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REHABILITATION AND CARE OF THE DISABLED IN BRITAIN

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INTRODUCTION

DISABLEMENT, the impairment of the capacity for life and work by injury, disease, or congenital deformity, is one of the world's great personal and social afflictions. Estimates of the numbers of disabled are necessarily vague and conflicting owing to differences in definitions and standards of normality and a number of practical difficulties, including the reticence of many disabled people. It seems probable, however, that in most countries at least 10 per cent, and possibly more than 15 per cent, of the population need some special care or help because they are disabled.

Britain has a comprehensive and unique system to reduce the incidence and severity of disablement and to help the disabled whatever the nature and cause of their impairment. Special services and priority treatment are available for the war disabled. This paper outlines the historical evolution of this system and describes its present working; it is mainly based upon legislation and administration in England and Wales, but is generally applicable to Scotland, with the substitution of 'Secretary of State for Scotland' and 'Scottish Home and Health Department' or 'Scottish Education Department' for Minister, and Ministry, of Health or Department of Education and Science respectively. For the position in Northern Ireland see pp. 61–62.

HISTORICAL DEVELOPMENT

IT HAS been the duty of local authorities, ever since the passing of the Poor Law Act 1601 to provide the sick, the needy, and the homeless with the means of subsistence. In the eighteenth and nineteenth centuries British medical services developed; medical science advanced and the number of qualified doctors greatly increased, hospitals were built with private endowments and subscriptions and were made increasingly available to the general population, while free infirmaries were provided under the poor law for the destitute, aged and infirm. Towards the end of the eighteenth century, the first schools for the blind and the deaf were established. In the latter half of the nineteenth century, there came into being a number of voluntary societies concerned with the welfare of particular groups of disabled people, such as the blind, the deaf and the crippled. Towards the end of the century, after the introduction of free compulsory education, statutory provision was made for special schools for blind and deaf children and for the mentally retarded.

By the beginning of the twentieth century there was thus a considerable amount of financial, medical and social help available to the disabled, but besides being inadequate by present standards it was very unevenly distributed and, in certain respects, misconceived. The connotation of disablement was narrow, embracing at most only the blind, the deaf and the crippled. The doctor and the voluntary organisation's worker were working in watertight compartments, the former concerned only with specific treatment for a particular disease or injury, and the latter actuated mainly by compassion and charity in the original sense of the word[1] rather than by insight and practical purpose. Even during the first decade of the twentieth century, which saw the starting by Dame Agnes Hunt of her convalescent home and after-care clinics for cripples, of the Lord Roberts Memorial Workshops for disabled soldiers, and of the Heritage Craft Schools and Hospital for crippled children, the major emphasis was on the alleviation of hardship. The importance of rehabilitation, the process in which medical, social and other workers co-operate to bring about a return to life and work, was not yet appreciated; nor were the possibilities of creating a special sheltered environment in which the severely disabled could live more normal lives (except perhaps in the case of the blind, for whom some special workshops had existed since the first half of the nineteenth century).

It was in the second decade of the twentieth century that it began to be realised that successful treatment for tuberculosis depended largely on finding for its victims a way of life which sustained their morale and gave them enough exercise to maintain their vitality. One of the difficulties was that the tuberculous were barred from most normal occupations. In 1917 Dr. (later Sir) Pendrill Varrier-Jones found a small-scale solution of this problem by setting up the first village settlement for the tuberculous, the Bourne colony, which was later transferred to the village of Papworth in Cambridgeshire (see p. 51). This settlement provided a special environment in which quiescent tuberculous cases could work and live normally with their families under medical observation.

During the first world war increasing use began to be made of massage and

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[1]Charity's prime meaning is love for one's fellow-man; it has come to acquire a connotation of condescending help from the better-off to the under-privileged.

remedial exercise in the treatment of orthopaedic cases. The military orthopaedic hospitals organised by Robert Jones provided a rehabilitation regime including physiotherapy, hydrotherapy, remedial exercises and occupational therapy. These facilities were financed by gifts from the British Red Cross Society. Meanwhile, the work of St. Dunstan's Hospital for blinded soldiers and sailors showed how experts with a medical approach could train the disabled to acquire self-reliance and compensatory skills.

Between the wars there was little further development of medical rehabilitation until 1935. The strict regimes worked out in the military hospitals by Robert Jones were found impracticable with civilians, and the use of rehabilitation in orthopaedic cases tended to decline. During this period occupational therapy was used mainly in a few mental hospitals. Then lay and medical opinion was aroused by the findings of the Fracture Committee of the British Medical Association (1935) and the Interdepartmental Committee of the Ministry of Health and Home Office on the Rehabilitation of Persons Injured by Accidents (1939). These reports emphasised the need for rehabilitation services in hospitals to aid functional recovery, and recommended the setting up of residential centres to provide the post-hospital reconditioning which was needed in certain cases. By 1939 there were about 40 hospitals providing some kind of rehabilitation treatment for orthopaedic cases, while rehabilitation centres outside the hospitals had been started by a few pioneer organisations.

Meanwhile, though a number of voluntary bodies cared for the welfare of the permanently disabled and some tried to find employment for them, government schemes for the employment of the disabled were limited to a fairly comprehensive scheme for the welfare and employment of the blind and to two schemes to help disabled ex-servicemen get work—the King's National Roll,[1] started in 1919, and the scheme of grants to undertakings employing severely disabled men.

The second world war brought rapid development of rehabilitation methods and of special schemes for the disabled. Under the Emergency Medical Service a large number of hospitals were taken over by the Ministry of Health to take care of war casualties and evacuated civilian patients. The concentration of various disabilities in special hospitals and the pooling of resources made more comprehensive rehabilitation programmes possible, while the war-time need for manpower and the moral obligation felt towards war casualties stimulated a progressive attitude. The range of occupations for which disabled men were trained was greatly widened to include much skilled engineering work, while, on the medical side, rehabilitation methods similar in principle to those used in orthopaedic cases were extended to all classes of sick and injured, and an increasing importance was attached to enlisting the patients' active co-operation in their own treatment through the extended use of group exercises and remedial games.

In 1941 the Ministry of Labour, in conjunction with the Health Departments (the Ministry of Health and the Department of Health for Scotland), started an Interim Scheme for the Training and Resettlement of the Disabled. The objects of the scheme were to help the war effort by making the most

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[1]A list, maintained by the Ministry of Labour, of firms employing an agreed percentage of disabled ex-servicemen of the first world war.

effective use of all disabled and to provide for the rehabilitation of war casualties. To achieve these objects advice and help and, if necessary, vocational training were given to men and women disabled through any cause. Close co-operation with hospitals and voluntary agencies made possible for the first time a continuous programme of rehabilitation from medical treatment to industrial resettlement. The scheme was considerably developed from 1942 onwards in accordance with recommendations of the interim and final reports of the Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons (known as the Tomlinson Committee). Some of the recommendations of the final report of the Tomlinson Committee could be implemented only by legislation. The Disabled Persons (Employment) Act 1944 gave effect to these recommendations and regularised, modified and extended existing practice under the Interim Scheme.

Five other Acts have consolidated and extended the provision for the rehabilitation, financial support and care of disabled people as part of the post-war social services in Britain. The National Health Service Act 1946 and the National Health Service (Scotland) Act 1947 made free medical treatment, including medical rehabilitation where necessary, available to everyone. The National Insurance Act 1946 entitles disabled persons, like other insured workers, to receive weekly benefits if they are ill or unemployed. The National Insurance (Industrial Injuries) Act 1946 provides benefits if incapacity or disablement results from injury at work. The National Assistance Act 1948, as well as providing monetary assistance for those in financial need, empowered the major local authorities to extend to all substantially and permanently disabled the same comprehensive welfare services, including sheltered employment, as they had already been obliged to provide for the blind. All these Acts came into force on 5th July, 1948. In addition, the health and welfare provisions of the National Health Service and National Assistance Acts have greatly assisted the steady and widespread development of co-ordinated local services for the care and welfare of the elderly, and the Education Act 1944 and the Education (Scotland) Act 1945 consolidated and extended provision for the education of handicapped children.

In 1953 a committee under Lord Piercy's chairmanship was set up 'to review in all its aspects the existing provision for the rehabilitation, training and resettlement of disabled persons, full regard being had to the need for the utmost economy in the Government's contribution, and to make recommendations'. The committee, which reported in 1956, found that the facilities for enabling disabled persons to get suitable employment were comprehensive and well established, needing little change or development, and that there had been a widening and deepening of the concept of rehabilitation on the medical side. The committee made a number of recommendations; those few which necessitated legislation gave rise to the Disabled Persons (Employment) Act 1958.

STRUCTURE OF THE SERVICES

TO REDUCE the incidence and severity of disablement and to mitigate its adverse effects on individuals and society, the first requisite is good medical treatment including medical rehabilitation, that is, a planned programme to restore maximum activity. Even with the best possible treatment, however, a number of people will be left with some fairly substantial permanent or semi-permanent impairment. A few of these will be too seriously incapacitated to take much active part in life. They need food, shelter, care and, possibly, medical supervision. They also want a tolerable environment and some diversionary occupation, but are unlikely, unless specially gifted, to be capable of work of much economic value. Another group consists of those who, while severely disabled and perhaps still needing medical care, can be taught to do work of considerable economic value under special sheltered conditions, although they cannot compete with the able-bodied. Others, again, forced to give up their work owing to injury or disease, need training in a new occupation and are then capable of ordinary competitive employment. By far the largest number only need help in finding a job which suits them and in which their disability is not a serious handicap.

In addition to their medical and vocational needs, the disabled often have related problems of social and psychological readjustment. The needs of disabled children are basically similar, except that in their case the critical factor is not employability but the ability to attend school and profit by education.

British services for the disabled are based on a realistic appreciation of their needs. For disabled people over school-leaving age they provide:

1 Free medical treatment for all, including medical rehabilitation, under the National Health Service.
2 A disablement resettlement service to place employable disabled persons in suitable work.
3 Welfare and social work services for the severely disabled.
4 Financial assistance where necessary.

Special services for children include a School Health Service, which discovers and examines children suffering from any form of mental or bodily disability, and special schooling for those children needing it.

These services are provided by a number of governmental and voluntary agencies. The Ministry of Health or Scottish Home and Health Department, and the medical, nursing and ancillary professions are concerned to prevent disablement wherever possible, as well as to reduce its severity and to restore the disabled to health and efficiency. The Ministry of Labour provides industrial rehabilitation, vocational training and resettlement in employment. The Ministry of Pensions and National Insurance is concerned with the welfare and compensation of the war-disabled and with cash benefits for the sick and unemployed and for persons incapacitated by injury at work or prescribed industrial diseases. The National Assistance Board is responsible for financial help to those in need. The Department of Education and Science is responsible, through the local education authorities, for the School Health Service in England and Wales, and for provision of special educational treatment for children needing it and of further education of disabled persons needing residential facilities; the Scottish Education Department has similar responsibilities. The larger local authorities (county councils, county borough councils in England and Wales and councils of large burghs in Scotland) provide

residential accommodation for people who by reason of infirmity or any other circumstances are in need of care and attention which is not otherwise available to them, and welfare services (including sheltered employment) for the blind; and they are increasingly providing similar welfare services for other severely disabled people. Moreover, as local health authorities, they provide a care and after-care service for the tuberculous, the mentally disordered and persons suffering from illness generally.

A large number of voluntary agencies specialise in the care and training of particular classes of disabled people, for example, the blind, the deaf and the crippled. They are therefore complementary to the governmental agencies which provide a particular type of service, such as treatment or help in finding employment, to all classes of disabled. Some voluntary agencies are employed by local authorities as their agents in providing welfare services to specific groups of handicapped people.

An important development is the growing interest of private firms in rehabilitation schemes for their employees. There are a number of schemes of this kind.

The size and complexity of the rehabilitation problem and the number of government departments and voluntary agencies concerned make co-operation and co-ordination essential features of the national provision. The Ministry of Health has an Advisory Committee on the Health and Welfare of Handicapped Persons, with membership drawn from a field representing all the major interests in the care of the handicapped and observers from other government departments. The Minister of Labour set up a National Advisory Council to advise and assist him in matters relating to the employment or training of disabled persons. The council is composed of an independent chairman, representatives of both employers and workers, and other persons with a special knowledge and interest in disablement questions, including doctors. Observers from other government departments also attend its meetings. Many of the voluntary organisations interested in the disabled are affiliated to the Central Council for the Disabled, which acts as a co-ordinating body, and there is also the British Council for Rehabilitation of the Disabled, whose object is to promote the development of unified rehabilitation services which it does by means of study conferences and the collection and dissemination of authoritative information.

MEDICAL REHABILITATION

IN BRITAIN the expression 'rehabilitation of the sick and injured' is used to define a continuous indivisible process which, starting from the onset of sickness and injury, comprises all the measures used (1) to prevent undue loss of physical and mental function during illness, (2) to assist convalescent patients to recover full function and to resume their normal way of life without undue delay, and (3) to help those for whom permanent disability is unavoidable to regain the maximum possible physical and mental function, to adapt to their residual disability and to live and work in the conditions best suited to their capacity.

It is recognised that there are medical, social, industrial, economic and other aspects of rehabilitation; but it is considered important that these should be regarded as interrelated parts of a single process rather than as separate services, and that specialist personnel concerned with the different aspects should work together as a team.

The reduction of the incidence and severity of disablement is primarily a medical problem. It is beyond the scope of this pamphlet to describe the medical services of Britain or the provisions made for the safety, health and welfare of working people.[1] This section covers the provision made by hospitals and other institutions for rehabilitation aimed at restoring general and specific functional activity. There are facilities for rehabilitation at all the main hospitals and there are a number of geriatric units for the rehabilitation of elderly people in danger of becoming permanently bedridden (see p. 34). There are also some residential rehabilitation centres of a specialised nature not connected with any single hospital but serving a large area—for example, the centre for general rehabilitation at Garston Manor, described on p. 9, and the industrial neurosis centre at Roffey Park. At the Nuffield Orthopaedic Centre in Oxford a 'living unit' has been designed to fill the gap between hospital on the one hand and home and a training centre on the other; at the unit methods and appliances are studied which might help in the process of reintegration into normal life.

There are eight special resettlement centres for miners (to which non-miners can be admitted if they are suffering from severe traumatic injuries), and the group Industrial Health Service of Slough Trading Estate started a centre of its own at Farnham Park which has now been taken over by the North West Metropolitan Regional Hospital Board (described later in this chapter).

The pioneer departments developed by the former Ministry of Pensions for the treatment of war injuries are now part of the National Health Service. The Limb Fitting Centre at Queen Mary's Hospital, Roehampton, now fits appreciably more civilians than servicemen with artificial limbs of every kind. The Spinal Injury Centre at Stoke Mandeville Hospital, a former war pensions hospital, is the central point in a highly organised system of rehabilitation for the paraplegic (see p. 58).

Hospital Rehabilitation Departments

Hospital rehabilitation departments vary in their methods and scope, but the following is the pattern of work in many general hospitals.

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[1]These are described in another COI reference pamphlet, R.F.P. 5154/64 *Health Services in Britain.*

A specialist in physical medicine is in charge of the organisation of rehabilitation services and prescribes a rehabilitation regime for each patient, in consultation with the physician or surgeon in charge of the case. Regimes will vary according to the nature of the injury or disease but are likely to include physiotherapy, remedial exercises and, possibly, occupational therapy.

Measures to prevent undue loss of function and to assist recovery are instituted at the earliest possible moment. The physiotherapist and remedial gymnast start work in the very early stages of recovery, often before or immediately after a major operation. Physiotherapy consists of massage, electrical stimulation of muscles, individual movements and remedial exercises. Active remedial exercises are often given by grouping patients with the same disability and adapting games to restore muscle power and joint movement. This method reduces boredom and stimulates a competitive will to recover. The exercises are progressive and carefully graded; patients usually start exercises in bed and proceed to the gymnasium as soon as they are allowed up. As well as specific exercises for the disabled part of the body, general exercises are used to restore and maintain physique.

Occupational therapy provides remedial exercise while diverting attention from the disabled part. The best and most natural occupational therapy is gradual resumption of the patient's own work, or training for new work suited to his modified abilities. This may not always be practicable in a hospital, but even here the tendency towards industrial or semi-industrial activities is increasing. Where these are inappropriate or impossible, use may be made of suitably adapted handicrafts such as weaving, leather-work, basketry or carpentry.

Patients well enough to leave hospital, but not yet fit to resume their normal work, may attend hospital each day, brought in by car if necessary. They receive physiotherapy if required and 30 to 60 minutes of remedial exercises, then spend the rest of the time, usually a morning or afternoon but in some cases the whole day, in the occupational workshops. Evening clinics are sometimes arranged for patients well enough to return to work but still needing treatment.

Throughout treatment, reassurance and encouragement of the patient are considered of the first importance. Within a few days of the patient's arrival in hospital—certainly if possible before he has an operation—he will be seen by a medical social worker, whose job it is to help solve any worries on the patient's mind, to tell the medical staff of social implications which may affect his recovery, and to help him and his family to make any personal social or family adjustments which may be required before he is able to return to work or take up a different kind of employment.

The needs of hospital patients with a residual disability or requiring social help of various kinds are discussed at some hopitals at a weekly meeting or 'case conference' attended by the rehabilitation medical officer, the medical social worker, the health visitor, the welfare officer, and the disablement resettlement officer of the Ministry of Labour (see p. 14) or other workers as appropriate. The need for vocational training or a period at a rehabilitation centre on discharge from hospital is reviewed, advice is given on placement in the most suitable job, and so on. At other hospitals the disablement resettlement officer may interview the patient by himself after being given medical details.

Aids for Disabled Housewives

The occupational therapy departments of hospitals are paying more attention to the special problems of disabled housewives. At some hospitals a room or rooms in the occupational therapy department are fitted up as if in a house and as many as possible of the household appliances in common use are adapted for special requirements, for example those of the one-armed or chair-bound. Disabled patients are taught while still under treatment, as in-patients or out-patients, how to undertake the common domestic tasks and to prepare a meal and wash up after it for other patients who are spending the whole day in the department. When it has been decided what patients need, visits are made to their homes and, in consultation with the husbands, various appliances are adapted either in the home, in the occupational therapy department, or with the help of local authorities and supplied to the patients at the cost of the materials used.

Garston Manor Rehabilitation Centre

Garston Manor Rehabilitation Centre was set up in Watford under the National Health Service in 1951. The centre provides rehabilitation for post-operative and other patients, the most suitable being those who have to return to heavy work or who require treatment to fit them for industrial training.

The manor house is a hostel for 61 patients, men and women, who, with some non-resident patients, attend a daily course in the remedial centre close to the house, comprising a gymnasium, physiotherapy and occupational therapy departments, a swimming pool and workshops in addition to the consulting room, offices and cafeteria. Each patient is given a daily programme which is altered according to progress. Particular attention is paid to the difficulties which patients have in everyday tasks such as walking, dressing, writing, cooking and travelling on public transport.

The workshops with their industrial machinery and equipment form a link between hospital and employment. Work therapy includes carpentry, painting, bricklaying, printing, gardening and heavy labouring. The workshops are also used to assess a patient's fitness to return to work or to undertake alternative work or training. A disablement resettlement officer visits the centre and problems concerning employment are discussed with him at weekly case conferences.

Apart from treatment, patients are encouraged to take part in the social life of the hostel which is organised by a committee elected by the patients themselves. Recreations include golf, bowls, billiards, table tennis, cinema, television and dancing.

Farnham Park Rehabilitation Centre

The rehabilitation centre at Farnham Park, near London, provides for 66 in-patients and up to 35 out-patients who are recovering from organic illness or injury and who can be expected to be fit for work or, if necessary, training in a maximum of ten weeks. The majority of patients are orthopaedic cases but there is an increasing number of general surgical cases and a small number of medical cases.

The rehabilitation team is headed by the physician or surgeon who accepts initial responsibility for the patient's case. Patients are referred back to him

at any time and invariably before discharge. Two orthopaedic surgeons and a plastic surgeon hold weekly clinics in the centre when they see their own patients. This continuity of responsibility is regarded as of vital importance. The medical director of the centre acts as rehabilitation medical officer responsible for organising and supervising the work of physical and mental restoration.

