INTERNATIONAL LABOUR OFFICE

REPORT

on

THE ILO/DANISH INTER-REGIONAL SEMINAR ON VOCATIONAL REHABILITATION OF THE MENTALLY HANDICAPPED

(Denmark, 10-30 October 1971)

ILO

GENEVA

1971
# TABLE OF CONTENTS

**INTRODUCTION** ................................................................. 1

**CHAPTER I. ORGANISATION AND ADMINISTRATION OF THE SEMINAR** .... 3

- Technical Preparations and Directing Staff ............................. 3
- Participants ........................................................................ 3
- Observers .......................................................................... 5
- Lecturers ........................................................................... 5
- Material Arrangements ......................................................... 6

**CHAPTER II. PROGRAMME AND ACTIVITIES** ................................. 7

- Opening of the Seminar ....................................................... 7
- The Seminar Programme ...................................................... 7
- Pattern of the Seminar ....................................................... 14
- Lectures ............................................................................ 14
- Group and Plenary Discussions ........................................... 14
- Country Papers .................................................................... 15
- Closure .............................................................................. 15

**CHAPTER III. FIELD STUDIES IN FYN AND JUTLAND** ............ 16

- Purpose and Method ............................................................ 16
  1. Group A Report - Fyn .................................................. 17
  2. Group B Report - Fyn .................................................. 18
  3. Group A Report - Jutland .............................................. 21

**CHAPTER IV. FINAL CONCLUSIONS** ........................................ 26

- I. Special Care and Rights of the Mentally Retarded ............... 26
- II. Pre-Vocational Preparation of Mentally Retarded Children ... 27
  and Young Persons ............................................................
- III. Intelligence Testing ....................................................... 28
- IV. Outlets in Normal Employment for the Mentally Retarded ... 28
- V. Sheltered Employment for the Mentally Retarded .............. 29
- VI. Rehabilitation of the Long-Term Psychiatric Patient and ... 30
  Transition from Mental Hospital to Employment .................
- VII. Industrial Therapy Organisations (ITOs) ....................... 31
- VIII. The Half-Way House .................................................. 32
IX. The Role of the Rehabilitation Officer .......................... 32
X. The Role of the Psychiatric Social Worker ...................... 32
XI. Research .................................................................. 33
XII. Training and Recruitment of Staff ............................... 33
XIII. Community Involvement ......................................... 33
XIV. International Assistance .......................................... 33

Annex 1. Draft Declaration on the Rights of Mentally Retarded Persons .................................................. 35
Annex 3. A Suggested Organisational Plan for Provision of Comprehensive Rehabilitation Services for the Mentally Ill .......................................................... 39

CHAPTER V. REVIEW AND EVALUATION ................................. 40

CHAPTER VI. A SELECTION OF LECTURE PAPERS PRESENTED AT THE SEMINAR ........................................ 41
1. Social and Economic Background to the Danish Rehabilitation Programme - Mrs. F. Hartmann .................. 41
2. Comprehensive Services for the Mentally Retarded and Mentally Ill in Denmark - Mr. O. Wandall-Holm ......... 45
3. Vocational Rehabilitation in Denmark - Mr. J. Kock ............ 49
4. Care of the Mentally Retarded in Residential Institutions - Dr. J. Lensstrup ............................................. 54
5. Education of Mentally Retarded Children - Mr. L. Bjonstrup ... 57
6. Social and Welfare Aspects of Mental Retardation - Mr. N.E. Bank-Mikkelsen ........................................ 60
7. Social Aspects in the Rehabilitation of Mentally Handicapped Persons - Mr. E. Kosunen ................................. 76
8. Intelligence Testing - Methods, Purpose and Value - Dr. A.H. Arnfred ....................................................... 80
9. Pre-Vocational Preparation and Counselling of Mentally Retarded Children and Young People - Mr. F.X. Lynch 84
10. Outlets in Normal Employment for the Mentally Retarded - Two papers - Mr. F.X. Lynch and Mr. H.O.T. Wildenskov .... 94
11. Work Schemes for the Mentally Retarded in Residential Care - Mr. H.O.T. Wildenskov .............................. 107
12. Sheltered Workshops for the Mentally Retarded - Mr. F.X. Lynch ............................................................... 111
13. Problems of Mental Retardation - Criteria and Classification, Causation and Prevention - Professor A.D.B. Clarke 118
14. Classification and Characteristics of Psychiatric Disorders - Dr. A.M. Battenburg-Plenter .......................... 127
| 15. | Rehabilitation of the Long-Term Psychiatric Patient - Vocational Aspects - Mr. N.E. Cooper | 130 |
| 16. | The Transition of Mental Patients from Hospital to Employment - Two papers - Dr. J. van Londen and Mr. W.M. Birkvad | 139 |
| 17. | Industrial Therapy in Psychiatry - Dr. D.F. Early | 148 |
| 18. | The Role of the Psychiatric Social Worker and After Care Services for the Mentally Retarded - Mrs. G. Hadell | 156 |
| 19. | The Role of the Clinical Psychologist in the Hospital, and in the Rehabilitation Centre - Mr. A.A. Staehr | 162 |
| 20. | Special Problems Encountered in Developing Countries in Rehabilitating the Mentally Handicapped - The Position in Uganda - Mr. P.S. Wabulya | 164 |
| 21. | The Care of the Mentally Handicapped - The Position in Mexico - Dr. L.F. Vales Ancona | 168 |
| 22. | General View of Research into Problems Affecting Vocational Rehabilitation of the Mentally Handicapped - Mr. F.X. Lynch | 171 |
| 23. | Theoretical and Practical Problems Regarding Research on Social Adjustment of Mentally Handicapped Persons - Mr. F.H. Kuhl | 178 |
| 24. | Training and Recruitment of Personnel - Mr. B. Nielsen | 181 |
| 25. | Community Involvement and Responsibility in the Problems of the Mentally Handicapped - Five papers - Father J.I. Eguia, Mr. B. Petersen, Mr. A. Christensen, Mrs. E. Hansen and Mr. S. Bache-Vognbjerg | 188 |
| 26. | ILO Technical Co-operation in the Field of Vocational Rehabilitation of the Disabled - Mr. N.E. Cooper | 202 |

**APPENDIX - COUNTRY PAPERS SUBMITTED BY PARTICIPANTS**

1. | Rehabilitation Programmes for the Mentally Handicapped in the Argentine Republic - Dr. R.A. Camino | 213 |
2. | Rehabilitation of the Mentally Handicapped in the Social Security System of Brazil - Dr. O. Mendez Pereira | 218 |
3. | Rehabilitation of the Mentally Handicapped in Chile - Miss E. Vidal | 220 |
4. | Rehabilitation of the Mentally Handicapped in Ethiopia - Mr. G. Abu | 221 |
5. | Rehabilitation Programme for the Mentally Handicapped in India - Mrs. L. Mazumdar | 222 |
6. | Rehabilitation Programme for the Mentally Handicapped in Indonesia - Mr. S. Mangoensandjojo | 225 |
7. | Iran's Rehabilitation Programme for the Mentally Handicapped - Miss A. Shashaani | 227 |
8. | Rehabilitation Programme for the Mentally Handicapped in Iraq - Mrs. A.B. Al-Jazrawi | 229 |
9. | Social Services in Jordan - Care of the Handicapped and Disabled - Mr. K. Faouri | 231 |
10. | Rehabilitation of the Mentally Handicapped in Kenya - Mr. S.M. Oisebe | 233 |
| 11. | Rehabilitation of the Mentally Handicapped in Malawi - Mr. R.J. Mbekeani | 236 |
| 12. | Vocational Rehabilitation of the Mentally Handicapped in Malaysia - Mr. L. Sun Leong | 239 |
| 13. | Rehabilitation Programme for the Mentally Handicapped in Nigeria - Mr. B. Akinwale | 242 |
| 14. | Vocational Facilities Offered to the Mentally Retarded in the Republic of Panama - Mr. F. Alvarado | 244 |
| 15. | Vocational Rehabilitation of the Mentally Handicapped in the Philippines - Mr. F. Pascual | 247 |
| 16. | Services for the Mentally Disabled in the Syrian Arab Republic - Mr. K. Tahhan | 250 |
| 17. | Vocational Rehabilitation of the Mentally Handicapped in Tanzania - Dr. P. Ladda | 252 |
| 18. | Vocational Rehabilitation of the Mentally Handicapped in Thailand - Miss P. Khanphaboo | 254 |
| 19. | Problems of Rehabilitation of the Mentally Handicapped in Turkey - Professor F.A. Gökşel | 257 |
| 20. | Rehabilitation and Care of the Mentally Handicapped in Uruguay - Mrs. A. Ainsa | 259 |
INTRODUCTION

Mental retardation and mental illness constitute one of the world's most critical social and health problems. They affect more people, waste more human resources, cause more unemployment than any other disabling conditions.

According to a report\(^1\) issued by the World Health Organisation 1 to 3 per cent of the population are mentally retarded to a greater or lesser degree. A recent United Nations report\(^2\) on the world social situation indicated that 1 per cent of any population group is incapacitated throughout life as a result of severe psychiatric illness and that at a conservative estimate, one person in ten is likely to suffer from illness of this kind at some time in life.

In the industrialised countries, improved methods of prevention and treatment, the establishing of sheltered workshop units within or near to mental hospitals and special institutions, the development of half-way houses to ease the transition from hospital to full social and economic activity, a better understanding on the part of the general public of the needs and working potential of the mentally handicapped - all these factors are contributing to the alleviation of the many problems which hinder or prevent the complete integration of the mentally handicapped in society.

In many developing countries of the world vocational rehabilitation services for the mentally handicapped are extremely limited and in some cases non-existent. Even where institutional rehabilitation services are available and applied successfully to the mentally handicapped, the lack of supporting vocational services - guidance, assessment, placement in open and sheltered employment - often precipitates a recurrence of mental illness or hinders and prevents discharge from institutionalised care. Consequently, large numbers of mentally retarded and mentally ill patients who could be productively employed remain under medical, social or family care for many years and are a heavy burden on limited national resources.

With these considerations in view the International Labour Office and the Government of Denmark agreed to hold an inter-regional seminar on vocational rehabilitation of the mentally handicapped to provide vocational rehabilitation staff from developing countries with the opportunity of seeing and studying at first hand the well-developed and co-ordinated Danish rehabilitation programme for the mentally handicapped. In particular the Seminar was designed to enable participants to:

- study the organisation, administration and operation of vocational rehabilitation services for the mentally handicapped within the over-all programme of rehabilitation, and the relationship of such services to medical, social, educational and vocational services for the general population;
- obtain new ideas, methods and techniques on the development of employment opportunities for the mentally handicapped and to consider how best they could be applied to their own countries;
- exchange information on rehabilitation programmes and the problems encountered or foreseen in developing such programmes for the mentally handicapped in the countries represented.

The Seminar was held in Denmark from 10-30 October 1971 and was organised jointly by the Government of Denmark and the International Labour Office as part of the joint technical co-operation programme of the ILO and the Danish International Development Agency (DANIDA).

The report of the Seminar which follows comprises six chapters:

Chapter I - Organisation and Administration of the Seminar
Chapter II - Programme and Activities
Chapter III - Field Studies in Fyn and Jutland
Chapter IV - Final Conclusions
Chapter V - Review and Evaluation
Chapter VI - A Selection of Lecture Papers Presented at the Seminar.

The country statements submitted by the twenty-two participants on the situation of vocational rehabilitation of the mentally handicapped in their respective countries are included as an appendix.

The Director-General of the International Labour Office wishes to express his thanks and appreciation to the Government and people of Denmark for their generosity in making the Seminar possible, and their co-operation and hospitality which contributed so much to the success of the project; also for the support and assistance given by the staff of the Danish International Development Agency, the Special Committee appointed to plan the Seminar, the Ministries of the Interior and Social Affairs, the County Councils of Fyn and Vejle and the City of Copenhagen. In particular he wishes to place on record the notable efforts made by all the Seminar staff who made such an outstanding contribution to the preparatory and operational stages of the Seminar.

Thanks are also due to the many Danish and international lecturers, the management and staff of the Seminar headquarters, the many hospitals, rehabilitation institutions, offices and workshops, all of whom helped to make the programme of lectures, discussions, visits and daily living activities so interesting and instructive for the participants.

The valuable support and assistance provided by the United Nations Rehabilitation Unit, the World Health Organisation, the International Society for Rehabilitation of the Disabled, the International League of Societies for the Mentally Handicapped, and the US President's Committee on Mental Retardation is also gratefully acknowledged.

It is hoped that this report will be of value and assistance not only to the governments of the participating countries, but also to those other countries and organisations which are interested in organising, developing or extending vocational rehabilitation programmes for the mentally handicapped.
CHAPTER I

ORGANISATION AND ADMINISTRATION OF THE SEMINAR

Technical Preparations and Directing Staff

Preparatory work for the Seminar commenced in September 1970 when Mr. Otto Wandal Holm, Head of the State Rehabilitation Centre on Fyn, and Miss Birgit Cederholm, a staff member of the Danish Society for Home for Cripples, were appointed as Danish Director and Administrative Officer of the Seminar respectively. At the same time, Mr. Norman E. Cooper, Head of the Vocational Rehabilitation Unit of the Vocational Training Branch, Human Resources Development Department, ILO headquarters, Geneva, was appointed as ILO Co-Director of the Seminar. He was assisted during the period of the Seminar by an ILO Associate-Director and lecturer, Mr. Francis X. Lynch, Director, Division of Developmental Disabilities, Rehabilitation Services Administration, Social and Rehabilitation Service of the US Department of Health, Education and Welfare.

The Danish Director travelled to Geneva in February 1971 when the programme for the Seminar was finalised. At the same time it was agreed that the division of responsibilities should be allocated as follows:

The Danish Director and his staff to take responsibility for:
- planning and shaping of the agreed programme (in close co-operation with the ILO Co-Director);
- recruitment of Danish lecturers;
- recruitment of supporting administrative staff;
- provision of board and accommodation for staff and participants;
- preparation of Seminar premises and provision of transport for visits;
- provision of technical supporting services (film projectors, duplicating machines, etc.);
- obtaining the full English texts of Danish lectures.

The ILO Co-Director to be responsible for:
- planning and shaping of the agreed programme (in close co-operation with the Danish Director);
- recruitment of international lecturers;
- selection of Seminar participants and arranging for their journey to Denmark;
- editing and stencilling of lecture papers;
- preparation and publication of the final report of the Seminar.

Participants

Twenty-five countries of Africa, Asia, Latin America and the Middle East were invited to participate and only two countries declined the invitation. Of the twenty-three participants finally selected the following twenty-two persons actually took part:

Argentina: Dr. Pau Antonio CAMINO, Director of the Rehabilitation Centre for Mentally Handicapped, Barracas 489, Buenos Aires.

Brazil: Dr. C. MENDEZ PEREIRA, Chief Adviser on Vocational Rehabilitation, National Social Security Institute.
Miss Eliana VIDAL LAGOS, Occupational Therapist for Mentally Handicapped, Emilia Tellez, 4021, Santiago.

Mr. Gari ABU, Matron, Amanuel Mental Hospital, P.O. Box 1971, Addis Ababa.

Mrs. Leena MAZUMDAR, Psychologist and Principal of School for Mentally Handicapped Children, A.I.V., 100 Dayanand Colony, New Delhi 24.

Mr. Siswadi MANGONDJOJO, Director, Placement Division for the Disabled, Department of Manpower, Djl. H.A. Salim No. 58, Djakarta.

Miss Aridah SHASHAANI, Director of International Relations and Vocational Assessment, National Iranian Society for Rehabilitation of the Disabled, 31 Maykaddh Av., Teheran.

Mrs. Angel Elia AL-JAZRAWI, Director, Workers' Establishment for Vocational Rehabilitation, Baghdad.

Mr. Khalil PAOURI, Social Worker for Delinquency and Social Societies, Social Affairs Dept., Ministry of Social Affairs and Labour, P.O.B. 122, Zerka.

Mr. S.M. OISEBE, Principal Vocational Rehabilitation Officer, Ministry of Co-operatives and Social Services, P.O. Box 30276, Nairobi.

Mr. Ronald J. MBEKEANI, Social Welfare Officer, Ministry of Labour, Department of Social Welfare, P.O. Box 835, Blantyre.

Miss Pongprabha KANPHABOO, Assistant Director, Public Welfare, Ministry of Interior, Bangkok.

Mr. Felix B. PASCUAL, Occupational Therapist, Bureau of Child and Youth Welfare, Department of Social Welfare, Manila.

Mr. Khalid TAIWAN, Director of Social Services, Social Affairs, Damascus.

Dr. Paul Egbert LADDA, Senior Assistant Medical Officer, Ministry of Health and Social Welfare, P.O. Box 22, Tabora.

Miss Pongprabha KANPHABOO, Assistant Director, Department of Public Welfare, Ministry of Interior, Bangkok.

Dr. Fluat A. GÜKSEL, Professor of Psychiatry, Medical Faculty, University of Ankara, Ankara.

Mr. Philip S. WABULYA, Principal Rehabilitation Officer, Ministry of Culture and Community Development, P.O. Box 7093, Kampala.

Mrs. Ana Basiinski de AINSA, Technical Secretary, National Rehabilitation Commission, Ministry of Education and Culture, Sarandi 450, Montevideo.
Observers
The following observers were authorised to attend the Seminar:

Mr. William B. Robertson - Special Assistant to the Governor of Virginia and member of the US President's Committee on Mental Retardation.

Dr. Emma Schmidt de Vales - Doctor of Psychology, Mexico City, and Representative of the International Society for Rehabilitation of the Disabled.

Lecturers
The following persons presented papers at the Seminar:

ARNFRED, Axel H., M.D., Chief Paediatric Psychiatrist, The Children's Hospital in Vangede, 40 Sognevej, DK-2820 Gentofte.

BACHE-VOGNBJERG, Svend, Secretary-General, Danish Federation of Trade Unions, 14 Rosenørnsallé, DK-2100 Copenhagen Ø.

BANK-MIKKELSEN, Niels E., Director of Mentally Retarded, Danish Board of Social Welfare, Department of Mentally Retarded, 1 Falkonerallé, DK-2000 Copenhagen Ø.

BATTENBURG-PLEMPETER, A.M., M.D., Chief Medical Officer and Psychiatrist, Beatrix-Irene Children's Hospital, Rotterdam, The Netherlands.

BIRKVAD, Wolder M., Director, Rehabilitation Unit Sønderbro, 6 Sundholmsvej, 2300-Copenhagen S.

BJÖDSTRUP, Leif, Director of Education, Children's Department of the Danish National Service for Mentally Retarded in Copenhagen, 40 Sognevej, DK-2820 Gentofte.

CHRISTENSEN, Albert, Barrister, President of the National Society for the Mentally Retarded, 96 Vester Voldgade, DK-1552, Copenhagen V.

CLARKE, A.D.B., Ph.D., Professor, Department of Psychology, The University of Hull, HU6 7RX, England.

COOPER, Norman Edward, ILO Co-Director of the Seminar and Chief, Vocational Rehabilitation Unit, Vocational Training Branch, ILO, Geneva.

EARLY, Donald F., Consultant Psychiatrist, Glenside Hospital, Blackberry Hill, Stapleton, Bristol BS 16, IDE, England.

EGUIA, Father José I., Vice-President, International League of Societies for the Mentally Handicapped, Reina Regente 6, San Sebastian, Spain.

HADELL, Gudrun, Chief of Section, Rehabilitation Department, National Board of Health and Social Welfare, 105 30 Stockholm, Sweden.

HANSEN, Else, Principal, Sofieskolen, 3 Gravvej, DK-2880 Bagsvaerd.

HARTMANN, Fanny, Chief of Section, Ministry of Social Affairs, 6 Slotholmsgade, DK-1216 Copenhagen K.

HESHE, Jørgen, M.D., Chief Psychiatrist, Sct., Hans Hospital, DK-4000 Roskilde.

JUEL-NIELSEN, Niels, Professor, M.D., State Psychiatric Department, County Hospital at Odense, DK-5000 Odense.

KOCK, Jørgen, Head of the State Rehabilitation Centre for the County of Vejle, G Nørrebrogade, DK-7100 Vejle.

KOSUNEN, Esko, Chief, Rehabilitation Unit for the Disabled, United Nations, N.Y. 10017, USA.
KUHL, P.H., Head of Research, Institute for Social Research, 28 Borgergade, DK-1300 Copenhagen K.

LENSTRUP, Jørgen, M.D., Chief Physician, The Children's Hospital in Vangede, 40 Sognevej, DK-2820 Gentofte.

LYNCH, Francis X., Associate Director of the Seminar and Director of the Division of Developmental Disabilities, Rehabilitation Services Administration, Social and Rehabilitation Service, US Department of Health, Education and Welfare.

NELSEN, Børge, Principal, The Personnel Training School, 83A Islands Brygge, DK-2500 Copenhagen S.

PETERSEN, Bent, Executive Director of the National Society for the Welfare of the Mentally Ill, 4 Sct. Marcus Allé, 1922 Copenhagen V.

STAEBH, Allan, Psychologist, Head of the Department of Psychology at the State Psychiatric Unit, The County Hospital at Odense, DK-5000 Odense.

VALES ANCONA, Luis P., M.D., Chief of Department for Vocational Rehabilitation, Ministry of Health and Welfare, Mexico D.F.


WABULYA, Philip S., Principal Rehabilitation Officer, Ministry of Culture and Community Development, Uganda.

WANDALL-HOLM, Otto, Danish Director of the Seminar and Head of the State Rehabilitation Centre on Fyn.

WILDENSKOV, H.O.T., Director of Social Work, The Central Institution at Brejning, 7090 Brejning.

Material Arrangements

Board and accommodation for participants and staff of the Seminar were made available by the Danish Government at the Scandinavian Course Estate, Holte, on the outskirts of Copenhagen. This purpose-built seminar centre is ideal, providing as it does every modern facility for administration, lectures, films, slides, group and plenary discussions, recreational and social activities, meals and single-room accommodation. Secretaries and administrative assistants appointed by the Danish Government provided efficient typing, stencilling, duplicating, photocopying, telephone, mail and other services.

Hotel accommodation was provided for participants during the three-day period of field studies in Fyn and Jutland.

A special taxi service was put at the disposal of participants when they arrived at the City Airport Terminal in Copenhagen and similarly for their return journey at the end of the Seminar. Special buses and taxis were also provided for the many field visits.

The display of rehabilitation literature (books, brochures, manuals, etc.) in the main lecture hall was very much appreciated by the participants.
CHAPTER II

PROGRAMME AND ACTIVITIES

Opening of the Seminar

The Seminar was opened informally on 11 October 1971 by Professor Kjeld Philip, Chairman of the Board of the Danish International Development Agency.

The Seminar Programme

The detailed programme of the Seminar was as follows:

SUNDAY, 10 OCTOBER - REGISTRATION

MONDAY, 11 OCTOBER

09.00-09.45 INTRODUCTORY TECHNICAL SESSION
10.00-10.45 SOCIAL AND ECONOMIC BACKGROUND TO THE DANISH REHABILITATION PROGRAMME
   Lecturer: Fanny Hartmann
11.00-12.00 OPENING OF THE SEMINAR
   by Professor Kjeld Philip
   followed by a Reception.
14.00-15.30 COMPREHENSIVE SERVICES FOR THE MENTALLY RETARDED AND MENTALLY ILL IN DENMARK
   Lecturer: Otto Wandall-Holm
   VOCATIONAL REHABILITATION IN DENMARK
   Lecturer: Jørgen Kock

TUESDAY, 12 OCTOBER

08.45 Visit to:
"The Children's Hospital at Vangede"
40 Sognevej, DK-2820 Gentofte,
(Central Institution for moderately, severely and profoundly retarded children).
09.00-11.30 CARE OF THE MENTALLY RETARDED IN RESIDENTIAL INSTITUTIONS
   - Medical Aspects: Lecturer Jørn Lenstrup
   - Educational and Prevocational Aspects:
     Lecturer: Leif Bjøgåstrup
   TOUR OF THE INSTITUTION "Vangede"

11.30-12.30 GROUP DISCUSSIONS
13.30-15.30 Visit to:
The Central Institution "Lillemosegaard",
163 Buddingevej, DK-2860 Soborg,
(Institution for moderately, severely and profoundly retarded adults).
TUESDAY, 12 OCTOBER (Continued)

SOCIAL AND WELFARE ASPECTS OF MENTAL RETARDATION

Lecturers: Niels E. Bank-Mikkelsen

Esko Kosunen

TOUR OF THE INSTITUTION "Lillemosegaard".

15.30-16.30 GROUP DISCUSSIONS
16.30-17.30 PRESENTATION OF GROUP REPORTS

WEDNESDAY, 13 OCTOBER

09.00-09.30 EDUCATION OF MENTALLY RETARDED CHILDREN

Lecturer: Leif Bjaéstrup

09.30 VISITS TO SCHOOLS AND KINDERGARTEN FOR MENTALLY

RETADED CHILDREN

The participants were divided into three groups and visited
one of the following institutions:

I. Kindergarten for mentally retarded children.

Head: Birgitte Schaumburg-Müller

Address: 19 Wagnersvej - DK-2450, Copenhagen SV.

II. "Skolen på Moseallé"

(School for moderately and severely retarded children)

Head: Birgit Kirkebaek

Address: 8 Moseallé, DK-2610 Rødovre.

III. "Skovagerskolen"

(School for mildly retarded)

Headmaster: P.O. Schaumburg-Müller

Address: 156 Brøndbyvestervej 156. DK-2650 Hvidovre.

11.30-12.30 GROUP DISCUSSIONS
14.00-15.30 PRESENTATION OF GROUP REPORTS
16.00-17.30 PRESENTATION OF PARTICIPANTS' OWN PAPERS ON VOCATIONAL

REHABILITATION PROGRAMS AND PROBLEMS CONCERNING THE MENTALLY

HANDICAPPED IN THEIR OWN COUNTRIES

(Followed by discussions)

20.00 FILMS - 'ORDINARY WORK' (Rehabilitation of the mentally

retarded in an agricultural setting)

'SELLING A GUY NAMED LARRY' (Rehabilitation of

the mentally retarded in an industrial setting)

'A CITY CALLED COPENHAGEN'

'AN INTRODUCTION TO DENMARK'.
THURSDAY, 14 OCTOBER

09.00-10.15 INTELLIGENCE TESTING, METHODS, PURPOSE AND VALUE
Lecturer: Axel H. Arnfred

PREVOCATIONAL PREPARATION AND COUNSELLING OF MENTALLY RETARDED CHILDREN AND YOUNG PERSONS
Lecturer: Francis X. Lynch

10.30-12.00 OUTLETS IN NORMAL EMPLOYMENT FOR THE MENTALLY RETARDED
Lecturer: H.O.T. Wildenskov
Lecturer: Francis X. Lynch

14.00-15.00 GROUP DISCUSSIONS
15.00-15.45 PRESENTATION OF GROUP REPORTS
16.00-17.30 CONTINUING PARTICIPANTS' OWN PAPERS
20.00 FILMS
'NOT LIKE THE OTHERS' (Danish programme for the mentally retarded)
'DISABLED CHILDREN IN PANAMA' (Panamanian programme for handicapped children)
'THE UMBRELLA MAN' (ILO assisted workshop for the disabled in Ethiopia)
'A CHANCE' (Goodwill Industries Film)

FRIDAY, 15 OCTOBER

08.30-09.30 WORK SCHEMES FOR THE MENTALLY RETARDED IN RESIDENTIAL CARE
Lecturer: H.O.T. Wildenskov

SHELTERED WORKSHOPS FOR THE MENTALLY RETARDED
Lecturer: Francis X. Lynch

09.30-10.45 GROUP DISCUSSIONS
10.45-12.30 VISIT TO WORKSHOPS FOR MENTALLY RETARDED:
The participants were divided into two groups and visited the following workshops:

I. Sheltered Workshop (Observation)
   122 Amager Strandvej,
   DK-2300 Copenhagen S.
   Manager: Mrs. Ellen Angelo

II. Sheltered Workshop (Production)
    12 Gungavæj,
    DK-2650 Hvidovre
    Manager: Mr. Børge Rasmussen
    Textile Workshop (same address)
    Manager: Mrs. E. Lindeborg Johansen
    Guides: H.O.T. Wildenskov and Poul C. LaCour
SATURDAY, 16 OCTOBER
09.00-11.00 PROBLEMS OF MENTAL RETARDATION
   Lecturer: A.D.B. Clarke
11.00-12.30 GROUP DISCUSSIONS
14.00-15.00 PROBLEMS OF MENTAL RETARDATION (Contd.) - A.D.B. Clarke
15.15-17.15 ENDING OF THE PRESENTATION OF PARTICIPANTS' OWN PAPERS

MONDAY, 18 OCTOBER
09.00-10.15 CLASSIFICATION AND CHARACTERISTICS OF PSYCHIATRIC DISORDERS
   Lecturer: A.M. Battenburg-Flenter
   REHABILITATION AND CARE OF THE MENTALLY ILL IN DENMARK
   Lecturer: Niels Juel-Nielsen
10.30 Visit to a mental hospital
   "Sot. Hans Hospital"
   DK-4000 Roskilde
11.30 Introduction by J. Heshe, Chief Psychiatrist
13.00-15.30 TOUR OF HOSPITAL
15.30-16.00 QUESTION TIME

TUESDAY, 19 OCTOBER
09.00-10.15 REHABILITATION OF THE LONG-TERM PSYCHIATRIC PATIENT
   - Medical Aspects, Lecturer: Jørgen Heshe
   - Vocational Aspects, Lecturer: Norman Cooper
10.30-11.15 GROUP DISCUSSIONS AND PRESENTATION OF GROUP REPORTS
11.30 Visit to the REHABILITATION UNIT, SØNDERBRO
   6 Sundholmsvej
   DK-2300 Copenhagen S.
   Introduction by Tove Søndergaard
13.00-14.00 THE TRANSITION FROM MENTAL HOSPITAL TO EMPLOYMENT
   Lecturers: J. Van Londen
            Wolder M. Birkvad
14.00 The participants were divided into three groups, each group visiting one of the following institutions:
   I. "Ungbo"
   Brydesallé, DK-2300 Copenhagen S.
   Director: Mr. Jørgen Christiansen
   New buildings with rooms for young people who have attended the Rehabilitation Unit
   II. Hostel at Backersvej,
        107 Backersvej,
        DK-2300 Copenhagen S.
TUESDAY, 19 OCTOBER (Continued)

III. Hostel at Amager Strandvej,
222 Amager Strandvej,
DK-2300 Copenhagen S.


15.00-16.00 GROUP DISCUSSIONS AT THE REHABILITATION UNIT
16.15-17.00 PRESENTATION OF GROUP REPORTS

WEDNESDAY, 20 OCTOBER

08.30-09.30 INDUSTRIAL THERAPY ORGANISATIONS FOR MENTAL PATIENTS IN THE UNITED KINGDOM
Lecturer: Donald F. Early

09.45 VISIT TO MENTAL HOSPITAL WITH REHABILITATION UNIT
"Statshospitalet i Glostrup"
DK-2600 Glostrup
Introduction by J. Flygenring, Chief Psychiatrist

14.00-15.15 GROUP DISCUSSIONS
15.45-16.15 PRESENTATION OF GROUP REPORTS
20.00 FILM - 'THE INVISIBLE BARRIER' (Schizophrenia)

THURSDAY, 21 OCTOBER

09.00-09.30 THE ROLE OF THE PSYCHIATRIC SOCIAL WORKER AND AFTER-CARE SERVICES FOR THE MENTALLY RESTORED
Lecturer: Gudrun Hadell

THE ROLE OF THE CLINICAL PSYCHOLOGIST IN THE HOSPITAL AND IN THE REHABILITATION CENTRE
Lecturer: Allan Staehr

10.15-12.00 GROUP DISCUSSIONS AND PRESENTATION OF GROUP REPORTS

12.45 Travel to Fyn (Odense) and Jutland (Vejle)

Field Studies in Fyn
FRIDAY, 22 OCTOBER (a.m.) Group A Visited the Psychiatric Ward of Svedborg General Hospital

Field Studies in Jutland
(a.m.) Group A Visited the State Hospital for Mental Diseases at Risskov, Aarhus, including hospital departments and workshops.

(a.m.) Group B Visited the Welfare Centre for Mentally Retarded at Brening, including departments and workshops.

(a.m.) Group B Visited the Psychiatric Ward of Odense General Hospital
FRIDAY, 22 OCTOBER (Continued)
(p.m.) Both Groups visited the Psychiatric Clinic in the Odense Rehabilitation Unit and an Occupational Centre (The Old Vicarage) for all handicapped Groups
(p.m.) Group A Visited the Outdoor Rehabilitation Unit at Horsens and the Psychiatric Department of Vejle General Hospital
(p.m.) Group B Continuation of visit to the Welfare Centre

SATURDAY, 23 OCTOBER
(a.m.) Both Groups visited the General Practitioners' Group Clinic in Langeskov
(p.m.) Discussions with the Staff of the Rehabilitation Centre, Odense and preparation of Group Reports
(p.m.) Discussions with the Staff of the Rehabilitation Centre, Vejle and preparation of Group Reports

(For further details see Chapter III)

SUNDAY, 24 OCTOBER
Travel back to Holte

MONDAY, 25 OCTOBER
Free day

TUESDAY, 26 OCTOBER
09.00-10.30 PRESENTATIONS OF GROUP REPORTS ON THE VISITS TO PYN AND JUTLAND
11.00-12.00 SPECIAL PROBLEMS ENCOUNTERED IN DEVELOPING COUNTRIES IN REHABILITATING THE MENTALLY HANDICAPPED
Lecturers: Philip S. Wabula Luis F. Valse Ascona M.D.
13.00-14.20 GENERAL VIEW OF RESEARCH INTO PROBLEMS AFFECTING VOCATIONAL REHABILITATION OF THE MENTALLY HANDICAPPED
Lecturers: P. H. Küh Francis X. Lynch
14.25 The participants were divided into groups, each group visiting a research institute:
I. The John F. Kennedy Institute,
7 Gl. Landevej,
DK-2600 Glostrup.
Introduction by: Erik Wamberg, M.D.
Chief Paediatrician
II. The Institute for Paedagogical Research,
156 Brøndbyvesterage,
2650 Hvidovre.
Introduction by: Niels E. Søndergaard,
Psychologist,
Research Co-ordinator.
III. Psychochemistry Institute,  
Rigshospitalet (University Hospital),  
9 Blegdamsvej,  
DK-2100 Copenhagen Ø  

Introduction and lectures by:  
Lars F. Gram, M.D. and  
Ole Sylvester Jørgensen, M.D.

WEDNESDAY, 27 OCTOBER

08.30 VISIT TO THE PERSONNEL TRAINING SCHOOL,  
83A Islands Brygge,  
DK-2300 Copenhagen S.

09.00-11.50 TRAINING AND RECRUITMENT OF PERSONNEL  
Lecturer: Børge Nielsen  
followed by  
A ROUND TABLE DISCUSSION WITH TEACHERS AND STUDENTS PARTICIPATING

14.00 PANEL DISCUSSION  
COMMUNITY INVOLVEMENT AND RESPONSIBILITY IN PROBLEMS OF THE  
MENTALLY HANDICAPPED

(1) International League of Societies  
for the Mentally Handicapped.  
Panellist: Father José I. Egua

(2) The Welfare of the Mentally Ill.  
Panellist: Bent Petersen

(3) The Welfare of the Mentally Retarded.  
Panellist: Albert Christensen

(4) Parent Groups.  
Panellist: Else Hansen

(5) Labour Market.  
Panellist: S. Bache-Vognbjerg

15.45-17.30 GROUP DISCUSSIONS AND PRESENTATION OF GROUP REPORTS

THURSDAY, 28 OCTOBER

08.45 VISIT TO MONTEBELLO HOSPITAL FOR YOUNG PERSONS,  
DK-3000 Helsingør.

Introduction by: Anker Ostergaard,  
Chief Psychiatrist

10.30-11.15 TOUR OF HOSPITAL

11.15-12.15 QUESTIONS AND DISCUSSIONS

14.00 Participants were divided into two groups, each group visiting  
one of the following institutions:

I. 'Højjærgaard',  
Agricultural Rehabilitation Centre,  
DK-3550 Slangerup.

Introduction by: Bent Nielsen, Principal
THURSDAY, 28 OCTOBER (Continued)

14.00 II. 'Montebello Day and Night Hospital',
20 Stolpegaardsvej,
DK-2820 Gentofte.

Introduction by: Poul Thelle, M.D.,
Chief Psychiatrist.

FRIDAY, 29 OCTOBER

09.00-09.20 ILO TECHNICAL CO-OPERATION IN THE FIELD OP VOCATIONAL
REHABILITATION OF THE DISABLED
Lecturer: Norman Cooper

09.20-12.00 REVIEW AND ADOPTION OF FINAL CONCLUSIONS

13.30 FORMAL CLOSURE OF SEMINAR.

Pattern of the Seminar

Following a general introduction to the Danish social and rehabilitation
services the programme was divided broadly into two main parts with the subject
of mental retardation covering the first half and mental illness the second part.
Interspersed was the short period of practical studies in Fyn and Jutland.

Wherever possible lecture subjects were so arranged as to provide the
participants with both a Danish and international viewpoint. Lectures were
linked with a visit to an institution or centre to see the practical implementa-
tion of the views expressed. (In some cases lectures were given at the
institutions themselves.) Specialist staff at each institution visited acted
as guides and provided verbal and/or written explanations of the aims, purpose and
function of the institution. Group and plenary discussions were then held with
lecturers and directing staff participating.

Lectures

Copies of the full English texts of lectures were distributed one day in
advance of the lectures being delivered so as to facilitate understanding of the
subjects. Normally the lectures were followed by a brief question and answer
period to permit clarification of any points not readily understood. Chairman-
ship duties were shared by the directing staff and occasionally the participants
themselves were invited to nominate their own chairman. In addition
Mr. N.E. Bank-Mikkelsen and Mr. L. Bjødstrup also acted as Chairman.

A selection of lecture papers presented at the Seminar is provided in
Chapter VI.

Group and Plenary Discussions

Throughout the Seminar participants were divided into four working groups to
allow a thorough examination of each subject and to help them formulate ideas and
the preparation of brief reports.

The working groups at the Seminar headquarters were arranged on a regional
basis as follows, each group having its own Chairman and Rapporteur:
Questions and special points for discussion by the groups were prepared by the Directing Staff. Although participants were free to discuss the special points and questions or any other aspect of the subject under discussion, the groups generally directed their discussion towards the points and questions suggested.

After the group discussions the rapporteur of each group presented his group's views, suggestions and recommendations in plenary session and this was followed by a general discussion. The conclusions reached by the groups were summarised each evening by the Directing Staff and distributed to the participants on the following day. These conclusions subsequently formed the basis for the discussion and adoption of final conclusions and recommendations on the final day of the Seminar (see Chapter V).

Country Papers

Each participant was invited, prior to the Seminar, to prepare a short paper describing the programme of vocational rehabilitation for the mentally handicapped in his or her country and any problems anticipated or encountered in developing the programme. Copies of these papers were distributed during the Seminar and three full sessions were devoted to their presentation and discussion. Copies of the country papers are included as an Appendix to this report.

Closure

At the formal closure of the Seminar on 29 October 1971, a certificate was presented to each participant.
CHAPTER III

FIELD STUDIES IN FYN AND JUTLAND

Purpose and Method

With a view to giving participants in the Seminar a practical insight into the detailed working arrangements of the Danish rehabilitation programme, in particular the services for the mentally handicapped, a short period of field study, discussions and visits were arranged in Fyn and Jutland on 22 and 23 October 1971. Staff of the State Rehabilitation Centres at Odense and Vejle actively participated in the programme together with placement officers from the local employment exchange and other rehabilitation specialists. In both areas the groups had the honour of being received and entertained to dinner by the Lord Mayors and members of the County Councils of Fyn and Vejle respectively.

For the field studies it was felt necessary to reconstitute the groups according to their particular interest and/or specialisation, taking into account the type of institution, etc., to be visited. The composition of the groups was as follows:

<table>
<thead>
<tr>
<th>Fyn</th>
<th>Jutland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group A</strong></td>
<td><strong>Group A</strong></td>
</tr>
<tr>
<td>Dr. L. Vales Ancona (Chairman)</td>
<td>Mr. B. Akinwale (Chairman)</td>
</tr>
<tr>
<td>Mr. P.B. Pascual (Rapporteur)</td>
<td>Mr. P. Wabulya (Rapporteur)</td>
</tr>
<tr>
<td>Dr. O. Mendez Pereira</td>
<td>Miss E. Vidal Lagos</td>
</tr>
<tr>
<td>Mrs. A.B. de Ainsa</td>
<td>Dr. R.A. Camino</td>
</tr>
<tr>
<td>Miss P. Kanphaboo</td>
<td>Mr. S. Mangoensandjojo</td>
</tr>
<tr>
<td>Mrs. E. Schmidt de Vales</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Group B</strong></th>
<th><strong>Group B</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. F.A. Göksel (Chairman)</td>
<td>Mr. W.B. Robertson (Chairman)</td>
</tr>
<tr>
<td>Dr. P.E. Ladda (Rapporteur)</td>
<td>Mr. F. Alvarado (Rapporteur)</td>
</tr>
<tr>
<td>Mr. S.M. Oisebe</td>
<td>Mr. L. Sun Leong</td>
</tr>
<tr>
<td>Mr. G. Abu</td>
<td>Mr. K.M. Faouri</td>
</tr>
<tr>
<td>Mr. R.J. Mbekeani</td>
<td>Mrs. A.B. Al-Jazrawi</td>
</tr>
<tr>
<td></td>
<td>Miss A. Shashaani</td>
</tr>
</tbody>
</table>

Each group was asked to study and prepare reports on the following subjects:

- The role of the Rehabilitation Centre at Odense or Vejle, as appropriate, as a focal and co-ordinating point for rehabilitation services in the area.
- The role of the rehabilitation counsellor in rehabilitating individual disabled persons including the mentally handicapped (i.e. covering detailed working methods and the rights of the disabled).
- A description of the rehabilitation facilities visited (hospitals, clinics, centres, etc.), including their role and purpose and an indication of the applicability of the facilities to developing countries.

During their studies, each group endeavoured to become fully acquainted with the organisation, administration aims and purpose of the Rehabilitation Centre service and its staff. Specialist staff of the Rehabilitation Centres...
explained their specific tasks and rehabilitation counsellors and placement officers accompanied the groups on their visits to the various institutions. In addition, case histories from the centres were distributed to participants in advance.

The following is a summary of the group reports.

1. Group A Report - Fyn

(a) The Role of the Rehabilitation Centre, Odense

This Centre is situated centrally in the town of Odense and functions as a bridge between the different services involved in the rehabilitation of the disabled. The Centre's clients are referred by the different agencies, e.g. labour exchange, local authority, school doctor, general practitioner, hospitals, clinics, etc.

Based on the Centre's statistics, general practitioners refer the greater number of psychiatric cases followed by the social welfare office and self-referrals.

The mentally retarded identified by the Centre are passed on to the specialised services provided for this particular group.

The Centre closely co-ordinates and collaborates with the different services. Frequent meetings of specialised staff are arranged with a view to better planning and implementation of individual rehabilitation programmes for each client.

The Centre has 60 staff, including 18 rehabilitation counsellors assigned to different areas of Fyn and 10 doctors. Psychological and other specialised services are available.

(b) The Role of the Rehabilitation Counsellor

The rehabilitation counsellor's role in planning individual rehabilitation programmes and as the co-ordinating link with other specialists and services is most important. In this connection he must have a full knowledge not only of each individual case but also of the functions of the various rehabilitation facilities and community resources best suited to serve his client's need.

(c) Description of the Various Rehabilitation Facilities Visited

(i) Psychiatric Ward - Svendborg General Hospital

The ward has 40 beds as well as out-patient facilities. Some 20-25 patients are being served on a consultation basis. The chronic cases receive in-patient treatment.

In addition to providing treatment and consultative services, case evaluation and occupational therapy services are also available. The hospital staff includes 3 psychiatrists and 3 doctors under training.

Intake procedure includes a thorough examination prior to admission. There is a regular evaluation of progress through case conference-type discussions involving specialist staff from all the services interested in the case. As the client progresses, he is referred for occupational therapy to ascertain what possibilities exist for vocational training and employment. Close contact is maintained with the rehabilitation counsellor serving the area and the client is transferred to other rehabilitation facilities at the earliest opportunity.

The group saw the case conference procedure in action and was most impressed by its effectiveness. Comments and reports presented by the various specialists
were brief and very much to the point. A businesslike atmosphere prevailed and it was possible to deal with several cases in a comparatively short time.

