteria for acceptance of trainees:

(*a*) Extent of disability so severe as to prevent: (1) entry into the usual school facilities established for general community use; (2) entry into regular channels of employment.

(*b*) Prognosis such that a reasonable period of productive activity can be expected.

(*c*) Condition such that it will not be aggravated by engaging in craft activity.

(*d*) Condition "static" as opposed to acute, temporary disability such as might follow accidents and some illnesses.

(*e*) Condition does not have an element of contagion.

3. Length of training: It is determined that a homecraft client is ready for closure when the training objective is realized and the course of instruction completed. If adequate instruction has been rendered it follows that the trainee has reached his maximum capacity, has developed skill in one or more crafts, and, with sales facilities continuously available to him, he will have a reasonably consistent earning capacity.

The less ability a client has, the shorter will be his length of training. The most capable, interested, and talented homecrafters require more extensive training to satisfy their maximum potentialities.

B. *Provision of occupational tools and equipment.*—The overall policy is based on the conviction that, to make satisfactory progress in pursuing a skill, adequate tools and equipment are necessary. After a fair trial period, the instructor determines on a definite craft to be pursued by a client. Because of the instructor's

training and experience, he is well able to determine the suitability of the activity required to manipulate specific occupational tools and equipment. The instructor substantiates the need for certain tools and/or equipment in the training for a skill or the adapting of the skill of the homecraft individual for the efficient realization of the objective before recommending the purchase. The case supervisor is consulted and, providing financial need has been established, the recommendation is made on the rehabilitation plan and submitted to the State office for the approval of, or rejection by, the homecraft supervisor.

Although all tools and equipment are purchased for a particular individual, and for his own use, the State retains a certain residual title to the equipment in case the client dies or can no longer make good use of it. The cost of homecraft tools and equipment cannot be considered excessive. They include looms, sewing machines, kilns, sanders, jigsaws, handsaws, drills, steam irons, sprayers, motors, and attachments, etc. During the past fiscal year (1951), 69 homecraft clients were provided with equipment at an average cost of $73.

C. *Marketing of products.*—1. Sales philosophy: All homecraft products are carefully screened by the instructor before being submitted to the local or State sales outlets. It then is the privilege and responsibility of the shop manager to accept or reject the product. Her decision is based on an analysis of the worthiness of the article:

(*a*) Is it marketable?
(*b*) Is it a quality product by virtue of excellence of workmanship and design?
(*c*) Does it have a use or function? (1) practical or (2) decorative—
(*d*) Is it appropriate and suitable in design and material for the function intended?

On this premise, the sales philosophy has evolved that each article is judged on its own merit and worthiness and not on the fact that it was made by a severely handicapped person. Future patronage can be assured on this basis only.

2. Marketing methods: The Wisconsin Association for the Disabled and its affiliated county units sponsor the sales of products fabricated by the homecrafters. The State Homecrafter Shop is located in Milwaukee. The State association pays for all expenses including rent, light, salary of personnel, packaging, advertising, etc.

The higher priced and more prestige articles are sent to the Milwaukee shop because the clientele is such as to be attracted by a superior type of merchandise.

The facilities of the Milwaukee shop are made available to all homecraft clients, both active and closed, in the State.

A bulletin, Rules and Regulations Governing the Sale of Articles at the Wisconsin Homecrafters Shop, is distributed statewide for the information of all persons concerned.

The county units have local sales outlets differing in setup and facilities appropriate to their respective communities. Several units cosponsor the service with other groups as social service groups, altrusa clubs, blue triangle clubs, women's clubs, and other interested organizations.

To supplement the established sales facilities, many special sales are conducted during the year. Some are social teas at interested persons' homes; others, preholiday sales and bazaars, each agency being original in its planning for sales of the products made by the local homecrafters.

No commissions are charged; the worker receives the full sales price minus the cost of material.

(*a*) It has been urgently recommended to the State association that a field contact man be employed as merchandiser. It would be his responsibility to know the homecrafters, the articles produced, production abilities and capacities, and make contact with shops, stores, and business houses to promote sales outlets, both wholesale and retail. He would be in charge of sales planning, operating, control, and promotion.

