NATIONAL ECONOMIC
AND SOCIAL COUNCIL

Major Issues in Planning Services for Mentally and Physically Handicapped Persons

No. 50

NATIONAL ECONOMIC AND SOCIAL COUNCIL
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NATIONAL ECONOMIC AND SOCIAL COUNCIL

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by

Pauline Faughnan and Sile O'Connor

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PART I

THE COUNCIL'S COMMENTS

ON

MAJOR ISSUES IN PLANNING

SERVICES FOR MENTALLY

AND

PHYSICALLY HANDICAPPED PERSONS

PART I

THE COUNCIL'S COMMENTS[1]

INTRODUCTION

1. In its comments on Professor Donnison's report the Council stated its belief that any change is desirable which brings nearer a situation in which the disadvantaged in the community "are assured of equal access to education, medical care, satisfactory housing, and satisfactory jobs, in which opportunities for improving their living standards are as nearly as possible equalised. . . ."[2] It was in this context that the Council decided to commission a study that would examine the position of handicapped people in Irish society. The consultants appointed were Ms Pauline Faughnan who had overall responsibility for the study and Ms Síle O'Connor.

2. The purpose of the study was to provide an operational definition of handicap, develop guidelines for the initial identification and classification of the handicapped by the appropriate authorities, identify the major issues in the field of current policies for the handicapped, and clarify the precise areas where further investigation and analysis are needed. The consultants' study is set out in Part II of this report.

3. The consultants' study contains detailed recommendations regarding the major areas concerning the handicapped. Since the Council is in broad agreement with these recommendations it has

[1]Following discussions by the Social Policy Committee and by the Council these comments were drafted by John Curry in the Council's Secretariat.
[2]NESC No. 8. *An Approach to Social Policy*, 1975, p. 13.

decided to comment on some broad issues rather than reiterate the more detailed recommendations in the consultants' study. Its concern is to help create a positive awareness of the needs of the handicapped in our society and help to formulate the overall goals that should guide policies for the handicapped in the future.

4. The consultants' study indicates that, until recently, the provision of services for the handicapped has, in general, been a neglected area of social policy. The main impetus for the provision of services has come from voluntary agencies and only in the recent past have statutory bodies increased their involvement to any noticeable extent. That more resources are now being devoted to training the handicapped, for example, is due mainly to the availability of finance from the European Social Fund since Ireland's entry into the EEC. The Council believes that if the needs of the handicapped are to be met then a change in the community's attitude towards handicapped people, accompanied by a conscious reallocation of resources is required.

5. The information available at present, as explained in the following two paragraphs, does not enable any precise estimation of the expenditure that will be involved. The Council recognised that resources are scarce and that all desirable objectives cannot simultaneously be attained. Nevertheless, the Council believes that within the level of public expenditure that is consistent with the development of the economy, attempts should be made to improve the treatment of the handicapped in the ways discussed below.

DEFINITION AND IDENTIFICATION

6. Despite the fact that there are data available on the number of persons with particular handicaps such as mental handicap, blindness and spina bifida, the consultants point out that "there is no accurate, comprehensive information available on the total number of people who are handicapped in this country". The consultants indicate that one of the main problems in righting this deficiency is the absence of a suitable definition of handicap. While considerable progress has been made in compiling a register of mentally handicapped people, an

operational definition of handicap in general is urgently needed as a basis for planning services. Council recommends that the EEC definition of handicap, which is the one deemed most suitable within an Irish context by the consultants, be used by health boards to ascertain the number of handicapped people in their area. The EEC definition is as follows:—

> "Handicap is any limitation, congenital or acquired, of a person's physical or mental ability which affects his daily activity and his work, by reducing his social contribution, his employment prospects and his ability to use public services. A handicapped person is one whose handicap (or potential handicap) is recognised by the authorities appointed to this purpose with a view to rehabilitation."

7. In the absence of reliable information on the number of handicapped people, their location, their economic and social situation, it is extremely difficult to plan the most appropriate means of meeting the various needs of the handicapped. In the process of carrying out this study it has come to the Council's notice that a number of organisations offering services to different groups of handicapped people have an interest in compiling registers for specific purposes. It is important that ultimately, there should be an overall register that would include all handicapped people. It is Council's opinion that as a preliminary step, a body representative of the various organisations concerned with compiling registers should come together, under the aegis of the Department of Health, to provide guidelines for the compilation of an overall register. The consultants have considered in depth various means of compiling such a register and they suggest that the most appropriate means is the collection of information at the community care area level.

INTEGRATION

8. The early provision of services for the handicapped was designed on a segregated basis which catered for different groups of handicapped people in specialised institutions such as schools and training centres. The Council wishes to draw attention to a very

important theme running through the consultants' report, i.e., the need for the integration and participation of the handicapped to the greatest extent possible at various levels of society such as education, employment, travel and social activities. The handicapped should be enabled to enjoy a normal life within the community using facilities available to the public at large. If for some reason a handicapped person cannot live with his/her own family, then the residential care provided should approximate as far as possible to an ordinary home.

9. The Council believes that there are three aspects which are crucial to the achievement of integration. In the first instance, if the handicapped are to be provided for in a community setting the provision of facilities such as hostels and social workers will be required for the handicapped and their families. Secondly, integration can be facilitated by the adaptation of existing general services. Thirdly, and perhaps most importantly, integration cannot be achieved unless there is an acceptance by the community at large that a need exists for the integration of the handicapped. This involves a willingness by us all to welcome handicapped young people in our schools and community and handicapped adults in our work places and neighbourhoods.

Education and Training

10. The Council believes that, as far as possible, handicapped children should be enabled to receive their formal education with non-handicapped children. The council agrees with the consultants' view that, "the focus should be on educational needs rather than particular handicaps". Integrated education means that handicapped children should as far as possible be accommodated within the ordinary school system and no child who can successfully be educated in an ordinary school should be educated in a special school. Full integration may not always be possible and in such cases the aim should be to achieve the greatest level of integration that is compatible with meeting the child's special needs and the needs of the other children in the school. A commitment to integration implies a greater allocation of resources—both financial and personnel. It involves, for example, making existing and future schools, accessible for handicapped children, the provision of personal assistance and/or additional teachers for children with particular handicaps. The Council recognises that if

integration in education is to be achieved then further work has to be done to ascertain all the implications of this for the various groups and agencies concerned.

11. At present AnCO is playing an increasing role in the provision of training for the handicapped on an integrated basis with the able-bodied. It is important that this role be widely publicised. The consultants have pointed out that there are certain limitations under the existing system. If AnCO's role is to be performed more productively there needs to be positive discrimination in favour of the handicapped trainees to enable them to be trained on a par with non-handicapped people. It is essential that adequate incentives are available to actively encourage the handicapped person to undergo training and rehabilitation. This involves not only financial incentives[3] but also the quality and choice of training facilities.

Employment

12. The Council believes that if integration is to be achieved the handicapped should have the opportunity of employment. Furthermore, the consultants point out that there is evidence to suggest that economic benefits may be derived from investment in rehabilitation through increased productivity and reduction in the cost of care of handicapped persons. As a first step towards employment it is important that assessment facilities are available to handicapped persons regardless of their geographical location or the nature of their handicap.

13. While training will enable many handicapped persons to undertake employment, the attitudes of employers and fellow workers are also vital and may affect employment opportunities. In this regard the Government's announcement in 1977 of a 3% employment quota scheme in the public sector is to be welcomed as an indication of its commitment to the employment of the handicapped and hopefully as an encouragement to employers in the private sector to follow suit. The consultants indicate, however, that little real progress has been made since the scheme was announced. The Council believes that there is an

[3]The consultants indicate that the payments made to trainees in community workshops are considerably less than those received by AnCO trainees.

urgent need to create a greater awareness among the public in general of the needs and potential employment contribution of handicapped persons in a wide range of occupations.

14. It is recognised that there may be concerns on the part of employers and other employees regarding the employment of the handicapped based on historical attitudes and perceived economic considerations. These concerns are more acute in a situation where there is a large supply of non-handicapped labour but this should decline as we move towards full employment. However, integration to the highest extent possible should be encouraged by specific measures pending the achievement of full employment.

15. While many handicapped people can take their place in the open employment market, there are others who, for a variety of reasons, cannot. There is a need to cater for this section of the handicapped population and the most appropriate means is through sheltered employment, i.e., "the employment for indefinite periods in special conditions of handicapped persons who are not suitable for open employment".[4] The consultants point out that sheltered employment is different to diversionary or therapeutic activities which may include occupational elements. Much of what is presently classified as sheltered employment is little more than occupational activity. Sheltered employment has a dynamic quality, is organised essentially on industrial lines, is productive and provides long-term employment. It is important that the sheltered employment needs of handicapped people be investigated in each community care area.

Accessibility of Buildings and Social Activities

16. The physical design of public and commercial buildings, housing, transportation, and other community facilities designed for the average person often does not take into consideration the wide range of mobility limitations caused by advanced age, physical disability or temporary injury. It is not simply those with obvious disabilities who are affected by the design, for example, of public buildings. Barrier-free designs would benefit not only the disabled but other members of society, e.g., the elderly. The additional costs involved in creating barrier-free public buildings and facilities constitute only a fraction of

[4]*Training and Employing the Handicapped*, Stationery Office, Dublin 1975, p. 17.

the overall cost. The Council recommends that all new public and commercial buildings be made accessible to handicapped people.[5] In this context the Council believes that the recommendations made by interested agencies on the Draft Building Regulations of 1976 be incorporated in revised regulations and that these be implemented as soon as possible. The Council also recommends that all new public transport facilities be suitably designed to meet the needs of handicapped people.

17. One of the best indications of integration is the extent to which the disabled person is able to choose which activity he/she will pursue and which activity he/she is able to participate in, in the widest sense as performer, spectator or helper. The Council recommends that the requirements of the disabled person should be considered when sport and leisure activities are being planned and designed.

INCOME MAINTENANCE

18. Many handicapped people, particularly severely disabled people who live in the community, depend largely on direct and indirect financial aid from statutory services. Additional burdens arise from the extra costs and demands of a disability and the reduction or loss of earnings frequently associated with its onset. The present system of income maintenance is, according to the consultants, not only complex and confusing but also, in some respects, inequitable. Unlike other income maintenance schemes, for example, the Disabled Persons Maintenance allowance scheme makes no provision for payment of allowances in respect of dependent adults or children.[6] In view of the complexity of the income maintenance system for the handicapped, serious consideration should be given to the amalgamation of functions by various agencies. This applies particularly to long-term benefits. There would appear to be a strong argument, for example, in favour of the Department of Social Welfare rather than Health Boards administering the Disabled Persons Maintenance Allowance Scheme.

[5]The criterion used in most countries is that buildings be accessible to the wheelchair-bound.

[6]The consultants also point out that the disabled housewife receives no direct income and yet the expense involved in running a home can be considerably higher than for her able-bodied counterpart.

19. The consultants have also highligted an important aspect of the income maintenance system which deserves particular attention, namely, the fact that additional costs related to the severity of a disability are not taken into account. In this context Council believes that there is merit in considering a two-tier structure of benefits along the lines suggested by the consultants. One element could be paid to all severely handicapped persons whether in employment or not and would be designed to compensate for the additional expenses that arise from the severe disability.[7] On top of this the handicapped person would be entitled to the other normal income maintenance benefits (e.g., unemployment benefit or assistance, old age contributory and non-contributory pensions). The first element should not be reckoned as means in determining eligibity for means-tested services.

ROLE OF VOLUNTARY AND STATUTORY AGENCIES

20. Services for the handicapped in Ireland developed over time as different voluntary bodies became involved in looking after different groups of handicapped people. The number of voluntary bodies engaged in the provision of services for the handicapped has grown in recent years. At the same time statutory agencies, especially the Health Boards, have become more active in this area. Because voluntary bodies provided services virtually unaided in the past there has been an uneven development of services for the handicapped.

21. The consultants point out that services for the handicapped may vary greatly from one Health Board area to another and indeed from one disability grouping to another within the same Health Board area. Duplication may arise not only between voluntary agencies but also between voluntary and statutory agencies. The consultants also highlight the fact that the acute needs of particular groups of handicapped people are not being met due to the total absence of any services in some areas or to the ineffectiveness of an organisation supposedly serving a particular group. The Council views these developments with concern and urges greater co-ordination between voluntary and statutory agencies so that obvious gaps and duplication in the provision of services are eliminated and that a reasonably comparable service is provided in all parts of the country to all groups of handicapped people.

[7]Some Council members consider that this element should be subject to an appropriate means test while others consider that it should be paid as of right to all severely handicapped persons.

22. Because of our particular tradition in caring for the handicapped Ireland now possesses two distinctive resources to work with the handicapped, i.e., the voluntary bodies and the statutory agencies. Each of these has a unique contribution to make but the crucial factor is that they should work in harmony. The Council suggests that in each health board area, the health board personnel and voluntary bodies should come together to ensure that a *real* partnership exists to meet the needs of handicapped people in their area. From a social planning viewpoint a vital step in this process will be their joint co-operation in obtaining information on the number of handicapped people as well as on their economic and social situation.

COMMUNITY SERVICES AND RESIDENTIAL CARE

23. If integration of the handicapped into the community is accepted as the overall objective of social policy for the handicapped then it follows that where possible, such persons should be enabled to live in the community. This implies that community services be adequate to meet their needs. The consultants have made a number of suggestions whereby the needs of handicapped people living in the community could be more adequately met than at present. These include the provision of flexible domiciliary care, day-care facilities, and the designation of a "named person" with responsibility for ensuring that the appropriate services are made available to each handicapped person.[8] The Council believes that investment in community services will help to achieve greater integration of the handicapped person in his/her community and will also enable the provision of much-needed support for members of families engaged in the care of a handicapped person.

[8]The consultants point out that this type of role is fulfilled in some cases by social workers and public health nurses and while the public health nurse would appear to be the most appropriate person to perform this role on a formal basis, social workers, teachers, psychologists or doctors could also act as the "named person".

24. The Council believes that residential care must be seen as one of a range of services that would be available to the handicapped person and his/her family depending on needs at different stages in the lifetime of the particular individual. The Council therefore recommends that, where necessary, alternatives to the traditional type of residential care be investigated as a matter of urgency. Alternative provision may take the form of hostels/group homes, short-stay accommodation or fostering. There will, however, remain a need to provide long-term residential care for some handicapped people who cannot be cared for in the community and the Council believes that greater emphasis should be paid to the quality of life available in institutions for such people.

PREVENTIVE ASPECTS

25. Since the development of a disability can be traced to a number of factors (e.g., genetics, nutrition, accidents, communicable diseases and degenerative disease) it is sometimes possible to prevent or minimise the effects of these disabling conditions. Prevention of handicap is not solely a medical problem. Attitutes of the general public towards health and the responsibility they assume for their health are also important. Prevention necessitates the provision of knowledge to the general public of factors associated with handicapping conditions. Consequently, the Council recommends that the provision of such information must be an integral part of the general health programme. Education programmes should include information on a wide range of areas including the importance of genetic counselling, ante-natal care, immunisation, child health services, industrial safety and on the impact of particular styles of living in causing handicapping conditions.

Conclusion

26. In conclusion, the Council wishes to reiterate that in commissioning this study its main concern was to focus attention on this disadvantaged group in our society. The objective of social policy for the handicapped should be their integration into the community to the greatest extent possible. The Council wishes to draw attention to the United Nations resolution of 1975 on the "Declaration of Rights of

Disabled Persons"[9] and recommends that these rights be implemented. In order to ensure that the special needs of handicapped people are fully met in an integrated fashion it may be necessary to introduce legislation to make the provision of certain services and facilities mandatory.[10] If the goal of integration is to be achieved it will necessitate a change of attitude among the general public and will involve an acceptance of the fact that healthy and handicapped persons should live and work side by side. It will also involve a commitment by the community to provide whatever financial and other support is necessary to achieve the highest level of integration possible.

[9]See text of resolution in consultants' report pages 27-28.

[10]The consultants have suggested that legislation could be based on the Chronically Sick and Disabled Persons Act (1970) in Britain and similar legislation in Northern Ireland (1978) provided that the shortcomings of that particular Act were taken into consideration when drafting legislation for the Republic of Ireland.

PART II

MAJOR ISSUES IN PLANNING SERVICES FOR MENTALLY AND PHYSICALLY HANDICAPPED PERSONS

by

Pauline Faughnan and Síle O'Connor

CHAPTER 1

HANDICAP IN IRELAND

INTRODUCTION

1.1 Every person has the basic right to the opportunity for personal and social development. The presence of a disability should in no way restrict access to that right. However, barriers exist which prevent many handicapped people in Ireland today from availing of such opportunities and from attaining a standard of living acceptable in contemporary society.

Studies in Britain[1] and what little evidence there is in Ireland, suggests that the handicapped are substantially worse off than their able bodied counterparts in many aspects of social and economic life and many experience acute deprivation.[2] Indeed the recent Snowdon Report on integration of the disabled in Britain speaks of two nations and of the great gulf between the able and the disabled often reaching its most unbridgeable where mental handicap or mental illness are involved. This report also emphasises that many physically disabled persons are not part of society. There are many whose greater potentialities could be realised, whose limitations could be mitigated and whose lives could be given more meaning.[3]

The goal of social policy in relation to the handicapped person should be to reduce inequalities and deprivations not only in the material and economic sense but also in terms of attitudes and social integration. Rehabilitation or habilitation is a combined and co-ordinated use of medical, vocational, educational and social measures to train or retrain the individual to the highest possible level of functional ability, to

[1]Townsend, P. The Disabled in Society in *The Handicapped Person in the Community*. London 1974.

[2]Faughnan, P. *The Dimensions of Need*, Dublin 1977.

[3]*Integrating the Disabled.* Report of the Snowdon Working Party, London 1976.

enable him to live as independent a life as possible and to participate fully in the life of the community.[4] How have Irish rehabilitation services facilitated these goals? Services for the handicapped in Ireland have grown in an *ad hoc* and fragmented manner. Like many other areas of social services, they have frequently been pioneered by voluntary groups as responses to unacceptable situations. Involvement of statutory agencies tended to be in terms of particular needs rather than overall policies. There is no comprehensive policy or framework within which the extensive number of agencies, both statutory and voluntary, can undertake long-term planning.

In the field of mental handicap some progress in the co-ordination of services has been made since 1975 when this question was considered and guidelines were drawn up by representatives of voluntary organisations and the Health Boards, in consultation with the Department of Health. The guidelines related, among other things, to the establishment of a mental handicap committee, representative of the voluntary organisations and the Health Board in each area. It was emphasised that there was a need for a three-way flow of information on significant developments between the Department of Health, Health Boards, and voluntary organisations, and that local committees had an important role in this area.

Another area where there has been an attempt to assess need and provide a framework within which needs may be met by statutory and voluntary agencies is in the sphere of vocational training and employment. This has been a fairly recent initiative (1975). No such assessment has been undertaken in relation to other areas such as education, medical services, community support services, and income maintenance programmes. Services have certainly evolved, however, the overall picture shows many of the needs as yet uncatered for, extensive inequalities and an inability on the part of many handicapped people to avail of opportunities in the social, vocational, and economic spheres currently enjoyed by a large portion of the population. There is also the situation whereby opportunities available to the handicapped person are vitally influenced by (a) the type of disability the person has, and (b) the area of the country in which he lives. Any overall development of services for the handicapped demands:

[4]Throughout the Report rehabilitation is used in the broad context and not simply in relation to vocational or medical aspects.

> that we know what is meant by handicap, not simply in the medical sense, but in terms of understanding the problems and limitations which the disability may impose,
>
> and
>
> that we know how many people there are, their location, and their social and economic situation.

Without such knowledge it is impossible to determine the scale and range of various needs and the most appropriate ways of meeting them.

1.1.1 *The Range of Handicap*

The "handicapped" are a very diverse category. Physical or sensory disabilities are closely related to the ageing process and many more elderly people are impaired than those in the younger age groups.[5] Nonetheless the past few decades have witnessed changes in the pattern of handicap among younger age groups. The increase in sporting, pedestrian, automobile and other accidents[6], and improved surgical techniques resulting in larger numbers of congenitally handicapped babies who live, means that the composition of the handicapped population is changing and there is an increasing number of disabled children and young adults.

While one may generally classify handicaps into mental, physical, and sensory, there are very great differences within these groups. Encompassed by the terms are mild, moderate, severe and profound mental handicap, profound deafness and hard of hearing, blindness and partial sight. Within the field of "physical handicap" the picture is even more complex. Under this general heading are orthopaedic impairments, infectious diseases, genetic and congenital disorders, traumatic injuries, neurological disorders, heart disorders, arthritis and bronchitis.

Some conditions are static, others are progressive; some are linked to particular age groups, others span all age ranges; some are visible, others are not; some are short-term, others chronic and long-term. Apart from differences between handicapped groups there are also differences within them. People with the same disability may differ greatly depending on their physical environment, educational

[5]Harris A. *et al. Handicapped and Impaired in Great Britain*, Office of Population Census, London, 1971.

[6]Kafafain H. *Cybernetics: Study of man-made communication systems for the Handicapped.* World Congress of Rehabilitation International, Sydney, 1971, p 42.

background, social situation and personality. Awareness of this diversity, basic as it may appear, and recognition that the handicapped are not a homogeneous group, is vital to laying a foundation for a more relevant and meaningful structure of services. In many instances it is much more relevant to talk in terms of particular needs rather than particular handicapped groups. What is really needed is an enabling structure which will offset the disadvantages currently experienced by many handicapped people and not a set of static services labelled "handicapped".

In some instances this will involve not only the provision of necessary services, but real change in the social and economic structure of society.

1.1.2 *Data on the handicapped population*:

> Disablement is the loss or reduction of functional ability caused by an impairment. Handicap is the disadvantage or restriction of activity caused by disability.[7]

In other words handicap is determined by more than the actual medical condition—it can be intensified or ameliorated by the physical environment, by supports and services available to offset it, by attitudes on the part of society, and by the handicapped person himself. The terms disabled and handicapped are often used interchangeably. Nonetheless it is important to make this distinction.

There is no accurate, comprehensive information available on the total number of people who are handicapped in this country. Despite this there are data available in relation to specific groups such as the mentally handicapped (see Table 1.1), the blind[8] and spina bifida.[9] Many voluntary organisations have statistical information on the particular groups they serve, or can provide estimates based on the prevalence of the disability in other countries.[10]

[7]Harris A. *et al.* op. cit. p. 2.

[8]Register kept by the National Council for the Blind (6,000 blind and partially sighted).

[9]The National Rehabilitation Board, in association with the Spina Bifida Association, has information on the total number of spina bifida children born each year, and the number who live.

[10]For example, it is estimated by the organisations concerned that 2,000 people have multiple sclerosis, 3,000 cerebral palsy, 3,500 polio, 14,000 epilepsy, etc. The National Association for the Deaf claim that 3% of the population in the Republic suffer from a marked hearing loss.

TABLE 1.1
Number of Mentally Handicapped Persons, 1974[a]

Number of moderate mentally handicapped	5936
Number of severely mentally handicapped	3738
Number of profoundly mentally handicapped	1582

[a]The overall prevalence of moderate, severe, and profound mental handicap identified was 3.8 per 1,000 of population. For the 10-14 age group the prevalence was 5.14 per 1,000 population. In the case of mild mental handicap 1,865 persons in residential centres in 1974 were functioning at a mild level of mental handicap. In 1978, 3,667 were in special schools and a further 2,074 in special classes.

Source: Mulcahy M., *The Prevalence of Mental Handicap in the Republic of Ireland*, M.S.R.B, Dublin 1974.

The Health Boards have data on the number of people in receipt of Disabled Persons Maintenance Allowance; the Department of Education know how many handicapped children are in receipt of special education; the Department of Social Welfare have statistics on the total number on long-term disability benefits and invalidity pensions.[11]

There are, however, some people who are appreciably handicapped who may not manifest themselves in any of these statistics. Firstly, there are a great many handicapped people who are not dependent on welfare or assistance benefits and who are working or are housewives or children, and so do not come within the income maintenance net. For example, by far the greatest cause of physical impairment in Britain is arthritis. Almost one million people are affected by it.[12] Many people in this country who are handicapped by this condition may not be in receipt of benefits or be known to voluntary organisations. In addition, there is the very large number of the handicapped population who are now over 65 years and are in receipt of old age pensions, who may not be included in any information relating to disability. Secondly, the statistics available are limited, because the corollary also holds, that many included in the statistics may not be handicapped in the real sense of the term, but could well be on disability related benefits.[13]

The absence of data has been noted and commented on in recent

[11]See section on Income Maintenance for a breakdown of these figures.

[12]Harris, A. et al. op. cit. p9. (200,000 men, 700,000 women).

[13]NESC Report No. 38 *Universality & Selectivity; Social Services in Ireland*, 1978, p.111.

years. In a general sense, a National Economic and Social Council report in 1978 highlighted that:

> Statistics on the number of chronically ill, disabled or handicapped are patchy . . . no national totals exist of the numbers of handicapped nor of the numbers whose mobility is impaired to differing degrees.[14]

The handicapped were consequently mentioned as a particular priority area in the compilation of statistical data. More specifically in relation to actually planning services, the working group set up by the Minister for Health in 1973 to make recommendations on Training and Employing the Handicapped was confronted by a total lack of adequate information. The working group points out; "we have had considerable difficulty in arriving at this figure because of the lack of precise information."[15] Consequently, many of the figures used for providing the framework for its recommendations were simply crude estimates.

The Report on Training and Employing the Handicapped suggested that the figure of 100,000 represents a reasonably valid estimate of the number of adult handicapped persons in the population with a long-term physical or mental handicap. This broadly agrees with British estimates.

1.1.3 *International Estimates*

Peter Townsend, referring to the accepted 3% of the population in Britain officially described as handicapped, suggests that this is a conservative estimate. Judging from research in other countries, (Denmark and Sweden), he claims that a figure of 6% of all adults aged 21 to 64 is likely to be reached when disability is defined broadly. Allowing for a smaller proportion of children, but a much larger proportion of the elderly, the figure for the whole population he suggests would probably be higher.[16]

The International Labour Organisation estimates that 10% of any population group are mentally or physically handicapped to such a

[14]NESC *Statistics for Social Policy*, Report No. 17, Dublin, 1976 p.5.

[15]*Training and Employing the Handicapped*, Report of a Working Party established by the Minister for Health, Dublin, 1975.

[16]Townsend, P. "The Disabled in Society" in the *Handicapped Person in the Community*, London, 1975, p.22.

degree that they require special help in making a satisfactory adjustment to community life.[17]

The number involved or the proportion of the population who could be termed handicapped is not small. When people think of the handicapped many do so only in terms of those who are severely incapacitated and who have visible handicaps. However, there are substantial numbers in modern societies impaired to varying degrees although many of them may have invisible handicaps such as epilepsy or heart disorders.

1.2 The Evolution of Irish Rehabilitation Services: The Voluntary Contribution

Any review of the situation relating to handicap in Ireland will very early encounter voluntary and private organisations. In no other area of social service is there such a predominance of voluntary organisations as in the field of handicap. This is possibly a result of, and indeed a contributing factor towards, the relatively slow involvement of the statutory services at both national and regional level in directly catering for particular needs and particular disabilities.

There are over twenty-six voluntary organisations affiliated to the Union of Voluntary Organisations for the Handicapped (UVOH). This is an umbrella organisation set up to co-ordinate the activities of member organisations engaged in work for the welfare and rehabilitation of persons suffering from mental or physical disabilities.[18] The corresponding organisation in the field of mental handicap, the National Association for the Mentally Handicapped of Ireland (NAMHI), has forty-three organisations providing services affiliated to it.[19] The situation is rendered even more complex by the fact that several member organisations of both UVOH and NAMHI have local groups or centres spread throughout the country.

These voluntary organisations grew up at various stages over the past decades in response to the needs of particular handicapped groups

[17]Cooper, N., Vocational Rehabilitation Section, International Labour Organisation, speaking at *Mobility International Conference*, Geneva, April, 1979.

[18]See Appendix IA for list of organisations, their functions and location, affiliated to UVOH. There are a further 14 organisations concerned with physical handicap not affiliated. These are also listed.

[19]Full information contained in *Directory of Services for the Mentally Handicapped*: NAMHI, 1977.

or to cater for a need common to several disabilities. Thus there are special organisations for the deaf, the blind, multiple sclerosis, spina bifida, polio, epilepsy, haemophilia, arthritis, cystic fibrosis and cerebral palsy, among others; the more broadly based organisations such as the Irish Wheelchair Association, encompassing many disabilities leading to severe restriction of mobility and organisations such as the Rehabilitation Institute, Cheshire Homes and the Central Remedial Clinic respectively providing services in the field of training, residential care, medical rehabilitation and education for the handicapped population as a whole.

The needs which motivated the establishment of some of these organisations have since been met and in some cases the organisation has moved on to serve a different set of needs and different groups of people. Obvious examples in this field are the Rehabilitation Institute established in the early 'fifties to provide for those with tuberculosis but which is now engaged in vocational training services for all groups of handicapped persons and the Cork Polio and General Aftercare Association now which is primarily concerned with providing services for mentally handicapped children and adults.

The majority of existing services for mentally handicapped people are provided by voluntary bodies, both religious and lay. The number of voluntary organisations involved in the provision of services is consistently increasing. The Commission of Inquiry on Mental Handicap which reported in 1965,[20] identified sixteen organisations involved in the provision of services. Apart from the expansion of the services provided by many of these organisations, twenty-seven other organisations have now become involved in the provision of services. These are mostly county or district associations for the mentally handicapped involved for the most part in the provision of schools, but also in the provision of day care and sheltered work facilities. The nuclei of these organisations have generally been parents of handicapped children and these groups have made a major contribution towards the development of services through highlighting needs within particular areas. Also eight religious orders, additional to those involved in 1965, are now providing residential services, accompanied in some cases by day services.

Although classified as voluntary organisations many of these

[20]*Commission of Inquiry on Mental Handicap.* Report, Dublin, 1965.

agencies would be more correctly termed private organisations. Many employ a very substantial number of personnel in the medical, paramedical, administration, training, personal care and education fields. Some of these organisations are dependent to a greater or lesser extent on support from the public and many engage in fund-raising on a highly organised and professional basis.[21] However, there is also a substantial measure of statutory financial support from various levels made available to some organisations. This is particularly true within the sphere of services for the mentally handicapped, which although provided by voluntary organisations, are almost totally financed by the State primarily through the Department of Health and through the Department of Education for educational services.

The same situation does not apply in the sphere of physical handicap, particularly where the services are not institutionally based. Various factors may influence the level of financial support available to organisations for the physically and sensorially handicapped:

(1) The type of services being offered—whether educational, vocational, residential or community supports.

(2) The Health Board area in which the agency operates. The overall level of development of the Health Boards' social services programme and the attitude of the various Boards to the voluntary contribution is very relevant. There is a very definite variation in the attitudes of individual Health Boards, for example, to subventing specialist organisations to employ social workers to meet the needs of special groups.

(3) The effectiveness of the organisation in developing a working or partnership relationship with the statutory authorities. Within the field of physical handicap there are extensive variations in the level of supports made available to voluntary organisations which seems to bear little relationship to the importance or indeed the quality of the service provided.

1.2.1 *Support of Voluntary Organisations*

Statutory support is given to voluntary agencies through various channels. It may be linked to a particular service, e.g., residential care or

[21]This is particularly true in the case of organisations for the physically handicapped where very substantial budgets may be based almost totally on the ability of the organisation itself to generate resources in the community.

social work provision; it may be a direct grant given by the relevant Health Board or; it may be through funding from central Government. On a general level statutory support to voluntary organisations may be divided into:

Capitation Grant Schemes: Whether for residential care, education or training, financing is on the basis of a capitation rate and paid to the agency. Examples of organisations receiving support on this basis are St. Michael's House, Cheshire Homes, schools for the deaf, Rehabilitation Institute training centres.

Section 65 Grants: This provision made under the 1953 Act permits Health Authorities with the approval of the Minister to give assistance in various ways to any body which provides or proposes to provide a service similar or ancilliary to a service which the Health Authority may provide. Some Cheshire Homes receive support under this system, as does the Irish Wheelchair Association.

Budgeting: This system is based on a formulated budget between the Department of Health/Health Board and the voluntary organisation with agreement on the level of services and the financial input of both parties. Such institutions as Baldoyle Hospital, St. Vincent's, Navan Road and centres of the St. John of God Brothers are on budget financing.

1.2.2 *Effectiveness of Voluntary Agencies*

Voluntary organisations for the handicapped differ greatly, not only in their structure and scope, but most importantly in their effectiveness, in the quality of their service and their ability to meet the needs of the group(s) they purport to serve. There is frequently discussion on the overlapping and duplication both between these organisations and the statutory services. This is certainly the situation in some instances. However, of greater concern is the probability that the needs and often acute needs of particular groups of handicapped people are not being met due to the total absence of any service or to the ineffectiveness of a voluntary organisation supposedly serving a particular group or providing a particular service.

Voluntary organisations have a definite contribution to make to a more effective welfare and rehabilitation service for the handicapped

person. They have done so in the past through providing much needed services and in highlighting areas of need. This dual role is important and sufficient attention must be given by voluntary agencies to the latter if changes in the social and economic structure of society are to be made. It is also important on the service front that they continue to fill the pioneering role, identifying new needs, creating an awareness of them, providing for them either in the short or long term and, most importantly, providing models of the best practices to be adopted by statutory and other agencies. The abilities of voluntary organisations to intervene rapidly in situations of stress, to respond to new needs and to harness enthusiasm and concern at local and national level should be exploited to the full.[22] It is essential that voluntary organisations do not become static and concerned with their own preservation but rather are prepared to adapt to new needs and new social situations. This is particularly relevant at present in Ireland where there is increasing involvement by statutory bodies, both directly and indirectly, in providing for the needs of the handicapped person.

Some form of co-ordination and monitoring of voluntary agencies is essential if an adequate and comprehensive network of services are to be developed. There is no effective form of monitoring at present. Two organisations, the National Rehabilitation Board and The Union of Voluntary Organisations for the Handicapped, have been given the task of co-ordinating voluntary bodies in the field as part of their terms of reference. While recognising the difficulties of "co-ordinating" the activities of voluntary organisations and the even greater difficulties of monitoring their effectiveness in areas of service, this role has not been fulfilled in any meaningful manner. There is always the danger that, in the absence of any overall direction, voluntary agencies could well end up serving the needs of groups who are relatively easy to cater for or attractive to work with. The needs of people in more remote geographical areas and the needs of the more severely handicapped and emotionally disturbed person for training, residential care and day-care facilities, could go unmet.

By examining the various areas of need this report will show that an overall policy is urgently required. Agreement as to the relative

[22] *A Chance to Care: A discussion document on Voluntary Service*, (examines the role which voluntary service agencies can fulfil), National Federation of Social Service Councils, September 1976.

contributions of the various voluntary bodies and statutory authorities to meeting agreed policy goals is essential to the improvement of existing services for the handicapped population.

1.3 Statutory Involvement in Rehabilitation

There is a wide range of statutory authorities at national, regional and local level concerned with the provision of services for handicapped persons. While some of these services are specialised others are related to general services available to the population as a whole.

Some statutory authorities are more directly involved and have an explicit responsibility for the provision of special services. Other authorities are only marginally involved. The Department of Health and Social Welfare and the regional Health Boards have a major role to play. Their involvement relates not simply to the whole area of health (both preventive and rehabilitative), but to welfare programmes, to community care, residential care and vocational training and employment. The Department of Education and educational authorities in their general provisions as well as their special education programmes, the Department of the Environment and the Department of Labour are all involved in meeting specific needs of the handicapped population.

There is, however, no one Government department or Minister with an explicit responsibility for co-ordinating or developing services across the very wide spectrum of areas involved. The recent Workshop Standards Committee Report points out that while "... rehabilitation has become an accepted general principle, the operation of rehabilitation services in Irish terms has developed without a clearly co-ordinated or sequential approach to the provision of services by State Departments, State agencies and voluntary organisations".[23] The function of co-ordination has tended to devolve on the Department of Health at national level and the Health Boards at regional level. As presently structured the Department of Health and its executive agency, the National Rehabilitation Board, provides the main co-ordination within the public services.

There is little legislative provision designed to meet the specific needs of the handicapped population. On occasions, existing services

[23]*Standards for Workshops: Report of the Standards Committee of the NRB*, April, 1978, p.2.

were expanded or adapted for the handicapped person. Where specific initiatives were taken these were often the result of Government responses to particular needs rather than as elements of an evolving policy.[24]

An EEC study, commenting on the situation in different countries, suggested that a number of factors were inhibiting the development of rehabilitation along modern lines in different countries. These were the dispersion of initiatives, the legacy of traditions of charitable work, the complexity of legislation which has developed on a piecemeal basis and the multiplicity of institutions competent to intervene.[25] These comments are particularly relevant to Ireland.

The establishment by the Minister for Health of the working party on Training and Employing the Handicapped in the early 'seventies was the first attempt to comprehensively examine provisions and needs within the sphere of employment and training for the handicapped person. The resulting recommendations now provide the framework within which these services have been developed.

Similar assessments could usefully be undertaken on residential care, educational facilities, community care support services, medical rehabilitation facilities, income maintenance programmes and mobility provisions for the handicapped person.

1.3.1 *The National Rehabilitation Board*

In 1967 the Minister for Health established the National Rehabilitation Board. The Board consists of twenty members nominated by the Minister for Health.[26] Functions of the Board include advising the Minister on all aspects of rehabilitation, co-ordinating the work of voluntary organisations engaged in rehabilitation and arranging for the provision of specialised services.

In pursuance of its functions the Board provides several services which are available to disabled persons, voluntary bodies, hospitals, Health Boards and educational establishments. These services include:

[24]There are such special allowances as Disability Benefit Schemes 1953, compensation for occupational injuries in 1967, elimination of road tax for disabled drivers in 1968 and constant care allowance introduced in the early 'seventies. However, some provisions have not had a legislative basis, e.g., a ministerial order of 1972 gave effect to the Disabled Persons Grant Scheme for Housing Adaptions.

[25]Referred to by Ross, M., in *State Aid to the Handicapped 1960-1977* Paper given at UVOH Conference, Wexford, 1977.

[26]This superseded the National Organisation for Rehabilitation 1957.

(1) Medical and vocational assessment.
(2) A national placement service for disabled persons.
(3) Youth employment and advisory service.
(4) Industrial service.
(5) National hearing aid and educational advisory service.
(6) An occupational therapy and speech therapy college.
(7) In association with the Sisters of Mercy—the National Medical Rehabilitation Centre in Dublin.

The Board co-ordinates services for children with spina bifida, it promotes recreation for the handicapped and is also involved in promoting ease of access for handicapped persons to all public facilities.

Aspects of the services delivered by the Board are excellent and their initiation has contributed greatly to the current state of rehabilitation services. However, the role of NRB as adviser on all aspects of rehabilitation and as co-ordinator of organisations working within the field, has been less effective. Like other agencies the NRB have also been hampered by the absence of statistical data on the dimensions of their task. Nonetheless, in the initial ten years of their existence no significant moves have been made to undertake research on a nationwide basis to obtain the necessary basic information.[27] Neither has this agency been totally effective in motivating other statutory agencies to plan and provide services where necessary. Its role as co-ordinator of voluntary organisations working in the field has not been an active one.[28] Apart from contacts with organisations involved in providing vocational services its ongoing contact and role as co-ordinator of agencies involved directly in community services has frequently been minimal.

A recent study undertaken on the structure of the NRB for the Department of Health will hopefully lead to a restructuring of this organisation and the increasing emphasis on its co-ordination, planning, and research functions.

1.3.2 *Health Boards*

The eight regional Health Boards through their three programmes of

general hospitals
special hospitals
community care

are directly involved in the planning and provision of services for the handicapped at regional and local level. The level of rehabilitation services and the adequacy of supports available to the handicapped person is directly related to the overall level of development of the individual Health Board's programme. There are wide variations between the Boards in the services provided to the handicapped population in their area and indeed from one disability grouping to another within the same area.

This distribution of services reinforces the already uneven availability of supports provided by voluntary organisations around the country with many disabled people faring badly purely by virtue of their geographical location. This variation in services will be highlighted throughout the report as different need areas are examined.

There are a wide range of services made available by the Health Boards—institutional services, general health and welfare services, community support services and income maintenance programmes. All of these are available to handicapped persons as well as to the general population. There are also specialised services available, geared towards the needs of groups of handicapped people—vocational training services, special residential centres, medical rehabilitation services and special income supports for the handicapped person.[29]

Many of these are not directly provided by the Board, and Boards may choose to make services available through voluntary agencies. In no area is this indirect involvement more apparent than in the field of services for the mentally handicapped, the vast majority of which are provided by voluntary organisations. However, there is frequently total subsidisation by central Government or the Health Boards of these services. Such voluntary involvement is certainly desirable. However, it calls for co-ordination by a central authority. Without this there may be inadequate provision for particular groups. For example, approximately 40% of mentally handicapped persons in residential centres are accommodated in psychiatric hospitals and geriatric homes.[30] Placement in these centres has generally resulted from the absence of

[27]See section on Identification Chapter 2.
[28]The NRB established the UVOH. and helped in establishing the NAMHI.

[29]These areas will be examined throughout the report.
[30]In 1974 there were 2,744 mentally handicapped persons in psychiatric hospitals and 642 in geriatric homes.

suitable alternative accommodation being offered by voluntary bodies in the area. Health Boards are consequently now becoming increasingly involved in the direct provision of special residential services for mentally handicapped persons.[31]

1.3.3 *Co-ordination—the Role of the Statutory Authorities*
A Council of Europe study on rehabilitation in looking at the marriage between State and voluntary organisations examined the systems in operation in different countries. It was interested in those which enabled the community to benefit from the dedication, initiative and flexibility of voluntary groups and the overall co-ordination and organisation of the statutory bodies. The existence of active voluntary bodies, it warned, should not be used to provide a pretext for the State to opt out. At the very least the State should lay down the principles and rules of rehabilitation, supervise and control, as well as finance realistically recognised bodies, within an overall plan of rehabilitation. Any gaps in the system are to be provided by the State.[32] This philosophy is very appropriate not only at regional level but also at national level in this country.

In their recent report the Workshops Standards Committee emphasise the need for co-ordination within the Irish situation:

> "There must therefore be close co-ordination and synchronisation to ensure that all components of rehabilitation work in harmony for the benefit of the handicapped. This does not always take place".[33]

1.3.4 *Co-ordination of services for Physically and Sensorially Handicapped Persons*
There has been little attempt by Health Boards until recently to assess the needs of the handicapped and to plan to meet them whether directly or indirectly. The absence of data at this level made planning difficult, and without clear directives from central Government no concentrated effort was made to approach the problem. However,

[31]A number of special centres are being planned, e.g., Loughlinstown, Co. Dublin, Swinford, Co. Mayo, Killarney, Co. Kerry. In the recent past centres have been opened at Castlepollard, Co. Westmeath and Cloonamahon, Co. Sligo.

[32]See Ross,M., op. cit., p. 14.

[33]*Workshop Standards Report,* op. cit. p.2.

some positive moves have been made by a small number of Health Boards. These have been influenced by:

(1) The implementation of the recommendations of the Robins Report and the increasing emphasis on the community care area as the basis on which identification of handicapped people suitable for training and employment should be undertaken. Although little progress has been made in drawing up the recommended register, the focus is increasingly on the Director of Community Care as the person responsible for such identification. The NRB placement service is also expanding within the community care area structure.
(2) The availability of European Social Fund financing for rehabilitation programmes within Health Boards and the resulting increase in emphasis on such programmes. In 1979 over £2.5 million was approved for Health Board projects from the European Social Fund.
(3) General progress in the development of the Health Boards' programmes and their movement into areas previously served exclusively by voluntary organisations or not served at all.
(4) The increasing emphasis on community care and the resulting need to provide services to realise the goal of maintaining people within their own community.
(5) The scarcity of specialists, particularly paramedical personnel, and the need to avoid duplication and use existing resources to the fullest.
(6) Increasing recognition by some voluntary organisations of their role in highlighting needs of the handicapped and encouraging Health Boards to plan to meet them.

Despite these trends some Health Boards have made little or no progress in providing an enabling structure of services for the physically and sensorially handicapped person. There is considerable progress however in some areas. The most notable of these in terms of a comprehensive attempt to identify and meet needs is that of the North Western Health Board. Their plans include the direct provision by the Board of community-based training and employment facilities for handicapped persons (a function almost exclusively undertaken by voluntary bodies to date), development of effective community support

services, early identification of handicap, counselling services, development of a register and the allocation of responsibility for the co-ordination of services to particular posts. It is interesting to note that this Health Board got approval for over £700,000 from the European Social Fund for rehabilitation programmes for 1979.

The allocation of responsibility for co-ordinating services for the handicapped to a particular post would seem to be a necessary step for all Health Boards to take if progress is to be made in co-ordinating and planning. Such machinery does not exist in most Health Boards as far as the physically and sensorially handicapped are concemed. Unfortunately too many Health Boards have yet to reach the stage of attempting to examine the special needs of this group.

1.3.5 *Co-ordinating Services for Mentally Handicapped Persons*

The heavy reliance on voluntary organisations in the development of services for mentally handicapped persons has also been associated both with an uneven geographical distribution of services, particularly until the recent past, and also with a relative shortfall in provision for particular groups. The latter is particularly evident in the case of adult mentally handicapped persons and severely emotionally disturbed persons irrespective of age and degree of handicap.

Co-ordination is essential if the most appropriate type of special service is to be provided and if, in the short term, those most in need of services that are in limited supply are to be catered for. With regard to the former point it is notable that there has been considerable development in the provision of residential schools for mild and moderately handicapped children. It is not clear that all those accommodated in these schools are in need of residential services. With regard to criteria for admission to services which are limited, it is extremely difficult to get agreement on acceptable criteria. Numerous factors have to be taken into account in each individual case, particularly family and social factors. In relation to residential services, there is considerable pressure on all centres, particularly in the case of adults and in the case of children functioning at severe and profound levels of handicap. The most easily realisable solution in the short term would appear to be the acceptance of a priority waiting list in each area agreed on by representatives of the various voluntary organisations concerned and the statutory bodies. This type of waiting list is in

existence in the Eastern Health Board area.

At the present time each Health Board has a liaison committee which includes representatives of the voluntary bodies and acts as a co-ordinating body for mental handicap services. Four Health Boards have appointed directors of mental handicap services, viz. the Eastern, North Western, South Eastern and Mid-Western Health Boards. In the latter two cases the person concerned is jointly appointed by the major voluntary organisation in the area and the Health Board concerned. A similar appointment is proposed for the Midland area.

A number of new trends in the provision of services for mentally handicapped persons have become evident of late in countries where services are at an advanced stage of development, e.g. Sweden. These trends are also becoming evident in Ireland, in particular:

(1) An emphasis on regionalisation and localisation of services.
(2) An emphasis on community care.
(3) An emphasis on integration of handicapped persons within the community.

Acceptance of these principles necessitates the development of services to meet the needs of the handicapped person within each area in terms of day services, diagnostic, assessment and advisory services and other support services for parents and finally local residential provision. The latter has led to an interest in the provision of hostels/group homes.

The effective realisation of these ideals is dependent on a co-ordinated approach both between various voluntary organisations and between all these organisations and statutory organisations. This is not to suggest that co-ordination alone will readily solve all problems. The answers to the problems associated with the provision of services for particular groups, e.g. disturbed adult mentally handicapped persons, are not yet available.

1.4 The Rights of the Disabled Person

The explicit recognition of the rights of the disabled person and their active pursuance is crucial in the planning of services for this minority group.

The rights of the disabled person are enshrined in many international

declarations[34] and in national constitutions. However, in order to focus special attention on these rights and the means of attaining them, the United Nations General Assembly passed a resolution in 1975—the "Declaration of the Rights of Disabled Persons".[35] This declaration calls for national and international action to ensure that it will be used as a frame of reference for the protection of these rights.

(1) The term "disabled person" means any person unable to ensure by himself or herself wholly or partly the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or mental capabilities.

(2) Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever, and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.

(3) Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.

(4) Disabled persons have the same civil and political rights as other human beings; article 7 of the Declaration of the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.[36]

(5) Disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible.

[34]Universal Declaration of Human Rights; International Covenant on Human Rights; Declaration of the Rights of the Child; Declaration of the Rights of Mentally Retarded Persons; Economic & Social Council Resolution on Prevention of Disability & Rehabilitation of Disabled Persons.

[35]United Nations General Assembly, Resolution 3447, Dec. 1975.

[36]Apart from the special rights guaranteed by Article 7 which provides protection in the case of any limitations imposed, all other provisions are contained in this more recent declaration. See Appendix IB for the *Declaration of the Rights of Mentally Retarded Persons.*

(6) Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthotic appliances, to medical and social rehabilitation, education, vocational education, training and rehabilitation, aid, counselling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the process of their social integration or reintegration.

(7) Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.

(8) Disabled persons are entitled to have their special needs taken into consideration at all stages of economic and social planning.

(9) Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive there from. If the stay of a disabled person in a specialised establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age.

(10) Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.

(11) Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

(12) Organisation of disabled persons may be usefully consulted in all matters regarding the rights of disabled persons.

(13) Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration.

This resolution was endorsed by the Irish Congress of Trade Unions

in 1977. At its annual conference in 1978 the ICTU undertook to make representation to the Government on areas relevant to the implementation of these rights.[37]

Based on the philosophy of the rights of the disabled person, the goal of rehabilitation policies is ultimately full integration. Often this means the need to positively discriminate in favour of the disabled person. As the Snowdon Report illustrates, integration for the disabled means a thousand things. It means the absence of segregation. It means social acceptance. It means being able to be treated like everybody else. It means the right to work, to go to a cinema, to enjoy sport, to have a family life and a social life and a love life. It means being able to contribute materially to the community, to have the usual choices of association, movement and activity, to go on a holiday to the usual places, to travel without fuss on public transport, to be educated to one's maximum potential with one's unhandicapped peers where possible.[38]

Many of these are simply aspirations within the Irish situation. The goal of planning must be to make them a reality. The Government should at this stage at least implement Article 13. The question of the involvement of consumers whether as individuals or organisations in planning to meet needs is also a very relevant one within the Irish context.

1.5 The Study

The study attempts to provide an overview of the situation relating to the handicapped person in Ireland. The focus of the study is essentially on needs rather than on disability groupings. Within this framework the following areas are examined:

Identification of the Handicapped Person
Education provisions
Employment and Training
Community Services
Income Maintenance Services
Residential Care Services
Mobility—personal and public
Preventive Aspects.

[37]The ICTU also held a two-day seminar on the Rights of the Disabled in May 1979.
[38]*Integration of the Disabled*, op. cit., p. 7.