(ii) The Psychiatric Rehabilitation Clinic, Odense

This clinic has workshop facilities for some 20 patients who are referred from the Psychiatric Unit at the General Hospital in Odense. Useful production work on a subcontract basis is provided but emphasis is placed on rehabilitation not productivity. During a two- to three-month stay in the clinic the patient's stability, working capacity, aptitudes, etc., are carefully noted and assessed prior to transfer to open or sheltered employment. Regular visits are paid by the placement officer, rehabilitation counsellor and psychiatrist. The services of an adjoining training and sheltered workshop are available to clients of the clinic.

(iii) The Old Vicarage, Tarup

This handicap centre was founded through voluntary effort but is now an approved institution under Danish Law 229, 1968 for the care of disabled people and old-age pensioners. It has 120 members but can only cope with 72 persons per day, mainly those who for physical or mental reasons cannot be rehabilitated through the normal services. The centre has a board of management with 11 members drawn from various voluntary organisations. Employers' and workers' organisations are also represented on the board. Meals may be obtained at the centre and there is a workshop where many of the patients are employed on handicrafts. Ten places at the centre are reserved for rehabilitation purposes and 10 for sheltered employment. The staff of 15 includes a technical manager, an assistant nurse and 4 occupational instructors.

(iv) Danish Group Surgery, Langeskov

This is serviced by a group of 3 general practitioners and is situated in the heart of a small country town. The surgery opens at 08.00 hours and closes at 16.00 hours. Treatment is by appointment. From 16.00 hours to 08.00 the surgery is closed but an automatic telephone gives the name and telephone number of the doctor on duty.

(d) General Remarks

The methods used in the various facilities described above could readily be adapted to serve developing countries, but bearing in mind the grave limitations of trained staff and financial resources. The group was particularly impressed with the trend in Denmark to develop small centres and units for the disabled, rather than the very large institutional facility.

2. Group B Report - Eyn

(a) The Role of the Rehabilitation Centre, Odense

The Centre is centrally placed, operating from the administrative capital of the county. It is headed by a Director (whose basic training was in law), and has an adequately representative Board of Consultation to advise him on matters involving pensions and grants. The Centre is comprehensively staffed by specialist services in all necessary fields. It maintains excellent contact with all rehabilitation facilities and the area it serves is fully covered by 18 rehabilitation officers. It is therefore an appropriate centre "as a focal point for co-ordination of the rehabilitation services in the area".

What is very exemplary and ideal for adoption by developing countries is the horizontal distribution of offices and responsibilities.
The Role of the Rehabilitation Counsellor

The rehabilitation counsellor plays a central and key role throughout the process of rehabilitation and in assisting the rehabilitee in planning this process. Through his activities he ensures that every officer connected with the process of rehabilitation plays his or her part actively. In particular:

- He maintains contact and exchanges information with the therapeutic team (psychiatrist, clinical psychologist, psychiatric social worker, occupational therapist, psychiatric nurses, hospital, physiotherapist, etc.) including the general practitioner where they are involved, during the client's stage as a patient.

- He is instrumental for vocational training and rehabilitation whether at a training workshop, a sheltered production or rehabilitation workshop or open production workshop.

- The response and attitudes of workshop managers and prospective employers is greatly influenced by the rehabilitation counsellor.

- Placement officers depend on his detailed information and the reliability of such information for successful placement of clients.

- The client's rights are protected through counselling by the rehabilitation counsellor, the access to information contained in his dossier, and the list of vocations open for him to choose from each time he pays a visit to the Centre.

- The Director for Rehabilitation through the Board of Consultation depends on the rehabilitation counsellor's information (among others) for fair and impartial decisions on allowances and grants awarded to clients.

Developing countries must ensure that they have this cadre of officers in adequate numbers if any rehabilitation programmes of any scale and at all stages are to succeed.

A Description of the Rehabilitation Facilities Visited

Five rehabilitation facilities were visited:

(1) Psychiatric Unit, General Hospital, Odense

This is a forty-bed modern psychiatric unit on three floors, part of a university hospital and a general hospital for the population of 150,000 in the city of Odense and its suburbs.

It admits short-stay patients who also provide material for teaching and research, and includes child psychiatry. The staff complement consists of 9 psychiatrists, 2 social workers, 2 occupational therapists, 4 clinical psychologists (available on request), 18 nurses with up to 5 auxiliary nursing personnel, and 6 secretarial and administrative staff.

The unit has open wards. It attends out-patients on the ground floor, where also follow-up sessions for ex in-patients are held. Some of the discharged patients attend as day patients for some days; others are referred to a psychiatric clinic attached to a sheltered workshop, and the rest are rehabilitated in various rehabilitation facilities, including the open market. About 12 per cent of discharged patients need some sort of rehabilitation, and 2 to 3 per cent need further hospitalisation and are transferred to mental hospitals.

In addition to its consultant relationship with the general and teaching hospital it co-operates by providing consultation services to alcoholics' clinics, the mothers' institute, the social office, and the Rehabilitation Centre.

The opportunity to participate in "case conference" was not utilised fully as at least two of the important members of the conference were indisposed, but a brief description of one of the cases which presented a number of problems was given by the staff present.
Small psychiatric units of this type and size are desirable in developing countries. Facilities provided to the unit and their methods of use are ideal whatever financial problems they may present.

(ii) Psychiatric Rehabilitation Clinic, Odense

This is a rehabilitation clinic for psychiatric patients within a rehabilitation unit which serves mainly as a half-way house between hospital and final rehabilitation. About one-third of the clients are drawn from the psychiatric unit mentioned above, the rest from two other mental hospitals within the County of Fyn. There were 20 psychiatric rehabilitees at the time of the visit, and staff stressed that more places were needed.

During the first year of the existence of this clinic (1978-79) 28 rehabilitees were seen and of these two-thirds were successfully rehabilitated, and the remaining one-third were recommended for pension. The clients are composed of one-third each psychotics, neurotics and character disorders. It is hoped in future to enlarge this clinic so as to include a training workshop within the clinic.

Psychiatric rehabilitation clinics of this type should be established in developing countries either through a central (state) organisation or a voluntary agency, or by a body formed by these two.

(iii) The Old Vicarage Handikapcentret

Established in 1965, this is a voluntary undertaking joint venture by the National League of Tuberculosis Patients in Denmark and the National League of Disabled People. Old buildings are in use, formerly owned by the Tuberculosis League. It is run by a board of 11 members drawn from various voluntary organisations and state departments and controlled by three Commissioners. It employs 15 people, one of whom is the Manager. It is protected by law (Danish Law 229 of 6 June 1968).

This is a day-care centre caring for pensioners, 17 per cent of whom are also physically handicapped. The centre provides transport to and fro for wheelchair cases. Its main aim is to provide diversional and recreational hobbies to the handicapped who for various reasons cannot be rehabilitated or cannot work satisfactorily even in a protected workshop, so as to offer them a feeling of meaningful existence.

All categories of handiwork are taught, as well as physiotherapy, chiropody, and sauna-bath treatments. Members are permitted to take home some of the work they have accomplished. There are 120 members registered, but the centre can occupy fully only 72 members per day. Refreshments, coffee and midday meals are available at minimal charges.

Care centres of this type are needed all over the world, including developing countries, regardless of family ties and systems prevalent in various cultural groups. They may appear to be a luxury at present but must be aimed at as the economy of the nations improves. Voluntary agencies could be encouraged to start them now.

(iv) Group Practice Clinic for GPs, Langeskov

Three medical practitioners run a general practice clinic at which patients can be attended on weekdays, Mondays to Fridays, from 09.00 hours to 16.00 hours. After these hours one practitioner is on call-duty, and his address and name are given to callers by the automatic telephone installed at the clinic. Each practitioner sees an average of 20 patients daily, and they will usually have seen several patients in their homes before they reach the clinic. Practitioners' cars are connected to the clinic by radio telephone.

The clinic is on road-surface level to allow wheelchair cases easy entry, and has a covered lobby for patients to wait when it is raining. The waiting room is spacious, and the appointment system has been devised so as to avoid queues of clients. Basic clinical diagnostic facilities can be carried out...
at the clinic, but there is easy access to consultant, laboratory and radiodiagnostic services at the General Hospital in Odense 12 km. away. Referred cases have free (and immediate) transport to Odense. There is provision for 8 consultations simultaneously and the group intends to receive clinical medical students for short postings during their vacations or as part of selective posting. Adjacent to the clinic is a kindergarten and a nursing home which the group supervise. There is a dental surgery nearby.

Group practice should be encouraged in developing countries. Where free medical service is provided to citizens a modified national health system of the Western type could be evolved. The need for intensive psychiatric orientation and exposure for medical students and nurses seemed important as the GP is increasingly called upon to counsel on social problems and he is often his own psychologist.

(v) Rehabilitation Centre for Fyn County

This is the hub of all rehabilitation and related social services for the county. It serves a population of 450,000 inhabitants headed by the Director for Rehabilitation aided by a deputy, a team of rehabilitation officers each serving his own area within the county, social psychiatrists, placement officers and administrative staff. All rehabilitation arrangements are under one roof.

We had opportunity to be briefed by the social psychiatrist, a rehabilitation officer, a clinical psychologist and a placement officer on the nature and the role of their duties in connection with the Centre, and the general impression was one of comprehensive and well-organised team work.

Placement officers are fed with detailed information on individual clients to ease placement procedures and enable them to place each client according to his capabilities. In the waiting room at the Centre a list of vacant appointments is maintained daily, and individual clients can receive vocational counselling on vocations of their choice.

The Centre is designed and run so as to protect the individual client's rights as prescribed in law, and advises on pensions. Loans and allowances (grants) are awarded by the Director in consultation with the Centre's doctor and the labour exchange, and clients are free to appeal against decisions finalised at the Centre. Due to the comprehensive and specialist services at their disposal as well as the wide-open ceiling for funds, appeals of this nature are rare.

Unconfirmed figures for 1970 show that:
- 1,612 cases were referred;
- 732 grants and aid of various types were given;
- 105 loans and grants for tools and businesses were issued;
- 181 clients were provided with vocational rehabilitation at workshops;
- 186 successful placements were achieved.

The Danish social and rehabilitation system should be the ultimate goal in all developing countries, however long it may take to reach this goal.

(3) Group A Report - Jutland

In order to give us practical experience and insight into the detailed working arrangements of the Danish rehabilitation programme, arrangements were made for us to visit Vejle Rehabilitation Centre (office) in Jutland, a state hospital for mental diseases at Risskov in Arhus, and a psychiatric department of the General Hospital at Vejle.
(a) **The Role of the Rehabilitation Centre at Vejie**

This is one of the 12 county Rehabilitation Centres set up in 1961 in accordance with the Danish Rehabilitation Act of 1960. According to the 1960 Danish Rehabilitation Act, the role of the Vejie Rehabilitation Centre, like any other rehabilitation centre in Denmark, is to provide vocational guidance to all disabled persons in relation to their vocational training and placement. There are 4 operational centres with the Vejie Centre being the administrative head. The Centre is administered by the Director assisted by a deputy and assistant supervisor, 10 rehabilitation counsellors, 5 part-time medical doctors and 12 supporting staff.

According to the Director of the Centre the role of the Centre is as follows:

- to co-ordinate the work of the 4 operational centres;
- to render advice to all disabled persons in relation to their rehabilitation;
- to finance the vocational rehabilitation plan agreed to by the rehabilitee, the rehabilitation counsellor, the placement officer and the medical adviser;
- to use all the resources available for the training and rehabilitation of the disabled;
- to co-operate and collaborate with other public agencies such as vocational rehabilitation units, hospitals, labour exchanges and pension courts.

(It should be mentioned that placement of the rehabilitee is usually the responsibility of the employment exchange but - as Denmark has full employment - more than 50 per cent of the rehabilitees do find jobs by themselves.)

(b) **The Role of the Rehabilitation Counsellor**

As the rehabilitation centre is the focal point of vocational rehabilitation the role of a rehabilitation counsellor is:

- to receive the disabled persons referred to him and to give them proper vocational guidance in relation to their training and rehabilitation;
- to give advice and where necessary refer disabled persons to appropriate rehabilitation agencies;
- to make contact with the disabled person and his family;
- to make regular contacts with the placement officer, rehabilitation unit, medical advisers and others concerned with the training and rehabilitation of the disabled;
- to prepare and keep case records of all rehabilitees referred to him and those under his care;
- to make regular follow-up of all the rehabilitees. (The group also noted that the rehabilitation counsellor is the co-ordinator of any rehabilitation plan for all the disabled persons in his area.)

(c) **The Rights of the Rehabilitee**

- The rehabilitee has the right to be received and served by the counsellor regardless of his sex, creed or colour.
- If he is not satisfied with the decision made by the rehabilitation centre he can appeal to a Rehabilitation Appeal Board in Copenhagen.
- He has the right to see his case papers.
Description of the Rehabilitation Facilities Visited

(i) Århus Mental Hospital

This hospital was established in 1852 as a state mental hospital. It is one of the few and oldest mental hospitals built in the early nineteenth century to care for the mentally handicapped. The hospital has children's, female and male wards with a total of 850 beds. The hospital admits only acute psychiatric cases for treatment. There are also 3 psychiatric nursing homes, each with 150 beds. In order to avoid overcrowding in the hospital and the nursing homes, many mental patients are given family care in selected families. It was stated by the chief psychiatrist of the hospital that family care is a transitional period between hospital care and the final integration of the patient in the community. The group felt that this system of care would be most practicable in developing countries where there are limited resources to build mental hospitals and nursing homes.

Occupational Workshops and Sheltered Workshops

An occupational therapy workshop, where patients are observed and prepared for sheltered workshops and the open labour market and 3 sheltered workshops where some of the patients were employed on productive work were also visited. Most of the work done in the sheltered workshops was on a contract basis, supplied by local firms. The group felt that this type of sheltered workshop could be introduced in developing countries to create employment for the mentally handicapped.

Administration

The administration of the hospital was divided into two parts, the economic administration unit and the medical administration. The economic administration dealt with budgeting for the funds required to run and improve the hospital while the medical administration dealt with medical treatment of patients and training of staff. Each administrative unit was independent but there was close co-operation between the various units. One of the most important factors noted by the group was that the medical administration was a council consisting of 8 heads of each medical department. The chairman of the council is appointed yearly and the chair usually rotates among all heads of department. The group found that the system of administration in the hospital was very democratic and led to efficient running of the hospital.

Training

It was interesting to note that the hospital offered psychiatric training to rehabilitation counsellors alongside medical staff.

Problems

The group was informed by the chief psychiatrist that for two years there had been a problem of terminology and concept of rehabilitation between the medical staff and the rehabilitation counsellors. This problem has now been overcome due to close co-operation between the rehabilitation counsellors and the medical staff. Nevertheless there still remains the problem of those concerned with the rehabilitation of the disabled attempting to understand each other's role and limitations. This is, of course, a universal problem.

(ii) Boller Forest Rehabilitation Training Unit

On arrival at the forest we were told by the forester in charge that the training scheme had facilities for training mental patients who had lost interest and desire for work. This scheme was started in 1959 to ascertain if the mentally ill could be trained and made to realise the value of work. We were told that a number of patients have been successfully trained and rehabilitated under this scheme. The trainees usually work 8 hours a day for 5 days a week and earn 500 kr. a week. Although it appeared to be an expensive type of rehabilitation training, the group noted that the idea could be adapted to
the needs in developing countries for the training and rehabilitation of mental patients.

(iii) Psychiatric Department of the General Hospital at Vejle

This is one of the departments in the 500-bed hospital. The psychiatric department was started in 1965 and has a total of 50 beds; it admits 1,100 patients every year but totals 3,000 consultations a year. There are 6 doctors, 2 social workers and 10 nurses. There is an occupational therapy workshop and well-furnished recreational rooms for the patients.

Patients admitted stay at the hospital up to a maximum of 17 days during which period they undergo medical psychiatric treatment; some of them are referred to the Rehabilitation Centre for counselling, etc.

The group noted that one of the psychiatrists in this department was the medical adviser at the Rehabilitation Centre and as a result there was a close system of co-operation between the Centre and the psychiatric department. The group felt that the ratio of 5 psychiatrists to 500 in-patients a year and only 3,000 consultations was rather generous.

(e) Problems Encountered

The problem of pioneering a service to co-ordinated heterogeneous services hitherto handled by a number of different agencies has called for some caution in asserting the rights and responsibilities of the Rehabilitation Centre. This is essential to avoid friction which may hamper harmonious and inevitable co-operation with agencies which are relieved of part of their past rehabilitation functions. The question of placement still entrusted to the Ministry of Labour was cited as a case in point.

The problem of educating newly recruited rehabilitation counsellors with regard to the requirements of the job is met through orientation courses. Occasional conferences and in-service training are utilised to keep all categories of staff abreast with the modern development, techniques and principles of rehabilitation.

The statutory system which compels all placement of rehabilitees who have not found jobs on their own and must depend on the Centre to be channelled through the placement officer of the Ministry of Labour also creates a problem. In the main, the client, particularly a mentally handicapped person who has established an effective working relationship with the rehabilitation counsellor, will start all over again the process of establishing rapport with the placement officer.

It is desirable to make greater use of schools, voluntary organisations, mass media communication, to educate the general public about the aims and purposes of the rehabilitation services.

The function of ensuring an adequate income for the dependants of the rehabilitees entails working in close co-operation with the social security committee of the municipal councils. Having regard to the fact of special needs, e.g., special medical prescription besides the basic subsistence requirement, it is essential that each case be considered on its merit and this is an aspect in which the rehabilitation counsellor may encounter difficulty in helping the social security committee to reach an equitable decision.

4. Group B Report - Jutland

(i) General Observations

It is felt that what we have seen on Jutland and other places in Denmark relating to the mentally handicapped can serve as a most useful guide for us as we go back to our countries. However, we cannot hope to implement these things on the scale that we have seen in Denmark because we must work within the framework of our economic and political conditions. Therefore, emphasis
must be placed on what is already in existence, along with educational programmes to inform the population within each country and appeals and educational programmes geared to reach our governments - national, regional and local, in order to see that necessary funds are allocated. We must learn that facilities used by so-called normal persons (schools, training centres, etc.) might be utilised by those in the retarded category. This is much more economical than setting up separate facilities. In effect we must always think in terms of integrating the retarded into normal life. There should be no segregation of those who are retarded because this is not the natural scheme of life.

The normal must come to appreciate the retarded for what they can do and because of this they will be more willing to assist in developing programmes for those who fall in this category. Again, we emphasise the fact that once we return home we must assess what we already have in the way of facilities and services and learn to make wider use of these while expanding the programmes to take in and use existing facilities. It has been said that a journey of a thousand miles begins with the first step and in our so-called developing countries that first step has been taken and now it is time for the second and third. Therefore, we realise that all the things we want to see accomplished will not come into being today or tomorrow, but we must think in terms of where we can be five, ten, fifteen or even twenty years from this point. If we start now with modest projects and programmes which will gradually expand as we proceed, ultimately we will see adequate facilities and services provided for the mentally handicapped.

With the above in mind, we have reached the following conclusions in terms of the three questions assigned to us relating to our visit here at Jutland:

- The Rehabilitation Centre at Vejle is a focal point for co-ordinating the services in the area. A main office and its branches seem to cover their main objectives with the co-ordinated co-operation of the labour office, private enterprise, school system and local government.

- The need for rehabilitation counsellors is one of the basic needs to be fulfilled in our developing countries in order to co-ordinate all the existing facilities and make them available to the rehabilitee during the period of time the client is receiving the service and the follow-up.

(ii) The Welfare Centre for Mentally Retarded, Breinig

We visited the Welfare Centre's sheltered workshops for the severely retarded. We found these to be well run with adequate work to keep the clients occupied. Also, there was sufficient staff but additional workshops are required in order to cater for those in need of this service and who are not presently served. The hospital houses approximately 1,000 clients in small accommodations which resemble family settings. Cottages have been built in the grounds with 24 clients housed in rooms of their own. The rooms are small but cosy and there are dining areas, living rooms, etc. The idea is to break the larger institution down into smaller components which will give the clients a sense of individualism as well as family atmosphere.

This concept (smaller units rather than huge institutions) should be examined and initiated by developing countries.
CHAPTER IV

FINAL CONCLUSIONS

The following conclusions were reached and agreed at the final plenary session of the Seminar on 29 October 1971. They take into account the objectives of the Seminar and the ideas, suggestions and recommendations which were put forward by participants and lecturers during group and plenary discussions:

I. Special Care and Rights of the Mentally Retarded

1. One half of one per cent of any given population is severely or profoundly retarded and requires some form of residential care.

2. In many developing countries the following factors are serious obstacles to the organisation and development of care services for the mentally retarded:
   - low priority of social welfare programmes;
   - preference given in rehabilitation programmes to the physically handicapped;
   - limited budgetary resources;
   - lack of specialised staff;
   - lack of appreciation on the part of the general public of the needs and potentials of the mentally retarded;
   - lack of information on the size of the problem.

3. There is a grave shortage (in some cases a complete absence) of care and rehabilitation facilities for the mentally retarded in the majority of developing countries and governments are urged to consider establishing the following services:
   - a mobile unit for the mentally retarded in rural areas, for diagnostic, evaluation advisory and treatment purposes;
   - a specialised department for the mentally retarded attached to either a regional or district hospital;
   - special classes integrated within the normal schools for the educable mentally retarded;
   - a rehabilitation centre (embracing educational, social and pre-vocational services) and including a sheltered workshop;
   - a permanent residential home for severely retarded.

(NB: These services are minimal and are suggested as a basis for a pilot programme.)

4. Developing countries should not repeat the mistake of Western countries in creating large institutional buildings for the mentally retarded in remote areas. The creation of small residential units for the severely or profoundly retarded (maximum of fifty cases) and day centres for less severe cases is a far better approach.

5. Governments should do everything possible to ensure that the United Nations Draft Declaration on the Rights of the Mentally Retarded is adopted (Draft Declaration, see Annex I).

6. To ensure that the human rights of the mentally retarded are respected and to enable them where possible to become independent and productive members of society, governments should ensure that the following action is taken:
- a public education programme through mass media channels (newspapers, radio, television, etc.);
- legislation to provide implementive and protective measures for the mentally retarded;
- the creation of a national body or organisation which would ensure the provision of special care facilities for the mentally retarded.

II. Pre-Vocational Preparation of Mentally Retarded Children and Young Persons

7. Pre-vocational preparation of the mentally retarded should be included in every educational programme for this group of handicapped. Pre-vocational preparation should include training in activities of daily living, i.e. such simple matters as using public transport, shopping, home-making skills, punctuality, personal hygiene, etc. Without this basis, the transfer to vocational training and employment would have little hope of success.

8. Pre-vocational preparation should not aim at training for a specific job or trade but concentrate on the world of work, i.e. handling of tools, use of machines, recognition of materials and skills common to all work, working with others, acceptance of workshop and safety rules, the following of simple instructions and working routines, etc. The pre-vocational process should be continued outside the institution workshop through periods of observation and trial employment in sheltered workshops. It should be recognised that pre-vocational preparation, which should be included as an integral part of the educational programme is a lengthy process to be measured in terms of several years and requiring a feeling of close mutual understanding between teacher and pupil.

9. Pre-vocational preparation should be planned on an individual basis according to the level of intelligence and aptitudes of each mentally retarded person. In the case of the severely mentally retarded pre-vocational instruction could be given in the form of occupational therapy.

10. The lack of trained teachers in educational programmes for the mentally retarded is a great drawback to the planning and implementation of pre-vocational activities. Special units for mentally retarded children should be attached to normal schools and special courses provided for teaching staff responsible for educational and pre-vocational activities.

11. Parents and parent groups should be regularly consulted in the pre-vocational preparation and counselling of mentally retarded children.

12. Employers should be encouraged to assist with the vocational assessment and pre-vocational preparation of the mentally retarded by offering trial employment and submitting progress reports to the institution from which they were referred.

13. Pre-vocational preparation should start at the earliest possible stage of education, i.e. as soon as the mentally retarded client is identified and admitted to either an ordinary or special school or rehabilitation centre. There is an urgent need, however, for:

- guidelines that stress vocational and social preparation for every level of training and education;
- materials on vocational and job-related subjects which should be written in simple language for use by mentally retarded individuals;
- increased use of voluntary organisations in arranging out-of-classroom instruction.

14. In summary, a pre-vocational preparation programme for mentally retarded children and young persons should embrace:

- training in basic skills of daily living activities;
opportunities for socialisation;
- group and individual counselling;
- actual near-life experiences involving contact with a specific skill or through field visiting to typical work situations;
- simulated job experiences to develop technical skills and experience in working with others on the job;
- development of desirable attitudes towards work, favourable work habits, and the stability necessary to hold a job;
- provision for suitable reception of the retarded in the community (living conditions, attitude of co-workers, employers, etc.).

III. Intelligence Testing

15. IQ ratings should not be used by the testers or practitioners to label or classify rigidly the clients they are serving. Intelligence and related tests are only one of the methods of assessing social competence and vocational potential of the mentally retarded.

16. In so far as developing countries are concerned, tests should be devised or reconstructed in accordance with the culture, socio-economic levels, multi-lingual and multi-racial characteristics of the country and the group being served.

17. In considering the problem of criteria of mental retardation and systems of classification, it is important to identify the underlying purposes for any particular system. Sometimes these may be scientific in aim, educational, medical or administrative.

18. The classification of an individual as mentally retarded does not necessarily imply a life-long condition of dependence. Among the milder grades particularly, there are those who either learn to adjust satisfactorily to society, or who through delayed maturation, move into higher levels of ability and competence. An intellectual ability in the range of mild retardation, therefore, only puts its possessor "at risk" of needing special help which if indeed is necessary may only be for a limited period of his life (e.g. the school years).

IV. Outlets in Normal Employment for the Mentally Retarded

19. Whenever possible, the aim must be to place mentally retarded persons in normal employment. This will prove possible especially for many of the mildly retarded, although the period of preparation and training may in some cases need to be prolonged.

20. The mentally retarded individual entering the competitive labour market needs to be physically, emotionally, socially and vocationally ready for job placement.

21. Non-repetitive and non-structured jobs are normally not suitable for the mentally retarded. It is emphasised, however, that after training the mildly retarded may be able to undertake relatively complicated work.

22. As with other disability groups it is unrealistic to draw up a list of jobs which the mentally retarded can perform - the range is too wide for this. Gardening, forestry, agriculture and service trades (e.g. laundries) may offer suitable outlets in addition to light industrial work such as umbrella assembly work, simple furniture making, etc.

23. In developing countries with their high levels of unemployment, government should set a lead in employing the mentally retarded through quota schemes or reservation of special jobs. Public information should be directed towards employers who should also be encouraged to train and employ rehabilitated mentally retarded persons.
V. Sheltered Employment for the Mentally Retarded

24. Production work undertaken in sheltered workshops for the mentally retarded should be related as much as possible to the economic needs and structure of the country. The need for a sound administration for the workshop is imperative, and government should take a lead in offering contracts. The making of uniforms, bed linen (as was seen in the sheltered workshops for the mentally retarded in Copenhagen), flags, silverware, cardboard boxes, brushes, assembly of electrical components, pressing of metal parts, simple soldering, making of sandals and shoes, printing work, wooden-box making, concrete-block making, ceramics, etc. Contract and subcontract work should be obtained for the workshop from both the public and private sectors. The manufacture of articles which have a ready sale such as handicrafts, woodwork (including carving which is of particular interest to tourists) are also suggested as suitable subcontract work. In the rural areas sheltered schemes for group employment of the mentally retarded in forestry, horticulture and agriculture should be organised.

25. Wherever possible and practicable, the mentally retarded should be integrated with other disability groups in the same workshop but work should be allocated according to capacity and capability. (It is appreciated that for the more severe cases of mental retardation, it is often necessary and advisable to provide either group work or even separate workshop facilities for them, in view of the need for individual tuition and supervision.)

26. It might be difficult for developing countries to establish different sheltered workshops for different categories of the mentally retarded. Workshop programmes should only be established after a careful evaluation of the clients by the workshop team. For the severely and profoundly retarded there should be a system of control and supervision to give their life a meaningful existence; for the moderately retarded efforts should be made through patient training (both socially and vocationally) to enable them to become as economically self-supporting as possible; for the mildly retarded the workshop should function as a stepping stone to placement in the open labour market.

27. The important role of sheltered workshops in developing countries, in view of the prevailing high levels of unemployment, is strongly emphasised.

28. A programme of training in daily living activities, social adjustment as well as education, training and employment components should be incorporated in the workshop programme to facilitate social as well as economic self-independence in the mentally retarded clients. To facilitate the transfer of the mentally retarded from the workshop to the outside world, there is a great need for public education programmes to convince employers and the general public of the employment potential of mentally retarded persons who have been trained in the workshops.

29. The establishment of co-ordinating boards at regional or district level to help with the planning and administration of sheltered workshop programmes is strongly urged.

30. It is the responsibility of governments to promote, support, finance and staff the total programme of sheltered workshops for the mentally retarded but financial support for the workshops should also be sought from the general public and employers.

31. The following protective measures should be introduced by governments in support of sheltered workshop programmes:
   - tax exemptions for the income of trainees and raw materials used;
   - individual trainees to be covered by the compensation laws in case of accident;
   - a grants system to cover operating losses.

32. It is strongly recommended that the principles of training of adult mentally retarded for industrial work (outlined in "Recent Advances in the Study of Subnormality" published by the UK National Association for Mental Health should be adopted) (see Annex 2).
VI. Rehabilitation of the Long-Term Psychiatric Patient and Transition From Mental Hospital to Employment

33. In many respects the rehabilitation of the long-term psychiatric patient has much in common with the rehabilitation of the mentally retarded, i.e. the process cannot be rushed - it must be a patient, individual approach to their problems with a comprehensive supporting programme of treatment, care, social adaptation and a gradual exposure to a normal living and work situation.

34. The mental hospital has a vital role to play in preparing its patients for employment. This may be achieved through:
- occupational therapy and active involvement of the patient in the daily living activities of the hospital;
- training in hospital maintenance departments and service areas;
- training in a hospital workshop in which normal employment conditions are simulated as far as possible;
- prompt reference of the patient to external rehabilitation and training facilities (using half-way house and hostel arrangements) when the appropriate stage of recovery and work output has been achieved.

35. Training and work orientation of mental patients in hospital maintenance departments and service areas (gardens, farms, kitchens, laundries, wards, etc.) should be arranged with rehabilitation, not cheap labour in view. (Too often in the past, employment of patients on such work has resulted in their becoming even more institutionalised.)

36. Similarly rehabilitation of patients not levels of output and production should be the prime consideration in the hospital workshop. If attempts are made to develop the workshop as a profit-making concern, it tends to become a terminal workshop with rehabilitation of the patients as a secondary consideration.

37. Government should accept full responsibility and provide adequate budgetary support and staff resources if an effective programme aimed at the smooth transition of the mentally ill from hospital to satisfactory community life is to be achieved.

38. Bearing in mind that eventually the long-term patient has to return to live and work in a society that may have undergone considerable social and economic changes since he was last acquainted with it, the rehabilitation process must take into account the prevailing social, economic and cultural conditions on the one hand, and the patient's background in vocational choice and aptitudes, personal characteristics, motivation, etc. on the other.

39. Close links should be established between the hospital's own rehabilitation services and those likely to serve their patients in the outside community. In this connection, the psychiatric social worker can play a key role.

40. A thorough investigation of employment opportunities should be undertaken on the client's behalf when his vocational potential has been assessed and before he is discharged into the community rehabilitation and selective placement officers should pay regular visits to the hospital so that such action can be initiated at the earliest possible stage.

41. Mental hospitals should be centrally located in the community (not hidden away from the public in isolated areas). This will greatly facilitate the social readjustment of the patients enabling them to keep in contact with their families and friends. In rural areas of developing countries the provision of mobile facilities, half-way houses and day centres should be considered. Also the creation of mental health units (incorporating farm training and farm work schemes) are recommended.

42. There is a great need to educate the general public in the problems facing the mentally ill and the excellent possibilities for their complete recovery through modern methods of treatment and therapy.
Foster homes and boarding house facilities should be provided for homeless patients and those who cannot rejoin their families. For patients in developing countries, the possibility of integrating them in village communities should be considered.

A suggested organisational plan outlining comprehensive rehabilitation services for the mentally ill is attached as Annex 3.

The most important aspects of the vocational rehabilitation process involving long-term mentally ill patients may be summarised as follows:

- the complete rehabilitation of the long-term patient is a long process;
- vocational preparation must begin while the patient is still in hospital;
- the introduction to work should be gradual;
- to offset the ill effects of institutionalisation and to develop motivation, the final preparation for work should be realistic and undertaken not in the sheltered atmosphere of the hospital ward, but in a separate workplace, or workshop;
- great care should be taken by the hospital staff in selecting patients for more intensive vocational rehabilitation outside the hospital service;
- the patients themselves should be aware of their progress towards recovery and should show some initiative and motivation towards resettlement in employment;
- adequate support both during and after rehabilitation must be provided for the patient;
- in evaluating readiness for vocational rehabilitation each case should be judged on merit and not by means of diagnostic labels;
- the need for close collaboration and consultation between hospital staff and vocational rehabilitation centres is imperative at all stages, i.e. the selection stage, and both during and after the course has terminated;
- the psychiatric social worker in collaboration with the rehabilitation officer can play a key role in the co-ordinating process involving medical, social and vocational services.

VII. Industrial Therapy Organisations (ITOs)

The Industrial Therapy Organisation (ITO) at Glenside Hospital, Bristol, England (see appropriate lecture) is an excellent approach to ensuring the smooth transition of mental patients from hospital to open and sheltered employment.

Such a non-profit making company, limited by guarantee, with a board of directors from all sectors of the community (churches, local authorities, doctors, employers and trade unionists) accepts patients direct from the community as well as from the hospital. It is responsible for:

- a piece-work factory (132 patients);
- a sheltered workshop (36 places);
- a car-wash scheme (20 patients);
- sheltered groups in industry (42 patients).

Living accommodation for rehabilitated patients is provided through the Industrial Therapy Housing Association.

The ITO system could be applied effectively to developing countries but in a somewhat slightly modified form, in line with the socio-economic conditions in the countries concerned. Whereas a piece-work factory, sheltered workshop and car wash could be organised in the large cities, the prevailing unemployment problem might preclude the organising of "sheltered" groups in industry. On the other hand such groups could be employed effectively in rural areas on private and governmental estates and in co-operative agricultural schemes.
VIII. The Half-Way House

48. The half-way house is a vital link in the rehabilitation of the mentally ill in that it enables the patient to shake off the protective atmosphere of the hospital and to become gradually accustomed to the harsh realities of everyday life. The sheltered accommodation facilities of the half-way house provide a stepping stone towards the ultimate goal of rehabilitation - full integration in normal society.

49. In developing countries half-way houses should be developed as an integral part of any rehabilitation programme aimed at the resettlement of the mentally ill. Development could be on the lines of village hostels or normal housing within easy reach of a psychiatric day centre, clinic or mobile unit. The effective use of the half-way house would help to ease the pressure on the great demand for the few beds available in the mental hospitals; it would also be a means of educating the public on the problems of the mentally ill.

IX. The Role of the Rehabilitation Officer

50. The rehabilitation officer plays a central and key role throughout the process of rehabilitation and assisting the rehabilitee in planning this process. Through his activities he ensures that every person connected with the rehabilitation process plays his/her part actively.

Developing countries must ensure that they have rehabilitation officers in adequate numbers if rehabilitation programmes of any scale and at all stages are to succeed.

X. The Role of the Psychiatric Social Worker

51. The role of the psychiatric social worker (PSW) in the rehabilitation team is that of an expert on the social support and help that society can contribute to the treatment of the patient to such a degree that he will be integrated as fully as possible in a normal setting.

52. The PSW should ensure that:
- the whole rehabilitation team understands the social and emotional factors in each case;
- the patient is introduced to external social and vocational conditions at the appropriate time, making the necessary contacts for the patient with the specialists concerned;
- follow-up and after-care services are provided for discharged patients.

53. In compiling a psycho-social history of each patient the PSW should take into account:
- the patient's personality;
- relationships with the family, employer, neighbours, friends;
- the patient's insight into his problems and how he has tried or can try (with help) to resolve them;
- the patient's external situation;
- the services society can offer the patient;
- the fundamental problem in the case as seen from the PSW's viewpoint.
XI. Research

54. In order to establish a firm basis for a rehabilitation programme for the mentally handicapped in developing countries, basic research and collection of data on the causative factors and incidence of mental handicaps should be undertaken. The research should be socially oriented with practical implications. Such a programme should be sponsored and financed by government but non-governmental organisations and universities should be invited to participate.

XII. Training and Recruitment of Staff

55. In order to attract, retain and train staff required for rehabilitation programmes for the mentally handicapped in developing countries, the following action is suggested:

- improvement of salary scales to attract well qualified personnel;
- professional recognition through graduate courses at college and university level leading to certification of proficiency;
- a career ladder for rehabilitation staff;
- organisation of specialised courses (in-service and refresher) for training of auxiliary personnel;
- organisation of regional seminars and training courses;
- a public information programme to attract young people to rehabilitation work;
- the interchange of technical staff on a regional basis.

XIII. Community Involvement

56. Voluntary organisations, especially parent and student groups can play a very important role in supplementing government efforts aimed at rehabilitation of the mentally handicapped. In particular they could help to organise small workshop units for the mentally handicapped (on Industrial Therapy Organisation lines - see Conclusions 46-47), recreation programmes, kindergarten and day-care programmes.

XIV. International Assistance

57. It is recommended that governments should give higher priority to programmes of rehabilitation for the mentally handicapped.

58. Similarly the United Nations and its specialised agencies (ILO, WHO and UNESCO) are urged to provide much needed additional and co-ordinated support in this field to developing countries through the provision of expert services, organisation of inter-regional and regional seminars and training courses and granting of fellowships.

59. The United Nations and specialised agencies are urged to include the problems of the mentally handicapped in their future research programmes.

60. Governments of developing countries are urged to obtain support for mentally handicapped programmes not only from the UN, ILO, WHO and UNESCO but also by requesting assistance on a bilateral basis from developed countries and from national and international volunteer organisations.

61. The International Labour Organisation is strongly urged to provide the services of regional vocational rehabilitation experts to give assistance on a continuing basis to developing countries with the organisation and development of their vocational rehabilitation programmes for the physically and mentally disabled.
62. The valuable contribution of international organisations such as the Danish International Development Agency, the International League of Societies for the Mentally Handicapped, the International Committee Against Mental Illness, the World Federation for Mental Health, the International Society for Rehabilitation of the Disabled, to programmes aimed at rehabilitation of the mentally handicapped is gratefully acknowledged.
RESOLUTION ADOPTED BY THE UNITED NATIONS ECONOMIC AND SOCIAL COUNCIL

1585 (L) Draft Declaration on the Rights of Mentally Retarded Persons

The Economic and Social Council,

Taking note of the Resolution 8 (XXII) of the Commission for Social Development requesting that the Economic and Social Council in its report to the General Assembly recommend the adoption of the declaration on the rights of mentally retarded persons,

The General Assembly

Decides to transmit to the General Assembly the following text of the draft declaration for adoption at the 26th Session:

Mindful of the pledge of the States Members of the United Nations under the Charter to take joint and separate action in co-operation with the Organisation to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the standards already set for social progress in the Constitutions, Conventions, Recommendations and resolutions of the International Labour Organisation, the United Nations Educational, Scientific and Cultural Organisation, the World Health Organisation, the United Nations Children's Fund and of other organisations concerned,

Emphasising that the United Nations Declaration on Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

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 fullest extent possible the same rights as other citizens.

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 all aspects 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 under 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. 
Principles of Training of Adult Mentally Retarded for Industrial Work

1. **Incentives.** The imbecile, like the normal, is very much affected in the learning situation by the presence or absence of suitable incentives. The most effective seems to be to set him a realistic goal to work for, a little above performance on the previous occasion. This goal can be indicated visually by, for example, having yesterday's pile of work in front of the person, or a simple scale and pointer. Needless to say, verbal encouragement and competition also reinforce his learning.

2. **Break-down of work.** The task to be learned needs to be broken down to its basic constituents: e.g. to screw two pieces of perforated metal together it is necessary (1) to pick up a screw and screwdriver; (2) to place the pieces in some securing device which will hold them steady; (3) to see that the two holes are opposite each other; (4) to push the screw into the hole and (5) to commence screwing. Each has to be taught separately but in the right sequence so that the whole job from start to finish is tried at each attempt.

3. **Correct movements.** It is essential that the correct movements should be insisted on from the very start, because by definition the correct ones are the easiest. Thus, following our example, if the imbecile fails to hold the screwdriver correctly he should repeatedly be shown how, no matter whether this takes five or twenty-five minutes.

4. **Learning should be spaced.** It is much more economical if learning is spaced rather than massed. Thus, three separate twenty-minutes periods will produce more learning than a one-hour session.

5. **Need for "over-learning".** The learning process should be taken well beyond the amount at which correct responses are made, so that it becomes deeply ingrained. This is familiar enough to us all in schooldays when, to our great advantage later, we have to "over-learn" our "times times" and other tables.

6. **Verbal reinforcement.** With normal subjects, the acquisition of skills is made easier if the learner uses words almost as a commentary on his own actions. This is very apparent with young children, whose learning may be greatly facilitated if they use words at the same time. Thus two chains of events are learned: first, the actual movement needed for the task, and second, a parallel verbal chain in the simplest language, describing the actions. It is, however, not entirely clear how far this applies to the severely subnormal, who are often particularly retarded verbally. Opinions differ on the subject and further research is needed to clarify the problem. This is the basis of verbal conditioning which is particularly difficult to achieve in the low-grade defective.

7. **At first, accuracy rather than speed should be stressed.**

8. **Material should be arranged in such a way that muddle or fumbling can be minimised.**

In general, the teacher must remind himself that initial level is a very inadequate predictor of response to training, and that even if no progress is made for a very considerable time, it is likely to occur if training is considerably prolonged. Finally, it is wise when teaching a new technique to keep the group small, and at first limited to two or three individuals at a time.

Speijer (1968) has described seven important principles relating to sheltered workshops:

(i) the workshop is a rehabilitation centre and not a place where subnormals are kept busy;
(ii) the trainee should perform work for which he is most adapted at any given time;

(iii) the subnormal must be transferred to more difficult work as soon as he is ready for it;

(iv) careful examination of the individual's failures should result in guided development;

(v) patience on the part of the instructor will often ultimately be rewarded by the emergence of unforeseen abilities in the trainee;

(vi) a fair wage system must be evolved; and

(vii) the sheltered workshop is not an end in itself but a means to an end: the social integration of the mentally handicapped.
Annex 3
(See Conclusion No. 44)

A Suggested Organisational Plan for Provision of
Comprehensive Rehabilitation Services for the Mentally Ill

[Diagram showing the organisational plan with labels for
Mental Hospital, Day Centre, Hostel, Hospital Workshop, Half-Way House,
Occupational Centres (Recreational), External Rehabilitation Centres and Workshops,
Vocational Training Centre, Selective Placement Service, Open Employment,
and Sheltered Workshop.]
CHAPTER V

Review and Evaluation

It is considered that the main purpose and objectives of the Seminar were achieved. Most of the participants felt that they had obtained new ideas and concepts on the problems involved in rehabilitating the mentally handicapped, through the comprehensive programme of lectures, discussions, studies and the many visits to institutions, schools, hospitals, clinics and rehabilitation centres. In particular the opportunity of discussing working methods and individual problem cases with the specialist staff of the institutions etc. was greatly appreciated, as were the practical studies in Fyn and Jutland. These studies not only allowed for personal contact and discussion with rehabilitation and placement officers, they also gave participants an insight into modest but effective services for the mentally handicapped which could be planned and developed with a small capital outlay and relatively few staff.

All in all, some thirty lectures, nine films and a panel discussion involving six persons were presented. Group visits involving some thirty institutions and centres were arranged, but not all groups visited the same institutions. All agreed that this full programme of activities was well worth while and finely balanced between activities for the mentally retarded and those for the mentally ill.

Obviously such an ambitious programme could not have been attempted without the fullest possible support of the many specialist staff of the public and voluntary organisations concerned. Their enthusiasm, deep interest and readiness to explain every facet of their work was a major factor contributing to the success of the Seminar.

It is suggested that the sixty-two conclusions and recommendations emanating from the Seminar should form a firm basis for the organisation and practical implementation of programmes for the mentally handicapped in developing countries; but the participants stressed that higher priority and much needed support from governments, the United Nations and its specialised agencies and interested international voluntary organisations were essential prerequisites for the success of such programmes.