Each patient is placed on admission in one of four physical grades and his treatment is discussed at a staff meeting. Treatment consists of work of therapeutic value, hydrotherapy, physiotherapy, remedial exercises, educational and recreational training, and good food well served.

The nurses, the catering officer, the physiotherapists and the remedial gymnasts all have important parts to play as members of the team. The social service officer maintains liaison with hospital medical social workers and studies the social background of the patients. It is her responsibility to follow up patients on their return to industry and to ensure that the work of restoration is continued. The education and recreation officer is responsible for the organisation of discussion groups, lectures, films, concerts, and anything else calculated to stimulate the mind. In the workshops the occupational therapy staff, aided by an engineer and a carpenter, provides each patient with a task involving the particular type of action he needs to practise. Progress is discussed at a weekly conference. There is close liaison with the local Government Training Centre (see p. 23) in passing on those patients who need training or placing in new work on completion of their treatment.

Rivermead Hospital

Rivermead Hospital is concerned with the re-education and rehabilitation of patients of all ages who have been disabled by chronic illness or accident. Part of the accommodation is used in the Oxford Geriatric Service for in-patients needing intensive nursing care, but there is a growing number of out-patients. The approach to rehabilitation is based on the principle that all activities should follow normal living patterns as far as possible.

The facilities for rehabilitation have been greatly helped by the Nuffield Provincial Hospitals Trust, which has provided workshops, canteen, offices, stores and cloakrooms. There is also a physiotherapy department which includes a gymnasium and facilities for retraining in the activities of daily living.

Bridge of Earn Fitting Centre

The Bridge of Earn Fitting Centre was opened at Gleneagles in January 1943 for the primary purpose of rehabilitating coalminers. It was transferred to Bridge of Earn Hospital, Perthshire, in 1948, and its facilities were opened to anyone in Scotland needing rehabilitation no matter what his occupation. Accommodation is provided for 160 men in 80 two-bedded rooms, giving a more independent existence than in a large hospital ward.

As well as living and dining rooms there are gymnasia, an occupational therapy department and other ancillary accommodation. Patients should be able to dress and make their own way from the sleeping quarters to the centre itself—a distance of about 100 yards. A few patients are admitted who require a wheelchair to take them from place to place.

The treatment provided consists of graded exercises, indoor and outdoor

physiotherapy and indoor and outdoor games, with recreational facilities provided for the evenings. The range of occupational therapy carried out is graded from light operations in the indoor workshops to heavy carpentry and concrete work. Patients are under specialist supervision whilst they are at the centre and special care is taken when they leave to ensure that they find work suited to their physical and other capacities. The hospital specialist, the disablement resettlement officer and the patient's doctor are all consulted, as necessary, for this purpose.

While the greatest number of patients entering the centre come from Bridge of Earn Hospital itself, many come from other hospitals including neuro-surgical units and chest clinics. Patients can be referred by general practitioners, by Regional Medical Officers of the Scottish Home and Health Department and by Medical Officers of the Ministry of Pensions. The Medical Officer of the National Dock Labour Board refers cases from all the Scottish ports.

Camden Road Rehabilitation Centre

The Medical Rehabilitation Centre, Camden Road, London, is the first purely out-patient centre, not attached to a particular hospital, in Britain. It is a part of the National Health Service and treats between 80 and 90 patients per day. At this centre and also at Farnham Park a balance is maintained between short-term (under six weeks) and long-term (over six weeks) patients by means of a selected waiting-list. A patient remains under treatment as long as improvement is taking place.

The Miners' Rehabilitation Service

The Miners' Rehabilitation Service for England and Wales comprises seven residential centres in country mansions, each serving a different area and having a capacity of between 50 and 100 places. They are now part of the National Health Service. Miners have priority for admission, but a small proportion of other orthopaedic patients are taken. There is also one miners' rehabilitation centre in Scotland, under the Coal Industry Social Welfare Organisation.

The service operates according to three main principles. The first is an insistence on good primary treatment in hospital. The second is continuity of treatment and complete integration between hospital and rehabilitation centre; this is ensured by appointing orthopaedic surgeons from the chief local accident hospitals to the centre staff. The third principle is that physical and psychological rehabilitation are not enough; to them must be added social and economic rehabilitation, with the aim of making a miner fit to go back to work.

There is the closest co-operation between the medical and social services at the centre and those in the mining industry. The problems encountered are often difficult and complex and they have been solved in the main by personal contact between the medical services and the medical-social worker at the centre, and the managerial staff of the individual pit. The rehabilitation service gives detailed guidance on problems of work selection or upgrading for miners discharged from the centres and contact is maintained with every patient for at least six months, and with some for much longer.

All the patients admitted to the centres have sustained serious injuries.

For the centres in England and Wales, the average period of total incapacity is about seven months and the average duration of stay is about ten weeks.

The follow-up results show that about three-quarters of the patients attending the centres are able to resume their work in the mines and most of the remainder are able to take up permanent but lighter work in the coal industry. About three per cent are resettled outside the industry. All but a very few of the patients are reinstated at work within a month of discharge from the centres.

Medical Services for War Pensioners

The provision of medical and surgical treatment for war pensioners is the responsibility of the Health Departments and, in general, treatment is provided under the National Health Service. In addition, war pensioners may receive treatment under contractual arrangements made with certain voluntary hospitals and homes which include epileptic colonies, homes for paraplegics and convalescent homes.

At National Health Service hospitals, the pensioners are entitled to priority for the treatment of their pensioned disabilities as in-patients and as out-patients, subject to the needs of emergency and other cases. The former war pensioner hospitals[1] are now administered under the National Health Service, and war pensioners continue to have first call on these services. The hospitals have special facilities for the treatment of war disabilities such as amputations and tropical diseases, in addition to providing general medical and surgical treatment. They generally provide a greater measure of rehabilitation and convalescence than is commonly available in the National Health Service, and close links are maintained with the welfare services provided by the Ministry of Pensions and National Insurance (see p. 27).

The Artificial Limb Service

The Artificial Limb Service, established during the first world war by the Ministry of Pensions primarily for war pensioners, was the first government-sponsored rehabilitation scheme in Britain. This service, together with the central contracting arrangements for the supply of invalid vehicles and appliances for war pensioners and National Health Service patients, is now the responsibility of the Health Departments.

In England and Wales, there are 22 limb-fitting centres so geographically distributed as to meet the needs of amputees without excessive travelling. In addition, there are five centres in Scotland and one in Northern Ireland.[2] At each centre there are trained limb surgeons experienced in all aspects of the fitting of artificial limbs and in the care and rehabilitation of the amputee. The centres have fitting rooms, plaster cast and measuring rooms and walking training schools, and the centres at Roehampton, Birmingham, Brighton, Cardiff, Gillingham, Leeds, Liverpool, Portsmouth, Edinburgh and Glasgow have, in addition, arm training schools where patients who have lost an arm are taught to become fully independent.

At Roehampton, which is the largest of the centres, there is also a research

[1]The Minister of Health directly administers a hospital and a limb-fitting centre in the Irish Republic exclusively for disabled ex-servicemen of the United Kingdom forces.
[2]And the one in Dublin administered by the Ministry of Health.

department with medical officers, an engineer scientist and technical experts engaged in improving existing designs of limbs, in following up new ideas, and in experimenting with new materials for the manufacture of limbs. These research experts arrange and evaluate pilot trials under the guidance of a Standing Advisory Committee. In Scotland there are research departments at Dundee (lower limbs) and Edinburgh (powered upper limbs).

Patients of all ages are provided for, and it has been found possible to fit a child as young as ten months successfully with a below-knee limb as well as an old lady aged 96 with an above-knee limb. Great help is being given by orthopaedic and general surgical and medical consultants of hospitals whose remedial therapy staffs help in the preparation of the patients for limb fitting and, in many instances, in their training to become independent.

Children suffering from severe congenital deformities and deficiencies of the limbs, whether or not associated with the administration of 'Thalidomide' (a drug formerly used in the treatment of sickness during pregnancy) to their mothers, present a special problem. Those with total or almost total absence of the upper limbs are provided, through the Ministry's Limb Fitting Service, with sophisticated pneumatically powered artificial arms, the design and application of which requires a high degree of skill and care. Thus fitting is being done while the child is in hospital and a special 'Children's Prosthetic Unit' was established at Roehampton for the purpose. Here the children are taught by specially experienced occupational therapists how to use their limbs and how to deal with essential requirements of everyday life. It is essential to make the mothers familiar with the powered equipment and for this reason it is customary to admit the mothers to the children's unit for a few days after their children have been fitted.

Similar facilities, on a slightly smaller scale, exist at Liverpool, Oxford and Edinburgh, and there is also a service at Chailey Heritage School.

Some congenitally deformed children, whose limb deficiences are less severe, can make adequate active use of their limbs, whilst others achieve function with the aid of non-powered artificial limbs.

RESETTLEMENT IN EMPLOYMENT

EMPLOYMENT services for the disabled are based on the Disabled Persons (Employment) Acts 1944 and 1958. These Acts give the Minister of Labour various powers to help the disabled to get work and to provide for industrial rehabilitation and vocational training.

The Register of Disabled Persons

The Acts define a disabled person as one who 'on account of injury, disease, or congenital deformity, is substantially handicapped in obtaining or keeping employment, or in undertaking work on his own account, of a kind which apart from that injury, disease or deformity would be suited to his age, experience and qualifications'. To make it quite clear who is entitled to special help in getting employment, the Acts provide for the maintenance at each employment exchange of a Disabled Persons Register on which persons who satisfy the conditions for registration can be enrolled if they wish.

There are about 656,000 persons on this register, of whom about 89,000 are women or girls. About two-fifths are registered on account of surgical disabilities, for example, amputations, about two-fifths on account of medical ones, for example, tuberculosis; other disabilities include blindness, deafness and psychiatric disorders. (For fuller analysis see Appendix 1.) These figures do not show the size of the disabled population as a whole, as the register excludes people unfit for work or not seeking paid employment, slightly handicapped people and those whose disability is not likely to last more than twelve months, and those disabled people who, though part of the working population, have decided not to register. There has been an appreciable fall in the last few years in the numbers on the register; for example, in 1950 the total was 936,000. The decrease can be attributed partly to the fall in the number of men disabled in the first world war who are still in the employment field.

Disablement Resettlement Officers

At each employment exchange and industrial rehabilitation unit of the Ministry of Labour there is a disablement resettlement officer (DRO) whose job it is to advise disabled persons and help them to find suitable employment. Any disabled person who wishes to have advice on an employment problem can arrange for an interview with the DRO. The DRO also visits hospitals, sanatoria and other medical institutions to interview and advise patients who are about to be discharged with a residual disability and who have an employment problem.

Placing people in employment is the primary function of employment exchanges. In addition to being taught the techniques of normal interviewing and placing, DROs are given specialised training in the problems which arise in finding employment for the disabled. After a period of practical experience the trainees attend further courses designed to give them a complete picture of the medical, industrial, and social aspects of rehabilitation with special emphasis on the problems of adjustment to work.

An important part of the work of the DRO is to keep in touch with local employers and to enlist their help on behalf of the disabled. He is informed of all vacancies notified to the employment exchanges by employers, so that he may submit disabled persons for any suitable jobs. Inquiries are made by

the DRO following the taking of a first job after disablement, so that he can find out if the man has been satisfactorily settled.

There are nearly 300 local Disablement Advisory Committees, each of which consists of an independent chairman with equal numbers of representatives of employers and workers, and of other people with experience and interest in disablement problems. Two of the questions on which their advice may be sought are applications for registration as a disabled person, and certain applications by employers for permits to employ people other than registered disabled persons.

Vocational Guidance

When giving vocational guidance to a disabled person, a disablement resettlement officer will have, to guide him, a medical report specially designed to interpret disabilities in terms of functional capacity (provided by the hospital concerned or through the Regional Medical Service of the Ministry of Health or Scottish Home and Health Department) and any information on the disabled person which he has collected from records or personal reports, for example from past employers or from such voluntary associations as those helping the blind and deaf or the National Association for Mental Health. He will have to decide whether the person is employable and for what kind of work he is most suited, whether he will need special help in finding and keeping a job and should therefore be registered as a disabled person, whether he needs rehabilitation or retraining before he can get a suitable job and whether he is likely to remain so severely disabled as to need sheltered employment. Medical interviewing committees or resettlement clinics have been set up at many of the principal hospitals and they provide a detailed medical and social assessment for the guidance of DROs in exceptionally difficult cases.

Open Employment

The great majority of disabled persons are able to hold their own in competition with the able-bodied once they have found suitable work. The placing of disabled persons in open employment is assisted by the provision in the Disabled Persons (Employment) Acts that employers of 20 or more workers must employ a quota of registered disabled persons, at present 3 per cent of total staff. The only exception is in respect of ships' crews, where there is a special percentage of 0·1.

Failure to employ the appropriate percentage of registered disabled persons is not in itself an offence, but an employer who is below quota may not engage a worker not registered as disabled unless he has a permit from the Minister of Labour to do so. Where it is proposed to refuse a permit because it is considered that the employer is unreasonable in refusing to engage a disabled person, the employer can ask for the case to be put to a Disablement Advisory Committee for consideration. An employer must not discharge a registered disabled person without reasonable cause if he is below his quota, or if the discharge would bring him below quota. There have been few prosecutions for infringements of the quota scheme and the Ministry of Labour's inquiries have shown that the successful placement of the disabled is mainly due to the efforts of the DROs and to the helpful attitude of employers.

The Ministry of Labour also operates a limited scheme for the loan of

special aids to registered disabled persons who need them to take up or keep a job. (Such a loan is made only when the person is unable to provide the aid at his own expense and the employer is unwilling to provide it.) The main object is to provide special pieces of equipment, or attachments such as a special seat or lever for use when working a machine, or a Braille micrometer for a blind employee, which the able-bodied would not need to do the same job.[1] Severely disabled persons unable to travel to work by public transport may exceptionally be given assistance towards their travel expenses.

Designated Employment

Under the Disabled Persons (Employment) Acts the Minister of Labour can 'designate' occupations which are then reserved for the registered disabled. Only two employments, car park attendant and passenger electric lift attendant, have been designated and the scheme is unlikely to be extended to other occupations.

Sheltered Employment

Severely disabled persons capable of making a significant contribution to production may yet need special sheltered conditions of work for a number of reasons. They may not be able to stand the strain of ordinary work in competitive employment. They may require special medical care or expert supervision. They may work too slowly to earn a normal wage. The Disabled Persons (Employment) Act 1944 gave the Minister of Labour authority to make arrangements necessary for providing sheltered employment (either in factories or workshops or in work on their own account) for severely disabled persons and to defray or contribute towards the resultant expenses or losses out of public funds by making grants to voluntary undertakings or local authorities or by arranging for one or more non-profit-making public companies to be formed, under the control of the Ministry of Labour or its agents, for the express purpose of providing sheltered employment for the severely disabled. A company of this type was registered in 1945 as the Disabled Persons Employment Corporation Ltd. (now Remploy Ltd., see p. 17.)

Under the National Assistance and National Health Service Acts, local authorities have the power to arrange, under the guidance of the Minister of Health (and the Secretary of State for Scotland) for the welfare of the severely disabled and they may be directed by the Minister to prepare schemes for particular classes of disabled (see p. 27). Under the Disabled Persons (Employment) Act 1958, however, the Minister of Labour took over the responsibility for the guidance of local authorities in making arrangements for the provision of sheltered employment.

Organisations providing sheltered employment for severely disabled persons may therefore be classified under three heads: (1) Remploy Ltd.; (2) local authorities and voluntary societies acting as their agents; and (3) approved voluntary undertakings. These three types of organisation between them give employment to about 13,500 severely disabled persons. As there were over 6,000 registered disabled persons capable of work only under

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[1]Ordinary tools or machines may also be supplied on loan under this scheme to workers confined to their homes.

sheltered conditions and unemployed in 1964, there must be nearly 20,000 registered disabled persons in all who are not capable of finding and keeping an ordinary job in competition with the able-bodied. In addition there may be other people, at present wholly dependent either on public or charitable funds or the support of friends or relatives, who may be capable of work of economic value under sheltered conditions but for a number of reasons have never taken the first step towards obtaining such employment—registration as a disabled person.

Remploy

Remploy Ltd. has its own board of directors who are appointed by the Minister of Labour, and include prominent businessmen, trade union officials, and people with particular interest and experience in the resettlement of the disabled.

The object of the company is to provide employment under special (sheltered) conditions for registered disabled persons who are so severely disabled as to be unlikely otherwise to obtain employment or to undertake work on their own account, either at any time or for a prolonged period. A Remploy factory is not a rehabilitation workshop through which disabled persons may pass, in a comparatively short period, to ordinary employment, although an average of about 150 workers move from Remploy factories to ordinary employment every year.

At the present time, 88 factories, employing nearly 6,800 severely disabled persons, are in operation. There are also nearly 150 homeworkers. Government loans are made to the company to cover capital expenditure and to meet operational losses, but assistance is kept to the minimum necessary to enable the company to discharge its functions, and it is regarded as being in the best interests of the community, and of the severely disabled workers themselves, that Remploy Ltd. should become as nearly as possible self-supporting.

Efforts are being made to improve the company's production and trading and to eliminate every source of avoidable loss so that further severely disabled persons can be recruited and the existing factories brought up to their full working capacity. The company aims at securing long-term contracts and concentrating mainly on the manufacture of goods or the performance of services for which large and repeated orders are likely to be forthcoming. Its sales organisation keeps in close touch with government contracting departments and the nationalised industries. The company is developing sponsorship schemes under which production is undertaken for other manufacturing concerns, the latter providing any necessary plant and equipment, training and technical advice and buying the finished goods at an agreed price. The advantages to Remploy Ltd. are that a Remploy factory is assured of a continuity of work and sales costs are avoided; the sponsoring firm gets the advantage of additional manufacturing space and additional labour under the skilled management of the Remploy factory staff. Several schemes are already operating and others are being negotiated.

To achieve the satisfactory resettlement of severely disabled persons, it is important to make them feel that they are playing a full and active part in the work of the community and, wherever possible, Remploy Ltd. employs its workers for a full working week of 40 hours.

It is in the general interests of the severely disabled that Remploy factories should be efficient production units and the management expects a good week's work from its workers within the limits set by their disabilities. The pace at which a man works and the facilities which he is given by way of modifications of equipment and easing of working conditions are carefully regulated in relation to his disability. At each factory there is a part-time doctor who advises on conditions of work, and a joint consultative committee, at the meetings of which the employees can raise questions about such matters as production, factory conditions, discipline, welfare, holiday arrangements and canteen facilities. Employees are allowed to join appropriate trade unions and facilities are allowed to union officials.

After consultations with the trade unions concerned, standard rates of pay were introduced for all the severely disabled workers, irrespective of the trade carried on, with provision for periodical increases. These rates are revised from time to time as a result of negotiations.

The company has permission to recruit up to 15 per cent of its total factory productive strength from the able-bodied or less severely disabled, to do work unsuitable for severely disabled persons and to fill key posts essential to the efficient running of the factories. In practice, the actual percentage employed is less than that permitted. The men are, in the main, craftsmen and skilled workers around whom the rest of the factory staff can be built up, and include those qualified to give training to the severely disabled workers.

The number of homeworkers for whom work is provided by the company is small on account of the difficulty in finding a continuous supply of sufficient suitable work to enable each homeworker to earn a reasonable livelihood or make a real contribution towards doing so. The scheme does not cover those capable only of diversionary work.

Local Authorities

Local authorities have been responsible since 1920 for providing sheltered employment for the blind (either directly or, more usually, through the agency of local voluntary organisations, in workshops for the blind and in homeworkers' schemes). They have long-standing powers to provide sheltered employment for the tuberculous and have more recently been given powers to make similar provisions for other seriously disabled people (see p. 16). There are four local authority undertakings providing training and employment for the tuberculous under sheltered conditions. Some local authorities provide employment for disabled sighted persons in workshops for the blind, and a number have established their own special workshops for such people, or have made agency arrangements with voluntary undertakings. Local authorities are now providing sheltered employment or training under these various arrangements for about 950 severely disabled sighted persons.

The Ministry of Labour gives financial help towards the current and capital expenditure incurred by local authorities on these services.