CHAPTER 2

IDENTIFICATION AND CLASSIFICATION OF HANDICAP

2.1 Identification of Mentally Handicapped Persons

The census of the mentally handicapped in 1974, undertaken by the Medico-Social Research Board, at the request of the Department of Health, provides essential information on the number of mentally handicapped persons in the country and their characteristics. The findings of this census have been used to date as a basis for planning services. However, it is clear that regularly up-dated basic information on the numbers of handicapped persons within each Community Care area is essential to ensure adequate planning of services not only at this level but also at Health Board and national level.

Very considerable information is available within each area at the present time, but statistics are not readily available from the point of view of planning services. Certain information is vital for planning purposes, e.g.:

(i) Number of persons functioning at the various levels of handicap and their age levels.
(ii) Number with handicaps additional to their mental handicap.
(iii) Number of persons attending and in need of various types of services, both residential and community.

The Medico-Social Research Board has proposed that a standardised record system relating to mentally handicapped persons be set up and maintained in each Community Care area. This would ensure the availability, through Directors of Community Care, of statistics on handicapped children and adults. It is proposed that only those mentally handicapped persons who have come to the attention of the Director of Community Care would be included; in practice, this would achieve total coverage of moderate, severe and profoundly handicapped

persons. It would include both persons in residential services as well as persons living in the community. The setting up of such a system in each Community Care area, would facilitate a further census of mentally handicapped persons, probably in 1981 to coincide with the national census.

Classification of Mentally Handicapped Persons

2.1.1 The terms "mental handicap", "mental retardation", "mental subnormality"[1] are used interchangeably to refer to a wide range of conditions rather than to a specific disease entity. As the Commission of Inquiry on Mental Handicap pointed out "Mental Handicap" which is the term used in Ireland, "is a condition characterised by varying degrees of impairment in maturation, learning and social adjustment".[2] In focusing on persons categorised as mentally handicapped, this variation is clearly evident; at one extreme are persons categorised as mildly mentally handicapped, who are in very many respects indistinguishable from the average population, at the other extreme persons categorised as profoundly handicapped are those persons who need full-time care and attention throughout life and whose mental handicap is generally accompanied by physical and/or sensorial handicaps.

In discussing the meaning of mental handicap, The Commission of Inquiry referred to the difficulty of formulating a definition:

> It is virtually impossible to produce a definition which will be universally acceptable or which will readily distinguish those in the upper levels of mental handicap, from those in the lower levels of what is regarded as normal. In practice, a mentally handicapped person must be regarded as one who is judged to be mentally handicapped after proper diagnosis and assessment on the basis of the criteria accepted and the techniques for diagnosis and assessment adopted in his particular country.[3]

Accepting these difficulties they decided to use the term "Mentally Handicapped" to describe "those who, by reason of arrested or incomplete development of mind, have a marked lack of intelligence and, either temporarily or permanently, inadequate adaptation to their

[1] "Mental Retardation" is the term generally used in the US. "Mental Subnormality" is the term generally used in the UK.

[2] *Commission of Inquiry on Mental Handicap*, op. cit., p. 19.

[3] ibid, p. 18.

environment".[4] At a theoretical level, most definitions of mental handicap imply that for a diagnosis the following criteria must be met concurrently:—

(i) Sub-average Intellectual Functioning
(ii) Impaired Adaptive Behaviour
(iii) The syndrome must have originated during the development period[5]

Generally accepted standardised criteria for the measurement of social adaptation are not at present available, though much work is being undertaken in this area.[6] Thus, the sub-average intellectual functioning criterion is generally used in studies on mental handicap.[7] With regard to test performance, the statistical criterion established is such that all those persons functioning at least two standard deviations below the population mean IQ of 100 are considered mentally handicapped.[8] The census of the mentally handicapped in 1974[9] following the WHO International Classification of Diseases used the following sub-divisions of mental handicap[10]:

Degree of Mental Handicap	Standard Deviations below the mean	IQ Range
Mild	2.0—3.3	50—70
Moderate	3.3—4.3	35—49
Severe	4.3—5.3	20—34
Profound	More than 5.3	Less than 20

[4] ibid., p. 18.

[5] Heber, R. "Modification in the Manual on Terminology and Classification in Mental Retardation" *American Journal of Mental Deficiency*, 1961, 65, pp. 499-500; Studies on Mental and Population Subjects, No. 22 *A Glossary of Mental Disorders*. London, HMSO, 1968; *Census of Mentally Handicapped People in England and Wales at the end of 1970*, London, HMSO, 1972.

[6] Leland, H. "Adaptive Behaviour and Mentally Retarded Behaviour" In *Sociobehavioural Studies in Mental Retradation*. Editors, Eyman, R. K., Meyers, C. E. and Tarjan, G. AAMD, Los Angeles, 1973 pp. 91-100. Nihira K. "Importance of Environmental Demands in the Measurement of Adaptive Behaviour" In Eyman, R. K. et al op. cit., pp. 101-117.

[7] Luckey, R. E. and Newman, R. "Practice in Estimating Mental Retardation Prevalence" *Mental Retardation*, Vol. 14, 1976, pp. 16-18.

[8] See Appendix IIA.

[9] Mulcahy, M. and Ennis, B. *Census of the Mentally Handicapped in the Republic of Ireland, Non Residential*. MSRB Dublin, 1974, p. 8.

[10] *International Classification of Diseases 8th Revision*. World Health Organisation, Geneva. The same classification is given in the latest revision of the ICD, i.e. the 9th revision.

In the case of those functioning at moderate severe and profound levels of handicap, few difficulties are encountered in identification as there is generally physiological damage evident and irrespective of whether the criterion for identification adopted was sub-average intellectual functioning or impaired social adaptation, the vast majority would be identified as mentally handicapped. This contrasts with the position relating to those functioning at a mild mental handicap level on the basis of intelligence tests. It has repeatedly been pointed out that for the majority of this group few direct associations between cause and effect are observable: "Most mildly retarded persons do not exhibit neurological signs of brain damage. (Stein and Susser, 1960, 1963) nor can the retarded intellectual functioning be directly related to the central nervous system dysfunction"[11] Studies on the social distribution of mental handicap consistently show a disproportionate number of children from lower socio-economic groups. On investigation it emerges that this over-representation relative to population distribution occurs in that portion of the mildly mentally handicapped who appear to be "clinically normal" and are frequently described as being "sub-cultural" or "familial".[12] It is estimated that this group makes up approximately 75% of the mildly mentally handicapped population.[13] In explaining this phenomenon, it has been suggested in a number of studies that the mentally handicapped form at least two distinct sub-groups—those who fall more than three standard deviations below the population mean IQ test score, and hence are outside the normal distribution of IQ test scores, and those who fall less than three standard deviations below the mean and thus are within the normal distribution of such scores.[14] The implications of this are that the majority of those functioning at a mild mental handicap level on the

[11]Tizard, J. "The Role of Social Institutions in the Causation, Prevention and Alleviation of Mental Retardation". In *Socio-Cultural Aspects of Mental Retardation.* Editor Haywood, H. C., New York, Appleton-Century Crofts, 1970, pp. 281-340; cited: Stein, E. and Susser, M. "Families of Dull Children" *Journal of Mental Science 1960,* 106 pp. 1,296-1,310. Stein, E. and Susser, M. "The Social Distribution of Mental Retardation" *American Journal of Mental Deficiency* 1963, 67, pp. 811-821.

[12]Penrose, L. S. *The Biology of Mental Defect,* London, Sidgwick and Jackson, 1954. Stein, E. and Susser M. 1960 op. cit.; 1963 op. cit.

[13]Zigler, E. "Mental Retardation: Current Issues and Approaches" In *Review of Child Development Research* Ed. Hoffman, L. W. and Hoffman, M. L., New York, Russell Sage Foundation 1966, pp. 107-168.

[14]Zigler, E. "Familial Mental Retardation: A continuing Dilemma" *Science* 1967, 155 pp. 292-298.

basis of IQ, i.e. those without demonstrable physiological damage, will be conceived as part of the continuum of normal intelligence, of slower and more limited intellectual development than the average population but not inherently different from that population.[15]

Numbers of Mentally Handicapped Persons

2.1.2 The principal source of information on the numbers of mentally handicapped persons in Ireland is the census conducted in 1974. Apart from persons in residential care who were functioning at a mild level of mental handicap the Census was confined to moderate, severe and profound handicap. Considering these groups only, 11,256 persons were returned as mentally handicapped in the Census, almost 56% of whom were in a variety of residential centres and 44% of whom were living at home. Fifty-three per cent of the total group were moderately mentally handicapped, 33% were severely mentally handicapped and 14% were profoundly handicapped. The overall ascertained prevalence was 3.8 per 1,000 population. Focusing on the 15-19 age group, which is usually used for comparative purposes since it is generally accepted that all cases of moderate, severe and profound handicap will have been ascertained by this age, the prevalence rate was found to be 5.17 per 1,000 of the population.[16]

This is somewhat higher than the corresponding rate for Northern Ireland which is 4.81[17] and somewhat lower than the rate for Bristol, i.e. 5.5.[18]

As already mentioned, mildly mentally handicapped persons, with the exception of 1,845 in residential centres, were not counted in 1974. Mild mental handicap presents as a problem primarily during school years and the majority achieve independence in post school and work situations. The Department of Education defines mildly mentally handicapped children as those "who through limited intellectual ability are incapable of benefiting from the ordinary school programme". The Commission of Inquiry on Mental Handicap was

[15]Zigler, E. 1966, op. cit., p. 123/124.

[16]Mulcahy, M. *The Prevalence of Mental Handicap in the Republic of Ireland,* Dublin, MSRB, 1974.

[17]McDonald, G. and MacKay, D. A. "Mental Subnormality in Northern Ireland" *J. Ment. Defic. Res.* 1976, 22, pp. 83-89.

[18]Midwinter, R. E. "Mental Subnormality in Bristol". *J. Ment. Defic. Res.* 1972, 16, pp. 48-56.

unable to reach firm conclusions as to the incidence of mild mental handicap among school children. However, it recommended that by 1975 services should be provided for about 1% of the school-going population between the ages of 7 and 16 years.[19]

Present provision is in the form of special schools, day, and residential, and special classes. There were 5,700 children attending these services in 1978.

2.2 Identification and Classification of Physical and Sensory Handicap

There is no comprehensive source of information available at present whereby data on the number, distribution, forms and extent of physical and sensory handicap may be obtained. This absence of information and the difficulties it presents for planning and for policies will be evident throughout the report.

This sparsity of information has been highlighted in recent years by both statutory and voluntary agencies. Since the publication of the Robins report the importance of data on vocational training needs has been widely accepted. Not quite so widely accepted is the need for adequate data for the planning of relevant services in such other areas as community supports, day care, residential care and medical rehabilitation.

The primary and one might argue the only basis for seeking out this information on people is the need to have a sound base on which to plan relevant services and policies. Such information is urgently required by voluntary and statutory agencies. In this sense the identification is a necessary prelude to assessing need and to social action.

Despite the acceptance of the importance of such identification little progress has been made nationally. Individual Health Boards accept the need for basic data (at least on vocational training needs). In 1978 the Department of Health requested that Health Boards draw up a register of the handicapped persons suitable for vocational rehabilitation as well as those in receipt of the DPMA.[20] To define handicap, to identify those in need of particular services and to classify the information in a meaningful and useful manner is a very complex task. To produce the best possible information more precise guidelines and assistance will have to be given to individual Health Boards in this task. While much of the information is already there it needs to be organised and made available in a standardised and useful manner. In this way it will be of benefit not only to the Health Board in planning services but also at national level in formulating better policies which are relevant to needs as well as highlighting areas where substantial social changes are required.

It will be necessary to devote more resources in terms of time and personnel to compiling such a register. This will have to be done both centrally and at regional Health Board level.

There are two stages in this process—

(1) the provision at central level of a standard definition and framework for identification;

(2) the operationalisation of this framework at regional level and its updating and on-going use.

Definition of Handicap

2.2.1 There are very apparent inherent difficulties in defining physical handicap. It is difficult to measure some forms of handicap. Others are invisible. Often the actual physiological impairment may not be the major determinant of the handicap.

There are many definitions of handicap. They vary greatly depending on the use for which they are required. Thus there are purely medical definitions, vocational definitions and handicap defined from a purely social perspective. There are definitions which although conceptually acceptable are too general to be functional. Others are so specific that they exclude many who could be termed handicapped.

A definition of handicap for administrative purposes must be relatively simple, functional and sufficiently broad to encompass those whom it is hoped to ultimately benefit. A number of widely used definitions are given in Appendix IIB.

Within the Irish context the EEC definition seems to be the most useful. It defines handicap as follows:

> Handicap is any limitation, congenital or acquired, of a person's physical or mental ability which affects his daily activity and his

[19] *Commission of Inquiry on Mental Handicap*, op. cit. p. 79.

[20] In April 1978 a circular was prepared by the NRB and the Department of Health and sent to to each of the Health Boards. It outlined the purpose of a register and enclosed a classification of disabilities. At present the whole question of the register and the way in which it can become operative is under serious consideration by the Department of Health and Health Boards.

work, by reducing his social contribution, his employment prospects and his ability to use public services. A handicapped person is one whose handicap (or potential handicap) is recognised by the authorities appointed to this purpose with a view to rehabilitation.

Although focusing on the vocational aspect it also has a broader focus encompassing people who are restricted in their daily activity and thereby affected in their social contribution and use of public services. This definition was also adopted in the Robins report.

Identification and Classification

2.2.2 There are various means of obtaining information on the handicapped population of a country:

The national census: The area of physical handicap is very complex. Even if an accurate description could be obtained, e.g. the medical diagnosis, this alone may give little information on its impact on a person's life. The adequacy of the information obtained through the mere inclusion of a question on the National Census and, more particularly, its usefulness, is seriously open to question.

A Sample Survey: A survey similar to that carried out by the Office of Population Census in Britain on Handicapped and Impaired in Great Britain[21]

Detailed Surveys of Particular areas: An in-depth survey of particular areas, e.g. a densely populated urban Community Care area and an essentially rural Community Care area. The focus would be on the total population and within this the survey could provide more detailed information on the incidence and prevalence of disability and on the extent and forms of handicap.

A survey at Community Care area level: This has been the approach envisaged to date. The focus has been primarily on identifying those who may be suitable for vocational rehabilitation. This approach could be broadened to include identifying all handicapped persons with a view to ascertaining the need for specific services and provisions. The Director of Community Care will be responsible for compiling the information from the various sources available to him.

[21]See Appendix IIC for details of the sample survey.

To approach the question of identification at Community Care level seems most appropriate and feasible. Information already available and the additional data collected could then be organised and co-ordinated with a view to developing services to meet the needs of handicapped people.

A "register" of handicapped persons by Health Boards

2.2.3 Before compiling the register the following areas should be clarified. This would be best done at central level in consultation with Community Care programme managers.

(1) What is the purpose of the "register"?
Identification only?
Identification for specific purposes, e.g. vocational rehabilitation?
Identification to assess needs generally?

(2) Who will the register include?
Adults only?
People living in the community only?
Those in receipt of specific Health Board benefits, e.g. DPMA only?

(3) What sources will be used to provide information?
Available information on those in receipt of particular handicap related benefits?
Available information on those in receipt of community services—vocational training, public health nursing, etc.?
Sources not related solely to "take-up" of Health Board services.

(4) Who will have the responsibility for formulating the register centrally and regionally?
The Department of Health?
The National Rehabilitation Board?
Other agency?

Agreement on all these areas must be reached centrally with programme managers before individual Health Boards embark on the task of organising the data. People will then be clear as to:

(1) definition and framework to be used;

(2) the scope;

(3) the use to which it will be put in immediate future, and on an ongoing basis.

2.3 Suggested Framework for the register

If the register is to provide the required data and to be of use subsequently it is strongly recommended that it be as broadly based as possible, while still being functional. Ideally the focus should not be on existing services but rather on needs and the implications of these needs for possible new forms of service.

Looking at the areas highlighted as requiring clarification the following framework is suggested:

Definition and Classification of handicap: The EEC definition (interpreted broadly rather than narrowly): In terms of classification while the actual disability should be recorded it is probably more useful to classify disabilities in functional groupings rather than medical ones. In this way information on the impact of the various disabilities can be retained. An example of a medical classification and a functional classification is given in Appendix II D and II E.

Purpose of Register: To identify people who are physically or sensorially handicapped, who are currently, or may be, in need of services (existing or new forms). The ultimate goal of such identification is to ensure that the rights of people who are handicapped are protected and that every opportunity is given whereby the full potential of the individual may be achieved. While the basic data on difficulties and deprivation will be obtained at Health Board level the implications will go beyond the Health Boards and there may well be a need for legislation or changes of policy in many areas.

Who will the register include:
(a) Initially all physically and sensorially handicapped persons between the ages of 16 years and 65 years. At a later stage it should be expanded to include children and the elderly handicapped.

(b) All handicapped persons living in the community, in long-term residential care and in hospitals.

What sources will be used:
Identification of people who are handicapped can be drawn from sources already available to the Health Boards and sources not currently available. An outline of these sources are:

A. (i) all DPMA recipients;
(ii) all people on *long-term* disability related social welfare benefits—invalidity pension, disablement benefits, blind pension, etc.
(iii) All persons on disability related income supports—constant care allowance, mobility allowance, etc.

B. People who are receiving/have received specialised services for handicapped persons—vocational training, day centres, medical rehabilitation, residential care services, special schools.

C. People who are receiving/have received general health and community services such as public health nursing, general practitioners services, home helps, meals-on-wheels, schools and training centres, community social work service and who are known to be handicapped.

D. Voluntary organisations working with specific handicapped groups.

E. People who come forward as a result of a regional mass media campaign to encourage handicapped persons who may have needs but who may not be known to the Health Boards or to voluntary organizations—e.g. disabled housewives, persons who are working, etc.

What information will the register contain:
(1) Basic information on the handicapped person—age, sex, disability, impact of disability, abode, agencies involved, services being received/have been received.

(2) Main need(s)—medical, social, vocational, educational, mobility, housing, community supports.

(3) Proposed action.

Who will undertake to compile the register:

(1) *Centrally:*
Either the Department of Health or the NRB would be appropriate authorities. However, if it is not possible to devote the personnel and the time to drawing up a framework, to doing the preparatory work and giving any help required to individual Health Boards, it would be more advisable to look at alternatives. The preparatory work is vital to the emergence of a standardised, comparable and effective system of gathering essential information. One possible alternative is to request the Medico Social Research Board to undertake the task.

(2) *Regionally:*
For maximum benefit to be obtained from the register it will not only have to be compiled but be kept updated and the data contained used. While the Director of Community Care would be ultimately responsible, one person in each community care area should be given the specific task for ensuring the register is compiled.

A scheme envisaged by the North Western Health Board has much to recommend it not only from the "register viewpoint" but also in facilitating follow-up and co-ordination of services for handicapped persons. It is suggested that one doctor in each community care area have responsibility for services for handicapped persons. These responsibilities will include liaison with relevant specialists, agencies, home and rehabilitation services. The doctor would lead a team comprising many specialists. They would be involved in the identification process, in follow-up and in devising comprehensive services.

CHAPTER 3

EDUCATION AND THE HANDICAPPED CHILD

3.1 Educational Needs of the Handicapped Child

The goals of education are to enlarge a child's knowledge, experience and imaginative understanding and to enable him to enter the world, after formal education, as an active participant in society and a responsible contributor to it, capable of achieving 'as much independence as possible. These goals determine the educational needs of every child. However, the help that individual children will need in progressing towards the goals will be different.

There are children who have particular obstacles to overcome whether physical, sensory, intellectual or emotional. There are increasing numbers of handicapped children many of whom would not have survived infancy in other periods of history. The help these children need may range from continuous support from specialist services in a special school to part-time assistance from a specially trained teacher to the modification of the environment and provision of aids.

Special education offers a continuous form of special teaching for children who need either a special environment, special medical treatment, special methods of teaching or a special curriculum.[1] It encompasses the idea of any form of additional help whenever and wherever it is provided.

A recent investigation of the education of handicapped children and young people in Britain has considerable relevance to the Irish situation.[2] The investigation, referred to as The Warnock Report, emphasised that the idea is deeply ingrained in educational thinking

[1] Guilford, R. *Special Educational Needs:* London, 1971, p. 7.

[2] Warnock Report: *Special Educational Needs: Report of the Committee of Inquiry into the Education of handicapped children and young people;* London, May 1978, p. 5.

that there are two types of children—the handicapped and the non-handicapped. Traditionally the former have been thought to require special education and the latter ordinary education. The situation is much more complex. There is no simple relationship between handicap in educational terms and the severity of a disability in medical terms. Whether a disability constitutes an educational handicap for an individual child, and if so to what extent, will depend on a variety of factors, some of which are more related to educational facilities and outlook rather than to the child and his disability. The Warnock Committee appeal for a more positive approach and a concentration on special educational needs rather than categories of handicap as the most appropriate framework within which the education of handicapped children should be approached. Unfortunately in this country we are very much still at the stage of thinking in terms of specific categories of handicapped children and their educational needs.

The Warnock Committee identify the different forms of special educational need in terms of:

(i) provision of special means of access to the curriculum through special equipment, facilities, resources, modification of the physical environment, acoustic treatment of the classroom or specialist teaching methods. This may be needed for children with impairments of sensory or motor function.

(ii) provision of a special or modified curriculum for children who are educationally sub-normal or possibly pupils with impaired hearing who may need particular emphasis on the development of language.

(iii) need for particular attention to the social structure and emotional climate in which education takes place. This is particularly relevant for children who have difficulty in meeting the demands of an educational regime and adjusting to its constraints.

Number of Children Involved

3.1.1 It is difficult to assess the number of children in Ireland who are handicapped—whether in the educational sense or in physical or intellectual terms. Many children who are handicapped receive their

formal education in the normal school system. Some of these may never be classified as handicapped.

On a purely statistical level the number of children in Ireland attending special schools or classes (1.4% of the school population)[3] is similar to comparable figures in England and Wales (1.8%) and Scotland (1.4%).[4] This figure does not of course represent the total number of handicapped children with special educational needs.

A better yardstick to gauge the extent of such need is available in the Isle of Wight study. This study found that one in six children in the middle years of schooling (9-11 years) had a chronic or recurring handicap involving considerable interference with their ability to lead a normal life. A quarter of these had at least two handicaps.[5] Using these figures it is evident that when one is talking about special educational needs relating to handicap we may well be talking not about a tiny minority of the schoolgoing population but about a potential substantial proportion. At the present time in Ireland special provision of some type is available for just over 5% of the primary school population, 3% being in the form of remedial teaching. Thus, on the basis of the Isle of Wight study, it would appear that the majority of children with special needs are being educated in ordinary schools without any formal special provision. It is not suggested that all these children are handicapped in the traditional sense of that term. The majority will be unlikely to have long-term disabilities, however, in the absence of suitable help at the optimum times their learning problems are likely to be reinforced by prolonged experience of failure.

3.1.2 *Range of Provisions*

Individual needs are extremely variable in their composition. The idea of a continuum of special educational needs as a concept is useful in conveying the idea of a spread of children's special needs and the provisions needed to meet them.

The following types of provision may be needed to meet this range of needs:

[3]School population taken to include First Level aided by Department of Education (541,687) and Lower Cycle Second Level (194,167).
[4]Warnock Report, op. cit. p. 37.
[5]ibid. p. 37/38.

(i) full-time education in an ordinary class with necessary help and support supplied;
(ii) education in an ordinary class with periods of withdrawal to special class units or resource centres;

(iii) education in a special class with periods of attendance at ordinary classes; however, there is full involvement in general community life and extra curricular activities of the school;

(iv) full-time education in special classes with social contact with the main school;

(v) education in a day special school but with some shared lessons with neighbouring ordinary schools;

(vi) education in a residential special school with social contact maintained with an ordinary school;

(vii) short-term education in hospitals and other institutions;

(viii) home tuition.

3.2 Provisions in Ireland

In this country the main choice available to the handicapped child is either placement in an ordinary school with little or no supports or placement in a special school. There is of course a wider range of provisions but their availability is related not only to the child's handicap but also to the child's geographical location. The range is:

(a) the normal educational system with no extra provisions;
(b) the normal educational system with some special provisions;
(c) special classes;
(d) special day schools;
(e) special residential schools;
(f) home teaching schemes.

3.2.1 *Special Schools and Classes*

Since 1960 the number of children in special schools has grown considerably. The number in 1960 was 2,170—the number in 1978

was 8,158. This increase, however, has been primarily for mentally handicapped and emotionally disturbed children. The numbers attending special schools for the physically handicapped have fallen from approximately 900 (1969) to approximately 400 (1978).

TABLE 3.1

Number of pupils and teachers in special schools by category, 1978

	No. of Pupils	No. of Teachers	No. of Schools
Mild Mental Handicap	3,667	250	30
Moderate Mental Handicap	2,006	176	28
Blind (52) and partially sighted (90)	142	22	2
Deaf and hard of hearing	825	144	4
Physically handicapped	415	39	7
Hospital schools	269	19	10
Multiple Handicapped	19	5	3
Emotionally disturbed	424	53	13
Non-handicapped children	391	49	10
Total	8,158	757	107

Source: Department of Education.

Apart from provision in special schools there are also arrangements for special education outside such schools in the form of special classes, remedial teaching, home teaching service and visiting teacher services (Table 3.2).

At present there are 70 pupils receiving home tuition. This is provided on the inspector's recommendation where children may have missed some time from school due to bad weather conditions or hospitalisation. Of this 70, 19 are spina bifida children, 9 haemophiliacs and 42 described as "home bound".[6]

[6]Department of Education, March 1979.

TABLE 3.2

Special Education outside of Special Schools, 1978

	No. Pupils	No. Teachers
Special classes for mild mentally handicapped	2,074	150
Remedial teachers in ordinary schools[a]	17,200	344
Visiting teacher service for deaf (full-time posts)	910	20
Visiting teacher service for blind (full-time post)	109	1

[a]There are also remedial schemes at child guidance clinics and on Saturday mornings in ordinary schools.

Source: Department of Education.

3.2.2 *Special Schools for the Physically Handicapped*

There are seven schools for the physically handicapped in the country. They are based in Dublin,[7] in Bray, Co. Wicklow and in Cork. Over 400 pupils attend them. The average teacher/pupil ratio in these schools is 1 : 11. There are 10 hospitals schools catering for almost 270 children many of whom are physically handicapped. These schools are more widely distributed geographically than the special schools and are located in the following counties: Dublin, Westmeath, Cork, Kilkenny and Galway. The teacher/pupil ratio is higher than in the special schools averaging out at 1:14.

Provision within the Ordinary Educational System for the Physically Handicapped

In 1977–78 there was a total of 542,972 children attending national schools. As mentioned before there is no way of estimating how many of these children are handicapped and participating successfully in the ordinary educational system. In some instances no special provisions

[7]A new school for spina bifida children is proposed for Clondalkin. Additional accommodation is also being provided in the Central Remedial Clinic in Dublin. There are also three pre-school groups run by the Spina Bifida Association in Dublin. Two are based in Ballymun and there is one in Tallaght.

are necessary. In others modifications may have been made by the school or special transport arrangements by the Department of Education. There are also approximately 340 remedial teachers catering for over 17,000 children throughout the national school system. It can be assumed that many handicapped children are benefiting from this service.

At second level, special arrangements have been made for the physically handicapped in two community schools and one comprehensive school in larger urban areas. These schools are ordinary schools, catering for a large school population and providing facilities to meet the special needs of physically handicapped pupils. While the children participate in ordinary classes a special teacher is provided to give supplementary assistance and to look after the needs of the handicapped pupils. Special transport is available and an aide to assist children throughout the day. The Health Board provide the meals for the pupils and the Department of Education the teaching service. These schools are in Dublin and Cork.

	No. of handicapped pupils, March 1979
Dublin—Community School, Ballinteer	20
Dublin—Comprehensive School, Ballymun	29
Cork—Mayfield Community School	7

Apart from individual arrangements by schools or the Department of Education there are no other special provisions at second level for the education of physically handicapped pupils.

3.2.3 *Educational Provision for the Blind*

Special education for the blind has existed in this country since the middle of the last century. This was the first form of handicap to be catered for by means of a special education programme.[8]

Until recently educational provision for the blind was located exclusively in two schools in Dublin—one catering for boys, St. Joseph's, and one for girls, St. Mary's. Both schools are residential.

[8]Address by Mr. Tunney, Minister of State at the Department of Education, at A.G.M. of National Council for the Blind, June 1978.

Originally the schools provided education up to primary level, but gradually post-primary programmes were developed. In 1978 they catered for 142 pupils, 52 of whom are blind and 90 partially sighted. The average teacher/pupil ratio is 1:6.

In the early '70s a number of boys from St. Joseph's started to attend a nearby ordinary secondary school—Rosmini. More recently a similar arrangement was made for girls in St. Anne's, Milltown. In both of these secondary schools a resource teacher is available to cater for the special needs of the visually impaired.

It is proposed that a new community school be built for boys at Drumcondra. This will replace the existing Rosmini college. Special facilities will be provided for the visually impaired at this school. The effective operation of this system is dependent on the presence of the resource teacher who works with the ordinary class teacher producing lessons in braille and being available for help with communication techniques where difficulties arise.

Under the existing system a partially sighted child can be educated locally provided the parents are prepared to give the supports needed and the school is aware of the difficulties and prepared to overcome them with special techniques.

The availability of peripathetic teachers is also an important element in such a system. There is at present one such teacher and the scheme will be expanded as the need is demonstrated.

3.2.4 *Educational Provision for the Deaf*

Over 800 deaf and hard of hearing children are currently attending special schools at primary and secondary level in Dublin (3 schools)[9] and Cork (1 school). The average teacher pupil ratio in 1978 was 1:6. There are also twenty teachers who provide a visiting teaching service throughout the country. This is primarily for pre-school children. These teachers are also involved to some extent with hard of hearing children attending their local school.

It is accepted by the National Association for the Deaf that the profoundly deaf child needs special school facilities. However, there is some debate as to whether such facilities should be provided in large urban areas on a residential basis or scattered on a regional basis throughout the country where the child would be nearer to home and to

[9]One of these schools has appointed its own social worker.

his family. In many instances, however, it should be possible for the hard of hearing child to receive his education in the normal school system given understanding on the part of the class teacher and possibly support from the home teaching service.

3.2.5 *Educational Provision for Mentally Handicapped Children*

The present administrative framework of mental handicap services in Ireland is strongly influenced by the recommendations of the Commission of Inquiry on Mental Handicap which reported in 1965. The Commission outlined the need for education and training as follows:

(a) Schools and classes for mildly handicapped children

(b) Schools for moderately handicapped children

(c) Care Units for moderately and severely handicapped children.

It was proposed that day schools for the moderately mentally handicapped should be closely associated with nursery and care units serving both severely mentally handicapped children and moderately mentally handicapped children who are unable to benefit from the education provided in schools for the moderately handicapped. In accordance with the recommendations of the Commission, special education is provided separately for children with mild and moderate degrees of handicap. The teacher/pupil ratio recommended for the former is 1:16 and for the latter 1:12.[10] The provision of education services is the responsibility of the Department of Education, while the responsibility for residential services and care-unit services is the responsibility of the Department of Health and the Health Boards.

Mild Mental Handicap—Present Provision

The Commission was unable to reach firm conclusions as to the incidence of mild mental handicap among school leavers. However, it recommended that by 1975 services should be provided for 1% of all children between the ages of seven and 16 years. By 1978, provision for mildly mentally handicapped children had reached 5,741. The present position is that some special provision is available in all

[10]The teacher/pupil ratios in 1977/78 were 1:14.7 (mild mental handicap) and 1:11.4 (moderate mental handicap).

counties. In 13 counties this provision is exclusively in the form of special day schools; in five counties the provision is, exclusively, in the form of special classes attached to national schools while in the remaining eight counties both special schools and special classes are available.[11]

In 1978 there were 2,074 children attending special classes for mild and borderline mental handicap. While special schools cater for the age group 6—18, special classes attached to primary schools cater only for children of primary school age. With regard to pupils attending these classes, departmental policy is that these pupils should proceed to post-primary schools along with their peers and that appropriate resource facilities should be available in such schools to enable the programme begun in the national school to be continued. The curriculum followed by them in the post-primary school should include provision for practical subjects and for a work orientation programme.[12] The vast majority of special classes at post-primary level are attached to vocational schools. Information on the total number of classes in existence is not available, however, it is clear that there is not an adequate range of post-primary special classes to complement the primary special classes.

Moderate Mental Handicap—Present Provision

In 1978 there were 2,006 moderately mentally handicapped children attending special schools either day or residential. This number is somewhat higher than that envisaged by the Commission on Mental Handicap, due to the expansion of provision to cater both for a wider range of handicap and a wider age range of the children.

The residential provisions available are special residential centres and hostels. There are 13 special residential centres, 12 of which have day attenders, spread over all Health Boards, with the exception of the Western Health Board. In this Health Board area hostel accommodation is provided in Galway, Mayo and Roscommon. Hostel accommodation is also available in Clare. There are 13 special day schools, four of which are in Dublin. Some special provision for moderately mentally handicapped children is available in all counties, with the exception of Carlow, Offaly, Laois, Monaghan, Donegal and

[11]See Appendix III A.

[12]Department of Education, February 1979.

Leitrim.[13] While on a national level the provision of places is adequate, many moderately mentally handicapped children, who could be educated on a day basis, are now in residential schools.

3.2.6 *Multiply Handicapped Children*

Statistics on the numbers of multiply handicapped children are not readily available. It is notable that in the epidemiological study carried out in the Isle of Wight it was found that 93% of children with intellectual retardation (IQ$<$70) had at least one additional handicap; in particular a very high rate of handicap in all aspects of speech and language was found among this group.[14] In discussing the education of moderately handicapped children, the Commission of Inquiry on Mental Handicap pointed out that this was complicated by the fact that a high proportion of moderately handicapped children suffer from one or more physical sensory or neurological handicaps.[15]

The proposals of the Department of Education with regard to the education of children with additional handicaps differentiates on the basis of degree of mental handicap and severity of additional handicaps. In the case of mildly mentally handicapped children with severe hearing or visual defects or with physical handicaps it is proposed that they should be educated in schools catering for children with these handicaps. In the case of mildly handicapped children with "partial" handicaps in hearing and vision it is proposed that they should be educated in schools for the mildly handicapped with the aid of a visiting teacher. Children with speech defects in addition to mild mental handicap are to have speech therapy provided while continuing to attend the school for mildly handicapped children. The Department of Education proposes that emotionally disturbed mildly handicapped children should if they have a serious disturbance be accommodated in a school for the emotionally disturbed.[16]

In the case of moderate mental handicap and an additional handicap

[13]See Appendix III B.

[14]Rutter *et al.* op. cit.

[15]*Commission of Inquiry on Mental Handicap,* op. cit., p. 85.

[16]In 1978, there were 424 children attending 13 schools for the emotionally disturbed (pupil/teacher ratio 8:1). Eleven of these schools are in Dublin, one in Cork and one in Kilkenny.

in the area of speech, hearing or vision it is proposed that education take place within the school for the moderately handicapped with aid from a visiting teaching service where necessary. In the case of moderately mentally handicapped children with physical handicaps or emotional disturbance placement is decided on an individual basis depending on the severity of additional handicap(s).

Special provision for multiply handicapped children is extremely limited. In 1978, there were only 19 children attending three special schools for multiply handicapped children (pupil/teacher ratio 3.8:1).[17] Any discussion of the problems associated with the education of children with multiple handicaps raises the issue of support services. It is clear that the effectiveness of any one service, such as, the school, may depend upon what other related services may or may not be provided; the decision concerning residential versus day-school placement will depend not only on educational provisions but on whether there is available adequate support services for teachers and parents, the possibility of adaptations to the child's home or the availability of suitable housing.

Educational provision for the multiple handicapped child urgently needs investigation. While the numbers are small, the problems are very great and adequate provisions are difficult to make.

3.2.7 *Costs of Special Education for Handicapped Children*

In 1977 the average cost per child in national schools was £196. The cost per pupil in all special schools was higher, averaging out at £562 per pupil. In some special schools the operating costs are over five times as much per child as for the average primary school pupil. The costs are almost totally determined by teacher costs, being closely related to the pupil/teacher ratio.

These costs relate only to expenditure by the Department of Education. They do not include expenditure by the Department of Health on school-based medical or paramedical services, meals or accommodation costs. Accommodation costs are borne by the Department of Health. An approximate indication of some of these costs is given in Table 3.4.

[17]Marino Clinic, Bray; Our Lady of Good Counsel, Lota, Cork; Asphasic Unit (St. Michael's House), Phibsborough, Dublin.

TABLE 3.3

Operating costs per child in special schools, special classes and supplementary education, 1977

	£
Special Schools	
Mild Mental Handicap	433
Moderate Mental Handicap	494
Deaf and Hard of Hearing	1,063
Blind and Partially Sighted	862
Physical Handicap	550
Hospital Schools	649
Emotionally Disturbed	784
Reading Disability	503
Multiple Handicap	1,726
Special Classes	
Mild Mental Handicap	386
Supplementary Education	
Remedial Teaching	114
Visiting Teaching (Deaf)	114

Source: Department of Education.

TABLE 3.4

Residential Costs per Child—1978

	Approx. Costs per Week £
Physical Handicap:	
St. Mary's, Baldoyle	84
St. Joseph's, Coole	63
St. Mary's, Cappagh	204
Mental Handicap:	
Range of Costs	60-80

Source: Department of Health.

The variation in costs in the case of mental handicap centres relates to the range of services provided: The costs per resident in smaller centres with limited assessment services is approximately £60 per week; the costs per resident in larger centres with extensive assessment services and nurse training schools is approximately £80 per week; centres where the weekly cost per resident is approximately £100 per week, are those which accommodate both adults and children, functioning at moderate, severe and profound levels of handicap; a breakdown on the basis of degree of handicap and age is not available.

3.2.8 *Identification of Special Needs*

Identification of special needs is of crucial importance if effective preventive and remedial action is to be taken. Identification arises at two levels. Firstly, identification of special needs at the pre-school level and secondly, identification of special needs within the educational system. The latter is of central importance for those children functioning intellectually at a mild level of mental handicap, which is generally not identified until the child enters the school system. Any process of identification by teachers calls for an awareness of the circumstances which give rise to difficulties in school, and an appreciation of the needs of children with developmental difficulties whether sensory, emotional, behavioural or learning.

Certain factors have consistently been found to be associated both with mild mental handicap and educational under-achievement in general: Studies of the social distribution of mental handicap consistently show a disproportionate number of children from lower socio-economic groups. On investigation it emerges that this over-representation relative to population distribution occurs in that portion of the mildly mentally handicapped who are "clinically normal", i.e. without overt indications of brain dysfunction or serious handicaps.[18] It is estimated that this group make up approximately 75% of the mildly mentally handicapped population.[19] At a more general level, research on educational achievement has repeatedly highlighted socio-economic status and numerous factors almost invariably found to be associated with socio-economic status as crucial influences on such achievement.

[18]Stein, E. and Susser, M. 1960, op. cit. 1963, op. cit.
[19]Zigler, E. 1966, op. cit.

Among the associated factors that have emerged, have been family size, parental education, attitudes and interest in education.[20]

It is clear that there is much evidence to indicate that intellectual under-functioning is frequently associated with adverse environmental factors. However, a focus on purely environmental factors is inadequate as it obscures the wide range of individual differences which exist among any group. The relationship between social, environmental and personal factors with regard to intellectual under-functioning is complex. Thus, while the evidence to date from studies on educational under-functioning in general and mild mental handicap in particular have identified certain factors as being of crucial importance and these factors must be borne in mind, it is clear that an effective programme of identification necessitates a screening process by teachers of all children who seem to be under-functioning educationally.

Any focus on the identification of educational difficulties within schools raises the question of support services available to teachers in terms of psychological assessment and advice on pedagogical matters.

3.2.9 *Diagnostic Assessment and Advisory Services*

The Commission of Inquiry on Mental Handicap recommended that there should be a clear obligation on every health authority to make arrangements for the provision of a diagnostic assessment and advisory service. It was suggested that this recommendation be effected by a combination of methods. Firstly, school teams, comprising the school medical officer, a school psychologist and a social worker should be formed. Secondly general teams, comprising a psychiatrist, a psychologist and a social worker should be formed by voluntary bodies providing services for mentally handicapped persons. It was recommended that:

> Teams based on School Medical Officers and School Psychologists would normally deal with the problem of mental handicap as it manifests itself in the ordinary school system. They would refer to special day schools and classes, such children as they were satisfied could suitably be dealt with in such schools

[20]Cullen, K. *School and Family: Social Factors in Educational Attainment* Dublin, MacMillan, 1969. Craft, M. (Ed) *Family Class and Education*, London, Longman, 1970. Central Advisory Council on Education. *Children and their Primary Schools.* London, HMSO, 1967, Vol. 2. 1967.

and classes. They would refer to the teams, consisting of a psychiatrist, a psychologist and a social worker, cases of doubt or difficulty, cases in need of residential care and cases where the parents or guardians requested that the children be referred for a second opinion. To enable them to operate, we consider it essential that a schools psychological service should be developed rapidly and that an adequate number of psychologists should be employed for work in the schools.[21]

As yet, a school psychological service for national schools, on the lines envisaged by the Commission of Inquiry, has not been established. While there are 23 posts of psychologist and inspector of guidance services in the Department of Education, the personnel are concerned mainly with post-primary schools. The present administrative arrangements provide for two modes of assessment for children. Referral is made either to a psychologist employed on a sessional basis by health boards, or to a general team, i.e. a diagnostic assessment and advisory service under the auspices of a voluntary body providing services for mentally handicapped persons.[22] The former arrangement is effected either through sessional arrangement with voluntary bodies providing diagnostic assessment and advisory services or through direct sessional arrangements with individual psychologists. The North-Western health board is in the process of developing its own assessment service. Increasingly psychological assessment in that area is being undertaken by psychologists employed by the Health Board. Referral for psychological assessment is made through Directors of Community Care, the process being initiated by school medical officers, parents, general practitioners or other medical personnel, teachers and others involved in the education and care of handicapped children.

3.3 Integrated Education

The most central element of the recent debates on education of the handicapped child centres on the question of integration.[23]

[21]*Commission of Inquiry on Mental Handicap*, op. cit., pp. 59-60.

[22]There are at present eleven Diagnostic Assessment and Advisory Services in Ireland, under the auspices of Voluntary Bodies providing a range of other services for mentally handicapped persons. See *Directory of Services for the Mentally Handicapped in the Republic of Ireland*. 9th. Ed., Dublin, 1977.

[23]Generally referred to as mainstreaming in the US and normalisation in the Scandinavian countries.

Handicapped children have the right to grow up as full members of the community. This has very definite implications for the type of educational provisions needed. It clearly implies the desirability of handicapped children receiving their formal education with their unhandicapped peers.

The Snowdon Report in England started from this premise and emphasised the beneficial effects of integration, not only on the handicapped child, but on the attitudes and concern of unhandicapped children. By contrast it suggested that lack of contact between handicapped and non-handicapped children often has a detrimental effect on the community's level of tolerance, understanding and acceptance. The mentally handicapped person probably suffers from this more than the physically handicapped person but prejudices based on ignorance are bound to arise wherever the handicapped are kept in isolation for a substantial part of their formative years.

Integrated education is basically a system which caters for the special needs of handicapped children within the ordinary school framework and is supported by a range of facilities geared to meeting the needs of children suffering from different kinds and degrees of handicap including such separate attention and protective arrangements as may be required.

The question of integrated education is frequently over-simplified—integrated education being equated with the ordinary school—segregated education with the special school. Just as it is too easy to assume that all handicapped children need special schooling so it is too easy to suggest that all handicapped children should be educated in ordinary schools. The ideal situation is that each handicapped child would be provided with the kind of special help he needs. This should be done however with the minimum degree of separation from his peers and the minimum disruption to normal family life.

Despite the potential of the ordinary school system in meeting special needs, special schools will nevertheless continue to be needed. They offer many advantages to the handicapped child and his family, particularly to the more severely handicapped child. Not only can they provide special teaching methods and more individual attention but also necessary medical and paramedical support services. These can

also be provided with the minimum of disruption to the child's class routine.

On the negative side there is a definite tendency for special schools to become isolated from the mainstream of education. There may also be an understandable temptation to concentrate on the child's physical welfare and the development of his physical capacities.

Separate provision is often needed for some very severely handicapped children in order to make available the specially high level of care and resources. The following groups of children were identified by the Warnock Committee as needing such provisions:

(1) those with severe or complex physical, sensory or intellectual disabilities who require special facilities and methods or expertise that would be impractical to provide in ordinary schools;

(2) those with severe emotional or behavioural disorders, who cause disruption in an ordinary school;

(3) those with less severe disabilities who, despite special help, do not perform well in an ordinary school and are more likely to thrive in the more intimate setting of a special school.

While accepting the need for special schools in some instances the principle of integration has been generally accepted both in this country and abroad. There is, however, a very definite gap between principle and practice in Ireland. There is general acceptance that integration is right provided all the circumstances are favourable. Many plausible reasons can be given for the absence of integration—inaccessibility of the ordinary school buildings, need for ancillary staff and other support services or simply the attitude that better services may be got through the special school. These are real problems. However, given the necessary will and commitment integrated education could be available to a greater number of handicapped pupils. This will demand an allocation of resources in both money and personnel terms to the ordinary school system comparable to that being allocated per pupil in special schools. The Snowdon Report calls for a philosophy that integration is right unless there is clear indication to the contrary. As far as is humanly possible, handicapped people should share the opportunity for self-fulfilment enjoyed by other people. This implies the

right of the handicapped child to full participation in the activities of everyday life.

3.3.1 *Principal Forms of Integration*

There are various levels of integration. The Warnock Committee distinguished:

(i) locational integration

(ii) functional integration

(iii) social integration

The first relates to the location of special education facilities—special units or classes in ordinary schools or a special school and ordinary school on the same site. Functional integration refers to a situation where the child with special educational needs has part or all of his education with his peer group. Social integration refers to the joint participation of special class children and regular class children in the use of recreational and other ancillary facilities. These different levels of integration will be appropriate to different handicapped children depending on their special needs. There is an urgent need for a greater range of provisions than exists at present as needs vary so greatly.

3.3.2 *Integration and the Physically Handicapped Child*

There are many handicapped children who can successfully participate in the ordinary school system with no extra provisions. There are also many children whose need for special educational provisions can be easily met with appropriate support within the ordinary school system.

It is important to critically evaluate the extent to which the ordinary school can cope with handicapped children who do not have severe learning difficulties. For example over 40% of the members of the Irish Wheelchair Association still in full-time education are attending special schools. In many cases this is because of the inaccessibility of the local school, the difficulties of securing transport or the need for personal assistance throughout the day.[24]

It is not enough to do nothing to meet the special educational needs of handicapped children in ordinary schools and then call this integration. There is a need for serious examination of the extent to

[24]Faughnan, P., *Dimensions of Need,* op. cit. p. 45.

which the integration ideal is not being achieved on account of surmountable barriers. Given sufficient commitment and flexibility these could be overcome. The following areas in particular warrant special attention;

(1) accesibility of existing schools and of future schools; serious consideration must be given not only to the policy of educational institutions at all levels in this regard but also the implementation of a policy of accessibility. Where existing schools are inaccessible provisions for modifying by the relevant authority should be formalised;
(2) transport provisions for the more severely handicapped child. In certain instances there is a definite problem related to transport provisions which present difficulties for more severely handicapped children in attending local schools.[25]
(3) the provision of personal assistance for the handicapped child; children with spina bifida for example often need personal assistance with toileting. There is need for close cooperation between the Health Board and the School Authorities to make this available where the mother is not in a position to do so.
(4) teacher attitudes to the handicapped child; the Warnock Committee felt that without wholehearted commitment by teachers to the reception of children with disabilities, particularly severe or complex ones, the most careful planning is likely to be unsuccessful.

The mere presence of a handicapped child in an ordinary school or class does not guarantee integration. This requires the fullest possible participation in the life of the school. Many handicapped children cannot simply be placed alongside able-bodied children in the hope that it will be to everyone's advantage. The child may be effectively isolated from his peers by being given different work or sheltered from group activities or through a lack of understanding of the problems associated with his disability.

Various studies have confirmed that attitudes of principals and staff towards handicapped children is crucial. The Warnock Committee recommend that basic training in special education should be a compulsory part of teacher training. This is equally applicable in this

[25]Irish Wheelchair Association report from Education Working Group 1979.

country, where special education does not at present form a compulsory part of teacher training courses.[26]

Towards Integration Until all these areas are thoroughly examined, existing provisions evaluated and necessary steps taken to improve arrangements and formally institute additional provisions, the goal of integration will not be achieved even for those with relatively minor handicaps in the educational sense. There is certainly concern for the handicapped and commitment at Departmental level to the ideal of integration. However, formal and mandatory provisions are necessary in the sphere of physical accessibility, transportation, provision of personal assistance at primary and secondary levels of the educational system, the existing ad hoc system cannot provide the framework within which substantial progress can be made. There is also the more long-term need for familiarising teachers with special educational needs as part of their normal teaching training programme.[27]

3.3.3 *Integration for Mentally Handicapped Children*

In considering integration it is important to make a distinction between the principle of integration and its implementation. With regard to the implementation of integration in the case of mentally handicapped children two mutually dependent questions must be considered:

(i) Who is to be integrated?
(ii) What form is integration to take?

In considering the first question it is necessary to focus on the goals of special education for particular groups. The Commission of Inquiry on Mental Handicap stated that "the purpose of special education for the mentally handicapped pupil is to enable him, through the development of social adequacy, to obtain security and happiness in adult life as a self-reliant member of the community".[28] With regard to the achievement of independence and the likely levels of independence which can be achieved a clear distinction was made between the goal of training of moderately mentally handicapped children and that of education of mildly mentally handicapped children. While the former

[26]A total of 282 teachers have obtained a diploma in special education in this country. It is not known how many of these are at present teaching in special schools or special classes (Department of Education, March 1979).
[27]A working committee established by the Department of Education is currently examining provisions for the education of the physically handicapped child.
[28]*Commission of Inquiry on Mental Handicap*, op cit., p. 67.

was seen as the achievement of social and vocational competence in a sheltered environment, the latter was seen as the achievement of full independence in the community.[29] On the basis of these goals, it can be argued that it is unrealistic to segregate children who function at a mild level of mental handicap, in special schools, frequently based outside their own community, when the long-term goal of their education aims at the achievement of full independence in the community and consequently their full participation and integration in the community. Furthermore, mild mental handicap is, in the majority of cases, evident as a problem only during school years and is generally not detected until the child is already within the ordinary national school system. Thus, both on the basis of the goals of special education for children found to be functioning within the range of mild mental handicap and on the basis of this being a problem primarily during school years, integration would seem in principle to be an optimum solution. However, it is clear that mildly mentally handicapped children are not a homogeneous group. Any one type of provision is unlikely to be the optimum solution for all children. A range of facilities may be necessary ranging from special residential schools to integrated classes. Despite this reservation, examination of the feasibility of integrating those children found to be functioning within the mild range of mental handicap and without major additional problems has much to recommend it.