Finally, it should be mentioned that the programme, covering as it did, both the mentally retarded and mentally ill, revealed certain similarities of approach to the vocational rehabilitation of these groups. For example, the long, careful and patient preparation period, with social readjustment as an essential component of any vocational rehabilitation programme aimed at the reintegration of the mentally retarded and mentally ill, was one of the valuable lessons learned. Time did not permit a close examination of other similar or dissimilar approaches to the rehabilitation of the two groups, but it was agreed that any programme of vocational rehabilitation planned for them should aim, wherever possible, at achieving their integration into normal social and economic life to the fullest extent possible.
CHAPTER VI

A SELECTION OF LECTURE PAPERS
PRESENTED AT THE SEMINAR

1. Social and Economic Background to the
Danish Rehabilitation Programme

by
Mrs. Fanny Hartmann, Chief of Section,
Ministry of Social Affairs, Denmark

It is obvious from the outset that the conditions of life of the handicapped are largely determined by the development of the national economy. A high level of employment, such as we have experienced in Denmark for a great number of years, enables many handicapped persons, (who in periods of unemployment would have little chance of working) to find normal employment today. In addition, the development of medical science and the better possibilities of treatment for the entire population enable many handicapped persons - who formerly were in need of permanent assistance and care - to become independent and capable of work.

On the other hand, the progress of medicine and hygiene, with the resulting decline in infant mortality, has also led to an increase in the number of handicapped persons.

A better appreciation of the problems of the handicapped by the general public has been of great importance, too, in the work for the handicapped. Such appreciation is, among other things, due to the fact that the public have been given more objective information on the problems concerned through the mass media, such as radio, television, the press, etc. Similarly, the ever increasing number of road accidents contributes to bringing home to people that the problems of the handicapped concern all of us. Today it may be my turn, tomorrow yours.

The original limits of our social policy have been far exceeded today. The trend of social policy, with which our views of general policy are in accord, is towards replacing the assistance granted to particular categories of the population by general social security measures for the benefit of the entire population. The legal provisions which reduce the benefits and allowances payable by the central and local government when the beneficiary has an income of his own, have been relaxed or totally repealed.

That development has permitted the creation of a fundamental economic freedom, which at the same time is a condition for a richer human life.

The rapid developments in the fields of general education and vocational training have led to the abandonment of the general view according to which a handicap was regarded as limiting any activity, whether of a personal or occupational nature. Aptitudes and interest, and not such factors as environment and financial situation of parents, no longer determine the choice of training and occupation.

A brief reference to our system of social administration also serves as a background for our rehabilitation programme.

Our country is divided into about 200 administrative units, called communes, so you will understand that they are very small units. Each commune is governed by its own democratically elected council, administering within the framework of the legislation and under a certain control from government, many aspects of our life, including educational services, health services, road construction, etc. and last but not least the social legislation.

A characteristic feature of Danish social legislation is the fact, that almost all the expenses are paid by public means, that is through general taxation. In many other countries a major part of the social security is financed by contributions paid by workers and their employers, but contributions of that kind only play a very small role in financing Danish social security.
It is an old tradition in our country to regard social security and social welfare as a public responsibility. The Government runs and finances the different schemes, old-age pensions, health insurance, child welfare, etc. The role of the voluntary organisations is not very important in running the services, but they are important as pressure groups.

After these introductory remarks I will try to give you a general outline of our Danish social legislation.

Old-Age Pension

All Danish citizens are entitled to an old-age pension when they grow old, that is, when they reach the age of 67; for single women, however, the entitlement age is 62.

The amount of the pension is independent of the income of the beneficiary, and independent of his work or employment. The pension is the same for any elderly Dane, whether he be a farmhand or a millionaire or a person who has never had paid work, e.g. a housewife. The pension corresponds to about 45 per cent of the wages of a non-skilled worker which at the present time is about 1,200 kr. a month for a married couple. In specified cases, such as advanced age, support of children, etc., a supplement will be paid to the pension.

The pensions are index bound, the rate increasing with the rise in the cost of living. The national old-age pension is financed by government through general taxation. It is administered by the communes.

Such a pension, as I said before, is payable to all Danish citizens. Those who have been wage earners receive an extra benefit, a supplementary pension. This latter pension is not financed from public funds, but through contributions from workers and employers. It was first introduced by collective agreement in some occupational fields, but has now been made compulsory by law to all wage earners.

This is a feature you will meet with time and again in our social system - that a new development in the social field is started through a collective agreement, and later on is gradually taken over by the public authorities.

Care of the Elderly and the Disabled

For the elderly (and for the disabled) we have a number of services besides the payment of pensions; cheap flats, nursing homes, home helpers.

One of the most important problems for the elderly and the disabled is the housing problem. One way of alleviating this problem is construction of cheap modern flatlets for old-age or disability pensioners.

Many elderly and disabled persons have difficulty in managing their household without assistance. If, however, help may be provided for household duties, rough domestic work, or maybe cooking or shopping, it may be possible for them to remain in their own homes thus avoiding or delaying the transfer to an old persons' home or nursing home. Therefore, we have established home-help services; women, employed by the commune, are sent to the homes of the old or disabled to give the necessary home help one or more hours every day or several times in a week.

In many cases transfer to an old persons' home or nursing home is unavoidable. Old persons' homes are situated in all parts of Denmark. Most of them are rather small, to give the residents the impression of living in a home. But today more than 40 per cent of the residents of the homes are more than 80 years old, and this situation has quite changed the character of the old persons' homes. We have to change them into nursing homes, where the majority of the residents are in need of constant nursing. We are suffering from a great shortage of nursing homes, and a great shortage of trained staff to take care of the elderly and sick patients in such homes.
Disability Pension

A pension almost equivalent to and calculated on the same scales as the national old-age pension is paid to disabled persons, that is, persons whose earning capacity owing to physical or mental disability is very much reduced compared with the earning capacity of a person of the same age, training, etc. Our disability pension is payable in three grades: one for persons who have no earning capacity at all; one for persons whose earning capacity is reduced to one-third or less of the average, and one for persons whose earning capacity is reduced to one-half.

Handicapped persons who need constant nursing are given a supplement to their pension. A person who suffers from a severe physical handicap, but who nevertheless goes on working, will receive a special allowance. The disability pension can be given to persons between the age of 15-67. Children under the age of 15 years are not entitled to a pension, but if a family has a child with a severe handicap, physical or mental, and they bring this child up in their home, not placing it in an institution, they are entitled to a special allowance.

No disabled person, however, is awarded a pension before the possibilities of his physical and vocational rehabilitation have been thoroughly examined.

Our rehabilitation service is rather effective. It provides for the following services: medical care and nursing facilities, educational services, social counselling, vocational rehabilitation services. As you will be given detailed information on the different services during the next few weeks by specialists in the field, I will only mention a few basic features: the services are available to all persons living in Denmark. A system of notification from doctors, hospitals, schools, midwives ensures that all handicapped persons are brought in contact with the rehabilitation service. All the rehabilitation services are provided free of charge independent of the economic conditions of the client or his family. Those handicapped persons who can be rehabilitated to perform ordinary work are trained or retrained for work which suits them best with the purpose, as far as possible, of encouraging them to take part in ordinary normal working life. If the person is so severely handicapped that this purpose cannot be achieved, we try to provide for sheltered employment. To facilitate the resettlement of the handicapped we may give him implements, machines, tools, a motor-car to bring him to and from work, a telephone to establish contacts for persons who cannot move outside their door, a tape recorder for the blind. The entire cost of disability pensions and rehabilitation services is met by government, that is by all taxpayers. Government also pays wages or assistance during the rehabilitation period.

Widows' Pensions

We have no general widows' pension for all widows. Entitlement to the pension is restricted to widows who are more than 55 years old and women who become widows after the age of 45 and who maintain two or more children under the age of 18. The pension is related to the income of the widow; if the widow has a larger income, her pension will be reduced. A widow who has a job and earns a normal wage will not be eligible for pension. But this does not mean that younger widows are entirely neglected; provision is made for payment of a special allowance to all widows for up to six months after the husband's death. This temporary allowance is meant for subsistence and for maintenance of the home. In addition the widow can be granted a special allowance to meet the cost of any reasonable training which may enable her to earn a living for herself and her children. We prefer to make the younger widow self-supporting rather than give her a pension.

Health Insurance

Thanks to our health insurance, it is never any financial disaster to a Danish citizen to fall ill. It is a voluntary scheme, but covers nevertheless over 90 per cent of the population. It is built up as a network of small health insurance societies, one in each commune. Any person living in Denmark can become a member of the health insurance societies - workers, employers, farmers, housewives, students. The members have to pay a contribution which is rather modest, not more than about 30 kr. a month. The members' contribution can be as low as this because in the main, all hospitals and clinics in Denmark are public, run by
government or communes and financed by the general taxpayers. The health insurance societies only pay a small amount for members’ hospitalisation.

All members are entitled to free hospital treatment and I should add that hospital treatment in Denmark is the same for all patients regardless of their financial situation. Medical care outside hospitals is free to members under a certain income level (corresponding more or less to the average earnings of a fully employed skilled worker). Members whose income is above that level have to pay their doctor themselves, but are reimbursed by the health insurance for the greater part of their expenses. All members are free to choose their own doctor. The health insurance pays part of the cost of medicine, and of massage, X-ray treatment and so on.

Wage-earners who suffer a loss of income because of sickness are entitled to a daily cash benefit amounting to about 70 kr. This sick-pay scheme was originally introduced through agreements between trade unions and employers. It is financed through workers’ and employers’ contributions.

Care of Mothers and Infants

All necessary expenses involved by childbirth are paid by the health insurance. Any woman who loses her earnings because of childbirth is granted a maternity benefit for fourteen weeks. Provision has just been made for a maternity benefit of about 900 kr. to be paid at every confinement. Mothers’ help institutions provide personal, medical, legal, and social assistance to all pregnant women and mothers with infants, proceedings in paternity cases, boarding out with foster parents and adoption. In addition, the institutions assist in examining whether the conditions of legal abortion are present. While in Denmark children are not liable to maintain their parents, parents are liable to maintain their children up to the age of 18. As far as legitimate children are concerned the liability devolves upon both parents even in the case of divorce. If, in the case of divorce, the children are submitted to the custody of the mother, the father has to make payments under a maintenance order. Similarly, the father of an illegitimate child has to make payments permitting the child to be maintained, brought up and educated. If the father is unable to pay this amount or if he just does not pay, government provides security for his payment. The child and the mother should not suffer because of the father’s inability and unwillingness to pay; they will obtain the money from the local authority, and then the authorities will have to compel the father to pay. Danish help to mothers and children is exactly the same whether the mother is married, has been married or is single. We do not care about her marital status, only whether she and her child are in need of help.

National Assistance

By now I have mentioned several social schemes covering different contingencies. But besides these special schemes we need a general assistance to meet contingencies not otherwise covered such as unstable workers, people suffering from long illness, negligent bread-winners, the dependents of men called up to military service and many others. The assistance given in these cases is given according to discretion in each particular case, the assistance given varying by the nature of the contingency and subject to a means test. Special consideration must be given to the prospects of the recipient for ultimately earning his own living. Accordingly he may be granted assistance for training and other education, for the purchase of tools and machines or for obtaining employment. Normally we prefer that the assistance be paid in cash, but in special cases it may be given in kind.

In former years, Danish legislation contained such provisions that national assistance or, as it was then called poor relief, was regarded in different ways as socially degrading. For example, recipients of poor relief lost their voting rights, they were not allowed to move freely, and their freedom and dignity was restricted in several other respects. Today we have completely changed our attitude. It is no longer considered humiliating and discriminating to receive any assistance under the social legislation. We require our social authorities not only to pay our social pensions and assistance but also to advise and counsel the citizens on all social questions.
2. Comprehensive Services for the Mentally Retarded and Mentally Ill in Denmark

by

Otto Wandall-Holm, Head of the State Rehabilitation Centre on Fyn

The services for the mentally retarded and the mentally ill in this country are generally speaking still organized outside the general social health and welfare system. This is due to historical and practical reasons.

Generally it is the local municipalities – with 10,000 inhabitants and upwards – which are responsible for the social welfare and care within their areas. The regional municipalities – varying between 250,000 and 500,000 inhabitants – are obliged to establish and operate the number of hospitals required.

As regards the mentally handicapped it is the State, however, which, according to tradition, has contributed partly to the establishment of a hospital system for the mentally ill, partly to a welfare and treatment system for the mentally retarded.

Thus there is today a dividing line between treatment and care for the mentally handicapped and the general hospital and welfare system, but in the group of mentally handicapped there is also a distinction in the organisation of care for the mentally retarded and the mentally ill. But I can add immediately that none of these distinctions is definite. In addition the last few years have seen great administrative changes. These changes are most likely to result in integration of services for the mentally handicapped in the general hospital and social welfare system.

It is, however, my task to submit a brief survey of services as they are today, and let me therefore start with the care for the mentally retarded. The care services for the mentally retarded are operated by the Danish National Board of Social Welfare which belongs to the Ministry of Social Affairs. The budget of the Ministry or the State for the operation of services for the mentally retarded for the year 1970-71 was 483 million Danish kroner. The number of patients in 1970 was about 22,000.

The care for the mentally retarded, like so many other organisations within the field of social welfare, was established as a private enterprise. The Act concerning the care of the mentally retarded and other exceptionally retarded persons was passed in 1959. Rules are laid down in this Act as to how the various authorities, doctors, schools, etc., must report to the Service for the Mentally Retarded if they identify the mentally retarded. Any person who is mentally retarded or whose condition is on a level with mentally retarded persons, and who is found to have a need for relief measures, has a right to receive assistance and support from this service. The person in question may also himself apply for support and parents can have their child examined and at the same time obtain advice and guidance from the counselling offices of the service or at one of the central institutions of a regional service unit.

The country is divided into eleven regions, each of them with a service unit. The daily operation of such units is placed in the hands of a team consisting of the chief physician, an administrator, a director of social work and a director of education. This team is jointly responsible to a board of directors for all activities within its region. Within each service unit there must at all times be available the necessary institutions and other necessary relief measures. Each of the regional service units of the Service for the Mentally Retarded thus covers a region of the country. Within each unit there is a central institution. Apart from this there are smaller institutions with special tasks. The intention is that the regional units should be able to secure residence, treatment, teaching and vocational training facilities for the mentally retarded. This might be performed in residential or non-residential institutions. The residential institutions first and foremost comprise a central institution, as well as children's homes, school homes, boarding schools for young persons, nursing homes and old people's homes. Among the non-residential institutions should be mentioned nursery schools,
day observation homes, recreation centres and schools. The day schools, which are found in a number of towns, are intended for mentally retarded children living in those towns and in the surrounding area, provided the children are educable and can live in their own homes. It should be noted that the duty of educating the mentally retarded has been extended until the age of 21, which is essentially longer than for normal children.

In addition, there are occupational schools, sheltered workshops and boarding houses. Finally I may mention that placing of the mentally retarded in individual care is utilised to a wide extent. As a consequence more than 50 per cent of persons under the care of the national service live outside institutions. The ultimate objective of such type of care is that the handicapped may lead a life as near to normal as possible and that later they may be able to become entirely independent. During the Seminar we shall have the opportunity of seeing a fair number of the various institutions mentioned. Moreover the Service for the Mentally Retarded will provide us with booklets containing detailed information and figures.

I shall now pass to the treatment and the services for the mentally ill.

While, as previously mentioned, the hospital system is generally based on the regional county districts, the hospitals for the mentally ill are organised under a special directorate in the Ministry of the Interior. The Ministry of the Interior also comprises the Public Health Board.

Nine hospitals (or ten if one includes the Faroe Islands) for treatment of the mentally ill (statushospitalerne) are operated within the framework of this directorate. Each of these hospitals serves a special part of the country so that any area is covered by a statushospital. The expenses of the State for operation of statushospitalerne during the year 1970-71 were 284 million Danish kroner. The city of Copenhagen is not included in this system, as the Municipality of Copenhagen City tackles the problems itself, but the State covers 90 per cent of the expenses in connection with the operation of the institutions for the mentally ill belonging to the Municipality of Copenhagen.

In the year 1970 statushospitalerne had 7,340 beds. This number includes among others 3 psychiatric departments for children with 102 beds and 11 nursing homes with 1,882 beds. The Copenhagen Municipality has one hospital for the mentally ill which you will visit during the Seminar. It is situated at a town called Roskilde, which is about 30 km from Copenhagen. It was built in the years 1808-16 and has 2,050 beds, a nursing home with 1,053 beds and a number of beds in the general hospitals belonging to the municipality. For the sake of completeness I shall mention that the State operates a teaching and research hospital (rigshospitalet) in Copenhagen. In this hospital you will find a psychiatric (including children's) department. In addition there exists an institution called Philadelphia at Sealand. It has 1,000 beds for epileptic patients as well as smaller departments for the mentally ill and neurotics. This means that statushospitalerne undertake the medical treatment of the patients, and in this connection it might also be a question of helping the patient to adapt to work and to a normalising of his life, as far as this is possible. In some hospitals one might even find rehabilitation units.

The hospitals for the mentally ill also operate nursing homes. Some of the nursing homes belong to the Service for the Mentally Ill, while others are municipal institutions, which, by arrangements with the municipality in question, admit patients from the state mental hospitals. The daily medical supervision is performed by the local doctor, while the psychiatric inspection is made by doctors from the mental hospital in question.

To a certain degree the Service for the Mentally Ill has made use of supervised foster homes, where the patients are placed in private homes. This kind of arrangement is, however, no longer of such great importance within the Service for the Mentally Ill as previously, as the present policy is that the patients are granted invalid pensions and out-patient treatment has been increased. It is important to note that psychiatric out-patient consultations with medical personnel from the state mental hospitals are held at the hospitals and in the towns of the surrounding areas.

I have already referred to psychiatric departments for children in rigshospitalet as well as in three of the state mental hospitals in other parts
of the country, and I may add that such a psychiatric department for children exists within the Municipality of Copenhagen. One work of this department is worth examining in some detail. The Child and Youth Welfare Service operates guidance centres with psychiatric management; there is a close co-operation with the schools, and the attention of the school psychologists is drawn to cases of children suffering from psychiatric illness. The psychiatric departments are especially concerned with solving problems of treatment of psychiatric children, observation and short-term treatment of neurotics and maladjusted children and possibly transfer to suitable institutions belonging to the Child and Youth Welfare Service. Moreover, these departments are able to co-operate with institutions for children, requesting necessary psychiatric supervision or treatment. With regard to the Service for the Mentally Retarded I wish to mention that the state mental hospitals only admit the mentally retarded for treatment if they require treatment for an acute mental illness. Patients in most cases do not have to pay for treatment in hospitals or for stay in the special institutions for the mentally handicapped.

I shall not go into details concerning the sickness insurance rules in this country, but I just wish to mention that people with a low or middle level of income have to pay neither for the treatment given by their general practitioner nor the specialist to whom they have been referred. This benefit, like so many other benefits in this country, also applies to the mentally handicapped.

As mentioned earlier the state mental hospital operates independently of the general hospital system. Most hospitals for the mentally ill were established in the middle of the last century and belong to a period when possibilities for treatment were limited, and when the aim was more that of isolating the chronic patients. Many of these hospitals are situated in areas of scenic beauty, but rather far from the larger towns, and at the same time far from the consciousness of the public. The development is similar to that found within the field of mental health in some other European countries and the USA. When examining this situation one finds that it was the State which was specially active in this field. It is not surprising therefore that the local communities by and large became accustomed to dismissing the problems related to the mentally handicapped.

With the treatment possibilities available today this development is neither practical nor necessary, and it must be said that in recent years the question as to whether the departments for the mentally ill should not become incorporated in the general hospital system has been carefully considered.

The new state mental hospitals are located close to the larger general central hospitals, and furthermore psychiatric out-patient clinics have been established in municipal hospitals independent of the state mental hospitals, where they are operating on the same lines as the general hospital departments. But the whole question of abolishing the old mental hospital system is still under consideration with a view to including treatment of psychiatric patients in the general hospital system. A development towards an integration of treatment and care of the mentally handicapped in the general hospital and welfare system will, it is generally believed, offer a happy solution. Consideration of possibilities for a decentralisation of treatment and care for the mentally handicapped aiming at arrangements which do not segregate them too much in special institutions should indeed always be present in the minds of the authorities who are responsible for the planning of hospital and service systems. Without jeopardising the increasing tendency to specialised treatment, it should be possible to carry out a community centered policy. It must be assumed that the future hospital system in Denmark will follow these lines with one hospital in each of the county district regions where all specialities are available including general and child psychiatry.

Furthermore it must be expected that the responsibility for establishment of the necessary nursing homes and welfare facilities for nearly all categories of the handicapped will rest on the regions.

I shall not go into details concerning the special institutions which exist for treatment of special social psychiatric cases or the problems related to narcotics, alcoholics, criminals, etc.

The intention of this Seminar is to deal with the more general cases and not necessarily to go into details concerning such problems. I shall, however,
in connection with the treatment of neurotics mention the Montebello Hospital in Copenhagen and the one at Helsingeør. We shall visit the youth department of the hospital in Helsingeør and there will also be an opportunity to visit the hospital in Copenhagen. Montebello Hospital in Copenhagen is a day and night hospital for psychiatric patients who can live in their homes overnight and come for treatment during the day; it also accepts patients who live at the hospital and receive their treatment there, but who are at the same time continuing their employment in town. In Jutland there exists a sanatorium for persons with nervous diseases. It might be possible for those of you going to Jutland on the field trip to visit this sanatorium.

The traditional division of the Danish system into services for the mentally ill and the mentally retarded has also influenced the planning of the Seminar programme. As you have learned, in the first week we are concentrating on the problems concerning the mentally retarded and the second week on problems of the mentally ill. Through this method an attempt has also been made to demonstrate that it might be wrong to mix the treatment of the mentally retarded and the mentally ill. During the third week we have planned a joint programme, including field trips, where you should get a feeling of the daily work as it affects the client and the people involved in the job.

The survey I have submitted is rather short because I know that there will be possibilities for detailed questions to be put not only to the specialists lecturing here at the Seminar but also to those at the various institutions which you will visit.

I have not mentioned that during the last ten years we have established in this country a network of offices and institutions especially for vocational rehabilitation. This general rehabilitation system is intended for all categories of the handicapped, and is thus also open to persons with mental as well as physical handicaps. But also within this system there are rehabilitation institutions which are particularly concerned with rehabilitation of the mentally handicapped. In the following lecture my colleague from the Rehabilitation Centre at Vejle, Jutland, Jørgen Kock, will give further details of this rehabilitation system.
3. Vocational Rehabilitation in Denmark

by

Jørgen Kock, Head of the State Rehabilitation Centre, Vejle

It is remarkable that, even if Denmark has a fairly long tradition in the field of social legislation, a comprehensive and co-ordinated vocational rehabilitation programme aiming at all groups of disabled persons - whether handicapped for physical, mental or social reasons - was not carried through in this country until 1960.

One of the main reasons for this, I think, is to be found in the fact that full employment in Denmark was not achieved until the late fifties, as you have learned from Mrs. Hartmann's lecture earlier today.

The Rehabilitation Act (Act No. 170 of 29 April 1960, as amended by Act No. 231 of 8 June 1966, Act No. 78 of 13 March 1969, Act No. 243 of 4 June 1969 and Act No. 229 of 27 May 1970) provides for assistance to be granted to handicapped persons for care, medical treatment, provision of hearing aids or any other aids, and various kinds of economic support aimed at vocational rehabilitation of the disabled.

I shall restrict myself mainly to this last subject, which is in focus at this Seminar, and which constitutes at the same time one of the most challenging features within the social policy in this country.

As you will readily appreciate, great attention has to be paid to the definition of the word "disabled", as the whole range of vocational rehabilitation possibilities provided under the Rehabilitation Act are available exclusively for disabled persons (or for persons who are likely to become disabled).

The Rehabilitation Act itself does not contain a definition of the word "disabled", but eventually an unofficial definition has appeared, according to which a person should be regarded as "disabled" in relation to the Rehabilitation Act if he or she, on account of physical or mental illness or for mainly social reasons, is substantially handicapped in his or her vocational activity, with the result that he or she is unable to obtain and to keep ordinary, remunerative work in the open labour market.

A few explanatory comments on this definition might be useful.

The "physically disabled" group may be divided into two categories: patients suffering from medical diseases and victims of accidents (e.g. traffic accidents and working accidents).

The "mentally disabled" group may likewise be divided into two categories: the mentally retarded and the mentally disturbed.

Not all physically or mentally handicapped persons are eligible for assistance under the Rehabilitation Act. If the handicap is considered to be of minor importance to the person's vocational possibilities and potential, he will not be regarded as "disabled". Colour-blindness in a school pupil diagnosed through medical examination will not constitute a "disability" in relation to the Rehabilitation Act; neither will the traumatic loss of one finger, say, to a carpenter.

Furthermore, whereas the rehabilitation of the mentally disturbed is the responsibility of the governmental rehabilitation centres (in so far as the patients satisfy the "disabled" criteria), the vocational rehabilitation of the mentally retarded is carried out by a specialised programme, which is part of the "special care" system that I shall mention later on in my lecture.

The "socially disabled" group consists of a great many different categories of disabled persons, the mutual characteristic being the absence of physical or psychiatric diagnoses influencing their working capacity.
The following groups might be mentioned as examples: widows without any educational background and with little or no experience of the labour market; criminals; persons who have been unemployed for a long period and have been supported by public means under the National Assistance Act and foreigners isolated in Denmark, e.g. after having been divorced from their Danish husbands or wives.

The vocational rehabilitation of the socially disabled is carried out in cooperation with the governmental rehabilitation centres and the social security committees in the municipalities, the latter being responsible for the decisions made as to the granting of the financial aid necessary for the rehabilitation process. The vocational rehabilitation of the physically and mentally disabled is, as a general rule, taken care of by the governmental rehabilitation centres.

Broadly speaking, there are three methods of approach available to the authorities in their task of vocationally rehabilitating the disabled, i.e. through:

(a) vocational assessment (evaluation) and training or retraining;
(b) education;
(c) establishment in a business, i.e. acquisition of tools, working machines, stalls, shops and workshops.

Vocational assessment and training is carried out both in special institutions and in private vocational undertakings.

Normally, medical treatment will have been completed - or at any rate set in train - before vocational rehabilitation is started. On the other hand, it may happen that, while undergoing out-patient treatment at a hospital, a patient actually commences vocational rehabilitation concurrently with such treatment.

In certain cases, specially organised functional training and personal work adjustment may be expedient. Such training may be provided in a special institution (a medico-occupational centre or so-called "rehabilitation clinic") where the adjustment takes place under medical guidance, concurrently if necessary with medical after-care under conditions which take into special account the occupational problems of the persons concerned. The first medico-occupational centre was set up in 1957 in Odense (Funen); since then, centres have been established in Copenhagen, at Arhus, at Aalborg, at Hald near Viborg (Jutland), and at Holbaek (Seeland). The trend in this field is towards the establishment of medico-occupational centres also for mental cases. The existing rehabilitation clinics throughout the country are now able to admit a total of some 500 persons.

Testing and more extensive assessment of working capacity may be undertaken, inter alia, at the Copenhagen Institute of the Danish National Society for the Prevention of Poliomyelitis, where research is being carried out with a view to finding methods of objective assessment of working capacity. The work of the Institute was originally based on experience gained in consequence of a serious polio epidemic in 1952-53. Testing of working capacity is now being undertaken not only in respect of polio cases, but also of other physically handicapped persons. Assessment of the purely physical working capacity and the mental ability is undertaken through regular testing on practical work; physical conditioning also forms part of the programme. As a basis for the assessment of the working capacity of the handicapped, the Institute has made a large number of similar investigations of working requirements in various occupations. Among the other institutions in this field may be mentioned the Vocational School in Copenhagen (vocational evaluation based upon practical work in a number of different workshops) and the "Sønderbro" rehabilitation unit in Copenhagen, which is chiefly concerned with testing of working capacity, especially of persons with psychogenic diseases. The special medico-occupational centres, which I have already mentioned, co-operate in the assessment of working capacity and employment opportunities in connection with the general observation of clients who, at the post-treatment stage, are received for functional and occupational training. The institutional assessment may, if appropriate, be supplemented by - or substituted by - assessment of working capacity in a private industrial undertaking. During their vocational testing period in rehabilitation clinics, other special institutions or private industrial undertakings, disabled persons will be granted economic support from the rehabilitation authorities.
In line with the results of the vocational testing (whether it has been carried out in special institutions or in private industrial undertakings) vocational guidance is provided by vocational rehabilitation counsellors attached to the governmental rehabilitation centres.

Since the end of the Second World War, a number of rehabilitation units (workshops) have been established through funds provided from various sources (local authorities and voluntary organisations, the Ministry of Labour, the Ministry of Social Affairs, etc.). In addition to general work adjustment, these institutions provide an actual training in industrial work under conditions adjusted, as far as possible, to those in open industry. The production of the workshops covers a variety of fields, such as metal work, woodwork, footwear, textiles, paper, gardening, etc. At present, there are some thirty-five rehabilitation units, capable of admitting a total of 1,000 persons.

The range of institutions also comprises a number of sheltered workshops, offering permanent employment possibilities for disabled persons who — on account of physical or mental diseases — are unable (or unable for the time being) to undertake normal employment in the open labour market.

The total capacity of these sheltered workshops is about 625 sheltered workers.

According to the Danish concept of "sheltered workshops" the erection of the latter is not primarily a governmental obligation as it is for example in the case of establishment of training workshops and rehabilitation clinics.

It is anticipated that local bodies such as municipalities and invalids' organisations will take the initiative in building sheltered workshops; then, if the project is accepted by the local governmental rehabilitation centre and by the local county rehabilitation committee, the institution has the possibility of being approved by the central authorities in the field of rehabilitation. Such approval means that state subsidies may be granted towards establishing and running the workshop.

In addition, the Rehabilitation Act provides for assistance to young handicapped persons for admission to a continuation school or a Folk High School, where such education is considered of importance for the assessment of their fitness for work in the general community, or is likely to be conducive to personal and occupational development. The "Egmont" Folk High School at Hou, Jutland, is especially equipped to receive students suffering from severe physical handicaps.

Assistance may also be granted to the disabled for any reasonable physical or vocational training or other education, i.e. assistance partly in the form of loans may be provided for quite expensive types of advanced training or education, if warranted by the abilities and interests of the handicapped, e.g. at teachers' training college, commercial college or university.

The assistance granted to the handicapped during rehabilitation in the form of education at a school, training course etc. is free and a maintenance allowance is paid in connection with such attendance and training. The criterion governing the amount of assistance is that the handicapped and his family shall be able, during the period of rehabilitation, to maintain their previous standard of living within reasonable limits. If necessary, the social security committee has to grant an economic supplement sufficient for reaching this level during the whole rehabilitation period and during the first two months thereafter.

Furthermore, the disabled may be equipped with machines and tools, for instance, where engagement is subject to the condition that the worker himself must be in possession of various hand tools, etc. and where this is normal practice within the particular occupation. As a rule, the assistance is granted by way of a loan. The granting of assistance for a telephone or a motor vehicle (plus, if necessary, the expenses connected with the obtaining of a driver's licence) may also be given where it contributes to meeting the occupational problems of the handicapped.
And last but not least, the disabled – according to the rules of assistance laid down for establishment of the handicapped through vocational rehabilitation means – may obtain economic support for taking over or setting up minor trade or business, including a kiosk, a hot-dog stand, etc., where the running of such a business, taking all factors into account, is considered to be the best and most reasonable solution of the occupational problems of the handicapped. Such assistance may be considered, for example, where the handicapped person is unable to keep up with the normal pace of a wage earner in an industrial undertaking. As a general rule, the assistance is granted in the form of a loan. When considering claims for assistance to set up an independent trade or business, great importance is attached to the question as to whether the person concerned has the necessary occupational, commercial and personal qualifications for carrying on such trade or business in a satisfactory way.

The "rehabilitation means" that I have just briefly described are administered throughout the country by regional rehabilitation bodies known as rehabilitation centres (in Danish: "revalideringscentre", not to be confused with "rehabilitation centres" in the English sense of the word, which often implies workshop and training facilities). These centres have wide powers to grant financial and practical assistance for vocational rehabilitation. As a rule, a centre serves one county. The functions of the centres comprise counselling services, co-ordination and the granting of assistance. On the other hand, it is not the business of the centres themselves to provide actual vocational assessment, training or retraining facilities for handicapped persons, but the centres may arrange for such rehabilitation to be initiated, e.g. at the special rehabilitation units. Where medical treatment is required, the centres may also arrange for such treatment to be given. A number of experts are available to the centres. The social and vocational counselling service is entrusted to special vocational rehabilitation counsellors, of whom the majority are trained as social workers. The total number of vocational rehabilitation counsellors at the twelve rehabilitation centres is some 200. Medical advisory officers are available to all the centres, which may also avail themselves of other specialised assistance, e.g. from psychiatric, psychological or business experts. The centres work in close contact with the local employment exchanges.

Through notification to the centres and through the latter's co-operation with hospitals, physicians, social welfare offices, industrial injuries insurance authorities, etc., efforts are being made to establish the earliest possible contact with persons who may be in need of rehabilitation. The centres are responsible for co-ordinating the rehabilitation process and are the focal point for the client throughout this process. As already indicated, the centres do not directly provide vocational assessment, training or retraining services for the handicapped, but they arrange for such services to be set in train. This takes place, in so far as possible, through ordinary courses, in schools, in industrial undertakings, or with private employers.

In so far as financial assistance is granted by the centres for vocational rehabilitation, the Rehabilitation Act provides for the decision to be made by the person in charge of the rehabilitation centre in consultation with one or more of the medical advisory officers and a representative of the local employment exchange.

The cost of running the rehabilitation centres is borne by the National Exchequer.

Each county (Denmark is divided into fourteen counties) has set up a rehabilitation committee composed of representatives of local authorities, of workers' and employers' organisations, of the confederation of handicapped persons' organisations, of the medical superintendents of hospitals, and of the rehabilitation units of the area. One committee serves the areas of Copenhagen and Frederiksberg. The Committee must be fully conversant with local rehabilitation activities, making recommendations for development and improvements.

The total expenditures incurred in the vocational rehabilitation programme amount to some 150 million Danish kroners a year, including 22 million kroners for the running of the twelve governmental rehabilitation centres and some 70 million kroners for financial aid granted for education of the disabled.
The remaining part of the expenses is divided between financial aid amounting to 14 million kroners for "establishment" of the disabled (and other similar rehabilitation measures aiming at vocational restoration of the clients) and governmental subsidies for the training workshops and the sheltered workshops, some 38 million kroners.

In addition to the figures just mentioned, there are municipality expenses for the running of the various types of institutions in the field of vocational rehabilitation and for the economic support of the rehabilitees and their families during the rehabilitation process, the latter expense being partly refunded to the municipality by the Government.

During recent years an average of some 16,000 persons a year have been referred to the twelve governmental rehabilitation centres, and according to investigations recently made, it is anticipated that more than 40 per cent of them will become fully rehabilitated, i.e. gainfully employed for example as self-supporting workers, craftsmen, employers or shop-owners in the labour market as a result of the vocational steps that will be taken.

The above investigation shows that more than 80 per cent of the rehabilitated clients will be absorbed in the labour market on a more permanent basis.

When speaking of the vocational rehabilitation system in Denmark, it should be kept in mind - mainly for historical reasons - that a distinction is to be found in this country between "vocational rehabilitation" on one side and "special care" of certain groups of handicapped persons on the other.

The special care system - aiming at the proper treatment, education and rehabilitation of the mentally ill, mentally retarded, epileptics, the maimed and crippled, the speech defectives, persons suffering from severe dyslexia, the blind and the deaf - has a much longer tradition than organised public efforts within the field of vocational rehabilitation.

Under the Rehabilitation Act of 1960, the "special care" system should be autonomous. Thus, you will find that special care institutions (schools for the deaf and dumb, institutes for the blind and so on) are administratively fully separated from the rehabilitation centres, although a close co-operation exists between the two concerning their mutual clientele. The methods employed in achieving this differ in various parts of the country and may be adapted to the local conditions. In some regions, the special care institutions will refer cases of handicapped persons who are in need of vocational assistance to the rehabilitation authorities; the latter will take over the case and try to solve the vocational problems, taking into account the information received from the special care institution. Elsewhere a more integrated form of collaboration has been tried, e.g. an arrangement whereby vocational counsellors who have been attached to the special care system prior to the passing of the Rehabilitation Act take over responsibility for such cases with whose problems they are familiar. Such cases then will not be treated at all by vocational rehabilitation counsellors attached to the rehabilitation centres, although the special care counsellor, of course, has the opportunity of discussing the case and the problems it raises with colleagues in the rehabilitation centre.

Generally speaking, the co-operation between the special care institutions and the rehabilitation authorities is a close and positive one, whichever method of collaboration is adopted.

I hope that it has been possible for me in my lecture to give you an impression of the main points of the Danish vocational rehabilitation programme.

We are looking forward to demonstrating to you, during the next three weeks, this national programme in greater detail and with particular reference to the mentally handicapped.
Care of the Mentally Retarded in Residential Institutions

Medical Aspects - New Approaches to Provision of Residential Services

by

Dr. J. Lenstrup, Chief Physician,
Children's Hospital; Vangede, Copenhagen

All over the world thousands of disabled persons are treated inadequately owing to insufficient facilities, lack of care and qualified staff. This situation must be improved but where shall we begin? What is most important?

I must stress that modern institutions with good living conditions for the disabled and good working conditions for the staff are of vital importance. It is not the only important factor but it is the field on which we must first concentrate.

The disabled include many categories of disability, physical handicaps, motor handicaps, convulsions, and other seizures, psychoses, mental retardation, etc. In most places these patients are nursed and treated in institutions characterised by a sterile hospital-like atmosphere - an atmosphere so unrelated to normal conditions of life that it has a restrictive influence on the patients' progress and on the possibilities of improving their conditions. Many institutions are far too big and overcrowded, and often the very institutional milieu has an injurious effect by causing neuroses or psychotic reactions.

My knowledge of this subject is based on working experience at the Children's Hospital at Vangede, Copenhagen, Denmark. The hospital serves the Copenhagen area with a population of 1 1/4 million inhabitants, and it takes retarded children in need of hospital treatment or institutional care. There are approximately 500 beds, and there is a great variety in the patients' disabilities - medium and low grade mental retardation, genetic diseases, inborn errors, metabolic conditions, brain damage, psychoses. About 100 of the children suffer from spasticity or athetosis or motor handicaps in various degrees, and about 100 suffer from epilepsy or epileptic equivalents.

I should like to illustrate with some slides how we have tried to solve the problems at the Children's Hospital in Vangede.

The hospital is divided into 21 wards - small houses spread out over an area like a village. Each ward has only 12 to 15 children. In each ward there are both boys and girls - which has caused no problems - and there are both older and younger children, which makes it possible for the staff to teach the older children the everyday functions of life, and at the same time take care of the smaller ones as to training them for cleanliness, eating, etc. In such a small group the individual difficult child may have all the special attention it demands.

Naturally, the children are allocated to the wards according to diagnostic lines. The spastic children occupy the spacious houses with special facilities for their handicap; the epileptic children are treated in wards with experienced nurses; the autistic children are treated in a ward by specially trained staff; and other psychotic and more violent children are placed in wards specially adapted for them. For most psychotic children it is best for them to be in a special ward. However, it must be mentioned that some psychotic patients can be treated successfully among retarded children who psychically are more normal. So, before allocating the children we individualise to a great extent in order to find the most suitable ward for each child.

None of the wards has big dormitories which are closed for cleaning and then left empty all day. There are rooms with one, two or four beds, and in the day-time the beds are made up as sofas, so that the rooms may be used for small groups of children. Besides the bed each child has a board for pictures and a closet for clothes and personal belongings, so the child can feel that he has a corner of his own. In each ward there is also a special room for group activities and a work room where the children can be occupied constructively.
All children who can benefit are given some hours special education in a special school building.

At the hospital we are 11 doctors - 5 fully-qualified paediatricians or child psychiatrists, and 6 young doctors in training. As consultants we have specialists in ophthalmology, otology, radiology, anaesthesiology and laboratory technique. There are 3 psychologists, 10 physiotherapists and 1 dentist. Children do not have to be sent away therefore for examinations in other hospitals and clinics where often the staff is not specially trained and not patient enough to handle the disabled children. Our children feel more secure when they are treated within the atmosphere of their own hospital.

I started by saying that the architectural framework is of vital importance for the treatment and care of the children. I will try to substantiate this statement.

I have seen many similar hospitals in many countries. Usually they have been much bigger - often large, solid buildings. In some countries the regulations require that the rooms be covered with tiles. I remember such a living-room in a quite new institution - there were no colours, no pictures, no place to put up a drawing - a few chairs were spread on the floor, and a television set was placed on a shelf under the ceiling. This cannot provide good living conditions or possibilities of progress to the disabled patients. In my opinion the atmosphere of a room is more important than the sterility. But I fully understand the rooms should be easy to clean. In this particular ward there were 160 patients.

This same hospital had some newly-built children's wards, the hospital having tried to comply with the demand for smaller units. There were 60 children in each ward, 30 in each dormitory, tiled walls, and windows placed so high up that the children could not look out. It is little use establishing "small" wards with 60 beds. It reminds one of the story about a man who walked in his sleep and was afraid of falling out of the window at the hotel where he had a room on the twenty-second floor. He was given a room on the seventeenth floor.

I recall yet another residential institution for 80 retarded adults with no possibilities of subgrouping, no possibilities of occupation. These 80 persons were supervised by two unqualified male nurses.

There is no doubt that patients in an institutional milieu can - and often do - develop certain symptoms. Just to live in the rather impersonal atmosphere of an institution without the personal contact with other persons is an unnatural situation that may cause neurotic reactions. This is a well-known phenomenon in all institutions. It is to some extent seen among the retarded - but even more among the disabled patients of normal intelligence. However, the institution will cause psychotic symptoms among predisposed patients or aggravate an existing psychosis. I think that to a great extent we ourselves create chronic symptoms in our patients by keeping them in unfavourable conditions. The condition of unoccupied patients in a group of 80 will inevitably deteriorate. Some of the patients will become absorbed in trivialities. They may sit swaying from side to side or walk around in circles, or perhaps develop a tendency to self-mutilation. Others develop dirty habits and again the need for tiled walls and stone floors is felt.

At the present time some centres adopt a form of therapy which may not be in keeping with modern methods but which, nevertheless, one has to accept if the lives of the self-mutilating patients are to be saved. From my experience I am convinced that these conditions have been created in the institutions. I have not seen these violent reactions in our hospital - and we receive the most severe cases from a town of 1 million inhabitants. Such reactions do not appear within the small groups where it is possible to occupy the patients and stay in contact with the children. In such conditions, at the first sign of abnormal behaviour, a child can be calmed down or soothed or included in a rhythmic dance.

The same difficulties are encountered with patients suffering from sensory handicaps - for example a blind child is "lost" in a large group. The blind child can only perceive a person with whom he has direct contact - he has no impression of the group. A child with brain damage is also "lost" in a large group. The spasms of the spastic child who receives no training become worse.
I well remember seeing 60 spastic children who on completion of their meal were placed by the wall in their wheelchairs; within the next hour they were all wheeled to the toilet. This occurred in a world-famous institution - it was a depressing sight.

In a large institution the patients may be well fed and they can be given vitamin pills. But they cannot be taught how to enjoy a meal or to recognise a spoon. They can be dressed individually and taken out for a walk but there is no time to teach them individually how to button their coats.

One cannot but admire the excellent work done by the staff in many of the big institutions, although the wretched milieu prevents the disabled from benefiting to any considerable degree from their efforts.

From what I have said it must be clear that smaller hospitals and a division into small units provide better conditions for treatment. When arguing with specialists and politicians it would be of great value if one could always quote useful statistic and research results. At the Children's Hospital in Vangede we receive patients from much bigger institutions, and it is our impression that the patients derive great benefit from the new conditions. It is our intention to illustrate this by tests, but it has not yet been possible to produce an actual statement. Many other factors are of importance - the children receive more specialised education, and there are more qualified staff to give treatment. It is difficult to express in exact words the importance of the small group in each ward.

However, the problems are all connected. When the outward requirements of treatment are met, one attracts more and better staff. Before our new hospital was opened we had an old, out-of-date institution. There it was very difficult to recruit a physiotherapist. Under the new conditions we have no problems: We have 10 young and clever physiotherapists who enjoy working in the hospital. A new three years' training programme has been elaborated for nurses' aids, and each ward has a staff of 10 to 15 persons. There are good possibilities of observation, and doctors are attracted to the hospital where they seek further education and training.

