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Contributors

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DEPARTMENT OF HEALTH AND SOCIAL SECURITY
WELSH OFFICE

Central Health Services Council

Rehabilitation

Report of a Sub-Committee of the Standing Medical Advisory Committee

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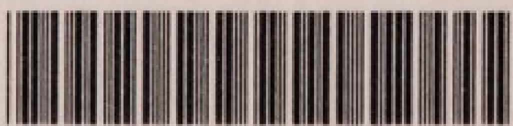
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Central Health Services Council

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*Appointed 27 September 1968. Resigned 31 March 1969.
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FOREWORD

(i) Insufficient attention is paid to the rehabilitation of the sick and injured. We believe that the restoration of normal or near normal capacities will become increasingly important during the next decade so that the need for rehabilitation is urgent. It is a problem which must be tackled now.

(ii) We consider six points to be of particular importance:

(*a*) first and foremost the Department of Health and Social Security is the government department with the major involvement in rehabilitation, and in consequence we recommend that the Department of Health and Social Security should be charged with primary responsibility for the development and co-ordination of the rehabilitation services;

(*b*) we propose that each regional hospital board or equivalent authority should appoint a regional medical adviser in rehabilitation, supported by an advisory committee to ensure that adequate and effective rehabilitation services are established throughout the country;

(*c*) we believe that every district general hospital should have a unified department of rehabilitation, and a community of 200,000 will require 100 places for general rehabilitation, 80 places for geriatric rehabilitation and 160 places for psychiatric rehabilitation. Remedial staff should be allocated fairly to the three sections of the department;

(*d*) we do not think that rehabilitation need be the prerogative of Physical Medicine and Rheumatology. We believe consultants from any clinical specialty with the interest, the necessary postgraduate training in rehabilitation and the normally accepted qualifications could be in charge of rehabilitation departments and should be called consultants in rehabilitation;

(*e*) we stress the need to ensure continuing assessment—it is an active process associated with change—and recommend that assessment clinics should be held in every rehabilitation department to act as the focal point for all services concerned both in the community and in the hospital. All staff involved with the patient should be able to attend assessment clinics;

(*f*) finally we recommend the encouragement of research into all aspects of rehabilitation and the early establishment of some professorial chairs of rehabilitation to form a nucleus of academic research and teaching.

(iii) It is eighteen years since the committee set up under the chairmanship of Lord Piercy reported authoritatively on rehabilitation, yet few of the important and practical recommendations in the report have been implemented. The Piercy Committee were largely concerned with the rehabilitation of persons of working age suffering in the main from physical disability. It may be that the long period of full employment and increased affluence in our society which followed the publication of the report muted the urgency of the reforms needed to establish a more comprehensive rehabilitation service.

(iv) Since then other factors have emerged. The changing pattern of disease due to improved preventive measures, more effective methods of treatment, the change in the age distribution of the population, increased awareness of mental ill health, generally improved standards of living, nutrition and health as well as the greater concern for personal care rather than institutionalisation have all contributed to the recognition amongst the professions and the public of the importance of temporary illness and permanent disability.

(v) The benefits of the National Health Service are today accepted and appreciated but there is a belief that they should be extended to meet the changed pattern of disability. The community is increasingly conscious of the need to provide the means for all to have the best help available to avoid or minimise the effects of mental and physical disability.

(vi) There are already centres of excellence in rehabilitation but they are few in number and have resulted from inspired local leadership rather than central plannidg. To establish the standards for a national service it is necessary to set up a broad administrative framework within which it is possible to use the skills of the medical and other professions, to foster communications between different services and departments and to provide adequate resources.

CONTENTS

		Paragraphs
INTRODUCTION		1–6
Chapter 1	BACKGROUND	7–13
Chapter 2	EXISTING SERVICES	14–45
	Hospital services	15–23
	Regional medical service	24
	Local authority rehabilitation services	25–30
	Voluntary organisations	31
	Services provided by the Department of Employment	32–41
	Other services	42
	Variation in the provision of existing services	43–45
Chapter 3	REASONS FOR FAILURE OF PRESENT PROVISION	46–78
	General lack of appreciation of the importance of rehabilitation	47–48
	Lack of interest in rehabilitation	49–53
	Medical education	54
	Poor organisation	55–62
	Nature of legislation affecting local authority provision	63–66
	The size of the problem	67–71
	Psychiatry and geriatrics	72–75
	The remedial professions	76–82
	Conclusions	83–84
Chapter 4	CONCEPTS OF REHABILITATION	85–92
RECOMMENDATIONS		
Chapter 5	THE ORGANISATION OF THE REHABILITATION SERVICES	93–105
	Statistical information on rehabilitation	97
	Research into rehabilitation	98–99
	Adviser on rehabilitation at regional level	100–101
	Location of rehabilitation facilities	102–105
Chapter 6	HOSPITAL REHABILITATION SERVICES	106–177
	Organisation of hospital rehabilitation services	106–110
	Nature of provision in the general rehabilitation department	111–114
	The consultant in charge of the rehabilitation department	115–122
	Organisation of the rehabilitation department	123–126
	Day to day organisation of the general rehabilitation department	127–131
	Assessment clinics	132–139
	The hospital rehabilitation team	140
	Medical staff	141
	Clinical psychologists	142

		Paragraphs
	The hospital nurse	143–148
	Remedial professions	149–155
	Speech therapists	156
	Staffing of hospital rehabilitation services	157
	Social workers in hospitals	158–159
	Hospital rehabilitation officers	160–162
	Workshop staff	163–166
	Workshop contracts	167
	Hostel accommodation	168–170
	Discharge procedures	171–174
	Hospital convalescent treatment	175–177
Chapter 7	REHABILITATION FACILITIES FOR CHILDREN	178–193
Chapter 8	REHABILITATION OF THE AGED	194–203
Chapter 9	REHABILITATION OF THE MENTALLY ILL	204–235
	Future pattern of services for the mentally ill	204–209
	Rehabilitation of the mentally ill	210–213
	Nominated consultant in charge of psychiatric rehabilitation	214–217
	Industrial rehabilitation of the mentally ill	218–221
	Workshops	222–228
	Staffing	229–235
	Clinical psychologists	229
	Nurses	230–231
	Remedial professions	232–233
	Workshop managers and supervisors	234–235
Chapter 10	REHABILITATION OF THE MENTALLY HANDICAPPED	236–239
Chapter 11	HOSPITAL REHABILITATION FACILITIES FOR SPECIAL CATEGORIES OF PATIENTS	240–257
	The blind and partially sighted	242–243
	The deaf and hard of hearing	244
	People with epilepsy	245
	Trauma, including head injuries and spinal injuries	246–247
	Head injuries	248–252
	Spinal injuries	253–255
	Drug or alcohol dependency	256–257
Chapter 12	AIDS FOR THE DISABLED	258–271
	The artificial limb service	258–260
	Integration of the limb fitting service	261–263
	Arrangements at district general hospitals	264–266
	Special artificial limb centres	267–268
	Voluntary work for the limbless	269
	Aids and appliances	270–271
Chapter 13	HEALTH IN THE COMMUNITY	272–324
	HEALTH SERVICES OUTSIDE HOSPITAL	273–303
	The general practitioner	273–277

		Paragraphs
	The relationship between the general practitioner and the hospital	278–281
	Direct access to hospital physiotherapy services by general practitioners	282–283
	The district nurse	284–286
	The health visitor	287–289
	The community physician	290
	Ambulance services	291–294
	The development of health centres	295–297
	Physiotherapy in health centres	298–299
	Domiciliary physiotherapy	300–302
	The school health service	303
	LOCAL AUTHORITY SOCIAL SERVICES	304–324
	The local authority social services department	309–310
	The social worker	311–312
	Residential accommodation	313–315
	Day centres	316–319
	Sheltered employment	320–321
	Home adaptations	322
	Recuperative holidays	323
	Information services	324
Chapter 14	THE ROLE OF VOLUNTARY ORGANISATIONS	325–332
Chapter 15	EDUCATION IN REHABILITATION	333–356
	The Undergraduate	334–338
	The Postgraduate	339–340
	Further education	341–342
	Training in psychiatry	343–345
	Training for nurses	346
	Training for the remedial professions	347–353
	Education of the public	354–356
		Pages
SUMMARY OF RECOMMENDATIONS		105–112
APPENDICES (See list on page 8)		113–178
INDEX		179–187

APPENDICES

I References.
II List of organisations and individuals who submitted written and/or oral evidence.
III List of establishments visited by members.
IVA List of official memoranda on rehabilitation.
IVB Summary of advice on rehabilitation issued by Health Departments.
V List of voluntary organisations known by the Committee to have an interest in rehabilitation.
VI List of Industrial Rehabilitation Units in England and Wales.
VII Department of Employment Statistics on Industrial Rehabilitation Units
Table 1. Analysis by main disability of persons terminating prematurely.
Table 2. Analysis by main disability of persons completing a course or terminating prematurely.
Table 3. As Table 2 but by percentages.
Table 4. Numbers admitted during the six months January–June, 1970 by sources of recruitment.
Table 5. As Table 4 but by categories of disability.
VIII List of Government Training Centres in England and Wales.
IX Social security and rehabilitation.
X Training credits.
XI Report on a survey of rehabilitation in large hospitals.
XII Distribution of consultants in physical medicine, by regions.
XIII Sickness benefit statistics.
XIV The purpose and organisation of the assessment clinic.
XV Report of a conference on rehabilitation after head injury.
XVI Report of a conference on the future of the services for paraplegics.
XVII Report of a conference on rehabilitation of the limbless.
XVIII Bibliography on rehabilitation of the mentally ill and handicapped.

INTRODUCTION

1. The Standing Medical Advisory Committee of the Central Health Services Council set up the Sub-Committee on Rehabilitation in May 1968, with the following terms of reference:

> "To consider the future provision of rehabilitation services in the National Health Service, their organisation and development, and to make recommendations."

2. In the course of our deliberations we consulted with the Standing Mental Health Advisory Committee, the Advisory Committee on the Health and Welfare of Handicapped Persons, the Standing Medical Advisory Committee's Sub-Committee on Group Practice, the Joint Sub-Committee on People with Epilepsy, and the Scottish Standing Medical Advisory Committee's Sub-Committee on Rehabilitation. Members of the Standing Nursing Advisory Committee have had an opportunity to consider our conclusions and their comments have been taken into account in the final report. All the services provided by the Department of Employment are outside our terms of reference, but we consulted with the Department and received evidence from them and from the Medical Committee of the National Advisory Committee for the Employment of the Disabled.

3. We worked in association with the Committee on the Remedial Professions which was appointed by the Secretary of State for Social Services and the Secretaries of State for Scotland and Wales in June 1969 with the terms of reference "to consider the function and inter-relationship of occupational therapists, physiotherapists and remedial gymnasts in the National Health Service, their relation to other personnel concerned with rehabilitation and the broad pattern of staffing required, and to make recommendations." To ensure a close liaison between the two committees four members of our Sub-Committee were also members of the Committee on the Remedial Professions.

4. We received written and oral evidence from the organisations and individuals listed in Appendix II and we would like to thank them for their contributions. On three occasions oral evidence was heard together with members of the Committee on the Remedial Professions. We also visited a number of establishments which provide various forms of rehabilitation and we would like to record our thanks to the people who gave us the benefit of their knowledge during our visits. A list of places visited is in Appendix III. We met in full committee 30 times.

5. Originally the joint secretaries to the Sub-Committee were Dr. C. Seeley and Miss A. M. Whitecross. Miss Whitecross resigned in January 1969 and was replaced by Miss M. F. P. Boys and in September 1969 Dr. Seeley retired and was replaced by Dr. D. C. Ower. In June 1970 Miss Boys gave up the post because of ill health and she was replaced by Mrs. S. E. Reeve.

6. We would like to place on record our thanks to the various officers of the Department of Health and Social Security who have participated in our discussions. Our deliberations were protracted partly because of major depart-

mental re-organisations and partly due to the changes in personnel which placed a very heavy burden on the secretariat. We wish in particular to express our sincere thanks to Mrs. Suzanne Reeve, Mr. L. W. Godfrey and Dr. D. C. Ower of whom we demanded so much when they had to piece together the deliberations of three years, for their readiness to meet our demands, despite the pressure of other duties, and often at great inconvenience to themselves, and to all of the above for the efficient and friendly manner in which they made the arrangements for our meetings, our visits and for the attendance of our visitors.

CHAPTER 1

BACKGROUND

7. We do not feel it is necessary for us to provide an historical survey of the development of rehabilitation services before the introduction of the National Health Service on 5 July 1948. Earlier committees have covered this ground and it is sufficient to recall that the most rapid periods of progress occurred during the wars of 1914–1918 and 1939–1945. The main pioneer of rehabilitation in this country prior to and during the First World War was Sir Robert Jones, who collaborated with G. R. Girdlestone in 1919 to propose a national scheme for the cure of crippled children (1) but little came of this except in a few isolated centres. The Second World War saw a resurgence of interest in rehabilitation when departments were set up in hospitals run by the emergency medical service and special rehabilitation centres were established in the armed services. Much of the early development of rehabilitation in the post-war years was influenced by these war-time experiences. The rehabilitative techniques were applied to civilians of all ages as well as servicemen and seen to be effective.

8. In 1941 the Ministry of Labour set up an Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons (2). The Committee reported in 1943 and their recommendations laid the foundations for a comprehensive resettlement service for disabled people.

9. The advent of the National Health Service made it possible to tackle the development of medical rehabilitation services on a national scale. Advice on the subject was issued to hospitals, family doctors and local authorities by the Health Departments, who tried to encourage those responsible for hospital administration to develop adequate rehabilitation services. Appendix IV summarises the advice given in memoranda sent to hospital boards, local authorities and executive councils since 1948.

10. In 1953 a committee 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 contributions, and to make recommendations". This was the Piercy Committee (3) which reported in 1956. Hospital authorities were advised on the action to be taken following the recommendations of the Piercy Report in a hospital memorandum (H.M.(58)57). The memorandum emphasised that rehabilitation should be a continuous process beginning with the onset of sickness or injury and that one consultant should be designated to organise and supervise the hospital rehabilitation facilities. These facilities should be concentrated in a department of physical medicine, and resettlement clinics should be set up to assess disability and recommend appropriate rehabilitation. It also emphasised the need for co-operation between all services concerned in rehabilitation.

11. In 1957 the Report of the Royal Commission on Mental Health was published (4). It was followed by the Mental Health Act of 1959 which reformed the law relating to compulsory powers to detain mentally ill people

in hospital. By encouraging early discharge it created a greater need for rehabilitation facilities, and a hospital memorandum on "improving the effectiveness of hospitals for the mentally ill" (H.M.(64)45), stressed the part that rehabilitation should play in psychiatric treatment.

12. Mental illness and the recurrent and progressive medical disorders which can benefit from rehabilitation are referred to in a memorandum sent to general practitioners in 1959. Entitled "Rehabilitation of the Sick and Injured", the memorandum was prepared by the Standing Medical Advisory Committee. It set out the general principles underlying modern methods of rehabilitation and indicated the essential contribution which can be made by the general practitioner. It pointed out that the recurrent and progressive disorders could benefit from rehabilitation but tended to be overlooked in rehabilitative treatment although they were numerically greater than the stable disabilities for which most rehabilitation was provided.

13. Recently the Chronically Sick and Disabled Persons Act has drawn attention to the problems of people of all ages who are handicapped by chronic sickness and disablement, and the Survey of the Handicapped and Impaired in Great Britain (5) has provided a considerable quantity of information, previously unobtainable, about the problems of physical handicap. The impact of these developments cannot be assessed at the present time.

CHAPTER 2

EXISTING STATUTORY SERVICES

14. Rehabilitation in the National Health Service is carried out by various agencies in the hospital and community services. In order to attempt an evaluation of the existing services it is necessary first to look at the general pattern of provision. Secondly, because of the close association between these services and the industrial rehabilitation and resettlement services, cognizance must be taken of the services provided by the Department of Employment.

Hospital services

Rehabilitation facilities

15. Some rehabilitation facilities are provided at most general hospitals normally in association with departments of physical medicine. They are available to patients of all ages, on medical recommendation, who have some form of physical disability, temporary or permanent. However, in spite of the importance of such facilities their provision throughout the hospital service is uneven and they are not always used effectively. Although measures to speed recovery and prevent undue loss of function should be instituted as soon as possible, clinicians do not pay sufficient attention to this; the physiotherapy or occupational therapy services are frequently misused, if used at all; the social worker may never be called in to see patients whom she could assist. There are some departments of excellence, but the overall pattern leaves much to be desired.

16. In some hospitals the needs of patients with substantial disability who may well require comprehensive help of various kinds to assist their return to the community are discussed at resettlement clinics* or case conferences which should be attended by the consultant in physical medicine, the consultant in charge of the patient, the social worker, the disablement resettlement officer of the Department of Employment and whenever possible, the patient's general practitioner. These arrangements are by no means common practice.

Rehabilitation hospitals and medical rehabilitation centres

17. Within the National Health Service there are a few medical rehabilitation centres and some institutions described as "hospitals" which provide re-

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*Resettlement clinics are not to be confused with medical interviewing committees, which are a responsibility of the Department of Employment. These are described in full in paragraph 33: the main difference between a medical interviewing committee and a resettlement clinic is that the former is expected to give expert advice on patients who may well have been unknown to them previously, whereas all those attending the latter have some connection with the patients whose cases are being considered. A resettlement clinic should be part of the ordinary activities of the hospital.

habilitation but are not hospitals in the true sense. Some are general, catering for all types of patients while others will only accept patients with specific disabilities. The majority of the centres are residential and patients attend at all stages of recovery once they are past the initial stages of illness requiring treatment in an acute hospital. Since 1968 one of these medical rehabilitation centres has been combined with an industrial rehabilitation unit which is run by the Department of Employment in the grounds of the medical rehabilitation centre. However fourteen years elapsed before this experimental comprehensive medical and industrial rehabilitation centre was established in accordance with the recommendations of the Piercy Committee, and it is still the only one of its kind.

18. There are seven miners' rehabilitation centres in England and Wales which were planned to cater for miners who sustained severe injuries but nowadays they take other groups of patients. The centres are administered by the regional hospital boards through individual hospital management committees.

Convalescence

19. Although all hospital authorities continue to provide limited convalescen facilities, statistics provided by the Department of Health and Social Security show that this is a gradually declining medical activity. In the 11 year period 1958–1969 the average daily occupancy of hospital convalescent beds fell from 1,938 to 1,181, a reduction of 39 per cent. In the same period the number of patients receiving convalescent treatment under contractual arrangements also decreased by approximately 37 per cent from 17,786 to 11,276.

Rehabilitation for mentally handicapped patients in hospital

20. Hospital rehabilitation for mentally handicapped patients necessarily takes a different form from the rehabilitation programme for physically disabled people. In hospitals for the mentally handicapped, the aim is to provide assessment and training, which in the case of the most able patients will stabilise them and enable them to live in the community. This is achieved by making the hospital a self-contained community with a wide range of workshops, recreational and social facilities. Earnings are intended to act as an incentive towards rehabilitation and while the majority of mentally handicapped patients remain in hospital for many years, an increasing number leave hospital daily to work in the community, and ultimately are discharged to live in the community.

Rehabilitation for mentally ill patients in psychiatric hospitals

21. Rehabilitation facilities for mentally ill patients in psychiatric hospitals are directed towards prevention of personality deterioration. In this connection the concept of the therapeutic community is widely adopted, and this has resulted in more effective rehabilitation. The majority of psychiatric hospitals operate industrial therapy units as a step towards the total rehabilitation of patients and also for those patients who are only able to work in sheltered conditions.

Rehabilitation for handicapped children

22. Increasingly early recognition of potential and established handicap in young children is not followed sufficiently widely by comprehensive programmes for assessment and rehabilitation in which the education and social services departments of the local authority must be closely involved. Following a report (6) a system of district and regional assessment centres has been recommended but as yet not widely implemented.

The artificial limb and appliance service

23. A comprehensive service is provided by the Department of Health and Social Security to meet the needs of amputees. There are 30 centres in England and Wales distributed geographically to ensure that amputees need not undertake excessive travelling. At each centre there are medical officers experienced in the prescription and fitting of artificial limbs and some take responsibility for the care and rehabilitation of amputees. Centres also arrange for the provision of invalid vehicles and supply certain other appliances including artificial eyes. In 1967 the Biomechanical Research and Development Unit was established at Roehampton to investigate all aspects of artificial limbs and equipment development.

Regional medical service

24. The regional medical service of the Department of Health and Social Security is based on six divisional medical offices in England. A similar service exists in Wales. The service undertakes the examination of persons who are absent from their employment because of sickness or injury and who have been referred by the Department of Health and Social Security or the Department of Employment in connection with claims for financial benefit, when a second medical opinion is required on their incapacity or fitness for work. General practitioners may also make use of the service. Regional medical officers can play a useful part in rehabilitation by drawing attention in their reports to cases which would benefit from the facilities provided. For example, some 17 per cent of rehabilitees admitted to industrial rehabilitation units in the first six months of 1970 were referred from the regional medical service (see Table 4 of Appendix VII).

Local authority rehabilitation services

With the exception of medical, nursing and ambulance services, the services described below are now provided by local authority social service departments.

Day centres for physically handicapped adults

25. Day centres are either provided directly by local authorities or by voluntary organisations acting as agents of the local authorities. The people who attend these centres suffer from many forms of physical disability and are unable to secure open or sheltered employment. The early centres provided only diversionary and social activities but greater emphasis is now placed on the provision of more purposeful work with some element of financial incentive.

Training centres for mentally handicapped adults

26. These centres are provided by local authorities and to a lesser extent by voluntary organisations. The aim is to provide a balanced programme of work, training and further education for all mentally handicapped adults who do not necessarily require hospital treatment and some of whom are able to live in the community. Work undertaken varies from simple assembly to the use of manual and powered machinery and again financial incentives have an important part to play. Trainees are also given social training e.g. home making, use of public transport etc.

Day centres for the mentally ill

27. Local authorities also make provision for mentally ill persons including former psychiatric in-patients who need occupation and social integration. However, provision is poor compared with that for the mentally handicapped: on 1st January 1971 there were 83 centres with 2,616 places for the mentally ill compared with 293 centres with 21,892 places for mentally handicapped adults.* The centres mainly provide social and group activities to further rehabilitation but some undertake industrial contract work. Some centres take both mentally and physically handicapped patients and all centres must be able to cope with patients with multiple handicaps.

28. These centres are non-residential but some local authorities also provide residential accommodation in the form of hostels, group homes and sheltered housing for those people who are unable to live with their families or in their own homes.

Ancillary services

29. Local authorities can provide a variety of supportive services which in many cases enable disabled patients who would otherwise remain in hospital to live in the community. These include home-helps, meals-on-wheels and a service of adapting the homes of physically disabled patients, particularly those in wheelchairs, e.g. to provide ramps, widen doorways etc., in order to give them a greater degree of mobility and independence. In some circumstances the medical officer of health may recommend a change of housing or specialised housing to the housing department. The organisation and control of the ambulance service is also a local authority responsibility and this service is important in enabling patients living at home to attend day hospitals and out-patient clinics for rehabilitation.

30. Local authorities employ district nurses and health visitors to provide primary health care in the homes of disabled persons, and social workers to provide support and help with socio-medical and psycho-social problems. The roles of these disciplines in the future organisation of the rehabilitation services are discussed in subsequent chapters.

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*Information provided by the Department of Health and Social Security.

Voluntary organisations

31. Organised voluntary effort for the care of the sick and disabled is traditional in Britain. Numerous voluntary organisations further and protect the interests of various groups of handicapped persons. Organisations usually represent a specific handicap or disability. They provide a variety of training and social facilities as well as residential accommodation, transport services, support for the families of disabled people and general publicity to educate the public about the needs of handicapped persons. A list of voluntary organisations known to us to be concerned primarily with illness and rehabilitation is given in Appendix V.

Services provided by the Department of Employment

The disablement resettlement officer

32. Under provisions contained in the Disabled Persons (Employment) Act 1944 the Department of Employment maintains a register of disabled persons and provides a specialist placing service operated through disablement re-settlement officers whose duties include advising disabled people and helping them to obtain suitable work in the light of a careful assessment of their individual capacity. For this assessment medical advice is essential on the function and capacity of disabled people and on any special conditions of employment which ought to be observed or avoided.

Medical interviewing committees

33. Medical interviewing committees were introduced in 1946. Their function is to interview disabled persons who are in need of advice regarding employment and to furnish medical reports for the guidance of the general practitioner and the disablement resettlement officer. Although the work of the committees are considered to be outside the National Health Service, they usually consist of two members, one nominated by the hospital service and the other a doctor with industrial experience. They are held occasionally in some of the larger hospitals at the request of the disablement resettlement officer.

Industrial rehabilitation units

34. Under the Disabled Persons (Employment) Acts 1944 and 1958 the Department of Employment provides courses of industrial rehabilitation at industrial rehabilitation units. At the present time there are twenty-four units (see Appendix VI) distributed throughout the country of which one is residential. The majority are associated with government training centres (see paragraph 39).

35. The aim of the course is resettlement by restoring the maximum degree of fitness for employment in people whose physical or mental work capacity has

declined through sickness or injury, to help them regain confidence in their ability to obtain and keep a job, and to adapt themselves mentally and physically to working under regular industrial conditions. Vocational guidance based on an assessment of physical and mental aptitudes and capacities is followed by all the necessary steps to place people in gainful employment or where appropriate, in vocational training.

36. The duration of the course is usually from six to eight weeks but they can last longer, up to a normal maximum of twelve weeks, with extension in exceptional cases up to twenty-six weeks. Entrants to the industrial rehabilitation units do not need to be "fit for work" before admission but in practice they must be certified as fit medically, i.e. active medical treatment, including the fitting of any appliances, must be complete, and the unit's medical officer must consider that they are likely to be fit for employment or vocational training by the end of the course, that is within six to eight weeks.

37. The statistics reproduced in Table 2 of Appendix VII to this report show that during the period January–June 1970 a total of 7,380 persons commenced a course of industrial rehabilitation at an industrial rehabilitation unit. Out of the total of 7,380 entrants, only 4,394 were recruited from medical sources. About one person in six fails to complete the course arranged for them, and for about half of these the cause is medical as often a subsidiary illness develops during the course. An analysis of some reasons for premature termination of courses is set out in Table 3 of Appendix VII. Of those who complete the course—about 10,000 persons per year—half are placed in suitable employment within thirteen weeks of completing their course and approximately one in six is sent for vocational training to a government training centre where they learn a skilled trade.

38. Psychiatric cases form 20–25 per cent* of admissions throughout the country and despite the fact that there are always considerable numbers of psychiatric patients awaiting entry to industrial rehabilitation units, the Department of Employment feels that if this proportion was substantially increased it would have a detrimental effect both on the psychiatric patients and the service as a whole.

Government training centres

39. The Department of Employment also provides courses of vocational training at government training centres (see list at Appendix VIII) many of which adjoin industrial rehabilitation units. This arrangement has certain practical advantages; for example trainees can graduate from rehabilitation to a training course without having to travel or change their accommodation, and certain facilities such as the canteen can be shared between the two buildings. The training courses are intensive and organised on the basis of a standard five-day working week. They are 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.

*Written evidence of the Department of Employment.

Sheltered workshops

40. Also under the Disabled Persons (Employment) Acts 1944 and 1958, the Department of Employment provides sheltered employment facilities for people who are so severely disabled that they are unlikely to obtain employment under ordinary conditions. Sheltered workshops are run either by local authorities or by voluntary organisations on an agency basis with financial support from the Department of Employment. In addition to the general workshops there are a number which cater solely for the blind.

Remploy Limited

41. Apart from this general provision the former Ministry of Labour set up a company—Remploy Limited—which has 76 factories and which provides sheltered employment for severely disabled people who are able to work for a full working day in sheltered conditions.

Other services

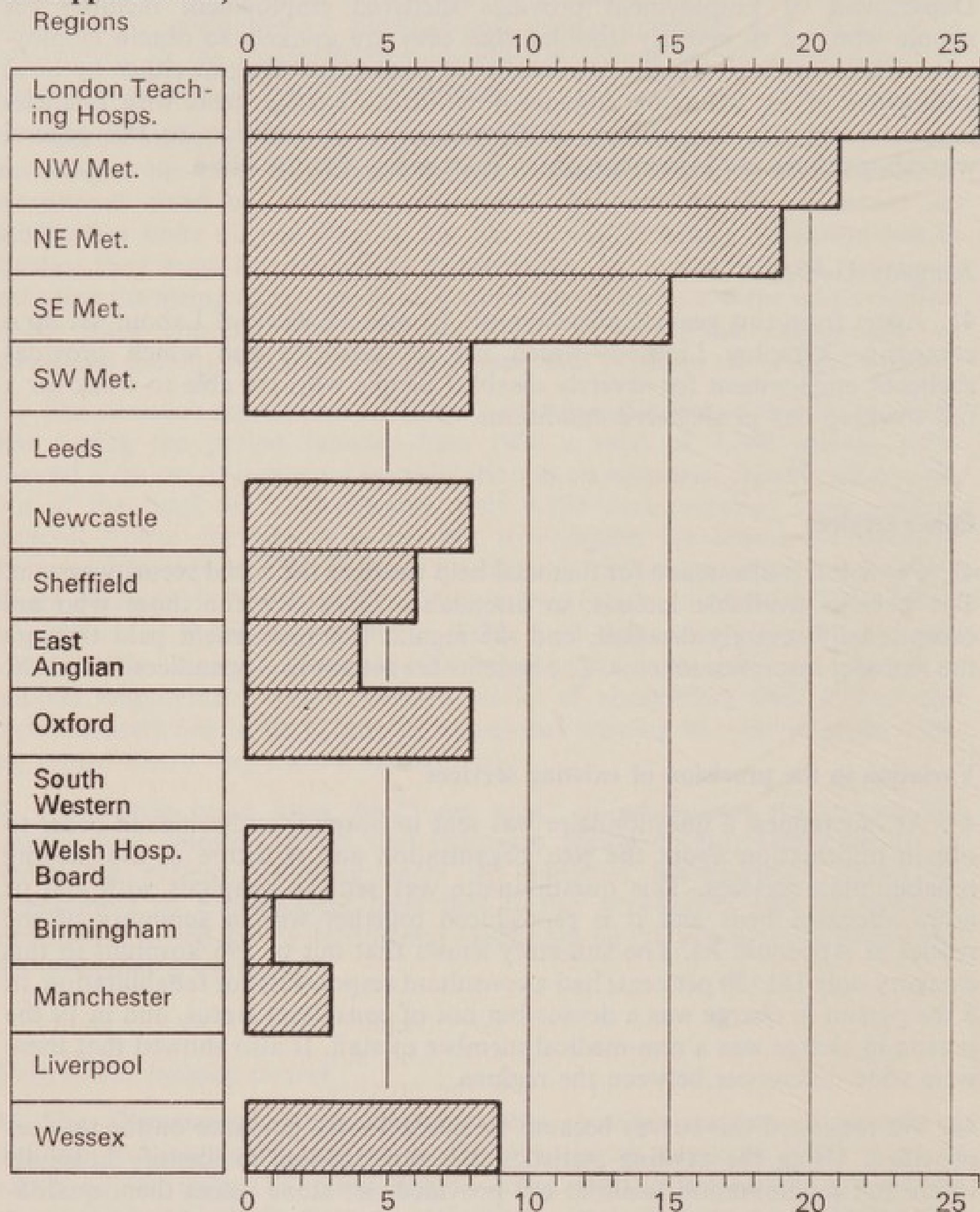
42. Provision is also made for financial help through the social security system. The benefits available include an attendance allowance for those who are exceptionally severely disabled, and the regular sickness benefit paid through the national insurance scheme. The benefits are set out in Appendices IX and X.

Variation in the provision of existing services

43. At our request a questionnaire was sent to hospital authorities in order to obtain information about the size, organisation and structure of the existing rehabilitation services. This questionnaire was sent to hospitals with 200 or more allocated beds and it is reproduced together with a summary of the replies at Appendix XI. The summary shows that out of 596 hospitals in this category only 181 (30 per cent) had a consultant responsible for rehabilitation, in 8 the person in charge was a doctor but not of consultant status, and in 19 the person in charge was a non-medical member of staff. It also showed that there were wide differences between the regions.

44. We requested this survey because we needed some guidance on the services provided. Using the existing statistics it is not possible to identify hospitals where full rehabilitation facilities are provided, let alone assess them qualitatively. Although the number of consultants in physical medicine has increased since 1956, their distribution (Appendix XII) suggests wide differences between the regions in the provision of rehabilitation services. In June 1971 there were 89 consultants in physical medicine in the London metropolitan area and only 39 consultants in this specialty in the remaining 10 regions, Oxford and Wessex having the most with 8 and 9 respectively and at the other end of the scale 3 regions, Liverpool, South Western and Leeds had no consultants in this specialty. In Wales there were 3. In the psychiatric and geriatric services there is no information on the number of consultants with special responsibility for rehabilitation.

Distribution of consultants in Physical Medicine and Rheumatology* in the National Health Service in England and Wales, June 1971 (for previous years see Appendix XII)



* These figures exclude consultants in Rheumatology only.

45. It is difficult to assess the provision made by local authorities in relation to need because of the difficulty of defining common criteria. The recently published survey of the handicapped (5) has provided a great deal of new information about the size of the problem of handicap and the extent to which certain services are provided for handicapped people on a national basis. It does not however indicate the extent to which specific services should be developed, nor does it make allowance for the individual variation in response to the same disability and the consequent differing demands upon the services.

CHAPTER 3

REASONS FOR FAILURE OF PRESENT PROVISION

46. We have received considerable evidence on the reasons for the deficiencies in the rehabilitation services from the organisations most concerned with rehabilitation, as well as from those with wider interests. While many reasons are cited, no single factor emerges as the failing which, if remedied, would automatically correct all others, but taken together, all the factors contribute to a general pattern of inadequacy. In the following paragraphs we attempt to identify the problems as we see them and to examine the nature of the failure and its causes.

General lack of appreciation of the importance of rehabilitation

47. During our deliberations we have been concerned by the failure on the part of administration, the medical and para-medical professions and the general public to appreciate the importance of effective rehabilitation. To some extent this failure has been concealed by circumstances. In the recent past full employment has masked the problem amongst males of working age; because it has been relatively easy to find work, there has been no pressing need to recognise the importance of good rehabilitation and little demand to provide it. Paradoxically the improved social security benefits which have done so much to alleviate financial anxiety during sickness sometimes militate against the incentive to return to work.

48. Many of the rehabilitation facilities that exist are based on the objective of a return to employment as soon as possible but a major change has taken place which makes this no longer the sole or even primary goal of rehabilitation. Two-thirds of the demand for the rehabilitation services comes from geriatric and psychiatric patients, for many of whom return to employment is not a relevant consideration. In these two specialties, the need for rehabilitation in the widest sense has been recognised and although the services are still inadequate, much pioneering work in the provision of rehabilitation services has been done in these fields. However other patients who do not have return to employment as a target but nevertheless need rehabilitation, for example, housewives and adolescents, have not fared so well.

Lack of interest in rehabilitation

49. Within the context of lack of interest, the medical profession must take due share of the blame. While there are some first class facilities in this country, they tend to be isolated and largely dependent upon the drive and leadership of an individual doctor and sufficient interest has not been created elsewhere for others to follow. Although much advice has been issued by the health departments, this has not been implemented generally by health authorities. There has been a general failure to appreciate the changing nature of the problem or the

growing need, and unless doctors are interested and prepared to press the interest, there is little or no effective pressure on hospital boards to provide the necessary rehabilitation facilities and to appoint a consultant to be in charge of them.

50. The British Association of Physical Medicine and Rheumatology comment on this aspect in their written evidence to the sub-committee:

> "The main hindrance to the development of rehabilitation services at the present time is the low level of interest in the medical profession as a whole and divided views concerning the need for and roles of the medical, para-medical and other categories of skilled staff in the rehabilitation services. Consequently in medical advisory committees the ever pressing need for additional accommodation, equipment and staff for diagnosis and definitive treatment tends to be given priority and the provision of additional facilities for rehabilitation postponed more or less indefinitely."

We consider this to be fair comment.

51. Many people fall into the trap of associating rehabilitation mainly with the management of permanent disability and the present services tend to be orientated towards provision for the rehabilitation of people with relatively severe but stable conditions such as loss of limbs, sight or hearing, and with crippling disorders. Less thought is given to patients with temporary incapacity due to illness or accident and to the prevention of further incapacity. This is well illustrated by a study which was done on absence from work after fractures of the wrist and hand (7). This showed that patients with temporary incapacity were taking far too long to return to work and that greater awareness of the disability in relation to the patient's work was necessary. In some conditions little or no rehabilitative treatment is required, but medical counselling is essential and in many cases instruction in simple rehabilitation exercises commenced in hospital and continued at home will speed recovery.

52. There is also much less professional and public awareness of what can be achieved in the rehabilitation of patients with chronic disorders which are liable to recrudescence or progressive deterioration with increasing disability, so that neither medical treatment nor social or industrial resettlement can be finalised. The medical profession and the public must appreciate how much can be done to ameliorate such conditions and ensure that the requisite facilities are available and used.

53. Curiously enough, no Executive Council circular was issued to general practitioners to bring the recommendations of the Piercy Report to their attention although a year later in July 1959 "Rehabilitation of the Sick and Injured" was issued. (See paragraph 12.) Nevertheless, it seems to us that partly because of the heavy demands on the general practitioner's time and partly because of the poor communications between the branches of the health service, he is seldom referred to during the rehabilitation period of his patient's treatment at hospital. The general practitioner, in fact, receives little encouragement from his hospital colleagues to be involved in the rehabilitation process and, coupled with minimal teaching in the subject during medical training, perhaps it is not surprising that he may fail to make use of the

facilities available. The Piercy Committee set out similar views on the rehabilitative role of the general practitioner and we have no evidence to suggest that the position has improved.

Medical education

54. The Piercy Report recommended better medical education in rehabilitation and better organisation of the rehabilitation services, and we consider that these two requirements remain the essential basis for a good rehabilitation service. However, with few exceptions, medical schools have not followed the Piercy recommendations to include rehabilitation as an integral part of undergraduate training or of postgraduate study. Until they do, rehabilitation will never become part of the young doctor's thinking.

Poor organisation

55. During our discussions we became aware that the division of responsibility for rehabilitation between several government departments had a deleterious effect on the rehabilitation services as a whole and that this situation was aggravated both by the internal organisation of the Department of Health, which divides responsibility for the service both organisationally and by specialty, and by the fact that the role of this Department, unlike the Department of Employment, is to give advice rather than instructions. At the centre there is an absence of direction and this is reflected in the service provided in the hospital.

56. One result of the lack of an authority with clear responsibility for the central organisation and co-ordination of the rehabilitation services was further brought to our notice when we met representatives of the Department of Employment. The division of responsibilities between the Department of Employment and the Department of Health has created fairly clear demarcation lines which are not always in the best interest of patients during the interim period between illness and return to employment, and it appears that there is a gap in the provision of facilities for some patients in the interval between the termination of medical and the beginning of industrial rehabilitation. Both Departments are aware of this problem and the Department of Health is sponsoring some research designed to determine the nature and extent of the gaps in facilities. We note this development and consider such research to be particularly important since any delay or break in continuity in the provision of rehabilitation services may cause the patient to regress, lower his morale and greatly increase the length of the rehabilitation period, making the transition back to work more difficult.

57. A major complaint in all the evidence was the general failure in co-ordination and communication between the hospital, the general practitioner, the community services and the services of the Department of Employment, and the unnecessary delays in starting rehabilitative treatment which result from this. We have referred to the results of the questionnaire to hospitals which indicated clearly that many hospitals do not have a nominated consultant in charge of rehabilitation in spite of the recommendations in the Piercy Report

and the advice given by the health department. We can only assume that the medical profession generally and others concerned with the health services have not appreciated the importance of such an appointment and the organisation that springs from it. The need for better communication will be even greater now that one hospital may be dealing with several social service teams within an area authority.

58. We make recommendations on the fundamental question of organisation in Chapters V and VI, but it is relevant when discussing reasons for certain failures in the present services to pinpoint deficiencies that arise from unsatisfactory organisation which are aggravated by the absence of a consultant in charge of rehabilitation:

(*a*) Physiotherapy and occupational therapy departments are often physically as well as organisationally separated and frequently operate as independent units. Time will eventually correct the division as new hospitals are built with fully integrated rehabilitation departments, but the existing badly co-ordinated remedial services could be greatly improved.

(*b*) The lack of clinics to assess a patient's progress also contributes to unsatisfactory rehabilitation, because these clinics are the main link between the various services, and they provide an opportunity for continuing review.

(*c*) Lack of co-ordination results in poor communication and unnecessary delays, not only within the hospital itself but between the hospital and the many other services involved in the total rehabilitation process, i.e. the artificial limb service, industrial rehabilitation and employment services, local health and social services, housing, education, and the voluntary services.

59. Further difficulties in organisation arise from the confusion over the correct distinction between the terms "case conference", "resettlement clinics", and "medical interviewing committees". We have been told that similar confusion is caused by ignorance about the role and function of the disablement resettlement officer. We have heard criticisms that these officers fail to provide the vital linking service between the hospital facilities and the facilities provided by the Department of Employment. For their part, the disablement resettlement officers say that they may discover patients who need medical advice but they do not know to whom they should be referred. The result of this confusion is that the services provided are not used to their full advantage.

60. The Department of Employment is of the opinion that the delay between the completion of medical treatment and the beginning of an industrial rehabilitation course is too long and that the resettlement process is not taken into account at a sufficiently early stage. We agree. There are many cases where people who have been discharged from hospital or "signed off" by their general practitioner visit the local employment exchange for a change of work on medical grounds. The hospital or general practitioner is then consulted by the disablement resettlement officer about the medical aspects of the case and the result is often a recommendation for a course of industrial rehabilitation. This initial delay is prolonged further by the waiting list for admission to industrial rehabilitation units.

61. Similar situations arise with referrals from the Regional Medical Service and when people visit employment exchanges within a month of discharge from hospital or following active treatment from their general practitioner. The need for reference back to the medical services by the disablement resettlement officer creates considerable delays causing the trainee to regard the course when it is eventually provided as a hindrance rather than assistance towards satisfactory employment.

62. This problem was clearly demonstrated in an exercise in collaboration between a hospital and an industrial rehabilitation unit in 1964 which showed that there was a considerable deterioration in willingness to reach maximum working capacity in many cases where more than 6 months had elapsed between the end of the acute stage of illness or injury and entrance to the industrial rehabilitation unit. This exercise also showed that there was an associated adjustment of their standard of living to the level of social security benefits.

Nature of legislation affecting local authority provision

63. The local authorities come in for their share of criticism in the evidence we have received about the causes of deficiencies in the rehabilitation services. Local authorities have a duty to provide the necessary services for those patients who remain disabled, sometimes severely, after their intensive period of hospital rehabilitation, and need one or more of the many community services which can be supplied temporarily or permanently for both the physically and mentally sick and disabled. A large range of services are available, some of them continuing the rehabilitation process but mostly providing assistance in daily living, such as home adaptations and aids, special accommodation such as homes for the elderly, and hostels for the mentally handicapped, and occupation through sheltered workshops and day centres.

64. Without the community facilities much of the intensive rehabilitation of disabled people undertaken in hospital can be rendered all but useless. For example, unless those physically and mentally disabled persons who cannot be found a place in normal employment can be placed at sheltered workshops or at day centres on discharge from hospital, they are likely to deteriorate, and risk the loss of incentive to live as full a life as their disabilities will allow; if there is no suitable accommodation available in the community the patient may have to remain in hospital. The evidence we have received indicates that many local authorities are failing to meet the need.

65. Much of the dissatisfaction with local authority services turns on what is usually described as the "permissive" nature of the legislation. The Royal College of Nursing blame the situation on the terms and wording of the National Health Service Act 1946, which they say, "accounts for the fragmentation of the various aspects of the local authority services and for the tremendous differences in the policy of local authorities up and down the country". The College go on to say that "according to the Act each local authority is free to interpret its responsibility to provide services according to its philosophy, finance and ancillary services".

66. We have been told by the health department that as local authorities were placed under a duty to exercise their powers under Section 29 of the National

Assistance Act, these powers are therefore not permissive. It would, they suggest, be clearly impossible to legislate for the exact level of service needed by any individual in particular circumstances; the type and intensity of service to be given can only be determined in the light of a knowledge of local needs and resources, and must therefore be matters of local administrative judgment. While we accept this as a statement of fact, we nevertheless consider that the result is the same.

The size of the problem

67. The absence of comprehensive figures is a serious impediment to demonstrating the inadequacies of the existing services. While we accept that there are difficulties in the collection of statistics relating to rehabilitation, in our view their absence gives rise to a major problem. It is hard to make a case without supporting evidence, and in a situation where facilities and services are in constant competition for limited resources, those facilities and services which cannot demonstrate first necessity, and second, results, tend to remain forever at the bottom of the list of priorities.

68. The Piercy Committee attempted to assess the size of the problem and they also found that no comprehensive figures were available. They came to the conclusion that the number of people for whom some sort of rehabilitation was needed could not be estimated with any certainty. They doubted whether the most elaborate machinery could compile satisfactory statistics and felt that the cost of such an exercise would not be justified.

69. The Piercy Report, however, recommended "that enquiry should be made to find out how many persons receiving sickness benefit for more than six months could be assisted in a return to work if suitable facilities for rehabilitation or resettlement were made available for them". An attempt was made by the Standing Rehabilitation and Resettlement Committee of the Ministry of Labour to carry out this recommendation. A survey was undertaken through the Regional Medical Service in 1958 but the results were considered then to be unsatisfactory as a guide to the general demand for rehabilitation.