When integration is discussed with regard to children functioning at moderate and severe levels of mental handicap, the usual solution proposed is that of locational integration rather than functional integration. This has been achieved to a certain extent both in Sweden and the United States. Consideration of integration of these children is somewhat premature in the Irish context for two reasons. Firstly, the present administrative framework of services for moderately mentally handicapped children is extremely centralised because of the relatively small numbers involved and the nature of their special needs. Secondly, integration has not been pursued to any major extent for the most numerous group for whom special educational provision is made at present, and whose need for special services arises for the most part only during school years, viz those children found to be functioning intellectually within a mild range of mental handicap.

[29]ibid., p. 87.

Integration for Mildly Mentally Handicapped Children

As has been pointed out there are three types of special educational provision in Ireland at present for mildly mentally handicapped children: residential special schools, special day schools and special classes. In recommending that special education for children functioning at a mild level of mental handicap should be provided mainly in special schools, both day and residential, the Commission of Inquiry on Mental Handicap emphasised the practical consideration of density of population.[30] While there has been a major expansion in the provision of day facilities it is clear that low density of population is associated with considerable centralisation and the development of these day facilities in many areas has been possible only through extensive transport arrangements. If the focus is confined to children functioning at a mild level of mental handicap and if a prevalence rate of 1.0% to 1.5% is accepted then special educational provision is inevitably confined to larger centres of population. However, a shift in focus from emphasis on the special needs of children with particular handicapping conditions to that of the special educational needs of all children, considerably broadens the number of children involved and the scope for integration.[31]

If integration is to be effective educationally it would appear that in addition to adequate preparation and planning to ensure that pupils now in special schools/classes can be educated in the ordinary school system without losing the benefits of these special facilities, it would be essential that adequate provision be made to meet the special needs of children at present in ordinary schools. If the latter were to be accomplished it would call for a range of provisions within national schools. As a consequence of this provision the integration of mildly mentally handicapped children in a greater number of schools would probably be facilitated.

Focusing on the present arrangements for special education for mildly mentally handicapped children it is clear that the potentially most segregated group are those in residential special schools. In 1976 there were 713 children under 16 in residential centres for the mildly mentally handicapped, in addition there were 258 persons over 16 in these centres.

[30]ibid., pp. 82-83.
[31]See page 49A.

A number of reasons can be suggested as to why residential placement is considered necessary. Firstly, while some special day provision is available in all counties there are, even with extensive transport arrangements, at least some children outside the range of special day facilities—this probably accounts for a minority of those in residential schools. Secondly, many children found to be functioning at a mild level of mental handicap have special needs other than purely educational special needs. These special needs may be associated with the social or economic circumstances of the families concerned or associated with the personal characteristics of the child such as additional handicapping conditions.

While there will, at any one time, be a certain number of children whose needs can best be met in residential schools, it is probable that the numbers could be reduced if hostels and support services for families were more widely available throughout the country. It is notable that many of the children in special residential schools return home at weekends thus, the segregation from their families and communities is to some extent limited. It is clear that even within a residential school setting the level of segregation can be kept to a minimum through participation in community activities, e.g. recreational activities with other children and through an emphasis on the preparation of the children for integration on leaving school.

What form is integration to take? The policy of the Department of Education with regard to children functioning at a mild level of mental handicap is that future provision should be mainly in the form of special classes within a national school complex, i.e. locational integration. It must be emphasised that a commitment towards special classes at primary level must be accompanied by a similar commitment for their adequate development at post-primary level otherwise such a policy is self-defeating. There is, at present, a totally inadequate number of special classes at post-primary level. While for children attending some national school special classes there are formal arrangements regarding transfer to post-primary schools with special classes, for those in many special classes there are no such arrangments. In some cases, children continue attendance at primary school special classes up to age 15, i.e. the minimum school leaving age. The development of special classes at post-primary level is essential for the achievement of a comprehensive special educational service. At present 36% of those children receiving

special education because of mild or borderline mental handicap are doing so in special classes. The classes are generally attached to relatively large national schools and generally cater for a wider catchment area than that of the particular school to which they are attached; thus, some of the characteristics of a special school are present, notably, transfer in the majority of cases, from the original school attended; in rural areas, this transfer entails travelling to school on special transport. However, there are some major differences between special schools and classes; special classes are located within national school grounds, with a relatively small enrolment of children whose needs differ from the majority within a total population.

3.3.4 *Integration for Deaf and Hard of Hearing Children*

The question of integrated educational facilities for the deaf is a very live and contentious issue internationally. Here in Ireland, also, there is strong feeling among some parents that better facilities should be available within the ordinary school system for the deaf. The visiting teacher service at present provides support for some children. However, in this area as in other aspects of special education, it is largely a question of making available the necessary specialist expertise within the ordinary school system which is currently available primarily in the special school. There are certainly difficulties particularly where there are communication and language problems. However, it is important that a choice is available, if at all possible, and children are given an opportunity to receive their education within, or close to, their local community.

Meeting Special Needs

If the special educational needs of all children are to be met there will need to be a shift in emphasis from special education as a separate entity to special education conceived as a continuum of graduated provision to complement "ordinary" education. In considering special education needs within such a perspective the whole range of services must be considered—pupil/teacher ratio in the regular class, identification of special needs, support services for teachers particularly the availability of remedial teaching facilities, psychological, speech therapy, nursing aide and visiting teacher services, in addition to special classes and special schools. The range of support services available

within the ordinary school system is limited, being mainly confined to remedial teaching services and, at a more general level, school health services.

Remedial Teaching Services While there was a consistent annual increase in the provision of remedial teachers for national schools up to 1974/75 at which stage provision had reached 330, there was no increase in 1975/76, in which year the complete emphasis was put on the reduction of the pupil/teacher ratio. In 1976/77 the number of remedial teachers available had reached 335 providing a service to approximately 17,000 children.[32] About 1,000 children were receiving remedial help through schemes associated with Child Guidance Clinics or Saturday morning schemes run in rural areas. Apart from the latter schemes remedial teaching services are generally confined to larger centres of population. Thus, while in general the availability of remedial teaching facilities is limited, in many areas it is non-existent.

School Medical Inspection A health examination and treatment service is available without charge for pupils attending a national school (Section 16, 1970 Health Act). The aim of the School Health Services for children, is to examine all new entrants and to carry our selective examinations of other children on the basis of identification at a previous inspection or referral by the public health nurse, parent, general practitioner or teacher. In 1976, 30% of all national school children were examined and approximately 98% of all new entrants were examined (Table 11). 37% of this group required further attention as did 39% of those seen at selective examinations. This further attention entailed either referral to a specialist or a family doctor or retention under observation.[33] A breakdown of the type of specialist referrals, which accounts for over 20% of the "further attention" group both in the case of new entrants and those examined at selective examinations, is not available. However, this category includes referrals to psychologists and speech therapists. Information on receipt of services and time spent on waiting lists is not available.

[32]Since 1967 over 750 teachers have undertaken remedial courses in Limerick, Cork, Galway and Dublin.

[33]Department of Health, March 1979. See Chapter 5, Table 5.3.

School Psychological Service As has already been pointed out the psychologists and inspectors of guidance services employed by the Department of Education are concerned mainly with the post-primary sector. There is a very limited input in the form of a guidance service to teachers at the primary level.[34] This contrasts with the situation in many special schools for mentally handicapped children where a service is available from psychologists employed by Diagnostic Assessment and Advisory Services, or in the case of schools run by some of the larger voluntary organisations from psychologists employed by these bodies as part of their general service.

Speech Therapy Services The provision of these services is the responsibility of Health Boards, and children are seen mainly at Health Board offices; however, a limited service is available to special schools. There is a shortage of speech therapists in all areas.

Youth Employment and Advisory Service

There are at present 16 youth employment advisers, providing a service in all areas with the exception of the Mid-Western Health Board area. These advisers are closely involved with children attending special schools for mildly mentally handicapped children. They work in co-operation with teachers in the provision of work preparation and work experience programmes and provide a placement service to children leaving these schools. This service is at present investigating the position of children attending special classes, with a view to extending the service. The unsatisfactory nature of the present provision of special classes at post-primary level is presenting difficulties in following-up children identified as having special needs at the primary level.

In terms of psychological services, speech therapy services and Youth Employment and Advisory Services it is evident that the services available to special schools are far superior to those available to ordinary schools. While the extension of the availability of these services to all schools is highly desirable it is essential in the short-term that these services be extended to all special classes.

[34]Psychological Assessment Services are the responsibility of Health Boards. See *Identification of Special Needs.*

In conclusion, it is suggested that rather than a focus on segregation/integration as mutually exclusive alternatives, it is necessary to consider special education as a continuum directed to meeting the special needs of particular children through a range of educational provision from the ordinary school class to the special school, both day and residential. While general conditions for the implementation of various levels of integration can be stated it is important to bear in mind that at the present time there are no detailed findings available on the effectiveness of integration. At a more fundamental level there is a lack of information on the effectiveness of the differing types of special educational facilities available in Ireland in terms of their social and educational benefits. Thus, irrespective of the issue of integration relating to special classes it is essential that an evaluation of the effectiveness of the present range of facilities takes place. In addition any commitment towards integration of handicapped children must be accompanied by a commitment to evaluate the programmes concerned.

3.4 Third Level Education

A NESC report emphasised that access to education is of major consequence in determining a person's subsequent life chances and in particular his ability to follow a career of his choice and benefit from further education and training.[35] The importance of further qualifications to the future employment prospects of handicapped persons is very evident. There is a need to positively discriminate in favour of the handicapped to increase their opportunities for further education. For the physically and sensorially handicapped person the difficulties of securing accommodation, the problem of transport, the extra costs incurred through the disability, the possible needs for special aids or equipment and the frequent inaccessibility of buildings can often combine to make it virtually impossible for the more severely handicapped student to pursue his education. For example, there are very few supports available to the blind in pursuing third-level education. The students choice of subjects is limited on account of translation facilities and there is no provision for a "paid reader service". At present the Health Board may pay accommodation costs and assist in the provision of transport for the handicapped student.

[35]NESC Report No. 12, *Educational Expenditure in Ireland,* Dublin 1976.

A more positive and flexible attitude is needed by the Health Boards and the Department of Education to enable the handicapped person to cope with the difficulties and to actively encourage him to further his education. There is also the question of adopting a more flexible approach to admissions criteria and permitting a degree of latitude provided the minimum entry requirements are satisfied.

3.5 Remedial and/or Adult Education

There is some evidence of the need for remedial education[36] for groups within the handicapped population. Training centres and workshops run by the Rehabilitation Institute have made available compensatory educational programmes for some trainees. This was felt to be a necessary requirement to enable many persons to benefit from the training programme. An AnCO study on the learning problems of disabled trainees found a relatively high level of literacy problems (14.7%) among the trainees as well as difficulties in concentration, communication and understanding.[37] The study on members of the Irish Wheelchair Association highlighted the very low level of educational standards achieved by a large proportion of the members. Almost 20% had obtained only an incomplete primary education, and almost one-third of these had no formal education or were functionally illiterate.[38] For some this may be due to their disability, to long periods of hospitalisation or to educational facilities which were not geared to catering for special needs in earlier years. For others the poor education attainment may be related to the particular socio-economic environment in which they live.

Some of the education required at this stage may need to be concentrated, relatively long term and perhaps compensate for

[36]"Remedial adult education seeks to fill any gap or lack in the education of an adult that ought to have been or might have been provided in the regular school system . . . remedial adult education will also include programmes for special social groups (e.g., the unemployed, itinerants, the handicapped, those anxious to proceed to higher level qualifications but who have not the required entrance qualifications . .)". *Adult Education in Ireland,* report of a committee established by the Minister for Education, Dublin 1973, p. 13

[37]*Learning problems of Disabled Trainees,* Research and Planning, AnCO, Dublin 1978, p. 57.

[38]Faughnan, P, *Dimensions of Need,* op. cit., p. 43.

inadequate formal education at earlier stages.[39] Others may need educational programmes more geared towards personal development.

For example, those who become traumatically deafened as a result of an accident or virus may have no lip-reading service available to them around the country. While technically not falling within the scope of the educational system there is very much a need for a remedial service. While the numbers may be quite small (estimated at about four per year)[40] the resulting isolation can be very great and there is a need for considerable rehabilitation.

Many voluntary agencies have become involved in providing remedial or adult education or in facilitating their members availing of existing services. St. Vincent's social club for the deaf run special night classes in conjunction with the Dublin Institute for Adult Education. The National League for the Blind pay 50% of the fees for blind people to attend adult education classes. Other organisations provide similar financial support and encouragement. This is an area where individual organisations could assess the need and the demand for adult education among the people they work with. Various centres of adult education or educational committees would no doubt be very receptive to helping to cater for them or if there was sufficient demand to provide special courses.

3.5.1 *Adult Education for Mentally Handicapped Persons*

A fundamental aim of education is to enable individuals to develop their full potential according to their personal capacities. It is clear that this aim can rarely, if ever, be fully achieved within the formal educational period. This is particularly true of mentally handicapped persons, many of whom show gains in ability in their late teens and early twenties. Thus, the concept of continuing or "permanent" education has particular relevance for mentally handicapped persons. The

[39]The special experiment in post-primary education for physically handicapped teenagers and adults in 1973/74 at a school in Cork provides an example of such a compensatory project. The aim of the project was to provide basic primary and post-primary education for those who because of their handicap, previous hospitalisation, or transport difficulties did not have this opportunity. Some of the pupils had no formal education. Ages ranged from 10-48 years. It was a joint project with the voluntary organisations, the Health Board, educational authorities and NRB actively involved. Residential accommodation was provided. Some of the pupils completed their leaving certificate.

[40]Information supplied by the National Association for the Deaf.

Commission of Inquiry on Mental Handicap recognised the need for adult education for mildly mentally handicapped persons and identified particular areas of need with regard to oral expression, reading, writing and simple calculation; it was pointed out that some mildly mentally handicapped persons, on leaving school, may not have sufficiently developed skills in these areas, all of which are vital in the attainment of social adequacy, while others may want to improve skills already acquired.[41]

In addition to this type of remedial education there are other areas of need relating to individual personal development. The study of disabled trainees, undertaken by AnCO indicated that the difficulties encountered by trainees were not related primarily to lack of physical or mental capacity but rather to "secondary" problems such as attitudes to themselves, their disability and to others.[42] These findings suggest that the development of social and interpersonal skills is an important area for consideration with regard to further education services of adult handicapped persons.

Up to the present time there has been very limited development in the area of further education for mentally handicapped persons in Ireland. The Commission of Inquiry on Mental Handicap recommended that Vocational Education Committees should provide special evening classes to meet the needs of mildly mentally handicapped persons who have left special schools. While it is possible that some of the needs of this group may be catered for in the ordinary programmes of adult education, there has been no development along the lines recommended.

The Cork Polio and After Care Association has initiated, on an experimental basis, night classes for adults within their own services, mainly employees of HELP sheltered factory. Basic skills in reading, writing and verbal communication are covered at present. These classes are run by volunteer tutors with help from teachers employed within the service. It is intended to extend these classes to provide for all the school leavers from the service who are likely to benefit from them. In addition a service aimed at developing social and interpersonal skills is being considered.

While organisations involved in the provision of services for mentally

[41]Commission of Inquiry on Mental Handicap. op. cit., p. 96.

[42]AnCO Report. op. cit., pp. 71-73.

handicapped persons should highlight the continuing educational needs of persons attending special services, it is clear that the need is far greater than this; in particular with regard to mildly mentally handicapped persons many have never attended special services yet their needs, particularly with regard to remedial education, are probably considerable. It is clear from the response to the Dublin Institute of Adult Education Literacy Scheme that the general need for literacy programmes is considerable. The feasibility of operating programmes as recommended by the Commission of Inquiry on Mental Handicap, should be investigated by VECs.

3.5.2 *Content of Adult Education Courses*

In addition to meeting the needs of handicapped adults, adult education services could make a major contribution towards the improvement of community attitudes to the handicapped, through the development of courses on handicap for the general public. Apart from the provision of basic information on handicapping conditions, the special needs of handicapped persons, the potential of handicapped persons and the whole area of attitudes towards the handicapped could be explored. This is of crucial importance, given the present emphasis on integration of handicapped persons.

3.6 RECOMMENDATIONS

General

On a general level, the educational needs of handicapped children should be approached within the broad context of special educational need rather than on the basis of particular handicaps. Within this broad framework a substantial proportion of the school-going population can be expected to have special needs. The early identification of educationally handicapping conditions should be a priority. The achievement of greater teacher awareness and understanding of special needs should be stressed at the training level and in in-service courses. Sufficient resources should be allocated to provide an effective remedial programme. The present range of educational facilities available to handicapped children should be evaluated in terms of their long-term educational and social benefits.

Integration

Integrated education is a system which caters for the special needs of handicapped children within the ordinary school framework. No child who can be successfully educated in an ordinary school should be educated in a special school. When full integration is not possible, the aim should be to achieve the greatest level of integration that is compatible with meeting the child's special needs.

First and Second Level Education

In the case of integration for the physically handicapped child the following areas need to be examined urgently:

(i) Policy on the accessibility of new school buildings and supports to enable existing inaccessible schools to be modified.

(ii) Transport arrangments.

(iii) Provision of personal help when required.

For the hard of hearing child and the partially sighted child integration will require a greater availability of resource and specialist teachers in the community and in ordinary schools.

In the case of mildly mentally handicapped children effective integration will necessitate:

(i) A comprehensive range of special classes at the post-primary level.

(ii) An extension of the present level of support services available to special schools, e.g., psychological services and youth employment and advisory services to all special classes.

In the case of both mild and moderately handicapped children, the reasons for admission, to residential schools should be investigated.

At a more general level, a commitment towards integration must be accompanied by a commitment to evaluate the programmes concerned.

Third Level Education

The problem at this level is probably more one of lack of opportunity than segregation. Given the importance of further qualifications to future employment prospects for handicapped people there is a need

for a measure of positive discrimination at this level of the educational system. The following areas should be examined in this regard:

(i) Availability of discretionary grant support.

(ii) Availability of financial aid to cover extra costs relating to the handicapped; transport, accommodation, aids, equipment and personal assistance.

(iii) The need for flexibility in admission criteria once minimum entry requirements are satisfied.

(iv) That existing buildings should wherever practical be adapted and all new buildings be required to provide total access for all handicapped students.

Adult Education

Voluntary bodies who may be aware of the needs of individuals or groups for adult, compensatory, or remedial education, should take the initiative in this area. Adult Education Institutes should be approached and asked to make special programmes available where necessary. Greater encouragement and assistance should be given by voluntary bodies as well as financial assistance with fees, or help with transport where required.

Agencies involved in the provision of services for handicapped persons should encourage and co-operate with Adult Education Centres in the organisation of educational and information programmes for the general public on handicap and the needs of handicapped persons.

CHAPTER 4

EMPLOYMENT AND TRAINING OPPORTUNITIES

4.1 Employment and Rehabilitation

The need to work is a very basic one in modern society. It gives one status, dignity and self-dependence through being a contributing member of the community. The need is no less real among the handicapped population although it is often more difficult to meet. There are many barriers existing in Irish society which prevent handicapped people obtaining their share of the available labour market. These barriers range from obvious physical and architectural ones to the less apparent but none-the-less real barriers of social attitudes. There are negative social attitudes on the part of some employers to employing people with epilepsy or with mobility problems, the blind and mentally handicapped person. There are the social attitudes in Irish society which, even in the early 80s, find it difficult to accept that handicapped people, especially those appreciably handicapped, can make a contribution or should even aspire to do so. There are also the negative attitudes of some handicapped people whose social experiences have not led to the development of high aspirations, expectations or self-confidence. These relate to the social and economic conditions of the handicapped minority in our society rather than solely to rehabilitation services.

From two perspectives the question of employment opportunities is central to any discussion on integration and equality:

(i) the handicapped person has a right to work.

(ii) the development of opportunities for the handicapped worker makes sound economic sense for the community. This has been illustrated in studies which point to the purely economic benefits of investment in rehabilitation, arising from increased productivity and the reducation in the cost of care for the unemployed person.

In 1968 Dr. Garret FitzGerald stated:

> It would be difficult to think of a more productive form of social investment yielding such a high retum through the reduction of unemployment benefit assistance payments and through the enhancement of the productive potential of the community.[1]

In 1974 Professor Kieran Kennedy demonstrated that there is strong support for the argument that rehabilitation is worth while in economic terms; concluding that it appears very likely that the state receives more than it spends on rehabilitation.[2]

The economic value of vocational rehabilitation to society is tangible and identifiable.[3] Rehabilitation is an investment that pays society for its efforts. Although open employment is one of the primary goals of vocational rehabilitation it is not the only one. Economic motives alone should not determine totally the direction and scope of vocational services. This danger is a real one in this country with the current rapid expansion of vocational services for the handicapped.

4.1.1 *Occupational Handicap*

People who are occupationally handicapped are not an easily definable minority in the labour market. Rather they are a large number of people who may need special help and support to obtain jobs suited to their actual or potential ability.

For the purposes of discussing vocational rehabilitation the occupationally handicapped can be broadly divided into the following groupings:

(1) People whose disability is congenital or acquired in youth and whose education and early training may therefore have been affected. This includes many people with mental handicap, organic nervous disorders such as epilepsy and spasticity, deafness and blindness. This group tends to dominate in statistics

[1]Quoted in Flannery, F., 'Rehabilitation—an Investment'. Paper delivered at U.V.O.H. Conference, Wexford 1977, p.1

[2]ibid. p.3.

[3]See also O'Toole, A., 'Rehabilitation makes sense'. *Business and Finance*, May 31st, 1979, p.11. Referring to Frank Flannery's study—'Rehabilitation in Ireland—a cost benefit analysis' (1976) she points out that for every £1 spent on providing rehabilitation services in 1972/73 Gross National Product rose by £24.

which refer to the age groups 16-25 but gradually to decrease in older age groups.

(2) People who through accident or illness become disabled during their working life having had employment experience and perhaps training. There is an ever growing number of disabled persons who are removed prematurely from the work process as a result of industrial accidents, traffic accidents and disease.

(3) People whose disabilities are either part of the ageing process or associated with illnesses of advancing age, e.g., particularly respiratory and heart conditions. These people tend to dominate the age groups over 45.

Vocational rehabilitation aims at helping people who have difficulties in obtaining or retaining a job to strengthen their position in the labour market. It includes measures on behalf of the individual and possibly also intervention at work places. Essential elements of the vocational rehabilitation process are:

vocational assessment and guidance;
work activation;
vocational training;
placement in open employment;
provision of sheltered employment.

4.1.2 *The Irish Situation*

Prior to 1975 the whole field of vocational training and employment for the handicapped in Ireland was undertaken largely by voluntary bodies. It was fragmentary, of varying quality, and large areas both geographically and in terms of particular groupings of disabilities were totally uncatered for. Provision and initiatives were almost exclusively undertaken by voluntary bodies. Although the Health Act 1970 obliges the Health Boards to make available services for the training of handicapped persons most Health Boards did not become directly involved in the provision although some support was given to voluntary groups in the field.

In 1973 the advent of the EEC, and the stimulus provided by the European Social Fund[4] and the establishment of the Working Party by

[4]In 1977 a total of £3,076,000 from the European Social Fund was approved for Ireland for training.

the Department of Health on *Training and Employing the Handicapped* altered radically the field of vocational rehabilitation in Ireland. The working party was requested to make recommendations for the creation of an effective and planned approach to the occupational rehabilitation of the handicapped. It recommended that facilities for training, activation and employment be made available through statutory and voluntary agencies. The recommendations of the Robins report, as it is now known, provide the framework within which vocational services are being developed.

Apart from the implementation of some of the recommendations contained in the Robins report the following developments have taken place since the mid-1970s:

(i) the announcement of a 3% quota system for the employment of handicapped persons in the public sector (May 1977);

(ii) the development of "Vocational Training Units" attached to special schools for the mentally handicapped provided with the assistance of the Departments of Health and Education.

4.1.3 *Overall Responsibility*

The responsibility of the Department of Health for providing training, activation and employment services was fully accepted by the Robins report. One must question the rationale of locating the new structure under the Department of Health rather than the Department of Labour. Training and employment, particularly in the open market, are basically concerned with manpower, with production and with meeting market requirements rather than with health specifically. This decision, coupled with the recommendation of the working party that services for the handicapped population should be integrated with existing training provisions for the community as a whole, appears contradictory.

4.2 Provisions for Training and Employment

The Working Party on *Training and Employing the Handicapped* defined handicap as, "any limitation, congenital or acquired, of a person's physical or mental ability which affects his daily activity and work by reducing his social contribution, his vocational employment prospects or his ability to use public services".[5] On the basis of this

[5]ibid., p. 12.

definition it was estimated that 15,000 out of an estimated 100,000 adult handicapped persons in this country would benefit from preparation and training for work. The location of this 15,000 is as follows:

Psychiatric hospitals	—	3,000
Special centres for the mentally handicapped	—	1,000
County Homes and other institutions	—	700
Blind	—	300
Others in the community	—	10,000
		15,000

It is estimated by the Workshops Standards Committee that there are now 5,500 places available for handicapped persons in various centres and institutions throughout the country providing skilled and semi-skilled training, activation and sheltered employment. These are distributed as follows:

2,600 places in Industrial Therapy units attached to or associated with psychiatric hospitals and catering for patients attending these hospitals;

1,625 places in centres catering for the mentally handicapped;

1,260 places in centres within the community catering for mixed handicaps groups;

50 places providing sheltered work for the blind and partially sighted.[6]

Since the Robins Committee first met in the early '70s when training facilities were limited in several respects and could be categorised very simply a whole new structure is emerging with a range of technical descriptions which not alone is confusing to the interested observer, but suggests a complex and massive vocational rehabilitation framework. However, this is not the situation and for the sake of clarity it is worth listing the different categories.[7] Often individual centres do not

[6]*Standards for Workshops; Report of Standards Committee of the NRB*, April 1978, pp 1-2. This committee was established by the NRB in Nov. 1975 in line with the recommendations of the *Report on Training and Employing the Handicapped* to monitor and set standards for workshops for the handicapped.

[7]Adapted from Workshop Standards Report, op.cit., pp.iii and iv.

describe themselves by their correct title.

Categories of Special Vocational Services

Special Training Centres—Centres in which training to skilled (including apprenticeship) and semi-skilled level is provided.
Community Workship—Workshops having two functions: (1) activation of handicapped persons for open employment; (2) provision of long-term employment for handicapped persons who have difficulty in obtaining or retaining open employment.
Sheltered Workshop—Workshops providing long-term employment for handicapped persons who have difficulty obtaining/retaining open employment.
Industrial Therapy Unit—Units attached to psychiatric hospitals for persons undergoing institutional care. They have two aims: (1) to condition the individual to the work habit; (2) to develop social habits.
Activation Unit—Units attached to, or associated with, centres for the mentally handicapped and having the same objectives as industrial therapy units.
Day Centre—Centres on a non-residential basis, providing facilities for persons capable of only a low level of productive work. The centres provide daily care and some occupational activities.
Vocational Training Unit—Units attached to special schools for the mentally handicapped provided with the assistance of the Department of Education. The objective is to introduce the handicapped school leaver to the world of work.
Assessment Unit—Special unit providing facilities for the assessment of persons over a period of 6-12 weeks. It provides (a) general assessment of the person; (b) detailed assessment in industrial and commercial activities.

4.2.1 *Identification*

Under the 1970 Health Act, Health Boards have an obligation to provide for the occupational rehabilitation of disabled persons. The Working Party on Training and Employing the Handicapped recommended that the Director of Community Care (D.C.C.) should have the duty of ensuring that all persons in his area suitable for occupational rehabilitation are brought to his notice, by the various

institutions and voluntary organisations concerned, by general practitioners, social workers, public health nurses, assistance officers and others. This identification would be facilitated by the fact that Health Boards already have details of persons in receipt of Disabled Persons Maintenance Allowance (D.P.M.A). In 1977 there were 24,000 persons in receipt of D.P.M.A.

It was also recommended by the Working Party that procedures should be established under which suitable cases in receipt of long-term benefits under the Social Welfare Acts should be notified to the D.C.C. by the medical referees who periodically review the medical condition of those in receipt of disability benefits. Such procedures have now been established. In September 1978 there were approximately 13,000 people in receipt of Invalidity Benefit and 5,000 in receipt of Disablement Benefit. It is estimated that the numbers involved would be approximately three or four hundred per annum.

It was recommended by the Working Party that each Director should keep a register of handicapped persons as a source of information regarding their occupational rehabilitation needs. Work is at present being undertaken to establish a community care based record system of mentally handicapped persons. In the case of the physically handicapped person little progress has been made.

A relatively simple operational definition of handicap is needed. Some of the information is already available within the Health Boards through data on recipients of benefits. The Department of Social Welfare has information also. It is essential that these data are pooled together and assessed in terms of occupational rehabilitation services. The data of course would have many more uses in planning relevant community care services. However, at this stage, with such extensive development taking place in the growth of community workshops throughout the country, with AnCO attempting to fill their training role in relation to the handicapped, with the Quota scheme hopefully to be implemented and a commitment by some Health Boards to expand their day care services for handicapped persons, the absence of such essential data make relevant planning difficult if not impossible.[8]

The Robins Report tentatively estimated that the number of places likely to be required in community workshops would be 5,000.

[8]There is a real danger that in the absence of adequate identification procedures, new opportunities offered by the various training centres may be under-utilised.

However, the Workshop Standards Committee feel that this provision is too great and based on its investigation and discussions with Health Boards recommends that 3,000 of these places be provided.[9] This approximates to one per 1,000 of the population. Obviously a sound base is essential to determine the exact number of places needed in community workshops as well as other forms of training and the best location for such facilities.

4.2.2 *Assessment*

The Robins Report recommended that initial assessment should be undertaken by the D.C.C. and a National Rehabilitation Board Placement Officer. While this type of assessment is adeqate for the majority of handicapped persons, a more extensive assessment is necessary in some cases. The services available for such assessments are:

(i) Day Assessment;

(ii) Assessment at the National Medical Rehabilitation Centre, The Central Remedial Clinic and St. Anthony's Rehabilitation Centre (all in Dublin).

Day Assessment involves the participation of a Medical Officer, a Psychologist and a placement officer—such a service is available in Dublin for the Eastern part of the country, and on a sessional basis in Cork and Galway. In 1977, 144 persons were referred to this service. Assessment at the National Medical Rehabilitation Centre is available for those with serious physical disability. In 1977, 148 persons were assessed. To facilitate prolonged assessment (6-12 weeks) where necessary, the Working Party on Training and Employing the Handicapped recommended that a special assessment unit, similar to the industrial rehabilitation units in operation in the United Kingdom, should be established in association with an AnCO training centre in the Dublin area. While such a unit has yet to be established its importance has been stressed.[10]

[9]*Workshop Standards Committee*, op. cit. pp. 158/159.

[10]Quilligan, J.—'Employability of the Handicapped', paper delivered at UVOH Conference. Limerick. 1978.

4.2.3 *Placement Service*

The primary link between the handicapped person and vocational rehabilitation services is the placement officer. The placement service is part of the network of services supplied by the NRB. It comprises medical and vocational assessment, a placement service for handicapped adults and a youth employment and advisory service for handicapped young persons of school-leaving age.

The objectives of the placement service are:

(1) To help handicapped persons obtain and hold suitable employment including sheltered employment;

(2) To arrange training or education for them where it is considered necessary as a preparation for employment;

(3) To promote equal work opportunities on their behalf. To seek a fair share of the available employment for them.[11]

The placement officer has an extremely important part to play in the rehabilitation process starting from the assessment of the handicapped person and continuing until the person is placed in employment.[12]

There are at present twenty-two placement officers based throughout the various health boards. To facilitate identification and assessment it is proposed to appoint one placement officer to each of the thirty-two Community Care areas. A substantial increase in the placement service is therefore envisaged in the near future. This increase is needed urgently.

In 1977, 1,899 persons were referred to the placement service; 50% of these were physically handicapped; 31% were mentally ill and 19% were mentally handicapped. Five hundred and twelve or 27% of these referrals were placed directly without work preparation or training (32% of the physically handicapped, 22% of the mentally ill and 23% of the mentally handicapped). Five hundred and sixty or 29% were placed in Training Centres operated by the Rehabilitation Institute and by AnCO (25% of the physically handicapped, 34% of the mentally ill and 34% of the mentally handicapped). Two hundred and twenty persons were placed in employment from Training.

[11]NRB *Annual Report and Accounts*, 1977. pp. 8-9.

[12]The importance of this role is emphasised in the Robins Report, op. cit., p. 8.

TABLE 4.1

Placement Service of the National Rehabilitation Board, 1977

	Physically Handicapped	Mentally Ill	Mentally Handicapped	Totals
Referrals	940	597	362	1,899
To Training	232	205	123	560
From Training to Employment	100	55	65	220
Direct to Employment	298	130	84	512
Closed Cases[a]	477	269	161	907

[a]This would include people closed for medical reasons, because they were unsuitable; because people refused help from the service; or no sheltered employment available. The discrepancy in total figures is explained by carry over workload from one year to another.

Source: Quilligan, J. op. cit.

In 1977, 48% of all referrals to the Placement Service came from Health Boards. Given the responsibility of the Directors of Community Care for identification of handicapped persons, it is now proposed that all referrals be channelled through them.[13]

Meeting Special Needs: The Role of the Placement Service Apart from the general placement service there are three specialist posts within the placement service:

(1) The Blind;

(2) The Deaf;

(3) Psychiatrically ill in Dublin.

The single post of placement officer for the blind is felt to be sufficient to meet demand and no staff increase is envisaged.[14] A recent study of blind people between 15 and 64 years living in Dublin city and county found that high proportions of the people surveyed were successfully employed and that there is not a large unemployment

[13]ibid.

[14]*Report on placement service of NRB* Dublin, 1978, p. 7.

problem among blind and visually handicapped persons within the age groups studied in Dublin city and county. However, it was felt that these findings could not be generalised to other geographical areas or to the country as a whole.[15]

The special placement officer for the deaf is responsible for people in the Eastern Region. Outside this area the general placement officers take full responsibility for the deaf as part of their workload. It was felt that general placement officers can give an equally good service to the deaf with the little extra training which they have now received.[16] The existing arrangements therefore for the placement of the deaf are seen to work well and no immediate changes are envisaged.

While further specialisation is not recommended within the placement service[17] certain groups of handicapped persons experience particularly acute problems in obtaining a job or even training. The wheelchair-bound are one such group. Although comprising a small minority of the handicapped they present special problems and often back-up supports are not available. The survey on members of the Irish Wheelchair Association ascertained that less than 10% were employed in open employment and a further 10% in home industries or sheltered work. Almost 60% were not employed in any capacity whatsoever. Although a substantial proportion of the membership of this Association is over 65 years of age and many would be too disabled to work, the figures serve to highlight the very limited employment opportunities available to date for this group.[18] Frequently transport and accommodation difficulties present insurmountable barriers for the wheelchair-bound. Suitable hostel accommodation for the wheelchair-bound is very limited throughout the country. Transport and the inability of those with severe mobility problems to avail of training facilities has also inhibited training opportunities. This can be further compounded by the physical inaccessibility of some training centres (even those specifically for the handicapped) which could otherwise offer scope to the wheelchair-bound. Better support services are needed.

Youth Employment and Advisory Service In 1978 there were

[15]Walsh, J. 'Report on Blind and Visually Handicapped Persons living in Dublin City and County'. Paper delivered at Conference, Dublin, November, 1978.

[16]ibid. p. 8.

[17]ibid. p. 17-18.

[18]Faughnan, P., *Dimensions of Need*, op. cit., Chap. 4.

fourteen Youth Employment Advisers working in the Eastern, South-Eastern, Southern, Western and North-Western Health Boards. During 1979 advisers were appointed in the North-Eastern region and the Midland regions. It is proposed to increase the number of advisers to 23. Young people under the age of 18 are referred to the Youth Employment Advisory Service for vocational assessment and guidance in relation to further education, training and employment. In 1977, 595 young people were referred to the service, 49% of whom were placed in employment, 30% of whom were placed in training and 4% of whom were placed in further education.

Referrals to the service came from a variety of agencies: over a three-year period it was found that 52% of referrals came from special schools, 11% from Health Boards, 11% from voluntary organisations and 5% from parents.[19] There is a very close involvement by the advisers with special schools for the mildly mentally handicapped in the operation of work preparation and experience programmes. Over 50% of the referrals to the service are mentally handicapped, for the most part mildly mentally handicapped and approximately 40% are physically handicapped. The proportion of mildly mentally handicapped people referred is growing with the development of the service and in particular its involvement with an increased number of special schools. The degree of involvement varies depending on the resources of the school concerned—a small number of special schools operate their own placement service, which is co-ordinated with the Youth Employment Advisory Service. Young people attending special schools are generally referred two years prior to leaving school. The youth employment advisers work in co-operation with teachers in the formulation and operation of work preparation and experience programmes. Of the young people leaving special schools in July 1977 who were assessed as suitable for open employment, 91% were placed by January 1st 1978.[20]

Follow-up of young people placed is undertaken for at least two years after placement and for longer periods depending on the adjustment of the young person concerned.

Involvement of the Youth Employment Advisory Service with young people attending special classes is at present complicated by the fact

[19]Youth Employment Advisory Service, NRB.
[20]Annual Report and Accounts, NRB 1978 p. 10.

that there is no clear-cut organisation of special classes at post-primary level. The service is undertaking an investigation of the need for vocational assessment and guidance in the case of young people attending such classes.

4.3 Employment and Training Provisions in Special Centres

The Robins Report made a very clear distinction between training and sheltered employment of the handicapped person. For the purposes of their recommendations training refers to the acquisition of skills leading on to employment in the open labour market. Courses of training are of a fixed duration. Sheltered employment on the other hand refers to the employment for indefinite periods in special conditions of handicapped persons who are not suitable for open employment.[21]

At that time it was pointed out that only a relatively small number of physically handicapped persons are accommodated in workshops compared with the numbers of mentally ill and mentally handicapped persons. This was felt to be related to the fact that physically handicapped persons were generally living within the community, consequently provision of sheltered work presented special problems. Additionally the Report emphasised there was not, however, the same awareness of their needs.

Until then provisions for sheltered employment tended to be for specific groups of handicapped persons. The basis for the new structure was to be totally different. It was recommended that in future selection for training facilities be on the basis of aptitude for training and not subdivided according to the type of disability. The new structure of community workshops and training centres was to be basically "integrated".[22] Within this system community workships would have the dual role of:

(1) Providing activation training;
(2) Providing sheltered employment for those capable of achieving a certain level of productivity.

Despite the emphasis on this integrated structure it was accepted that there would be a continuing need for separate units at mental hospitals

[21]*Training & Employing the Handicapped,* op. cit., p. 17.
[22]ibid. p. 27.

and centres for the mentally handicapped person where work activation facilities are required. However, community workshops were to cater for mixed handicap groups. For example, approximately 48% of those participating in Rehabilitation Institute Centres in 1978 were mentally handicapped, 32% were physically handicapped and 20% had psychiatric problems. The vast majority of the mentally handicapped persons concemed were functioning at a mild or borderline level of handicap.

4.3.1 *Training Centres and Community Workshops*

The provision of community workshops on a nationwide basis forms a major part of vocational rehabilitation services. The objectives of a community workshop are:

(i) To build up work tolerance

(ii) To develop acceptable work habits

(iii) To introduce the trainee to the organisation and structure of industry. industrial hygiene and safety

(iv) To familiarise the trainee with materials, equipment and machinery most commonly used in industry

(v) To provide activation in an area of work in which open employment is available locally

(vi) To build up a favourable self-image

(vii) To provide practical assessment as a continuous element of activation in a variety of industrial processes

(viii) To ascertain motivation and ability

(ix) To provide long-term sheltered work.[23]

The idea of a community workshop is new in so far as it:

(a) includes both activation and provision of sheltered employment in the one centre

(b) is designed to cater for all local needs in the one centre, i.e. different handicaps as well as activation and sheltered employment needs.

Training centres are concerned with the provision of training for handicapped persons to skilled (including apprenticeships) and semi-skilled levels. The term "special training centre" is used by the

[23]*Workshop Standards Committee,* op. cit., p. 38.

Workshops Committee to refer to the engineering, woodwork and watch and clock repair centres in Dublin, commercial training centres in Dublin, Cork and Sligo, special areas of training in Goldenbridge Centre, Dublin, all run by the Rehabilitation Institute and to the horticultural training in Park House.

The Rehabilitation Institute provide the vast bulk of the places currently available in community workshops and training centres throughout the country. Although other organisations provide "community workshop" facilities, many of these are for particular groups of the handicapped population. From this perspective it is useful to examine in Appendix IVA the current provision of places in community workshops and the range of activities provided in training centres by the Rehabilitation Institute throughout the country on a Health Board basis.

There has been a rapid expansion in the number of places available in such centres over the past few years. There are currently a total of 1,263 places in Rehabilitation Centres alone and the estimate for September 1979 is 1,363 places. Additional places are provided by other organisations around the country. Not all of these, however, could be classified as community workshops in the sense of the term as defined in the Robins Report. A full list of these is contained in Appendix IVB.

The Workshop Standards Committee recommend that such workshops should aim at providing a minimum of 45 places, with the facility to expand to meet local needs if required.[24]

The Committee recommend an increase to 3,000 in the number of places available in community workshops and these additional places should be developed over a period of three years from 1978 to 1980 inclusive.[25]

With such a rapid development of community workshops and the investment of very substantial resources by the statutory authorities, the European Social Fund and voluntary organisations themselves, it is imperative that there is a sound base on which to plan developments and that the functioning of the new concept "Community Workshop" is kept under review. Until adequate information is available on the handicapped population and their vocational needs at community care

[24]ibid p. 37.
[25]ibid.

level, it is difficult to plan the best location and structure for new workshops.

4.3.3 *Sheltered Employment*

While many handicapped people can take their places in the open employment market, there are many who cannot. There is an equally urgent need to cater for what appears to be a very substantial number who may never be capable of achieving the level of output regarded as acceptable for open employment. This may be due to the severity of a physical disability, to the degree of impairment or to factors related to the disability which has inhibited the person's educational and vocational progress.

This section of the handicapped population need special conditions of employment either within an ordinary work setting or in special workshops.

Sheltered employment is different to diversionary or therapeutic activities which may include occupational elements. Sheltered employment has a dynamic quality, is organised essentially on industrial lines, is productive and provides long-term employment.

The Robins Report recommended that one of the functions of community workshops is to provide long-term sheltered employment. However, only those capable of ultimately achieving a level of output not less than one-third of that of an able-bodied worker should continue to be employed.[26]

The Workshop Standards Committee state that the greater need is for sheltered work. Consequently they recommend an initial ratio of 2:3 activation : sheltered work to be achieved during the first two and a half years of operation and a ratio of 1 : 2 thereafter. Their report also states that in larger urban areas where the demand for rehabilitation services is such that workshops with the sole function of providing sheltered work can be maintained, these should be developed.

However, it is anticipated that in rural areas particularly, the community workshop will cater for all local needs in the one centre.

Much of what is classified as sheltered employment around the country is little more than occupational activity. There are some workshops, mainly for mentally handicapped persons, which provide sheltered employment. There is also a production workshop operated

[26]Report on Training and Employing the Handicapped, op. cit., pp. 45-6.

by the National League for the Blind which could be described as sheltered employment in the technical sense of the term. There are over fifty employees including apprentices; wages are negotiated through trade unions; there is a contractual agreement; insurance and tax are paid by the employees and conditions are essentially industrial. Such sheltered work is basically protected industrial work and not simply occupational activity.

Apart from establishing the ratio of sheltered work places to activation little work has been done on the provision of sheltered employment in Ireland. The Workshop Standards Committee suggests that the inclusion of the two functions in community workshops creates operational difficulties. It emphasises the need to investigate the operation of such workshops thoroughly and set up a pilot scheme in two of the workshops to do this.

More attention should be given to sheltered work facilities in Ireland. The following areas need to be examined urgently:

(i) Is the community workshop reservation of sheltered work places adequate?

(ii) What is the quality of other centres providing "sheltered employment" facilities?

(iii) What alternatives are needed to "sheltered employment" facilities for those who will not achieve the necessary level of productivity?

(iv) Can sheltered work places in community workshops meet the need for long-term, secure employment?

(v) How will the "integrated" concept operate for long-term work as opposed to short-term training/activation?

(vi) On what basis will people in sheltered work be paid? There are very great variations currently in this area in what is termed "sheltered workshops".[27] In community workshops sheltered work employees receive the same allowances as those in training/activation. They are categorised as trainees who remain in the centre on a long-term basis.

[27]The Workshop Standards Committee have recommended that persons in sheltered employment should be paid a basic rate of 75% of the average minimum Joint Labour Committee rate. This would provide a nett basic wage of approximately £23 per week for a person 21 years of age or over, after deduction of tax, social insurance (figures as at June 1977). Bonus incentives related to productivity should also be paid. *Workshop Standards Committee,* op. cit., p. 188.

(vii) What type of support services are needed? Does the absence of appropriate transport and accommodation facilities prevent the more severely handicapped person from availing of the developing provisions?

(viii) What level of State subvention will be necessary to develop the necessary sheltered work facilities? What is the Government's position on the matter? Will the European Social Fund financing dictate the direction which all vocational rehabilitation services will take?

More information is needed both in terms of the take-up of sheltered work facilities and the effectiveness of the current structure in meeting long-term needs. Equally a response from the Government on the sheltered work situation, on its development and its financing is urgently required.

4.3.4 *Sheltered Workshops and activation centres for Mentally Handicapped Persons*

The Robins Report made a number of recommendations relating to "occupational"/"industrial" therapy units for mentally handicapped persons. It proposed that these units should be reorganised for the purpose of activation which was seen as having two aims—firstly to condition the individual psychologically and physically to the work habit so that he could benefit to the greatest extent from subsequent training, and secondly where necessary to develop his social habits and thus smooth the way for integration into the community. It was stated that "the aim in regard to persons undergoing activation in special units for the mentally handicapped should be to prepare them for employment in the open market or in community workshops. They should not be retained indefinitely in activation units".[28] Accepting that many seriously handicapped persons would not be able to go into open employment or to engage in sheltered employment, it was proposed that they would benefit from the services of an Occupational Centre.[29] However, for those who could benefit from activation it was proposed that the occupational/industrial therapy units, both day and residential,

[28]Dept. of Health, 1975. op. cit. p. 37.
[29]See section on Adult Day Care.

should be reorganised as Activation Units which should be run by suitably trained personnel.[30]

Of the 19 special residential centres which had residents over the age of 18 in 1976 only 12 had day attenders at activation units (day workshops)—the total involved was 109 persons.[31] Since 1976 there has been an increase in this type if provision with the opening of the Brothers of Charity Centre at Bawnmore, Limerick, and the opening of a new training centre at the Mary Immaculate Centre in Carriglea, Co. Waterford.

The former centre had 12 day attenders at a pre-vocational training unit in March 1979 and the number of day attenders is expected to increase to approximately 70 both in this section and also in a vocational training section and sheltered factory; the Mary Immaculate Training Centre will eventually cater for approximately 20 day attenders at its sheltered workshop. In addition to these centres, Moore Abbey in Monasterevan has initiated a day-attendance programme for 10 day attenders at its sheltered workshop.

Four organisations providing services for mentally handicapped persons provide sheltered work or activation facilities exclusively for day attenders. These centres are variously referred to as sheltered workshops, sheltered factories, long-term training centres, and are concentrated in larger centres of population. Approximately 485 places were provided in 1978.[32]

Considering the provision of activation/sheltered workshop services on a national basis with reference to the findings of the census of the mentally handicapped in 1974, it is clear that there is still a major shortfall in such services for moderately handicapped adults living in the community. This is particularly evident for those aged over 25, many of whom have never attended special facilities. In the census it emerged that of 1,444 moderately mentally handicapped persons living at home aged over 25, less than 2% were attending sheltered workshops. While 14% were described as being of "considerable help

[30]Activation/Occupation services for persons in residential care are considered in the section on Residential Services.

[31]Forty-seven persons at five centres in the Eastern Health Board area, 49 at two centres in the North-Western Health Board area, 9 at three centres in the South-Eastern Health Board area and four at one centre in the Western Health Board area. See Appendix IVC.

[32]Dublin (215 places), Cork (200 places), Kilkenny (70 places). See Appendix IVD.

at home" and 31% were described as being of "limited help" 52% were not employed in any way. It was concluded that even allowing for the fact that some of these could be mentally ill or otherwise incapacitated, there was an obvious need for sheltered workshops and support facilities for this group.[33] A study conducted by the Medico-Social Research Board in the Midland Health Board region, of those persons aged 20-40 who were returned as moderately mentally handicapped in the 1974 census, indicates that 17% of this group were on the basis of psychological assessment mildly mentally handicapped; however, it is notable that of those so returned the majority were in receipt of DPMA and none had ever been employed in the open labour market or participated in workshops or activation centres. These facts strongly suggest that many of these persons in addition to many moderately handicapped persons are in need of activation, training or sheltered work facilities.

4.3.5 *Vocational Training Centres*

These centres, which are jointly assisted by the Department of Education and the Department of Health, provide a vocational training course primarily for moderately handicapped school leavers but also for some mildly handicapped school leavers. The age range of trainees is generally 18 to 21 years though some of the trainees are older. The courses, which last for periods from 18 months to two years, are aimed at preparation for sheltered and open employment. The general focus of the courses is on social training and training in work skills. A range of activities is provided, e.g. occupational therapy, domestic economy and home management, woodwork, horticulture, art, remedial teaching. The training programme includes work experience and there is an emphasis throughout on vocational assessment. A small number of trainees for these courses have been accepted onto CERT and AnCO training courses.

There are at present 10 centres providing approximately 450 places.[34] The general guidelines relating to the establishment of further centres is that there be a minimum of 40 trainees, however some centres have been established with fewer than this number.

[33]Mulcahy, M. & Ennis, B. op. cit. p. 17.

[34]The locations of these centres are Cork, Dublin (3), Kilkenny, Longford, Bray, Celbridge and Galway. See Appendix IVE.

4.4 Planning to Meet Needs

An effective plan to meet the vocational needs of all handicapped persons calls firstly for a commitment within each Community Care area towards the identification of those who are in need of services and secondly to comprehensive planning of services within each Health Board area.

Identification at Community Care level of persons suitable for training, sheltered employment and occupational services

The need for identification points to the crucial importance of a register within each Community Care area and a mechanism for notification of persons suitable for rehabilitation to the Director of Community Care. Such identification has particular relevance for that group who have never had an opportunity to attend specialist facilities such as schools or assessment and advisory services. This would include a large proportion of the adult mentally handicapped persons in the community.