Voluntary Organisations

Voluntary organisations were first in the field of sheltered employment in Britain, some being of very long standing, for example, the Lord Roberts

Memorial Workshops (see p. 2). There are at present about 40 workshops for the sighted severely disabled providing employment and training for about 1,000 people, run by voluntary organisations which are aided by grants from the Ministry of Labour. Nine are covered by the local authority agency arrangements mentioned in the preceding paragraphs. The rest receive financial help direct from the Ministry in the form of a 'deficiency grant' towards trading losses, training fees and grants towards capital expenditure. Some workshops cater for disabilities of all kinds, others only or mainly for a special group, such as the tuberculous, the mentally ill, spastics, or epileptics.

Industrial Rehabilitation

Industrial rehabilitation schemes provide further help towards getting back to work, over and above the medical facilities described in the last chapter, through vocational guidance and the improvement of the physical condition and mental outlook of disabled people. The most important of these are provided by the Ministry of Labour.

Industrial Rehabilitation Units

The Ministry of Labour's industrial rehabilitation scheme was started in 1943 by the opening of the Ministry's first Industrial Rehabilitation Unit (IRU) at Egham, Surrey. The scheme began as the result of a recommendation in the report of the Tomlinson Committee, 1943 (see p. 4), that the Ministry should make provision for people who needed help to become fit for work after hospital treatment. This recommendation was embodied in the Disabled Persons (Employment) Act 1944.

Since 1948, there has been an expansion of the service and there are now 17 units. They are at Aintree (Liverpool), Birmingham, Bristol, Cardiff, Coventry, Denton (Manchester), Egham (Surrey), Felling-on-Tyne, Granton (Edinburgh), Hillington (Glasgow), Hull, Leeds, Leicester, Long Eaton (Nottinghamshire), Perivale (north-west London), Sheffield and Waddon (Croydon). Egham is an entirely residential unit and there is some residential accommodation at Leicester and Granton. The rest are day centres but lodgings are found in the neighbourhood, if required, and lodging allowances are paid.

Plans are also being prepared for the establishment of an experimental combined rehabilitation and assessment centre. This will provide, under one roof, facilities for both medical and industrial rehabilitation and will be administered jointly by the Ministry of Labour and the Regional Hospital Board concerned.

The early years of experiment at Egham proved that the majority of people coming for courses needed not only physical toning-up and help in regaining confidence in their ability to get and keep a job but also a skilled assessment of their aptitudes and abilities, so that they could be guided to the type of work most suited to them. Developments in the work of rehabilitation in recent years have increasingly been concerned with these problems of readjustment and vocational assessment.

For the most part, the units provide for people recently sick or injured who, after medical treatment has been substantially completed, need further help in getting back to work, but they also take people who have been disabled for

some time and are proving difficult to place in suitable employment; people who, although apparently not disabled, are nevertheless finding exceptional difficulty in getting and keeping employment; and those who, although already in employment, are finding it difficult to continue in their normal jobs on account of sickness or age. Recommendations come from hospitals, doctors, employers and medical and welfare organisations. All applications and recommendations are dealt with by disablement resettlement officers at employment exchanges, but the final decision on admission rests with the staff at the IRU. In each case there must be a reasonable prospect that, at the end of the course, the person will be able to get and keep a job. People are accepted for a full course from school-leaving age onwards but a special service is provided in co-operation with youth employment officers for young people, over 15 years of age, who have left school and who present particularly difficult employment problems. A limited number of these young people are accepted into the units for a short but intensive vocational assessment by the industrial psychologist. A development has been the acceptance of a limited number of people before discharge from mental hospitals.

The organisation of each unit is built round a 'case conference', led by a rehabilitation officer and including a vocational officer (an industrial psychologist), a social worker, a doctor, a disablement resettlement officer and a chief occupational supervisor in general charge of the workshops. The occupational supervisors in the individual workshops are skilled craftsmen in their trade who also have special skill and experience in the supervision and assessment of disabled people.

It is considered that the best results are likely to be obtained in a unit catering for 80 to 100 people (men and women). Smaller units are disproportionately expensive while larger ones impose too great a strain on the members of the case conference, or, alternatively, require the duplication of professional staff, with consequential loss of unity in operation.

A feature of the IRU is that rehabilitation is carried out under conditions closely akin to those which people are likely to encounter on re-entering industry. The workshops are equipped and run according to modern workshop practice and maximum use is made of actual production work. This raises morale, accustoms men and women to an industrial atmosphere and facilitates vocational assessment. Besides a series of workshops, each unit has a gymnasium, and many units have gardens. The units do not attempt to train a man for any particular trade although training elsewhere is often recommended.

Courses average 7 or 8 weeks, but can be extended to a maximum of 12 weeks. During the course, tax-free maintenance allowances are paid.

Over 10,000 people a year enter the units for courses. About three-quarters of them are men and women whose need for rehabilitation arises from recent sickness, but some are people with poor employment records whose employment prospects it is thought could be improved by a course of industrial rehabilitation and a small number are candidates for employment by Remploy Ltd. (see p. 17).

About 17 per cent of those who enter a unit fail to complete a course. Of those who do, the proportion placed in employment or accepted for training averages two-thirds to three-quarters according to the current employment prospects.

Industrial Rehabilitation of Newly Blind

Rehabilitation of the newly blind (see p. 44) calls for special techniques. Such people may go to residential centres, where those who are likely to become fit to take up employment can also be given a course of industrial rehabilitation.

Industrial Rehabilitation of the Mentally Disabled

Two pilot schemes have been set up for the industrial rehabilitation of long-term patients of mental hospitals (see pp. 40-41).

Industrial Rehabilitation by Industrial Firms

Several large industrial firms, including two leading car manufacturers, run rehabilitation workshops for their employees. Such rehabilitation workshops deal almost entirely with employees temporarily disabled—usually by accidents—who have had some medical treatment and are on the road to recovery. The aim of the workshops is to speed up the return to normal work and to sustain morale. Their method is to provide, on standard or specially adapted tools or machines, productive work graded to give each injured man the right amount and kind of exercise for his particular injury and stage of recovery. The planning of the rehabilitation programme and the design of the modifications to tools and machines require close co-operation between surgeons and engineers—in practice between the supervisory and technical staff of the undertaking, the company medical officer and the consultant surgeons at the local hospital. Much useful work is being done in other firms to meet the needs of workers who have been absent through injury or sickness.

Re-establishment Centres

Four other establishments whose work borders on that of industrial rehabilitation units are the National Assistance Board's residential re-establishment centres at Henley-in-Arden, Warwickshire, and West Hill, Plawsworth, near Chester-le-Street, Co. Durham, and their non-residential re-establishment centres in Whitechapel, London, and Openshaw, Manchester. These centres cater mainly for men who have become demoralised through long unemployment. The aim of the centres is to build up the men's strength and vigour, to accustom them to regular work and to stimulate pride in themselves and a greater interest in life in general.

Vocational Training

Arrangements for the vocational training of disabled persons over school-leaving age who need training to fit them to undertake employment suited to their age, qualifications and experience are also the responsibility of the Minister of Labour under the Disabled Persons (Employment) Acts. The Ministry has for a considerable time provided or arranged training for certain able-bodied adults and the Minister's powers in this connection were consolidated and extended by the Employment and Training Act 1948.

It is the Ministry's policy not to segregate disabled trainees but to provide in general the same facilities and broadly the same training arrangements for the disabled and able-bodied. Disabled trainees do, however, have special needs. In the first place, their varied limitations restrict their field of possible employment and make it necessary to provide a wider range of training

courses, whereas training for the able-bodied is mainly provided in trades of importance to the national economy which are short of skilled manpower. Secondly, disabled persons may not be able to learn so quickly or so easily and may require special supervision, and perhaps a longer course or other adjustments of the curriculum. Finally, some disabled persons cannot travel far and must live at or near their place of training.

To be eligible under the scheme the applicant must:

(a) be disabled as defined in the Disabled Persons (Employment) Acts (see p. 14), but not necessarily registered as disabled;

(b) need training to render him competent to undertake suitable work;

(c) have a good chance of getting and holding a job under normal working conditions after he has been trained.

The Ministry's training arrangements cover a wide variety of trades. Courses are mainly in skilled crafts, though training for semi-skilled work may exceptionally be provided or arranged for disabled persons.

The Training Department at the Ministry's headquarters has agreed the general principles of the various training schemes with representatives of employers and workers and in planning the courses for particular trades or groups of trades—that is, in determining the numbers to be trained and the type of establishment at which training is to be given and in drawing up the syllabuses—it consults employers' and workers' representatives in the industries and occupations concerned who, for their part, agree that trainees shall be accepted for work which makes full use of the knowledge acquired in training.

Training for the disabled, as for the able-bodied, is given mainly at 28[1] government training centres (see p. 23) but is also arranged at technical and commercial colleges and employers' establishments. In addition, a number of places have been reserved at residential centres conducted by voluntary organisations for the purpose of training the more severely disabled, including those who do not live near a government training centre or, if they do, are unable to undertake daily travelling or to live in lodgings.

The Ministry's regional offices carry out the final selection of applicants for training, consulting the representatives of the industry and occupations where necessary. This usually means in practice that the admission of an applicant to a training course is finally determined by an interview with a panel representing the Ministry and employers and workers in the trade. The regional offices are also responsible for the day-to-day running of the government training centres and for the inspection of training carried out in employers' establishments.

The Ministry's local offices are responsible for advising potential trainees on the selection of a suitable trade and for helping them to apply for training. This help is given to the disabled by disablement resettlement officers. The placing of trainees in employment at the end of the course is carried out either by a placing officer at the government training centre or by the local office in whose area the trainee wishes to obtain employment.

The provision of training facilities for agriculture is the responsibility not of the Ministry of Labour but of the Ministry of Agriculture, Fisheries and

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[1]Shortly to be increased to 38.

Food (or the Department of Agriculture and Fisheries for Scotland). Suitable people for training are, however, recruited through the employment service. There are special arrangements for training disabled ex-merchant seamen in agriculture at the Springbok Agricultural Establishment in Surrey, which is run by the Merchant Seamen's War Memorial Society with the aid of a grant from the Ministry of Agriculture, Fisheries and Food.

No charge is made for training, and maintenance allowances are paid to trainees.

Government Training Centres

The 28 government training centres are non-residential, although hostels are attached to two of the centres where accommodation can be provided if necessary. Trainees who are required to leave home for training at other centres are accommodated in private lodgings. Many of the centres adjoin an industrial rehabilitation unit. This arrangement has certain obvious practical advantages besides providing a psychological stimulus to people taking industrial rehabilitation courses. For example, they can graduate from a rehabilitation to a training course without having to travel or change their lodgings; and certain facilities, for example, the canteen and a qualified nurse, can be shared between the two institutions.

Though a few short courses are provided in semi-skilled work, for example in light engineering for blind people, courses are mainly for skilled work and are upwards of six months in length. Training is intensive and organised on the basis of a standard five-day week of 42 hours. It is designed to equip trainees with a degree of basic skill which, when consolidated by a further period in industry, enables them to undertake a wide range of work at the skilled level.

Each centre is equipped with modern machine and hand tools and is in the charge of a manager with experience of industrial management and methods. Instruction is both theoretical and practical and is given by qualified instructors, who are craftsmen recruited from industry and trained in instruction methods in the Ministry of Labour's Instructor Training College at Letchworth. The practical instruction is carried out, as far as possible, in conditions similar to those in industry; progressive exercises serve as tests during the course. Special supervision is given to the disabled by instructors and the centre medical officer, and the curriculum may be adjusted to meet their special needs.

Tools are supplied to trainees in any trade where it is usual for an employee to possess his own tools, and remain their property when they take up their trade after training.

Technical and Commercial Colleges

Training in commercial subjects and shorthand and typing is not provided in government training centres but instead arrangements are made for training at technical or commercial colleges. Where possible, classes are organised exclusively for Ministry trainees and a standard class fee is fixed and paid by the Ministry. If this is impracticable, for example, because there are too few trainees, the Ministry pays the normal individual fee charged by the college.

Training with Employers

Courses at government training centres may be followed by training with an employer, which continues for periods varying between 13 and 78 weeks according to the particular occupation. During this period the employer usually pays an agreed percentage of the basic wage on an ascending scale and receives from the Ministry a fee on a descending scale.

In some instances it has been found most suitable for training to be given throughout by employers. It is then usual for the trainee to be paid the normal training allowances (see p. 31), to which the employer is required to make a contribution on an ascending scale. Sometimes the arrangement is that the employer pays the trainee wages and receives a fee from the Ministry. Training throughout with an employer is normally confined to skilled trades but exceptionally arrangements may be made to assist employers to train severely disabled persons for semi-skilled work.

Centres Run by Voluntary Bodies

A number of places are at the disposal of the Ministry of Labour at six residential establishments run by voluntary organisations. These establishments are able to deal with the more difficult cases and aim at fitting them for jobs in open industry. Four of these centres—Queen Elizabeth's Training College (Leatherhead), St. Loyes' College (Exeter), Finchale Abbey (Durham), and Portland College (Notts)—accept trainees with a wide range of disabilities, and the first two, which are the oldest, have a reputation for dealing successfully with people disabled from birth or early childhood.

Queen Elizabeth's, Portland and St. Loyes' Colleges accept men, women and young people, whilst Finchale Abbey accepts only adult males. On the average, courses last about ten months. Between them, these four centres provide nearly 600 places.

Queen Elizabeth's College is making arrangements to provide special hostels for those of its trainees who would otherwise be debarred from working by their inability to live in ordinary lodgings or travel far to work, and is developing workshops to provide sheltered employment for those trainees whom it cannot place in open industry (see p. 18).

The Royal National Institute for the Blind runs a school of physiotherapy in London and a college for blind shorthand-typists and telegraphists, also in London.

Results Achieved

Vocational training for the disabled has been provided by the Ministry of Labour since 1919. The present more highly developed arrangements came into force in 1941 under an interim scheme which preceded that set up under the Disabled Persons (Employment) Act 1944. A total of 2,988 disabled men and women completed a vocational training course in 1964 and 2,980 were placed (some of whom had been unplaced at the end of the previous year).

Professional Training

Disabled persons (including the blind) of suitable ability may be helped to undertake courses of training or study, including university degree courses, for professional callings. The basic conditions for obtaining such help are

that the disabled person should have the necessary educational background and that training for a professional qualification is necessary for, and likely to lead to, his satisfactory resettlement. Apart from the specialised training for physiotherapy which is available for blind people at the Royal National Institute for the Blind School of Physiotherapy, disabled persons have to follow the normal professional training arrangements in the same way as non-disabled persons.

In the five years ended December 1964 grants were made to 125 disabled men and women under the Disabled Persons Acts for professional training—covering educational costs and providing a maintenance allowance for full-time students.

Further Education of Disabled People aged over 16

The Ministry of Labour has power to provide vocational training only and it is clear that a substantial number of disabled young people require more than this. They frequently require additional general education, a well-ordered life under careful medical supervision, and good opportunities for recreation and social activities. Generally these can best be provided in residential institutions. The responsibility for disabled people aged over 16 who need further education as well as practical training to fit them for eventual employment, and whose needs can be adequately met only by a prolonged course at a residential institution, rests with local education authorities and the Department of Education and Science in England and Wales and the Scottish Education Department in Scotland.

AFTER-CARE, WELFARE AND SOCIAL RESETTLEMENT

WHEN everything possible has been done to rehabilitate the disabled medically and to help them to resume their old job or take up some suitable work, residual disablement may make it difficult for them to lead an ordinary home life, they or their families may need personal help in adjusting to the disability, and some may be unable to follow any occupation. Some may need continuing care which cannot be provided in their own homes. Statutory and voluntary services are both engaged in trying to help the handicapped people they serve to live as full and normal a life as possible within the limits of their disabilities.

Aids in Daily Living

It is now realised that one of the first essentials is that the disabled person should be as independent as possible in such everyday activities as dressing, feeding, washing and so on. This was not always recognised, if only because the natural instinct of fit people is to come to the aid of disabled people without realising that dependence on the goodwill of others causes frustration, and that it is kinder to help them to help themselves. Pioneer work in this field has been done by voluntary organisations such as the British Red Cross Society and the Central Council for the Disabled, who have shown ways of modifying clothing and made appliances to facilitate feeding, dressing and hygiene. Hospitals have taken up the subject; physiotherapists are adapting remedial exercises to teach patients movements such as those used in dressing and occupational therapy departments are making appliances and demonstrating their use. (For the special attention being given to the home needs of disabled housewives see p. 9.) Local authority welfare departments can help with adaptations to premises (for example, to provide ramps for wheelchairs, widened doorways, ground-floor bathrooms, special switches, taps and door handles) and the provision of daily living aids (such as gadgets to help with dressing, eating or cooking). A large variety of aids for the handicapped are made by the Ministry of Labour in its training establishments and are supplied to hospitals and local authorities.

Welfare Services to People in their own Homes

Services to help the handicapped to be cared for in their own homes are provided by local authorities as part of the National Health Service and also under the National Assistance Act. Home nursing is provided free of charge and domestic help at a charge according to means, or free if necessary. Tuberculous patients are visited by the tuberculosis nurse or health visitor and, when there are social problems, by the medical social worker or chest clinic social worker (see p. 50). The National Health Service Act extended the duties of the health visitors (nurses with special additional training), who were formerly concerned only with mothers and infants, to include the visiting and advising of households containing invalids. Other care and after-care services may be provided by local health authorities, including the loan or provision of nursing requisites. Appliances, including wheeled chairs and powered vehicles, are supplied through the hospital service. Motor cars are provided for the use of some severely disabled war pensioners.

Local authorities have been required since the passing of the Blind Persons Act 1920 to keep a register of blind people and to provide welfare services for them, either directly or through the agency of voluntary organisations.

This remains a duty under the National Assistance Act 1948 which also empowered local authorities to extend to the deaf, the dumb and the severely physically handicapped, welfare services of a similar kind to those provided for the blind. (There is also a register for the partially sighted, and welfare services for them are closely linked to those for the blind.)

In 1951, the Minister of Health and the Secretary of State for Scotland, issued guidance to local authorities on the planning of their schemes for the welfare of the deaf or dumb and the severely physically handicapped, and in 1960 the Minister of Health issued a direction that the council of every county and county borough in England and Wales should be under a duty to exercise their powers under the National Assistance Act 1948 in respect of the deaf or dumb or those substantially and permanently handicapped by illness, injury or congenital deformity. A similar direction was issued in 1962 by the Secretary of State for Scotland. All local authorities in Great Britain have approved schemes for both the general classes of handicapped and the deaf and dumb (see p. 48). The services generally provided include the teaching of handicrafts, the provision of personal aids to living, the establishment of social centres, clubs and other social activities, the adaptation of premises to meet individual disabilities, and the provision of holidays for those too handicapped to make use of normal facilities. Separate clubs for people with different types of handicap often use the same premises at different times, and transport between members' homes and the meeting place may be arranged where necessary. Handicapped people are invited to register with their local authorities so that these special services can be made available to them. The number of people registered as deaf, including hard of hearing, or severely physically handicapped, in England and Wales is about 163,000. The staffing of the services is being progressively built up, and in some areas co-ordinating committees, consisting of representatives of the council and of the voluntary organisations concerned, have been established.

The special welfare service for the war disabled developed by the former Ministry of Pensions continues under the Ministry of Pensions and National Insurance, which has local offices throughout the United Kingdom. (Agency arrangements operate for the welfare of war pensioners living outside the United Kingdom.) Members of local war pensions committees and other voluntary workers, including members of the British Legion and other ex-service organisations, share with the Ministry's welfare officers the work of visiting the 15,700 severely disabled war pensioners and 8,300 elderly war widows who are on their visiting list (see p. 36). These severely disabled pensioners are encouraged to engage in a homecraft, such as basketry, artificial jewellery making, leather-work or embroidery. The Ministry's team of handicrafts instructors visits them in their homes and sales of work are arranged.

The Central Council for the Disabled, founded in 1919, is a voluntary society which co-ordinates the work of other voluntary organisations concerned in order to promote on the national level the welfare of the physically handicapped. It encourages the formation of local associations to do the same locally and also to assist individual handicapped persons. In some areas, including London, there are special aid societies for invalid and crippled children.

National associations to forward the interests of sufferers from a particular handicap include the Royal National Institute for the Blind, the Royal National Institute for the Deaf, the Spastics Society, the Scottish Council for the Care of Spastics, and the British Epilepsy Association. Some of these bodies are in the nature of mutual aid societies run largely by members who themselves suffer the disability concerned—for example the British Diabetic Association (1934), the British Polio Fellowship (1939), the British Rheumatism and Arthritis Association (1947) and the Multiple Sclerosis Society (1953).