Although an exact estimate of the production capacity of the homecrafter workers is somewhat elusive, it is a reasonable conviction that with adequate sales facilities and promotion, sales should increase to a total of $200,000 annually.

D. *Placement of homebound.*—1. Nature and extent of placement services: Self-employment or home industry is the usual placement service for the homecraft client. When the client has completed his training course, mastered a skill or skills, and has at his disposal adequate tools and equipment for the utilization of his skill in carrying on efficiently within his occupational objective, and has assurance of continued marketing facilities, he is given a placement status and is ready for closure.

Occasionally, the homecraft client enjoys such a decided physical improvement as to become eligible for regular rehabilitation services and full-time employment. This improvement may or may not be due to improved morale, motivation, and good work habits established while receiving homecraft service.

Other severely handicapped trainees, being skilled in their chosen fields, may be employed on a part-time basis outside of the home, providing transportation is made available; for instance, a needleworker in a dressmaking shop, a reweaver in a cleaning establishment, a jig-saw operator in a woodworking shop, a caner in a furniture repair shop—many are the possibilities, providing proper working conditions can be planned and put into effect.

2. Provision of followup supervision: It has been demonstrated that, after closure, homecraft clients need limited service and supervision. Although effort is made to encourage the clients to become as independent as their physical conditions and circumstances will allow, nevertheless, this group is a very dependent one. Having mastered skills, they still require limited service in the way of information as to market trends, design suggestions, and availability of marketing facilities. To satisfy and meet this need, the instructors make periodic but infrequent calls (possibly once a month) on the closed persons in his assigned service area.

IV. Community support for program

Community support is recognized as essential if service to the homebound is to function satisfactorily, especially in the area of marketing. The service is a popular and appealing one and the community agencies and groups respond warmly. It is a twofold service; namely, training and marketing. The latter must be assumed by some agency other than the Rehabilitation Division. This realization makes emphatic the necessity for community interest and active support.

Rehabilitation staff members and homecraft instructors schedule many talks during the year to inform the public and solicit community support. Frequently a display of articles and colored films enlists the active participation and support of lay groups. For example, in the capital of this State, the local county unit maintains a permanent sales display and outlet in one of the leading department stores in the city with a professional full-time salesperson in attendance. Several of the patrons of the shop, who are members of the University Women's League, interested the group in the program and last year 200 talks were scheduled for the members to give before other organizations. In another city, one club pays or arranges for its members to transport the clients to the sheltered training center twice a week.

The homecraft program lends itself to numerous and varied activities which agencies and clubs can include as worthy projects and services in their program to aid in good community living.

V. Integration of program for homebound with State vocational rehabilitation

With the enactment of Public Law 113, the homecraft program was included as an integral part of the Vocational Rehabilitation Division, falling into the classification of training service and designated as "tutorial instruction." The homecraft trainee, as a rehabilitation client, is entitled to any and all services offered by the Rehabilitation Division which he needs to bring him to his highest level of capacity and usefulness. The case counselor supervises the total rehabilitation planning and progress of the homecraft trainee to ultimate closure. Regardless of extent of disability or disabilities, all referred handicapped persons follow the same procedures for processing into the rehabilitation service. The rehabilitation counselor obtains all the required information and data, arranges for the physical examination and any approved recommended treatments, and submits the survey. All possibilities for the improvement of the physical, mental, and employability status of each client are thoroughly investigated and exhausted. Not until all the required information is obtained and the doctor's recommendations received and fulfilled is the client's eligibility established. If, after thorough investigation, diagnosis, and prescribed treatment, the client's handicap is of such an extensive and serious nature as to make him unfit to engage in training or employment under normal conditions, he is accepted as a homecraft trainee and assigned to the homecraft instructor. With the instructor, the case counselor determines the occupational objective and course of instruction to be offered the trainee. He follows through on all rehabilitation procedures, submitting rehabilitation plans, statements of need, and when equipment is recommended by instructor, processes same through regular channels. He calls on the trainee periodically to observe his progress and assumes responsibility for supervision. When training is completed and the client has received services needed to complete

his rehabilitation, the case counselor assembles data and submits closure consistent with accepted rehabilitation procedure.