Comprehensive planning of services within each Health Board area

This would call for close co-operation between the various statutory (Health Boards and the National Rehabilitation Board) and voluntary bodies involved in the provision of services for the handicapped. The whole range of services needs to be considered—community workshops, particularly the sheltered component, and training and activation centres. In this planning, both residential and day facilities should be considered; in particular cases it may be possible to initiate or widen the participation in residential facilities on a day basis. In the case of mental handicap, a mechanism exists for this type of planning, in that mental handicap committees exist in all health board areas through which voluntary bodies involved in mental handicap and Health Boards are in consultation concerning the provision of services. Given the commitment to integration of the various groups of handicapped persons in the Report on Training and Employing the Handicapped, the scope of the committees would need to be broadened to include all those organisations involved in the provision of activation/occupation services for handicapped people. The feasibility of a comprehensive planning approach to the identification of the activation/occupation needs of an area has been demonstrated in the North-Western Health Board area; this has resulted in a plan outlining the range of services necessary, given the existing facilities.

The services proposed range through occupation centres, sheltered workshops, community workshops with subsidiary workshops and hostel provision.

The need for an overall plan for each community care and Health Board area is essential if shortfalls in service provisions for particular groups are to be avoided.

4.5 Incentives to Training and Employment

The results of many investigations prove that every form of vocational rehabilitation is useful, since employment of the disabled brings many positive effects.[35] Society has a definite role to play in providing alternatives to inactivity through rehabilitation services. However, it is also important for the handicapped person to be motivated towards rehabilitation. To help this process the handicapped person must be afforded the same range of training facilities and monetary incentives as the non-handicapped. There is a danger also that social security and welfare benefits will be seen as alternatives to rather than an encouragement towards retraining or employment. This is discussed at greater length in the section on income maintenance service. Nevertheless, any discussion on vocational rehabilitation services must take cognisance of the importance of motivation and the need for incentives. The disabled person should be encouraged in every way possible to undergo rehabilitation in his own and in society's interest.

4.5.1 *Monetary Incentives*

There is a discrepancy between the payments currently made to trainees in Community Workshops and allowances made to AnCO trainees. For example a 21-year-old in a community workshop in Sligo and staying in digs locally receives a weekly allowance of £20 per week made up of DPMA and an allowance from the workshop. All trainees, whether married or single, regardless of age receive the same allowance. A 21-year-old in the AnCO training centre in Sligo receives £30 per week allowance, plus £6.75 for his wife and an additional £1.50 for each child. He also receives an allowance of £12 per week for his digs.[36] "There is need for improvement in and streamlining of the system of payments during rehabilitation. It is an archaic fragmented system which is time consuming, delays the process and certainly places the handicapped person at a serious disadvantage with the non-handicapped."[37] Not only is there a gross discrepancy between allowances for the able-bodied trainee attending an AnCO centre and a handicapped person attending a community workshop, but the difference between the DPMA and the training allowance when all the additional expenses are taken into account, is very small. It is difficult to talk about incentives for rehabilitation given this situation. The Workshops Standards Committee have examined and made recommendations on payments and allowances for persons in training and sheltered work.[38]

[35]Seminar on the Contribution of Social Security and Social Services to the Rehabilitation of the Disabled, Poland, United Nations, New York 1973, p. 10.

4.5.2 *Range of Training Facilities*

A similar range of training facilities should be available to the handicapped as to the non-handicapped person. This certainly suggests the desirability of using existing facilities whenever possible. However, where special facilities are needed it is essential that they not only provide a full range, affording the handicapped person the best possible choice within the limits imposed by the disability, but that the training is also of comparable standard to that available in non-specialised centres. "We must ensure also that programmes which may be organised for groups of clients do not set limits to any individual. Access is still a big problem."[39] The rigid implementation of the standards specified in the Report on Standards for Workshops for training centres, occupational and activation units, community workshops and sheltered workshops is vital in this regard. It is proposed that the National Rehabilitation Board should be the agency responsible for this.[40]

[36]Flannery, F., "Community Workshops—the Irish Experiment", paper at UVOH Conference, Limerick, 1978.

[37]Quilligan, J., op. cit.

[38]See p. 117. However, no response has been received from the Department of Health on their proposals.

[39]Quilligan, J., op. cit.

[40]*Workshop Standards Report*, op. cit., p. 163.

4.6 Financing of Training and Employment Facilities

Over the past four or five years there has been extensive and growing financial investment in the field of training, and employment for the handicapped. This investment has been primarily in training facilities for open employment, as outlined in the Robins Report. Financing of developments takes place in a variety of ways but mainly through the following sources:

(1) Department of Health/Health Board Funding;

(2) European Social Fund;

(3) Voluntary organisations, where involved.

The Department of Health and the Health Boards are involved at various levels in the financing of community workshops and training centres. From April 1st 1979 there is a capitation grant operative of:

£315 per annum for community workshop trainees;

£350 per annum for skill training centres.

In addition the Rehabilitation Maintenance allowance of £18.80 (payable to trainees who are training away from home) and the Disabled Persons' Maintenance Allowance are paid into the centres on behalf of the trainees who subsequently receive "wages" in lieu of these maintenance payments.

The Health Board also provides commuter tickets for trainees or help in other ways towards the provision of transport.

In terms of capital investment both the relevant Health Board and the Department of Health (the latter through the N.R.B.) provide support. For an indication of the level of statutory financial support given during 1977 see Table 4.2.

TABLE 4.2

Levels of support to Training Centres and Workshops, 1977

	£
Capitation rates to training workshops	246,000
Maintenance of persons attending courses	100,000
Bus fares for trainees	146,000
Provision of other transport	45,000
Capital Investment	100,000

Source: Department of Health.

The Workshop Standards Committee devoted considerable time to an assessment of the financing of their recommendations and estimating costs on the development of the programme over the next few years. The various areas of cost examined comprised:

(a) Operating costs of special training centres,

(b) Operating costs of community workshops,

(c) Payments to trainees in special training centres,

(d) Payments to trainees in community workshops,

(e) Payments to sheltered employees in community workshops,

(f) Costs of transport and accommodation,

(g) Financing future capital development.

Detailed estimates of these areas and of the current levels of financing available are contained within the Workshop Standards Committee Report.[41]

The estimates call for a considerably greater financial commitment by the State to this area of rehabilitation, than has existed previously. The Government's response to these proposals for financing the new developments are currently awaited.

European Social Fund The European Social Fund provides assistance for projects designed to help handicapped people pursue a profession or trade after medical rehabilitation, vocational training or re-training (Tables 4.3 and 4.4). The Social Fund may grant assistance for handicapped persons as follows:

(1) assistance for short-term demonstration projects aimed at improving the quality of vocational rehabilitation facilities and for training of persons involved in social and vocational rehabilitation of handicapped persons and those specialising in the training of instructors;

(2) assistance towards measures on behalf of handicapped persons who it is thought will be able to take up gainful employment after rehabilitation.[42]

[41] *Workshop Standards Report*, op. cit., pp. 171-195.
[42] *Paper on operation of Social Fund*, N.R.B.

TABLE 4.3

European Social Fund—Applications approved 1973–79

(approved grants not always paid in full)

	Total £
1973	184,448
1974	402,840
1975	636,688
1976	1,724,969
1977	2,946,350
1978	4,462,074
1979	6,615,256

Source: Statistical Information relevant to the Health Services 1979, Department of Health.

TABLE 4.4

Distribution of funds from European Social Fund, 1979

Health Boards	£ (to nearest thousand)	£
Eastern	275,000	
Midland	245,000	
Mid-Western	203,000	
North Eastern	250,000	
South Eastern	333,000	
Western	314,000	
Southern	334,000	
North Western	713,000	2,667,000
Special Rehabilitation Schemes in the West	167,000	167,000
Voluntary Organisations		
Rehabilitation Institute	1,367,000	
Other voluntary organisations	2,415,000	3,782,000
Total:	6,616,000	

Source: Statistical Information relevant to the Health Services 1979, Department of Health.

In general applications from Irish organisations (both statutory and voluntary) are classified under:

(a) those which are considered to be involved exclusively in training for open employment;

(b) those operating mixed centres which have elements of training activities and sheltered employment.

Operations under (a) receive the full grant; operations under (b) receive grants related to placements (excluding placements to sheltered employment).

The European Social Fund has been a major innovation in the vocational rehabilitation scene over the past few years. However, its assistance is primarily for projects and people geared towards open employment. It is very important that such support, vital as it is for ongoing development, will not be the sole determinant of the direction which all vocational rehabilitation services will take. If this happens, people who are not capable of going into open employment even with training and rehabilitation will tend to lose out and sheltered work will not be given the recognition necessary to develop it as an integral part of vocational services. It is important for the Irish Government to look at the supports it offers and examine the way additional inputs could complement the European sources of finance and permit development at several levels.[43]

4.7 Open Employment

4.7.1 *Training Provisions in AnCO:*

In line with its recommendation that "as many as possible of the handicapped should be trained in association with able-bodied workers"[44] the working party on Training and Employing the Handicapped recommended that AnCO should have the main role in the provision of training for the handicapped on an integrated basis with the able-bodied. In addition to providing training it its own centres the working party recommended that, where appropriate, AnCO should

[43]Ross, M., op. cit. pp. 17/18.

[44]Report on *Training and Employing the Handicapped*, op cit., p. 41.

make arrangements with selected industrial firms or technological colleges for the training of handicapped persons.

In 1979 AnCO hopes to train 13,000 persons throughout its fourteen centres. Out of this national target there is provision to train 300 handicapped persons on an integrated basis with able-bodied trainees. Since the inception in 1975 by AnCO of its pilot scheme to train handicapped persons on an integrated basis with the able-bodied the number of such trainees has been increased progressively from 50 in 1975. It is also possible that handicapped people are being trained by AnCO who are not classified as handicapped.

AnCO's policy is to provide training for handicapped persons who have been assessed as suitable for open employment and who can take their place alongside able-bodied trainees throughout the training process. It is very desirable that wherever possible handicapped persons be trained in an integrated setting with able-bodied colleagues. The facilities provided by AnCO for training and retraining should be utilised to the fullest possible extent.

Accepting that within its overall brief it was concerned with the training needs of the disabled, AnCO set up a pilot programme in 1975 which catered for 50 disabled persons at four training centres throughout the country. This project led to a subsequent study and the production of a report on the learning problems of disabled trainees.[45] The study focused on those problems arising from the psychological and social reactions to a disability, loss or lack of confidence and ambition, difficulty in mixing with others and lack of motivation. All the trainees had been assessed as suitable for open employment and the study hoped to ascertain if disabled trainees have problems unique and distinct from those of non-disabled trainees.

The results of the study were interesting. Lack of confidence in relation to their ability to obtain and hold a job was very evident among the disabled. Some of the disabled trainees also seemed to have considerable inter-personal difficulties in mixing with other trainees and showed a lack of social skills generally. In this study the most common disability was psychiatric (17.7%). However, it also included people

[45]AnCO Report, op cit.

who were deaf, blind, amputees, people with injuries of the head and body, people with epilepsy as well as the "educationally subnormal". The vast majority of the disabilities were congenital or had been acquired in youth.

Disablement is often thought of as consisting simply of a physical or mental impairment. In practice, however, it may not be so much the impairment itself as what it produces in the impaired individual's attitude to himself or to society, or added social problems which inhibit his performance. However, this should not necessarily be seen as a justification for continued specialised training services. It seems to emphasise the need for integrated educational facilities where possible and the need for prevocational courses prior to receiving training in an integrated setting.[46] The field of "normal" training provisions as provided by AnCO and their use by handicapped people should be examined further particularly by AnCO themselves, those in the placement service and in community workshops and skill-training centres.

Can the possible lack of social skills which according to the AnCO Report inhibits training be offset only by placing the person within a specialised environment? Is there no other means of gaining social training and compensatory education as well as vocational skills? AnCO acknowledges that there are a number of possible ways in which AnCO could present training opportunities for handicapped persons. Handicapped persons could be—

(1) selected and trained on specially prepared courses in work areas where handicapped persons have traditionally been employed;

(2) form a special group of general intake of trainees on a general type of training programme and be selectively placed in industry;

(3) totally integrated with the able-bodied from the selection stage to final placement.[47]

[46]The provision of prevocational programmes particularly for those who have difficulty in making the transition from a sheltered environment (e.g., a special school for the physically handicapped or deaf) to the training situation could be investigated more thoroughly by Education and Health Authorities.

The third option was chosen by AnCO as the most suitable. Notwithstanding this decision it is reasonable to ask if AnCO has a role in attempting to meet special needs where these present obstacles to participating in the normal training programme?

Is there a need for greater understanding of the disability on the part of the instructors? Does the physical structures of some AnCO centres militate against those with mobility problems?

The Workshop Standards Committee estimated that only the "top 5%—10% of the handicapped could benefit from training under the aegis of AnCO.[48] It would be interesting to know on what basis this figure is arrived at? Is it related to the total numbers referred to the placement service or to those currently receiving training at the specialised training centres? It is wasteful of resources to have duplication at any level of training. This is particularly relevant in the sphere of skilled and semi-skilled training for handicapped persons where there is already a wide range of courses available through AnCO. More investigation is currently needed to assess why the remaining 90—95% are thought to need specialised training and whether existing facilities could not be used to a greater extent by the handicapped rather than the continued development of a parallel structure. This is an area where closer study between the Department of Health, the N.R.B. and AnCO may be necessary. There is also the question of the need for AnCO, the N.R.B. and the Health Boards to create a greater awareness among handicapped people of AnCO's role in the field of training. Lack of knowledge could be influential in the relatively low participation of handicapped people in training centres. In particular there may be a lack of knowledge by handicapped persons about eligibility for this type of training and the procedures involved in gaining access to such courses. While those in contact with the Placement Service have a possibility of being referred to an AnCO centre there are handicapped people who are under-employed and for whom retraining could open up more appropriate and productive opportunities.

4.7.2 *Company-based Training*

This type of training has been on the increase in recent years and has

[47]Information supplied by H. Murdoch, AnCO.
[48]*Workshop Standards Committee*, op. cit., p. 15.

proved to be extremely successful with up to 90% of those being trained in this way being placed in open employment.[49] The procedure is that the Placement Officer arranges the kind of training most suitable to the handicapped persons and the trainee payment is financed either through AnCO or the relevant Health Board.

4.7.3 *Quota Scheme*

In May 1977 the then Government announced the introduction of a Quota Scheme for the employment of disabled persons in the public sector—the target set was a 3% quota to be achieved over a period of 5 years. The Scheme was confirmed by the present Government in December 1977 and an interdepartmental committee was set up to deal with problems arising in the implementation of the Scheme and to monitor progress.

The aim of any Quota Scheme is to secure for the handicapped population their full share, within their capacity, of such employment as is ordinarily available.[50] An employment Quota Scheme is in operation in many Western European countries. There are many criticisms of Quota Schemes—some of which are quite valid. People claim that the idea of handicapped people holding their own on the labour market is inconsistent with a scheme that places obligations on employers to employ such persons.

However, a Quota Scheme properly operated does not try to create employment for disabled people regardless of their capacity to undertake the work required. It is based on the assumption that the disabled person, once in the job, can do it competently. The Quota Scheme helps to ease the way into employment for him. It aims to protect an identifiable group of people who have special employment problems and to provide them with equal employment opportunities.

Apart from giving increased employment opportunities to the handicapped person a Quota Scheme also provides evidence that the government supports the employment of the disabled. It can also be a means of introducing employers to the idea of employing the handicapped and thereby break down preconceived attitudes and prejudices.

[49]*Annual Report and Accounts*, N.R.B. op. cit., p. 9.
[50]Tomlinson Committee (para. 71) in *Quota Scheme for Disabled People*, Consultative Document, Department of Employment, England 1973, p.7.

In effect this aspect of vocational services is not simply concerned with helping people who wish to work but with trying to improve the ability of society to offer employment.

However, there are disadvantages and dangers inherent in the Quota Scheme.[51] It does not always fulfil the function intended and implementation of the scheme presents difficulties. The operation of the Quota System in Great Britain illustrates these difficulties.

Within the Irish context effective operation of the Quota Scheme demands the following;

(1) a practical definition of "disabled person";
(2) existence of effective machinery for registration;
(3) existence of specialised rehabilitation and employment service to assist employers and the handicapped;
(4) system of inspection and enforcement.

The implementation of the Quota Scheme is a difficult task. Many areas will have to be examined closely to ensure that the scheme will genuinely benefit handicapped employees who might otherwise have difficulty securing employment or perhaps be under-employed due to various factors. For example, the Civil Service Commission, Local Authorities and Semi-State bodies will have to review their policies and selection procedures to ensure that these do not discriminate against handicapped applicants. The most obvious of these discriminatory procedures is the question of the health of the applicant. Not quite so apparent but equally important are age restrictions and formal educational qualifications which may discriminate against the handicapped applicant but may not affect his ability to perform the work competently.

There has been little progress evident in the implementation of the Scheme in this country. The inter-departmental committee set up a number of sub-committees—one of which has been examining the establishment of a register of disabled persons suitable for employment under the scheme. To help in preparing such a register the National Rehabilitation Board carried out surveys in some Government departments and State-sponsored bodies to obtain a picture of the types of jobs into which eligible disabled persons could be placed, along

[51]It is important to emphasise that the Quota Scheme is not related to "designated" jobs but to all grades of employment within the public sector.

with job descriptions covering each post or grouping of posts at recruitment level.

Some problems arose in carrying out these surveys because of anxieties expressed by staff members seeking assurances before authorising their union or staff association to agree to the absorption of disabled persons into the staff.[52] With the overcoming of the anxieties and the strengthening of the staff working for the inter-departmental committee it is hoped that greater progress will be made.

Despite this there appears to be little prospect of reaching the deadlines initially envisaged. One might reasonably question the future of the Quota Scheme in Ireland.

4.7.4 *Open Employment and the Mentally Handicapped*

Most mildly mentally handicapped people go into the open employment market. Comprehensive studies on the employment and social adjustment of mildly mentally handicapped adults are few and the evidence on adjustment is far from clear cut. A major problem in considering available studies relates to the fact that almost all are concerned with a relatively short time span after school leaving. The evidence available indicates that the types of jobs obtained are in the majority of cases either semi-skilled or unskilled in nature.

Placement of mildly mentally handicapped school leavers assessed by the youth employment advisers as being suitable for open employment, was in 1977, mainly in the area of manual work at a semi-skilled level—viz, factory work—19.5%; general helper and labouring positions—26%; general domestic work—16%. Apprenticeships were secured by only 4% of the group.[53] This pattern is very much in line with the findings of studies in Britain on the employment patterns of persons who had attended schools for the ESN.[54] It would appear that the vast majority of people who during school years are ascertained as mildly mentally handicapped, make a satisfactory adjustment to work, however, there is evidence to suggest

[52]Department of Labour. June 1979.

[53]*Annual Report and Accounts,* 1977. NRB. p. 10.

[54]Ferguson. T. and Kerr. A. Handicapped Youth—*A report of Handicapped Youth in Glasgow*—Oxford University Press. 1960.Jackson. R. N. "Employment Adjustment of Educable Mentally Handicapped Ex-pupils in Scotland". *American Journal of Mental Deficiency*—Vol. 72. No. 6. May 1968. Richardson. S. A.. "Careers of Mentally Retarded Young Persons: Services. Jobs and Interpersonal Relations". *American Journal of Mental Deficiency, 1978,* Vol. 82. No. 4. pp. 349-58.

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[53] *Annual Report and Accounts,* 1977, NRB, p. 10.

[54] Ferguson, T. and Kerr, A. Handicapped Youth—*A report of Handicapped Youth in Glasgow*—Oxford University Press, 1960.Jackson, R. N. "Employment Adjustment of Educable Mentally Handicapped Ex-pupils in Scotland". *American Journal of Mental Deficiency*—Vol. 72, No. 6, May 1968. Richardson, S. A., "Careers of Mentally Retarded Young Persons: Services, Jobs and Interpersonal Relations". *American Journal of Mental Deficiency, 1978,* Vol. 82, No. 4, pp. 349-58.

that about one-third prove unemployable. The reasons for failure are complex. Study findings vary in the influence accorded to intelligence.[55] However, a number of areas of difficulty have been identified generally associated with the nature of the employment obtained, the attitudes of employers and the social adjustment of the person concerned. Jackson noted that the jobs held by many educable mentally handicapped school leavers in Scotland were impermanent and age restrictive in nature and pointed out that many firms expressed little interest in retaining these young people once they reached adulthood, because it was cheaper to employ the younger school leaver.[56] Thus, the process of adjustment has to be gone through again but under more difficult circumstances.

The generally low level of wages obtained by mildly mentally handicapped people in employment has been repeatedly noted. In one recent study in Britain it emerged that the wage levels of twenty-two year olds who had attended special schools was on average only two-thirds of that of comparison groups matched on age and social background.[57] The low level of wages is partly related to the fact that the jobs and industries which pay the lowest wages accord broadly with the jobs and industries that mentally handicapped people go into; in addition many are in jobs with a low level of union representation, thus, those starting with very low wages continue to get wages below average. Jackson noted the failure of some mildly mentally handicapped school leavers to achieve increased productivity and evidence of lack of adaptive power. This points to the need for training for transferability of skills rather than training for specific skills. In industralised societies, job changes for the general population are more frequent than in the past; in this situation it is unrealistic to suppose that the initial placement after school will necessarily be permanent. Thus, while initial placement is crucial it may be extremely important that placement and advisory services be available on a long-term basis.[58] This need is highlighted when the relatively high unemployment rates for mentally handicapped adults, which have emerged in various

[55]Jackson, R. N., op. cit., Ferguson, T. & Kerr, A. op. cit.
[56]Jackson, R. N., op. cit.
[57]Richardson, S. A., op. cit.
[58]St. Michael's House, Dublin, has appointed an Employment Adviser, part of whose function relates to the ongoing support of mentally handicapped trainees placed in open employment.

studies, are considered—e.g., a recent study in Britain found that unemployment was four times as high for mentally handicapped twenty-two year olds as for a control group of similar age and social background.[59]

The need for adaptability with regard to employment highlights the need for further education for school leavers. It has been noted that many adolescents show gains in ability during their late teens and early twenties so that many of the skills which could not be taught earlier may be able to be taught when this rapid growth occurs. Thus it is suggested that there should be a more continuous educational process encompassing social and vocational aspects for handicapped people.

In conclusion, while there have been no comprehensive follow-up studies of the employment adjustment of mildly mentally handicapped adults in Ireland, a number of factors have consistently emerged in studies of adjustment in Britain. The primary factor is that while the majority of mildly mentally handicapped people make a satisfactory adjustment it is estimated that up to one-third of those identified as mildly mentally handicapped during school years prove unemployable in the open labour market. A number of difficulties have consistently emerged in studies of the adjustment of mentally handicapped adults in the open labour market suggesting that this is an area that needs to be investigated in detail within the Irish situation.

4.7.5 *Attitudinal Barriers to Open Employment:*

The survey on the Handicapped and Impaired in Great Britain found that as many as a quarter of the workers said that they had at some time experienced difficulties getting a job because of their disability.[60] While many of the barriers encountered by handicapped people may be directly related to the disability and the restrictions it may impose on the person's ability to perform the job, social attitudes have a definite part to play in the question of the employability of the handicapped person.

Attitudes on the part of employers are vital and may affect employment opportunities. Attitudes may be favourable or unfavourable, they may differ greatly for visible as opposed to invisible

[59]Richardson, S. A., op. cit.
[60]Buckle, J., *Work and Housing of Impaired Persons in Great Britain,* Part II of Handicapped, and Impaired in Great Britain, op. cit. p. 28/29.

handicaps and may be determined by stereotyped assessment of suitable occupational outlets for different disability groups (e.g., blind telephonists). Attitudes to such a disability as epilepsy consistently emerge as presenting enormous difficulties to employment opportunities[61] "Worse still is the restriction imposed by certain disabilities. I refer in particular to those who suffer from epilepsy. Repeatedly I am asked by Placement Officers what they might do for some epileptic whom they cannot find a place for—what indeed?"[62] It has been found that personnel officers show a clearly practical ranking of the different disability types.[63] The three clear strata that emerged were—the limb or spine crippling disabilities followed by those of sight and hearing and then by the nerve and brain related types. The main advantages of a Quota scheme are the opportunity it affords for the employment of the handicapped person and consequently, the opportunity to break down barriers based on ignorance and prejudice.

There is also the question of the attitudes of the disabled themselves to their employment. The study carried out by AnCO and mentioned previously demonstrated a lower level of confidence among disabled trainees when matched with able-bodied trainees of similar age and educational background. This lack of confidence apparent in this one particular study should not of course be generalised to the occupationally handicapped as a whole, who are a very diverse group. Nevertheless, there is the possibility that for some "segregated or special treatment in their formative years may leave others with hopelessly unrealistic expectations of the business market."[64]

There is a definite role for agencies such as the NRB to become active in the slow process of creating an awareness of the rights, needs and potential contributions of the handicapped person in the employment field. Attitudes may be slow to change, but change is necessary at several levels, by the disabled themselves, by employers, by the work force in general and at the legislative level. Of course in the long run the main inducement for open employment of the handicapped person must be the fact that he has been thoroughly prepared for employment and has the necessary skills and competence to be

[61] Irish Epilepsy Association.

[62] Quilligan, J., op. cit.

[63] Malone, B. "Attitudinal Barriers", paper delivered at UVOH Conference, Limerick 1978.

[64] Malone, B., op. cit.

effective at the job. In this context the importance of adequate and where possible integrated educational and training facilities are paramount.

4.8 RECOMMENDATIONS

A handicapped person has the right to work which will enable him to make the maximum contribution that is possible. To help the person exercise this right vocational rehabilitation services are needed.

Indentification and Standards

To ensure that there is a sound factual basis for the rapid development of vocational services, the identification and assessment of training and employment needs at all levels be undertaken in community care areas as a matter of urgent priority.

Assessment of needs and planning of services be undertaken by each individual Health Board to ensure that needs can be met.

That the Department of Health respond to the Workshop Standards report with regard to their recommendations on;

(1) physical and structural standards of workshops:
(2) training and operating standards;
(3) organisational and operational standards for activation units;
(4) financial considerations in the development of workshops.

Assessment and Placement

That adequate assessment facilities are available to handicapped people regardless of their geographical location and the nature of their handicap. Such facilities should not be confined to those of school leaving age.

That at least one Placement Officer works with each Director of Community Care;

That realistic attempts are made by the N.R.B. to ensure that the special needs of particular handicapped groups are met by the Placement Service.

That the need for vocational assessment and guidance for young people attending special classes be investigated.

Sheltered Employment

That the field of sheltered employment be thoroughly examined in terms of present provisions, the sheltered employment/training ratio,

geographical distribution, most appropriate structure, basis for payment, the involvement of community workshops in long-term employment, integration, and support services needed.

That the sheltered employment needs of mentally handicapped persons, physically handicapped persons and sensorially handicapped persons be investigated in each community care area.

That the operation of the vocational centres for the mentally handicapped be monitored with a view to increasing their provision where necessary.

That the need for similar pre-vocational course be assesed for those who may have difficulty making the transition from, for example, special schools for the physically and sensorially handicapped to ordinary training situations.

Open Employment

That adequate incentives (both financial and in terms of the quality and choice of training facilities) are made available to actively encourage the handicapped person to undergo training and rehabilitation.

That the possible role of AnCO in providing training facilities for the handicapped be reviewed. This is essential in terms of promoting integration and using existing and very costly resources to the maximum.

That more publicity be given to AnCO's current role in training handicaped persons.

That the reasons for the apparent lack of progress in the Quota Scheme announced over two years ago be examined and impetus given for its speedy implementation.

That the long-term adivsory and support needs of the mildly mentally handicapped persons in open employment be investigated.

That the type of support services required to enable the more severely physically handicapped person to work be examined.

That the importance of changing social attitudes to the employment of particular handicapped groups be recognised and appropriate steps taken by such agencies as the N.R.B. and the Health Education Bureau.

CHAPTER 5

COMMUNITY SERVICES

5.1 Introduction

One of the most important developments of the Health Act of 1970 was the delegation of responsibility for the delivery, management and organisation of the Health Services to eight regional Health Boards. Within this new structure a separate programme was introduced to provide for people whose needs could be met within a community rather than a residential setting. Under this "community care" programme it was proposed to develop services which would ensure and maintain a high level of care within the community. One of the hoped for consequences from this programme was to reduce the necessity for people to go into institutions and reduce the length of stay for those who needed this form of care. This restructuring had important implications for the development and delivery of services to the handicapped person.

Many people classified as handicapped will simply need the general Health and Welfare Services available to the community as a whole. However, sections of the handicapped population will need more at particular times and in many cases special provisions will be needed. Such groups may be particularly vulnerable and dependent on an effective community care programme, as well as on the general health services, to meet their special needs.

The main aim of services for handicapped persons should be to enable them to lead as full and productive a life as possible by providing appropriate support and care within the community. This implies a wide range of services and a flexibility in their provision if the individual needs of the handicapped person are to be met.

There are many areas of service which could be examined in this regard. However, an in-depth investigation is difficult as the needs of

handicapped people and their families vary greatly from situation to situation and from one point in time to another. Again the concept of a dynamic flexible enabling structure is more appropriate rather than a specific set of "services for the handicapped" into which people's needs are expected to fall.

The problem of investigating the adequacy of the existing structure is made even more difficult because of the variations both within and between the eight regional Health Boards and because of the varying availability of effective voluntary organisations. Assistance with housing, help in the home, the supply of aids and equipment, the availability of a social work advisory service, even basic medical rehabilitation services, could be generous or virtually non-existent depending on which area the handicapped person lives in.

However the following areas of community services from both voluntary and statutory sources will be examined on a general level with reference to specific handicapped groups where appropriate: appropriate:

(1) Health Services;
(2) Domiciliary Care;
(3) Day Care Services;
(4) Support services—social work; paramedical; family advice;
(5) Aids and appliances;
(6) Housing;
(7) Sexual Needs;
(8) Recreation and Leisure.

5.2 Health Services

Availability of Health Services can be considered under two headings:

(i) Services available without charge to the entire community;
(ii) Services dependent on income.

Services available without charge to the entire community are:
Immunisation;
Diagnostic and treatment services for infectious diseases;
Hospital in-patient and out-patient services for children suffering from certain long-term diseases and disabilities, including mental handicap and certain physical handicaps;

Medicines for persons suffering from certain diseases including mental handicap and certain physical handicaps.

Services dependent on income: as from April 1979, the population is, for the purposes of determining eligibility for the services, divided into three categories:

Category I consists of persons with full eligibility, i.e., persons who, in the opinion of the Chief Executive Officer of the Health Board, are unable to afford general practitioner services for themselves and their dependents. Persons in this category are issued with medical cards for presentation when services are needed and are entitled to the full range of health services without charge. Something less than 40% of the population are in this category.

Category 2 consists of persons other than those in Category 1 whose income in the year ended 5th April, 1979 was less than £5,500, together with persons who, on 5th April, 1979, had eligibility for certain health services, including in particular hospitals services, by virtue of being voluntary contributors under the Social Welfare Acts. Persons in this category are entitled, without charge, to hospital services (both maintenance and treatment) in public wards, to specialist services in out-patient clinics and to maternity and infant welfare services. They are entitled to a refund of part of the cost of prescribed medicines and to a subsidy towards the cost of maintenance in approved private hospitals or homes. Approximately 45% of the population are in this category.

Category 3 consists of persons whose income in the year ended 5th April, 1979 was £5,500 or more. Persons in this category are entitled without charge to hospital services on the same basis as those in Category II except that they are liable to pay hospital consultants' fees. They are also entitled to avail of the refund scheme for prescribed medicines and a subsidy towards the cost of maintenance in approved private hospitals or homes. Something more than 15% of the population are in this category.

5.2.1 *Child Health Services*

Child health services can be considered under two headings viz. Pre-school Services and School Services. A health examination

and treatment service is available without charge;

(1) at clinics, health centres and other prescribed places for children under the age of six years;

(2) for pupils attending a national school (Section 16, 1970 Health Act).

Treatment services include dental, ophthalmic, aural, specialist services and hospital out-patient treatment. Out-patient services are available, without charge, to children, irrespective of parental income;

(a) in respect of diseases and disabilities of a permanent or long-term nature,

(b) in respect of defects noticed at examinations at child health clinics and school medical inspections (Section 56, 1970 Health Act).

With regard to the pre-school services for children, developmental paediatric examinations are confined mainly to centres with 5,000 and over population; this services provides for developmental examinations at 6-10 months, 12-18 months and two years. In 1976, it is estimated that 85% of the children eligible (i.e., born in centres where the developmental clinics are held) had a first examination. The percentage varied from 65% in the Mid-Western Area to 86% in the South-Eastern Health Board Area. In all 24,836 children were examined (Table 5.1). Twenty-two per cent of the children examined at the 6-12 examination, required further attention, as did 20% of those examined at the 12-month stage and 19% of those examined at the 24-month stage. The action taken was either referral to a specialist or a general practitioner or retention under observation (Table 5.2). With regard to the School Health Services for children, the aim is to examine all new entrants and to carry out selective examinations of other children on the basis of identification at a previous inspection or referral by a public health nurse, parent, general practitioner or teacher. In 1976 30% of all national school children were examined and approximately 98% of all new entrants were examined (Table 5.3). Thirty-seven per cent of this group required further attention.

5.2.2 *Public Health Nursing Service*

"The primary aims of home visiting by Public Health Nurses are

the promotion of positive health in each child, the early discovery of defects or other physical, mental, social and emotional problems and the prevention of avoidable physical, mental, social and environmental deprivation."[1] In complying with these aims a wide range of activities are undertaken by Public Health Nurses—these include:—

(i) A nursing service for infants up to six weeks.

(ii) Home visiting of handicapped children.

(iii) With regard to other children:

(a) Those aged 6 weeks to 2 years; home visits and attendance at developmental and child health clinics.

(b) Those aged 2-5 years; developmental paediatric work.

(c) Those aged 5-15 years; school health.

The working party on the *Survey of Workload of the Public Health Nurses* (1975), estimated on the basis of the provision of a comprehensive public health nursing service for all population groups that the total requirement was for 1,152 nurses or on average 1 per 2,616 population (varying for 1 : 2,233 in Leitrim to 1 : 3,014 in Dublin City). In 1978, there were 1,091 Public Health Nurses posts approved by the Department of Health; however, only 1,010 of these positions were filled in June 1978. It is clear from Table 5.4 that the greatest shortfall in the service was in the North Eastern and Southern Health Board Areas.

Table 5.1 Pre-School Child Health Examinations 1976

Numbers examined at Development Paediatric Clinics[a] 1976

6-month Examination	Percentage of eligible children examined[b]	12-month Examination	24-month Examination	Total
15,032	85	5,330	4,474	24,836

[a]These figures do not include those for Dublin. In the case of the Eastern, Midland, Southern and Western Health Board areas the numbers have been estimated.

[b]This refers to children born in centres where developmental clinics are held.

Source: Department of Health.

Table 5.2 **Pre-School Child Health Services: Action taken for children requiring further attention, 1976.**

Action Taken	6-month Examination %	Percentages 12-month Examination %	24-month Examination %
Referred to specialist	29.5	39.7	44.9
Referred to family doctor	12.4	11.3	14.1
Retained under observation	58.1	49.0	41.0
Total	100	100	100
N	3,309	1,059	860

Source: Department of Health.

1. Explanatory memorandum on the Public Health Nurses Home Visiting Card for Pre-School Children. Department of Health, 1978.

Table 5.3 School Health Examination Service 1976[a]

Number of Schools Visited	Percentage of Schools Visited	Number of Children Examined	Percentage of Children Examined	Number of New Entrants Examined[b]	Percentage of New Entrants examined
1,280	43%	102,521	30%	49,116	98.5%

[a]The figures do not include Dublin.
[b]Includes some new entrants from previous year.
Source: Department of Health.

The Public Health Nurses and the Pre-School Child

In 1978, a Public Health Nurses Home-Visiting Card was designed by a Working Party set up by the Department of Health—the card is produced as "an aid to the Public Health Nurses in providing a comprehensive nursing service for each child and as a means of

Table 5.4 Public Health Nurses Employed by Health Boards or in Training (June 1978)

Health Board	Population (1979)	Posts Approved	Posts Filled	Numbers in Training[a]
Eastern	1,163,442	294	291	40
Midland	197,782	74	63	7
Mid-Western	300,645	101	95	9
North Eastern	280,833	104	89	12
North Western	204,035	96	89	11
South Eastern	366,490	136	128	8
Southern	516,016	142	123	13
Western	335,638	144	132	10
Total	3,364,881	1,091	1,010	110

[a]Completion of training by this number of nurses will not necessarily lead to an increase of 110 in the overall complement of nurses; at least some will replace retiring and temporarily employed nurses.
Source: Department of Health, February 1979.

recording the valuable information she collects about the child on a home visit or in any other situation where information becomes available to her."[2] It is recommended that each child should be visited at least six times during the first year of life and in the case of children who appear to be vulnerable more frequently. The recommended timing of visits is as follows;

(1) as soon as possible after the birth is notified

(2) at three months

(3) at five months (in particular for advice on immunisations)

(4) at seven months (if no full paediatric examination is available)

(5) at nine-ten months

(6) at twelve months.

Further visits are recommended at 18 months, two years and three-four years. The Public Health Nursing Service is particularly important in rural areas where the child might not necessarily be seen and assessed

[2]Explanatory Memorandum, op. cit.

by a doctor before he reaches school age. Thus, the Public Health Nurse is one of the key persons or in certain areas may be the key person, from the point of the Community Care Services, in the detection of handicaps during the pre-school period.

The Public Health Nurse and Handicapped Persons

The Working Party on the *Survey of Workload of the Public Health Nurses* recommended that a register of mentally and physically handicapped persons in her district should be maintained by the nurse (Recommendation 5.42). It is probable that at present Public Health Nurses would have a register of all those handicapped persons in receipt of Handicapped Children's Allowance and Disabled Persons Maintenance Allowance. No exact information is available on actual Public Health Nurses contacts with handicapped persons. It appears that the level varies in different areas and depending on the development of other services both voluntary and statutory.

5.2.3 Home Help Service

Under Section 61 of the 1970 Health Act, Health Boards are empowered to make arrangements to assist in the maintenance at home of a number of categories of persons among whom are persons who without home help would be unable to continue living at home—it is probable that certain sections of the handicapped population would come under this provision. The operation of the service varies from area to area and in general is operated by voluntary organisations with grants from the Health Board. The vast majority of people who benefit are aged 65 and over. In 1976, for example, 4,241 people aged 65 and over received help under the scheme while only 856 others received such help.

5.3 Domiciliary Care for Handicapped Persons

Increasingly the emphasis in providing for handicapped people is on living in the community where possible. Given the increasing emphasis on community care it is of the utmost importance that the implications of this concept be clarified. Community care is not simply care outside of residential centres, i.e., care in the community.

Definitions of community are numerous. The Seebohm Report illustrated the difficulties inherent in any definition:

> The term "community" is usually understood to cover both the physical location and the common activity of a group of people. The definition of a community, however, or even a neighbourhood, is increasingly difficult as society becomes more mobile and people belong to "communities" of common interest, influenced by their work, education or social activities, as well as where they live. Thus, although traditionally the idea of a community has rested upon geographical locality, and this remains an important aspect of many communities, today different members of a family may belong to different communities of interest as well as to the same local neighbourhood. The notion of a community implies the existence of a network of reciprocal social relationships, which among other things ensure mutual aid and give those who experience it a sense of wellbeing.[3]

This network of reciprocal social relations was illustrated by Bayley, in his study of adult mentally handicapped people in Sheffield, to be the most relevant level of community for handicapped people living at home and their families.[4] Though generally assumed to exist it is by no means clear that a supportive network actually exists for many handicapped people living within the community, particularly handicapped adults. Thus it is crucial to consider what care services are necessary and in particular how they fit in with existing support networks and encourage the development of such support networks.

Handicapped people, regardless of the type of handicap, have different needs to be met if they are to achieve the goal of community care. The extent of the handicap is a most relevant factor. It is necessary to distinguish between the following categories of physical and sensory handicap when talking of the need for domiciliary care:

(i) The very severely handicapped person—needing special and constant care and dependent on someone else for the performance of everyday activities. The survey of *Handicapped and Impaired in Great Britain* looked at the impaired people's ability to look after themselves as far as their basic needs were

[3]*Report of the Committee on Local Authority and Allied Personal Social Service,* (Seebohm Report), HMSO, 1968, para. 476.

[4]Bayley, M. *Mental Handicap and Community Care,* London, 1973.

concerned. The survey found that groups falling into this general category represented approximately 5% of the handicapped identified.[5] The numbers consequently are very small both in relation to the handicapped population and particularly in relation to the general population.

(ii) Severely handicapped, needing considerable support but able to do quite an amount for themselves. In the survey in Great Britain approximately 12% of the handicapped population fell into this grouping.

(iii) Appreciably handicapped requiring some support in looking after their basic needs, for example, help with one or two items—lifting, bending, areas of dressing. A higher proportion of 20% in the survey in Great Britain could be classified in this category.

(iv) Impaired but needing no support for normal everyday activities. Approximately 62% of the handicapped population in the British survey were classified as being impaired but requiring little or no support.

It is necessary to make a similar distinction with regard to domiciliary care, between the various categories of mental handicap:

(i) Profound Mental Handicap: This category refers to those persons requiring constant care and dependent on someone else for the performance of everyday activities. Physical co-ordination and sensory development are generally impaired and multiple handicap is the rule. The Census of the Mentally Handicapped in 1974 found that there were 1,582 persons in this category, i.e., 14% of the total number of persons who were either moderate, severe or profoundly handicapped; 331 or 22% of profoundly handicapped persons were living at home.

(ii) Severe Mental Handicap: This category refers to those persons who require a great deal of care but are not completely dependent on other people. Severely mentally handicapped people are generally retarded in their physical development and in speech and language; they are often, but not always, multiply

[5]Harris, A. *et al.*, *op. cit.*, pp. 16-18, based on people living in private households.

handicapped. In 1974, there were 3,738 persons in this category or 33% of the total number of persons who were either moderate, severe or profoundly handicapped; 1,278 or 35% of severely handicapped persons were living at home in 1974.

(iii) Moderate Mental Handicap: Many moderately handicapped persons can learn to care for themselves, but at least minimal supervision is necessary in all cases. For children attendance at special school is necessary; many as adults can work in sheltered employment, though some need the services of an occupation centre. Problems with language, both expressive and receptive, are frequent. In 1974 there were 5,936 moderately mentally handicapped persons identified, i.e., 56% of the total number of persons functioning at moderate, severe and profound levels of handicap; 3,254 or 56% of moderately handicapped persons were living at home.

In Ireland the main domiciliary services available to the handicapped person requiring assistance or support are home nursing and the home help services.[6] There are of course allowances for members of a family to look after certain categories of handicapped children and adults. However, we are concerned with direct domiciliary services. The home help service is available primarily for the elderly. There are also very definite limitations in the home help scheme as it exists in terms of meeting the needs of the severely handicapped person. Similarily, the public health nursing service—valuable as it is—is not geared towards providing constant and comprehensive help, often at "unsocial hours", which a severely handicapped person or their families may need. Without an adequate domiciliary service there may be no real alternative for the severely handicapped person, except residential care. Moroney in his study of policies and services for frail, elderly and severely handicapped persons in Britain found that services were more likely to be available when families were unable or unwilling to provide care. Comparable levels of provision were not available to families who wished to continue caring for their handicapped member but who could have benefited from support services.[7]

[6]There are also social work services, occupational therapy and physiotherapy services available. These will be discussed in greater detail in the section on paramedicals.

[7]Moroney, R. M. *The Family and the State, Considerations for Social Policy*, London 1976, p. 87.

More recently in Ireland, Dr. Helen Burke looks at the needs of families who attempt to care for their severely handicapped members at home.[8] She also emphasises the need for social policies to be designed in such a way that they help families care for their dependent members—not just at times of major crisis or when families can no longer carry out their caring functions.

Flexibility must be the key element of such a domiciliary service. It is necessary to investigate the possible types of service needed to fill this need. A totally new concept may well be required and possibly a new category of personnel, rather than simply an extension of existing services.

Experimental schemes which could provide models for this country have been operated successfully elsewhere. Such "attendant" schemes as offered by Fokus in Sweden, the "Aides Soignantes" in France and the Crossroads Care Attendant Scheme in Britain provide examples.

The Crossroads Care Attendant Scheme under the direction of a nursing officer and originally financed by Associated Television recruited a number of employees through normal advertising. They were required to work when necessary during unsocial hours ranging from four to 40 hours a week. During the first two years the scheme operated very successfully and apart from providing relief and regular support for the handicapped it prevented four or five families from breaking up through the strain of coping with a severely disabled person. The helpers have no clinical expertise but are given a certain amount of basic training on how to look after a disabled person. They are in fact combining in many cases the role of the public health nurse and the home help. They can give the care that a relative normally provides either on a temporary or permanent basis. The Crossroads Scheme has published the statistics from its nine operating schemes from April 1978 to 1979. These show that 228 families containing 330 disabled children were helped over that period. A total of over 24,000 hours of care were provided. It is significant that about half of that care was provided at week-ends, bank holidays and between 8 p.m. and 9 p.m.[9]

In this country there is often a reluctance to invest even a small

[8]Burke, H. 'Who cares for the family?—a Social Policy Perspective.' Paper given at centenary congress of the Hospitaller Order of St. John of God Healing Society, Dublin, June 1979.

[9]*Contact,* Liverpool Association for the Disabled. April/May/June 1979, p. 11.

amount of resources to enable a person remain within the community while that person, if hospitalised, will cost the Health Board or Department of Health a considerable amount depending on whether it is a special home, a special centre for mentally handicapped persons, a psychiatric hospital, an orthopaedic hospital, a county hospital or a regional hospital.[10] (Table 5.5).

TABLE 5.5

Costs to Department of Health of Different Forms of Residential Care

		Year ended April 6th 1978
Physically Handicapped	Cheshire Homes (Capitation Rate)	£5.45 per day
	Royal Hospital, Dublin (Capitation Rate)	£10.00 per day
Mentally Handicapped[a]	Special Residential Centres (i) Average cost at beginning 1978 (ii) Range	(i) £2,895 p.a. (ii) £1,184—£4,654
	Psychiatric Hospitals (i) Average at beginning 1978 (ii) Range	(i) £3,648 p.a. (ii) £2,058—£4,485

[a]The difference between costs in psychiatric hospitals and special residential centres can be attributed to some extent, to the higher salaries paid to psychiatric nurses compared with mental handicap trained and general trained nurses, and the higher overheads in mental hospitals. The difference between the costs in various types of special residential centres relates to the range of services provided in centres and the degree of handicap of the persons resident in various centres.

Source: Department of Health.

A much greater flexibility is needed as well as a real attempt to translate the commitment to the ideal of community care into a reality. The numbers involved are possibly quite small in any one community care area. However, the benefits both financially for the state, in terms of relieving intolerable strains on caring relatives and in enabling a person live in a normal community environment could be quite extensive.

[10]*Statistical Information relevant to the Health Services, 1978,* Tables G3, G4, G5, G6, G9.

5.4 Day Care Services

5.4.1 *Day Care for Children*

The Commission of Inquiry on Mental Handicap identified the provision of both nursery units and care units as a key component of the services necessary for mentally handicapped children living at home. It proposed that both be provided in conjunction with schools for the moderately mentally handicapped. Apart from the provision of relief to parents, the functions of a nursery unit for pre-school mentally handicapped children were conceived as supplementing the efforts of the family in providing training and stimulation through the provision of services such as physiotherapy and play therapy and specialised equipment to help in the development of the child.[11] Care units were conceived as a continuation of nursery units and the type of care and training as similar, however, with a greater emphasis on training in such areas as personal hygiene, physical education, simple vocabulary, social training and training in manual skills. Care units were seen as providing a service to severely handicapped children of school age and those moderately handicapped children who could not benefit from formal schooling.[12]

In 1976, there was a total of 614 children under the age of 16 attending various day care facilities for mentally handicapped children (Table 5.6).

TABLE 5.6

Children Aged Under 16 Attending Day Care Facilities 31st December 1976

Degree of Handicap	Mild	Moderate, Severe and Profound	Totals
Type of Centre: Unit attached to Residential Centre	3	76	79
Day Centre	63	472	535
Totals	66	548	614

Source: Statistical Information relevant to the Health Services, Department of Health, 1978, Table F1, p. 29.

[11]*Report of the Commission of Inquiry on Mental Handicap,* op. cit., pp. 63-65.
[12]Ibid, p. 90.

In addition to children attending these centres, a minority of mentally handicapped children functioning at a moderate level of handicap attend pre-schools provided for "ordinary" children. This is highly desirable provided the level of skill of the persons running these schools is adequate to meet the special needs of the children concerned. However, these types of facility are generally privately run and fee-paying and in addition are usually available only in large centres of population.

There are at present 30 centres providing care unit and/or nursery unit facilities; they vary both with regard to the degree of handicap of the children attending and with regard to their age range. Most of the centres are care units providing a service for moderately and severely handicapped children aged from approximately 4 years; the upper age limit varies from 10 to 16 years. Many of the centres provide a nursery unit service, admitting children at the age of 2 years. A few units function specifically as nursery units—the largest of which is Dalymount House, run by the Cork Polio and After Care Association, providing a service for children up to the age of six, functioning at mild, moderate and severe degrees of handicap. The provision of care units is increasing. However, there are still many areas without any provision and provision is inadequate in many others, particularly for children aged 10 and over. Some indication of the need is evident from the fact that of the 835 severely handicapped persons aged 0-19 in 1974, 41% were not attending day centres; the corresponding figure for the 244 profoundly handicapped persons in the same age group was 64%.[13]

The Commission of Inquiry on Mental Handicap suggested that it would not be feasible to provide care units outside large centres of population. However, the developments to date demonstrate that the provision of a range of small units is feasible in some areas. For example, in Galway—five care units have been provided, one in Galway city catering for 20 children, while four others, one each in Portumna, Tuam, An Ceathru Rua and Glenamaddy provide a service for 10 children each. In contrast in Co. Kildare, through extensive transport arrangements, children throughout the whole county attend one relatively large unit.

With regard to future provision of care units and in investigating the feasibility of provision in various areas in terms of numbers and location

[13]For planned provision see Apendix V.

the Director of Community Care and Directors of Mental Handicap Services, where available, are the key co-ordinating persons within each area; in addition Diagnostic Assessment and Advisory Services and any other support services for the handicapped, could play a vital part in indicating need. In sparsely populated areas the feasibility of providing services to meet the needs of groups with various handicapping conditions needs to be investigated.

5.4.2 *Day-Care facilities for Adults*

A day centre provides training, occupation and social activities for sections of the population. It can be particularly effective in catering for severely handicapped or older handicapped persons who are unemployed but who can carry out in some measure a productive task and can achieve a measure of social resourcefulness that will enable them to live in a normal environment.