70. Statistics on duration of incapacity are collected by the Department of Health and Social Security, and we have been provided with information on the number of patients with certain selected conditions on sickness benefit for up to 3 months (Appendix XIII). However, as the Piercy Committee discovered, these figures exclude men over 65 and women over 60 who are retirement pensioners, all men over 70 and women over 65, members of the armed forces, mariners while at sea, most non-industrial civil servants, married women and certain widows who have chosen not to be insured for sickness benefit, so their value for our purposes is severely restricted.

71. Not only are there virtually no figures, there is also a paucity of research on the requirements of rehabilitation and the evaluation of rehabilitative treatment and techniques. Evidence we have received suggests that where research is done, there is difficulty in obtaining acceptance for publication because the subject matter is not considered to be of sufficient interest compared with other research.

Psychiatry and geriatrics

72. So far we have not considered the particular problems of rehabilitation in the psychiatric and geriatric fields. Psychiatric and geriatric patients make the greatest demand on the rehabilitation services, and those responsible for the provision of facilities have been slow to realise this. The changed emphasis in the main role of the psychiatric hospital from the provision of custodial care to the preparation of patients for return to life in the community has made it essential to carry out successful rehabilitation initially in the hospital environment. In the main, this rehabilitation has been directed to those patients whose primary psychiatric disabilities are aggravated by the secondary social disabilities of institutionalism but increasingly the problem is becoming one of rehabilitating those with unstable psychiatric disabilities who may have spent only a short time in a hospital environment, and of applying psychological principles to rehabilitation problems in general.

73. We have already referred to the advice of the health department in the hospital memorandum (HM(58)57) following the Piercy Report, but this was directed principally to hospitals for physical disease. The section referring to mental disorder (paragraphs 11, 12 and 13) gives only very general advice on industrial rehabilitation unit attendances, hostels, employment inside and outside hospital and the appointment of industrial officers. The later memorandum on improving the effectiveness of mental hospitals (HM(64)45) makes no reference to a designated consultant in rehabilitation.

74. In spite of the importance of rehabilitation for psychiatric patients the organisation of this service presents a special problem. The relationship between the psychiatrist and the patient is such that the appointment of another person in charge of the rehabilitation for that patient may create serious difficulties in the treatment process. A balance has yet to be achieved between the needs of the patient and the organisation of the department which has to provide rehabilitation for large numbers of patients.

75. The geriatric rehabilitation services are more bedevilled by chronic staff shortages in all professions, medical, remedial and nursing, than by lack of interest on the part of geriatricians in the problems of the rehabilitation of the elderly. The British Geriatric Society consider that "where the consultant geriatrician organizes his own service there is usually no lack either of interest or organisation", but they claim that "where he depends on a service organised by a (non-geriatric) colleague there is sometimes lack of interest and in those cases the geriatric department is often the first to suffer in times of staff shortage". The very nature of geriatrics, with the ever increasing number of elderly patients entering hospital, creates an awareness in this specialty of the need to get such patients back to the community and, in consequence, the value of progressive patient care, in which rehabilitation plays a vital part. However, too often patients arrive too late for effective rehabilitation to take place, and many of those who are rehabilitated cannot be discharged because there is nowhere for them to go.

The remedial professions

76. The Committee on the Remedial Professions was set up in 1969 to consider the function and inter-relationship of occupational therapists, physiotherapists

and remedial gymnasts in the National Health Service and their relationship to other personnel concerned with rehabilitation. The Committee has submitted a statement of their views to the Secretary of State for Social Services and the Secretaries of State for Scotland and Wales and this was published on 10th February 1972.* In their statement the Committee has identified four main problems that confront the professions. These are:

(i) the low level of remuneration in comparison with other professions of equivalent responsibility;

(ii) poor career prospects;

(iii) the lack of clarity over professional role;

(iv) the lack of critical assessment of treatment techniques and the serious lack of research.

77. We have been particularly concerned with the role of the remedial professions in rehabilitation. All three professions have been affected by the changes in patterns of disability and the consequential changes of emphasis in treatment, yet insufficient attention has been paid to these changes. In many centres there has been a persistence in the use of obsolete methods to the detriment of more modern techniques, and many of the treatments applied by the professions have an historical rather than a scientific basis. There is a considerable amount of overlap in the work undertaken by the three professions, and while this is inevitable to a certain extent, there are indications that the present level is hindering the development of the future role that the professions will be called upon to play.

78. Although the remedial professions have developed separately the problems they have encountered are strikingly similar. All three professions work to medical prescription and this may vary in precision from the highly specific to the merest indication of the treatment required. Surprisingly few doctors have sufficient experience of the range of modern occupational therapy, physiotherapy and remedial gymnastics to be able to prescribe in detail the most effective treatments and those who have the necessary experience rarely have time to see the patient sufficiently frequently to vary the treatment as soon as the need arises.

79. Many doctors are not prepared to delegate reasonable responsibility to the therapist to adjust treatment to the changing condition of the patient. The traditional relationship between the doctor and members of these professions is such that all too often it is difficult for them to challenge the medical direction as they feel they should, not only in the hospital but also in the training schools where teachers feel obliged to instruct students in the types of treatment they will be asked to give, even though some of these are of doubtful value. The absence of research into and evaluation of these treatments exacerbates the situation.

80. Despite an annual increase in the numbers in post in each of the three professions, hospitals continue to complain of shortages of staff. The shortage is

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*Statement by the Committee on the Remedial Professions. London. H.M.S.O., 1972.

related to the fact that the remedial professions are predominantly female,* and this makes them extremely vulnerable to loss of skilled staff through marriage. While marriage in itself should not compel a woman to cease work, many newly qualified therapists find neither the career prospects nor the net level of remuneration sufficient to compensate for the inconveniences of combining domestic duties with a full-time or major part-time job. The low salary scale and poor career prospects also deter men from entering these professions.

81. The training schools also face problems. There is increasing competition for students with the educational attainments required for entry into the remedial professions, and it is no longer realistic to rely on a sense of vocation and personal service to provide sufficient numbers of suitable recruits for the professions. While a sense of vocation and a desire to help the disabled will always be factors in recruitment, they are no longer sufficient in themselves to withstand the pressure from the attractions of further education on the one hand and other careers with better prospects and higher salaries on the other. Consequently the standard of recruits to the remedial professions and their number is placed in jeopardy.

82. The pattern of training based on a number of relatively small schools has not changed significantly since 1948 and has been determined largely by clinical opportunism. The present pattern is useful for clinical work but teaching facilities are limited and the majority of existing schools are isolated from other educational establishments, as well as from each other. As a result, there is a tendency for schools to lag behind developments in teaching, and students in the remedial professions are deprived of the companionship of their fellow students in other disciplines. Many schools have difficulties in recruiting staff: the hours of work are long, the work load is heavy, and few teachers have the time for study, preparation and research which is necessary for the maintenance of high standards.

Conclusions

83. The evidence we received on the deficiencies in the rehabilitation services made rather depressing reading. For example, the Royal College of Nursing said that "deficiencies are to be found in almost every aspect of the rehabilitation services of the National Health Service . . . in terms of personnel, finance, communications and knowledge of all services available". Although we have felt it necessary to draw attention to several problems we do not think that such a bleak view is wholly justified. In the course of our deliberations we have met many of those concerned with rehabilitation who are well aware of the problems and we have visited a number of establishments, and heard reports of others,

*The ratio of women to men in the three professions in England, Scotland and Wales is as follows:

Profession	*Number*	*Whole time equivalent*
Occupational therapists	23·5:1	22·3:1
Physiotherapists	9 :1	7 :1
Remedial gymnasts[1]	1 :2	1 :2

[1] Remedial gymnasts are predominantly female in the younger age groups. The ratio for those under 40 years old is 3:1.

[Figures taken from an unpublished census conducted by the Department of Health and Social Security in 1969.]

where the full possibilities of rehabilitation have been realised. Unfortunately the need to provide a comprehensive and nationwide rehabilitation service still remains.

84. The end result of the weaknesses and unevenness of the rehabilitation services is that both the patient and his family suffer. Further the temporarily ill patient or disabled person may take longer than necessary to return to work, those with permanent or unstable disabilities may suffer delays in being trained for alternative work, may not be rehabilitated to their maximum possible function and may be discharged from hospital with no proper provision made for their continuing care in the community. In total, this adds up to a complex social and economic problem, which is wasteful not simply of resources and facilities but more significantly, which is destructive of the quality of people's lives. It would be foolishly optimistic to assume that this could be remedied with ease, but in the following chapters we have set out our views on the ways in which the existing services could be re-organised in the hope that this will improve the quality of a service that is essential for the whole country.

CHAPTER 4

CONCEPTS OF REHABILITATION

85. In the previous chapter we have attempted to identify some of the factors which contribute to the failure to provide a comprehensive and effective rehabilitation service within the framework of the National Health Service. In spite of a wealth of advice on the subject from a number of experts and committees the service remains patchy and unevenly distributed. If this situation is to be improved we consider it essential that the nature of the problem should be clearly stated. Once the principles have been established, the organisational pattern which we recommend in subsequent chapters automatically follows.

86. We have deliberately avoided any attempt to re-define rehabilitation. In 1958 the World Health Organisation stated that "Medical rehabilitation has the fundamental objective not only of restoring the disabled person to his previous condition, but also of developing to the maximum extent his physical and mental functions". It aims not only at "physical cure" but also at "social cure" (8). While we approve of this as a comprehensive statement, we consider that it is important to avoid the risk of rigidity inherent in any definition, and for this reason we have confined ourselves to a statement of principles as we see them and not attempted to finalise the concept of rehabilitation by a new definition.

87. Although the principles of rehabilitation as propounded by Piercy and others have not changed, there has been a dramatic change in the problem to which they relate. The pattern of disease and disability has altered over the past thirty years, and the emphasis in rehabilitation has shifted from a primary concern with restoring physical fitness to members of the working population to a much wider concern with four main groups of disability: recurrent illness and progressive unstable disability; definitive disability; psychiatric conditions; and the multiple disabilities due to the degenerative changes associated with advancing years. With the exception of the latter these disabilities are found in all age categories and rehabilitative measures are equally necessary for all to enable the individual to lead as full and independent a life as possible.

88. The essential features of any rehabilitation programme are that in addition to restoring the individual patient to the highest level of functional activity, both mental and physical, in the shortest possible time it is necessary to consider the programme in terms of the individual's morale, motivation, and relationship to the society in which he lives and to which he will return. Even for the individual with one of the more readily assessable disabilities, for example loss of a lower limb, the degree to which rehabilitation is possible and successful will depend not merely on the individual's age and general mental and physical health, but also the kind of work and mode of life he is expected to pursue, the social environment, the attitude of dependants and friends, his own latent abilities and interests and the extent to which he is motivated to achieve a purposeful and satisfying life.

89. It is often stated that doctors should take into account the problems of rehabilitation on first contact with the patient. This is clearly untenable for many patients either because of the severity of their condition and the urgent need for immediate treatment or because the existence of multiple pathologies, particularly in persons over the age of 60, often makes immediate assessment difficult. However, the need remains for the doctor responsible for care to keep in mind the concept of total patient care so that as soon as practicable he initiates rehabilitation procedures and when necessary seeks the advice of those more experienced in the problems that may be encountered in the rehabilitation of his patient.

90. Rehabilitation implies more than therapeutic supervision including the application of physical methods: there is the need for dynamic leadership, clinical competence combined with a sensitivity to individual needs and awareness of the patient's socio-economic environment. Few doctors other than those specialising in rehabilitation can be expert in all the intricacies of a complete rehabilitation service but they should be made aware of the potentialities of such a service and be willing to seek and utilise the experience of those with specialised knowledge at the earliest opportunity.

91. In our deliberations we have been aware that much of what we would say in our Report had been said before in the various official memoranda and circulars issued by the Health Departments, in the British Medical Association Memorandum of 1954 (9) and in the Piercy Report of 1956 (3). Our aim in making recommendations has been to set out a broad framework for the rehabilitation services taking into account past advice which is still pertinent, the advances in medical, psychological and surgical practices, and the likely future pattern of the National Health Service, and still leaving scope for experimentation and initiative.

92. We have drawn attention in Chapters 2 and 3 to the considerable advice available on rehabilitation and to areas of deficiency and failure, and we have not thought it necessary to make any further references to earlier and current guidance, whatever the source. We appreciate that some of our recommendations will take some time to implement, but much that we suggest can be put into effect immediately. We hope that progressive management committees and/or area health authorities will take the earliest opportunity to initiate pilot schemes for departments with unified rehabilitation services in order that a sound basis for such departments can be evolved compatible with the diversity of human and community needs.

CHAPTER 5

THE ORGANISATION OF THE REHABILITATION SERVICES

93. In Chapter 3 we have drawn attention to the serious disadvantages that arise when responsibility for the rehabilitation services is divided between several government departments and it thus falls to no one person or agency to supervise the establishment and effective operation of a national service. To prevent a repetition of the missed opportunity that followed the Piercy Report, we consider that overall responsibility for the provision of a rehabilitation service must be clearly vested in one government department.

94. We have considered carefully which of the departments with an interest in rehabilitation is the most appropriate to exercise this responsibility and in our view, it falls most logically to the Department of Health and Social Security. This department already has responsibility for the health service, the personal social services and social security, and it may shortly acquire responsibility for the school health service. Although the Department of Employment has and must retain responsibility for the industrial rehabilitation services, these services are for the secondary, rather than the primary stage of rehabilitation, and they cannot operate efficiently if the earlier medical rehabilitation has not been provided.

I. WE RECOMMEND that the Department of Health and Social Security should be charged with the primary responsibility for developing and co-ordinating the establishment and subsequent organisation of the rehabilitation services.

95. We note that legislation is in progress at present to establish an Employment Medical Advisory Service as part of the services provided by the Department of Employment, to rationalise medical resources in the field of occupational health. The Employment Medical Advisory Service is intended to give medical help and advice on any aspect of the services provided by the Department of Employment and to co-ordinate the medical inspections of factories, industrial rehabilitation units and government training centres. It is also intended that the service should be the focal point for all medical activities in the Department and create a nucleus of experts in the field of occupational health. It is expected that the Employment Medical Advisory Service will eventually take over the medical examinations at present carried out by the Regional Medical Service, and the Regional Medical Advisers (recently renamed Regional Medical Consultants) would also be brought into the new service.

96. With one exception,* we are most concerned that the development of the Employment Medical Advisory Service in the way proposed will extend the confusion and overlap of services which we consider to be a major impediment to effective rehabilitation at the present time. We feel that if a state occupational health service were to be created, this should be provided within the National

*Dr. V. Wilkinson.

Health Service, unless the fragmentation and division of services that has had such a bad effect in the past is to be allowed to continue.

Statistical information on rehabilitation

97. We discussed in Chapter 3 the lack of statistics and information on the size of the demand for rehabilitation in the National Health Service. We recognise the difficulties highlighted by the recent survey on the handicapped (5) and appreciate that there are many unknown factors which are difficult to quantify: for example, difficulty arises because morale, a crucial factor in rehabilitation, cannot be measured. Any attempt to compile comprehensive statistics will be a major and costly exercise but nevertheless, we think the matter should be pursued and not allowed to lapse as happened after the failure of the enquiry which was undertaken in 1958 in response to the Piercy Report recommendation.

II. WE RECOMMEND that operational and other research should be undertaken into the demand for and provision of rehabilitation facilities in the National Health Service. The research should be co-ordinated and supported nationally, but there is ample scope for local initiative.

Research into rehabilitation

98. Research and development in all branches of the rehabilitation services has been seriously neglected in the past in spite of the fact that research is a prerequisite to advances in medical treatment. The Department of Health and Social Security sponsors some research in the subject and a number of voluntary organisations support specialised research but in general sufficient funds are not and have not been readily available, and those studies which are undertaken and completed receive little publicity and tend not to attract the attention of the medical profession other than those already interested.

99. We deplore the lack of research studies in all aspects of the rehabilitation services. The establishment of new academic departments as suggested later (see paragraph 337) would provide a much-needed stimulus to the development of more active and intense research.

Adviser on rehabilitation at regional level

100. In our view one important reason for the failure to develop the rehabilitation services after the recommendations of the Piercy Report was the lack of continuous review of progress in providing these services. To ensure that this does not occur again we think there should be advantage in appointing a medical adviser in rehabilitation to each regional hospital board or its equivalent who might be supported by a regional advisory committee of experts interested in rehabilitation and with practical knowledge in different fields. One of the initial tasks of these advisers would be to review the present rehabilitation services in each region and to prepare a plan for their development. This would include recommendations on consultant medical staffing for the immediate future and in the long-term; recruitment of other staff; provision of equipment and co-ordination of teaching. The regional plans should be submitted by April 1973 to the central department who we hope would recommend that adequate resources should be made available to implement them.

101. The advisers should be consultants with a wide knowledge of rehabilitation who would have to devote a substantial amount of time to this work during the initial period of review and planning. They might conveniently be consultants already working in the field who could be seconded for this task and who would be prepared to continue to give a limited amount of time to act as regional adviser at a later stage.

III. WE RECOMMEND that each regional hospital board or equivalent authority should appoint a medical adviser in rehabilitation, supported by a regional advisory committee and adequate staff, whose initial task would be to review the existing services and prepare plans for their development, which should be considered by the regional hospital board and submitted to the Department of Health and Social Security by April 1973.

Location of rehabilitation facilities

102. The location of hospital rehabilitation facilities is of major importance to their effectiveness and we have looked at the role played by a number of medical rehabilitation centres, some of which are geographically separate from general hospitals.

103. The reasons for the establishment of these separate medical rehabilitation centres were partly to clear beds in acute hospitals and partly because of the traditional practice of sending patients to convalesce in the country or at the seaside away from the hospital atmosphere. Furthermore because these centres are independent and physically separate units, they have fostered unwittingly the attitude held by many hospital staff that rehabilitation itself is a separate process commencing only when patients are recovered sufficiently to be transferred to such centres and that the rehabilitation processes are confined almost wholly to the types of physical disabilities most commonly in need of referral to the centre.

104. Although we were impressed by the standards of rehabilitation attained in some of these centres, rehabilitation is an integral component of the clinical management of sickness and injury and we consider that appropriate services should be contiguous with facilities for definitive medical and surgical treatment at the district general hospital. In our opinion the concept of rehabilitation centres that are geographically separate is no longer appropriate and there should be no need to build new ones as rehabilitation departments are established at district general hospitals.

105. We have referred in Chapter 3 to the apparent gap in the division of responsibility between medical and industrial rehabilitation and we think this may be overcome in certain areas by linking the medical and industrial rehabilitation services. This has been done successfully in one instance and as a result the Department of Health and Social Security and the Department of Employment have been co-operating in an attempt to locate new industrial rehabilitation units on the sites of hospitals. The latter has only met with limited success to date, and we consider that there is scope for further experiment before any decision is taken to establish linked medical and industrial services as the basis of future policy. Our recommendation that one government department should have primary responsibility for the development and co-ordination of the

rehabilitation services would facilitate the streamlining of services and reduce the likelihood of the pursuit of parallel but not necessarily complementary policies.

CHAPTER 6

HOSPITAL REHABILITATION SERVICES

Organisation of hospital rehabilitation services

106. In considering the organisation of hospital rehabilitation services we have assumed that the major functional unit for medical care will consist of the district general hospital or hospitals which will probably serve populations of about 200,000 and the related community services of which health centres and group practices will form the basic units. Although the changing pattern of community care may bring certain rehabilitation techniques well within the scope of the general practitioner, especially working in a health centre or group practice premises, we consider that the rehabilitation service should be based on district general hospitals or, where these are not yet available, in the larger acute hospitals or in specialist hospitals.

107. The rehabilitation department of the district general hospital will provide three types of facilities and will be the focal point of the service in the community: there will be general rehabilitation which should be intensive and at a fast tempo. It should be for all patients likely to benefit from such a programme regardless of age or disability. In addition to the general provision, there should be separate facilities provided by the rehabilitation department for the geriatric and the psychiatric services so that the tempo and style may be adapted to suit the particular needs of patients in these groups for whom the general facilities would be unsuitable. We anticipate that in time, all district general hospitals will have geriatric and psychiatric departments designed to meet the needs of the local population, and that attached to each of these departments will be a day hospital which will provide rehabilitation facilities suited to the requirements of the speciality. In our view it is essential that arrangements are flexible so that any patient can be provided with the most suitable programme at any point in time when a change is deemed necessary.

108. Full co-ordination between the geriatric and psychiatric day hospitals and the general rehabilitation department would be essential. Some elderly and mentally ill patients, particularly those with physical disabilities or those capable of a faster tempo, would need the use of the general facilities, and some physically ill patients would benefit from help offered by the psychiatric rehabilitation services. Co-ordination is also essential for the best deployment of remedial staff. For these reasons, there would also be a clear advantage in siting new day hospitals adjacent to or as close as possible to the general rehabilitation department. We consider that the geriatric day hospital should provide 80 day places for people from the hospital and the community, and the psychiatric day hospital about 160 places.

109. The experience of those working in centres with full rehabilitation services suggests that there are a few categories of patients who require treatment at special centres either because the environment of the general department is not suitable for them or because they need special facilities which can be best

provided in a separate unit. We consider these groups in more detail in Chapters 7, 9 and 10. However, these are exceptions and in general one rehabilitation department with three component parts should provide the main service. The organisation of such a service together with the way in which the hospital programme fits in with the provision in the community is described in later chapters.

110. We recognise that in some rural areas where the population is scattered and communications are poor, such as East Anglia, Cumbria, Mid-Wales and some parts of the West Country, there may be a special need for rehabilitation facilities outside the district general hospital. For communities of about 20,000 or more in such areas the inclusion of facilities for physiotherapy and occupational therapy might be justified at a health centre or in peripheral hospitals of approximately 100 beds or less, provided that they are under the close supervision of a consultant in rehabilitation. General practitioners with the relevant experience could undertake day to day clinical supervision at such isolated units and at some hospitals, provided this is under the overall supervision of the appropriate consultant. In an urban area where there is reasonable access to a district general hospital there is no justification at the present time for the provision of such treatment in health centres, group practices or hospitals with less than 50 beds. (See also paragraphs 153 and 299.)

IV. WE RECOMMEND that a general rehabilitation department of 100 places should be located at every district general hospital or district group of hospitals, serving communities of approximately 200,000. There should also be provision alongside for a psychiatric day hospital of 160 places and a geriatric day hospital of 80 places. Special provision at selected district general hospitals will be required for certain categories of patients. In planning new hospitals consideration should be given as to how facilities and staff could be shared.

Nature of provision in the general rehabilitation department

111. Broadly speaking we consider that the general rehabilitation department should evolve from the existing department of physical medicine and in future perform in addition the function of a day hospital. It should be equipped and organised to provide activities up to the equivalent of half a day's normal activity. This does not mean that patients may not need to attend for a whole day, but experience has shown that it is possible to make a reasonably definitive assessment of his needs by the time a patient is capable of three to four hours sustained normal activity a day.

112. Ideally, all aspects of rehabilitation should be concentrated in one department, which would cover all activities and include a gymnasium, hydrotherapy pool, areas for individual exercises and treatment, heavy and light workshops, daily living area, seminar room, and offices not only for the consultant in charge of rehabilitation, other medical staff and remedial staff, but also for the speech therapist, the social worker and the disablement resettlement officer. In addition an adjacent outdoor area for exercises, gardening, etc., will be required.

113. The equipment provided in the department is obviously of great importance and may well influence the type of treatment given. In this field the changing emphasis in rehabilitative treatment from passive individual therapy to active exercises and purposeful work therapy has an important bearing. In our view,

much expensive electrical physiotherapy equipment is of limited value and could be dispensed with without any serious loss of therapeutic effectiveness. Further, the equipment used by occupational therapists should be designed to provide purposeful work and re-education in daily living activities. It is important that the advice of a consultant well-versed in the details of modern rehabilitation techniques should be sought when all major equipment is purchased. This is the advice which a regional medical adviser could be expected to give.

114. We were particularly impressed with the equipment at one rehabilitation centre attached to a large factory where production machines are adapted to provide suitable exercises for individual disability. These arrangements are designed primarily to help skilled workers and while this has limited applicability for the hospital service, it does give a clue to the kind of hospital workshop provision that can be to the best advantage of patients, namely the provision of machines used in local industry. Industrial rehabilitation is at present the responsibility of the Department of Employment but the general rehabilitation department must provide a work component in remedial treatment.

The consultant in charge of the rehabilitation department

115. We have considered carefully the controversial problem of who should be in overall charge of the rehabilitation services. It is clear that this person must be a consultant; rehabilitation is concerned with the clinical problem of the management of disability and the organisational problem of the management of the remedial staff and the rehabilitation department. In theory the assessment and arrangement of remedial treatment can be done by the clinician responsible for the treatment of the initial condition, but in practice he may not be familiar with the refinements of assessment of physical disability nor conversant with the remedial techniques of the physiotherapist, occupational therapist and remedial gymnast. One clinician must assume the responsibility for rehabilitation and be able to vary the treatment programme according to the patient's changing needs, in consultation with the appropriate consultant.

116. We are convinced that with the increasing awareness of the importance of rehabilitation and the change in emphasis away from passive and palliative treatment towards intensive and meaningful rehabilitation, the consultant in charge of the department, who should be called the consultant in rehabilitation, should devote a substantial part of his time to this work. We accept that there is advantage in the consultant in rehabilitation having his own clinical field (and one member thinks this indispensable*), but some consultants may be prepared to devote the whole of their time to rehabilitation especially in some of the larger hospital groups, though it must be admitted that efforts to recruit full-time consultants to this specialty have rarely been successful in the past.

117. In the immediate future the most likely source of heads of department will be from the ranks of consultants in physical medicine and rheumatology, many of whom are of course already working in the field, and there should therefore be a controlled expansion in the numbers of training posts in these specialties. In future training should take due account of the importance of psychological and social factors in rehabilitation.

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118. However, if our recommendation that each district general hospital should have a rehabilitation department is accepted, it is quite clear that there will be a considerable problem in finding a sufficient number of consultants to take charge. The tables in Appendix XII show that the discipline of physical medicine and rheumatology could not provide enough consultants in the immediate future for all the departments we hope will be established. The problem will be increased because, as we discuss later, we consider that each department should also have at least one further consultant as well as adequate numbers of junior medical staff.

119. As an interim measure therefore we consider that a consultant from any discipline could be appointed to take charge of the rehabilitation department providing he has the necessary interest, experience and training and can devote sufficient time to the work. We are aware that consultants from many different disciplines are already doing valuable work in rehabilitation and we hope that some of them will be prepared to take charge of departments. Where established consultants show an interest in the work but have not had adequate experience or training we consider that facilities for training them should be made available and financially supported from central funds.

120. The consultant appointed to take charge of rehabilitation services must have qualifications which conform with those required for consultant posts in other specialties, and he will have the same duties, rights and privileges as any other physician in a medical division. In many instances he will have to build up the services since proper facilities for rehabilitation are lacking. His initial task will be to organise the para-medical services and to teach all categories of staff (medical, nursing and remedial) how to apply modern rehabilitation techniques by working together as a team within the hospital and outside with the various services responsible for the resettlement of the patient in the community.

121. He will have responsibility for the rehabilitation department and will be responsible for supervising the patients being treated within it. It is essential that all staff, especially other consultants, should accept that the application of modern medical techniques including rehabilitation involves a team approach. Once this concept is accepted there should be no problem of conflicting interests over clinical responsibility. The consultant in rehabilitation will have overall control of all the rehabilitation staff working in the hospital and although the majority of patients requiring treatment in the ward will remain under the clinical care of others and remedial treatment will be prescribed by them, he will set the broad areas of treatment within which these prescriptions must fall—in other words he will direct the rehabilitation services throughout the hospital.

122. When an efficient service has been established the consultant in rehabilitation will have responsibility for:

(*a*) keeping the facilities for rehabilitation up to date and adequate to meet changing needs;

(*b*) informing consultants in other disciplines of administrative and technical developments in all branches of the rehabilitation services which may affect them and their patients;

(*c*) the education of ever-changing junior medical and para-medical staff;

(*d*) persuading consultants and their junior medical staff in all clinical disciplines to make efficient and adequate use of the rehabilitation services.

V. WE RECOMMEND that there should be a consultant in charge of the rehabilitation department in each district general hospital and that he should be called the consultant in rehabilitation. He should devote a substantial part of his time to this work, and could be drawn from any clinical specialty.

VI. WE RECOMMEND that the Joint Committee on Higher Medical Training should examine the standards that should be attained by prospective consultants in rehabilitation and further, that the Department of Health and Social Security should make arrangements without delay with the appropriate bodies for the organisation and financing of special courses for clinicians known to have had some experience and to be interested in rehabilitation and wishing to obtain special training in this field.

Organisation of the rehabilitation department

123. The consultant will have overall managerial responsibility for the rehabilitation services and will decide how the general day to day running of the rehabilitation department should be organised according to local circumstances. Rehabilitation plays an important part in both the geriatric and psychiatric day hospitals and as these are essential components of the geriatric and psychiatric services they come under the clinical control of the geriatrician and psychiatrist; it therefore follows that rehabilitation provided for patients in the day hospitals must be the responsibility of the geriatrician and psychiatrist, although the rehabilitation consultant will retain the overall administrative responsibility for the service.

124. Besides the aspects of the role of the consultant in charge of rehabilitation services which we have discussed earlier we consider that he should also be responsible for:

(*a*) planning the general programmes for the rehabilitation of patients;

(*b*) organising facilities for the assessment of clinical, social and vocational aspects of disability;

(*c*) the reasonable deployment of all remedial staff (physiotherapists, occupational therapists and remedial gymnasts, and possibly aides), clinical psychologists and technical advisers, e.g. workshop managers and instructors, in consultation with geriatricians, psychiatrists and other main users of the service, ensuring a fair allocation of staff according to need; and

(*d*) the organisation of assessment clinics (see paragraphs 132–137) including:

(i) the arrangements for the association of general practitioners with the rehabilitation and after-care arrangements for patients; and

(ii) maintaining links with health and social services, the disablement resettlement officer of the Department of Employment, voluntary services, in fact all the community services in the area to facilitate the rehabilitation and resettlement of patients in the community.

125. The organisation in the rehabilitation department should be on the basis of the co-ordinated care of the patient through team work. The arrangements would fall into three main categories:

(*a*) the day to day care of the majority of hospital patients, including simple remedial exercises, would remain the responsibility of their own clinicians. The consultant in charge of rehabilitation would be involved only in so far as he had arranged the deployment of remedial staff for ward duties and work in departments other than the rehabilitation department and was responsible broadly for the use of their services by these departments;

(*b*) remedial treatment would be provided in the rehabilitation department for patients under the care of their own clinicians who could seek the advice of the consultant in rehabilitation. Treatment given in the rehabilitation department would be under the direct supervision of the consultant in rehabilitation;

(*c*) the treatment of patients who present major rehabilitation problems transferred to the care of the consultant in rehabilitation.

126. In rehabilitation departments where their services are needed, nursing staff should be responsible to and under the supervision of an experienced and well qualified nurse, at least a Grade 8 senior nursing officer, who in turn would be clinically responsible to the consultant in rehabilitation and professionally accountable to the Chief Nursing Officer of the appropriate authority.

Day to day organisation of the general rehabilitation department

127. We have recommended that the general rehabilitation department in a district general hospital serving a population of 200,000 should have 100 places. In a unit of this size we would expect something in the order of 800 patients a day to be treated. (This figure includes in-patients and out-patients.) Patients would be attending daily throughout treatment and there should be no question whatever of attendance on only two or three days a week for other than a small minority of cases.

128. Serious consideration should be given to the organisation of evening clinics for patients who cannot attend during the day either because they are working while needing treatment or because there are relatives who are only able to bring them by car after working hours.

129. We appreciate that it may be difficult to persuade some patients to attend in the evening, and that there are substantial difficulties in recruiting staff to treat them. The staffing situation is aggravated by the fact that overtime cannot be paid to a member of staff working in their own hospital group. Nevertheless we feel that the advantages of evening clinics are such that every effort should be made to organise them: part-time staff for these clinics might well be recruited from the ranks of suitably qualified people who could work only in the evening.

VII. WE RECOMMEND that where there is sufficient demand and where circumstances permit, evening clinics should be organised in rehabilitation departments.

130. We think there is a place in the general rehabilitation department for the appointment of a non-medically qualified co-ordinator who would, among other

duties, oversee the appointments system and organise day to day programmes but not treatment. A senior member of the remedial professions would be the most appropriate person to do this.

VIII. WE RECOMMEND the appointment of a non-medically qualified co-ordinator to organise the programmes of patients attending the rehabilitation department.

131. A somewhat difficult aspect of planning appointments can be the arrangements for transporting patients to and from the hospital and home, and within the hospital, from the wards and ambulance reception to the rehabilitation department. We have suggested the use of the evening clinics with patients being brought by relatives, as one means of overcoming transport difficulties (see paragraphs 128–129); voluntary aid can also be mobilised, and in some cases, the school bus service has been used (see also paragraphs 291–294). In our view the large numbers of patients needing transport is placing an intolerable load on the already inadequate transport service, and to achieve the best utilisation of the existing services for transporting patients, it will be necessary to appoint a special person to organise them. The existing arrangements whereby a clerk is responsible for out-patient transport are not adequate. This should not be a task which falls on the remedial professions.

IX. WE RECOMMEND the appointment of a person to deal with the transport arrangements for patients attending the rehabilitation department.

Assessment clinics

132. We have drawn attention in Chapter 3 (paragraph 59) to the confusion which appears to exist in the hospital service over the functions of case conferences, resettlement clinics and medical interviewing committees.

133. We feel that the term "case conference" is misleading since it applies to a wide variety of case discussions in hospital concerning patients. Resettlement clinic, on the other hand, suggests a static medical condition requiring only a decision on a patient's working potential. We therefore use the term "assessment clinic" in our recommendations, firstly to break away from the terminology which has failed to become regular usage and secondly to emphasise the function of the clinic. This would be to provide regular medical assessment of the rehabilitation needs of patients and to give those responsible for the care of the patient an opportunity to discuss with each other and the consultant in rehabilitation the facilities necessary for the restoration of the patient to the fullest degree of independent living.

134. The consultant in rehabilitation would be responsible for organising the assessment clinic and would normally take the chair but would have available a panel of consultants who could deputise for him. It would be attended by staff both from the rehabilitation department and elsewhere in the hospital and when required, by staff from outside the hospital including the appropriate representatives of statutory and voluntary organisations and occupational health teams, the disablement resettlement officer and the patient's general practitioner or a member of his team.

135. Those patients unable to return to their normal work would, according to their age and disability, be referred to the disablement resettlement officer for

direct placement in suitable work or for a period of industrial rehabilitation in an industrial rehabilitation unit and thereafter may be returned to their former employment, recommended for a change of work or considered for employment in a sheltered workshop or by Remploy. The elderly, those permanently disabled, and certain selected patients with chronic disability might be referred to the social services or other appropriate local authority department.

136. It has been suggested to us that the Piercy Committee's recommendation that resettlement clinics should be set up in hospitals has never been properly implemented because of the difficulty of getting key people to attend. We do not dispute that this difficulty exists and clearly every patient need not be discussed, and for many patients only a few members of staff need attend, but we believe that the principle that there should be regular meetings to consider the rehabilitation problems of the more difficult cases is so fundamental to successful rehabilitation that those concerned must accept the assessment clinic as an essential part of their work. We believe that the assessment clinic would provide:

(i) a focal point to bring together all services concerned in a patient's rehabilitation, both inside and outside hospital;

(ii) assessment reports which should be accepted by the Department of Employment and the local authorities;

(iii) a safeguard against patients becoming "lost" and failing to obtain the rehabilitation services they need;

(iv) a teaching function in the training of doctors, remedial staff and nurses.

The detailed organisation of the assessment clinic is set out in Appendix XIV.

X. WE RECOMMEND that in order to foster full communication between the various rehabilitation agencies, the hospital authorities should set up assessment clinics to cover all hospitals and local authorities within specified areas. The consultant in rehabilitation should be responsible for organising the clinic and should normally take the chair or arrange for the chairmanship. The clinic should have a full-time secretary.

XI. WE RECOMMEND that the assessment clinic should provide the common basis for all services concerned with future rehabilitative action on behalf of the patient.

137. The assessment clinic must also be recognised administratively by the hospital authorities. The proper consideration and discussion of referred cases takes time, and sessional time must be adequately allowed for in the contracts of the chairman of the clinic and the staff who are required to attend regularly.

XII. WE RECOMMEND that regional hospital boards and hospital management committees should make adequate allowance for time spent in assessment clinics in the contracts of appropriate staff.

138. It was suggested to us in evidence by the Department of Health and Social Security's former Advisory Committee on the Health and Welfare of Handicapped Persons that local liaison committees should be formed to co-ordinate rehabilitation services in their areas and that, because the object of rehabilitation is to restore disabled people to maximum community life, the responsibility for organising liaison committees should lie in the future with local authority social services departments.

139. We agree entirely with the Advisory Committee that there is a need for improved co-ordination in the rehabilitation services and we accept that liaison committees would provide a means of such improvement but in our view, the hospital will become the focal point of rehabilitation services. Intensive medical rehabilitation starts there, and the problem of recurring disabilities makes it essential that liaison should be hospital-based. We consider that the liaison between the hospital and community services should be the hospital assessment clinics. After a patient's discharge, the general practitioner would be mainly responsible for liaison between medical and social services and he would be able to refer patients back to the assessment clinic. The local authority social services departments would nevertheless play a vital part in the line of communication because many of the services for the patient come after the patient is no longer the responsibility of the hospital service.

The hospital rehabilitation team

140. The evidence submitted to us placed great emphasis on the need for multi-disciplinary team work in the rehabilitation services, chiefly because so many agencies can be involved in a patient's progress through rehabilitation that one failure in the line of communication can be disastrous for the welfare of the patient. By "team" we mean a more or less permanent group and we see this being provided in the hospital by the members of the assessment clinic. The existence of such an organisation should ensure that clinicians are invited when the assessments of their own cases are under consideration and that the other staff of the rehabilitation department and the social work department who are involved can participate in the discussions on the assessment of their patients.

Medical staff

141. Besides the consultant in rehabilitation we consider that the rehabilitation department should have an established post for at least one other consultant with experience in rehabilitation as well as a clinical specialty of his own, who in addition to providing help for the consultant in charge, would act when occasion demanded as an alternative chairman of the assessment clinic.

Clinical psychologists

142. It is recognised that clinical psychologists can do much to assist psychiatrists and neurologists in the assessment and treatment of patients. While vocational psychologists play an important part in industrial rehabilitation units, their skills are not so often utilised in general rehabilitation. Ten years ago there were about 180 clinical psychologists in the National Health Service in England and Wales; now there are some 380 and the number is slowly increasing. They are employed mainly in mental hospitals but there is scope for their employment in general hospitals as well. We feel that the important part the clinical psychologists can play in rehabilitation is gradually gaining acceptance and we believe that psychological assessment could well open new avenues of treatment and rehabilitation for many patients. We have therefore included the clinical psychologist as a member of assessment clinics.

XIII. WE RECOMMEND the appointment of clinical psychologists to all rehabilitation departments.

The hospital nurse

143. The nursing profession must be given the credit for initiating simple occupational and physiotherapy treatment, and thus for pioneering the remedial professions. The hospital nurse has always been intimately involved in the patient's rehabilitation, and her modern role in this process is crucial because she is the one member of staff with the patient for twenty-four hours and therefore she has the greatest opportunity to observe the patient and report progress to other members of the rehabilitation team.

144. The continuous presence of the nurse means also that the nurse must be aware of the remedial treatment that the patient is undergoing. There is a danger of conflicting functions because, for example, patients are being taught by the remedial therapist to help themselves in eating, washing and daily living, yet the nurse does not generally carry this therapy through because ward routines do not allow the necessary time; it is quicker, in fact, for the nurse to wash disabled patients than to encourage them to do it themselves, with the result that the patient's progress is slowed.

145. The nursing profession is very much aware of this problem and in their evidence the Royal College of Nursing referred to the need to actively encourage patients towards self-support, and for a gradual withdrawal of nursing support as the patient takes on increasingly the activities of every day life.

146. On the psychiatric side, there is the feeling that nurses are losing their remedial role because of the increase in the various types of "therapist" in psychiatric hospitals, yet paradoxically, because of the shortage of these therapists nurses are still expected to undertake remedial therapy. We deal with psychiatric nursing in Chapter 9, but in our opinion there is common ground between the nurses and the remedial professions which should be recognised and developed. Certainly, in order to use manpower to the best advantage of the patient, there should be no strict lines of demarcation in the work of the professions. The Committee on Nursing,* under the chairmanship of Professor Asa Briggs, are reviewing the nursing services in general, but we feel it is proper for us to give our views on the nurse's function in rehabilitation.

147. The achievement of rehabilitation in the ward depends greatly on good communication between nursing and remedial staff. This can be obtained if the patient's rehabilitation programme is fully discussed to ensure that such rehabilitation as can be carried out in the ward is continued throughout the day, and particularly in the evenings and at weekends; the involvement of the appropriate nursing officer is essential to take account of the constant changes in the shifts of nursing staff. The nurse must be aware of the objectives of remedial treatment and how much support the patient requires; this information should be indicated on a simple form placed with the temperature chart and prescription sheet at the end of the bed so that it is readily available for consultation by all members of staff as well as the patient.

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*The terms of reference of the Committee on Nursing are: "to review the role of the nurse and midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service".

XIV. WE RECOMMEND that consideration should be given to the introduction of a simple rehabilitation form for general use in hospital wards to provide information on a patient's remedial programme.

148. A valuable link between the nursing and remedial aspects of treatment should be provided through the attendance of the appropriate nursing officer at assessment clinics (see Appendix XIV). The nurse, for her part, should be able to give the remedial therapists any information required about a patient. In normal situations the nurse should encourage patients to do more for themselves, but she must be trained to recognise when a patient needs a high level of care; she should not necessarily accept that a patient is not rehabilitable, especially in the elderly where motivation is lacking. She should also understand the proper use and value of the various aids for the disabled. We consider that all nurses should gain practical experience of rehabilitation and the work of the remedial professions.

Remedial professions

149. In the evidence we received and in our discussions we have been impressed by the professions' awareness of the problems that confront them and by their anxiety to find solutions. We are in agreement with the problems identified in their statement and we consider it essential that the importance of the work done by the remedial professions should be recognised, and demonstrated by improved salary scales. In Chapter 8 we suggest that consideration should be given to the introduction of a pay "lead" for members of these professions working in geriatric departments, but we also think that there should be an overall improvement in remuneration if these professions are to continue to recruit students of the necessary calibre.

150. In addition to remuneration we think that much can be done to improve their working arrangements, in particular, the amount of responsibility that they have for the patient. Remedial staff with sufficient experience should be given greater discretion than at present to decide on patients' treatment within specific limits set by the appropriate consultant, having been given full guidance as to the object of treatment. This responsibility should include assessment of a patient's progress, adjustment of treatment in the light of progress, and referral to the clinician in charge of the patient as necessary. We have been impressed by the use in some centres of prescription forms which allow initiative to the therapist within prescribed limits.

XV. WE RECOMMEND that delegation of responsibility for day to day treatment of patients should be permitted to members of the remedial professions, provided that they are always under the supervision of the appropriate consultant.

151. We have heard justifiable complaints from remedial staff about the inadequate prescriptions for treatment that are given to them by many doctors. The prescription is a communication from one professional person to another and as such, should contain an accurate diagnosis and any special points concerning that diagnosis, particularly as regards the functional prognosis.

152. We are disturbed that prolonged and ineffective treatment is being given when intensive treatment would be more effective and enable more patients to be

treated promptly. The advice given in HM(62)18 is still appropriate, except we consider that patients receiving intensive physiotherapy should have their progress reviewed at least once a fortnight, and preferably weekly, instead of monthly.

XVI. WE RECOMMEND that patients receiving intensive physiotherapy should have their progress reviewed at least once a fortnight, and preferably weekly.

153. In the district general hospital of the future, with the full range of rehabilitation facilities which we are recommending there will be provision for intensive remedial treatment, supervision of the consultant, and hostel accommodation for those who need out-patient treatment but live at a distance. In such conditions, correct prescribing of remedial treatment should be assured. If the rehabilitation services, and physiotherapy in particular, are dissipated in a multiplicity of small clinics at peripheral hospitals, health centres and group practices, we believe that the standard of treatment would suffer because of inadequate supervision. We had this point in mind when suggesting that small clinics should only be set up in isolated areas with populations of 20,000 or more and always under direct supervision of a consultant in charge of hospital rehabilitation services.

XVII. WE RECOMMEND that those responsible in hospital should review the procedures in their hospitals to ensure that remedial treatment is correctly prescribed and recorded.

154. For the longer term, we consider it essential that a considerable amount of research should be undertaken into the work of the remedial professions. This research should be directed at treatment techniques and at work analysis (see paragraph 155). The latter is particularly important since the evidence we received indicates that much of the work undertaken by the remedial professions is common to all three. This is strikingly the case in the work of physiotherapists and remedial gymnasts, and we understand that the registration boards of these professions have been holding consultations with a view to amalgamation. We wish to give every encouragement to these consultations, as we consider that amalgamation would be in the best interests of patients and ultimately of the professions themselves.

155. It may be that in the future the true distinction in remedial therapy is not between the physical and the occupational but between the physical and the psychiatric aspects of this therapy. At the present time only one of the remedial professions, occupational therapy, is involved to a major extent in the rehabilitation of psychiatric patients, but the need is apparent for their greater involvement and developments in psychiatric treatment indicate that this need will increase. We see a danger that decisions on the future role of the remedial professions may be taken before any reliable study has been done as to their actual role at the present time. The importance of their role in rehabilitation makes it essential that a work study and analysis, based on hospitals throughout the country, randomly selected, be undertaken urgently.

