COMMISSION
OF THE
EUROPEAN COMMUNITIES

Directorate-General
for Social Affairs

Doc. No 3128/75 e

COMPARATIVE STUDY ON THE REHABILITATION OF HANDICAPPED PERSONS IN THE COUNTRIES OF THE COMMUNITY

Legal, administrative and technical aspects

VOLUME III

Denmark
Republic of Ireland
United Kingdom

Rapporteur : Dr James G. SOMMERVILLE

Interim edition

C O N T E N T S

Page

page

D E N M A R K

REHABILITATION SERVICES IN DENMARK

1. Summary of the Legal and Administrative Aspects

During recent years a complex of Acts based on the work of a special committee has been carried through in order to renew social legislation. The central administration is the responsibility of the National Office of Social Welfare which attends to all matters that previously belonged to the provinces of the Directorate of Child and Youth Welfare, the Directorate of Rehabilitation and Welfare Services and the National Service for the Mentally Retarded.

All persons residing in Denmark whose income does not exceed a certain level are entitled to free medical attention, free midwife's assistance, part payment of medicine, dentist treatment, physiotherapy treatment etc. For persons with an income exceeding this level, subsidies are granted towards the payment of part of the expenses of such benefits. The payment of daily benefit on account of illness is not limited in time, but not later than three months after the onset of the illness, and after that once every three months, the local welfare committee considers whether the payment of daily benefits should continue, or whether treatment or retraining is needed, or whether a social pension should be awarded. This must be done in co-operation with medical doctors, hospitals, rehabilitation institutions and the employment service. The central administration of the National Health Security Act, the Daily Cash Benefit Act and the Industrial Injuries Act lies with the National Social Security Office. At the moment the Danish parliament is dealing with legislation concerning a Bill of Social Assistance which is expected to take effect from April 1975. The main principle of this Bill is an administrative simplification which for

the individual person should result in the fact that any claim for social assistance should be addressed to the Social and Health Administration of the municipality where he is resident. The municipal authority can consult the Social Centre of the County and the types of assistance will be worked out in detail in relation to the needs of the individual. The system of cash benefits will be adjusted according to the regulations of extended assistance in the present legislation concerning social care.

The responsibility of establishing and running social institutions will be decentralised to counties and municipalities. Thus the rehabilitation offices will be closed but there are at the moment no intentions to decentralise the special care institutions and finally the financial provisions will be revised.

In addition to the help given by the State to disabled people, very significant contributions are provided by voluntary bodies who work in the field of rehabilitation. It is the State, usually through one of its twelve rehabilitation centres, which decides whether under the Rehabilitation Law assistance can be granted for job analysis, training, re-adaptation or education of the individual handicapped person. As far as possible efforts are made to rehabilitate persons in the ordinary educational system and the private labour market.

The handicapped person may also be referred to the private or municipal rehabilitation centres created under Section 5 of the Rehabilitation Law which receive State grants for their establishment and maintenance. By supervising these Centres, and making the grants subject to certain conditions, the State ensures they are operated

in accordance with the meaning of the Rehabilitation Law. The rehabilitation centres rulings in individual cases are co-ordinated primarily by a Central Court of Appeal.

1.1 The Concept of Handicap

There is no definition in Danish law of the term "handicapped person". So far as the Danish people are concerned, reference can be made to the definition given in Regulation 73 (1) adopted by the Council of Europe and relating to Social Services for the Physically or Mentally Handicapped. Therein handicapped persons are defined as persons who for physical or mental reasons encounter difficulties in their daily life and/or are in need of special action in respect of education, training, employment, standard of living or social adaptation.

1.2 Statistics - Estimated number of handicapped persons

There is no complete return of the number of handicapped persons as defined in Item 1 (1). The rule is to list persons who have applied for financial assistance, for occupational rehabilitation at a given time or within one financial year. In 1972 the rehabilitation centres treated just under 55,000 people. About 34,000 people received assistance under other special care provisions and about 22,000 under the provisions for the care of the mentally handicapped. Finally, about 129,000 people were in receipt of disablement pensions. As the same person may be registered both at a special care centre and a rehabilitation centre, or as being in receipt of a disablement pension, the above figures cannot be simply added together.

In publication No 16 of the Institute of Social Research, the number of handicapped persons aged 15 to 61 years outside institutions is given at about 65,000. For a person to be registered as handicapped

he must fulfil the conditions for being taken into special care. The total number of physically handicapped persons aged 15 to 61 whether registered or not in this way, is given by the Institute of Social Research at about 180,000, with about the same proportion of men as women. Of the 90,000 men, 80 % were gainfully employed.

As at the 31st March, 1972, 129,228 people were in receipt of disablement pensions; 17,790 women were in receipt of widow's pensions; 20,603 people were in receipt of early retirement pensions; a total of 167,621 people. According to reports from the rehabilitation institutions to the Social Welfare Board in the financial year 1971/1972 5,862 people were being maintained in Section 5 institutions on a doctor's certificate. 20,120 people were receving financial aid for their education and on the 31st March 1973 1,443 people were in sheltered employment. In the financial year 1971/1972 about 24,000 people applied for admission to or were referred to rehabilitation centres.

Information obtained from the Labour Directorate, based on reports from the employment exchanges in 1972/1973, shows that 8,800 handicapped persons applied for work at the official employment exchanges, of whom about 6,000 were referred from the rehabilitation centres and a total of 6,100 were offered jobs.

As at the 31st March, 1972, a total of 35,465 people were undergoing rehabilitation in Denmark.

1.3 The historic development of rehabilitation

A very comprehensive account of the development of assistance to disadvantaged people in Denmark is given in "Outlines of the National

Assistance Act" third revised edition, published by the Ministries of Labour and Social Affairs, International Relations Division, Copenhagen 1970. This account can be summarised.

As long as Denmark was a Roman Catholic country, poor relief was the responsibility of the church which saw to it that the old and sick, who were without resources to meet their requirements, were admitted to monasteries and charitable institutions where monks and nuns provided for their care and maintenance. After 1536, at the time of the Lutheran Reformation, the State took over the land of the church, while provincial towns took over most of the monasteries and charitable institutions in their locality.

In addition, the State became responsible for most of the former functions of the church, apart from poor relief. The reason that the State did not take over poor relief was because it lacked an external framework. The Grammar Schools and church buildings remained but the monasteries that were not pulled down had lost their importance now that the attendance of the monks and the nuns was no longer there. The revenue of the newly established church was small and due to the inadequate administrative machinery at that time remittance of money was impractical. As a result, poor relief became a purely municipal responsibility.

2. Mendicancy orders of the 24th September 1708 covering Copenhagen and the rest of the country respectively made provision for the poor. The chief purpose, however, was not that of helping the poor but of protecting the well-to-do classes against the importunities of the poor. The rules provided for paying as little as possible in order to put a stop to begging. Any additional assistance was considered superfluous.

According to the orders, needy persons were to be divided into three groups, a system maintained in Danish National Assistance legislation right up to the Poor Law of 1891.

The first group was composed of blind, bed-ridden and other persons being incapable of earning anything at all. The second group was made up of orphans and the third group of persons who owing to ill-health, a large family or for any other lawful reason were unable to meet their requirements. In other words, the orders applied to categories of persons who later came to be called the "deserving poor"; the "undeserving" ones being sent to the penitentiary.

The Poor Relief Scheme of 1799 made provisions for the Poor Relief Authorities to attend to all indigent persons, seeing to it that all who were capable of work were found employment - that sick people received treatment and that the young people got the necessary schooling.

A distinction was made between regular public charges and those who were granted assistance only in the case of illness. Moreover, provision was made for payment of assistance for redemption of tools from the pawnshop and payment of debts with a view to preventing people from becoming regular public charges; thus being a fore-runner of the idea of rehabilitation.

These provisions which were quite revolutionary for the age, had a sad fate due to the very ill-conceived organisation of finance. The Poor Relief Service had large receipts in periods of trade prosperity and very small receipts in slight periods when, of course, the call upon the services was greatest.

After 1807, when Danish trade and industry were subject to a very long term crisis, a disproportion arose between the receipts and

expenditure of the Poor Relief Service and this led to the abandonment of these excellent ideas.

In 1824 prohibition of marriage was introduced for those who had received poor relief without paying it back. The introduction of representative government in 1849 led to another legal effect which was applied immediately. Recipients of poor relief were deprived of the vote and of eligibility. Another way found to discourage people from claiming assistance was to introduce maintenance in workshop or poorhouse. Up to 1890 nearly 300 poor-houses were established. This strictness in developments led legislators to reconsider the appropriateness of dividing the applicants into "deserving" and "undeserving" poor, a distinction underlying the orders of 1708. In 1891 the law recognised that there were cases in which the public authorities could grant assistance without any legal effects, the care of the blind, the deaf, the mentally deficient and the insane in special institutions, members of sickness funds which had exhausted their right to benefits from the fund but continued to be ill, shipwrecked seafarers and, in time of war, family members of men called up to service.

The Social Reform Acts of 1933 did not in fact produce any sweeping reforms, the three types of assistance being maintained, poor relief, ordinary national assistance and special relief. The range of special relief was somewhat extended. In addition, the Social Reform Acts included up-to-date provisions on National Insurance relating to sickness funds and benefits to disabled persons and old people on industrial injuries, providing for all employers to take out an insurance for their workers against accidents; unemployment insurance and the setting up of unemployment offices.

Following the destruction in the Second World War, the Danish economy was reconstructed in the 1950's and social security legislation developed rapidly. So far as the handicapped were concerned, a number of ministerial advisory boards were set up and many provisions were provided for all types of disabled people. In particular, the provisions on rehabilitation became unified in one Statute and a number of rehabilitation centres were established to provide facilities for practical work.

Child care was separated from the National Assistance Act and came under the Child and Youth Welfare Act. The care of invalids and old-age pensioners was given special provision and legislation in 1969 on family allowances provided for advanced payments of maintenance to be transferred to that Act together with the rules relating to family allowances in respect of children of parents who had no known father or mother.

The history can be summarised by stating that social development has, on the whole, followed the same lines in Denmark as in most other European countries. From the time when social welfare was carried out mainly by the church, the family and the employer, there has been a steadily widening development until the present day when the State has more or less overtaken the responsibility of seeing that no citizen suffers material need on account of lost or never attained ability to work.

1.4 Basic legislative documents and their application

Following the earlier legislation which has been summarised in Section 1.3, laws were passed in April 1968 in relation to accident

insurance; in June 1972, in relation to daily allowances in cases of sickness or maternity; in April 1960 in relation to rehabilitation and in November 1969 in relation to Public Assistance.

Other Acts were passed in August 1956 in relation to Maternity Aid Institutions; in April 1970, on pensions and assistance for widows; in August 1970, in relation to childrens and young peoples welfare; in June 1972 on daily allowances in case of sickness or childbirth, and in April 1970 in relation to disablement pensions. These laws, their fields of application with regard to disabled people and the assistance which is provided as a result of this legislation are detailed in Appendix 1.

1.5 Financial responsibility

Generally speaking the National Assistance Act 1961 is of importance only to Danish citizens who for one reason or other have not made adequate provisions for themselves through saving or insurance, or where the period of entitlement has expired. More often than not, the social insurance system comes into operation in Denmark in the case of loss of income. Only when that system cannot provide the necessary help does the National Assistance Act become effective. The central administration is the responsibility of the National Office of Social Welfare which attends to all matters that previously belonged to the provinces of the Directorate of Child and Youth Welfare; the Directorate of Rehabilitation and Welfare Services and National Services for the Mentally Retarded. The municipal authorities provide facilities within their own areas. Present developments appear to suggest that in future the running of social institutions will be decentralised to counties and municipalities.

The financial responsibility in relation to the Act is shown in Appendix 1.

2 Systematic Study

2.1 Adaptation and social integration of children

The majority of infants in Denmark are born in the maternity wards of hospitals and both here and in the case of home and nursing home confinements, the midwife and the doctor are present and the infant is examined by the midwife and/or the doctor immediately after birth. If abnormalities are observed on this occasion or later in the first few months of life, the infant will generally be admitted to a paediatric ward for closer examination. For example, in cases of mental deficiency, hare lip and/or cleft palate and other malformations. The babies are screened shortly after birth for phenylketonuria. All children have the right to regular medical examinations - nine altogether from birth to school age, but there are no regulations about compulsory examinations. As a rule, the authorities responsible for the care of children and young people intervene in these fields only where and insofar as the parents cannot cope with the situation and the special provisions made have become inadequate. The main directive governing the care of children and young people is indicated in the following preamble to the Care of Children and Young Persons Act 1964 - "the purpose of the relevant care is to ensure that children and young people grow up under conditions likely to promote a sound, mental and physical development".

Local authorities and institutions are responsible for the care of children and carry this out by means of local child and youth welfare committees, homes for children and young people, child guidance centres, day care institutions and societies for the care of children and young people.

The central administration of care is performed by the following governmental agencies subordinate to the Ministry of Family Affairs : -

1. The Directorate of Child and Youth Welfare Services
2. The Economic Board of the Child and Youth Welfare
3. The Educational Board of the Child and Youth Welfare
4. The National Council of Child and Youth Welfare Services.

The blind and very weak sighted, the deaf and very hard of hearing, the mentally deficient or other particularly backward children with serious cases of word blindness or retarded reading ability, the special laws on the care of handicapped persons, impose on the doctors and the schools a specific duty to report such handicaps to the authorities responsible for this care. The doctors and the schools are moreover obliged to communicate with the appropriate rehabilitation centres if in their work among young people under the age of 18, they observe disorders which involves the need of special instruction, training or some other form of rehabilitation.

A government publication on the care of children and young people published by the Ministries of Labour and Social Affairs, International Relations Division, Copenhagen 1967, states that at the end of March 1965 a total of 11,064 children and young persons were in care outside their own homes, of whom 6,947 were boys and 4117 girls. 14 % were boarded out, 65 % were committed to homes for children and young people, of the 20 % remaining well over one half have been restored to their parents on probation, the rest being placed in apprenticeship service etc., or in hospitals or in institutions for handicapped persons. The number of day care institutions in relation to the percentage of population in respective ages is as follows : -

Day Nurseries	260
Nursing Schools	1,250
Recreation Centres	260
Special Playgrounds	25

The training for nursing school teachers and recreation centre teachers is of three years duration. Seventeen colleges train 1,200 nursery school teachers every year, five colleges train 400 recreation centre teachers each year. The Danish parliament has decided to increase facilities for the education of handicapped pupils, so that children can be taught in the primary schools in an ordinary educational environment, provided the parents so wish, and are able to care for the child at home and no institutional treatment is called for. The State is responsible for the running of schools for children who are too handicapped to be taught in the primary schools. There are five schools for the deaf, one for the blind and one for the physically handicapped with about 800 pupils in all schools. For mentally handicapped children there are boarding schools at each of the ten regional care centres with a total of about 2,300 pupils. The care centres also manage some 80 day schools with a total of 4,300 pupils. These pupils either live at home or at boarding homes run by the care centres. The Social Welfare Board is the main body responsible for the supervision of State special schools. Thirteen primary school centres for special educational treatment have been established with about 900 pupils in all, for children so handicapped that special educational treatment in the ordinary school is inadequate. These centres are supervised by the provincial authorities who are also responsible for the general supervision of the primary schools but the special centres advisory services are provided by the Ministry of Education.

Parents of handicapped children living at home are entitled by law to receive public assistance to defray special expenses in this connection. Financial aid is given towards additional expenses directly resulting from the maintenance of the child in consequence of its handicap. Under the special laws relating to welfare services for the blind and deaf, the special State schools give the parents of deaf and blind infants guidance on problems entailed by defects of vision, hearing, speech and language. Financial aid is also given if the child requires special food or there is a need for special furniture, or alterations to the home, to allow the child to remain at home in the care of his or her parents.