MINNESOTA HOMECRAFTERS [3]

I. Legal basis of program

Legal status is given the homebound program through the State law regarding the Division of Vocational Rehabilitation which provides—

> The Division of Vocational Rehabilitation may, of its own accord, establish, or maintain, or, in cooperation with local boards of education, assist in establishing or maintaining, such courses as it may deem expedient and otherwise may act in such manner as it may deem necessary to accomplish the purpose of training and instruction for residents whose capacity to earn a living has in any way been destroyed or impaired through industrial accident or otherwise.

with the enactment of Public Law 113 in 1943, the homebound program was included as an integral part of the Vocational Rehabilitation Division, falling within the classification of training and designated as tutorial training.

II. Finances

A. *Source of funds.*—1. For training: From 1943 to 1947 a special legislative appropriation was earmarked for the homebound as part of the appropriation for the Vocational Rehabilitation Division. Since 1947 it has been made part of the Division of Vocational Rehabilitation appropriation with the understanding that the program be continued.

2. Merchandising under the Minnesota Homecrafters, Inc.: Beginning December 1945 the Minnesota Society for Crippled Children and Adults paid the salaries of two commercial workers, and later, in December of 1947, the rental of the building housing the office of the Minnesota Homecrafters in Minneapolis was assumed by the society. This assistance was discontinued on September 1, 1951.

III. Program services

A. *Training.*—The initial call by the teacher is most important. It is at this point that treatment as well as training begin. Chronic or seriously disabled persons need to be stimulated. Their confidence must be restored by a practical evaluation of their residual capacities following a thorough medical examination. Years of complete dependence and purposeful inactivity may have sapped their ability to believe in themselves. Fear of failure may make them refuse to try training. Experience has revealed that the early stages of rehabilitating a homebound person are slow and apt to be interrupted by real or imaginary physical setbacks. The teacher must be patient and persistent and have a philosophy that each client has possibilities. It is advisable to select moderate goals with provision for extending plans as required.

Policies, procedures, and standards governing:

1. Types of training to be provided: Tutorial training included needlecraft, machine sewing, crocheting, knitting, wood carving, wood construction and wood finishes, painting in oil and watercolors, textile painting, sculpturing in clay and plasteline mold making, plaster casting plastics, novelty jewelry, and weaving.

2. Selection of trainees: Follows all regular case procedures. Regardless of the extent of disability all referred handicapped persons follow the same procedure for processing it to the rehabilitation service. Rehabilitation personnel obtain all the required information, such as application, basic survey and financial statement, and investigate the physical, mental, and employability status of each client.

The following factors are used to determine eligibility: (*a*) The person must be homebound; (*b*) age limit for craft training is 60 years; (*c*) housewives are not eligible if they have adequate support from their spouse; (*d*) those housewives who must contribute to the family budget may be accepted; and (*e*) the client must be capable of working at least 4 hours per day.

3. Selection of training facilities: Training is arranged with the Minnesota Homecrafters, Inc., which has a staff of teachers prepared to give tutorial instruction.

4. Provision of training materials and supplies:

(*a*) Training materials are included as part of tuition and therefore issued by Minnesota Homecrafters as required.

---

[3] From a report by Mrs. Grace Polski, supervisor, program for disabled homebound adults, Division of Vocational Rehabilitation, Minneapolis, Minn., and submitted to the Fifth Annual Workshop on Guidance, Training, and Placement sponsored by the Office of Vocational Rehabilitation, Washington, D. C., April 1952.

(*b*) The necessary materials that are required for each craft have been carefully worked out. Sufficient materials are issued to a client during the training period to learn a craft by making a product that will meet the standards set by the advisory board.

5. Supervision of trainer and trainee:

(*a*) An outline is prepared showing the number of lessons for each craft and giving the procedure to follow in instructing the client.

(*b*) Progress reports:

(1) Daily contacts.
(2) Monthly reports.
(3) Quarterly reports.

6. Length of training: The range of training is from 6 to 48 months. This again will vary depending on the craft and the client. Upon inspection, if the product meets the standards and a decision is made that it is a salable item, training is terminated in that particular craft.