The British Red Cross Society, the Order of St. John (in Scotland, St. Andrew's Ambulance Association), the Women's Voluntary Service and the Family Welfare Association are chief amongst the many other voluntary organisations which in various ways help the handicapped as well as others in need of welfare services.

Several hundred meals services and several thousand clubs besides other welfare services for old people are being operated by voluntary organisations in Britain, many with assistance from local authorities (see p. 36).

Residential Care

Residential care for the chronic sick and the permanently disabled is provided in hospitals and homes under the National Health Service; in residential hospitals and homes under voluntary management, often that of a religious order; and in residential accommodation provided by the local welfare authorities under the National Assistance Act for the less severely handicapped who are in need of care and attention they cannot get elsewhere. Welfare authorities may take responsibility for the cost of maintaining infirm people in voluntary homes.

About 45,000[1] physically or mentally handicapped or infirm people, both young and old, are cared for in accommodation provided by or on behalf of local welfare authorities in England and Wales. Most of them are in local authority homes or premises vested in the Minister of Health as hospitals, but about 15 per cent are cared for in voluntary homes on behalf of local authorities. Another 15,000 disabled people in England and Wales are in voluntary and private homes for the disabled and old registered with the local authorities.

The trend in the provision of homes is away from large institutions and towards accommodation on a smaller and more homely scale. There is also a trend towards single and double rooms, particularly the former. Some authorities have been able to make specialised provision for particular groups. Two homes with a specially designed wing for the blind have been opened in Bury St. Edmunds and Great Yarmouth, where the blind residents can enjoy in their own living quarters the special facilities they require but mix with sighted residents in the common dining-room and exchange visits to their rooms. There is still a shortage of suitable homes for younger severely handicapped people who cannot live in their own homes, but many local authorities are building and planning homes designed specifically for them. Six such homes have recently been opened and a further 34 are planned for the next decade.

[1]Exclusive of aged and other persons who are the responsibility of local authorities and may be handicapped but are not materially so.

FINANCIAL PROVISION

Statutory Sources of Financial Help

Five State schemes provide cash allowances or pensions for the maintenance of the disabled and their dependants.

All employed persons, including the self-employed, are required to contribute to the national insurance scheme, from which they are entitled to various benefits, including sickness benefit which is paid for periods of incapacity due to sickness or injury. Employed contributors, excluding self-employed, injured at work are covered by the national insurance industrial injuries scheme, which provides special benefits at a higher rate for injured workers (or those suffering from certain specified industrial diseases). Employed persons and employers pay a small compulsory weekly industrial injuries contribution but there are no contribution tests for benefit. For those disabled as a result of war, a pension is payable under the war pensions provisions. These three schemes are administered by the Ministry of Pensions and National Insurance.

Any person aged 16 or over whose resources, including any national insurance or industrial injury benefits, are insufficient for his needs and those of any dependants can apply for national assistance. The national assistance scheme is administered by the National Assistance Board (which is represented in Parliament by the Minister of Pensions and National Insurance).[1] The Ministry of Labour pays maintenance allowances to disabled men and women training under the official schemes, with additions for dependants.

National Insurance Sickness Benefit

National insurance sickness benefit is paid, broadly, without limitation of period if 156 weekly contributions of the appropriate class have been paid. The standard rate of benefit for contributors is £4 a week for men, single women and widows, and £2 15s. for married women, with additional allowances for dependants. Boys and girls under 18 get lower rates, unless they are maintaining dependants.

Industrial Injuries Benefits

Under the industrial injuries scheme the basic weekly rate both for injury benefit and for 100 per cent disablement pension is £6 15s. Lower rates are payable for boys and girls under 18 who are without dependants. Weekly rates of pension for partial disablement are proportionately lower. For minor degrees of disablement lump-sum gratuities are paid instead of pensions. Injury benefit is payable during incapacity for work for a period of not more than 26 weeks from the date of the accident or the date of development of the prescribed disease. Disablement benefit becomes payable from the end of the twenty-sixth week, or, if incapacity does not last so long, from the date incapacity ceases, if there is then any remaining disablement due to the accident or disease. For the prescribed diseases pneumoconiosis and byssinosis, however, no injury benefit is payable, but a weekly industrial disablement pension becomes payable immediately benefit is awarded.

If a disablement beneficiary has to go into hospital for approved treatment for his injury or disease, his pension (or his gratuity), if not already at

[1]For further information on these benefits, pensions and grants see COI reference pamphlet RF.P. 5455/64, *Social Security in Britain.*

the 100 per cent rate, may be increased to that rate while the treatment lasts. When a disablement pensioner is permanently rendered virtually incapable of work as a result of accident or prescribed disease he may receive an unemployability supplement to his pension.

Dependants' allowances are payable with injury benefit as for sickness benefit and also when a disablement pensioner is in receipt of an unemployability supplement or is undergoing approved treatment in hospital.

Where, as a result of his accident, a person who has been awarded disablement benefit is unable to follow his regular occupation and is also unable to take up suitable alternative work of an equivalent standard, he may be granted a special hardship allowance. A pensioner with a 100 per cent assessment who requires constant attendance as a result of his accident may be granted a constant attendance allowance.

A person receiving disablement pension can qualify for sickness or unemployment benefit in addition to his pension, but these benefits cannot be paid if he is receiving a supplement for unemployability.

The National Insurance (Industrial Injuries) Act allows representatives of workers and of employers in any industry to submit supplementary schemes to the Minister. Coalmining, as one of the most hazardous occupations in Britain, is so far the only industry to avail itself of this facility. A special fund raised by compulsory regular contributions from the National Coal Board as employer and from employees (and administered by their representatives) provides substantial supplementary benefits for coalminers suffering from industrial injuries or prescribed diseases. Adult workers can receive up to £2 1s. a week as a supplement to injury or disablement benefit. Lower rates, corresponding to the lower rates of benefit under the Industrial Injuries Acts, can be paid to people under 18 who are without dependants. Payment of the supplement after the first three continuous weeks of benefit is subject to an income rule.

War Pensions

The basic war pension for 100 per cent disablement is £6 15s. a week but the amount varies according to the rank held and the degree of disablement. Additions for wives and children, supplementary allowances for unemployability, constant attendance, additional comforts, lowered standard of occupation, and age are also payable. The degree of disablement for pension purposes is assessed by comparing the disabled person with a normal healthy person of the same age and sex, without taking earning capacity into account.

National Assistance

Grants under the national assistance scheme are assessed according to the needs and resources of the individual applicant, wife or husband, and dependants. They may be made to supplement national insurance benefits where necessary. Special higher rates apply in the case of the blind and of persons who have suffered a loss of income in order to undergo treatment for respiratory tuberculosis.

Normally, people who are in full-time employment may not receive assistance except in case of urgency, but this exclusion does not apply to disabled people, not employed under contract of service, whose earning

power is substantially reduced by their disability. The question whether a person is in need and the extent of his need is settled by reference to standards laid down in parliamentary regulations (the National Assistance Determination of Need Regulations) which are revised from time to time.[1]

Allowances for Disabled Persons Undergoing Rehabilitation and Training

Disabled persons admitted to the Ministry of Labour schemes of industrial rehabilitation or to training for open employment or employment in approved sheltered workshops, receive allowances which vary according to their age, sex and number of dependants. The allowances are, in most cases, higher than sickness or unemployment benefit but lower than the wages a person may expect to receive when he takes up work after rehabilitation or training.

Voluntary Sources of Financial Help

In addition to their statutory National Insurance benefits, many workers are entitled to supplementary sickness and accident benefits in return for voluntary weekly payments to a trade union or friendly society. Although membership of these friendly societies fell in the years immediately after the introduction in 1948 of the enlarged scheme of National Insurance, they still have some 5·8 million members.

The voluntary sources of financial aid in sickness or disablement include, besides these mutual aid funds, a large variety of charitable sources. A disabled man or woman might receive, for instance, a grant or allowance from his or her employer or fellow workers, from a benevolent fund connected with his or her trade or profession, from church funds, from an endowed charity connected with the locality, or from one or more of the funds for the relief of distress amongst ex-service men and women.

[1]The National Assistance Board has an important discretionary power to provide for special expenses in individual cases.

HANDICAPPED CHILDREN

Child Welfare Services

As part of the local authorities' welfare services, child welfare centres provide advice to mothers and supervision of their children up to the age of five. Special care is taken in the care and treatment of children in whom congenital deformities were noted at birth, and for all children brought to the clinics routine tests are given for handicaps including deafness, congenital dislocation of the hip and phenylketonuria (one of the less common but very severe forms of mental deficiency).

Special Education

Not all handicapped children need to go to special schools; many of those less severely handicapped can get the special educational treatment they require in the ordinary schools. Certain defects, particularly blindness and deafness, can only be adequately dealt with in a special school owing to the nature of the educational methods required (see pp. 43 and 48). Boarding special schools have to be provided for all children who cannot get appropriate educational treatment in either ordinary schools or day special schools, and home tuition for those children unable to attend any kind of school.

The Education Act 1944 gave fresh impetus to the work which had been done in the past for handicapped children. The general duty laid upon every local education authority to provide sufficient variety of primary and secondary education to suit the different ages, abilities and aptitudes of the children in their area was reinforced by a specific charge to have regard to the needs of pupils suffering from a disability of mind or body, and to provide special educational treatment for them; and by a further duty to find out what children in the area require such treatment. (In carrying out the latter duty the authorities take account of the advice of their medical officers.) Parents may be required to have their children examined for this purpose at any time after the children are two years of age in England and Wales and five in Scotland. Similarly, a parent may ask a local education authority to examine his child once he is over two years old. The Education Act provides that children in need of special educational treatment may be required to attend special schools; pupils at these schools remain of compulsory school age until they are 16 years old (instead of 15 as in other schools). There are ten categories of handicapped pupils for whom local education authorities must provide special educational treatment: blind, partially sighted, deaf, partially hearing, educationally subnormal, epileptic, maladjusted, physically handicapped, suffering from speech defects, and delicate.[1] (See also pp. 57 and 58. Arrangements for the training of mentally subnormal children are described on p. 38.)

Voluntary Organisations

Much of the pioneering work in the provision of special schools and hospitals for handicapped children has been done by voluntary bodies,

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[1]For further information on special education for handicapped children see COI reference pamphlets RF.P. 4751/64, *Education in Britain*, or RF.P. 5236/64, *Children in Britain*. The Advisory Council on Education in Scotland has produced a comprehensive series of reports dealing with the primary and secondary education in Scotland of pupils who suffer from disability of mind or body, or from maladjustment due to social handicaps (see Appendix 3, p. 68).

although the majority are now maintained by the State. Voluntary organisations still do much work for the welfare of handicapped children.

The Shaftesbury Society, for example, besides maintaining schools for handicapped children from any part of Britain, undertakes welfare work in the London area such as arranging holidays and visits or assisting handicapped people of all ages.

Another society working mainly in the London area, the Invalid Children's Aid Association (ICAA), has in the past 70 years helped to restore to health nearly half a million invalid and physically handicapped children. Since 1948, the work of the association has changed. The National Health Service and other extensions of statutory responsibilities for children's health and care, together with improvements in child health and in social and economic conditions, have removed the need for convalescence and other services for sick children which the ICAA formerly provided on a large scale. The association now concentrates on running a small number of holiday homes and boarding schools for certain types of delicate or handicapped children, and on the associated social casework with these children's families. As in other branches of social casework, the association's skilled workers, relieved of much routine work to meet material needs, now devote more attention to the emotional problems which underlie illness.

Outside the London area a number of invalid and cripple children's aid societies are doing similar work, while in some places local associations for the aid of cripples work for both adults and children.

THE ELDERLY

OLD AGE is not a type of disability, and many people of even very advanced years are in no need of help from doctors or social workers. Nevertheless, the elderly as a group present certain special problems, medical, occupational and social, which have recently received much attention because of the increasing proportion of older persons in the population.

The problem of the employment of the older worker is not in general connected with the subject of this paper. Although older people are often less suited than their juniors to jobs requiring speed and agility, they have compensating qualities and their difficulties in finding and holding employment are mainly due, not to any shortcoming in themselves, but to prejudice on the part of the employers and adverse institutional factors (for example, inflexible pension schemes).

Financial Assistance

Financial provision for the aged in Britain is made through retirement pensions under the National Insurance Acts (though a certain number of old age pensions awarded under previous legislation continue in payment), and through National Assistance grants and allowances.[1]

Hospital Treatment

Great importance is attached to the treatment and rehabilitation of the elderly, including the chronic sick. Hospital authorities have been asked to give high priority to the establishment of geriatric departments, and there are now over 130 in England and Wales.

It has been found possible to improve very considerably both the degree and rate of recovery of older patients admitted to hospital. Improved diagnosis and treatment, better equipment and brighter wards have been found substantially to speed up recovery and discharge and ultimately to lighten the burden of medical and nursing care. Patients are encouraged to get up and move about. Long-stay annexes for those no longer requiring active treatment, but in continuing need of nursing care under medical supervision, can free beds in hospital wards for new patients, who can be admitted at an earlier stage and therefore be made fit for discharge after a shorter stay. In hospitals where the long-stay elderly patients have received active treatment, it has been found possible to reduce the number of beds required for this type of patient.

Success depends on the collective efforts of a team headed by a medical officer who has made a special study of the abilities and disabilities of old age, and including, besides nurses, a physiotherapist, an occupational therapist, and also a medical or other social worker who, in turn, will enlist the aid of appropriate local authority services and of outside agencies to keep the patient in touch with the outside world and help to re-establish him in it when fit for discharge from the hospital wards. There may also be a chiropodist, a remedial gymnast, a speech therapist, or a psychiatric social worker. The doctors concerned in this work have formed the British Geriatric Society; its aim is to collate information on the treatment of the elderly and so help to raise standards.

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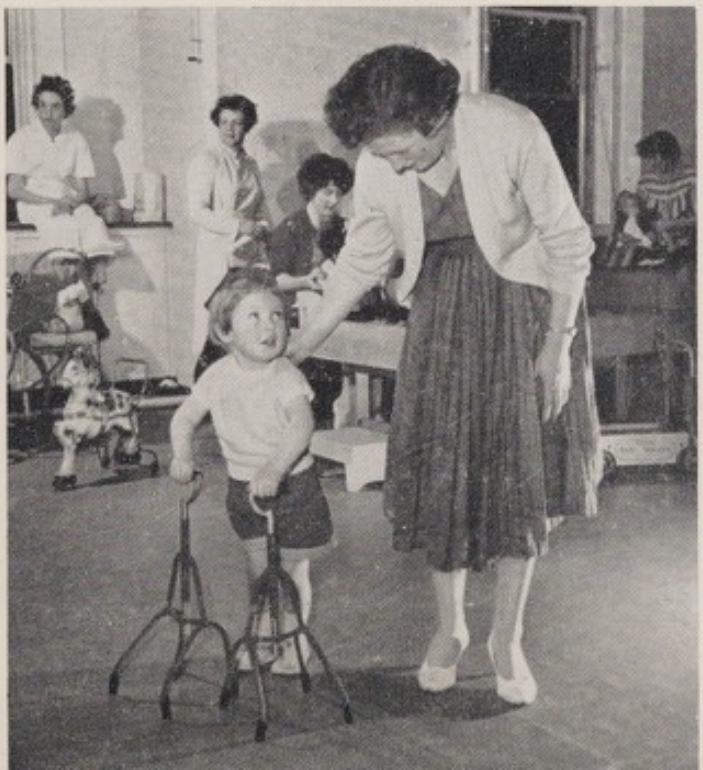
[1]For fuller information see COI reference pamphlet RF.P. 5455/64, *Social Security in Britain.*



Top left and right:
At Roehampton Limb Fitting Centre this little boy, born without hands, learns to feed himself and to play happily.

Left: At Great Ormond Street Hospital for Sick Children a handicapped little girl learns to walk with the help of her mother, who is then able to continue the treatment at home.

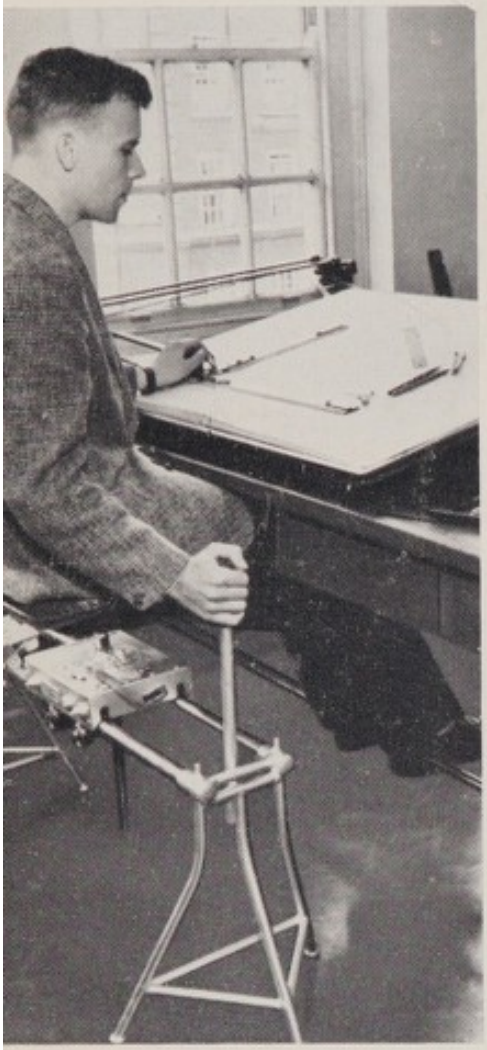
work in special schools

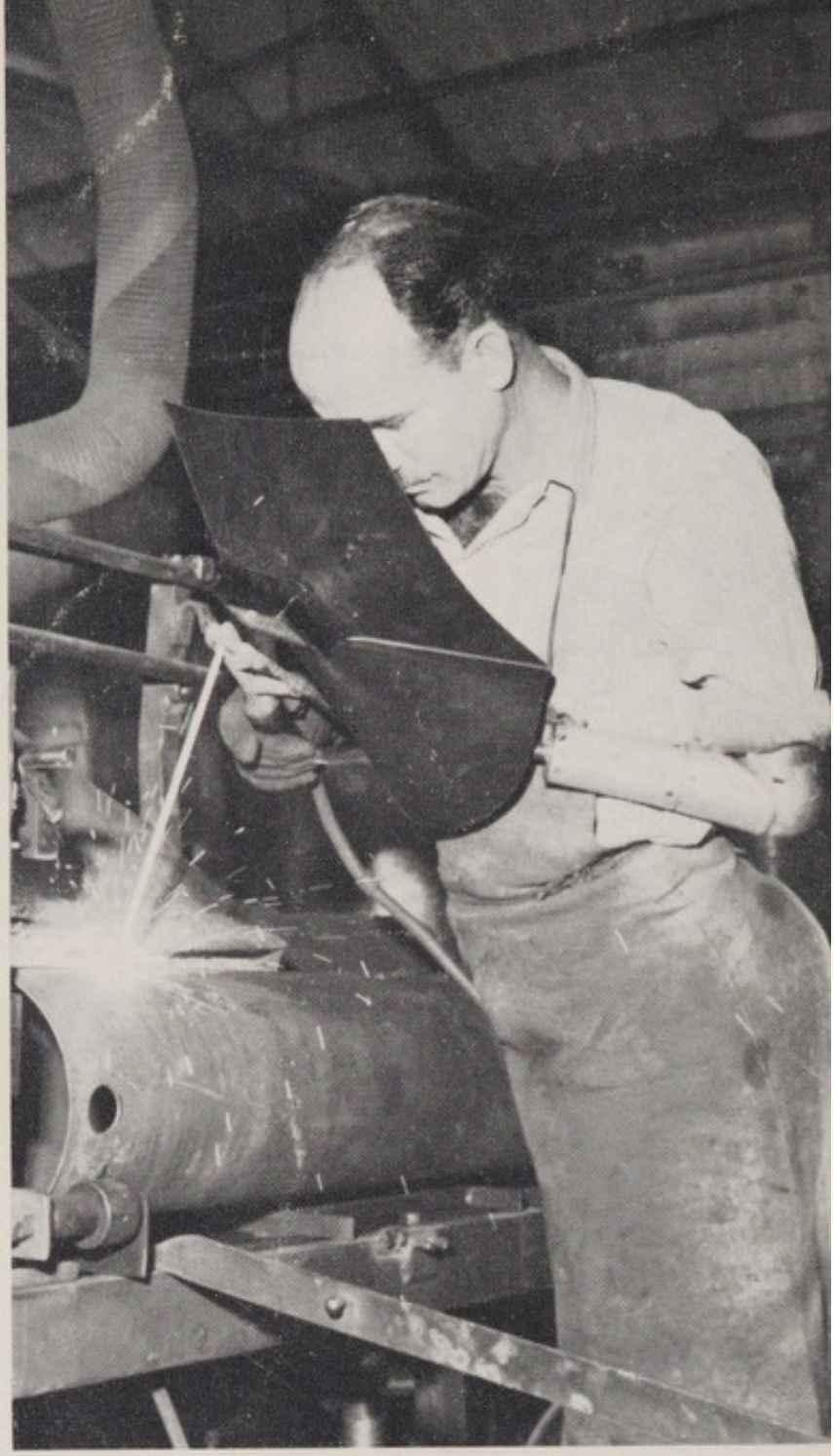
Top : Deaf children being taught arithmetic.