2.2 Medical Rehabilitation

The steps taken by public authorities to rehabilitate handicapped persons are based primarily on the Rehabilitation Law of 1960. Like all other citizens rehabilitees are covered by the general health and hospital services. Decisions on rehabilitation cases must be based on statements by general practitioners, specialists and hospitals relating to the person concerned. Furthermore, a doctor must always be consulted before it is actually decided to rehabilitate a person. Among the rehabilitation institutions approved under Section 5 of the Rehabilitation Law are seven rehabilitation clinics which are directed by doctors and whose staff include a relatively large number of therapists. Medical and therapeutic assistants can also be provided at other rehabilitation institutions. A large number of Danish hospitals have physiotherapy departments which are occupied in treating the patients referred to them. The patients are referred from the hospitals to the rehabilitation centres which do not form part of the hospital service, but in the

report of the Social Welfare Reform Commission it has been proposed that the rehabilitation centres should be transferred to the hospital service and the National Board of Health considers that this is a desirable move. It is not clear whether the intention is that such Centres, if transferred to the hospital service, would retain their identity or merely become extensions of the physiotherapy department. It would be undesirable if this was in fact to occur. There are tremendous advantages in separating physically the rehabilitation facilities from the hospital facilities, although they may, with advantage, be adjacent to each other.

One of the aims of the Rehabilitation Law was to bring about an administrative reform by setting up twelve regional rehabilitation centres which were among other things to co-ordinate and extend the rehabilitation efforts which were already being made, partly on private initiative and partly under among other things the legislation on the care of the handicapped persons, disability pensions and unemployment insurance. However, the Rehabilitation Law goes further on a number of points. The aim of this law is to relieve or to limit the sequelae of disablement or sickness irrespective of what has caused them by granting aids and assistance for special medical treatment and to initiate instruction, training, education and other occupational arrangements for handicapped people so that they may, as far as possible, achieve complete financial and social independence. The law concerns both persons who are handicapped on account of physical or mental disease and persons whose handicaps are essentially due to other causes, i.e. social.

Assistance under rehabilitation law is not conditional on membership of any insurance scheme and no stipulations are made with regard to

age, character or financial need.

During the 1960's it became necessary to adapt rehabilitation to the rest of the social assistance apparatus which in this period underwent extensive modernisation as regard both content and organisation.

The starting point for social assistance should be the individual of a family's overall social situation. Assistance may simultaneously be needed from the doctor, the family guidance counsellor, the vocational guidance counsellor, the psychologist and the social worker. A joint effort like this makes great demands on co-ordination between the individual members of the team. What is called the "single string system" which originated from the work of the Social Welfare Reform Commission is aimed precisely at creating the administrative conditions for effective social welfare efforts from the comprehensive point of view.

The present Bill brings together, in connection with the already implemented legislation on sickness, insurance and daily allowance, all the social welfare activities in a joint system on these principles. The organisational framework for this is already under construction in accordance with the 1970 law and in this legislation an effort has been made to gather a number of previously separate functions under one authority on both the government, the county and the municipal levels. At the same time, there has been a certain decentralisation of the duties. The main standpoint was that the Municipal Social Welfare Committees should bear the responsibility for the development of social welfare policy at the local level. This allocation of responsibility is to be followed by a concentration of powers in that the tasks which have hitherto been taken care of by the Health Insurance Societies, the

Family Guidance Bureaux, the Childrens and Young Persons Welfare Service and the Social Welfare Administration are brought together under the Social Welfare Administration. A social welfare centre will be built up under the Social Welfare and Public Health Committees in each county borough and this will take over a number of tasks which at present are being taken care of by the Maternity Aid and Rehabilitation Centres and other bodies and will perform certain supervisory and advisory functions in relation to the municipality. Furthermore, the social welfare centres will be assigned the task of preparing cases for the County Rehabilitation and Pensions Boards which are supposed to take over, among other things, the functions of the Disablement Insurance Tribunal. The County borough will in principle be made responsible for the social welfare developments in the County as it will be charged with the preparation of an overall social welfare development plan and will prepare annual reports.

On the central plain three Boards have been set up, the Social Welfare Board, the Insurance Board and the Appeals Board which replace a large number of direct trades tribunals and councils. Moreover a number of tasks which were previously looked after by the Ministry of Social Welfare have been transferred to the Boards. In consequence of the social welfare reform the government rehabilitation centres will be closed down - only the care of handicapped persons will remain under government control but this, incidentally, is also expected to be decentralised, in the long run, by transferring the hospital treatment to the hospital services, the training to the educational system and the occupational rehabilitation and the care facilities to the social welfare authorities.

Section 5 of the Law contains the following definition of the responsibilities of rehabilitation institutions :

(a) to test the working capacity of the handicapped person with a view to evaluating his prospects of obtaining gainful employment.

(b) to develop the handicapped person's working capacity in connection with medical treatment.

(c) to give handicapped persons occupational training or retraining previous to placing them in gainful employment.

(d) to give handicapped persons vocational training.

As at the 1st April 1973 there were 43 institutions with a total of 1,489 places. Seven of these institutions, with a total of 480 places, are rehabilitation clinics in which emphasis is given to the responsibilities outlined in (a) and (b) above.

2.3 Prosthetic and Orthotic Devices

Under Section 3 of the Rehabilitation Law the public authorities provide without regard to the recipient's earnings or financial circumstances assistance in obtaining artificial limbs, trusses and belts and a number of technical aids for handicapped persons.

The total expenditure under this provision in 1970/71 was about 58 million kroner of which about 10 million kroner was spent on artificial limbs, trusses and belts.

In 1970, about 1725 persons received artificial limbs. A "prosthetic team" consisting of a doctor, a maker of surgical aids and, on most occasions, an occupational therapist and/or a physiotherapist, decide when the prosthesis is to be prescribed.

No real international standard for prostheses has been laid down, but close international collaboration has resulted in the standards in the technically developed countries being fairly identical.

Surgical aids and parts of prostheses are duty-free, whereas raw materials such as leather, hide and felt, are dutiable. Surgical aids and prostheses are subject to a value-added tax of 15 %.

Four years training are required for an orthopaedic technician, followed by 2 ½ years of theoretical and practical work at a clinic. When the training is finished, the candidate is examined in accordance with the rules laid down by the Association of Surgical-aid Makers.

There is no established authority which makes decisions concerning the quality of prostheses or parts of prostheses. In practice, these decisions are made by the clinical team.

2.4 Career Guidance

All persons who are handicapped in the meaning of the Rehabilitation Law may apply to a rehabilitation centre for advice or occupational guidance, Section 14.3 of the Rehabilitation Law refers.

Vocational rehabilitation services are chiefly designed to settle or resettle the handicapped in open employment in normal competition with other applicants for work. Experience shows, however, that many handicapped persons require special assistance to meet their occupational problems. Considerable efforts are made through public and private enterprise to assist the handicapped in the occupational field. The basic view is that training or education for children and adults alike should as far as possible take place under the same conditions as for normal persons. Only when this is not possible is training provided in special institutions.

The general vocational and guidance services are the responsibility of the public employment service in close co-operation with the edu-

cational authorities. The purpose of vocational guidance is to give on the one hand a general information on occupational opportunities and on the other individual counselling service with a view to individual choice of occupation.

The general vocational and guidance services include a pre-vocational orientation at the workplace so as to familiarise the young person with the conditions of work and the climate of an ordinary workshop.

Normally the medical treatment will have been completed before vocational rehabilitation is started. On the other hand, it may happen that, while undergoing out-patient treatment at a hospital, a patient commences an actual vocational rehabilitation, concurrently with such treatment.

2.5 Vocational training

Since the end of the second world war a number of rehabilitation units or workshops have been established through funds provided from various sources, such as local authorities, voluntary organisations, the Ministry of Labour and the Ministry of Social Affairs. In addition to general work assessment these institutions provide an actual training in industrial work under conditions being adjusted as far as possible to those in local industry. The production of the workshops covers a variety of fields such as metal, wood, footwear, textiles, paper and gardening.

At present there are about 35 rehabilitation units capable of admitting a total of 1,000 people. The assistance granted during rehabilitation is free of charge for the handicapped and a maintenance allowance is paid in connection with such attendance and training. The criterion governing the amount of assistance is that the handicapped

and his family shall be able, during the period of rehabilitation, to maintain their previous standard of living within reasonable limits.

In 1970/1971 40.7 million kroner was spent on running institutions established under Section 5 of the Law, 33.7 million from the State and 7 million from the municipalities.

In addition to the training which has been described, occupational assistance is given under Sections 6 and 8 of the Law insofar as the expenditure is not prohibited by the Law relating to accident compensation, special care or by other statutory provisions. The relevant decisions are made by the rehabilitation centres or by the Rehabilitation Board.

In 1970/1971 expenditure for educational purposes under Section 6 was 72.2 million kroner and 2.2 million kroner was spent on providing tools, machinery etc., under Section 8.

2.6 Employment under normal conditions

Under Section 14(3) of the Rehabilitation Law handicapped persons are placed in suitable occupations in close collaboration with the rehabilitation centres and the official employment exchanges. Job consultants are engaged at the employment exchanges - their duties including the placement of handicapped persons. The granting of assistance for a telephone or a motor vehicle may be given where it contributes to meeting the occupational problem of the handicapped and further assistance may be granted for taking over or setting up a minor trade or business where, everything being considered, such is the best and most reasonable solution of the occupational problem of the handicapped. Such assistance may be considered say for the handicapped who

will be unable to keep up the pace of a wage-earner in an industrial undertaking. As a general rule, the assistance is granted in the form of a loan.

2.7 Sheltered employment

Under Section 10 of the Law, financial aid may be given to persons handicapped in obtaining ordinary employment. In 1970/1971 sheltered establishments received subsidies totalling 7.2 million kroner of which the State contributed 3.7 million and the municipalities 3.5 million. In addition, the State gave a subsidy of 1.6 million kroner to sheltered workshops.

Under Section 7 of the Law whenever a person is rehabilitated the Social Welfare Committee is obliged to relieve his needs and those of his family to whatever extent is considered necessary. These sheltered workshops are established by local authorities or as independent institutions and at present sheltered workshops in Denmark are capable of admitting about 700 disabled people.

The principle purpose of sheltered employment is that of providing opportunities for permanent employment of disabled people. Obviously, however, employment in a sheltered workshop may result in rehabilitation at a level that may enable the handicapped person to enter open employment.

2.8 Social integration

Many aspects of social integration have been dealt with under 2.4, 2.5, 2.6 and 2.7. However, much attention is given to training the disabled to cope with the demand of everyday living. By way of example those with a walking handicap will be trained in climbing and

descending stairs, boarding buses and trains and those who have lost the capacity to write with their right hand will be trained in writing with their left. Those suffering from acquired blindness will learn to manage in the traffic. Model kitchens for the rehabilitation of disabled housewives are found in certain hospitals and other institutions. In many cases, however, it is necessary to adjust the external conditions to the abilities and needs of the handicapped so as to enable them, as far as is possible, to become independent of outside assistance. In some cases, aids are granted as a loan. For example, wheel chairs, tape recorders etc. As a rule the assistance is granted by the Social Welfare Committee serving the place of residence of the handicapped; while certain cases are submitted to the Rehabilitation Board for decision.

Every effort is being made to publicise the fact that public buildings should be accessible to handicapped people and as the result of this, considerable progress in this respect has been made. It is interesting to note that pamphlets have been produced in the cities of Copenhagen and Aarhus explaining the conditions of entry to the railway stations, cinemas, theatres, department stores, museums, hotels, restaurants etc. Assistance can be given towards the purchase of wheel chairs, the purchase of hearing aids and also it is possible that a patient may be eligible for the installation of a telephone as well as for the payment for the charge of telephone subscriptions. In the Copenhagen area and in some other parts of the country, all pensioners are issued with a simple booklet setting out all the allowances they might be entitled to as well as details of other practical assistance offered. A similar booklet has been prepared for non-pensioners receiving public assistance. Maximum publicity is given to the whole range of

benefits available in a way that encourages people to take full advantage of the services and allowances offered. Practically all building of a public utility character is carried out with financial support under the housing law which under the Ministry of Housing may stipulate, as a condition for the grant of a government subsidy, that a certain proportion of the drawings are adapted for the use of handicapped persons. The tendency now is to make it obligatory for all housing to be adapted for the use of handicapped persons as far as is technically and financially possible. For example, the building regulations for boroughs and rural areas contain a provision to the effect that all those in dwellings provided for renting or built for sale must be at least 90 cms in width. Many of the municipalities grant financial aid on condition, for example, that 10 % of the dwellings are reserved for persons who have difficulties in walking, elderly people etc.

Within certain limits existing dwellings may be adapted with public financial support so that they can be used by handicapped persons.

In recent years great progress has been made with regard to the provision of technical aids for handicapped persons and financial assistance is granted to severely handicapped people to acquire such aids, irrespective of the fact that this improved provision has facilitated the social integration of handicapped persons who constantly meet with great difficulties in work places, in training situations and in daily life. It is considered that the main factors responsible for this are firstly, the lack of public knowledge of the problems of handicapped persons and the attitude of the general public towards the handicapped and secondly, a number of unsolved technical problems - for example, the means of communication available to persons with impaired hearing and vision.

In co-operation between the public authorities and a number of private travel agencies, handicapped persons (and old people) like the rest of the population, are now able to take cheap holidays abroad.

An increasing number of television programmes are being supplied with sub-titles for the benefit of the deaf and the hard-of-hearing.

Through the government-financed production of films in sign language, the deaf receive, amongst other things, information on current events, entertainments etc. Furthermore, the State has lent, free of charge, a large number of video-recorders to deaf persons.

In some churches, cinemas and other public premises, telephone loops are provided for disabled people.

As far as the blind are concerned, the State lends them, free of charge, tape-recorders and tape-recordings.

3 General Considerations

3.1 Assessment of Requirements at National Level - Programme of Economic Development and Programme of Rehabilitation

A proper current evaluation of need is made by analysing the actual development at the Rehabilitation Centres institutions on the basis of statistical reports. Following this a running adjustment is made of the resources which are to be used in rehabilitation work. In addition, the Institution of Social Research in Denmark draws up summaries of needs by making individual representative questionnaire enquiries of the whole population.

Examples that may be mentioned are the Handicapped Persons Enquiry and the Social Reform Enquiry.

Finally attempts were made in 1970 and 1973 to evaluate future needs through the work on the account of the prospective plan sent to

the Danish Ministry of Finance.

As regards the special enquiries the Directorate of Rehabilitation and Care prepared the report entitled "A Follow-up Investigation of some Rehabilitation Centres". In addition, the Publication No. 30 of the Institute of Social Research entitled "Sheltered Employment - Advantages and Disadvantages of Employment under Sheltered Conditions" was published in 1968. All information concerning cost which is available has been incorporated in this paper under the relevant headings.

3.2 Information, Documentation and Research

Within the field of rehabilitation and the care of handicapped persons no systematic programme of experimentation and research has been carried out up to the present time. However, in Section 3.1 certain aspects which could be considered to be research have already been referred to. At the John Kennedy Institute, run by the National Association against Poliomyelitis, scientific work is being carried out on methods of job testing and analysis of job requirements. In the care of the mentally handicapped, research work on education, social and medical subjects is organised and pursued by the Research Committee of the Mental Deficiency Service. Educational and psychological research concerning the mentally handicapped is also in progress in the research departments of the Social Welfare Board and medical research on mental deficiency is also going on at the John F. Kennedy Institute which consists of a nursing home and a research department for phenylketonuria and also a chromosome laboratory.

3.3 Instruction for specialists

The training of doctors does not include any particular instruction in rehabilitation. The physiotherapy speciality includes systematic

clinical training in rehabilitation and is, therefore, known as "physiotherapy and rehabilitation". The training of psychologists does not include any systematic instruction in the rehabilitation of the handicapped but as this training is largely project and problem orientated, many students of psychology have opportunities to become acquainted with these special fields.

The training of social workers and other courses of training for work in the field of social welfare and public health includes rehabilitation studies with varying amount of emphasis on the instruction in social welfare law and methods of treatment. However, the consultants employed at the Rehabilitation Centres are also obliged to take Courses in labour market conditions. Work in these fields helps to promote the professions which play a part in the rehabilitation of handicapped persons. It also assists to raise their status and facilitate team-work by making each aware of the other's contribution in this respect. No particular information work is carried out on the rehabilitation and employment of handicapped persons but occupational information is sent out by the Labour Directorate which administers the public employment agencies to both the vocational guidance counsellors and the employment bureau and the consultants at the Rehabilitation Centres. The following institutions produce or distribute audio/visual instructions for the use of staff or handicapped persons.