The main tasks of a day care centre in relation to the handicapped are:

(i) to provide work to suit the residual capacity of the handicapped person;

(ii) to provide training in hobbies for the handicapped person's social development;

(iii) to provide training in social competence, self-care, mobility and communication skills;

(iv) to prevent boredom and isolation for the handicapped person;

(v) to provide relief for families.

The provision of adequate day-care facilities is a very necessary prerequisite to the development of an effective community care system for severely handicapped persons (both young and old) and their families. The recommendations of the Robins Report limit participation in sheltered employment to people capable of achieving a certain level of output. This will result in many handicapped people having no occupational outlets whatsoever and little prospect of participating in a normal environment outside the home. The strains imposed on caring relatives can also be very great and the provision of day care facilities may provide the necessary relief.

5.4.3 *Day-Care Facilities for Physically Handicapped Adults*

The study of members of the Irish Wheelchair Association showed that almost 60% of the members were not employed in any capacity whatsoever. Less than 4% were engaged in sheltered work/day care centres of any kind.[14]

The Workshops Standards Committee of the National Rehabilitation Board also note the absence of facilities for those people who cannot undergo intensive training or whose level of production is too low to "justify the allocation of a place in a sheltered or community workshop."[15] Nonetheless they recognise the acute need for work or for some form of occupational activity and emphasise that Health Boards are the bodies responsible for this aspect of rehabilitation services. For some participants it may be the beginning of a gradual process through the various stages of rehabilitation. Even for those who will never achieve this level, such centres would provide a form of activity which in itself can be therapeutic. The Workshops Standards Committee recommends that such centres:

(a) provide a mix of work activities;

(b) provide assessment to ensure that persons with the potential for training activation or sheltered employment be referred on;

(c) establish a close liaison if possible with a local activation unit, community workshop or training centre.

Day Care Provision It is a very difficult task to provide adequate day care facilities. It is important that such centres are well organised and competently run. Well run centres may fill more than a purely social function. Generally professional expertise is essential for this. The difficulties in obtaining Occupational Therapists, the problem of organising transport (in both rural and urban areas) and the extensive resources which have to be allocated, have meant in effect that progress in this field has been slow in many areas and virtually non-existent in others over the past years.

Some voluntary organisations,[16] and Health Boards nonetheless are

[14]Faughnan, P. *Dimensions of Need*, op. cit., pp. 35-6.
[15]Workshop Standards Report, op. cit., p. 71.
[16]The voluntary organisations may be specialist ones—for example, the National League for the Blind have a day centre catering for 23 blind and partially sighted people in Dublin—or they may be generic catering for a local community.

actively involved in the field. In the Eastern Health Board area, for example, there are 30 day-care centres for the elderly. These are heavily subvented by the Board. There are handicapped people, many of them young, participating in these centres. In the Eastern Health Board region there are two day-care centres being planned particularly for the physically handicapped. One of these is in Fenian Street which has an Occupational Therapist employed and is run by a committee composed of Health Board personnel and voluntary bodies. It will be funded 95% by the Eastern Health Board and when fully operative should cater for up to 30 handicapped people. The other project will be run by the Polio Fellowship in Park House. The numbers catered for will start at 20 and work up to 40. This will also be heavily subvented by the Eastern Health Board.

The absence of adequate statistical information on the numbers of handicapped, their distribution and social situation is limiting the Eastern Health Board in planning to meet needs. Indeed the absence of adequate information on the possible take up of day-care facilities, on the areas such centres should serve, on the type of resources—both financial and personnel—needed to run them, makes long-term planning for this area of service very difficult for Health Boards and voluntary organisations. It is possible that some handicapped people could avail of day-care facilities provided within the local community by voluntary organisations. Data must become available on physically and sensorially handicapped people and on their needs in each community care area to facilitate planning in this sphere.

5.4.4 *Occupational Centres for Mentally Handicapped Adults*

The Robins Report proposed that Occupational Centres should be provided for those mentally handicapped persons, who would not be able to go into open employment or engage usefully in sheltered employment. As is the case with Activation Units, these centres are available on a day basis, either in association with residential services or under the auspices of organisations providing day services. They are generally referred to as Adult Day-Care facilities. In 1976, there were 161 persons over the age of 16, attending day-care centres—23 were attending centres attached to residential services and 138 attending special day centres. Since then the provision has increased slightly. However, there is still a major shortfall in provision, particularly outside

the Dublin area.[17] The extent of the need is evident when the findings of 1974 Census of Mentally Handicapped[18] people are considered: in that year there were 470 severely mentally handicapped persons and 111 profoundly handicapped persons aged 20 and over living outside of residential care; 87% of the former group and 92% of the latter group were not attending day centres. Many of these persons are likely to have severe physical handicaps or severe behavioural disorders,[19] thus, intensifying the difficulty of providing day services. It is clear that the majority of these adults are or will be in need of long-term residential care; yet the fact is that at present this is the group for whom such facilities are in shortest supply. Thus the problem of meeting their needs in community settings must in the short-term be regarded as a priority. Detailed evidence on the real needs of adult mentally handicapped persons living in the community is not available in Ireland.[20] While it is not clear that day-care facilities are in all cases the crucial need for all severely mentally handicapped persons,[21] one British study, has highlighted the fact that assistance to families needs to be reliable, regular and punctual and found that one of the services that met these needs relatively successfully was the Adult Training Centre.[22]

There are major difficulties associated with the provisions of Adult Day Care outside the large centres of population, because of the relatively small numbers involved and the difficulties associated with transport provision for adults with severe handicaps (Table 5.7).

If the focus is changed from particular handicapping conditions to all handicapping conditions, the provision of day-care units is obviously more feasible in smaller centres of population. While it is recognised that there may be objections to the integration of different groups of severely handicapped persons, it may be feasible to use Day-Care facilities on different days for different groups or use different

[17] At present there are approximately 160 places available in the Dublin area, 10 in Kildare and 15 in Kiltimagh, Co. Mayo. For planned provision see Appendix V.

[18] Mulcahy, M. *Census of the Mentally Handicapped in the Republic of Ireland, 1974, Non-Residential.* Dublin, MSRB, 1974.

[19] Ibid, pp. 24-25.

[20] A pilot study undertaken in one Dublin Community Care Area in 1979 should provide such evidence.

[21] There is some evidence that parents of adult severely mentally handicapped persons, who have not had services as children, are reluctant to accept day-care services. However, with the development of services for children the percentage of people in this category will decrease.

[22] Bayley, M. op. cit.

Table 5.7 **Distribution of Persons, Aged 20 and Over, Living at Home, and Functioning at Severe and Profound Levels of Mental Handicap by Health Board—1974.**

Eastern Health Board	Midlands Health Board	North Eastern Health Board	Western Health Board	Southern Health Board	Mid-Western Health Board	South Eastern Health Board	North Western Health Board
81	62	45	104	87	45	98	59

Source: Derived from Mulcahy, M., and Ennis, B., op. cit.

sections of a particular unit for different groups. While most of the evidence to date on day-care facilities relates to those provided for children, one key factor that emerges with regard to their success, i.e., in terms of family support, is flexibility in operation. As was illustrated in Bayley's study a key need for families was practical help related to their everyday needs. Thus, the needs of particular adults and their families with regard to day-care may be for use of such units for one day a week ranging to five days a week. It is essential that the need for day-care facilities either on a full or part-time basis, as part of a range of services necessary for severely handicapped adults, be investigated in each Community Care Area.

5.5 Advice and Support Services

5.5.1 *Family Advice and Support for Physically Handicapped Persons*

Services for the handicapped person are complex in their operation. Some are part of the general health and welfare services, others are specialised services; some are part of the community care programme, others part of the special or general hospitals programme; some are means tested, others are not; some are available from voluntary organisations, others from many statutory sources. Often the handicapped person or caring relatives may be unaware of benefits or services to which he is entitled or unsure of how to get them. It is doubtful if the fragmentary nature of the services can ever be overcome completely due to the complexity and diversity of the problems encompassed within handicapping conditions. Nevertheless, there is

need for better information and more support particularly for the parents of handicapped children. Often these services are provided by voluntary organisations or are available at diagnostic centres. However, this depends on the disability and the level of services available in particular geographical areas. "There is much stress on the parents of the deaf, blind and physically handicapped infant and there is a 'crying out' for help and counselling by the parents".[23]

The North Western Health Board has recognised the need for their direct participation in this regard. They are concerned that an adequate counselling service be made available to all the parents of handicapped children. They hope to recruit two teams consisting of a social worker and a public health nurse who would be specially trained and equipped to provide counselling. This service would be available in each community care area.

As part of its programme to meet the needs of the handicapped person, the North Western Health Board also intends to develop in the near future a number of resource centres throughout their area. These centres would incorporate information on services and entitlements, library or relevant literature on handicapping conditions, a toy library, supplies for the handicapped child, a child-minding service and an aids centre. The latter would not only display aids of various kinds, but would also supply information on the range available and have the facilities whereby people could be assessed in terms of the appropriateness of particular pieces of equipment. The idea is very simple but the advantages to the handicapped person and the caring relative are extensive. Pulling together into one centre a range of previously diffuse facilities and services often difficult and complex to obtain, provides a focal point and a ready source of reference.

These two proposed initiatives could well be adopted by other Health Boards.

5.5.2 *Family Advice and Support Services for Mentally Handicapped Persons*

The purpose of early identification of handicapping or potentially handicapping conditions is the provision of appropriate assistance to children so identified and to their families at the optimal times for the development of motor, sensory, intellectual and emotional functioning.

[23]*Annual Report and Accounts*, 1977, NRB p. 8.

An essential part of this assistance is an assessment of functional level and the provision of information, practical advice on management and counselling to parents.

The present administrative arrangements are that there are eleven diagnostic, assessment and advisory services, under the auspices of voluntary bodies providing a range of other services for mentally handicapped persons.[24] These correspond broadly with the general teams as envisaged by the Commission of Inquiry. Referrals to these services are made either directly by Directors of Community Care or through Directors of Community Care by general practitioners, public health nurses, parents, school medical officers or teachers. It is repeatedly stressed by personnel involved in these services that referrals are made too late.

The basic team in Diagnostic, Assessment and Advisory services consists of a psychologist, a psychiatrist and a social worker. In the case of moderate, severe and profoundly handicapped children, contact once initiated is generally long-term, with the team in some areas assuming responsibility for the provision of ongoing advice and support services. Apart from the basic team, some services have available other specialists such as physiotherapists and speech therapists; however, the number of these specialists available is far short of the number necessary to meet needs. Apart from the accepted role of the physiotherapist in the case of children with physical handicaps, it is now widely accepted that a physiotherapist has a major contribution to make in the early stimulation of the majority of moderately and severely handicapped children, especially Downs Syndrome children, and in the provision of practical advice to parents. Speech and language difficulties are extremely common in the case of mentally handicapped persons, thus the speech therapist has a vital role to play; however, this type of service is extremely limited.

The level of ongoing support to families from assessment and advisory services varies depending not only on the needs of the family and the level of support available—e.g., through day-care facilities or schools and from public health nurses and social workers employed by Health Boards, but also depending on location. In some areas the service available is confined to assessment and the advice and support

[24]See section on Diagnostic Assessment and Advisory Services, pp. 65-66 and Appendix VC.

which accompanies this, while in others there is a major ongoing involvement of social workers and psychologists. In general the level of ongoing support tends to vary depending on the proximity of the service to the area served. It also varies depending on whether a relatively clearly defined responsibility is allocated to a particular service by the Director of Community Care concerned, for meeting the advisory and support service needs of handicapped persons, or whether the Diagnostic Assessment and Advisory service is viewed mainly in the role of assessment service. It is clear that while the overall responsibility for the provision of services rests with the Director of Community Care the roles of the various agencies and personnel involved need to be clearly defined to ensure that the needs of particular individuals or groups will not be overlooked.

Adults While advice and support services for children are in general improving, the provision of family advice and support services to adults, particularly older adults, has received little attention. Many adults living at home have had little contact with special services—almost 98% of those aged over 30 in 1974 and identified as moderately, severely and profoundly handicapped, had never had a psychological assessment. Over half of the moderately handicapped were not employed in any way and the vast majority of the severe and profoundly handicapped were not attending any services.[25] The level of support that public health nurses are in a position to provide may be adequate in many cases; however, this is not known at present. The support service needs of this group should be identified by a joint approach between Directors of Community Care, public health nurses and diagnostic, assessment and advisory service personnel.

5.5.3 *Named Person*

In considering the provision of an effective co-ordinated service to handicapped persons and their families the idea of designating a "Named Person" in each case has much to recommend it. Apart from the provision of a point of contact for the parents of every child or adult discovered to have a handicap or potentially handicapping condition this person would have a clearly stated responsibility to ensure that recommendations were followed up, that difficulties in implementation

[25]Mulcahy, M., op. cit., p. 14, p. 17.

were highlighted and that there was a co-ordinated approach to the particular family's needs. This idea has proved effective in the Honeylands Family Support Service in Essex[26] and has been adopted in its recommendations by the Warnock Committee.[27] This type of role is in some cases fulfilled on an informal basis by social workers and public health nurses. What is being suggested is that in the case of every handicapped person some one person should be allocated this role on a formal basis. In very many cases the public health nurse would be the ideal person to adopt this role. However, social workers, teachers, psychologists and doctors could also fulfil this role.

5.5.4 *Other support services*

Apart from the direct personal contact between parents and various professionals, other methods of delivery of information, advice and emotional support to parents can play a major role. Parent meetings are increasingly being organised in various parts of the country, usually under the auspices of diagnostic, assessment and advisory clinics in co-operation with the Community Care team. Evidence from Britain suggests that these types of groups can be very successful, both for the dissemination of information and the provision of emotional support.[28]

Toy Library Service The purpose of this service is to make available suitable educational toys on loan. Professional advice on selection and suitability is generally available. These services are frequently run in association with diagnostic, assessment and advisory services and are associated with the Toy Library Association in Britain.

Early Stimulation Programmes Health Boards and diagnostic, assessment and advisory services are now involved in the development of programmes. Pilot programmes in selected Community Care areas are being undertaken with the support of the Department of Health.

[26]Brimblecombe, F. "Honeylands—A project for handicapped children", *Action Magazine*, Sept. 1976, pp. 16-21.

[27]Warnock Report, op. cit.

[28]Jeffree, D. M., Mc. Conkey, R & Hewson, S "Parental Participation is essential: The Parental Involvement Project", *Apex* 1975, Vol. 3, No. 3, pp. 20-22; Mc. Conkey, R & Jeffree, D.M., "Partnership with parents", *Special Education: Forward Trends*, 1975, Vol. 2, No. 3, pp. 13-15.

5.6 Social Work and Paramedical Services for the Handicapped Person

5.6.1 *Structure of social work*

The restructuring of the Health Services provided for the development of a generic social work service available to members of the community. Apart from these community based social workers, there are also psychiatric and medical social workers employed by the Health Boards and hospitals and a wide range of voluntary organisations offering specialised social work services to particular minority groups. The whole picture of social work provision in Ireland at present is a very complex one.

Health Boards differ greatly in the development of their community care programmes in general and in the level of their social work service. Table 5.8 shows the numbers of social workers employed by the Health Boards. The level of service available to the handicapped population in the community direct from statutory social workers is very low or virtually non-existent—with some notable exceptions in particular Health Board areas. Handicapped people in short-term hospital care would frequently have the hospital social work service available to them. However, provision on the community front is less adequate.

At present whether a social work service is available to the handicapped person in Ireland depends on:

(a) type of disability and extent to which a voluntary organisation catering for that group provides a social work service to the handicapped person;

(b) geographical location of the person and the availability of a social work service from both statutory and voluntary sources in the area.

The various handicapped groups are often seen as requiring specialised assistance. Many voluntary organisations in the field of mental handicap, physical handicap, the deaf and the blind have employed their own social workers to provide basic services to their members. Some Health Boards subvent social workers employed by particular agencies; other agencies receive no subvention for provision of social work services to handicapped groups.

Table 5.8 Number of Social Workers employed by individual Health Boards, 1978

Region	No. of Social Workers	Population (1979)
Eastern	85	1,163,442
Midland	12	197,782
Mid-Western	13	300,645
North Eastern	9	280,833
North Western	24	204,035
South Eastern	13	366,490
Southern	31	516,016
Western	34	335,638
Total	221	3,364,881

Source: Department of Health.

The situation varies greatly from Health Board to Health Board and from one handicapped group to another, (See Table 5.9).

5.6.2 *Role of Social Worker*

While there may be a need among handicapped people for help in coping with the psychological, emotional and practical problems resulting from the disability, often the need is simply for practical advice and assistance in obtaining benefits or services to which the person may be entitled. The role of the social worker in relation to the handicapped person in the community could be classified under the following areas:

(i) To support and help the person accept his disability, live within his limitations and encourage him towards independence.

(ii) To try and help the person cope with any social or financial problems.

(iii) To co-operate with other members of the rehabilitation team and to pass on information which may be significant to the person's progress.

(iv) To liaise with community services both statutory and voluntary to ensure continuity of care.

Some of these functions could be undertaken by the generic social worker.

TABLE 5.9

Examples of Specialised Social Work Services

Disability	Agency	No. and Area	Supports
Blind	National Council for Blind	Employs 39 "social workers" throughout the country[a]	Health Boards pay from 40%-50% of the salary. Variations between Health Boards
Deaf	National Association for Deaf	Two social workers based in Eastern area	80% subvention from Eastern Health Board.
Spina Bifida	Spina Bifida	One social worker providing a national service	Employed by the NRB
Wheelchair-bound	Irish Wheelchair Association	Eight social workers serving regional Health Board areas	Extensive variations in levels of overall support from different Health Boards—generally no direct subvention for social workers.
Mental Handicap	Diagnostic, Assessment and Advisory Services; Residential Centres	Forty social workers operating jointly as members of Diagnostic, Assessment and Advisory teams and also in the provision of a service to persons in residential or day services. Eight social workers are attached solely to special residential centres and day services.	Salaries paid from general funding services by Department of Health. Sessional arrangements with Health Boards in the case of Diagnostic, Assessment and Advisory Services.

[a]Some of these social workers in recent years are obtaining basic social work training.

5.6.3 *Generic or Specialised Social Work Services?*

A study undertaken in England is very relevant to the debate on the need for specialist social workers for handicapped groups. A working party established by the CCETSW examined the question of training for social work with handicapped people.[29] It points out that it is often taken for granted that a high degree of specialisation in the provision of services is required if the special needs of the handicapped person are to be met. However, it claims that the necessary knowledge and expertise can be made available without establishing a specialised service providing that workers are adequately trained. The working party emphasises that the provision of services specifically for the handicapped tends to isolate them from other people and may deny them equal opportunity. It is suggested by them that the range and nature of skills required by social workers interested in working with the handicapped person are essentially the same as those needed in working with any client in any setting. It is clear though that all social workers need to have knowledge of handicap, chronic disablement and rehabilitation over and above what they have been generally taught about health and diseases. For instance, knowledge about impairments, the difference between static, remediable and progressive disorders, characteristics of the various handicaps and their implications, remedial and therapeutic measures and the uses and limitations of rehabilitation, are vital elements in providing a social work service to those with special needs.

The working party identified different categories of people with handicaps who would have different requirements in terms of the social work expertise required:

Group		The implications for social work expertise suggested by the working party are:
A	All handicapped without "special" needs but requiring social workers to be alert to the part played by handicap in the presenting problem;	Could be helped by any basic grade social worker who must therefore acquire at least some degree of knowledge about the disabled and their handicap in order to be able to assess the situation and needs correctly;
B	Handicapped with "special" needs arising from nature/consequences and developmental stage of handicap;	Social workers would be required to have some expertise in helping the handicapped person. The following would fall into this category: the blind, the deaf with speech, those with spina bifida or cerebral palsy, the mentally retarded, those with epilepsy. Such workers require opportunities for the acquisition of additional skills in order to meet "special" needs;
C	Severely handicapped with "extra" needs (e.g., profoundly deaf, or severely subnormal*).	The handicapped who, because of their disability are likely to require assistance of an expert nature including special technical skills. This group would include the prelingually profoundly deaf, severely mentally retarded, the multiply handicapped. Social workers would need considerable time and experience as well as expert teaching to acquire specific skills, some of them technical.

*Equivalent to moderate and severe mental handicap classifications in this country.

[29] "People with handicaps need better trained workers." *Report of a Working Party on Training for Social Work with handicap people* CCETSW, 1974.

The field of social work provision is a vital one to examine closely at present in view of the developing statutory service. The handicapped group can be particularly vulnerable. Apart from problems associated with the disability, mobility or communication problems[30] can make it particularly difficult to use the normal channels and general community services. There is at present no accepted policy among the Health Boards as to the way the social work needs of the handicapped person may be best met. Some Health Boards aspire to provide the service

[30] For example, there is virtually no social work service available to the profoundly deaf outside the Dublin area as generic social workers have not got the communication techniques.

themselves[31]; others assist voluntary bodies to provide it to particular groups; yet others have made no arrangements to date.

The development of a framework for a comprehensive social work service for the handicapped person with provision for the various levels of specialisation needs to be examined jointly by the relevant statutory and voluntary agencies.

5.6.4 *Social Work and Mental Handicap*

Social workers in mental handicap services are employed either as members of a diagnostic assessment and advisory team and/or attached to other services such as residential services and special schools—residential or day.

Social workers employed in diagnostic, assessment and advisory services operate as part of a team, also consisting of a psychologist and psychiatrist, in initial and ongoing assessment. In addition in some areas they provide a casework service and an advisory and support service with regard to implementation of programmes agreed at assessment. As has been pointed out the degree of involvement varies depending on a number of factors.[32] The level of handicap of the persons to whom they provide a service also varies: In the case of mild mental handicap some agencies, particularly those that are not involved in the provision of educational services for mildly mentally handicapped persons, have a policy of referring mildly mentally handicapped persons, where necessary, to Health Board social workers. In contrast those agencies involved in the provision of educational facilities for mildly handicapped children are likely to provide a service to those groups.

With regard to persons functioning at moderate, severe and profound levels of mental handicap, a specialised social work service is being offered in many areas and a number of agencies have built up considerable expertise. However, access to such a service is dependent on referral to a diagnostic, assessment and advisory service and then on the role of that service within the area in which one lives. Clearly many handicapped persons with special needs and their families are not getting a service.

[31]The North Western Health Board is committed to the ideal of a basic community social work service to all who need it and the development of its service tends to reflect this.

[32]See section on Family Advice and Support Services for Mentally Handicapped Persons. pp. 149-151.

5.6.5 *Sexual Needs of the Disabled Person*

The past decade or two has witnessed considerable changes in social attitudes towards disabled people. Over the same period a marked change has also taken place in society's outlook on sexual matters. There is now a more open consideration and discussion of sex and sexual relationships. This more open treatment has not always extended to the disabled person. The area of sexual rights, sexual needs and problems confronting the disabled person is still very much a taboo subject. This applies to both the physically and the mentally handicapped person and the individual problems they encounter.

In relation to the more severely handicapped person there is often a tacit assumption that sexual needs become less important to the individual as disability develops.[33] This attitude is reflected not only in the general population but frequently among those working with the handicapped person—doctors, paramedics, staff in residential care and social workers.

In 1973 a Committee was formed in Britain to study and advise on sexual problems of disabled people in the community (SPOD). This committee undertook a project to investigate the nature and extent of sexual problems among physically disabled people. The study found that;

> sexual problems and hence sexual deprivation are widespread among physically disabled people, considerably more so than in the community at large. Such difficulties are in part an exacerbation of the problems which might affect any man or woman, but in major part stem uniquely from the circumstances of physical disability[34]

The study emphasised that sexual problems are associated with particular disorders rather than caused by them. However, it noted that the considerable majority of respondents[35] subject to a wide range of disorders such as paraplegia/hemiplegia, coronary disorders, high blood pressure, bronchitis, disorders of the stomach, hernia, osteo-arthritis, muscular dystrophy, multiple sclerosis, cerebral haemorrhage, were also subject to sexual problems.

[33]Stewart, W. *Sex and the Physically Handicapped*, Sussex. 1975, p. 1.

[34]Ibid, p. 66.

[35]The actual numbers in the survey are quite small. The full population was only 212, ibid., p. 7-10.

In Ireland, a seminar was held in Dublin in March 1978 on the sexual problems of the disabled in association with SPOD England. A SPOD (Ireland) resource group was established to provide advice and counselling for disabled people and their partners. Their specific aims are;

(1) to arrange for an advice and counselling service for the disabled;

(2) to provide information for the disabled themselves, the general public and those concerned with the welfare of the disabled;

(3) to organise training of workers in the field of disability on aspects of disablement relating to sexual functioning.[36]

This SPOD group uses existing resources—doctors, marriage counsellors, social workers—who are willing to act as advisers and counsellors. It also provides information, organises lectures, seminars and training courses on the subject.

There is a need for such a counselling and information service in this country. Stewart in talking about the British situation pointed out;

> many disabled people could derive benefit from and desire advice or counsel in sexual aspects of their lives. It is equally evident that resources for this are slight in extent, largely unknown to the people concerned . . . without doubt the best source of counsel and advice for the disabled person as well as the one who has most opportunity for early action is the professional worker with whom he will be in contact, the surgeon, physician, paramedical or social worker or the person responsible for his or her resident care.[37]

In Ireland such advice and information is not always available. In relation to paraplegics Suzanne Quinn[38] in her study found;

> that there is every indication from my research that it is inhibitions on the part of professional staff rather than on the part of the paraplegics that prevents more open discussion of an aspect of paraplegia which in this country is more or less taboo at present.

[36]SPOD (Ireland) c/o UVOH offices, 72, Northumberland Rd., Dublin 4.

[37]Stewart, W., op. cit., p. 72/75.

[38]Quinn, S. *Paraplegia—its consequences and implications for social work practice,* unpublished thesis, Dublin, 1976, p. 38.

In the case of physical disability it is desirable that the implications of disability for sexual functioning be discussed with people during their normal rehabilitative treatment in hospitals and rehabilitation centres.

In fact in relation to sexual functioning and handicap in general the recommendations of the British report are equally applicable to Ireland. It emphasises very strongly the need for bodies involved in the training of medical and paramedical personnel and those in the educational, social work and residential care professions to pay particular attention to this aspect as part of their basic training and to focus on the acquisition of methods of help and counsel.[39]

5.6.6 *Rehabilitation Personnel*

Adequate rehabilitation services rely on co-operative multi-disciplinary effort because of the varied and complicated nature of the problems. Rehabilitation is concerned not only with restoration but resettlement and continuing care.

Occupational Therapists, Speech Therapists and Physiotherapists have all a vital contribution to make in this process. However, these specialists are in very short supply in this country. Table 5.10 shows the distribution of those employed by Health Boards and Voluntary Hospitals throughout the various Health Board areas.

This table illustrates firstly, the wide differences in availability of such specialists in the different Health Board areas and secondly the considerable discrepancies between the number of specific posts approved and the number actually filled. On an overall basis there are considerably more posts approved than filled. This is particularly true in the case of occupational therapists.[40]

Apart from personnel attached to hospitals, assessment centres and rehabilitation units, there is also an increasing demand for domiciliary based services such as Occupational Therapy. This is a very important aspect in an adequate community care programme. Adequate follow-up and support could be a determining factor in helping to maintain a handicapped person within their own home—helping the person become more independent whether in activities of daily living, through

[39]Stewart, W., op. cit., p. 84.

[40]From its inception in 1973 to 1977 the Dublin College of Occupational Therapy trained 237 occupational therapists. From its inception in 1969 to 1977 the Dublin College of Speech Therapy trained 67 speech therapists.

the provision of equipment or the modification of the home environment.[41] Some Health Boards have such specialists working in the community as well as in institutions. However, there will be increasing demand as the reality of care in the community develops.

TABLE 5.10

Paramedicals employed by Health Boards and Voluntary Hospitals (June 1978)

Health Board	Population (1979)	Occupational Therapists Posts Approved	Occupational Therapists Posts Filled	Speech Therapists Posts Approved	Speech Therapists Posts Filled	Physiotherapists Posts Approved	Physiotherapists Posts Filled
Eastern	1,163,442	18	17	10	10	16	21
Midland	197,782	11	7	6	4	16	12
Mid-Western	300,645	8	4	5	5	13	13
North Eastern	280,833	10	7	7	7	14	10
North Western	204,035	14	12	6	6	17	14
South Eastern	366,490	5	—	8	8	18	20
Southern	516,016	16	12	4	2	30	28
Western	335,638	22	4	10	3	44	23
	3,364,881	104	63	56	45	168	141
Voluntary Hospitals		39	32	20	17	170	188
Total		143	95	76	62	338	329

Source: Department of Health.

There is the fear that with the shortage of staff the opening up of additional posts in the community sector will deplete the numbers available within hospitals and institutions.

[41]This service is available to some physically handicapped people through voluntary organisations—for example, the Irish Wheelchair Association has eight domiciliary occupational therapists based in Health Board areas serving the wheelchair-bound. The Irish Association for Spina Bifida and Hydrocephalus initiated domiciliary physiotherapy for its members.

5.6.7 *Aids and Appliances*

The provision of aids, appliances and equipment is an essential part of rehabilitation. Such items are designed to compensate for loss of function and thereby foster greater independence or simply make it easier for a caring relative to cope. They can range from very simple modifications of commonplace articles to complex, costly and specially designed equipment.

Adequate assessment of the degree of handicap and of the handicapped person's situation is essential to ensure that the aid will fulfil a need and be suited to the person for whom it is prescribed. It is also important that the person be taught how to use the aid. For example, social workers in the National Association for the Deaf are very anxious that a follow-up service be available to the elderly deaf who have been fitted with hearing aids. Such a service they feel could help overcome the problem which frequently ends in terminating their use. In this country assessment for aids and appliances is done by various agencies and people ranging from the public health nurse to the limb-fitting centre in the National Medical Rehabilitation Centre.

Provision of aids, appliances and equipment throughout the country is difficult to assess on a general level. There are huge variations between health boards in their responsiveness to supplying recommended aids and in their administration of such a service. In many areas there are lengthy delays, some caused by the bureaucratic structure, others by difficulties at the level of the suppliers. In some areas the situation is chronic with long delays and difficulties in securing most basic and essential aids to mobility.[42] The availability of aids is something which must be examined very closely in each Health Board area and a better system of assessment and supply inaugurated for the different handicapped groups who are dependent on such appliances for a fuller life.

The proposal of the North Western Health Board to establish a number of resource centres for the handicapped which would supply an information and assessment service on aids and also serve as a depot for supplies and equipment is a positive attempt to meet needs at a local level and in a manner which could speed up a rather lengthy process.

[42]Reports from the Irish Wheelchair Association point to extreme variations between areas with chronic delays in providing wheelchairs in some regions.

5.7 Housing

Housing presents many problems in modern society. To obtain adequate housing at a price or rent one can afford presents difficulties for many families. The handicapped person encounters the same situation, and frequently on a lower income than the rest of the population. However, he may face even greater difficulties. Frequently for the handicapped person it is not just a question of adequate shelter but of housing which is physically suited to his special needs; housing which may need to incorporate provision for special help to make living in the community possible or housing which can help offset the danger of isolation which a disability could carry with it.

People who are physically, mentally or sensorially handicapped frequently have special housing needs. This does not necessarily mean that they all need special housing. A large proportion of the population who are handicapped simply need ordinary housing which is convenient to live in with possibly small modifications. A small proportion of disabled people do have a real need for special housing. These are generally people who have severe mobility problems or who require constant care and attention. Suitable housing may be one of the environmental factors which will determine how handicapped a physically disabled person is. This is particularly relevant with regard to the disabled housewife and mother.

5.7.1 *House adaptation*

The Disabled Person's grant scheme was introduced early in 1972. It set out to provide financial assistance for people who required special adaptations to their houses on account of their disability. It was extended to include the mentally handicapped in 1975. The maximum grant at that stage was £800 for adapting a house. Half of this was from the local housing authority and the other half recoupable by them from the Department of Local Government. In November 1977 the first increase in this grant was made and it now stands at a maximum of £2,400 total. This was an extensive increase but was necessary to bridge the gap between building costs in 1971 when the grant was first negotiated and building costs by the end of 1977.[43] Since this increase building costs have once again soared. It is imperative that the disabled

[43]A few Housing Authorities raised the grant to £1,000 in the interim period.

person's grant keep pace with building costs. The current grant is totally out of line with current costs. It should be reviewed annually or automatically linked to building costs.

Table 5.11 provides information on the number of grants paid since the inception of the scheme and the total amount spent on it.

TABLE 5.11

Disabled Persons Grants paid by Local Authorities

Year	Number	Amount
		£
1973/74 ...	126	64,059
1974 (April-Dec.) ...	201	107,695
1975 ...	432	256,653
1976 ...	582	415,443
1977 ...	592	365,734
1978 ...	692	662,580

Source: Quarterly Bulletin of Housing Statistics.

The house adaptation scheme, progressive as it was at the conception stage, has suffered from difficulties in implementation. Following the Ministerial order which gave effect to the scheme there were very different interpretations of it by the various housing authorities around the country. A person's geographical location could influence not only the speed with which an adaptation would be approved and undertaken but also whether it would be undertaken by a housing authority even where they owned the house.[44] While some of these problems have since been solved by individual housing authorities, the operation of the scheme is still far from uniform and is subject to many delays at various stages and is not adequately linked to the costs of adapting houses.

5.7.2 *Special Housing*

Apart from an effective scheme of adaptations, housing policy should take the needs of the more severely physically and mentally handicapped minority into account at the planning stage. The total

[44]Faughnan, P., Report on the operation of the Disabled Persons' Grant, Irish Wheelchair Association, 1975.

numbers at national level are very small. British figures suggest that in a town with a population of 100,000 there will be a need for 100 dwellings to cater for the wheelchair-bound.[45] This provision could be made as an integral part of the normal house building programme. In this way a stock of housing could be built up whose basic structural design would suit anyone who has severe mobility problems or would be equally suited to the general population. The study of members of the Irish Wheelchair Association found that just over a quarter of them were living in houses which were accessible to them.[46] This Association has called for a provision whereby 1% of houses built would be accessible to the wheelchair user.[47]

A study carried out by Milton Keynes Development Corporation showed that the cost of making physical adaptations to a house for a wheelchair user is up to twice as high as incorporating the adaptations at the design stage; ". . . from the design point of view, good principles can be incorporated at the initial stages—for example, a ground floor bathroom is suitable in general, not only for disabled and/or elderly people."[48]

5.7.3 *Housing with Support Services*

Also falling within the range of housing policy and again applying to relatively small numbers but involving care agencies is the need for housing with support services. This is closely related to the need for better domiciliary care services discussed earlier. Several attempts have been made in different countries to meet the accommodation needs of handicapped persons in conjunction with their need for domiciliary support. On a very large scale there is the Het Dorp village scheme in Holland. More modest experiments, more easily realisable and probably more desirable are the John Grooms and Habintag housing schemes in Britain. In these schemes severely handicapped people are able to lead relatively normal lives in the community while yet receiving the personal help or support required.

This area of housing need could be investigated more thoroughly and

[45] Stark, V. "Towards a Housing Policy for Disabled People", *Contact Journal,* July/Aug., 1976, p. 2.

[46] Faughnan, P. op. cit. p. 26.

[47] A.G.M. Irish Wheelchair Association, April 1979.

[48] *Interim report of the Working Party on Housing for Disabled People,* United Kingdom.

a pilot scheme initiated in possibly an urban area. This provision is particularly relevant within the context of providing alternatives to residential care.[49] It would of course involve Housing Authorities, Health Boards and interested voluntary organisations working closely together to produce a workable scheme.

In summary an effective housing policy for physically disabled persons must involve three elements:

(1) a satisfactory adaptation scheme;
(2) provision for special housing as part of the building programme;
(3) provision of housing with support services where the demand exists.

5.8 **Recreation and Leisure Activities**

Possibly one of the best indications of integration is the extent to which the disabled person is able to choose which activities he will pursue and whether he is able to participate in them in the widest sense as performer, spectator or helper. Participation in leisure pursuits is both a reflection of integration and in turn a determinant of it.

The range of disabilities and the different problems they give rise to affect each disabled person in a specific and individual way. While many handicapped people participate quite successfully in the recreational life of the community others encounter barriers which prevent full integration:

(i) The actual physical or mental limitations arising from the disability which can prevent participation in some activities, e.g., such disabilities as haemophilia, heart disorders, and communicative impairments. In this regard the mentally handicapped person has additional problems which can prevent full social integration. However, limitations imposed by the disability itself while presenting barriers is not the only, nor indeed, the most prohibiting factor.

(ii) Inaccessibility and absence of personal mobility can restrict one's choice of leisure pursuits—whether it's going to theatres, cinemas, clubs, pubs or hotels; sport centres or parks; adult

[49] See section on residential care.

education classes, public lectures, art exhibitions or museums. These are major barriers and until there is ease of access and adequate transport facilities the disabled person with mobility problems will not have the freedom of choice available to the general population.

(iii) Social barriers which may become more accentuated in a leisure setting. Negative attitudes and an absence of understanding may result in people being self-conscious. Attitudes may vary, depending on the handicap itself, whether it is visible or not, whether it is congenital or acquired and how severe it is. However, people with epilepsy, people who are hard of hearing, people with disabilities such as cerebral palsy, may be isolated due to a lack of understanding on the part of the public.

(iv) The social and economic position of some of the handicapped population. There are handicapped people who have not the resources to participate in leisure time pursuits, even where these are available. The economic position of

(a) those dependent on the D.P.M.A. who may have to incur additional expense in pursuing activities of their choice

(b) those handicapped people, particularly the young person in long-term residential care, who have no direct source of income and are totally dependent on voluntary groups for all their social contacts, are of particular concern.

Handicap and Social Isolation Little research has been done on the opportunities of the handicapped person to participate in leisure and social pursuits. However, studies have focused on the extent to which handicapped people are socially isolated. In Britain, Goldberg[50] highlighted this problem;

> many handicapped . . . people who are isolated lack a social network of some kind. They do not necessarily need a great deal of individual casework, but help towards reconnecting them with a social network of neighbours and friends so they can feel part of a community in whose life they can participate. . . .

[50]Goldberg, E. M., *Welfare in the Community*, London, p. 73.

The study on persons of the Irish Wheelchair Association reinforces, very strongly, Goldberg's assessment. One of the most acute needs of this group of the handicapped population was for increased social contact and help in achieving this. The study depicted a picture of severe social isolation experienced by members of the Association with a large proportion having virtually no social outlets except those made available through the Association or other voluntary organisations. There was a correspondingly very low participation in local clubs, societies or organisations.[51]

Improved Opportunities On the positive side, over the past number of years there have been improvements in the opportunities availabile to the handicapped person for a fuller recreational life. Some of these are in the form of special activities, others part of the general pursuits available to the community as a whole. In the field of sport, the following areas are relevant:

The Physically Handicapped In recognition of the therapeutic and rehabilitative functions of sport, the Irish Wheelchair Association devotes considerable resources to encouraging participation in sport at local, national and international levels. There is also an increasing emphasis on facilitating young handicapped people participating in local sport activities in their own community, e.g., community games, sports clubs. Teams are sent to the international games each year and to the paralympics every four years.[52]

Mentally Handicapped Persons A seminar, in September 1978, organised by the National Association for the Mentally Handicapped, demonstrated considerable interest in a commitment towards meeting the recreational needs of mentally handicapped persons living in residential centres and in the community. Papers presented illustrated the wide range of activities being undertaken, ranging from the very passive to the very active, depending on individual need. The interest in the recreational needs of mentally handicapped persons has led to the setting up of the Special Olympics and National Indoor Games

[51]Faughnan, P., *Dimensions of Need*, op. cit., pp. 52-62.
[52]The N.R.B. also run courses on sport for handicapped persons.

Competition, both of which are held annually.

At local level, clubs for mentally handicapped people—Arch Clubs—similar to the Gateway Clubs in Britain and Northern Ireland, have been set up in a few areas in Dublin and also in Cork and Dundalk. A national federation to which new clubs can affiliate is being established.

Many voluntary organisations are active in providing holiday opportunities for their members. Some of these are special holidays catering for particular groups such as multiple sclerosis, spina bifida, wheelchair-bound, asthmatic children, moderately and severely mentally handicapped children.

Agencies such as the Irish Wheelchair Association are placing greater emphasis on facilitating handicapped people and families with a handicapped member to organise their own holiday, through providing the necessary personal help or financial assistance. Ordinary activities available to youth generally, such as work camps, Gaeltacht holidays and special interest projects are being availed of by young handicapped people. There are also increased international opportunities provided by the recent formation of Mobility International—designed to promote integration for all who are handicapped through travel and exchange. This international network provides integrated opportunities for young handicapped people to avail of opportunities existing for youth generally.

Many voluntary organisations and their local groups devote considerable energy to providing social outlets on an ongoing basis through running clubs, outings, social functions. Many of these are specialised, e.g., St. Vincents Club for the Deaf, while others are part of a general movement, e.g., the "handicapped troop" of the Scout Association of Ireland.

Towards Integration? Many severely handicapped people are dependent on the efforts of voluntary groups for their social contacts. Such groups have played a major role in this regard. However, it is very important that such organisations do not unwittingly perpetuate segregated activities where integration could be encouraged.

It is certainly more convenient, administratively, to provide for special needs in segregated projects. Indeed, there are situations where

segregation may be inevitable or even desirable, e.g., some competitive sports to enable people to compete on equal terms. However, there are many areas where such segregation is not necessary and is undesirable. Segregated activities can serve as a very useful stepping stone to further participation. This is often necessary, but there should be deliberate efforts towards fuller participation where this is possible. Voluntary organisations have a vital role to play in this regard.

Sport, leisure and recreational groups, ranging from the girl guides to the I.C.A., from sports clubs to drama groups, have also an important contribution to make in encouraging disabled people to become involved whether as participant or spectator and meeting any special needs they may have.

The requirements of the disabled person should be considered when sport and leisure facilities are being planned and designed. Disabled people themselves should be actively represented on national councils, boards and committees concerned with policy and with specific leisure pursuits.

5.9 RECOMMENDATIONS

That the special needs of the handicapped person within the community be recognised and appropriate steps taken by Health Boards and the Voluntary Organisations involved to assess needs and to plan to meet them.

Such recognition implies that one person within each Community Care area be allocated responsibility for the planning and development of services for

(1) the physically and sensorially handicapped
(2) the mentally handicapped in areas where this has not been done to date

Effective planning at Health Board level necessitates basic information currently not available on physically and sensorially handicapped persons in the area, on their distribution, extent of the disability and need for services. The collection of this basic information is an urgent priority in each Health Board area.

Domiciliary Care

That the verbal commitment to care in the community is supported by a willingness to invest sufficient resources to make it a reality for the

more severely handicapped population. In this regard the provision of a flexible form of domiciliary care on either long-term or short-term "crisis" basis should be investigated and initiated where required.

Day Care

Recognising the importance of day care provision to the handicapped person—both child and adult—and/or his/her family, that the demand for such services in each Community Care area be assessed and an appropriate form of service provided geared towards the needs of the recipient. Means of providing this should be investigated within the context of using existing resources, e.g., community workshops, training centres, special residential centres and available paramedical personnel, where possible.

Advice Supportive and Paramedical Services

That the need of parents of handicapped children for ongoing support, advice and information be recognised and appropriate steps taken to meet this need making use of the "named person" idea or the counselling team and resource centre concept to be adopted by the North-Western Health Board.

That the advisory and support needs of handicapped adults within each Community Care area be investigated.

Social Work

That immediate steps be taken within each Health Board area to examine the adequacy of the

(a) generic social work service

(b) specialist social work service

available to the handicapped person. While recognising that some handicapped persons may need a specialist service, many require simply a service which is accessible and acceptable and may be provided by the generic team (where it exists). Closer liaison should be initiated by Health Boards with specialist organisations to assess the situation and jointly plan to ensure that all needs are met.

Where a Health Board cannot supply the social work service

themselves that appropriate support be given to the specialist agency to make the service available.

Paramedical Personnel

That the N.R.B. in conjunction with schools of occupational therapy, physiotherapy and special therapy examine, as a matter of urgency the adequacy of the numbers being trained to meet

(i) current needs

(ii) more long-term development

The existing supply of such specialists and their distribution presents a serious limitation to the development of effective community care programmes.

That attention is paid in training courses of medical, paramedical and residential care personnel to the sexual needs and rights of the handicapped person.

Aids and Appliances

That each Health Board examine its system of assessment, supply and availability of those aids and appliances needed by the handicapped person or by the caring relative. Particular attention should be given to

(i) assessment: who undertakes it, how appropriate are the aids recommended, are these aids recommended where necessary, who does the follow-up, are such specialists as occupational therapists being used to the maximum in this regard?

(ii) supply of aids: where are the delays being encountered, is it at the level of suppliers or within the Board's administration structure, could basic aids be provided locally, with each Community Care area carrying a stock of such aids and equipment which would be readily accessible to the client for both assessment and supply purposes?

Housing

That housing authorities take the special needs of the handicapped person into account in their building programmes. Three areas in particular should be examined

(i) efficiency of the house adaptation scheme

(ii) advantages of planning to meet the needs of that proportion of the population who will require special housing

(iii) the need for housing schemes with support services. It is recommended that a pilot project in this field be initiated by a Housing Authority, Health Board and Voluntary Organisations.

Leisure and Recreation
That efforts be made to facilitate the participation of handicapped persons in the recreational and leisure pursuits of the community. These efforts need to be directed towards the general facilities available within the community and towards providing to meet special needs of particular groups. The following groups have a particular role to play: national sport and recreational bodies and voluntary organisations catering for the handicapped.

CHAPTER 6

INCOME MAINTENANCE SERVICES

6.1 Sources of Financial Support

Since the mid 1970s several studies in Britain have revealed that poverty is closely related to handicap.[1] Peter Townsend found that many of the worst cases of financial hardship in Britain today are to be found among disabled people.[2] Financial deprivation is often concurrent with handicap whether mental, physical or sensory he claims. Compared with the non-disabled of similar age many more of the disabled have low incomes, fewer own their own homes, fewer have substantial assets and personal possessions and fewer have rights to occupational benefits and other welfare benefits from employers. The greater the severity of the handicap the greater the deficiency of resources.[3]

In Ireland the levels of deprivation in housing, employment, income and social life identified in the recent study on wheelchair-bound persons points strongly to the same situation existing in Ireland for this particular category of physically handicapped persons.

Many disabled people, particularly severely disabled persons who live in the community, depend to a great extent on direct and indirect financial aid from statutory services.[4] For the handicapped individual

[1]Abel Smith, B. and Townsend, P.—*The Poor and the Poorest,* London. 1965: Coates, K. & Silburn. R.—*Poverty: The forgotten Englishman,* Harmondsworth, 1970: Economist Intelligence Unit, *Care with Dignity: An Analysis of Costs of Care for the Disabled,* London 1974.

[2]Townsend, P.—"The People who really need an Income Policy". *The Times,* December 10th, 1973.

[3]ibid.

[4]For example, over 50% of members of the Irish Wheelchair Association are dependent solely on social assistance or social welfare. A further 15% have no direct source of income.

the critical pressures are the extra costs and demands of a disability and the earnings loss or reduction frequently associated with its onset. As Peter Townsend points out the disabled have less money than other people and they need more money than other people. This was confirmed in the British Government survey of the handicapped in Britain—"there can be no doubt . . . that the proportion of people with very low incomes is greater for the impaired than for the non-impaired, even after allowance has been made for the impaired population containing a disproportionate number of elderly."[5]

6.2 The Income Maintenance Structure

In Ireland the field of income maintenance for handicapped persons is a complex, confused and often inequitable one. There are many different forms of benefits—some short-term, others long-term; some for insured persons, others for uninsured; some administered by Health Boards, others by the Department of Social Welfare. There are some direct cash payments and other cash substitute benefits in the form of concessions. Basically there are three elements in the Irish income maintenance system for the handicapped person:

(i) a basic cash benefit. This will vary both in amount and source depending on how the handicap is acquired, its duration and whether the person is fully insured;

(ii) "topping up" payments in the form of supplementary welfare allowance if it is felt that the person has requirements exceeding his ability to pay;

(iii) special additions in various areas related to the handicapped person's incapacity, or special concessions related to the type of benefit being received.

Encompassing these areas the following tables give an indication of the range of benefits and payments, which government department is responsible, the applicability of the benefit and the current rates.

[5]Harris, A., *et al.*, op. cit., p. 58.

TABLE 6.1
Social Insurance Schemes (from 1 October 1979)

Benefit	Agency responsible	Applicability	No. in receipt[a]	Current rate Personal	Current rate Married
				£	£
Disability Benefit[b]	Dept. of Social Welfare	Payable to insured persons during periods of incapacity for work due to illness or disablement	71,109	17.05	28.01
Invalidity Pension[c]	Dept. of Social Welfare	Payable instead of disability benefit to insured persons who are permanently incapable of work	13,367	17.65	29.10
Disablement Benefit	Dept. of Social Welfare	Payable to an insured person who as a result of occupational accident or disease is suffering from loss of physical or mental faculty, payable when injury benefit ceases; amount is dependent on degree of disablement. The benefit can be either a pension or a lump sum.	5,470	23.50 (100% disablement)	34.55
Injury Benefit	Dept. of Social Welfare	Payable to insured persons during a period of incapacity for work due to an accident arising out of and in the course of employment or to persons with prescribed occupational diseases. Maximum period of payment is 26 weeks.	650	23.50 (100% disablement)	34.55

[a]Figures as at September 1978 (Department of Social Welfare).

[b]This scheme covers absence from work through illness and not specifically disablement as the title suggests. A doctor's certificate must be submitted each week. Some people with long-term illnesses remain on this benefit rather than transfer to invalidity pension. In 1972/73, 15% of claims were 50 weeks or over in duration.

[c]This benefit is taxable. It was announced in mid-April that from April 1980 the Disability Benefit would also be taxable.

TABLE 6.2

Social Assistance Schemes

Benefit	Agency responsible	Applicability	No. in Receipt	Current Rate (max) Personal	Current Rate (max) Married
				£	£
Blind Persons' Pension	Dept. of Social Welfare	Payable to blind persons over 21 years. Rate of pension depends on whether the person is married, the number of dependent children and amount of weekly means.	6,000	16.80	25.25
Blind Welfare Allowance	Health Boards	Payable to persons in receipt of blind pension who are in necessitous circumstances and unemployable. The amount is at the discretion of the Health Board.	1,710		

TABLE 6.3

Other Income Supports Related to Disability[a]

Benefit	Agency responsible	Applicability	No. in receipt	Current rate (Max.)
DPMA	Health Boards	Cash allowance payable in cases of need to chronically disabled persons over 16 living in the community.	24,000[b]	£15.20 (A personal allowance only—no payments made for dependents).
Handicapped Children's allowance (HCA)	Health Board	Paid in respect of a severely physically or mentally handicapped child between the ages of 2 and 16. The child must be maintained at home needing constant care and supervision substantially greater than that required by a child of the same age and sex. The handicap must be present for at least six months and be likely to continue for at least one year.	4,400	£35 per calendar month
Prescribed Relative allowance	Dept. of Social Welfare	Payable to an incapacitated pensioner who is receiving full-time care and attention from a prescribed relative and provided there are no able children over 18 years living with him.	3,921[c]	£8.80

[a] There is also the Infectious Diseases Maintenance allowance payable to persons prevented from making adequate provision for themselves or their family because they are undergoing treatment for specified infectious diseases. However, the numbers in receipt are relatively small (380 in 1977).