XVIII. WE RECOMMEND that an analysis of the work of the remedial professions based on hospitals throughout the country, randomly selected,

should be undertaken urgently, and that this study should precede any re-organisation of the career structure or role of these professions.

Speech therapists

156. With the increase in the number of neurological patients suffering from organic brain damage, the need for speech therapy in medical rehabilitation has grown over the last few years. A Committee of Enquiry into the Speech Therapy Services was set up by the Secretary of State for Education and Science in 1969 with the following terms of reference: "To consider the need for and the role of speech therapy in the field of education and medicine, the assessment and treatment of those suffering from speech and language disorders and the training appropriate for those specially concerned in this work and to make recommendations." The Committee is to report on the role of speech therapists in the hospital service. We would merely emphasise that speech therapists have a place in the hospital rehabilitation team and should attend assessment clinics when patients with speech disorders are reviewed.

Staffing of hospital rehabilitation services

157. In discussing the organisation of the services we have not indicated the staffing levels that are required. Despite the expert advice which we have received we do not think that specific staff numbers can be given at present. There are only a few good rehabilitation departments and little experience of team work in this field. Also there is very little evaluation of the work done by the different staff involved in the rehabilitation process. In these circumstances, it is not possible to do more than guess at the appropriate numbers of staff required for the departments we envisage.

XIX. WE RECOMMEND that further consideration should be given to the staff establishment requirements for the rehabilitation services. Detailed studies of the role and work load of representative samples of the different professions should be instigated.

Social workers in hospitals

158. Social work departments are autonomous in the hospital setting, providing a social welfare service for all patients who require it. The future of the hospital social worker is being considered by the Government in the light of the Local Authority Social Services Act and the recommendations of the Seebohm Committee (10). It is not within our terms of reference to suggest how hospital social work should be organised or whether hospital social workers should be employed by the local authority social services departments and seconded to the hospital service. It is, however, our concern that social workers are needed as members of the hospital rehabilitation team to provide the consultant in rehabilitation and other clinicians with basic social information upon which the patient's rehabilitation programme can be based and to provide the patient with social help and support.

159. We think it may be helpful, therefore, if we set out briefly our views on the kind of service which can be given by hospital social work departments in the sphere of rehabilitation:

(i) to assess prior to discharge the social circumstances of patients undergoing rehabilitation, i.e. home conditions, family support and commitments, financial state, employment situation (in co-operation with the disablement resettlement officer, where necessary), need for residential accommodation, and to provide the assessment clinic with a social prescription;

(ii) case work for those patients requiring it;

(iii) to give encouragement and support to hospital patients and their families in adjusting to changed circumstances brought about by new disability;

(iv) to be able to advise on the availability of local authority services, aids and appliances, the disablement resettlement service, etc. and to enlist, after consultation with the appropriate consultant, the services necessary for the particular patient.

Hospital rehabilitation officers

160. There are a number of *ad hoc* posts of hospital rehabilitation officer in the hospital service and it has been represented to us that such appointments assist in the rehabilitation of patients. The functions of these hospital rehabilitation officers vary considerably, but they are mainly concerned with patients' employment problems.

161. In a paper (11) submitted to the Committee, an opinion on the value and duties of a hospital rehabilitation officer in the employment field is described:

> "Successful return to work after illness or injury often depends on an efficient exchange of information between doctor and employer. Rehabilitation officers who are experienced in industry have been employed (a named hospital) for several years and have established their value in acting as direct links between hospital and industry. They are available to discuss employment problems with patients, doctors and other hospital staff, and they spend half of their time in industry negotiating the best solutions with management, foremen and unions; frequently this had proved successful when a less direct approach would have failed. The constant flow to the hospital of information about industry and work resettlement has been invaluable, both in general and in the medical management of individual patients."

162. The British Orthopaedic Association supported this concept of the post mainly because they considered that the present disablement resettlement officer service was inadequate. The Department of Employment has recently reorganised the service to provide more senior posts for experienced disablement resettlement officers, well qualified in rehabilitation procedure by training and experience, so that the service will retain a sufficient number of experts to provide at least one at area level. Furthermore, we suggest that disablement resettlement officers should be invited to attend hospital assessment clinics and should be given the use of a room in the rehabilitation department where they can meet patients to discuss their employment problems. We feel that these developments will provide much improved links between the hospital and the employment field and will render unnecessary the post of a hospital rehabilitation officer whose special expertise would be essentially similar to that of the disablement resettlement officer.

Workshop staff

163. Hospital authorities experience considerable difficulty in recruiting technical staff for their medical and psychiatric rehabilitation workshops. The presence of such staff is essential if up-to-date machinery is to be used in the heavy workshops and particularly to carry out adaptations to machines to provide "while-you-work" remedial exercises for physically disabled patients, but it is also necessary for such staff to have an appreciation of the therapeutic role of a hospital workshop.

164. A number of titles, such as instructor, technician, are used to describe the technical staff employed in therapeutic workshops according to the type of hospital and, because of the diversity of skills involved, many are not included in a recognised Whitley Council grade structure. For the kind of work carried out in light workshops, such as purely remedial activities, simple assembly and clerical work, the help and instruction can be provided by occupational therapists and their aides under the supervision of a senior occupational therapist. The proper use of heavy workshops demands the technical skill of qualified craftsmen to advise and supervise patients in undertaking this type of therapeutic work. In such circumstances a workshop manager should be in charge, co-operating with the occupational therapists on the remedial aspects of the work.

165. The situation in workshops in psychiatric hospitals might be considered somewhat different as the workshops are designed to acclimatise psychiatric patients to conditions in outside employment or provide worthwhile occupation in a closed environment. Nevertheless, the same rehabilitation workshop staffing problems exist in psychiatric hospitals as in general hospitals.

166. We think that one way of overcoming the problem would be for technical staff in these workshops to be employed by the Department of Employment, paid on the latter's salary scales and seconded to the hospital service. The alternative to this would be for the Health Service to set up its own organisation for workshops in the health field. By either means there would be a much better career structure for managers and instructors in the rehabilitation services which should assist recruitment.

XX. WE RECOMMEND that managers and instructors in hospital rehabilitation workshops should either be seconded to the hospital from the Department of Employment or that the hospital service should set up its own organisation for workshops in the health field.

Workshop contracts

167. In many areas contract work is negotiated independently for workshops in hospital medical rehabilitation departments, medical rehabilitation centres, psychiatric hospital industrial therapy units and local authority sheltered workshops and day centres. There is only limited scope for work which can be undertaken in these workshops. In consequence there is sometimes difficulty in obtaining the necessary contracts for suitable work and this is aggravated by competition between the three categories of workshops. We see a need for some organisation in the seeking and placing of contracts for work in all workshops in a defined area.

XXI. WE RECOMMEND that several experimental appointments of area managers be made to be responsible for work contracts for all hospital workshops and for workshops run by local authorities and grant-aided by the Department of Employment.

Hostel accommodation

168. As a number of witnesses have pointed out, hostel accommodation is required for patients who no longer require nursing care but still need intensive treatment in the rehabilitation department. It is cheaper than accommodation in acute wards, avoids the blocking of much needed hospital beds, relieves pressure on the ambulance services and overcomes geographical difficulties for patients who live far from the rehabilitation unit and for whom lengthy daily journeys are exhausting and detrimental to their treatment.

169. The number of hostel beds needed will obviously vary according to the district served by the hospital, i.e. whether urban or rural, but as a broad guide based on limited evidence, we consider that, excluding provision for the mentally disordered, 20 beds per 200,000 population are the minimum required. However we anticipate that where these beds are provided there will be an increasing demand for transfer of patients to them and therefore more may be needed. The accommodation should be sited in or near the district general hospital and should preferably be in single rooms, attractively decorated, where patients can take care of themselves, with dining and rest facilities and adequate recreational amenities, otherwise boredom or depression could well undo much of the work of the rehabilitation department.

170. As hostel accommodation becomes available for use by patients attending rehabilitation departments there will be a decrease in the number of patients who will need to be referred to independent medical rehabilitation centres and it should eventually be possible to phase these centres out completely.

XXII. WE RECOMMEND that hostel accommodation of a good standard of comfort should be provided for all general rehabilitation departments on a minimum scale of 20 beds per 200,000 population.

Discharge procedures

171. If the principles of good practice in the discharge of patients from hospital set out in hospital memorandum HM(63)24 are applied, instances of failure to communicate should not occur. The consultant, the ward sister, the social worker, the nurse in the district and the general practitioner may each have a part to play in these arrangements, but if there is a failure in the line of communication the patient may well not obtain the care and facilities which are available to him. The proper time to make these arrangements is well before the patient is discharged from hospital but too often patients or their relatives have to demand the services which should be offered to them.

172. In this connection we would mention that a patient's return to work can be unnecessarily delayed if the consultant's discharge letter to the patient's general practitioner is imprecise. If it advises no more than that the patient should return to the out-patient department in so many weeks time the general

practitioner often infers that the patient is unfit for work of any kind during the interim. This is by no means always the case and it may lead to considerable difficulty for the patient and unnecessary expense to the State.

XXIII. **WE RECOMMEND** that discharge notes should include a clear recommendation by the consultant on the degree of a patient's fitness for work and that a specific reference to this should be added to the model letter to general practitioners, suggested in the hospital memorandum HM(63)24.

173. An experiment allowing patients undergoing medical rehabilitation to undertake half a day's work in an industrial rehabilitation unit has shown that once a patient has achieved this standard it is usually possible to make a definitive assessment of his capabilities and potential requirements. In the light of this experience we feel that further thought must be given to the possible usefulness of certificates of partial incapacity. We were impressed by the effectiveness of the rehabilitation we saw being done in industry where the employer accepts that an employee who has suffered injury or illness is not capable of working to full capacity or returning to his normal work but neverthless can continue in some less active or alternative capacity to his own benefit and sometimes to that of his employer, until such time as he can return to full activity.

174. Where such arrangements exist, unnecessarily prolonged absence after illness or injury can often be avoided. In contrast to this we know that often an employee is prevented from returning to work either because he is not recovered sufficiently to work a full day or because he is not fit enough to return to his particular job. We feel there should be a place for a certificate of partial incapacity and despite the difficulties of introducing such a system we urge the responsible departments to give urgent consideration to the means of doing this.

XXIV. **WE RECOMMEND** that in spite of the administrative difficulties urgent consideration should be given to the provision of a certificate of partial incapacity.

Hospital convalescent treatment

175. Convalescence has usually been associated in the public's mind with a not unpleasant period following treatment of illness when the patient gradually recovers his strength, preferably at a convalescent home in the country or by the coast. This view also used to be held by many in the medical profession and to some extent it lingers on so that many patients still consider they should be sent for convalescence as a routine procedure by the hospital branch of the National Health Service.

176. We referred earlier to the declining facilities for hospital convalescent treatment (paragraph 19) some of which are provided through contractual arrangements with private homes and homes run by voluntary organisations, and later (paragraph 323) we make reference to the recuperative holiday type of convalescence which can be provided by local authorities either directly or on an agency basis under their discretionary powers. We recognise the contribution made by the homes but in our view convalescent treatment should not now be a responsibility of the hospital service.

177. Patients who need rehabilitation will be treated by the hospital either as out-patients or as in-patients and many of the latter will be sufficiently ambulant to occupy hostel beds (paragraphs 168–170). There are, however, a few patients who, while they no longer need hospital treatment, cannot be sent straight home. Although strictly they could be said to be the responsibility of social service departments we recognise the importance of hospitals being able to make direct arrangements for their transfer to convalescence. We therefore feel that there would be advantage in a strictly limited number of convalescent places remaining under the responsibility of the reorganised health authorities. There would be no reason why homes providing such places should not do so both for health authorities and social service departments.

XXV. WE RECOMMEND that existing convalescent facilities provided by hospitals should be gradually reduced as new provision for rehabilitation becomes available but that health authorities should have access to a small number of places which could be in homes run on a joint-user basis with social service departments.

CHAPTER 7

REHABILITATION FACILITIES FOR CHILDREN

178. The Department of Health and Social Security have issued a hospital memorandum on "Hospital Facilities for Children" (HM(71)22). This stresses the need for all children admitted to hospital to be dealt with in children's departments and for special provision to be made for them in out-patient and in accident and emergency departments. It is noted that in certain specialties, for example otorhinolaryngology, ophthalmology and orthopaedics, children comprise 25 per cent of the patients coming to the out-patient clinics, and often these specialties have a significant number of children as in-patients and have developed the appropriate rehabilitation skills and facilities. All staff working with children should be skilled in the handling of children. Within this broad framework we considered how far the rehabilitation needs of children can be met by the comprehensive rehabilitation department of the district general hospital and what special facilities, if any, may be necessary.

179. Long-term disability in children may be congenital or acquired; multiple handicaps are common and often these handicaps include visual and hearing defects. Rehabilitation, therefore, may present many specialised aspects in relation to any one particular child. The problems of rehabilitation and of education are further complicated by the need to take cognizance of growth and development, which of themselves can produce problems and difficulties.

180. We accept the view that the care of children admitted to or attending hospital for whatever reason should be undertaken in specially designed accommodation. The rehabilitation facilities for younger children should be supervised by the paediatricians in co-operation with all concerned in the assessment, treatment and welfare of children. Most of the care will be on an out-patient basis, but some children may need to be admitted for diagnostic study to the children's wards. We consider that there is an additional need for more adequately staffed research units to undertake studies of the methods of remedial therapy suitable for young children with a view to their improvement.

XXVI. WE RECOMMEND that a number of adequately staffed research units should be set up to study methods of remedial therapy suitable for young children.

181. Disability in children is rarely easy to analyse in the early years. The early identification of disability is best achieved by a periodic developmental assessment for all children but the compiling of observation registers by local authority health departments and the increasing use of child assessment clinics are valuable though less comprehensive methods of achieving this, as is the follow-up of the small number of groups of "at risk" children. These methods inform the general practitioner, parents and social workers of the special needs of certain children. There is also a need for continuing supervision and guidance both for the child and for the parents. In our opinion, the care of handicapped children requires the skills of a multi-disciplinary team in which

the paediatrician would be expected to play a major role during the pre-school period. A senior medical officer from the local child health services should be a member of this team. Such a team would be fully informed of the problems of total care and would ensure that adequate attention is paid to the child's happiness and security, and also that assessment is continuous.

182. Education in the broadest sense plays a vital part in the life of a child, whether normal or handicapped. Before the handicapped child reaches the statutory age of school entry much can be done to provide the child with a suitable environment where his special therapeutic, social and educational needs can be fulfilled as early as possible, for example in a special unit in a day nursery, by regular attendance at a paediatric or rehabilitation department, or in special units such as a unit for pre-school autistic children, or in a nursery class in a special school.

183. After the age of five formal schooling becomes important. For many children with physical handicaps the acquiring of habits of learning and special skills are vital for their successful living and employment at a later stage. We endorse the policy of sending as many children as possible to normal schools, although such a policy depends on suitable school buildings and may require the provision of special transport, improved grants for parents, and improved training for school teachers about handicapped children and the methods of education and rehabilitation most advantageous to them.

184. However, this policy presents a problem for those children who require some form of regular therapy. In the new large secondary schools arrangements are made for special classes for handicapped children and periods are provided for remedial therapy, but such arrangements are rare. We hope that they can be extended wherever possible, because children attending hospital during school hours lose valuable learning time, and special clinics held at the hospital after school hours or on Saturday mornings can put the child under considerable strain. However, at the present time this is often the only way to give the child the therapy he needs.

XXVII. WE RECOMMEND that as many handicapped children as possible should attend normal schools and special provision should be made for them in all new schools.

185. There is also a need to adapt services in order to ensure continuity of treatment during holiday periods. The rehabilitation undertaken for two thirds of the year can be rendered useless if the process ceases for the remaining third and in order to achieve continuity it is essential for the school medical officer to have close contact with the hospital and the various community services.

186. Special schools for some handicapped children have provided an excellent rehabilitation service of a multi-disciplinary kind and they will continue to be needed. We consider such schools should provide for those with major degrees of disability who cannot attend an ordinary school, although after a period in a special school they may be able to proceed to an ordinary school. It is important to integrate hospital and special school services as closely as possible, and the school medical officer has a key role in this. Physiotherapy is best provided within the school for the physically handicapped by physiotherapists seconded from the district general hospital and under the general direction of the

consultant in charge of rehabilitation services who should visit the school regularly.

187. In addition to special schools provided for physically handicapped and delicate children, schools should be provided for the blind, the deaf, those both blind and deaf, the mentally handicapped and the maladjusted, including autistic children, and those with a combination of severe motor disability and mental retardation. Some types of disability can best be catered for in special units attached to normal schools, for example units for those with partial hearing.

188. In special schools consideration should be given to the need for the provision of educational facilities throughout the year. In making this suggestion we appreciate the problems of staffing but we are most concerned with the quality of life for the child. Holidays can be very lonely periods for the severely handicapped child, particularly if both parents are working and they do not belong to a large family, and in addition his learning is at best reduced. There is no easy solution to this difficulty but the division of the school year into four terms would ensure shorter periods of confinement at home for the handicapped child while allowing for the essential breaks for the staff involved in onerous teaching situations.

XXVIII. WE RECOMMEND that consideration should be given to the provision of educational facilities for handicapped children throughout the year.

189. The rehabilitation services in hospitals for children up to the age of nine or ten should be planned as an integral part of the childrens' department of the district general hospital or existing hospital complex. The evidence we received was conflicting as to whether or not after that age they should attend the general rehabilitation department of the district general hospital, a special department for children only, or simply receive the services provided in their schools. No hard and fast rule can be made because the problems of each child are peculiar to that child, and in many cases the need for physiotherapy decreases and the need for occupational therapy increases as the child gets older.

190. In our view there is only a limited need to provide special accommodation and equipment in hospitals for the rehabilitation of children over the age of ten since for the most part their needs can be met in the general rehabilitation department. Arrangements can be made where necessary for children to attend at special times or in accommodation temporarily allocated to them. However, we must emphasise that where children are concerned, the consultant in rehabilitation should work closely with the paediatrician or appropriate consultant to ensure that the overall needs of the child are taken into account in the planning of his rehabilitation; unfortunately this rarely happens at present.

XXIX. WE RECOMMEND that the rehabilitation of children over the age of ten should take place in the general rehabilitation department of the district hospital, but that a limited amount of special accommodation and equipment should be provided for a minority of patients in this age group.

191. In general the services for handicapped children below and of school age are good, but we are concerned about the provision for the handicapped adolescent on leaving school. The residential and vocational training units make

special provision for some handicapped adolescents and a number of voluntary organisations provide residential homes for the training of some disabled adolescents, but we should like to see the provision of continuous supervision and guidance for all disabled adolescents: at present there can be a break in continuity of supervision between the ages of sixteen to eighteen.

192. The special problems of these children should be made known to the youth employment service or similar service at least by the age of twelve. Experience in some authorities has shown the value of attaching social workers to special schools to maintain contact between the school and the home, and also to provide the essential follow-up of the school-leaver and disabled adolescent beyond that afforded by the careers officer of the youth employment service.

193. This is not intended as a criticism of the youth employment service but few of the officers have the necessary knowledge and training to deal with the many problems that arise in this group of patients and the continuous supervision over a period of years which is essential for disabled adolescents cannot be provided under the present terms of service of the careers officer. Support should continue where necessary until the age of eighteen and longer if required, although the lowering of the age of majority may make the latter suggestion administratively difficult.

XXX. WE RECOMMEND that consideration be given to the appointment of persons with specialised knowledge, to guide the disabled adolescent. They could be (and in some areas already are) careers officers with special training in the problems of the disabled adolescent. Alternatively this could be an extension of the role of the disablement resettlement officer, or a specialised branch of that service.

CHAPTER 8

REHABILITATION OF THE AGED

194. We have made an earlier reference to the increase in the number of elderly patients attending hospital departments. Over 60 per cent of all admissions to the so-called acute medical wards are persons of pensionable age. Inevitably these patients tend to suffer from progressively disabling conditions so that cure in the accepted sense of the term is not attainable, and in addition, they often have multiple disorders and are slower to respond to rehabilitative measures. All these factors are placing an increasing load upon the rehabilitation services.

195. The early identification of disability and the assessment of functional loss—psychological and social as well as physical—is necessary if the elderly are to be assisted to maintain an independent existence in the community, and especially to return to it after admission to hospital for acute illness. In the past reluctance on the part of the elderly to seek help has led to the late admission to hospital of many elderly patients by which time their condition is unresponsive to treatment. This is one factor that has led to the all too familiar complaint of the "blocking" of beds.

196. The necessity for an expansion of community and hospital services for the elderly is now generally recognised. Nevertheless, a better understanding is required by the medical and para-medical professions as to what can be achieved by the proper deployment of the services of modern rehabilitation departments. Too often in the past the attitude of doctors, the professions supplementary to medicine, the relatives and even the elderly themselves, has been one of resignation to the pains and infirmities of old age. It cannot be emphasised too strongly that the proper use of the rehabilitation services will benefit not only the patient and the relatives but also relieve pressure upon the community and hospital services.

197. The objectives of rehabilitation need to be defined for the elderly. No longer is there an economic pressure to return to work, neither is a cure possible in the generally accepted meaning of the term. The main objectives of rehabilitation in the elderly are to enable the individual to attain the greatest degree of restoration of function both physical and mental and if possible to regain the ability to live independently. The latter is of supreme importance to the individual, to the relatives and to the community, but it can only be achieved if the geriatric department has the necessary staff and facilities to devote to this work. Remedial staff are particularly important in this context, and because of this we think that consideration should be given to the introduction of a salary "lead" for remedial staff working in geriatric departments.

XXXI. WE RECOMMEND that consideration be given to the urgent need for training of the medical and other professions in the new concepts and special

problems of rehabilitation as applied to the older age groups in modern geriatric practice.

XXXII. WE RECOMMEND that the geriatric department should always have an allocation of the remedial staff employed in the hospital, and that consideration should be given to the introduction of a salary "lead" for remedial staff so allocated.

198. The planning of rehabilitation for hospital patients begins in the wards where about a third of the beds should be used for intensive rehabilitation. Just as in the care of children we have advocated that the paediatrician should normally be responsible for all children in hospital, so we consider that the geriatrician should have responsibility for the care of the elderly, and that he should work closely with the consultant in rehabilitation in the planning of the rehabilitation programmes for geriatric patients. There are special needs particularly in psychiatry, orthopaedics, and gynaecology but these needs are best met by co-operation between the consultants in the appropriate specialties and the geriatrician.

199. The concept of total care is essential for the proper practice of medicine and is particularly so in the case of the elderly because the various aetiological factors, physical, mental, social and economic, are so interwoven that they all need to be assessed if adequate provision is to be made for the elderly patient. Even the smallest improvement in function will often improve the quality of life for the elderly patient. It is essential for the morale of the patients, of the staff and of relatives that minor improvements should be noted and regarded as worthwhile. Lack of appreciation of this fact by the medical profession, accompanied by intolerance of the slowness of response of elderly patients has contributed to a failure to appreciate the benefits of rehabilitation to the individual. Ideally, rehabilitation should be a basic objective of all staff in the ward. This applies particularly to the nurse who should take an active role in the rehabilitation programme after adequate instruction.

200. Much of the rehabilitation of elderly patients takes place in the ward, making the design of the accommodation of great importance. Because of this

XXXIII. WE RECOMMEND (i) the provision of adequate space in the ward between beds, together with day space, so that there is room for occupational as well as therapeutic procedures; (ii) ward surfaces should be non-slippery; (iii) there should be easy access to sanitary annexes with entrances wide enough to permit the use of wheelchairs; (iv) there should be a plentiful supply of hand rails and other aids to movement; (v) beds should be adjustable in height.

201. After initial treatment in the ward, elderly patients will be ready to use the rehabilitation facilities of the geriatric day hospital, or if they are fit enough the general rehabilitation facilities in the main hospital. We would accept the general thesis expressed in a recent book (12) that the facilities of the geriatric day hospital should be for those patients, both in-patients and out-patients, who need medical and nursing supervision as well as the facilities of an active rehabilitation unit. Some patients will progress to the general rehabilitation section before returning home. Others may continue to attend the day hospital as day patients every day or as infrequently as one day a week. We have already recommended that for a population of approximately 200,000 some eighty places will be required in the geriatric day hospital and that some

provision of hostel accommodation may be necessary, particularly in rural or semi-rural areas.

202. Elderly patients who may no longer need to use the rehabilitation services once they are discharged may be helped by attendance at day centres. These should be sited locally and under the care of the local authority or a voluntary organisation. The centres would provide simple forms of occupation, possibly including some assembly work. There would be opportunity to have light refreshments or meals, a bath, chiropody services and general recreational facilities appropriate to the age group. Active therapy would not be undertaken in the day centres. (See also paragraphs 316–319.)

203. The centres should be sited so as to permit ready access from their locality thus diminishing transport needs. Ideally patients should not have to travel more than ten miles. Adequate transport from home to the day hospital is also essential as it cannot function properly if patients do not arrive with reasonable punctuality. The assistance of a transport officer is important to arrange a satisfactory service, and care must be taken to use only those vehicles suitable for elderly people. (See also paragraph 131.)

CHAPTER 9

REHABILITATION OF THE MENTALLY ILL

Future pattern of services for the mentally ill

204. The full range of psychiatric services for the mentally ill and mentally handicapped is under constant review by the Standing Mental Health Advisory Committee and we have exchanged views with this committee. In our consideration of this subject we have taken into account the likely future pattern of services for the mentally ill which is described in the memorandum "Hospital Services for the Mentally Ill" (HM(71)97) issued by the Department of Health and Social Security. The memorandum recognises that the aim in modern psychiatry is to return the hospitalised patient to his home environment and that to achieve this, treatment and rehabilitation must be completely integrated.

205. The basic concept for future provision of services for the mentally ill is that of an organisation in which all the various services—in-patient, out-patient and community—are combined in a single comprehensive service. The emphasis is on maintaining inter-personal relationships and in this process rehabilitation plays a major part. Contacts with the local community should be maintained through a "therapeutic team" comprising psychiatrists, nurses, social workers and other staff drawn from both hospitals and local authorities. This method of organisation, which is already being practised in a number of areas, will be based on district general hospitals or district groups of hospitals which should include a mental illness department of 100 to 120 beds for populations of 200,000 with a closely linked day hospital of 160 to 180 day places.

206. The success of such a service will depend largely on the attitudes and initiative of a rehabilitation team which is similar in concept and function to our proposed general rehabilitation team. It is envisaged that the psychiatric rehabilitation team would consist of a consultant psychiatrist, junior medical staff, nurses, occupational therapists, social workers, local authority and other services, a psychologist, the disablement resettlement officer and others concerned with patients' problems, including the general practitioner, workshop manager, health visitor and voluntary workers. This team, or the appropriate members, would be expected to make assessments and to maintain continuity of treatment and rehabilitation wherever this is undertaken. The emphasis throughout would be on a flexible and comprehensive approach by all staff involved.

207. It is axiomatic in this concept of future services for the mentally ill that preparation for discharge will begin whenever possible as soon as a patient is admitted to hospital and that the psychiatric rehabilitation team will discuss the patient's programme at an early stage of treatment. In order to achieve a successful return to the community the patient must retain his normal social functions. Regular daily occupation is essential and must be meaningful if it is to promote independent living, so a considerable variety of paid work should be

available. Normal home activities and recreation also play a vital part in psychiatric rehabilitation.

208. All these activities will be provided in a psychiatric day hospital which is likely to become the stepping stone between hospital and home for many patients and like the geriatric day hospital, it will be the rehabilitation unit of the psychiatric department. It will have all the facilities essential for the rehabilitation of the mentally ill, including a handicrafts room and a light workshop. Resettlement of the mentally ill is more successful if patients are adequately prepared for their return to work and full use must be made of the resettlement services of the Department of Employment.

209. It will take many years before all mental illness services are provided in district general hospitals throughout the country and in the meantime the large mental hospitals will continue to give treatment and care. These hospitals will be included in a district group framework but they will be run down as mental illness departments open in new district general hospitals. Emphasis is rightly placed on the need to ensure that a new mental illness department is supported by adequate community facilities and the existence of a complementary geriatric department with facilities for psycho-geriatric assessment.

Rehabilitation of the mentally ill

210. We have described the broad basis for the planning of future hospital services for the mentally ill as envisaged in the memorandum to hospital authorities issued by the Department of Health and Social Security. Our own views on rehabilitation are in keeping with this concept. However, there are certain dangers inherent in the change of emphasis in the rehabilitation of the mentally ill. There is a risk that patients on short-term care will be inadequately prepared for their return home and patients in large mental hospitals will remain unprepared because of their isolation from the community. The paragraphs that follow are intended to be read in the context of the changing mental health services organised on a district basis.

211. All the services must work to further the continuing aim of the patient's rehabilitation, but that aim has to be flexible: the original aim often has to be modified, while all the services still have to keep in step. This change of rehabilitation aim may be due to the patient's unexpected improvement, to some previously undetected limitations of his capacity, to the instability of his disability or to some limitation or lack of support in his social situation. Patients may lose momentum or progress rapidly in rehabilitation and the services must be designed to accommodate those whose rehabilitation follows an erratic course.

212. The special need in psychiatry to control patients' deviant and unpredictable behaviour has led in the past to two forms of psychiatric patient care: custody and treatment. Until the large mental illness hospitals are run down, this division is likely to be maintained, but it is important that rehabilitation in these large hospitals should be continued, and every care taken to avoid a "final disposal" for any mentally disabled person in either hospital or community.

XXXIV. WE RECOMMEND that more attention should be given to the development of psychiatric rehabilitation services in the district general hospital, but at the same time such services must be maintained and improved in existing mental illness hospitals.

213. The separation of patients with special disabilities in special units may be essential, but it is not usually desirable and such separation should be of short duration. The aggregation of patients with similar handicaps produces a less stimulating situation than one in which patients with different disabilities share activities. Staff who are dealing with only one type of disability tend to stagnate, and there is little or no questioning or reconsideration of established techniques. Rather there is often a perpetuation of traditional practices. This is illustrated by the history of workshops for the blind (13) which continued to rely for too long on trades which were not only outdated and unprofitable but were unsuited to the needs of their sheltered workers.

Nominated consultant in charge of psychiatric rehabilitation

214. Responsibility for the co-ordination of the various hospital and community services should rest with the consultant in rehabilitation in the district general hospital. The same principle applies in psychiatry but as we have pointed out there are special difficulties in the designation of a psychiatrist to be in charge of rehabilitation services in the psychiatric department.

215. However, these difficulties are not insuperable and in our opinion the organisation of the new services for the mentally ill will need the advice and supervision of a psychiatrist who really understands rehabilitation and who can make the necessary innovations in the light of knowledge and experience. While the patient-doctor relationship is particularly important in psychiatry, a designated consultant is vitally necessary to implement and supervise the rehabilitation services in each existing psychiatric hospital and in psychiatric departments ofdistrict general hospitals. There is no reason why this appointment should damage or interfere with the special relationship mentioned above.

216. The designated consultant psychiatrist should work in close co-operation with the consultant in rehabilitation who will be responsible for the overall service. He should be concerned with training and for establishing close and effective relationships with other agencies. If one consultant in each hospital were adequately trained to understand the principles of rehabilitation and its practical organisation and operation, he would influence not only his own team, but many, if not most, other staff. Since circumstances differ from hospital to hospital and area to area, training of consultants is preferable to the promulgation of plans or exhortations which fail to match the needs of the local situation. A suitable course of about three months' duration could perhaps be provided through the King's Fund or other educational body. This solution would offer a chance to repair many present defects and would result in much better use of the available staff.

217. In our view, the psychiatrist in charge of rehabilitation should be available to advise other members of the hospital, industrial and community services on the psychological aspects of ill health and the more complicated mental illness cases which often involve all the rehabilitation services. He should encourage other psychiatrists, officers of the local authorities and officers of the industrial

rehabilitation and resettlement services to make use of his help and advice, attend meetings of the assessment clinic when required, and be available to give advice concerning the management of psychiatric problems in physically disabled patients.

XXXV. WE RECOMMEND that hospital authorities should nominate a suitably trained consultant psychiatrist to be responsible for the supervision of all stages of rehabilitation in mental illness hospitals and mental illness departments of district general hospitals. Consideration should be given by the appropriate bodies to the provision of suitable training.

Industrial rehabilitation of the mentally ill

218. One of the functions of a psychiatrist responsible for the organisation of rehabilitation will be in the supervision of the use made of hospital workshops and the arrangements for a patient's transfer on discharge to industrial rehabilitation or other occupational activity. The separation of the industrial and medical phases of rehabilitation has produced a rigidity of outlook on both sides, a spurious certainty about techniques and a conflict of aims. There is little or no "feed back" of information between these separated areas of rehabilitation. This failure of communication has been referred to already but more is needed than the passing of information from the doctor to the industrial rehabilitation unit or vice versa. Information may prevent misunderstandings but it will not automatically improve the patient's rehabilitation.

219. Particular difficulties arise in the rehabilitation of patients with unstable disabilities. The judgment and timing of the patient's transfer from the medical to the industrial setting is always difficult and if it is assumed that this transfer is a one-way process and a once-for-all decision, effective resettlement is less likely. Relapse after transfer to an industrial rehabilitation unit can be reduced if clinicians understand the functions and requirements of these units, and see that patients are properly selected and prepared for industrial rehabilitation. This can best be achieved through close association between the medical and industrial rehabilitation services. Psychiatric rehabilitation has to progress by carefully graded steps so that the stress of each step is mastered before the patient advances to the next stage. This means that patients cannot make a sudden leap from a few hours occupational therapy in hospital to the full working week required in an industrial rehabilitation unit.

220. From the oral evidence given by the representatives of the Department of Employment it is clear that industrial rehabilitation units are concerned mainly with the resettlement of rehabilitated patients by integration into an industrial community working normal hours, and they should be ready for employment within ten weeks. It was clear, too, that these patients should have completed their preparation in hospital before being selected for a period of industrial rehabilitation. In any event, it is unlikely that there will ever be enough places in these units to meet the needs of psychiatric patients.

221. Industrial therapy organisations were intended to give a longer period of work preparation before patients were referred to an industrial rehabilitation unit, but the evidence we received made it clear that they were not attracting enough patients. This is not surprising because they too only select patients who have already had a fair degree of work preparation in hospital. Sheltered

workshops in the community, whether voluntary or provided by the local authority, should not be used routinely in the rehabilitation process as they are intended for the employment of patients who, after adequate rehabilitation and detailed and careful assessment, are too disabled to have a reasonable chance of resettlement in economic work.

Workshops

222. Work is an essential component of psychiatric rehabilitation in hospital. It should not be undertaken as an end in itself but should be integrated in a planned process of rehabilitation with emphasis on the assessment of the patient's disabilities and abilities and his preparation for a useful life in as normal a social context as possible. The context varies and the patient may live at home or in lodgings, in a hostel or even in the hospital, while working in open or sheltered employment.

223. Handicraft rooms and workshops will be provided in future day hospitals and these facilities will be used by patients in the mental illness departments of the district general hospital. We consider that careful attention must be paid to the scale and type of this workshop provision. The value of work in psychiatric rehabilitation has led to a proliferation of workshops of various kinds and it is not always recognised that similar types of work or workshops serve different purposes depending on the needs of the patient. A wide range of work of varying complexity and type should be provided to meet the needs of all patients and should include machine work, secretarial and clerical work, data processing and labouring work. The hours of work and the complexity of work should fit in with a plan for the preparation and assessment of patients for life in the community. If a patient's suitability for transfer to an industrial rehabilitation unit, or to open or sheltered employment is to be assessed adequately and the risk of relapse avoided as far as possible, the work and conditions of work during the later stages of rehabilitation must be comparable to outside employment.

224. In many aspects the day hospital workshop should perform a similar function to an industrial rehabilitation unit, differing only in that it would allow the psychiatric patient to continue specialised treatment, provide him with a longer period of industrial rehabilitation, accept him at an earlier stage and allow him more time to consolidate his improvement before return to the community. However, although the employment of the mentally ill patient in a day hospital may continue for a longer period than that of the physically disabled patient, work in the community either in open or sheltered employment is the ultimate objective and long-term employment in the hospital setting should be avoided as far as possible.

225. Besides the workshop activities the day hospital must also cater for the resettlement of housewives, young adults still training for a career, active retired people, and psychogeriatric patients, as well as offering recreation and hobbies. Provision should therefore be made in the day hospital for cooking, carpentry, do-it-yourself activities and gardening, as well as for participation in art, music and educational facilities. There should also be provision for a therapeutic social club and other specialised group activities directed towards improving inter-personal relationships.

226. Most existing mental illness hospitals, many of which will continue for some years to come, already have large workshops which undertake contract work. The report of a survey of industrial units in psychiatric hospitals, (14), showed that industrial work is an established form of occupation in the great majority of these hospitals; over a quarter of the patients were occupied in the units and three-quarters of the discharged male patients went to open employment. Emphasis in the function of the units differed widely and frequently was never clearly defined. Overall, the units covered in the survey undertook a great variety of work but individually each hospital's range of work was very limited, and in our view, the wide range of work suggested for day hospitals should be introduced to all mental illness hospital workshops.

227. Relatively small individual workshops can find it difficult to obtain suitable work. To overcome this we have suggested that contract work for all hospital workshops should be negotiated on a co-ordinated basis (see paragraph 167).

228. We do not propose to go into the question of payment for work in hospital workshops except to point out that the system of payment is at present too rigid to provide adequate incentives for some patients. A King's Fund Report (15) examines the subject in detail and it is shown that at most hospitals pay is generally below the earnings limit of £2 allowed to patients without loss of sickness benefit. This does not matter greatly for many patients who would not earn very much anyway, but for those employed on industrial work, difficulties do arise and the low rates of payment can inhibit rehabilitation and resettlement in the community.

XXXVI. WE RECOMMEND that the Department of Health and Social Security should examine the whole question of remuneration for therapeutic work in hospitals.

Staffing

Clinical psychologist

229. See paragraph 142.

Nurses

230. The mental health services suffer from a grave shortage of psychiatrically trained nursing staff. Attention is drawn to the problems this creates in the first annual report of the Hospital Advisory Service (16) which comments on the impossible task placed on nurses in overcrowded wards. The report emphasises the importance of a nurse-patient relationship which can be developed and continued in the follow-up after discharge. If the initiative is allowed then nurses can play a useful role in the patient's rehabilitation and resettlement. It is important that they should be involved in the rehabilitation team, be consulted in decisions about their patients' future and should, if necessary, continue to provide support after patients are discharged. This continuity of personal care is an important part of the future policy for the treatment of the mentally ill.

231. We note that nurses provide a large proportion of the staff of hospital workshops. Although we wish to see this function taken over by technical staff (see below) we recognise that nurses will continue to staff many industrial

therapy units in existing psychiatric hospitals for some time to come. The King's Fund Report (14) suggests that relevant industrial training might be given to these nurses by a scheme of in-service attachment to selected hospitals, that is to hospitals with industrially trained staff. We agree that this would be beneficial to the rehabilitation service and would encourage psychiatric hospitals to adapt their workshops to a more commercial outlook in the interest of the patients by introducing the work situation assessments suggested later (paragraph 235).

Remedial professions

232. At present there are only a few physiotherapists and remedial gymnasts working in psychiatric rehabilitation (though the former are being employed in increasing numbers), but occupational therapists have always played an important part in remedial work. Their former role of providing occupation for patients confined to hospitals for a long period has been replaced by active participation in the patient's treatment during the process of recovery. The occupational therapist is now more concerned to assist in the assessment of the psychological or social difficulties confronting the patient and to devise methods of overcoming these. The occupational therapist will also be involved in behavioural exercises for specific psychiatric syndromes and in helping the patient to meet the intellectual and social expectations of others, for example, the family or the employer.

233. Both occupational therapists and industrial managers have a part to play in rehabilitation but there is a major difference in the sequence of their contribution. Initially, the occupational therapist will take the major role in the patient's rehabilitation, gradually handing over to the manager as the patient progresses, learns to manage his disability and becomes orientated towards resuming his normal life in the community.

Workshop managers and supervisors

234. We have already mentioned briefly the problem of workshop staff in psychiatric hospitals (paragraph 163). The King's Fund survey on industrial therapy in psychiatric hospitals (14) found that nursing staff predominated as supervisors in psychiatric hospital workshops, giving the impression that industrial therapy is an extension of the nursing function. In the units covered by the survey, approximately 60 per cent were supervised by senior nursing staff, 25 per cent by occupational therapists and only 14 per cent by industrial managers. Generally speaking the management and staffing situation in many existing workshops presents a picture in which the work background is not truly industrial but serves more as a means of keeping long-term patients usefully occupied than as a preparation for return to the community. We find it significant that the survey noted that the workshop runs better when a psychiatrist has designated clinical responsibility for it, a point which emphasises the need for a nominated consultant psychiatrist to be in charge of psychiatric rehabilitation services.

235. In our view the rehabilitation workshops of day hospitals for the mentally ill fall into two categories: therapeutic and industrial. The latter should be staffed by commercially and industrially experienced managers and supervisors

who would be able to provide the rehabilitation team with a work assessment of the patient based on their knowledge and experience of the realities of normal social and industrial life. They would see the patient as a potential worker and not, as nurses might, as a mentally ill person. At present there is not a career structure in the National Health Service for industrial managers and instructors and we have recommended that such staff should be seconded from the Department of Employment (see paragraph 166). We hope that by this means new mental illness day hospital workshops can be suitably staffed from the beginning.

CHAPTER 10

REHABILITATION OF THE MENTALLY HANDICAPPED

236. The general services for the mentally handicapped have been the subject of a recent Command Paper (17) and therefore we have not considered it necessary to make recommendations on these services. It is arguable that those who are mentally handicapped from birth require training rather than rehabilitation. We do not take that rather restricted view. In our opinion the principles of rehabilitation apply equally to mentally handicapped people as to those with other kinds of handicap and they benefit in the same way from encouragement and the assumption that they are always capable of doing a little more and achieving a further step towards the goal of maximum attainable independence.

237. Mental handicap is a general term covering a number of different handicaps of varying severity. These can be divided broadly into four main groups:

(i) those who have progressive mental handicap associated with severe physical illness or disability. These patients require constant nursing attention, and some form of hospitalisation is normally necessary. Where the patient is nursed at home, a system of "sharing" between the hospital and the home can be arranged to the advantage of the patient and his family.

(ii) those who combine mental handicap with static physical disability or severe emotional disturbance. Many patients in this group are institutionalised, either in hospital or in local authority accommodation. Such patients have benefited from intensive treatment given in small groups and it may be that more of them would show a similar response if treated in the same way. In our view, the institutional solution should normally be the last resort.

(iii) those who are mentally retarded and have emotional behavioural disturbances. Primarily those in this group need psychiatric help.

(iv) the less severely mentally handicapped, some of whom may not be able to live at home but with help, are capable of living and working in the community. Initially, in addition to medical help this group require education. Later they may need hostel accommodation and sheltered work. Over a period of time it may become possible for them to become fully integrated into a normal working life in the community.

238. While the physical treatment of the mentally handicapped should never be isolated from the mainstream of medicine, neither should their need for psychiatric help be disassociated from the psychiatric unit. In their rehabilitation it is particularly important to provide the right kind of help during their early years. We see a special need for small units to provide intensive therapy and research on the training of young severely mentally handicapped

children. If these units were associated with regional assessment centres for handicapped children they would probably yield good dividends in enabling these children to lead a more independent life.

239. It is important to realise that rehabilitation of the mentally handicapped is not a matter for the hospital service alone. Although doctors play the key role in the early years, they can only diagnose or describe specific handicaps and treat complicating problems such as fits, hyperkinesis, heart lesions and so on, and their role necessarily diminishes as the child grows older. Their welfare in adult life depends more on good community services than upon the hospital service.

CHAPTER 11

HOSPITAL REHABILITATION FACILITIES FOR SPECIAL CATEGORIES OF PATIENTS

240. In addition to the rehabilitation facilities required for the majority of patients there are other groups of patients whose rehabilitation poses special problems. In the past many of the needs of such patients have been met by special centres set up to deal exclusively with a particular problem. While these centres have done invaluable pioneering work, they have certain disadvantages for rehabilitation: there is often a tendency to look inward rather than towards the general trends in rehabilitation, and few of the centres are prepared to take patients with multiple disabilities. There is the overall disadvantage of isolating the patient from the community in which he lives.

241. We have given considerable thought to the need for special centres and in general we have concluded that they will rarely be necessary once the rehabilitation departments described in Chapter 6 are fully operational. These departments should be able to cope adequately with the majority of patients, whatever the nature of their disability, and the patient may be expected to benefit from the company of other patients with disabilities different from his own, and from remaining near his own community. From time to time, requests are made for special facilities for groups of patients, for example, those suffering from cancer or tuberculosis. We think the answer to such demands is to set aside a small number of beds within the district general hospital, rather than to set up special centres. However, particular consideration needs to be given to the appropriate facilities for patients with multiple handicaps. There are also some groups of patients for whom special provision will always be necessary and these are discussed in the following paragraphs.

The blind and the partially sighted

242. We accept that special provision for blind people is necessary and the existing rehabilitation services for the blind are very comprehensive. Nevertheless difficulties do arise in particular for blind people with a physical disability whom the Royal National Institute for the Blind cannot accept for training because their facilities are not suitable for physically disabled people and rehabilitation departments cannot accept because their facilities are not suitable for the blind. The problem requires further examination but it is our view that where blindness is one of multiple handicaps, blind training must precede other forms of rehabilitation.