Right : Mentally subnormal boys have practice with money.

Left : Physically handicapped children at play.

Below : Totally blind and partially sighted pupils take part in chemistry experiments where they can use their senses of sound and smell.





Top left: This chair for disabled draughtsmen can be easily moved and locked in position.

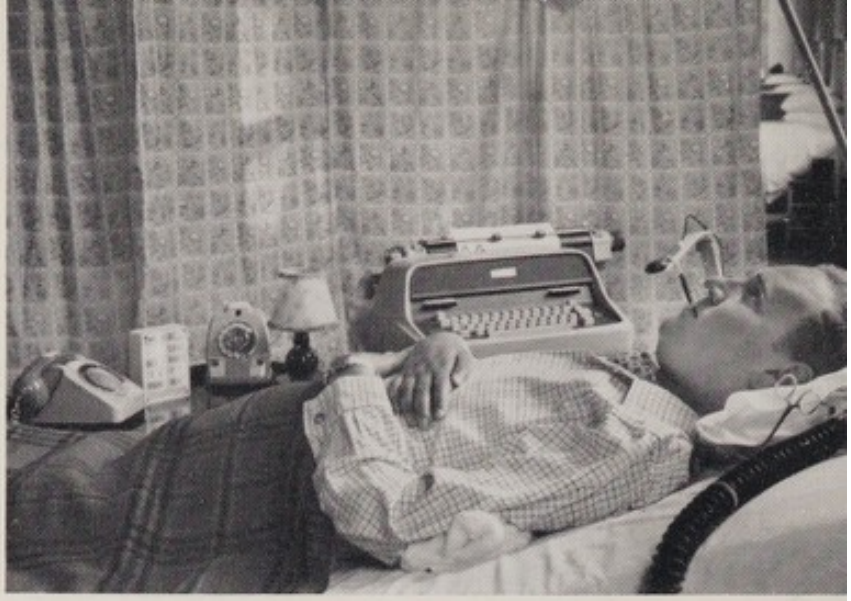
Top right: A welder, who has lost his arm, is able to continue to use his skill with the aid of an artificial arm and adapted equipment.

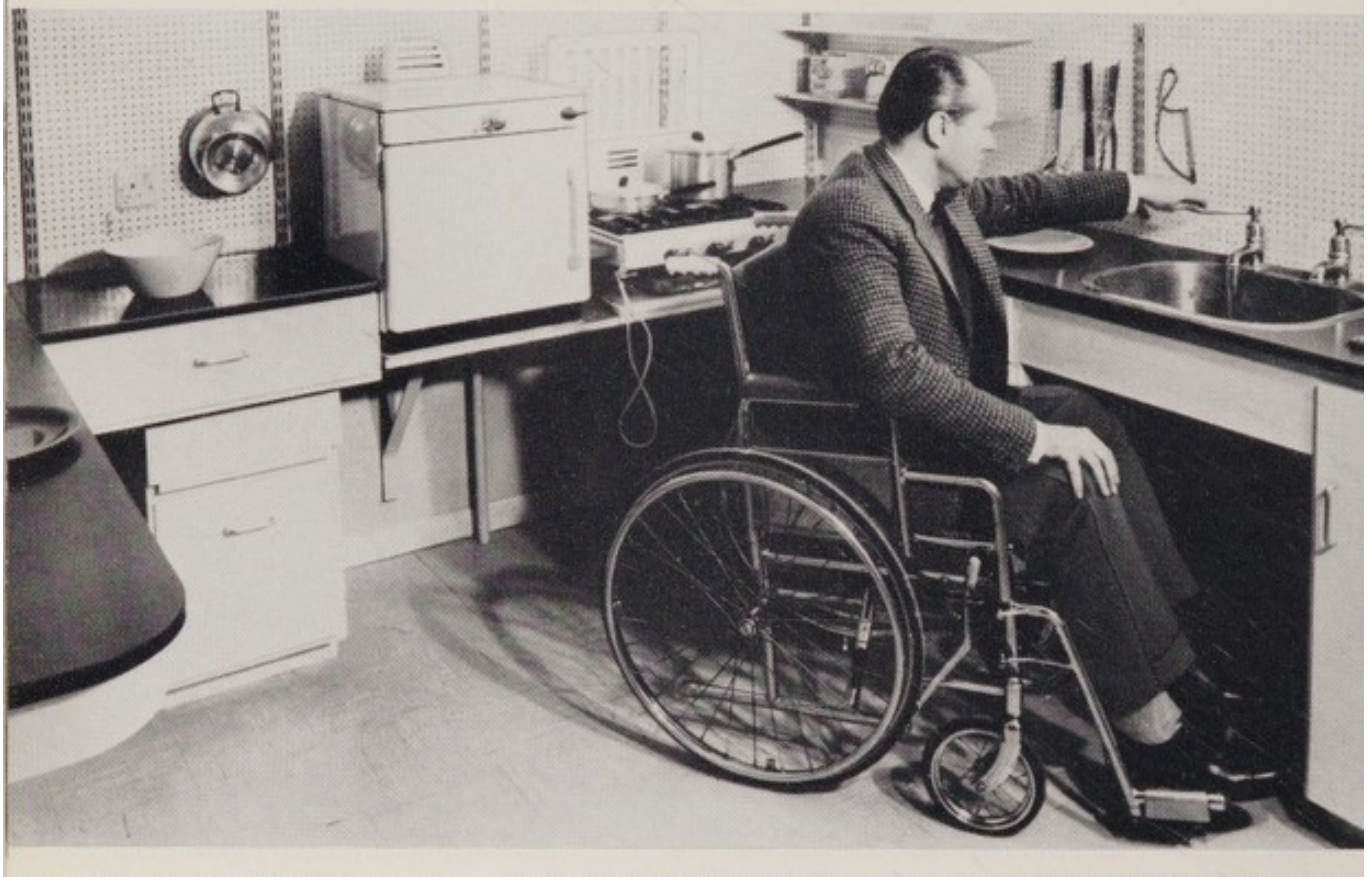
Right: A Welsh rehabilitation hospital has a gymnasium in which injured miners recover their strength through physiotherapy.

help for the elderly disabled in the home

Top: In cooking, a mixing bowl anchored to the table by a suction pad can be used with one hand.

Right: A home-help and a district nurse visit regularly.

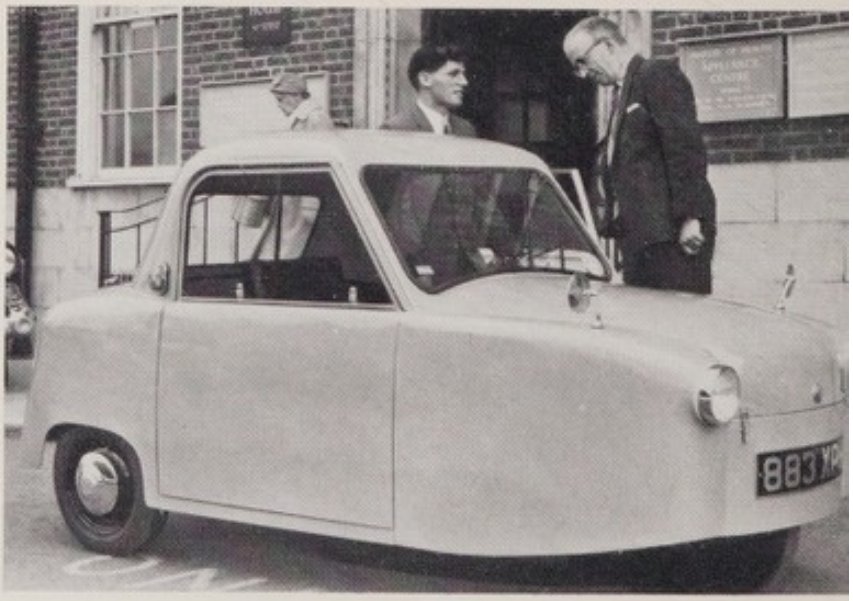




Top : A business-man completely paralysed by poliomyelitis can operate a telephone, typewriter and other pieces of equipment by means of advanced electronic apparatus. He selects them individually by blowing or sucking through a mouthpiece.

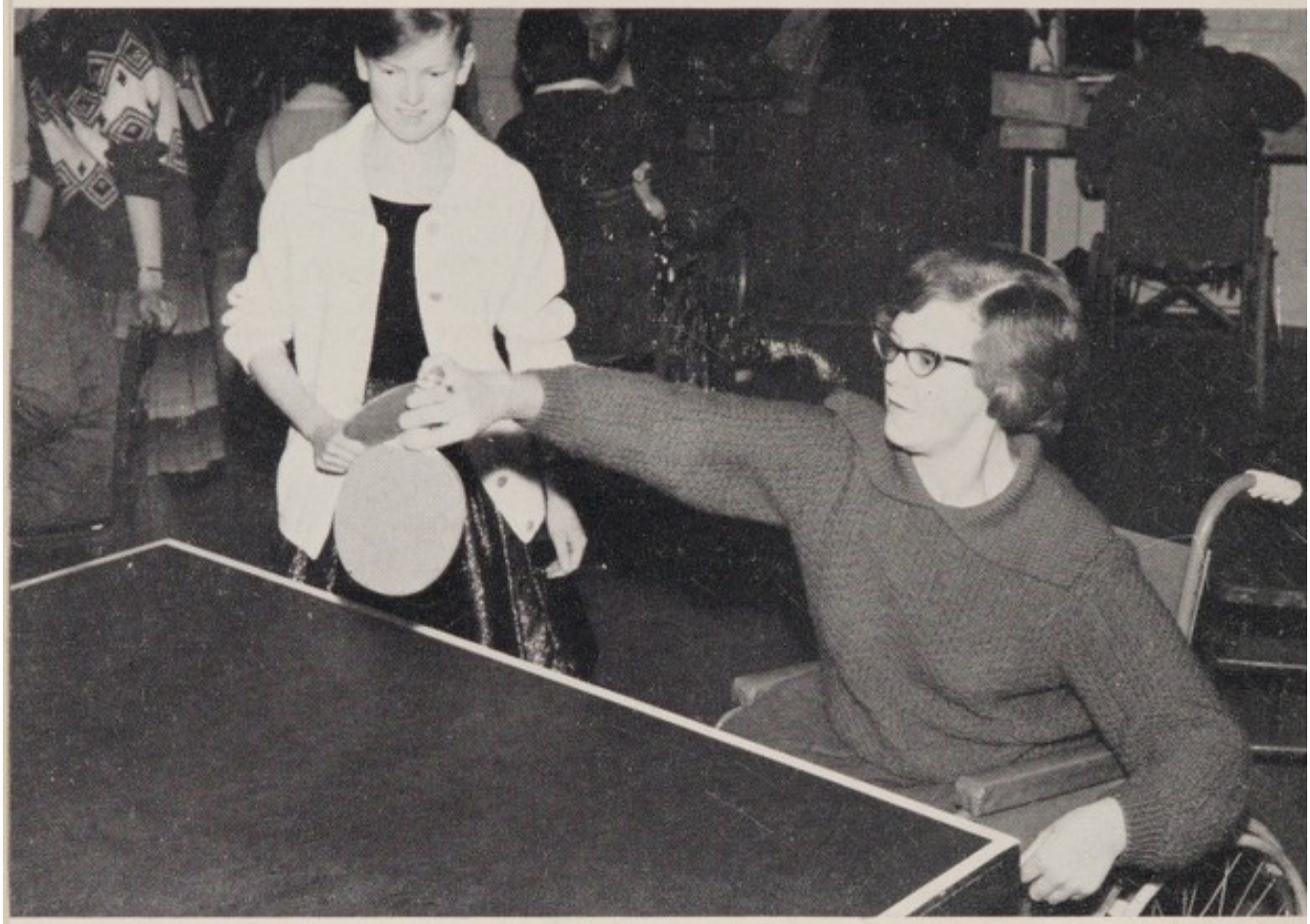
Centre : This modern kitchen is designed specially for the use of disabled people.

Right : Invalid tricycles are available to severely disabled people.



Top : An arthritic patient feeds himself with the help of a spoon/fork gadget and a ball-bearing arm support.

Left : A blind lady listening to an advanced 'talking book' tape machine. Each tape will play for 20 hours.



Top : Blind girls learning to use cosmetics.

Centre : Table-tennis at a youth club where disabled and fit people meet together.

Right : The women's section of the Pro Canto Singers—a well-known blind amateur choir—at rehearsal.

King Edward's Hospital Fund for London has 12 homes for the aged sick. The homes are managed by voluntary bodies. Each home is linked with a special hospital unit for old people. Patients come from these units to the homes and, if their condition requires it, they can return to hospital. Others come from their own homes for short periods while their families have a holiday. Patients from hospitals are visited in the home by the doctor who attended them in hospital and they remain under nursing supervision, but active nursing is not provided and all reminders of hospital life are, as far as possible, excluded, the object being to give these elderly patients practice in ordinary, independent living. Similar homes have been opened in connection with hospitals in Scotland and Northern Ireland. The rest homes established by the National Corporation for the Care of Old People also provide accommodation intermediate between home and hospital. They are maintained partly by the regional hospital board and partly by the local welfare authority.

One of the most complete schemes for the care of the elderly sick is provided by the Bermondsey Medical Mission, which combines general practice, a long-stay annexe, a convalescent home and a hostel for frail elderly people.

Hospital admission may be postponed or avoided, or earlier discharge from hospital arranged, by means of geriatric out-patient clinics and by day hospitals. The number of day hospitals is increasing steadily. The majority of patients attend from outside the hospital, but some are in-patients who are being prepared for discharge. In some cases, elderly mentally confused patients are mixed with others who are mentally alert but whose disability is physical. Patients attend for the whole day (but not necessarily every day) for occupational therapy, physiotherapy and medical supervision. A mid-day meal is provided and transport is arranged where necessary.

Home Care and Welfare Services

A generally accepted principle in work for old people is that everything should be done to enable them to live independent lives in their own homes for as long as possible.

As part of the National Health Service, local health authorities provide a home nursing service and a home help service. Over half the work done by both these services is for old people. Home nursing, by a visiting nurse, is provided free of charge, on the recommendation and under the supervision of a doctor (everyone is entitled to a doctor's services under the National Health Service). The scope of the home help services varies greatly from one area to another; charges may be made according to the means of the person using it, but not exceeding the economic cost of the service to the authority. About a third of the local health authorities also provide to a limited extent a night attendance service for seriously ill people who live alone or whose relatives need relief. A chiropody service may be provided by local authorities as part of their preventive services; this also is a service particularly useful to elderly people, many of whom have foot trouble which, especially when combined with other infirmities, may make it difficult for them to get about. A number of local authorities are now providing a free chiropody service to old people.

Much has been done during and since the second world war to develop local services for the welfare of old people and, with official encouragement

from the Health Departments and the stimulation and assistance given by the voluntary National Old People's Welfare Council and the Scottish Old People's Welfare Committee, these services are spreading throughout Britain. The National Assistance Act 1948 (Amendment) Act 1962 empowered local authorities to arrange for the provision of meals and recreation for old people, both through voluntary organisations and otherwise. Many social clubs and a number of services delivering hot meals to old people in their own homes are organised by voluntary bodies, who also arrange for the regular friendly visiting of old people who welcome it. Bathing and special laundry services are other services which are operating in some areas. There are over 1,500 local Old People's Welfare Committees which co-ordinate local effort for the welfare of the elderly. Women's Voluntary Service and the British Red Cross Society are two of the voluntary societies most active in welfare work for old people.

The National Corporation for the Care of Old People, a voluntary body set up in 1947 by the Nuffield Foundation and the Lord Mayor's Air Raid Distress Fund to stimulate and aid schemes for the welfare of the aged, has assisted the starting of homes by giving grants and technical advice. It has supported a number of research projects concerning the needs of the elderly.

The King George VI Foundation, financed from the fund raised in the King's memory, spent nearly £600,000 on schemes for old people. The Foundation's aid to old people's welfare took three forms—grants for the development of existing old people's clubs, the foundation of new clubs, and the training of workers to help old people.

At least 425 clubs have received grants under the King George VI Old People's Development Scheme for clubs and associated services such as meals, handicrafts and chiropody. Five King George VI Memorial Clubs have been built and established with the co-operation of local authorities and private local initiative. One of these, the Camberwell and Lambeth club, in South London, was designed as an experiment to cater for elderly infirm people. The building has no stairs but many handrails; the bathroom is a popular feature, as many members cannot bath without assistance; and the club has its own ambulance, which has an hydraulic tail-lift for the convenience of members using wheel-chairs or crutches.

The King George VI Social Service Scheme was started in 1954 to assist in the training of workers, mainly voluntary workers, engaged in the care and welfare of old people. It is organised by the National Old People's Welfare Council with the co-operation of the Ministry of Health and the Department of Education and Science and of local authorities.

The war pensioners' welfare service of the Ministry of Pensions and National Insurance (see p. 27) offers a visiting service to all war widows aged 70 years and over. The object of the visits is to discover social needs and, if necessary, to arrange continuing friendly calls either through the resources of the Ministry's welfare service or by arrangement with other organisations concerned with the welfare of old people.

Homes and Houses

Local authorities provide homes for infirm old people as part of their welfare services. The new homes usually have accommodation for 25 to 60 residents; some 1,500 have been opened in Great Britain since the second

world war. These smaller homes are gradually replacing the larger institutions which were previously maintained by local authorities. County welfare authorities in Northern Ireland have provided about 35 similar homes.

There are also about 2,300 small homes for old people run by voluntary bodies. Most of these homes also have been provided since the second world war, usually with the assistance of grants from public funds. Those providing accommodation on behalf of local authorities are subject to inspection and the local authorities have power to prescribe a maximum number of residents they may have.

Much attention is given to the special needs of the elderly in the planning of housing estates and new towns, and it is usual to include some special provision for them in any new housing scheme. There may be pairs of specially designed bungalows amongst the family houses as well as a group of old people's dwellings with some communal facilities and accommodation for a warden or caretaker.

The Ministry of Housing and Local Government has published two handbooks[1] for the guidance of local housing authorities in England and Wales showing how to build a one-storey or two-storey block of flatlets with good-sized bed-sitting-rooms and a common sitting-room as well, with central heating, and with a flat for a caretaker or warden who can help if needed. In Scotland, similar advice on the design of houses for old people has been given in a report of the Scottish Housing Advisory Committee.[2] Some local authorities are buying large old houses and converting them for old people. Conversion grants from the Exchequer are available to local housing authorities for this purpose. An Exchequer subsidy for the building of new one-bedroom dwellings is available in England and Wales, while in Scotland small houses suitable for old people attract the same higher rate of Exchequer subsidy as larger houses built by local authorities for families with approved housing needs.

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[1] *Flatlets for Old People* (HMSO, 1960) and *More Flatlets for Old People* (HMSO, 1960).
[2] *Housing of Special Groups* (HMSO, 1952).