Yes, indeed, the buildings are all-important.

We must go back home to our politicians and governments, authorities and organisations and insist on good settings for the treatment of our disabled patients.
5. Education of Mentally Retarded Children

by

Leif Bjødstrup, Director of Education,
Children's Department, Danish National Service
for the Mentally Retarded

It is my duty to give two lectures in this Seminar: the first on educational and prevocational aspects of this specific institution, The Children's Hospital at Vangede, a residential institution for moderately, severely and profoundly retarded children.

Tomorrow, I shall continue more generally on education of mentally retarded children. Both presentations are to be followed by a survey of practice.

I beg you to consider both presentations as complementing each other, and I want to emphasise strongly that I will be at your disposal outside this formal and restricted meeting to give you individual orientation on the vast amount of data which constitutes our educational work in the service for the mentally retarded.

It is true that the object of the Seminar is vocational rehabilitation. I shall, however, stress that vocational rehabilitation cannot be performed or even discussed if you do not accept the fact that rehabilitation of a handicapped person starts at the moment of first contact, which may be — though rarely — already at birth, that is, when the handicap is identified.

Following this, any form, any organisation, any pedagogical technique within special education must have the general psychical, mental and social rehabilitation of the client as one of the ultimate objectives.

This triad, the psychical (or biological), mental and social aspects of the client, is reflected in the general organisation of our national care system for the mentally retarded. During your stay in Denmark you will be confronted with a system which from my professional point of view could be characterised in essence as social-paedagogical. The latter term may be new to you, who are accustomed to using the one word "education", but in this country (and by the way also in Germany) you will observe a strong movement or construction of educational thinking, which started around 1860 and is called social-paedagogics.

The basic assumption for our work is that the right to education and treatment for all the handicapped without regard to degree of handicap whatsoever, and the corresponding obligation for society, is an essential part of a social philosophy which wants to respect free and equal rights for all citizens.

In Denmark today the mentally retarded have the right to education from the age of 7 to 21, whereas other Danish citizens only have a compulsory education of about eight years.

The right to education for the handicapped was proclaimed long ago, during the French Revolution, by Condorcet, but it is a tragic fact that the full realisation of this point of view was not achieved in this country until 1959, when the Act which forms the basis for our work was implemented. Before that time very little organised education of the mentally retarded took place, and even then only for the group of mildly retarded. The objectives in terms of rehabilitation were correspondingly diffuse and not well organised.

Today, the greatest expansion of work for the mentally retarded since 1960 has taken place within the educational field, and the group which at present is most prominent in our planning is the group of moderately and severely retarded persons.

Within the service system, which is described to you elsewhere, the types of institutions can be divided into residential and non-residential, also called intramural and extramural services.
The organisation of educational stimulation as an integrated part of the general service penetrates into the residential system for moderately, severely and profoundly retarded and is realised as an ordinary school parallel to those which serve children who live at home with their parents or relatives, as do most children.

Today, in this institution, you will see the children in their living milieu - the residential setting - as well as in the educational milieu, which is established as a school, situated on the premises and only serving the children in this miniature society.

The school employs some fifty-five trained teachers who in the main have three different professional backgrounds. We believe that the educational needs of the children can best be met first of all by the kindergarten teacher, who has a three-year professional training and is the expert in the pre-school activities.

Next we employ the teacher, who is trained for the normal public school service, and thirdly the teacher, who is professionally trained extramurally for work with children and youngsters, i.e. afternoon activities, evening youth-club work, playground activities, etc.

There is no specific training for teachers of the mentally retarded, but we have the possibility of sending our colleagues on twelve-month courses in special education at the National Teacher's High School for Advanced Paedagogics without any cost at all for the person concerned and with full pay. In addition, we have a comprehensive intern training on a national basis mainly organised through weekend courses in educational methodology and also in seminars or workshops of longer duration - mostly one week - with emphasis on group dynamics and problems of general theoretical or organisational relevance.

The school here in Vangede is able to serve about 220 students out of a total population of 300 on a five-day week basis with weekly hours of education varying from sixteen to thirty-three.

The idea at Vangede is, as I see it, to create and offer a way of life as similar as possible to average life as part of our so-called principle of normalisation.

The school here represents a normal institution in society just as the single wards or cottage in this institution endeavour to represent or simulate the children's home life. Every day, every morning, the children leave the home to go to school and return in the afternoon for leisure time and home life.

The ultimate educational objective in the school is in principle the same as for children in other public schools.

The theoretical foundation mostly favoured at present is the so-called social learning process, considering personality as a function of a sequence of learning processes.

The educational programme or programmes for each individual student are based on his actual overt level of performance, and are structured in the smallest possible functional units. The progress of learning is closely observed and registered. Effective control, a constant adaptation of thinking, adoption of new ideas, etc., are achieved through individual meetings and general case-conferences, where all persons involved in the comprehensive service of the child, i.e. care assistants, nurses, medical officers, social workers, psychologists and others are contributing. Recently we arranged for the parents of the child to be invited to participate in the treatment-oriented conferences.

With the ultimate objective in mind, the curriculum of this school embraces the following single "disciplines" or areas of behaviour:

- Body and ego perception
- Social performance
- Sense training
Physical training
Language and concept construction
Non-verbal communication
Self help
Creative work
and General orientation.

These subjects are then subdivided according to the level of the children's actual potential.

The theory behind this may be provocative. We wish to stress that, given sufficient time, the student could be taught far beyond the limit which we, by habit and prejudice, are expecting.

We think that most people, because of these prejudices, which are commonly associated with the handicapped, are establishing barriers not only for the development of the teaching and stimulation of all handicapped groups but also for our goals and expectations. In the days ahead, you will hear and see what is done in my country. We can only present one example.

In your own societies and cultures, special conditions may affect the development of programmes in which approaches to special education and vocational rehabilitation quite different from ours may be adopted.

As already indicated, because of the enormous problems in planning and constructing comprehensive educational systems at all levels, the problems inherent in special education for all groups of the handicapped have not received much attention.

However, whether considered from the point of view of simple human rights or from the point of view of economics or manpower strategies, we strongly recommend action here and now. Actually, we are still at the stage where at best only "lip service" is paid to the idea of everybody's right to education.

The fact that special education has been neglected for so long can be illustrated by the fact that it took many years before UNESCO could focus attention on this problem. As a matter of fact it is only in the last three or four years that a UNESCO programme for the education of handicapped children has been established. From my personal point of view I strongly recommend:

- the creation and formation of public and official attitudes of acceptance and acknowledgment of the fact that any citizen has a right to the development of his faculties;
- that there should be included in any basic Act on general educational planning what I call "trigger mechanisms", which can be realised on the legal level as well as in the minds of teachers and rehabilitation workers;
- that there must be a strong, central (state) initiative, influenced by and with the co-operation of those involved, i.e. the clients, parents or relatives.
Mental Retardation. Brief History of the Development

Handicapped people have throughout the ages been considered as persons who did not belong to society. The handicapped were for centuries segregated from the general community. This segregation resulted as a rule in a poorer treatment of the handicapped than of the rest of the population. It is generally acknowledged that group-segregation is equal to discrimination.

Mentally retarded form such a group, a group which although difficult to define, could easily be segregated, as they have common group characteristics. Until the nineteenth century no distinction was made between mentally ill and mentally retarded persons. It was not until the middle of the nineteenth century that attempts were made to separate these two groups. The belief in treatment and cure of mental retardation, then defined as a special medical problem, curable through treatment, was rather short-lived optimism. The cure which was expected, did not occur, and the result was negative attitudes towards the mentally retarded citizens and mental retardation as such. One did not believe in treatment of mental retardation, either by medical, or educational methods. The human attitude towards these "poor" citizens then resulted in mere nursing and caring. That is why large, often remotely placed institutions were built where the mentally retarded were hidden away. Those giant institutions with 1,000 or more beds took the view that mental retardation was a permanent condition, not one to be improved through treatment. As mentally retarded were labelled "useless" citizens, there seemed to be no special reason to treat them well; they merely should be kept alive.

It was usual then to display human attitudes towards the mentally retarded, protecting them against the society in which they had to live. Until the middle of this century this protection marked all activities in the field of mental retardation. Psychiatric circles considered the mentally retarded, even until this century, as dangerous or potential criminals with an innate need for vagabondage. This theory strengthened the protective tendencies in two ways: on the one hand to protect the mentally retarded against society, and, on the other hand, to protect society against the mentally retarded.

This two-fold human protective attitude towards the mentally retarded led to the same result as the generally prevailing negative attitudes by society towards any people who deviate from society's norms. Such deviations include race, religion, physical or mental conditions.

Manifestations of these attitudes and the resulting policies take the form of giant institutions or ghettos and are found all over the world; most of these institutions are marked by hopelessness, overcrowding and understaffed conditions and are generally of a poor standard.

The assumptions behind this treatment of mentally retarded persons have proved to be wrong. New knowledge, improved financial and technical possibilities and consequently more human attitudes towards handicapped people, in this case the mentally retarded, have resulted in a brand new internationally accepted treatment policy.

For this reason, countries which formerly merely protected or segregated their mentally retarded citizens in ghettos of hopelessness are today breaking up their old, unsuitable institutions and are now starting to establish more suitable homes for their handicapped citizens.

Developing countries must avoid the mistakes that were made in other countries over the centuries. A country which starts new programmes for the mentally retarded should base its work on other countries' experiences in order to avoid the innumerable mistakes which countries with existing service systems are now zealously trying to amend.
The term "mental retardation" in general. A definition of the term "mental retardation" depends on the angle of approach, as there are no international diagnoses and whether it is viewed from a medical, a pedagogical-psychological or a legal socio-administrative point of view (cf. WHO Report 392, pages 8-12).

Common to the delimitations of "mental retardation" is the characteristic feature of mental retardation, namely deviation from the normal, average or typical, and especially a deviation in relation to the mental, intellectual development.

From a medical angle mental retardation will often be confined to cases of organic origin, a syndrome; in this connection a symptom. The USSR uses the delimitation to describe "oligofrenia" a term which is used there. Typical examples: mongolism, hydrophalus etc. In Western countries, the term includes cases of other origin, e.g. partial or total lack of development, because of insufficient stimulation due to poor economic or social conditions. Thus one can speak of mental retardation through environmental causes - socially or culturally deprived persons who function as mentally retarded.

From an educational angle, mental retardation is limited to cases where specially arranged educational programmes are considered necessary during school age.

From a social angle, mental retardation can be confined to persons who, due to dull intelligence or poor development need special help and support to manage in society.

The legal-administrative definition of mental retardation, the most important one to initiate an adequate service form, refers to people who due to poor development, especially mental development, need special help throughout life or for a period of their lives. Thus the definition describes persons who need special treatment in a hospital, special education during pre-school, and school-age, or special social service forms when grown up.

The most reliable term, of course, will be the precise medical term, where mental retardation is a detectable, pathological case, including borderline cases. Today we know of some 300-400 different causes of mental retardation: mental retardation of pre-natal origin (German measles in the mother during the first months of pregnancy), mental retardation stemming from the delivery itself (injuries due to difficult delivery, lack of oxygen), mental retardation of post-natal origin (meningitis, encephalitis etc.).

Some countries only speak of mental retardation of ante-natal, pre-natal, or post-natal origin. Other countries include cases arising at a later stage, for example cases resulting from road accidents etc.

The medical conception includes mental retardation of a genetic origin - familial mental retardation.

Until the middle of this century one generally assumed that 80 per cent of all mental retardation cases were of genetic origin, but concurrently with more exact differential diagnoses many other specific causes of mental retardation have been detected.

Today we believe that about 40 per cent of cases are of genetic origin, a percentage which most likely may be reduced with improving techniques of detection.

Differential diagnoses are very important for two reasons; firstly, for the preventive treatment aiming at a reduction of mental retardation cases, secondly for the treatment and education of the mentally retarded.

Primary prevention should be initiated in cases of mental retardation resulting from metabolic disorders.

PKU, or Pellings disease, is one of the classic examples that can be detected by means of a simple Phenistix test on the urine of newborn babies. This disease can be cured by a rather strict diet during the first years of childhood. Cases of PKU are rather infrequent, probably one case out of 10,000 childbirths.
A special syndrome, Down's Syndrome, or mongolism, scientifically described since 1866, has been subject to special research for ten to fifteen years; in 1959 Lejeune, a Frenchman, detected the special chromosome component in patients suffering from Down's Syndrome, usually one additional chromosome (21-trisomy).

New techniques were developed during these years to detect chromosome anomalies by means of amniotic fluid tests during the first month of pregnancy. In such cases abortion may be induced on eugenic indication in countries where abortion is permitted.

Prevention of Down's Syndrome, or mongolism, is imperative if the incidence of mental retardation is to be reduced as mongoloids form a major part of all cases of mental retardation who are in need of special services throughout life.

Western countries estimate two per thousand live births are mongoloid babies. The origin of this chromosome anomaly is unknown, but the risk of having mongoloids has been proved to increase markedly with the mother's age, as half of all children with Down's Syndrome are borne by women over 37 years of age.

The psychological-pedagogic delimitation of the term "mental retardation" is mostly made by means of different tests, of which there are many. The first intelligence test was presented in the beginning of this century by the Frenchmen Binet and Simon, whose IQ-test discovered the relation between real age and mental age. Binet-Simon tests for many years were considered sufficient to diagnose mental retardation. Today we have many additional tests that supplement Binet-Simon which, in this context, contribute to a more differentiated picture of a person's intellectual level and his developmental possibilities.

The borderline between mental retardation is usually an IQ of 65-75. No expert would today rely on IQ-tests as the only criterion, but the different tests are all instruments, each contributing to give a varied picture, a profile, of the person in question.

We are inclined to use IQ's regardless of the international objection to IQ-tests as reliable criteria; IQ's are used even today in the latest sub-grouping of mental retardation. Many countries in fact still use the classification of mental retardation suggested by WHO:

1. mild mental retardation .......... IQ's 50 - 70;
2. moderate mental retardation ....... IQ's 35 - 50;
3. severe mental retardation .......... IQ's 20 - 35;
4. profound mental retardation ........ IQ's 0 - 20.

Now, after the latest revision, the group formerly known as borderline cases is omitted when referring to mental retardation - cf. WHO Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, 1969 Revision, Geneva.

The practical legal-administrative definition of mental retardation clearly described mental retardation as a somewhat relative term, depending on the development in the society in question (countries with a well-developed special school programme have thus fewer pupils in their mental retardation schools). Besides, mental retardation is no permanent, lifelong condition.

Statistics of countries with well-developed service systems for the mentally retarded have shown an increase of mental retardation cases during school age, compared with the rate for adults, which merely explains that mental retardation is a question of a person's capability to manage in school or society. It is quite clear that mentally retarded persons are handicapped, especially when schools make such heavy demands on reading, writing and arithmetic, whereas many of these handicapped individuals have practical skills which enable them to manage in society without the need for any special help. These cases should not be called mentally retarded in the proper sense of the term. The great number of mental retardation cases at school age is actually due to the fact that the condition is more easily recorded at that stage from an administrative point of view, because these age-groups must attend school, or are at least presumed to go to school.
Active Treatment of Mental Retardation

A. General Remarks

The mentally retarded are a natural element of any population. Some mentally retarded persons are minus variants of the general mental distribution; some are pathological deviants; others again are mentally retarded as a result of the social and environmental conditions in which they have to live.

Consequently, mentally retarded persons are no special group, which can or should be segregated, but members of the society, born with the same right to live, and with the same right to treatment as all other citizens.

Possibly all kinds of mental retardation could be subject to treatment. Mental retardation is not a permanent, lifelong condition, but dynamic in its nature, which means susceptible to improvement.

Without regard to the degree and category of mental retardation it is possible through treatment, training and education to develop a mentally retarded person. In principle, mentally retarded persons can be developed to the same degree as other persons, namely to the optimum of their capacity. In practice there will be great differences as to how far development can be reached, but all human beings have possibilities for development, and a right to have these possibilities realised.

There are today medical, educational and social methods of treatment, which have proved to be effective in the development of mentally retarded individuals.

We know today that early stimulation is of vital importance. Early identification and the earliest possible initiation of treatment are therefore absolutely necessary.

Any of us can have a mentally retarded child, no matter what his financial or social position. In past years the superstitious belief that a mentally retarded child was a retribution of one's sins is today completely unfounded. Parents of mentally retarded children should therefore never feel guilty or ashamed. The mentally retarded individual is just as valuable as the so-called normal individual.

Early treatment, education and training of the mentally retarded individual will enable him to become a useful member of the community living independently without financial support from society or the family. Active treatment of the mentally retarded is thus indicated, among other reasons, from an economic point of view.

Primitive societies often absorb their mentally retarded individuals to a certain degree, in spite of their "uselessness", while in the main, modern, urban societies complicate life for the handicapped, although offering them productive work. Modern industrial working processes with conveyor-belt techniques can usually be mastered by mentally retarded persons, providing the work is well-organised, so that the mentally retarded and other handicapped individuals form a valuable part of the labour force which is to their own and the community's advantage.

But those who cannot be labelled "useful", who cannot work, also have a right to develop to the best of their abilities, to be supported equally as other citizens with physical handicaps.

B. Medical Treatment

It is often equally difficult for a parent to face the problem of having a mentally retarded child as it is for the retarded child himself to confront his own problems. Therefore, prevention to the greatest extent possible is to be recommended. Today, 40 per cent of all cases of mental retardation are considered to be of genetic origin, so that genetic counselling as a preventive factor would be of vital importance.
The risk of having a handicapped child will always be greater in families with inborn dullness or weak sensory faculties. Such families should be advised to avoid having children or, at least, be informed about the risk involved so that they may choose whether or not they want to have children.

Some diseases during early pregnancy or other ante-natal complications may result in mental retardation. Pre-natal examination is therefore indicated. Expectant mothers should consult a doctor or a hospital if any such conditions should arise during pregnancy.

Expectant mothers over 35 years of age should be informed of the risk of having mongoloid children.

It is to be recommended that girls be exposed to German measles before maternity.

Complications during delivery itself often cause brain injuries etc., and delivery should, therefore, take place under the supervision of a doctor, a midwife or at the hospital. Anaesthesia and drugs to expedite delivery should be avoided.

Beyond the usual examination of new-born babies, W.R. PKU-examinations should be performed, as PKU-cases always result in mental retardation. This simple test can be made by means of a Phenistix-test in a wet napkin. The test, however, should be followed by a more differentiated blood test. Treatment aims at avoiding mental retardation by means of a rather strict diet, cf. enclosed screening of the John F. Kennedy-Institute.

Any infection during early childhood must be examined and treated effectively, especially in cases of meningitis and encephalitis which will often result in mental retardation.

Signs of slow development - if a child of six months, for example, cannot sit up by himself - may be observed closely and may indicate examination by a doctor or a hospital.

A doctor should observe the child most carefully - he should be well aware of the many implications of slow development in early childhood.

While a so-called normal child will develop without any special stimulation, the mentally retarded child should be strongly supported and stimulated by the mother or by professionals.

A very passive child may become permanently passive if not stimulated in time.

Experiences from developing countries have shown that among the mentally retarded low-weight babies are a predominant group. Therefore, appropriate nutrition during pregnancy and the first years of childhood are of vital importance, both for the physical and mental development of the child.

Children must be examined for possible blindness and deafness. Blind and deaf children have often been labelled mentally retarded with the result that their primary handicap was untreated and they consequently appeared as mentally retarded.

Mothers, and others who care for children, should be requested to be active towards the child, to talk with him, teach him how to walk, play with him, expect something from him. Passivity is always a signal of danger, and the earlier a diagnosis has been made, the better the child will develop. Co-operation between parents on the one hand and therapists (physicians, psychologists, social workers etc.) on the other is most important. A great part of the treatment of the mentally retarded can be performed by parents and relatives under the supervision of professionals.

Medical work includes psychiatric and somatic treatment. Mental retardation is often combined with psychoses and neuroses which demand special psychiatric and child psychiatric therapy.

Mental retardation is often combined with multi-handicaps, mostly motor handicaps, but also hearing defects and visual disorders.
Good results have been achieved in recent years by physiotherapeutic treatment, both in cases of mental retardation combined with poliomyelitis and cerebral palsy where physiotherapeutic treatment was obviously indicated.

Physiotherapy, however, is also indicated in less clearly manifested cases of physical handicaps. Scientific studies have proved that mentally retarded usually have a weaker constitution than other people, so training and strengthening of their physique will be advisable.

One should generally aim at treating the secondary handicaps and defects of the mentally retarded with a view to making his appearance as natural and normal as possible. Spectacles, hearing aids, artificial appliances etc. are necessary to improve the appearance of the mentally retarded. Technical "improvements" of that kind will also result in their intellectual development.

Dental treatment of the mentally retarded is of vital importance, as many are born with teeth defects. Dental treatment of the mentally retarded is at present subject to scientific research.

From a medical point of view there are today many more possibilities for the treatment of the mentally retarded as compared to the former days of passivity.

C. Educational Treatment

Since the Second World War the educational working methods in the field of mental retardation have progressed rapidly.

During the first period of special education the main emphasis was put on developing methods of teaching the mildly retarded in traditional subjects such as writing, reading, arithmetic. Today's educational objectives are much broader, as we know that all mentally retarded can be educated and trained.

Education today includes more practical subjects such as, for example, toilet training, eating habits, dressing etc.

The objective of special education is more than a wish to alleviate the weakness associated with the handicap; it is a direct attack aimed at reducing these handicaps and improving the intellectual functions of the mentally retarded; thus special education will influence the handicap itself.

Reading techniques, for example, are practised with children who cannot read letters. They are taught the so-called signal words, so they can recognise in pictures most common words such as "men", "women" "toilet", "stop" etc. Research has shown which words are of essential importance for a person to recognise to enable him to manage in a modern community.

Sensory training is important, and in the opinion of many educators the learning process in one field will exert its influence on other fields, because a kind of transfer takes place. It goes without saying that special education of this type will require specially trained teachers. It is also necessary to work in smaller class-groups than in the normal schools. The lower the intelligence level of the pupils, the greater the educational support required. For mildly retarded children, a class quotient of ten is the maximum. For other retarded children the number must not exceed six, and in regard to the education of psychotic and behaviour-disordered children, the group should be reduced to three, supplemented by much individual instruction.

It should be emphasised that the instruction or the educational influence will have greater effect if started at a very early stage. Recent research has shown that the training should be started by the time the child is about three months old. In the majority of cases this will not be practicable, but it will on the other hand be practically possible to start the educational treatment at kindergarten age, i.e. from about the age of three, for children identified as mentally retarded at that age.

Experience shows, unfortunately, that most of the mildly retarded children are not identified until they start attending school or are about to be sent to school.
During the last years at school the instruction must be focused on occupational training, always with the goal in view of providing the pupils with the best possibilities for managing on their own in the adult environment. Even in so far as the SSN's are concerned, the objective should be to teach them some useful and practical subjects, so as to give them a chance of being active later in life, perhaps under sheltered conditions. (See below)

D. Social Adjustment

The training given to the mentally retarded child should always be aimed at adapting him so that he can manage in the community with a minimum of support. On completion of their school-life, many mentally retarded persons will thus be able to perform simple tasks and earn their living.

The object of rehabilitation workshops is to train or retrain handicapped persons primarily for the ordinary labour market or alternatively for work in the so-called "sheltered workshops". In arranging the work at such establishments the greatest possible regard should be paid to the worker himself. The work should be supervised and organised by specially trained persons who are familiar with the needs and requirements of the physically or mentally handicapped. The objective is partly to activate the worker, partly to produce, and it should also be mentioned that the workers concerned must be paid for their work in proportion to their performance.

As a rule, however, the worker's performance will be below normal, and he will therefore not be able to earn full wages. Consequently, it will be necessary to supplement his wages with a disablement pension or similar cash contributions granted by the public authorities, considering that all citizens have a right to receive public support to enable them to lead an ordinary or normal life.

Whereas experience has proved that an adaptation of handicapped persons to a work situation is a comparatively easy matter, their leisure time presents greater problems, and they will, moreover, be in constant need of some directive help in the administration of their income and arrangement of their daily life.

Social workers should cover these social welfare aspects even during the school-years in order to ensure that after schooling and training in a rehabilitation workshop or centre the mentally retarded will be integrated in the community.

Special reference to this is made in the chapter on "The Normalisation Principle".

The Size of the Problem

Innumerable analyses have been made on the number of mentally retarded in a society - the prevalence of mental retardation. These analyses, however, are usually of little interest in practice, as they are generally based on different definitions of mental retardation and, therefore, seldom comparable. In Western countries it is generally recognised that 1-2 per cent of the total population would be classified as mentally retarded if they were given a standard IQ-test. It is obvious however, taking into account the concept of mental retardation outlined earlier in this paper, that this estimate is of little interest in so far as organisation of services for the mentally retarded is concerned.

1 I.e. severely subnormal persons, see page 67.
Good results have been achieved in recent years by physiotherapeutic treatment, both in cases of mental retardation combined with poliomyelitis and cerebral palsy where physiotherapeutic treatment was obviously indicated.

Physiotherapy, however, is also indicated in less clearly manifested cases of physical handicaps. Scientific studies have proved that mentally retarded usually have a weaker constitution than other people, so training and strengthening of their physique will be advisable.

One should generally aim at treating the secondary handicaps and defects of the mentally retarded with a view to making his appearance as natural and normal as possible. Spectacles, hearing aids, artificial appliances etc. are necessary to improve the appearance of the mentally retarded. Technical "improvements" of that kind will also result in their intellectual development.

Dental treatment of the mentally retarded is of vital importance, as many are born with teeth defects. Dental treatment of the mentally retarded is at present subject to scientific research.

From a medical point of view there are today many more possibilities for the treatment of the mentally retarded as compared to the former days of passivity.

C. Educational Treatment

Since the Second World War the educational working methods in the field of mental retardation have progressed rapidly.

During the first period of special education the main emphasis was put on developing methods of teaching the mildly retarded in traditional subjects such as writing, reading, arithmetic. Today's educational objectives are much broader, as we know that all mentally retarded can be educated and trained. Education today includes more practical subjects such as, for example, toilet training, eating habits, dressing etc.

The objective of special education is more than a wish to alleviate the weakness associated with the handicap; it is a direct attack aimed at reducing these handicaps and improving the intellectual functions of the mentally retarded; thus special education will influence the handicap itself.

Reading techniques, for example, are practised with children who cannot read letters. They are taught the so-called signal words, so they can recognise in pictures most common words such as "men", "women" "toilet", "stop" etc. Research has shown which words are of essential importance for a person to recognise to enable him to manage in a modern community.

Sensory training is important, and in the opinion of many educators the learning process in one field will exert its influence on other fields, because a kind of transfer takes place. It goes without saying that special education of this type will require specially trained teachers. It is also necessary to work in smaller class-groups than in the normal schools. The lower the intelligence level of the pupils, the greater the educational support required. For mildly retarded children, a class quotient of ten is the maximum. For other retarded children the number must not exceed six, and in regard to the education of psychotic and behaviour-disordered children, the group should be reduced to three, supplemented by much individual instruction.

It should be emphasised that the instruction or the educational influence will have greater effect if started at a very early stage. Recent research has shown that the training should be started by the time the child is about three months old. In the majority of cases this will not be practicable, but it will on the other hand be practically possible to start the educational treatment at kindergarten age, i.e. from about the age of three, for children identified as mentally retarded at that age.

Experience shows, unfortunately, that most of the mildly retarded children are not identified until they start attending school or are about to be sent to school.
During the last years at school the instruction must be focused on occupational training, always with the goal in view of providing the pupils with the best possibilities for managing on their own in the adult environment. Even in so far as the SSN's are concerned, the objective should be to teach them some useful and practical subjects, so as to give them a chance of being active later in life, perhaps under sheltered conditions. (See below)

D. Social Adjustment

The training given to the mentally retarded child should always be aimed at adapting him so that he can manage in the community with a minimum of support. On completion of their school-life, many mentally retarded persons will thus be able to perform simple tasks and earn their living.

The object of rehabilitation workshops is to train or retrain handicapped persons primarily for the ordinary labour market or alternatively for work in the so-called "sheltered workshops". In arranging the work at such establishments the greatest possible regard should be paid to the worker himself. The work should be supervised and organised by specially trained persons who are familiar with the needs and requirements of the physically or mentally handicapped. The objective is partly to activate the worker, partly to produce, and it should also be mentioned that the workers concerned must be paid for their work in proportion to their performance.

As a rule, however, the worker's performance will be below normal, and he will therefore not be able to earn full wages. Consequently, it will be necessary to supplement his wages with a disablement pension or similar cash contributions granted by the public authorities, considering that all citizens have a right to receive public support to enable them to lead an ordinary or normal life.

Whereas experience has proved that an adaptation of handicapped persons to a work situation is a comparatively easy matter, their leisure time presents greater problems, and they will, moreover, be in constant need of some directive help in the administration of their income and arrangement of their daily life.

Social workers should cover these social welfare aspects even during the school-years in order to ensure that after schooling and training in a rehabilitation workshop or centre the mentally retarded will be integrated in the community.

Special reference to this is made in the chapter on "The Normalisation Principle".

The Size of the Problem

Innumerable analyses have been made on the number of mentally retarded in a society - the prevalence of mental retardation. These analyses, however, are usually of little interest in practice, as they are generally based on different definitions of mental retardation and, therefore, seldom comparable. In Western countries it is generally recognised that 1-2 per cent of the total population would be classified as mentally retarded if they were given a standard IQ-test. It is obvious however, taking into account the concept of mental retardation outlined earlier in this paper, that this estimate is of little interest in so far as organisation of services for the mentally retarded is concerned.

---

1 i.e. severely subnormal persons, see page 67.
In the USA, the number of mentally retarded in the population is estimated to be about 3 per cent of the population - a figure considerably higher than corresponding figures in Scandinavia. The main reason for this is that mental retardation cannot be defined in the same way in USA and in Scandinavia. The USA with great population groups living in stimuli-poor areas, has a very great number of socially and economically deprived persons many of whom are mentally retarded. An analysis referred to in a report of the President's Committee on Mental Retardation showed that in a Californian ghetto up to 10 per cent of children of school age were mentally retarded. In the Scandinavian countries, where poverty problems hardly exist, the number of mentally retarded is generally estimated at 0.5 per cent of the population at any given time.

The WHO Technical Report No. 392 indicates that 1-3 per cent of the population are mentally retarded (pages 6-7), the prevalence being higher at school age than before or after.

As mentioned earlier the WHO classifies the mentally retarded into the following categories: mildly, moderately, severely and profoundly as well as unspecified. Earlier tripartite systems of subclassification (idiocy, imbecility and feeble-mindedness or debility) can be correlated to the quadripartite system mentioned.

It should be stressed, that none of these delimitations include the so-called slow-learners, who are low-gifted persons (IQ 70-85) with need for special education, but who afterwards will be able to manage in society. This means that they are not mentally retarded, but if they do not receive special education, they may become mentally retarded, i.e. function as mentally retarded.

In the United Kingdom a dichotomy is generally applied, SSNs - severely subnormals, and MSNs - mildly subnormals. SSNs comprise profoundly, severely and moderately retarded of the WHO system, and MSNs mildly retarded. There are differences of practical nature between SSNs and MSNs and, therefore, practical differences in the services necessary. This division, therefore, deserves a study, and it will be used as a basis for the practical recommendations of this report.

Dr. Albert Kushlick in a paper to the International League of Societies for the Mentally Handicapped (Jerusalem, October 1968) has given a short and precise description of the two groups:

"The term SSH is used to mean individuals who score quotients of less than fifty on a standardised intelligence test, i.e. more than 3 s.d. under the mean IQ-score. This includes those formerly classified as idiots and imbeciles. In the ¶10 classification it includes those people categorised moderately, severely and profoundly mentally retarded. Virtually all SSH individuals will, if they survive long enough, need residential care outside their immediate families at some time in their lives. Very few under the present circumstances will become socially and economically independent - very few ever marry and set up independent households and only 5-10 per cent appear to be able to hold jobs. The severity of their social and intellectual incapacity makes it certain, in industrial countries, that these people will be identified by school age. Nearly all have some autopsy evidence of pathology in the brain and the majority have obvious clinical signs such as mongolism or Down's Syndrome (about one quarter), epilepsy or spasticity, microcephaly or hydrocephaly. Their parents come from a cross-section of all social classes in the society.

By contrast, the MSN subjects (who include those classified as feeble-minded, moron, debile, mildly retarded, educationally subnormal) tend to have higher IQ-scores. These are mainly in the IQ range 50-70 but sometimes higher than 70; the majority have no detectable brain pathology or clinical signs. Among the majority without such signs the chance of achieving social and economic independence, or marrying and finding open employment are very favourable, indeed in Britain their chances are as good as those of children with higher IQ-score but who come from the same social background. The parents of MSN subjects without clinical signs are virtually all semi-skilled or unskilled
working class. Only a minority of MSN subjects ever receive special services of their retardation, and those who do have often been reared in badly broken homes and have severe personality and behaviour problems which are more serious and disabling than their intellectual deficiencies. They seldom appear on waiting lists for residential care and their proportion in institutions in Britain is declining fairly rapidly. As to the number of mentally retarded Kushlick, who has carried out detailed studies of frequencies, states that the prevalence of SSNs at school age is 3.7 per 1,000 children, which in England corresponds to 1 per 1,000 of the total population.

In the WHO Technical Report No. 392 the number of SSNs (moderately, severely and profoundly retarded) is estimated at 4 per 1,000 in the age group 10-14, i.e. approximately the same number quoted by Kushlick. In the same report it is stated that SSNs account for one-quarter of all retarded and MSNs for three-quarters. This should lead to a maximum prevalence of 4 per 1,000 SSNs and 12 per 1,000 MSNs, in total 16 per 1,000. This frequency is higher than generally calculated, and the reason is that it is based on the number at school age. Considering the English figure for the total population - 1 per 1,000 SSNs - and calculating this as one-quarter of all mentally retarded, the total for the whole population will be four per 1,000.

Empiric studies and statistical estimates in Denmark show the following figures: in 1965 the number of registered mentally retarded in Denmark (defined as the prevalence of care) was 4.3 per 1,000 (4.9 for male and 3.8 for female). The maximum rate of registration of a generation is 8.1 per 1,000 (9.4 male and 6.8 female), defined as the incidence of mental retardation care. On this basis the incidence of mental retardation at birth (the calculated number of mentally retarded new-born) is estimated at 17 per 1,000 (19 male and 14 female), and the average prevalence of mental retardation is calculated at 8.1 per 1,000 (9.4 male and 6.8 female).

A study from Sweden (Karl Grunewald in "Changing patterns in residential services for the mentally retarded, President's Committee on Mental Retardation, Washington D.C., 21, 201, January 10, 1969") shows that in Sweden the number is estimated at 7 mentally retarded per 1,000 of the population or practically the same as in Denmark.

For the purpose of building up the services for the mentally retarded it is realistic to build on the Danish experiences, i.e. that 5 per 1,000 of the population are mentally retarded to a degree that they need some form of care.

Two per 1,000 are in need of residential care; but this certainly is a maximum, because Denmark during the period from 1855 to 1955 followed a protectionist line, leading to a relatively great number of institutionalised mentally retarded. The expansion of day facilities will reduce this number.

At school age the Danish mental retardation register comprises 8 per 1,000 of each age group, 2 per 1,000 of SSNs and 6 per 1,000 MSNs. It should be noted that in Denmark about 13 per cent of the population are in the school age group (7-15 years) and that average life expectancy at birth in Denmark is about 70 years.

Services for the Mentally Retarded

The Normalisation Principle

We have already shown how services for the mentally retarded in the nineteenth century developed into protective measures of a somewhat passive pattern. This development continued far into the twentieth century, and it was not until after the Second World War that pre-conditions existed for a more active treatment.

These pre-conditions coincided with a better economic basis in many countries which facilitated efforts on behalf of those people who had been labelled "useless", and with a more positive attitude towards deviants and handicapped - factors that have led to a reappraisal of the principles hitherto adopted as regards improvement of the services.
The relatives of the mentally retarded, who in many countries have formed organisations of their own, demand that the mentally handicapped persons' civil rights be guaranteed. Negative discrimination and segregation are now giving way to the concept of equal legal status for these citizens. We are moving from "charity to rights", as the International League puts it. The object in view now is to offer the mentally retarded an existence as far as possible equal to a normal existence. This is what, for a number of years, has been the objective for the improvement of services for the mentally retarded in the Scandinavian countries, where it is called the normalisation principle.

This principle simply means that the handicapped - in the present case the mentally retarded - shall have the same rights and obligations as other citizens. That the normalisation principle has proved to be comparatively revolutionary with positive consequences to the mentally retarded is bound up with its contrast to the anything but normal conditions formerly offered the mentally handicapped. Normalisation does not aim at making the mentally retarded into so-called normal people. For one thing, there is no description of "normalcy" for another, it has to be realised that the mentally retarded are defined as a group of persons who in several respects are not what we would call normal. What is aimed at is not "normality" but "normalisation". Normalisation means acceptance of the mentally retarded with their handicap, and offering them normal living conditions, i.e. offering them the same conditions as are offered to other citizens, inclusive of treatment, education and training adjusted to the handicapped person's individual need for the purpose of enabling him to develop optimally.

What is "Normal"?

The interpretation depends on the conditions in the country concerned; it is dependent on the social, cultural and religious conditions existing at any time. Any detailed description of normalisation must distinguish between general conditions of life and treatment in its widest sense.

Conditions of life must be viewed in the three dimensions: housing conditions, working conditions, and leisure.

As regards housing conditions: in most countries it is considered normal for children to live with their parents. What this is generally the best thing for the children, too, is here taken for granted.

Mentally retarded children, therefore, ought to live with their parents, wherever this is feasible. There are mentally retarded children, whose state of mind is such that they cannot live at home, and there are homes which are unable to offer the mentally handicapped acceptable living conditions. In such cases the mentally retarded must be invited to live outside their homes at institutions established to meet these exigencies. The principle is thus entirely opposed to the institutionalisation principle under which the mentally retarded were removed from their natural homes and isolated in generally large, remote, inhumane institutions with such consequences as discontinuance of connection between parents and children to the injury of both parties, and an existence in dehumanised institutionalisation. Where a child in the said situation cannot live at home, it must be asked to live in an institution, but this ought to be a small one, i.e. with no more than 20 or, at the most, 30 children in the same house. The object of such small institutions must be to create a substitute home with a definite rhythm in everyday life, as in a private home. All institutional routine of a collective character must be avoided. Bedrooms should be arranged as in private homes - large dormitories are at variance with the normalisation principle. Meals should be taken in the same way as in a private family, and life must on the whole be organised on a private-life pattern. This in itself is rather a revolutionary idea in many countries, not because of the principle itself, but in relation to what has been done for decades.

It also means that boys and girls should live at the same place, as they do in private homes, and that relations between children and personnel shall be warm and affectionate - the personnel endeavouring to do what the parents would do, without, however, trying to compete with the parents, who have by no means renounced their right to their children; on the contrary, they should visit their children as often as possible, have the children living with them during
holidays, week-ends and the like, wherever this can be realised. It presupposes a close co-operation between the institution and the parents. Where a child develops in such a way that it may return home, or where the treatment is completed, the child should, of course, return to his home: the basic principle is, as already stated, that the parental home is the best place for the child.

Several countries attach such great importance to this point that public funds, if necessary, will be available to the parents to enable them to keep the child at home. In addition, child and parents are offered expert advice, e.g. visiting nurses, therapists, social workers, etc., who all make it their business to contribute to the child's well-being in his home.

In most countries it is customary for a child to move from his parental home on attaining adult age, whether the move be to his own house, a flat, or a room. It is likewise right and proper for the mentally handicapped to move away from home when they reach adulthood, especially for the sake of the parents. Having a mentally retarded child is in itself a heavy strain, and it is not reasonable for parents to shoulder this duty longer than they do in the case of their other children. Moreover, the mentally retarded's development will generally be advanced when he moves away from home, inasmuch as experience goes to show that parents are apt to adopt an exaggeratedly protective attitude towards their mentally retarded child, an attitude that will not promote the child's self-dependence, but may keep him constrained in an artificial child-to-parent relationship.

The mentally handicapped person has now reached adulthood and must be treated as an adult, i.e. be accepted with an adult's characteristics, for instance, accepted also as a sexually developed adult. This latter problem is as a rule hedged with many deep-rooted prejudices, prejudices that are apt to be intensified in the case of handicapped people's sexual life. We do not propose here to enter into a detailed discussion on these problems, the elucidation of which would take some time, but confine ourselves to point out the importance of taking a natural view of the sex life of handicapped persons. They will generally be quite normally developed in this respect, and must be entitled to have a natural sex life.

Mentally retarded persons who have lived at home in their childhood will, because of their handicap, often be in need of help and support in so far as their housing problems are concerned. Some can manage their separate household. The requirement will be for small homes, nursing homes, hostels and the like, where the mentally handicapped can live in small communities. Here, too, a number of 20 to 30 in one place will be the maximum, seeing that the objective is to create a normal housing environment - and, at any rate, to prevent any institutional routine.

Experience, inter alia in Denmark, proves that it is no more, and rather less, expensive to build and run small units than the large institutions of former times.

Housing conditions of mentally retarded persons should be no different from those of other people; any departure from this rule should be made only where special reasons prove it justifiable. The residence of physically handicapped persons for instance, must be without, or with only few, stairs, and provided with corridors and doors that are wide enough to admit wheelchairs.

Bedrooms should be arranged on the customary pattern for adults and for children. Children in the Scandinavian countries generally sleep in one and the same room, for which reason our houses for the mentally retarded are provided with a maximum of four beds, even though there is a tendency nowadays towards separate bedrooms for children too.

It is, however, customary for adults to have separate bedrooms, so in consequence thereof modern housing for the mentally retarded is provided with private rooms, which can conveniently be used as sitting-rooms in daytime (bed-sitters).

Housing, more especially sleeping accommodation, will under the normalisation principle, be determined by the prevailing general housing conditions. However, when planning new buildings we should plan ahead and think of the future housing standard, not the present standard which will be more or less modified in step with developments in respect of housing.
Now turning to the second aspect of everyday life, work, we must once more distinguish between children and adults. Children's "work" consists of going to kindergarten and to school. Mentally retarded children should likewise be offered kindergarten, and they should be entitled to education.

The predominant element in a service system for the mentally retarded is education of the children. In this respect the mentally retarded have been neglected in many countries. General compulsory education has been limited to those who could learn to read, write and do arithmetic. It appears that children who are mildly retarded are able to learn the three R's, so this group has a clear right to be taught, but, as stated above, all children can be taught, and it must be the duty of every country to extend an offer of teaching to all children, irrespective of their mental development. It must be considered a human right to have access to education. Backward children are more in need of education than any other group, and investment in education is invariably a good investment. We have already demonstrated that invitation to spend the day in a kindergarten or day nursery is of pedagogical value to the children and a relief for parents who have their mentally deficient children at home. It is of importance that this pedagogical influence is brought to bear as early as possible.

Mentally retarded adults ought to have the same right to work and pay as other citizens. This often presupposes that they must be given preliminary vocational training, but many years' experience goes to prove that mentally handicapped, even severely handicapped, can be trained to work in modern industries to mutual enjoyment and benefit for themselves and their community.

That they should be paid in proportion to their performance would seem to be a foregone conclusion; many countries, however, have not lived up to this idea, but have exploited the mentally or otherwise handicapped.

As to those so poorly endowed by nature that they are unable to work, it must be the duty of the community to take care of them in a way commensurate with the normal standard of the community in question. This applies clearly to old mentally retarded people who must be offered conditions on a par with those of all other aged citizens in the country.

In this sphere application of the normalisation principle leads to different results in different countries and culture. In Mahomedan countries it is as a rule incumbent on the children to support the aged members of the family. Any mentally retarded members of the family will have to be supported according to the existing social and cultural pattern.

The third aspect in a normal existence consists in spare time occupation and recreational activities. It must be a natural thing for the mentally retarded to have the same access to leisure hours and to participate in such recreational arrangements as the community extends to all other citizens. I mention this specifically because all countries have at all times failed to consider the mentally retarded as persons who had a right to activities during their leisure hours. Games and sport, holidays, travels and so on were considered a luxury as far as the handicapped were concerned. Nowadays it must be an established fact that the mentally retarded are entitled to the same benefits as other citizens.