243. The lack of provision for the rehabilitation of the partially sighted, particularly for those whose condition is not severe enough for them to be registered as blind, also gives cause for concern. The condition may be of congenital or acquired aetiology and it may occur at any age. Children and young persons are well provided for in school, but facilities are needed for adolescents. We hope that the Committee of Enquiry into the education of the

visually handicapped, under the Chairmanship of Professor M. D. Vernon,* may make some comment on this. The Department of Employment accepts partially sighted rehabilitees for assessment and in the more severe cases, a special placing service is provided. The partially sighted person who is not in the employment field, such as the housewife or elderly person, does not appear to be provided for unless they are approaching total blindness, and for an older person the problem may be worsened by the difficulty in assimilating retraining or learning braille.

XXXVII. WE RECOMMEND that the problems of the partially sighted should be the subject of studies designed to ascertain the needs of this group and the ways in which their needs can best be met.

The deaf and the hard of hearing

244. The Royal National Institute for the Deaf made a number of criticisms in their evidence of the services involved in the rehabilitation of the deaf. They considered that prelingually deaf people seldom fit into the existing provision for industrial and other occupational work in rehabilitation, and they commented on the shortage of clinical psychologists with experience of the prelingually deaf and of trained social workers experienced in dealing with the profoundly deaf. We concur with their views.

XXXVIII. WE RECOMMEND that consideration should be given to the provision of special rehabilitation facilities for those suffering from deafness and that more research should be undertaken into the needs of the deaf, and to the ways in which they can obtain maximum benefit from the services available.

People with epilepsy

245. We have studied the report on "People with Epilepsy" (18) and have discussed the recommendations of the report with the Chairman of the Joint Sub-Committee, Dr. J. J. A. Reid. We are in complete agreement with and accept his Committee's views on the rehabilitation requirement of people with epilepsy and we note that the Department of Health and Social Security are now in the process of setting up three experimental centres for people with epilepsy in areas with good rehabilitation services in accordance with the recommendations of the report.

Trauma, including head injuries and spinal injuries

246. The incidence of serious accidents which cause multiple injuries, particularly among those in the younger age groups, is such that we agree with the policy of nominating accident centres in certain areas, but if this is done, it is essential that these centres have the support of first-class rehabilitation facilities. A sub-committee of the Standing Medical Advisory Committee reported on Accident and Emergency Services in 1962, and recommended that "there should be close and continuous co-operation between the hospital service and all outside agencies concerned with the resettlement of the injured". Although the

*The terms of reference of the Committee of Enquiry are: "To consider the organisation of educational services for the blind and the partially sighted and to make recommendations."

report was commended to hospital authorities in HM(63)40 there was no monitoring by the central department on the practical effect of its commendation.

247. A working party on accident services (19) commented that "Rehabilitation centres, as such, were conspicuous by their absence. The overall impression gained is that the value of rehabilitation is appreciated but that, in practice, its application is patchy." If these centres are to treat patients successfully we suggest that rehabilitation facilities must be set up in association with accident centres. Accident services should utilise the expertise of the consultant in rehabilitation among others, in providing a comprehensive care programme, and all staff must be trained in this philosophy and practice. However, some injuries, such as head and spinal injuries, are so special as to require separate facilities and these are discussed below.

XXXIX. WE RECOMMEND that all accident centres should be supported by adequate rehabilitation facilities.

Head injuries

248. A conference on rehabilitation after head injury was held in October 1968, under the Chairmanship of Mr. J. J. Pennybacker. The report of this conference is reproduced at Appendix XV. We endorse the conference's conclusions and recommendations. Each year there are some 200 patients who have been so severely disabled by head injury that they have to be classified as severely mentally handicapped. Another 800 are cases of severe head injury, often needing 2–4 years of rehabilitation and these tend to be lost in psychiatric or chronic sick hospitals; if the present rate of increase in incidence continues, it will create a developing load on the rehabilitation services.

249. It was suggested to us that this problem could be tackled by setting up a national head injuries centre on lines similar to the Stoke Mandeville National Spinal Injury Centre. In our view, however, the present position of head injuries is quite different from that of the treatment of spinal injuries before Stoke Mandeville was set up. A special centre means a concentration of similar patients and the Committee considers this is undesirable for patients suffering from severe head injury. These patients need the whole range of services which can be provided only in a district general hospital with full rehabilitation facilities and a psychiatric department.

250. Some members of the Committee visited the Wolfson Rehabilitation Centre, attached to the Atkinson Morley Hospital, Wimbledon, which specialises in neurological conditions. They were impressed by the fact that although the Centre was established originally for the rehabilitation of head injury patients, less than 15 per cent of patients in the Centre were being treated for this condition at any one time. The Centre demonstrated that units catering for special conditions such as head injury should accept other less severe conditions to encourage both the severely disabled and the staff.

251. One feature of the Centre is the average length of stay. This is eight weeks for the majority of head injury patients, and the aim is to intersperse periods of intensive rehabilitation with periods at home to consolidate progress. A difficulty often arises, however, in organising occupation at home. This policy of discharge

after eight weeks' rehabilitation is one approach to the problem of rehabilitating this type of patient, but it demonstrates the need for a "holding unit" to enable patients to keep as active as their condition allows between spells of intensive treatment. Many patients with a good eventual prognosis need not return to an acute hospital but deteriorate if they return home unless activity is organised for them. Some patients, however, may create impossible situations for their families if they return home and alternative accommodation needs to be provided for them. In our view this problem requires further study.

252. The severe head injury cases also illustrate the problem of the gap between the rehabilitation services of the Department of Health and Social Security and the Department of Employment to which we referred in Chapter 3. We understand that the Departments are exploring ways and means of making provision for the severely physically disabled who are in need of long-term rehabilitation and we would urge them to look particularly at the needs of the patient with a head injury.

XL. WE RECOMMEND that patients suffering from head injuries should be treated initially in district general hospitals with neurosurgical units providing assessment and early treatment, and in these hospitals rehabilitation facilities should be shared with other categories of patients. Provision should also be made for the long-term rehabilitation of severely disabled head injury cases and research should be undertaken into this problem.

Spinal injuries

253. Some members of the Committee visited the spinal injuries unit at Stoke Mandeville and observed that the imaginative leadership of Sir Ludwig Guttman was still apparent in the broad concept of rehabilitation which is being maintained by the present Director of the unit, Dr. J. J. Walsh. We feel, however, that the disadvantage of Stoke Mandeville is its remoteness and in view of the long-term problems of many of these patients, distance from home is likely to be a factor in making discharge more difficult; this aspect needs to be taken into account in the siting of any new units.

254. Our attention was drawn to a serious problem in the treatment of spinal injury which was discussed in the House of Lords during the debate on the Chronically Sick and Disabled Persons Bill, namely the need for patients with disabling neck or back injuries to be transferred as soon as possible after the accident to one of the spinal injury units. Cases were mentioned of paraplegics being kept in local hospitals to the detriment of their treatment and rehabilitation. The Department of Health and Social Security asked hospital boards to ensure that the facilities available at the special units were known, especially to doctors in accident and emergency departments, and that they were aware that the doctors at these units were available to give immediate advice on treatment, and where possible, to arrange an early transfer when in the consultant's opinion, this was in the best interest of the patient.

255. We have seen the report and recommendations of the conference on the future services for paraplegics which was held in July 1969, under the Chairmanship of Dr. J. J. Walsh. The report is reproduced in Appendix XVI. We note that in the light of the recommendations of the conference on services for paraplegics, the Department of Health and Social Security are carrying out a

thorough review of the services for spinal injury patients in order to decide on future provisions.

XLI. OUR OWN CONCLUSIONS AND RECOMMENDATIONS on the rehabilitation aspects in the treatment of paraplegia and tetraplegia are:

(i) there should be eight spinal injury units in England and Wales to provide a sound geographical distribution over the whole country. They should be attached to selected district general hospitals to enable use to be made of common services including rehabilitation;

(ii) patients should be transferred as soon as possible to one of these special units for treatment during the acute stage where early rehabilitation procedures should be initiated;

(iii) at the later rehabilitation stages, it is to the advantage of spinal injury cases to share facilities used by other groups of patients;

(iv) in order to keep the centres free for new cases spinal injury patients should be transferred at the earliest appropriate time to district general hospitals capable of accepting such cases and of continuing rehabilitation, and near the patient's home;

(v) suitable minimal care accommodation should be provided for the small residual number of paraplegics and tetraplegics who cannot return home for various reasons;

(vi) adequate training should be provided to ensure that sufficient experienced remedial staff are available for the units and for other district general hospitals accepting transfer of spinal injury cases from the units.

Drug or alcohol dependency

256. The rehabilitation of alcoholics and drug dependent persons demands continuity of care of a high order over very long periods of time. This has usually been provided through voluntary efforts in specialist hostels or day centres. In addition to their medical needs these people have problems due to homelessness, poverty, lack of work and conflicts with the law, so their rehabilitation is not entirely, or even principally, a matter for the hospital service, since social security, welfare, probation and the prison services are also involved. These people are very mobile and move rapidly from place to place and service to service. The statutory services cannot always meet their needs in a flexible way and find it difficult to cope with their unreliability, their awkwardness and their tendency to let people down; as a result they rarely seek them out when they fail to attend clinics or keep appointments.

257. The public anxiety concerning the misuse of drugs has in part been responsible for the failure to appreciate the magnitude of the problem of alcoholism. More attention should be paid to the prevention of alcoholism and the rehabilitation of the alcoholic. Rehabilitation of alcoholics and drug dependent persons must be based on the possibility of a continuing relationship to a person, group or organisation and is likely to be a protracted process. But, given this relationship, their chances of rehabilitation or resettlement are perhaps better than the public or the professions realise, and for this reason we consider that special facilities should be provided for them. An increasing number of centres have been established during the last ten years to deal with drug dependent

individuals. In the light of this experience it would seem appropriate for a working party to study the siting, size and staffing of such units and to make recommendations.

XLII. WE RECOMMEND that some special facilities for the treatment of alcoholics and drug dependent persons should be established in a limited number of centres but it must be appreciated that the total rehabilitation requirements for these patients will only be met in part by the general rehabilitation department.

CHAPTER 12

AIDS FOR THE DISABLED

The artificial limb service

258. The artificial limb service was established during the First World War by the Ministry of Pensions primarily for war pensioners. It was not extended to include all patients until the introduction of the National Health Service in 1948. Even then it continued to be the responsibility of the Ministry of Pensions up to 1953, since when it has been administered directly by the central Health Department. The service is linked with the service for provision of invalid vehicles and some other appliances which are based at artificial limb and appliance centres.

259. The numbers of new patients attending limb-fitting centres in 1970 are given in the statistical tables attached to Appendix XVII. These show that the elderly lower-limb amputees are the major burden numerically. A total of 2,531 patients in the 60–79 years age-group attended limb-fitting centres in 1970 and of these 2,482 were lower-limb amputees (2,166 single and 316 double). The next largest group was the 40–59 years age-group with 816 patients of whom 704 were lower-limb amputees (633 single and 71 double). The statistics also show that many of these patients had associated diseases: of a total of 4,076 lower-limb amputees in all age-groups, 3,630 were the result of disease including tumour, the other causes being trauma and congenital malformation.

260. The particular problems relating to the rehabilitation of the limbless were discussed at a one-day conference, held in December 1970. The conference was attended by members of the medical profession interested in the subject, technical experts from the Department of Health and Social Security and some "consumers" who were able to contribute to the discussion from personal experience. A note of the conference is at Appendix XVII.

Integration of the limb-fitting service into the National Health Service

261. The main criticism of the existing organisation of the limb-fitting service is that medical care of the patient should not be divided between the amputating surgeon at the hospital and the medical officer at the limb-fitting centre. It is argued that the patient would be better served by being under the care of one surgeon throughout the whole process of amputation, limb replacement and subsequent rehabilitation. To this end it has been suggested that the limb-fitting service should be integrated with the National Health Service and administered by regional hospital boards. However, the issue is complicated by the development of modular limbs and by the method of provision and fitting of limbs which rests with a number of private contractors.

262. We understand that the Department of Health and Social Security has been considering the integration of the limb-fitting service for some time, and that a study is being undertaken on the practicability of such a step. In any event, it is their policy to build new artificial limb and appliance centres in the grounds of

district general hospitals. The opinion reached by the conference was that there is an urgent need for closer co-operation between the limb-fitting service and the hospitals where patients are treated and that if it can only be achieved by full integration with the National Health Service, then this step should be considered.

263. The question of integration was also considered in some depth in a British Medical Association Report (20) where it was concluded that integration of the limb-fitting service with the hospital service was of prime importance in improving the service. We are in agreement with the views expressed at the conference on this matter and we note that the Department of Health and Social Security is already working towards phased integration. Such a development seems only logical now that the unification of the National Health Service is certain to take place in the near future.

XLIII. WE RECOMMEND that in the interest of the patient, the limb-fitting service should be fully integrated with the hospital service without delay.

Arrangements at district general hospitals

264. The conference put forward broad proposals for the future organisation of the limb-fitting service at most district general hospitals, taking into account that the problem over the whole country is not, in fact, very large, that many amputations are carried out at general hospitals as emergency operations, and that for some elderly lower-limb amputees crutches or a wheel-chair may be preferable to the rigorous preparation for and fitting of a prothesis. It was the conference's conclusion, with which we agree, that each district general hospital should have a medical team with a special interest in amputation and with the necessary expertise for assessment, surgery and rehabilitation for routine cases. We do not feel, however, that this is a large enough problem to warrant a separate specialty providing a full-time career.

265. The medical rehabilitation department at the district general hospital could undertake some of the rehabilitation procedures for routine limb-fitting cases. The team would need to gain experience in the training of patients who had lost a limb and would need the part-time assistance of a prosthetist based on a limb-fitting centre.

266. We also agree that more participation in this field by remedial staff is desirable. The part to be played by the remedial professions—particularly the physiotherapists—in fitting limbs could be complementary to the prosthetist; a remedialist with special training could fit an immediate temporary prosthesis but definitive fitting and repairs should always be carried out by the prosthetist at a limb-fitting centre or by a peripatetic fitter from such a centre. In appropriate cases it will be necessary to include the limb-fitter as a member of the rehabilitation team to advise on the specific problems of patients requiring artificial limbs.

Special artificial limb centres

267. Whatever the outcome of re-organisation and integration, limb-fitting centres will continue to supply all types of artificial limbs and to carry out repairs; it is from these centres that amputees at district general hospitals will obtain their prostheses, the fitting being carried out either at the hospital or the

centre. Certain cases, however, such as upper-limb or bi-lateral lower-limb amputations, provide complex problems which call for specialised treatment. The conference suggested that a number of special limb-fitting centres should be set up in association with district general hospitals for the referral of difficult cases and for the specialised aspects of rehabilitation of amputees, notably people with bi-lateral upper-limb amputations. The "consumer" representatives at the conference pointed out that patients with these difficult problems would be willing to travel considerable distances in order to attend centres where the necessary expertise was available. The centres would also provide advice for the large proportion of elderly patients.

268. We suggest that, as old limb-fitting centres are replaced, the new centres associated as they will be with district general hospitals, should be developed as special referral centres with amputation units for difficult cases. It should be possible to be resident at these centres while fittings or repairs are being undertaken and hostel beds should be provided within the hospital for this purpose. They should maintain close links with all the community health and social services to ensure that the patient's rehabilitation is not hampered by difficulties at home. Each centre should cover a population of 1½–2 million. There should also be two or three more research and development centres in addition to the one located at Roehampton so that the benefit of technological advances can reach the patients as soon as possible.

XLIV. WE RECOMMEND that comprehensive limb-fitting and appliance centres associated with district general hospitals should be developed as special referral centres, each one to cover the needs of a population of 1½–2 million.

XLV. WE RECOMMEND that two or three further research and development centres should be set up to study the technical problems of limblessness.

Voluntary work for the limbless

269. The British Limbless Ex-Servicemen's Association provides a very valuable service by arranging visits to recent amputees from persons who have undergone similar experiences and who are able to give personal advice both to these new patients and their relatives. It is vital that new amputees should receive as much help as possible in preparing themselves for the future and this system of passing on personal experience is admirable and should be continued.

Aids and appliances

270. The provision of aids and appliances for the disabled is an essential part of the National Health Service since it often means the difference between enabling disabled people to lead independent lives in the community rather than the necessarily more restricted life in local authority care or even as hospital in-patients. Aids and appliances are provided mainly in three ways:

(i) through the general medical service, i.e. general practitioners;
(ii) through the local health services; and
(iii) through the hospital and specialist services.

The first two of these methods are rather limited as the majority of aids and equipment are available only on consultant prescription. The organisation for

the supply of aids and appliances is complex and fragmented, varying from the direct supply of wheel-chairs by artificial limb and appliance centres upon consultant prescription, to the provision of a large range of nursing aids which can be supplied by hospitals or local authorities. We do not propose to attempt to explain the system of administration which is described in detail in the Health Department's handbook issued with the hospital memorandum HM(71)94.

271. The Planning Unit of the British Medical Association were aware of the problems in the appliance services and set up a working party to assess the nature and value of appliances and to examine the arrangements for their provision. The working party's report (20), published in 1968, deals exhaustively with the subject. We would have given this subject much more consideration but for the fact that we are in broad agreement with the working party's recommendations and consequently we do not consider it is necessary for us to repeat their conclusions.

CHAPTER 13

HEALTH IN THE COMMUNITY

272. Until recently services outside hospital would have been properly dealt with in separate chapters on general practitioner services, local health authority services and welfare services. The recent legislative changes in the social work services of local authorities, the impending changes in the organisation of the National Health Service and the increasing deployment of local authority nursing and in some instances also social services staff to work alongside general practitioners make comprehensive consideration of these services more appropriate, though we are faced with the difficulty that as far as the National Health Service is concerned, their future pattern has not yet been precisely established.

HEALTH SERVICES OUTSIDE HOSPITAL

The general practitioner

273. Whilst the general practitioner must be recognised as the personal doctor of individual patients, the trend towards teamwork in which he may work not only alongside his own colleagues but also in close association with health visitors and district nurses, has obvious advantages for the identification, treatment and support of handicapped patients. Similar links with social workers, though at present less practical owing to staff shortages, are of vital importance.

274. Earlier we mentioned briefly the role of the general practitioner in the early assessment of his patient's needs for rehabilitation and while we hold to the view that the focal point of the rehabilitation services should be the hospital rehabilitation department, we recognise that the general practitioner is, or should be, closely involved. As the personal doctor, he should be familiar with the individual's background and therefore in a position to give invaluable help and advice. In the more obvious cases, for example, when admission to hospital is for operative treatment or is an emergency following an accident, the rehabilitation will be initiated by the hospital but the general practitioner should be brought in at an early stage, possibly at the first assessment clinic, and will take over major responsibility for the continuation of his patient's rehabilitation and ultimate resettlement after full discharge from hospital care. In this way he and his community team provide the essential link between the hospital and community services.

275. The general practitioner is not infrequently in a position to initiate rehabilitation for a patient and it is here that he needs to know not only where rehabilitation facilities are available at hospitals and in the community but also something of the nature of the facilities and to what extent they can provide for and help his patients.

276. The general practitioner is the doctor of first contact responsible for the medical care of most of the disabled living in the community. A high proportion

of these are elderly, and in some instances their management can be jointly undertaken by hospital and general practitioner, through regular attendance at out-patient clinics and/or in day hospitals. An important part of his duty is to treat and support the elderly disabled, and to use the community services to help prevent deterioration of the patient's condition. In all other respects, the general practitioner's role in the rehabilitation of the elderly in no way differs from his role in rehabilitation generally. The general practice team have a special responsibility towards the elderly to ensure that deterioration is recognised and that the patient receives the remedial treatment and training which will help him to maintain his place in the community and live as full a life as infirmity in old age will allow.

277. A good example of this is the stroke patient who cannot at present always obtain appropriate in-patient or out-patient assistance from the hospital but who can be treated at home by the general practitioner and a district nurse who has had training in simple therapeutic procedures, including "daily living". If possible such a case could be referred at a suitable point of recovery to the geriatric day hospital for rehabilitation, and as the numbers of day hospitals increase, this course of action should become more frequent. Ideally with more efficient utilisation of hospital beds there should be sufficient to permit emergency admissions of all stroke cases, when the chances of maximum restoration of functions through early remedial treatment would greatly improve.

The relationship between the general practitioner and the hospital

278. We were told in oral evidence that the general practitioner's only chance of breaching the barrier between the hospital and general practice is through a clinical assistant appointment and his only chance of bringing the hospital facilities into the domiciliary scene is through a domiciliary consultation. It was said that general practitioners will be increasingly keen to take hospital appointments. We agree entirely that the general practitioner, notwithstanding the heavy demands on his time, should have a closer involvement with the hospital in relation both to the after-care, rehabilitation and resettlement of his patients and to broadening his own medical experience. Clearly the latter can be achieved by clinical assistant appointments and we suggest that general practitioners should be appointed to rehabilitation departments and that those who thus gain experience and training in rehabilitation could be responsible for remedial services in isolated group practices or health centres.

279. In our view, an important point of contact for the general practitioner with the rehabilitation department of the hospital will be through his attendance at assessment clinics dealing with the rehabilitation of his own patients. For those patients not being discussed at assessment clinics it is valuable and a matter of good practice that the general practitioner, health visitor or district nurse should visit them in hospital before their discharge date, for discussion with the hospital medical or other staff concerned with the patient's after-care. There should also be the opportunity for relatives to join such discussions. The letter sent to the general practitioner at the time of the patient's discharge should contain all the information needed for the patient's continued rehabilitation and eventual resettlement. General practitioners should also be encouraged to attend

post-graduate meetings and multi-disciplinary meetings in the rehabilitation department.

280. The general practitioner should take full advantage of hospital domiciliary visiting by inviting the consultant in rehabilitation to examine a patient at home when hospital attendance is not possible and advice is required on the patient's rehabilitation programme or home needs. It would be open to the consultant to take with him or to send members of the hospital remedial staff to provide additional advice. Local authority health and social work staff could also be invited to attend domiciliary visits where action by their departments might be required. We do not envisage that many patients will require such attention: nevertheless we wish to ensure that a domiciliary rehabilitation visiting scheme exists for the few who require it.

XLVI. WE RECOMMEND that the attention of general practitioners is drawn to the value to them of attending hospital assessment clinics at which their patients are discussed. On the consultant's advice, it should be acceptable for the appropriate member of the hospital remedial staff to make a domiciliary visit when the patient is unable to attend hospital.

281. Once the patient is discharged from hospital care, the medical oversight of patients naturally devolves on the general practitioner and he should be actively involved as a member of a community rehabilitation team which would meet from time to time according to each patient's needs. The team should include, as appropriate, the general practitioner, health visitor, district nurse, social worker, the disablement resettlement officer and the medical officer from the industrial rehabilitation service. The first three, and perhaps the fourth, will increasingly be working together to serve the same population from a group practice or health centre.

Direct access to hospital physiotherapy services by general practitioners

282. The suggestion was put to us that general practitioners should have right of access to hospital rehabilitation services, particularly physiotherapy. The argument in favour is that the referral of a patient by his general practitioner direct to the physiotherapist would cut out the delays caused by the wait, often of several weeks, to see the consultant in rehabilitation, followed by another wait of some weeks before physiotherapy treatment starts. The argument against is that regrettably at the present time many general practitioners are out of touch with the modern concepts of remedial treatment and departments might become overburdened with patients for whom unnecessary or inadequate treatment has been prescribed. We consider that there is some justification for this argument, and with improved and more efficiently used services the delay complained of should not occur.

283. The Standing Medical Advisory Committee's Sub-Committee on Group Practice, under the Chairmanship of Dr. Harvard Davis, recently published their report (21) in which they examine the future role of general practitioners as members of group practices. The sections of the Report which particularly interest us are on rehabilitation and on the provision of physiotherapy in group practice centres. We are not entirely in agreement with their views on physiotherapy in health centres, and we discuss this in detail in paragraphs 298–299.

The district nurse

284. The nature of the district nurse's work brings her in contact mainly with the more severely disabled who are confined mostly to their own homes. She may also attend the less severely disabled at home for a period after discharge from hospital. She is for many, and particularly for the elderly, a valuable link in the lines of communication to the general practitioner, the local authority services and the district general hospital. Yet, important as this link is, the great value of the district nurse lies in her ability to give both moral and physical support to newly disabled patients and to many chronically sick and severely disabled people who may be beyond further rehabilitation but through her ministrations can at least maintain their residual abilities for as long as possible.

285. The district nurse should observe whether patients recently discharged from hospital who require her help are adjusting to the new circumstances at home and are able to cope with any adaptations or aids in their home; if not, she should advise the general practitioner and the social worker or health visitor as appropriate. In addition much help can be given to patients at home by the district nurse through the use of simple therapeutic procedures.

286. In brief, we consider that the district nurse can make a vital contribution to rehabilitation, as well as adding interest to her work, by giving domiciliary support to the chronically disabled who require nursing and taking note of their rehabilitation needs; by assisting in the continuation of the rehabilitation of the recently discharged disabled patient and by providing simple rehabilitation procedures for patients under treatment at home for disabling conditions. We hope that the Committee on Nursing which we have mentioned earlier (paragraph 146) will take note of our views.

The health visitor

287. In the field of rehabilitation we consider that the most important function of the health visitor or geriatric visitor is the identification of deterioration in elderly patients. Time does not permit general practitioners to pay routine visits to all the vulnerable aged on their lists, and experience has shown that by and large they are unlikely to attend for routine checks. Where general practices have age/sex registers, these visitors can pay home visits to old people on behalf of the general practitioner and ascertain whether there is deterioration and whether medical attention or supportive services are required. In the latter case this will often entail contact with the social services department of the local authority.

288. Many handicapped patients discharged from hospital will not require the home nursing services and it is for these patients in particular that the health visitor can provide the links from home to other local authority services, the general practitioner and the hospital. Continuity of rehabilitation in the community is ultimately the responsibility of the general practitioner but he has to rely on the rest of the community team. We suggest that one of the important functions of the health visitor is to make sure that patients obtain the community services they need. The development of health visitor attachments to group practices and health centres should help to eliminate the risk that now exists of patients missing out on rehabilitation and resettlement services.

289. To summarise we consider that as a representative of the community team, the health visitor should attend the rehabilitation assessment clinic at the request of the general practitioner either with him or alone. She should, through her visiting practice, give domiciliary support to patients who have been discharged from in-patient treatment in the rehabilitation department and who are not receiving home nursing care, ensuring that their rehabilitation continues and their after-care needs are met. She should also, in consultation with the general practitioner, be prepared to instigate rehabilitation for people in the community who appear to need it but have, for some reason, been overlooked. Between them, the district nurse and health visitor should be able to prevent many of the failures in the lines of communication whereby people with disabilities fail to reach the rehabilitation services.

The community physician

290. At present medical officers of health and principal school medical officers (almost invariably holding these two posts jointly) are in charge of local health and school health services respectively. When these services are transferred from local government to the new unitary health service organisation, the co-ordination between local authority social and education services and the National Health Service, as well as within the latter, is likely to be even more complex than before. This is especially so in the field of medical rehabilitation, for there will not then be senior doctors working directly within the local authority. The Working Party on Medical Administrators under the chairmanship of Dr. R. B. Hunter* is at present concerned with the future pattern of medical administration in the National Health Service, but we must stress the vital importance of the availability of senior doctors whose responsibility will be the comprehensive planning and organisation of community medical services and liaison with local authorities in respect of services which the latter will continue to provide. The designation "community physician" seems to us very appropriate for this function.

Ambulance services

291. Several witnesses have pointed out the need for better transport services to encourage regular attendance at day centres and also to ease the difficulty for some patients of getting to out-patient departments, particularly the rehabilitation department, and the geriatric and psychiatric day hospitals. Complaints refer to the disincentive of high fares on public transport and inadequate bus and train services, long journeys in ambulances after which patients are often too cold and stiff to participate in remedial treatment, and long waits at hospitals for ambulances to take patients home.

292. All these difficulties operate against successful rehabilitation and maintenance of activity in disabled people and we consider that both local authorities and hospitals could find ways of improving the situation. It is not at present a hospital function to supply transport and the present system of services is provided under Section 27 of the 1946 National Health Service Act. The usual

*The terms of reference of the Working Party on Medical Administrators are: "To review the functions of medical administrators in the health services and to make recommendations regarding the provision required for their training."

ambulance service resources are employed, that is, ambulances, multi-seater ambulances, ambulance cars, the hospital car service and to a small extent hire-cars.

293. The "milk-round" system of collecting patients creates problems in that it makes an appointments system difficult to administer. However we accept that because of scarce resources it is often necessary to use this method but it must take account of the length of time patients will be in vehicles and zoning, i.e. collecting patients from selected areas, can help in shortening the journey. Coaches can be used in heavily populated areas without detriment to patients, particularly for transport to day centres in towns and cities. We would draw attention to a report (23) published in August 1964, which shows that physiotherapy departments together with orthopaedic and fracture clinics account for approximately 60 per cent of the requirement for ambulance transport for out-patients, and recommends various ways in which the efficiency of the ambulance services could be improved.

294. There are other methods of improving the situation which we suggest are worthy of consideration by local authorities and hospital authorities. The hours of opening of out-patient departments and day centres should be adjusted to enable all-day patients to be transported by relatives or friends on their way to and from work. Evening clinics can also make it possible for relatives to bring and take patients home. Ingenuity and flexibility in planning of both transport services and the working hours of the rehabilitation department and day centres could transform the rehabilitation prospects for many disabled people.

The development of health centres

295. A fast moving development in the community health services is to be seen in the building of new health centres which ideally provide a comprehensive range of general practitioner and other community health services; in a few provision is made for hospital out-patient clinics. In addition to these centres there is the development of group practices which increasingly also provide for the attachment of other health workers in purpose-built or adapted premises. Clearly the newly disabled person will benefit by this bringing together of the community team who are responsible for his rehabilitation and resettlement on discharge from hospital.

296. However, local authority clinics will continue for the time being to exist side by side with health centres and group practices, especially in areas in which there is much single-handed general practice. These clinics originally dealt entirely with young children and pregnant women. Nowadays they are often a base for preventive and supportive geriatric services. Their function in rehabilitation is therefore two-fold: the ascertainment of potential and established handicap in the very young and the support of the aged in the community—including the extremely important provision of chiropody.

297. The pioneering work of local authority clinics in the ascertainment of potential and established handicap in the very young has been highlighted in the report of the Sheldon Committee (6). Sophisticated screening and recording techniques have been developed and increasingly these are becoming standard practice in clinics throughout the country. Such techniques require special training which is generally not yet part of the curriculum for medical under-

graduates, but is available for local authority medical officers. Organisational changes in the health service must not lead to a reverse in these developments. Training in developmental paediatrics must be specially devised for general practitioners wishing to undertake this work but who find it difficult to absent themselves from their practices for long periods at a time. Alternatively, medical officers at present working in local clinics could be attached to group practices or work in health centres alongside general practitioners. Whilst regular screening of all young children is essential, it is particularly important to ensure that the regular follow-up of "at risk" and handicapped children is a continued responsibility of experienced senior medical staff, whatever the future pattern of administration of the medical services.

XLVII. WE RECOMMEND that community medical staff engaged in child health work should have had special training in developmental paediatrics, including screening techniques.

Physiotherapy in health centres

298. Some local authorities wish to include provision for physiotherapy at health centres and in local authority clinics. The Standing Medical Advisory Committee's Sub-Committee on Group Practice have suggested in their report (21) that there is a need for some physiotherapy services outside the hospital and that these could probably best be provided in association with the group practice team at a health centre, with well established links with the hospital rehabilitation department. Witnesses, too, have told us that although the district general hospitals of the future would provide intensive courses of rehabilitation, the hospital service needs to be complemented by efficient community physiotherapy services of which the nucleus would be the health centre or group practice. We understand that the Department of Health and Social Security is undertaking some research into the need for physiotherapy services outside hospital.

299. We have already expressed our view that physiotherapy facilities should for the present only be provided outside the district general hospital at a peripheral hospital in an area where the population is scattered and communications with the appropriate district general hospital are poor (paragraph 110). We recognise, however, that there may be group practices or health centres serving populations which are not within reasonable access of either a district general hospital or peripheral hospital with a physiotherapy service. Community physiotherapy might be needed in such circumstances but as with peripheral hospitals, such facilities should be provided only when they would serve a community of 20,000 or more and patients should be under the clinical care of a general practitioner with special training in rehabilitation. It is of the utmost importance that the consultant in rehabilitation at the appropriate district general hospital should have overall supervision of rehabilitation services in the area, and it would be open to local authorities to arrange with the hospital authority for such a service to be provided by the rehabilitation department.

Domiciliary physiotherapy

300. It has been suggested to us that a domiciliary physiotherapy service ought to be provided by hospitals or the local authorities. Occasionally, physiotherapy

treatment is provided for patients in their own homes by voluntary bodies or by sending staff from hospital physiotherapy departments. Evidence was given to the Committee about a trial of a mobile physiotherapy service which was being undertaken in the Newcastle-upon-Tyne area. The object of the service was to give early treatment in their own homes to those who had suffered paralytic strokes. We thought the results of the trial were inconclusive at the stage at which they were discussed with us.

301. We consider it to be an uneconomic use of scarce skills for physiotherapists to give treatment in patients' homes. The only home visiting which should be undertaken by hospital physiotherapists is shortly before or after a patient's discharge from hospital to give advice to patients or their relatives or to make arrangements, in conjunction with the community team, for simple remedial exercises, home aids or equipment. The visiting physiotherapist should be attached to the hospital and work under the supervision of the consultant in rehabilitation, who would also arrange for domiciliary assessments or visits by a remedial team to make suggestions about rehabilitation at the request of the general practitioner.

302. Special training courses have been introduced for district nurses to enable them to carry out simple remedial procedures (see paragraph 346) and we believe that, once this aspect of their duties is widely established and known to general practitioners, it will go a long way to meet the need for the type of remedial treatment which can be given in the patient's home.

The school health service

303. The young handicapped are dealt with more fully in Chapter 7 but mention must also be made of the role of the school health service and school doctor in the detection and support of the handicapped school child in ordinary and special schools. As in the case of the very young child the doctor in the school health service, be he or she part-time or full-time, or perhaps a general practitioner, must have special knowledge of the ordinary and special schools, and of teaching provisions, and the gift of communicating with teachers whose charges may be handicapped children.

XLVIII. WE RECOMMEND that medical staff working in the school health service should possess, in addition to their clinical skills, full knowledge of the principles and the provision of ordinary and special education.

LOCAL AUTHORITY SOCIAL SERVICES

304. An almost revolutionary change has been brought about by the Local Authority Social Services Act, 1970 which is now in the early stages of implementation. Social services departments will be responsible for many of the services which affect the rehabilitation and resettlement of the mentally and physically disabled, including residential accommodation, day centres for the physically and mentally handicapped, sheltered workshops, recuperative holidays, home adaptations, family case work and social work. Remaining with the community health services will be responsibility for child health, health eductaion, home nursing, health centres, clinics, ambulances and the school health service.

305. Another Act of Parliament which should have a profound effect on the lives of the disabled in the community is the Chronically Sick and Disabled Persons Act 1970. Its underlying purpose, as explained to hospital and local authorities, "is to draw attention to the problems, varying with age and capacity, of people who are handicapped by chronic sickness and disablement, to express concern that these problems should be more widely known and studied and to urge that when priorities are settled full weight is given to finding solutions". This Act should give a much needed stimulus to local authorities to make proper provision of welfare services for physically and mentally handicapped people. The Act also requires local authorities to ascertain the number of handicapped people in their area and to make sure that information about the services reaches those likely to need them.

306. It has been thought for a long time that the numbers of the disabled on local authority registers do not reflect the true state of affairs. One recent survey of the handicapped (5) produced a figure of 3,000,000 impaired people in the community. Of the very severely disabled only 18 per cent were on local authority registers, similarly only 11 per cent of the severely handicapped and 7 per cent of the appreciably handicapped. Nevertheless, 41 per cent of all handicapped people were receiving services of some kind and the indications were that many of those unregistered did not wish to be placed on the register. Another report of interest was a local survey carried out recently (22) which found that the estimated number of physically handicapped in the area was almost five times higher than the number registered as handicapped with the welfare department.

307. In the next few years the rehabilitation services will be affected by a multiplicity of administrative changes. The questions which faced us as a Committee were: what effect will these changes have on the rehabilitation of the newly disabled, and is the seeking out of unregistered disabled people likely to throw up a proportion of people whose handicap could be lessened by medical or industrial rehabilitation? Although the organisation of administration has changed, the services, the needs and the deficiencies remain the same. With so much thought and work now being devoted to the local authority services, the sector related to rehabilitation should benefit by a fresh appraisal of the requirements of physically and mentally disabled people. We can therefore draw attention to the rehabilitation problems in the present community services and suggest where improved provision should be made.

308. The second point, i.e. the numbers who may be found to need rehabilitation, is an enigma. It may well be that disabled people who could benefit by rehabilitation will be found in the community, for example, disabled housewives. If so, we would certainly regard it as a duty of the local authorities to refer such people who wished it to the appropriate rehabilitation services either in the community or in the hospital; in the latter event, referral to the assessment clinic through the consultant in rehabilitation would be appropriate.

The local authority social services department

309. The extent of the services provided in the past by health and welfare departments but which are from now on being provided by the local authority social services departments, has a profound effect on the success or failure of the hospital rehabilitation services for the physically and mentally handicapped. Unless

there are day centres, sheltered workshops and residential homes available with sufficient places for those rehabilitees who need them, the discharge of some patients, particularly elderly and severely handicapped people, may be prevented or long delayed and the successful rehabilitation of others nullified. If good and adequate facilities exist, however, patients can be discharged early to continue their rehabilitation in the community.

310. Many of the services are not in themselves rehabilitative, such as meals-on-wheels and home helps, but they are as essential to the ultimate success of rehabilitation as the supply of aids and appliances. Indeed, this applies equally to the provision of work in day centres and sheltered workshops which will continue the process of rehabilitation for some, while for others it will only maintain what has been achieved in rehabilitative treatment. We hope that the new social services departments will examine their supportive services with a view to improving the home help service and the supply of home aids.

The social worker

311. We have made much of the need for co-ordination of rehabilitation services and proper lines of communication between each service. This communication has to be established with members of the medical profession both in hospital and in the community, and with all the other people involved in the provision of services affecting rehabilitation. In many ways at present the social worker is the focal point of this essential communication and once a pattern is established, there should be no risk of patients failing to obtain the services they require. Initially the onus should be on the social work service in hospital to check that patients have reached their next place of residence. It will then rest with the local authority social worker or her staff to ensure that all the social services each person needs are forthcoming, whether provided by the local authority or voluntary organisations. The necessity for close co-operation with the latter cannot be over-emphasised and we have already drawn attention to the importance of establishing close links with general practitioners (see paragraph 273).

312. It is vitally necessary for the social worker to be completely conversant with the needs of physically and mentally disabled persons, both in relation to the type of physical assistance and to the social support they and their families require. Social workers of all persuasions, whether they work in the hospital or community services, with the physically disabled, the mentally ill or mentally handicapped, should have an understanding of the real meaning of the rehabilitation processes and should be able to recognise cases which are deteriorating and which might benefit from medical assessment and rehabilitation. In this connection the policy of providing a basic generic training for all social workers must be supplemented by more specialised training subsequently to qualify workers for fields requiring special expertise.

XLIX. WE RECOMMEND that the local authority social services departments should, with the help of hospital rehabilitation departments and industrial rehabilitation units, provide special instruction for their staff in the processes and objectives of rehabilitation.

Residential accommodation

313. Residential care of the aged, the physically disabled, and the mentally ill and handicapped is provided by local authorities. There is, however, a need for more accommodation for those people who have been rehabilitated to their maximum potential but nevertheless have remaining disabilities of varying severity and who have no home that they can be discharged to, either because they have no relatives or the relatives are not able or prepared to look after them. Unless there is somewhere for them to go, they have to remain in hospital, blocking beds required for acute cases.

314. We have already drawn attention to this problem in Chapter 8. Provision for the younger chronically sick is also a problem, although we have been told that only one in ten of definable younger chronically sick are in hospital accommodation. There is also the minority problem of the severely disabled, including patients in respirators and head injury patients who have been largely unprovided for except in places run by such voluntary bodies as the Cheshire Foundation Homes. The survey of the handicapped (5) has shown that 20 per cent of handicapped people live alone, including 5 per cent of those needing constant care.

315. Special provision now has to be made for the younger chronically sick under the Chronically Sick and Disabled Persons Act, 1970. With a unified National Health Service there is more likely to be recognition of the economic value of residential homes for the aged and the handicapped in relation to the high cost of retaining these people in hospital. Special provision, whether in hospital or residential home, should be of a standard which will enable the residents to maintain or improve upon the treatment they received in the hospital rehabilitation services.

Day centres

316. A wide range of day centres is provided by local authorities and voluntary bodies for the aged, the physically disabled, the mentally ill and the mentally handicapped. There is, of course, no reason why some of the mentally ill and mentally handicapped should not attend centres designed primarily for aged or physically disabled people.

317. Day centres vary greatly in size and facilities, ranging from purpose-built centres with many facilities including workshops undertaking contract assembly work, almost in the category of sheltered employment, to small centres in adapted old houses which provide little more than recreation and a chance to meet other people. The larger centres can, however, provide a rehabilitative influence enabling some people to move on to sheltered employment and, in a few cases, to open employment. Such an objective should always be held in view by the staff of these centres as the rehabilitation aspect will add interest to their work as well as allow places to become vacant. We know that the numbers of day centres for the physically handicapped and elderly are increasing and we think that it would be an advantage if such centres were planned with certain objectives in view. For example it is the policy of the Department of Employment to provide comprehensive sheltered workshops in which all categories of handicapped people are employed together. We consider that

similar comprehensive facilities could be applied with advantage to local authority day centres.

L. WE RECOMMEND that local authorities should provide day centres with separate accommodation for three streams of activity:

(i) for people who could maintain a fairly fast tempo, benefit from the company and gain a sense of purpose;

(ii) for people who require a slower tempo of work and who might in due course improve sufficiently to be transferred to sheltered employment;

(iii) for people who require slower tempo occupation essentially but not necessarily of a recreational kind, and who place an undue burden on relatives if they remain at home all day.

Payment should be made for the work done. In all cases there should be a close link with the appropriate hospital department and day hospital to facilitate the smooth transfer of patients from one to the other and to allow referral back to the hospital if necessary for re-assessment.

318. The staffing of day centres can be a problem in itself and we believe that the streamlining of the functions of centres, by concentrating particular activities into each, would be advantageous in saving on administration and staff. Generally these services should be operated by craftsmen and aides under a manager who could be responsible for several centres but an occupational therapist employed by the local authority services or seconded from the hospital service should advise on the management and work capabilities of disabled people; alternatively, a useful link between hospital and day centres could be achieved if occupational therapists of the hospital rehabilitation department visited day centres to advise on work therapy. There may also be scope for joint appointments of occupational therapists.

319. Where day centres undertake contract work they should be party to the central arrangements for negotiating contracts suggested for hospital workshops, that is, through a common organisation (paragraph 167).

Sheltered employment

320. Sheltered workshops are provided by local authorities and voluntary organisations under Section 15 of the Disabled Persons (Employment) Act, 1944. There is obvious advantage in contact being maintained through the local authority social services between sheltered workshops, day centres and hospital workshops through the co-ordination of contract work.

321. Members of the Committee who visited the London Borough of Croydon in July 1969 were particularly impressed by the work of the Bensham Rehabilitation and Assessment Centre which was started because the local authority considered it was necessary to assess the ability of patients before placing them in one of the work centres. Such an assessment system could be complementary to assessment in hospital and could well be adopted by other local authorities.

Home adaptations

322. We have received complaints that adaptations to the homes of newly disabled people are often delayed so that the patients have to be kept in hospital

longer than necessary and that when the adaptations have been carried out, they are sometimes unsatisfactory, for example, doors have not been widened sufficiently to allow a wheel-chair through and ramps are not correctly sloped for the easy passage of a wheel-chair. In the first instance, local authorities blame the hospitals for not giving enough notice of a patient's discharge. In the second instance, the local authorities are blamed for not ensuring that the adaptations are tailored to the equipment that is supplied to the patient and for failure to co-ordinate building and engineering services. In either event, there is failure in communication and we hope that the establishment of the hospital assessment clinic and the co-ordinating function of the new local authority social services departments will minimise such errors.

Recuperative holidays

(See also hospital convalescent treatment: paragraphs 175–177.)

323. Local authorities have powers under Section 12 of the Health Services and Public Health Act, 1968 to provide recuperative holidays where patients require little more than rest, good food, fresh air and regular hours and no more medical or nursing attention than is provided by a general practitioner and a district nurse These holidays are taken either in the authority's own holiday homes or, more usually, in homes run by an independent or voluntary body, the local authority paying the fee and recovering all or part of the cost from patients according to their means.

LI. WE RECOMMEND that local authorities should make arrangements to provide recuperative holidays following medical treatment for special cases such as the severely disabled who are recovering from another illness or accident and who require special provision for recuperation; people who live alone or may be an unwilling burden to others such as the elderly; people who should not return too soon to family commitments, such as mothers and housewives. Although it is mandatory in new buildings it is essential that hotels, hostels or homes providing recuperative holidays are adapted to be able to accept wheel-chairs, people using crutches and people who cannot climb stairs.

Information services

324. It is important that general information should be available about the rehabilitation and community services in each local authority area. Some voluntary organisations provide information services, such as the Disabled Living Foundation who run an information service for the disabled which is subscribed to by some local authorities, hospital boards and other voluntary bodies. The implementation of Section 1(2) of the Chronically Sick and Disabled Persons Act, 1970, should improve the situation by requiring local authorities to publish information as to the services provided by them under Section 29 of the National Assistance Act, 1948, and Section 2 of the Chronically Sick and Disabled Persons Act and to ensure that anyone using these services is informed of other services relevant to his needs. This of course covers only those services we have so far described in this chapter in addition to the provision of certain recreational and education facilities. We do not consider such an information service provided by local authorities to be wide enough in scope truly to help the people who need to know the range of services available. Much general information could be prepared centrally but it would require supplementing locally with the names,

addresses and telephone numbers of the appropriate organisations and departments.