THE MENTALLY DISORDERED

CARE and treatment for the mentally ill and the mentally subnormal,[1] whether in hospitals or in the community, are provided as part of the National Health Service under the supervision of the Ministry of Health and the Scottish Home and Health Department. The local health authorities are responsible for the provision of community care services for all categories of mentally disordered people. Hospital care and most of the community care services are provided free of charge. In Scotland, boarding-out has always been much used in the mental health services; this provides the advantages of family care and useful occupation both for the mentally ill and for mental defectives.

The National Association for Mental Health is the principal voluntary body concerned with the interests of the mentally ill or subnormal and provides educational and advisory services. Other voluntary organisations which give help through services and advice are the Mental After Care Association and the National Society for Mentally Handicapped Children. The Scottish Association for Mental Health and the Society for Mentally Handicapped Children do similar work in Scotland and, through their local associations, assist in the care and after-care of patients.

The Mentally Subnormal

It is the duty of the local health authorities to provide services in the community for people suffering from mental subnormality. Many of these are brought to the notice of the local health authority through the schools, but others are referred by parents, the family doctor, hospitals, child welfare clinics or other interested people. With the help of a report from a social worker who has visited the patient's home, the medical officer and the local health authority determine what form of care is needed, for instance, friendly advice and help from a visiting social worker, attendance at a training centre or hospital care.

Most local authorities provide occupation and training for subnormal children and adults at training centres in their own areas with the aim of developing mind and body to the fullest extent possible. At centres for adults there is increasing emphasis on providing workshop facilities which enable trainees to carry out simple process work in conditions similar to those of normal employment.

In Scotland, junior training centres are maintained by education authorities and the children remain the responsibility of the education authority unless the authority considers that they are unsuitable for education or training in a special school or a training centre. The local authority then has a duty to see that suitable occupation and training is provided either in a special centre or otherwise. Senior training centres, that is centres for people over 16 years of age, are the responsibility of local health authorities.

Local health authorities are increasingly providing residential accommodation, including hostels for those who do not need hospital care but cannot satisfactorily live at home, or by arranging boarding out in suitable private households.

If care in the community is not adequate for the patients' needs, admission

[1]In England and Wales the expression 'mentally subnormal' is used broadly corresponding to the use of 'mentally defective' in other parts of Britain.

to hospital may be arranged. The most severely disabled may need prolonged, possibly life-long, nursing care but may nevertheless respond to hospital nursing and rehabilitation and be able to return to their own homes or to residential accommodation provided by the local authority. On their return they again receive help from the community services described above.

Training and Rehabilitation in Hospitals for the Mentally Subnormal

It is the aim of the hospitals for the mentally subnormal to give their patients, especially in the higher grades, training which will stabilise them and enable them to return to life in the community. This is done by making the hospital a self-contained community for mentally subnormal adults of all types, provided with a wide range of workshops and recreational and social facilities. A large proportion of the patients live many years in the hospital, but very substantial numbers go out to work alongside ordinary workers on housing construction, on farms or in gardens, hotels or factories. As local authority services—including residential accommodation—develop, it is likely that increasing numbers of these patients will be able to live in the community after a period of training in hospital.

The various forms of training may be grouped broadly into three. In the first group the principal aim is to stabilise the patient and adjust him to society, in the second to develop manual dexterity, and in the third occupational therapy is the main object. The teaching of games, especially team games such as cricket and football, is an important item in the first group of activities, together with the creation of settled habits of work by progressive training in a steady and interesting occupation. Earnings act as an incentive. Some patients are employed on simple factory work sent in from outside factories. Some improve sufficiently to go to work daily in one of these factories, some to be given weekly or longer-term leave, and ultimately to be completely discharged. Occupations in the second group include gardening, wood-working, brush-making, basket-making, printing, tailoring, and other trades, laundry (for women) and domestic work. Each patient specialises in one particular skill. Many different types of craft are practised by way of occupation for those patients unfit for the workshops.

All workshops and almost all of the wards in which the patients live are kept open. The hospital staff and the local health authorities co-operate in keeping in touch with former patients and in giving them help and moral support. An additional aid to rehabilitation is the accommodation of patients, who are expected to become suitable for discharge, in groups of about 20 or 30 in houses owned by the hospital but separate from the main hospital buildings. There patients can live under conditions more like those they will meet in the general community.

It seems likely that in future, owing to changes in methods of treatment and the present trend towards community rather than hospital care wherever suitable, hospitals of this type will be nearer to towns and centres of employment, and also rather smaller, than has sometimes been the case in the past. But changes of this sort will inevitably take place slowly.

The Mentally Ill

Modern therapeutic methods—physical, psychological and occupational—have greatly improved the prospects of treatment for mental illness in recent

years. Advances in therapy have been accompanied by a greater readiness on the part of the patient to accept early treatment. This has been facilitated by the possibility of voluntary admission and (under the Mental Health Act 1959 and the Mental Health (Scotland) Act 1960) of entirely informal admission, which makes it possible for a patient to receive psychiatric treatment with no more formality than in the case of physical illness. At the same time, increased emphasis has been placed medically on forms of treatment and services which can be given without bringing the patient into hospital as an in-patient or which make it possible to discharge him sooner than was usual in the past. As a result of these developments, although an increasing number of patients have been admitted to hospital, they are remaining for much shorter periods. Most newly admitted patients need to stay for less than three months, and although a considerable proportion may have to be re-admitted for further short periods of treatment, comparatively few need long-term in-patient treatment. A higher proportion of psychiatric hospital beds is still occupied by patients whose illnesses developed before modern treatments were available but many of these patients also can now be rehabilitated. As the number of these patients declines through discharge and death they are not being replaced by a comparable number of long-stay patients, and the total number of psychiatric hospital beds needed is likely to be considerably reduced.

The pattern of psychiatric services for the mentally ill is also changing. For the short-stay patients, the emphasis is on providing treatment in small units as near as possible to the patient's home; a number of general hospitals already have in-patient units for mentally ill patients and others are planned. The longer-term patient needs the rehabilitation facilities of the specialised psychiatric hospital, but here again there have been important developments in recent years. Closer links with the local community, the removal of unnecessary restrictions, giving patients greater responsibility, and the extension of occupational and recreational activities have all contributed to more effective rehabilitation. The use of industrial work in psychiatric hospitals is spreading. Some hospitals take in work from outside firms, others manufacture their own articles for sale. Arrangements are also made for patients to go daily from hospital to outside employment. In some areas a non-profit-making organisation, Industrial Therapy Organisation Ltd. (see p. 41), provides a training factory and sheltered workshops which are attended by hospital patients, and form an additional intermediate stage between work within the hospital and outside employment.

A wide range of closely related services is needed to avoid unnecessary in-patient admission and to help the discharged patient to readjust to life in normal society. These services include out-patient clinics, home visiting services, day hospitals, social clubs and hostels. Day centres and hostels are now being provided to an increasing extent by local health authorities, who are also responsible for providing social support for people who are or have been mentally ill and are living in the community, and for their families. Links with education authorities through child guidance, with the Ministry of Labour through the disablement resettlement officers at employment exchanges, with the courts and with voluntary agencies, are all important. In recent years there has been a large increase in psychiatric out-patient services, particularly at general hospitals, and there are also now a substantial

number of day hospitals and centres. Social clubs are run by hospital and local health authorities and by private bodies, mainly for ex-patients or out-patients, but sometimes including friends and relatives in their membership.

Different ways of providing a comprehensive service will no doubt develop in various parts of the country, as experience shows how best to deploy medical, nursing and social skill for the mentally ill, according to local conditions.

Industrial Rehabilitation of the Mentally Disabled

In some areas, Industrial Therapy Organisations (ITO) have been formed by voluntary workers, local industrialists, representatives of mental hospitals and trade unions. Two of these organisations, ITO (Epsom) Ltd. and ITO (Thames) Ltd., working in conjunction with mental hospitals at Epsom and Southall respectively, have started pilot schemes aimed at the industrial rehabilitation of the long-term patients of mental hospitals for whom the normal Industrial Rehabilitation Unit course is insufficient. The Ministry of Labour is giving them financial help.

THE BLIND

IN Great Britain, a person may be voluntarily registered as blind under the National Assistance Act 1948 if 'he is so blind as to be unable to perform any work for which eyesight is essential'. Over 96,000 people are so registered, of whom only a small proportion are totally blind. Many can distinguish between light and darkness, and some may see comparatively well within a small area. As wide a variety of skills and abilities will be found among the blind as in any cross-section of the population; and the effects of blindness will vary widely according to the individual's natural abilities and degree of adjustment to his circumstances.

Care of the blind is a long-standing British tradition; the first training establishment for the blind in Great Britain was founded in 1791. The Royal National Institute for the Blind was established in 1868 and it had pioneered the general use of Braille by the turn of the century.

Welfare Services

County councils and county borough councils (in Scotland, town councils of large burghs) have been responsible for the welfare of the blind since 1920, when the first Blind Persons Act was passed. Statutory provision for blind welfare is now included in the National Assistance Act of 1948. Each local authority provides welfare services for the blind, in accordance with a scheme approved by the Minister of Health or Secretary of State for Scotland, and while the services to be provided are, in general, similar their administration often differs from one area to another. Under these schemes local authorities, either directly or through the agency of a voluntary organisation, keep a register of all blind people in their area and employ home teachers to discover the needs and wants of the blind.

Many local authorities have appointed local voluntary organisations as their agents in providing welfare services for the blind. Home teachers are primarily social workers with a special technical teaching function. They teach Braille, Moon, and handicrafts, and arrange the supply of books, periodicals and music in Braille or Moon, and of talking books (readings recorded on tapes or gramophone discs). These are circulated by the National Library for the Blind[1] and the Royal National Institute for the Blind (see below). The Ministry of Health pays these bodies a grant in respect of Braille/Moon production, and local authorities make contributions on a *per capita* basis. Local schemes provide a number of homes for elderly blind people.

To co-ordinate services in England, there are three regional associations for the blind, each composed of representatives of local authorities and voluntary associations in each county, and an Inter-Regional Committee of the Regional Associations for the Blind.

There are a number of national bodies concerned with blind welfare. The Royal National Institute for the Blind (RNIB) provides a representative council where matters concerning national services for the civilian blind of England and Wales can be discussed. The RNIB trains blind physiotherapists, shorthand-typists and telephonists. It provides embossed literature, 'talking books' and a wide range of special equipment. It maintains schools for blind

[1]A national lending library through which books are lent and returned post-free to and from blind readers in Britain and overseas.

children (including two grammar schools), two residential centres for the rehabilitation of the newly blinded and homes for the aged and for the deaf-blind. It places blind workers in industry and commercial and professional occupations, and carries on educational and scientific research. In Scotland, all blind welfare organisations are members of the Scottish National Federation for the Welfare of the Blind.

The Guide Dogs for the Blind Association trains dogs to accompany blind people. The British Wireless Fund for the Blind, raised largely by Christmas radio appeals, provides free wireless sets for many blind people. St. Dunstan's and the Scottish National Institution for the War Blinded care for ex-service blind. St. Dunstan's is a voluntary organisation which was founded in 1915 under the auspices of the Royal National Institute for the Blind, and has pioneered new standards in blind rehabilitation. It is the best endowed of the organisations for the blind and has been independent of the RNIB since 1922.

Many of the pioneers and leaders in blind welfare have been, or are, themselves blind. Blind people sit on many committees for the blind; blind workers have their own trade union, the National League of the Blind, affiliated to the Trades Union Congress, and blind professional workers are represented by the National Federation of the Blind. To encourage self-help, deaf-blind people have formed themselves into an organisation called the National Deaf Blind Helpers League.

A special non-contributory blind pension of up to 28s. 4d. a week is available to blind people over 40 whose means are within certain limits and who are not retirement pensioners. This pension is paid by the National Assistance Board who can also supplement the pension (or make a straightforward assistance grant if a pension is not payable) for those who are in need. Registered blind people have their needs for assistance purposes assessed according to a special scale which is higher than for sighted people. Blind workshop employees and homeworkers have their wages supplemented by the local authority. The blind are not required to pay for wireless licences and are allowed special voting facilities and postal concessions.

Education and Vocational Training of Blind Children and Adolescents

In England and Wales, the Department of Education and Science and local education authorities, besides their duty to all handicapped children of providing suitable education up to the age of 16, are also generally responsible for the further education and assessment for employment of blind young people below 18 years of age.

There are 20 boarding special schools approved by the Department in England and Wales which admit blind pupils. These provide for about 1,300 blind children and include five Sunshine Home Nursery Schools, two grammar schools for pupils up to the age of 19 and the Royal Normal College for the Blind. The Sunshine Home Nursery Schools, established and maintained by the Royal National Institute for the Blind, are for very young blind children who may stay until they are nine years of age if backward, but who are normally transferred to other schools for the blind at the age of seven or earlier. (Blindness in young children is now very rare, affecting probably not more than one in 5,000 babies.) The Royal Normal College provides a general education for selected pupils up to the age of 20 or 21, with more

specialisation after the age of 16; pupils may learn music, piano tuning or shorthand and typewriting. Teachers in all schools for the blind must obtain the School Teacher's Diploma of the College of Teachers of the Blind, or complete a year's extra training at the Department of Education of the University of Birmingham.

Pupils leaving schools for the blind at 16 normally attend the pre-vocational courses provided by the Royal National Institute for the Blind at Hethersett, Reigate, Surrey, or by the Royal Institution for the Blind, Birmingham, at the Queen Alexandra Training College, which are recognised by the Department of Education and Science. Local education authorities are responsible for the fees at these centres.

In Scotland, almost all blind children stay at school until they are 18, and over 75 per cent of them attend the Royal Blind School in Edinburgh which provides nursery, primary and secondary education. After the age of 16 the school course becomes increasingly vocational for those not preparing for the university or a profession.

Rehabilitation of the Newly Blind

The first need of those who are blinded, or become blind in adult life, is instruction in adjusting themselves to blindness, which may be provided in their own homes or in a residential establishment. Some 800 social workers (known as home teachers) are employed by local authorities, or voluntary agencies acting on their behalf, in visiting the blind in their homes and assisting the newly blinded to adjust themselves; more than 80 of these home teachers are themselves blind. The Royal National Institute for the Blind provides residential centres for the rehabilitation of civilians at Queen Elizabeth Homes of Recovery for the Blind (America Lodge and Manor House) at Torquay, and a centre for social rehabilitation at Oldbury Grange, Bridgnorth. In Scotland, a residential rehabilitation centre is provided at Alwyn House, Ceres, Fife, by the Edinburgh and South-East of Scotland Society for Welfare and Teaching of the Blind. The courses are designed to re-establish self-confidence in everyday activities and no attempt is made to teach a trade. Instruction is given in the reading and writing of Braille type and the use of a typewriter, and there are workshops where practical methods of working without sight can be taught. During the course, the aptitudes, inclinations and employment capacity of each person are carefully assessed and this information is passed on, where appropriate, to the responsible local authority or to the Ministry of Labour. Whilst most of the persons attending these courses intend to fit themselves for training or employment, some places are reserved for such persons as housewives who do not intend to take up paid work.

Vocational Training

The blind may be trained for the professions or for industrial, commercial or sheltered employment.

The cost of vocational training for the blind is met by the Ministry of Labour and training allowances are payable to those in training, other than those receiving wages. For the professions, the course of training and the examinations are normally the same as for the non-disabled. Special courses are available in music and the only approved training course in

physiotherapy is that of the Royal National Institute for the Blind School of Physiotherapy. Training for industry and commerce may be in employers' establishments, at special centres or at the Letchworth Government Training Centre, where a special course for the blind is conducted in capstan lathe operation, inspection with use of Braille precision instruments and repetition assembly work for the light engineering industry. The Ministry of Labour and the Royal National Institute for the Blind have arranged for the training of blind persons in employers' establishments by specialist training officers. Training for sheltered employment is undertaken in workshops for the blind.

Employment

Employment in Ordinary Industry

One of the most significant changes which have occurred in the employment of blind people during recent years is the development of opportunities for their employment in industry. Experience gained during the second world war proved that suitable blind people could be satisfactorily employed on a variety of jobs in ordinary factories. Specialist Placing Services for the Blind have been set up by the Ministry of Labour to assist blind people to obtain suitable employment in industry. The RNIB operates a specialist service for placing blind people in commercial and professional occupations. The Ministry of Labour has appointed Blind Persons Resettlement Officers who find jobs for the blind and submit suitable candidates; where blind workers are placed, they pay regular follow-up visits to ensure continued satisfaction on both sides. A small staff of technically qualified Training Officers is available to give service and assistance on the adaptation of machines and training on the job. In addition to factory work, blind people are being employed to an increasing extent as shorthand-typists, telephonists and on executive and administrative work in commerce, industry, and central and local government service. The employment of blind people in ordinary industry is based essentially on the principle that they can and should do a full week's work in return for a full week's wage.

Workshops for the Blind

In the discharge of their responsibilities for the welfare of the blind, local authorities had been empowered by the Blind Persons' Acts to maintain, or contribute to the maintenance of, workshops and homeworkers' schemes; these powers and responsibilities, continued by the National Assistance Act 1948, are now contained in the Disabled Persons (Employment) Acts 1944 and 1958. There are over 60 workshops for the blind, about one-half administered directly by local authorities and the remainder by voluntary organisations; they provide employment for some 3,600 blind people and training for about 150 more. About three-quarters of the employees are men. Their main trades are basket, mat, brush and bedding manufacture. To help these workshops to sell their products they are given a measure of priority when government contracts are placed. The Ministry of Labour has assumed financial responsibility for the training of approved blind people in workshops for the blind, and also makes grants for a proportion of approved expenditure on capital development and for the cost of providing workshop employment for approved blind people (see p. 18). The workshops are subject to inspection

by the Ministry, which must be satisfied that they are conducted efficiently if grants are to be paid.

Industrial Advisers to the Blind Ltd.

As a result of the recommendation of the working party on workshops for the blind the Ministry of Labour has set up Industrial Advisers to the Blind Ltd. to advise on the modernisation of workshops for the blind.

National Joint Council for Workshops for the Blind

In 1964 a National Joint Council was established to deal with remuneration and conditions of service in workshops for the blind.

Homeworkers' Schemes

For those blind people who cannot or do not wish to be employed outside their homes local authorities and voluntary organisations have developed homeworkers' schemes, providing at present for about 1,000 blind homeworkers in Great Britain. These homeworkers are mainly in business on their own account and are assisted in such matters as the obtaining of raw materials, the advertising and marketing of products and in technical matters connected with the trade or profession practised. Blind homeworkers usually carry on the same types of trade as do the workshops for the blind and receive weekly cash payments from the responsible local authority to augment their earnings. Some are, however, engaged in other occupations such as poultry-keeping, piano tuning, shopkeeping and music teaching. The Ministry of Labour makes grants to local authorities towards the cost of administering homeworkers' schemes and providing tools, equipment and working accommodation.

The Partially Sighted

Local authorities keep a register of partially sighted people and the welfare services for the partially sighted, which date effectively only from 1951, follow a broadly similar pattern to those for the blind. At the outset a close link was made between the services for the partially sighted and those for the blind. The arrangements for registration and for care by the home teacher are the same. Once a partially sighted person is on a local authority's register, he will be visited by a home teacher and any welfare services which are included in the authority's scheme may be provided for him; these are normally a number of the services contained in their scheme for the blind. Over 100 local authorities have now amended their schemes for the partially-sighted, in accordance with advice given by the Ministry of Health in 1963 to enable them to provide a service for partially sighted people unlikely to go blind, under their schemes for the general classes of the physically handicapped. The aim of this is to encourage those unlikely to go blind to make full use of such sight as they have and to lead an active life as part of the general community.

Authorities have a responsibility for directing partially sighted people to appropriate sources for obtaining treatment, financial assistance, education, rehabilitation, training and employment, aids to mobility, holidays and recreation, and may themselves have social or handicraft centres which partially sighted people may attend. If the partially sighted person is nearly

blind or likely to become blind, the home teacher will give instruction in reading embossed print and in suitable handicrafts. There are about 27,000 partially sighted people on local registers in England and Wales. Over one-third were regarded as nearly or prospectively blind.

There are separate special schools for partially sighted children.

THE DEAF AND THE HARD OF HEARING

THERE are estimated to be between 25,000 and 30,000 people in Great Britain who were born totally deaf or who became so at a very early age. In addition, there are over 1½ million people who are hard of hearing, that is to say who suffer from varying degrees of deafness, including total deafness, but who have received some normal education. With the deaf the great problem is communication; with the hard of hearing it is psychological readjustment.