As stated in the introductory remarks, the normalisation principle is essentially a corrective to the former negative discrimination of mentally handicapped as a body. The normalisation principle simply means that all citizens shall have equal access to the same benefits. On this principle all problems of treatment of the mentally retarded can be solved. I have in the preceding exposition given a broad outline of the rights to housing, work (training and education) and leisure, and now propose to give a brief account of the right to special treatment, which is also a consequence of the normalisation principle.
The mentally handicapped are essentially ordinary people with ordinary civil rights who happen to have a handicap; indeed, the majority of them are multi-handicapped.

Modern health and social policy makes it a rule that the citizens are entitled to treatment for diseases and weaknesses. In the more advanced countries this service is performed free of charge or it is part of a health insurance system, where all citizens are offered medical and hospital services on an insurance basis and at a price within the means of all concerned. This service may consist in treatment of common diseases or in specialist treatment. Mentally retarded persons are in need of specialist treatment, and it is therefore in consequence of the normalisation principle that mentally retarded persons shall be offered specialist treatment. This treatment may be of different types and in principle comprises special education.

As stated above, modern science has opened up new vistas for treatment methods, and we may expect in the coming years to see a marked development of these comparatively recent discoveries. Whereas developments concerning housing, working and leisure conditions will consolidate the similarity of existence in these respects of the handicapped with that of other members of the community, we may look forward to a great acceleration of developments in such spheres as specific treatment and special education techniques.

It is of importance for planning to distinguish clearly between the housing situation and the treatment situation. By way of example, in many countries it was customary in the past to make mentally retarded children live in boarding-schools, where residence and education were inseparable, as a rule without clear distinctions as to time and place. Today, day schools for the mentally retarded are built all over the world or special classes are arranged in ordinary day schools. The handicapped children live in their own homes wherever this is feasible, or in small family-like institutions. The children in these small institutions leave their living quarters in order to go to school, and go home after school-hours - just like all other children. A matter of course, you will say. Yes, but a matter of course which as far as the mentally handicapped are concerned was not clearly realised until after the Second World War.

Institutes for special treatment of a medical nature will become necessary, but here, too, a distinction must be made between housing and treatment. If hospitalisation is required, which will often be the case, it must be with a view to discharge as soon as the treatment no longer demands hospitalisation. This, too, is self-evident, but was not put into practice for decades.

In relation to specialist treatment it is natural to discuss the question as to whether it should be voluntary or compulsory. The old protectionist principle often tended to coercive measures under which the mentally retarded against their will were placed in institutions, where many of them remained for the rest of their lives. The segregation conception even led to removal on principle of mentally retarded children from their parents. In many countries there still exists a fear stemming from that time that mentally retarded children may be taken away from family care and installed somewhere away from the home. The normalisation principle clearly indicates that handicapped children wherever possible should live at home with their parents, and that handicapped adults should live in the same way as other people do. This, then, means that the services should in principle be voluntary. The principle of equal legal status with other people - e.g. right to training and education - and regard to the individual handicapped person's development will in concrete cases operate to modify the voluntary principle. The right to be taught means eo ipso that he who fails to accept this offer and thus neglects to qualify himself for some kind of employment must be obliged to have tuition, and compulsory education ought therefore to be extended to the mentally retarded, too; in other words, it must be incumbent on the public authorities to offer education; but for the mentally handicapped it is a right to education, which may become an obligation on the part of the individual person to accept the offer. Correspondingly, it must be an obligation on the part of the individual person to submit himself to such treatment as must be presumed to improve his condition. The United Nations Declaration of Human Rights sanctions these forms of compulsion.
With the normalisation principle in view the services extended to the mentally retarded should be given by the established social authorities to the exclusion of any formation of special administrative organs for the handicapped. This means that in its planning the Ministry of Health shall provide for medical treatment of the mentally handicapped (and other groups of handicapped), that the Ministry of Education shall provide for the education of all mentally retarded as an integrated element in the educational system, and that the Ministry of Labour and Social Affairs shall plan occupational training and rehabilitation facilities also for the mentally retarded (and for other groups of handicapped).

In many countries these ministries have as a first step planned for so-called normal citizens, and then, as a kind of ambulance service, continued by providing facilities for the handicapped. The mentally retarded constitute, as repeatedly stated, a natural part of the population, and the general planning must therefore include services for these people. Seeing that mental retardation in the nature of things presents problems which - cf. above - involves three ministries, it would be reasonable to establish an inter-ministerial co-ordinating body or committee; and as experience shows that the mentally retarded are after all a weak group it would be advisable at any rate during the early planning period to place the responsibility for adequate services for the mentally retarded with a specially appointed person or administrative body who in respect of both planning and implementation should be responsible for the co-ordination of the multi-disciplinary team work involved.

Realisation of the fact that this sphere of activity cannot be covered by one discipline (because it is by its very nature and in general multi-disciplinary) is perhaps the most important achievement within this field for many years.

This is clearly apparent in WHO Technical Report No. 392.

Danish legislation on mental retardation has on this point drawn a very clear conclusion as regards to administration, in that a multi-disciplinary collective leadership has been set up in each of the administrative service districts - a leadership that is jointly responsible for the execution of the welfare services. This leadership consists of a medical officer, an educator, and a social worker, and as technical administrative executive an inspector versed in economic and administrative matters. The old system under which an expert for instance a physician, was solely responsible for the administration, was abandoned long ago.

Organisation of Services for the Mentally Retarded

The Central Administrative Organisation

Services for the mentally retarded are organised in different ways in the countries having such services. In some countries the whole responsibility rests with the State; in other countries the responsibility is shared by the State and the municipalities, and in most countries, moreover, private initiative contributes to the efforts. History tells us that the pioneer work has in many cases been based on private initiative.

When services for the mentally retarded are to be established the administrative structure etc. of the country concerned must, of course, be taken into consideration.

However, certain basic views will probably always apply regardless of the administrative structure of the country, and it is especially important for countries confronted with the task of building up such services to ensure that the mistakes made by other countries starting at an earlier date and on a different background are not repeated.

The mental retardation policy characterised by protectionism and segregation which was generally pursued up to the middle of the twentieth century in many countries resulted in the establishment of a special organisation of services for the mentally retarded, either under the Ministry of Health, the Ministry of Education, or the Ministry of Social Affairs. A special organisation of this type, generally associated with a special legislation, has, of course,
its advantages, seeing that such systems may contribute to accelerate developments within this limited field. On the other hand, experience shows that special systems will often result in segregation, which is generally characterised by a negative aspect. Consequently, special services and special legislation for the mentally retarded will frequently result in the mentally regarded not being placed on an equal footing with other population groups with respect to civil rights in their widest sense.

It must therefore be recommended that the organisation of services for the mentally retarded and the necessary legislation on the rights of the latter should form an integral part of the general legislation of the country. This also means that the planning of facilities etc. must form a natural part of the national planning in general. Other experience goes to show that services for the mentally retarded should be based on an inter- or multi-disciplinary cooperation between a number of professions. As repeatedly stressed in WHO Technical Report No. 392, the problems relating to mental retardation are so comprehensive that they go beyond the competence of any single profession. The professions traditionally dealing with mental retardation comprise doctors (particularly paediatricians, psychiatrists and child psychiatrists as well as neurologists), psychologists, educators, and social workers. The ministries which either fully or partially have administered these services are the Ministry of Health, the Ministry of Education, and the Ministry of Social Affairs. Co-operation between these three ministries and their experts is imperative.

In many countries the Ministry of Health has considered the organisation of services for the mentally retarded its natural responsibility. This is due to the fact that mental retardation is sometimes looked upon as a disease and that parents, owing to the pathological phenomena often associated with mental retardation, will apply to their doctor for help. However, the majority of cases of mental retardation are not pathological cases but cases of backwardness, which may be influenced by educational stimulation in childhood. As far as adults are concerned, mental retardation to a higher degree is a question of social adjustment. It is therefore of primary importance that the mentally retarded should be given an education and training, which means that the most essential effort should be made by the school authorities and the authorities responsible for social rehabilitation. It is here assumed that assistance is rendered to the mentally retarded in need of special medical examination and treatment via the ordinary health service system (including mental health) and that the service offered in schools, rehabilitation centres, institutions and homes, is rendered under sufficient medical supervision.

The following distribution of responsibility between the three ministries is suggested.

It is the responsibility of the Ministry of Health to ensure that experts acquainted with mental retardation - etiology, treatment and prevention - are available within the ordinary health service system.

The prenatal, paranatal and postnatal service must be alive to the problem of mental retardation.

Special hospital departments or units should be established in existing hospitals, provided with a skilled medical and nursing staff as well as with the technical facilities required for making a differentiated diagnosis and offering the treatment required to prevent mentally retarded persons from dying, their condition from worsening considerably, or additional complications connected with their mental retardation from arising. An adequate number of medical experts must be available for kindergartens, schools, rehabilitation centres, institutions and homes catering for mentally retarded persons. These experts should be in charge of the medical supervision and co-operate with the other responsible executives of the institution concerned.

It is the responsibility of the Ministry of Education to ensure that education is offered to all children and young people. The old concept "compulsory education" should be replaced by the concept "right to be given an education", which means that the Ministry of Education has a duty to see that the necessary institutions are available. Mentally retarded children form a natural part of a population. They should have a right to education, and as a rule they will need instruction for a longer period of time than other children.
This applies to all mentally retarded children, also to those who formerly were considered non-educable. The instruction should be adapted to the children's abilities and intelligence level and should, among other things, to a great extent be aimed at a training in daily living activities, such as going to the lavatory, dressing and undressing, eating and general adaptation to social life.

These functions may as a rule be performed in day schools and day kindergartens, but in so far as some of the mentally retarded children are concerned it will be necessary to establish small homes, from which these children go to school, kindergarten etc. (Old-fashioned boarding-schools where the children live and receive their education in the same premises are generally incompatible with the normalisation principle, but are acceptable in communities where the boarding-school system is a normal principle for other children, e.g. as in the United Kingdom.)

Any adult education offered should also comprise the mentally retarded.

As previously mentioned, there is, however, a great need for long-term education of the mentally retarded, which has led to the result that in most Scandinavian countries there is now compulsory education (right to be given an education) for mentally retarded persons up to the age of 21-23.

The Ministry of Social Affairs is traditionally responsible for establishing and running the requisite number of homes or institutions for children and young people having no home, or whose parents are unable to keep the children at home. These institutions are not hospitals but substitute homes. Similarly the ministry is responsible for ensuring the availability of homes or institutions for persons (in the present case mentally retarded) who for reasons of security (criminals) cannot live in the community or, with a view to their development, have to be institutionalised against their will. These cases are few and especially comprise MGs. The necessary legislation guaranteeing the legal rights of such persons should be provided on the basis of the normalisation principle which means that handicapped people and other persons should be given the same legal status.
7. Social Aspects in the Rehabilitation of Mentally Handicapped Persons

by

Esko Kosunen, Chief, Rehabilitation Unit for the Disabled, United Nations

The United Nations General Assembly, during its 26th Session in New York, is expected to discuss a draft declaration on the rights of mentally retarded persons, submitted to it for final approval by the Economic and Social Council. This presentation will be largely based on the text of that draft declaration (see pages 52-53), particularly on the social elements contained therein.

The purpose of the declaration is to guarantee to mentally retarded persons the same rights that their co-citizens enjoy in the community - with certain limitations. These are basically the same rights that have been proclaimed in the Universal Declaration of Human Rights as well as in the Declaration of the Rights of the Child to be the rights of all human beings, including children, without any discrimination. The draft declaration I am speaking of would make it clear that these rights expressly also belong to mentally retarded persons and makes specific points in this regard.

The following rights amongst those proclaimed in the draft declaration might be considered in relation to the subject, "Social aspects in the rehabilitation of mentally retarded persons": rights to

- economic security;
- a decent standard of living;
- productive work;
- family life;
- participation in all aspects of community life;
- protection from exploitation, abuse and degrading treatment.

1. Economic security - decent standard of living.

What is meant by these concepts in this connection?

They do not give very precise advice to governments as to what is meant by "economic security" or what the term "decent standard of living" implies in any given situation. Apparently these concepts are to be considered against the background of the community where a mentally retarded person is living. What is needed for economic security in that community, what is regarded as a decent standard of living in that community, the same should be guaranteed to mentally retarded persons.

2. The draft declaration refers to one of the normal means through which economic security and a decent standard of living can be achieved, namely stating that mentally retarded persons should also have the right to perform productive work or to engage in any other meaningful occupation.

How far is it possible to go in this respect?

Obviously, if there are in a community a large number of people without the possibility of performing productive work, it is hardly reasonable to claim that the mentally retarded persons - or disabled persons in general for that matter - should be singled out and be provided with some kind of productive work before all other members of that community. So, what is reasonable to expect for other members of any given community in this respect, that is what the mentally retarded persons have a right to expect for themselves. Obviously there are certain other conditions to be met too before these persons can be considered for productive work: they must have been provided with such education and vocational rehabilitation to enable them to use their capabilities to the fullest possible extent.
We may make here a distinction between productive work and meaningful occupation, as is done in the draft declaration, and state that although productive work is not available to all members of the community, there are usually those jobs that might be termed as meaningful occupations, in which many members of the given community are normally engaged in their daily routine, e.g. taking care of the house, of family members, of the land belonging to the family, of animals, of collecting fuel needed in the house, etc. I assume that this kind of activity, though not remunerative, is most useful and considered as an essential part of every-day work. Maybe, primary efforts in rehabilitation of mentally handicapped persons in developing countries should be concentrated on preparing them to participate in these kinds of activities with the rest of the family, thus helping the family to maintain a decent standard of living for the family as a whole. In fact, this kind of meaningful occupation might be considered as very productive work in the conditions prevailing in many developing countries.

3. This last-mentioned arrangement would also fulfil another requirement of the draft declaration, namely the right to family life.

Whenever possible, mentally retarded persons should live with their own families and should receive the necessary social rehabilitation to make it possible. In addition, the rest of the family should be effectively advised on how to maintain the mentally retarded person's ability to stay with the family.

Accordingly, the total social rehabilitation process requires:

(a) measures that aim at the social integration of mentally retarded persons into the family and community; and

(b) measures that aim at "rehabilitating" the family to accept, help achieve and maintain that integration.

These are no easy tasks. They cannot be fully accomplished outside the community and family sphere, for instance, in an institution where the mentally retarded person may be given a part of the necessary rehabilitation. The rehabilitation process needs to be taken to that person's home - eventually to a foster home - and it may be a lengthy process.

In this connection, reference is made to the role of the social worker. As his/her ordinary duty requires visiting the families who may need community assistance, he/she often has to deal with problems related to the presence of a mentally retarded person in the family home. To enable social workers to fully perform their share of the total rehabilitation process, their training of course should include adequate preparation for that task. Perhaps this training course should pay some attention to this problem and recommend measures that should be undertaken in developing countries in this respect.

4. Not only does the family of a mentally retarded person need to be "rehabilitated", the community as a whole needs to be prepared to accept the participation of such persons in all aspects of community life as is required in article 4 of the draft declaration. Without this, the integration of mentally retarded persons into the community can scarcely be contemplated.

The concept "all aspects of community life" may embrace many factors depending particularly on the nature of the community concerned. In a well-developed urban community its normal life includes such activities as arts, entertainment, religious services and other church activities, sports, etc., while in an isolated rural village there may not be much community life so to speak outside the daily work activities that are necessary to keep the members of the community alive.

But whatever community life there is that the members of the community commonly attend, mentally retarded persons in that community should be allowed to participate in it. And not only that - as part of their social rehabilitation program they should be motivated and encouraged to participate and their rehabilitation should aim at preparing them to be able to do so. Such participation in various activities with other members of the community in fact means continuation of the rehabilitation process. It is a lifetime process.
But here again, we encounter the manpower problem: whose duty is it to ensure that wherever possible mentally handicapped persons are capable of participating in community activities and of preparing the community to accept that participation and help it continue? With the shortage of adequately trained personnel in developing countries, how can all this be accomplished (a) in an urban setting, (b) in rural villages? Perhaps you may wish to pay some attention to such a problem during your discussions here although it is somewhat outside the scope of the subject of this training course.

5. Successful integration of mentally handicapped persons into the community would no doubt also help eliminate the possibilities for their exploitation and abuse at least to some extent. But we all know only too well that with the exception of very few societies, the integration of mentally handicapped persons into the community has not yet reached such an advanced stage and that there is a real danger of exploitation and abuse.

What should be done to protect the mentally handicapped from exploitation and abuse?

This is certainly a very complicated problem and I shall only briefly mention some aspects of the problem which are referred to in the draft declaration.

First of all, the appointment of a qualified guardian when this is required could provide sufficient protection in this respect and the draft declaration states that mentally retarded persons have a right to such a guardian (article 5). What is considered "qualified" in this connection needs to be well defined. In addition, it may be necessary to make the appointed guardian responsible for reporting on his action to a public authority. After all, we probably all know of instances where guardianship has been used for exploitation and abuse and not for protection only.

Institutionalisation could be considered in some cases as a protective measure. At least it would accomplish an effective separation of the mentally handicapped person from those who might have used him for exploitation. Institutionalisation has its disadvantages, however, and has not always been free of exploitation and abuse either. It should be considered as a temporary measure and the position reviewed at regular intervals. One and the same type of institution cannot cater to all the different individual needs of the mentally handicapped. Ideally, there should be a range of various types of institutions with different programmes and goals. But it must be admitted that funds will not be available in developing countries in the near future for any radical improvement of the system of institutions.

In conclusion, I wish first, to emphasise, as does the draft declaration, the value of family life in social rehabilitation of mentally handicapped persons. I believe that a successful integration of the mentally handicapped into family life is a key to the success of many other measures that may be considered, for instance, of any vocational rehabilitation programme. There needs to be a firm and solid base from which new efforts can be launched to keep pace with whatever progress may have been made in his social rehabilitation.

It is admitted that not every mentally handicapped person can successfully stay with his own family throughout his lifetime. A foster family can of course be a good substitute if carefully chosen. Even an institute can overtake the role of the family but then, I believe, the present system of institutions needs a very thorough overhaul in most countries, so that institutional care could be provided "in surroundings and under circumstances as close as possible to those of normal life" as is required by the draft declaration (article 4).

Secondly, I should like to underline the importance of preparing the members of the family or foster family to assume their role in the continuing process of maintaining mentally handicapped persons' ability to stay with the family. Here we are faced with a serious manpower problem: where is it possible to find the necessary personnel to work with families, to educate the community, to man new types of institutions that may be developed and to supervise the progress that may be made in each individual's rehabilitation process? We know that developing countries have a shortage of most categories of adequately trained personnel. Which of those that are available at the village level could best serve the
purposes mentioned and what kind of additional training and preparation do they need? What could be the role of various international organisations in the process of preparing personnel for rehabilitation of the mentally handicapped?

Perhaps these questions need further discussion at the international level since they may go partially beyond the scope of the present Seminar which deals with vocational aspects of the problem.
I was asked to speak about the methods, purpose and value of intelligence testing, and first of all I propose to deal with the purpose of the subject. What are our aims when we use a test? I think it is true to say that we administer psychological tests in order to obtain an assessment or estimate of our clients. In doing so we indicate a human relationship of inequality between ourselves, who possess the power to test, and other persons, whom we treat as clients to be tested. Some psychological tests have been designed to elucidate the total personality of the client, but our concern here are those tests designed to indicate the level of intelligence.

There are three prerequisites which must be fulfilled if the use of intelligence tests is to be meaningful.

Firstly - and this is concerned with the purpose of testing - we must be in a position where it is important for us to know what our client could yield in a given situation, structured by means of an intelligence test. Let me give two examples. One instance would be that of determining eligibility for admission to an on-going programme of education or training. If we are dealing with a programme for the mentally retarded we should need to decide not only whether our client is retarded to a degree that he would be entitled to be enrolled in the special programme, but also whether he is sufficiently developed to be able to benefit from it. Another instance would be the case of a client accepted for some form of care or treatment, our task being to determine what kind of support would benefit his actual well-being and further development.

Secondly - we must master some methods that provide an estimate of the level of intelligence of our client. That is to say we must select some of the many methods available and get to know them so well that we become really familiar with the way they are presented and the way they are scored.

Every method of psychological testing includes the collecting of data related to the client's behaviour when certain tasks are presented to him. Later on I will describe some of the tasks used in intelligence testing and the reasons for using them, but here I would just mention that some tests are so designed that the collecting of data takes place in a direct person-to-person situation between tester and client, whereas the situation in other tests is so arranged that the tester needs not to be confronted with the client all the time. I myself prefer to have this confrontation, using the test-situation as a formal framework for meeting my client.

To score what our client yields in a test-situation involves the collecting of data through formalised statements about his behaviour in that situation. And in learning to administer a test we must acquire a systematic method of recording observations of the client's behaviour - or some consequences of this behaviour such as drawings he has made.

In many different intelligence tests the scoring could be summarised as a profile in which the results relating to different areas of function are separately indicated, supplemented by a total score in which the area scores are taken together. One method of indicating these results is through the mental age, that is the age at which normal children would be expected to yield the same score. Another method is the percentile approach which indicates what percentage of the population of the same age would be expected to achieve lower scores. I think many statisticians would prefer the percentile method whereas I myself - for reasons I will explain - find the mental age approach most meaningful.

I spoke about three prerequisites essential to the meaningful use of intelligence tests. The first was concerned with the purpose of testing, namely the use of tests to determine admission to programmes or the planning of treatment. The second was concerned with the methods of testing, especially the application of the tests and a thorough understanding of them. Now the third prerequisite I wish to stress is related to the value of the tests
themselves or more precisely the practical value of the test results. These results could be misleading unless certain precautions are taken. Such precautions include the careful observation of any abnormality which may indicate that the test results are not an adequate expression of the psychic potentialities of our client. In this connection we should take particular note of:

- any hearing or sight defect in our client;

- speech defect or unco-ordinated movement of the designing hand, as in some cases of cerebral palsy;

  (In these circumstances, testing should provide opportunities for the client to compensate for such defects.)

- signs of fatigue or illness;

  (In such cases, consideration should be given to postponing the test, particularly if the illness is likely to be of a temporary nature.)

- disturbed or abnormal behaviour, as in a psychotic person.

  (Such behaviour should be noted, including obvious avoidance of correct answers to questions.)

In the majority of cases coming to us for testing, however, there are no obvious abnormalities and so we can assume that the scores achieved give a meaningful indication of the intelligence of our client. But what do we then mean by intelligence?

I would say that assessment of a child's intelligence, including that of a pre-school child, through testing procedures is entirely relative. In other words, it can be defined, not in the same terms as intelligence relating to normal adults, but as different developmental steps through which ordinary children pass in controlling their own behaviour before they reach adult intelligence.

Adult intelligence has to do with knowledge, how it is arranged, how it can be modified and how it becomes activated. A good adult intelligence thus indicates a comprehensive body of knowledge, which is not only relevant to the society in which the person lives, but which is also well organised, easily activated and ready to be adapted in a flexible way to new sensory stimulation.

(A person who shows a specially good adult intelligence can be said to be highly intelligent. If this same person is transferred to another society in which his knowledge is no longer relevant, then he cannot claim to be of good adult intelligence within the new society; however, providing he is not overwhelmed by the new conditions he encounters and is able to modify his thinking and former knowledge, this in itself is proof of his intelligence.)

The society in which we mature offers us specific tools which facilitate the systematic accumulation of knowledge:

- a verbal language with meaningful sequences of words; and

- a structure with spatially arranged geometrical shapes.

In the intelligence tests constructed by Wechsler, a rough profile is indicated which comprises just two major area scores, a verbal and a non-verbal or performance score.

The distinction between these two areas of function is not clear cut - many clients tend to use words in their thinking when they are faced with some of the non-verbal tests - but, nevertheless, it has been clinically confirmed that damage to the dominant half of the brain - usually the left side - which perceives language and controls verbal behaviour and movements of the right hand - manifests itself in a low verbal score, whereas damage to the other side which perceives shapes and spatial relations gives a low performance score.

A third tool which is also indispensable in acquiring ordinary adult intelligence is concerned with the short time storage of actual input. This
facility is not supported in its development by other people in the same way as our language and the geometrical shapes, but is inherent to a greater or lesser degree in each of us. If I refer verbally to three digits and ask you to repeat them immediately, all of you who listen to me and accept the request will be able to do so. For example, if I were to say "two - eight - five", all of you could repeat this without any difficulty. The same would be true for an ordinary child of three, but there would be some time during his third year of life when he could repeat one or two digits but not all three. And many mentally retarded children who at the age of eight years or more have attained a use of language and a mastery of shapes as would an ordinary child of four or five would still be unable to achieve the input storage which is necessary to hold and retain and tell all three digits.

In administering an intelligence test therefore to a mentally retarded client we cannot think in terms of some very complicated challenges to adult intelligence and then present them to our client. Rather we should follow the lines, originally proposed by Binet, and present different tasks that give an indication as to what stage of development our client has reached on the path towards normal adult intelligence. This, in effect, means that we must present tests concerned with use of language, reproduction or rearrangement of shapes and short time storage of auditory input and describe the result in terms of a mental age. A mental age, in fact, is not an age but a behaviour - the behaviour characteristic of an average child of that age. Even if the behaviour of ordinary children varies widely, their development to adult intelligence in our culture is so similar that it is meaningful to speak about the behaviour characteristic of an average child of a certain age and use that to describe a developmental level.

Among tests that combine verbal and spatial tasks are the different versions of Binet tests, in which the tasks are mixed together; also the Wechsler tests, in which, as I have already mentioned, a verbal score and a performance score are indicated separately. Particularly verbal is the Peabody picture test; a broader description of the level of development of language in a child is obtained by means of the Illinois Test of Psycholinguistic Abilities. Other tests which are entirely non-verbal are the Hasty picture completion, the Leiter, the Goodenough draw-a-person, the Bender gestalt and the Raven progressive matrices. The latter operates with shapes and comprises tasks that challenge high intelligence in adults; most of the former-mentioned tests would differentiate most precisely at mental ages below ten.

Rather than give more examples of testing methods I will now proceed to the question of the value of a test result.

Having taken precautions to avoid misleading results and on the understanding that our client is not psychotic, then a test result could be seen as a fairly adequate indication of the actual intelligence-developmental stage of the client. If the resulting intelligence age is found to be rather low, there may be a tendency on the part of some people to regard this as an insult to the client and to try to find excuses for his poor performance. This to me is a position of prejudice. Some clients are severely retarded and we cannot escape this fact; our task is not to try to conceal their retardation but to discover what are the possibilities of a meaningful life for them, even at the range of low intelligence ages, and thus provide them with opportunities to realise such possibilities.

Now it is known that in underprivileged populations many children will show a progression in intelligence age which is much slower than it could have been if more intensive stimulation, adequate for early intelligence development, had been provided. But it is also known that many children do survive from damage to or disease of the brain which develops its capacities rather slowly, even when stimulating conditions are ideal.

Of course, to state that a mentally retarded client has the mental age of say four years is by no means the complete picture. If a test profile is added we could no doubt qualify our findings; perhaps we should find the sub-test scores so varying that it seems arbitrary to indicate a common score. If, moreover, the client has reached puberty this means some new dimension of adult self-regard to his personality, and so it becomes less meaningful to speak of his intelligence age as a mental age.
We often speak of an intelligence quotient. I would like to emphasise that no intelligence test has the capacity to disclose such a quotient in a child. What I mean simply is that the quotient of a child is between an intelligence age and a calendar age, and the latter cannot be found in a test; somebody — perhaps the child himself — must indicate his date of birth and we must know the day the testing was done. In people above the age of 15 the denominator of the quotient is usually taken to be 15.

When we have this information we can easily progress from intelligence age to quotient and vice versa, so it is not very important if we speak of the intelligence age or the quotient. (As you probably know, the quotient is calculated by multiplying the fractional difference between actual and mental age by 100, e.g. the quotient of a child age 12 with a mental age of 6 is 6 divided by 12 and multiplied by 100 which gives a quotient of 50.)

Dealing with mentally retarded children, one sometimes indicates the number of years the mental age lags behind the calendar age; but expressed in this way, the developmental gap becomes bigger and bigger as the child gets older, even in cases when the quotient is relatively unchanged. The actual development of many moderately and severely retarded children is such that the quotient also is found to diminish. With good stimulation such a child could for instance reach intelligence age four before he is eight, thus achieving a quotient of more than fifty, but the further development of intelligence will proceed so slowly that at calendar age 15 he has only reached an intelligence age of, say, five or six, the quotient thus having fallen to 33 or 40.

Speaking of the intelligence age we usually have progress to report, even if it may be very limited. Another advantage of the intelligence or mental age is that it gives some guidance to the kind of educational stimulation that would fit the child. And the idea of 100 or more as an indication of a good quotient and thirty as a bad one need not be so discouraging if we do not primarily speak about the quotient.

We could look at the result of intelligence testing in pragmatic terms as a profile or a common score. But if we do the testing in a person-to-person situation we could also regard the result as a contribution to our own image of the particular client. If this contribution to our image of the client could be utilised in his favour, I find it meaningful to do the testing.

Much of course depends on the tester himself. The dangers of preconceived ideas and prejudices are all too obvious. Our aim and purpose in testing must always be creative and constructive, helping our clients to achieve a better life through realistic guidance and encouragement.
9. Pre-Vocational Preparation and Counselling of Mentally Retarded Children and Young People

by

Francis X. Lynch, Director,
Division of Developmental Disabilities
Rehabilitation Services Administration
Social and Rehabilitation Service
Department of Health, Education, and Welfare

Introduction

What does it take to hold a job in the world of work? Ability to perform certain tasks, yes; but far more. It takes certain attitudes: appreciation of and respect for, a job; willingness to accept responsibility (even if it is for mopping floors or loading trucks); ability to get along with others; capacity to manage the details of life (getting places, being on time, handling of money, etc.).

Long, long before the prospective retarded employee is a candidate for the open or sheltered labour market in a world not attuned to accept him, his training and counselling should have been carried on in an informal and formal basis.

Too often, positive attitudes and work habits are not taught early enough to the retarded. They usually are added as afterthoughts to a curriculum.

Rather, they should weave their way through the education of the retardate, from his earliest days onward.

The United States Government appropriates billions of dollars annually to habilitate and rehabilitate the mentally retarded and other handicapped individuals. Now it is reaching down to the very young and up into the ranks of the elderly with programmes to solve their problems of adjustment.

And the effort is not entirely vocational - for social, emotional and educational adjustments are included in the federal authorisations to provide financial support for assisting agencies, schools, institutions, and private non-profit organisations at state and local levels to help mentally retarded persons develop as normally as possible and take their place in the community, industry, or (if necessary) in a sheltered setting.

Training

Training should begin very early - and the younger the client - the more unstructured will be the training.

Training may take place in the home, the pre-school and day activity centres, the special classroom, the institution, the vocational training centres, sheltered workshops, and even with generic services in the community.

Federal financial assistance for these training programmes is given through the medium of awards (grants) for research, training, and services.

It is available for programmes serving all ages and to persons with all degrees of handicapping conditions.

And it is available under several laws of the United States Government focused on a particular population group (or groupings) and stressing specific activities for that population group.

It is possible under certain conditions for a recipient of services to be eligible for services under more than one law, and under more than one department of the United States Government.

The mentally retarded, for example, may receive vocational benefits under the Vocational Rehabilitation Act, the new Developmental Disabilities Services and Facilities Construction Act, the Social Security Act, the Vocational Education for Handicapped Children's Amendments to the Vocational Education Act of 1963.
Then there are laws which benefit the mentally retarded's vocational training indirectly through financial and medical assistance to them and their families, and through training of personnel to work with them.

The programmes developed under this assistance reach down to the younger retardates in institutions as do the projects of the Office of Education in the school systems.

With two programmes for the disadvantaged, "Head Start" and "Model Cities" and the provision for day-activity centres for the very young mentally retarded and otherwise developmentally disabled, a beginning has been made in catching the younger mentally retarded individuals in the poverty sections where most of the retardation is found.

Historically

When the Vocational Rehabilitation Act was passed in 1920, the mentally retarded individuals and otherwise handicapped were not thought of as capable of entering into the rehabilitation process, and to think of wasting time trying to rehabilitate the institutionalised was unheard of.

But, we had a president and a vice-president with mental retardation in their families. The condition was not hushed up. It was talked about.

Congress passed the Mental Retardation Act in 1963 which, when joined to the provisions of the Vocational Rehabilitation Act (especially the expanded amendments) and the Vocational Education Act provided a tremendous impetus for the development of services to the mentally retarded.

We had improved communications - radio and television were bringing messages to the public - messages about neglected segments of the population, some housed in obsolete, unsanitary facilities and forgotten.

And the public, with its growing social consciousness, was listening.

So, today, we are thinking of institutions not as places where the mentally retarded can be placed and forgotten, but rather facilities where the retarded will receive training for successful living within their physical, social and vocational potential - as we already have learned in many cases - can go on from the institution to dependent or independent living in the community.

Let's start with the state institutions' programmes and see how they prepare the residents through training and counselling for the labour market.

Pre-Vocational Counselling in State Institutions

Since 1964 we have had a hospital improvement grant programme designed to assist state institutions for the mentally retarded to improve their care, treatment, and rehabilitation services.

This programme benefits the residents of state institutions only and will continue under our new and expanded legislation, the Developmental Disabilities Services Act of 1970.

An analysis of the current hospital improvement projects shows that the majority of the projects are focused on improving long-term care and treatment, and many involve services to residents functioning at severe and profound levels of retardation.

In the past few years many projects have emphasised training in basic living and social skills, and placement preparation.

In fact, through arrangements with the state vocational rehabilitation staff, counsellors may make regular visits to the institution. Some institutions even have full-time vocational counsellors on the staff.

Let me give you an example of pre-vocational counselling in a state residential institution.
This particular institution has two distinct pre-vocational programmes; one formal, and one informal.

The formal one is for severely retarded youngsters and adults and lasts about a year for six hours a day, five days a week.

The intent of the programme is to teach greater work tolerance, manual and finger dexterity, and develop the ability to do simple tasks.

From this programme the residents on the programme move into the sheltered workshop.

When we consider that over half the number of residents in state institutions for the mentally retarded are children, it is particularly important to start them on a habilitation programme in the early years. Each programme should be individualised and include, besides promoting physical and mental health and developing social amenities, the continuing assessment of the progress being made towards realisation of vocational goals.

The younger the child, the more informal the programme.

The informal programme in this institution is for the mild and moderately retarded youngster. In this, the home setting is simulated. A child of five, for example, may be told to empty the waste basket and he repeats the task until he does it correctly and accepts the responsibility for doing so.

An eight-year old might be told to make her bed, and this assignment will be given to her until she does it correctly and accepts it as a "work responsibility".

As they grow older additional tasks are assigned them, and then — at age sixteen — they are ready for the preplacement cottage programme. The average stay in this facility is nine months.

While in the cottage programme, the retardate gets tried out working in several departments — laundry, kitchen, medical, etc. — and the idea is to see which one he does best in and where his interests lie.

He is given a six-week evaluation, taught proper work habits, and receives thorough counselling.

Then he is, as a rule, considered ready for the labour market — in the open market or in sheltered employment.

Once the resident is prepared for the labour market in the preplacement cottage (or other similar programmes being carried out throughout the United States) or — as in many cases — the move to community placement is more abrupt, we find that there is a shortage of suitable living facilities for mentally retarded individuals, and/or even a shortage of suitable jobs.

As the resident moves towards the community there should be a gradual change in the environment giving the retarded individual opportunities to express independence or semi-dependence while still on the institution's grounds.

Even after community placement it is helpful for the retardate to continue his relationship with the counsellor at the institution. He will have problems of adjustment, and it is essential that he continue his institutional contact — at least on a transitional basis — with the counsellor with whom he has established a satisfying relationship.

Co-operative Vocational Rehabilitation School Programmes

The specialised vocational rehabilitation staff working with the mentally retarded has been particularly effective in the development of co-operative vocational rehabilitation school programmes designed to assist the retarded young person make a satisfying transition from school to work.

These co-operative school programmes are found in many communities throughout the country and have greatly strengthened both special education and vocational rehabilitation efforts with the mentally retarded.
The co-operative programme structure varies from state to state, and the variety of approaches is extraordinary. In some states, programme administration is statewide and in others there are individual agreements with individual school districts.

Some programmes function only to serve the mentally retarded, while others include youth with all kinds of disabilities. In some states, only vocational rehabilitation and special education are administratively involved, while other representation includes vocational education.

Most co-operative arrangements have brought about the development of vocationally-oriented curricula within the schools. All of them, however, provide for a comprehensive evaluation of the retarded young person's vocational rehabilitation potential; the provision of personal adjustment and pre-vocational training; counselling; on-the-job training and work experience; job placement, follow-up and related vocational rehabilitation case services.

The number of retarded young people enrolled in co-operative vocational rehabilitation work-study programmes is increasing steadily as new programmes are developed. These co-operative programmes have proven themselves effective in reducing the school dropout rate of retarded youngsters and have provided a technique for continuous service to youngsters during the school years when they are best able to benefit from them.

Federal financial participation in the training services grant programme may assist in the cost of such services as training in occupational skills, work evaluation, work testing, and the provision of occupational tools and equipment necessary for training purposes, and job tryouts.

Whether pre-vocational counselling goes on in the school or in the institution there are factors affecting the counselling programme that can promote or block the retardate's rehabilitation.

What Goes into Pre-Vocational Counselling?

A broad criterion in predicting "vocational success" for the retarded is needed. There are many criteria for success or failure for the retarded; each with its own determiners.

The counsellor for the young as well as the adult retardate must weight many factors in predicting success for his client. This judgment must be essentially clinical in nature, and he will be wise to use assessment data more as a measure of present rather than future performance.

From our research studies we've learned the measures of work efficiency and social competence are better guides to the next step in training rather than to long-range, future plans. Therefore, repeated assessments are needed as the client progresses.

Furthermore, intelligence tests cannot be used with any precision in predicting success of retardates nor even as a sure basis for classifying retardates educationally.

Manual dexterity and social maturity as measured by the Purdue Pegboard Test and the Vineland Social Maturity Scale are useful for predicting work efficiency and social competence in training situations. However, their usefulness has been validated only for the small industry type of workshop.

There is no reliable way to predict success or failure on the basis of personality measures even though it is agreed that personality greatly affects adjustment.

Psychological assessment depends on the experience of the psychologist in interpreting the client's responses.

Final outcome depends not only on the individual but also on effective environmental intervention and societal accommodation.
In the studies reviewed, no evidence appeared that actuarial methods of prediction could displace clinical judgment.

What Goes into Job Preparation of Mentally Retarded Children and Young People

- Training in basic skills of daily living activities.
- Opportunities for socialisation.
- Group counselling as well as individual counselling.
- Actual near-life experiences involving contact with a specific skill, or through field visiting to typical work situations.
- Simulated job experiences to develop technical skills and experience in working with others on the job.
- Development of desirable attitudes toward work, favourable work habits, and the stability necessary to hold a job.
- Provision for suitable reception of the retarded in the community. This reception would include living conditions and attitudes of co-workers.

In one research study, work exposure proved to be the most basic, dynamic aspect of a job preparation programme.

But, it cannot stand alone. It must be combined with other indicated services and with counselling.

Without counselling, the mentally retarded young person may be deprived of the opportunity to evaluate for himself, to comprehend, and to change his attitude.

The readiness of the counsellor to deal with the non-vocational problems troubling the client often cements the relationship between the counsellor and the mentally retarded individual.

Some Further Observations on Pre-Employment Counselling

Counsellors should be aware that certain aspects of their own personalities may trigger harmful reactions in his client.

Counsellors should avoid mentally retarded youngsters with whom they cannot work well.

Interpersonal relationships between client and counsellor appear to be more important in determining outcome of the rehabilitation process than does the severity of a client's impairment.

It is likely that good counselling has many of the same basic elements as any good interpersonal relationship.

Some attraction between retardate and counsellor is needed before any real influence can occur.

When value systems of the retarded client and counsellor are moderately similar, constructive change in client is more likely than when similarity is high or low.

During the maintenance (Middle) phase of counselling, the values of the client, in a successful case, tend to shift toward those of the counsellor.

Counsellors tend to express higher regard for clients who are later to receive placement assistance, and interpersonal relationships with these clients appear to be better than with others.
The retarded young people who later receive placement assistance have markedly higher concepts of other people at initial job interviews than those who receive no such help.

It should be remembered that adverse social and cultural factors influence the motivation of the individual, and the movement from instability to stability may take years.

The importance of favourable attitudes towards a mentally retarded person cannot be overstressed since he is at a disadvantage in society anyway, and the bruises encountered throughout his emotional development are likely to affect the outcome of rehabilitation efforts on his behalf.

Unfavourable attitudes towards the mentally retarded may be found -
- within the family;
- among the institutional employees;
- within the school system;
- with the counsellor;
- on the job; and
- within the community.

Thus, at many points in the life of the retarded individual, the attitudes of professional workers, employees, and other associates deeply affect the welfare of the person, his social reactions, and his vocational success.

In particular, the vocational counsellor - whether at the pre-counselling level or concerned with normal job placement - can greatly damage the rehabilitation process even though he believes he hides his prejudices.

Government Aid

There will always be a certain segment of the mentally retarded population that can never expect to attain job placement in either a sheltered workshop or in industry.

But, certain rehabilitation project grants are available to aid these individuals attain more satisfaction out of their limited lives.

These projects are supported with financial assistance in part from the Rehabilitation Services Administration, particularly the Division of Developmental Disabilities which administers the new Developmental Disabilities Law, and the older Mental Retardation Law which it supplanted, and part of the Vocational Rehabilitation Act as amended.

Grants are available to improve the training of personnel working with the retarded.

Grants for the initiation or expansion of programmes for retarded individuals with special problems such as multi-handicapped adolescents, or mentally retarded adults who might not be eligible for the regular VR services, or the children who cannot profit from the available educational or vocational rehabilitation programmes.

Many of these grant programmes are concerned with teaching skills for daily activities, improving behaviour, and encouraging socialisation.

They may sound elementary but when the skills are successfully developed the trainer's time is freed for more complicated tasks, and the retarded individual is ready to attempt to master a skill at a higher level.

Realism must be the key to counselling and training of the mentally retarded at the pre-vocational level.
Retardates will have to face up to social and interpersonal relations not always pleasant, to basic problems of living regarding money, transportation, housing, to unpleasant job situations.

In order that the preparation of the retardate helps him to meet these challenges, we feel there are certain needs in pre-employment training.

**Needs**

- There should be guidelines for every level of training and education - guidelines that stress vocational and social preparation.
- There should be materials on vocational and job-related subjects which should be written in simple language for use by mentally retarded individuals.
- There should be increased use of voluntary organizations in arranging out-of-classroom instruction.

**Conclusions**

Rehabilitation services for the mentally retarded have advanced more rapidly than for any other disability group.

- Basic to this dramatic progress has been:
  - the supportive habilitative services within the institution;
  - the assignment of specially-trained counsellors to give long-term pre-counselling;
  - the establishment of workshops and simulated job situations for job trials;
  - the development throughout the United States of co-operative vocational rehabilitation - special education programmes to assist the retarded in making a satisfactory transition from school to work;
  - the continued guidance and financial support available from the federal Government.

But, despite the dramatic progress, there remains much to be done if the rehabilitation needs of the young mentally retarded individuals are to be met. That is why we are looking forward to the enlarged programme under the new Developmental Disabilities Act.

We will continue the successes of our former programme and use these as bases to build an expanded programme to care for human needs seriously neglected before.

Pre-vocational training and counselling as well as suitable job placement requires utilisation of the skills of many disciplines. We need manpower.

Our programme requires the involvement of people. We've learned that we must draw on many people and many disciplines in our communities to discover the potential of mentally retarded persons, to develop the potential, then to reap the economic benefits of our rehabilitation programmes.

But, boundaries are shrinking and who knows in how short a time we will become one community with the outstanding successes of rehabilitation programming available equally to all countries.
BIBLIOGRAPHY
(For all Mr. Lynch's Papers)

An Introduction to the Vocational Rehabilitation Process. McGowan, John and

Paper presented at National Association of Superintendents of Public Residential
Facilities for the Mentally Retarded in San Francisco, California. Contact author.

September 1969. Rehabilitation Services Administration (Sponsor): Social and
Rehabilitation Service: US Department of Health, Education, and Welfare,
Washington, DC 20201. 12 pp. Available from Rehabilitation Services
Administration, Social and Rehabilitation Service, US Department of Health,

Department of Labor - HUD Appropriations for 1972: Hearings Before a Subcommittee
Committee on Appropriations, House of Representatives, US 92nd Congress. 1173 pp.

Fiftieth Anniversary of Vocational Rehabilitation in the USA 1920-1970.

MR 70: The Decisive Decade. The President's Committee on Mental Retardation.
Available from Programs for the Handicapped, Room 7135, US Department of Labor,
Washington, DC.