B. *Provision of occupational tools and equipment.*—Only hand tools are used for arts and crafts, such as leatherworking and metalworking tools, knitting needles, frames for weaving, etc., and are provided client by the Minnesota Homecrafters. Equipment is purchased under the regular rehabilitation program policies.

C. *Marketing of products.*—1. Probable demand for items: Factors that determine the demand for items are the quality and workmanship of the product, a useful as well as a decorative object, distinctive styling, seasonal product, price, and whether it can be produced in volume. It has been learned that products and prices cannot be standard in all communities.

2. Maintenance of standards of workmanship and design: The Minnesota Homecrafters label on a product means that it has been carefully constructed and artfully finished. It can, therefore, compete with similar work on its merit and not on the sympathetic appeal of having been made by a handicapped person. The standard committee of the Minnesota Homecrafters, Inc., decides on the model articles that are to be allowed to use the label.

3. Distribution of product: The following methods are utilized in selling craft products:

A centrally located gift shop is ideal. Recently a gift shop was established in the Duluth Homecrafters Office. It serves as an outlet for products made by homebound clients serviced by the three offices. It is a little early to determine how successful the shop will be.

Displays and sales at the State, county, and local fairs, conventions, and special holidays have proved successful. The concerted effort of the community to assist in the development of the sales program has indeed been encouraging. Various clubs have accepted as part of their service program, the sponsorship of seasonal sales in leading department stores. Numerous organizations request displays at meetings and conventions throughout the year. Those do not always bring large immediate financial returns, but present an opportunity to keep the work before the public.

Permanent display space has been obtained in the lobbies in leading hotels. The desk clerk handles the sales in most hotels, in others a small commission is given the person in charge of the booth. Similar arrangements have been made with eating shops and hospitals. They choose the products they will accept at our price and mark them according to their experience. It has been learned that products and prices cannot be standard in all communities.

Clients are quite successful in finding their own outlets. By careful study of new materials on the market, it is possible to train clients to make inexpensive articles, something new and different, for which they can find their own sales. We make reference to one item, novelty jewelry, made from metallic acetate, which added more to the clients' earnings than any single craft in the past. The combined earnings of 35 clients who were instructed in this craft totaled $3,610.45. The clients found their own outlets for these products.

The advisory board has secured space at the hotel to set up a gift show. Invitations have been extended to buyers from gift shops or department stores. Merchandise is marked at wholesale prices. Orders are taken and turned over to clients who have been trained in that particular craft.

4. Maintenance of cost records: A record of material and labor costs is kept. A wholesale and retail price is established. A 10-percent handling charge is deducted at the time of sale through the homecrafters. This charge is on articles handled through such sales as State fair, gift shops, and contract work.

D. *Placement of homebound.*—1. Nature and extent of placement services: Placement of homebound is entirely different from placing an ambulatory patient.

Placement services include counseling, advisement, and merchandising information given to the client through the State personnel services. Contracts made by the merchandising unit are also in the nature of placement services.

2. Provision of follow-up supervision: The merchandising unit provides follow-up supervision and reopens cases to teach new crafts when necessary. This work represents a continuing service. The needs of the homebound group change so that they remain in what is termed "supervised employment." Since many craft products go out of vogue, new designs must be furnished to clients to supplement those waning in popularity. Markets must be watched and trade magazines studied. Merchandising outlets vary.

IV. Community support for program

State funds are earmarked for the Minnesota Homecrafters. The organization consists of a group of representative citizens interested in the problems confronting the physically handicapped homebound adult. It was incorporated as a nonprofit organization in 1939. The primary function is to provide craft training for physically disabled adults who are homebound. Committee members assume responsibility for details related to the sale of products and payment to clients. They determine standards and the products to be made. Members' contacts are useful in developing outlets for articles. In addition there are organizations responsible for obtaining space at fairs, shows, and department stores to display and sell craft products. The advisory committee hires the staff, except the supervisor and supervisor of arts and crafts training. A great amount of community interest has been stimulated by the homecrafters.