[b] Figures as at December 1977 (latest available, Department of Health).

[c] As at August 1978 (Department of Social Welfare).

TABLE 6.3—*continued*

Benefit	Agency responsible	Applicability	No. in receipt	Current rate (Max.)
Constant attendance allowance	Dept. of Social Welfare	Payable to persons in receipt of 100% disablement benefit if they require someone to attend to personal needs.		Ranges from £4.40 part-time attendance to £17.60 exceptionally severe disablement.
Disabled Drivers	Health Board	Payable to help a disabled person buy a car. Subject to means test.		£1,000
Mobility Allowance	Health Board	Payable to severely handicapped persons between 16 and 65 years who are unable to walk and would benefit from a change in surroundings. Subject to means test. (Operative from September 1979)		£150 per annum (means test applies)

TABLE 6.4

Cash Substitute Benefits for Handicapped Groups

Benefit	Eligibility	Agency Responsible
Free electricity	available to— (a) over 66 years—persons in receipt of any kind Old Age/Widow's/Retirement pensions from Dept. of Social Welfare, retirement pension from UK or Garda Widow's pension; (b) at any age—persons in receipt of Blind Pension, Invalidity Pension or DPMA *may* qualify. These categories must be living alone or with a (i) dependent spouse (ii) invalid (iii) person living there to give constant care and attention to incapacitated pensioner.	Dept. of Social Welfare
Free Bottled Gas	As for free electricity where there is no electricity connected	Dept. of Social Welfare
Free T.V. Licence	As free electricity	Dept. of Social Welfare
Free Telephone Rental	People in receipt of Irish social welfare pensions aged over 66 and living alone	Dept. of Social Welfare
Cheap Fuel scheme	Old-age non-contributory pensioners; Blind pensioners, those in receipt of supplementary allowance; those on unemployment assistance	Dept. of Social Welfare
Other Fuel schemes	Conditions vary but designed to help elderly on low incomes or people with exceptional heating needs	Health Boards and local voluntary organisations
Hearing Aids	People holding medical cards; people insured may be entitled to assistance	Dept. of Social Welfare
Supply of medical and surgical appliances.	Health Boards consider each case on its own merits	Health Board through Public Health Nurse or Community Welfare Officer
Free Travel	On road and rail to (a) persons 66 and over; (b) blind persons 21 and over; (c) people in receipt of invalidity pension from Dept. of Social Welfare; (d) DPMA from Health Board. There is no means test	Dept. of Social Welfare

Benefit		Agency responsible
Drugs and Medicines free of charge	Available to persons suffering from a range of long-term diseases and disabilities. There is no means test	Health Board
Hospital in-patient and out-patient services	Provided free of charge for children suffering from following conditions: Mental handicap, mental illness, P.K.U., cystic fibrosis, spina bifida, hydrocephalus, haemophilia, cerebral palsy. There is no means test	Health Board
Other services primarily for the elderly—meals on wheels, chiropody, home help, laundry service	Also available to handicapped persons in some areas	Voluntary organisations and Health Board
Travel concession for families of persons in long-term residential care.	Concession covers transport cost for six visits per year for two members of family of person in residential care. There is a means test. It is applicable to medical card holders.	Health Board

6.2.1 *A special note on the DPMA*

The Disabled Person's Maintenance Allowance scheme was introduced in 1954. The original intention of the service was to relieve the chronically ill from the necessity of making weekly application for home assistance.[6]

The medical criterion for eligibility is that the applicant is unemployable by reason of some disability which is expected to last at least a year.

Up to 1969 a family means test operated, taking into account the income of parents and other family members. However, now only the applicant's means and those of his spouse are taken into account. Indeed as Eithne Fitzgerald points out in the prevailing climate when the scheme was introduced it was expected that few of the chronically ill who were then drawing home assistance would be married and no

[6]NESC Report, No. 38, op. cit., p. 161–162.

provision was made for payment of allowances for adult and dependent children. However, in 1976 about one-third of the 28,000 persons receiving DPMA were married. Where necessary supplementary welfare allowance is payable to recipients with dependants. However, Home Assistance was availed of by only a very small proportion in 1974.[7] The administration of the means test is fairly flexible and there is a fairly wide degree of discretion.

This is evident in the huge variation in the rate of the DPMA on a population basis. On the basis of the rate per 1,000 of the population there are variations of from 4.2 on the Eastern area to 14.4 in the Western. (See Table 6.5).

TABLE 6.5

Disabled Person's Maintenance Allowance by Health Board area

Health Board		Rate per 1,000 population
Eastern	—	4.2
Midland	—	10.3
Mid. Western	—	7.9
North Eastern	—	7.7
North Western	—	12.3
South Eastern	—	8.6
Southern	—	8.7
Western	—	14.4

Source: *Statistical Information relevant to the Health Services*, 1979, op. cit., p. 23.

6.3 Income Maintenance and Rehabilitation

In talking about disability benefits it is very important to distinguish between the short-term sick who are in receipt of them and the long-term disabled. In the case of the former the person is absent from work for a period and he usually has a job to which he will return. The disability, while it may involve him in short-term domestic and economic upset, will not usually require an adaptation to totally changed circumstances. The long-term recipient, on the other hand, may be permanently dependent on the benefit for his sole source of

[7]ibid., p. 162.

income and may have little prospect of employment without rehabilitation or re-training. There are some of course who, even with rehabilitation, may be unable to take their place on the open market.

Social welfare and assistance benefits may in some cases hamper rather than facilitate the rehabilitation of the disabled person. As presently structured there is a danger that for many the system of benefits may fail to motivate people and be considered as alternatives rather than an encouragement towards rehabilitation and retraining. Cash benefits, unfortunately, can encourage involuntary passivity. Often it is not simply the adequacy of the benefits themselves which are a disincentive to working as the abrupt loss of benefits if people try to work. Incentives are needed to encourage the handicapped person return to work, to undertake formal training or to engage in some form of productive activity which may lead to fuller rehabilitation.

A close look should be taken at possible ways in which disability related benefits could be used in a more pertinent manner as incentives to full rehabilitation. Could benefits be designed to taper off if people return to work (even on an intermittent basis) leaving people better off as a result of their efforts while at the same time providing them with underlying and readily available security if continued work is not possible? The same situation applies to recipients of the DMPA. Could the disabled person add supplementary income to the benefits he receives at least for a transitional period during which time work can be considered as part of the rehabilitation process? Could welfare benefits attain their maximum level after every feasible effort is made to rehabilitate oneself? The need for these incentives will apply only to a portion of the handicapped population. However, it is an important portion and where there is a possibility of re-training and rehabilitation every effort should be made to encourage the handicapped person. Such encouragement is not present in the current system.[8] Nevertheless, in cases where no further rehabilitation is possible, disabled persons must be provided with cash benefits so that they can lead a life

[8]This problem is acknowledged in the Robins report where it was felt that a large proportion of those on welfare benefits could be restored to a working life given a willingness on their part. However, it pointed out that because of the relatively small gap between social welfare benefits and wages in available employment, particularly in the less industrialised areas, there is no great incentive to them. The Department of Social Welfare have now begun to refer people felt to be suitable for rehabilitation to the NRB.

compatible with human dignity. One must question whether an allowance of £15.20 permits a chronically handicapped person to do this?

6.4 Additional Expenses of Disability

There are two elements to be taken into account in considering the income maintenance services for handicapped persons:

(1) the provision of an adequate basic income;

(2) the special needs and expenses arising from the handicap.

The current system of income supports for the handicapped person is not only geared towards subsistence but takes little account of these additional elements. There are extra expenses incurred through disability—special diets, laundry, clothes, aids, transport[9] and heating can all impose additional costs over and above that borne by the ordinary person or family. In a study Mavis Hyman claims that the extra costs of disablement incurred by wheelchair users out of their own resources averaged 24% of their income. It has been estimated on an international basis that the additional costs incurred as a result of blindness are one-third above the normal cost of living.[10]

The Disability Alliance in Britain also undertook a special survey in the North and Midlands of families with a handicapped child.[11] It pointed out that it has been generally accepted that it is in the child's best interest to be brought up at home by his own family. Approximately 90% of severely physically handicapped children are brought up by their families at home. When the child is living at home all the difficulties—practical, emotional and financial—devolve onto one small group of people experiencing all the normal strains of bringing up other dependent children and earning a living. Adequate supports are needed both in the form of services and financial help. The study points out that to date there has been surprisingly little policy discussions on how best to recognise the financial hardships families with a handicapped child experience in providing at home a service

[9]There are transport concessions for the handicapped person in this country. However, some are limited to those dependent on social welfare or assistance and are only of limited use to certain categories, e.g., those with severe mobility problems or the severely mentally handicapped.

[10]World Council of the Blind (source National League of Blind).

[11]*Disabled children—Counting the Costs*, Sally Baldwin, The Disability Alliance, London, 1977, p. 1.

which would cost the community so much to provide in hospitals and other long-stay institutions. The study found that in the vast majority of families interviewed the disabilities of the child created extra costs. These costs related to extra food, special diets, incontinence equipment, extra washing and extra clothes. The average amount spent on these extra items in a year was over £107. There were, however, wide variations in the amount spent. Families were meeting these extra costs with difficulty out of incomes which were in turn often reduced as a result of the child's condition.

A clear understanding is needed, the study claims, of these financial problems in terms both of extra expenditure and of income lost as a direct result of the child's handicap. It is difficult to quantify "extra" costs and to distinguish between direct and indirect costs. However, the picture which emerges from the study is clear. It showed the need for allowances to help with the costs that arise directly from certain handicapping conditions. The Disability Alliance therefore calls for a system of special allowances to offset costs directly associated with the disability, to help the handicapped child live more fully and bring the rest of the family at least to the level they would have achieved had the child not been handicapped.

In this country as in Great Britain there is no special allowance to offset the additional financial strain incurred by a handicapped child. The allowance for the domiciliary care of handicapped children is paid in respect of severely mentally or physically handicapped children who need constant care or supervision. Though it is a very welcome initiative the allowance of £35 a month is in stark contrast to the £100 a week it costs the State to maintain a severely handicapped child in residential care.[12]

The disabled housewife is another category who receives no direct income and for whom the expenses of running a home and looking after a family can be considerably higher than for her able-bodied counterpart. Obviously the extent to which this is so depends on the degree of disability, the restrictions it imposes on her and the additional demands it makes on other members of the family. These extra costs where related to the severity of the disability should be taken into account in the income maintenance services as a basic allowance or in the income tax code.

[12]See *Residential Costs per child 1978*, p. 69.

Current Tax concessions relating to Extra Expenses:
There are some minor tax deductions on assessable income currently available in respect of incapacitated persons in Ireland. Briefly these are:

(1) *Incapacitated child allowance*: a deduction of £320 per annum is allowed to the claimant if a child is incapacitated (before attaining the age of 21 years) by reason of mental or physical infirmity from maintaining himself.[13]

(2) *Dependent Relative allowance*: an individual may claim this allowance in respect of a relative who is incapacitated by either old age or infirmity from maintaining himself. The infirmity need neither be total or permanent. A deduction of £95 per annum is allowed. This cannot be claimed by a parent who is in receipt of the incapacitated child allowance in respect of the same person.[14]

(3) *Allowance for an employed person taking care of an incapacitated individual*: a deduction of £165 is allowed where the individual can prove that:

(a) he is totally incapacitated by physical or mental infirmity throughout the year of assessment or that his wife was incapacitated;

(b) that he employed someone to take care of the incapacitated individual.

In this instance the incapacity need not be such as to prevent the person from maintaining himself. Thus a disabled person who is able to earn his living may claim the allowance provided he employs someone to take care of him. The employed person cannot be the subject of a claim for Dependent Relative or Incapacitated Child Allowance.[15]

6.5 An Adequate Income?

The whole area of income maintenance services should be reviewed in relation to the long-term or chronic handicapped person.[16] The benefit structure is currently very complex, both in terms of the different types

[13]Income Tax Act, 1967, ss 140-141.
[14]Income Tax Act, 1967, ss 142.
[15]Section 3 Finance Act, 1969.
[16]The situation of those in residential care who have no source of income is dealt with in the section on residential services.

of benefits, their applicability, and the various agencies responsible for them. There is much to recommend a "one door" approach for all long-term disability related cash benefits with just one government department being responsible. All cash benefits could be administered by the Department of Social Welfare with the Health Boards accepting responsibility for the delivery of benefits in kind. The complexity of the present structure also suggests the need to initiate campaigns to inform people of their welfare rights, not only in terms of the cash allowances but also of relevant benefits and concessions.

The advantages of a two-part structure of income maintenance services for the handicapped person should be examined closely. One part of this structure—the basic cash allowance—to be paid as of right to the handicapped person to live on. This allowance must be adequate and kept in line with rising costs of living. There should also be an inbuilt flexibility in its administration with the possibility of it tapering off as and if employment becomes possible. The second element would be an allowance related to the individual's disability and to the additional costs incurred by him or by the caring relative as a result of it. This should not be affected by working and could be administered as a basic cash allowance or as part of the income tax code.

6.6 RECOMMENDATIONS

(1) In view of the complexity of the structure, consideration should be given to a "one-door" approach for all those on long-term benefits/assistance.

(2) That handicapped people be informed of their welfare rights and of the various benefits/concessions which may be available to them.

(3) That the DPMA as the sole source of income for many of the severely handicapped who have never worked be reviewed with regard to—

- (a) eligibility for it;
- (b) adequacy of it;
- (c) question of allowances for dependants.

(4) That serious consideration be given to the manner in which income maintenance programmes could be used as an incentive to

rehabilitation rather than a disincentive. Greater flexibility and imagination is needed in this area.

(5) That the additional expenses incurred through handicap be recognised in the income maintenance services or the income tax code.

(6) That the adequacy of the basic allowance be reviewed.

CHAPTER 7

RESIDENTIAL CARE SERVICES

7.1 Introduction

Increasingly the emphasis in providing for handicapped people is on living in the community and not in hospitals or residential homes. It should not of course be automatically assumed that living in the community will necessarily provide the optimum life for a physically or mentally handicapped person. Living in a residential home could in some circumstances be more enriching for a particular individual. However, generally, institutional care is viewed as a last resort when personal independence is no longer possible and family and community supports are not available. "Institutional care is of course often unavoidable; but frequently it is, and the fact that a person has to go into an institution represents a defeat—not so much for the patient himself as for those of us, no matter what our role may be, who are involved in developing and operating the health services. If there is a single person in an institution who could be provided for outside, he or she must be the concern of us all."[1] The importance of adequate community support and early family support services cannot be over emphasised in terms of maintaining the handicapped person within his own community.[2]

7.2 Services for Physically Handicapped Persons

Given the present availability of data it is difficult to even estimate the number of physically handicapped people living in residential care. Specific data is available on particular groups; for example, in 1976 20% of the members of the Irish Wheelchair Association were in long-term residential care.[3] However, even for this group more detailed study

[1]Dr. J. Robins, Department of Health, Paper delivered at Irish Wheelchair Association Seminar—"Residential Care for the Physically Handicapped", 1978.

[2]See Chapter 5 on *Community Services—Domiciliary Care.*

[3]Faughnan, P., *Dimensions of Need*, op. cit., p. 31.

would be needed to ascertain why they are in residential care and what form of supports would be needed to keep the person in the community.

In Ireland there are special homes for the handicapped run by the Cheshire Foundation;[4] other special institutions such as the Royal Hospital in Dublin and the Home for the Deaf in Stillorgan as well as orthopaedic hospitals around the country provide long-stay accommodation. There are also people who are physically and sensorially handicapped living in psychiatric hospitals,[5] in general hospitals, in welfare homes, in county homes and in nursing homes.[6]

This area of residential provision needs to be investigated thoroughly particularly within the context of providing adequate community services as well as acceptable long-term care. For example, it is essential to know:

(i) How many physically handicapped people are in long-term residential care?

(ii) How and why are they admitted? Here the distinction between acute medical needs as opposed to the need for a certain level of care, is very relevant.

(iii) What types of residential accommodation are people in? Is it the most appropriate in terms of meeting individual need? How many relatively young people are in institutions primarily for the aged?

(iv) What is the quality of life available to people in long-stay homes—to what extent can contact be maintained with the community, what form of occupation and activities are available to people within the home, how much independence have they got?

(v) What are the alternatives to residential care? Have hostels[7] and housing with support services a role to play? What supports are needed to make them effective? What form of financial

[4]There are seven Cheshire Homes around the country at present accommodating almost 200 residents.

[5]Irish Wheelchair Association and National Association for the Deaf. It is not known how many of these are in such institutions as a result of the absence of alternative accommodation.

[6]Faughnan, P., *Dimensions of Need*, op. cit., p. 31.

[7]While hostels exist around the country these are provided primarily for those undertaking vocational training in Rehabilitation Institute workshops and are not an alternative to residential care on a long-term basis.

investment is demanded? How does such investment compare with the costs of long-term residential care?

There has been considerable concern expressed at this whole area of long-term care for the physically handicapped particularly in relation to the quality of life available to the handicapped resident. Within the Irish context such concern was very evident at the recent seminar on residential care for the handicapped when the Department of Health was called on to appoint a working party on the matter.

Much has also been written on the dangers of institutionalisation[8] and the tendency for young people in particular to be admitted to residential care for social rather than medical reasons and for their care to be custodial in type.[9]

Within the Irish situation particularly, the following factors have a bearing on the quality of life available to physically handicapped residents:

(i) The absence of any personal income for many of those in long-term residential care. Residents who are dependent on DPMA as their sole source of income generally have this terminated when they go into care. Sometimes arrangements may be made regarding pocket money either within the home/hospital or between the home and the Health Boards.[10] Residents also are deprived of related benefits, e.g., free travel. This is a totally unacceptable situation, rooted in the Poor Law tradition, whereby a destitute person qualified for indoor relief (the precursor of residential care), or outdoor relief (the first income maintenance service), but never for both.

(ii) The absence of any training facilities in this country for non-nursing residential care staff working with the physically handicapped.

(iii) The limitations on personal decision-making within a residential setting and the availability of acceptable outlets in occupational social and leisure spheres.

[8] Brattgard, Sven-Olaf—"Integrated Living for the Severely Disabled" in *Contact Journal*, London, 1974.

[9] Hospital Advisory Service Annual Report—London, 1973.

[10] The Cheshire Homes have negotiated between £2 and £4 a week pocket money or residents in their homes with individual Health Boards.

(iv) The relative non-involvement of the Department of Health in

(a) non-statutory residential institutions;

(b) in assessing and planning to meet long-term accommodation needs of the severely disabled person.

Dr. Robins has stated that, "there are very few residential centres specifically for the physically handicapped and it is not anticipated that there will be any significant departure from the practice in the future . . . when I speak about a policy in regard to the residential care of the physically handicapped I speak about it in the context of all those requiring long-term care. To a considerable extent they have similar needs. . . . The stated philosophy of the Department of Health in the provision of long-term institutional care is to create within the institution a reasonably normal environment and as decent and comfortable a life as possible."[11]

The National Rehabilitation Board has also expressed concern about this area of rehabilitation services: ". . . long-term care for many of the severely disabled remains unsatisfactory. Further community care and support may enable more to stay at home".[12] Within this context the N.R.B. suggests that the development of good nursing homes or hostels in the local community would enable a severely disabled person live nearer home, while also freeing hospital beds. The Board recognises that "much needs to be done" and where the home cannot cope ". . . some consideration must be given to providing a tolerable life for the severely disabled in various types of centres. A home is an urgent necessity and other facilities should be researched and developed".[13]

The quality and availability of existing residential care services for the physically handicapped person and long-term planning of a wider range of options need to be investigated urgently. Virtually no work has been done in this field and the existing structure reflects this. The demands of the Irish Wheelchair Association for the Government to establish a Working Party should be adopted as an initial step in examining the area.

[11] Robins, J., op. cit.

[12] *Annual Report and Accounts*, N.R.B. 1977, p. 8.

[13] *Annual Report and Accounts*, N.R.B. 1976, p. 8.

7.3 Services for Mentally Handicapped Persons

The difficulties associated with the provision of residential services for mentally handicapped persons and in particular the shortfall in provision for particular groups has been a major area of concem to those working in mental handicap services for many years. A Department of Health Working Party is considering this area at present. However, a brief review of the present situation highlights some of the major issues involved and the complexities associated with any solution of the difficulties evident.

In 1974, 43% of moderately mentally handicapped persons, 64% of severely handicapped persons and 77% of profoundly handicapped persons were living in residential centres (Table 7.1). In addition to the 6,293 persons functioning at moderate, severe and profound levels of mental handicap there were 1,845 mildly mentally handicapped persons in residential centres in 1974. The total of 8,138 persons were resident in a variety of settings; the majority were in Special Centres (52%) and Psychiatric Hospitals (34%) (Table 7.2).

7.3.1 *Special Residential Centres*

There are at present 41 special residential centres in the country, seven of which are residential schools for mildly mentally handicapped children, (Eastern Health Board, four schools providing 495 places, Southern Health Board, two schools providing 176 places and Westem Health Board, one school providing 83 places). Of the remaining 34 centres, 21 are children's centres, 11 are centres for adults and three cater for both children and adults. Few, if any, of the children's centres are in fact catering only for children—in many there are persons aged over 18 years for whom no alternative accommodation is available, e.g. in St. Mary's, Drumcar, about 55% of the residents are aged over 18 years. This is in fact one of the major problem areas relating to residential provision throughout the country—due to a shortage of places for adults, places intended for children are being occupied by adults. As a consequence there are waiting lists not only for moderate, severe and profoundly handicapped adults but also for children functioning at severe and profound levels of handicap. By December 1976, the number of mentally handicapped persons in special residential centres had increased to 4,751.

TABLE 7.1

Location of Mentally Handicapped Persons Related to Degree of Mental Handicap and Age 1974

Degree of Mental Handicap	Moderate			Severe			Profound		
Age	0-14	15 & over	All ages	0-14	15-19	All ages	0-14	15 & over	All ages
Location	%	%	%	%	%	%	%	%	%
Residential	31	48	43	48	73	64	69	83	77
Community	69	52	57	52	27	36	31	17	23
Total	100	100	100	100	100	100	100	100	100
N.	1,979	4,148	6,165	1,370	2,395	3,765	639	967	1,606

Source: Mulcahy, M. and Ennis, B., 1974, op. cit. Mulcahy, M. 1974, op. cit.

TABLE 7.2

Type of Residential Setting Related to Number and Percentage of Residents and Degree of Handicap

Type of Residential Setting	Number of Residents	% of Total	Mild	% of Total	Moderate Severe and Profound	% of Total
Mental Handicap Centres	4,256	52.3	817	44.3	3,439	54.6
Psychiatric Hospitals	2,744	33.7	576	31.2	2,168	34.4
Geriatric Homes	642	7.9	208	11.3	434	6.9
Paediatric Hospitals	286	3.6	98	5.3	188	3.0
Residential Homes	181	2.1	119	6.4	62	1.0
Homes for Young Offenders	29	0.4	27	1.5	2	—
All Centres	8,138	100.0	1,845	100.0	6,293	100.0

Source: Mulcahy, M. and Ennis, B., op. cit., p. 11.

TABLE 7.3

Numbers in Special Residential Centres by Age and Degree of Handicap 1976

Type of Centre	Age Range	Degree of Handicap: Mild	Degree of Handicap: Moderate, Severe and Profound
Special Residential	Under 16	723	1,680
Centre	Over 16	263	2,085
	All Ages	986	3,765

Source: Statistical Information relevant to the Health Service 1978.

Since 1976, the Brothers of Charity Centre at Bawnmore, Limerick has been opened; this centre has accommodation for 100 moderately handicapped and 60 severely handicapped adolescents and adults—approximately 100 had been admitted by early 1980. A number of centres are planned or in the initial stages of construction in other areas. Under the present capital programme 1,510 additional residential places are at various stages of planning or construction and the vast majority of these places are for adults (1,159 places for adults and 351 for children).[14]

7.3.2 *Psychiatric Hospitals*

In 1974 there were 2,744 mentally handicapped persons, or 34% of the total in residential care, accommodated in pychiatric hospitals; 22% of this group were mildly mentally handicapped, 31% were moderately mentally handicapped and 47% were severe or profoundly handicapped.

On the basis of a comparison of admissions to and discharges from psychiatric hospitals of people with a diagnosis of mental handicap for 1975 and 1976, it is evident that there had been no appreciable change in the numbers of mentally handicapped persons in these

[14]See Appendix VII A.

centres up to the end of 1977.[15]

The problems associated with the provision of services for mentally handicapped persons in psychiatric hospitals have repeatedly been highlighted by those persons working in these hospitals, other Health Board personnel and various other groups. It is clear that there are no easy solutions and that the particular problems of mentally handicapped persons in psychiatric hospitals are inextricably linked with the larger problem of psychiatric hospitals in general: The long-stay sections of psychiatric hospitals provide care for not only the chronic mentally ill and psycho-geriatrics but also for mentally handicapped persons. These three groups have differing needs in terms of nursing care and support services. Apart from these facts, the sheer size of psychiatric hospitals present major problems in the delivery of services—the numbers of mentally handicapped persons in many psychiatric hospitals are greater than the numbers in even the larger special residential centres.

The present policy with regard to psychiatric hospitals is that there should be no future admissions of mentally handicapped persons to these centres. Given that there are waiting lists for people at present in the community in need of residential care, it is likely that these will take priority in admission to special residential centres. Transfer of persons from psychiatric hospitals is thus highly unlikely. Any attempt towards solution of the problems associated with accommodation of mentally handicapped persons in psychiatric hospitals must take into account the characteristics of the residents. It is notable that the characteristics of mentally handicapped residents identified in psychiatric hospitals in 1974 differed from the characteristics of those persons in special residential centres in a number of respects:

(i) Age: 71% were aged 30 and over in psychiatric hospitals compared to 16% of those in special residential centres.

(ii) Length of stay: 55% of those persons in psychiatric hospitals had spent 10 years or more in residence compared to 29% of those in special residential centres.

(iii) Mental illness: 45% of those persons in psychiatric hospitals had a diagnosis of mental illness in addition to mental handicap compared to 3% of those in special residential centres.

(iv) Contacts outside the centre: 30% of those in psychiatric hospitals were never visited or never went on holidays to relatives/friends compared to 13% of those in special residential centres.

These characteristics impose considerable limitations on the possible options open; three of these options will be briefly considered.

Hostels/Group Homes: Of those in psychiatric hospitals in 1974 22% were mildly mentally handicapped and 31% were moderately mentally handicapped; it is evident from the foregoing that it is probable that many of these persons are in the older age groups, have spent long periods in hospital and are suffering from mental illness thus hostel/group home provision in the community is likely to be an optimum solution for a relatively small number. It is notable that the experience from Britain indicates that there was considerable reluctance on the part of local authority hostels to accept persons from subnormality hospitals.[16] This may in part be associated with pressure for admission to hostels of persons from the community. Clearly these same pressures would operate in Ireland, thus the question of special provision of hostels to meet the needs of mentally handicapped persons from psychiatric hospitals would have to be considered.

New Units: The creation of units within each region, preferably a series of small units, to meet the needs of mentally handicapped persons in psychiatric hospitals is a very desirable solution. While it is clear that this solution would involve major capital investment and is relatively long-term it is notable that the experience from Wessex indicates that the *per capita* costs involved in the provision of locally based hospital units catering for approximately 25 people are considerably lower than those incurred in the provision of new hospitals on traditional lines and that the average revenue costs, per child/adult are similar to those in traditional hospitals.[17]

The creation of separate units for mentally handicapped persons within present psychiatric hospitals is probably the most feasible and

[15]O'Hare, A. and Walsh, D. *Activities of Irish Psychiatric Hospitals and Units 1975 and 1976.* Dublin, Medico-Social Research Board. 1978, Tables 49, 50, 53, 54. See Appendix VIIB.

[16]Campaign for the Mentally Handicapped. *Residential Provision for Adults who are Mentally Handicapped.* Enquiry Paper No. 5, London, CMH, 1977.

[17]Kushlick, A. et al. *Summary of Current Research in Mental Handicap Work 1977.* Research Report No. 126. Wessex Health Care Evaluation Research Team, 1977.

least costly solution in the short-term. This policy is being pursued to some extent at the present time: For example, in the Eastern Health Board of St. Ita's Hospital, Portrane, the services for mentally handicapped persons are under the direction of the Medical Director of Mental Handicap services for the region; in the Southern Health Board, St. Raphael's Hospital, Youghal, caters solely for 308 mentally handicapped adults. In the Midland Health Board, St. Peter's Hospital, Castlepollard, has been opened as a centre for mentally handicapped persons and will eventually provide services for 130 persons; this centre provides services for some mentally handicapped persons previously accommodated in St. Loman's Hospital, Mullingar.

If separate units for mentally handicapped persons within the psychiatric service are to be a real alternative to the present psychiatric hospitals, the creation of such units must be accompanied by the provision of the necessary facilities and the appointment of specialist personnel including nursing staff with qualifications in mental handicap; while there is a relative shortage of these nurses at the present time, post-graduate courses in mental handicap nursing for psychiatric nurses is one possible solution to this problem.

It is frequently argued that psychiatric hospitals are, irrespective of any improvements that could be made, totally unsuitable for the care of mentally handicapped people. However it is clear that the majority of mentally handicapped persons in psychiatric hospitals have been admitted because they have nowhere else to go and that given financial constraints large numbers of mentally handicapped people are going to spend their lives in these centres. Basically the problems associated with psychiatric hospitals while being historical in origin are at present financial; there is no shortage of solutions both from people working in these hospitals and from others; however, most solutions tend to be long-term and involve considerable costs.

The crucial question at the present time relates to how those mentally handicapped persons in psychiatric hospitals can in the short-term be guaranteed the same rights and standards of special care as persons accommodated within other services for the mentally handicapped. The most feasible short-term solutions would appear to be twofold:

(i) First, to investigate the feasibility of hostel/group home provision for those persons in psychiatric hospitals who could with the aid of community support services benefit from this type of service.

(ii) Second, to provide specialist services in separate units within existing psychiatric hospitals. It is clear that this will entail a considerable financial commitment.

7.3.3 *Activation Services*

The Census of the Mentally Handicapped in 1974 indicated a clear need for the development of activation/occupational services for persons in residential centres; of the 1,972 mild and moderately handicapped persons in residential care between the ages of 25 and 65 it was found that only 30% were attending sheltered workshops or working at the centre; 36% were reported to be of limited help while 33% were not employed at all. It was concluded that these last two categories representing 1,377 or 69% of those aged 25-65 would appear to contain a considerable number of persons for whom activation should be provided.[18]

The Robins report recommended that for "persons who are undergoing care in institutions the proper place for starting their activation is in a centre associated with the institution". It was considered that medical treatment should not be separated from physical, psychological and social activation.[19] The report pointed to a number of difficulties relating to the occupational or industrial units available both in special centres for the mentally handicapped and in psychiatric hospitals and recommended that they should be organised as work activation units. The purpose of these units for mentally handicapped persons, whether living in residential centres or in the community[20] are similar, viz., to condition the individual psychologically and physically to the work habit and to develop social habits. It was emphasised that persons should not be retained indefinitely in activation units. It was recommended that these units should have the following personnel:

(i) a person with experience at supervisory level in industry and capable of giving instructions in elementary manual skills and of organising work, who would be in charge of the unit

[18]Mulcahy, M., Ennis, B. op. cit., p. 16.
[19]Report on Training and Employing the Handicapped, op. cit., p. 35.
[20]See Section on Occupational Centres for Mentally Handicapped Adults, pp. 146-147.

(ii) nurses who would provide nursing support and social training and

(iii) an occupational therapist.

The Workshops Standards Committee also considered the operation of these centres and emphasising their vital role in rehabilitation recommended that placement officers and youth employment advisers should maintain close contact with the units and attend regularly for case conferences. Regular reviews, (as to suitability for long-term sheltered work, activation for or placement in open employment, training to skilled or semi-skilled level or participation in a day centre), was recommended and in the event of suitability for alternative placement referral to the youth employment or placement officer.[21]

Most of the units at present available function to varying degrees as sheltered workshops in the provision of long-term sheltered employment rather than as activation units.[22] Clearly this is realistic for many persons in residential centres, however, it is also clear that this should not be the only option available. Implementation of the guidelines laid down by the Robins report and Workshops Standards Committee could have considerable advantages not only in the provision of vocational services to persons within special residential centres and psychiatric hospitals but also in facilitating the participation of some residents in community based services.

7.4 Alternatives to Traditional Type of Residential Care

It is frequently suggested that some of those most in need of residential care are not admitted while people with lesser handicaps are; however, it is clear that admission to residential care is frequently sought for social and family reasons and because of absence of day facilities rather than because of the degree of handicap. Thus, it is understandable that in the absence of alternative provision in the form of hostels/groups homes or fostering arrangements, residential care in special residential centres is sometimes sought for people without marked additional handicaps.

[21] *Workshops Standards Report*, op. cit.

[22] It is estimated that there are at present approximately 1,000 sheltered work/occupational places available in special residential centres; there are approximately 2,500 such places available in psychiatric hospitals, however information on the number of these provided for mentally handicapped persons is not available.

The problem of the relative shortfall in places is exacerbated by the fact that places tend to be sought and taken up before they are essential as parents/families fear that places in special residential centres may not be available when the real need becomes evident.

A further problem is that many mentally handicapped persons are in residential centres long distances from their own homes, e.g., in 1974, over 40% of those in residential centres in the Eastern Health Board and North-Eastern Health Board areas were from outside these regions.[23] This is partially associated with the fact that many services have traditionally been geared towards the provision of services on a national basis. It is also associated with the absence of, or shortfall in, services in many areas. The provision of sufficient places in special residential centres to meet needs is a relatively long-term solution and may not be an optimum type of residential service for all mentally handicapped persons in need of accommodation. This raises the question of alternatives and particularly alternatives that can be realised in the relatively short term. Three types of provision will be considered:

(i) Hostels/Group Homes.

(ii) Short-stay Accommodation.

(iii) Fostering.

It is emphasised that the feasibility of effective services within these types of provision is dependent on the development of other community facilities. Where transfer from existing residential services is discussed, it must be born in mind that these services have been the long-term "homes" of many mentally handicapped persons and that such transfers while objectively desirable may not always be in the best interest of the person concerned. The costs of various types of residential services have already been outlined.[24] These costs are considerable, thus a crucial question relates to whether or not the financial commitment at present devoted to maintaining handicapped persons in traditional forms of residential care is in all cases the most cost effective way of meeting residential needs. It is not suggested that effective alternatives will necessarily be cheaper, rather the same level of financial commitment, if, spent in an alternative way, may prove more effective in meeting individual needs in many cases.

[23] Mulcahy, M. and Ennis, B., op. cit., Table 3, p. 29.

[24] See Chapter 5, Table 5.5, p. 141.

7.4.1 *Hostels/Group Homes*

In Ireland the terms hostel and group home are used inter-changeably to refer to units/houses providing residential accommodation for six to ten adults or children, though some units accommodate larger numbers.[25] Units providing accommodation for six to ten persons correspond with units referred to as group homes in Britain and Sweden. In Britain the term hostel refers to larger units catering for approximately 25 people. Apart from size the essential differences between hostels/group homes and special residential centres relate to

(i) the range of facilities available within the unit

and

(ii) its location.

In contrast to special residential centres the function of hostels relates solely to the provision of residential accommodation, and while a training element is included in this, the hostel does not provide educational/occupational/activation/employment facilities.

The level of intellectual functioning of adults in hostels/group homes at present ranges from severe mental handicap to dull normal ability with the majority being moderately mentally handicapped.[26] Children accommodated in hostels/group homes are either mild or moderately handicapped and generally attend special schools. Hostels are staffed by care staff, or nurses functioning as house parents,[27] and are generally located within residential areas in ordinary rather than purpose built housing.

Provision In 1976 there were 362 mentally handicapped persons accommodated in 29 hostels.

Since 1976, the number of places available has increased, particularly for adults and has now reached approximately 250.[28] The

[25]One hostel in Cork accommodates 15 people, another accommodates 23 people and one in Dublin accommodates 13 people.

[26]This and other information on the characteristics of adults in hostels has been made available by Dr. G. Carroll of the Medico-Social Research Board, who has undertaken a study of hostels.

[27]There are at present no specific training requirements for hostel personnel.

[28]Hostels for adults are located in Cork, Dublin, Galway, Kilkenny, Foxford and Tralee.

adults accommodated in hostels attend Vocational Training Centres, Sheltered Workshops, Occupational Centres and a minority are in open employment.[29] There are a small number of mentally handicapped adults accommodated in hostels run by the Rehabilitation Institute located in Dublin and Sligo. There are hostels for children who attend special schools in Mayo, Galway, Roscommon, Clare and Dublin.

TABLE 7.4

Persons Accommodated in Hostels 1976

Age	Degree of Handicap	
	Mild	Moderate/Severe
Under 16	90	38
16 & over	52	76

Source: Statistical Information relevant to the Health Services 1978.

Hostels can differ in their function in the sense of being either "transitional" or "permanent". The two functions are not mutually exclusive, the achievement of greater levels of independence being a general goal of all hostels. However, in the case of "transitional" type hostels the expressed emphasis is on the development of skills with a view to the resident moving on to a more independent existence, e.g., to a group home with minimal supervision, or one without supervision, or to lodgings. This type of hostel may function as a "half-way" in the transition from full-time residential care in a special residential centre to a relatively independent existence either in the person's own home or one of the other options in the community mentioned above. Considering hostels with a broadly "permanent" function, the focus is on the provision of a permanent home for the residents.

Feasibility of Hostel Development Given the evidence to date which suggests that hostels/group homes are a suitable form of provision for mild and moderately handicapped children and adults without

[29]Of the 160 adults in hostels in 1978, it was found that 47% were attending Sheltered Workshops, 19% were attending Adult Training Centres and 16% were in open employment. Source: Dr. G. Carroll, M.S.R.B.

additional handicaps, the potential for development is considerable. As has been pointed out, admission into residential centres is not in many cases related to the severity of the persons handicap but rather to the non-availability of day services or the breakdown of existing caring networks. Provision for two groups needs to be considered.

(i) mild and moderately handicapped persons already in residential centres

(ii) persons living in the community whose families are unable to provide for them or at least not on a full-time basis.

(i) In 1974, there were 400 mildly mentally handicapped persons and 719 moderately mentally handicapped persons in residential care who had no additional complications, either in terms of incapacities or behaviour problems.[30] While many of this group may have spent long periods in residential care and consequently a move to hostel accommodation may prove merely to be disruptive rather than beneficial, it is probable that at least some could be accommodated in hostels. The feasibility of this type of provision for some of these persons in residential centres needs to be investigated.[31] With regard specifically to mild and moderately handicapped children, the fact that there is not a shortage of residential places at present should not preclude the investigation of alternatives to residential special schooling—this of course pre-supposes the availability of special schools on a day basis.

(ii) It is clear that residential provision is a necessity at some stage in life for many of this group due either to the breakdown of caring networks, e.g., ageing or death of parents and inability or reluctance of siblings to provide support, or significantly it may be in the best interests of the person concerned to live away from his/her family. It is notable that 56% of those aged 15 and over living in the community in 1974, did not present severe behaviour problems and were not incontinent, thus hostel provision in conjunction with workshop or occupational centre placement is probably appropriate for very many of this group.

[30]Mulcahy and Ennis, 1974, op. cit.

[31]Of the 160 adults in hostels in 1978 61% were admitted from residential centres and 16% from residential schools; only 16% came directly from their family home. Source: Dr. G. Carroll, M.S.R.B.

Hostel/group home type residential provision offers a number of advantages:

(i) Hostels for mild and moderately handicapped persons without additional handicaps do not need to be purpose built. Ordinary residential accommodation is adequate and desirable. Modifications of buildings for people with physical handicap would present no greater problems than would such modifications as are necessary in the case of people living in their own homes. The use of ordinary residential accommodation would permit easier and faster provision of these services relative to special residential centres.

(ii) Integration: Optimally hostels are located in residential areas, thus permitting at a minimum locational integration; functional integration implying the use of the same facilities as the rest of the community is the general aim of training in hostels. Social integration is more difficult to achieve being crucially dependent on the societal attitudes towards people with handicaps. While the level of integration achieved will vary it is clear that the physical possibilities for integration are greater in the case of persons resident in hostels compared to those in residential centres. However, in this regard it is clear that location within the community is merely a first step towards integration and that adequate support services are essential, on the one hand, to foster greater levels of integration of handicapped persons and importantly to avoid possible social isolation.

(iii) Location: Because of the relatively small number of residents in any one hostel, the location of hostels can be relatively dispersed. The constraint being that they should be provided in areas where the residents can have access to community workshops, sheltered workshops, occupation centres, or schools, depending on their needs.

(iv) Flexibility: Hostels/group homes can vary in staffing levels, at the one extreme are hostels with full-time care staff and at the other those without resident staff but with support available when sought by the residents.

Taking an overall view of residential needs over the life time of particular mentally handicapped persons, hostels with varying levels of support can be perceived as one of a range of options from independent living in the family home to a full-time residential care.

7.4.2 *Short-term Residential Care*

Short-term care generally refers to care for periods of up to two months. There is some evidence from both Britain and Sweden to suggest that adequate provision of short-term care as part of a range of community services on a local basis is associated with a reduction in demand for admission to long-term residential care.[32] It is notable that, the evidence to date relates to children, thus one cannot generalise on the effectiveness of this type of provision in reducing demand for long-term residential care. However, as has been outlined there is effectively a shortage of residential places for children within the Irish situation. Apart from its possible effects on demand for residential places, there is evidence from agencies involved in the provision of services to families with mentally handicapped persons and from studies of such families[33] that short-term care is a crucial component in the range of facilities necessary for coping with a handicapped child or adult.

Many of the agencies involved in the provision of long-term residential provision for mentally handicapped children provide holiday care and a limited number of short-term beds on a year-round basis at present. There is one centre in Galway providing specifically for short-term care in which there are seven places available on a year round basis and a new centre is planned for the Dublin area and will probably open in 1981 providing 14 places for children and adults from the South side of the city.

Despite these developments, the availability of short-term care on a year round basis is not sufficient to meet needs, particularly those of adults. The provision available is in the main confined to that for children and is mostly available in the Dublin area and, apart from the regular holiday care available tends to be seen as "crisis" care.

[32]Evans, R. and Fyhr, G. "Sharing the Caring: a Swedish approach to short-term care of mentally handicapped children", *Child care, health and Development*, 1978. Vol. 4, No. 2, pp. 69-78. Brimblecombe, F. "Honeylands—A project for handicapped children" *Action Magazine*, 1976, pp. 16-21.

[33]Bayley, op. cit.

Functions One of the primary functions of a short-term care service is the provision of planned relief to families through regular breaks throughout the year or at holiday periods. Apart from the benefit to the family, this type of arrangement can have very beneficial effects for the mentally handicapped child/adult: Given that full-term residential care is often essential in the long-run, planned short breaks from the family environment can facilitate separation in a supportive way thus ensuring that admission to residential care is not a traumatic experience. In addition, depending on the type of short-term care available, a placement may function as an opportunity for assessment and the development of programmes suited to individual needs.

The evidence from Britain and Sweden suggests that the success of programmes is in large part associated with the flexibility of the arrangements possible, many families making use of short-term care for single nights or weekends depending on their own circumstances.[34]

While the availability of short-term care is aimed at the prevention of "crisis" admissions it is clear that one of the essential features of any such programmes must be the possibility of emergency admissions, in the event of family crisis; this type of admission is dependent on the availability of places at short notice, thus each facility must at any one time have at least one place available for such admissions.

Type of Centres Short-term care can be provided in a variety of settings:

Special Residential Centres Most short-term care is provided in these centres at present, particularly those catering for children, during holiday periods when beds become vacant—thus the range of time over which places are available is of necessity limited. Despite this, these services fulfil a very necessary function with regard to holiday relief at a period when day services are generally closed. While there are particular difficulties associated with the provision of short-term care for adults it is probable that this type of holiday care would present less difficulties than crisis type care.

Many special residential centres make available a limited number of short-term places on a year-round basis. Apart from the obvious advantages to the mentally handicapped persons concerned and their families, this type of arrangement has the advantage of involving

[34]Brimblecombe, F. (1976), op. cit.; Evans, R. and Fyhr, G., op. cit.

personnel in residential centres with the community and vice versa. The range of services available in a residential setting facilitate a range of options with regard to the type of assessment and treatment services that can be offered to persons availing of short-term care.

Special Short-stay Centres The possibilities for greater flexibility exist in this type of provision relative to special residential centres. One of the key elements in the success of short-term care is accessibility to families; it is obvious that small units catering for five or six persons can be widely dispersed geographically, thus continued attendance at day facilities would be facilitated particularly in urban areas. Apart from accessibility, it is probable that flexibility in terms of use of such a centre would present less problems than it would in a special residential centre, e.g., overnight stays or weekend stays.

A major advantage relates to provision. Purpose built centres are not essential—modifications to ordinary residential accommodation would be sufficient to cater for many handicapped persons. While purpose built accommodation may be desirable for people with particular disabilities, it is clear that many handicapped children and adults are being cared for by families in home surroundings not specially adapted to their needs. Thus, the availability of trained staff with support services should facilitate a high level of care for small numbers of people with special needs in residential type accommodation that has been adapted in certain respects—one study reports the use of two adjoining flats for short-term care for six children.[35] This type of short-term care has been provided only to a limited extent in Ireland, thus it is difficult to evaluate its effectiveness. However, the evidence available from Britain and Sweden does suggest that this type of service as an integral part of a range of services within a community has major advantages.

Adults: The provision of short-term care for adults is complicated by the fact that many of those most in need of such care are those people who require full-time residential care. This can be associated with the "blocking" by such adults, of temporary beds when provided. This is understandable, given the shortage of places for adults in special residential centres, however, it inevitably leads to a reluctance on the part of some agencies to provide temporary places for adults. Thus,

[35]Evans, R. and Fyhr, G., op. cit.

rather than a gradual transition to long-term residential care, admission can, for many adults, be a sudden break as the result of a family crisis such as the death of a parent.

While this pattern will only be alleviated by the provision of extra residential places, it is clear that this is a relatively long-term solution. In the short-term it may be possible to extend the period over which families could cope if they could have reasonable certainty that regular short-term care would be available. Given the special difficulties associated with this provision for adults in special residential centres, the feasibility of small short-term units in the community for adults needs to be explored. In addition, the use of one or two places within hostels for those with mild and moderate degrees of handicap may prove feasible.

7.4.3 *Fostering/Family Care*

The Commission of Inquiry on Mental Handicap identified fostering as one method of family care that should be investigated for handicapped persons.[36] Such an investigation has not taken place to date, thus it is not clear whether this form of care for mentally handicapped persons is feasible within the Irish situation. However, there is evidence from both Britain and the United States that this type of care is feasible. With regard to the United States it is notable that the President's Committee on Mental Retardation has identified fostering as a primary resource in its goal to reduce, by one-third, the population of mentally handicapped persons in institutions by the turn of the century.[37]

Within the Irish situation this form of care may have relevance only for a relatively small number of mentally handicapped children, however, this should not preclude investigation of its feasibility.

It is clear that many handicapped children do not have specialist nursing needs, yet some cannot live with their natural families thus fostering either on a short or long-term basis can possibly offer a less restrictive opportunity than can residential care. Some evidence to date suggests that children with very specialised needs can be fostered and adopted.[38]

[36]Commission of Inquiry on Mental Handicap, op. cit., pp. 164/5.

[37]President's Committee on Mental Retardation. *Action for the Retarded.* Washington, 1972, p. 5.

[38]Parents for Children. First Year's Report, 1976/77, London, 1978.

Two conclusions emerge from a consideration of fostering schemes:

(i) Fostering can offer a feasible and flexible form of care for many children with either mental and/or physical handicap.

(ii) Successful long-term fostering demands a similar range of facilities in terms of family support for foster families as does an effective programme of support to other families with handicapped children.[39]

Fostering can offer a range of possibilities from long-term fostering, where family involvement has completely broken down, to holiday relief, crisis care, weekend or day-care provided by substitute families when the need is for support of the natural family. A survey of agencies involved in fostering in the United States has indicated that long-term fostering has proved feasible for mentally handicapped children both from their own homes and from residential centres. While some agencies concentrate their efforts on children achieving at relatively high levels intellectually, viz. an IQ level of 45 or above, the degree of handicap has varied from severe to mild, including children with multiple handicaps. The age range of children fostered ranged from six months to 18 years—there being general agreement that fostering is more difficult over the age of ten.

Short-term fostering Some agencies have used fostering for short-term or crisis care. As with short-term residential care it may be possible by guaranteeing short-term or crisis time breaks from caring through fostering to enable certain children, who would not otherwise be able to do so, to stay with their own families for a greater length of time.

It is clear that foster parents in general are not more likely than natural parents to be able to offer the skilled care a handicapped child may need without help from advisory and support agencies. In this regard it is notable that the Honeylands Family Support Service has found fostering to be feasible with support service.[40] In addition to support, once fostering has taken place, it is clear that prior to fostering there is a need for adequate preparation of the child and his/her natural family, and the foster family. Some fostering agencies in the United

[39]Campaign for the Mentally Handicapped. *Fostering Mentally Handicapped Children—Is It Feasible.* Enquiry Paper. No. 3. London. 1974.
[40]Brimblecombe. F., op. cit.

States offer courses covering basic information on handicap, the aim being to make foster parents part of the professional caring structure. However, in general the preparation for fostering centres on individual work with the child, natural parents or residential care staff if the child is being fostered from a residential setting. The foster parents' allowances and/or salaries paid are generally similar to those paid to families fostering other children.

The selection of foster parents is a specialised activity and this is particularly true with regard to the selection of suitable foster parents for mentally handicapped persons; the question of ongoing involvement into adulthood is of crucial importance, particularly for those mentally handicapped persons without contact from natural families; this is true irrespective of whether or not the mentally handicapped person is at that stage of life accommodated in a residential centre. Much experience is being built up with regard to fostering in general by social workers within health boards, in particular within the Eastern Health Board. The feasibility of fostering for handicapped children could be investigated jointly by these agencies, and those involved in the provision of support services for handicapped persons. However, consideration of the feasibility of fostering should not be confined to children. It may be possible to make use of fostering type support arrangements, either on a short- or long-term basis, also for some adults with less severe handicaps.