January 1971. The Secretary's Committee on Mental Retardation, Office of the
Secretary. 86 pp. Price $1.00. Available from US Government Printing Office,
Washington, DC.

MR 69: Toward Progress; The Story of a Decade. The President's Committee on
Mental Retardation. 1969. The President's Committee on Mental Retardation.

Pending Legislation Affecting Mental Retardation and Vocational Rehabilitation
Programs, Congressional Record. Daily while Congress is in session. US Congress.
Price $45.00 subscription per year. Available from US Superintendent of Documents,
Washington DC.

Programs for the Handicapped. Secretary's Committee on Mental Retardation.
9 August 1971 (No. 71-7) and 24 October 1967 (No. 67-16). Secretary's Committee
on Mental Retardation, Office of the Secretary, US Department of Health, Education,
and Welfare, Washington, DC 20201. 20 pp. Available from the Secretary's
Committee on Mental Retardation, Office of the Secretary, US Department of Health,

Rehabilitation Services Administration: Statement of Organisation, Functions, and
Delegation of Authority. Richardson, Elliot L., Secretary of Health, Education,
and Welfare. 1971. Rehabilitation Services Administration, Social and
Rehabilitation Service, Department of Health, Education and Welfare, Washington,
DC. 4 pp. Available from Rehabilitation Services Administration, Social and
Rehabilitation Service, Department of Health, Education, and Welfare, Washington,
DC 20201.

The President's Committee on Mental Retardation. May 1970. The President's
Committee on Mental Retardation. 16 pp. Price 50 cents. Available from


These Too Must Be Equal. The President's Committee on Mental Retardation. 1969. The President's Committee on Mental Retardation. 22 pp. Available from Pograms for the Handicapped, Room 7135, US Department of Labor, Washington, DC.


10A. Outlets in Normal Employment for the Mentally Retarded

by

Francis X. Lynch, Director,
Division of Developmental Disabilities
Rehabilitation Services Administration
Social and Rehabilitation Service
Department of Health, Education, and Welfare

Introduction

The demand for jobs at the unskilled and semi-skilled level of the American labour market far exceeds the supply of competent, reliable manpower. These job shortages are causing management more splitting headaches than any other manpower problem. It takes more than highly-skilled people to keep any plant or office moving smoothly; it takes faithful lower-skilled people as well.

So, management is searching desperately for a source of manpower assuring reliability and stability. No wonder it accepts mentally retarded workers who can demonstrate these characteristics. There is room for the retarded in employment today, and there will be more room tomorrow.

The labour force is expanding rapidly. Jobs of all categories are on the increase. Automation is not causing less-skilled jobs to disappear.

Service occupations (many of them well suited for the retarded) are increasing faster than any other single category. The number has tripled since the beginning of the twentieth century; no other category has risen so rapidly.

America's current stress on jobs for the disadvantaged is causing employers to be more open-minded about all manpower sources - not only the disadvantaged, but the handicapped and retarded as well.

It is not enough to stop short with the preparation of the mentally retarded for employment. America must be told, and told again, of their abilities. We must constantly emphasise their capacity to work, their assets, what they can do rather than what they cannot do.

The United States Government has a huge rehabilitation programme focused on furthering the habilitation of all mentally retarded individuals and, where feasible, preparing them for gainful employment.

The Government does this through financial assistance to states, universities and private non-profit organisations by awarding monies for projects for research, demonstrations, training of the retarded themselves or of personnel to improve the services to the retardees, for innovative methods of care, and for construction of facilities.

At the same time a Rehabilitation Section of the Government is progressing in rehabilitating the mentally retarded through these project awards, other agencies within the Government are supporting projects to find the causes of mental retardation, prevention, basic supportive services such as comprehensive health programs, and providing financial assistance to eligible persons in need.

Perhaps it is here that I should call your attention to a special source of federal monies for rehabilitation. I am speaking of trust funds of the Social Security Administration.

Social Security Money for Rehabilitation

We usually think of social security benefits being paid to the retired elderly citizens aged 62, 65 and older, or to eligible disabled individuals at an earlier age. Mentally retarded individuals aged 65 or over, too, qualify if they meet certain necessary conditions.
What we hear less about is the investment the Social Security Administration has in the dependants and survivors of social security recipients.

Mental deficiency is a major factor in more than 65 per cent of cases involving dependants or survivors who have been continuously disabled since childhood. It is the primary diagnosis in about half of all childhood disability cases. In the fiscal year 1970, an estimated 168,000 mentally retarded adults disabled in childhood and 8,000 mentally retarded workers received $156 million.

The number of mentally retarded children under 18 who receive payments as dependants of retired, disabled or deceased workers is unknown, since their benefits are payable regardless of disability.

The regulations of the Social Security Administration contain guides as to the level of severity required in disability cases involving mental retardation. These regulations have the effect of law.

Under social security's "Childhood Disability" provisions, lifetime monthly payments can be made to a person aged 18 or over who has been disabled by mental retardation - or other impairments - since childhood. In many cases, the monthly benefits enable the retarded childhood disability beneficiary to be cared for at home instead of in an institution. Furthermore, as more and more retarded people outlive their parents, the programme offers reassurance to fathers and mothers who know that financial help for their disabled child will be forthcoming even after their death. (About half of the childhood disability beneficiaries are over 35 and 25 per cent of them are over 45.)

If the parents are dead, a relative who has demonstrated a continuing interest in the beneficiary's welfare, a welfare agency or a legal guardian may be chosen as representative payee to handle the benefit funds and plan to use them on behalf of the beneficiary. A representative payee receives social security benefits in trust for the beneficiary and, as trustee, is held accountable for the way in which he uses the benefits.

There is a special programme where these social security trust funds are used to pay for rehabilitation of certain beneficiaries - including the mentally retarded - by the state vocational rehabilitation agencies.

The transfer of the trust funds to the Rehabilitation Services Administration may be made as necessary up to a maximum of 1 per cent of the social security benefits certified for payment in the previous year.

These funds are for services to the "Childhood Disability" beneficiaries.

Disabled persons applying for disability benefits under social security are promptly referred to the Rehabilitation Services Administration to the end that the maximum number may be rehabilitated into productive activity or to a level of self-care. Working relationships have also been established with all agencies and institutions that work with mentally retarded children, so that proper referrals may be made to district offices.

Besides its financial benefits to certain mentally retarded individuals, and its participation in their rehabilitation, the Social Security Administration (SSA) is an employer of the mentally retarded.

SSA has participated in the employment of the mentally retarded since the inception of the employment programme in 1964. It has also tried, through the co-ordinator for employment of the handicapped, to generate interest in the programme of private employers and other federal agencies. Experience has demonstrated conclusively that the retardate can perform excellent work in basically routine positions when placement is carefully selected or the job re-engineered to the level or degree of his handicap.

The ultimate goal in recruiting and hiring the mentally retarded is to assist in their rehabilitation to a productive life. In the SSA, retardates are successfully performing in such positions as mail and file clerk, messenger, operators of printing, xerox, and card reader machines.
Recently, the SSA has experimented with the colour coding of file cabinets and cartridges of microfilm, an area of work which requires a very high degree of accuracy. To date, the retardates have performed their duties in an excellent manner.

Retardates are performing so well that many have been promoted. At least two have qualified on a competitive examination and have been converted to status appointments, and several have received superior accomplishment awards.

Within the Department of Health, Education, and Welfare the Social and Rehabilitation Service joins under a single leadership the Department's income-support programmes for needy Americans and the social and rehabilitation programmes of which mental retardation is one.

Six of eight major components of the Social and Rehabilitation Service have responsibilities in the area of mental retardation, and of these the Rehabilitation Services Administration has the major responsibility.

Rehabilitation Services Administration

The Rehabilitation Services Administration is responsible for a broad range of programmes designed both for the provision of diagnostic, treatment, and rehabilitation services for the mentally retarded, and for the support of special facilities and activities to expand and improve national resources for serving the mentally retarded.

These programmes include the state-federal vocational rehabilitation programme, as well as special project grants for the expansion and innovation of vocational rehabilitation services; the improvement of state residential institutions and sheltered workshops for the mentally retarded; the planning and construction of rehabilitation facilities and sheltered workshops, the construction and staffing of specialized community facilities, and the construction of university affiliated facilities for the mentally retarded; and training for professional, supportive and technical personnel already engaged or preparing to engage in occupations in the care and rehabilitation of the mentally retarded.

These diverse activities are unified by the common goal and objective of assisting mentally retarded individuals to achieve and maintain the maximum personal, social, and economic competence of which they are capable. Underlying these activities is the continuing concern for expanding the opportunities and resources available to the more severely mentally retarded.

Authorisation for rehabilitation activities is obtained from the Vocational Rehabilitation Act of 1920 and its amendments; from the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963; and from the Developmental Disabilities Services and Facilities Construction Act of 1970.

The Vocational Rehabilitation Act

The Vocational Rehabilitation Act was passed by Congress in 1920 and set up for a very small, temporary programme.

Then, through a series of amendments and as the social consciousness of the people improved, the concept of rehabilitation broadened, services were added, and the rehabilitation programme expanded to include a larger population.

It was not until 1954 that mentally retarded individuals were included as a group eligible for rehabilitation services.

Vocational Rehabilitation

Under the public rehabilitation programme, grants are made to state vocational rehabilitation agencies to assist them in providing rehabilitation services to mentally and physically disabled individuals who have substantial employment handicaps and who can reasonably be expected to be rehabilitated into gainful employment.
Among the services provided by state vocational rehabilitation agencies are comprehensive medical, psychosocial and vocational evaluation; physical restoration; counselling; personal adjustment; prevocational and vocational training; maintenance and transportation during the rehabilitation process; placement in suitable employment; services to families of handicapped people when such services contribute substantially to the rehabilitation of the handicapped client; recruitment and training services to provide new careers for handicapped people in the field of rehabilitation and other public service areas; and follow-up services to assist handicapped individuals to maintain their employment.

Recent years have seen dramatic advances in the provision of vocational rehabilitation services to the mentally retarded. The retarded now comprise nearly 13 per cent of the people rehabilitated from all categories of disability by the state-federal programme of vocational rehabilitation. In 1971, about 37,000 retardates were rehabilitated.

Yet even these dramatic statistics do not reveal the entire story, for at any one point in time about 100,000 mentally retarded individuals are receiving services as part of the rehabilitation process. In other words, they are in some stage of a planned programme which is designed to enable them to make a satisfactory vocational adjustment in the community. They may, for example, be undergoing a comprehensive evaluation, receiving prevocational adjustment help, acquiring a vocational skill, receiving medical restoration services, or awaiting job placement.

Basic to the vocational rehabilitation effort has been the growing reliance on counsellors and other vocational rehabilitation staff who work exclusively with retarded clients.

This specialised staff may be assigned to local vocational rehabilitation offices, schools, institutions, sheltered workshops, or other facilities serving the mentally retarded.

By concentrating their attention on the mentally retarded clients, these counsellors are successfully developing rehabilitation plans based on the special problems of the retarded, and are able to be broadly responsive to the needs of both the client and his family.

As special vocational rehabilitation and facilities for the retarded continue to be developed and expanded, the number of specialised counsellors within state vocational rehabilitation agencies is expected to increase.

The largest share of the vocational rehabilitation money goes to the states on a matching basis (80-20) for a federal-state partnership programme.

Mentally retarded individuals are rehabilitated under this programme with the time limit extended to eighteen months for their extended evaluation.

Once an individual is considered "rehabilitated" by vocational rehabilitation standards, he is ready for job placement.

One avenue open to him is the federal government employment programme.

Federal Government Employment Programme

The federal Government has a programme of hiring the retarded directly without going through usual civil service procedures.

The programme for federal employment of the mentally retarded has been an outstanding success, with 7,200 placements in 143 different job titles at federal installations across the country. The retention rate for these retarded employees has been far superior to that of other employees in similar jobs; and the programme has become a part of the permanent personnel policy of the US Civil Service Commission. State vocational rehabilitation agencies play a highly important role in this programme in that they certify all retarded applicants as job-ready.
Only about 7 per cent have had to be separated, largely for inability to make social adjustments.

The federal government project has had a 90.5 per cent success rate; 243 retarded persons received excellent or outstanding ratings; 657 have been promoted.

The federal employment programme is a co-operative venture between the US Civil Service Commission and state vocational rehabilitation agencies to encourage federal agencies to hire the mentally retarded.

The programme was set up on a temporary basis for two years but its success enabled it to become part of the federal programme to employ the handicapped.

A written agreement requires a statement from the federal participating agency. The statement lists positions available, titles, and grades to be assigned to the jobs set aside for the mentally retarded.

Before hiring a mentally retarded person, the federal agency must obtain a certificate from the appropriate state vocational rehabilitation agency that the retarded person:

1. can perform the duties of the position;
2. is physically qualified to do so without hazard to himself or others;
3. is socially competent to maintain himself while on the job.

The federal agency hiring the retarded person is also committed to full use of the advice and assistance of the state vocational rehabilitation agency regarding:

- supervision;
- training;
- post-placement counselling; and
- agreement not to abolish the job or fire the employee without prior notice to the vocational rehabilitation counsellor concerned.

All fifty state vocational rehabilitation agencies have made referrals to federal agencies.

There are 143 job titles such as messenger, laundry worker, kitchen helper, medical aide, etc.

The basic policy underlying the programme is that quality of placement is more important than sheer numbers.

The placement process operates through a network of some 3,500 co-ordinators specially designated by their agencies to facilitate the placement of qualified mentally retarded individuals and other handicapped persons in the right jobs.

Existing jobs may be adapted to fit special needs, but no extra jobs are created.

The federal employment programme has proved that retardation does not mean a complete absence of ability and aptitude; often the retarded person has a good clerical or mechanical aptitude, manual dexterity, or other vocational assets.

The average salary is $5,223 and with about 5,000 of the 7,200 placed over the years currently employed, the $26,115,000 a year which they earn might be considered a good return on our rehabilitation investment.

The human benefits to these mentally retarded employees of federal agencies cannot be measured in dollars and cents - more beneficial is the dignity and worth of each gainfully employed individual.
In an analysis made of these workers it was found that they were typically:

- young - about two-thirds were 20 to 24 - and some were teenagers;
- with a mean IQ of 73;
- 25 per cent non-white;
- 50 per cent from disadvantaged backgrounds;
- 32 per cent finished high school.

Follow-up with the client and employer by the vocational rehabilitation counsellor is necessary until job adjustment seems assured.

**Contract Programmes**

When the United States Department of Labor began to develop special projects for training and placement of the mentally retarded, it, too, turned to the state rehabilitation agencies for selection of job candidates.

The first of these special projects was a contract between the Department of Labor's Bureau of Apprenticeship and Training and the Institute of Industrial Launderers, Inc., which provided for the training and placement of 1,000 retardates in industrial laundries over an eighteen-month period on a nationwide basis.

This was called Project Manpower. The Institute of Industrial Launderers signed subcontracts with member companies, and eligible mentally retarded individuals 18 years of age and older without severe secondary physical or emotional disabilities and certified by a state vocational rehabilitation agency as feasible for training and employment could obtain training.

615 entered the programme, of whom 75 per cent had had a total of no more than six months' prior work experience, mostly at odd jobs. Thirty-six per cent terminated during the initial ten-week training period mostly because of adjustment problems.

In the industrial laundry project 94 per cent had perfect attendance records; 93 per cent had satisfactory production records; only ten had accidents on the job, nine of them minor.

Another contract programme is that between the United States Department of Labor and the National Association for Retarded Children which provided placement for 1,500 mentally retarded individuals, primarily in retail trades in the first attempt at job placement. These job candidates, too, were screened by the state vocational rehabilitation offices.

The National Association for Retarded Children has had three contracts to date and is presently negotiating for a fourth.

Under the first contract (two years) 1,800 were placed.

The second contract was for fifteen months and placed 750 in manufacturing and food services.

The present contract (for one year) only calls for 477 to be placed, but already 550 retardates have been placed.

There is a new contract planned for 1972 which calls for the placement of another 550 in essentially the same trades.

The National Association for Retarded Children reports no problems in employing the mentally retarded, but there were problems with bureaucracy since the job placements had to be made through employment agencies.

In the NARC projects, Howard Johnson, Marriott Hot Shoppes, Schrafft's Restaurant Operations, and Sky Chefs (organisations hiring the retarded) have been pleased with performance records and have asked for more retarded workers.
In Sum

There are job openings for the mentally retarded. There are growing numbers of employers willing to accept the retarded. Often there are not enough trained retarded workers ready for available jobs. The retarded can do the work, but sometimes they have trouble with social and personal adjustment to the job.

Prospective employers might note the double advantage of restructuring their simpler jobs for retarded persons: more opportunities for the retarded and better utilisation of present manpower. Since such restructuring occurred in only about 15 per cent of these placements, more of it may be possible.

Encouragement should be given to job redesign - removing routine functions from existing jobs, grouping the functions together, and creating new lesser-skilled jobs which the retarded can perform. Job redesign is possible for both white-collar and blue-collar jobs. It can serve to make better use of highly-skilled persons by not wasting their time on routine functions. It can open new job opportunities for the retarded.

Labour unions should be encouraged to exempt low-echelon jobs from usual "career ladders", so that the mentally retarded might fill them without having to face upward steps to jobs beyond their capabilities.

State and local governments should be encouraged to establish special hiring procedures for the mentally retarded similar to those of the federal Government. Only a dozen states have such procedures at present.

Promotional efforts should be directed to top management to encourage written policy statements favouring jobs for the retarded; to middle management to encourage implementation of these policies; to rank-and-file workers to gain their acceptance of the retarded as fellow workers.

There should be more employer conferences on utilisation of less-skilled manpower in the labour force, with special reference to the retarded.

Preliminary Work

The mentally retarded individual entering the competitive labour market needs to be physically, emotionally, socially, and vocationally ready for job placement.

The rehabilitation counsellor should certify that this is so.

State vocational rehabilitation offices are allowed to work up to eighteen months with a mentally retarded client who gives promise of meeting the demands of the open labour market.

The preparation means hours of individual counselling on a face-to-face basis. This personalised contact is considered one of the reasons for success in the vocational rehabilitation effort.

Client evaluation, review and analysis of job tasks and work environments before placement, and continued contacts between employer and counsellor afterwards to assure work adjustment are made by team effort.

After job placement, continued contacts between employer and counsellor are needed to assure work adjustment.

Transition to the Community

Too sudden a transition from the security of the institution to the trauma of a new job, new associates, and unfamiliar living conditions may mean the difference between success and failure of the retarded individual in his community employment.

The transition should be gradual and should begin on institutional grounds with simulated community conditions and various gradations of dependent living.
With the mentally retarded work is certainly important. Where and how they live is at least equally important. More retarded workers fail on the job because of problems of living than because of problems of working.

Therefore, close attention must be paid to adequate living conditions so that their lives after work will be as full and meaningful as their lives during work.

Living facilities for the mentally retarded should be established in the vicinities where they work. These facilities can include hostels, group homes, halfway houses, co-operative apartments, community homes or farms.

Independent living facilities in institutions should be encouraged when possible. These facilities go hand-in-hand with the development of sheltered workshops on the premises.

If the counsellors and others can improve the client's home environment, help him toward more realistic aspirations, provide better employment training, and mobilise community services to deal effectively with off-the-job problems, even greater success can be attained.

Once on the job, absenteeism and unacceptable habits and behaviour may cause failure on the part of some clients unless counsellors intervene. Follow-up with client and employer until job adjustment seems assured is needed if these main sources of failure are to be remedied. Counsellors and their supervisors, even though already heavily burdened, need to bear this in mind.

Maximum effort should be made to maintain a regular counselling relationship with the client to help him work through difficult situations that confront him in the community.

Attitudes

Yet all is not as sunny for the retarded as one might expect. Too many employers still have unflattering images of mental retardation in their minds. An employer attitude study was conducted several years ago under a grant from the Social and Rehabilitation Service. It was found that most employers thought of the mentally retarded as dependent rather than self-reliant; unimaginative rather than of independent thought; slow and passive rather than fast and active. Further, employers tended not to distinguish between degrees of retardation. They included all the retarded under one common stereotype: a helpless person of little use to society.

Roper Research Associates, a study group, sampled 1,000 persons across the country in 1968 to study their attitudes about the handicapped. This hypothetical case was presented:

"Thomas B. is aged 20 and mentally retarded. Outwardly normal, he has the intelligence of an average 8-year-old child. He can care for himself, do simple chores, and read and write at the third grade level."

Should he, and others like him, be encouraged to work? Fifty-eight per cent thought the retarded should only be in sheltered workshops; 13 per cent believed they should be trained for work only if they strongly desire it; 10 per cent contended they should not work at all; only 16 per cent thought they should be trained for regular employment where they would work side-by-side with others.

In sum, America is just beginning to see the light about the mentally retarded, just beginning to grant them a degree of acceptance in the labour force. But we have a long way to go.

Failures

Generally, retarded workers who are employed are performing quite well on the job, considering that many had never worked before and considering that the fast-moving world of business and industry must have seemed strange to them.
Yet there have been failures. Most have not been caused by inability to
do the work, but by inability to cope with the social and personal and inter-
personal problems that arise in any employment situation.

Getting along with others, public transportation, handling money, personal
cleanliness - these have been among the factors of failure.

The nation's three major manpower training and placement projects for the
mentally retarded mentioned previously have underlined these factors.

**Economic Benefits of Rehabilitating the Mentally Retarded**

Has the expenditure of billions of the tax payers' dollars to rehabilitate
a group of individuals whose incomes will always be among the lowest in the
labour market, or those who will never be able to compete without a sheltered
setting or not at all, been justified economically?

We think we can present evidence here of the economic soundness of rehabili-
tating retarded persons.

Part of this evidence lies within the belief that every man has value and
that it is to his best interest and to society's that he be given the opportunity
to develop as far as his capabilities and talents will permit.

Of the 6 million mentally retarded individuals in the United States, most
(or 5.3 million) are mildly retarded and as such usually educable and able to
acquire the social and vocational skills needed for minimum support.

Institutional care runs as high as $100,000 during a lifetime. And we
know that many residents can be released and make successful adjustments in
the community.

Some 2 million retarded persons capable of learning to support themselves
need job training and placement services. Even at minimum wages, they have a
potential annual earning capacity of $6 billion.

We know that the average mentally retarded person is younger than other
handicapped persons when rehabilitation is completed and thus has more years
to work.

Rehabilitation is a social and economic necessity for the handicapped
individual. The money invested in habilitation reduces the burden on the tax-
payer while contributing to the client's sense of worth.

Yearly maintenance of the retarded in an institution costs from $2,000
to $10,000. In contrast even at the minimum wage of $1.60 per hour a retarded
person will earn over $3,000 per year and instead of becoming a burden to tax-
payers he will actually lessen their tax burden since about $600 of his earnings
will be paid to the community in the form of state and local taxes. The total
cost of providing vocational training to the retarded so that they might become
employable will probably range between $1,000 and $9,000 in the great majority
of cases. It appears that the average cost to taxpayers of preparing the
retarded for employment will be about the cost that they would incur for the
provision of only one year of institutional care for the retarded.

**Conclusions**

In our society employment has many values in addition to the obvious one
Employment fosters a feeling of usefulness, without which life seems futile.
Employment leads to personal growth, both social and intellectual.

For the mentally retarded, employment is a burst of sunlight - particularly
for those who had never worked before and those who had never dared hope of work.

During the past decade the mentally retarded have entered the work-world
in significant numbers for the first time. It has been an eye-opening experience
for all concerned. Employers whose original motivation in hiring retarded
workers came perhaps more from charity than business sense have discovered that there are many jobs that the retarded can do well - often better than other workers - and that intelligence is not the only qualification for successful employment.

Friends and families of the retarded are discovering to their surprise in many cases that the trained retarded can earn and live their own way, that the true dignity of work lies in doing well and productively those things that one can do.

And the retarded themselves are finding themselves liberated into "real" life. They go to work, earn pay, have their own places to live and their own possessions. They have become people!

Because of time limitations it has been possible only to touch very superficially upon the multiple activities of the state-federal programme of vocational rehabilitation in the area of mental retardation, and indeed I have not even mentioned some of the newer developments, such as serving the retarded through special projects for the youthful public offender and for the Selective Service rejectees. In closing, I should like to say that the road to improved services for the retardate is one that cannot be travelled alone, and that such progress as we have been able to make has been largely attributable to the splendid co-operation received from other agencies, public and voluntary, and universities.
Outlets in Normal Employment for the Mentally Retarded

by

H. O. T. Wildenskov, Director of Social Work, Central Institution, Brejning, Denmark

Before starting to tell you about our experiences in placing the mentally retarded in normal jobs, it is necessary to explain the background to such work.

You may know that Denmark is divided into twelve service units and I am responsible for one of these units. Our unit covers a part of Jutland and has a population of some 400,000. The greater part of the population lives in the eastern area, and towards the west it is more and more sparsely populated. In the eastern part of the service unit we have a central institution, which was built around the turn of this century, and today it has some 1,200 patients suffering from various degrees of mental retardation and of all ages. In the central institution we operate a number of workshops, which I shall describe in more detail in my paper tomorrow. In addition we have four towns some twenty-five kilometers apart, each with a population of approximately 50,000. In one of these towns we have a workshop with 50 clients and in the other two workshops for a total of 100 people. These four towns are typical Danish provincial towns with various kinds of smaller and larger industrial undertakings. In the northern part of our district we also have a town with a population of some 50,000, here we have also established a workshop for 60 clients. Finally in the extreme west there is a small town with a population approaching 10,000, where we operate a workshop for 30 clients.

My own experiences concerning placement of the mentally retarded in normal jobs first and foremost originated in the towns where we are operating two workshops. The oldest of these workshops was started ten years ago, and in the early stages excellent progress was achieved. We soon realised that our clients were able to perform more complicated work procedures and handle machines to a much greater extent than we had ever imagined. As a result we started to plan for a workshop in which would be simulated as far as possible, normal factory conditions. We intended to select the most competent clients from the general workshop and transfer them to this new workshop for final preparation before placing them in normal jobs.

This workshop was started in 1966 and has been developed into a highly industrialised workshop equipped with machines which ten years ago would have been regarded as being too complicated for the mentally retarded to operate. The workshop at present has a capacity of 40 clients with four instructors and a manager. It is divided into three departments, one for metalwork, another for woodwork and the third an assembly department. The clientele for this workshop are selected from the above-mentioned four towns and the central institution. During the training period proper, the clients receive training allowances and go on to receive wages at piece-work rates. The clients elect shop-stewards from each of the groups and these representatives meet with co-workers in the workshops. The clients are given various kinds of tests and evaluations during their stay.

At the same time as this workshop was started, we attempted for the first time in this country a group placement of mentally retarded in a factory. For several years we had received orders from a textile factory in the town, and we conceived the idea that instead of having the goods delivered to our workshop we might send a group of our people to work in the factory. Following negotiations with the management of the factory, the shop-stewards and the trade union a meeting, with the participation of all co-workers, was held at which the idea was developed. All co-workers accepted the idea and we selected 8 female clients, who we estimated would have great difficulties in managing on their own in a normal working place. Their IQ was just around the limits for imbecile and debile. The factory management, in accepting the arrangement, insisted that the Service for Mentally Retarded should put a co-worker at their disposal who could instruct and take care of the clients. This group placement was in the nature of an experiment during the first year or so, but eventually all involved were satisfied. We were particularly pleased that all fellow workers in the factory completely accepted the presence of our clients. It should be mentioned that our clients worked in a group in the main workshop where some 100 other workers of the
factory were employed. This group placement lasted for three and a quarter years, then most unfortunately owing to competition, a limitation and change of the production process was introduced with the result that there was no longer a need for the work of our group and we were compelled to cancel the arrangements for group placement.

Since then group placement has been considered in connection with our western workshop. Unfortunately after detailed negotiations, a rationalisation also took place at the factory in question and they could not make use of our group. Group placement has been tried also in another area - a metal factory where the proprietor who had a special interest in the problem was positive to the idea. In connection with an expansion of the factory a special work room was arranged for a group of mentally retarded together with a supervisor. This group is still functioning.

The conclusions which can be drawn from these group placements are that we have made positive progress. The criteria are a positive attitude of the employer and his co-workers as well as production work which can be managed by our clients. Through such group placements it is possible to occupy a number of mentally retarded who cannot individually manage a job in normal industry, but as members of a group they are able to do so. Owing to competition in the labour market we have not succeeded in obtaining more working places of this kind.

I should also mention that some ten years ago an arrangement was made between the parents' association and the Federation of Trade Unions and the Service for the Mentally Retarded by which mentally retarded persons could work in a job at an income lower than the current rate. In such cases negotiations must be made between the Service for the Mentally Retarded, the local trade union, and the employer. In our centre we have, with few exceptions, never needed this permission to negotiate.

Reverting to the above-mentioned workshop, during recent years some 40 clients left this workshop and a few of them have left the Service for the Mentally Retarded. Our optimistic belief that the mentally retarded only required training in a work place which came as close as possible to a normal work situation was not substantiated; selected cases transferred to this workshop were indeed able to perform the tasks set them, as for instance to handle the machines, but either they were not able to maintain a tempo of work corresponding to that of the labour market, or their behaviour was so deviating, that they could not establish themselves in a work place. In addition lack of social training was a contributory factor.

Now let me give you some examples:

1. A man, now 27 years old had an IQ of 69. After finishing school with the Service for the Mentally Retarded he was employed with a private craftsman, but needing further training he was transferred to our general workshop, where he showed such great abilities that after one month he was placed in a blacksmith's shop. After six months he became redundant and was admitted to our special workshop as he could not obtain another job. There he remained for one and a half years after which he was placed in a cement works. He has coped well and is described as a good worker but a bad organiser.

2. The second case is that of a man, now 23 years old with an IQ of 66. After attending school at the Service for Mentally Retarded he was employed for six months in a workshop. After this he was a labourer at a furniture factory, but left on his own initiative and found himself a job in a chocolate factory, where he was fired. After this he obtained a job in a car workshop, where he stayed for one and a half years, but owing to increasing difficulties in his job he was discharged. Then he stayed one and a half years in our special workshop, but as he was reluctant to follow instructions he was fired. His next job immediately after was at a cement works. Here he stayed one and a half years and since then he has frequently changed his job. He owes some 3,000 kr. on a stereo set and we have also heard that he bought a speedboat incurring another debt of some 6,000 kr.

3. A third case is that of a man now 25 years old with an IQ of 71. Before coming to our workshop he had been occupied as a farmhand. After some years at our workshop he was placed in metalwork, but could not stand the noise; he then returned to our workshop for one month whereas he obtained temporary work at a
sawmill. When this job finished he came again to our special workshop where he stayed for two and a half years, then obtained a job in a furniture factory and after a year he left the Service for the Mentally Retarded.

4. My fourth example is a girl of 27 years of age with an IQ of 47. She was in our workshop for four years and there she revealed really special ability. For this reason we obtained special mechanical work on subcontract from a factory, and gradually she became so well trained that we made an arrangement with the factory to employ her instead of being employed with us. She has now been there for six years, and copes very well. Socially she lives with very sensible parents.

5. My last example is of a man of 45 with an IQ of 79. He was originally referred to the mental health service for criminal reasons. On release he went from job to job and most of the time he lived on public assistance. He married and his wife had eleven children. Through the rehabilitation agency, the Service for Mentally Retarded came in contact with him again, and for nine months he has been under observation in our special workshop, where we judged him to be reasonably stable. The rehabilitation agency found him a job as a general labourer but owing to bad health he intends to leave his job and we shall again take him into our special workshop for a period of six months for retraining. Eventually it is hoped that the rehabilitation agency will find him a job in a sawmill.

As mentioned previously our hopes concerning vocational training of the mentally retarded were not realised. This does not indicate, however, that I am against every region or area having a workshop such as the one I have mentioned; on the contrary I feel there is a great demand for such workshops, in which those of our clients, who cannot cope with open employment, mainly because of odd social behaviour, have a possibility to become acquainted with modern machinery which they can operate very well in a sheltered workshop.

Our experience also tells us that work training has to be combined with an efficient training in social behaviour and self-help. Over and over again we learn that our clients lose their jobs because they cannot organise their spare time, their housing situation and their income. It is imperative therefore to intensify the instruction in this field, and for our clients in the workshop we must ensure social aftercare and follow-up after they have left the workshop. It is extremely important to support the mentally retarded for varying periods according to individual needs, in any new working employment, with the help of social counsellors who can support the client in several ways. Finally I shall not fail to mention that in this paper I have referred only to placement via our workshops to normal working places in industry. In addition, however, we also place our clients in farming, gardening, service at sea, household work to mention just a few of the jobs. Where previously the majority were placed in farming and household work the number placed in such jobs has now dropped substantially. This is due to contraction of the farming industry and the fact that people can no longer afford to have help in the house. I may mention as an example that in the central institution we once had a large herd of cows and our clients were trained as cow hands. The herd was, however, dispensed with because there were too few outlets for our clients in that kind of work.

And so we try to help the mentally retarded to follow the pattern and structure of normal social life. This can be achieved through the intensive arrangements for rehabilitation and training which I have mentioned. In addition, with the co-operation of fellow workers and shop-stewards all the mentally retarded can become accustomed to changes in society and the demands of the normal working population. We must also try to intensify placing the mentally retarded on equal terms with the other workers, participating in and benefiting from changes.
As mentioned in my paper yesterday we have in the eastern part of our district a large central institution for the mentally retarded of all ages and of all degrees. The institution is old, dating back to the change of century – and during the period from 1940 to 1960 was rather overcrowded with a case-load of some 1,700 clients. This number has today been reduced to about 1,200. This means that today we have an old and rather shabby institution in which it has been extremely difficult to find premises suitable for workshops for our clients. From the start of the institution it has been a goal to have the clients occupied as far as possible, partly for the sake of treatment, partly for the sake of training. This method has been practised extensively throughout the years. First and foremost outdoor work in the park around the institution, in the gardens and at the farm has been undertaken. Among the indoor activities I can mention weaving, lace-making, knitting, embroidery, woodwork, cleaning, assisting the personnel in the care of sick clients, etc. In an old institution there are traditions which are difficult to change. Not until we had workshops outside the institutions which were not bound to tradition were we able to introduce the concept that the job performed by the mentally retarded should be the same as that performed in the ordinary labour market, e.g. pre-manufactured industrialised work of varying kinds which is prepared and returned to the industrial factories. It was the non-residential workshops which were the forerunners of this new approach to occupations performed in institutions. The former arts and craft-type work such as knitting, weaving, lace-making and embroidery has almost disappeared from the list of occupations. Today we operate three workshops in our institution with about forty employees. Two of the workshops are devoted to weaving but further changes are likely to occur. Domestic work performed by patients in the institution has disappeared except for one department where it forms part of the training. Assistance in the care of sick clients has also disappeared as adequate personnel are now employed. Finally there are the outdoor activities, which have been greatly reduced, especially as regards farming. As in the case of the normal population the working interests of our clients have changed with the emphasis on industrial work. Practically the only outdoor activity remaining is concerned with maintaining the premises around the institution, but in this field too we can no longer count on the same manpower as previously and, as a result, working procedures have to be rationalised. It is obvious that in an institution of this size we must constantly ensure that the clients undertake as wide a variety of work as possible. We must also ensure that there is a variety of work and offer our clients, partly to cover their field of interest, partly to cover their aptitude and to provide training for a job within their mental/physical capacity. This applies to all categories of the mentally retarded and especially in the institution where we have such a wide range of categories and age groups. The demand for varied work therefore presents a formidable problem to us. Approximately 300 persons are employed. Out of this total 175 are occupied in our workshops, some 40 at the previously mentioned weaving shops, etc., and about 70 in outdoor activities such as farming, forestry and gardening, as well as a small group which is occupied in the production of concrete blocks, etc. Moreover we have work delivered to them at the wards because we do not have room for them in the workshop.

All clients are occupied and our attempts to train them have been outstandingly successful. I wish to mention two groups in this connection.

One of them included mentally retarded who were borderline idiots; several of them with psychoses and behaviour difficulties. They were young boys who were taken out of a large group of seventy clients. First of all we found a room in the basement and with great patience started to train them in the simplest kind of assembly work. Gradually they improved and became interested in the job and eventually reached day-production standard. Then we had the opportunity to move the workshop to another building together with two other workshops, where the clients were imbeciles. In the first instance there was some opposition from the staff to the move (500 m) to the other building. The
staff felt that the clients would lose their way or be run over by cars, etc. We therefore had to accompany them initially but this difficulty was overcome by the clients themselves and in a short time the better of them could guide the more profound cases. Gradually all of them were able to go safely to and from the unit and the workshop. The group was not split up in the transfer but continued to work together. The occupation was changed, involving more complicated working procedures, for example assembling of electrical components. As in the workshops for the other clients we introduced pneumatic tools; we also installed a compressor system in this workshop and a single pneumatic screwdriver. The consequence was that the other clients also wanted to try these tools and today we have come so far that most of them are able to use pneumatic screwdrivers in the production, something which I myself and others had never dreamed possible.

This small experiment is instructive. First we were told by the clients that they could not walk to the other building, but after training they were able to accomplish this. This convinced us that, as far as possible, we should establish our workshops in buildings other than those in which the clients are living, i.e. as for normal workers. We all travel from our homes to our jobs - the mentally retarded should do the same and he should enjoy the right of having his home separated from his job. The concept that the mentally retarded could only perform the most simple jobs was also disproved. As I have indicated, they can use powered tools such as those used in normal industry. Therefore through training and patience we can help our clients achieve much, with the possible exception of attaining normal working speeds. With such help our clients are more confident, more active and content whereas before they were helpless, noisy and inactive.

The second group included adult psychotic mentally retarded in a closed unit. In this case (about the same time as the first experiment) we started a workshop within the unit, where the clients were brought down for employment. It called for extensive patience and individual attention to the condition of each individual client, e.g. the client's daily doses of medication involve close co-operation with the doctors. At the outset our clients could only work a few hours, but gradually they became more stable and could perform more complicated working procedures. What is equally important, they themselves wanted to come to the workshop. It must be admitted that no great progress has been made as to ability in using tools, but some progress can be noted all the same. The most essential factor, however, is that many of the clients have become better adjusted and of quieter behaviour. In fact the doctors have been able to reduce the amount of sedatives they prescribed and this alone must be regarded as a positive achievement of the stay in the workshop. A very great deal of patience is required to get them started, and there are several who can only stay for a few hours in the workshop, including those who relapse into their former unemployable state. The doctors have noted, however, a positive improvement in the conditions of the clients through this occupational activity and therefore the workshop section is pressed to admit more clients of this type. Unfortunately, however, the lack of premises is a hindrance. Lack of and unsuitable premises are our greatest problems.

As already indicated we can only occupy some 300 clients, which represents one quarter of our case load. No doubt many of the remaining 900 would benefit from occupational activity which would no doubt influence their psychical condition. I am sorry to say, however, that we cannot admit them.

For our most able clients we have expanded the workshop activities so that some vocational training can be undertaken. It should be recalled too that I mentioned the openings which were available with employers.

As mentioned yesterday it is our experience that vocational training in itself is not sufficient and this applies to most of our clientele. Dependent on their working efforts the clients are moved to more demanding work but at the same time we are trying to ensure that they are trained to cope with the everyday demands of normal life, e.g. provision of outside accommodation for them as distinct from the closed form of accommodation in an institution. Gradual transfer from the institution to a half-way house, boarding houses and ultimately independent apartments is the ideal aim.

According to our experience, however, clients should not change their job and accommodation at the same time. In most cases they are unable to cope with
the difficulties involved. It is therefore our practice to let the clients change their jobs and only when they are well established in the job should they be encouraged to change their accommodation. To decide whether it is advisable for the client to change his job his performance must be evaluated. In this connection, we must determine how many days per month the client has been employed, whether he has been absent with or without permission and what he has earned. Finally our assessment must indicate what type of work he has performed during the period under review and remarks on his behaviour. These monthly assessments of performance can be completed in the workshop office but in addition we have a special evaluation form which is filled in by the workshop staff once every half year or according to demand. A description of the form may be of interest.

Under item 1 is recorded the workshop in which he is employed, item 2 indicates whether he receives medical treatment and, if so, whether this may influence his working capacity. Item 2 indicates whether he has undertaken a psychotechnical test. Item 4 gives the total number of working days he could have worked as well as the number of absences (authorised and unauthorised) including sick leave. Item 5 indicates his income during the last three months, whether it has been piece work or hourly payment, as well as the number of effective working hours per week. Item 6 gives a description of the client, for instance, whether he can tell the time, understand measurements, weights, coins, value of money, whether he can write his own name, read street names, etc. Item 7 gives information about his conditions - left- or right-handed, skills, dyslexic difficulties, whether he uses glasses, etc. Item 8 is an indication in percentages of his working speed and the quality of his work evaluated on the basis of a normal working capacity. Item 9 concerns the working situation, his speed, endurance, quality, independence in work, ability to concentrate, co-operation, observance of rules, interests, ability to change work. Item 10 tells about the client's hobbies, his attitude to the other clients in club activities, at week-end activities. Item 11 indicates his home conditions and finally item 12 is a description of his behaviour, personal hygiene, attitude to the working environment, his moods, judgment of his own situation, handling of tools, materials and equipment, reaction to instruction, honesty, helpfulness, etc. These items must be completed by the group leader and there is adequate space for remarks from other specialists such as, for instance, teacher, doctor, social worker, and finally for concluding remarks about the client.

According to the regulations of our board we must hold meetings (or case conferences) about each individual client in which various specialists participate to discuss the client, his present situation and prognosis. It is very useful to have the above data collected for these meetings and the conclusions reached are entered in the client's record. Up to now we have only occasionally involved the client in the discussions, but I think we must try to do more of this in future. These meetings where the client is assessed are very interesting and revealing. All members of the staff who are dealing with the client participate in these meetings and have the opportunity to submit descriptions and observations on the client; a general discussion is held concerning the present situation and the further measures which should be taken. Many small details about the client are revealed in this way and like a jigsaw they can be assembled to make an excellent total picture. For the staff it is of immense importance that they all participate in the meetings. In this way they are able to follow the treatment plan which has been unanimously agreed, and as a result they are much more interested in their work.

In both my papers I have attached special importance to describing our workshops which incidentally have been visited by a great number of visitors from abroad. Until six to eight years ago we also provided training instruction in farming and domestic work, but parallel to the alteration of the occupational structure of the normal population, together with the change in Denmark from an agricultural to an industrialised country, the consequence was that these two institutions were increasingly unable to provide trainees and therefore we had to change their structure or abolish them. It is my experience that the mentally retarded will follow the pattern of the normal population concerning the choice of vocation and accommodation, even if this happens at a slower speed than is the fact in the normal population. Therefore, as mentioned before, we must always be on the look-out for changes affecting the normal population, for these undoubtedly will influence the requirements of the mentally retarded.
Some twenty years ago we were criticised because we placed the mentally retarded in farming jobs or domestic work. Today we meet criticism because we employ the mentally retarded on monotonous work, but I think this criticism is unfair because many of the normal population are occupied in similar jobs in industry. I do not believe that we have yet found the complete solution to occupation of the mentally retarded. Their occupational needs will constantly change and we must be prepared to adapt our thinking to changing conditions in the labour market.
12. Sheltered Workshops for the Mentally Retarded

by

Francis X. Lynch, Director,
Division of Developmental Disabilities
Rehabilitation Services Administration
Social and Rehabilitation Service
Department of Health, Education, and Welfare

Introduction

Although a number of rehabilitation services are needed by the mentally retarded at different stages of life, the sheltered workshop represents the major rehabilitation service with the most general application. Many mildly retarded adults can, with assistance, obtain employment in the open labour market. Others will require the service of a rehabilitation counsellor. Still others will need further training prior to entering the competitive world.

Few moderately retarded persons will independently obtain employment. For them as a rule, competitive employment is not feasible, yet they are fully able to work in a protected environment.

The sheltered workshops we have in the United States are found in connection with a residential institution for the retarded, or a facility within the community serving the mentally retarded and/or others from a given geographic area.

The Laws

The US government has several laws authorising financial assistance to state, local, and private non-profit organisations that want to construct, initiate, or operate a workshop as a stepping stone in the rehabilitation process, or for aiding allied educational, training, and rehabilitation aspects of the many services the handicapped individual needs to be prepared for employment. The Rehabilitation Services Administration has responsibility for implementing the laws relating to vocational rehabilitation of the mentally retarded.

These laws are the Vocational Rehabilitation Act of 1920 and its series of amendments all the way up to 1971.

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 and its successor, the Developmental Disabilities Services and Facilities Construction Act of 1970, authorise services to the mentally retarded and others who have a substantial neurological disability originating in childhood and requiring similar treatment to that of mental retardation.