V. Integration of program for homebound with State vocational rehabilitation program

There is a special homebound office where the records are kept and cases receiving training are served. This office may accept initial referrals from various sources or accept cases transferred from other vocational rehabilitation district offices. In like manner, cases may be transferred from homecrafters office to other district offices.

If, after thorough investigation, it is determined that the vocational objective is not training within the homebound program, the case is transferred by homecrafters office to the regular rehabilitation program for other training opportunities. Since not all homebound persons have interests, aptitudes, and skills to benefit from training in homecraft, these clients are given other types of training through the regular offices—for example, radio repair training and equipment, correspondence courses in accounting, etc. In some instances regular counselors will make the initial visit and acceptance of cases to be served by homecrafters office. All regular vocational rehabilitation procedures, policies, reports, and records are followed as far as possible.

HOME SERVICE PROGRAM OF THE BROOKLYN BUREAU OF SOCIAL SERVICE AND CHILDREN'S AID SOCIETY, BROOKLYN, N. Y.[4]

The department for the handicapped of the Brooklyn Bureau of Social Service and Children's Aid Society has over a period of years developed a multiservice program of assistance to the adult physically handicapped, including the blind and the homebound. It provides employment for the homebound in addition to such ameliorative services as recreation, guide service, and home service for blind women.

Homework for the homebound

The bureau is limited by the New York State Department of Labor to 75 homework licenses. Because of this limitation and because work suitable for the homebound is difficult to obtain, the agency makes financial need a criterion for acceptance of an applicant for homework. Screening of applicants is done by two caseworkers and a case aid of the agency's social service department.

Characteristics of homebound clients

Of the 75 clients served, 37 are men and 38 are women. The age range is from 20 to over 70 years of age. Twelve are under 30 while 15 are over 60 years of age. Four are 70 years of age and over.

The types of disabilities are broken down as follows: orthopedic (32), cardiac (14), multiple sclerosis (7), muscular dystrophy (6), blind (6), epilepsy (3), Parkinson's disease (2), psychiatric (1), and other (4).

---

[4] From a report by Jewell K. Phillips, assistant director, department for the handicapped, Brooklyn Bureau of Social Service and Children's Aid Society, Brooklyn, N. Y.

Nature and extent of homebound service

In the initial intake process full medical, social, educational, and vocational information is obtained. At the same time any immediate problems in any one of these areas receive attention. In the opinion of the supervisor of the intake workers, from 60 to 70 percent of the applicants accepted need casework services to help them to accept their disabilities and to help them with severe family problems. However, casework services on a continuing basis cannot be offered. Casework service is given only in those cases where real emergencies arise.

In cases where further physical education is possible a great effort is made in collaboration with such agencies as the Visiting Nurse Association to help the individual to learn to use his body with facility enough to get about and eventually perhaps to seek outside employment. Less than 5 percent of the 75 homebound workers have been able through the help of the homebound program to make sufficient gains to go into outside employment. The remainder have proved to be permanently homebound.

The Bureau now has a contract with the State Division of Vocational Rehabilitation whereby it trains homebound workers. The purpose of the program is threefold: to determine (1) whether the person can become employable for outside employment; (2) whether the person can do homework for a regular business organization; and (3) whether the person can work on a homebound basis. This program is in its beginning stages.

Staff for the homebound program

The staff members of the Bureau who contribute to the homebound program are as follows: a teacher for the physically handicapped; a female aide who is concerned with the preparation, pressing and processing of sewing, handwork and light assembly work; a male aide who is concerned with the preparation and processing of heavy contract work; an overall supervisor for the division; a driver; two caseworkers and a case aide of the Social Service Department who do intake for all services of the Department for the Handicapped; and a production manager who solicits contracts for the homebound program as well as the workshops.

Factors which limit services

The following have been identified by the agency as factors which are currently limiting the provision of services to the homebound:

1. Number of licenses granted by the New York State Department of Labor.
2. Difficulty of obtaining suitable work:

   Work for the homebound must be geared to their individual abilities. Many are able to do only the simplest kinds of assembly work. The work in all cases must be such that it can be efficiently handled and transported to and from the homes. If customers want their work completed in less than 10 days, and many of them do, the work cannot be done in the home. With one vehicle it takes the Agency 10 days to round out the delivery and pickup cycle.
3. Cost of the program:

   Intake: The caseworker must make a home visit and this is both costly and time consuming. The applicant usually has many problems which may involve referral to other agencies and hospitals. Some of the problems usually have to be met before homework can actually begin, and these require additional visits.