1. <u>Institutions for groups of persons with single handicaps</u>

Materials Laboratory
Refsnaesskolen (State Boarding School for the Blind and
4400 Kalundborg Weaksighted)

(National Institute for the Blind and Weaksighted)
Rymarksvej 1, 2900 Hellerup.

Library of Textbooks for the Blind
(National Institute for the Blind and Weaksighted)
Rymarksvej 1, 2900 Hellerup

Films for the Deaf
National School for the Deaf
Kastelsvej 58, 2100 København Ø.

Special School for the Hard-of-Hearing
Kollegievej 1, 9000 Aalborg

Fredericiaskolen,
National School for the Deaf and Hard-of-Hearing
Dronningensgade 99, 7000 Fredericia

The Deaf Institutes' Materials Centre (for adult education)
Nørregade 42, 8000 Aarhus C.

Geelsgard Boarding School (for disabled children)
Kongevejen 252, 2830 Virum.

2. Institutions for groups of persons with multiple handicaps

(Materials Laboratory for Special Instruction in the Primary School), Bethaniagade 2B, 7400 Heming

Staff College
Islands Brygge 83 A, 2300 København S.

National Film Centre
Vestergade 27, 1456 København K

National Educational Study Collection

The Society and Home for the Disabled is a private foundation which provides extensive facilities for treating disabled people. It controls orthopaedic treatment institutions, schools and nursery schools for disabled children and vocational establishments for young disabled persons. It has an international reputation as have the statutory bodies dealing with disabled people in Denmark. The State refunds all expenses incurred by the Society under the legislation dealing with Special Care.

APPENDIX 1

Basic Legal Text	Field of application with regard to persons	What assistance can be given
Law of 26 April 1968 on accident insurance	Every worker in permanent or temporary employment	Disablement compensation, medical treatment, compensation for surviving relatives and possibly funeral benefit in connection with an accident or an occupational disease
Law of 7 June 1972 on daily allowance in case of sickness or maternity	Self-employed persons	Daily voluntary-insurance allowances as compensation for loss of income, on account of sickness or maternity, in the first 5 weeks of the period of absence from work. Amounts to 90 % of previous income (On daily compulsory-insurance allowances after 5 weeks incapacity for work)
	Persons who do housework in their own homes	Daily voluntary-insurance allowances from the first day on sick leave after 1 week's sickness.
Law of 29 April 1960 on rehabilitation, Sections 5-6	Handicapped persons, irrespective of whether the handicap is due to physical or mental disease or to mainly social causes	Assistance during rehabilitation with special expenses connected with the rehabilitation (for example), school fees, books and fares and for food, personal necessaries, clothing and lodgings. The assistance is normally given according to fixed rates, but if the person is rehabilitated at an institution under conditions similar to those at work, it is equivalent to the minimum wage. If the person is rehabilited in private employment the assistance is given in the form of a supplement to the wage, up to the minimum-wage level. It is granted without a means test and with no obligation to repay. In connection with further education at the university or a similar institution however part of the assistance is given in the form of loan.

APPENDIX 1

Basic Legal Text	Field of application with regard to persons	What assistance can be given
Law of 29 April 1960 on rehabilitation, Section 7		If the rehabilitee is the family breadwinner, supplementary assistance for the family's maintenance may be granted. This assistance is subject to a means test.
Law of 10 November 1969 on public assistance Section 56	Single persons with one or more dependent children under 18 years of age	Assistance with maintenance etc., during their education. The assistance is subject to a means test.
Law of 10 November 1969 on public assistance Section 53	Persons suffering from tuberculosis or poliomyelitis or the sequelae of these diseases or from other diseases, when the illness has lasted 3 months and it is considered that it will result in incapacity for work for an even longer period.	Assistance with maintenance etc. for the person concerned and his family for up to 2 years (in special cases 4 years). The assistance is subject to a means test.
Law of 10 November 1969 on public assistance Sections 70-72 (and also the special laws on the deaf and hard-of-hearing (27 January 1950), the blind and very weak-sighted (11 May 1956) and the mentally handicapped and other particularly backward persons (5 June 1959)	Mentally diseased, mentally deficient and other particularly backward persons, epileptics, disabled persons, persons suffering from speech defects and word blindness, the blind and weak-sighted and the deaf and hard-of-hearing.	Financial assistance in connection with upbringing (education), maintenance, treatment and nursing, either in institutions or outside them. Under this law, financial assistance may be given to cover additional expenses if the person is maintained in his or her own home. The assistance is generally not subject to a means test until the person has reached the age of 60.
Law of 10 November 1969 on public assistance Section 73	Children with physical or mental discrders who do not fall in the above group	Financial assistance to cover additional expenses if the child is maintained at home. The assistance is not subject to a means test

APPENDIX 1

Basic Legal Text	Field of application with regard to persons	What assistance can be given
Law of 24 August 1956 on maternity-aid institutions	Single mothers with one or more children less than 2 years old	Assistance with maintenance etc. during education. The assistance is not subject to a means test.
Law of 15 April, 1970 on pensions and assistance for widows etc.	Widows, irrespective of whether they have children or not	Assistance with maintenance etc. during education. The assistance is subject to a means test.
Law of 28 August 1970 on children's and young person's welfare	Children and adolescents who receive assistance from the Children's and Young Person's Welfare Department	Assistance with maintenance etc. in connection with education among other things. The assistance is not subject to a means test.
Law of 7 June 1972 on daily allowances in case of sickness or child-birth	Wage-earners	Daily allowances as compensation for loss of income from employment in case of incapacity for work on account of sickness, including injury or maternity. Amounts to 90% of the income from employment and is given from the first day of absence from work
Law of 7 June 1972 on daily allowances in case of sickness or child-birth	Self-employed persons	Daily allowances of 90% of the income with qualifies for such allowances after 5 week's sickness (on voluntary insurance to secure daily allowances in the first 5 weeks. At the latest, 4 months after the sickness commenced, an enquiry must be made in both groups as to whether there is need of treatment rehabilitation, super-annuation and guidance and perhaps other assistance for the insured person and his family.

APPENDIX 1

Basic Legal Text	Field of application with regard to persons	Assistance granted
Law of 15 April 1970 on disablement pensions etc.	Persons whose earning capacity has been permanently reduced an account of physical or mental disablement	Disablement pension, which is divided into three grades, according to the degree of disablement : (1) The maximum disablement pension is awarded to persons whose earning capacity has been reduced by 100 %. (2) The medium disablement pension is award to persons whose earning capacity has been reduced by 66 % of the normal. (3) The minimum disablement pension is awarded to persons whose earning capacity has been reduced by 50 % of the normal.

REPUBLIC OF IRELAND

REHABILITATION SERVICES IN THE REPUBLIC OF IRELAND

1. Summary of the legal and administrative aspects

The Department of Health, under the direction of the Minister for Health, is responsible for the essential direction of health services. This responsibility involves the determination of national policy, the preparation of legislation and the financing of the services. The organisation and provision of health services at local level is the responsibility of Health Boards. For this purpose the country is divided into eight areas, each administered by a Health Board which includes representatives of the main local authority and of the medical and paramedical professions. The operation and planning of the health services in each Health Board area is carried out under three separate programmes, in general hospitals, in special hospitals and community care with a programme manager in charge of each. At the moment community care services are being restructured. The intention is to divide each Health Board into a number of community care districts - each under the direction of a director of community care.

In 1967 the Minister of Health established the National Rehabilitation Board under the Health Corporate Bodies Act of 1961. The Board consists of not more than 20 members inclusive of the chairman and all members give their services in a voluntary capacity. The Board is charged with the function of supervising, operating or arranging for the operation of services for the welfare of persons who are disabled as a result of physical defect or injury, mental handicap or mental illness. The services include the following :

(a) the co-ordination of voluntary bodies engaged in the provision of rehabilitation and training services for disabled persons;

(b) the giving of medical treatment to disabled persons;

(c) the provision of a service for the assessment of disability and the giving of vocational guidance to disabled persons;

(d) the training of disabled persons for employment suitable to their condition of health;

(e) the provision of a service for the placement of disabled persons in employment;

(f) the making of arrangements with other bodies for training disabled persons.

Other functions include the furnishing to the Minister or to any Health Board of advice, information and assistance in relation to any aspect of rehabilitation services. The Board is also charged with the provision of courses of training for students of occupational therapy and speech therapy.

1.1 The concept of handicap

Both the Disabled Persons (Rehabilitation) Regulations 1973 and the Disabled Persons (Maintenance Allowances) Regulations 1973 made under the Health Act 1970 define a disabled person as a person who is substantially handicapped in undertaking work of a kind which if he is not suffering from that disability would be suited to his age, experience and qualifications.

The Government consider that this definition is sufficiently wide to embrace both the mentally ill and the mentally handicapped. The latter categories are not defined by law in Ireland. However, in broad terms, mentally ill is used to describe those people who are born with a normal mind which developes normally but breaks down through stress or strain. The mentally handicapped are those who by reason of arrested or incomplete

development of mind have a marked lack of intelligence and either temporarily or permenantly inadequate adaptation to their environment. Insofar as intelligence quotient can be used as a measure of mental handicap, mentally handicapped persons would generally have an intelligence quotient less than 70.

1.2 Statistics, estimated number of handicapped persons

Comprehensive figures are not available in Ireland as to the number of adult disabled persons in the country. There is, however, a number of sources of information of which the main ones are, firstly the lists of persons receiving disabled persons maintenance allowances from Health Boards, secondly the register of persons receiving invalidity and long term sickness benefits under the social services scheme and, thirdly, the total of mentally handicapped and mentally ill undergoing care.

In addition, there are probably thousands of unidentified handicapped persons living in the community who are not in receipt of public allowances either because they are ineligible because of means or have not sought them. Some of these may be self-employed or in paid employment but may be working at a level below their potential because they have received no training or guidance to fit them into employment suitable for their full potential. Taking all these persons into consideration, it has been estimated that there are altogether between 80,000 and 100,000 people over 16 and under 70 years of age in Ireland. The figures include physically and mentally handicapped including the mentally ill.

The latest figures show that there are 25,065 disabled people in receipt of maintenance allowances; that there are 28,000 people in receipt of long term disability benefit under the Social Welfare Act and that there are about 6,000 blind people who are drawing pensions.

The handicapped people in the country can be divided into two major groups, (1) those in institutions and (2) those in the community.

1. In institutions, mental hospitals, excluding short-term patients, approximately	12,000
Mental handicapped institutions, residential and day, approximately	3,000
County homes and other institutions for infirm and handicapped persons	10,000
2. In the community : On disabled persons maintenance allowances	25,065
On Dept. of Social Welfare benefits, long-term disability benefits	28,000
Invalidity pensions	8,000
Occupational injury benefits	5,000
Other handicapped persons, approx.	10,000

There is a certain amount of duplication in these figures. For example, some mental hospital patients are in receipt of long-term disability benefits or invalidity benefits but the total figure appears to provide a reasonably valid estimate of the number of adult persons in the population with a long-term physical or mental handicap. Precise figures are not available but it is estimated that about 2,500 handicapped persons are seeking employment each year. The estimated number undergoing rehabilitation, either in training centres and sheltered or industrial workshops is 4,000. The source of these figures is either the information provided by the Government of Ireland to the Directorate General for Social Affairs or information contained in a Working Party Report which was established by the Minister for Health entitled "Training and Employing the Handicapped".

It is interesting to note that Dr Kennedy, Director of the Economic and Social Research Institute, Dublin concluded that it was likely that the State would recover more than it spent on rehabilitation, something that would be difficult to show from many other categories of State spending. This comment was published in the Economics of Rehabilitation in Public Affairs, April 1974.

1.3 Historic development of rehabilitation

No information under this heading has been provided by the Irish Government. However, it is clear, from a study of the literature, that as is common in many countries the early attempts to provide rehabilitation services were initiated by individuals who developed voluntary bodies to achieve this end. In Ireland, the early efforts to rehabilitate disabled children, for example, were due to the efforts of Lady Valerie Goulding who has worked in this field for many years and has been successful in raising the necessary finance to produce a large central remedial clinic on the outskirts of Dublin. There has also been early pioneer work carried out by Mr John Bermingham, Secretary of the Cork Polio and General After-Care Association, Mr Frank Cahill, General Manager, Rehabilitation Institute Limited and Dr Thomas Gregg, Medical Director of the National Rehabilitation Board. The first formal efforts made by the Government in this respect are referred to under the next heading.

1.4 Basic Legislative Documents and their application

The main Government acts which are involved in relation to this study are : -

1. The Health Act of 1970
2. Social Welfare Acts which were made operable between 1950 and 1973 :

The Occupational Injuries Act of 1966
The Health Contribution Acts of 1971
The Disabled Persons Rehabilitation Regulations of 1973 and the Disabled Persons Maintenance Allowances Regulations of 1973 which were made under the Health Act of 1970.

The details of how these legislative provisions are applied are shown in Appendix 1.

1.5 Financial responsibility

The cost of the operation of the health services is borne partially by central taxation and partially by local taxation. As has been stated it is in accordance with Government policy that the cost will shortly be transferred entirely to central taxation. However, at the present time it is worth noting that a very substantial part of the cost is met by voluntary agencies. The financial responsibility in relation to the Acts is shown in Appendix 1.

2 Systematic Study

2.1 Adaptation and social integration of children

The Child Health Service provides for detailed clinical and neurological examination of pre-school children at the ages of six months, 12 months and 24 months. There is also a scheme for the medical examination of infants in the first and sixth week of life whose parents are entitled to the full range of health services free of charge. A national phenylketonuria testing service has been in operation for a number of years. A coverage of 95,3% of all births is being achieved. The detection rate is approximately 1 in 5,000. There is also a service for the comprehension assessment of the mentally handicapped by multidisciplinary teams comprising psychiatrists, psychologists and social workers.

Medical examination of infants for the detection of injuries or abnormalities is not, however, obligatory. The detection services described above are regarded as sufficiently comprehensive to enable needs to be evaluated.

Special schools and classes exist for the handicapped child, e.g. blind, deaf, physically and mentally handicapped and there are special classes for slow learners in some schools.

Lists of recognised special schools and classes for handicapped children are shown in Appendix 2. The educational aspects of these schools is under the control of the Department of Education. The medical examination of all children at National schools is provided under the school medical service of the local Health Boards.

All children with the following long term conditions are entitled to free in-patient services and necessary drugs and medicines - mental handicap, mental illness, phenylketonuria, cystic fibrosis, spina bifida, hydrocephalus, haemophilia, cerebral palsy, epilepsy and malformations or abnormalities attributable to the drug thalidomide. Children suffering from diabetes are also entitled to necessary drugs free of charge.

A scheme is in operation for the payment of allowances to parents for the domiciliary care of severely handicapped children who need constant care.

2.2 Medical rehabilitation

In the Republic of Ireland there does not appear to be a concept of functional or occupational rehabilitation centres and certainly they are not defined by law. In fact, the emphasis appears to be on using the term 'rehabilitation' in relation to the retraining of disabled

people rather than in relation to treating them initially for the diseases or injuries which have made them unable to continue with their previous occupation. However, the Terms of Reference of the National Rehabilitation Board certainly include the giving of medical treatment to disabled persons and there is no doubt that such treatment is given at such Centres as the National Rehabilitation Centre at Dun Laoghaire and at the Central Remedial Clinic at Dublin. There is also a day centre attached to St Anthony's Hospital in Dublin. The general tendency in Ireland appears to be to equate medical rehabilitation with the provision of intermittent physiotherapy and occupational therapy in the departments in the hospitals. This attitude is in no way unique to the Republic of Ireland but it often means that many disabled people are given far less adequate treatment than they in fact require to overcome their disability, so far as is possible, with the minimum of delay. In view of this the information provided by the Republic of Ireland in relation to rehabilitation training centres is dealt with under section 2.4. It is to be hoped that the future activities of the National Rehabilitation Board will help to spread the information that rehabilitation is a continuous process which starts in the ambulance and that no amount of rehabilitation at a later stage will undo the harm that results from a patient having either poor definitive treatment or inadequate treatment at an early stage in relation to the individual disability.