LII. WE RECOMMEND that the information service provided by local authorities under Section 1(2) of the Chronically Sick and Disabled Persons Act, 1970 should be run by an officer responsible for the maintenance of up-to-date information on all health, social and industrial rehabilitation services. Such a service should be available to all those concerned with rehabilitation and resettlement. The rehabilitation department of the appropriate district general hospital will provide much of this information and should have copies of all information service material.

CHAPTER 14

THE ROLE OF VOLUNTARY ORGANISATIONS

325. The voluntary organisations provide a wide range of services for the elderly, the disabled and mentally ill or handicapped. Many of these services are provided on an agency basis for local authorities, including schools, colleges of further education, vocational training, hostels, holiday homes, residential care, day centres, sheltered employment, industrial therapy units, transport, aids to daily living, home visiting, and information services. They also support various research projects. It is no criticism of local authority social and community health workers, who do a difficult job with understanding and kindness, to say that the voluntary worker can bring a freshness of approach to people who often regard official visits as an invasion of their privacy and independence, however necessary it may be for their welfare and though they may come to appreciate them later.

326. We thought that the evidence of the Disabled Living Foundation provided an admirable description of the aims of voluntary organisations:

> "It is surely the role of all voluntary bodies to study the needs they exist to serve; and where it is a statutory duty that the needs should be provided for, to agitate with those responsible to fulfil their duty. Where there is no statutory requirement concerning needs, or where the statutory requirement is obviously inadequate to meet the needs, then it is the duty of the voluntary body to pioneer. In studying the needs it may be found that the necessary information either medical or in some other field does not exist. In this case it is the duty of the voluntary body to instigate research and study.
>
> All voluntary bodies require to collect and disseminate information in their own fields to those concerned in whatever capacity including where appropriate sufferers in need of rehabilitation or receiving it. The national bodies will work nationally, and represent at national level in their appropriate field. It is their role to ensure that all those who need it have access to their help wherever they may reside. Local bodies study needs and represent on them locally."

327. An immense amount of work is done by voluntary organisations in the field of rehabilitation. We have attempted to list them in Appendix V but it is impossible to give credit in this report to all those who have done so much for the disabled and have encouraged others to do the same. There is no doubt that what they do has made and continues to make an indispensable contribution to the rehabilitation services, often pioneering the way for the National Health Service in new developments. It is significant that in recent years there has been an increase in the number of voluntary bodies concerned with disabling conditions which are not being covered by the health service rehabilitation services. Some of the work of the voluntary organisations for

particular conditions could not be carried out by the health service because the organisations provide advice, support and services of a personal nature based on the experiences of their members. Nobody can help a newly disabled person with the problems of adjustment more than someone who has been through a similar experience himself. This is a function of voluntary bodies which can never be statutorily replaced.

328. The Joint Council for Voluntary Work for the Disabled suggest that new ideas in rehabilitation, if successful, should be recognised by the government and provided by statutory services. We would agree with this view in principle and suggest that to encourage voluntary bodies to seek new fields for experiment public financial support should be given where deficiencies in the health services are identified and met by voluntary bodies.

329. An example of valuable service and pioneer work is provided by the four residential colleges, Queen Elizabeth's Training College, Leatherhead; St. Loye's College, Exeter; Finchale Abbey Training Centre, Durham; and Portland Training College, Mansfield; and by the Duchess of Gloucester House, Isleworth. They are needed because they are able to house patients during training while arrangements are made with local authorities to provide adaptations to homes, etc., but if the rehabilitation services develop as we have anticipated in this report, their present function may well become redundant. There are new categories of severely disabled patients in other fields such as spina bifida and head injury, some of whom will never be able to live and work in the community. The colleges may perhaps like to think of enlarging their role to meet the needs of these patients.

330. On the mental health side industrial therapy organisations were set up in the early 1960s primarily to provide industrial rehabilitation for those long-stay psychiatric patients who had improved sufficiently to be considered for discharge and required the opportunity for employment in open industry. We recognise that the industrial therapy organisations have done a great deal as pioneers in the field of rehabilitation and resettlement of the mentally ill who had become institutionalised, but as the organisations themselves realise, their primary work is almost done and the way in which the services for the mentally ill are developing will mean that their role in the context of psychiatric rehabilitation is likely to become very limited and difficult.

331. Most of these organisations provide industrial rehabilitation at a slow tempo, but the industrial therapy organisation at Bristol has been adapting itself to the changing circumstances by providing sheltered employment in addition to its training programme. It is in this direction that we suggest the industrial therapy organisations should turn their attention, particularly as the increasing pressure on community services for the mentally ill will make facilities for sheltered employment one of the greatest needs in the future mental health services.

332. In the main, voluntary organisations will continue to provide invaluable support to the rehabilitation services but, at present, many of these agencies tend to work in isolation both from one another and from official authorities. At the same time as effective liaison and co-ordination of the hospital, industrial and community services is being achieved, we suggest that steps should

be taken to encourage the voluntary agencies to work more closely together than at present and to ensure that there is effective liaison between official and voluntary bodies so that the disabled can use the facilities they need whether provided statutorily or voluntarily.

CHAPTER 15

EDUCATION IN REHABILITATION

333. "The Committee feels that in the present education and training of doctors and of the remedial professions, the references to rehabilitation are inadequate." We made this statement in September 1969 when we wrote to various organisations inviting written evidence. No one disagreed and we received a considerable number of suggestions for practical measures to improve the situation. Subsequently we came to the conclusion that we should also consider the education in rehabilitation of nurses and the remedial professions, and ways and means of improving public awareness of the problem. We hope that the bodies responsible for training will do all they can to introduce the concepts of rehabilitation into their curricula.

The undergraduate

334. The Report of the Royal Commission on Medical Education (24) stressed that medical education is a continuing process and indicated that the purpose of the undergraduate course is to lay a foundation of principles in preparation for the postgraduate years. Yet the Report mentions the term rehabilitation only twice, once under psychiatry, which we deal with separately although of course the principles are the same, and the second time in the part on the undergraduate medical course where it recommends the formation of departments of community medicine with, among others, a section dealing with rehabilitation. We think that the teaching of rehabilitation should be given far greater prominence.

LIII. WE RECOMMEND that medical schools give immediate thought to the inclusion of teaching on rehabilitation in the medical curriculum to a greater extent than at present.

335. The foundation for the understanding and application of rehabilitation as part of total patient care ought to be established during the earliest days of medical training. The increasing emphasis on the functional aspects of the basic medical sciences and on instruction in the behavioural sciences during the pre-clinical phase, together with the current trend in some schools towards integration between pre-clinical and clinical studies, offer a new opportunity to demonstrate the financial and social implications of loss of function and the importance of its preservation or restoration as a social and economic, as well as individual, need. This opportunity should not be lost.

336. In the clinical years instruction in rehabilitation must be regarded as an essential part of total patient care. While detailed tuition in the methodology of rehabilitation need not be given, its principles must constantly be integrated into clinical teaching. Visits to the rehabilitation department and to industrial and community rehabilitation facilities should be arranged, so that the student will appreciate the methods used to bring a patient back to full activity and the general roles of the remedial professions and social workers in achieving this. The use of films and other audiovisual aids should be encouraged. Attendance at

assessment clinics would stress the importance of team work and a short attachment to the rehabilitation department later in the curriculum could consolidate the student's earlier instruction.

337. While we consider that initially the consultant in charge of rehabilitation could be regarded as the natural source of education in this specialty, we recognize that full realisation of its educational potential can come only from the injection of academic activity into the rehabilitation service. It would not be practical to set up an academic department of rehabilitation in each medical school, but we consider there is merit in the establishment of a small number of Chairs in Rehabilitation to provide the nucleus for training in academic rehabilitation and research. Evaluative research is needed particularly with the treatment techniques of the remedial professions and there should be designated senior full-time research posts to undertake this.

LIV. WE RECOMMEND that consideration be given to the establishment of a small number of Chairs in Rehabilitation.

338. Essential to these recommendations is a change of attitude on the part of all teachers and senior medical staff. Unless the student sees that positive steps are being taken after injury or onset of illness to plan rehabilitation with the patient's social and employment needs in constant view, he cannot be expected to appreciate the importance of rehabilitation in the day-to-day care of the patient.

The Postgraduate

339. Education is a continuing process and continued awareness of the importance of rehabilitation to the full clinical care of the patient must follow the student to his postgraduate years, irrespective of his ultimate specialty. Much would be done were hospital medical staff to attend the rehabilitation assessment clinic when their patients were being reviewed.

LV. WE RECOMMEND to Universities and Postgraduate Deans that attendance at the rehabilitation assessment clinic should be regarded as an essential duty during the pre-registration period.

340. While the needs for detailed instruction in rehabilitation are determined by the particular field of specialisation chosen by the postgraduate, there is an obvious need for more formal instruction in rehabilitation for those who wish to specialize in general practice, orthopaedics, neurology, geriatrics and psychiatry. It is the duty of those who plan training programmes to ensure that postgraduate students master the application of rehabilitation to their specialty, possibly by planned rotational attachments to rehabilitation departments and other relevant industrial and community centres.

Further education

341. Further medical education in rehabilitation will primarily consist of refresher courses, conferences and other activities. These should be planned by the consultant in charge of rehabilitation in conjunction with the area post-graduate organiser and based on the appropriate postgraduate medical institute. We hope also that medical and voluntary bodies with an interest in fostering knowledge of rehabilitation amongst doctors, many of whom already

are doing good work in this field, will make every effort to organize post-graduate courses and seminars in the subject.

342. Another valuable source of education can be provided through the Department of Employment's industrial rehabilitation service. We would particularly commend the idea of "open days" at industrial rehabilitation units to provide an opportunity to discuss the rehabilitation of patients in the industrial setting. Apart from their educational value, such sessions would help overcome the complaints by medical officers of industrial rehabilitation units about inadequate assessments, slow referrals and lack of interest by hospital doctors and practitioners.

Training in psychiatry

343. At present and for some years to come, the large psychiatric hospital will remain a separate entity and doctors wishing to specialise in psychiatry will still spend a good deal of their postgraduate time in hospitals designated solely for the treatment of mental illness. It is essential that the psychiatrists of the future should be taught the principles of rehabilitation during the under-graduate and early postgraduate periods, so that they carry the image of rehabilitation with them into the wholly psychiatric setting. This is in keeping with the Todd Report (24) recommendation on professional training in psychiatry which states that "it is highly desirable that future psychiatrists should have an opportunity to encounter a wide range of everyday general morbidity before narrowing their clinical experience to the purely psychiatric field".

344. On psychiatric training generally we cannot better the advice given in that report (24) in the same paragraph that "the trainee should receive instruction in planning for discharge, rehabilitation and job placement, use of social services, consultation with the patient's general practitioner and management of acute psychiatric emergencies". All these aspects are the essence of rehabilitation and of course apply equally to physical conditions.

345. The changes suggested in the report (24) represent the long-term aim of education in rehabilitation but at present further training should be afforded to all psychiatrists. Many of them are unaware of the importance of rehabilitation and in view of the difficulties which arise in organising psychiatric rehabilitation services (see paragraphs 74 and 214) it is particularly important to provide proper training for them in this aspect of treatment.

Training for nurses

346. The Committee on Nursing under the chairmanship of Professor Asa Briggs is still sitting and will be considering nurse training. Furthermore, we have been informed that the rehabilitation content of the General Nursing Council syllabus now includes "awareness of local authority and voluntary services available", "principles of occupational and industrial therapy", "convalescence" and "rehabilitation" and "rehabilitation as an aspect of the patient's treatment". We note the general introduction of special training courses for district nurses, based on a syllabus drawn up by the Chartered Society of Physiotherapy and the Queen's Institute of District Nursing, and we also note that the training for district nurses now includes not only the teaching

of simple therapeutic measures but also of the wider aspects of rehabilitation. Rehabilitation, including the place of physiotherapy and occupational therapy, is also included in the training of State Enrolled Nurses. What we have said earlier reflects the medical viewpoint on the role of hospital and community nurses in rehabilitation, and we hope that both the Committee on Nursing and the General Nursing Council will take note of our comments.

Training for the remedial professions

347. In the past, the remedial professions have suffered from isolation, both geographical and professional. We do not consider that isolated schools of physiotherapy, occupational therapy or remedial gymnastics should continue, but rather that training facilities should be concentrated in a few centres throughout the country. Substantial benefits could be gained from the integration of schools with universities and colleges of further education. Closer association would encourage a more experimental approach to training and increased knowledge of any new information in the sciences and in teaching methods. Such an arrangement would also facilitate the organisation of specialist and refresher courses. Selected students might be able to benefit from a longer training which, if opportune, could be up to university degree standard.

LVI. WE RECOMMEND that training for the remedial professions should be concentrated into some twenty centres in England and Wales and these centres should be integrated with centres of further education.

348. Many potential applicants acquire their basic educational qualifications by the age of 17 and neither wish to stay a further year at school nor wish to seek alternative employment for a year before commencing training. The lowering of the age of majority to 18 has removed the significance of qualification at 21 and these two factors lead us to conclude that the age of entry for all three professions should be 17 years.

LVII. WE RECOMMEND the age of entry to training for the remedial professions should be reduced to 17.

349. All three professions do three years training, although remedial gymnasts take their examinations after two years and serve one year as a trainee remedial gymnast. We consider three years to be sufficient for a basic qualification but we are not satisfied that the content of the training is arranged to the best advantage. The evidence we received suggests that there is a substantial degree of common ground in the courses of the three professions, although the emphasis on the subjects may be different.

350. In our view, the introductory syllabus in psychology, psychiatry, medicine, pathology, anatomy and physiology could be used for all three professions, together with common courses in social sciences, rehabilitation, administration and management. Specialisation according to different aptitudes might take place during the second year but would certainly do so during the final year. The Remedial Professions Committee of the Council for the Professions Supplementary to Medicine reached similar conclusions in their report (25). We hope that common courses in the above subjects will be introduced in the near future by those schools where it is administratively possible to provide such courses.

LVIII. WE RECOMMEND the introduction of common training for the remedial professions for the first year, and for a considerable proportion of the second year.

351. Planning programmes of combined training would have an added advantage in that it would provide the opportunity to scrutinise and reassess the content of the syllabi. In our view a substantial amount of the subject matter that is taught is outmoded and irrelevant. The increasing emphasis on the patient and his disability in his own environment rather than in the hospital setting necessitates a corresponding change of emphasis in the training, and this requires a re-orientation as to the amount of theoretical study and an increase in the emphasis placed on the assessment of disability and practical observation. If the remedial professions are to be given greater initiative in the treatment of patients it is essential that their training should fit them for this increased responsibility.

352. In addition to the inadequacies of basic training, the provision of post-registration supervision and training is totally inadequate. Newly qualified therapists should be adequately supervised in their first year, and there should be designated posts for them to give them the opportunity to work with experienced therapists in well-run departments.

LIX. WE RECOMMEND that appointments for the remedial professions during the first year after qualification should be at approved centres only.

353. Post-registration training should be purposeful and related to practical work, and it should be available to teachers, clinical supervisors, researchers and married women returning to the professions. More post-registration courses should be available for instruction in the acquisition of special skills. When these courses have been arranged in the past, staff shortages have caused problems over the release of staff to attend them. While this is understandable, in our view it is not defensible; it is impossible to maintain the high standards in rehabilitation departments if the staff are inadequately acquainted with modern practice.

LX. WE RECOMMEND that post-registration courses for the remedial professions should be run regularly, staff should be released to attend them and hospital authorities should be urged to allocate more of their funds for this purpose.

Education of the public

354. The general public's knowledge of rehabilitation is probably confined to the achievements in the training of certain categories of severely disabled patients through the efforts of voluntary organisations. The more the general public know about rehabilitation the better they will be able to understand the problems and needs of both the temporarily and permanently disabled, and to apply effective pressure for good rehabilitation services. We think that the exhibitions and displays put on by voluntary bodies are to be encouraged as a useful means, not only to raise funds but also to educate the public.

355. The press, television and radio, can also help to spread awareness of the problems of the disabled. We would suggest to editors of newspapers and magazines and to producers of television and radio programmes that re-

habilitation provides a wider field than they may realise for articles and documentary programmes which will interest the public, but care is necessary to avoid misrepresentation through over simplification and by the misuse of the dramatic story. False hopes are easily created in disabled people by articles, radio and television programmes which do not always appreciate the wide range of severity of some disabilities and the importance of other factors, personal and environmental, in determining the specific regimen of rehabilitation best suited to an individual's needs.

LXI. WE RECOMMEND that more attention should be paid to the education of the public in the value and advantages of rehabilitation.

356. When a disabling illness or accident strikes at a member of a family they may be only vaguely aware of the rehabilitation and resettlement services which should be brought into operation. It is therefore essential that the relatives should be brought fully into the picture by the hospital team and instructed how to help the patient. This can be done prior to discharge by demonstration of the techniques used, so that the relatives can see how best to manage the patient at home. The relative should also be provided with information about the social services available to the patient in the district in which he lives and put in touch with the agencies providing them. This could be done by means of a simple leaflet, which should be supplied to the patient and his relatives by the hospital (see paragraph 324).

SUMMARY OF RECOMMENDATIONS

CHAPTER 5

The Organisation of the Rehabilitation Services

I The Department of Health and Social Security should be charged with the primary responsibility for developing and co-ordinating the establishment and subsequent organisation of the rehabilitation services (paragraphs 93–94).

II Operational and other research should be undertaken into the demand for and provision of rehabilitation facilities in the National Health Service. The research should be co-ordinated and supported nationally, but there is ample scope for local initiative (paragraph 97).

III Each regional hospital board or equivalent authority should appoint a medical adviser in rehabilitation, supported by a regional advisory committee and adequate staff, whose initial task would be to review the existing services and prepare plans for their development which should be considered by the regional hospital board and submitted to the Department of Health and Social Security by April 1973 (paragraphs 100–101).

CHAPTER 6

Hospital Rehabilitation Services

IV A general rehabilitation department of 100 places should be located at every district general hospital or district group of hospitals, serving communities of approximately 200,000. There should also be provision alongside for a psychiatric day hospital of 160 places and a geriatric day hospital of 80 places. Special provision at selected district general hospitals will be required for certain categories of patients. In planning new hospitals considera-tion should be given as to how facilities and staff could be shared (paragraphs 107–110).

V There should be a consultant in charge of the rehabilitation depart-ment in each district general hospital and he should be called the consultant in rehabilitation. He should devote a substantial part of his time to this work and he could be drawn from any clinical specialty (paragraphs 115–116).

VI The Joint Committee on Higher Medical Training should examine the standards that should be attained by prospective consultants in rehabilitation and further, the Department of Health and Social Security should make arrangements without delay with the appro-priate bodies for the organisation and financing of special courses for the clinicians known to have had some experience and to be

interested in rehabilitation and wishing to obtain special training in this field (paragraphs 117–120).

VII Where there is sufficient demand and where circumstances permit, evening clinics should be organised in rehabilitation departments (paragraphs 127–129).

VIII A non-medically qualified co-ordinator should be appointed to organise the programmes of patients attending the rehabilitation department (paragraph 130).

IX A person should be appointed to deal with the transport arrangements for patients attending the rehabilitation department (paragraph 131).

X In order to foster full communication between the various rehabilitation agencies, the hospital authorities should set up assessment clinics to cover all hospitals and local authorities within specified areas. The consultant in rehabilitation should be responsible for organising the clinic and should normally take the chair or arrange for the chairmanship. The clinic should have a full-time secretary (paragraphs 132–136).

XI The assessment clinic should provide the common basis for all services concerned with future rehabilitative action on behalf of the patient (paragraphs 135–136).

XII Regional hospital boards and hospital management committees should make adequate allowance for time spent in assessment clinics in the contracts of appropriate staff (paragraph 137).

XIII Clinical psychologists should be appointed to all rehabilitation departments (paragraph 142).

XIV Consideration should be given to the introduction of a simple rehabilitation form for general use in the hospital wards to provide information on a patient's remedial programme (paragraphs 145–147).

XV Delegation of responsibility for day-to-day treatment of patients should be permitted to members of the remedial professions, provided that they are always under the supervision of the appropriate consultant (paragraph 150).

XVI Patients receiving intensive physiotherapy should have their progress reviewed at least once a fortnight, preferably weekly (paragraphs 151–152).

XVII Those responsible in hospital should review the procedures in their hospitals to ensure that remedial treatment is correctly prescribed and recorded (paragraph 153).

XVIII An analysis of the work of the remedial professions based on hospitals throughout the country, randomly selected, should be undertaken urgently and this study should precede any re-organisation of the career structure or role of these professions (paragraphs 154–155).

XIX Further consideration should be given to the staff establishment requirements for the rehabilitation services. Detailed studies of the role and workload of representative samples of the different professions should be instigated (paragraph 157).

XX Managers and instructors in hospital rehabilitation workshops should either be seconded to the hospital from the Department of Employment or the hospital service should set up its own organisation for workshops in the health field (paragraphs 163–166).

XXI Several experimental appointments should be made of area managers to be responsible for work contracts for all hospital workshops and for workshops run by local authorities and grant-aided by the Department of Employment (paragraph 167).

XXII Hostel accommodation of a good standard of comfort should be provided for all general rehabilitation departments on a minimum scale of 20 beds per 200,000 population (paragraphs 168–170).

XXIII The discharge notes should include a clear recommendation by the consultant on the degree of a patient's fitness for work and a specific reference to this should be added to the model letter to general practitioners, suggested in the hospital memorandum HM(63)24 (paragraph 172).

XXIV Urgent consideration should be given to the provision of a certificate of partial incapacity (paragraphs 173–174).

XXV Existing convalescent facilities provided by hospitals should be gradually reduced as new provision for rehabilitation becomes available but health authorities should have access to a small number of places which could be in homes run on a joint-user basis with social service departments (paragraphs 175–177).

CHAPTER 7

Rehabilitation Facilities for Children

XXVI A number of adequately staffed research units should be set up to study methods of remedial therapy suitable for young children (paragraph 180).

XXVII As many handicapped children as possible should attend normal schools and special provision should be made for them in all new schools (paragraphs 182–184).

XXVIII Consideration should be given to the provision of educational facilities for handicapped children throughout the year (paragraph 188).

XXIX The rehabilitation of children over the age of ten should take place in the general rehabilitation department of the district hospital, but a limited amount of special accommodation and equipment should be provided for a minority of patients in this age group (paragraphs 189–190).

XXX Consideration should be given to the appointment of persons with specialised knowledge to guide the disabled adolescent. They could be (and in some areas already are) careers officers with special training in the problems of the disabled adolescent. Alternatively this could be an extension of the role of the disablement resettlement officer, or a specialised branch of that service (paragraphs 191–193).

CHAPTER 8

Rehabilitation of the Aged

XXXI Consideration should be given to the urgent need for training of the medical and other professions in the new concepts and special problems of rehabilitation as applied to the older age groups in modern geriatric practice (paragraphs 196–197).

XXXII The geriatric department should always have an allocation of the remedial staff employed in the hospital, and consideration should be given to the introduction of a salary "lead" for remedial staff so allocated (paragraph 197).

XXXIII In the design of ward accommodation in geriatric departments, adequate space should be provided between beds, together with day space, so that there is room for occupational as well as therapeutic procedures; ward surfaces should be non-slippery; there should be easy access to sanitary annexes with entrances wide enough to permit the use of wheelchairs; there should be a plentiful supply of hand rails and other aids to movement; and beds should be adjustable in height (paragraph 200).

CHAPTER 9

Rehabilitation of the Mentally Ill

XXXIV More attention should be given to the development of psychiatric rehabilitation services in the district general hospital, but at the same time such services must be maintained and improved in existing mental illness hospitals (paragraphs 210–212).

XXXV Hospital authorities should nominate a suitably trained consultant psychiatrist to be responsible for the supervision of all stages of rehabilitation in mental illness hospitals and mental illness departments of district general hospitals. Consideration should be given by the appropriate bodies to the provision of suitable training (paragraphs 214–217).

XXXVI The Department of Health and Social Security should examine the whole question of remuneration for therapeutic work in hospitals (paragraph 228).

CHAPTER 11

Hospital Rehabilitation Facilities for Special Categories of Patients

XXXVII The problems of the partially sighted should be the subject of studies designed to ascertain the needs of this group and the ways in which their needs can best be met (paragraphs 242–243).

XXXVIII Consideration should be given to the provision of special rehabilitation facilities for those suffering from deafness and more research should be undertaken into the needs of the deaf, and to the ways in which they can obtain maximum benefit from the services available (paragraph 244).

XXXIX All accident centres should be supported by adequate rehabilitation facilities (paragraph 247).

XL Patients suffering from head injuries should be treated initially in district general hospitals with neuro-surgical units providing assessment and early treatment, and in these hospitals rehabilitation facilities should be shared with other categories of patients. Provision should also be made for the long-term rehabilitation of severely disabled head injury cases and research should be undertaken into this problem (paragraphs 248–252).

XLI To meet the rehabilitation requirements in the treatment of paraplegia and tetraplegia:

(i) There should be 8 spinal injury units in England and Wales to provide a sound geographical distribution over the whole country. They should be attached to selected district general hospitals to enable use to be made of common services including rehabilitation;

(ii) Patients should be transferred as soon as possible to one of these special units for treatment during the acute stage where early rehabilitation procedures should be initiated;

(iii) At the later rehabilitation stages, it is to the advantage of spinal injury cases to share facilities used by other groups of patients;

(iv) In order to keep the centres free for new cases spinal injury patients should be transferred at the earliest appropriate time to district general hospitals capable of accepting such cases and of continuing rehabilitation, and near the patient's home;

(v) Suitable minimal care accommodation should be provided for the small residual number of paraplegics and tetraplegics who cannot return home for various reasons;

(vi) Adequate training should be provided to ensure that sufficient experienced remedial staff are available for the units and for other district general hospitals accepting transfer of spinal injury cases from the units (paragraphs 253–255).

XLII Some special facilities for the treatment of alcoholics and drug dependent persons should be established in a limited number of centres but it must be appreciated that the total rehabilitation requirements for these patients will only be met in part by the general rehabilitation department (paragraphs 256–257).

CHAPTER 12

Aids for the Disabled—The Artificial Limb Service

XLIII In the interest of the patient, the limb-fitting service should be fully integrated with the hospital service without delay (paragraphs 262–263).

XLIV Comprehensive limb-fitting and appliance centres, associated with district general hospitals, should be developed as special referral centres, each one to cover the needs of a population of 1½–2 million (paragraphs 267–268).

XLV Two or three further research and development centres should be set up to study the technical problems of limblessness (paragraph 268).

CHAPTER 13

Health in the Community

Health Services Outside Hospital

XLVI The attention of general practitioners should be drawn to the value to them of attending hospital assessment clinics at which their patients are discussed. On the consultant's advice, it should be acceptable for the appropriate member of the hospital remedial staff to make a domiciliary visit when the patient is unable to attend hospital (paragraphs 279–280).

XLVII Community medical staff engaged in child health work should have had special training in developmental paediatrics, including screening techniques (paragraph 297).

XLVIII Medical staff working in the school health service should possess, in addition to their clinical skills, full knowledge of the principles and the provision of ordinary and special education (paragraph 303).

Local Authority Social Services

XLIX The local authority social services departments should, with the help of hospital rehabilitation departments and industrial rehabilitation units, provide special instruction for their staff in the processes and objectives of rehabilitation (paragraph 312).

L Local authorities should provide day centres with separate accommodation for three streams of activity:

(i) for people who could maintain a fairly fast tempo, benefit from the company and gain a sense of purpose;

(ii) for people who require a slower tempo of work and who might in due course improve sufficiently to be transferred to sheltered employment;

(iii) for people who require slower tempo occupation essentially but not necessarily of a recreational kind, and who place an undue burden on relatives if they remain at home all day.

Payment should be made for the work done. In all cases there should be a close link with the appropriate hospital department and day hospital to facilitate the smooth transfer of patients from one to the other and to allow referral back to the hospital if necessary for re-assessment (paragraphs 316–317).

LI Local authorities should make arrangements to provide recuperative holidays following medical treatment for special cases such as the severely disabled who are recovering from another illness or accident and who require special provision for recuperation; people who live alone or may be an unwilling burden to others such as the elderly; people who should not return too soon to family commitments such as mothers and housewives. Although it is mandatory in new buildings it is essential that hotels, hostels or homes providing recuperative holidays are adapted to be able to accept wheelchairs, people using crutches and people who cannot climb stairs (paragraph 323).

LII The information service provided by local authorities under Section 1(2) of the Chronically Sick and Disabled Persons Act 1970 should be run by an officer responsible for the maintenance of up-to-date information on all health, social and industrial rehabilitation services. Such a service should be available to all those concerned with rehabilitation and resettlement. The rehabilitation department of the appropriate district general hospital will provide much of this information and should have copies of all information service material (paragraph 324).

CHAPTER 15

Education in Rehabilitation

LIII Medical schools should give immediate thought to the inclusion of teaching on rehabilitation in the medical curriculum to a greater extent than at present (paragraph 334).

LIV Consideration should be given to the establishment of a small number of Chairs in Rehabilitation (paragraph 337).

LV It is recommended to Universities and Postgraduate Deans that attendance at the rehabilitation assessment clinic should be regarded as an essential duty during the pre-registration period (paragraph 339).

LVI Training for the remedial professions should be concentrated into some twenty centres in England and Wales and these centres should be integrated with centres of further education (paragraph 347).

LVII The age of entry to training for the remedial professions should be reduced to 17 (paragraph 348).

LVIII Common training for the remedial professions should be introduced for the first year, and for a considerable proportion of the second year (paragraphs 349–350).

LIX Appointments for the remedial professions during the first year after qualification should be at approved centres only (paragraph 352).

LX Post-registration courses for the remedial professions should be run regularly, staff should be released to attend them and hospital authorities should be urged to allocate more of their funds for this purpose (paragraph 353).

LXI More attention should be paid to the education of the public in the value and advantages of rehabilitation (paragraphs 354–355).

APPENDIX I

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APPENDIX II

ORGANISATIONS AND INDIVIDUALS WHO SUBMITTED EVIDENCE TO THE COMMITTEE

(*a*) Organisations and individuals who submitted written evidence only.

Dr. Margaret Agerholm.
Arthritis and Rheumatism Council for Research.
Association of British Neurologists.
Association of Occupational Therapists.
Dr. D. A. Brewerton and Mr. J. W. Daniel.
British Diabetic Association.
British Epilepsy Association.
British Medical Association.
British Psychological Society.
British Society for Surgery of the Hand.
British Thoracic and Tuberculosis Association.
Chartered Society of Physiotherapy.
Cheshire Foundation Homes for the Sick.
Dr. M. A. X. Cocheme.
Disabled Living Foundation.
Dr. Eric Eason.
Executive Councils' Association (England).
Federation of Associations of Mental Health Workers.
Finchale Abbey Training Centre for the Disabled.
Mr. N. H. Harris.
Institute of Medical Social Workers.
Multiple Sclerosis Society.
National Corporation for the Care of Old People.
National Deaf Children's Society.
National Society for Mentally Handicapped Children.
Queen's Institute of District Nursing.
Mr. R. W. Raven.
Royal College of General Practitioners.
Royal College of Surgeons.
Royal National Institute for the Deaf.
Mr. A. F. Rushforth.
St. Loye's College for Training and Rehabilitation of the Disabled.
Society of Occupational Medicine.
Society of Remedial Gymnasts.

(*b*) Organisations and individuals who submitted written and oral evidence.

Department of Employment.
Dr. W. Russell Grant.
Health Visitors' Association.
Joint Council on Voluntary Work for the Disabled—representing:
(i) British Council for the Rehabilitation of the Disabled.
(ii) Central Council for the Disabled.
(iii) National Fund for Research into Crippling Diseases.
Dr. S. Mattingly.
National Old People's Welfare Council.

Spastics Society.
Dr. G. Yates.

(*c*) Organisations who submitted written evidence to the Committee and gave joint oral evidence to the Rehabilitation Committee and the Committee on the Remedial Professions.

Association of Directors of Welfare Services.
British Association of Physical Medicine and Rheumatology.
British Geriatric Society.
British Orthopaedic Association.
Royal College of Nursing and National Council of Nurses of the United Kingdom.
Royal Medico-Psychological Association.
Society of Medical Officers of Health.

(*d*) Organisations and individuals who submitted oral evidence only.

Accident Committee of the British Orthopaedic Association.
Miss M. S. Coltart.
Dr. B. G. Adams.
Dr. F. S. W. Brimblecombe.
Dr. D. F. M. Early.
East Anglian Regional Hospital Board.
Dr. M. B. Edwards.
Mrs. L. Farmer.
Miss E. R. Gloyne.
Dr. M. R. P. Hall.
Professor J. L. Henderson.
Mr. R. Huws Jones.
Professor R. E. Lane.
Professor C. R. Lowe.
Dr. R. C. MacKeith.
Professor T. Oppé.
Miss P. M. Perrott.
Royal National Institute for the Blind.
Mrs. B. Z. Sargeaunt.
Sheffield Regional Hospital Board.
Dr. J. G. Sommerville.
Dr. M. Thompson.
United Cambridge Hospitals.
United Sheffield Hospitals.
Dr. W. V. Wadsworth.
Dr. M. D. Warren.
Mr. J. E. Westmorland.

APPENDIX III

LIST OF ESTABLISHMENTS VISITED BY MEMBERS

Bristol Industrial Therapy Organisation.

London Borough of Camden:
- (i) Fitzroy Industrial Training Centre.
- (ii) Lynden Centre.
- (iii) Raydon Day Centre.

Medical Rehabilitation Centre, Camden Road, London.

Cowley Road Hospital, Oxford.

London Borough of Croydon:
- (i) Bensham Rehabilitation and Assessment Centre.
- (ii) Crosfield Industrial Unit.
- (iii) Rees House Day Hospital.

Ealing Industrial Therapy Organisation.

Epsom Industrial Therapy Organisation.

Garston Manor Comprehensive Rehabilitation Centre, Watford.

Mary Marlborough Lodge, Nuffield Orthopaedic Centre, Oxford.

Odstock Hospital, Salisbury.

Queen Elizabeth's Foundation for the Disabled, Leatherhead.

Rivermead Rehabilitation Hospital, Oxford.

Spinal Injury Centre, Stoke Mandeville Hospital, Aylesbury.

Vauxhall Motors Rehabilitation Centre, Luton.

Wolfson Medical Rehabilitation Centre, Wimbledon.

APPENDIX IV(A)

LIST OF OFFICIAL MEMORANDA ON REHABILITATION AND RELATED SUBJECTS SINCE 1948

(Issued as hospital memoranda (HM), local authority (LA) circulars, and executive council letters (ECL). A summary of the memoranda follows the list.)

RHB(48)1	National Health Service—The Development of Specialist Services.
RHB(49)36 HMC(49)26	Rehabilitation and Resettlement.
RHB(49)114 HMC(49)93 BG(49)98	Physiotherapy Services.
LA Circular 32/51	Welfare Services for Handicapped Persons.
HM(54)89	The More Effective Use of Hospital Beds.
HM(57)84	Rehabilitation of Disabled Nurses.
HM(57)86	Geriatric Services and the Care of the Chronic Sick.
HM(58)57 LA Circular 16/58	Rehabilitation in the Hospital Service and its relation to other services (the Piercy Report).
ECL 38/59	Rehabilitation of the Sick and Injured.
HM(59)93	Convalescent Treatment.
HM(62)18	The provision of physiotherapy in hospitals.
HM(63)24 LA Circular 3/63	Discharge of Patients from Hospital and Arrangements for After-care.
HM(64)45	Improving the Effectiveness of Hospitals for the Mentally Ill.
HM(65)77	Care of the Elderly in Hospital and Residential Homes.
HM(65)104	Improving the Effectiveness. of the Hospital Service for the Mentally Subnormal.
Departmental letter of 8.3.67 to hospital authorities LA Circular 4/67	Report of a Working Party on Industrial Rehabilitation.
HM(70)11 LA Circular 4/70 ECL 15/70	Psycho-geriatric Assessment Units.
HM(70)52 LA Circular 12/70	Chronically Sick and Disabled Persons Act, 1970.
HM(71)22 LA Circular 17/71	Hospital Facilities for Children.
HM(71)97 LA Circular 61/71 ECL 133/71	Hospital Services for the Mentally Ill.

APPENDIX IV(B)

SUMMARY OF ADVICE ON REHABILITATION

1. In 1946 the National Health Service Act was passed which made free medical treatment, including medical rehabilitation services, available to everyone. In the same year, the National Insurance Act entitled disabled people, like other insured workers to receive weekly benefits if they were ill or unemployed, and the National Insurance (Industrial Injuries) Act provided benefits for persons injured at work. In 1948, major local authorities were empowered under the National Assistance Act, to extend their comprehensive welfare services for the blind to make provision for the substantially and permanently disabled. All these Acts came into force on 5 July 1948.

2. During the same year, prior to the appointed day, a memorandum (RHB(48)1—National Health Service—The Development of Specialist Services) was sent to hospital authorities to assist the Boards with the planning and future development of the specialist services; in the memorandum it was emphasised that this was not intended to be a set of instructions, but merely advice and guidance. Chapter 18 dealt with Physical Medicine. The memorandum explained that this specialty had only been developed in a few hospitals, and that generally the work was either supervised by doctors who were only able to devote part of their time to it or it formed part of the orthopaedic department. However, the development of active rehabilitation during the war and the increasing use of active remedial exercises had emphasised the importance of establishing departments of physical medicine and rehabilitation. Physical medicine was described as the work of doctors specialising in the achievement and maintenance of health through physical education; the restoration to health and efficiency after sickness or injury through medical rehabilitation; the conservation and maintenance of function in degenerative or disabling conditions; the development, co-ordination and clinical supervision of physiotherapy, remedial gymnastics, occupational therapy and associated social services.

3. The memorandum went on to say that physical medicine and rehabilitation must be regarded as a specialty but would only succeed if there was sufficient interest on the part of the clinicians. Other consultants should be made aware of the benefits from the services so that they would make use of them for their own patients. It was important that close links should be maintained with industry so that there would be opportunities to use restored abilities, especially where these were limited and therefore social service was an important part of any department of physical medicine and rehabilitation.

4. On the utilisation of resources, the memorandum said that as resources in this field were limited they should not be stretched to provide a domiciliary service even though this was likely to be required in rural areas. It was thought that adequate transport provision would overcome the problems of those who otherwise might require treatment at home. Hospitals should arrange evening treatment sessions for employed persons. It was suggested that all large existing hospital centres should provide in-patient accommodation for rehabilitation under the supervision of a consultant in physical medicine, but that for the most part treatment should be provided on an out-patient basis under specialist supervision. The shortage of specialists in this field was blamed on insufficient training of medical students and the memorandum stated that the training of specialists in physical medicine and the staff of the remedial professions should be rapidly developed.

5. In 1949 the former Ministry of Health issued a circular (RHB(49)36 HMC(49)26) to all regional hospital boards and hospital management committees, entitled Rehabilitation and Resettlement, which set out the responsibility of the National Health Service in relation to disability. It described the role of the Ministry of Labour in providing training and employment for those who had reached terminal disability arising from earlier sickness or injury and pointed out that it was for the hospital service to make adequate provision prior to that stage, by regarding disability as essentially a medical problem. In the same year another circular was sent to the hospital authorities, including the boards of governors of teaching hospitals (RHB(49)114 HMC(49)93 BC(49)98) on the subject of physiotherapy services, which recommended that physiotherapy treatment should only be provided under specialist prescription as part of the hospital and specialist service and that regional hospitals boards should only accept responsibility for treatment prescribed by hospital specialists and carried out under their supervision.

6. In 1951 a circular (LA circular 32/51) was sent to all local authorities which contained advice based on recommendations from the Advisory Committee on the Health and Welfare of Handicapped Persons and stressed the importance of co-operation between all agencies concerned with providing after-care services for the disabled, viz. local authority health and welfare departments, hospital authorities and the Ministry of Labour and the need to inform all handicapped persons of services available to them in the community.

7. When the Ministry of Health offered advice to hospital authorities on "The more effective use of hospital beds" (HM(54)89) the memorandum which had been endorsed by the Standing Medical Advisory Committee emphasised the importance of the proper application of modern methods of rehabilitation and resettlement to reduce the duration of a patient's stay in hospital. The Ministry was itself aware of its responsibilities in the field of rehabilitation and in 1957 it sent out a memorandum to hospital authorities (HM(57)84) entitled "Rehabilitation of Disabled Nurses" which described an extension to an existing scheme (set up in 1943) for the training, at Government expense, of disabled nurses as nurse tutors.

8. Also in 1957, hospital authorities were informed of suggested improvements to hospital services for geriatrics and the chronic sick in a memorandum entitled "Geriatric services and the care of the Chronic Sick" (HM(57)86); these improvements included the provision of physiotherapy and other forms of rehabilitation on an out-patient basis at an early stage either to eliminate the need for admission to hospital or to prevent deterioration after discharge; the provision of day hospitals where rehabilitation facilities would be available to supplement out-patient clinics, and adequate consultation with local authority staff to ensure that all necessary community after-care services were arranged on a patient's discharge from hospital.

9. Advice on action to be taken following the publication of the Piercy Committee Report was sent to hospital authorities in a memorandum (HM(58)57) entitled "Rehabilitation in the hospital service and its relation to other services", and to local authorities under cover of circular 16/58. Some recommendations of the Piercy Committee required legislative changes and these were included in the Disabled Persons (Employment) Act, 1958.

10. In the following year, a memorandum prepared by the Standing Medical Advisory Committee for the guidance of general practitioners entitled "Rehabilitation of the Sick and Injured" was sent out under cover of ECL 38/59. This memorandum made the very important point that the rehabilitation of recurrent and progressive disorders would not result in the same degree of success as the rehabilitation of predominantly stable disabilities following injury and it is the former which is numerically the greater problem and with which the general practitioner is principally concerned. It stressed

the importance of applying the principles and methods of rehabilitation to medical disorders with the same vigour that was successful with surgical cases, although the progressive type of disorders were undoubtedly a deterrent to rehabilitation. The general practitioners were advised that the need for rehabilitation should be constantly kept in mind and appropriate measures prescribed in good time from the onset of illness. Doctors were also reminded of the need for positive management in the convalescent period, if necessary with the introduction of medical rehabilitation techniques, e.g. physiotherapy and occupational therapy, in order to prevent the unjustified extension of this stage by patients who were reluctant to return to work.

11. The memorandum also contained useful information for general practitioners on the various forms of rehabilitation and after-care services which were provided by the hospital service, local health and welfare authorities, local education authorities and the Ministry of Labour.

12. Finally it stated that there was much for the general practitioner to learn and to be kept aware of in this field and that as a first step rehabilitation should be included in refresher courses for general practitioners. A wide variety of professional and lay persons working as a team were concerned with helping the disabled, but it was the general practitioner who was responsible for the long-term management of the disabled and who would be consulted most frequently by the community team.

13. Also in 1959, the Department sent a leaflet "A Challenge—Living a Full Life Without Sight" to all local authorities and hospital authorities with the suggestion that social workers might find it useful when advising newly blind persons who might benefit by a course of residential social rehabilitation.

14. Departmental guidance to hospital boards on convalescent treatment was given in HM(59)93 which enclosed the Report of a Working Party under the Chairmanship of Dr. Neville Goodman, published in 1959. The Report pointed out that changes in the health of the nation, in the prevalence of disease, and in medical and surgical practice had resulted in a decreasing need for passive convalescence for medical reasons. The decrease in use of general convalescent facilities has continued steadily since the Report and consequently regional hospital boards have closed some of their own under-used homes and terminated contractual arrangements with private and voluntary homes.

15. In the following year the Ministry commended to all hospital authorities a note prepared by the Standing Medical Advisory Committee on "the provision of physiotherapy in hospitals" (HM(62)18). This advice forms the basis of the policy on physiotherapy services in hospitals which is followed by the Department of Health and Social Security today.

16. More advice on the already familiar theme of the importance of arranging adequate after-care arrangements following discharge from hospital and the need for co-operation between hospital and community authorities was sent to hospital authorities and local authorities in HM(63)24 and local authority circular 3/63 "Discharge of patients from hospital and arrangements for after-care". This memorandum described the parts to be played by the hospital almoner (today known as the medical social worker), the general practitioner and the staff of the local authority in mobilising and organising all the services necessary when a patient leaves hospital to live in the community whether they are completely recovered, temporarily or permanently disabled.

17. In 1964–5 the Ministry was particularly concerned about services for psychiatric and geriatric patients and in HM(64)45 and HM(65)104 hospital authorities were given the outline of comprehensive services including rehabilitation to be provided in hospitals for the mentally ill and the mentally subnormal together with suggestions for

the means by which some obstacles to improvements in existing services could be overcome.

18. HM(65)77 "Care of the elderly in hospital and residential homes" supplemented HM(57)86 (see paragraph 8) and offered general guidance and advice on hospital and community services for the elderly including a recommendation that hospital authorities should ensure that when considering demands for staff including physiotherapists and treatment facilities including rehabilitation the needs of the geriatric department should not be overlooked. Here again authorities were reminded of the need for consultation and co-ordination between all concerned with after-care arrangements. Advice in similar terms was sent in a circular to the local authorities.