In conclusion, residential services must be seen as a continuum, providing a range of options depending on needs at different stages in the life time of particular individuals. This type of perspective implies that, in the long-term, persons accommodated in special residential centres are likely to be those with more marked degrees of handicap and additional incapacities and older mentally handicapped people. Any such change in residential populations would imply changes in staffing requirements. Large centres catering only for those with the most marked handicaps would have their own particular problems. Thus the development of alternative provisions would have to be accompanied by a monitoring of the implications for special residential centres.

7.5 RECOMMENDATIONS

(1) That a Working Party be established on residential care services for the physically handicapped person. Data be obtained on the number

of physically and sensorially handicapped people in residential care and the reasons for such placements.

(2) That alternatives to long-term residential care in the form of hostels and houses with necessary support services be investigated for physically handicapped persons. Some of the initiatives in providing "homes" for mentally handicapped persons could provide useful models.

(3) That the Department of Health and individual Health Boards take a more active interest in this area, recognising that the needs of the younger disabled person may not be effectively met by the same means as the needs of the aged, or other groups in long-term residential care.

(4) That the training requirements of staff working in residential care with the physically handicapped persons be investigated.

(5) That the quality of life available to residents within long-stay residential centres should be examined with particular reference to:

(a) personal income

(b) ability to determine one's own life style in very basic respects.

(6) That there be a commitment in terms of financial resources to psychiatric hospitals to ensure that residents in these centres enjoy the same standards as persons in special centres.

(7) That the provision of hostels/group homes, with reference to the vocational and occupational services available, be investigated within each Community Care area.

(8) That the feasibility of providing short-term residential care within each Community Care area be tested out in specific Health Boards.

(9) That the feasibility of fostering for handicapped children be investigated by agencies experienced in this form of care and agencies involved in the provision of support services for mentally handicapped persons.

CHAPTER 8

MOBILITY

8.1 Physical barriers to integration

> "Despite everything we do, or hope to do, to assist each physically disabled or mentally disabled person achieve his or her maximum potential in life, our efforts will not succeed until we have found the way to remove the obstacles to this goal erected by human society—the physical barriers we have created in public buildings, housing, transportation, houses of worship, centres of social life and other community facilities; the social barriers we have evolved and accepted against those who vary more than a certain degree from what we have been conditioned to regard as normal."[1]

The environment designed for the "average" person often does not take into consideration the wide range of mobility limitations caused by advanced age, physical disability or temporary injury. People can find themselves isolated and segregated from the mainstream of society because they are unable to enter into all aspects of community life.

The idea that a "barrier-free architecture" is catering to a minority is no longer valid. Maurice Short, the Director of the United Nations, Environmental Programme, estimates that at least 10% or possibly as many as 20% of the population suffer from some form of disability which has implications for environmental development.[2] Writing more recently Bill Hastings of the Housing Research Unit in University College, Dublin, said—

> ". . . the disabled constitute a significant proportion of the overall population whose design requirements are regularly

[1]Norman Acton, Secretary General, Rehabilitation International, in foreward to *Barrier-Free Design.* Report of a United Nations Expert Group Meeting, New York, 1975, p. 3.

[2]ibid., p. 4.

misunderstood or ignored . . . there is no reason why the design needs of the disabled and of the old should not be included in the brief for every new building".[3]

In other words it is not simply those with visible and severe mobility problems who are affected by the design of public buildings, private dwellings and public transportation. It is also the aged, mothers with prams, pregnant women, people with heart or bronchial conditions, the person with a crutch and those with sight defects are all impeded, inconvenienced and even endangered by architectural barriers. Barrier-free design would benefit all of society and not just the disabled. While these barriers represent an inconvenience for many within the general population, for the more severely disabled they can restrict totally their mobility whether it is simply going shopping, attempting to gain employment, taking a holiday or seeking accepted levels of recreational and educational pursuits.

It is often thought that the cost involved in producing a barrier-free environment is excessive. The United Nations Expert Group point out that it is a mere fraction of the overall cost of public buildings and facilities. They also rightly emphasise that if the comparison of costs between barrier-free design resulting in independence and employment of the handicapped and the cost of segregating this section of society, forcing them to be dependent on the community, were made known, politicians as well as planners would opt for complete integration by means of barrier-free design.[4] Despite the validity of this claim, if only on the basis of human rights, there is adequate justification for ensuring that the disabled person has the right to move freely without impediments.

The record in Ireland has been very bad. This is often due, not to indifference on the part of the architects and planners, but to a lack of awareness.[5] It is also related to the absence of effective legislation which should be formulated, implemented and monitored.

[3]Hastings, W., *The Rehabilitation of Housing for the Physically Handicapped,* Housing Research Unit, School of Architecture, University College, Dublin, March 1979, p. 69.

[4]*Barrier-Free Design,* op. cit., p. 8.

[5]A welcome initiative was made in November 1979 by the National Rehabilitation Board's Committee on Access when they published a booklet on minimum design criteria to provide easy access for disabled people to buildings—*Access for the Disabled: Minimum Design Criteria*—NRB, Dublin, 1979.

The Draft Building Regulations[6] has been in circulation since November 1976 and interested agencies have had adequate opportunities to comment in terms of their effectiveness in creating a more accessible environment. Sections relating specifically to the disabled persons is reproduced in Appendix VIII. The inclusion of the recommendations made by these agencies would help eliminate barriers from new buildings and provide the necessary legislative basis for a more suitable physical environment. It is essential that these recommendations are incorporated in revised regulations which should then be implemented immediately. A close watch will have to be kept on its implementation and a system of ensuring its effectiveness devised and pursued. The disabled person himself, as well as voluntary organisations, could play a supplementary part in this monitoring process.

8.2 Transportation

In referring to transport the Snowdon Report in Britain summarised the situation as follows:

> The disabled are not fully integrated in any areas of transportation. The main reasons are lack of understanding of the problem, lack of co-ordination or lack of resources. Given understanding, co-ordination and resources there is no reason why a vast improvement should not be achieved over the next decade, providing the will (both social and political) is there.

Their investigation covered all the major areas of public transport—rail, air, road. While recognising that the social needs of the physically and sensorially handicapped vary, the report emphasises that the linchpin of many of their needs is the availability of transport—for work, for training and for social enjoyment. It is also clear that as techniques of rehabilitation improve so also will the ability of the handicapped person to travel increase.[7]

Some countries have made considerable progress in adapting public transportation systems to the needs of those with mobility problems.[8]

[6]Draft Building Regulations, Proposed to be made by the Minister for Local Government under the Local Government (Planning and Development) Acts, 1963 and 1976, Dept. Local Government, Dublin, 1976.

[7]Snowdon Report, op. cit., pp. 46–49.

[8]From September 1979 Federal funds will not be available to those companies in the US whose buses are not accessible to the wheelchair user.

As in the question of public accessibility the resulting designs have led to more accessible systems for all the community. However, in Ireland virtually no progress has been made in public transportation systems. Aids which exist are directed towards specific forms of transportation. These aids may broadly be divided into

(i) public transportation concessions;

(ii) assistance for the disabled driver.

8.2.1 *Public transportation concessions*

Free travel on road and rail is available to all persons aged 66 or over, to all blind aged 21 or over, to blind persons aged 18 to 21 attending a general workshop or training school, to people in receipt of an Invalidity Pension or the Disabled Person's Maintenance Allowance. While there is no limit to the amount of free travel, there are some restrictions during peak travel periods. Useful as this concession is, it has limitations:

(i) there is no provision for the handicapped person (apart from the blind) who is working and has mobility problems and consequently is more dependent on public transport than the general population;

(ii) the concession is virtually useless to those people with very restricted mobility (e.g. wheelchair users, and those who can walk and climb very little) on account of the current inaccessibility of buses and trains;

(iii) the concession is not available to the handicapped person who goes into residential care and whose D.P.M.A. is stopped by the Health Board. This is a very serious anomaly as many such people are not working and have no source of income.[9]

Many voluntary bodies operate specialised transport to meet the needs of their members whether in relation to education, employment or for social reasons. Support is given in some instances towards this transport by relevant statutory authorities.

8.2.2 *The Disabled Driver*

In 1968 the then Government introduced a grant for Disabled Drivers.

[9]See section on residential care.

At the time this was a progressive piece of legislation and provided the handicapped person with a means of mobility which was acceptable and geared towards integration.[10] The car grant is available from the Health Board for those who need adapted cars. The grant is 75% of the total cost of a car up to a maximum of £1,000. The grant is payable subject to a means test. In the selection criteria for the grant the chief consideration is that a car is essential to earn a living. This is the basic qualification necessary to obtain a grant and Health Boards must be satisfied that the person concerned is capable of holding down a job. The handicapped person's capacity to drive and the holding of the appropriate driving licence are also essential criteria. Despite this in extreme instances, where perhaps a disabled person is living alone in a very isolated area and where transport would enable him to maintain social contact, a Health Board may with the prior consent of the Minister agree to dispense with the employment condition.

A driving school for physically handicapped persons is operated by the Irish Wheelchair Association. This service is available free of charge to all trainees. Located at several centres throughout the country it offers a range of different saloon cars with various hand controls. A full advisory and supportive service is also given by the school and its six driving instructors. For the first six years of its existence the school was financed totally by the Association. However, it is now recognised as a training unit and supports are obtained from the Health Boards and the European Social Fund.

There are a considerable number of concessions, granted over the past number of years, available to disabled drivers.[11] They apply only to those with an adapted car:

(i) New cars specially adapted are exempt from value added tax:

(ii) Excise duty is also refunded provided the car is kept for two years:

(iii) An adapted car is also exempt from Road Tax:

(iv) Disabled drivers are entitled to a tax rebate on petrol up to a maximum of 450 gallons a year;

[10]At the same time in Britain the primary aid to personal mobility was the provision of the three-wheeler inva-car which was a classic barrier to integration.

[11]Many of these were brought about as a result of negotiation by the Irish Wheelchair Association.

(v) Parking concessions are also available to the disabled driver displaying the International Symbol of Accessibility:

(vi) There are concessions for transport of a disabled person's car on the major car ferry routes from Ireland to Great Britain and France.

All of these concessions are based on the philosophy that for a handicapped person with severe mobility problems (i.e. who needs a specially adapted car) the car is not a luxury but a necessity.

There are, however, severe limitations in the scheme as it stands;

(a) it is linked exclusively to the disabled driver. Those who are too severely disabled to drive or who are restricted by the very nature of their disability from driving, receive no supports. Their need and the need of their relatives for help with mobility may be greater than that of the less severely handicapped person. The possibility of abuses, if the scheme is extended to the disabled passenger, are frequently mentioned. It would be extremely unfortunate if this anomaly is allowed to persist as a result of these fears;

(b) it is very closely linked to the employment conditions. Only in extreme instances and with the prior approval of the Minister will consideration be given to making a car grant available for social reasons, even under a means tested situation. The needs of the disabled housewife and mother, of the unemployed handicapped person living in remote areas, and indeed of the unemployed person living in urban areas who may well be equally isolated, are not being met as a general rule. A condition of the grant is that the Health Board will not be called upon at any stage to contribute towards the running costs of the car. While some handicapped people could maintain a car even if not working full-time, the initial investment without the financial support of the Health Board may be prohibitive;

(c) the maximum amount of grant payable is often not sufficiently closely linked to current costs of purchasing a car. Recently, the car grant was increased from £500 maximum to £1,000. With the current cost of any new car starting at over £3,000 one could still question the adequacy of the size of the grant.

(d) The problem of giving a reasonable opportunity in assessing a person's suitability for driving. This is a difficulty for the medical profession particularly where the person is suffering from a progressive disease.

8.3 Mobility Allowances

British Mobility Allowance: Until the end of 1975 the Department of Health and Social Security in Britain provided three-wheeled vehicles for handicapped persons who were unable to walk[12] or who needed a vehicle for employment purposes. Alternatively a quarterly allowance of £25 was given to help maintain a car.

Since 1976 the British Government's policy in the field of mobility has changed. It is now based on a "mobility allowance" which is paid regardless of the person's ability to drive. The scheme is expected to benefit over 140,000 people between five years of age and pension age. Having established eligibility, beneficaries will be able to retain the allowance up to the age of 75 years. The allowance is currently £10 per week. Safeguards against inflation will be built into the allowance from November 1979.[13]

New Irish Mobility Allowance: This scheme was introduced in September 1979. Although having the same title as the British scheme it is very different in both concept and applicability. The Irish scheme applies to severely handicapped persons in the age groups 16-66 years who are unable to walk and who would benefit from occasional trips away from home. The allowance is £150 per annum.[14] A means test is applied similar to that operable for the purposes of the Disabled Person's Maintenance Allowance. It is confined to persons normally living at home.

The medical criterion for the grant is inability to walk even with the use of artificial limbs or other aids or that the person is in such a condition of health that the exertion required to walk would be

[12] This criterion is interpreted more flexibly than this suggests. Provided one of three conditions is fulfilled the person is regarded as being unable to walk. See "clarification of new rules to govern mobility allowance" in *Contact* LAD. April/May/June. 1979. p. 30.

[13] Ibid.

[14] Dept. Health Circular No. 15/79.

dangerous. The inability to walk has to be likely to persist for at least a year. The person applying for the grant must also be in a condition to benefit from a change in his surroundings and must not be forbidden for medical reasons from being moved.

Unlike the British Scheme which recognises the additional expenses of mobility which can be incurred by handicapped persons and which offers a weekly cash grant to be spent as the person chooses, the Irish scheme is a recognition of the need for severely handicapped persons to get a break and offers a grant to the more severely handicapped person of very limited means. The scheme is a welcome initiative. While one may be disappointed in terms of its applicability the adequacy of the amount granted and even the title which tends to be misleading, it is a new concept in Irish services for the handicapped person. It implicitly recognises the right of people to something more than the mere subsistence level which the current Disabled Persons' Maintenance Allowance permits. Although it is difficult to comment on the operation of the scheme at this early stage two restrictive elements which appear to be built into the allowance should be highlighted:

(i) medical criterion which confines the allowance to persons who cannot walk at all or for whom walking could be dangerous. There are people who are severely handicapped (for example people with cerebral palsy) who cannot use the public transport services who have little outlets socially or occupationally but who can walk a little.

(ii) the allowance appears to be limited to persons living at home. This excludes that proportion of the severely handicapped population who are in residential care of various kinds. In fact it is reasonable to assume that many such people in residential care are more severely handicapped. This group often have no direct source of income[15] and have a very restricted style of life. Is their need for a change in their surroundings any less acute than for severely handicapped persons living within the community?

Conclusions

Mobility in Ireland should be examined in relation to:

(a) meeting long-term goals of a more accessible public transport system;

[15]See section on Residential Care.

(b) more short-term question of supports needed to facilitate the mobility of persons. This is crucial to the concept of integration and to the right of the handicapped person to have equal opportunities to work and to socialise as and when he wishes. Within this context the anomalies mentioned in free public transport and in the car grant as well as the relative advantages of a comprehensive mobility allowance should be examined.

8.4 RECOMMENDATIONS

(1) A commitment to the development of a barrier-free design in all new public buildings.

(2) The immediate implementation of the National Building Regulations with the suggested amendments or at least of Sections.

(3) A commitment to the creation of an accessible public transportation system.

(4) Removal of anomalies in present public transport concessions.

(5) Review of the car grant scheme taking the needs of the disabled passenger and the socially isolated person into account.

(6) Regular updating of the car grant within the context of rising prices.

(7) Examination of provisions for all those who have mobility problems and extra expenses deriving from them, with particular reference to the scope of the mobility allowance.

CHAPTER 9

PREVENTIVE ASPECTS

The development of a disability may be traced to many factors—genetics, nutrition, communicable diseases, trauma or degenerative disease ". . . the most significant similarity among these potentially disabling conditions is that it is often possible to prevent or minimise their ill effects."[1] Public health is not remote from rehabilitation and while not readily visible it directly or indirectly contributes to preventive rehabilitation.

Consequently the problem of handicap must be considered within the more general context of health care generally. The basic health services include both personal and environmental health care. Personal health care consists of preventive and curative aspects. Environmental health involves the control of factors in the physical environment which exercise a deleterious effect on the person's physical and mental development, health and survival.

9.1 Levels of Prevention

Prevention of handicap at all levels must form an essential part of general health services:

> Primary Prevention: Encompasses health promotion and education generally and more specific measures such as genetic counselling, good prenatal and maternal care, control of communicable disease, removal of environmental hazards.
>
> Secondary Prevention: Early diagnosis and effective treatment and rehabilitation, for example, PKU screening and treatment, surveillance of high risk population for cardio vascular problems.

[1]Masayoski, Itok. *Public Health Aspects of Rehabilitation*, Rehabilitation International Conference, Australia, 1972, p. 48.

> Tertiary Prevention: Includes limitation of the disability and effective care.[2]

Although outside the scope of this study the question of the adequacy of specialist medical facilities particularly outside the larger urban areas is of crucial importance.

The causes of handicap are complex and varied, consequently the question of prevention is a complex one. Preventive programmes must take a wide range of factors into consideration. It is necessary to consider general preventive programmes aimed at total populations and also specific measures aimed at particular groups known to be at increased risk.

9.1.1 *Immunisation Programmes*

Apart from the general health services there are, at the present time in Ireland, two programmes aimed specifically at the prevention of handicapping conditions in children, viz. an immunisation programme (primary prevention) and a screening programme, aimed at the detection of inborn errors of metabolism (secondary prevention). Both of these services are available free of charge (Table 9.1).

TABLE 9.1
Immunisation Against Diphtheria, Poliomyelitis and Rubella[1]

	1976	1975
Diphtheria:		
Courses of Immunisation completed	41,209	46,973
Total number of Pre-School Courses	40,392	44,229
Pre-School Courses as percentage of births in that year	59%	66%
Poliomyelitis:		
Number of Immunisations	41,401	45,272
Number of Immunisations of children aged under 2 years as percentage of births in that year	56%	63%
Rubella (Immunisation of girls aged 12-13)		
Number of Immunisations	22,566	27,740
Number of Immunisations as percentage of girls aged 12 years	71%	91%

Source: Statistical Information relevant to the Health Services, 1978, p. 19.

[2]Ibid., p. 47.

It is notable that the percentage of eligible children who availed of immunisation services decreased in 1976 relative to 1975. This may be associated with the controversy relating to the whooping cough vaccine. However, irrespective of the cause, this decline in the take up of these services points to the crucial importance of public education on the importance of immunisation. This public education has particular importance with regard to the rubella immunisation, which has been introduced relatively recently. The effects of rubella on the foetus, particularly if contacted by the mother in the earlier stages of pregnancy, can be associated with a range of handicapping conditions, affecting one or more of the following, the brain, the eyes, ears or heart. Many of the children affected are multiply handicapped. While 80% of mothers are estimated to be immune to this condition, it is clear that as the handicapping conditions associated with rubella are preventable, information on the availability of immunisation should be widely disseminated, not only to the parents of 12-13 years old girls, but to all women in the child-bearing years.

9.1.2 *Screening Programmes*

A national screening programme for the detection of inborn errors of metabolism, the major one of which is phenylketonuria (PKU) was introduced in 1966. The programme is operated from Temple Street Hospital and almost 99% of births are screened annually. PKU is treated by the introduction of a low phenylalanine diet and if left untreated it generally leads to severe mental handicap. The evidence now available indicates that treated females are at risk of producing children with a range of seriously handicapping conditions unless a low phenylalanine diet is maintained throughout pregnancy. To ensure that

TABLE 9.2

Phenylketonuria Screening

	1977
Number of infants tested	67,651
Percentage of all new born infants tested	98.9%
Number of cases detected	13
Incidence of PKU per 100,000 infants tested	19.2

Source: Statistical Information relevant to the Health Services, 1978

this is avoided a programme has been initiated jointly by Temple Street Hospital and the Medico Social Research Board to monitor treated females throughout their reproductive lifetime.

9.2 Maternal and Neo-natal Services

Handicap can originate at any age from serious illness or trauma. However, it is found in practice that the more serious the handicap the earlier in life it is likely to have originated.[3] While the causes of many handicapping conditions in infants are not as yet known, there is considerable evidence to suggest that if the best care that is possible, at the present time, were given to every expectant mother and every newly born infant, the risk of neurological damage and consequently the number of handicapped children born would be reduced.[4] This would not necessarily be associated with a proportionate overall reduction in handicap, as it would probably be associated with increased survival of seriously handicapped children.

In considering preventive programmes, the evidence from France is of particular interest. There a wide ranging plan was embarked on, as part of Government policy on the prevention of handicaps of perinatal origin[5] and within this plan the greatest emphasis was placed on antenatal care. In formulating the programme, the origins of handicap in children surviving 12 months in the 1968 cohort of births (4.8% of the cohort) were studied.

On the basis of these findings it was decided that while 35% of handicap happens too early in pregnancy to be affected by antenatal care, the remaining 65% is amenable to antenatal care, or improved delivery, or special neonatal care or other measures taken after the end of the first trimester of pregnancy.[6] While the percentage of handicapping conditions associated with each cause differs in different countries, these estimates give an indication that a considerable proportion of those handicapping conditions, evident at one year, may be preventable.

[3] Wynn, M. and Wynn, A. *Prevention of Handicap of Perinatal Origin*, London. Foundation for Education and Research in Child-Bearing, 1976, p. 4.

[4] *Fit for the Future*, Report of the Committee on Child Health Services, HMSO, London, 1976.

[5] "Perinatal" is defined internationally as covering the period from the 28th week of gestation to the end of the first week of life; in the case of the French plan it is taken to cover the last 2 trimesters of pregnancy and the first week of life.

[6] Wynn, M., & Wynn, A., op.cit., p. 8.

TABLE 9.3

Origins of Handicap: Children Surviving First Year Estimated to be Handicapped: France 1968

		Percentage
1.	Difficulties of delivery including asphyxia	14.1
2.	Prematurity, low-birth weight and postmaturity and related socio-economic factors	33.7
3.	Isoimmunisation and related difficulties	2.1
4.	Previous obstetric complications and illnesses of the mother including viral infections such as rubella and influenza and diabetes	14.6
5.	Initial anomalies of the foetus, including genetic and chromosomal anomalies and defective early development	35.5
		100.0

Source: Wynn, M., and Wynn, A., op. cit., p. 8, Table 4.

The programme of prevention formulated by the French Government was wide ranging and covered the following areas:

(a) Medical education in obstetrics and neonatal medicine.

(b) Records and research; collection of data on all pregnancies and confinements; introduction of a maternity book for mothers.

(c) Inoculation against rubella.

(d) Antenatal care: Increase in the number of antenatal visits and establishment of referral centres for women at risk.

(e) An increase in the number of obstetric departments with a high level of staffing and equipment.

(f) Enforcement of minimum standards for resuscitation of the newborn: Enforcement by law of standards for construction size, equipment and staffing of all maternity units.

(g) An increase in the number of intensive care units for the newborn.[7]

[7]Ibid, p. 9.

Despite difficulties associated with particular aspects of these programmes it is claimed that they have been more successful than anticipated on the basis that their introduction has coincided with a considerable reduction in the perinatal mortality rates in France;[8] however, it must be emphasised that this does not necessarily imply a direct causal relationship. Despite this reservation the range of the programmes does illustrate the need for an investigation of a wide range of factors in formulating a preventive programme in Ireland. Consideration of the organisation of the obstetric, neonatal, paediatric and other specialist facilities is outside the scope of this report. However, it is notable that deficiencies in these areas have received considerable attention of late. For example, the problem associated with smaller obstetrical units, in terms of availability of adequate specialist staffing and equipment to meet the needs of high risk births, has been highlighted by Comhairle na nOspidéal and in medical journals;[9] at a more general level the shortage of obstetricians, neonatologists and paediatricians has also been high-lighted.[10] It is clear that if a realistic commitment towards the prevention of handicapping conditions in infants is to be made, a crucial first step must be taken to remedy deficiencies in these areas. It is notable that the National Health Council in its 1978 report indicated that special priority in preventive health services should be given to the areas of ante and postnatal services, neonatal and paediatric services,[11] and that the Journal of the Irish Medical Association has referred to the urgent need for a national policy for the express purpose of preventing handicap in children. "There is considerable evidence that on cost analysis alone the profits could be enormous—not to mention the benefits to the next generation."[12]

The effectiveness of any preventive programme is clearly dependent not only on the medical facilities available but also on the expectant mother's knowledge of the availability of services and on her

[8]Ibid, p. 28.

[9]*Journal of the Irish Medical Association*, 1977, Vol. 10, No. 4, p. 105. Cussen, G. "The Paediatric Dimension", *Journal of the Irish Medical Association*, 1978, Vol. 71, No. 11, pp. 367-371.

[10]*Ibid.*

[11]The National Health Council, *Report for the Year Ended 31 March, 1978.* Dublin, Stationery Office, 1978.

[12]*Journal of the Irish Medical Association*, 1977, Vol. 70, No. 4, p. 105.

appreciation of the importance of the take-up of these services at the appropriate times. This entails an obligation to convey this information to her. There is considerable evidence from studies conducted in Britain that many expectant mothers appear to be unaware of the crucial importance of early attendance at antenatal clinics.

> It has been estimated that some 20% of women in Britain do not seek assistance and guidance before the end of the first trimester of pregnancy, some fail to keep appointments and a minority remain unknown to the health services until they go into labour.[13]

Furthermore, there is evidence that the tendency towards late attendance is greater among younger women and those having first pregnancies and high parity pregnancies.[14] The findings of the 1958 British Perinatal Mortality Survey demonstrated a five-fold increase in perinatal mortality in the offspring of women who did not receive any antenatal care compared with those who did and a four-fold increase in women attending on only 1 to 4 occasions, compared with those attending more than 4 times.[15] More recent studies indicate a similar pattern.[16] Studies have also indicated a very close relationship between mortality in early life and low birthweight, a relationship which also holds for the incidence of mental and physical handicap;[17] furthermore it has repeatedly been emphasised that maternal nutrition is an important influence on the baby's weight.[18] Thus, it is clear that any efforts towards the improvement of take-up of antenatal care service and the provision of education to expectant mothers on risk factors could be associated with considerable benefits, in terms of maternal and infant health. It is notable that in France where payment of antenatal allowances is made in 3 instalments contingent on attendance for antenatal care at specified times, approximately 96% of women attend for their first examination prior to 14 weeks' gestation. Within the French programmes specific steps have been taken to ensure that expectant mothers are aware of the services they should avail of and that they cooperate at the primary care level. A "Maternity Record Book" which is the property of the mother is issued for each

[13]*Birth Impairments*, London, Office of Health Economics, 1978, p. 34.
[14]Ibid.
[15]Ibid, pp. 34-35.
[16]Ferster, J. and Jenkins, D. M. *Lancet*, 1976, 2, pp. 727-9.
[17]*Mental Handicap Ways Forward*, London, OHE, 1978, p. 17.
[18]*Birth Impairments*, p. 35.

pregnancy. Apart from providing general advice to the mother this covers obstetric history, antenatal care, delivery, state of the newborn infant and postnatal care and includes a standard record form completed by the doctor undertaking the antenatal examinations and which is supplied to the hospital receiving the pregnant woman for delivery. It is considered that this type of record book has an important educational role for the parents.

A crucial need that has been highlighted in the operation of the French preventive programme has been for home visiting by medico-social personnel, particularly as a means of reaching those women who under-utilise the antenatal services. This type of service is particularly important given that studies have illustrated that the underutilisers of the antenatal services tend to be women from lower socio-economic backgrounds with a low level of education and that these were women who because of poverty and over-work were at higher risk.[19] It is notable that home visiting is an integral part of the antenatal care programme in Finland, which has one of the lowest perinatal mortality rates in the world.[20]

It is clear that perinatal mortality rates and the incidence of handicapping conditions are influenced not only by services but also by the general living standards in different countries and among different sections of the community in each country, thus programmes successful in one country cannot be directly applicable to other countries. However, given the evidence relating to the importance of antenatal care in the reduction of perinatal mortality and the prevention of handicapping conditions in infants, it is of crucial importance that the effectiveness of these services and their take-up should be investigated in Ireland. It is notable that the publicity associated with the French programmes was found to have a beneficial "catalytic effect" not only among the medical and paramedical personnel concerned but also among expectant mothers.[21] This illustrates the beneficial effects of a national policy on prevention of handicapping conditions and in particular the effects of widespread dissemination of information on the factors necessary to achieve the objective of preventing handicapping conditions.

[19]Wynn, M. and Wynn, A., op.cit.
[20]Ibid, p. 19.
[21]Ibid, p. 20.

9.3 Genetic Counselling Services

The operation of genetic factors in the causation of handicap are complex and may be either hereditary or spontaneous. Examples of the former are such conditions as Huntington's Chorea, Cystic Fibrosis, inborn errors of metabolism (such as Phenylketonuria), Haemophilia. The degree of risk associated varies depending on the nature of the inheritance. In the case of dominant conditions such as Huntington's Chorea, there is a 1 in 2 chance of a child having the condition when one parent is a carrier of the condition. This condition is thought to occur in about 1 of every 4,000 births. In the case of recessive conditions, both parents must be carriers though not affected by the condition themselves, for example, cystic fibrosis and PKU. There is a 1 in 4 chance of each child being affected and a 1 in 2 chance of each child being a carrier. In the case of sex linked conditions, such as Haemophilia, the condition is carried by females who are not affected by the condition but whose male children have a 1 in 2 chance of being affected and whose female children stand a 1 in 2 chance of being carriers.

Down's Syndrome is one of those conditions which usually results from a spontaneous change in the germ cells. These conditions are not inherited beyond one generation. In the case of Down's Syndrome, which is estimated to account for approximately 30% of all moderate, severe and profoundly mentally handicapped children of school going age,[22] the risk of having an affected child increases with the age of the mother. In women under 30 the incidence is about 1 in 1,000 births, but increases to about 1 in 60 for women over 45. Approximately 30% of children with Down's Syndrome are born to women aged 35 and over.[23]

At a specific level genetic counselling refers to "the assessment and communication of specific risks in a given pregnancy,"[24] however it has a far wider function than this. Because of the difficulty of identifying high risk cases in most genetically transmitted disorders, genetic counselling has to be in most cases retrospective in that those who seek advice already have handicapped children and are seeking advice about the risks in future pregnancies. Prospective genetic counselling is

[22]*Mental Handicap Ways Forward,* p. 15.
[23]*Reducing the Risk,* D.H.S.S.
[24]*Birth Impairments,* London, OHE, 1978, p. 39.

dependent on greater knowledge concerning the causes of handicapping conditions and the identification of carriers. At the present time genetic counselling services in Ireland are limited as is also take-up of these services. It is clear that information on the availability of this type of service should be communicated to parents of children with handicapping conditions, known to be genetically transmitted, particularly those conditions where the chances of having an affected child are high and those conditions, such as Spina Bifida, where the risks are known to increase after the birth of one affected child.[25]

9.4 Early Identification of Handicapping Conditions

The purpose of early identification of handicapping conditions is to ensure that preventive action is taken and where this is not possible that appropriate services are provided from the earliest possible time. Age at identification depends to a considerable extent on the child's clinical condition. Some conditions are evident at birth, for example, Spina Bifida and Down's syndrome.[26] However, only a minority of handicapping conditions are evident at birth. Consequently the developmental examinations at the child health clinics and the public health nurses' reviews are of crucial importance. As has been pointed out, while 85% of eligible children attended the child health clinics for the 6 month examination in 1976, only those children in centres of population of 5,000 and over have access to these clinics. Thus, the role not only of public health nurses, but also of general practitioners in identification and notification to the Director of Community Care of handicapping conditions in early childhood is of crucial importance.

Identification of handicapping conditions raises the questions of "at risk" registers and selective or universal screening of the child population. Davie and associates in a report on the National Child Development study in Britain considered this question and identified optimal groupings of criteria for prediction and entry onto an "at risk" register for two groups of children:

[25]Ibid, pp. 30, 31.
[26]With regard to Down's Syndrome it is notable that a study conducted in Birmingham on children born between 1965 and 71 found that only 56% of mothers learned of the diagnosis shortly after birth, while 13% said they did not know they had a handicapped child until after his or her second birthday. Smith, B. and Phillips, C. J., "Identification of Severe Mental Handicap", *Child Care, Health and Development,* 1978, 4, pp. 195-203.

In the case of those with severe physical, mental or multiple handicap (excluding those with defects detectable on routine medical examination at birth, i.e. about $\frac{1}{3}$ of this handicapped group) it emerged that with 13.2% of live births registered, 25.3% of handicapped children would be included.

In the case of the second group considered, i.e. those who because of educational or mental backwardness were receiving or thought to be in need of special schooling at the age of 7 years, the inclusion of 24.7% of live births on the register would cover 53.6% of the handicapped children in the category. It was concluded "that certain carefully selected, yet easily recorded, birth factors are of value in the prediction of handicaps. Furthermore, it can be established that there is always a benefit to be gained from the differential allocation of resources between children at "high" and "low" risk, particularly in authorities where the existing detection rate is low."[27] Despite this, it is clear that the applicability of the "at risk" concept is limited; in the case of those with severe handicap 75% were not identifiable on the basis of the selected criteria and could only be identified by periodic developmental screening of the whole child population. This is not to suggest that clearly identified high risk factors should not be taken into account, but that an exclusive focus on these factors is too limited. The Court Committee[28] on child health services in Britain pointed out that the use of at risk registers had not proved satisfactory there and advocated the use of standard health records for all children aged 0-15 in relation both to preventive and therapeutic care. It stressed that "in their health surveillance of all children, health care staff should recognise in the case of each child any factor that should alert them to a greater than average risk af ill-health, developmental disorder or handicap occurring in the child".[29]

Given the facts that the value of risk registers has been widely questioned but that the early recognition of handicap conditions has not, developmental screening of the whole child population is of crucial importance. Thus, every effort should be made to ensure take-up of the available services by all the eligible population and towards the extension of these services to cover all areas.

[27]Davie, R., et. al., op. cit., pp. 185-6.

[28]Committee on Child Health Services, *Fit for the Future*, Vol. I, HMSO, 1976, p. 191.

[29]ibid., pp. 139-140.

At the present time while general practitioners and Child Development Clinics have crucial roles to play in the early identification of handicapping and potentially handicapping conditions, it is clear that the role of the public health nurse as the person who has access to all children, will in many cases be primary.

TABLE 9.4

Optimal Groupings for Prediction and Entry onto "at risk" Register

	Register	
	Severe physical or mental, or multiple handicap[a]	Educational backwardness requiring special schooling
Prevalence per cent	1.4	2.3
Criteria for entry into the register	1. High birthrank (fifth or later) or: 2. Abnormal delivery (breech, face, internal version or by untrained person) or: 3. Abnormal signs or serious illness in first week (convulsions, cyanotic attacks, cerebral signs, hypothermia, serum billrubin 15 mgm per 100 cc or more, Rh incompatibility or other serious illness).	1. Illegitimate birth or father unskilled worker or: 2. High birth rank (fifth or later) or: 3. Abnormal delivery (breech, face, internal version or by untrained person) or: 4. Abnormal birthweight or gestation (a) $5\frac{1}{2}$ lb (2,500 g) or less, or born before 37 weeks. (b) Born 43 weeks or later.
Children on register as percentage of all live births	13.2	24.7
Percentage of handicapped children included in register	25.3	53.6

[a]Excluding those with defects detectable on routine medical examination at birth, i.e. about $\frac{1}{3}$ of this handicapped group.

Source: Davie, R. et. al., *From Birth to Seven*, Longmans London, 1972, p. 185, Adapted from Table 7.

9.4.1 *Mild Mental Handicap*

The possibility of preventive action, through intervention in the pre-school years, in the case of mild mental handicap, particularly mild mental handicap in the absence of overt neurological factors has received considerable attention.[30] Assessment of the need for services for this group at the present time is complicated by the fact that difficulties are generally not highlighted until the child has entered the ordinary school system. However, there is considerable evidence available on the characteristics of children who are ascertained as mildly mentally handicapped during school years. The significance of socio-economic background and numerous factors found to be associated with socio-economic background such as family size, housing conditions, level of educational achievement of parents and siblings has repeatedly been highlighted in the case of sub-cultural or familial mental handicap.[31] Many of the factors found to be associated with mild mental handicap, in the absence of neurological damage, are also found to be associated with general educational disadvantage.[32] Furthermore, the evidence of many studies indicates that rather than an inherent difference in intellectual functioning between the majority of those ascertained as mildly mentally handicapped and the rest of the population, the functioning of the former group should be conceived as part of the continuum of normal intellectual functioning.[33] While of slower and more limited intellectual development than the average population, this group are not inherently different and their educational problems can be conceived as a more extreme expression of general educational under-achievement. Thus, the provision of an effective pre-school service for the general population would facilitate this group.[34]

The type of pre-school programme that should be provided is an extremely complex question. However, most studies to date indicate that such programmes should be accompanied by support programmes for families. In particular the Milwaukee project, which is one of the most successful projects reported, suggests that efforts in the

[30]Forrest, A. D. "Subcultural Handicap", In *New Perspectives in Mental Handicap.* Eds. Forrest, A. D. et al., Edinburgh, Churchill, Livingstone, 1973; Tarjan, G. "Some thoughts on sociocultural retardation", in Haywood, H. C. (ed), op. cit. pp. 745-758.

[31]Saunders, M., op. cit.

[32]Rutter, M. et al., *Education, Health and Behaviour,* Longmans, London, 1970; *A Pattern of Disadvantage,* National Foundation of Educational Research, Slough, 1972.

[33]Zigler, E. op. cit.

[34]Warnock Report, op. cit.

prevention of mild mental handicap can be successful, provided intervention is not confined to an early stimulation programme for children from high risk families, but that support programmes are also directed towards the mothers concerned.[35]

Pre-school facilities, except on a fee-paying basis, are extremely limited in Ireland. The limited evidence that is available, apart from highlighting the complexity of effective pre-school provision for educationally disadvantaged children, does indicate that certain long-term gains can be achieved through such a programme.[36]

While definitive answers on the most effective types of programmes are not yet available it is clear that the feasibility of various types of programmes within the Irish situation, particularly within larger urban areas, needs to be investigated and could have considerable long term advantages.

9.5 Adult Handicapping Conditions

Many of the handicapping conditions which have their onset in adulthood have complex causes related to medical factors. However, very many are either exacerabated by environmental factors or totally related to environmental factors. Environmentally induced handicaps are in theory preventable; such prevention is dependent on awareness of the factors associated with the causation of handicapping conditions and a commitment towards prevention; consequently health education is crucial.

Spinal injuries: In 1977, 104 cases of spinal injury, including 55 cases of paraplegia, were admitted to the National Medical Rehabilitation Centre; the corresponding figures for 1976 were 99 cases admitted, including 46 cases of paraplegia. The causes of these injuries were as follows:[37]

	1976	1977
Road Accidents	53	59
Falls	45	32
Sporting Accidents	5	6
Other	1	2

[35]Heber, R. and Garber, H. "The Milwaukee Project: Intervention in Preventing Mental Retardation" in *Research To Practice in Mental Retardation,* Ed. Mittler, P., Baltimore, University Park Press, 1977, pp. 119-127.

[36]Kellaghan, T. *The evaluation of an intervention programme for disadvantaged children,* N.F.E.R., Slough, 1977.

[37]*Annual Reports,* 1976 and 1977, N.R.B.

The nature of these causes illustrates clearly that many of these injuries are preventable and highlights the crucial importance of health education and the enforcement of available preventive measures, notably those relating to the Road Traffic Acts.

Industrial Accidents: In Ireland each year there are approximately 3,500 reported industrial accidents.[38] Apart from the small number of these which are fatal at least some of these accidents result in long-term handicaps for the persons concerned. These accidents are preventable, provided there is a commitment to the implementation of safety standards; there is a clear need for an effective information and education programme aimed at this objective.

9.6 RECOMMENDATIONS

(1) That a national policy on the prevention of handicapping conditions in children be developed.

(2) That the pre-school child development examination services be extended and made available in all areas.

(3) That pre-school services be developed in urban areas—particularly in the more deprived areas.

(4) That research be undertaken on the early identification of children at risk of mild mental handicap and educational underachievement in general, with a view to developing support programmes.

(5) That research into the medical aspects of adult handicapping conditions be promoted and a realistic financial commitment be made to appropriate individuals and research organisations.

(6) That a greater allocation of resources be made, not only financially, but also in terms of expertise. This is particularly necessary in the treatment of chronic handicapping conditions.

(7) That the distribution and adequacy of specialist medical rehabilitation facilities throughout the country be evaluated.

Health Education

(8) Prevention of handicap is not solely a medical problem; attitudes of the general public towards health in general and the responsibility they assume for their own health are also crucial.

[38]See Appendix IX, Summary of Accident Statistics 1975-1978.

Thus, prevention necessitates knowledge by the general public of factors associated with handicapping conditions; consequently, the provision of such information must be an integral part of the general health programme. Educational programmes should include information on a wide range of issues including the following:

(i) Ante-natal care: Apart from take-up of medical services the expectant mother's responsibility needs to be highlighted through the provision of information on the effects of such factors as nutrition, smoking, alcohol and unprescribed drugs during pregnancy;

(ii) Maternal age: Information on the increased risk of having a baby with Down's Syndrome in the case of older mothers;

(iii) Immunisation: Information on the availability and importance of immunisation and the prevention of infections in young children;

(iv) Services for particular groups: Information on such services as genetic counselling;

(v) Child Health Services: Information on availability and importance of take-up;

(vi) Information on Industrial Safety;

(vii) Information on the prevention of accidents, both in the case of children and adults;

(viii) Information on the impact of particular styles of living in causing handicapping conditions.

CHAPTER 10

CONCLUSIONS

Several points emerge quite clearly from this preliminary investigation of major issues in planning services for physically and mentally handicapped persons:

Services for mentally handicapped persons are better developed relative to those for physically and sensorially handicapped persons. This is evident in:

(1) The better information sources available on the number, situation and needs of mentally handicapped persons. These sources include the Census of the Mentally Handicapped[1] and also the Department of Health.

(2) The existence of a structure at both Regional Health Board and Departmental level whereby attempts are made to co-ordinate services and to plan for existing needs.

(3) The level of statutory financial support made available to voluntary bodies providing services to mentally handicapped persons.

The situation in relation to the physically and sensorially handicapped persons has not reached a comparable stage of development in any of these major areas and in some, progress has been virtually non-existent. Planning of long-term policies must be initiated now. It should not be assumed that the planning of services for mentally handicapped persons is sufficiently progressive or comprehensive. It has been noted throughout the report that there are shortfalls in provision for particular

[1]Mulcahy M. & Ennis B. op. cit & Mulcahy M., op. cit.,

groups and in particular geographical areas. This illustrates the crucial need for comprehensive planning and co-ordination both nationally and regionally.

The report highlights the need for a greater commitment, at Governmental level, to reduce the inequalities and social deprivations experienced by many of the handicapped population in Ireland. The goals of planning for the handicapped persons should be:

(1) The full integration of the handicapped person into the community;

(2) The active promotion of the rights of the handicapped person;

Planning for these long-term goals can be initiated immediately. They necessitate changes in the economic and material situation of the handicapped person. Changes may be brought about in the quality of life through more adequate provisions in training and employment fields, income maintenance programmes, health services, community support services, housing and residential care services. However, they also necessitate change in social attitudes and the outlook of society. Attitudinal changes are essential if the potential of the person, rather than the handicap is to become the focal point. They are necessary if the rights of the handicapped person are to be implicitly recognised and actively promoted. Changes in attitudes are also relevant to the development of appropriate services. For example, a change in attitude to residential care provisions could lead to a more flexible range of provisions. Residential care and community care need not be viewed as an either/or situation. Various intermediate provisions are possible, such as short-term residential care or supported domiciliary care.

Planning and Social Policies

Research and planning in social policy are basically concerned with:

(a) measuring the dimensions of a social problem;

(b) ascertaining its causes;

(c) taking appropriate preventive and remedial action.

The collection of basic information is an essential prerequisite to such planning and in the case of physically and sensorially handicapped persons this must be given utmost priority.

Effective planning is dependent not only on adequate information upon which relevant services may be based but also on having a policy framework within which statutory and voluntary agencies are clear as to their contribution, their area of responsibility and the dimensions of their task. The information, the structure of relevant services and the policy framework are very sparse in relation to physically handicapped persons. This is evident at both govemmental and regional Health Board levels.

In view of the piecemeal development of services for handicapped persons to date, the dimensions and complexity of the problem and the progress which has yet to be made, on a general level, two specific recommendations are made:

(1) The appointment of a Minister of State at the Department of Health and Social Welfare who would have a particular responsibility for the development of services for the handicapped population. While, ideally, provisions for the handicapped person should be an integral part of those for the population generally, often additional facilities are necessary. Where the special needs of the handicapped person, in relation to employment, mobility, accommodation, income or education are not recognised and met, he may not be able to avail of normal social and economic opportunities. It is often necessary to positively discriminate in favour of the handicapped population to ensure equality of opportunity. This has not happened in many areas of planning to date. A strong political voice is necessary to ensure that the needs and the rights of the handicapped population are taken into account at all stages of economic and social planning. A person with a particular responsibility for this area could liaise with other government departments and statutory agencies such as N.R.B. and Health Boards as well as with voluntary bodies in the field.

(2) The formulation of legislation to protect the rights of the disabled person and to make the provision of certain services and facilities mandatory. The Chronically Sick and Disabled Persons Act in Britain (1970) was not only a "humane charter for the handicapped" but it added a new dimension to welfare services. It covered welfare, housing, public premises, universities and school buildings, advisory committees and the need for representation of the disabled person on them, residential accommodation and miscellaneous provisions. However, most interestingly, it placed a new obligation on local authorities to go out and find all disabled people who could benefit from the support of welfare services.[2] This was an entirely new concept and a dramatic change in the law[3]. The implementation of the Act was not totally satisfactory due, partly, to the ambiguous instructions which accompanied it and their varied interpretation by local authorities. However, similar legislation, with safeguards to ensure its proper implementation, has much to recommend it in Ireland. It could provide a solid framework for evolving a more meaningful structure of services as well as placing statutory obligations on local authorities to meet needs.

Need for Research

The report has highlighted many areas of need. In the process, it has also shown how much more work needs to be done before appropriate services can be initiated. Information is lacking not only on the handicapped population, their range of needs and the problems they encounter, but also on the types of services needed, the appropriateness of existing ones and the contribution of various agencies. The social aspects of handicap are virtually untouched from a research point of view. There are many areas to be examined and bodies such as the Medico Social Research Board, the National Rehabilitation Board, the Health Education Bureau and AnCO must be encouraged to undertake research into particular aspects of handicap.

[2]The Chronically Sick and Disabled Persons Act (1970) did not extend to Northern Ireland except for sections 9.14 and 23. However, a Chronically Sick and Disabled Persons (Northern Ireland) Act came into force on 31 July 1978. The Act charged the Department of Health and Social Security with responsibility to discover the identity, number and needs of handicapped people, to advertise services and advise disabled people of sources of help. This task was begun in 1978.

[3]Jaehnig, W. "Seeking out the Disabled" in the *Handicapped in the Community*, op.cit., p. 441.

Community Education

Within the field of community education, the Health Education Bureau has a particular role to play. Its terms of reference are to advise the Minister on priorities in health education, to draw up and implement health education programmes in co-operation with statutory and voluntary bodies in the field; to maintain contact with appropriate voluntary bodies, assisting them financially as appropriate; to help with local health education programmes; to promote and conduct research.

Within these terms of reference it appears that the Health Education Bureau potentially has a valuable contribution to make in relation to handicap in terms of both prevention and attitudes. The following areas are of particular relevance;

(a) prevention of handicap through health education

(b) creating a greater awareness of the existence and needs of the handicapped population. The role of the media should be examined more closely in this regard.[4]

(c) fostering positive social attitudes towards handicapped persons,

(d) promoting and undertaking relevant research.

In conclusion it is evident that the handicapped population are a very diverse group and that they comprise a substantial proportion of the total community. Handicapped persons who need total care are a minority of the total handicapped population. Many handicapped people do not require this total care but rather need a range of services and facilities which will help to offset the impact of the disabling condition and enable them to realise their potential to the maximum extent possible.

The report has highlighted major deficiencies in the structure of services for handicapped people. Given the present level of development of these services this is a relatively easy task. It is more difficult to remedy the situation in a manner acceptable to all the groups concerned—handicapped people themselves, voluntary bodies and statutory agencies.

Given sufficient political commitment, resources and imagination the United Nations nominated "International Year of Disabled Persons" in 1981 can be a milestone in services for and attitudes towards the handicapped person in Ireland.[5]

[4]Such R.T.E. programmes as "Listen and See" and "Going Strong" have been welcome initiatives.

[5]See Appendix X for information on preparatory work by the United Nations on the IYDP, 1981.

SUMMARY.

The basic premise on which this report is based is that services for handicapped persons must be conceived within a framework of justice rather than one of charity. It is emphasised that every person has the basic right to the opportunity for personal and social development and this right exists irrespective of whether the individual concerned is or is not handicapped. This basic right relates not only to access to appropriate services but also encompasses such frequently neglected factors as the sexual rights of the handicapped person and the right of access to recreation and leisure facilities. Based on the acceptance of this basic right it is pointed out that what is needed is an enabling structure to offset the disadvantages sustained by many handicapped people and not a set of static services labelled "handicapped".

The following sections outline briefly some of the major points emerging in each of the chapters.

Chapter 2 considers Identification and Classification of Handicap. It is pointed out that certain information is essential for effective planning of services to meet the special needs of handicapped persons. Availability of this information is dependent on an agreed definition of handicap and on a system for obtaining regularly up-dated basic information on the numbers of handicapped persons within each community care area. At the present time the situation relating to mental handicap is better than that relating to physical handicap;—firstly the Census of Mentally Handicapped Persons undertaken in 1974 has provided information on the number of moderate, severe and profoundly handicapped persons in the country; secondly work is being undertaken towards the establishment of a basic record system at Community Care level which will ensure the availability of essential statistics.

On the basis of the Commission of Inquiry on Mental Handicap Report (1965) the term mental handicap is used to describe those

"who by reason of arrested or incomplete development of mind have a marked lack of intelligence and either temporarily or permanently inadequate adaptation to their environment." The criteria for diagnosis are outlined as are the subdivisions of mental handicap and the major variations in functioning evident among persons included under the general "mental handicap" classification.

In 1974, there were over 11,000 persons functioning at moderate, severe and profound levels of mental handicap in the country, 56% of whom were in a variety of residential centres. Apart from those in residential centres (1,845), persons functioning at a mild level of mental handicap were not included in the 1974 census. It is pointed out that mild mental handicap presents a problem primarily during school years; in 1978 there were 5,700 children attending special schools and classes provided for children functioning at a mild level of handicap.

While information already exists on particular groups of handicapped persons virtually no progress has been made in compiling a "national register" of physical and sensory handicap. There are however very great difficulties in defining and classifying physical handicap. These have contributed to the lack of progress in providing comprehensive data which is urgently required for planning.