2.3 Prosthetic and orthotic devices

262 lower limbs and 86 upper limbs were supplied in 1970 through the National Medical Rehabilitation Centre, otherwise amputees made their own arrangements and there is no information concerning the total number of people involved. The National Medical Rehabilitation Centre is

responsible for the various procedures in the provision of artificial limbs to applicants. The Centre has a limb fitting unit and orders limbs from abroad where necessary. Limbs are supplied to Medical Doctors' specifications to suit applicants requirements and standards of quality of the limbs supplied are checked by medical specialists.

No duty is paid on imported limbs or parts used specifically for the assembly of limbs.

Before commencing training as a limb maker a trainee must have 3-4 years experience in wood or metal and have obtained a Junior Trade Certificate from the Department of Education. This is followed by a three year course of training in limb-fitting. The actual fitting of the limb is supervised by a medical specialist.

All limbs supplied through the Health Services are tested for quality and proper fit by medical specialists employed by the National Medical Rehabilitation Centre.

2.4 Career guidance

The National Rehabilitation Board includes in its activities an assessment and guidance service for disabled people and operates a service for their placement in employment. This service operates as a link between the training centres and the employers. Cases are referred to this service by social workers, doctors and organisations for the handicapped. The Health Board also arranges, in special cases, for training and assessment to be carried out. It is the function of the Placement Officers employed by the National Rehabilitation Board to place handicapped persons in suitable employment where possible.

The Placement Officer keeps in touch with trainees in the initial stages of their employment. The report of the Working Party established

by the Minister for Health on training and employing the handicapped states that the present arrangements for bringing such persons to notice are haphazard and that while the National Rehabilitation Board has this service its use varies according to the interest and enthusiasm shown by local officials and voluntary organisation. This report estimates that there are at least 15,000 handicapped persons in the country who are potentially employable.

2.5 Vocational training

The Health Act 1970 provides that a Health Board shall make available a service for the training of disabled persons for employment suitable to their condition of health and for the making of arrangements with employers for placing disabled persons in employment. This responsibility is shared by the National Rehabilitation Board and it is not always clear whose particular responsibility it is to deal with the individual case. A list of rehabilitation training centres is attached - Appendix 3. In addition to these training centres there are industrial workshops attached to most psychiatric hospitals and centres for the adult mentally handicapped. Long stay institutions such as orthopaedic or tuberculosis hospitals have occupational therapy units. There are also a number of sheltered workshops at community level for handicapped persons which are operated by Health Boards and by voluntary bodies with support from the Health Boards.

Appendix 3 shows the types of training available at the various institutions. Occupations are chosen by reason of their suitability and the availability of employment. The responsibility for the co-ordination of the various training centres was assumed by the National Rehabilitation Board in 1963. It operates a placement service which acts as a link between the training centre and employers. It is a function of the Placement Officers employed by the National Rehabilitation Board to place handicapped

persons in suitable employment where possible. The Placement Officer keeps in touch with trainees in the initial stages of their employment. In some cases it is necessary for short periods to supplement wages by maintenance allowances. Accomodation problems are usually settled by Welfare Officers attached to the Placement Services. Grants of up to £ 400 are available to disabled persons who are licensed to drive, towards the purchase of cars for getting to and from their work. Voluntary bodies often make up the balance of the cost of cars.

2.6 Employment under normal conditions

There is no obligation on employers to employ handicapped persons. Legislation to improve the employment prospects of handicapped persons is under consideration. Placement Officers have built up a commendable rapport with employers in the public and private sectors and these contacts are used to the best advantage towards the employment of handicapped persons or their retraining.

The Minister for Health has requested public authorities to consider specially the employment of the disabled in all suitable cases. If the need for temporary or part-time work arises the Placement Officer would endeavour to make the necessary arrangements. It would depend on the goodwill of the employer and it would not constitute a normal practice in the Republic. The Working Party report points out that the ultimate objective for handicapped persons undergoing rehabilitation should be **integration into** open employment and the Working Party suggests that it may be necessary to provide some **inducement** to cushion employers against the risk that they may suffer by employing a handicapped worker. The Working Party believes that the public sector, the Civil Service, the Local Authorities, the Health Board and public enterprises should set a dead-line in relation to the

employment of the handicapped.

It is also suggested that selected posts in the public service should be designated as carrying special preference for handicapped persons and that there should be an extension of the practice, operated by some public authorities, under which a small number of posts are filled on a part-time basis by persons recuperating from mental or physical disability as a final step in their rehabilitation.

2.7 Sheltered employment

Sheltered workshops for disabled persons are not provided for by law. Some voluntary bodies operate workshops for persons who are inadequate for commercial employment. There are 50 workshops in the Republic catering for approximately 3,400 disabled people. In such workshops it is mainly light assembly and home-craft work which is carried out. The line of work is chosen, having regard to its suitability for the disabled person being catered for, the commercial possibilities for any products produced and the extent of finance available. There is provision whereby bodies and organisations engaged in operating special workshops may obtain financial assistance towards the initial establishments of the workshop and also in relation to its continued functioning. A few of the larger workshops operate on a semi-commercial basis where production is geared to the sale of products. The proportion of such workshops which offer accomodation as well as work is about 15 %.

2.8 Social integration

Building regulations issued by the Minister for Local Government provide in the design of public swimming pools of ramp access to facilitate persons using wheel-chairs. Regulations also provide special access facilities, where practicable, in all new public buildings. The Minister has

also appealed to local authorities when planning housing schemes to advert to and provide for the special needs of handicapped people. The existence of a permanent handicap of a certain degree of severity does not confer a priority right to obtain allocation of accomodation. However, special grants are available ranging from two-thirds of the total cost of re-construction to provide an additional room designed to meet the special needs of a disabled person or the provision of bathroom and toilet facilities at ground floor level. Other works for which grants are available include ramps, widening door openings, lowering door handles, light switches etc.

Building regulations require all new public buildings to have facilities for wheel-chair cases, i.e. ramp access, sufficiently wide door openings, suitable light switches, door handles etc. In regard to public transport there are no special construction requirements but ramps can be provided at railway stations for wheel-chairs. Disabled persons purchasing cars are entitled to recoup V.A.T. imposed on vehicles by law.

The question of grants of up to £400 being paid to assist disabled persons to buy cars for the purpose of getting employment or holding down a job has been mentioned earlier. Very seriously disabled persons (without the use of each leg) are entitled to recoup duty paid on petrol and are exempted from motor taxation. It has been suggested that free telephone services for disabled people who live alone would play an important part in social integration. Such a service is presently under consideration.

Voluntary organisations cater for the social integration of disabled persons through the organisation of social events and by promoting annual holidays, providing sports facilities and organising various cultural activities.

3. General considerations

3.1 Assessment of requirements at national level, programme of economic development and programme of rehabilitation

District Medical Officers bring local rehabilitation needs to the notice of Area Health Boards. Employment prospects for individual handicapped persons are discussed with the Area Placement Officers. The National Rehabilitation Board in 1970 commissioned a European expert in the rehabilitation field to evaluate and make recommendations on the rehabilitation requirements of the State. The objectives which are laid down in economic development plans and programmes, in operation, or in preparation, in respect of the rehabilitation and employment of handicapped persons endeavour, as far as possible, to remove obstacles which hinder handicapped persons in matters of employment and social integration, in the event of the State being unable to undertake the complete responsibility to create the necessary conditions to enable voluntary bodies to give maximum assistance in the development of social facilities, sheltered workshops and advisory services.

3.2 Information and documentation and research

The National Rehabilitation Board, which is a state sponsored body, operates in relation to assessment, training and placement schemes for handicapped persons whether they have physical or mental disabilities. It is a function of the National Rehabilitation Board to research matters in the rehabilitation field. There are two state sponsored research bodies, i.e. the National Medical Research Council and the Medico-Social Research Board which are available if required to research specific matters in relation to rehabilitation. The main source of specialised information material relating to rehabilitation and employment of handicapped people

is the National Rehabilitation Board, 25 Clyde Road, Ballsbridge, Dublin 4.

The National Rehabilitation Board operates a 'Hearing Aid' service, which embraces assessment and supply of units. Two colleges for the blind - St Joseph's and St Mary's operate their own machines for the production of braille. The Irish Association for the Blind also operates a braille printing unit and maintains a braille library.

3.3 Instruction for specialists

There is no formal training procedure, as such, for doctors and psychologists employed in the rehabilitation of the handicapped. The National Rehabilitation Board require members recruited to the Board's employment to have special aptitudes and wide experience in rehabilitation. The Board operates two training colleges for paramedical personnel, i.e. a College of Occupational Therapy and a College of Speech Therapy, both colleges are internationally recognised. When organisations such as Rehabilitation International hold Seminars in the Republic the government provides generous help in relation to providing facilities in relation to such conferences and also, on occasions, supports them financially.

APPENDIX 1

1.4 Basic Legislative Documents and their application

(1)

Scheme	Basic Legal Text	Field of application	Assistance granted
Health Scheme	Health Contributions Acts 1971	+Persons with incomes up to £1,600 p.a.	Full or limited eligibility for Hospital and Out-Patient services
Welfare Scheme	Social Welfare Acts 1950 to 1973	+Wage and salary earners up to £1,600	Fixed Weekly Allowances
Workmen's Compensation	Occupational Injuries Act 1966	do.	do.

(2) (Non-contributory)

Disablement Allowances	Health Act, 1970 (Section 69)	Disabled Persons over 16 years certified as unemployable for at least 12 months	Weekly Allowance
Blind Pensions	Social Welfare Acts	Blind Persons	Weekly Allowance

+ The income level for eligibility for these is being revoked as from 1st April, 1974.

APPENDIX 1

(1) Usual Therapeutic Assistance

Scheme	Field of application with regard to persons	Public and Semi-Public Institutions responsible for implementation	Annual budget used for that purpose by the institution mentioned 1969-1970
Health Services Section 51 Health Act 1970	Hospital In-patient services for persons with full and limited eligibility (including specialised services for disabled)	Health Boards	Not available
Section 56, Health Act - 1970	Hospital Out-patient service for persons with full+ and limited∅ eligibility (including specialised services for disabled)	Health Boards	do.

(2) Medical Assistance for Rehabilitation

Section 58, Health Act - 1970	See 15.(1) Also General Practitioner medical and surgical service for persons with full eligibility	Health Boards, through agreements with medical practitioners	do.

(3) Grant for Artificial Limbs and Appliances

Section 59, Health Act 1970	Supply without charge to persons with full eligibility. Supply to an amount determined by regulation to persons with limited eligibility	Health Boards, on prescription by a registered medical practitioner	do.

+) persons with full eligibility are persons in the lower income bracket - about 30% of population

∅) persons with limited eligibility are those in a higher income bracket - about 60% of population.

APPENDIX 1

Scheme	Field of application with regard to persons	Public and Semi-Public Institutions responsible for implementation	Annual budget used for that purpose by the institution mentioned 1969-1970
(4) Occupational Guidance, Training and Rehabilitation			
(5)			
(6)			
Section 68 Health Act 1970	Assessment, Advisory and Placement Service for disabled persons over 16 years	National Rehabilitation Board	do.
(7)			
(8)	Employment in Open Labour Market Employment in Sheltered Workshop No specific legislation at present Legislation is however in train to encourage employment of disabled persons		do.
(9) Social Welfare Allowances			
Social Welfare Acts 1952-1973	Disability Benefit paid to an insured person incapable of work	Department of Social Welfare	do.

APPENDIX 2

MENTAL HANDICAP CENTRES (RESIDENTIAL) FOR CHILDREN

Institutions	Administered by	Grades
Stewart's Hospital, Palmerstown Co. Dublin	Committee of Management	Moderate, severe and some mild
St Augustine's Obelisk Park Blackrock	Brothers of St John of God	Mild
St Mary's Drumcar, Co. Louth	do.	Moderate and severe
St Raphael's Celbridge	do.	Moderate and some mild
House of Our Lady of Good Counsel, Lota, Co. Cork	Brothers of Charity	Mild, moderate and some severe
Holy Family School, Renmore Galway	do.	Mild
St Vincent's Cabra, Dublin	Sisters of Charity of St Vincent de Paul	Moderate, severe and some mild
House of Holy Angels, Glenmaroon	do.	Mild and some moderate
St Vincent's, Lisnagry, Limerick	do.	Moderate and some severe
St Teresa's Home, Blackrock Co. Dublin	do.	Mild and some moderate
St Mary's, Delvin, Co.Westmeath	Sisters of Charity of Jesus and Mary	Mild, moderate and severe
La Sagesse Convent, Cregg House, Sligo	Congregation of the Daughters of Wisdom	Moderate, severe and some mild

APPENDIX 2

Institutions	Administered by	Grades
Queen of Angels School, Montenotte	Cork Polio and General after-care Association	Mild and moderate
St Elizabeth's Beech Hill) Cork))	do.	Severe
Tracton Park,Montenotte, Cork)	do.	Severe
St Paul's School, Montenotte, Cork	do.	Moderate
St Patrick's Kilkenny	Irish Sisters of Charity	Severe and moderate
Sunbeam House, Bray, Co. Wicklow	Protestant Child Care Association	Mild and Moderate
St Mary of the Angels, Whitefield	Franciscan Missionary	Moderate and severe
Beaufort, Co. Kerry	Sisters	(M. and F.)
St Anne's, Corville, Roscrea, Tipperary		Females - moderate and severe

DAY SCHOOLS FOR MENTALLY HANDICAPPED CHILDREN RECOGNISED BY THE DEPARTMENT OF EDUCATION

County	School
Carlow	St Laserian's Special School, Brownshill, Carlow
Clare	St Clare's Convent, Turnpike Road, Ennis
Cork	Our Lady of Good Council, Lota, Glanmire, Cork
"	St Bernadette's 9 Dyke Parade, Cork
"	Queen of Angels, Montenotte, Cork
"	Naomh Pol, Montenotte, Cork

APPENDIX 2

County	School
Dublin	Benincasa, Sion Hill, Blackrock, Co. Dublin
"	Child Guidance Clinic, Orwell Road, Dublin, 14
"	Holy Angels, Glenmaroon, Chapelizod, Co. Dublin
"	Mater Hospital, Eccles Street, Dublin
"	St Augustine's Obelisk Park, Blackrock, Co. Dublin
"	St Ciaran's Special School, Church Avenue, Dublin, 9
"	St Declan's, Northumberland Road, Ballsbridge, Dublin 4
"	St John's School, St Augustine's Street, Dublin 8
"	St John of God, Dunmore House, Glenageary, Co. Dublin
"	St John of God, Islandbridge, Dublin, 8
"	St Loman's, Ballyowen, Co. Dublin
"	St Michael's House, Ballymun
"	St Michael's House, Grosvenor Road, Dublin 6
"	St Paul's Hospital, Beaumont
"	St Vincent's, Navan Road, Dublin 9
"	Stewart's Hospital, Palmerstown, Co. Dublin
"	Treasa Naofa, Temple Hill, Blackrock, Co. Dublin
Galway	Holy Family School, Renmore, Galway
"	St Joseph's, Newcastle, Co. Galway
Kildare	St Anne's, Newbridge
	St Raphael's, Celbridge
Kilkenny	Mother of Fair Love, James's Street
"	St Patrick's, Sisters of Charity, Kells Road
Portlaoise	Portlaoise Special School
Limerick	Catherine McAuley School, Rosbrien
"	St Vincent's, Lisnagry
Louth	St Brigid's Special School, Dundalk
"	St Ita's Drogheda
"	St Mary's Drumcar
Mayo	St Anthony's, The Lawn, Castlebar

APPENDIX 2

County	School
Meath	St Ultan's School, Navan
Monaghan	Holy Family Special School, Carrickmacross
"	St Enda's Special School, Monaghan
Sligo	Cregg House, Sligo
Tipperary	Scoil Cormac, Cashel
Waterford	St John's School, Dungarvan
"	St Michael's, Lady Lane
"	St Martin's Springarden Abbey, Waterford
Westmeath	Scoil Mhuire, Delvin, Westmeath
"	St Hilda's Special School, Athlone
Wexford	Our Lady of Fatima School, Green Street
"	St Patrick's Bohreen Hill, Enniscorthy
Wicklow	Sunbeam House, Bray