19. The first major guidance to hospitals and local authorities about industrial rehabilitation was a circular sent out in 1967 enclosing a reprint from the Ministry of Labour Gazette of part of the report of a Working Party on Industrial Rehabilitation. The circular told authorities that the Working Party's recommendations had been endorsed by the Ministry of Health and were to be brought to the attention of those concerned with rehabilitation. The recommendations relevant to the medical rehabilitation services were:

(i) That Health Services should play their part in sustaining and developing the concept of rehabilitation as a continuing process;

(ii) Professional staff in the medical and associated fields should be introduced to the "rehabilitation concept" during their training; the importance of timely referral should be stressed;

(iii) The Piercy recommendation for experiment with combined medical and industrial rehabilitation should be pursued.

20. In 1970 advice was sent to hospital authorities, general practitioners and local authorities from the Standing Mental Health Advisory Committee under cover of HM(70)11, LA circular 4/70, ECL 15/70 entitled "Psycho-geriatric assessment units", which dealt with arrangements for psycho-geriatric assessment of elderly patients in hospital, and particularly emphasised the need to prevent the misplacement of old people in hospital which could delay recovery and impede rehabilitation.

21. Finally, the most recent advice, issued in a circular for local authorities (12/70) prepared jointly by the Department of Health and Social Security, the Department of Education and Science, the former Ministry of Housing and Local Government and the former Ministry of Transport (now both incorporated in the Department of the Environment) and a memorandum to hospital authorities (HM(70)52) following the passing of the Chronically Sick and Disabled Persons Act, 1970, informed authorities of the underlying purpose of the Act which was to draw attention to the various problems of people who are handicapped by chronic sickness or disablement and to urge that these problems should be more widely known and studied. The circular was principally aimed at local authorities and covered such areas as improving methods of locating and registering handicapped persons; providing an adequate service to assess the requirements in terms of local authority services of individual handicapped persons; the removal of barriers to mobility in the community particularly relating to access to public buildings for handicapped persons; and the provision of suitable housing for the disabled. It also mentioned that the Department of Health and Social Security was now required to prepare annual reports on the state of research and development under Government auspices into equipment for the disabled.

APPENDIX V

LIST OF VOLUNTARY ORGANISATIONS KNOWN BY THE COMMITTEE TO HAVE AN INTEREST IN REHABILITATION

Organisation	*Date of Foundation*
Arthritis and Rheumatism Council for Research	1936
Association for Spina Bifida and Hydrocephalus	1966
Birmingham Industrial Therapy Association	1965
British Association of the Hard of Hearing	1947
British Council for the Rehabilitation of the Disabled	1944
British Diabetic Association	1934
British Epilepsy Association	1950
British Heart Foundation	1961
British Limbless Ex-Servicemen's Association	1932
British Polio Fellowship	1939
British Red Cross Society	1876
British Rheumatism and Arthritis Association	1947
Central Council for the Disabled	1919
Cheshire Foundation Homes	1948
Chest and Heart Foundation	1899
Cripples Help Society (Manchester, Salford and N.W. England)	1897
Disabled Drivers' Association	1948
Disabled Drivers' Motor Club	1922
Disabled Living Foundation	1940
Enham-Alamein Village Settlement	1918
Ex-Services' Mental Welfare Society	1919
Finchale Abbey Training Centre for the Disabled	1943
Forces' Help Society and Lord Roberts Workshop	1899
Geriatric Care Association of Great Britain	1962
Haemophilia Society	1942
Ileostomy Association of Great Britain and Ireland	1956
Invalid Children's Aid Association	1888
Mental After-Care Association	1879
Multiple Sclerosis Society of Great Britain and N. Ireland	1953
Muscular Dystrophy Group	1958
National Association for Mental Health	1946
National Advisory Council of Industrial Therapy Organisations	1964
National Corporation for the Care of Old People	1947
National Fund for Research into Crippling Diseases	1953

National Old People's Welfare Council	1940
National Society for Autistic Children	1962
National Society for Epileptics	1882
National Society for Mentally Handicapped Children	1946
Papworth Village Settlement	1937
Portland Training College for the Disabled	1950
Queen Elizabeth's Foundation for the Disabled	1967
Queen Elizabeth's Home for the Recovery of the Blind	1940
Remploy Ltd.	1945
Royal Air Force Association	1943
Royal Association in Aid of the Deaf and Dumb	1840
Royal British Legion	1921
Royal National Institute for the Blind	1868
Royal National Institute for the Deaf	1911
St. Dunstan's (for Men and Women Blinded on War Service)	1915
St. Loye's College for Training and Rehabilitation of the Disabled	1937
Shaftesbury Society	1844
Soldiers' Sailors' and Airmen's Families Association	1885
Spastics Society	1952
Star and Garter Homes for Sailors, Soldiers and Airmen	1916
Women's Royal Voluntary Service	1938

APPENDIX VI

LIST OF INDUSTRIAL REHABILITATION UNITS IN GREAT BRITAIN

I.R.U.S OPERATING AT DATE OF THE PIERCY REPORT (NOVEMBER 1956)

Unit	*Nominal places*
Egham	200
Birmingham	100
Coventry	100
Felling-on-Tyne	100
Manchester	100
Leicester	100
Cardiff	100
Edinburgh	100
Hull	100
Leeds	100
Sheffield	100
Glasgow	200 (Now 112)
Long Eaton	100 (Now 75)
Bristol	100
Waddon	100
Total (15 Units)	1,700 (Now 1,587)

I.R.U.S OPENED SINCE NOVEMBER 1956 (WITH DATE OF OPENING)

Perivale	13.6.60	100
Liverpool	8.8.61	100
Port Talbot	6.3.67	60 (Now 75)
Billingham-on-Tees	1.5.67	60 (Now 75)
Killingworth	16.10.67	100
Bellshill	5.2.68	100
Garston Manor	27.5.68	60
Plymouth	26.1.70	60
North Staffordshire	11.1.71	60
Dundee	28.6.71	60
		760 (Now 790)

LIKELY FUTURE DEVELOPMENTS

1972/3 Increase from 60 to 70 places at Garston Manor.

1972/3 Increase at Long Eaton Nottingham I.R.U. from 75 to 100 places.

1973/4 Opening of 150-place I.R.U. at Birmingham and closure of present 100-place Unit.

1973/4 Opening of 60-place I.R.U. at Portsmouth (August 1973).

1974/5 (i) Opening of a 200-place part-residential Unit at Preston.
(ii) Opening of a 60-place Unit in North London.

1975/6 Opening of a 200-place part-residential Unit in East London.

APPENDIX VII
TABLE 1

Industrial rehabilitation units in Great Britain

Analysis by main disability of persons terminating prematurely

Entrants during period January-June 1970

ALL UNITS

MEDICAL GROUP	Reason for premature termination													Total
	Unlikely to benefit —medical (main disability)	Unlikely to benefit —medical (other illnesses)	Unlikely to benefit —other reasons (apart from items 7–12)	Prolonged absence —medical (main disability)	Prolonged absence —medical (other illnesses)	Prolonged absence —other reasons (apart from items 7–12)	Found work	Left to seek work	Disciplinary reasons	Financial difficulties	Domestic reasons	Travelling difficulties	Other reasons or reason unknown	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
0 Able-bodied	2	3	9	2	5	3	5	8	2	1	3	1	18	62
1–5 Amputations	3	—	1	3	1	—	3	1	1	—	—	1	2	16
6 Arthritis and Rheumatism	3	4	2	4	5	—	2	2	—	1	—	—	1	24
Diseases of: 8 Digestive system	4	3	—	8	7	3	5	3	—	1	—	—	3	37
10 Heart and circulatory system	15	2	2	24	4	3	7	3	—	1	4	2	1	68
11–13 Respiratory system (other than TB)	7	1	3	17	8	7	7	1	—	2	2	1	6	62

APPENDIX VII

TABLE 1 (cont.)

15–16 Ear defects	—	—	—	2	—	—	2	1	1	—	—	—	1	7
17 Eye defects	2	3	4	—	1	2	—	1	1	—	1	2	4	21
18 Injuries of head and trunk	6	1	1	2	3	—	4	2	—	—	2	—	4	25
Injuries, diseases and deformities of: 19 Lower limb	10	5	5	9	13	5	10	5	2	2	3	2	10	81
20 Upper limb	3	2	2	7	5	2	11	2	2	1	3	1	6	47
21–22 Spine (including paraplegia)	13	10	12	33	17	3	21	13	—	2	4	7	11	146
23 Psychoneurosis	38	3	10	18	18	6	17	13	4	3	9	1	23	163
27 Psychosis	44	6	5	12	7	3	8	9	1	1	2	2	13	113
26 Mental Subnormality	4	2	5	—	2	3	2	3	1	—	1	—	2	25
24 Epilepsy	7	3	6	4	2	2	4	3	2	1	2	—	4	40
25 Other organic nervous diseases	18	1	7	3	3	2	4	2	1	—	1	1	5	48
28 Respiratory TB	1	—	1	2	—	—	2	—	—	—	—	—	3	9
29 TB, other forms	1	—	—	—	—	—	1	—	—	—	1	1	—	4
30 Other diseases	10	3	4	10	7	6	8	3	—	1	5	1	12	70
— Not recorded	22	2	9	4	5	—	11	7	—	1	10	4	18	93
TOTAL	213	54	88	164	113	50	134	82	18	18	53	27	147	1,161

APPENDIX VII

TABLE 2

Industrial rehabilitation units in Great Britain

Analysis by main disability of persons completing a course or terminating prematurely

Entrants during period January–June 1970

ALL UNITS

MEDICAL GROUP	Number of entrants during period	Premature terminations			Completed course			
						Placed in		
		For medical reasons	For other reasons	Total	Total	Employment	Training	Unplaced not allocated or accepted for training at 3 months (see note below)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0 Able-bodied	412	12	50	62	350	180	67	103
1–5 Amputations	158	7	9	16	142	58	34	50
6 Arthritis and Rheumatism	199	16	8	24	175	73	29	73
Diseases of: 8 Digestive system	195	22	15	37	158	81	28	49
10 Heart and circulatory system	602	45	23	68	534	243	80	211
11–13 Respiratory system (other than TB)	469	33	29	62	407	156	77	174

APPENDIX VII

TABLE 2 (cont.)

15–16	Ear defects	112	2	5	7	105	47	20	38
17	Eye defects	189	6	15	21	168	88	25	55
18	Injuries of head and trunk	167	12	13	25	142	67	21	54
19	Injuries, diseases and deformities of: Lower limb	611	37	44	81	530	222	91	217
20	Upper limb	349	17	30	47	302	142	56	104
21–22	Spine (including paraplegia)	941	73	73	146	795	317	175	303
23	Psychoneurosis	927	77	86	163	764	390	108	266
27	Psychosis	445	69	44	113	332	169	28	135
26	Mental Subnormality	269	8	17	25	244	142	2	90
24	Epilepsy	310	16	24	40	270	122	29	119
25	Other organic nervous diseases	408	25	23	48	360	153	34	173
28	Respiratory TB	94	3	6	9	85	32	18	35
29	TB, other forms	24	1	3	4	20	7	5	8
30	Other diseases	405	30	40	70	335	142	63	130
—	Not recorded	94	33	60	93	1	—	—	1
	TOTAL	7,380	544	617	1,161	6,219	2,841	990	2,388

Note—or at 26 weeks from beginning of course, whichever is the earlier.

APPENDIX VII

TABLE 3

Industrial rehabilitation units in Great Britain

Analysis by main disability of persons completing a course or terminating prematurely
Entrants during period January–June 1970

ALL UNITS

MEDICAL GROUP	Number of entrants during period	Premature terminations (as % of Col. (2))			Completed course			
						% of Col. (6)		
						Placed in		
		For medical reasons	For other reasons	Total	Total (as % of Col. (2))	Employment	Training	Unplaced not allocated or accepted for training at 3 months (see note below)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
0 Able-bodied	412	2·9	12·1	15·0	85·0	51·4	19·1	29·5
1–5 Amputations	158	4·4	5·7	10·1	89·9	40·9	23·9	35·2
6 Arthritis and Rheumatism	199	8·1	4·0	12·1	87·9	41·7	16·6	41·7
Diseases of: 8 Digestive system	195	11·3	7·7	19·0	81·0	51·3	17·7	31·0
10 Heart and circulatory system	602	7·5	3·8	11·3	88·7	45·5	15·0	39·5
11–13 Respiratory system (other than TB)	469	7·0	6·2	13·2	86·8	38·3	18·9	42·8

APPENDIX VII

TABLE 3 (cont.)

15–16	Ear defects	112	1·8	4·4	6·2	93·8	44·8	19·0	36·2
17	Eye defects	189	3·2	7·9	11·1	88·9	52·4	14·9	32·7
18	Injuries of head and trunk	167	7·2	7·8	15·0	85·0	47·2	14·8	38·0
	Injuries, diseases and deformities of:								
19	Lower limb	611	6·1	7·2	13·3	86·7	41·9	17·2	40·9
20	Upper limb	349	4·9	8·6	13·5	86·5	47·0	18·6	34·4
21–22	Spine (including paraplegia)	941	7·8	7·8	15·6	84·4	39·9	22·0	38·1
23	Psychoneurosis	927	8·3	9·3	17·6	82·4	51·1	14·1	34·8
27	Psychosis	445	15·5	9·9	25·4	74·6	50·9	8·4	40·7
26	Mental Subnormality	269	3·0	6·3	9·3	90·7	62·3	0·8	36·9
24	Epilepsy	310	5·2	7·7	12·9	87·1	45·2	10·7	44·1
25	Other organic nervous diseases	408	6·1	5·7	11·8	88·2	42·5	9·4	48·1
28	Respiratory TB	94	3·2	6·4	9·6	90·4	37·6	21·2	41·2
29	TB, other forms	24	4·2	12·5	16·7	83·3	35·0	25·0	40·0
30	Other diseases	405	7·4	9·9	17·3	82·7	42·4	18·8	38·8
—	Not recorded	94	35·1	63·8	98·9	1·1	—	—	100·0
	TOTAL	7,380	7·3	8·4	15·7	84·3	45·7	15·9	38·4

Note—or at 26 weeks from beginning of course, whichever is the earlier.

APPENDIX VII

TABLE 4

Industrial rehabilitation units in Great Britain

Numbers admitted during the six months January–June 1970
By sources of recruitment

UNIT	Recent sickness or injury								Others			Grand total
		Outside sources							Department of Employment sources			
	Hospital etc. (excl. col. (3))	Hospital residents	MIC/ Res. clin.	GPs	RMS	RMO	Industry	Other A1	A2	B1 LO/ GTC/ YPSA	B2 LO/ GTC/ YPSA	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Belshill	58	13	5	16	110	22	1	49	5	58	9	346
Billingham-on-Tees	54	4	—	17	77	21	6	—	23	65	11	278
Birmingham	106	1	—	8	2	2	—	7	88	99	8	321
Bristol	103	—	13	10	79	15	—	27	14	19	42	322
Cardiff	63	4	—	17	85	12	—	7	22	98	27	335
Coventry	52	—	—	29	33	4	1	9	47	103	19	297
Edinburgh	94	—	2	22	20	141	1	7	3	64	12	366

APPENDIX VII

TABLE 4 (cont.)

Egham	223	7	5	14	102	37	—	23	39	116	9	575
Felling-on-Tyne	74	—	16	9	35	29	2	2	30	101	30	328
Garston Manor	84	64	1	8	21	11	2	15	18	17	5	246
Glasgow (Hillington)	67	17	2	34	92	26	2	32	5	38	42	357
Hull	41	—	—	95	86	6	1	7	4	38	29	307
Killingworth	55	3	5	4	55	7	2	12	45	81	27	296
Leeds	86	—	—	29	84	12	1	3	13	50	12	290
Leicester	98	—	3	32	87	12	2	3	17	61	15	330
Liverpool	87	1	4	4	68	17	1	—	6	102	12	302
Long Eaton	56	—	1	19	26	77	3	22	14	17	85	320
Manchester	124	—	2	13	8	9	1	7	72	53	5	294
Perivale	119	—	2	17	50	8	—	20	49	54	21	340
Plymouth	26	1	1	8	20	10	—	7	21	36	24	154
Port Talbot	45	2	4	13	39	3	2	9	19	48	86	270
Sheffield	87	3	—	38	68	24	2	3	9	98	12	344
Waddon	104	16	2	8	31	36	1	6	20	127	11	362
TOTAL	1,906	136	68	464	1,278	541	31	277	583	1,543	553	7,380
Percentage	25·8	1·9	0·9	6·3	17·3	7·3	0·4	3·8	7·9	20·9	7·5	100

APPENDIX VII

TABLE 5

Industrial rehabilitation units in Great Britain

Numbers admitted during the six months January-June 1970
By categories of disability

UNIT	Not recorded	Able-bodied	Amputations	Arthritis and Rheumatism	Diseases of: Digestive System	Heart and Circulatory Systems	Respiratory System (other than TB)	Ear Defects	Eye Defects	Injuries of Head and Trunk	Injuries, diseases and deformities of: Lower Limb	Upper Limb	Spine (incl. paraplegia)	Psychoneurosis	Psychosis	Mental Subnormality	Epilepsy	Other Organic Nervous Diseases	Respiratory TB	TB Other forms	Other diseases	GRAND TOTAL
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
Belshill	—	6	—	6	10	33	25	7	15	9	22	12	44	41	26	30	12	22	7	2	17	346
Billingham-on-Tees	26	9	5	19	8	17	25	8	8	8	21	13	32	31	11	3	14	9	2	2	7	278
Birmingham	3	6	9	20	11	26	13	6	12	7	31	13	36	39	28	4	15	20	3	1	18	321
Bristol	4	32	3	4	11	15	10	3	7	6	30	17	46	47	23	8	18	20	1	—	17	322
Cardiff	1	18	7	5	17	22	23	7	10	3	33	23	39	42	14	13	15	16	1	—	26	335
Coventry	11	20	6	9	6	29	15	5	7	2	28	16	36	23	28	18	5	18	5	—	10	297

APPENDIX VII

TABLE 5 (cont.)

Edinburgh	—	7	11	3	9	25	24	8	7	4	35	12	42	25	44	39	13	36	3	3	16	366
Egham	25	11	16	13	7	34	13	8	11	2	26	16	52	124	33	17	42	73	8	2	43	576
Felling-on-Tyne	1	34	2	9	10	24	36	4	7	9	27	17	56	33	19	8	8	11	2	—	11	328
Garston Manor	3	—	3	16	2	18	9	2	4	15	28	17	32	39	1	10	7	20	3	2	15	246
Glasgow (Hillington)	—	19	7	6	3	38	24	5	9	9	24	16	25	48	25	33	18	11	13	3	21	357
Hull	—	21	8	4	12	38	29	3	6	9	21	13	45	38	15	5	5	12	4	1	18	307
Killingworth	2	25	5	5	10	25	23	6	3	7	34	9	59	28	15	3	7	11	4	—	15	296
Leeds	—	7	17	12	6	31	32	1	3	7	20	14	37	32	11	10	15	11	7	—	17	290
Leicester	—	13	13	14	3	26	25	4	8	10	19	9	43	55	15	11	19	28	3	1	11	330
Liverpool	2	12	—	7	20	16	19	6	11	21	42	35	2	39	13	3	11	7	6	—	30	302
Long Eaton	2	38	3	6	9	27	22	5	6	5	24	14	46	43	12	9	11	19	1	—	18	320
Manchester	6	3	13	5	4	38	10	3	4	5	28	26	58	24	18	1	12	9	6	4	17	294
Perivale	2	11	8	13	5	34	19	5	18	8	24	11	39	46	28	8	15	13	6	1	26	340
Plymouth	2	18	2	10	6	7	6	3	1	2	11	4	22	26	11	2	5	6	1	—	9	154
Port Talbot	4	84	4	3	5	15	14	5	11	4	12	8	35	20	6	8	11	5	2	—	14	270
Sheffield	3	5	7	7	9	24	31	5	11	5	33	18	58	37	23	23	17	7	4	2	15	344
Waddon	3	8	12	3	12	40	22	3	10	10	38	16	55	48	26	3	15	23	2	—	13	362
TOTAL	100	407	161	199	195	602	469	112	189	167	611	349	939	928	445	269	310	407	94	24	404	7,381
Percentage	1·4	5·5	2·2	2·7	2·7	8·2	6·4	1·5	2·6	2·3	8·3	4·7	12·6	12·6	6·0	3·6	4·2	5·5	1·3	0·3	5·4	100

APPENDIX VIII

LIST OF GOVERNMENT TRAINING CENTRES IN GREAT BRITAIN

Region/Centre	*No. of places*		*Opening Date*
	GTC	*IRU*	
Northern			
Billingham-on-Tees GTC/IRU	252	+ 75	September 1964
Darlington	138		April 1970
Durham	311		November 1969
Felling-on-Tyne GTC/IRU	296	+ 100	1946
Killingworth GTC/IRU	274	+ 100	October 1967
Maryport	97		September 1968
Middlesbrough	112		April 1971
Yorkshire and Humberside			
Hull GTC/IRU	151	+ 100	December 1963
Leeds GTC/IRU	249	+ 100	1947 (re-opened)
Sheffield GTC/IRU	181	+ 100	December 1963
Wakefield	218		January 1970
Eastern and Southern			
Basildon	126		January 1971
Letchworth	423		October 1930
Norwich	122		August 1967
Slough	305		1934 (re-opened)
Southampton	218		July 1964
London and South Eastern			
Enfield	304		1947
Medway	263		February 1967
Perivale GTC/IRU	309	+ 100	1947
Poplar	342		May 1965
South East London			Not Yet Open
Waddon GTC/IRU	340	+ 100	February 1931
Twickenham	187		December 1970
West Sussex	155		September 1967
South Western			
Bristol GTC/IRU	283	+ 100	March 1946
Gloucester	189		August 1964
Plymouth GTC/IRU	161	+ 60	October 1966
Wales			
Cardiff GTC/IRU	330	+ 100	1945
Llanelli	167		September 1964
Port Talbot GTC/IRU	310	+ 75	December 1968
West Monmouthshire	143		March 1971
Wrexham	119		March 1970

APPENDIX VII (cont.)

Region/Centre	*No. of places* *GTC*	*IRU*	*Opening Date*
Midlands			
Birmingham (was Handsworth) GTC/IRU	248	+ 100	October 1925
Coventry GTC/IRU	159	+ 100	July 1967
Leicester GTC/IRU	249	+ 100	July 1936
Long Eaton GTC/IRU	254	+ 75	September 1963
North Staffs GTC/IRU	114	+ 60	October 1970
Dudley			Not Yet Open
North Western			
Blackburn	173		May 1965
Hindley	247		September 1964
Liverpool GTC/IRU	397	+ 100	1940
Manchester (was Denton) GTC/IRU	181	+ 100	June 1966
Runcorn	249		December 1968
St Helens	122		May 1971
Scotland			
Belshill GTC/IRU	213	+ 100	June 1968
Dumbarton	76		September 1964
Dunfermline	120		September 1963
Dundee GTC/IRU	46	+ 60	April 1971
Edinburgh GTC/IRU	119	+ 100	October 1967
Glasgow (Hillington) GTC/IRU	221	+ 112	1946
Glasgow (Queenslie)	169		October 1965
Irvine	152		November 1964
Motherwell	43		September 1963
Port Glasgow	83		October 1965

APPENDIX IX

SOCIAL SECURITY AND THE REHABILITATION SERVICES

(Paper prepared by the Department of Health and Social Security)

1. When a person falls sick he may receive financial help from any one or more of a number of schemes. Details of these are set out briefly below. Under recent legislation, changes in the National Insurance Scheme were introduced from September 1971 and what follows describes the position under the Scheme as a result of the changes. Besides a general uprating of benefits, the changes include an invalidity pension for insured people who have been sick or disabled for 6 months or more, and an invalidity allowance for those who fall sick while they still have a substantial part of their normal working lives ahead of them. Invalidity pension also carries with it an improved earnings rule for working wives of invalidity pensioners and higher children's allowances for their children. Thus a married invalidity beneficiary with 2 children receives £16·60 a week from invalidity benefit and family allowances (assuming an invalidity allowance of £1 a week), even where the wife's earnings are as much as £9·50 a week. By comparison, sickness benefit and family allowances would provide the same family with a weekly income of £13·40, which would be reduced as soon as the wife's earnings exceeded £3·70 a week.

Social security provision

2. The basic first-line provision for people who are sick or disabled, and incapable of work, is National Insurance flat-rate *sickness benefit*. Provided 156 (3 years') flat-rate contributions have been paid as an employed or self-employed person, sickness benefit is payable for the first 168 days of incapacity and is then replaced by invalidity pension (see paragraph 5). Invalidity pension may then be payable for as long as incapacity continues, through to pension age, when it is replaced in turn by retirement pension. The weekly rate of sickness benefit for a single person is £6 and for a married couple £9·70. There are additions for dependent children. These are payable on top of family allowances, which are paid whether or not a man is working, and together they provide £1·85 per child. A married couple with 2 children would have a weekly sickness benefit and family allowance income of £13·40.

3. From October 1966 an earnings-related supplement became payable for 6 months, from the *3rd to the 28th week of incapacity*, to those entitled to flat-rate sickness benefit. The amount of the supplement is one-third of the person's average weekly earnings between £9 and £30 in the last tax year, provided that, together with flat-rate benefit, the total does not exceed 85 per cent of the average weekly earnings. (On flat-rate personal and dependency benefits there is no ceiling.) As much as £7 a week is payable on earnings of £30 or more. The basic object of the supplement is to cushion the drop in family income which can occur when a person is suddenly taken ill.

4. The Government have now taken power to increase the lower limit of £9 on which the supplement is paid to £10 to take some account of the increase in earnings levels since the supplement was introduced in 1966. At the same time, the upper limit will be extended from £30 to £42. The weekly rate of earnings-related supplement will be one-third (as at present) of the amount of average weekly earnings (calculated as one-fiftieth of earnings from employment in the relevant income tax year) lying between £10 and £30, and 15 per cent of earnings lying between £30 and £42. The new rates will start after the end of the 1972/73 income tax year, by which time contributions will have been paid for a full year up to the new earnings level of £42.

5. *Invalidity pension* is payable to all who are eligible for it—including married women —at the full standard rate for National Insurance benefit—£6 single and £9·70 for a married couple. In addition to it, people who fall sick more than 5 years before pensionable age qualify for Invalidity Allowance. The maximum rate of this allowance —£1 a week—is paid to people whose incapacity for work begins before age 35; an allowance of 60p a week is payable where the onset of incapacity falls between the ages of 35 and 45; and an allowance of 30p where the onset occurs between 45 and 60 (55 for women). Where illness has been continuous since 5 July 1948, the £1 rate applies. Anyone who has qualified for invalidity allowance and is still receiving it at pension age will have an amount equal to the allowance added to his or her retirement pension entitlement as a life-long benefit. Parallel arrangements will be introduced for people in receipt of unemployability supplement under the War Pensions and Industrial Injuries schemes.

6. The increases of benefit paid for the dependent children of invalidity pensioners are at a higher rate than those paid to sickness beneficiaries. Including any family allowances, the amount payable for each child is £2·95 a week.

7. The rule under which the increase of benefit for the dependent wife of a sickness beneficiary is totally withdrawn as soon as her earnings exceed whatever the amount laid down for that increase may be from time to time is modified for the wife of an invalidity pensioner. If she is residing with him, she is subject to the same tapered earnings rule as applies to retirement pensioners, which does not begin to operate until earnings exceed £9·50.

8. Accordingly, a married couple with 2 children would have a weekly income from invalidity benefit and family allowances (assuming an invalidity allowance of £1) of £16·60, even where the earnings of the wife were as much as £9·50.

9. From 6.12.71 *attendance allowance* at a weekly rate of £4·80 is payable for severely disabled adults and for children over the age of 2, who satisfy certain medical requirements for at least 6 months. These requirements are that a person must be so severely disabled, physically or mentally, that either he requires from another person frequent attention throughout the day *and* prolonged or repeated attention during the night, or he requires continual supervision from another person in order to avoid substantial danger to himself or others. There is an additional medical requirement for a child between the ages of 2 and 16 years which is that he must require attention and supervision substantially in excess of that normally required by a child of the same age and sex.

10. There are also conditions relating to residence and presence in the United Kingdom. Attendance allowance is not payable to people in National Health Service hospitals (other than as private patients) or to people in accommodation which is provided by a local authority either directly or indirectly (e.g. through a home run by a voluntary organisation).

11. *The Industrial Injuries Scheme* provides insurance against an accident or illness arising out of employment. Unlike the National Insurance Scheme, entitlement to benefit under the Industrial Injuries Scheme does not depend on the number of contributions paid, but on the employment being an insurable employment. Self-employed people are not eligible. Injury benefit is payable for the first 6 months of incapacity for work at the weekly rate of £8·75 for a single person (£2·75 more than sickness benefit), plus additions for a dependent wife and for dependent children which, with family allowances, also provide £1·85 per child. Earnings-related supplement of up to £7 a week may be paid on top. If after 6 months the person is still incapable of work he may receive sickness benefit followed by invalidity benefit if he satisfies the contribution conditions.

12. Disability pensions at various rates are payable under the Industrial Injuries Scheme after injury benefit ceases, and whether or not the beneficiary returns to work. The amount of benefit depends on the extent of the disablement as assessed by a Medical Board. Disablement pension varies from £10 a week for 100 per cent disability to £2 a week for 20 per cent disability. Various allowances are payable on top, so that a person who is exceptionally severely disabled may be entitled to as much as £28 per week. The main supplementary allowances and their broad purpose are listed below.

Special hardship allowance—up to £4, as long as the disablement pension and allowance together do not come to more than £10 a week, if as a result of the injury or disease the person is unable to return to his regular job or work at a job of a similar standard.

Constant attendance allowance—up to £4 a week for a person needing regular attendance and with a 100 per cent disability (disablement due to some other cause, e.g. war injuries, may be taken into account for this purpose). In cases of exceptionally severe disablement the allowance can be increased to £6 a week or £8 a week.

Exceptionally severe disablement allowance—£4 a week; if a constant attendance allowance of more than £4 is in payment, or would be but for the fact that the person .ospital, and the need for constant attendance is likely to be permanent.

Hospital treatment allowance—raises a person's disablement pension to the 100 per cent rate, with increases for dependants, while he is in hospital for treatment of the injury or disease.

Unemployability supplement—£6 a week with increases for dependants, if a person is permanently unfit for work as a result of the injury or disease. It cannot be paid with sickness benefit or retirement pension, but an addition equivalent to invalidity allowance in the National Insurance Scheme may be payable with it, at weekly rates from 30p to £1 according to the date of onset of unemployability or sickness. If a person is incapable of working, sickness or invalidity pension benefit can be paid in addition to the disablement pension, unless unemployability supplement is in payment.

13. Besides the main schemes there are special schemes such as the Colliery Workers' Supplementary Scheme, the Pneumoconiosis, Byssinosis and Miscellaneous Diseases Benefit Scheme, and the Workmen's Compensation (Supplementation) Scheme. The Colliery Workers' Scheme is approved by the Secretary of State under the National Insurance Acts and provides payments in addition to injury benefit and disablement benefit where the injured person is a colliery worker. The maximum amount payable where there is 100 per cent disability is £2·38 a week. The other two schemes enable allowances and benefits to be paid out of the Industrial Injuries Fund to people disabled by industrial injury or disease as a result of employment before 5 July 1948. Under the Pneumoconiosis scheme, the weekly rate for total disablement is £10, and for partial disablement £3·65. There are three allowances under the Workmen's Compensation Scheme, the basic allowance of £2 for a person injured before 1924, a total disablement allowance of £10 and a partial allowance of up to £3·65.

14. *Supplementary benefit* is payable to a person *not in full-time work* whose income is insufficient to meet his requirements as defined by the Ministry of Social Secuirty Act 1966. The basic allowance is £5·80 for a single householder and £9·45 for a married couple, plus rent and rates which are normally met in full. There are additions for dependent children related to the age of the child. Family allowances are taken fully into account in assessing entitlement to supplementary benefit. For those over pension age and certain other long-term cases there is a standard addition of 50p and excep-

tional expenses from, for example, disablement will attract further additions. Various other forms of income may be disregarded up to certain limits. A married couple with 2 children aged 6 and 11, would be entitled to a basic weekly allowance of £13·90, plus rent.

Occupational sick pay schemes

15. In January 1961 it was announced in the House that a special enquiry into the incidence of incapacity for work would be undertaken by the Ministry of Pensions and National Insurance. Information about occupational sick pay schemes which was collected incidentally to the main enquiry was published as Part I of the main report.* In 1963 a Committee of the National Joint Advisory Council was set up to study the information which was available about sick pay schemes, and much of the information obtained by the Ministry of Pensions and National Insurance Enquiry was included in their Report.†

16. The Ministry of Pensions and National Insurance Enquiry estimated that rather more than one-half of the employed population, i.e. some 13 million people then, were covered by occupational sick pay schemes. The following table gives some idea of the distribution.

Millions

	Public Sector		Private Sector		All
	Manuals	White Collar	Manuals	White Collar	
Total	2½	3	13½	3½	22½
Covered	2½	3	4½	3	13

The amount and period covered by these schemes varied widely. Some 70 per cent of men and nearly 90 per cent of women covered by sick pay arrangements were said to be entitled to receive "full pay" at the beginning of sickness. National Insurance benefit was usually deducted. 11·5 per cent of the men, mainly in the coal-mining industry, received £1 or more but less than £2. In a quarter of cases the period of payment was unknown but for about half the men covered it was between 9 and 26 weeks. It is likely that very few firms now provide sick pay at a level which takes no account of national insurance sickness benefit and because of this takes provision while sick above earnings while working.

17. Although the new survey is not on a strictly comparable basis, a comparison of the 1961/62 Survey with the results of the New Earnings Survey (part 5), April 1970,‡ suggests that there has been an increase in sick pay scheme coverage over the decade. An estimated 10 million men were covered by sick pay schemes in 1970, compared with 7·6 million men in 1961/62; the figures for women were 5·7 million in 1970 compared with a rough estimate of 4·5 million in 1961/62. The 1970 figures represent 72 per cent of all male, and 67 per cent of all female, employees. The coverage for non-manual workers is still significantly greater than that for manual workers (91·6 per cent of men, and 82·3 per cent of women, non-manual employees are covered, compared with 62·9 per cent of men, and 48·8 per cent of women, manual employees).

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* Report of an Enquiry into the Incidence of Incapacity for Work.
  Part I: Scope and characteristics of Employers' Sick Pay Schemes.

† Report on Sick Pay Schemes. Published 1964.

‡ Published in 1971 in the Department of Employment Gazette.

Sickness benefit costs and cost factors

18. There has been a persistent upward trend in sickness benefit costs. Recent figures suggest that this trend may have halted, but in view of the pronounced upward trend over earlier years, this halt is probably only temporary. In 1961/62 the cost of sickness benefit was £154½ million, in 1970/71 £386 million. The increase is very largely attributable to improvements in the benefit rates including the introduction of earnings-related supplements, but at constant benefit levels there would have been an increase in benefit expenditure of about 20 per cent over these 10 years. Size and age distribution of the insured population are relevant factors, and an increase in the proportion of male claimants has meant an increase in the cost per claim as more dependants are being paid for.

19. Demographic factors apart, the number of claims for sickness benefit has been rising in this country as elsewhere. In 1961/62 there were just over 9 million claims. In 1970/71 there were over 11½ million.

20. Unlike wages and salaries which do not take account of family size, sickness benefit provides substantially more generous benefits for a married man with children than for a single person. It is for the low paid man with a large family rather than the high paid single man that benefit tends to come nearest to earnings.

21. Analyses of figures produced in 1967 show that for some causes of incapacity a high proportion of beneficiaries were incapacitated for a year or more. Among the more common causes of incapacity with this feature were tuberculosis of the respiratory system 66 per cent; psychoneuroses and psychoses 60 per cent; and arthritis 52 per cent. With wasting diseases such as multiple sclerosis 85 per cent of cases had been incapacitated for over a year. Longer spells of sickness are, as might be expected, noticeably higher in the higher age groups (50+).

22. Various studies have indicated that substantial variations in the duration of illness can be found within a comparatively small area and among medically similar cases. One such study was carried out by Professor Donald Acheson, now Dean of the Medica School at Southampton, who conducted a Survey of men who in 1967 underwent abdominal operations in hospitals under the Oxford Regional Hospital Board. His findings were reported to a Symposium on Sickness Absence held in June 1968 at the London School of Hygiene and Tropical Medicine. Dr. Acheson looked at the dates of commencement of incapacity and the date of return to work; the dates on waiting lists for admission and discharge; the age, occupation and place of residence of the patient; the diagnosis and type of treatment; any characteristics of the General Practitioner and hospital; and employment status. He concluded that variations in the duration of illness could be attributed to the advice given by the General Practitioner and therefore presumably to his training and characteristics and to hospital administration and the type of treatment and advice given at the hospital. For example in some hospitals a patient was not permitted to return to work until after a follow-up appointment in the out-patient clinic, which could cause considerable delay.

Earnings while sick

23. National insurance sickness benefit is not normally paid in whole or in part to people who are capable of, or actually engaged in, remunerative employment. However, it has been recognised that some patients may need to undertake a small amount of therapeutic work as part of their treatment and rehabilitation. Accordingly if the work is therapeutic and has been approved by the doctor as being beneficial a person can normally have earnings of less than £2 without affecting his entitlement. Once earnings exceed this limit entitlement to benefit ceases.

24. Under the supplementary benefits scheme, the first £2 of the claimant's part-time earnings are not taken into account in assessing his entitlement to benefit. (His wife can also earn £2 without affecting their entitlement.) A sliding scale is applied to earnings over £2, so that for each £1 earned, the amount of benefit paid is reduced by a corresponding amount.

Sickness benefit provision during rehabilitation

25. As defined in the National Insurance Acts sickness benefit is a payment for insured people *when they are incapable of work through illness or disability*. Incapacity is related initially to the job which the claimant does normally; when sickness is prolonged, the incapacity test is related to incapacity for work in general—i.e. work for which an employer would pay. The present £2 earnings limit in the N.I. scheme is not an earnings rule in the accepted sense. It is simply a measure of what a person may be allowed to do by way of diversionary work while still being properly regarded as incapable of earning his living. Nor is it designed as an incentive to rehabilitation: it is probably more often of value to someone with long established static incapacity who can earn a little pocket money. A sliding scale earnings-rule would fundamentally alter the nature and scope of sickness benefit, and would tend to become a State subsidy for those who could not or, in some cases, would not earn a "normal" wage. Moreover it seems doubtful whether sickness or invalidity benefit could provide the sort of purpose-built incentives required of a rehabilitation payment. (Changes in the earnings-limit could have repercussions on unemployment benefit and supplementary benefit.) If a single man could earn say £4 in part-time earnings plus invalidity benefit of £6–£7, he might feel it was not worth working full-time. If earnings over £2 were offset against sickness benefit as they are under the supplementary benefits scheme, there would be little real incentive to start earning as financially the man would be no better off. Already a person receiving invalidity benefit may be better off than a disabled person in full-time work. With part-time earnings a sick person receives virtually £8 a week; if he is married £11·70 a week, and if as an invalidity pensioner he has a wife and 2 children, £17·60 to £18·60 with family allowances. Moreover he is automatically credited with contributions for pension purposes and is not liable for tax. On the other hand, a disabled person in full-time work, particularly one with a family, may earn less, and in any case his earnings will be taxable and he will be liable for Class 1 contributions, currently 88p (£1 for contracted-out employees). Although the new Family Income Supplement for low-income families with one child or more where the bread-winner is in full-time work may provide additional income in some cases.

26. The Committee will be aware of the respective responsibilities of the Department of Employment and the Department of Health and Social Security for rehabilitation. The Department of Employment pay their own allowances. Few of those undergoing medical rehabilitation earn as much as £2 a week, and earnings tend to be at a very low level even where the absence of benefit entitlement, e.g. for the congenitally disabled—avoids any "restriction" from this direction. Nevertheless, the £2 earnings limit is not, of course, necessarily fixed for ever in money terms.

Partial certification

27. For national insurance sickness benefit purposes, a medical certificate is normally required as evidence of incapacity. Medical certification in its present form is unpopular with many General Practitioners, who hold that they are not always in a position to judge whether a patient can do his job. Certification of partial incapacity would present far greater difficulties. It could lead to premature return to work, even though the work was limited in extent, with a consequent relapse in health. Assessment of the extent of a person's recovery would be difficult as would the timing of any changes in assessment as his recovery continued. Provision for people who may be fit for part-time work but

not yet ready to return to full-time work was considered in the Piercy Committee's Report of 1956. The T.U.C. and C.B.I. gave evidence to the Committee and among other things were not in favour of the suggestion that firms should take back their disabled workers on a part-time basis if some inducement were offered in the form of continuing payment of sickness benefit proportionate to the reduced hours of working.

28. In those countries where invalidity pension does take account of partial incapacity, the pension tends to be paid only to those whose incapacity is relatively stable. Thus it is designed more as a compensatory payment, on the lines of the pensions paid in this country under the Industrial Injuries and War Pensions schemes, than as a benefit specifically designed to encourage the gradual process of rehabilitation.

Conclusion

29. Cash benefits have grown up alongside the range of measures available to assist rehabilitation. Clearly, the better the financial provision made for someone who is sick or disabled and unable to work, the less financial incentive there is for him to return to work. Cash is, of course, by no means the only relevant factor; nor are benefit levels such that the average earner with normal commitments will find benefit preferable to earnings. There is interaction in the other direction too. The better and the more readily available rehabilitation facilities are, the easier it is for someone to resume work and cease to draw benefit. The interaction of cash benefits and rehabilitation is seen at its most fruitful where a firm is able to provide both its own sick pay scheme—taking account of the State provision and supervised by its own personnel and welfare section —and also facilities to enable an employee to return to work in a controlled environment adapted where necessary to his medical needs.

30. The rules of the National Insurance Scheme and its administration are as flexible as the need for justice as between claimants and the scale of operations allow; but sickness benefit and invalidity benefit are not designed to be used as an instrument in rehabilitation, but as a protection for the insured person unable to work.

APPENDIX X

NATIONAL INSURANCE CONTRIBUTION CREDITS FOR PEOPLE UNDERGOING REHABILITATION

Incapacity credits

1. A person who satisfies certain contribution conditions (meaning broadly that he has had a recent record of employment or self-employment) can usually be credited with a contribution for each complete week (Monday to Saturday) throughout which he is certified to be incapable of work. A credit is automatically given for each complete week of sickness benefit (or industrial injury benefit) and conversely incapacity credits are not given if sickness benefit ceases because weekly earnings from therapeutic or diversionary work go above the £2 disregard. These incapacity credits are the equivalent of employed or self-employed contributions, and so count towards both long-term and short-term benefits.

Training credits

2. A person who is undergoing full-time training at a course approved by the Secretary of State—that is a course of vocational, technical, rehabilitative or like character—is excepted from liability to pay contributions and may be credited with a contribution, broadly of the class normally paid by the trainee—

(*a*) unconditionally for any week before he reaches the age of 18 and

(*b*) for any week after the age of 18 if

(i) the training was not, at the commencement, intended to last more than one year or, where the training is provided under the Disabled Persons (Employment) Act, such longer period as the Secretary of State may allow;

(ii) at least 104 Class 1 (employed) or (self-employed) contributions have been paid by or credited to the trainee in the three years (disregarding any period of full-time education) before the course began. (This test can be waived in exceptional circumstances, e.g. where disability occurs early in employment and the person concerned has made an effective entry into employment.)

(iii) the Secretary of State is satisfied that if the trainee had not taken the course he would have become or remained unemployed.

I.R.U.s and vocational training centres

3. Trainees attending industrial rehabilitation units and centres for the vocational training of the disabled are accepted as satisfying the conditions in paragraph 2 and training credits are given under en bloc arrangements.

Industrial therapy organisations

4. When an I.T.O. or similar organisation not under the direct control of the Department of Employment, e.g. the Maudsley Hospital Workshop or Re Instate Ltd. at Bexley Hospital is set up, it is examined sympathetically and, if the essential criteria are satisfied, is designated as an establishment providing approved training. The position of each trainee is considered individually. Some in the early stages of rehabilitation will still be drawing sickness benefit—if so they will get *incapacity credits*. When earnings reach £2 a week and sickness benefit ceases the trainee can qualify for

training credits if the conditions in paragraph 2 are regarded as satisfied. Training credits are given for the duration of the course or for one year if that is shorter. If training credits cannot be awarded or cease after one year the person concerned is, while still under training, excepted from liability to pay contributions but may, if he wishes, pay contributions at the class 3 (non-employed) rate. These contributions can be paid at any time up to the end of the sixth contribution year after the year in which the course ends.

Sheltered employment

5. Wage paid workers in Remploy factories or sheltered workshops are liable, for Class 1 contributions just like any workers in open employment.

6. People receiving training in sheltered workshops can sometimes receive training credits.

Mentally and physically handicapped

7. Young people attending schools and institutions approved by the Department of Education and Science under the Handicapped Pupils and Special Schools Regulations 1959 (or the equivalent in Scotland) who are

(*a*) under 18, receive credits automatically

(*b*) between 18 and 21, are treated as under full-time training at a course approved by the Secretary of State and training credits awarded.

(*c*) over 21, Department of Employment assume responsibility for continued training under the Disabled Persons (Employment) Act and training credits are given under the en bloc arrangements in paragraph 3. (These will be credits at the non-employed rate if the young person has not established himself beforehand as an employed or self-employed person. They will preserve title to long-term benefits.)

8. People attending adult training centres set up by local authorities receive "incentive" payments which are kept below the £2 earnings disregard for supplementary benefit (or sickness benefit where exceptionally this is payable). Few would have title to sickness benefit but in the exceptional cases where sickness benefit is payable *incapacity* credits would be given. Otherwise *training credits* are given up to the age of 18 and after that there is exception from liability to pay contributions. These are severely handicapped people who are really unemployable and attend the centres for purposes of social and occupational therapy rather than for any organised or purposive training for future employment. They are thus distinguishable from the people described in previous paragraphs who can qualify for training credits.