   Supervision: The home instructor must make regular home visits to all and frequent home visits to those who are being trained.

   Clerical: There is a tremendous amount of clerical work involved in sending out material, inspecting, and counting finished work, making up the payrolls, etc.

Home services to blind women

Intake for this service is done by caseworkers and the initial step of helping individuals adjust personally to their handicaps is the direct responsibility of the caseworkers. Coordinated with this service is that of the home teacher, who is herself blind. She is provided with a guide who is also on the staff and who helps with the clerical work. She goes into the home to help the client to arrange her daily life as comfortably and pleasantly as possible.

Instruction in braille reading, writing, typewriting, and music are available as the need or desire of the client is indicated. Ordinary typing, scriptwriting, dialing of telephone numbers, and handicrafts are taught. The simple but necessary tasks the normal housewife takes for granted are retaught the blind woman: how to measure her foods, use her stove, cook, scrub her floor, darn her

husband's socks, and keep his clothes clean and pressed; how to handle her children and go about her life with confidence and pride. It may be necessary to teach her how to stand and walk correctly and how to attend to her personal appearance—all necessary in her personal contacts, but even more necessary if she wishes to seek employment. Talking books are installed in the homes of those that wish them, and help is given in the choice of records available through the facilities of the New York Public Library.

The number of clients provided with this service for the period May 1, 1953, to April 30, 1954, was 91.

Recreational services

The purpose of the Recreation Division is twofold. First, it meets a real need for entertainment and social contact for the handicapped person who has been, or is shut off from normal social contacts either because of the severity of his handicap or because of his inability to compete psychologically. Secondly, in a very simple and natural way attention can be focused on undesirable characteristics in appearance, dress, speech, and group adjustment patterns so that they can be eliminated and more suitable patterns of behavior instituted.

The recreation program is of necessity greatly varied so as to meet the interests of a large number of people with different tastes and backgrounds. It must be flexible enough to permit participation by people with all types of physical limitations.

By utilizing the normal recreational methods many positive values are achieved as follows:

Music: Corrective speech; breathing, language difficulties.

Drama: Posture improvement; speech; dress; makeup.

Dancing: Muscular control and coordination, public performance, self-confidence.

Indoor and field sports: Muscular control and coordination; ability to compete and to take criticism, good sportsmanship.

Hobbies: Develop new leisure time interests; provide outlet for creative activities.

Useful classes: Braille combined with drama (transcription and learning parts); helps spelling, sentence construction; recognition of the printed word. Typing.

Currently recreation service is provided for 150 clients, 100 of whom attend regularly each week. Seventy of the one hundred clients are provided with transportation weekly because they are too severely handicapped to use public transportation.

Guide service for blind women

The Department for the Handicapped has a paid guide as a member of the staff for the purpose of guiding blind women of Brooklyn to and from hospital and dental clinics.

In the month of March 1954, a fairly representative month, guide service for 48 blind clients was provided. Policywise, guide service is provided only for essential trips and only when the client has no other guide resource.

HOME SERVICE PROGRAM OF THE CHICAGO METROPOLITAN UNIT, ILLINOIS ASSOCIATION FOR THE CRIPPLED [5]

The Chicago metropolitan unit of the Illinois Association for the Crippled is a private agency affiliated with the National Society for Crippled Children and Adults. Its purpose is to provide essential rehabilitation services to physically handicapped children and adults in the Chicago metropolitan area.

The major source of income is from Easter seal sales which amounted to 76 percent of the total receipts for the fiscal year 1953–54. Other contributions resulted from membership fees, foundations, bequests and wills, organizations (sororities, fraternities, service groups), and remembrances (anniversaries, birthdays, memorials). The total receipts for the year amounted to $161,789.26.