SPECIAL CLASSES FOR SLOW LEARNING PUPILS IN NATIONAL SCHOOLS

County	School	No. of Classes
Cavan	St Clare's Convent	2
"	St Felim's B.N.S.	2
Cork	Ballyphenan Convent	1
Dublin	Central Model Boys, Marlborough Street	1
"	Baggot Street Convent	2
"	Clochar San Dominic, Dun Laoghaire	1
"	City Quay B.N.S.	3
"	Gardiner Street, Convent	2
"	Scoil Aine Naofa, Milltown	2
"	Scoil Enda, Whitefriars Street	1
"	St Vincent's North William Street	1
"	St Catherine's, Donore Avenue	1
"	Pro-Cathedral, Marlborough Street	2
"	Scoil an Croi Naofa, Ballygall Road	1
"	Scoil Una Naofa, Crumlin	1

APPENDIX 2

County	School	No. of Classes
Dublin	Muire na Dea-Comhairle, Drimnagh	2
"	Scoil Caitriona, Cabra	2
"	Scoil na Croise Naofa (B) Dundrum	1
"	St Michael's Infants B, Ballyfermot	1
"	St Raphael's Girls, Ballyfermot	2
"	Scoil Baintiarna, Rathfarnham	1
"	St Brigid's Girls, Finglas	1
"	Scoil Caitriona, Coolock	1
"	St Pater's B.N.S. Greenhills	1
"	St Paul's G.N.S. Greenhills	1
"	Eoin Vianney B. Bonnybrook	1
"	St John's School, St Augustine's Street 104	1
Donegal	Clochar Mhuire gan Smal, Letterkenny	2
Kerry	Croi Ro Naofa, Tralee	1
Offaly	Clochar Mhuire, Tullamore	2
"	Scoil Bride Buach, Tullamore	2
"	Birr Convent	1
"	St Brendan's Monastery, Birr	1
Roscommon	St Anne's Convent, National School	1 temporary class
Sligo	Eoin Naofa	1
Tipperary	St Mary's Convent, Nenagh	2
"	C.B.S. Nenagh	1
Westmeath	Presentation Convent Jun., Mullingar	1
"	Presentation Convent Sen., Mullingar	1
"	Mullingar C.B.S.	1
Wicklow	Arklow Boys	1
"	Arklow Convent	1
"	St Patrick's Monastery, Wicklow	1
"	St Kyran's N.S., Rathdrum	1
"	Holy Rosary Convent	1
"	Loreto Convent	1

APPENDIX 2

SCHOOLS FOR HANDICAPPED CHILDREN RECOGNISED BY THE DEPARTMENT OF EDUCATION

Category of Handicapped Child	County	Roll No.	School	Manager
Blind and Partially Sighted	Dublin	16583	St Mary's School for Blind Girls Merrion, Dublin 4	Mother Frances Joan O'Rourke St Mary's Blind Asylum, Merrion, Dublin 4
do.	Dublin	18417	Joseph Naofa de Bhuachailli Dalla, Drumcondra, Dublin 9	Very Rev. C. O'Donovan, St.Joseph School for the Blind Drumcondra, Dublin 9
Physically Handicapped	Cork	18483	Spastic School of the Divine Child, Ballintemple, Cork	Very Rev. T.J.Walsh, P.P., Parochial House Blackrock, Cork
do.	Dublin	18317	Central Remedial Clinic, Vernon Ave Clontarf, Dublin 3	Very Rev. Patrick Carton, P.P., 186 Clontarf Road Dublin 3
do.	Dublin	18370	St Brendan's Sandymount Ave., Dublin 4	Dr W.J.Roche St Brendan's Sandymount Avenue, Dublin 4
do.	Wicklow	18281	Cerebral Palsy Clinic Bray	Rev. F.Farrelly,C.O. The Presbytery Bray Co. Wicklow

APPENDIX 2

SCHOOLS FOR HANDICAPPED CHILDREN RECOGNISED BY THE DEPARTMENT OF EMPLOYMENT

Category of Handicapped Child	County	Roll No.	School	Manager
Hospital	Cork	17927	St Finbarr's Gurranebraher CORK	Very Rev.Arthur Murphy O'Connor PP., Parochial House Guerranabraher CORK
do.	Galway	18218	Naomh Padraig Western Regional Sanatorium GALWAY	Very Rev.J.V.Horan PP., Holy Family Presbytery Nervue GALWAY
do.	Kilkenny	18620	Lourdes Hospital Kilcreen KILKENNY	Most Rev. Dr Birch DD., Bishop of Cssory Sion House KILKENNY
do.	Westmeath	17673	St Joseph's Orthopaedic Hospital, Coole	Sr Clare Stakelum St Joseph's Orthopaedic Hospital Coole, Mullingar Co. Westmeath
do.	Dublin	17890	Temple Street Hospital Dublin 1	Sr Anne Eucharia McHale Children's Hospital Temple Street, DUBLIN 1
do.	Dublin	18815	Our Lady of Lourdes Hospital Dun Laoghaire	Mother M.Bernadette Ryan Our Lady of Lourdes Hospital Rochestown Avenue Dun Laoghaire Co. Dublin

APPENDIX 2

Category of Handicapped Child	County	Roll No.	School	Manager
Hospital	Dublin	19217	St Francis Clinic N.S., Temple Street DUBLIN 1	Sr Anne Eucharia Mc Hale Children's Hospital Temple Street DUBLIN 1
do.	Dublin	16258	Orthopaedic Hospital Clontarf DUBLIN 3	Mr Ivor Harte Barry MS., LL.B., Dip.Ed., 2 Pembroke Park DUBLIN 4
do.	Dublin	16624	St Mary's Orthopaedic Hospital Cappagh Finglas Dublin 11	Sister Teresa Assumpta Foley St Mary's Orthopaedic Hospital Cappagh DUBLIN 11
do.	Dublin	18210	Orthopaedic Hospital Baldoyle DUBLIN	Sister Margaret Sisters of Charity Baldoyle DUBLIN
do.	Dublin	18788	Our Lady's Hospital for Sick Children Crumlin DUBLIN 12	Sister Anne O'Brien Our Lady's Hospital for Sick Children CRUMLIN DUBLIN 12
do.	Dublin	19207	Federated Dublin Voluntary Hospitals N.S., Harcourt Street Hospital DUBLIN 2	Co. Managers 1) Rt.Rev.Monsignor Hurl PP., Harrington Street DUBLIN 8 2) Rev.Dr S.G.Poyntz Vicar of St Anne's Dawson Street DUBLIN 2

APPENDIX 3

	Places	Training Centre	Duration of Course
Clonleigh, Lifford (Provisionally approved up to 31 October 1972)	25	Upholstery Shirt-Making	1 year
St Loman's Hospital Mullingar	15	Furniture Workshop for trainees not residing at Lomans	1 year
b) Toghermore Re-Ablement and Training Centre, Tuam, Co. Galway			
Residential Centre :			
Toghermore Re-Ablement and Training Centre Tuam, Co. Galway	30	Wood-work (men) Boot and shoe-making and repairing (men) Upholstery	2 years 2 years 18 months
c) The Training Workshops at :			
The Central Remedial Clinic, Clontarf	100	Printing, Garment-Making Assembly work	6 months initially - Period may be extended where there is prospect of open employment
St Patrick's Hospital ø James's Street, Dublin	14	Assembly Work	
St Michael's House, Jamestown Road, Finglas	24	Carpentry, Metal Work (Boys) Needlework and Handcrafts (Girls	24 months
(Association of Parents and Friends of Mentally Handicapped Children	-	Assembly Work (Boys and Girls)	
Rotos Limited Shannon Airport ø (Re-employment Training Organisation (Shannon) Ltd	35	Final rehabilitation training mainly for psychiatric cases. Manufacture, assembly work	9 months
Park House Stillorgan (Polio Fellowship)	14	Horticulture	2 years

ø applied for training grants

U N I T E D K I N G D O M

REHABILITATION SERVICES IN THE UNITED KINGDOM

1. Summary of the legal and administrative aspects

Medical rehabilitation is a function of the National Health Service and is made available for all NHS patients who need it. Industrial rehabilitation is provided through the Employment Services Agency. Social rehabilitation is provided primarily by Local Authorities and mainly in day centres of various sorts. Voluntary bodies are also involved, particularly in social rehabilitation and many of these receive considerable financial assistance from government departments or agencies and from local authorities.

A network of Artificial Limb and Appliance Centres, managed by the Department of Health and Social Security, assesses patients and supplies artificial limbs and eyes, invalid vehicles and wheelchairs for disabled people on the recommendation of NHS doctors. For the hearing impaired there are some 150 centres at hospitals providing assessment facilities and hearing aids.

In considering this question it will be as well to make it clear what is meant by rehabilitation in Great Britain. If we use the term in the same way as most countries, it could be divided into (a) Medical Rehabilitation, (b) Social Rehabilitation, (c) Employment Rehabilitation. Employment Rehabilitation can be further sub-divided into (1) Placement in Employment, (2) Sheltered Employment, (3) Training, (4) Making fit for Employment and assessing what is the best form of resettlement.

In the main, initiative in the provision of employment rehabilitation is taken by the State. Where initiative is taken by private organisations or by local Government Authorities, these may be financed by the State. Thera are a number of schemes organised by employers which are directed

to returning people to employment with the same employers. Some local Government Authorities and voluntary organisations operate schemes which may condition people to the stage when they become acceptable for employment rehabilitation at State-financed centres or organisations providing employment rehabilitation on an agency basis.

The network of State-financed employment rehabilitation centres are modelled on similar lines and are guided by policy and procedural decisions made at the central office. Programmes within each Employment Rehabilitation Centre are individually planned for each entrant, taking into account the individual's physical ability, needs and employment opportunities.

1.1 The concept of handicap

The generally accepted definition, laid down by Section 29 of the National Assistance Act 1948, is that a handicapped person is one who is blind, deaf or dumb or who is substantially and permanently handicapped by illness, injury or congenital deformity. In order to apply this definition in practice detailed ophtalmological criteria have been published to delineate the separate categories of blindness and partial sight. No similar criteria have been issued in relation to the deaf and hard of hearing or the physically handicapped. For the latter, however, following a national survey published in 1971 by the Office of Population Censuses and Surveys, a six-fold classification of severity of handicap based on capacity for self-care is gaining currency but without statutory support.

Under the Disabled Persons (Employment) Act, 1944, a disabled person is defined as "a person who, on account of injury, disease, or congenital deformity is substantially handicapped in obtaining or keeping employment, or in undertaking work on his own account, of a kind which apart from that

injury, disease or deformity would be suited to his age, experience and qualifications".

In the United Kingdom there have, over the years, been many attempts to produce a definitive definition of medical rehabilitation. One states that medical rehabilitation is the process whereby a man is made either wholly or in part mentally, physically, socially, technically and economically equivalent to what he was before he became sick or injured. Medical Rehabilitation is essentially a philosophy of living, an attitude of mind on the part of the medical profession and of the patient alike. Rehabilitation is more of an art than a science and is not intimately concerned with the minutiae and technicalities of apparatus used in physiotherapy and occupational therapy, except insofar as they contribute to a total situation.

A shorter working definition of medical rehabilitation is that it consists of the planned withdrawal of facilities pari passu with a patient's progress and that the treatment of the individual patient should be planned, intensive and have a background of discipline.

There is no statutory definition of the mentally ill or the mentally handicapped. It is, however, generally accepted that people who are mentally ill were born with a normal mind which later breaks down under stress or strain. Many have a family history of mental abnormality. The mentally handicapped are those whose minds have developed incompletely or in whom development has been arrested. Mentally handicapped people would generally have an intelligence quotient below 70.

1.2 Statistics, estimated number of handicapped persons

A survey which was carried out in 1969 published their results in 1971. This provided the basis for some estimates about the handicapped

population in England. Excluding those with a visual, hearing or mental disability and allowing for an increase in population since the survey was undertaken, there are approximately 950,000 - 1,000,000 physically handicapped adults in England living in private households. In 1973 some 95,000 blind adults were registered with local authorities in England and this figure probably represents at least 90 % of the total. In addition some 35,000 partially sighted people and some 46,000 deaf or hard of hearing people were registered but we know that these figures fall very far short of the total. Registration is voluntary. It is estimated that 1½-2 million people in the United Kingdom have some degrees of hearing impairment.

The number of registered disabled people was 574,640 in April 1974.

The number of registered disabled people seeking employment in February 1975 was 64,887.

The number of handicapped people undergoing employment rehabilitation at the beginning of 1975 was 1,800 in Employment Rehabilitation Centres and 350 in other centres. On average, between 13,500 and 14,000 people enter ERC's each year and another 1,300 to 1,500 enter agency organisations.

Handicapped people qualify for benefits which the state provides under its national insurance, industrial injuries, war pensions, family allowances and supplementary benefit schemes. Some 3½ million adults with some physical or mental disablement receive cash benefits because of disablement, or depend wholly or mainly on public funds.

(i) Retirement pension : This is payable to men aged 65 and over and women aged 60 and over who satisfy prescribed contribution conditions and have retired from work (after five years, retirement is deemed to

have taken place). In November 1973, there were roughly 8 million pensioners. It has been estimated that roughly 2½ million retirement pensioners have some disablement (vide "Social Security Provision for Chronically Sick and Disabled People", HMSO House of Commons for Chronically Sick and Disabled People", HMSO House of Commons Paper 276, 1973).

(ii) Invalidity Pension : This is payable to persons aged 70 (65 for women), who have not retired, have satisfied prescribed contributions conditions and have been incapable of work and in receipt of sickness benefit for 28 weeks. There are roughly 450,000 invalidity pensioners, three-quarters of whom became incapable of work before the age of 60 (55 for women) and therefore receive additionally an invalidity allowance.

(iii) Attendance Allowance : is a non-contributory benefit payable to persons who are so severely disabled that they satisfy prescribed criteria regarding the requirement of frequent attention or continued supervision by day and prolonged or repeated attention or continual supervision at night. At 7 February 1975, nearly 116,000 persons were in receipt of a higher rate attendance allowance (i.e. requiring attention both by day and at night) and 68,000 persons were in receipt of a lower rate attendance allowance (requiring attention either by day or night).

(iv) Sickness benefit is payable, subject to the satisfaction of contribution and other conditions, to persons who are incapable of work in general during the first 28 weeks of incapacity. In 1973 there were 10 million new claims for sickness benefit (Social Security Statistics 1973). The numbers of persons incapacitated by sickness

and invalidity varies according to the time of year but during 1973 the number varied between 936,000 at the beginning of August and 1,293,000 at the beginning of January (DHSS estimate).

(v) Injury benefit is payable for up to 26 weeks to a person incapable of work as a result of industrial injury or prescribed industrial disease. In 1973 there were 741,000 new claims for injury benefit. The number of persons incapacitated by industrial accident or prescribed disease varied in 1973 between 51,000 at the beginning of May and 65,000 at the beginning of November (DHSS estimate).

(vi) Industrial Disablement Benefit is a benefit for persons disabled as a result of an industrial injury or prescribed disease, is payable from the cessation of injury benefit and is assessed according to the degree of disablement. A gratuity is normally paid for assessments of less than 20% otherwise benefit is paid as a weekly pension. Provisional figures show that 202,000 persons were in receipt of a pension for industrial disablement at 30 September 1973 and that 186,000 gratuities were paid during 1973 (Social Security Statistics 1973). 82,000 people received a special hardship allowance in addition to industrial disablement benefit in pension form at 30 September 1972, on account of their inability to continue with their former or comparable employment because of their disablement and a further 61,000 special hardship allowances were in payment to persons who had received a gratuity. 600 received an unemployability supplement in addition to their disablement pension, 2600 received a constant attendance allowance and 800 received an exceptionally severe disablement allowance, in addition to the pension.

(vii) Workmen's Compensation Supplementation Scheme Allowances are payable to persons industrially injured who were covered by the pre-1948

workmen's compensation legislation. There were slightly over 8,000 allowances in payment at 30 September 1973. In addition, about 3,300 allowances were payable under the Pneumoconiosis, Byssinosis and Miscellaneous Diseases Benefit Scheme to persons benefitting from pre-1948 legislation (Social Security Statistics).