Other rehabilitation services

9. Hospital in-patients or out-patients undergoing rehabilitation in occupational therapy units or workshops may be "rewarded" for any work they do as part of their treatment. If exceptionally the rewards amounted to £2 a week or more any sickness benefit to which the person concerned is entitled would cease and so would the *incapacity credits* that go with it. Some patients would progress to organised training courses and be considered for credits as in paragraphs 3, 4 or 6.

10. Young people admitted to psychiatric hospitals before reaching school-leaving age are treated as receiving full-time education or rehabilitative training. They are entitled to credits from the date of entry into insurance until the age of 18 and after that are excepted from liability to pay contributions so long as they are patients in (or on leave from) the hospital and are non-employed.

APPENDIX XI

Report on a survey of rehabilitation arrangements in large hospitals—September 1969 by the Statistical Branch of the Department of Health and Social Security.

Introduction

1. On 27th August 1969 a questionnaire (form SBH 161) was sent to secretaries of Boards of Governors and Hospital Management Committees for completion by hospitals with 200 or more total allocated beds. The questionnaire was designed to obtain factual information about the present rehabilitation arrangements in large hospitals and was undertaken on the behalf of the Standing Medical Advisory Committee's Sub-Committee on Rehabilitation. A copy of this questionnaire is given below.

SBH 161

Department of Health and Social Security
Rehabilitation

NOTES

1. Hospitals concerned in this enquiry. The questionnaire should be completed by hospital secretaries of hospitals with 200 or more allocated beds.

2. Layout of the questionnaire. This form is designed so that the questions may be answered as far as possible by a figure, or a tick, in the box provided.

Name of Board of Governors or
Hospital Management Committee..

Name of Hospital..

Address.. ....

Number of staffed beds allocated at 30 June 1969 [ ]

Type of hospital (SH3 classification) [ ]

QUESTION 1

(*a*) Is one person responsible for the organisation of medical rehabilitation?

Yes	No

(*b*) If one person is responsible, is the appointment held, one of:

Consultant	
Other medical member of staff	
Non-medical member of staff	

(*c*) If a consultant is responsible

What is his speciality?	
How many sessions per week does he give to rehabilitation?	

QUESTION 2

(*a*) Have you either a resettlement clinic, a case conference committee on rehabilitation and/or resettlement, or a medical interviewing committee for assessment of disability?

Yes	No

(*b*) How many times did it meet in the 6 months to 30 June 1969?

(*c*) How many patients were discussed at the last meeting in that period?

(*d*) Who attends the clinic/committee (tick appropriate column and add others who attend):

	Regularly	Occasionally for special purpose	Never
Clinician responsible for the patient			
Clinician responsible for rehabilitation			
Patient's general practitioner			
Disablement resettlement officer			
Psychiatric social worker			
Medical social worker			
Psychiatrist			
Officer of the local health authority			

General

2. Replies to the questionnaire were received from 596 hospitals. This represents an extremely high rate of response; there were 622 hospitals with 200 or more beds on 30th June 1969.

3. The breakdown by type of hospital was as follows:

Type of Hospital	*Number of hospitals*
Acute	147
Mainly acute	79
Partly acute	36
Mainly long-Stay	22
Long-stay	24
Chronic	11
Rehabilitation	1
Isolation	1
Maternity	2
Psychiatric—mental illness	106

Type of Hospital	*Number of hospitals*
Psychiatric—Mental Subnormality	73
Orthopaedic	6
Tuberculosis and Chest	10
Tuberculosis, Chest and Isolation	2
Children's Acute	3
Others	27
Teaching Hospitals	46
Total	596

Summary

4. Thirty-five per cent of hospitals had one person responsible for medical rehabilitation and 32 per cent held resettlement clinics or their equivalent.

5. Eighty-two out of the 181 consultants responsible for rehabilitation were consultants in physical medicine and/or rheumatology and a further 65 (in mental illness and subnormality hospitals) were psychiatrists. Teaching hospitals had a greater proportion of hospitals with one person responsible for rehabilitation than did non-teaching hospitals. The number of sessions per week given to rehabilitation by the consultant in charge was very variable, from less than one to eleven sessions. The majority ranged from one to four sessions.

6. The proportion of teaching hospitals with resettlement clinics was similar to that for non-teaching hospitals. The psychiatric hospitals had a high proportion of hospitals with clinics. Short-stay hospitals tended to hold more frequent meetings of their clinics than long-stay hospitals, but the number of patients discussed at the last meeting was extremely variable and did not appear to follow any pattern.

7. There were broad differences between the regions, i.e. Sheffield and North West Metropolitan had proportionately more hospitals with a consultant in charge of medical rehabilitation and/or with resettlement clinics, and Liverpool and Birmingham had a smaller proportion of such hospitals, (based on acute and psychiatric hospitals).

Responsibility for rehabilitation

8. In 388 hospitals (65 per cent) there was no one person responsible for the organisation of medical rehabilitation. In the 208 hospitals (35 per cent) where there was a single person in charge of rehabilitation the appointments concerned were as follows:

Appointment	*No of hospitals*	
Consultant	181	87%
Other medical member of staff	8	4%
Non-medical member of staff	19	9%
	208	100%

9. The proportion of hospitals with a single person in charge of medical rehabilitation varied between the types of hospital. Psychiatric-mental subnormality hospitals (53 per cent), teaching hospitals (48 per cent), and "other" hospitals (41 per cent) had a high proportion, and long-stay hospitals (17 per cent) had a low proportion.

Specialty of consultant in charge of rehabilitation

10. In the 181 hospitals where a consultant was responsible for the organisation of medical rehabilitation, the pattern between types of hospital was quite varied; in acute hospitals and mainly acute hospitals 52 out of the 60 consultants specialised in either "Physical Medicine" or "Physical Medicine and Rheumatology". In many cases the specialty of the consultant in charge was related to the main function of the hospital as shown below:

In mainly long-stay, long-stay and chronic sick hospitals for 8 out of 12 consultants the specialty was "Geriatrics". In the single isolation hospital the specialty was "Infectious Diseases" and in the single rehabilitation hospital the specialty was "Physical Medicine". In the psychiatric hospitals all 26 mental illness hospitals gave the specialty of the consultant in charge as "Mental Illness", and similarly the 37 mental subnormality hospitals gave "Mental Subnormality" as the specialty of the consultant. The 3 tuberculosis and chest hospitals all gave "Diseases of the Chest" as the specialty of the consultant in charge. In teaching hospitals out of the 19 consultants, 16 gave their specialty as "Physical Medicine", "Physical Medicine and Rheumatology", or "Rheumatology".

Sessions per week given to rehabilitation

11. Fifty-three out of 181 hospitals could not give a definite number of sessions per week devoted to rehabilitation by the consultant in charge. The distribution of the remaining 128 was as follows:

No of sessions per week	*No of consultants*
Less than one	19
One	28
Two	21
Three	19
Four	14
Five	4
Six	2
Seven	4
Full time	17
Total	128

12. The number of sessions given to rehabilitation did not appear to be related to the size of the hospital. Comparison of the types of hospital showed that there was a high proportion of consultants in psychiatric subnormality hospitals who devote all their time to rehabilitation, 8 out of 37 (22 per cent) compared with 9 out of 144 (6 per cent) in all other hospitals.

13. Because of the irregular distribution it is difficult to quote an average value. The mode (the most popular value) was one session, the median (that value that has half the results above it and half the results below it) was 1·8 sessions and the arithmetic mean was 3·4 sessions. For those consultants who do not work full time on rehabilitation the median becomes 1·4 sessions and the arithmetic mean becomes 2·3 sessions, the mode is unchanged.

Resettlement clinics

14. One hundred and ninety-four out of the 596 hospitals (33 per cent) held a resettlement clinic or its equivalent. There was some variation between the different types of hospital; the psychiatric hospitals having a high proportion of hospitals with

clinics (mental illness 51 per cent, mental subnormality 44 per cent), and the mainly long-stay hospitals had a low proportion of hospitals with clinics (9 per cent).

15. The most popular frequencies of meetings of these clinics in the six months to 30th June 1969 were once a month, once a fortnight, and once a week, but 17 hospitals who said they had a resettlement clinic reported that there was no meeting of the clinic in the six month period, and 19 gave no information.

16. The short-stay hospitals tended to have less frequent meetings of their clinics, i.e. for the 57 acute and mainly acute hospitals, 27 clinics (47 per cent) met less frequently than once a month, and 22 clinics (39 per cent) met more frequently than once a month. The longer-stay hospitals tended to have more frequent meetings of their clinics, i.e. for the 86 long-stay, chronic sick, psychiatric—mental illness and psychiatric/subnormality hospitals 14 clinics (16 per cent) met less frequently than once a month, and 64 clinics (74 per cent) met more frequently than once a month.

Number of patients discussed at resettlement clinics

17. One hundred and fifty-three hospitals gave information on the number of patients discussed at resettlement clinics. The most frequent number of patients discussed was four, but there was a large range. One psychiatric-mental Illness hospital discussed no patients, 12 clinics discussed only one patient, whilst 5 clinics discussed more than 30 patients. There appears to be little difference in the pattern between the various types of hospital apart from a tendency of long-stay and chronic sick hospitals to discuss comparatively large numbers of patients at their clinics.

Constitution of resettlement clinics

18. The main types and numbers of people who attend these clinics were as follows:

	No of regular attenders	*No of regular plus occasional attenders*
Clinician responsible for patient	113	155
Clinician responsible for rehabilitation	111	116
Medical social worker	92	107
Disablement resettlement officer	85	132
Psychiatric social worker	76	96
Psychiatrist	69	91
Officer of the local health authority	55	118
Patient's general practitioner	6	46

One hundred and ninety-four clinics gave information about attendances.

19. There was duplication of function in some clinics, i.e. in some clinics the psychiatrist was also the clinician responsible for the patient, and in 4 clinics the psychiatrist was also the clinician responsible for rehabilitation.

20. The most noticeable feature of the table above is the minor role played by the patient's general practitioner at meetings of resettlement clincs. The type of officer attending clinics varied according to the type of hospital, i.e. the disablement resettlement officer was a regular attender at most clinics in acute hospitals but at only one clinic in a psychiatric-mental subnormality hospital.

21. The most numerous of the other types of officer who attend regularly at meetings of resettlement clinics were:

	No of clinics
Occupational therapist	51
Physiotherapist	31
Ward sister/charge nurse/senior nurse	25
Other nurses	19
Other medical staff	11

Comments by participating hospitals

22. There was a certain amount of correspondence with hospitals as a result of the questionnaire, the points most frequently raised were:

(i) a large amount of rehabilitation takes place in smaller hospitals, and where rehabilitation is treated as a group function, the larger hospitals often used a smaller, more specialist hospital for their rehabilitation function, and these large hospitals were concerned that their nil return would imply that the hospital did not have adequate rehabilitation facilities for its patients.

(ii) Many hospitals had different rehabilitation arrangements for different types of patients, e.g. psychiatric, geriatric and orthopaedic, and, because they had no single person in charge of rehabilitation these hospitals were concerned that the impression might be given that they did not pay due regard to rehabilitation.

(iii) Some hospitals pointed out that although they held regular case conferences at which all aspects of the patient's well being (including rehabilitation) were discussed they did not hold case conferences at which only rehabilitation aspects were considered.

23. Much of this correspondence appears to have arisen because hospitals considered the survey as an enquiry into rehabilitation arrangements in general whilst the survey was designed to elicit factual information about two aspects of the organisation of rehabilitation services which had been suggested to the Committee as being of importance. Some hospitals appeared to be concerned that because they had different arrangements it might be thought that they did not have adequate arrangements for rehabilitation.

APPENDIX XII

N.H.S. CONSULTANTS IN PHYSICAL MEDICINE AND RHEUMATOLOGY*

England and Wales

	1949	1952	1956	1960	1963	1966	1970	1971 to 30/6
London Teaching Hospitals								
Undergraduate and Postgraduate	14	14	15	16	16	18	24	26
Metropolitan Regions								
North West	9	12	13	12	16	18	20	21
South West	4	5	6	6	7	6	8	8
North East	2	7	7	11	13	14	19	19
South East	5	7	8	9	13	13	15	15
Provincial Regions								
Newcastle	—	1	2	3	5	5	8	8
Leeds	—	—	—	—	—	—	—	—
Sheffield	—	—	1	2	3	5	6	6
East Anglia	1	1	1	1	1	2	3	4
Oxford	1	3	4	5	6	8	8	8
South Western	—	—	—	—	—	—	—	—
Welsh	1	1	1	1	1	1	2	3
Birmingham	1	1	1	1	1	1	1	1
Manchester	1	2	1	1	1	1	2	3
Liverpool	—	—	—	—	—	—	—	—
Wessex	5	6	6	8	8	8	9	9
Total	44	60	66	76	91	100	127	131

This table shows the number of individual persons holding consultant posts in the combined specialty of physical medicine and rheumatology at National Health Service hospitals in England and Wales. A substantial proportion of consultants on the staff of teaching hospitals also work in non-teaching hospitals which are not necessarily in the same region, especially in the metropolitan area where they have been counted only under the heading of teaching hospitals. Hence the actual number of consultants working at non-teaching hospitals in the metropolitan regions is higher and the full-time equivalent number of consultants in the teaching hospitals is lower than shown on the table.

In addition there are about 10 clinicians holding consultant posts as general physicians with special interest in rheumatology whose training included a period as registrars in a department of physical medicine and rheumatology, and who are responsible for the management of the medical rehabilitation services at one or more of the hospitals in which they work.

* The figures exclude consultants in rheumatology only.

APPENDIX XIII
SICKNESS BENEFIT STATISTICS

Great Britain
Duration of incapacity up to 3 months in the period 6th June 1966–3rd June 1967

	Units	Males								Females							
		All spells in the year	Spells lasting							All spells in the year	Spells lasting						
			Less than 4 days	4 to 6 days	7 to 12 days	13 to 18 days	19 to 24 days	25 to 48 days	49 to 78 days		Less than 4 days	4 to 6 days	7 to 12 days	13 to 18 days	19 to 24 days	25 to 48 days	49 to 78 days
Mental, Psychoneurotic, and personality disorders																	
Psychoneuroses and psychoses	Number	181260	4340	22960	38420	29640	17100	32680	14160	99520	1800	11140	22120	16980	9240	17800	7300
	Per cent	100	2	13	21	16	9	18	8	100	2	11	22	17	9	18	7
Psychoses	Number	14300	360	700	1500	1100	1180	2440	1900	5740	160	340	520	260	280	800	420
	Per cent	100	3	5	10	8	8	17	13	100	3	6	9	5	5	14	7
Anxiety reaction without mention of somatic symptoms	Number	48660	1180	6600	11400	8180	4880	9020	3760	25760	540	3280	6140	4620	2540	4420	1580
	Per cent	100	2	14	23	17	10	19	8	100	2	13	24	18	10	17	6
Other psychoneurotic disorders	Number	118300	2800	15660	25520	20360	11040	21220	8500	68020	1100	7520	15460	12100	6420	12580	5300
	Per cent	100	2	13	22	17	9	18	7	100	2	11	23	18	9	18	8
*Disorders of character, behaviour and intelligence	Number	2660	40	240	300	260	160	480	420	440	20	40	60	60	—	20	120
	Per cent	100	2	9	11	10	6	18	16	100	5	9	14	14	—	5	27
Diseases of the nervous system and sense organs:																	
Vascular lesions affecting central nervous system	Number	7180	40	280	520	360	140	880	760	560	—	20	100	20	20	—	—
	Per cent	100	1	4	7	5	2	12	11	100	—	4	18	4	4	—	—
*Multiple sclerosis	Number	1680	40	100	120	240	100	260	180	680	—	80	20	80	60	80	40
	Per cent	100	2	6	7	14	6	15	11	100	—	12	3	12	9	12	6
*Paralysis agitans	Number	1340	—	100	80	160	60	180	80	220	—	—	20	20	—	—	—
	Per cent	100	—	7	6	12	4	13	6	100	—	—	9	9	—	—	—
*Cerebral paralysis	Number	5500	20	220	480	260	160	540	700	840	20	60	60	40	20	60	60
	Per cent	100	—	4	9	5	3	10	13	100	2	7	7	5	2	7	7
*Epilepsy	Number	8040	440	1100	1520	980	520	1340	680	3140	100	240	600	340	260	440	300
	Per cent	100	5	14	19	12	6	17	8	100	3	8	19	11	8	14	10
*Migraine	Number	15780	2420	4280	4320	2260	1100	980	240	9840	740	3100	2960	1400	380	880	240
	Per cent	100	15	27	27	14	7	6	2	100	8	32	30	14	4	9	2
*Other diseases of central nervous system	Number	3820	—	140	320	420	280	680	600	940	40	80	80	120	120	120	120
	Per cent	100	—	4	8	11	7	18	16	100	4	9	9	13	13	13	13
*Sciatica	Number	44760	820	4620	9720	8580	5160	9460	3540	6480	140	780	1400	1360	620	1260	380
	Per cent	100	2	10	22	19	12	21	8	100	2	12	22	21	10	19	6
*Other diseases of nerves and peripheral ganglia	Number	22740	1300	360	5120	3680	2420	4020	1300	8100	380	1340	1700	1420	680	1580	400
	Per cent	100	6	16	23	16	11	18	6	100	5	17	21	18	8	20	5
Diseases of the respiratory system:																	
Bronchitis	Number	620700	16100	86800	168280	129680	65220	87760	27300	124640	2900	22260	38740	26520	11500	14180	368
	Per cent	100	3	14	27	21	11	14	4	100	2	18	31	21	9	11	30

Diseases of the digestive system:																	
Diseases of stomach and duodenum, except cancer	Number	459500	34560	98400	118900	75100	35120	56020	21260	104800	6080	30720	31400	14400	6540	9780	3080
	Per cent	100	8	21	26	16	8	12	5	100	6	29	30	14	6	9	3
Ulcer of stomach	Number	58160	1320	6120	10580	10340	6160	11720	5700	3340	60	320	740	540	300	560	380
	Per cent	100	2	11	18	18	11	20	10	100	2	10	22	16	9	17	11
Ulcer of duodenum	Number	45900	1520	4800	8300	7680	4540	9600	5160	3040	60	340	480	520	240	640	360
	Per cent	100	3	10	18	17	10	21	11	100	2	11	16	17	8	21	12
Gastritis and duodenitis	Number	239740	23780	63100	70180	38980	15820	20510	4180	70940	4560	23700	22700	9100	3940	5180	1060
	Per cent	100	10	26	29	16	7	9	2	100	6	33	32	13	6	7	1
Other diseases of stomach and duodenum, except cancer	Number	115700	7940	24380	29840	18100	8600	14160	6220	27480	1400	6360	7480	4240	2060	3400	1280
	Per cent	100	7	21	26	16	7	12	5	100	5	23	27	15	7	12	5
Accidents, poisonings and violence (nature of injury)																	
Accidents, poisonings, and violence (nature of injury)	Number	798680	36240	147260	224940	139320	71220	103180	35960	142140	5460	29200	40180	22580	12200	18420	7180
	Per cent	100	5	18	28	17	9	13	5	100	4	21	28	16	9	13	5
Fracture of skull, spine and trunk	Number	15320	160	920	1920	2320	1740	4240	1920	1880	20	120	240	200	220	440	360
	Per cent	100	1	6	13	15	11	28	13	100	1	6	13	11	12	23	19
Fracture of upper limb	Number	29240	320	860	2560	3140	4280	11120	4640	6120	—	260	560	520	800	2000	1220
	Per cent	100	1	3	9	11	15	38	16	100	—	4	9	8	13	33	20
Fracture of lower lmb	Number	35320	240	940	2080	2520	2460	7380	6020	5620	20	180	440	340	340	1400	900
	Per cent	100	1	3	6	7	7	21	17	100	—	3	8	6	6	25	16
Dislocation without fracture	Number	5620	80	400	740	620	780	1640	700	820	—	40	120	100	100	220	160
	Per cent	100	1	7	13	11	14	29	12	100	—	5	15	12	12	27	20
Sprains and strains of joints and adjacent muscles	Number	265360	13740	58840	83480	51820	21840	24780	6180	42080	1660	9920	12700	7520	3300	4660	1240
	Per cent	100	5	22	31	20	8	9	2	100	4	24	30	18	8	11	3
Head injury (excluding skull fracture)	Number	34440	1000	5680	10760	5760	3460	4280	1580	7320	200	1360	2100	1200	740	1120	320
	Per cent	100	3	16	31	17	10	12	5	100	3	19	29	17	10	15	4
Laceration and open wound of face, neck and trunk	Number	4740	220	880	1780	700	420	440	100	740	20	180	320	100	60	40	20
	Per cent	100	5	19	38	15	9	9	2	100	3	24	43	14	8	5	3
Laceration and open wound of upper limb	Number	16920	400	2780	6380	3740	1400	1520	420	2600	100	600	1020	360	220	160	80
	Per cent	100	2	16	38	22	8	9	2	100	4	23	39	14	8	6	3
Laceration and open wound of lower limb	Number	9000	260	1840	3060	1600	760	960	360	2280	40	360	520	440	260	420	100
	Per cent	100	3	20	34	18	8	11	4	100	2	16	23	19	11	18	4
Laceration and open wounds of multiple location	Number	3280	300	700	1020	560	280	320	80	820	—	160	220	160	120	140	20
	Per cent	100	9	21	31	17	9	10	2	100	—	20	27	20	15	17	2
Contusion and crushing with intact skin surface	Number	42300	3360	11180	13200	6640	2980	3580	560	8280	560	2560	2660	1100	620	520	200
	Per cent	100	8	26	31	16	7	8	1	100	7	31	32	13	7	6	2
Foreign body in eye and adnexa	Number	2360	480	740	660	200	160	60	40	20	—	—	20	—	—	—	—
	Per cent	100	20	31	28	8	7	3	2	100	—	—	100	—	—	—	—
Burns	Number	13020	440	2440	3680	2360	1380	1760	480	4940	200	1000	1780	900	340	440	120
	Per cent	100	3	19	28	18	11	14	4	100	4	20	36	18	7	9	2
Injury of other and unspecified nature	Number	321760	15240	59060	93620	57340	29280	41100	12880	58620	2640	12460	17480	9620	5080	6860	2440
	Per cent	100	5	18	29	18	9	13	4	100	5	21	30	16	9	12	4
Contacts with infectious diseases(b)	Number	400	20	60	120	120	40	20	20	200	—	20	100	40	—	40	—
	Per cent	100	5	15	30	30	10	5	5	100	—	10	50	20	—	20	—

* Part of the residual Group C 49 (Other specified and ill-defined diseases).
(*a*) Persons who were not sick but who were excluded from work.

APPENDIX XIV

THE PURPOSE AND ORGANISATION OF THE ASSESSMENT CLINIC
(Chapter 6 paragraphs 132–139)

1. The purpose of assessment clinics would be:

(*a*) to advise clinicians on the immediate and likely future rehabilitation requirements of their referred patients;

(*b*) to advise disablement resettlement officers on patients' future employment potential and whether they might need industrial rehabilitation or Remploy employment;

(*c*) to provide assessment and medical reports in confidence which should accompany forms DP1 referring patients for industrial rehabilitation. It is essential that where a patient is referred from a hospital the Department of Employment will accept these reports in place of the existing methods of medical assessments to save time in waiting for a place in an industrial rehabilitation unit;

(*d*) to provide local authorities well in advance of a patient's discharge with precise information on his likely need for the various community services, i.e. special residential accommodation, day centre, home adaptations, nursing aids, home help, district nurse, etc. The assessment clinic would also discuss the reports on domiciliary assessment visits to patients' homes made by remedial staff;

(*e*) the secretary should keep the general practitioner informed on his patient's progress and needs.

(*f*) it should be the duty of the assessment clinic secretary to keep a record of the clinic's recommendations and to write to any absent member giving details of the recommendations on patients in whom the member has an interest.

(*g*) the secretary of the assessment clinic could act on his or her own initiative with the co-operation of the medical social work department and subject to the approval of the chairman of the clinic, in minor cases needing referral to local authority services. This would, however, in no way relieve clinicians and others of their responsibilities in ensuring that proper discharge arrangements are made for the majority of patients who require some after-care but have not been referred to the assessment clinic.

2. Membership of the assessment clinic would of necessity vary according to the cases and, to avoid the waste of members' time, a certain amount of change-over between cases would be inevitable. Besides the rehabilitation consultant as chairman and a member of his staff as secretary, a consultant psychiatrist should attend as required to give advice or a report if necessary.

3. The following should be regular members of the clinic who could meet together on a separate occasion to review the progress of all assessment cases and select those to be discussed at future clinics:

Head occupational therapist
Superintendent physiotherapist and/or head remedial gymnast
Social worker

4. The following would attend discussions on individual cases in which they had an interest:

The clinician in charge of the case (or deputy)
Clinical psychologist with some knowledge of vocational psychology
The appropriate nursing officer
The speech therapist
The patient's general practitioner (or a member of his team)
A social worker from the patient's home area
The disablement resettlement officer for the patient's home area
A responsible relative of the patient

5. Referral of adult patients to the assessment clinic (provision for children is discussed in Chapter 7) could be made by any clinician of the hospital or of other hospitals where the necessary facilities did not exist; by general practitioners; and by doctors in the industrial medical service. It would be open to members of the remedial professions and the social work department to suggest cases which they thought might be considered by the assessment clinic, subject to the consultant's approval. Referrals of new patients for assessment could also be made by the disablement resettlement officer and by local authority social workers direct to the rehabilitation consultant who could accept them under his clinical care for record and examination purposes. General practitioners, disablement resettlement officers and social workers could refer back to the assessment clinic patients whom they considered needed re-assessment because of their unsatisfactory progress at work or in the industrial and community services.

APPENDIX XV

REPORT OF A CONFERENCE ON REHABILITATION AFTER HEAD INJURY HELD AT ALEXANDER FLEMING HOUSE ON 11 OCTOBER 1968

Those present:

Mr. J. S. Pennybacker (in the chair)
Dr. F. S. Cooksey
Dr. H. I. Glanville
Professor W. B. Jennett
Mr. W. S. Lewin
Mr. P. S. London
Mr. J. M. Potter
Mr. A. E. Richardson
Professor W. Ritchie Russell
Dr. I. Sutherland
Professor W. H. Trethowan
Dr. C. K. Westropp
Dr. M. I. P. Wilkinson
Representatives of the Department of Health and Social Security
Representative of the Scottish Home and Health Department
Representative of the Ministry of Health and Social Services, Northern Ireland.

1. The terms of reference of the conference were to consider the needs of specialised rehabilitation after head injury, the extent to which this is being met and to make recommendations. This is only part of the wider problem of rehabilitation in general which is at present being considered by a sub-committee of the Standing Medical Advisory Committee. It is hoped that the conclusions and recommendations of this conference will be put to this sub-committee.

2. Although there are similarities between the effects of head injury and neurological disease, after head injury the damage is maximal at or shortly after the time of injury, whereas with neurological disease it is usual to expect progression.

3. Three major groups can be defined, all with different needs.

Group 1—Severe

4. These patients (probably about 400 per year) suffer prolonged unconsciousness. The problem is largely one of where to care for them. They need acute services but tend to block acute beds.

5. Special hospitals for this type of patient create many problems (for instance staffing difficulties and relatives' emotions) and are probably impracticable. On the other hand, wards designed for the care of the younger chronic sick, two-thirds of whom are suffering from neurological disease, might be a suitable place to accommodate them. Wards or units of this type are being established in district general hospitals where facilities for rehabilitation and neurosurgical treatment can be made available.

6. There is no firm dividing line between this group and the next, so that these units will have to have the necessary facilities to deal with both cases that will not recover and those that will. It may be difficult to accommodate dying patients with those

undergoing rehabilitation, but it is possible that some degree of progressive patient care could be introduced into these units to deal with the recovering case.

Group 2—Intermediate

7. This group, probably amounting to 7,500 plus per year, can conveniently be classified as those who suffer a major head injury and have a period of amnesia of one day or more.

8. Eighty per cent or more of this group can be expected to recover and ultimately return to work if necessary facilities are available. Failure has occurred because these patients are discharged from an acute hospital and, except in a few areas, there are no suitable places for them. They might be discharged home with inadequate follow-up and considerable interruption in treatment; similarly it is often inappropriate for them to go straight from an acute bed to a rehabilitation centre. Rehabilitation must be a graded process and, after initial assessment, each patient must be placed on a specific programme which gives him the best chance of rapid recovery and also makes the best use of expensive facilities. There must be provision for places somewhere for patients for whom the time is not right for intensive rehabilitation.

Group 3—Minor

9. This is by far the largest and perhaps the most important group. All should make 100 per cent recovery. Only simple treatment is necessary for this group but it must be carefully supervised over a number of weeks and it should be made easy to bring these patients quickly into a rehabilitation centre or department, either as out-patients or for short periods as in-patients. Good initial assessment is necessary but the experience required to give this can be acquired quite quickly. However, recovery of many of this group of minor head injuries may be delayed for many weeks, often due to lack of guidance to general practitioners in the management of post-concussion syndrome. The majority of these patients are treated by general and orthopaedic surgeons and it is important that those whose progress is not rapid and straightforward should be referred for expert advice.

10. An important aspect of the problem is how the rehabilitation of these patients can be carried out efficiently, under medical supervision, near their own homes, although with modern transport distance becomes less important. One solution is that these patients should be treated in the physical medicine department of district general hospitals, although this might present difficulties.

11. A large number of patients who should be quickly rehabilitated are delayed, but this could be avoided by improving the facilities and enlarging where necessary the district general hospital departments. Regional centres specialising in head injury rehabilitation tend to get choked by a relatively small number of severe cases; they should be used more as referral centres with whom the district general hospital should maintain close links. It is essential to maintain continuity of treatment for these patients over as long a period as is necessary and there are advantages in one person, possibly the surgeon who first treats the patient, seeing them for regular follow-up and review.

12. Severely injured patients may require treatment in rehabilitation departments for periods up to four years and every department should be prepared to accept a small number of such patients. It is essential that if these services are to be provided in district general hospitals adequate facilities should be available.

13. The re-employment of severely disabled patients presents considerable difficulty and workshops should be set up in association with more rehabilitation departments. Such workshops are already in existence at Odstock and in Birmingham and they

serve to bridge the gap between hospital and I.R.U. or between hospital and return to the community.

14. Psychiatrists have an important part to play in the treatment of these patients and rehabilitation centres and departments should be able to call on their services where necessary. Where possible a psychiatrist should watch the progress of all cases and decide himself when treatment is necessary. Some patients who become aggressive may require psychiatric accommodation but, in units where isolation facilities are available, this can sometimes be avoided. Drug therapy can play an important part in controlling aggressive symptoms. Where psychiatric accommodation is used there may be advantages in concentrating it in a small number of hospitals in each region. It may be possible for some of these patients in psychiatric accommodation to attend rehabilitation departments during the day.

15. The problem of follow-up of cases is extremely important, especially for minor head injuries, and some mechanism is required to ensure that all patients receive adequate follow-up to the point where they become fully rehabilitated. Large central or regional bureaux or registers might be difficult to organise and this could probably be done by each department or centre maintaining its own register, possibly supervised by a medical social worker.

16. Although there may be differences of opinion as to the best place to treat these patients, it should be remembered that there are many effective ways of rehabilitating them. There may be advantages at present in having a number of smaller and special units where research can be carried out before a standard pattern for rehabilitation services becomes established.

Conclusions and recommendations

(1). Present figures indicate that approximately 150 patients per million of the population will need rehabilitation each year and approximately 8 patients per million will need long-term care. At present, some 1,200 patients per year are left either unemployed or at a very reduced level of employment.

(2). The system must remain flexible but provide a continuous process of rehabilitation.

(3). Rehabilitation of these patients should usually take place in rehabilitation departments in district general hospitals, which should have residential accommodation for those needing it.

(4). Special centres, normally associated with neurological and neurosurgical centres, should act as assessment and reference units. These units should also have residential accommodation.

(5). Existing facilities should be integrated and improved where necessary to enable the present caseload to be dealt with.

(6). A system to ensure effective follow-up of all patients should be introduced. This could probably best be done by each department or centre keeping a register of all patients and employing a medical social worker to supervise the follow-up.

(7). More data should now be collected with a view to assessing what additional facilities should be provided.

(8). Long-term follow-up of patients and research into all aspects of the problem is essential and should be encouraged.

APPENDIX XVI

REPORT OF A CONFERENCE ON THE FUTURE OF THE SERVICES FOR PARAPLEGICS HELD AT ALEXANDER FLEMING HOUSE ON 23 JULY 1969

Present

Dr. J. J. Walsh (Chairman)
Dr. A. G. Hardy
Mr. T. McSweeney
Dr. H. W. F. Jones
Dr. D. F. Lewis
Dr. J. B. Cook
Dr. J. Silver
Dr. J. A. Oddie
Dr. F. S. Cooksey
Mr. J. S. Pennybacker
Mr. H. Jackson Burrows
Dr. A. Talbot Rodgers
Dr. R. T. Bevan
Dr. H. Millar
Dr. M. Bell
Dr. G. W. Knight
Mrs. B. Richards

Also present:

Representatives of the Department of Health and Social Security

1. The Chairman welcomed those present. He said the purpose of the meeting was to discuss how the services for paraplegics should develop in the future and consider requirements. The Tunbridge Committee would be asked to consider the views of the meeting on the rehabilitation aspects of paraplegics in so far as they concerned the National Health Service.

Functions of spinal units

2. It was agreed that the present spinal units had evolved from a need to assess, treat, rehabilitate and initiate resettlement in the community of patients suffering from paraplegia. There was now pressure on the units to increase the numbers of non-traumatic cases accepted. Most units said they were reluctant to accept patients with rapidly progressive disease as they could not be rehabilitated. The general view of the meeting was that although the case load of trauma patients was at present taking the greater part of the capacity of the units, particularly as the incidence of tetraplegia has increased, a service also needed to be provided for non-traumatic patients who would benefit from a period at a paraplegic unit.

Statistical information

3. A Review Committee had drawn attention to the fact that the diagnosis and incidence of spinal injury cases could not be accurately recorded because the diagnostic categories in the Seventh Revision of the International Classification of Diseases were inadequate. The Eighth Revision (use of which became obligatory in 1968) provided more detailed coding. The Hospital In-patient Enquiry figures 1962 to 1966 had been studied. Apart from the diagnostic coding, two further limitations to this data should be noted. The Enquiry is a sample study of discharges and deaths and

so estimates are subject to sampling error. Also it is not possible to link the series of spells of in-patient treatment common for a paraplegia patient. But it had been possible to agree the Review Committee's figures of new cases for 1967. General Register Office mortality data (based on death certificates) confirmed the Hospital In-patient Enquiry estimate of hospital deaths. The majority of these deaths occurred in non-specialised units but in most cases the patients had spent only a few days there, and it could be assumed that in some cases the patients had been too ill to be moved to the specialised units.

4. The Chairman said more accurate statistics were required to indicate future trends. He wondered whether paraplegia and tetraplegia could be made notifiable diseases. It was agreed it would be quite easy to notify all new patients on an informal basis to a regional centre.

5. An example of informal notification of a non-notifiable disease was quoted from Hertfordshire where the medical officer of health was able to obtain comprehensive statistics relating to hypothermia in his area. This information was obtained on an informal basis whereby hospitals routinely advised him of all new cases admitted. There was no reason why medical officers of health could not make similar arrangements in relation to paraplegia, where local authority services were likely to be required to support the patient in the community.

Numbers of beds in spinal injury centres

6. The meeting agreed the total number of beds was sufficient to deal with new patients suffering from trauma but those present from the centres emphasised this was only at the expense of all other work, in particular re-admission for treatment of complications and routine check. There was a need for expansion of the units at Hexham, Southport and Cardiff and more female beds should be provided. The increase in life expectancy of these patients and the higher survival rate of tetraplegics added to the numbers of past patients who needed to be regularly reviewed and it was becoming increasingly difficult to deal with the accumulating commitments.

Pattern of treatment

7. The Department said it would be useful if the meeting discussed the present and future pattern of treatment at the units, whether it would be possible to increase throughput at the centres by discharging patients to district general hospitals once the acute stage had been passed, and the special facilities of the units not required. The problems of the spinal units needed to be considered against the background of the hospital service as a whole if the best use was to be made of all available resources.

8. The majority of patients required, and continued to require, treatment for their urinary tract and for the prevention of bed sores, and district general hospitals appeared unwilling, because of lack of facilities, to provide this type of treatment. Few district general hospitals had large enough physiotherapy departments to cope adequately with the needs of this type of patient. It was not practicable to transfer a patient until he was mobile in a wheelchair, and he had achieved some control of his bladder. By this time the social worker at the unit had, in most cases, made all the necessary arrangements for housing adaptation or rehousing, and had often obtained employment for the patient who was ready for discharge home. In view of these circumstances it is unlikely that at the present time more than a few patients will be suitable for completing their rehabilitation at another hospital.

9. Sometimes patients discharged home for follow-up locally fared badly. They did not command the full interest of the hospital and were at the back of the queue for occupational therapy and physiotherapy. Cases had been known where unnecessary surgical procedures had been carried out. This destroyed the patient's confidence and

not unnaturally he turned to the spinal unit for attention. It was not felt that there were enough cases of paraplegia to enable every district general hospital to reach the degree of expertise necessary in their treatment.

10. The Department said future provision ought to be considered in the light of the improved facilities it was expected would be available at district general hospitals, and not against the background of what might happen in certain hospitals at the moment. The Tunbridge Committee would want to consider what rehabilitation arrangements were needed for paraplegic patients and what contribution could be made by district general hospitals in the future.

11. A paraplegic patient after his discharge from a spinal unit required observation particularly of the urinary tract and possible occasional physiotherapy. If he was employed he did not need occupational therapy. A tetraplegic patient, with a more severe disability and heavier demands on the medical and nursing services, if not able to return home, should be accommodated in a chronic sick unit in the grounds of a general hospital. Day centre facilities were essential for tetraplegics being cared for at home. The meeting accepted that while the part a district general hospital can play at present in the care of the paraplegic is limited, the district general hospital of the future with its larger rehabilitation facilities could take over some of the more routine after-care from the spinal units.

Early transfer

12. It was agreed that in some hospitals knowledge and information about the spinal units was minimal and this delayed transfer of patients in the acute stage. At Stoke Mandeville delayed admission showed a positive correlation with increased duration of stay and this association was supported by individual experience at other centres. The need to make more widely known the fact that the spinal centres are available for immediate advice as well as for the earlier admission of cases was stressed.

Staffing of units

13. The Review Committee had stressed the need of a career structure to attract suitable medical staff. The Department said in future the units would not be able to recruit junior medical staff on "pair of hands" basis.

14. It was the general opinion that it was difficult to arrange training for paraplegic work. It was a small field and a consultant in charge needed to have some expertise in urology, neurology and orthopaedics. A good basic general training was required with training in some of the above mentioned specialties.

15. Training programmes in these specialties could provide for a period in a spinal unit but those present stressed the lack of time in the units to spend on training junior doctors who by the time they became useful had to move on. General practitioner sessions were also suggested as a method of medical cover. The meeting agreed 60 beds was a satisfactory size for a unit with two consultants to provide adequate cover. This was thought to be the minimum economic size.

16. Most units relied on a few loyal highly qualified nurses backed up by nursing auxiliaries and ward orderlies. It was suggested that this type of nursing, which was physically very arduous, should attract additional salary, as geriatric nursing does.

17. Lack of funds played some part in the shortage of nurses but they were also in competition with more "exciting" types of nursing such as intensive care units and this did not help recruitment. A high nurse-patient ratio was needed in these units. Paraplegic training should be integrated in the nurse training programme. A small intensive care area in the larger unit might well be of great help both for progressive nursing care purposes and also as an added attraction.

18. The Department said most of the problems stemmed from the organisation of nursing services within the hospital groups but with the introduction of the Salmon senior nursing staff structure and the appointment of a chief nursing officer to a group of hospitals a more realistic approach to the maintenance of an adequate nursing service with promotion prospects in all fields could be made and this should help to solve the problem of nurse staffing and of competition between types of nursing.

19. We could not expect an easy solution to the chronic shortage of student nurses as we were in competition with other professions and employers. One way of making nursing more attractive to potential and present staff was to relieve them of all non-nursing duties and to introduce mechanical aids and equipment.

20. The meeting agreed that there was a need for adequate numbers of physiotherapists and occupational therapists. There continues to be a shortage of trained medical social workers but with more trained social work staff in health and welfare departments this should ease some of the problems in the future. More social workers should be attached when this was possible.

Discharge arrangements

21. The meeting agreed many difficulties were encountered when the patient was ready for discharge and emphasised the need to place patients in the community as soon as their period of useful rehabilitation at the special units was completed so enabling the units to make the best use of their beds. The ideal placement for paraplegic patients is in their own home but this depends on the ability and willingness of relatives to take the patient. It was agreed relatives can be helped very considerably by the general practitioner and local authority services. But the general practitioner has usually little or no experience of paraplegia and he is placed in the position of dealing with a patient who, as a result of some months in hospital, is often quite knowledgeable about his illness. The district nurse is in a similar position. It was agreed with better geographical distribution of patients it should become less difficult for consultants to make personal contact with the general practitioner. It was suggested the production of a booklet on the treatment of paraplegics which would be suitable for distribution to general practitioners, would be extremely useful. A copy of the booklet might be attached to the consultant's discharge letter. The booklet should contain a list of aids for the disabled and addresses of organisations skilled in work of this type. The Sheffield unit invited district nurses to visit the unit for instruction and it was agreed this was very desirable.

22. The disparities between provision in different local authorities were mentioned. Some did not give any priority to rehousing medical cases. Often difficulties arose in county areas where both county and district councils are involved. The meeting agreed it would seem sensible to ask the medical officer of health of a large authority to co-ordinate the efforts of his colleagues when several departments were involved in resettlement of a patient.

23. In some cases home placement is not possible and concern was expressed about the difficulty of finding suitable accommodation for those patients ready for discharge who blocked beds. More homes similar to the Duchess of Gloucester and more places in local authority and voluntary homes were asked for.

24. It was agreed that paraplegics and tetraplegics needing permanent hospital care would be most suitably placed in younger chronic sick units which hospital boards had been asked to provide at selected district general hospitals.

25. Difficulty was experienced in reviewing patients and the need for out-patient facilities in all the units was stressed. But not all patients could be dealt with on an out-patient basis and bed turnover, X-ray facilities and ambulance service were other

factors which set a limit on the numbers. There were difficulties in immediately re-admitting ex-patients who have developed complications and this constituted a most serious inadequacy in the service.

26. The difficulties in obtaining adequate vocational training for paraplegics were mentioned. Several consultants in spinal injuries had experienced considerable delays in admitting their patients to industrial rehabilitation units. It was agreed that these units did invaluable work in helping the paraplegic patient and it was suggested more such units should be established. However, heavily handicapped paraplegics were often difficult to place in the industrial rehabilitation units.

27. On Merseyside where there was a high level of unemployment able-bodied people tended to be given priority in employment in light industry.

28. Vocational training was the responsibility of the Department of Employment and Productivity but pre-vocational assessment was an essential preliminary which should be carried out in the occupational therapy department of the units, starting in the early months of the patient's stay and should include consultation with the disablement resettlement officer. It was agreed that there should be facilities there for pre-vocational assessment but that some aspects of vocational training should also be included. Many jobs were dependent on sound legs. If any of the men or women in these jobs became paraplegic it was necessary to assess their educational background and suitability for a variety of office jobs ranging from general clerical work to book-keeper, secretary, accountant, draughtsman, etc. People without the educational background, aptitude and liking for office jobs and those with a preference for manual work had to be considered for a variety of jobs, skilled and semi-skilled, which could be done sitting at a bench in a wheelchair. It was often necessary to arrange for paraplegics to have a course of educational revision and most of them needed to be tried out in possible alternative types of employment before a final decision about vocational training could be reached. It was, of course, a great advantage, both for patients' morale and to save time, to test their potential abilities and to decide on their future during the long period that most of them have to remain in the units.

29. Low-level paraplegics could travel to government training centres for vocational training, live at home and be resettled in open industry, but high level paraplegics and all quadriplegics were so much more disabled that many required facilities for sheltered living and working and there was much to be said for providing vocational training for them at the paraplegic units. Therefore the units required realistic facilities for pre-vocational assessment for most paraplegics and full vocational training in a few specially selected occupations for the more severely disabled.

30. Good, early vocational assessment and contact with employers, and trade unions at an early stage is essential in all cases of permanent traumatic disability. The British Orthopaedic Association had drawn the Department's attention to this and to the need for hospital resettlement officers.

31. Tetraplegics were not generally suitable for industrial training.

32. Paraplegic patients of undergraduate standard were admitted to degree courses at some universities where there were suitable conditions. The point was made in discussion that it was easier to obtain gainful employment for patients of undergraduate standard.

Siting of units

33. The Department said it was essential to obtain a realistic appreciation of the problem. Regions were busily planning their capital development programmes and needed to be appraised now of provision required for the future. The anticipated role of specialised units in this context must be regarded in relation to the concept of

district general hospitals which were being planned to provide a wide range of treatment and diagnostic facilities for in-patients and out-patients. If spinal units were to be included it was essential for boards to have this information. The meeting agreed that ideally spinal units should be sited in district general hospitals with adequate services and facilities. With careful planning other related activities particularly those for patients requiring rehabilitation for locomotor disabilities could be associated or incorporated with the spinal units. There was an insufficient case-load to justify one spinal unit as they are at present conceived in each region. Future units should however be based on selected district general hospitals with extensive rehabilitation facilities. The spinal units should be functional in approach and accept more non-traumatic cases.