The various means by which the data may be collected and the various definitions and classifications of handicap are discussed. It is proposed that the EEC definition of handicap be used. This is felt to be sufficiently broad to include different types and degrees of handicap. It defines handicap as;

> any limitation, congenital or acquired, of a person's physical or mental ability, which affects his daily activity and work by reducing his social contribution, his vocational employment prospects or his ability to use public services.

A functional rather than a medical classification is recommended for use.

The various means of collecting the data are outlined. These range from a national census to detailed social surveys. Regardles of the actual technique to be used it is apparent that the "register" will not simply emerge; considerable time and energy will need to be devoted to it particularly if it is to be of optimum value.

A framework is put forward for identification of handicapped persons by Health Boards. It outlines the purpose and scope of the "register", whom it will include, the sources which will be used, who will compile it and the type of information it will contain.

Chapter three focuses on Education and the Handicapped Person. Considering the broad goals of education as being to enlarge knowledge, experience and imaginative understanding and to enable the individual to achieve as much independence as possible, it is clear that the help that individual children will need in progressing towards these goals will differ. Rather than categorising children, from an educational point of view, as handicapped, and requiring "special" education, and non-handicapped, as requiring "ordinary" education it must be borne in mind that there is no simple relationship between handicap in educational terms and the severity of a disability in medical terms. The present report points out that a focus on special educational need rather than category of handicap is the most appropriate framework within which the education of children should be approached. Thus, special education encompasses the idea of any form of additional help whenever and wherever it is provided. Studies indicate that up to one in six of the school population at any one time may have special educational needs. At the present time in Ireland special provision of some type is being provided for just over 5% of the primary school population, 3% being in the form of remedial teaching; thus it would appear that very many children with special needs are being educated in the ordinary school without any special provision.

In Ireland the main choice available to the handicapped child is either placement in an ordinary school with little or no supports or placement in a special day or residential school. While there is a range of provision including special classes and special provisions within the ordinary school, their availability is related not only to the child's handicap but also to his/her geographical location. In 1978, the number of children attending special schools was 8,158—the majority of whom were mentally handicapped (3,667 functioning at a mild level of handicap and 2,006 at a moderate level of handicap). The other most numerous groups were 684 physically handicapped children (269 of whom were in hospital schools), 825 deaf and hard of hearing children, 424 emotionally disturbed children and 142 blind and partially sighted

children. Apart from mildly mentally handicapped children for whom there is some provision either in the form of special schools or special classes in each county, provision for other groups of handicapped children is relatively centralised.

Integration: Integrated education is basically a system which caters for the special needs of handicapped children within the ordinary school framework supported by a range of facilities geared to meet the needs of children suffering from different kinds and degrees of handicap including such separate attention and protective arrangements as may be required. Segregated education and integrated education are not mutually exclusive alternatives; special education must be seen as a continuum of graduated provision to complement "ordinary" education ranging from integrated classes to residential special schooling and home tuition, the provision necessary for each child being decided on the basis of educational needs rather than handicap.

While recognising the need for special schools for some children the principle of integration has generally been accepted both in this country and abroad. However, there is a gap between principle and practice in Ireland. A realistic commitment towards integrated education for a greater number of handicapped children will necessitate, firstly an allocation of resources in both monetary and personnel terms to the ordinary school system comparable to that being allocated per pupil in special schools (the higher costs per child in special schools are accounted for almost exclusively by the higher teacher/pupil ratio). The following areas also warrant special attention; accessibility of existing and future schools, transport provision and the provision of personal assistance for more severely physically handicapped children, teacher attitudes towards the handicapped child, availability of support services, e.g. remedial teaching, psychological services, speech therapy, youth employment and advisory services.

Third Level Education: Difficulties in a number of areas can effectively prevent the participation of handicapped persons in third level education: e.g. those relating to accommodation, transport, extra costs incurred through the disability, the need for special aids and equipment, inaccessibility of buildings and age related admission criteria. A positive and flexible approach both by the Department of Education and the Health Boards is needed to enable handicapped persons to overcome these difficulties.

Remedial and/or Adult Education: Educational facilities for adult handicapped persons are extremely limited. The facilities necessary may vary from those geared towards compensating for inadequate formal education at earlier stages to those geared towards personal development. Voluntary agencies involved with particular groups have a key role to play in identification of the needs of individuals or groups for adult, compensatory or remedial education. In addition to meeting the needs of handicapped adults, adult education services could make a major contribution towards the improvement of community attitudes to the handicapped through the development of information courses on handicap for the general public.

Chapter 4 which is concerned with employment opportunities for handicapped persons is based on two basic premises:

(i) The handicapped person has the right to occupational opportunities, which will enable him/her to make the maximum contribution possible and this should be implicit in the development of vocational rehabilitation services.

(ii) The development of occupational opportunities for the handicapped person makes sound economic sense for the community.

Vocational rehabilitation aims at helping people who have difficulties in obtaining a job to strengthen their position in the labour market and includes the following essential elements:

Vocational assessment and guidance;
Work activation;
Vocational training;
Placement in open employment;
Provision of sheltered employment.

Each of these areas is considered in some detail.

The Irish Situation: The recommendations of the *Report on Training and Employing the Handicapped*, (The Robins Report) published in 1975, provide the framework within which vocational services are being developed in Ireland. While recommending that services for the handicapped population should be integrated with existing training provisions for the community as a whole, the report accepted the placing

responsibility for providing training, activation and employment services within the Department of Health. The Robins Report defined handicap as "any limitation, congenital or acquired, of a person's physical or mental ability which affects his daily activity and work by reducing his social contribution, his vocational employment prospects or his ability to use public services". On the basis of this definition it was estimated that 15,000 of the 100,000 adult handicapped persons in Ireland would benefit from preparation and training for work; it was estimated that over 10,000 of these were living in the community. The Workshops Standards Committee which reported in 1978 estimated that there were 5,500 places available for handicapped persons in various centres and institutions throughout the country providing skilled and semi-skilled training, activation and sheltered employment.

The Robins Report recommended that the Director of Community Care should have the duty of ensuring that all persons in his area suitable for occupational rehabilitation are brought to his notice by the various institutions, voluntary organisations and personnel involved. It was also recommended that a register of handicapped persons should be kept by Directors of Community Care as a source of information regarding their occupational needs. It is pointed out in the report that there are considerable difficulties at present in the achievement of this objective with regard to physically handicapped persons because of the absence of any agreed operational definition of handicap. The work of the NRB and in particular its placement and youth employment advisory service in vocational rehabilitation is considered. It is pointed out that particular groups of handicapped persons, e.g. the wheelchair-bound experience acute difficulties with regard to vocational rehabilitation; it is concluded that there is a need for special support services for such groups, particularly, with transport and accommodation.

The provision and functions of community workshops are considered in detail. The Robins Report outlined a dual role for these workshops viz. a training role and the provision of sheltered employment for those capable of achieving a productivity level equal to at least one-third of that of the average worker. Since the publication of that report there has been a rapid expansion in the number of places available in community workshops and the Workshops Standards Report has recommended that 3,000 additional places be provided by 1981. These

facts highlight the crucial importance of adequate information on the numbers with various types and degrees of handicap in each area.

It emerges clearly from the review of the present situation that not only is there a relative shortage of sheltered work places in community workshops but also in other centres providing sheltered work facilities. It is pointed out that there is a need for investigation of a number of areas relating to the provision of sheltered work.

With regard to the provision of vocational rehabilitation services in general it is emphasised that there is a need for a commitment within each Community Care Area towards identification of those who are in need of services and secondly if shortfalls in provision for particular groups is to be avoided there is need for comprehensive planning of services within each Health Board area.

Emphasising the importance of motivation and the need for incentives to undertake training and employment it is pointed out that there is a discrepancy between the payments currently made to trainees in community workshops and allowances made to AnCO trainees and furthermore that the difference between the DPMA and the training allowance, when all additional expenses are taken into account, is very small.

The problems relating to participation in open employment for handicapped persons are considered as are also the difficulties associated with the implementation of the Quota Scheme, announced in May 1977.

The crucial role of attitudinal barriers in both these areas are highlighted and it is suggested that agencies such as the Health Education Bureau and the NRB should take the initiative in the process of creating an awareness by the population in general of the rights, needs and potential contribution of handicapped persons in the employment field.

Chapter 5 is concerned with Community Services. It is pointed out that while many people classified as handicapped will simply need the general Health and Welfare Services, sections of the handicapped population will need more at particular times and in many cases special provision is needed. In considering the existing structure of services it is evident that there are variations in level of provision, both within and

between the eight Health Boards related not only to the involvement of these Boards but also to the varying availability of effective voluntary organisations.

The following areas of provision are examined:

(1) Health Services
(2) Domiciliary Care
(3) Day Care Services
(4) Support Services
(5) Aids and Appliances
(6) Housing
(7) Sexual Needs
(8) Recreation and Leisure

In discussing domiciliary care it is emphasised that this is not simply care in the community but involves the provision of an effective range of services. Without such services there may be no real alternative for the more severely handicapped person except residential care. In Ireland the main domiciliary services available to the person requiring personal assistance are home nursing and the home help services. To date the latter has been made available primarily to the elderly. Even if the service were available, as it at present operates, it would have very definite limitations in terms of meeting the needs of more severely handicapped persons. Similarly, the public health nursing service is not geared towards providing constant aid, often at "unsocial hours" which severely handicapped persons and their families may need. The types of services that are needed are considered with reference to severity of handicap and it is strongly recommended that the provision of a flexible form of domiciliary care on both long-term and short-term crisis basis be investigated. Examples of some services operating abroad are considered.

The provision of day care facilities for children and adults are considered in detail. It is acknowledged that the provision of such services on an effective basis is a difficult task. The difficulties in obtaining occupational therapists, the problems in organising transport and the extensive resources that are needed have meant that progress

has been slow in many areas and non-existent in some. This is particularly evident with regard to adult services. Planning is further impeded by the absence of adequate statistical information on the numbers of handicapped persons, their distribution and social situation.

The report highlights the needs of parents of handicapped children and of handicapped persons themselves for ongoing support, advice and information regarding services and entitlements. In discussing these needs the present provisions are outlined.

The availability of advice and support services often depends on type of handicap and geographical location. While in general such services for children are improving, the provision for adults has received very little attention in many areas.

With regard to social work services the question of generic versus specialist services is considered and it is concluded that both are necessary for a comprehensive service. It is pointed out that there is at present no generally accepted policy by all the Health Boards regarding the way the social work needs of the handicapped may be met—some Health Boards aspire to meet the needs of all groups through their own social workers (North Western); others financially assist voluntary bodies to provide a service while some have made no arrangements to date.

With regard to occupational therapy, speech therapy and physiotherapy services serious shortages of personnel are evident in all areas.

In considering the provision of an effective co-ordinated service to handicapped persons and their families it is pointed out that the idea of designating a "named person" in each case has much to recommend it.

As with the availability of specialist personnel, there are also huge variations evident between Health Boards in their responsiveness to supplying recommended aids and in their administration of this service.

The difficulties experienced by handicapped persons both with regard to housing and home adaptations are considered and it is concluded that three areas should be examined:

(1) the efficiency of the house adaptation scheme;
(2) the need for housing with support services;
(3) the advantages of planning to meet the needs of persons with special housing needs.

The participation of handicapped persons in leisure and recreation is considered; it is pointed out that difficulties in participation are related not only to actual physical and mental limitations arising from their handicap but also inaccessibility of certain leisure centres, social barriers and the social and economic position of many handicapped persons. It is proposed that the requirements of the disabled person should be taken into account when sport and leisure facilities are being planned and designed.

In Chapter 6 Income Maintenance services are considered. It is pointed out that many handicapped persons, particularly those with severe handicaps who are living in the community depend to a great extent on direct and indirect financial aid from statutory services.

The field of income maintenance for handicapped persons is complex. There are many different forms of benefit—some short-term, some long-term; some for insured persons, others for uninsured; some administered by Health Boards, others by the Department of Social Welfare; there are some direct cash payments and other cash substitute benefits in the form of concessions. The various types of benefit are outlined.

The question of additional expenses associated with handicap is considered and it is pointed out that in considering income maintenance services for handicapped persons, two elements must be taken into account:

(1) the provision of an adequate basic income;
(2) the special needs and expenses arising from the handicap.

The present system of income supports for handicapped persons is not only geared towards subsistence but takes little account of these additional elements. Furthermore as presently structured the system of benefits may in some cases hamper rather than facilitate rehabilitation: benefits can cease abruptly for people who secure a limited or intermittent income from work.

It is proposed that the whole area of income maintenance ser-
ces be reviewed. Given the complexity of the present structure it is ›commended that there be a "one door" approach for all on long-term enefits and in addition a campaign to inform people of their welfare ghts. It is further recommended that the advantages of a two-part roposed structure of benefits be examined.

'hapter 7 focuses on residential services. Special residential services ›r physically handicapped persons are extremely limited as are data on ›e number of physically handicapped persons living in residential care. ›part from those living in Cheshire homes there are physically and ensorially handicapped persons living in a variety of settings such as rthopaedic, psychiatric and geriatric hospitals, in welfare homes and ursing homes. The whole area of residential provision needs to be ›vestigated particularly within the context of providing adequate ommunity services as well as acceptable long-term care. With regard › residential care four points of particular concern emerge: They ›late to personal income for those in residential care, quality of life vailable to residents, training facilities for non-nursing staff and the ›lative non-involvement of the Department of Health both in non-tatutory residential centres and in assessing and planning to meet ccomodation needs of severely disabled persons.

In contrast to the lack of information on residential services for hysically handicapped persons there is considerable information vailable on such services for mentally handicapped persons both from ›e Census of Mentally Handicapped Persons conducted in 1974 and om Department of Health returns. In 1974 there were 8,138 mentally andicapped persons living in a variety of residential settings: 52% ›ere in special residential centres for mentally handicapped persons, 4% were in psychiatric hospitals and 8% were in geriatric hospitals.

Despite an increase in the number of places in special residential entres since 1974, one of the major areas of concern with regard to ›sidential provision for mentally handicapped persons is a shortfall in rovision for adults—due to this shortage places intended for children re being occupied by adults. As a consequence there are waiting lists ot only for moderate, severe and profoundly handicapped adults but lso for children functioning at severe and profound levels of handicap.

At present over 1,500 additional places are at various stages of planning and construction and the vast majority of these places are for adults.

The problems associated with the provision of services for mentally handicapped persons in psychiatric hospitals have repeatedly been highlighted. The present policy is that there should be no future admissions of mentally handicapped persons to these hospitals. Given the waiting lists for special residential centres it is unlikely that there will be any transfers from psychiatric hospitals to these centres. It is notable that those mentally handicapped persons in psychiatric hospitals (2,744 in 1974) differ in a number of respects from those in special residential centres: they are in general older, have spent longer periods in residence, are more likely to have additional psychiatric problems and are less likely to have contacts outside the centre. These characteristics impose considerable limitations with regard to alternative types of care. The most feasible short-term solutions would appear to be firstly, to investigate the feasibility of hostel/group home provision for those persons who could with the aid of community support services benefit from this type of service and secondly the provision of specialist services in separate units within existing psychiatric hospitals.

Alternatives to Traditional Residential Care: Increasingly organisations involved in the provision of services for mentally handicapped persons are becoming involved in the development of hostel facilities; the present provision caters for approximately 250 persons. This type of provision has a number of advantages both for children and adults, particularly those functioning at mild and moderate levels of handicap. Taking an overall view of residential needs over the lifetime of particular mentally handicapped persons, hostels with varying levels of support can be perceived as part of a continuum of options from living in the family home to full-time residential care.

Short-term residential care refers to care for periods of up to two months. One of the primary functions of this type of care is the provision of planned relief to families through regular breaks throughout the year or at holiday periods. Apart from holiday care in special residential centres short-term care is relatively limited in Ireland. There is some evidence from both Britain and Sweden that adequate provision of short-term care as part of a range of community services

on a local basis is associated with a reduction in demand for admission to long-term residential care.

The Commission of Inquiry on Mental Handicap identified fostering as one method of family care that should be investigated. Such an investigation has not taken place to date. This form of care may be an optimum solution only for a relatively small number of mentally handicapped persons; however, this should not preclude an investigation of its feasibility.

Chapter 8 is concerned with mobility. Three areas are considered:

Physical Barriers to Integration.
Transportation.
Mobility Allowance.

With regard to physical barriers it is pointed out that the idea that a "barrier-free architecture" is catering to a tiny minority is not valid—it has been estimated that at least 10% and possibly as many as 20% of the population suffer from some form of disability which has implications for environmental development. Progress in this area in Ireland has been very slow and there is as yet no effective legislation. It is emphasised that the recommendations of interested agencies should be incorporated in the new Building Code and that it should be implemented immediately and monitored subsequently.

Transportation: Virtually no progress has been made in Ireland in making public transportation accessible to disabled persons. The only aids which exist are

(i) public transport concessions
(ii) assistance for the disabled driver.

Both of these provisions are considered in detail and a number of recommendations are made for their more effective operation.

Mobility Allowance: The concept of a mobility allowance is evaluated through an examination of the British Mobility Allowance Scheme and the recently introduced Irish Mobility Allowance. The advantages and limitations of the Irish scheme are highlighted.

In *Chapter 9*, preventive aspects are considered at a general level. It is pointed out that prevention of handicap at all levels must form an essential part of health care services. This chapter outlines the general preventive programmes aimed at the total population such as immunisation and screening for metabolic disorders also some specific measures having relevance for particular groups known to be at increased risk.

It is strongly emphasised throughout that the prevention of handicap is not solely a medical problem, that the attitudes of the general public towards health in general and the responsibility they assume for their own health are crucial. Thus public education programmes are of considerable importance in the prevention of handicap. A number of areas are highlighted for particular attention in health education.

APPENDICES

APPENDIX IA

Voluntary Organisations for Physically Handicapped Persons affiliated to UVOH

Agency	Location	Functions
Asthma Association	Dublin	To promote research and help sufferers of asthma. Holidays are run each year for asthmatic children.
Central Remedial Clinic	Dublin	Medical Rehabilitation Centre providing a range of specialist services including a special primary school.
Cheshire Foundation, Ireland	Seven homes throughout the country	To provide residential accommodation for people who are chronically ill or permanently disabled.
Cystic Fibrosis Association	Headquarters in Dublin but branches in several areas throughout the country	Advisory service to parents, physiotherapy and social work service.
Irish Arthritis and Rheumatism Assoc.	Headquarters in Dublin but has some regional branches	To stimulate greater awareness of the problems associated with arthritis and rheumatism and promote rehabilitation.
Irish Association for the Blind	Headquarters in Dublin	Operation of a Braille Lending Library, a Braille printing press and production of a bi-monthly magazine.
Irish Association for Spina Bifida and Hydrocephalus	Headquarters in Dublin and branches throughout the country	Care, welfare, education and treatment of persons suffering from Spina Bifida and Hydrocephalus.
Irish Cancer Society	Dublin	To conduct programmes of health education, to finance research and provide assistance for terminal cancer patients.
Irish Epilepsy Association	Dublin	To help, advise and assist people with epilepsy. To improve understanding of it and eliminate prejudice. To promote awareness of the need for education and rehabilitation.

Agency	Location	Functions
Irish Haemophilia Society	Dublin	To create an awareness of the disease and assist in the solution of individual problems.
Irish Wheelchair Association	Headquarters in Dublin. Regional offices throughout the Health Board areas: Network of local branches throughout the country	To achieve full integration of the wheelchair-bound. A wide range of community-based services through social workers, occupational therapists, driving instructors and local branches are provided.
Multiple Sclerosis Society of Ireland	Headquarters in Dublin, but branches throughout the country.	To help sufferers of multiple sclerosis ameliorate their condition and encourage them to take an active part in social activities.
Muscular Dystrophy	Galway	To help the sufferers of muscular dystrophy through aid to themselves and their families and through medical research.
National Association for Cerebral Palsy	Dublin, Wicklow, Cork	To provide for the treatment and education of children suffering from cerebral palsy and other disabilities. There are two day clinics offering a range of medical rehabilitation and educational services and a residential clinic for children.
National Association for the Deaf	Dublin	To educate the public on the problems of deafness and provide advice and help through their social workers.
National Council for the Blind	Headquarters in Dublin but social workers based in every county, and there are branches throughout the country	Home visiting and teaching the blind, prevention of blindness and provision of radios and talking books.
National League of the Blind	Dublin	Self-help organisations who protect interests of the blind through (1) trade union, protecting employment conditions of the blind; (2) acting as a pressure group; (3) providing help and support.

Agency	Location	Functions
Polio Fellowship of Ireland	Dublin	Aftercare of post-polio victims. It provides training facilities and hostel accommodation at its residential centre in Dublin.
Rehabilitation Institute	Headquarters in Dublin but a number of skill training centres and a network of community workshops throughout the country	Provides vocational training facilities for the disabled. The vocational training programme covers: (1) assessment; (2) education and training; (3) on the job training.

KNOWN GROUPS AND ASSOCIATIONS RELATING TO PHYSICAL HANDICAP BUT NOT AFFILIATED TO U.V.O.H.

Association of Parents of vaccination damaged children;

Association for welfare of children in hospitals;

Brucellosis Anonymous;

British Cysticitis Association (Irish Base);

Irish Coeliac Society;

Irish Diabetic Association;

Dyslexic Association;

Illiostomy Association;

Mastectomy Association;

Irish Kidney Association;

Psoriasis Association;

Spastic Colon Society:

Children's Leukemia Research Project;

Disabled Action Group.

APPENDIX IB

RESOLUTION ADOPTED BY THE GENERAL ASSEMBLY OF THE UNITED NATIONS

2856 (XXVI) DECLARATION ON THE RIGHTS OF MENTALLY RETARDED PERSONS

Proclaims this Declaration on the Rights of Mentally Retarded Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings.

2. The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

3. The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities.

4. Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life.

5. The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.

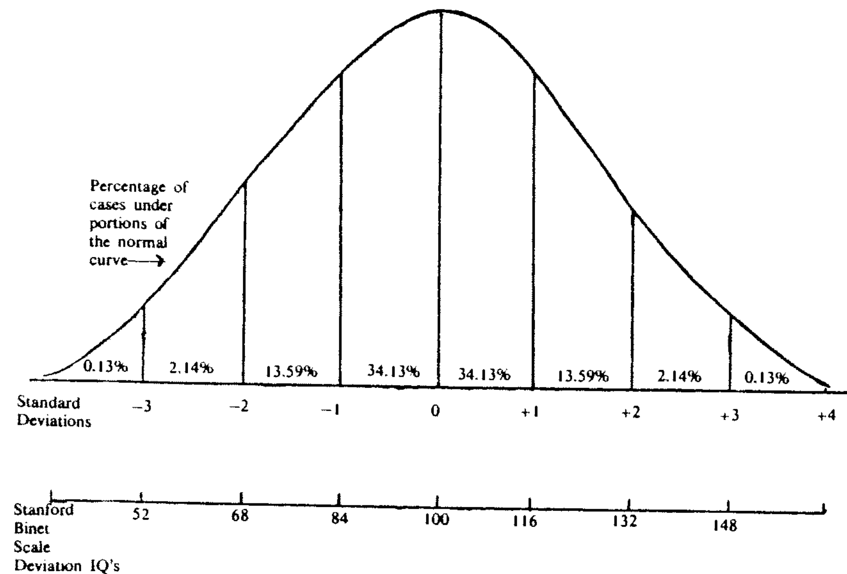
6. The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence, he shall have a right to due process of law with full recognition being given to his degree of mental responsibility.

7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

2027th plenary meeting
20 December 1971.

APPENDIX II A

A NORMAL DISTRIBUTION CURVE AND DEVIATION IQ'S FOR THE 1960 STANFORD-BINET INTELLIGENCE SCALE



Source: Munn, N.L. *Psychology* (5th ed.); George G. Harrup and Co. Ltd., London, 1966. Table 5.3 p 121. The mean IQ is 100 and a score one standard deviation above this is evaluated as an IQ of 116, a score one standard deviation below, as an IQ of 84. The percentage of the population which might be expected to have a particular IQ, e.g. an IQ of 140 (at the very superior, or "potential genius" level) could be expected in only about 2 per cent of the population while at the other extreme an IQ of 60 or lower could also be expected in only about 2 percent of the population.

APPENDIX II B

DEFINITIONS OF HANDICAP

A. A disabled person is an individual whose prospects of securing and retaining suitable employment is substantially reduced as a result of physical or mental impairment (International Labour Organisation).

B. A disabled person is one who, on account of injury, disease, or congenital deformity, is substantially handicapped in obtaining or keeping employment of a kind . . . suited to his age, experience and qualifications. (Disabled Persons (Employment) Act 1944, UK)[1].

C. The term, handicapped individual, means any individual who:

(a) has a physical or mental disability which, for such an individual constitutes or results in substantial handicap to employment and

(b) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services (Rehabilitation Act 1973, U.S.).

D. The same Act goes on to define "severe handicap" as the disability which requires multiple services, over an extended period of time and results from amputation, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, neurological disorders (including strokes and epilepsy), paraplegia, quadraplegia and other spinal cord conditions, renal failure, respiratory or pulmonary dysfunction and any other disability specified by the Secretary in regulations he shall prescribe. (Rehabilitation Act 1973, U.S.).

[1]This definition has been adopted by the Interdepartmental Committee on the operation of the Irish Quota Scheme.

APPENDIX II C

"HANDICAPPED AND IMPAIRED IN GREAT BRITAIN"

Information on the Sample Used

There being no comprehensive lists of handicapped people, nor, indeed, any recognised criteria for identifying the "handicapped", the only way of obtaining a sample was to select a representative sample of households, and identify the impaired by asking as few questions as were necessary to establish whether there was anyone in the household aged 16 or over who was physically impaired, or had any other impairment or condition which made it difficult for them to take care of themselves, carry out their domestic responsibilities, or limited their occupational or social activities.

From preliminary estimates of the incidence of impairment, made as a result of the pioneering work of the Social Medicine Research Unit of Bedford College, London, and our own small pilot, and in view of the complexity of the analyses required, it was decided that a sample of 100,000 households would be necessary (Sample A).

Even a sample of this size would not be large enough to allow for reliable data on the very small group of those so severely handicapped as to need constant care, and a further 150,000 households were approached to identify this group (Sample B).

The actual study comprised:

(1) a postal stage to all households in the sample and

(2) interview stage of people identified in stage 1 as impaired.

Source: *Handicapped and Impaired in Great Britain,* Appendix B op cit. p. 240.

APPENDIX IID

Medical Classification of Handicap used in British Social Survey

Main Cause of Impairment	*Proportion of Impaired Group suffering from Specified Disease*[a] %
1. Infective and parasitic diseases: respiratory tuberculosis, non-respiratory tuberculosis, other infective and parasitic diseases	1.0
2. Neoplasms: Cancer, malignant tumours; benign and unspecified tumours	0.8
3. Allergic, endocrine, metabolic and nutritional diseases: Diabetes (Mellitus), other endocrine, nutritional, etc.	1.7
4. Diseases of blood and blood-forming organs: Haemophilia, other diseases	0.9
5. Mental, psycho-neurotic and personality disorders: mental illness, psychosis, nervousness, debility, mental sub-normality	3.3
6. Diseases of central nervous system: Polio, strokes, multiple sclerosis, parkinsonism, cerebral palsy, paraplegia, hemiplegia, epilepsy, migraine, dizziness, convulsions, vertigo, sciatica, head injury, other central nervous system diseases	11.8
7. Diseases of circulatory system: congenital heart disease, rheumatic fever, coronary diseases, arterio-sclerotic diseases, high blood pressure, hypertension, diseases of the arteries, varicose veins, other diseases of circulatory system	16.0
8. Diseases of respiratory system: Bronchitis, emphysema, asthma, pneumon-coniosis, silicosis, other lung diseases	9.1
9. Diseases of digestive system: Stomach and duodenum, intestines, liver, gall bladder, pancreas, hernias, other diseases of digestive system	2.7
10. Diseases of genito-urinary system: Diseases of kidney, diseases of bladder, prostate, diseases of female genital organs	1.2
11. Diseases of sense organs (excluding blindness): Diseases of eye, partial blindness, deafness, menieres disease, other ear diseases	8.9

12. Diseases of skin and cellular tissue: Dermititis, eczema	0.7
13. Diseases of bones and organs of movement: Rheumatoid arthritis, osteo arthritis, other arthritis, osteomyelitis, slipped disc, lumbago, muscular dystrophy, fractures, sprains, strains, dislocations, other diseases of bones and organis of movement	38.7
14. Congenital Malformations: Spina bifida, hydrocephalus, other congenital, excluding heart	0.6
15. Injuries: Birth injuries, bums, other injuries	3.7
16. Senility and ill defined conditions	4.0
17. Amputations:	4.2
18. Blindness:	2.4

All persons with some impairment: 3,081,000

[a]Percentages add to more than 100, as a person may have more than one disability.

Source: Harris, *et al.,* op. cit., p. 718.

APPENDIX IIE

Functional Classification

Classification of Intrinsic Handicaps:

1. Locomotor handicap
   - (a) impaired mobility in environment
   - (b) impaired postural mobility
   - (c) impaired manipulation
2. Visceral handicap
   - (a) disorder of ingestion
   - (b) disorder of excretion
   - (c) artificial openings
   - (d) dependence on life-saving machines
3. Visual handicaps
   - (a) total loss of sight (blindness)
   - (b) partial loss of sight (partial sight)
   - (c) perceptual disorder
   - (d) interpretative disorder
4. Communicative handicap
   - (a) receptive
   - (b) expressive
   - (c) language disorder
   - (d) intellectual disorder
   - (e) emotional disorder
5. Intellectual handicap
   - (a) mental retardation (congenital)
   - (b) mental retardation (acquired)
   - (c) memory impairment
   - (d) orientation impairment (time or space)
   - (e) impaired consciousness
6. Emotional handicap
   - (a) psychoses and neuroses
   - (b) behavioural disorders
   - (c) drug addict
   - (d) inappropriate cultural patterns
   - (e) other
7. Invisible handicap
   - (a) reduced exercise tolerance
   - (b) metabolic disorders
   - (c) haemophilia and other haemorrhagic disorders
   - (d) fragility of skeleton
   - (e) epilepsy
   - (f) intermittent "prostrating" disorders, e.g. migraine, asthma, vertigo
   - (g) causalgia and other pain disorders without other associated disorder

	(h) sexual and reproductive disorders (excluding emotional)
8. Visible handicap	(a) visible congenital abnormalities (excluding those of the skin)
	(b) skin disorders
	(c) scarring and abnormal hair distribution
	(d) loss or distortion of part of the body
	(e) mobile abnormalities of posture (grimacing, athetosis, etc.)
9. Other handicaps	

Source: Angerholm, M.: Association of Disabled Professionals, memorandum to the Department of Employment, London, 1973, pp. 5 and 6.

APPENDIX IIIA

EDUCATIONAL FACILITIES FOR MILDLY MENTALLY HANDICAPPED CHILDREN

RESIDENTIAL SCHOOLS

(all these schools have day attenders)

Eastern Health Board:
St. Augustine's, Blackrock, Co. Dublin.
St. Teresa's, Blackrock, Co. Dublin.
House of the Holy Angels, Glenmaroon, Dublin.
The Sunbeam House, Bray, Co. Wicklow.

Midland Health Board:
St. Mary's, Delvin, Co. Westmeath.

Southern Health Board:
St. Mary's School, Rochestown, Co. Cork.
Queen of Angels School, Montenotte, Cork.

Western Health Board:
Holy Family School, Renmore, Galway.

SPECIAL DAY SCHOOLS—LOCATIONS

Eastern Health Board:
Dublin; Kildare; Wicklow.

Midland Health Board:
Laois.

Mid. Western Health Board:
Clare; Limerick.

South Eastern Health Board:
Tipperary South Riding, Carlow, Kilkenny, Wexford.

North Eastern Health Board:
Cavan; Louth; Meath; Monaghan.

Western Health Board:
Mayo.

Southern Health Board:
Cork; Kerry.

North Western Health Board:
Sligo.

SPECIAL CLASSES—LOCATIONS

Eastern Health Board:
Dublin; Kildare; Wicklow.

Midland Health Board:
Offaly;* Longford;* Westmeath.

Mid. Western Health Board:
Limerick; Tipperary North Riding.

North Eastern Health Board:
Cavan.

Western Health Board:
Roscommon.*

Southern Health Board:
Cork; Kerry.

North Western Health Board:
Donegal;* Leitrim.*

*Special Educational Provision exclusively in the form of special classes.

APPENDIX IIIB

Special Schools for Moderately Mentally Handicapped Children

Residential and Day	*Day Only*
Eastern Health Board	
Stewart's Hospital, Palmerstown, Dublin St. Vincent's, Navan Road Dunmore House, Glenageary St. Raphael's Celbridge	St. Michael's House, Rathmines St. Michael's House, Ballymun St. Michael's House, Clontarf St. John of God Centre, Islandbridge St. Anne's, Newbridge St. Catherine's School, Newcastle, Co. Wicklow
Midland Health Board	
St. Mary's, Delvin, Co. Westmeath	St. Christopher's, Longford St. Hilda's, Athlone
Mid-Western Health Board	
St. Vincent's, Lisnagry St. Anne's, Roscrea	St. Clare's School, Ennis
North-Western Health Board	
Cregg House, Sligo	
North-Eastern Health Board	
St. Mary's, Drumcar, Co. Louth	Holy Family School, Cootehill St. Mary's School, Navan
South-Eastern Health Board	
St. Patrick's, Kilkenny	St. Martin's School, Waterford St. Patrick's School, Enniscorthy
Southern Health Board	
St. Mary of the Angels, Beaufort, Co. Kerry St. Paul's, Montenotte, Cork House of Our Lady of Good Counsel, Lota, Glanmire, Cork[a]	Holy Family School, Charleville Presentation Convent, Lixnaw, Co. Kerry (Special Classes) St. Joseph's School, Bantry (Special Classes)
Western Health Board	
	St. Joseph's, Galway St. Brid's School, Castlebar St. Anne's Primary School, Roscommon (Special Classes)

[a]Residential only.

APPENDIX IIIC

Diagnostic Assessment and Advisory Services

Health Board	*Community Care Areas*	*Organisations*
Eastern	Dublin City and County: The 8 Community Care areas are divided into 4 catchment areas for the purpose of Diagnostic Assessment and Advisory Services	Child Study Centre (St. Vincent's, Navan Road), Hospitaller Order of St. John of God, (St. Augustine's, Blackrock), St. Michael's House (Goatstown and Ballymun) Stewart's Hospital (Palmerstown).
	Kildare	Moore Abbey (Monasterevan)
	Wicklow	Hospitaller Order of St. John of God (Blackrock)
Midland	Laois and Offaly	Moore Abbey (Monasterevan)
	Longford and Westmeath	Child Study Centre (St. Vincent's Hospital, Dublin)
Southern	Cork City and County (5 Community Care Areas)	Cork Polio and After Care Association, Brothers of Charity (Lota)
	Kerry	Brothers of Charity (Lota)
Mid-Western	Limerick, Clare, Tipperary N.R.	Brothers of Charity (Bawnmore, Limerick)
Western	Galway, Mayo and Roscommon	Brothers of Charity (Renmore, Galway)
North-Eastern	Louth, Monaghan and Cavan	Hospitaller Order of St. John of God (Drumcar, Co. Louth)
	Meath	Child Study Centre (St. Vincent's Dublin)
South-Eastern	Kilkenny, Waterford and Wexford	Brothers of Charity (Belmont Park, Waterford)
	Tipperary, S.R.	Brothers of Charity (Lota, Cork)
	Carlow	Moore Abbey (Monasterevan)
North-Western	Leitrim, Sligo and Donegal	Diagnostic Assessment and Advisory Service being developed by Health Board

APPENDIX IVA

Rehabilitation Institute Centres & Places in Each Health Board Area (April 1979)

Eastern Health Board[a]

Location	Training	Places
Northbrook Road	Secretarial School	
Portland Row	Woodwork Training	
Pleasants Street	Garment Making	
Northbrook Road	Watch & Clock Repairs	
Upr. Basin Street	Light Engineering	Total of 203 places
Upr. Basin Street	Leather Goods	
Merrion Road	Merrion Station	
Goldenbridge	Draughtsmanship/ Construction Industry/ Trades/Business Studies/Preparatory Skills	
Naas	Community Workshop	40
North Eastern Region		
Cavan	Community Workshop	50
Monaghan	Community Workshop	30
Navan	Community Workshop	50
South Eastern Region		
Carlow	Community Workshop	50
Wexford	Community Workshop	40
Clonmel	Community Workshop	55
Waterford	Community Workshop	55
Midland Region[b]		
Athlone	Community Workshop	30
Longford	Residential Training	46
Portlaoise	Community Workshop	50

[a]Community Workshop opened in Bray, September 1979.
[b]Tullamore Community Workshop opened in September 1979.

APPENDIX IVA—*continued.*

Location	Training	Places
Southern Region		
Cork (2 centres)	Light Engineering Knitwear Upholstery Leather Goods Clothing Manufacture Woodwork Secretarial	138
Tralee	Opening April 1979	60
Mid-Western Region		
Limerick	Community Workshop	50
Western Region		
Galway (2 centres)	Community Workshop	80
Castlebar	Community Workshop	70
North-Western Region		
Sligo	Community Workshop and Secretarial School (including unit for partially sighted) Light Engineering	100
Lifford	Community Workshop	26
Ballinamore	Community Workshop	40
Total number of places		1,263

APPENDIX IVB

Special Training Centres, Community and Other Workshops Catering Mainly For Mixed Handicaps

Organisation	Centre	No of Places
Eastern Region		
Rehabilitation Institute	8 Centres in Dublin	203
Rehabilitation Institute	Naas, Co. Kildare	40
Central Remedial Clinic	Clontarf, Dublin	100
National Assoc. Cerebral Palsy	Sandymount, Dublin	14
Polio Fellowship of Ireland	Stillorgan, Dublin	15
	Total number of places in Eastern Region[a]	372
South Eastern Region		
Rehabilitation Institute	Suirside, Waterford	55
Rehabilitation Institute	Carlow, Co. Carlow	50
Rehabilitation Institute	Clonmel, Co. Tipperary	55
Rehabilitation Institute	Wexford	40
Co. Wexford Community Workshop Ltd.	Enniscorthy, Co. Wexford	40
Co. Wexford Community Workshop Ltd.	New Ross, Co. Wexford	40
	Total number of places in South Eastern Region	280
Mid-Western Region		
Rehabilitation Institute	Limerick	50
Retos Ltd.	Shannon, Co. Clare	98
	Total number of places in Mid-Western Region	148
Western Region		
Rehabilitation Institute	Galway	80
Rehabilitation Institute	Castlebar, Co. Mayo	70
Ballina Community Centre	Ballina, Co. Mayo	10
	Total number of places in Western Region	160

[a]Rehabilitation Institute Centre opened in Bray, September 1979.

APPENDIX IVB—*continued.*

Organisation	Centre	No. of Places
North Western Region		
Rehabilitation Centre	Sligo	100
Rehabilitation Centre	Ballinamore, Co. Leitrim	40
Rehabilitation Centre	Lifford, Co. Donegal	26
Total number of places in North Western Region		166
Midland Region		
Rehabilitation Institute	Coolamber Manor, Co. Longford	46
Rehabilitation Institute	Athlone, Co. Westmeath	30
Total number of places in Midland Region[b]		76
North Eastern Region		
Rehabilitation Institute	Navan, Co. Meath	50
Rehabilitation Institute	Monaghan	30
Rehabilitation Institute	Cavan	50
Order of Malta	Drogheda, Co. Louth	15
Total number of places in North Eastern Region		145
Southern Region		
Rehabilitation Institute	Cork	138
St. Joseph's Industries	Charleville, Co. Cork	20
Total number of places in Southern Region[c]		158

[b]Centres opened in Portlaoise and Tullamore by Rehabilitation Institute 1979 provide an extra 100 places; fifty in each centre.
[c]Centre in Tralee opened 1979, by Rehabilitation Institute provides 60 places.
Source: *Workshops Standards Report* and Rehabilitation Institute.

APPENDIX IVC

Residential Centres With Attenders At Activation Units 1976

Eastern Health Board:

Stewart's Hospital, Dublin.
St. John's Unit, Peamount, Co. Dublin.
St. Vincent's, Navan Road, Dublin.
St. Raphael's, Celbridge, Co. Kildare.
Moore Abbey, Monastereven, Co. Kildare.

North Western Health Board:

Cloonamahon, Collooney, Co. Sligo.

South Eastern Health Board:

St. Patrick's, Kells Road, Kilkenny.
St. Michael's Adult Training Centre, Waterford, Camphill Village Community, Camphill, Co. Wexford.

Western Health Board:

St. Joseph's, Kilcornan House, Galway.

APPENDIX IVD

WORKSHOPS FOR MENTALLY HANDICAPPED PERSONS— COMMUNITY PROVISION

	Approximate no. of places (1979)
Eastern Health Board:	
Cherry Group Sheltered Workshop, Dublin	88
Cherry Group Training Workshop, Dublin	10
St. Michael's House, Goatstown, Dublin	30
St. Michael's House, Finglas, Dublin	36
St. Michael's House, Templeogue, Dublin (Long-term Training Centre)	50
Southern Health Board:	
H.E.L.P. Industries, Cork	200
North Western Health Board:	
Sligo Association of Parents and Friends of the Mentally Handicapped, Cleveragh Industrial Estate, Sligo.	48

APPENDIX IVE

VOCATIONAL TRAINING CENTRES

	Approximate no. of places (1979)
St. Vincent's, Navan Rd., Dublin	80
St. Michael's Home, Ballymun Rd., Dublin	72
Mill Lane, Stewart's Hospital, Dublin	40
Adult After Care Training Centre, Dunmore House, Glenageary, Dublin	24
St. Raphael's, Celbridge, Co. Kildare	89
Sunbeam House, Bray	22 *(to increase to 35)*
St. Patrick's, Kilkenny	12
Cork Polio, Montenotte	51
St. Christopher's Training Centre, Leamore Pk., Battery Rd., Longford	5
St. Joseph's Training Centre, Snipe Rd., Galway	30

APPENDIX VIIA

Location of projects and number of places planned or under construction for mentally handicapped persons under 1978 and 1979 Capital Programmes

Health Board Area	*Residential*		*Day Care*	
	Children	Adults	Children	Adults
Eastern				
Dublin	104	180	60	150
Kildare	—	22	—	—
Health Board[a]	—	210	50	70
North-Eastern				
Louth	20	—	—	—
Midland				
Westmeath	10	—	—	—
South-Eastern				
Kilkenny	—	20	—	—
Dungarvan	—	20	—	—
Waterford	—	15	—	—
Wexford	—	12	—	—
Southern				
Cork	6	50	—	—
Kerry	45	30	—	—
Health Board[a]	—	20	—	—
Western				
Mayo	—	12	—	—
Galway	6	54	—	—
Health Board[a]	50	200	—	60
Mid-Western				
Limerick	—	—	—	30

[a]Indicates direct Health Board provision.

Source: Department of Health, April 1979.

APPENDIX VIIB

Admissions to and Discharges[a] from psychiatric hospitals of persons with a diagnosis of mental handicap, 1975, 1976 and 1977 for each Health Board

Health Board	*1975* Admissions	*1975* Discharges	*1976* Admissions	*1976* Discharges	*1977* Admissions	*1977* Discharges
Eastern	167	165	183	174	148	137
South-Eastern	134	118	127	135	115	114
Southern	101	85	95	97	85	104
Mid-Western	79	94	55	55	80	77
Western	74	83	74	88	69	77
Midland	34	42	59	59	58	77
North-Western	72	77	73	81	56	64
North-Eastern	58	61	49	57	60	64
Non-National	0	0	1	1	1	1
Total	719	725	716	747	672	691

[a]Includes deaths.

Source: O'Hare, A., Walsh, D. *Activities of Irish Psychiatric Hospitals and Units,* 1975 and 1976, Dublin, M.S.R.B., 1978 Tables 49, 50, 53, 54; O'Hare, A., and Walsh, D. *Activities of Irish Psychiatric Hospitals and Units,* 1977, Dublin, M.S.R.B., 1979 Tables 25, 27.

APPENDIX IX

Summary of Accident Statistics, Causation and Nature of Injury for 1975-78

The numbers include both fatal and non-fatal accidents. The numbers of fatal accidents are shown in brackets.

Causation	1975	1976	1977	1978
Machinery	508 (4)	510 (2)	429 (1)	421 (2)
Hot Substances	184	213	228	257
Hand Tools	181	164	197	218
Falling Objects	564 (4)	576	516 (5)	630 (10)
Persons Falling	487 (7)	501 (3)	518 (4)	621 (6)
Handling Goods	661	655	742 (2)	994 (1)
Stepping on Objects	668 (1)	771	594	739 (1)
Electricity	22 (1)	20 (5)	16 (6)	16 (1)
Transport	116 (3)	101 (5)	105 (6)	76 (4)
Others	52 (1)	70 (3)	122 (6)	101 (1)
Nature of Injury				
Fractures	504	475	454	459
Dislocations	29	33	26	45
Sprains	596	693	599	720
Concussions	14	12	33	4
Amputations	50	63	61	87
Lacerations	935	957	910	1,316
Burns	193	225	181	247
Bruising	858	815	564	628
Asphyxia	6	4	11	10
Electric shock	5	4	7	5
Radiation	—	—	—	—
Superficial	65	52	420	325
Foreign body	167	230	175	210
Fatal	21	18	26	26
Totals:	3,443 (21)	3,581 (18)	3,467 (26)	4,073 (26)
Males:	3,196 (21)	3,321 (18)	3,195 (26)	3,755 (26)
Females:	247	260	272	318

Source: *Report of the Industrial Inspectorate,* Department of Labour.

APPENDIX X

Preparatory work for the International Year for Disabled Persons (IYDP)

I. IYDP Secretariat and Liaison Officers

1. At its thirty-first session in 1976, the United Nations General Assembly proclaimed 1981 as the International Year for Disabled Persons (resolution 31/123). At its thirty-second session in 1977, the General Assembly considered proposals received from Member States and international organisations concerned for the IYDP programme and approved, in its resolution 32/133, certain preparatory measures including the setting up of an IYDP secretariat in the United Nations Office at Geneva. The IYDP secretariat started its functions in February 1978 and its principal tasks are:

—to plan and carry out the measures to be taken by the United Nations in the implementation of the objectives of the International Year (as enumerated in General Assembly resolution 31/125);

—to co-ordinate the activities of the United Nations agencies in this regard;

—to assist, within the available resources, Member Governments in the planning of activities at the national level within the framework of International Year;

—to co-ordinate with the interested non-governmental organisations and voluntary groups in matters concerning the International Year.

2. Early in 1978, an aide-memoire on IYDP was sent to the Member States of the United Nations, through their Permanent Missions to the United Nations in New York, suggesting the designation by Governments of an officer or agency to ensure the liaison with the IYDP secretariat at Geneva for the purpose of exchanging information concerning IYDP and the activities that might be undertaken within the framework of IYDP. By 31 January 1978, the IYDP secretariat was informed of the appointment of national liaison officers/agencies in the following countries: Australia, Bahrain, Barbados, Belgium, Botswana, Canada, Chile, Cuba, Ethiopia, Fiji, German Democratic Republic, Germany, Federal Republic of Ghana, Guyana, India, Iraq, Iran, Israel, Japan, Luxembourg, Malawi, Mexico, Morocco, Norway, Philippines, Qatar, Seychelles, Surinam, Syria, Thailand, United Kingdom, Upper Volta, Uruguay, Venezuala and Zambia. Information on IYDP plans and activities is provided to these officers and agencies on a regular basis and they are expected to inform the IYDP secretariat of plans, as these are developed, for the celebration of IYDP in their respective countries.

II. National Committees:

3. It was also suggested in the aide-memoire that consideration be given to the formation of national committees for IYDP comprising the representatives of both the Government agencies and voluntary groups concerned with the task of preparing a concerted national programme of activities in observance of IYDP.

APPENDIX VIII

Draft Building Regulations

Part S

BUILDING STANDARDS TO CATER FOR THE SPECIAL NEEDS OF THE DISABLED

Application:

S1 This Part shall apply to any building ordinarily used, in whole or in part, as a church or other place of public worship, or as a hospital, public institution, college, school, university or as a hall, concert room, theatre or cinema, lecture room, exhibition room or place of assembly, being a hall, concert room, theatre, cinema, lecture room, exhibition room or place of assembly, to which the public have access whether as of right or by permission and whether subject to or free from charge.

Means of approach:

S2 (1) There shall be provided from the adjacent road, car park or other adjacentarea accessible to motor vehicles to at least one entrance to every building to which this Part applies a means of approach which is without steps and has a gradient at no point exceeding 1 in 12.

(2) Where the means of approach provided in accordance with paragraph (1) is a ramp, such ramp shall have—

(a) a clear width of at least 1 m,

(b) a handrail fixed to the balustrade or other structure provided in accordance with regulation G10 at the exposed side of the ramp not less than 860 mm and not more than 960 mm above the level of the ramp, and

(c) a level space at its foot not less than 1.8 m in length.

(3) Where the ramp exceeds 9 m in length, the gradient thereof shall not exceed 1 in 20.

(4) Where the gradient of the ramp exceeds 1 in 20, handrails shall be fixed to all walls adjoining the ramp not less than 860 mm and not more than 960 mm above the level of the ramp.

Access:

S3 (1) At least one entrance door, hereinafter in this Part referred to as the "invalid entrance door", served by an approach provided in accordance with regulation S2 shall have a clear opening width of not less than 785 mm.

(2) The invalid entrance door shall be provided at the level of principal pedestrian access to the building unless a lift is provided having dimensional characteristics not less than those specified in regulation S4 (1) and connecting the level of the invalid entrance door with the level of principal pedestrian access.

(3) Any raised threshold at the invalid entrance door shall not exceed 20 mm in height.

Internal Circulation:

S4 (1) At least one route free from steps and having a width (apart from internal doorways) of not less than 1.2 m shall be provided from the invalid entrance door to all parts of the building which—

(a) are used for any of the purposes specified in regulation S1;

(b) are parts to which members of the public or persons attending at the building for purposes of education, recreation, medical treatment or similar purposes normally have access; and

(c) are either on the same or approximately the same level as the invalid entrance door or on a level to which access by means of a passenger lift is provided and the lift car has

(i) a clear width at the entrance of not less than 835 mm;

(ii) an internal width of not less than 1,070 mm; and

(iii) an internal area of not less than 1.5m².

(2) Any ramp along a route provided in accordance with paragraph (1) shall have a gradient not exceeding 1 in 12 and any internal door along the route shall have a clear opening width of not less than 785 mm.

(3) Where one or more passenger lifts are provided having dimensions not less than those specified in paragraph (1) giving access to a level of the building used wholly or partly for any of the purposes specified in regulation S1, access to at least one such lift shall be provided at the level of the invalid entrance.

Extract from Draft Building Regulations, Department of Local Government, Dublin, 1976, pp. 155-157.

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NATIONAL ECONOMIC AND SOCIAL COUNCIL PUBLICATIONS

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