(viii) War Disablement Pensions are payable to persons disabled as a result of military service during the First World War, the Second World War or subsequently. At 31 December 1973 there were 345,000 war pensioners receiving a pension because of their disablement (Social Security Statistics 1973). Of this number 11,300 were in receipt of an unemployability supplement because of incapacity for employment, 7,500 were in receipt of a constant attendance allowance, 16,500 in receipt of an allowance for lowered standard of occupation, 600 in receipt of an exceptionally severe disablement allowance, 14,500 in receipt of a comforts allowance and 39,100 in receipt of a clothing allowance in addition to their pension.

(ix) Supply of vehicles or allowances in lieu. The numbers of handicapped people at 30 September 1974 being supplied with an invalid three-wheeler vehicle, a car or a £100 a year allowance in lieu, was as follows

	National Health Service Patients	War Disabled	Totals
Three wheelers	22,630	237	22,867
Motor cars	3,117	7,480	10,597
Cash grant	16,771	3,189	19,960
	42,518	10,906	53,424

NUMBER OF HANDICAPPED PERSONS UNDERGOING REHABILITATION

MEDICAL REHABILITATION

From the figures available it is not possible to identify the condition of patients before treatment or whether after treatment they were still substantially or permanently handicapped. Statistics are available for the numbers of in-patients and out-patients treated during a year shown by speciality or according to the department in which they are treated. The following are the total such numbers in England in the year ended 31st December 1973 (DHSS statistics).

Nearest thousand)

	In-Patients		Out-Patients	
	New Patients	Total attendances	New Patients	Total Attendances
Physiotherapy - individual treatments	1,263	13,497	732	8,867
Physiotherapy - group exercises	246	1,564	207	2,234
Occupational therapy	164	3,906	57	1,564
Chiropody	98	424	21	243
Electroencephalography	39	58	74	106
Electrocardiography	624	1,153	366	586
Speech therapy	10	113	15	264
Hearing aids	1	5	88	865
Audiometry	11	19	177	343
Sight-testing (by hospital opticians)	5	7	110	210
Optical dispensing (by hospital opticians)	3	5	48	152
Orthoptics	10	24	87	744
Surgical appliances	57	100	416	1,051
Dietetics	244	3,705	132	444
Other	183	1,008	262	888

The following are estimates of the total annual numbers of discharges and deaths for certain examples of conditions, on a one in ten sample of in-patient records from National Health Service hospitals in England and Wales. The latest year for which estimates are at present available is 1972. (Report on Hospital In-Patient Enquiry for 1972).

	Estimated Total Discharges and Deaths
Rheumatoid Arthritis and Allied Conditions	24,600
Spina Bifida and Congenital Hydrocephalus	6,020

1.3 Historic Development of Rehabilitation

In recent years it has been suggested that there is something new about this subject but the following facts will show that, so far as the United Kingdom is concerned, the present developments represent merely an extension and practise of principles which have been known for many years.

In the United Kingdom the earliest planned approach to convalescence followed the construction of the Manchester Ship Canal which was built between 1888 and 1893. In such a project many thousands of men were involved and large numbers became incapacitated. The late Sir Robert JONES, an orthopaedic surgeon, provided a fracture service and included continuity of treatment in his philosophy in relation to the care of the individual patient. In 1900 Dame Agnes HUNT, who was herself crippled at the age of ten, opened the first convalescent home for cripples in England which later became The Robert JONES and Agnes HUNT Orthopaedic

Hospital. Dame Agnes was also responsible for founding the first after-care clinic in 1907. In the early years of this century the Lord Mayor Treloar Hospital and College for Cripples at Alton and the Heritage Craft School and Hospital in Chailey were opened and these organisations provided vocational training for crippled children as well as medical treatment.

In 1912 a Committee of the British Medical Association reported on the results of the treatment of 3,000 fractures, stressing that a good anatomical result did not necessarily mean a good functional result. Mal-union was present in 40 % of the cases.

During the 1914-1918 war there were two outstanding developments in rehabilitation. In 1915 Sir Pendrill Vanier-Jones founded the Papworth Village Settlement, the earliest attempt in the world to deal with the problem of tuberculosis in which emphasis on resettlement was considered as an essential part of the planned programme for each patient. The second development again involved Sir Robert Jones who established a number of rehabilitation departments in orthopaedic hospitals dealing with Service casualties. It is interesting to note that the reason for this development which spread overseas was the need to minimise the loss of manpower in precisely the same way as was quoted when history repeated itself in the Second World War.

In the words of an American physician "the development of physical medicine and rehabilitation in America received its first impetus in World War 1 and American physicians owe a great debt of gratitude to Sir Robert Jones who during World War 1 developed at Shepherds Bush, London, a service in physical rehabilitation where approximately 400 young American surgeons were trained in the rehabilitation of men injured in war. These men then formed the nucleus of the reconstruction services

of the United States Army. After World War 1, these physicians and the technical workers who served under them spread their work into civilian hospitals and inaugurated many of the programmes which have expanded so rapidly since then".

I have studied all the major reports concerning the need to develop rehabilitation services in the United Kingdom and these were spaced over the years as follows : 1935, 1939, 1943, two in 1946, 1947, 1949, 1952, 1956 and two in 1972. A survey of these reports shows that except in times of war more work seems to be expended on producing the reports of committees than in taking practical steps to resolve the problem. What is affirmed from these reports is that there has been a gradual growth of the appreciation of the problem, a gradual increase in the scope of the investigations, a shift of emphasis from the simple fracture in 1912 to the entire field of rehabilitation in 1972. The source material of these reports are itemised under references 1 to 11 inclusive. It must be stressed that rehabilitation should be initiated early in the patients treatment and its use as a salvage service is to be deprecated. Furthermore, general practitioners and hospital doctors alike should be much more aware of the social, industrial and domestic problems of gainful occupation when disease or injury, at an early stage, is known to project difficulties in this area.

References

(1) Report of a Committee on Fractures (1935), Brit. Med. J., 1, Suppl. 53.

(2) Final Report of the Interdepartmental Committee on the Rehabilitation of Persons Injured by Accidents,(1939) London H.M.Stationery Office.

(3) Report of Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons, (1943), London, H.M.Stationery Office.

(4) Ministry of Labour and National Service, (1946) Report of Standing Committee on the Rehabilitation and Resettlement of Disabled Persons, London, H.M.Stationery Office.

(5) Liverpool Hospitals Joint Advisory Committee (1946) The Demand for Rehabilitation and Convalescent Treatment, Conclusions.

(6) Department of Health for Scotland, (1947) Rehabilitation, The Report of the Medical Advisory Committee (Scotland), Edinburgh H.M. Stationery Office.

(7) Ministry of Labour and National Service, (1949) Second Report of Standing Committee on the Rehabilitation and Resettlement of Disabled Persons, London H.M. Stationery Office.

(8) United Nations, (1952) Modern Methods of Rehabilitation of the Adult Disabled. United Nations Publications, ST/TAA.SER.C/4,29.

(9) Ministry of Labour and National Service, (1956) Report of the Committee of Enquiry on the Rehabilitation and Resettlement of Disabled Persons, London. H.M. Stationery Office

(10) Rehabilitation - Report of Sub. Committee of the Standing Medical Advisory Committee, Central Health Services Council. H.M.Stationery Office.

(11) Medical Rehabilitation - the Pattern for the Future. Report of Sub. Committee of the Standing Medical Advisory Committee Scottish Health Services Council, H.M.Stationery Office, 1972

1.4 Basic legislative documents and their application

The provision of medical rehabilitation services as part of the health services is provided under the Health Service Acts.

The National Health Service Reorganisation Act 1973 provides the powers under which the arrangements are undertaken. The Chronically Sick and Disabled Persons Act 1970 drew attention to the problems, varying with age and incapacity, of people who are handicapped by chronic sickness and disablement, so that these problems should be more widely known and studied; and required of authorities that they take action to find out the extent and nature of these problems and give full weight to finding solutions.

Field of Application:	Residents of England and Wales
Responsible organisations:	Regional Health Authorities Local Authority Social Service Departments
Annual budget:	Not known since therapeutic and medical provision for handicapped people cannot be separated from that for the non-handicapped.

Artificial Limbs and Appliances

General arrangements	The provision of artificial limbs and appliances.
Legislation :	The National Health Service Reorganisation Act 1973 provides the powers under which these arrangements are undertaken.
Responsible organisations:	Department of Health and Social Security (for artificial limbs and appliances for war pensioners) and Regional Health Authorities (for appliances for all NHS patients other than war pensioners).

Annual budget Approximately £9.4 million in 1974/75.

The details of Acts, how they are applied, their fields of application and the assistance granted are tabulated in Appendix 1.

1.5 Financial responsibility

The cost of the National Health Service facilities is borne by the Central Government through the Department of Health and Social Security. The cost of industrial rehabilitation services, vocational guidance and training is borne by the Central Government either directly through the Department of Employment or indirectly by that Department providing financial assistance to approved voluntary bodies engaged in the field. The cost of social services and occupational centres is the responsibility of the Local Authorities.

The social welfare assistance is provided under Section 29 (1) of the National Health Assistance Act 1948 (as amended). The annual budget is not distinguisable from other costs.

Details of these provisions are included in Appendix 1.

2 Systematic Study

2.1 Adaptation and social integration of children

NHS obstetric services' personnel, in co-operation with paediatricians, are responsible for monitoring the growth and development of the fetus during pregnancy and labour. The doctor or midwife attending the delivery is responsible for assessing the status of the baby at birth including weight,(where for low birth weight babies, i.e. below 2,500 grammes, care is provided in special care baby units in hospital) and for detecting any abnormality present during the immediate postnatal period. Special tests are carried out routinely during the first two weeks of life such as screening for congenital dislocation of the hip and the

Guthrie test for phenylketonuria.

All births are notified to the health visitor who visits the mother and baby at home as part of the Area Health Authority surveillance programmes to detect as early as possible deviant development and abnormalities in children. These programmes are followed in collaboration with family doctors. Health visitors are nurses with special training in the detection of deviations from the normal in young children and take part in the child health clinic services where some sessions are undertaken by doctors skilled in developmental medicine. Parents are encouraged to take their children to a child health centre regularly for screening tests for specific defects such as of vision, hearing or congenital dislocation of the hip, and for examinations to detect any developmental delay. Any child thought to be suffering from a defect for any reason is referred to the comprehensive assessment service (see below).

There is no obligatory medical examination of children under 5 years of age. Medical and dental inspection of school children is provided for all pupils attending schools maintained by local education authorities.

Needs are evaluated by comprehensive assessment which is a process whereby a child with one or more physical, mental, or emotional (including behavioral) handicap is assessed and periodically reassessed, by a multidisciplinary team (comprising doctors, nurses, health visitors, therapists, education and social work staff as necessary) to determine his potential abilities and disabilities with the object of formulating a continuous programme of management designed to meet his special health, education and social needs and to provide support and advice for his parents.

If hospital treatment is needed it is provided by the children's department on an out-patient or day-patient basis if possible. A child who is admitted to hospital is nursed in the children's department under the care of a consultant paediatrician and staff trained in the care of sick children.

Section 34 of the Education Act 1944 lays upon local education authorities the duty to ascertain which children require special educational treatment and to provide it for those who do.

There is a list of special schools (list 42 (1974) of Special Schools for Handicapped Pupils in England and Wales).

All schools, including special schools, are open to inspection by Her Majesty's Inspectors of Schools.

By the Local Authority Social Services Act 1970, the major local authorities are required to establish social services committees to which stand referred social services functions, including those in (1) Section 21 of the National Assistance Act (residential accomodation for handicapped people), Section 29 (welfare services for them), (2) The Children Act 1948 (provision for children in need of care), (3) Children and Young Persons Act 1963 (promotion of welfare of children etc. (4) Section 1 and 2 of the Chronically Sick and Disabled Persons Act 1970 (obtaining information as to the need for and publishing existence of certain welfare services, provision of certain services).

Together these provisions enable a social services department of a local authority to provide any necessary social work services for handicapped school-leavers including social work support, hostel accomodation, adaptations to dwellings.

As regards the provision of medical, para-medical (eg physiotherapy, occupational therapy) and nursing services by an Area Health Authority for this group, powers are to be found in the National Health Service Reorganisation Act 1973.

The Welfare Food Order, 1971, as amended, provides that a child who is not less than five years and under sixteen years of age and, by reason of disability of mind or body, is not a registered pupil at a school, is entitled to receive free seven pints of liquid milk per week.

Central Government Assistance

The Family Fund was set up by the Government in November 1972 initially with £3 million, to assist the parents of severely congenitally handicapped children under the age of 16 by implementing the provision of services, and cash benefits from both voluntary and statutory sources. The Fund is administered on the Government's behalf by the Joseph Rowntree Memorial Trust.

In October 1974 the Government announced that a further £3 million would be paid into the Fund. In December 1974 the scope of the Fund was extended to include non-congenitally and severely handicapped children.

After the disaster concerning "thalidomide children" large sums of money were raised by voluntary bodies and this has been used, to a large extent, in furthering research into means of helping such severely handicapped children to lead as full a life as possible.

2.2 Medical Rehabilitation

There are no specific legal or statutory provisions in respect of developing medical rehabilitation in the hospital environment.

There is no legal (or indeed generally accepted) definition of a medical rehabilitation centre. Information about all rehabilitation

centres in the country is not collected centrally. There is an urgent need to rectify this.

It is Departmental policy that every new District General Hospital should have a Department of Rehabilitation and a Design Guide for such a department has been prepared and circulated by the Department. Most existing District General or Teaching Hospitals will have either a rehabilitation department or separate physiotherapy and occupational therapy departments, but many of these would need considerable up-grading to bring them to the standards of the Design Guide. There are in addition a number of separate rehabilitation centres which do not restrict their intake to patients from a particular hospital. Some of these specialise in dealing with patients suffering from particular conditions, others provide more general rehabilitation.

However, there is a huge gap between the provision of such facilities and their proper use which must be the responsibility of the hospital consultants. Until now recognition of the importance of medical rehabilitation has been ignored by the profession, with a few notable exceptions.

Attempts have been made to bracket medical rehabilitation with rheumatology. Although the two aspects are in no way mutually exclusive rheumatic patients represent only a fraction of the problem in relation to medical rehabilitation. The government reports (references 10 and 11 in the section dealing with the historic development of rehabilitation) emphasise the need to improve not only the services but medical education. An academic chair has been sponsored by the Government at the University of Southampton (European Chair of Medical Rehabilitation). A Professor of Rehabilitation Studies has been given a Chair at the University of Edinburgh and the writer has been appointed Senior Lecturer in Rehabilitation to the University of London. The diploma awarded jointly

by the Royal College of Surgeons and the Royal College of Physicians has been changed from "Physical Medicine" to "Medical Rehabilitation".

In order to encourage improvement in rehabilitation services the Department has set up nineteen Rehabilitation Demonstration Centres to demonstrate, both locally and nationally, what can be done to rehabilitate particular groups of patients. They are intended to act as focal points for the development of services, illustrating the most recent advances in clinical practice, showing what can be done for the conditions treated at the centres and how best services can be linked with those in the community and in industry. General practitioners, hospital doctors, nurses, social workers, members of the remedial professions and others interested in rehabilitation will be able to use the centres, attending courses and clinical sessions and exchanging information with others involved in the field.

In most cases the centres are individual hospital departments but a number are combinations of two or three departments and three are special rehabilitation centres not on hospital sites. One of these, the Medical Rehabilitation Centre, Camden Road, London, is specifically linked with University College Hospital and the Medical Director is also a medical consultant in rehabilitation on the staff of this large teaching hospital.

2.3 Prosthetic and orthotic devices

In 1973 in England and Wales 4,876 people received artificial limbs for the first time. For the total limbless population of some 65,000, over 23,000 artificial limbs were made in 1974.

All these limbs were provided through the specialist clinics of the British National Health Service.

The specialist medical and technical staffs of these clinics determine the range of artificial limbs offered and the standards of suitability. Research in this field is financed by the Department of Health and Social Services.

There are at present no known definitive international standards on artificial limbs. We would recognise any standards that are adopted internationally, subject to usual right of national interpretation.