34. Experience in Cardiff showed the minimum size of a viable unit was 60 beds. The ratio of female to male beds should be 1:3.

35. It was suggested that if in the light of a more rational distribution of services it was considered that another spinal unit should be established in the south of England; south London or Southampton which was to have a new university hospital should be looked at seriously.

General

36. When the question was raised whether paraplegic and tetraplegic patients could be exempted from paying prescription charges the meeting was told that paraplegia as such is not an exempt condition but a paraplegic patient can usually claim exemption under paragraph 7(d)(iv) of the statutory instrument embodying the regulations regarding prescription charges on the ground that he is suffering from a continuing disability which prevents him leaving his residence except with the help of another person.

Conclusion

37. The Chairman concluded the meeting by summing up the points made in discussion:

(1) Units regarded as their first priority patients with traumatic paraplegia and tetraplegia. However it was recognised a service needed to be provided for non-traumatic patients who could benefit from treatment at the units. (Paragraph 2.)

(2) The total number of beds available is sufficient to deal with all new patients suffering from trauma but limits the range of all other work which should be accomplished. The siting of units is far from ideal. (Paragraph 6.)

(3) To provide an adequate regional service the consultants felt that the units at Hexham, Southport and Cardiff need to be expanded and generally more female beds provided. (Paragraph 6.)

(4) A future consultant in paraplegia needs a good basic general training with training in some of the following specialties: neurology, urology and orthopaedics. (Paragraph 14.)

(5) The consultants felt that paraplegic nursing should attract additional salary as does geriatric nursing. (Paragraph 16.)

(6) Paraplegic nursing should be included in the nurse training programme. (Paragraph 17.)

(7) A booklet on the care of paraplegics suitable for general practitioners should be prepared and a copy attached to the patient's discharge letter (Paragraph 21.)

(8) The medical officers of health of large authorities should be asked to co-ordinate the efforts of their colleagues in re-establishing the paraplegic and

tetraplegic patients in the community and giving support to relatives. (Paragraph 22.)

(9) There is a need for more provision for those patients not able to return to their own homes. (Paragraph 23.)

(10) There is a need for out-patient facilities related to the units. (Paragraph 24.)

(11) Ideally future spinal units should be sited at district general hospitals with adequate supporting facilities. (Paragraph 25.)

(12) If another spinal unit in the south of England is to be established, south London or Southampton should be considered. (Paragraph 26.)

APPENDIX XVII

REPORT OF A CONFERENCE ON REHABILITATION OF THE LIMBLESS HELD AT ALEXANDER FLEMING HOUSE ON 16 DECEMBER 1970

Those present:

Professor Sir Ronald Tunbridge (Chairman)
Mrs. Ann Blades
Mr. H. Jackson Burrows
Dr. F. S. Cooksey
Dr. I. H. M. Curwen
Mr. C. W. Dunham
Professor R. B. Duthie
Dr. A. M. Exton-Smith
Dr. W. Russell Grant
Dr. P. J. R. Nichols
Mr. P. Kingsley Robinson
Mr. D. A. Skidmore
Professor G. Slaney

Also present:

Representatives of the Department of Health and Social Security

Representative of the Scottish Home and Health Department

1. The Chairman welcomed those present and explained that the conference had been called to provide the sub-committee on Rehabilitation of the Standing Medical Advisory Committee with views on the special rehabilitation problems of the limbless. He explained that the sub-committee had paid particular attention to the problems of special categories of patients and that in the case of two other groups, paraplegics and head injury cases, similar conferences had been held. The sub-committee hoped that there would be a generally improved rehabilitation service, largely based on departments in district general hospitals. For other special categories they felt that most rehabilitation could take place in the general departments, but in a few cases some special facilities would be needed; in the case of the limbless it was important to know how they would fit into the general pattern of service and what extra provision was necessary. The rehabilitation service for the limbless had started as a result of the large number of young ex-service amputees who survived the First World War. A similar population was created as a result of the Second World War and, following the introduction of the National Health Service, the service had embraced all limbless patients. The problem was a large one and constantly changing, most of the patients now being in the older age groups predominantly with lower limb amputation and many with multiple handicaps. From time to time new groups emerged, the dysmetic children born as a result of the thalidomide tragedy being an example. Advances in medicine and in prosthetics made the possibilities of helping amputees much greater than before.

2. Following the opening remarks by the Chairman contributions were invited from those attending. It was pointed out that following the First World War rehabilitation had largely been confined to the provision of an artificial limb; despite this however many amputees had been successfully rehabilitated.

3. Rehabilitation should be seen as a whole and not compartmentalised; there was more than merely medical rehabilitation of the patient. He must be seen in his total environment and account taken amongst other things of the effect his disability would have on his family. The value of personal advice from a rehabilitated amputee to a patient and his family either after or preferably before amputation was stressed. It was mentioned that BLESMA provided such a service and its value was endorsed by

those who had had personal experience of it. It was felt that much more use should be made of this service.

4. A further serious problem was caused by breakdown of artificial limbs and delay in repairs. Amputees on the whole were well adjusted when fitted with limbs but when deprived of their use they became handicapped, it was essential to provide a quick service.

5. BLESMA held the view that the services for the limbless should be fully integrated into the hospital service and that regional amputation centres should be established staffed by interested surgeons who would be responsible for the total care of the patient from admission to full rehabilitation.

6. The importance of the difference in attitude between the upper and lower limb amputee and between the young and the elderly was stressed. For instance advice was much more valuable to the young upper limb amputee. In some elderly patients the stimulus of advice was also important, the "never walk again" attitude could often be softened by example. The age of the patient also has an important bearing on the type of prosthesis fitted or in fact whether to fit any prosthesis at all. All patients should be carefully assessed before fitting and the assessment must include for elderly patients the ability to undergo what may be a rigorous rehabilitation programme; for some elderly patients crutches or a wheel chair may be preferable to a prosthesis.

7. The burden of the problem, as was well illustrated by the statistics circulated,* was the elderly lower limb amputee and for these patients, many of whom would have associated disease, the facilities of a general hospital were essential. Although the statistics referred only to patients attending limb-fitting centres and were therefore an underestimate of the total number of amputees, the problem over the whole country should be seen in proper perspective as not very large and because of the nature of the underlying disease process it was likely that many amputations were carried out as emergency procedures. It was therefore inevitable that many amputations would take place in district general hospitals and because they were only a small part of the clinical work-load little attention was paid to their special problems. Nevertheless it was essential that district hospitals should have the necessary expertise for treatment, including assessment, surgery and rehabilitation. It was felt that a team in each district general hospital should be encouraged to take a special interest in amputation. For specialised aspects of general rehabilitation and the treatment of difficult cases, e.g. upper limb or bilateral lower limb amputations, it would be valuable to have special referral centres but these must be associated with general hospitals with the full range of facilities. A proposal to build an experimental amputation unit at Roehampton was being considered and this might provide a prototype for regional reference centres. There were however difficulties in the concept of a centre based on a particular form of treatment rather than on a disease process or body system although integration of the centre into a district general hospital might overcome this. Full integration within a district general hospital was also necessary to provide the geriatric advice required for the large proportion of elderly patients. The special centre must also have good links with the community health and social services in all areas from which its patients come.

8. The problem of upper limb amputation was discussed and it was felt that although this represented a very small total problem it was nevertheless important. Most of the patients were young and presented very often as complex problems; they should be treated in special centres where the necessary expertise was available and should be transferred there as soon as possible after injury. The better treatment possible in special centres outweighed the disadvantages of distance from the patients homes; but it was

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* The statistical information in Tables I, II and III which follow this Report has been updated to Dec. 31, 1970

important to establish local links (patient's home, work and local authority) and members of the team in the special centre should be prepared to visit patients' homes and discuss problems with local health workers (e.g. social workers and health visitors) who in turn should be encouraged to visit the centres.

9. The place of limb-fitting doctors and prosthetists in the general pattern of service was discussed. It was felt that both had a valuable part to play but that in some district general hospitals where only a small number of amputations were performed, some of their functions could be undertaken by a physical medicine team with the necessary experience and interest, with the part-time services of a prosthetist who might be based on a regional centre. Doubt was expressed about the contractual arrangements for supply of artificial limbs and the employment of prosthetists by the firms supplying limbs which might on occasion cause a conflict of loyalties; it was pointed out however that there was considerable advantage in having large independent backing for the prosthetic service. The need for much closer co-operation between the limb-fitting service and the hospitals where patients were being treated was paramount and if this could only be achieved by full integration of the limb-fitting service with the National Health Service then this would have to be considered.

10. The part to be played by the remedial professions in fitting limbs could well be complementary to the prosthetist. Where, as often happens, there is a need for an immediate temporary prothesis then this could quite easily be fitted by a remedialist with special training. Although it would be possible to establish links in the training of remedialists and prosthetists, the fitting of limbs would only be a small part of remedialists work and training would probably best be given as in-service training at a special unit rather than as part of the students' curriculum. Remedialists might also be able, with the introduction of modular limbs, to effect temporary repairs. Definitive fitting and repairs will always remain the province of the prosthetist who is the vital link between the doctor and the supplier.

11. In discussing the supply of artificial limbs and parts for limbs the need for the early introduction of standardised modular prostheses was emphasised. It was felt that the Department should continue to have a central responsibility for supply and should invite competitive tenders for items which would be strictly controlled as to design and quality; a healthy industry would be necessary to meet these requirements as well as to take maximum advantage of the expanding export opportunities for the products of British prosthetics research and development. Modular limbs were still in the experimental phase and sufficient field experience must be gained before full standardisation techniques can be applied, there was therefore bound to be a gradual introduction of the new system necessitating parallel continuity with the old.

12. An ideal would be for one standardised limb with interchangeable parts but the industry would undoubtedly face labour problems in changing to the new system. This should not be allowed to inhibit the introduction of modular assemblies. It was suggested that during the present developmental stage one centre should fit modular limbs exclusively. The most important standardisation would be of the interface between component parts and this should be the first aim. The Department was already looking at the problems of standardisation and it was felt that there was no need at present for a separate committee to be formed. The existing arrangements whereby several limb manufacturers operated in most centres did not lend itself to efficiency and would not simplify standardisation; there was much to be said for allocating regions to manufacturers; the Department agreed. The safety record of artificial limbs is very good and this must not be sacrificed by undue haste for standardisation.

13. In the new organisation which would necessarily follow on the introduction of modular limbs it was felt that limb-fitters should be reorganised on similar lines. Despite the fact that there were advantages in having fitters employed by the contractor

who was responsible for supplying a satisfactory, safe, functional and reliable limb, it was felt that at least some limb-fitters should be employed full-time by the National Health Service at the regional special centres. In the district general hospital remedialists should be able to do the immediate fitting following which patients should either be referred as soon as possible to the special centre for the skilled attention of a limb-fitter or should be visited by a peripatetic fitter based on the centre. It was generally agreed that integration of the limb-fitters into the National Health Service was likely to be a slow process and that there was likely to continue to be a place for a considerable period for some fitters employed by contractors.

14. Repairs should be exclusively undertaken in the special regional or sub-regional centres where there can be continuity of care for the individual patient and also sufficient experience for efficient feed-back of information. Full overhaul of limbs needing repair should continue. The introduction of such a repair service will be gradual and will involve a considerable amount of de-centralisation; it was unlikely that repairs would be undertaken more peripherally than the special centre.

15. Other appliances for the limbless were mentioned. Wheelchairs were obviously important and it was felt that supply arrangements for them were improving. There should be a central supply, purchase and design with competition between manufacturers but commercial competition at regional level led to considerable waste of space and should be discouraged. In the design of wheelchairs stability was obviously an important factor but there was a tendency to ignore the problems encountered in getting in and out of the chair when it was also important that stability was maintained. It was mentioned that B.S.I. standards were about to be introduced for walking aids and that the design of these aids was likely to become standardised.

16. Full resettlement of the limbless involved many problems, e.g. adaptation to disability, independence, home and work environment and the attitude of the community health and social services. There tended to be a lack of knowledge of available services but the introduction of the Chronically Sick and Disabled Persons Act, 1970 would help in this direction; not all the limbless however can be classified as severely disabled; a young amputee with a prosthesis can be a fit and able person.

17. A problem existed in the gap between hospital discharge and return to work Improved liaison was necessary between the hospital and the Department of Employment and between hospital and local authority. An improved rehabilitation service must ensure better communications between hospital and community services and with the disablement resettlement officer of the Department of Employment who must recognise the special problems of the amputee in industry.

Statistical information

Analyses are given in Tables I, II and III of the numbers of new patients attending limb-fitting centres in England since 1970.

The causes are given under the headings of trauma, congenital malformation and disease. The latter is divided up under the headings of vascular including diabetes (diabetes accounts for approximately one-quarter of these figures), malignant disease and other. Under the heading of "other" are included non-malignant tumours osteomyelitis, a few cases of tuberculous disease of bone and the later effects of burns, poliomyelitis, malunion and failed arthrodesis.

The following points of interest arise from these tables.

Table I—Analysis by site, cause and sex.

Of a total of 4,500 new cases about 70 per cent were men. Vascular disease including diabetes accounted for 70 per cent of the total.

Single leg cases (3,663) formed 80 per cent of the total; of the remainder there were more double leg than single arm cases.

Table II—Analysis by age, cause and sex.

Vascular disease is again shown as the major cause of amputation but it is not exclusive to the aged since 481 out of a total of 3,176 cases occurred in the 40–59 age group.

171 children under age 10 attended for congenital malformations.

Table III—Analysis by site, sge and aex.

The 0–9 column includes the 171 cases of congenital malformation referred to above and some estimate of the numbers of limbs involved in these patients may be made by extrapolation.

Table I

New patients attending limb-fitting centres in England in 1970
Analysis by site, cause and sex

		Total all causes	Trauma	Congenital malformation	Disease			
					Total	Vascular including diabetes	Malig-nancy	Other
Total	M	3,154	502	101	2,551	2,190	147	214
	F	1,405	95	70	1,240	986	127	127
	T	4,559	597	171	3,791	3,176	274	341
Single arm	M	292	195	60	37	7	17	13
	F	134	41	54	39	6	21	12
	T	426	236	114	76	13	38	25
Single leg	M	2,499	287	29	2,183	1,884	130	169
	F	1,164	50	12	1,102	892	106	104
	T	3,663	337	41	3,285	2,776	236	273
Double arm	M	9	3	5	1	—	—	1
	F	2	—	1	1	—	—	1
	T	11	3	6	2	—	—	2
Double leg	M	346	13	3	330	299	—	31
	F	102	4	2	96	87	—	9
	T	448	17	5	426	386	—	40
Multiple	M	8	4	4	—	—	—	—
	F	3	—	1	2	1	—	1
	T	11	4	5	2	1	—	1

Table II

New patients attending limb-fitting centres in England in 1970
Analysis by age, cause and sex

		Total all causes	Trauma	Congenital malformation	Disease			
					Total	Vascular including diabetes	Malig-nancy	Other
Total all ages	M	3,154	502	101	2,551	2,190	147	214
	F	1,405	95	70	1,240	986	127	127
	T	4,559	597	171	3,791	3,176	274	341
0–9 years	M	84	12	67	5	—	1	4
	F	62	4	47	11	—	6	5
	T	146	16	114	16	—	7	9
10–19	M	117	73	20	24	1	17	6
	F	38	13	10	15	1	12	2
	T	155	86	30	39	2	29	8
20–39	M	301	205	6	90	24	33	33
	F	64	21	5	38	8	17	13
	T	365	226	11	128	32	50	46
40–59	M	661	143	7	511	381	45	85
	F	210	29	7	174	100	36	38
	T	871	172	14	685	481	81	123
60–79	M	1,751	64	1	1,686	1,561	47	78
	F	783	24	1	758	651	48	59
	T	2,534	88	2	2,444	2,212	95	137
80 and over	M	240	5	—	235	223	4	8
	F	248	4	—	244	226	8	10
	T	488	9	—	479	449	12	18

Table III

New patients attending limb-fitting centres in England in 1970
Analysis by case, age and sex

		Total all ages	0–9 years	10–19	20–39	40–59	60–79	80 and over
Total	M	3,154	84	117	301	661	1,751	240
	F	1,405	62	38	64	210	783	248
	T	4,559	146	155	365	871	2,534	488
Single arm	M	292	45	47	93	69	35	3
	F	134	44	16	19	33	21	1
	T	426	89	63	112	102	56	4
Single leg	M	2,499	26	64	193	514	1,483	219
	F	1,164	15	20	42	160	689	238
	T	3,663	41	84	235	674	2,172	457
Double arm	M	9	3	3	—	1	2	—
	F	2	1	—	—	1	—	—
	T	11	4	3	—	2	2	—
Double leg	M	346	6	2	13	76	231	18
	F	102	1	2	3	15	72	9
	T	448	7	4	16	91	303	27
Multiple	M	8	4	1	2	1	—	—
	F	3	1	—	—	1	1	—
	T	11	5	1	2	2	1	—

A special study has been made by reference to the files of all patients on the books of limb-fitting centres in England at 31 December 1969. An analysis of limb-deficient patients according to site of amputation or deformity is shown at Table IV. Where a patient has more than one site of amputation he is shown under the heading of "Double" or "Multiple" deficiencies and the entry here relates to the primary or to the major site. Thus a patient with an above-knee amputation on one side and a below-knee on the other is shown as an entry under "Double: above-knee". The total number of prosthesis in use cannot therefore be accurately gauged from these figures.

The term "Non-amputation" used in this table refers to patients with a variety of congenital deformities and to others who attend for consultation to assess their suitability for amputation and the subsequent fitting of a prosthesis.

Table IV

Patients on the books of limb-fitting centres in England in 1969

Analysis by site of amputation or deformity

Leg	*Single*	*Double*	*Multiple*	
Hindquarter	328	—	—	
Through hip	809	6	6	
Above knee	28,579	5,523	66	
Through knee	6,353	1,061	12	
Below knee	13,553	2,430	12	
Ankle or foot	1,124	193	21	
Non-amputation	551	96	70	
Totals:	51,297	9,309	187	60,793

Arm	*Single*	*Double*	*Multiple*	
Forequarter	228	—	—	
Through shoulder	392	—	9	
Above elbow	1,072	20	42	
Through elbow	324	6	—	
Below elbow	1,368	53	14	
Wrist or hand	1,883	75	—	
Non-amputation	2,057	143	72	
Totals:	7,324	297	137	7,758

Grand total: 68,651

APPENDIX XVIII

BIBLIOGRAPHY ON REHABILITATION OF THE MENTALLY ILL AND HANDICAPPED

The early pattern of psychiatric rehabilitation was laid down by pioneers in the training and employment of the subnormal patient. Stensley of Darenth Park stated his aim of training defectives at a meeting of the Royal Medico-Psychological Association in 1913. His method which was elaborated by Bickmore was to occupy the patient on maintenance work within the institution. This work was brought up to date by Tizard and O'Connor (22). They emphasised the influence of social stress in the hospital and home environment on the subnormal patient's adjustment. They pointed out, as did other authors (12) the need for attention to personality variables, for training, and the development of skill. The effects of the hospital environment on feeble-minded (E.S.N.) defectives was reported by Penrose (19). 44 per cent of the patients studied were found to be emotionally unstable but 32 per cent were not permanently neurotic. Their instability was related to features of the hospital setting and they tended to lose their symptoms when their environment was changed. While it is not suggested that the hospital automatically produced instability, it was considered that this was a function of separation from normal community life. Alterations in institutional life which affected the lives of the mentally ill, as well as the subnormal, and made rehabilitation possible, were foreshadowed in the Wood Report (32). This report recommended that "institutions should no longer be a stagnant pool, but should become a flowing lake, always taking in, always sending out". At the same time a departmental committee of the Board of Control (33) expressed the view that institutions which took subnormals of all types and ages were economical since high-grade patients could do the work and make everything necessary. Tizard and O'Connor (23, 18) criticised the committee's views. They believed that the teaching methods of the trainers and the equipment used in the workshops were often extremely old-fashioned. They considered that the work was occupational and did not provide suitable training for outside employment. They suggested that it would be better to use simple sub-contracted work which would be carried out by patients for an outside firm. This would give the subnormals experience of the types of work which they could hope to obtain when they left hospital. It would provide up to date equipment and enable the staff to gain a better understanding of the employment problems of mentally handicapped patients. These views on the rehabilitation and resettlement of subnormals were applied to the mentally ill, whose care had been changing over the century since Conolly's introduction of treatment without restraint (4). As public and professional attitudes to mental illness altered it became possible to consider the effect, on the patient's condition, of a long stay in a mental hospital environment (5, 1, 7, 26). Changes were made both through the large-scale reorganisation of mental hospitals, and the introduction of occupational therapy and group activities directed to the needs of the individual patient (34, 11, 20). The failure of many patients to respond to these measures led to a recognition of psychiatric disabilities and attempts to assess and counteract them (27, 16, 2).

The M.R.C. team which had been responsible for studies of work for subnormal patients, established a factory at Banstead Hospital (8, 9). Here they set up research on patients' disabilities and the influence of monetary incentives (15). Similar work on the performance and employability of patients was undertaken by Wadsworth and others (24) while the possibilities of resettlement of psychiatric patients were explored in co-operation with Industrial Resettlement Units (28) and Industrial Therapy Organisations (14). The psychological problems of physically disabled entrants to

I.R.U.s were also examined and compared with those of the disabled psychiatric patient (21, 30).

The many severe disabilities of long-stay mental hospital patients limit their chances of resettlement (10). This did not halt further progress. Advances were made in the recognition of the effect of social and family stress on schizophrenic patients (6) and by the extension of work facilities for disabled psychiatric patients both in the hospital and the community (3, 13, 17, 25). The provision of a range of different types of residential accommodation which match the disabilities and needs of the psychiatrically handicapped is another rehabilitation asset (31).

In spite of a belief in the value of rehabilitation for the mentally ill, evaluation of results is limited (29).

With the dissolution of the mental hospitals, one can hope that, providing rehabilitation facilities for psychiatric patients are established in the new district and specialised units, more will be learned about the disabilities and rehabilitation of a wider range of psychiatric conditions.

APPENDIX XVIII

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INDEX

	Paragraphs
Accident and emergency services	*see* Trauma
Adolescent rehabilitation	48, 191–193
Advisory Committee on the Health and Welfare of Handicapped Persons	*see* Committees
Aids and appliances	270–271
Alcohol dependency	*see* Drug or alcohol dependency
Ambulance services	29, 291–294, 304 *see also* Transport
Artificial limb and appliance service	23, 258–259, 261–268, 270–271
integration into the N.H.S.	261–263
special artificial limb centres	267–268
	see also British Limbless Ex-Servicemen's Assoc.; Remedial professions; Research.
Assessment centres	*see* Handicapped children
Assessment clinic	58, 124, 132–139, 148, 156, 274, 279, 289, 322, 336
Attendance allowance	*see* Social security
Autistic children	*see* Handicapped children
Better Services for the Mentally Handicapped-Command Paper	236
Biomechanical Research and Development Unit	23, 268
Blind and partially-sighted	242–243 *see also* Handicapped children; Research; Workshops
Briggs Committee	*see* Committees
British Association of Physical Medicine and Rheumatology	50
British Geriatric Society	75
British Limbless Ex-Servicemen's Association	269
British Medical Association	
Memorandum on the Rehabilitation and Resettlement of Disabled Persons (1954)	91
Planning Unit Report No. 2 Aids for the Disabled (1968)	263, 271
British Orthopaedic Association	162
Cancer	241
Case conference	16, 59, 133, *see also* Assessment clinics; Resettlement clinic
Certificate of partial incapacity	173–174
Chairs in rehabilitation	*see* Medical education
Chartered Society of Physiotherapy	346
Cheshire Foundation Homes	314
Children	178–193, 238, 303
disabled adolescent	191–193
education	182–188
hospital facilities	189–193
special schools	186–188
youth employment service	192–193, *see also* Adolescent rehabilitation; Handicapped children; Remedial professions
Chronically Sick and Disabled Persons Act 1970	254, 305, 315, 324
Chronic progressive disorders	52

	Paragraphs
Clinical assistant (general practitioner)	278
Clinical psychologist	142, 206, 229, 244, *see also* Hospital rehabilitation team
attendance at assessment clinic	142
in psychiatric departments	229
working with pre-lingually deaf	244
Combined medical and industrial rehabilitation unit	62
Committees	
Advisory Committee on the Health and Welfare of Handicapped Persons	2, 138
Committee of Enquiry into the Education of the visually handicapped	243
Committee of Enquiry into the Speech Therapy Services	156
Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled persons	*see* Piercy Committee
Committee on Local Authority and Allied personal social services (Seebohm)	158
Committee on Nursing	146, 286, 346
Committee on the Remedial Professions	*see* Remedial professions
Joint Committee on Higher Medical Training	122
Joint Sub-Committee of the Standing Medical Advisory Committee and the Advisory Committee on the Health and Welfare of Handicapped Persons	2, 245
Scottish Standing Medical Advisory Committee's Sub-Committee on Rehabilitation	2
Standing Medical Advisory Committee's Sub-Committee on Child Welfare Centres	22, 297
Standing Medical Advisory Committee's Sub-Committee on the Organisation of Group Practice	2, 283, 293
Standing Mental Health Advisory Committee	2, 204
Standing Nursing Advisory Committee	2
Standing Rehabilitation and Resettlement Committee of the Ministry of Labour	69
Working Party on Medical Administrators	290
Community physician	290
Community rehabilitation services	272–324
Health services outside hospital	273–303
Social services	304–324, *see also* Ambulance services; Community physician; Day centres; District nurse; General practitioner; Health centres; Health visitor; Home adaptations; Information services; Physiotherapy; Recuperative holidays; Residential accommodation; School Health Service; Social work
Concepts of rehabilitation	85–92
Consultant geriatrician	44, 75, 198
Consultant paediatrician	180
Consultant in physical medicine	16, 44, 117–118
Consultant psychiatrist	44, 206, 214–219
Consultant in rehabilitation	57–58, 101, 112, 115–126, 134, 141, 158, 186, 208, 214, 280, 282, 301
Contract and Pay Questions in Industrial Therapy Units	*see* King Edward's Hospital Fund
Contractual arrangements for convalescence	*see* Convalescence
Convalescence	19, 175–177
contractual arrangements	176, *see also* Recuperative holiday
Co-ordinator, non-medical	130

Paragraphs

Council for the Professions Supplementary to Medicine 350

Day centres 25, 27, 202–203, 256, 291, 293, 304, 309–310, 316–320, 325
  for alcoholics and drug addicts 256
  for the elderly 202–203, 316
  for the mentally handicapped 27, 304, 316
  for the mentally ill 27, 316
  for the physically handicapped 25, 316
  contract work 319
  managers and staffing 318
  transport to 203, 291, 293
Day hospital 107–108, 123
  geriatric 201, 277
  psychiatric 205, 208, 317
Deaf and hard of hearing 244, *see also* Handicapped children
Definition of rehabilitation *see* World Health Organisation

Department of Employment 14, 16–17, 24, 32–41, 55–57, 60, 94–95, 105, 114, 136, 162, 166, 208, 235, 243, 252, 317, 342; *see also* Disabled Persons (Employment) Act; Disablement Resettlement Officer; Employment Medical Advisory Service, Government training centre; Industrial rehabilitation units; Medical interviewing committee; Regional medical service; Remploy; Youth Employment Service
Department of Health and Social Security 19, 23–24, 55–57, 94, 98, 105, 228, 252, 254–255, 258, 260, 262–263
Department of physical medicine 15, 111
Disabled Living Foundation 324, 326
Disabled Persons (Employment) Acts 1944 and 1958 32, 320
  register of disabled persons 32
Disablement resettlement officer 16, 32–33, 59, 60–61, 112, 124, 134–135, 159, 162, 206, 281
Discharge procedures 171–172, 279, 281, 288–289, 295
District general hospital 104–177, 189–190, 196–200, 205, 208–209, 214, 241, 249, 255, 262, 264–265, 267–268, 277, 284, 298–299, 317, 324
  artificial limb centres 262, 264–265, 267–268
  children's department 189
  general rehabilitation department 111–131, 190, 241
  geriatric department 196–200, 209
  psychiatric department 107–108, 205, 209, 214, 249
  spinal injury units 255
District nurse 30, 277, 279, 281, 284–286, 289, 302, 346
Domiciliary physiotherapy *see* Physiotherapy
Domiciliary visiting 280
Drug or alcohol dependency 256–257
Duchess of Gloucester House, Isleworth 329, *see also* Voluntary organisations
Education in rehabilitation 333–356
  education of the public 354–356
  further education 341–342
  nurses' training 346
  postgraduate education 339–340
  remedial professions' training 347–355
  undergraduate education 334–338

Elderly people *see* Geriatric rehabilitation
Employment Medical Advisory Service 95–96

	Paragraphs
Epilepsy	245
Evening rehabilitation clinics	128–129, 294
Existing statutory services	14–45
Failure of present provision	46–84
lack of interest and appreciation of rehabilitation	47–51
medical education	54
poor organisation	55–62
size of the problem	67–71
Financial incentives	20, 25–26, 228, 317
Finchale Abbey Training Centre, Durham	329, *see also* Voluntary organisations
Gaps in rehabilitation services	56–57, 61–62, 105, 136, 252, 288–289
General Nursing Council	346
General practitioner	53, 110, 134, 139, 206, 273–283, 285, 288–289, 295–299, 301, 303
attendance at the assessment clinic	134, 139, 279, 289
direct access to physiotherapy service	282
domiciliary physiotherapy	301
group practice	273, 278, 281, 283, 288, 295–299
health centre	110, 273, 278, 281, 283, 288, 295–299
liaison with district nurse	277, 279, 281, 285
liaison with health visitor	288–289
liaison with social worker	273, 281
relationship with hospital	278–281, *see also* Clinical assistant
Geriatric rehabilitation	48, 72, 75, 87, 89, 107–108, 123, 194–203, 209, 277, 287, 296, 316
day centre	202–203
day hospital	201
ward accommodation	200
Government training centres	37, 39, *see also* Industrial rehabilitation units
Group practice	106, 110, 153, 273, 278, 281, 283, 288, 295–299, *see also* General practitioner
Handicapped and Impaired in G.B.	
survey by the Office of Population Censuses and Surveys	45, 97, 306, 314
Handicapped children	22, 178–193, 238, 303
assessment centres	22, 181, 238
autistic children	187–188
pre-school provision	181
special schools	187–188
Head injuries	248–252
national head injury centre	249, *see also* Trauma
Health centre	106, 110, 153, 273, 278, 281, 283, 288, 295–299, 304
physiotherapy in	283, 298
Health Services and Public Health Act 1968	323
Health visitor	30, 206, 279, 281, 285, 287–289
Historical development of existing services	7–13
Home adaptations	*see* Housing
Hospital Advisory Service	230
Hospital memoranda	
HM(58) 57 Rehabilitation in the hospital service and its relation to other services	73
HM(62) 18 Physiotherapy in hospitals	152
HM(63) 24 Discharge from hospital and arrangements for after-care	171
HM(63) 40 Accident and emergency services	246

	Paragraphs
HM(64) 45 Improving the effectiveness of hospitals for the mentally ill	73
HM(71) 22 Hospital facilities for children	178
HM(71) 94 Provision of medical and surgical appliances	270
Hospital rehabilitation facilities	15–23, 106–180, 189–190, 194–201, 205–212, 214–218, 222–235, 237–257, 262–268, 278–283
Hospital nurse	*see* Nursing staff
Hospital rehabilitation department	111–139
consultant in charge	115–122
evening clinics	128–129
facilities	111–114
organisation	123–131
size	127, *see also* Assessment clinic; Co-ordinator
Hospital rehabilitation officer	160–162
Hostel accommodation	28, 63, 153, 168–170, 237, 325
at the district general hospital	153, 168–170
for the mentally handicapped	63, 237
for the mentally ill	28
Housewives, rehabilitation needs	48, 225, 308, 323
Housing for the disabled including home adaptations and special housing	29, 63, 285, 304, 322
Industrial rehabilitation units	24, 34–38, 60, 105, 135, 173, 219–221, 223–224, 342
psychiatric admissions	38, 220
statistics	37
Industrial Therapy Organisation, Bristol	331
Industrial therapy units	21, 221, 231, 330–331
Information services and publicity	31, 305, 324, 354–356
In-patient treatment record card	147
Invalid vehicles	23
Joint Committee on Higher Medical Training	*see* Committees
Joint Council on Voluntary Work for the Disabled	328
Joint Sub-Committee of the Standing Medical Advisory Committee and the Advisory Committee on the Health and Welfare of Handicapped Persons	*see* Committees
King Edward's Hospital Fund for London	216, 226, 228, 231, 234
Report on Contract and Pay Questions in Industrial Therapy Units	228
Report on Industrial Therapy in Psychiatric Hospitals	226, 231, 234
training course for consultant psychiatrists	216
Local Authority Rehabilitation and Assessment Centre, Croydon	321
Local authority services	22, 25–30, 45, 57, 63–66, 84, 136, 138–139, 158–159, 176–177, 196, 202, 205–206, 214, 217, 237, 239, 270, 272–276, 281
health services	284–303, *see also* Community rehabilitation services
social services	304–324, *see also* Community rehabilitation services
Local Authority Social Services Act 1970	158, 304
Local liaison committees	138–139
Location of hospital rehabilitation facilities	102–105

	Paragraphs
Medical education in rehabilitation	54, 79, 81–82, 99, 120, 122, 136, 216, 297, 333–345
Chairs in rehabilitation	99, 337
educational function of the assessment clinic	136, 336, 339
further education	341–342
postgraduate education	54, 339–340
training of consultant psychiatrists in rehabilitation	216
training in psychiatry	343–345
undergraduate education	54, 297, 334–338
Medical interviewing committee	33, 59, *see also* Assessment clinic; Case conference
Medical rehabilitation centre	17, 102–104, 170
Medical staff concerned with rehabilitation apart from the consultant in rehabilitation	141–142
Mental handicap	20, 26–27, 236–239, 248
rehabilitation facilities	20, 237–239
special schools	187–188
special units for children	238
Mental illness	21, 27–28, 38, 48, 72–74, 87, 107–108, 205–235, 249, 316, 331, 343–345
consultant in charge of psychiatric rehabilitation	214–217
future pattern of services	204–209
industrial rehabilitation and therapy	21, 218–228, 231, 330–331
nursing staff	230–231
psychiatric day hospital	205, 208, 317
rehabilitation facilities	222–235
remedial staff	232–233
special units	213
workshops	234–235
Miners' rehabilitation centres	18
Mobile physiotherapy service	*see* Physiotherapy
Multiple handicaps	27, 87, 89, 179, 240–241, 246
National Assistance Act, 1948	66, 324
National Health Service Act, 1946	65
Non-medical co-ordinator	*see* Co-ordinator
Nursing staff	126, 143–148, 171, 206, 230–231, 346
hospital nurse	143–148
psychiatric nursing	146, 230–231
training	346
Occupational therapy	15, 58, 110, 112–113, 164, 189, 206, 234, 318, *see also* Remedial professions; Workshops
Organisation of the rehabilitation services	93–131
of the rehabilitation department	106–131
Out-patient department	*see* Report on
Paraplegics	*see* Spinal injuries
Partial incapacity	*see* Certificate of
Partially-sighted	*see* the Blind
Peripheral hospitals	110, 153, 299
Physiotherapy	15, 58, 78, 110, 113, 186, 189, 278, 282–283, 298, 300–301, *see also* Remedial professions
domiciliary and mobile services	300–302
equipment	113
for children	186, 189

	Paragraphs
in group practices	278
in health centres	110, 278, 283, 298
Piercy Committee	17, 53–54, 57, 68–70, 73, 87, 91, 93, 97, 100, 135–136
Portland Training College, Mansfield	329, *see also* Voluntary organisations
Postgraduate education	*see* Medical education
Psychiatric rehabilitation	*see* Mental illness
Publicity	*see* Information services
Queen Elizabeth's Training College, Leatherhead	329, *see also* Voluntary organisations
Queen's Institute of District Nursing	346, *see also* Nursing staff
Recuperative holidays	176, 304, 323, 325, *see also* Convalescence
Regional medical advisor on rehabilitation	100–101
Regional medical consultant	95, *see also* Employment Medical Advisory Service
Regional medical service	24, 61, 70, 95, *see also* Employment Medical Advisory Service
Rehabilitation centres	*see* Head injuries; Medical rehabilitation centres; Miners' rehabilitation centres; Wolfson Rehabilitation Centre
Rehabilitation facilities	*see* Existing statutory services
Rehabilitation in-patient treatment record card	*see* In-patient treatment card
Rehabilitation for Sick and Injured— memorandum by the Standing Medical Advisory Committee	53
Remedial gymnastics	78, *see also* Remedial professions
Remedial professions	15, 58, 76–82, 110, 112–113, 115, 121, 125, 130, 153–154, 180, 184, 186, 189, 197, 206, 232–233, 266, 276, 278, 280, 282–283, 300–302, 318, 346, 350
amalgamation	154
Committee on the Remedial Professions	76, *see also* Council for the Professions Supplementary to Medicine
co-ordinator in general rehabilitation department	*see* Co-ordinator
delegation of responsibility for day-to-day treatment	150
district nurse	302, 346
domiciliary treatment	*see* Physiotherapy
domiciliary visiting	280, 301
inadequate prescription	151–152
in the district general hospital	110, 112–113, 115, 121, 125, 153, 197
limb-fitting service	266
married women remedialists	80
nursing staff	143–148
psychiatric rehabilitation	232–233
salary "lead"	197
staff shortages	80
research and analysis	154–155, 180
training—pre and post registration	76,82, 347–353
treatment for children	180, 184, 186, 189
Remploy Ltd.	41, 135
Report of a Working Party on the Provision of Accident Services	247
Report of the Royal Commission on Medical Education	334, 343–345
Report of the Standing Medical Advisory Committee's Sub-Committee on Accident and Emergency Services	246

	Paragraphs
Report on the Working Party on Workshops for the Blind	213
Report on Contract and Pay Questions in Industrial Therapy Units	*see* King Edward's Hospital Fund for London
Report on Industrial Therapy in Psychiatric Hospitals	*see* King Edward's Hospital Fund for London
Report on Out-patient Departments and the Ambulance Service	293
Report on Physical Disability and Community Care in Tower Hamlets	306
Research	51, 56, 71, 98–99, 154–155, 180, 243–244, 268, 337
deafness	244
evaluation of remedial techniques	71, 98, 337
gaps in the rehabilitation services	56
partial-sight	243
prosthetics	268
voluntary organisations	98
work of the remedial professions	154–155, 180
Resettlement clinic	16, 59, 133, 136, *see also* Assessment clinic; Case conference; Piercy Committee
Residential accommodation	28, 31, 63, 153, 168–170, 237, 304, 309, 313–315, 325
Royal College of Nursing	65, 83, 145
Royal National Institute for the Blind	242, *see also* Voluntary organisations
Royal National Institute for the Deaf	244, *see also* Voluntary organisations
School Health Service	303
Seebohm Committee	*see* Committees
Severely disabled	16, 42, 248–255, 284, 314, 323
Sheltered employment	25, 40, 63–64, 135, 221–222, 237, 304, 309–310, 317, 320, 325, 331, *see also* Workshops
Sheltered housing	28
Social security including:	42
attendance allowance	42
sickness benefit	42
Social work	15–16, 30, 112, 158–159, 171–172, 181, 205–206, 244, 273, 280–281, 285, 304, 311–312
Special schools	*see* Children
Speech therapy	112, 156
Spinal injury	249, 253–255
St. Loye's College, Exeter	329, *see also* Voluntary organisations
Staff employment contracts	137
Staffing of hospital general rehabilitation department	140–156
Staffing of hospital general rehabilitation services	140–167
Staffing of hospital psychiatric rehabilitation services	203–235
Staff shortages	75, 80, 163, 167, 318
day centres	318
geriatric departments	75
remedial professions	80
workshops	163–167
Standing Medical Advisory Committee	*see* Committees
Standing Mental Health Advisory Committee	*see* Committees
Standing Nursing Advisory Committee	*see* Committees
Statistics	19, 24, 27, 37, 43–44, 67–71, 97, 234, 248, 259, 306

	Paragraphs
consultants in physical medicine	44
consultants in psychiatry and geriatrics	44
consultants in rehabilitation	43
convalescence	19
day centres	27
existing hospital rehabilitation services	43–45
head injuries	248
industrial rehabilitation units	24, 34, 37
limb-fitting centres	259
size of the rehabilitation problem	67–71, 97
survey of the handicapped	306
Statutory rehabilitation services	14–23
Stoke Mandeville Hospital	249, 253, *see also* Spinal injury
Study on absence from work after fractures of the wrist and hand	51
Survey of the handicapped	*see* Statistics
Temporary incapacity	51
Tetraplegics	*see* Spinal injuries
Transport	29, 31, 128, 131, 203, 291–294, 304
co-ordinator	131
voluntary organisations	31, 131
Trauma	246–247, *see also* Head injury; Spinal injury
Tuberculosis	241
Undergraduate education	*see* Medical education
Voluntary organisations	26–27, 31, 98, 176, 202, 269, 311, 316, 323–332
aims	326
industrial therapy organisation	330–331
Joint Council on Voluntary Work for the Disabled	328
Wolfson Rehabilitation Centre, Wimbledon	250–251, *see also* Head injury
Working Party on Medical Administrators	*see* Committees
Workshops	20, 25–26, 40–41, 63–64, 112, 114, 135, 163–167, 206, 208, 213, 218–228, 231, 233–235, 237, 304, 309–310, 317, 320, 325, 331
blind	213
contracts	167, 226–227
managers	164, 206, 234–235
mentally handicapped	20
mentally ill	208, 218–220, 222–228, 231, 234–235
sheltered	25, 40, 63–64, 135, 221–222, 237, 304, 309–310, 317, 320, 325, 331
staffing	163–167
World Health Organisation	86
Youth Employment Service	192–193, *see also* Children

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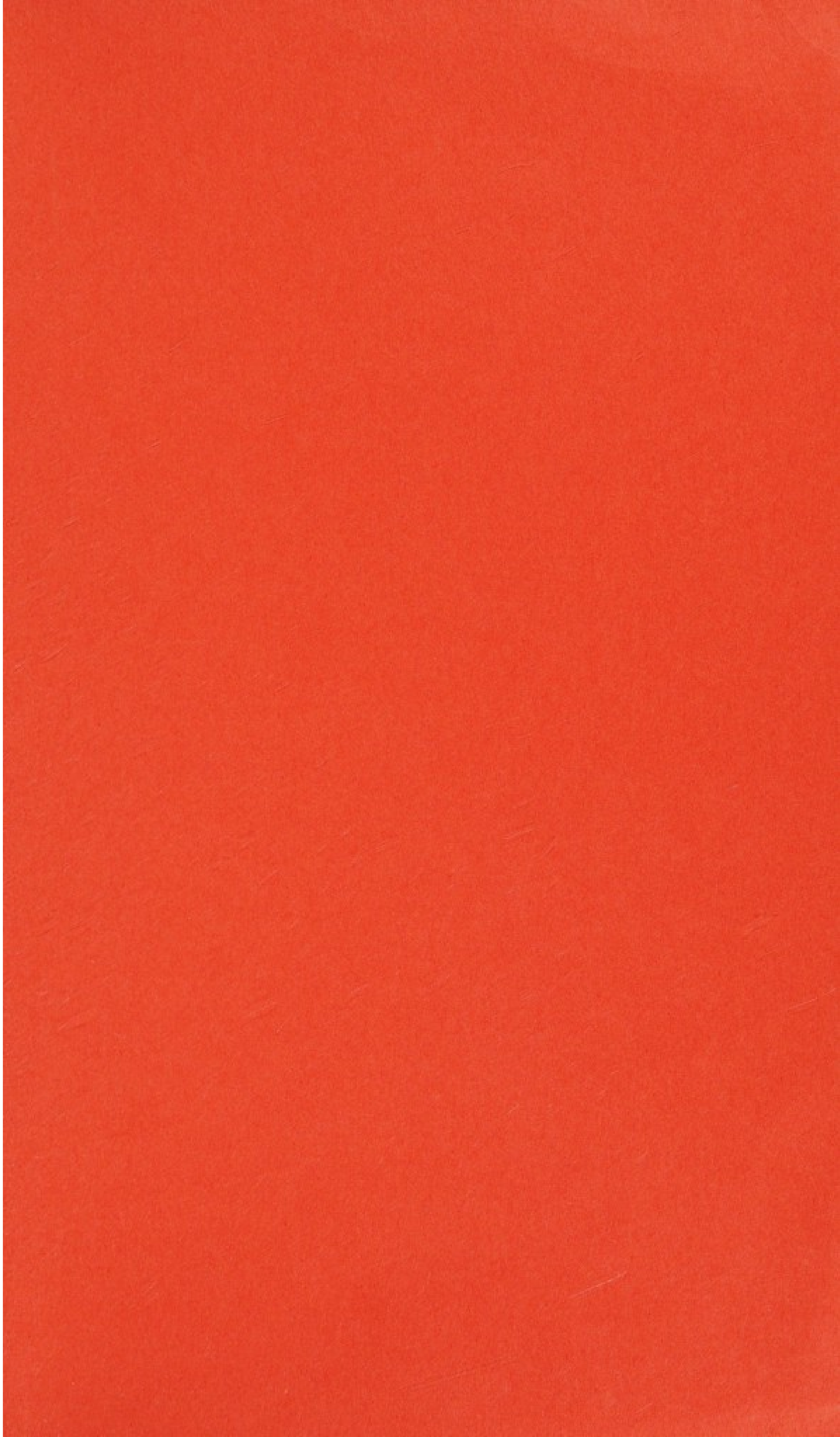

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