In implementing a new law, it is the role of the federal Government to draw up standards, guidelines, and regulations to assist in the interpretation of the law to interested citizens.

Included in these are always some definitions of the terms we use.

Definitions

A sheltered workshop means a charitable organisation or institution conducted not for profit but for the purpose of carrying out a recognised programme of rehabilitation of handicapped workers, and/or providing such individuals with remunerative employment or other occupational rehabilitation activity of an educational or therapeutic nature.

That is the definition in the regulations governing wages and hours in sheltered workshops. Do you agree with it, or do you think it is too inclusive?
Here is a related definition, that of a work activities centre. It shall mean a workshop or a physically separate section of the workshop having an identifiable programme, separate records and supervision, for those who are so severely handicapped that their productive capacities are inconsequential.

The National Association of Sheltered Workshops and Homebound Programs defines a sheltered workshop as a work-oriented rehabilitation facility with a controlled working environment and individual vocational goals which utilises work experience and related services for assisting the handicapped person to progress toward normal living and a productive vocational status.

For some mentally retarded individuals the sheltered workshop is a stepping stone to the labour market, for others it is an "end port".

Some candidates for sheltered employment will have a background of years of training and habilitation prior to entering the workshop, while for others it will be an abrupt transition from a lifetime as a sub-citizen in the community.

So it is important to look at the candidate's qualifications for some of these workshops.

It is assumed that the more fortunate ones - those who have been prepared by years of training and counselling in the institution or in the special education or vocational training classes of the school systems - will be better prepared for the routine of a workshop. Much of their preliminary screening would have been done by knowledgeable individuals. Their aptitudes, emotional problems, etc., will be better known.

Workshop Site

Some workshops are already on institutional grounds, others are struggling in inadequate facilities and on inadequate funds to bring a service to the community.

Our federal Government offers assistance in the establishment of workshops, and the local government or non-profit organisation wishing to start one might wish to investigate the types of assistance.

A workshop should serve a specified geographic area and within that area have a sufficient number of candidates suitable for work or training in the protective setting.

Then, too, there must be adequate and suitable transportation to and from the workshop. Some of the candidates will undoubtedly have mobility problems.

There should be parking and loading space.

The workshop should be near the work source.

There should be adequate space for the duties to be performed and, if possible, room for expansion.

The community should endorse the workshop as might be evidenced by putting up the matching funds required for federal aid.

The President's Committee on Mental Retardation suggests that workshops be established in regional shopping centres and industrial parks. With the move of people as well as industry to suburban communities, this sounds logical.

The Client

Intake

Entrance into the workshop is often a post-school experience and when the workshop is away from the institution many factors automatically taken care of in institutional living must be provided for in the community workshop.
There should be medical information available on the client. What drugs does he take? Is he subject to seizures? Has he disruptive behaviour problems?

What is his IQ? What aptitudes does he possess? Disabilities other than retardation? Etc.

What are his living conditions in the community? What is the attitude of his family towards him?

Clients are referred to the workshop from a number of sources. Besides the intake interview, as complete a background record as possible should be available to the workshop.

Counselling in the Workshop Setting

The qualities producing a good counsellor-client relationship were discussed in my paper on prevocational counselling.

The same favourable attributes are needed also in the sheltered workshop atmosphere.

Here, the counsellor may operate in individual or group settings. Contacts with the trainees may be on a casual basis as might occur when an immediate decision must be given, or on a formal basis at specific sessions for such.

The trainee has brought along to the workshop problems from his old environment and now has added the ones necessitated by the social, emotional, and vocational impact of the new environment.

Also his counsellor may have changed, and he may be counselled by not one but several staff members.

There should be long-term counselling sessions while the person is in the workshop, brief short-term sessions to settle an immediate issue, and group meetings for informational, social, and even therapeutic purposes.

Evaluation of the Trainee

When the trainee in the sheltered workshop is confronted with his new job duties, there are many factors which will affect his on-the-job performance and final evaluation.

He may be filled with anxiety lest he fail.

Dependent as he has been all his life on other people, he may fail to establish good rapport with the supervisor.

His frustration tolerance, his fatigue tolerance, will be noticeable.

His physical limitations may affect his job performance.

During the evaluation and before the trainee is released to an occupation in industry, simple things in relation to everyday living should be evaluated. For example:

- Is his attendance record good, and is he punctual?
- Can he get to and from the workshop alone? Make change? Use the telephone?
- Is he clean and well-groomed?
- Is he usually at his bench or are there frequent departures?
- When he completes a job, does he ask for more work?
- How does he show his interest in his work?
- Does he appreciate or resent criticism?
Is he a self-starter or does he need frequent reminders to get started?
Does he forget easily?
How does he mix with his fellow workers?
Has he expressed any interest in more challenging job duties?
Is his job performance talked over with him at stated intervals?
Who will do the follow-up after his job placement?

Effective Supervision of the Workshop

No one person can be the counsellor, the production manager, the work procurer, trainer, book-keeper, and all the other individuals whose skills are needed in the operation of a workshop. It takes a team.

Nevertheless, there are critical requirements needed for the overseer of the workshop.

Specifically, the floor supervisor in a sheltered workshop has several functions in common with industrial foremen, which puts him in a good position to make realistic evaluations. He also spends more time with the client than other rehabilitation professionals, hence should have a greater impact. Thus, whether the final goal for a given person is competitive or sheltered work, workshops and their floor supervisors should play important roles in the rehabilitation process.

(a) Implications for Use

Workshop supervisors are in a key position to improve the rehabilitation potential of clients. It follows that supervisor and workshop can also have negative effects. The counsellor should keep these two points clearly in mind.

In ordering workshop services for his client, the counsellor should make sure that (1) the supervisor is not given to ineffective or harmful behaviours; (2) the workshop and its equipment are relevant to employment opportunities in the community; and (3) the work activities chosen are meaningful in themselves, suitable for the client, and well designed to bring the client closer to his vocational goal. He should also maintain close contact with the supervisor to assure a positive experience for his client.

Administrators and counsellors should note that emotional maturity and interpersonal skills are even more important in a floor supervisor than technical knowledge.

Floor supervisors must play roles for which they need systematic training. To meet this need, comprehensive training materials must be developed.

Workshop differences - especially subcontract versus renovation work - have a bearing on the skills needed, and may affect the recruitment, orientation, and training of floor supervisors.

(b) Most Frequent Effective Supervisor Behaviours

- The supervisor deals well with problems which hinder employment, such as deviant personalities and attitudes, poor work habits, and low productivity. He does this by strict discipline, gentle persuasion, and changes in work environment.

- The supervisor tries - by a supportive relationship, careful training, and placement on the right job - to reduce client limitations.

- The supervisor promotes and maintains high morale and motivation by creating a positive social-emotional climate in the work group.
Most Frequent Ineffective Behaviour

- The supervisor is a poor human relations agent and leader who fails to respect workers' ideas, opinions and feelings; has poor self-control under stress; and relates inappropriately to his workers.
- The supervisor sets a poor example by violating safety rules, showing poor work habits and attitudes, and disregarding other rules.
- The supervisor fails to deal effectively with workers who break specific rules or display poor work habits or attitudes.

Findings from Questionnaire Used in One of Our Research Projects

Top-Ranked Personal Characteristics of "Good" Workshop Supervisor

- plans and schedules work well;
- is patient with slow learners and thinkers;
- communicates well with persons of all educational levels;
- has good work skills and knowledge;
- keeps confidential information to himself;
- knows how to motivate and stimulate others;
- is convinced the handicapped are not "different" from others;
- keeps the organisation's major objectives in mind.

Work Projects

Where does the sheltered workshop get the work for its employees, assuming that it is interested in industrial work rather than the manufacture and sale of its own articles?

It reaches out into the community through its board members, chamber of commerce, civic and health and welfare organisations and employment agencies. If time and staff permit a staff representative goes out and contacts industry looking for job possibilities.

Where there is more than one sheltered workshop, centralised contract procurement systems should be encouraged, either within individual communities or within a geographic region.

Centralised contracting can funnel contracts to workshops best equipped to handle them, and can properly assign contracts too large for any single workshop.

There are firms which contract work out regularly and which are among the best prospects from which to solicit work.

It would be well if the workshop could try out duties on a new job prospect; in that way it could make a more effective bid for the contract.

The job could be broken down into its elements and time studies made of the number of units that could be completed in an hour.

Thus the studies would form a basis for wages.

The cost to the industry should allow for overhead expenses.

Other considerations before contracting would be:
Many sheltered workshops for the retarded face problems of operations, productivity, safety, and management.

Standards for workshop operations are essential and should be considered in all phases of planning.

- The workshop should conform to all health, safety, and fire codes and standards.
- Equipment may have to be adapted to certain handicaps.
- Special safety devices may be necessary on machinery.
- Periods of instruction may be lengthy and require much patience.
- The importance of placement, care, and storage of tools cannot be overstressed.
- Shop rules, discipline, coffee breaks, etc., should be the same for all.
- The work should be full time for all, if possible. Part-time workers, coming and going, disturb the routine of the job.
- Some workshops separate the transitional from the permanent retardate; others do not.
- The goals of the two groups will be different.

Wages

The federal government, through amendments to the Fair Labor Standards (Public Law 89-601) administered by the Department of Labor, provides for the employment of individuals whose productive capacity is impaired by mental deficiency at wages which are lower than the minimum wage applicable but not less than 50 per cent of such wage, and which are commensurate with those paid to non-handicapped workers in the geographic vicinity for the same type, quality, and quantity of work.

These workers perform their job duties under special certificates.

Wage Payments

Salaries for the trainees (or clients, however they are termed) may be paid at a piece rate. This method may be a frustration for those with poor eye-hand co-ordination or poor manual dexterity.

This method, which offers more incentive for some workers, adds to the bookkeeping.

Hourly rates are easy to compute.

They can be computed on average output, and so, critically, do not provide incentive for the faster worker.
Job Placement

There are in the United States today mentally retarded individuals ready for job placement in the community, but the community does not have enough suitable jobs, living arrangements, and/or other supportive services to make it feasible to send these individuals into the open labour market.

There are jobs in the community that could be adapted to the skills of the mentally retarded.

We are still faced with community attitudes towards the retarded, and also the attitudes of non-disabled employees, and even employers.

Another factor affecting community job placement is the performance record of earlier "graduates of the sheltered workshop".

The counsellor can work very closely with the Vocational Rehabilitation Service and State Employment Service in discovering where job vacancies are.

Another possibility would be in the industry with which the workshop has a contract. That industry would have first-hand knowledge of the quality of the products made in the workshop.

When the client is ready to "graduate", the workshop staff must take the active role in placement of the retardate in a community job.

Conclusions

By the close of 1970 there were 1,487 sheltered workshops serving 68,060 handicapped clients under the certification programme on minimum wages of the US Department of Labor.

These are not the total number of workshops nor does it indicate how many mentally retarded individuals were served.

Figures taken from different sources do not agree with each other.

Studies made of a selected sample of sheltered workshops showed that roughly one-third of the clients were in long-term placement there, and the other two-thirds went on to community placement or failed as "non-rehabilitated".

Some workshops met the definition of "activity centre" although called workshops.

It is estimated that at least 600 workshops are needed for the mentally retarded individuals who could benefit from workshop training for either competitive or sheltered employment.

Simultaneously communities must use these trained retardates, which means opening doors to many, many more simple jobs that the retarded groups have been found capable of performing.
13. Problems of Mental Retardation - Criteria and Classification, Causation and Prevention

by

A.D.B. Clarke, Ph.D., Professor of Psychology, University of Hull, England

I. Criteria and Classification

In the past, as well as at the present time, different countries have employed widely different practices for, and concepts of, mental retardation. It is scarcely surprising, therefore, that there are many different definitions of these conditions. It is probable that at all times and within all cultures, the moderately, severely and profoundly handicapped have been identified as such because of their difficulty without help in adapting themselves to social demands. Hence, one finds a greater agreement in defining the more severe than the milder forms of mental retardation. Indeed, these latter will only tend to come to notice when the complexity of society advances above the limits of their spontaneous competence. In a very real sense technological advance, urbanisation and industrialisation create conditions which pose problems for, and thus reveal for the first time, the slow learner. Paradoxically, therefore, the development of a country will increase the number of mentally retarded persons.

The World Health Organisation (1954) referred to mental retardation as "incomplete or insufficient general development of the mental capacities ... it is intended to cover only cases in which general mental development is insufficient". The American Association on Mental Deficiency (Heber, 1959) defined mental retardation as "sub-average general intellectual functioning which originates during the development period and is associated with impairment in one or more of the following: (1) maturation, (2) learning, and (5) social adjustment". Here "sub-average" refers to performance more than one standard deviation below the population mean; "general intellectual functioning" may be assessed by one or more of the objective tests developed for the purpose; and the upper age limit of the "development period" is regarded as about sixteen years. Maturation and learning are also carefully discussed and "social adjustment" at the adult level is regarded as the degree to which the individual is able to maintain himself independently in the community and in gainful employment, as well as his ability to meet and conform to other personal and social standards as set by the community. In its Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death, the World Health Organisation (1967) follows the American suggestion in defining "border-line mental retardation" (and hence all lower levels of subnormality) as lying between IQ 85 and 68. The WHO Expert Committee (1968), however, deplored this widening of the concept, believing both that the quality of available services, geared to lower ability, would be damaged and that the category would become a repository for other conditions.

Conventional definitions use rather similar phrases, such as "incomplete or insufficient general mental development", "sub-average general intellectual functioning", and "arrested or incomplete development of mind ... which includes subnormality of intelligence" and focus on lack of intelligence as an essential criterion. Indeed, with such a wide group as the retarded, heterogeneous in causation, level of functioning and outcome, low or very low intelligence is perhaps the only quality its members have in common. Moreover, when such criteria as social adjustment are used, these can never be precisely defined so that in practice all such terms, particularly of the higher levels of retardation, permit wide differences in interpretation and in practice.

In considering the problem of criteria of mental retardation, and systems of classification, it is important to identify the underlying purposes for any particular system: sometimes these may be scientific in aim, or educational or medical or administrative. A system developed for one purpose may not be appropriate for another. Members of this Seminar will be especially interested in a system (see figure I) which: (1) gives information on the level of handicap; (2) gives some broad and actuarial guide to the likely outcome; and (5) less certainly gives some broad indication of probable causation. It should be noted, however, that the classification of an individual as mentally
retarded does not necessarily imply a life-long condition of dependence. Particularly among the milder grades, there are those who either learn to adjust satisfactorily to society, or who through delayed maturation move into higher levels of ability and competence. (Some of these points are considered in greater detail in WHO, 1968.)

This point cannot be emphasised too strongly, and is illustrated by a literature survey we recently undertook in England. Two per cent of the population represents about 960,000 persons who have IQs of 70 and below (i.e. all grades of retardation). By examining all official statistics we could only account for a third of these receiving special assistance at any one point in time. And of this third, the vast majority were moderately, severely and profoundly retarded. One cannot escape the conclusion, therefore, that a large majority of mildly retarded persons (with IQs between 50 and 70) are not receiving any special help from the community, in a country where the complexity of society is considerable, but where ordinary welfare services are available to all citizens. It is obvious, therefore, that limited intelligence is far from necessarily implying a very poor outcome. It seems that, even in a complex society, the majority of the mildly retarded can find a niche, and also that in some there are maturational processes at work, to be described later, which as adults lift them above their own childhood levels. An intellectual ability in the range of mild retardation, therefore, only puts its possessor "at risk" of needing special help, which, if indeed necessary, may only be for a limited period of his life (e.g. the school years).

II. Causation

Attempts have been made, with some over-simplification, to identify three headlines in the causation of the many conditions subsumed under the heading of mental retardation, and to relate them to the levels of ability within the whole group (see figure I).

First, ordinary polygenic variation is certainly responsible for a fair proportion of those in the higher grades (above IQ 50 or thereabouts). With parent-child IQ correlations of about 0.5, it is obvious that children may show different levels of ability from their parents, even though there is a clear tendency for parent-child resemblance. Thus, for parents who are themselves below average there is some chance of their producing children of average levels or above, as well as the milder grades of retardation. No unusual mechanism need therefore necessarily be invoked for those mildly retarded persons (a) whose conditions of childhood have been reasonable, (b) whose parents are of average or below average ability themselves, and (c) who have no history, or signs suggestive of, an organic pathology.

The second aetiological group which is usually identified is termed sub-cultural. With perhaps dull parents together with adversity of social and child-rearing conditions, their level is considered to result from a complex interaction of poor genetic endowment and poor environment. It is this group which is thought most likely to benefit from social and special educational programmes.

Thirdly, there are those whose condition is largely pathological in origin. Obviously, pathological changes in the central nervous system may operate at almost any grade of ability, reducing its functional level by various amounts.
MENTAL RETARDATION: CAUSES AND CLASSIFICATION

<table>
<thead>
<tr>
<th>Causes</th>
<th>IQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing genetic normal variation</td>
<td>0-20</td>
</tr>
<tr>
<td>Increasing pathological</td>
<td>20-50</td>
</tr>
<tr>
<td>Increasing subcultural</td>
<td>50-75</td>
</tr>
</tbody>
</table>

MENTAL DEFICIENCY

<table>
<thead>
<tr>
<th>Old Scientific terminology</th>
<th>Old WHO Expert Committee (1968)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDIOT</td>
<td>PROFOUND</td>
</tr>
<tr>
<td>IMBECILE</td>
<td>SEVERE</td>
</tr>
<tr>
<td>FEEBLE-MINDED OR MORON</td>
<td>MODERATE</td>
</tr>
<tr>
<td></td>
<td>MILD</td>
</tr>
</tbody>
</table>

Within the range of retardation, however, we are dealing with grosser changes and grosser effects. And as one descends the IQ scale, the more likely it is that a given condition is pathological in origin. In developing countries, those suffering pathologically induced defects will tend to be a relatively large group; infective agents will constitute an important set of causes, and early and severe malnutrition appears to make a large contribution to moderate retardation.

Mental retardation poses two main problems; first, the task of primary prevention of these conditions, whether they be of medico-biological or socio-cultural origin, or, more commonly, resulting from the interaction of both. The second problem is the amelioration or treatment of existing mental retardation wherever possible, again whether by medical, social or educational means. Of course, these aspects overlap to some extent; if amelioration is highly effective it becomes prevention, so that division of research into two categories is to some extent artificial. There have been recent important theoretical advances in the first sphere, leading to some practical results, though it is very unlikely that, in the immediately foreseeable future, mental retardation will be substantially reduced in incidence. In the second, however, the increased awareness of mental retardation as a special problem in learning has already borne practical fruit. Although not wishing to minimise our continuing ignorance, it is now obvious from a variety of broad educational and training programmes that much can be done to use, develop and indeed sometimes to create, limited assets in a way thought impossible a mere fifteen years ago. The ground has thereby been cleared and the way is now open for behavioural scientists to explore in depth the details of learning and other processes. Work of this nature takes time to yield applicable knowledge; it seems that the foundations of adequate educational or training programmes for the future will be laid on the basis of research carried out under conditions sufficiently controlled to indicate causes of behavioural deficits and precise methods of overcoming them.
In this brief paper I propose to indicate something of the scope and limitations of work relating to prevention of mental retardation and second, to its amelioration. These problems are outlined in greater detail by Clarke (1969).

III. Prevention and Amelioration

Estimates of the effectiveness of preventive methods must in the last resort depend upon accurate studies of incidence and prevalence, which ultimately depend upon proper case finding techniques. The complex issues involved in such studies have been outlined in detail by Tizard (1964) and more briefly by O'Connor (1965). In developed countries, over-all prevalence is usually taken as about 2 per cent of the population with an upper limit of IQ 70 or thereabouts although in the USA 3 per cent is a more frequently quoted figure. Three-quarters of the retarded have IQs between 50 and 70, about 20 per cent between 20 and 50 and the remaining 5 per cent below IQ 20.

True prevalence can best be established for those grades where the condition is easily recognisable and where diagnosis (of retardation though not necessarily the specific cause) is thus not in dispute. In practice the moderately, severely and profoundly retarded in later childhood are most easily identified. A careful English study in the 1920s indicated a rate of 3.88 of such children per thousand. Tizard (op. cit.) has carefully surveyed the Middlesex (England) area and estimated the figures as 3.45 per thousand for a similar group. Excluding mongols, whose surviving numbers in developed countries have quadrupled in the last forty years (although incidence is unchanged), the rates are respectively 3.37 and 2.31. It seems that a constellation of social factors has led to this decrease which is partly masked by the increasing survival rate for mongols. These factors include better maternal and child health services, better nutrition, family planning, earlier marriage and earlier completion of families, reduction of serious childhood diseases and immunisation against those infections which may have neurological sequelae, the use of "risk registers", genetic counselling and the early diagnosis of some metabolic defects where remedial action seems possible. The detection of enzyme defects or chromosomal aberrations in utero by the examination of foetal cells cultured from small amounts of amniotic fluid is also likely to prove a practical method which would aid decisions to terminate pregnancy in families at risk (Steele and Breg, 1966).

It has long been known that some rare types of mental retardation (e.g. cretinism) can be successfully treated by means of replacement therapy. Or again, an understanding of haemolytic disease of the newborn due to Rhesus incompatibility has enabled successful exchange transfusions to be made, consequently affecting the incidence of retardation from this cause. More importantly, Clarke (1967) has shown that it is possible to immunise rhesus-negative mothers and prevent Rh sensitisation by rhesus-positive foetuses. Controlled studies in Liverpool, England, indicated a high degree of protection. Much publicity has also been given to the treatment of phenylketonuric children with a diet low in phenylalanine.

The prevention of higher (and much more common) grades of mental defect turns upon many complex and interacting factors. Those who owe their condition to pathological agents may be reduced in number for such reasons as those advanced above, but mild retardation is much more often caused either by normal genetic variation or by subcultural factors. It is in the latter category that the hopes for prevention are greatest. Although the evidence is not always unequivocal, it seems clear that extremely adverse social conditions play a part in retarding development. These studies indicate that if the period of deprivation is not too long there is a certain degree of reversibility in such effects. Intervention programmes such as the American "Headstart" educational schemes have attempted to prevent the development of mild retardation, but their duration is all too short, the methods used appear inappropriate and the children remain in conditions which militate against any permanent change in their developmental path. Nevertheless, a few studies indicate a successful outcome, and currently Heber (1968, 1971) is undertaking an ambitious, controlled experimental study in Milwaukee. This study, in a slum area of high prevalence for mental retardation, shows a statistical risk factor for 14 year olds of .90 when the mother's IQ is less than 80, and only .13 when maternal IQ is 80 or above. Hence low intelligence mothers (and there was strong evidence of
paternal/maternal IQ congruence) in this area have been randomly assigned either to experimental or control conditions. The newly born children of the former group were stimulated intensively from birth onwards to see whether or not it might be possible to reduce the occurrence of mental retardation. From four months of age the babies attended a special infant education centre initially with a 1:1 teacher/infant ratio, and followed a daily programme of sensory and language stimulation from early morning until late afternoon. The major emphasis has been to facilitate achievement motivation, problem solving skills and language development. Early results at age three-and-a-half show striking differences between the experimental and control children on all behavioural variables, and in terms of IQ an average difference of 37 IQ points. While Heber is professionally cautious, he concludes that "the performance of these children today is such that it is difficult to conceive of their ever being comparable to the 'lagging' control group. We have seen a capacity for learning on the part of extremely young children which exceeds anything which, previously, would have been believed possible. And the trend of our present data does engender the hope that it may prove to be possible to prevent the kind of mental retardation associated with both poverty and parent of limited ability. And should the means of prevention fall within our grasp surely our society will have the responsibility to do so."

Turning now to amelioration, this overlaps to some extent with the previous paragraphs, for really successful amelioration becomes prevention. Amelioration may take place through social improvements, educational or training methods, through administrative changes and above all, through the careful step-by-step investigation of what may be broadly termed the learning processes - simple words used to describe the highly complex modes of modification of behaviour which occur throughout life. There can be little doubt that the amelioration of subnormality, sometimes profound, sometimes barely measurable, can and does occur. The gap, however, between research findings and administrative practice remains wide. These problems have been discussed in detail by Clarke (1969) and Baumeister (1967) among many other writers. A few examples of recent work are offered below.

(a) The moderately, severely and profoundly retarded and their problems in industrial communities have been carefully described by Saenger (1957) and by Tizard and Grad (1961).

The effects upon development of different forms of residential care have been described by Lyle (1959; 1960(a) and (b)) and by Tizard (1960). Institutionalisation clearly retards verbal development, but the effect may be reduced in small units generously staffed (e.g. the Brooklands Experiment, Tizard, op. cit.). It was the view of the experimenter that considerably better social and emotional adjustment resulted from the greater attention given to the children in the residential unit. Tizard, Raynes, King and Ruchlick (1968) have studied differences in child management techniques, and believe that it is the social organisation of our present residential institutions which is the main factor responsible for the poor quality of care which many of them provide.

Most studies on the effects of special class training of imbecile children have been poorly controlled and of short duration. Charney (1965) gives a useful over-view of this field. It is significant that, in a lengthy and more recent review on educational research, Guskin and Spicker (1968) are able to devote less than three pages to the educational and training problems of the moderately and severely retarded. They cite, among others, a carefully controlled study by Cain and Levine (1963) which showed that home-based children, attending or not attending school, increased significantly in social competence over a two-year period, although they failed to differ significantly from each other. Institutionalised groups decreased substantially in social competence over this period. The lack of significant differences between school and non-school children substantiates some earlier findings. Careful surveys of curriculum content forced the authors to conclude that two of the major reasons why educational programmes have not been shown to facilitate social competence are (a) inadequacy of curriculum content and (b) poor teaching. They conclude also, "that special classes for the trainable as presently constituted cannot be defended on the basis of benefit to parents".
Such findings are in sharp contrast with those of the early experimental laboratory and workshop studies on imbecile adults in England. Gordon, O'Connor and Tizard (1954 and 1955), Tizard and Loos (1954) and Clarke and Hermelin (1955) gave evidence for substantial modifications of perceptual-motor behaviour. Much of this, together with corroborative independent findings in sheltered workshops in Holland, laid the basis for the better training and sheltered employment now available in some developed countries.

There appear to be several reasons for greater ignorance of appropriate training methods for children than for adults. First and foremost, until recently educational research upon severely subnormal children was, on the whole, poorly controlled and scanty. Second, both in the United States and in England, that section of the teaching profession concerned with these children has been accorded short and inadequate training and low professional status. Third, the commendable provision of beautiful buildings as training centres appears in some countries to have diverted educational authorities from any precise evaluation of what goes on inside them.

This subsection can be concluded by a reaffirmation of the earlier statement that to varying extents (sometimes large, sometimes negligible) the behaviour processes of the severely retarded are subject to modification. More is known about the appropriate methods for adults than for children but there is a dearth of properly controlled long-term evaluative studies. For such persons, the starting level for learning is usually poor on most tasks, and yet subsequent learning and retention can often occur. This suggests, as a main deficit, a relative inability to learn from ordinary life experience, a disability which individual training under special conditions can do something to overcome. Although our ignorance cannot be minimised, it is already clear from experimental studies that novel curricula could be devised for the education and training of the moderately or severely retarded, which would allow controlled evaluation and identification of critical aspects of such methods.

(b) The mildly retarded. It is generally estimated that about 2 per cent of the population may be regarded as intellectually retarded, in the proportion of 3 million to every one case below IQ 50. It has already been indicated that an IQ between 50 and 70 puts its possessor "at risk" of needing special help, perhaps temporarily, and does not necessarily imply a poor outcome. This analysis is supported by the results of long-term social follow-up of mildly retarded persons (Charles, 1953; Miller, 1965). A large group identified as retarded and attending "opportunity classes" was originally studied in the 1930s. Detailed analysis of the ways in which its members differed from the general population has been provided and the successively improving outcome carefully documented. A final monograph by Baller, Charles and Miller (1967) indicated that the majority were functioning adequately as low-average members of the population, working in unskilled or semi-skilled employment. Of average age 55 years, this group has "continued to fare much better than could have been predicted or even hoped for".

A detailed summary of American work on social and occupational adjustment of mental retardates is provided by Goldstein (1964) who concluded that (1) the results of follow-up studies of former inmates of institutions for the mentally retarded indicated that the prevailing pessimism of professional and lay people is unwarranted; (2) comparative studies of the social adjustment of adult retardates and normal peers indicated that the former were generally inferior on most criteria, including employment, but it was difficult to be sure whether these differences might be accounted for by intellectual differences or by social factors; (3) occupationally the retarded cluster in the unskilled category or service occupations; they did not appear to change jobs more frequently than normal workers, but tended to be the first to be discharged during slack periods; and (4) there was encouraging evidence that training programmes and counselling services were effective. Guskin and Spicker (1968) have reviewed educational research undertaken in America with both educable and trainable mental defectives of school age; although the results of special educational interventions have not always shown gains, on the whole there are grounds for cautious optimism in this area.

Another source of supportive evidence for their thesis emerges from prevalence studies. Analysis of age rates (Penrose, 1949) indicates a marked reduction in numbers from adolescence onwards, a fact confirmed in general by more recent surveys in Baltimore and Onondaga County in the United States.
According to Clarke (1969) this is accounted for by three factors: (1) "camouflage" which implies no change in the individual but a lowering of intellectual demands following school age and hence reasonable adjustment; (2) prolonged but ultimately successful social learning; and (3) delayed maturation, characterised by IQ increments which tend to occur in some subcultural members of the mildly retarded population. These factors, singly or in combination, may account for the diminution in identifiable numbers as age increases.

In summary, it seems that among the mildly retarded there are those whose condition, to varying extents, spontaneously improves. Other studies (e.g. Skeels and Dye, 1959; Skeels, 1966) suggest that planned intervention, initiated early and reinforced throughout life, can result in more profound changes.

Many such studies can be criticised on methodological grounds but, even so, the data have been carefully collected and have led to methodologically purer research (Gray and Klaus, 1965; Heber, 1968, 1971; Gray and Klaus, 1970). It is likely that in the next few years the detailed results of these more recent studies will give a fuller understanding of the problems of amelioration of mild retardation.

IV. Discussion on Training, Habilitation and Employability

The research so far quoted has emerged from complex industrial societies, and it might well be thought to have little relevance to problems in developing countries, where lack of funds, lack of special staff, unemployment or under-employment of normal persons are often typical. It will be argued here, however, that a number of broad general principles which have emerged from such research are indeed of relevance, and these will be enumerated below.

1. In no population more than the mentally retarded is it more important to make a distinction between performance in a given situation, based on spontaneous incidental learning, and capacity to acquire certain skills, granted clear instruction and a fairly long period of training. It is clear that the retarded of all levels are strongly affected by (a) the type of training or education offered and (b) the expectancies which surround these. Structured, programmed and directed training is needed, in the context of high demands being made upon the handicapped person. This is the only way of combatting and ultimately minimising the handicap.

2. Whenever possible, the aim must be to place the retarded person in normal employment. This will especially prove possible for many of the mildly retarded, although the period of preparation and training may in some cases need to be prolonged. As Oobb (1969) puts it, in a very useful monograph, "failure at any point should never be taken as conclusive. The general principle ... is that predictions of adaptive success are generally more reliable than predictions of failure".

3. For the moderately and severely retarded, with proper training on unskilled tasks, their performance need not differ from that of mildly retarded persons. Nevertheless, sheltered work appears most appropriate for the majority, because of their relative inability to acquire a wide range of skills, including complex social skills.

4. Repetitive tasks are obviously more suitable for the retarded than non-repetitive. This does not necessarily imply that after training these persons cannot undertake relatively complicated ones, however.

5. Advances in ameliorating mental retardation are usually initiated by small experimental pilot schemes. These (a) can yield new knowledge, in the context of a particular society or culture; (b) permit flexibility in developing the best type of programme; and (c) have a "political" advantage in enabling reformers to put forward realistic plans.

It is hoped that discussion with members of the Seminar will enable points of interest to be developed after the paper has been delivered. Participants will find the WHO Technical Report No. 392 on "Organisation of Services for the Mentally Retarded" (1968) particularly helpful in this respect.
REFERENCES


14. **Classification and Characteristics of Psychiatric Disorders**

by

Dr. A.M. Battenburg-Plenter,
Chief Medical Officer and Psychiatrist,
Beatrix-Irene Children's Hospital, Rotterdam

The title of my paper comprises almost the whole of psychiatry and therefore I think I have to restrict myself to mentioning a number of main features in this presentation, and to making choices which I hope will be relevant to you.

First of all some general remarks about psychiatric symptoms, syndromes and diagnoses;

(a) With regard to symptoms:

In physical pathology symptoms themselves are often directly identifiable as disease phenomena, such as fever, inflammation, pain, etc. In psychiatry, however, one has often to deal with phenomena which can be labelled as "symptoms" only if the biographic, personal, psychological and social data of the subject in the case are known, such as for example: anguish, sorrow, irritability, etc., etc. Not the phenomenon as such makes it a "symptom" but the connection of data within which it manifests itself. These data can certainly not be produced by the psychiatric discipline alone.

(b) With regard to syndromes:

A group of symptoms, often occurring together, is called a syndrome, for example (1) elated but unstable mood with (2) flight of ideas and garrulousness and (3) increased motor activity. A syndrome is not a diagnosis, but may render important indications for a diagnosis.

(c) With regard to diagnoses:

In physical pathology the diagnosis is very important for the physician, it being the spring-board for an adequate treatment.

In psychiatry also, diagnosis and classification are very important, but on the other hand certain objections are felt: (1) the singularity of each psychiatric patient cannot be pushed into a diagnostic pigeon hole; (2) consequently psychiatric diagnosis would always be incomplete and often impossible; (3) the demarcations between various psychiatric disorders are often vague and confluent.

For some psychiatrists the objections weigh so heavily, that they reject diagnostic systems and prefer a multi-disciplinary description of the patient. These seemingly controversial opinions will not be discussed further now.

Personally I range myself among those, who consider psychiatric diagnostics and classification as a valuable framework from which one knows what one wants to describe and against which the description can be grouped together and selected.

The name of the founder of psychiatric classification should be mentioned here: Emil Kraepelin, who lived in Munich from 1856-1926.

At present the World Health Organisation recommends the ICD classification of psychiatric disorders (International Classification of Diseases, chapter on Mental Disorders). I shall now continue to discuss the main features of my presentation: psychoses, neuroses, disturbances of personality and oligophrenias (about the latter you have been informed on 16 October).
Psychoses

A psychosis indicates a situation in which the conscious functions of the ego (sensation, will, thinking, perception) are insufficient to adapt to the surrounding world, and in which moreover the "reality testing" fails, i.e. the distinction between reality and inner fantasy - or wish - world.

In this paragraph on psychoses I would like to discuss in summary the two "big" psychoses, i.e. schizophrenic psychosis and manic-depressive psychosis.

I. Schizophrenia

In schizophrenia almost all of the psychotic phenomena can be found together in all kinds of combinations: for example delusions, hallucinations, disturbances in thinking and in motor activity, etc. However, the schizophrenic patient does not demonstrate an impairment of consciousness or twilight - or dream conditions. Not only with regard to psychotic manifestations, but also to the course of the disease and its endpoints, schizophrenia is very varied. Sometimes the onset is stealthy and hardly noticeable; sometimes the onset is acutely psychotic.

Mostly the course of schizophrenia shows acute phases (Schübe) each of which will "heal" with mental scars and altogether can lead to a seriously damaged personality. In the most serious cases a patient can be maintained only if institutionalised. In less serious cases a patient can hold his own in the community if supported and guided by re-socialising teams.

In the most serious cases the patient seems to be "extinguished", i.e. emotionally unapproachable and inactive. But, especially with regard to this Seminar, it should be pointed out that by applying modern therapies such as psychotherapy, occupational therapy, creative therapy and drug therapy the group of totally extinguished schizophrenics becomes smaller and smaller all the time.

You will undoubtedly be able to see activities in this field in Denmark, intramurally as well as extramurally.

II. The Manic-Depressive Psychosis

This psychosis manifests itself in the patient's inner life, which shows severe fluctuations. Within the framework of this psychosis, maniacal and depressive syndromes occur. The maniacal syndrome consists of elated but unstable mood, flight of ideas and over-talkativeness and increased motor activity. The depressive syndrome is characterised by disinhibition.

The depressive syndrome is the counterpart and is characterised by inhibition: depressed mood, psychomotor inactivity, slowing in thinking. The depressive patient talks only reactively, i.e. in response and preferably in "one-word sentences". A given individual may show any combination of manic and depressive episodes, for example a single period of depression or mania, or repeated attacks of depression or mania alone, or periodic alternations of manic and depressive episodes. Whether the manic-depressive patient will be able to hold his own in his family, profession or in society depends to a great extent on the length of the healthy inter-phasic periods. These may vary from a few weeks - in which case the patient can hardly be maintained - to a number of years.

Neurosis

In neurosis the development of the personality has been hampered and disturbed, based on conflict situations in the central and inner self. There are conflicts between the conscious ego (thinking, will, sensation, conscience) and the unconscious instinctive impulses. Such conflicts are in their deepest roots inaccessible to the patient. He is unable to "solve" them consciously. But the conflicts influence his development, behaviour, relationships and use of energy: he is not "free".

Contrary to the psychotic patient, the neurotic patient does not show misinterpretations of external reality. If a psychotic thinks that two and two make five, the neurotic knows it makes four, but this makes him nervous ...
all neuroses anguish and feelings of guilt occur, which are either expressed as such, or in a camouflaged form. Some main features of the variated field of neuroses may serve as examples:

(a) Anxiety neurosis: the patient experiences anxiety or agony periodically and sometimes continuously, accompanied by physical side effects.

(b) In phobic neurosis the patient experiences fear, i.e. fright, related to an object or situation: for example being frightened when in the street, or afraid to blush.

Such symptoms are also known to exist in apparently healthy persons, but in phobic neurosis the intensity and frequency of fears is such that the patient's life is dominated by them (for example a patient who never dares to go into the street).

In both neuroses (i.e. anxiety neurosis and phobic neurosis) the patient very well realises the irrational aspects of the phenomenon, but this does not help him, because he is unaware of the deeper roots of the symptoms of the inner conflict situation.

(c) In compulsion neurosis the patient's inner self forces him inevitably to think and do certain things, to have certain ideas (obsessions) and to carry out acts (compulsive acts) which he rejects rationally and which he experiences as tormenting and absurd (for example the hand-washing compulsion).

The neurotic anxiety is hidden behind the symptom and will appear if the symptom is forbidden.

(d) The hysterico neurosis has the most variegated symptomatology of all neuroses. In a great variety of combinations neurotic phenomena may occur in many fields: physical, mental, relational, etc.

Finally a few words about neurasthenia and the neurasthenic syndrome. This consists of prolonged feelings of weakness and fatigue, poor concentration, many aches and pains (headaches), insomnia and irritability. The syndrome may occur in all kinds of situations, for example if a person is overworked, but also as the main constituent part of a longstanding condition in which the patient moreover often expresses feelings of inferiority and inadequacy.

With regard to disturbances of the personality I just wish to mention the psychopaths. These relate to persons with a dysharmonic structure, who are often in conflict with their environment and with society (the so-called "sociopathic personalities") and who always blame others for this. They often make other people suffer, but may also indirectly suffer from what they do.

In the lay-world "psychopath" is regarded as an abusive word. But also in the profession the diagnosis often has certain overtones: a negative value judgment with prognostic defeatism. This is based mainly on the obsolete unicausal conception of psychopathy: "It is predisposition and nothing can be done about it."

Modern research has shown that a number of predisposing factors can play a role in the development of psychopathy, such as a natural bent, plus early emotional deprivation, plus minimal brain damage. Gaps may occur in the personality, for example a warped capacity for love, i.e. the potency to recognise or to receive love will atrophy. Because of this gap, many enthusiastic, devoted and expert rehabilitation efforts have failed and so the gloomy prognosis of incurability has been generated.

However, modern experience has shown that if a psychopathic development is recognised in good time (preferably in early age) treatment is still possible, be it difficult and of a long-term nature.

I am aware that I have been far from comprehensive with this presentation.

Yet I hope to have presented to you a canvas and that by study and experience you will be able to help the psychiatrically disabled towards a fuller and more active life.
15. Rehabilitation of the Long-Term
Psychiatric Patient - Vocational Aspects

by
Norman E. Cooper,
International Labour Office, Geneva

In a recent United Nations report on the world social situation, indications were given that 1 per cent of any population group is incapacitated throughout life as a result of severe psychiatric illness, and that at a conservative estimate, one person in ten is likely to suffer from illness of this kind at some time in life. The same report also emphasises that the developing areas of the world are not exempt from this problem and that what few studies exist indicate that severe mental disorders are probably as prevalent in these countries as elsewhere among comparable age groups; moreover, as a result of the gathering pace of industrialisation and urbanisation which appears to be one of the main factors leading to a rise in the incidence of neurotic and psychological problems, the burden of mental illness imposed on these communities seems likely to increase.

The extent of the incidence of mental illness and the serious problems it presents in socio-economic terms, to say nothing of the anxiety and suffering which it leaves in its wake, are well portrayed by the following data published by the United States Department of Labor and the US President's Committee on Employment of the Handicapped:

- each year about 600,000 persons are admitted to hospitals for psychiatric treatment. Of these at least 100,000 are admitted for the second or third time;
- each year some 1,450,000 persons receive treatment in public, federal and private mental hospitals or in the psychiatric wards of general hospitals;
- on any one day of the year about 790,000 persons are under the psychiatric care of these hospitals;
- the annual over-all costs of the public hospitals alone run close to US$2 billion;
- at least 50 per cent of all the millions of medical and surgical cases treated by private doctors and hospitals have a mental illness complication;
- more than half of the hospital beds in the country are occupied by mental patients.

The need for drastic rethinking in the approach to vocational rehabilitation of the long-term psychiatric patient became apparent in the 1950s when pharmacological developments resulted in changes in the patterns of several types of mental illness. As a result, large numbers of patients who had spent 10 to 20 years in the sheltered environment of a mental hospital were declared fit for discharge into the community. My personal recollection of efforts directed towards the vocational rehabilitation of such long-stay patients at that time is still very vivid. The non-residential vocational rehabilitation centre with which I was associated was situated in a heavily populated industrial area serving several large general and mental hospitals. The increase in referrals of psychiatrically disabled from the latter hospitals was quite dramatic and in fact so many cases were referred that entry had to be limited to maintain a balance between physically and mentally handicapped which is so essential in order to gain the full benefits of group support and integration.

Not surprisingly, it was found that many of the patients had lost all desire or ability to help themselves; they were socially withdrawn to varying degrees, extremely dependent, slow to react, reluctant to converse and in many instances devoid of initiative or ability to plan a realistic future for themselves. It soon became obvious that the standard vocational rehabilitation course averaging eight weeks, was totally inadequate to help the patient attain a standard of work which would be acceptable to employers, and enable them to become an independent member of society.

The influx of these problem cases had immediate repercussions on the organisation and day-to-day running of courses, particularly in the workshop sector. As the proportion of psychiatric cases rose, the tempo in the workshops tended to fall as so many of the rehabilitees required individual tuition and attention. The number of people in all disability groups abandoning their courses, increased and placement results were adversely affected. Reluctantly, but quite understandably, many of the long-term psychiatric cases who failed to respond to the industrial therapeutic treatment had to be returned to hospital, their course having been prematurely terminated on the grounds that they were unsuitable for competitive employment.

Many valuable lessons were learnt from this and similar disappointing experiences in the early 1950s, in attempting to vocationally rehabilitate the long-term psychiatric patient, and these can be summarised as follows:

- the complete rehabilitation of the long-term psychiatric patient is a long-term process;
- vocational preparation must begin while the patient is still in hospital;
- the introduction to work should be gradual;
- to offset the ill-effects of institutionalisation and to develop motivation, the work should be realistic and undertaken not in the sheltered atmosphere of the hospital ward, but in a separate workplace or workshop;
- great care should be taken by the hospital staff in selecting patients for more intensive vocational rehabilitation outside the hospital service;
- the patients themselves should be aware of their progress towards recovery and should show some initiative and motivation towards resettlement in employment;
- adequate support both during and after rehabilitation must be provided for the patient;
- in evaluating readiness for vocational rehabilitation each case should be judged on merit and not by means of diagnostic labels;
- the need for close collaboration and consultation between hospital staff and vocational rehabilitation centres is imperative at all stages, i.e. selection stage, and both during and after the course has terminated;
- the psychiatric social worker can play a key role in the co-ordinating process involving medical, social and vocational services.