Customs import duty is levied at 3.2 %. Value Added Tax is imposed on all artificial limbs (including incorporating imported prefabricated units) at 8 %. The number of imported prosthesis is very small. Almost certainly more are exported than imported.

Almost all artificial limbs are provided in the UK through the National Health Service and fitted by prosthetists who have been trained to the standard set by the British Institute of Surgical Technicians or to a recognised equivalent.

To obtain the necessary qualifications, a trainee prosthetist must undergo a 3-year course of academic and practical training at a specialist establishment.

The small number of artificial limbs not provided through the National Health Service, i.e. privately, are sold by companies who employ prosthetists with the same qualifications as above.

The manufacturers of artificial limbs supplied through the National Health Service are responsible for the technical quality control of their products under the supervision of the Department of Health and Social Security for private supplies through the trade, but these clearly benefit from the government controls effected on National Health Service supplies.

Employment Serv. Agency
↓
Occupational guidance service
Disablement Resettlement Serv.

2.4 Career guidance

Guidance on change of trade or profession is obtainable from the Employment Service Agency, Disablement Resettlement Service of the Employment Service Agency Occupational Guidance Service (also available to able-bodied), general employment services of the Agency and the Careers Service for young people administered by Local Educational Authorities. A special division provides advice for people with professional or executive backgrounds.

Similar guidance is available also from voluntary bodies interested generally and in specific disabilities working in conjunction with the statutory agencies, e.g. the Royal National Institute for the Blind, the Royal Institute for the Deaf, The Spastics Society and Residential Training Colleges for Disabled People. People recommended by the Employment Services Agency for retraining at an institution not provided by the Agency are given financial support during their training as is the organisation providing it.

1
Employment Rehabilitation Centres assess as to the best form of alternative employment and give vocational guidance to the client. If
2 training for the alternative occupation is considered necessary, this will take place at a Skill Centre of the Training Services Agency or one of the other training centres financed by them. In general, the training centres cater for all people over school leaving age.

2.5 Vocational training

The medical team may realise that the disabled person cannot return to his former work and may advise him of the need to change; the Employment Services Agency may take the decision when he comes to them for help in finding work or the patient himself may realise the situation

and take the initiative.

In some cases, particularly where there is a Disablement Resettlement Officer working in the hospital, the decision may be taken jointly at a case conference to discuss the patient's resettlement at home and work.

Liaison between medical and industrial rehabilitation (training tends to come after initial industrial rehabilitation) is steadily being improved. Some hospitals have DRO's based on the premises or visiting regularly and in such cases liaison is obviously better than when a special approach has to be made to a DRO at an office some distance from the hospital. There are still, however, many cases where the patient has no contact with the DRO until he is discharged from medical care. Attempts are being made to publicise industrial rehabilitation facilities to the medical services to encourage them to bring the DRO into each case at the earliest possible moment.

Employment rehabilitation centres are provided specifically for handicapped people to make them as fit as possible and assess them for employment. They do not prepare for specific occupations but, by means of psychological and practical tests, can identify what occupations are most likely to lead to satisfactory resettlement.

Employment Rehabilitation Centres are part of the Employment Resettlement Services of the Employment Service Agency and are linked closely with them. Application for courses at Employment Rehabilitation Centres are obtained from Disablement Resettlement Officers in the client's home area and after the end of the course the recommendation as to future employment is sent by the Employment Rehabilitation Centre to the Disablement Resettlement Officer of the Employment Offices.

The policy for training disabled people for employment is that wherever possible they should train alongside able-bodied trainees. Thus the whole range of vocational training courses in all training establishments is available to disabled people subject to their ability to meet the demands of the job.

Institutions which cater specifically for the training of disabled people are : -

Royal National Institute for the Blind

Commercial Training
Computer Programming
Physiotherapy

Royal National Institute for the Deaf

Bricklaying, Painting
Carpentry, Gardening
Electronic Wiring/Assembly

The concept of functional or occupational "Rehabilitation Centre" is not defined by law. One of the difficulties in understanding the work of employment rehabilitation centres is that other organisations tend to use the same title, even though frequently they are dealing with people who cannot be regarded as in the employment field or likely to be in the employment field in the foreseeable future.

A list of Employment Rehabilitation Centres is shown overleaf. The object of these Centres is the same, that is - to make a person as fit as possible within the limitations of the disablement, to restore confidence, give practical work experience in simulated working conditions, to give vocational guidance by psychological and practical tests and provide an assessment as to the best form of resettlement.

There may be a degree of work preparation within the course, but training for a skill is not given at an Employment Rehabilitation Centre, but may be recommended to take place at a "Skillcentre" or other training centre. Centres are as follows : -

Bellshill	-	100 places	Killingworth	-	100 places
Billingham	-	75 "	Leeds	-	100 "
Birmingham	-	150 "	Leicester	-	100 "
Bristol	-	100 "	Liverpool	-	100 "
Cardiff	-	100 "	Long Eaton	-	100 "
Coventry	-	100 "	Manchester	-	100 "
Dundee	-	60 "	Nth Staffs	-	70 "
Edinburgh	-	100 "	Perivale	-	100 "
Egham	-	200 "	Plymouth	-	70 "
Felling	-	100 "	Portsmouth	-	60 "
Garston Manor	-	70 "	Port Talbot	-	75 "
Glasgow	-	112 "	Sheffield	-	100 "
Hull	-	100 "	Waddon	-	100 "

There are no legal or statutory provisions for promoting employment rehabilitation centres in a hospital environment. There is, however, a form of rehabilitation generally of the work therapy category in many hospitals. In order to further the concept that rehabilitation is a continuous process, an experimental employment rehabilitation centre was set up in the grounds of Garston Manor Medical Rehabilitation Centre in 1968, and in 1974 a large Employment Rehabilitation Centre was set up in the grounds of the Birmingham Queen Elizabeth Hospital complex.

Training occupations are chosen according to feasibility and demand in co-operation with the Training Services Agency if public

finance is required. Any type of vocational training may be arranged if it is likely to lead to suitable employment of disabled people.

These training centres are either wholly independent or parts of independent organisations with a corporate existence in the community. Some of them provide course recruiting and/or placement services in co-operation or in parallel with the statutory Employment Service Agency or with the Local Authority Careers Service. Their links with industry are in pursuit of their broad aim to resettle disabled people. All are charities and depend upon public subscription through appeals, endowments etc., whilst receiving public funds support for their vocational training functions.

The person who decides on the need for or advantage of arranging a change of trade or profession for a handicapped person is, and can only be, the handicapped person himself. However, he will make this decision on the advice of his doctors, social workers, therapists and the Disablement Resettlement Officer. Liaison and co-operation between these four services is organised locally and in practice Disablement Resettlement Officers are constantly in touch with the other three chiefly by informal day-to-day contacts but in some cases by membership of a standing resettlement clinic or medical interviewing committee both of which are based upon hospitals in the National Health Service.

The Employment Service Agency operates a specialist employment service for disabled people known as the Disablement Resettlement Service. Disablement Resettlement Officers are responsible for the placement and follow-up work of handicapped people.

Specially trained employment officers, known as Disablement Resettlement Officers (DRO) advise on and arrange suitable vocational

assessment and resettlement programmes for disabled people. DROs may recommend a rehabilitation or training course before placing a person. DRCs are in contact with employers both to advise them which jobs be undertaken by disabled people, and to discuss possible adjustments to the **working** environment that would increase the suitability for disabled people. A voluntary body - the British Council for the Rehabilitation of the Disabled, provides tutors for handicapped school leavers. Special aids or adaptations to the working environment are provided to take account of any special working needs. Some personal aids, such as braille micrometers, are provided directly by the Employment Service Agency on an indefinite loan basis to severely disabled people, who when provided with such aids can obtain work but cannot afford to purchase them themselves.

There are no particular obstacles to temporary or part-time work. Further information concerning training services are given in Appendix 2.

2.6 Employment under normal conditions

A handicap is accepted as grounds for refusal of employment by decision of an employer only if his handicap renders a person incapable of doing the job, and is never accepted by decision of an insurer.

Under the Disabled Persons (Employment) Act 1944 all employers of not less than 20 people are obliged to employ a quota (3% of their total work-force) of registered disabled people. Furthermore, an employer with a quota obligation may not discharge a registered disabled person without reasonable cause if he is, or by doing so would be, employing less than his wuota. While below quota, an employer may not take an able bodied person into employment without first obtaining a permit to do so.

These obligations are the same for public and private sector employers and for industrial, agricultural and administrative undertakings. Some employers, on a voluntary basis, provide suitable alternative work for their employees who have become disabled and also provide "in-service" training if this is required. Restrictive practices by Unions often produce difficulties in training or placing disabled people. The general level of employment is always significant in relation to the opportunities for successful placement of disabled people.

2.7 Sheltered Employment

Under Section 15 of the Disabled Persons (Employment) Act, 1944, the Secretary of State for Employment is empowered to provide employment under special conditions for people registered under the Act who by reason of the nature or severity of their disablement are unlikely to obtain employment, or to undertake work on their own account in the open labour market, either at any time or in the foreseeable future.

Workshops assisted under this legislation are provided by :

(a) Remploy Limited, a non profit-making company set up for the purpose by the Secretary of State;

(b) Local authorities; and

(c) Voluntary undertakings approved by the Secretary of State.

The capacity of sheltered workshops for disabled people is approximately

(a) Remploy Limited	86 workshops, about 8,000 places
(b) Local authorities	49 workshops, about 4,000 places
(c) Approved Voluntary undertakings	65 workshops, about 2,000 places.

A list of trades undertaken in sheltered workshops is :

Traditional Trades	New Trades
Baskets	Assembly and light engineering
Bedding and upholstery	Cardboard boxes
Boots and shoes	Carpentry (including wooden furniture)
Bookbinding	Chain link fencing
Brushes and mops	Coach building
Candles	Commercial stationery
Cane furniture	Computer card punching
Fly-dressing	Concrete moulding
Gardening	Crutches and walking aids
Garden produce	Detergents
Glasswear	Electrical goods and assembly
Laundry	Industrial protective clothing
Machine knitting	Metal goods and processing
Mats	Motor repair
Piano tuning	Packaging
Pottery and ceramics	Painting and finishing
Sewing, dressmaking etc	Parachutes
Ships fendoffs	Plastic and leather
Toys	Printed textiles
Watch and clock repairs	Printing
Weaving	Radio and TV repair
Wirework	Road signs
	Soap and cosmetics
	Surgical appliances
	Souvenirs
	Temperature service
	Timber buildings
	Wigmaking

Trades to be undertaken by new workshops are chosen by the authorities concerned by means of market research carried out to test the viability of a new workshop.

Remploy limited is funded by the Secretary of State for Employment and its total loss is met by the Department of Employment.

Workshops provided by local authorities are assisted with approved capital expenditure; up to 75 % is met by the Department of Employment. The Department also meets 75 % of trading losses, up to a per capita maximum of £ 550.

Workshops provided by voluntary organisations are of two kinds - independent, or operating as the agent of the local authority. Voluntary bodies operating independently are assisted by the Department to the same extent as local authorities. Voluntary bodies operating as agents of local authorities receive similar assistance, but to a limit of 50 %, the local authority providing 25 %. In general, production tasks only are provided in sheltered workshops. About 10 % of sheltered workshops provide accomodation facilities as well as work; these are run by voluntary undertakings.

Patients who are capable of work but cannot accept it because of their severe mobility problems can be provided with a motor propelled invalid tricycle or given financial assistance to convert their own car in relation to their disability. Further details are provided under 2.8 and in Appendix 2.

2.8 Social integration

A large number of bodies, both official and voluntary, are involved in promoting the social integration of the handicapped. No single Government department has overall responsibility, although the Parliamentary

Under Secretary of State (Disablement) has a particular interest in encouraging the further development of opportunities for handicapped people. The Central Council for Physical Recreation, the Sports Council and British Sports Association for the Disabled are three of the bodies principally concerned with promoting the interests of handicapped people, particularly in the fields of physical and outdoor recreation and leisure pursuits. Voluntary organisations play an important part, also, on a local and national basis. Local Authority Social Services Departments contribute mainly through the establishment of Day Centres and, although opportunities at particular centres vary, there is often a wide range of cultural and recreational activity arranged.

People with a severe disability which limits walking ability to the extent that they need personal transport to go to and from work can get help from the National Health Service providing they can drive themselves. (Help is available too for other more severely disabled people but that is given irrespective of the employment situation). Assistance is in three forms -

a) a single-seat three-wheeled vehicle, petrol engined or electrically propelled. These are issued free of charge and are maintained and insured by the Department.

b) small cars, converted to hand control if necessary. These are issued free of charge and an annual allowance as a contribution towards maintenance and repairs is also paid.

c) an annual cash grant of £100 plus exemption from vehicle excise duty (worth a further £25 a year). This is not so much a contribution towards the cost of a car but rather a contribution towards the expenses of running a car. It is paid as an alternative to the supply of a vehicle where the person chooses to run his own car. The car must be insured and registered in the name of the disabled person.

Under section 4 of the Chronically Sick and Disabled Persons Act 1970, anyone providing any building or premises to which the public are to be admitted is required to make provision for disabled people to gain access to and within such building as far as it is both practicable and reasonable to do so. However, that does not mean that such access must be provided in all existing buildings open to the public, for the section only applies to new construction and the conversion of existing buildings. When the Act was passed the attention of local authorities was drawn to the section. Where private development was concerned local authorities were advised to draw private developers' attention to the Section, for example when they were dealing with an application for planning permission. No powers of enforcement are given by the Act but civil action can be taken in the Courts, as a last resort, to determine whether it was practicable and reasonable to provide access for disabled people in a building which was being provided. Further information on standards and recommendations on the subject can be found in :

a) British Standard Code of Practice CP96 : Part 1 : 1967. Access for the Disabled to Buildings Part 1 : General Recommendations; published by the Council for Codes of Practice, British Standards Institution, British Standards House, 2 Park Street, LONDON W1 and

b) Planning for Disabled People in the Urban Environment, published by the Central Council for the Disabled, 34 Eccleston Square, LONDON SW1V 1PE.

The matter is being considered in connection with the Health and Safety at Work etc., Act 1974. This extends the range of purposes for which building regulations (which are enforceable by local authorities) may be made to include matters of welfare and convenience. So the Department of the Environment can now, if it is thought right to do so, make building regulations in aid of disabled people.

It will be necessary to be quite clear whether, and how, building regulations should be used in this way. Strictly enforceable regulations have to be both exact and explicit. They have also to be framed so as not to put an impracticable burden on developers. Great care will be needed to ensure that any regulations drafted with these necessary conditions in mind do, in fact, bring some benefit to the disabled. The Department of the Environment also need to be clear that regulations will, in fact, produce better results than a more flexible approach based on the initiative of local authorities and interested groups. Such an approach might well produce uneven results between areas, but might still be more effective because it would be based on local appreciation of what is needed and what is practicable. The Department of the Environment has started discussions on the possibility of making building regulations, under the new powers, with the Central Council for the Disabled.

Although the Chronically Sick and Disabled Persons Act 1970 requires the needs of disabled people to be taken into account in the construction of buildings to which the public have access, including port facilities, bus and railway stations and airports, there are no similar requirements as such for moving vehicles although the spirit of the legislation is being increasingly applied to these where practicable.

In August 1973 the Department of the Environment issued a circular to bus operators and manufacturers entitled "The Disabled Traveller on Public Transport". This reviewed the problems facing disabled people wanting to use public transport and made various constructive suggestions for overcoming some of the more widespread and tractable problems.

A report on the first stage of this work, using a mock-up vehicle and a group of volunteers of various ages and degrees of disability was published in July 1974. This showed that over half of Britain's elderly

and disabled population - nearly four million people - are unlikely to be able to negotiate the current legal maximum bus entrance set height of 17 inches. The tests showed that to provide ease of entry for the majority of elderly and disabled people the bus entry step height should not exceed 7 inches, and steps are now being taken to remove the current legal minimum height of 10 inches. Other factors considered during the first phase of the research work were ; the location, size and shape of hand holds and rails; the grip and pulling strength of disabled passengers to resist acceleration and braking; the ability to reach bell pushes and emergency-door locks; seat height and spacing and the direction of seat facing.