Under the National Health Service patients are referred by diagnostic clinics in hospitals to Hearing-Aid Distribution Centres staffed by specially trained technicians, where they may be supplied with hearing-aids specially designed and made for the service. These aids are supplied and maintained without charge.

Welfare services for the deaf take a different form from those provided for other handicapped people because of the nature of the problems imposed by this handicap, which, more than any other disability, tends to cut off those whom it afflicts from the rest of the community. The aim behind the services —to enable the handicapped people to live as full and normal a life as possible—is the same as in services for other groups. Work for the deaf is carried on mainly by local missions or welfare societies for the deaf. There are some 90 such societies in Britain with centres staffed by missioners and assistant missioners, of whom about one-quarter are themselves deaf. The missions provide the deaf with spiritual care and their own religious services, and also give them a social centre and educational and general social help. Most of the missioners are priests or ministers or lay preachers. A hearing interpreter is essential to the deaf person, and all welfare societies provide interpreters.

All local authorities in England and Wales have schemes for the welfare of the deaf and dumb approved by the Minister of Health (see p. 27), and of these many have entered into agency arrangements with the appropriate local voluntary associations, usually on the basis of a *per capita* grant for the services rendered.

The Royal National Institute for the Deaf promotes the interests of the deaf nationally, and there are a Scottish Association for the Deaf and Regional Associations in England and Wales on which local missions, public authorities, schools, hospitals and other bodies are represented. The National Institute's services include a special information service for the deaf, the provision of seven special homes and hostels, a training centre for maladjusted deaf youths, and the free testing of hearing aids for acoustic efficiency.

The needs and problems of the hard of hearing are in many ways so different from those of the deaf who have never known normal hearing, that the former wish to have services separate from the latter. They have formed their own association to promote their interests, the British Association for the Hard of Hearing, to which are affiliated most of the lip-reading clubs, social clubs and leagues for the hard of hearing in all parts of Britain, which number about 150.

Education and Employment

The number of deaf and partially hearing children in Britain is several times the number of blind children, but it is still very small and is probably rather below one in a thousand. Special provision is made for their education (see

p. 32). There are over 50 special schools for the deaf, the partially hearing, or both, approved by the Secretary of State for Education and Science in England and Wales, and over 10 in Scotland. A number of ordinary schools have special classes for the partially hearing.

Local education authorities have power to provide education from the age of two and most schools for the deaf admit children from the age of two or three. Increasing stress is being laid on the need for the very early training of deaf children. Pioneer work in this field has been carried out at the University of Manchester and at the Royal National Throat, Nose and Ear Hospital (which now has a hostel for young deaf children and their parents) where classes are held not only for the children but also for their parents, who are thus helped to give their children training at home from a very early age.

Special schools for the deaf are being reorganised to separate the deaf from the partially hearing. The statutory maximum size of all classes of deaf or partially hearing pupils in a special school is ten.

Teachers in special schools for the deaf and partially hearing must obtain a special qualification, either by training at the Department of Education of the Deaf at the University of Manchester, or by obtaining the Teachers' Diploma of the National College of Teachers of the Deaf.

Placement and maintenance in industry are among the most important tasks of the missioners or welfare workers for the deaf, who work in co-operation with the disablement resettlement officers of the Ministry of Labour. A leaflet designed to encourage the employment of the deaf is distributed by disablement resettlement officers to employers whose help they wish to enlist in placing deaf applicants. The deaf present a much more limited employment problem than the blind. Even complete deafness is only disabling in most occupations in so far as it limits the ability to receive instructions, to take orders, or to co-operate with other workers.

THE TUBERCULOUS

THERE has been a very marked decline in recent years in the incidence and severity of tuberculosis in Britain; whereas the control and treatment of this disease was one of the biggest problems facing the medical services at the end of the second world war, institutional provision now exceeds demand. Between 1948 and 1963 the yearly number of deaths from tuberculosis in Great Britain fell from 26,511 to 3,455. In spite of a reduction in the number of beds allocated to treatment of the disease, hospital waiting lists have been virtually eliminated and some of the village settlements for tuberculous patients are now giving places to settlers with other handicaps.

Pulmonary tuberculosis has been a notifiable disease in England and Wales since 1912 and all forms since 1913 (1914 in Scotland); the Tuberculosis Act of 1921 laid a duty on county councils and borough councils to make adequate arrangements for diagnosis, free treatment and after-care. These duties have been re-allocated under the National Health Service. Measures for the prevention of tuberculosis, such as tracing sources of infection, and preventing its spread are the responsibility of the local authorities. Facilities for diagnosis and treatment are the responsibility of the hospital service and are provided through hospitals, sanatoria and chest clinics. The chest physicians staffing these clinics are often employed jointly by regional hospital boards (or boards of governors) and local health authorities to ensure that diagnosis and treatment are properly co-ordinated with prevention and after-care. They are assisted in this work by tuberculosis health visitors and nurses and, in some areas, medical-social workers (almoners). Among the duties of these officers are those of making recommendations for residential treatment, visiting the homes of patients, and examining and advising 'contacts'. Most local authorities have statutory or voluntary tuberculosis care committees.

A Chest Radiological Service which is freely available is provided by mass radiography units, chest clinics and the radiological departments of general hospitals. The mass radiography units alone X-ray about 3½ million people each year, concentrating increasingly on specially susceptible groups in the population.

Measures are also taken to protect organised groups of children against the risk of infection by adults suffering from tuberculosis, by arranging for the X-ray examination of those whose employment involves close contact with groups of children.

Care and after-care of patients is supplemented by general advice and assistance given to households in which the patients live. This includes supplying chalets for erection in the patient's own garden, beds and bedding to enable the patient to sleep alone, and nursing requisites; helping the family to find better housing accommodation; making arrangements for boarding out the children of infected parents; the provision of occupational therapy; helping to find extra food and clothing, and other similar matters. Patients whose sickness benefit or other income is insufficient for their needs by National Assistance standards can be given supplementary help by the National Assistance Board; for people who have suffered a loss of income during treatment for respiratory tuberculosis this is based on special higher rates. In other cases, special provision may be made for necessary extra expenses (see p. 30).

A register of cases of tuberculosis excreting drug-resistant bacilli has been

formed. Specimens of sputum are referred to a central reference laboratory when resistant strains are suspected and every endeavour is made to prevent their spread.

For the prevention of the disease, under a scheme launched in 1949 and later extended, local authorities provide BCG vaccination for school-children from age ten, for older students and for people specially exposed to risk. Streptomycin, para-aminosalicylic acid (PAS), and isoniazid are the drugs most commonly used in the treatment of tuberculosis. Treatment, which before the advent of these drugs largely consisted of rest with various measures of collapse therapy, has been revolutionised; collapse therapy, apart from selective surgical measures under drug cover, is a thing of the past. Many patients now are treated in their own homes after a comparatively brief spell in hospital for assessment. Return to work, whilst drug treatment continues, is often possible after a comparatively short period.

The more severely ill patient who has needed a sanatorium regime may be able to undertake light part-time work once the disease becomes quiescent. Sanatoria provide occupational therapy as a normal routine, both as a therapeutic measure and to fit the patients for employment. The occupations carried on include gardening, carpentry, leather-work and clerical work. For the later stages of recovery, when more sustained effort is possible, a number of sanatoria have workshops and some ex-patients get temporary or permanent jobs on the sanatorium staff. Sanatorium nursing is a particularly suitable employment for ex-patients. Close collaboration between tuberculosis authorities and disablement resettlement officers has been successful in some measure in finding suitable employment for tuberculous persons still under medical supervision. Some are employed in the Remploy factories and in the special workshops provided by local authorities or voluntary organisations. Training for employment is carried out in conjunction with the training and resettlement schemes of the Ministry of Labour. The majority of patients are ultimately able to return to their normal occupations.

Local health authorities may arrange for suitable patients to go to the village settlements for the tuberculous run by voluntary bodies. Perhaps the most complete type of after-care for the tuberculous person and his family is the combination of hospital and sanatorium treatment with a village settlement. There are half a dozen village settlements run by different welfare agencies and co-ordinated by a Tuberculosis Rehabilitation Council. The largest and oldest is Papworth, near Cambridge (see also p. 2), which, though run under voluntary auspices, receives most of its patients from local health authorities under their tuberculosis schemes and paid for on agreed terms. There has, however, been a marked falling off in applications from suitable tuberculous patients, and the governing body now offers admission to men suffering from forms of non-tuberculous disability; but Papworth will continue to take, at any rate, sputum negative tuberculous cases and carry on its long-established policy of rehabilitation and colonisation. Another old-established settlement is the British Legion Village for ex-servicemen at Preston Hall in Kent, which dates from 1925. Two other settlements were started primarily for ex-servicemen. Of these, Enham-Alamein in Hampshire, which is administered by the Papworth organisation, has been established since the second world war and now takes men suffering from non-tuberculous

conditions, restricting the admission of the tuberculous to those with negative sputum. Besides giving up-to-date facilities for treatment, these settlements train and employ a large number of the settlers in a variety of occupations and allow them, while still under constant medical supervision, to live under normal conditions with their families in modern houses on the estate.

Three local health authorities own and administer tuberculosis colonies, at each of which there is a sanatorium. Patients are sent from the sanatorium to the colony for rehabilitation and resettlement.

The Chest and Heart Association (formerly known as the National Association for the Prevention of Tuberculosis), a voluntary body founded in 1898, carries out education and works in various ways to promote the prevention of tuberculosis and to assist those who have been handicapped by the disease. Similar associations throughout the Commonwealth are affiliated to it. Clinical progress and research are fostered by the British Tuberculosis Association (1928), an association of doctors. The Joint Tuberculosis Council (1925), a medical body, devotes itself to medico-administrative problems and publishes clinical and scientific reports.

PNEUMOCONIOSIS

THE term 'pneumoconiosis' means simply dust disease of the lungs, and is used to describe a wide group of diseases arising in a number of occupations from different types of dust, for example, silicosis, due to silica dust; asbestosis, due to asbestos dust; and coal-workers' pneumoconiosis, due to coal-mine dust.

In Britain, because of the large number of men employed in coalmining, coal-workers' pneumoconiosis is the commonest variety. In the anthracite mines of South Wales, it has presented a serious problem to the coal industry and the community, and in the last ten to twenty years, it has been shown to occur in other areas, although to a lesser extent.

There are two main forms of coal-workers' pneumoconiosis: (a) simple and (b) complicated. The simple form is due to the accumulation of inhaled coal-mine dust in very small foci in the lungs. There is growing evidence that simple pneumoconiosis alone causes little or only slight disability. The complicated form shows larger areas of consolidation but the mechanism leading to the formation of these is obscure: recent research suggests that an immunological factor may be involved. Here, disability is generally present and may be considerable but, fortunately, complicated pneumoconiosis is only found in a small proportion of men with coal-workers' pneumoconiosis.

Much effort and money have been expended on dust control in British coal-mines in the past ten to twenty years, and although the increase in mechanised mining has brought greater problems in the control of airborne dust, the dust conditions in the mines of Britain are vastly improved in comparison with those existing before the second world war. However, improved diagnostic facilities, and much broader schemes of assistance to miners suffering from pneumoconiosis, caused the certifications on account of this disease to rise rapidly, particularly between 1948 and 1955, but within the last three years they have shown a decline in all regions of the country. It must be emphasised that as coal-workers' pneumoconiosis is a condition which normally develops slowly, after many years of exposure to dust, the certification figures do not provide a guide to present dust conditions.

The National Joint Pneumoconiosis Committee, set up in 1947 by the Government to keep the whole problem of dust and pneumoconiosis under review, meets under the chairmanship of the Parliamentary Secretary to the Ministry of Power, and includes representatives of all government departments concerned and of the National Coal Board, the National Union of Mineworkers and the Epidemiological and Pneumoconiosis Research Units of the Medical Research Council.

The measures taken before and since 1947 may be classified under the following heads: prevention; treatment and rehabilitation; resettlement; compensation.

Prevention

Measures have been taken for many years, and intensified by the National Coal Board since 1947, to reduce concentrations of airborne dust. In suitable coal seams, water is forced, under high pressure, into the coal before extraction, and it thus wets the coal thoroughly. When machinery is used to cut and extract the coal, water is sprayed on to the cutting edges of the machine, to allay the dust produced there. Percussive drills are equipped with water attachments to deliver water around the drill tip, thus helping to

prevent any dust formed from becoming airborne. Generally speaking, all dusts are regarded as harmful, and efforts are directed at keeping all dust concentrations below certain maximum levels.

The Mines and Quarries Act 1954 which consolidated and extended health and safety legislation in mines and quarries, lays on managers of mines and quarries the duty of ensuring that steps are taken to minimise the formation of dust likely to be injurious to the worker. Dust entering the air stream should be trapped or so dispersed as to render it harmless.

At the request of the National Joint Pneumoconiosis Committee, the National Coal Board is carrying out long-term field research on pneumoconiosis at 25 collieries, employing altogether some 35,000 men. The aims of this research are:

(a) to ascertain the true prevalence of pneumoconiosis at these collieries;
(b) to discover the dust conditions which must be maintained if mineworkers are not to be disabled by dust which they breathe at work; and
(c) to determine more accurately the relationship between pneumoconiosis and respiratory disability.

The research involves the regular examination of these 35,000 miners, and the collection of very detailed records of dust conditions at the collieries concerned.

The Safety in Mines Research Establishment of the Ministry of Power also carries out research into a number of problems connected with pneumoconiosis.

A scheme for the periodic voluntary X-ray examination of all mineworkers was approved by the National Coal Board in 1956, and has now been established in all coalfields. Besides offering a diagnostic service to mineworkers, it will provide a check on the efficiency of dust control, and will also, to some extent, assist in the eradication of tuberculosis amongst miners.

Treatment and Rehabilitation

The Pneumoconiosis Research Unit of the Medical Research Council has done a considerable amount of work on the treatment and rehabilitation of pneumoconiosis cases. Since 1955 the unit has been assisted by the Miners' Chest Diseases Treatment Centre in these clinical studies. It is not necessary to treat patients with simple pneumoconiosis unless they co-incidentally suffer from bronchitis, a common condition in miners (and also in miners' wives).

Miners with complicated pneumoconiosis may, in the later stages, be increasingly disabled by cough, breathlessness, and recurrent chest infections. Much can now be done to alleviate these troubles, although no way is yet known of stopping the slow progression which occurs in many of the cases.

Resettlement

It has already been stated that simple coalminers' pneumoconiosis arises from the inhalation of excessive quantities of coal mine dust. Obviously, a person who has radiological appearances of pneumoconiosis will show a worsening of the X-ray picture if he continues to work in excessive dust. However, it is believed that such a miner can work safely in low dust concentrations without further deterioration, but if the miner is a young man, who

might be expected to work for a further 30 years or more, it may be best to advise him even if he does work in low dust concentrations to leave underground employment and to seek work in a dust free atmosphere. To determine the advice which should be given to a mineworker with pneumoconiosis is a complex matter, and depends upon the man's previous working history, age, expectation of working life, probable future dust exposure, and, from the social point of view, his family responsibilities also.

Before mid-1948, a miner certified as having pneumoconiosis was automatically debarred by law from further work in which he would be exposed to coal mine dust. When the National Insurance (Industrial Injuries) Act came into force in 1948, the law was altered to permit men certified under that Act to be paid industrial disablement benefits for pneumoconiosis, even through they continued to work in coalmining. Such men are examined periodically by Pneumoconiosis Medical Panels of the Ministry of Pensions and National Insurance, and are advised by the doctors of these panels on the dust conditions in which they should work. It is not, however, obligatory for them to accept the advice given. In 1951 a further alteration in the law permitted men who had been certified before mid-1948, under the Workmen's Compensation Acts, to apply to the Silicosis Medical Board for permission to return to work in the coalmining industry, under suitable dust conditions. There are now about 18,000 men with pneumoconiosis who are employed in mining by the National Coal Board.

Other factors which have contributed to reduce the number of unemployed men with pneumoconiosis are: expansion of trades providing employment suitable for disabled miners in the South Wales development area; the obligation under the Disabled Persons (Employment) Act 1944 on employers of twenty or more workers, to engage a quota of disabled persons; and the willingness of humane and progressive employers to accept many more than their quota. For example, although the quota has been set at 3 per cent of total staff, statements made voluntarily by fourteen representative firms have shown that the pneumoconiosis cases employed between them amounted to 8·5 per cent, while in three firms such cases form more than 20 per cent of male employees and in one case nearly 100 per cent of the total staff.

In South Wales there are ten 'Grenfell' factories set up by the Board of Trade following a report in 1945 by a committee under the chairmanship of Mr. D. R. Grenfell, M.P. They are let under leases providing for rebates of rent dependent upon the employment of disabled persons and their employees include people disabled by pneumoconiosis. There are also a number of other Board of Trade factories, let on special terms, for the employment of disabled persons.

Compensation

In 1928, the first scheme of compensation under the Workmen's Compensation Acts that dealt with coalminers suffering from silicosis was introduced.

This was gradually extended in scope until, under the National Insurance (Industrial Injuries) Act, which came into operation on 5th July 1948, disablement benefit was provided for pneumoconiosis broadly in the same way as for industrial accidents (see p. 29). Diagnosis of the disease, and assessment of the resulting disablement, are the responsibility of pneumoconiosis medical boards constituted from panels of specially qualified medical practitioners.

In 1952, under the Pneumoconiosis and Byssinosis Benefit Act 1951, a scheme was introduced for the most severe of the cases which arose from employment before 1948, but had not attracted compensation under the Workmen's Compensation Acts, nor come within the scope of the present Industrial Injuries scheme. The scheme is called the Pneumoconiosis and Byssinosis Benefit Scheme and under it benefits are made available for total disablement or death at rates comparable to those provided under the Workmen's Compensation Acts. Under the Industrial Diseases (Benefit) Act 1954 the scheme was extended to cases of partial disablement due to pneumoconiosis where no compensation would otherwise be payable.

A number of supplementary benefits are also paid out of the Industrial Injuries fund in cases where the disease was contracted before July 1948, and weekly payments of Workmen's Compensation are being made.

OTHER SPECIAL GROUPS

Epileptics

It has been estimated that the incidence of epilepsy in the population of Britain is about 4 in 1,000 and that, therefore, the total number of epileptics (including all grades of severity) is 200,000. Children under school-leaving age probably account for over 40,000 of this number. Of the adults, 2,000 are in epileptic colonies and about 15,000 are registered for employment as disabled persons.

The problem of epilepsy differs from that of most other permanent handicaps in that, between seizures, the epileptic may appear, and indeed may be, quite normal. Medically, the main need is for careful and early diagnosis and appropriate treatment designed to stabilise the condition and bring the fits under control. The majority of people with major fits who have no other signs of brain damage and whose personality is unaffected, can live useful lives in the community given early diagnosis and treatment, and the same applies to sufferers from *petit mal*, though in this case treatment may be more difficult. When there is associated brain damage or personality disorder or treatment has been delayed or inadequate and the epileptic cannot be cared for at home, some form of residential care may be necessary. Epileptic colonies provide for a large number of this group, but others may be found in some local authority homes for other groups. It is hoped in the future, by better case finding and early treatment, to reduce considerably the numbers receiving institutional care, and hospitals and colonies are being encouraged to concentrate on the return of their patients to the community rather than their retention in a sheltered environment.

The great majority of epileptic children can be satisfactorily educated in the ordinary schools. For the most seriously affected (amounting to between 700 and 800 at any one time) special education in boarding schools is necessary, though some are able to transfer to ordinary schools after a period.

The majority of epileptics registered as disabled are employable in the normal way if their tasks are such that a sudden seizure is not dangerous to themselves or others, in particular if not in the proximity of moving machinery. The number of their seizures tends to diminish when they are in regular work. The chief obstacle to their employment is the alarm and revulsion of fellow workers at their seizures, and attempts are being made to overcome this by education. To secure the co-operation of employers a leaflet has been prepared by the Ministry of Labour, in conjunction with the Ministry of Health, the British Epilepsy Association and the National Association for Mental Health, giving guidance on the employment of epileptics. This leaflet is issued by disablement resettlement officers to potential employers of epileptics and special approaches are made by DROs from time to time to employers urging them to consider offering suitable employment to particular epileptics who have applied at an employment exchange for work.