The Home Service Department provides the following services: (1) Social service, (2) occupational therapy for children and adults, (3) physical therapy for cerebral palsied preschool children, (4) speech therapy (Blue Island and Bellwood Centers), (5) parent education, (6) periodic check by therapists on all equipment on loan, (7) home employment—teaching of industrial processes, arts and crafts, (8) outlets for craft items for those instructed, (9) periodic surveys by the therapists of those being served, (10) friendly visitor program.

[5] From information obtained from the association's annual report for the year September 1, 1953, to August 31, 1954.

Types of disabled individuals served

Among the homebound individuals served the following disabilities occurred in order of frequency: (1) Arthritis and polio; (2) multiple sclerosis; (3) cardiac; (4) hemiplegia; (5) cerebral palsy; (6) muscular dystrophy; (7) amputation; and (8) cord injuries.

Home employment

Four full-time instructors, and three occupational therapists who devote a portion of their time to this service, instruct homebound persons in industrial projects which are subcontracted from industry, and in the craft program which furnishes employment for some of the homebound.

The total number of industrial contracts during the year was 39, including typing; packaging; assembling; pasting labels; wire weaving; contest mail screening; painting names on plastic belts; radio and TV monitoring; sewing; and making color charts. Two full-time drivers pick up and deliver the work from the factories to the homebound workers; 435 persons were given employment last year.

The typing and preparation of the Easter seal agency's campaign letters were done by the homebound, and by workers at the Chicago Welfare Rehabilitation Center. A total of $8,995.78 was paid to the workers for typing and preparation of the campaign mail last year. Sixty home typists addressed this mail.

Wages in the amount of $56,313.39 were collected and paid to workers in the homebound division. Of this amount, $3,777.57 was paid out to craft workers.

Treatment program

Treatment for handicapped persons is carried out under the physician's prescription. Home treatments include occupational therapy for handicapped children and adults, and physical therapy for cerebral palsied preschool children.

Occupational therapy for homebound school age children and for adults continues to be an important service offered by this agency. Eighty-eight individuals were provided with these services during the year. Improvement of Muscle function through supervised activities and development of self-care and independent activity are important factors which aid in adjustment to the severe types of disabilities with which the therapists work.

Physical and occupational therapy for the preschool child with cerebral palsy are also important services. The therapists, in addition to working directly with the patients, aid in parent education and teach the proper use of equipment. A total of 819 physical and occupational Services were provided during the year in this program to 84 individuals.

Social service

The social service department coordinates the services of the agency with the existing resources in the community. It acts as a clearinghouse for all intake, as well as medical clearances and referral matters. Placement service is also an important function of this department. During the year 33 individuals were referred to jobs and were successful in securing employment.

HOME SERVICE PROGRAM OF THE PENNSYLVANIA BRANCH, SHUT-IN SOCIETY [6]

I. History

The Pennsylvania branch, Shut-In Society was initially incorporated in 1907, a benevolent society to "bring cheer and comfort to the homebound," using friendly visitors and home teachers. The first 15 years showed that the homebound needed a service beyond "cheer and comfort." The society then concentrated on merchandising articles made by the homebound. Finding these articles generally unsalable, an occupational therapist was employed to train and supervise the work. During the next few years the articles, due to supervision, improved to the point where they became salable but the merchandising problem was great and proved too costly to continue.

II. Purpose

In the course of the society's growth and development it learned that better services could be rendered to the severely disabled by providing opportunities for remunerative employment both in the homes, for those who are medically homebound, and in a sheltered workshop, for those who are ambulatory. The sheltered workshop is also a "proving ground" for those individuals in need of work discipline and work tolerance. Therefore, the society is now demonstrating

[6] From a report by Elizabeth K. Lammie, executive director, Pennsylvania branch, Shut-I Societ Philadelphia, Pa.

that the severely disabled can be helped through an integrated program of vocational rehabilitation providing:

1. Remunerative industrial subcontract work in the homes;
2. in the sheltered workshop; and
3. selective placement in industry.