In the second phase further trials are being undertaken using a real bus and the question of balance and the ability to move about is being studied. The engineering work required to produce mechanical aids, such as retractable steps, is also being included. The results of the research work are being drawn to the attention of a joint working group (Department of the Environment, operators and manufacturers) which is looking at the scope for improvements to the new bus grant scheme. (This specifies design standards to which vehicles must comply in order to obtain grant).

The facilities for disabled persons travelling by train fall within the management responsibility of the British Railways Board, who were among the recipients of the Department's of Environment's circular mentioned above. The decision of what is practicable to do in the interests of disabled passengers is wholly a matter for the Board to consider, making a case as necessary to the Department when expenditure needs specific Government approval. The facilities already provided by the Board for disabled persons include wheelchairs at principal stations and special narrow wheelchairs to provide access to a seat in the train. New Inter-City

rolling stock has wider doors and handrails, and some future Inter-City stock is being designed to accomodate an occupied wheelchair, as an alternative to travel in the guard's van for wheelchair bound persons. Special toilet facilities are provided where practicable in station re-construction and re-furnishing schemes and medical centres with fully qualified staff are available at major stations. The Board also propose at main stations a route offering disabled persons ease of access to arrival and departure platforms for principal trains.

Local authorities can provide concessionary travel on buses for disabled people whose walking ability is seriously impaired and for other groups of handicapped people registered as handicapped with the local authority. These concessions, which usually are in the form of tokens which when surrendered provide a discount on the normal fare, or a pass enabling the holder to travel at a reduced rate or free, allow for travel in a local authority area. For example, disabled people in London can travel, during off-peak hours, free of charge within the area covered by the Greater London Council, on London Transport buses.

The main obstacles are lack of knowledge among the general public of handicap, what handicapped people can achieve and what sort of help they need. This may give rise at worst to social ostracism and at best lack of encouragement to the handicapped person to take part in social activities. Inadequate assessment of the need for aids (often quite small or simple items), limitations in their provision and lack of training in their use can also restrict handicapped people from taking part in activities in which they could achieve some success.

3 General Considerations

3.1 Assessment of requirements at National level, programme of economic development and programme of rehabilitation

Studies have been done to determine the level of staffing required

for rehabilitation departments and the extent of the service provided. Secondly the type of assistance required by handicapped people in the process of rehabilitation.

A small job analysis study was carried out on the work of therapists by the Department of Health and Social Security, also a Work Study Exercise in Physiotherapy Departments. Regional Health Authorities use statistics to determine the level of service to be provided within their Regions. Additionally, the management structure of the National Health Service provides for information and advice on the development of services to be provided at District, Area and Regional level.

Information on the needs of the handicapped is provided by research projects sponsored by the Department of Health and Social Security, private research funding organisations, charities and educational organizations. Surveys are carried out by staff working in the health and social services and voluntary organisations. Local Authority Social Service Departments are responsible for keeping a register of all chronically sick and disabled persons within their area and finding out what services they require. The Community Health Councils act as a consumer group and may offer advice as to the provision of services. Statistics are, of course, the main form of information on which needs are based. They indicate the number of people unemployed, the number of people needing sheltered employment and to a certain extent the number of people likely to need rehabilitation and training services. From time to time surveys are carried out to identify and measure the need for sheltered employment. Sometimes recruitment campaigns for Employment Rehabilitation and vocational training are mounted to identify people unknown to the Service who might benefit.

The sitting of ERCs is decided in relation to the needs of the community. In general, therefore, they are sited in large areas of population where the needs are likely to be greatest. When considering the claims of

any particular area, account is taken of the working population of the area, the insured people in the area and, in particular, the number of disabled unemployed people in the area and the hospital facilities in the area. As all expansion has to be contained within a budget, this results in a system of priorities for the area with the greatest needs.

There has been no evaluation of the cost of rehabilitation in specific cases, as the method of rehabilitation is to use what a person has to offer - the abilities - rather than any specific cause of disablement.

The objectives of employment rehabilitation are two-fold (1) to provide a social, personal service to disabled and handicapped people to enable them to take up a normal social and working life and (2) to utilise manpower resources fully and at the same time obviate the need for payment of Social Security Benefits.

3.2 Information and documentation, research

Medical Rehabilitation Centres do not normally specialise in providing information material relating to rehabilitation; this is usually prepared by government bodies and voluntary agencies. One rehabilitation Demonstration Centre, at Middlesbrough General Hospital has an Information Centre within the rehabilitation complex. A publication "Equipment for the Disabled" giving information about equipment which can assist disabled people in various ways is prepared for the Department by Mary Marlborough Lodge, Oxford, also a Rehabilitation Demonstration Centre.

A voluntary body, the Disabled Living Foundation, provides an elaborate and useful information and retrieval service. Many hospitals and local authorities subscribe to this service. The Foundation also has permanent exhibitions of equipment for the disabled in London, Liverpool

and Newcastle and hopes to open at least two more centres, one in Birmingham and one in Scotland

Three of the Demonstration Centres are working on visual aids to help in training and demonstrating to staff involved in rehabilitation, and it is likely that other centres will become involved in this work. The NHS Audio Visual Aids Unit responds to requests from health authorities for material to be produced.

One of the Employment Medical Advisory Service's general functions is to provide a service of information and advice on occupational medicine. This function extends to the rehabilitation and employment of handicapped people, though since the service is only now developing specific expertise in these areas it is not yet able to provide a full range of advice upon them.

So far as the Department of Health and Social Security is concerned it is funding research on the following subjects : -

Back pain, including assessment of different regimes of treatment
Rheumatic and arthritic conditions
Prostheses and orthoses
Stroke
Muscular and articular pain
Respiratory conditions
Rehabilitation following myocardial infarction
Rehabilitation following surgical joint replacement and amputation
Haemophilia
Aids and appliances, including those for the assistance of persons suffering from various degrees of blindness and of deafness
Socially handicapping conditions such as incontinence and speech impediments

Note

The above are not placed in any ranking order, either of priority or of the amount of research currently in hand.

In addition, research programmes are being sponsored by the following bodies : -

A number of universities and hospitals (and also a number of pharmaceutical companies)
Royal National Institute for the Deaf
Royal National Institute for the Blind
National Fund for Research into Crippling Diseases
The Back Pain Research Society
Arthritis and Rheumatism Council

The Employment Service Agency plan the setting up of a Research Centre to look into all aspects of employment rehabilitation with a view to improving the service where necessary. Trials are being carried out to consider whether it is appropriate to extend the vocational assessment arrangements for handicapped people and others who may have similar problems.

The public employment service is in touch with research programmes being carried out by independent institutions usually Universities. Recently, the Production Engineering Research Association carried out a project, financed by the Government, enquiring into the possibility of extending employment opportunities for blind people by the development of electronic measuring equipment. Also the Royal College of Surgeons is researching into the results of rehabilitation courses.

The Employment Medical Advisory Service which forms part of the Health and Safety Executive, set up under the Health and Safety at Work etc., Act 1974, has recently created two senior medical posts to cover the fields of mental health and of rehabilitation. Part of the concern of the Senior Employment Medical Adviser for Mental Health will be with the

rehabilitation of people suffering from mental stress or illness while the Senior Employment Medical Adviser for Rehabilitation will be responsible for the development of general policy in the field of rehabilitation and re-employment of disabled people. Both doctors will pursue research into rehabilitation and employment problems, co-ordinating their efforts as necessary with those of the Department of Health and Social Security which deals with the purely medical as distinct from the occupational medical aspects of rehabilitation, but since the posts are new, research proposals are at an early stage of formulation.

As well as its own research capacity the Employment Medical Advisory Service has access to funds with which it can sponsor work by the Medical Research Council and research into rehabilitation problems could be promoted through that body.

3.3 Instruction for specialists

Recommendations on training for consultant appointments in the National Health Service are normally made by the appropriate college, in the case of rehabilitation by the Royal College of Physicians. Training is provided in suitable hospital posts approved by the college and appointments are made by a health authority on the recommendation of an Advisory Appointments Committee which will normally include a representative of the appropriate college. Junior training posts may be occupied by doctors intending to practise in fields other than the hospital service, or in other hospital specialities.

A variety of courses for consultants, for doctors in formal training posts and for other doctors with an interest in the subject, are arranged at postgraduate education centres or at rehabilitation departments where the necessary facilities and expertise exist. These may be orientated

to the needs of hospital doctors or of general practitioners or of both.

In general the cost of attendance at courses by hospital doctors is met by health authorities within arrangements for study leave. The advanced professional training scheme is designed to assist senior doctors to attend certain approved courses or clinical attachments. Health authorities are encouraged to send members of their staff on these courses and the costs are met by the Department from central funds. Two courses in the field of rehabilitation have been granted approval under this scheme; these are at Liverpool and at the Middlesex Hospital, London.

If courses are provided or approved for the attendance of general practitioners by the postgraduate medical deans (there is a dean for each region) in accordance with arrangements made under Section 63 of the Health Service and Public Health Act 1968, payments in respect of the organisation of courses may be made to the universities concerned and travelling and subsistence allowances may be paid to the doctors who attend.

Active steps have and are being taken by the Department of Health and Social Security to promote the development of the para-medical professions involved in rehabilitation, although much of the initiative lies with the professions themselves. A DHSS Working Party on the future role of the Remedial Professions reported in December 1973, and a Co-ordinating Committee has recently been established to suggest further action to implement recommendations in the Report on which there is general agreement, and to continue discussion on those which are not acceptable to all the parties concerned. The Working Party paid particular attention to the organisation of the professions and their training.

APPENDIX 1

LEGISLATION RELATING TO CONTRIBUTORY SCHEMES

Scheme	Basic Legal Text	Field of application with regard to persons	Assistance granted
State basic scheme (National Insurance Scheme)	Social Security Act 1975	Employed and self-employed earners	Sickness benefit:- payable for the first 28 weeks of incapacity for work, subject to satisfaction of contribution conditions. Flat rate benefit, with additions for dependants, Supplemented for employed earners by earnings related supplement of 1/3 of earnings at the lower end of the scale and 15% of the portion above that.
State basic scheme (National Insurance Scheme)	Social Security Act 1975	Employed and self-employed earners	Invalidity benefit:- a) Invalidity Pension - payable for incapacity for work following expiry of sickness benefit. Flat rate benefit, with additions for dependants, at a higher rate than sickness benefit. b) Invalidity Allowance - payable in addition to invalidity pension to those whose incapacity began before age 60 for men or 55 for women, the rate being dependent upon the age of onset of incapacity.
State basic scheme (National Insurance Scheme)	Social Security Act 1975	Universal	Retirement pension:- Flat rate pension payable from age 65 (60 for women) to persons who have retired from employment (Retirement is deemed at age 70 (65 for women) graduated pension is additionally paid, the rate being dependent on the amount of contributions paid until April 1975 -an addition is payable to persons age 80 or over.

APPENDIX 1

Scheme	Basic Legal Text	Field of application with regard to persons	Assistance granted
Industrial Injuries Scheme	Social Security Act 1975	Employed earners	Injury Benefit:- -Flat rate benefit with additions for dependants, at a higher rate than sickness benefit -payable during incapacity for work for the first 26 weeks from the date of an accident in the course of employment or of the development of a prescribed industrial disease
Industrial Injuries Scheme	Social Security Act 1975	Employed earners	Industrial Disablement Benefit: -a pension or gratuity for any disablement which remains when injury benefit ceases or immediately if no injury benefit was payable. -assessed according to the degree of disablement in percentages to 100% -assessments of 19% or less usually paid as a gratuity. -supplemented by the following additional benefits in appropriate cases:- a)Special hardship allowance:- - payable with pension or following gratuity if as a result of the injury or disease the beneficiary is unable to return to his regular or a comparable job. - rate of benefit subject to maximum, dependent on loss of earnings b)Unemployability supplement:- - payable to a person permanently unfit for work as the result of an industrial injury or disease c)constant attendance allowance - payable to a person assessed as 100% disabled who needs someone to look after him d)exceptionally severe disablement allowance:- - payable tc a person where receipt of constant attendance allowance is likely to be permanent e)Hospital treatment allowance which raises the assessment of disablement to 100% while the beneficiary is in hospital to receive treatment for the injury or disease.

APPENDIX 1

Scheme	Basic Legal Text	Field of application with regard to persons	Assistance granted
Workmen's Compensation Supplementation Scheme and Pneumoconiosis Byssinosis and Miscellaneous Diseases Benefit Scheme	Industrial Injuries and Diseases (old cases) Act 1975	Persons in prescribed employments prior to 5 July 1948	Allowances are paid to persons with an injury or disease as a result of employment prior to 5 July 1948. Benefit is usually payable either at a single rate for 100% disablement or in accordance with loss of earnings as a result of the disablement.
State basic scheme (National Insurance Scheme)	Social Security Act 1975	Universal	Attendance Allowance: -payable for adults and children who are severely disabled and satisfy prescribed criteria regarding frequent attention or continual supervision throughout the day or prolonged or repeated attention during continual supervision throughout the night. Two flat rates are payable:- -the higher rate for attention both by day and at night -the lower rate for attention either by day or at night
State basic scheme (National Insurance Scheme)	Social Security Act 1975	Universal	Old Persons' Retirement Pension (Category C) Retirement Pension:- -flat rate pension payable to persons aged 65 (60 for women) on 5 July 1948 and to their wives, if not in receipt of a contributory pension. Retirement Pensions for persons over 80 (Category D Retirement Pension):- -flat rate benefit for persons aged at least 80, satisfying residence etc., qualifications, with no other retirement pension title. -both the above are paid at the rate 2/3 of that of contributory retirement pension. Non-contributory invalidity pension - for persons who have been incapable of work for more than 6 months but have no contributory entitlement.

APPENDIX 1

Scheme	Basic Legal Text	Field of application	Assistance granted
Supplementary Benefits Scheme	Supplementary Benefits Act 1966-1975	Universal	Supplementary Pension for persons aged at least 65 (60 for women) Supplementary Allowance for persons not yet 65 (60 for women) -the income of a person's household (except where the head of the household is in full time employment) is brought up to a prescribed level.
War Pension Scheme	Ministry of Pensions Act 1916 Air Force (Constitution) Act 1917 Personal Injuries (Emergency Provisions) Act 1939 Pensions (Navy, Army, Air Force and Mercantile Marine) Act 1939 Polish Resettlement Act 1947 Home Guard Act 1951 Ulster Defence Regiment Act 1969 Injuries in War (Compensation) Act 1934 Injuries in War (Compensation) Act 1914 (Session 2) Under these statutes, benefit is payable in accordance with various Warrants, Orders and Pensions Schemes	War disabled injured during the 1914-1918 war, during the 1939-1945 war or subsequent to 1945	War Disablement Benefit:- -Pension assessed according to percentage disablement to 100% -Pension also dependent on rank of disabled person. Additional benefits payable with the pension:- Unemployability Supplement for persons permanently unfit for work because of the disablement -Constant attendance allowance for a person requiring to be looked after. -Comforts allowance for provision of comforts for a severely disabled pensioner. -Allowance for lowered standard of occupation for persons less than 100% disabled whose earnings are reduced because of their disablement, benefit being assessed in accordance with loss of earnings. -Clothing allowance for pensioners with excessive wear caused by the disablement (flat rate benefit).

APPENDIX 1

Scheme	Basic Legal Text	Field of Application	Assistance granted
Occupational Guidance rehabilitation and resettlement, Employment and Training Act 1953	Employment and Training Act 1973 authorised the setting up of the Manpower Service Commission which operates the employment resettlement and rehabilitation services through the Employment Service Agency	Male and female over school leaving age	Employment Service Agency funds are financed by grants from the Exchequer The 1975/6 budget is £ 6.37 M.

APPENDIX 2

Vocational training for employment in open industry Employment & Training Act 1973	Training Services Agency, an executive arm of the Manpower Services Commission	Disabled people, within meaning of statute (Disabled Persons Empl. Act 1944), over school leaving age	Training Services Agency funds are financed from the Exchequer 1975/6 budget is £8.07M.
Sheltered Employment	The Department of Employment	People registered as handicapped by disablement unable to obtain employment or work on own account by virtue of the nature of severity of the disablement, either in the foreseeable future or after a prolonged period	The estimate for 1975/6 is £15.5m.