About 500 of the more severely afflicted epileptic workers are being provided with sheltered employment in Remploy factories. Remploy Ltd. does not segregate epileptics from other workers and the company has found that, as a class, they are satisfactory employees and their fits cause little disturbance or worry to other severely disabled workers.

Most of the colonies for epileptics were established about fifty years ago and are built on the villa principle. All but three are provided by voluntary organisations, which may receive financial help from the local authorities for

the home areas of the colonists. Some colonists spend most of their lives in the ordered environment of the colony, where they tend to have less frequent fits than they would do in the outside world. Others are ready to leave after a period of stabilisation. On the basis of the experience of a hostel for epileptics opened in 1948 in connection with St. David's Hospital, London, the Advisory Council for the Welfare of Handicapped Persons in its report on the special welfare needs of epileptics[1] recommended the provision of special hostels for epileptics who are ready to leave a colony and to try out their ability in employment, but who still require some care before entering, or re-entering, the general community.

Spastics

The majority of people described as spastics are suffering from cerebral palsy, that is to say they are suffering from a form of paralysis as a result of brain damage or defect occurring before or at birth, or during childhood. Cerebral palsy presents particularly difficult problems because there is often a mental as well as a physical handicap. On the other hand, the physical defect may mask a normal, or above normal, intelligence.

The number of spastics in the population is not known, but the proportion of spastic children amongst those of school age has been estimated at about 1 in 1,000, and the proportion of severely handicapped spastic adults at perhaps 0·5 in 1,000. Of the children, it is estimated that about half are so slightly handicapped that they can attend an ordinary school. More severely handicapped children may need to attend a special school, usually one for the physically handicapped.

Apart from the schools for the physically handicapped generally, some of which contain special units for spastics, a number of schools have been established since the second world war which provide solely for spastic children. There are now 11 approved special schools of this kind in England and two in Scotland, and also a number of independent schools. One of these is an independent boarding school for boys and girls between 14 and 21 where courses up to 'A' level of the General Certificate of Education are provided. In 1963 a centre was opened by the Spastics Society (see below) to provide further education and assessment for employment of spastic school leavers.

The development of new techniques of physiotherapy in recent years has demonstrated that improvement is possible in a large number of cases and that in some it may be considerable.

The Spastics Society formed in 1963 by the amalgamation of the British Society for the Welfare of Spastics and the National Spastics Society, provides a wide range of services for spastics, including five residential schools, four residential homes, three holiday hotels and a vocational training and employment service.

Paraplegics

The Spinal Injuries Centre at Stoke Mandeville Hospital, near Aylesbury, Bucks, has developed special methods for the treatment and rehabilitation of

[1] *The Special Welfare Needs of Epileptics*, Ministry of Health Circular 26/53 (HMSO). See also the *Report of the Sub-Committee on the Medical Care of Epileptics* (HMSO, 1956).

paraplegics (persons paralysed by spinal cord lesions). This pioneer centre was established for the treatment of men injured in the second world war.

The fundamental principles of the treatment given at Stoke Mandeville are: avoiding immobilisation, stimulating activity in the upper, still mobile, portion of the body, and aiding high morale. Treatment is aimed at preventing the severe complications such as infection of the bladder, skin and lungs to which these patients are prone. Where these have already occurred and the sufferer has become severely emaciated, special diets and frequent blood transfusions may be needed. Games, recreations, occupational therapy, and reassurance of the possibility of gainful employment are therefore as important as exercises to restore the maximum physical function, and are introduced at an early stage of the treatment. Archery is a sport that the patients practise successfully in their wheel-chairs. A swimming-bath provides one of the newest forms of treatment. A special creation of Stoke Mandeville is the Stoke Mandeville International Games, a meeting for paraplegic competitors from all parts of the world.

Several units with facilities similar to those at Stoke Mandeville have been established, such as those at Lodge Moor Hospital, Sheffield, Rookwood Hospital, Cardiff, and Edenhall Hospital, Edinburgh. There are other units at Hexham, Oswestry, Southport and Wakefield.

Certain wards at the Star and Garter Home, Richmond (established after the first world war as a home for severely disabled ex-servicemen), have been set aside for ex-service paraplegics, while a number of paraplegics, mostly those progressing favourably, are accommodated at the Chaseley Paraplegic Home, Eastbourne, established by the former Ministry of Pensions. The Thistle Foundation in Edinburgh also treats and houses paraplegics, as well as those disabled in other ways.

Paraplegics have special limitations and need medical supervision, but experience at Stoke Mandeville has shown that the great majority can undertake gainful work under suitable conditions. Home work can be arranged for those who cannot go out to factories. Through the co-operation of the Lord Roberts Memorial Workshops and the Enfield Clock Company, clock assembly work is being provided as a home industry for certain paraplegics who are unfit to go out to work.

A settlement at Lyme Green Hall provided by the Joint Committee for Cheshire of the British Red Cross and Order of St. John houses single paraplegics and has bungalows for married men and a clinic. Clock and watch or boot and shoe repairing, or carpentry, are undertaken, under qualified instructors.

Also built under the auspices of the British Red Cross and Order of St. John is Kytes, near Watford, Hertfordshire, a settlement where a group of specially designed bungalows for ex-service paraplegics is sited round a clubhouse and clinic, and is associated with an ordinary housing estate. The men go out to ordinary work.

A hostel at Isleworth, Middlesex, 'Duchess of Gloucester House', designed to give paraplegics maximum independence and confidence, is managed by the Ministry of Labour. It provides 70 men and a small number of women with a home and treatment and is within range of a number of light industries. The paraplegics go out daily in motor tricycles or hand-controlled motor cars to work in factories and offices in the neighbourhood.

There are about 5,000 paraplegics registered with the Ministry of Labour as disabled persons. More than 90 per cent of these are in employment or working on their own account; under 10 per cent are unemployed. About 270 paraplegics are employed under sheltered conditions in Remploy factories.

Wheeled chairs and powered vehicles are provided for the use of paraplegics and other heavily handicapped people through the hospital service (see p. 26).

Rheumatism

A number of chronic diseases of the locomotor system are commonly grouped under the name of rheumatism. There are great technical difficulties in making a precise estimate of the incidence of these diseases but the number of their victims certainly runs into millions and their adverse effect on industrial efficiency is very great.

Since 1945, certain regional schemes for the diagnosis and treatment of the chronic rheumatic diseases have been developed in accordance with the recommendations of a sub-committee of the Standing Medical Advisory Committee of the Ministry of Health. The essential feature of the schemes is the establishment of a diagnostic and research centre, preferably at a teaching hospital with a few short-stay beds, linked with hospitals, out-patient clinics and centres with facilities for rehabilitation.

REHABILITATION AND CARE OF THE DISABLED IN NORTHERN IRELAND

IN Northern Ireland provision for rehabilitation and care of disabled people is similar in character to that in other parts of Britain, and was in general made under schemes parallel to those already described. There are, however, some differences, mostly administrative, and, since Northern Ireland has its own Parliament, a different set of central departments is concerned.

The Ministry of Education and the National Assistance Board for Northern Ireland have responsibilities corresponding to those of the departments of the same names for England and Wales or Great Britain. From 1st January, 1965, the health functions of the former Ministry of Health and Local Government were joined with those of the former Ministry of Labour and National Insurance in the Ministry of Health and Social Services. This department combines central health, labour and national insurance functions but is not concerned with war pensions; these are administered throughout Britain by the Ministry of Pensions and National Insurance, which is also responsible for the provision of special treatment required by war pensioners.

The Ministry of Health and Social Services does not administer any of the health services directly. This responsibility rests with the various statutory bodies, each of which exercises wide powers. These bodies are the Northern Ireland Hospitals Authority, the Northern Ireland General Health Services Board and local health authorities, these latter being the councils of counties and county boroughs. All general hospital services, including mental hospitals and special care (that is mental deficiency institutions and services for mental defectives in the community), are in the hands of the Northern Ireland Hospitals Authority. The General Health Services Board is responsible for the provision of medical, dental, pharmaceutical and supplementary eye services in the community. Local health authorities have functions similar to their counterparts in Great Britain. In addition, there are in Northern Ireland separate local welfare authorities which provide services for the disabled under the Welfare Services Act (Northern Ireland) 1949. The statutes under which the Health Services operate are the Health Services Acts (Northern Ireland) 1948 to 1958, and the Mental Health Act (Northern Ireland) 1961. The Public Health and Local Government (Administrative Provisions) Act of 1946 is the Act under which health authorities and welfare authorities for counties and county boroughs are established.

The Disabled Persons (Employment) Acts (Northern Ireland) 1945 and 1960, which are administered by the Ministry of Health and Social Services for Northern Ireland, follow very closely the corresponding Acts for Great Britain, and reciprocal agreements made under provisions contained in these Acts enable registration as a disabled person in one country to count in the other. In exercising its functions under these Acts, the Ministry has the advice and assistance of a Central Advisory Council and nine District Advisory Committees. The steps which have been taken to implement the various provisions of the Acts are substantially the same as in Great Britain. The register, quota and designated employment schemes, the disablement resettlement officer and placing service and the facilities for vocational training and industrial rehabilitation are on similar lines. The number of registered disabled persons at 30th September, 1964, was 17,128.

Ulster Sheltered Employment Ltd. operates in Northern Ireland on the same lines as Remploy Ltd. for the employment of the severely disabled.

Sheltered employment is also provided by voluntary organisations, which receive assistance from public funds on the same scale as in Great Britain.

The national insurance, industrial injuries and family allowances schemes of Great Britain and Northern Ireland operate as a single system.

APPENDIX 1

ANALYSIS OF DISABILITIES AMONG REGISTERED DISABLED PERSONS IN GREAT BRITAIN AT 20th APRIL, 1964

Nature of Disability	Number	Percentage of Register
SURGICAL		
Amputations	48,376	7·4
Head and body injuries	27,494	4·2
Injuries and diseases of lower limbs	86,327	13·2
Injuries and diseases of upper limbs	58,489	8·9
Injuries and diseases of the spine	41,718	6·4
Tuberculosis (non-pulmonary)	7,535	1·2
MEDICAL		
Arthritis and rheumatism	28,647	4·4
Digestive system	26,230	4·0
Genito-urinary system	5,628	0·9
Heart and circulatory system	56,327	8·6
Respiratory system (except tuberculosis)	63,050	9·5
Skin diseases	6,171	0·9
Organic nervous diseases	39,677	6·0
Tuberculosis (pulmonary)	33,358	5·1
PSYCHIATRIC		
Psychoneuroses	16,626	2·5
Other mental illnesses	6,425	1·0
Mental subnormality	8,879	1·4
OTHERS		
Ear defects—total deafness	13,991	2·1
Ear defects—others	16,096	2·5
Eye defects—total blindness	10,557	1·6
Eye defects—others	36,933	5·6
Other diseases and disabilities	17,344	2·6
Total, all disabilities	655,878	100·0

APPENDIX 2

LIST OF DEPARTMENTS AND ORGANISATIONS CONCERNED WITH THE HANDICAPPED

Government Departments and Official Bodies

Department of Education and Science, Curzon Street, London, W.1.
Ministry of Health, Alexander Fleming House, Elephant and Castle, London, S.E.1.
Ministry of Labour, 8 St. James's Square, London, S.W.1.
Ministry of Pensions and National Insurance, 10 John Adam Street, London, W.C.2.
Ministry of Power, Thames House South, Millbank, London, S.W.1.
National Assistance Board, 6 St. Andrew Street, London, E.C.4.
Scottish Education Department, St. Andrew's House, Edinburgh.
Scottish Home and Health Department, St. Andrew's House, Edinburgh.
Ministry of Education, Northern Ireland, Netherleigh, Massey Avenue, Stormont, Belfast.
Ministry of Health and Social Services, Northern Ireland, Dundonald House, Belfast, 4.
National Assistance Board for Northern Ireland, Fermanagh House, Ommeau Avenue, Belfast.
Medical Research Council, 20 Park Crescent, London, N.W.1.
National Dock Labour Board, 22 Albert Embankment, London, S.E.11.
Remploy Ltd., Remploy House, 415 Edgware Road, London, N.W.2.

Professional Bodies

Arthritis and Rheumatism Council, 8 Charing Cross Road, London, W.C.2.
Association of Mental Health Workers, c/o N.A.M.H., 39 Queen Anne Street, London, W.1.
Association of Occupational Therapists, 251 Brompton Road, London, S.W.3.
Association of Psychiatric Social Workers, 1 Park Crescent, London, W.1.
British Medical Association, B.M.A. House, Tavistock Square, London, W.C.1.
British Orthopaedic Association, 45 Lincoln's Inn Fields, London, W.C.2.
British Tuberculosis Association, 59 Portland Place, London, W.1.
Chartered Society of Physiotherapy, Tavistock House (South), Tavistock Square, London, W.C.1.
College of Speech Therapists, 68 Queen's Gardens, London, W.2.
Institute of Home Help Organisers, 15 Blackheath Road, London, S.E.10.
Institute of Medical Social Workers, 42 Bedford Square, London, W.C.1.
Joint Tuberculosis Council, c/o Dr. R. Midgeley, Hawkmoor Sanatorium, Bovey Tracey, Devon.
Medical Society for the Care of the Elderly, Secretary, Dr. H. P. Jameson, Romeland Cottage, St. Albans, Herts.
National Association of Home Teachers of the Blind, 24 Berkeley Terrace, York.
Queen's Institute of District Nursing, 57 Lower Belgrave Street, London, S.W.1.
Royal Medico-Psychological Association, 11 Chandos Street, London, W.1.
Society of Medical Officers of Health, Tavistock House (South), Tavistock Square, London, W.C.1.
Women Public Health Officers' Association, 36 Eccleston Square, London, S.W.1.

Other National Bodies

British Association for the Hard of Hearing, Hon. Secretary, Mr. C. H. Mardell, Briarfield, Syke Ings, Iver, Bucks.
British Council for Rehabilitation of the Disabled, Tavistock House (South), Tavistock Square, London, W.C.1.

British Diabetic Association, 152 Harley Street, London, W.1.
British Epilepsy Association, 27 Nassau Street, Mortimer Street, London, W.1.
British Legion, 49 Pall Mall, London, S.W.1.
British Limbless Ex-Servicemen's Association, (BLESMA), 105-107 Cannon Street, London, E.C.4.
British Polio Fellowship, Clifton House, Euston Road, London, N.W.1.
British Red Cross Society, 14–15 Grosvenor Crescent, London, S.W.1.
British Rheumatism and Arthritis Association, 11 Beaumont Street, London, W.1.
Central Council for the Disabled, 34 Eccleston Square, London, S.W.1.
Chest and Heart Association, Tavistock House (North), Tavistock Square, London, W.C.1.
Ex-Services Mental Welfare Society, 37–39 Thurloe Street, London, S.W.7.
Family Welfare Association, 296 Vauxhall Bridge Road, London, S.W.1.
Forces Help Society and Lord Roberts Memorial Workshops, 122 Brompton Road, London, S.W.3.
Guide Dogs for the Blind Association, 81 Piccadilly, London, W.1.
Haemophilia Society, 94 Southwark Bridge Road, London, S.E.1.
Institute of Social Psychiatry, 9 Fellows Road, London, N.W.3.
Institute of Social Welfare, County Hall, Chester.
Inter-Regional Committee of the Regional Associations for the Blind of England and Wales, Headingley Castle, Headingley Lane, Leeds 6.
Invalid Children's Aid Association, 4 Palace Gate, London, W.8.
King Edward's Hospital Fund for London, 34 King Street, London, E.C.2.
Mental After Care Association, 110 Jermyn Street, London, S.W.1.
Multiple Sclerosis Society, 10 Stratford Road, London, W.8.
National Association for Mental Health, 39 Queen Anne Street, London, W.1.
National Association of Workshops for the Blind, 205–209 Salisbury Road, London, N.W.6.
National Corporation for the Care of Old People, Nuffield Lodge, Regent's Park, London, N.W.1.
National Council of Social Service, 26 Bedford Square, London, W.C.1.
National Deaf Children's Society, 1 Macklin Street, London, W.C.2.
National Federation of the Blind, 11 Albany Street, London, S.W.1.
National League of the Blind, 262 Langham Road, London, N.15.
National Old People's Welfare Council, 26 Bedford Square, London, W.C.1.
National Society for Epileptics, Chalfont Colony, Chalfont St. Peter, Bucks.
National Society for Mentally Handicapped Children, 5 Bulstrode Street, London, W.1.
Nuffield Foundation, Nuffield Lodge, Regent's Park, London, N.W.1.
Order of St. John, St. John's Gate, London, E.C.1.
Royal National Institute for the Blind, 224 Great Portland Street, London, W.1.
Royal National Institute for the Deaf, 105 Gower Street, London, W.C.1.
Royal Society for the Promotion of Health, 90 Buckingham Palace Road, London, S.W.1.
St. Andrew's Ambulance Association, 98–108 North Street, Charing Cross, Glasgow, C.3.
St. Dunstan's (for war-blinded), 191 Marylebone Road, London, W.1.
Scottish Association for the Deaf, 85 Queen Victoria Drive, Glasgow, 4.
Scottish Association for Mental Health, 57 Melville Street, Edinburgh, 3.
Scottish Council of Social Service (Committee on the Welfare of the Disabled), 10 Alva Street, Edinburgh, 2.
Scottish Council for the Care of Spastics, Rhuemore, Corstorphine Road, Edinburgh, 12.
Scottish Epilepsy Association, 24 St. Vincent Place, Glasgow, C.1.

Scottish National Federation for the Welfare of the Blind, 4 Coates Crescent, Edinburgh, 3.
Scottish National Institution for the War Blinded, Gillespie Crescent, Edinburgh, 10.
Scottish Old People's Welfare Committee, 10 Alva Street, Edinburgh, 2.
Scottish Society for Mentally Handicapped Children, 69 West Regent Street, Glasgow, C.2.
Shaftesbury Society, 112 Regency Street, London, S.W.1.
Spastics Society, 12 Park Crescent, London, W.1.
Special Schools Association, Miss G. L. Vaughan, 356 Yardley Wood Road, Birmingham, 16.
Thistlecraft Ltd., 22 Charlotte Street, Edinburgh.
Tuberculosis Rehabilitation Council, Barrowmore Hall, Gt. Barrow, Cheshire.
Women's Voluntary Service, 41 Tothill Street, London, S.W.1.

APPENDIX 3

READING LIST

Statutes

		s.	d.
Disabled Persons (Employment) Act 1958	*HMSO*		6
———(Northern Ireland) 1960	*Belfast, HMSO*		6
Disabled Persons (Employment) Act 1944	*HMSO*		9
———(Northern Ireland) 1945	*Belfast, HMSO*		6
Education Act 1944	*HMSO*	6	6
Education (Scotland) Act 1962	*HMSO*	7	0
Industrial Diseases (Benefit) Act 1954	*HMSO*		3
Mental Health Act 1959	*HMSO*	10	0
Mental Health Act (Northern Ireland) 1961	*Belfast, HMSO*	8	6
Mental Health (Scotland) Act 1960	*HMSO*	6	0
National Assistance Act 1948	*HMSO*	4	6
———(Amendment) Act 1962	*HMSO*		3
National Health Service Act 1946	*HMSO*	6	0
National Health Service (Scotland) Act 1947	*HMSO*	5	0
National Insurance Act 1946	*HMSO*	5	0
National Insurance (Industrial Injuries) Act 1946	*HMSO*	5	0
Pneumoconiosis and Byssinosis Benefit Act 1951	*HMSO*		2
Trading Representations (Disabled Persons) Act 1958	*HMSO*		6
———(Northern Ireland) 1958	*Belfast, HMSO*		6
Welfare Services Act (Northern Ireland) 1954	*Belfast, HMSO*		4
———(Amendment) Act (Northern Ireland) 1961	*Belfast, HMSO*	1	0

Annual Reports[1]

DEPARTMENT OF HEALTH FOR SCOTLAND: Health and Welfare Services: Report for 1963. Cmnd. 2359	*HMSO*	1964	6	0
HEALTH AND LOCAL GOVERNMENT ADMINISTRATION IN NORTHERN IRELAND: Report for 1962 and 1963. Cmd. 474.	*Belfast, HMSO*	1964	10	0
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[1]See also annual reports of voluntary organisations listed in Appendix 2.

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