III. Statistics

In 1941 the society inaugurated an industrial program which furnished subcontract work to 96 "shut-ins" with an annual payroll of $8,000. In 1951 a sheltered workshop was started so that those "shut-ins" who were able to leave their homes could receive further vocational training as a second step in their rehabilitation training program. Today, the society's payroll has increased to $74,000 annually, paid to 200 physically handicapped persons, 150 of whom are homeworkers and 50 sheltered workshop employees.

From 1951 through 1954 the society has paid in wages $298,085 to a total of 872 home and shopworkers. Of this number, 188 have been employed in the sheltered workshop and 684 in the homes.

During the past 4 years emphasis has been placed upon developing the work capacity of the individual to the point where he may take on an outside job. As a result, during the 4-year period, 63 workers have been graduated from the home to the sheltered workshop, and an additional 19 have gone directly from the homes to full-time jobs in industry. Of the 188 shopworkers, 73 have been placed in suitable industrial jobs, making a total of 92 physically handicapped persons placed in industry through the society's program since 1951.

It is important to bear in mind that the length of time a person is on the payroll varies considerably. In some cases a person may be on the payroll for only a few months before he is able to move on from the sheltered workshop to outside employment, while in many cases the more severely handicapped may never be able to leave his home or the sheltered workshop.

Using 1953 as an average year, the society finds that 68 percent of its homeworkers earned up to $300 annually, 17 percent earned $300 to $500, 7 percent $500 to $700, 4 percent $700 to $1,000, and 4 percent earned over $1,000. Assuming that the maximum grant from a department of welfare or public assistance to a single physically handicapped person is from $500 to $600 annually, the above figures demonstrate the extent to which an industrial homebound program saves the taxpayers thousands of dollars.

A further saving to the taxpayer is shown in the 92 physically handicapped individuals placed in outside industry who are now earning approximately $190,000 annually. Not only are a number of these individuals removed from the category of recipients of welfare but they have now become taxpayers.

All home and shopworkers are paid at a piecework rate based on a nonhandicapped worker's average production at 75 cents per hour or higher. All workers are covered by social security.

IV. Staff

The staff includes an executive director, an assistant director, a director of social service, a medical consultant, three home instructors, a checker, a finance clerk and payroll clerk, a secretary, an office manager, a workshop foreman, a telephone operator, a truckdriver, and a janitor.

Board of directors.—Twenty-one representative lay and professional men and women of Philadelphia.

V. Budget

The Pennsylvania branch, Shut-In Society is a member of the Community Chest of Philadelphia and vicinity from which it receives an annual grant of approximately $40,000. The total budget for 1953 was $136,000, the major portion of which came from industrial subcontracts.

APPENDIX XII

Official State Committees and Commissions in the Field of Aging

California: Interdepartmental Coordinating Committee on Aging, 1025 P Street, Sacramento 14
Colorado: The State Advisory Committee on Chronic Illness, Aging, and Rehabilitation, 414 State Office Building, Denver
Connecticut: Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm, Rocky Hill
Flordia: Florida State Improvement Commission
Illinois: Advisory Committee, Illinois Public Aid Commission, Room 1500, 160 North La Salle Street
Maine: State Committee on Aging, Statehouse, Augusta
Massachusetts: State Council on Aging, Boston
Michigan: Commission to Study Problems of Aging (study completed)
Minnesota: The Governor's Advisory Committee on Problems of the Aged, 134 Courthouse, Minneapolis
New Mexico: Citizens' Advisory Committee on Needy Aged Citizens of New Mexico, Post Office Box 1391, Santa Fe
New York: State Joint Legislative Committee on Problems of the Aging, 94 Broadway, Newburg
North Carolina: Special Committee on Aging (report completed)
Oregon: Governor's Committee on Aging, 509 State Office Building, Salem
Pennsylvania: Joint State Government Commission of the General Assembly, Room 450, Capitol Building, Harrisburg
Rhode Island: Rhode Island Committee on Aging, 40 Fountain Street, Providence
Vermont: Commission on the Chronically Ill and Aged, Statehouse, Montpelier
Washington: Governor's Council for Aging Population, Post Office Box 1162, Olympia
West Virginia: Governor's Committee on the Aging, care of Marshall College, Huntington
Wisconsin: Committee on the Problems of the Aged to the Legislative Council, State Capitol, Madison (study completed)