The important role of the mental hospital in preparing their long-stay patients for subsequent training and/or employment in the open labour market (or in sheltered workshops not attached to the hospital) was vividly portrayed by Professor T. Lynch, Head of Psychiatric Services of the Dublin Health Authority, Ireland at the Eleventh World Congress of Rehabilitation International viz. "For the majority of long-term patients work therapy within the hospital provides an entirely new purpose in life. It is found that all men and women have a latent work ability higher than previously appreciated and industrial work can be carefully graded to bring this dormant skill to the surface. In a re-employment unit, with the right supervision and the correct type of work, patients make dramatic progress and can attain a higher standard of manual dexterity.

One of the most important aspects in this highly-specialised selection of therapeutic work for patients is the provision of a mature supervisor who will have experience in production techniques and in the art of man-management. It is
necessary to ensure that the work is broken down into simple stages ... With the right supervision and the correct type of work, quite rapid and dramatic progress can be achieved. One must however, never forget that these people are still sheltered completely ... and have still to learn about the work-day world outside the walls of the hospital. Previously, these people if deemed medically fit, had to plunge straight into the frightening new world outside the hospital and tackle the various problems of public transport, checking into work, normal working hours ... Also the problem of obtaining suitable accommodation had to be faced. Indeed to many these dramatic changes were too much and the patients returned time and again to hospital defeated, only because of a lack of proper preparation for what was ahead. The necessity of finding suitable accommodation is of paramount importance. It is unreasonable to expect a patient, who has spent many years in the artificial atmosphere of the hospital, to settle immediately in the community where he obtains employment. Unlike short-term illness, long-stay patients are not unfit for work today and fit for full-time employment tomorrow. As the industrial training of a patient may take a considerable time, so too may his social training. Together with industrial training and resettlement, must go social rehabilitation. The need is apparent for some half-way houses to bridge the enormous gap between the hospital wards and open employment."

An extension of the hospital work therapy unit facility involving the use of transitional employment in the rehabilitation of psychiatric patients, has been developed in the United States at a day centre operated by the Fountain House Foundation of New York City, in co-operation with commerce and industry. The purpose of the scheme is to facilitate work adjustment of vocationally disabled psychiatric patients and its main characteristics are:

- job positions in commerce and industry are made available for rehabilitation purposes;
- all patients placed receive the prevailing rates of pay;
- a social worker can accompany the patient to the job if necessary and assist with job induction and familiarisation;
- the level of technical skill required for the job placement is purposely below the capacity of most patients;
- patients can remain on the job for as little as one hour per day, increasing their hours of work as confidence and assurance are developed;
- regular employees of the firm are made fully aware of the purpose and objective of the project;
- the length of time a patient may spend on the job is limited to three or four months.

The full value of the scheme has still to be assessed but first results indicate that it helps psychiatric patients to face the transition from the protective atmosphere of a rehabilitation setting to the more exacting demands of industry and commerce with a greater degree of confidence. Equally important is the direct involvement of employers in the scheme, thus resulting in a better understanding and appreciation of the employment needs and potential of the psychiatrically disabled worker.

During the past twenty years, the need for the establishment of hospital work therapy units and half-way house facilities for psychiatric patients has been generally accepted, although opinions differ as to whether the work itself should be regarded in the light of a specific group therapy and accompanied by some form of group psychotherapy. What is generally recognised, however, is the fact that the pre-vocational preparation stage for the majority of long-term patients cannot be completed within the hospital itself. To complete the transitional phase from hospital to employment, the half-way house arrangement and further vocational preparation and training under simulated open employment conditions, are essential if permanent resettlement of the patient is to be achieved. In the latter connection (further vocational preparation) industrial rehabilitation units, such as those in the United Kingdom, can make a significant contribution, particularly when patients are carefully selected. These units with specialised staff including, doctor, psychologist, social worker, resettlement officer,
remedial gymnast and occupational supervisors, offer courses averaging seven to eight weeks in a busy workshop atmosphere. The courses are designed to enable the individual employment problems of the physically and mentally disabled to be assessed, to restore employment confidence and a sense of mental and physical well being. In addition they provide an opportunity for the disabled to become accustomed to the mental and physical requirements of a full day’s work (i.e. daily travel to work, clocking in and clocking out, employment on production work, industrial discipline, mixing with fellow workers) and for the testing of occupational aptitudes.

From 1955 to 1965 the proportion of psychoneurotic patients entering United Kingdom Industrial Rehabilitation Units (IRUs) has remained fairly constant between 12 per cent and 13.4 per cent, whilst the proportion of psychotics rose from 3 per cent in 1955 to 8.9 per cent in 1965. No doubt the willingness of IRUs to admit an increased number of psychotic patients over this ten-year period is related to the improving selection techniques and pre-vocational facilities developed in mental hospitals over the same period.

When the results of IRU courses are considered, those for the mentally disabled are similar to those for the physically disabled:

<table>
<thead>
<tr>
<th>Percentage of Rehabilitates Placed in Employment or Training within Thirteen Weeks of Completing a Course at an IRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1962</td>
</tr>
<tr>
<td>Psychoneurosis</td>
</tr>
<tr>
<td>Psychosis</td>
</tr>
<tr>
<td>Mental subnormality</td>
</tr>
<tr>
<td>All disability groups</td>
</tr>
</tbody>
</table>

When the situation at the six-months follow-up stage is considered the relative percentages are much the same. It should be emphasised, however, that these figures do not take into account those rehabilitees whose courses are prematurely terminated for reasons of unfitness or unsuitability. In the case of psychoneurotics, premature terminations averaged 22.8 per cent, psychotics 24.4 per cent as against 19.4 per cent for all disability groups.

Finally a brief reference to job selection for psychiatric patients: research results certainly support the long-standing belief of rehabilitation workers that disabled persons and jobs can only be matched on an individual basis. A recent survey of 1,000 psychiatrically disabled veterans in the United States showed that they were employed in the full range of professions and occupations to be found in that country (see Annex I). The study showed that contrary to generally-held opinion, veterans with a history of psychiatric disability were employed in jobs involving person-to-person relationships. Eleven per cent were in management supervisory and foreman-type work, 8 per cent in sales jobs and 3 per cent did personal service work. The survey also helped to disprove the concept that the psychiatrically disabled can only cope with a narrow range of employment under such headings as "outdoor work", "working alone", "work free of responsibility".
Employed Psychiatrically Disabled Veterans
By Major Occupational Group Division

<table>
<thead>
<tr>
<th>Major Occupational Group Division</th>
<th>% of Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional and managerial:</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>5.5</td>
</tr>
<tr>
<td>Semi-professional</td>
<td>2.0</td>
</tr>
<tr>
<td>Managerial and official</td>
<td>9.2</td>
</tr>
<tr>
<td>Clerical and sales:</td>
<td></td>
</tr>
<tr>
<td>Clerical and kindred</td>
<td>12.3</td>
</tr>
<tr>
<td>Sales and kindred</td>
<td>8.5</td>
</tr>
<tr>
<td>Service:</td>
<td></td>
</tr>
<tr>
<td>Domestic service</td>
<td>0.1</td>
</tr>
<tr>
<td>Personal service</td>
<td>2.8</td>
</tr>
<tr>
<td>Protective service</td>
<td>1.9</td>
</tr>
<tr>
<td>Building service workers and porters</td>
<td>2.7</td>
</tr>
<tr>
<td>Agricultural, fishery, forestry and kindred:</td>
<td>4.3</td>
</tr>
<tr>
<td>Agricultural, horticultural, and kindred</td>
<td>0.3</td>
</tr>
<tr>
<td>Forestry, hunting, and trapping</td>
<td></td>
</tr>
<tr>
<td>Skilled:</td>
<td></td>
</tr>
<tr>
<td>Manufacturing and related</td>
<td>9.4</td>
</tr>
<tr>
<td>Non-manufacturing</td>
<td>7.3</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>7.9</td>
</tr>
<tr>
<td>Foremen</td>
<td>1.5</td>
</tr>
<tr>
<td>Semi-skilled:</td>
<td></td>
</tr>
<tr>
<td>Manufacturing and related</td>
<td>5.4</td>
</tr>
<tr>
<td>Non-manufacturing</td>
<td>7.3</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>2.1</td>
</tr>
<tr>
<td>Apprentices</td>
<td>0.1</td>
</tr>
<tr>
<td>Unskilled:</td>
<td></td>
</tr>
<tr>
<td>Manufacturing and related</td>
<td>3.8</td>
</tr>
<tr>
<td>Non-manufacturing</td>
<td>2.1</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
REFERENCES


O'Connor, N., A. Heron, and G.M. Carstairs: Work performance of chronic schizophrenics. Occup. Psychol. 30, 155 (1956);


- and G. W. Brown: Social treatment of chronic schizophrenia. J. Ment. Sci. 107, 847 (1961);

International Labour Office, Geneva

(1) Vocational Assessment and Work Preparation Centres for the Disabled - D15/1970.
(4) Adaptation of Jobs for the Disabled.
(5) ILO Recommendation No. 99 concerning Vocational Rehabilitation of the Disabled.
(6) The ILO and Vocational Rehabilitation.

Rehabilitation International

US Department of Veterans Benefits
They Return to Work - The Job Adjustment of Psychiatrically Disabled Veterans. 1963.

US Vocational Rehabilitation Administration
Rehabilitation Record - Helping the Mentally Ill.
US Journal of Nervous and Mental Disease

US President's Committee on Employment of the Handicapped
16A. The Transition of Mental Patients from Hospital to Employment

by

Dr. J. van Londen, Chief,
Department of Public Health,
Municipal Health Service,
The Hague, Netherlands

1. Before I proceed to the subject as mentioned in the title, I must explain from what context I address myself to you.

I am working in The Hague, Holland, as a social psychiatrist. I am head of the Mental Health Department of the Municipal Health Service. Consequently I look upon the subject from the angle of the extramural mental health care.

What exactly is understood by extramural mental health activities is less fundamental than historic. What matters is that, in every region, there is a chain of provisions with a large variety of possibilities from intramural to extramural care. It is essentially unimportant who provides this chain, the hospital or, for instance, the social psychiatric service, as long as this circuit of provisions is established.

I will now give you some information on the situation in the Netherlands with regard to mental health care. I will attempt to explain the problems in their wider context to facilitate discussion. However, it is impossible to generalise too much; the differences, even among the countries in Europe, are too great.

2. With a population of over 13 million, Holland has 39 mental hospitals. These hospitals, together with the university mental hospitals and the mental departments of the general hospitals, have a bed capacity of 4 psychiatric beds per 1,000 inhabitants (Giel 1971). Great Britain has the same figure.

Sweden has 6.8, Norway 6.1, and Denmark 1.9 beds per 1,000 inhabitants. These figures have been taken from a test research of the World Health Organisation into the "Classification of Mental Health Service Activities".

One should, however, not draw any conclusions as to the quality of the health care from the number of beds per 1,000 inhabitants. For instance, a country without extramural care will require more beds; a country with good extramural care might be able to reduce the need for beds.

It would be more worthwhile to see the developments over a longer period of time and also to learn how the extramural mental health care functions.

According to Giel (1971) Switzerland, Sweden and Norway are richest in psychiatrists: 8, 7.4 and 7.2 respectively per 100,000 inhabitants. Holland has 6.3, Great Britain 5.3 and Denmark 1.7 beds per mentally trained nurse whereas Holland has 8 beds per nurse. I quote these figures in order to show you how difficult it is to form an idea of the scope and the quality of mental health in a country.

Neither the number of beds nor the number of psychiatrists or nurses provide sufficient indication of the situation. It becomes clearer if one looks at the figures in relative terms, not from the point of view of the quality of the care, but with basic ideas in mind.

As a matter of fact, basic philosophies may change in the course of time.

In Holland the social psychiatric services (in the 1950s they were solely concerned with after care of mental patients) were established with two objects in view:

(1) an idealistic point of view in the world of the mental hospital: the need was felt to keep a close watch on the results of the treatment, also when the patient had returned to society;
(2) An economic aspect: hospital beds tend to become increasingly more expensive.

If, by providing alternatives, one can prevent a patient being admitted to hospital (preventive care), or if one can prevent relapses (after care), one not only renders a great service to the patient, but also to the community from a financial point of view. For, no matter how payments are settled and in what legal framework it exists, a psychiatric admission will always have financial consequences for both the individual involved and the community.

I will touch upon this later on in my paper.

The fact is that in Holland a situation has developed in which a patient may benefit financially by being nursed in a mental hospital, and consequently the stimulus to be discharged has been removed.

In the course of years a discrepancy has arisen in Holland between the number of patients whose admission to a mental hospital is requested, and the number of available beds. There is a greater demand than available capacity. An empty bed in a mental hospital is rare nowadays and, as a result, "precious", not only in terms of money but also in emotions.

The more intensive prevention and after care are, the better one will be able to make a bed available for the patient who really needs it. In other words, a relative shortage of beds contributes to better extramural care.

Seen from the viewpoint of the government, would it not also be in the interest of improving extramural mental health care if the need for beds by the intramural care could be satisfied at random? This, however, is a different problem to resolve.

When there exists such a shortage of beds that the social psychiatric services can no longer cope with the work, then a dangerous situation has arisen.

Recapitulating, I submit that in the last few decades the basic philosophy of mental health care in Holland has gradually changed. Financial considerations of psychiatric nursing play a less important role than the ideal considerations; attempts are being made to develop the intramural and extramural care in such a way that quality is the primary object, with regard to both services. A remarkable fact is that the maintenance of a certain tension between these two (a relative shortage of beds) seems to work towards a greater stress on extramural care. Indeed, the latter is by no means cheaper than intramural care. One is willing to make the same financial sacrifices as for intramural care, or even greater, if it appears feasible to have the patient remain in his own environment.

Experience and insight into the so-called hospitalisation syndrome play an important role here; also the more recent ideas about the role of the family when an individual appears to be suffering from a mental illness, would indicate that we sometimes would do better in directing our therapeutic provisions towards the family itself rather than towards the patient (Cooper, Laring).

A change in basic philosophy should at the same time involve a regrouping of mental health care; in the days when economically it was a great achievement to get a patient out of a hospital or to prevent him from being admitted, the social psychiatric services could be established according to the ideas of Meyers and Querido. (The so-called Querido model was even internationally known.)

Presently, attempts are being made to provide a so-called comprehensive mental health service regionally, which, as I mentioned previously, offers a variety of provisions; the co-ordination in this package of provisions is guaranteed by the joint responsibility for the care of patient and community. In other words, the structure is no longer that of hospital versus society, but over-all: the hospital forms part of all the provisions in society.

3. Frets (1971) systematised the principles of assistance in the field of mental health care as follows:
Accessibility guaranteed for everybody: no financial, geographical or social barriers.

Simpler identification and easier location of individuals and authorities rendering assistance to the public and the people and with delegation of responsibilities.

Continuation of the care. Restriction of the number of delegations by making use of the possibilities of consultation (Caplan).

Sufficient variety in the package of provisions. Continuation and variety may be seen as counterparts, but need not necessarily be so; sufficient variety compels us to make the right choice at an early stage.

The development of preventive work in combination with curative work.

Information to the public, mental health education.

4. Based on the division:
   - primary prevention: the prevention of the occurrence of an illness;
   - secondary prevention: the restriction of the illness spreading;
   - tertiary prevention: the limitation of the consequences of the illness for the patient;

we arrive at the essence of our subject – the place of sheltered employment in health care.

In Holland the Social Employment Act (January 1969) has legally ratified a development which had been previously promoted by non-legal regulations. Thus, the provision of adapted employment for the handicapped citizen (both physical and mental) became a right instead of a favour (Rommo 1971). The Social Employment Act has two main aims:

(1) provision of adapted employment;
(2) provision of work rehabilitation.

All rehabilitation is aimed at the limitation of disability and the consequences thereof.

The provision of sheltered employment has been given a task in the field of tertiary prevention.

If the workshop is to carry out its work as effectively as possible, it must co-operate carefully with those authorities who deal with the restriction of the other aspects of disability (apart from work disability).

Consequently the workshop will have to operate in the chain of varied provisions of curative and preventive care. In a comprehensive mental health service there is no place for autonomy based on specialisation.

On the other hand it should be recognised that the fact that one is being cared for by social institutions in itself forms an aspect of the disability. Therefore, it is understandable that, in the performance of its duties – the provision of adapted employment – the sheltered workshop should, as far as possible, regard the client as a mentally fit employee.

You will appreciate that this task of the sheltered workshop may give rise to discussions depending upon the viewpoint from which it is being discussed.

The situation in Holland at the end of 1969 was as follows: of the 43,873 employees of the sheltered workshops 7,818 (17.8 per cent) were mentally disturbed. This number does not include the number of mentally handicapped (oligophrenic) employees.

5. Work therapy and vocational rehabilitation.
Work therapy forms part of the therapeutic activities of the mental hospital, apart from the creative therapy, the treatment therapy, the psycho- and group-psychotherapy, etc. In other words, the choice of the work object will be determined by the consideration — in what way will it benefit the patient therapeutically and will it help the patient in recovering from his illness?

Vocational rehabilitation is based on the consideration that one is dealing with a defective situation resulting from an illness, the consequences of which should be compensated for as much as possible; vocational rehabilitation aims at the special abatement of reduced work capacity.

Therefore the fundamental purpose of the sheltered workshop is to enable the employee to transfer to normal employment. The possibilities for doing so depend upon a number of factors:

1. the general conjuncture: does the labour market need manpower?
2. the usefulness of the patient on transfer to normal employment.

The latter is by no means a simple matter. For the usefulness of an employee does not only depend on his skills and his abilities. We all know from experience how many barriers are raised for psychiatric patients in society: a psychiatric incident still threatens one's social career.

Vocational rehabilitation of the mentally handicapped and the mentally disturbed is highly dependent upon the image which the patient has in a certain culture.

Therefore the activities of the sheltered workshop for the mentally handicapped and the mentally disturbed should be combined with general information to the public. The tendency of the workshop to break away from the "psychiatric image" is therefore understandable, but not really effective. It does not alter the actual credibility.

It can be realistically recognised that the sheltered workshop will have to provide durable adapted employment for many handicapped and disturbed individuals. This means that the workshop must be within easy reach of the other facilities in mental health care: the mental hospitals, the hospitals for the mentally handicapped, the half-way hostels, the parents' associations, the special schools for backward children, etc.

6. The mistake is often made that a patient from a mental hospital could easily be transferred to a sheltered workshop, for he has had work therapy for such a long time. One forgets that the relationship between work therapy and output is of no importance whatsoever. What is important, as I have said before, is work therapy as a means of helping a patient to recover from his illness.

A transfer from hospital to workshop should be carefully prepared by both the hospital and the social psychiatric service. It will often be necessary for the patient to be tested and trained at the workshop during a trial period.

One must have an idea of his ability to work. If an individual obtains work beneath his level of intelligence, his level will gradually drop (Speyer); if an individual gets work far above his capacity, he will become so discouraged that his level will drop also. It is most difficult to determine what is the most favourable "burden" which will create a normal incentive towards effort-making.

When the work capacity increases, the work load may be extended.

If transition from hospital to workshop takes place simultaneously with discharge from hospital, the new social setting will have to be most carefully arranged; the social psychiatric service has an important task here.

In what foster home would the individual be best suited? Can he return home and, if such is the case, under what conditions?

Therefore, a discharge plan must be prepared well in advance.
Seventy-five per cent of the patients (55,000 in total) in the mental hospitals in the Netherlands stay there for one year or more and some, 50 per cent, remain in hospital more than ten years.

Costs per day (1969) in a psychiatric hospital are f.39.61 (general hospital f.72.89).

7. The problems of admission to a mental hospital are very closely linked with those concerning discharge. Therefore, there must be no preventive care without after care. It would be better to abolish these two terms, and to use social psychiatric care, social psychiatric guidance and social psychiatric treatment instead. This is a most extensive task which enables not only the mental hospitals, but also the intermediate facilities such as the workshop, the day hospitals, the day centres for the mentally handicapped, etc., to function properly.

Without a well-prepared discharge plan, the entire admission will have been useless. Without a well-indicated admission, discharge is not possible.

The indications for admission are becoming wider instead of narrower through the establishing of proper intermediate facilities.
The Sønderbro Rehabilitation Unit is a social institution operated without direct medical or psychological supervision but with a staff whose training is social-educational or vocational-educational in character.

I mention this at the outset because the Unit only receives clientele from groups of mentally sick persons, including schizophrenics, those with character deviations, neurotics, persons with intelligence defects, young people with narcotic problems, drug addicts and alcoholics. The physically handicapped are seldom seen. The work of this Unit has to some degree to be regarded as a continuation of the work which has in most cases been initiated in other hospitals or treatment institutions. It is clear, however, that the treatment procedures in such a social institution as Sønderbro must be different in character from those used in the hospitals. Some of our clientele receive treatment in close co-operation with the hospital to which they were originally admitted. During their stay in the institution a series of case conference meetings are held involving all those who have been in contact with the client.

But in the majority of cases the institution makes an independent evaluation of the client’s general state of health and formulates its own treatment programme.

The main goal of the treatment is to investigate whether the client is able to work and manage economically; but with a clientele of mentally ill persons such an evaluation would be impracticable without the inclusion of social and educational treatment. The treatment is planned individually, but there are common features which apply to most of our clients, mainly the neurotic patients, those with character defects, narcotics and others.

These features, which have their origin in most cases in the great social stress associated with everyday life, may in a somewhat simplified form be reduced to the following two concepts:

1. a feeling of hopelessness and lack of self-confidence;
2. fear.

I shall later revert to the social strains and stresses which are at the root of these general main problems, but first of all I wish to elaborate on this theme.

Obviously we have not attached sufficient interest to what happens in a human being when he gives up his former job, when he falls sick, when he is admitted to hospital or asks to be rehabilitated.

Just to have the feeling that your problems are now so serious that it is impossible for you to handle them yourself and that help must be sought elsewhere must surely have far deeper importance for a human being and a negative influence on the social ambition than we can imagine.

On the whole it must be said that for the greater part of our clients the most severe hindrance to their recovery and ability to go back again to a normal place in society is their lack of self-confidence.

It can also be said that fear too is at the root of the problem and this is an important element responsible for bad re-adaptation of mental patients.

In the difficult transition from a normal social life, where the client has by and large managed his own affairs, his work and family, to the rehabilitation situation, it is necessary to initiate prompt help to help him overcome the feeling that he himself was to blame. In my opinion therefore institutions have to make every effort possible to create a warm and friendly atmosphere for their patients. The more institutionalised the atmosphere and the greater the gap between client and staff, the more difficult it is for the
client to adjust to his new milieu and cooperate fully in his treatment and rehabilitation. The more homely and unconventional the surroundings the more he will be ready to settle down and obtain the maximum benefit from his stay. In the first place we must ask him about his wishes and expectations and leave it to him to decide the conditions under which he wishes to function. Such an arrangement may help restore some of his lost self-confidence, and lessen his fear of associating with other people. This will help to lay a firm foundation towards restoration of self-confidence and the conviction that he can eventually rejoin his family and be re-integrated into active social and economic life.

In this institution we are trying all we can to let the client decide the conditions under which he wants to work with us. This is particularly important in the workshops where production work is organised to the greatest possible extent on an individual basis and in this respect the client's own initiative and wishes are extremely important. By and large therefore it is not the institution which should decide what the client should do - rather we must ask him what he wants to do.

I now wish to turn to another part of our work which is important and which is the focal point for your visit today.

This concerns the question of the client's home situation, relationships with his family and also housing problems. It is our experience that neurotic and psychiatric patients invariably have experienced very difficult situations. If one investigates the background of the patient - going back to the time of childhood as well as the period just prior to his present situation - we usually discover a history of severe social strains and stresses in his life, which undoubtedly account for and explain his present situation. The strain to which he has been exposed and for which he did not have the compensating natural resources to resist may be related to one or more of the following factors in his social environment: in the wider sense the whole structure of this country - its morals and ethics; in a more specific sense factors such as poverty, insecurity, changing emotional attitudes; a large family; harshness and brutality; divorced parents; early experiences of life in an institution, etc. Such factors are of course often detrimental to normal childhood development. We also discover other stresses which our patients have encountered in life due to lack of education and/or vocational training, changing work conditions, poverty, unhappy marriage, as well as housing.

Our client himself is usually not responsible for such misfortunes but it is he who will bear the consequences of them and eventually give way under the burden they impose. In order to help our client in this situation we must of course first of all try to find out whether we can change the situation in which he finds himself. In other words we must relieve him of some of the strains and try and ensure that he faces a better situation when he leaves our care. We must also try to help him financially and with his housing problems, his problems in relation to his children, his parents or spouse. Moreover we must try to get him interested in solving his own social problems as they occur and not to give way or turn to alcohol, or drug addiction, or a state of illness as a means of escape from reality. The situation also demands that we ourselves try to become genuinely interested in our client's problems, not just concerning his job but also his leisure time.

With this in view we have employed five social workers, one of whom has the special task of visiting the patients' homes to talk with relatives, help them with daily problems, influencing the parents or the spouse to give effective help and support to our client so that there is a uniform approach to his rehabilitation both in the institution and in his home environment. We arrange for our clients and their relatives to be visited at least once per month. To foster the social spirit we have created a kind of social club, where the client can meet others with problems similar to his own and where the staff can also change views in a very informal way. For the young people we have tried to create a special atmosphere in this social club where they play their own music, where other young people come and play music for them, and where they can dance and entertain themselves in their own way.

We have noticed that the progress made by our clients in the workshop is often reinforced during these get-togethers. In the relaxed social atmosphere they feel free and uninhibited; their attitude to the staff becomes more
positive and last but not least it helps to facilitate contact with their families. Two of the social workers have the special task of solving the financial problems of the patients, e.g. to have old debts paid, to provide clothes or furniture for the home.

It is our opinion that as far as possible the patients should stay in their homes while they are rehabilitated with us, i.e. come to the workshop in the morning and return in the afternoon. This is the best way to observe what the home conditions really are and how best we can help to resolve them. But we do not always succeed, nor is it always advisable for the patient to stay in his home during the rehabilitation treatment. In some cases initially at least it might be advisable for our client to stay in the hospital and work with us only for a limited number of hours agreed with the hospital. This arrangement often enables the patient to become adjusted to a new group of people. Such arrangements have been particularly successful in some special psychiatric youth hospitals, but they have also been of some help to individual patients from the large mental hospitals. I do not wish to give the impression that such arrangements offer a solution in every case and they may have to be discontinued before the end of the rehabilitation treatment.

Dependence on the hospital and the hospital's method of treatment can be so strong that it might be difficult for our client to adapt to our method of treatment, even when we and the hospital have a close team co-operation and try to plan the same lines of treatment. At any rate we must discharge our client from the hospital some time during the treatment here and bring him into a more natural social atmosphere than the one which can be offered by the hospital.

Discharge may in many cases be to the home of the client, which means to his own home and family or parents or other relatives. It will not be possible, however, in all cases to go directly back to his normal family environment. He may not be able to face up to such a move, and in such cases it will be necessary to allocate him to one of our half-way houses or flats. We also have hostels for the hospital patients mentioned above, also for use by young persons from rural districts who came to us for rehabilitation and young people with special behaviour problems who often make the situation in their home so difficult that the parents need to be relieved of the burden at least for a short time. The hostels are also available to young homeless people with special problems, e.g. drug addiction.

Elderly persons who are living in remote areas and who are unable to travel daily to and from the rehabilitation unit or have an acute housing problem may also be admitted. Our hostel system has three distinct functions:

1) There is a paedagogically operated hostel with nine single rooms where we receive young people in need of intensive support.

2) There are nine hostel rooms which are less sheltered than the first mentioned, and which cater for people who have the possibility of their own way in life, but where night and day supervision is provided and where meals are served in a common dining room.

3) A quite new form of hostel which we are opening in the very near future. This is an institution called "Ungbo" (young people's home) planned on the lines of ordinary dwelling-house accommodation, where young people below the age of thirty live together in small units of three persons. (Our clients will have to live with two or three ordinary young people from the normal population.)

Our clients who are admitted there can receive guidance and counselling from a social worker who is attached to the house — one supervising social worker for twenty residents. And so you will see that this hostel system includes sheltered paedagogical arrangements (through which it is possible to continue an intensive support and influence on the more seriously disabled clients); a less sheltered form of hostel where the young people have to manage themselves to a rather wide extent (including administration of their own leisure time) and finally a hostel in which normal living conditions are simulated and where they must be entirely socially self-dependent and where they can stay only during the period when a final solution to their housing problems is being sought, i.e. until a hired room or apartment has been found in town. There
is also the possibility of admitting our clients to the special youth boarding houses which are located in ordinary housing environments.

The young people who need to be influenced socially and educationally in a transitional period thus have a possibility, during the period of rehabilitation and six months after it has terminated, of being moved to a hostel of the types described above. This ensures that the demands on them are gradually increased so that they gradually learn to adjust themselves to other people, other environments and other situations, so that at last they should be in a position to stand completely on their own feet in society.

In this short paper I have given special emphasis to certain treatment procedures used at Sønderbro. There are of course other supporting measures which are just as important, but time does not permit me to go into detail.

Undoubtedly the main aim of this Unit is to try to help persons who have become specially isolated from society, who are very sensitive and afraid and who have, each in his own way, tried to obliterate their problems and lack of self-confidence by turning to alcohol and drug addiction, crime, etc. One of the means at our disposal for helping them is to offer support in finding and keeping a job, but this is not the only objective. A better life and better inter-relationship with other human beings is, I think, our primary goal.
The psychiatric services in the United Kingdom, similar to psychiatric services elsewhere in the world, have been the most under-capitalised branch of the Health Service and running costs have been kept to a minimum. There is some indication that there may be slight amelioration of this position in the future but there is little firm evidence of immediate improvement.

The basis of the psychiatric services has been, and remains, the psychiatric hospital. There were approximately 120,000 beds in the adult psychiatric hospitals of England and Wales at the beginning of 1969. Wing, Bennett and Demakis estimated in 1964 that within these hospitals, there are 46,000 schizophrenic patients under the age of 60 (22,000 men, 24,000 women). This problem alone represents a major challenge in rehabilitation; undoubtedly a large proportion of such patients are capable of gainful employment and of life in the community. The Department of Health and Social Security which now incorporates the old Ministry of Health has never had a statutory obligation to retain or to provide sheltered working conditions, and the Department of Employment (formerly the Ministry of Labour) has no responsibility for the rehabilitation of patients in hospital. The other statutory authority with responsibility in this regard - the local authority - has traditionally been associated with the rehabilitation of subnormals and has taken little initiative in providing facilities for socio-economic rehabilitation for adult psychiatric invalids.

Prior to the introduction of industrial therapy, there were two sources of employment within the hospital.

1. Maintenance departments, i.e. the service departments of the hospital such as gardens, kitchens, laundries, etc. These have traditionally been used for the employment of patients and, indeed, one of the main problems in introducing industrial therapy has been the difficult experience in persuading these departments to relinquish their patients' labour and the expectancy of these departments still to have an abundant source of cheap labour. The therapeutic disadvantages of these departments are: (a) encouragement to settle down to a hospital routine, (b) the under-estimation of abilities and (c) the undermining of the sense of responsibility. In Bristol we try to ensure that there is an element of training available for any patient who is employed in a maintenance department and that any patient who is employed doing a job which would normally be done by a paid operative should be paid the rate for the job. There are, of course, still patients who fall into neither category and who do minor chores in various departments for small amounts of pocket money. However, these now number only 44 in Glenside Hospital and one would anticipate the disappearance of this category of patient.

2. Occupational therapy in some hospitals has been widely and usefully developed. Recent modifications in the training programme in this field ensure that there is a cadre of occupational therapists, both interested and able to undertake the supervision and direction of industrial therapy. The old-fashioned approach to occupational therapy never, in our experience, prepared a long-stay patient for open employment. There are two further practical points with regard to occupational therapists: (a) their number is restricted and they mostly avoid working in the poor conditions of the psychiatric hospital and (b) the hours which occupational therapists work do not conform to industrial hours. It is not possible to have a supervisor working a 36-hour week supervising an industrial worker on a 40-hour week. The skills and initiatives of occupational therapists have contributed in the past and will undoubtedly do so in the future, and the concept of an occupational therapy department working in isolation from the rest of the psychiatric unit has largely disappeared.

The post-war introduction of industrial therapy in the United Kingdom dates from the middle fifties. Industrial therapy was, of course, used in psychiatric hospitals long before this time. The difference on this occasion was that since the introduction of the National Health Service Act, 1948, after which
patients were maintained free in national health service hospitals, this form of therapy could proceed without the necessity or desirability of the hospital authority deriving any financial gain from the work. In this regard, I will postulate as a basic principle that no organisation or body should gain financially from patients’ work and that, apart from necessary industrial expenditure, the total product of patient-labour should be paid to the patient. If this principle is not firmly established, then the danger of industrial therapy in hospital contributing to continuing hospitalisation with exploitation of patient-labour is very great.

The introduction of industrial therapy in hospital depends on many factors. The simplest pattern is that which we adopted in Bristol where local industrialists send work into hospital, which work is paid for on a contract basis. The King's Fund has published the results of research by Mrs. Nancy Wansbrough into industrial therapy in hospitals, which demonstrate the divergence of practice in hospitals throughout the country and point to many problems which have yet to be solved. There is no doubt that industrial therapy, with its resultant great increase in the amount of money circulating, raises the morale of the hospital and that social institutions within the hospital undergo revolutionary changes as a result of this.

The introduction of industrial therapy in hospital depends on many factors. The simplest pattern is that which we adopted in Bristol where local industrialists send work into hospital, which work is paid for on a contract basis. The King's Fund has published the results of research by Mrs. Nancy Wansbrough into industrial therapy in hospitals, which demonstrate the divergence of practice in hospitals throughout the country and point to many problems which have yet to be solved. There is no doubt that industrial therapy, with its resultant great increase in the amount of money circulating, raises the morale of the hospital and that social institutions within the hospital undergo revolutionary changes as a result of this.

In the first two years after industrial therapy was introduced in Glenside Hospital, the discharge rate amongst patients who had been in hospital for two years or more was the highest ever recorded. However, this peak passed and uncovered the next great problem of how to prepare for work in the community the patient with a long history of unemployment and hospitalisation.

In this, the two statutory organisations with duties for retraining and rehabilitation are (1) the Department of Employment and (2) the local authority.

**Department of Employment**

The facilities provided by the Department of Employment function under the authority of the Disabled Persons (Employment) Act, 1944, and consist of (1) Industrial Rehabilitation Units - these are short courses, usually of 8-12 weeks, serving two purposes (a) that of "toning up" after illness and (b) that of assessment with regard to future employment or training; (2) Government Training Centres - these are more sophisticated courses which involve training and result in skilled qualification which is acceptable to trade organisations and employers and vary in length from six months to two years; and (3) Support for Sheltered Workshops.

All of these facilities were set up with the needs of the physically disabled in mind and in spite of the attempts by the Department to help in the new problem of the long-term mentally disabled, these facilities lack usefulness in dealing with psychiatric patients. Of the 14,150 people who entered Industrial Rehabilitation Units during 1969, 824 were suffering from psychoses, i.e. 5.8 per cent of all entrants. Six hundred and seventeen of these completed their course, 49 per cent went to employment and 7.5 per cent of them were chosen for training.

Apart from the IRU's, the Department of Employment may support workshops for the industrial rehabilitation of long-term mental patients. The Department provides financial assistance under section 3 of the Disabled Persons (Employment) Act, 1944, to three voluntary bodies, Industrial Therapy Organisation (Epsom) Ltd., Industrial Therapy Organisation (Thames) Ltd., Birmingham Industrial Therapy Association, and one local authority rehabilitation and assessment centre (LABAC) run by the London Borough of Croydon as part of its community welfare services. The Department of Employment regards these workshops as a valuable ancillary and sometimes as an alternative to the services provided at IRU's. They realise that many long-term patients require a longer and less sophisticated course than is provided at an IRU and they are prepared to allow the acceptance of applications for industrial therapy workshops from people who may not be ready for employment in less than six months. Where progress in the workshops has been slower than expected, the course may be extended up to a further six months. The Department suggests that the evidence of their statistics tends to confirm that the need for resettlement facilities for long-term schizophrenics diminishes after the workshop has been in operation for 4-5 years. As I will show later, this is at variance with the experience
of the Industrial Therapy Organisation (Bristol) Ltd. The agency schemes for the mentally disabled which began in 1964 with the help of the Department of Employment had 2,292 admissions to the workshops up to September 1970, of which 972 people were placed and 1,174 terminated for various reasons.\(^6\)

**Government Training Centres**

The small number of psychiatric patients chosen for training is an indication that this approach to the chronic psychiatric problem offers small relief.

**Sheltered Workshops**

The biggest sheltered workshop organisation in the United Kingdom is the Remploy Organisation. Remploy was incorporated as a company in 1945 and is limited by guarantee and without share capital. The object of the company is to provide facilities for the employment of severely disabled people. The Department of Employment provides the necessary capital by way of a loan which makes up the difference between sales and costs with a revenue subvention. The Department works in close co-operation with Remploy and the Secretary of State for Employment is responsible to Parliament for the company’s policy. Remploy provides employment for nearly 7,500 severely disabled people in eighty-six factories and in a number of homeworking centres throughout the United Kingdom. The revenue subvention during the financial year ending 31 March 1970 was £4,730,000.\(^7\) The chairman, in his annual report, points out that this is offset by the consideration of the heavy burden of social security benefits which would fall on public funds if Remploy did not exist and the substantial income which is contributed to public funds by way of purchase and income tax and the National Insurance Contributions of the disabled workers. The chairman estimates that the combined benefits to public funds from these sources amounted to £4,500,000 in the year under review. By balancing these figures, the chairman maintains that the economy has benefited by virtually the whole of the productive effort of Remploy during the year.

However, the possibility is remote that such an organisation as Remploy could be expanded sufficiently to cope with the large number of psychiatric patients who require work. The capital involved would be very high and the running costs likewise, so that this method of approach to our problems is unlikely to be developed.

**Local Authorities**

The local authority services in the United Kingdom have provided, in general, extensive services for the subnormal patients in the community but have not involved themselves in the training, rehabilitation and re-employment of the adult psychiatric patient. In Bristol, where local authority facilities for the subnormals were highly developed,\(^8\) there were no openings for our hospital patients to enable them to take the next step towards the community.

Because of the difficulties which statutory bodies have in adjusting to changing need or of initiating activities appropriate to new requirements, it was considered that an independent organisation was needed to probe new channels of approach. This view was strengthened by the opinion of many psychiatrists that there is a need, especially in the case of schizophrenia, to provide a step or a series of steps intermediate between the hospital workshops and open industry. This stage is not provided by the existing facilities of the statutory authorities.

**Industrial Therapy Organisation (Bristol) Limited**

In March 1960, the Industrial Therapy Organisation (Bristol) Ltd., was formed.\(^9\) This is a non-profit-making company, limited by guarantee, with a board of directors representing the churches, civic authorities, doctors, employers and trade unionists. The original aim was to provide outside hospital a second step towards industrial rehabilitation. Initially in its old headquarters (a disused schoolhouse), it provided piece work for hospital
patients in the same way as in a hospital workshop. Industrial discipline was closer to normal than in hospital, in that patients worked a 40-hour week, clocked in and out and had normal factory meal-times and tea-breaks. At first almost all patients came from hospital but now about 50 per cent directly from the community.

Supervisory staff consists mainly of nurses from Glenside Hospital, seconded by an enlightened hospital management committee, who agreed that a nurse's duty is where a patient needs him or her. Additional staff is recruited from industry. Domestic staff for the canteen and for cleaning come from the ranks of patients.

During the course of its ten years' history, the facilities of the Industrial Therapy Organisation have become more complex. In October 1969, extensive new premises were obtained. The Organisation is now responsible for:

(1) a piece-work factory;
(2) a sheltered workshop;
(3) car wash;
(4) "sheltered groups" in open industry.

The clearly declared object of the Organisation is to place its workers in open industry or commerce. The steps between referral to ITO and this end may be many or few and for many patients open industry may be unattainable. In this case, the aim is to achieve the highest possible attainment, e.g. in a sheltered group.

### 1. Piece-Work Factory

This is still the main facet of ITO's activities. On 26 August 1971, it contained 132 out of a total of 229 patients. In addition to psychiatric hospitals, patients are referred from out-patient departments, day hospitals, general practitioners, local authorities, ministries and from personnel officers in industry. Assessment of ability and suitability is carried out in the factory during the first weeks of attendance. In this part of the factory, patients work on a piece-work basis being paid according to the amount of work that they perform. There is no contract of employment between ITO and the patient. As performance improves, the worker-patient progresses to open industry or to one of ITO's other activities. Approximately 20 per cent of patients achieve open conditions and 25 per cent "sheltered" conditions.

### 2. Sheltered Workshop

At present this shop has thirty-six places with a plan to increase to fifty in the near future. Here the worker is employed by the Industrial Therapy Organisation and paid a weekly wage. This workshop is supported by the Department of Employment, which is responsible for 75 per cent of losses incurred up to a maximum of £385 per place per annum. This Department also helped with a small capital grant (£4,000) when the new factory was opened in October 1969. The local authority subscribes 25 per cent of the loss not covered by the Department of Employment.

### 3. Car Wash

This activity, which was established in October 1960, is of the rapid drive-in, drive-out variety. Twenty patients are employed and they wash approximately 100 cars per day. This is the only direct commercial activity of ITO, all other activities being the performance of contracts for other firms. This was the first "five-minute car wash" in Bristol and it has shown that schizophrenics do not require to be subsidised if suitable work can be provided for them. Furthermore, it has brought schizophrenics into direct contact with the general public in large numbers and has probably contributed considerably to overcoming prejudice to employ them.
4. "Sheltered Groups" in Open Industry

On 26 August 1971, forty-two patients were employed thus.

The prospect of providing sheltered workshops or self-supporting work for large numbers of schizophrenics in the near future is remote. The statutory authorities have been unable to cope with the problem. Voluntary organisations have great difficulty in setting up such factories - a complex and a costly procedure. Apart from the financial and industrial difficulties, the medical and social aspects of sheltered workshops render them a poor second-best to open industry. It is undesirable to have large numbers of handicapped people working together with little hope of progressing further. Because of these considerations, the Industrial Therapy Organisation negotiated with the Department of Employment in 1966 to establish sheltered groups in open industry. By this agreement, ITO may send groups of patients into factories and be paid the worth of their work for their services. ITO guarantees to each employee a minimum wage. If the amount paid to ITO for worker-patient labour is insufficient to meet this wage (plus supervisory and administrative costs), then the Department agreed to make good 75 per cent of the deficit up to a maximum of £385 per place per annum; the local authority makes up the remaining 25 per cent, i.e. patients working in "sheltered groups" in open industry attract the same privileges as those working in sheltered workshops.

Since industry carries all the overheads, this scheme is financially more economical than the sheltered workshop approach. Socially it is superior since patients work all the time with normal people.

During the period 1960-1970, the following figures have been achieved by the Industrial Therapy Organisation:

<table>
<thead>
<tr>
<th></th>
<th>1960-65</th>
<th>1966-70</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Industry</td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>and Car Wash</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheltered Work</td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>Unplaced</td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>Died or retired</td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>on pension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In ITO on 1.7.71</td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td></td>
<td>172</td>
<td>78</td>
<td>250</td>
</tr>
<tr>
<td></td>
<td>72</td>
<td>90</td>
<td>162</td>
</tr>
<tr>
<td></td>
<td>257</td>
<td>164</td>
<td>421</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>83</td>
<td>39</td>
<td>122</td>
</tr>
<tr>
<td>TOTAL OPERATIVES ACCEPTED UP TO 31 DECEMBER 1970 = 971</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Domestic Resettlement - Accommodation

The ultimate aim in the case of economically self-supporting patients is that they should make their own arrangements for accommodation in the community. This is not practicable in the majority of long-hospitalised cases who have been conditioned to artificial highly organised dependence during a long stay in hospital. As in industrial rehabilitation, it is desirable to have a series of steps, each step representing additional independence progressing towards open living. If this end is not attainable, then the nearest possible to it should be sought after, e.g. self-supporting supervised accommodation.

The Mental Health Act, 1959, envisaged a great increase in local authority facilities for the care of the psychiatrically disabled. In spite of the powers given to the authorities, progress has been slow and uneven. This has been due to a shortage of finance, as well as to lack of expertise and a failure
of communication between hospital and local authorities. Phillips (1965) surveyed the local authorities' developments in England and Wales and showed a picture which was patchy and, at times, disconcerting. Local authorities have found the expense of providing hostel accommodation very high and have understandably lost enthusiasm for this approach to the problem. The twelve to twenty-bedded hostel, whether a renovated old building or purpose built, has made a disappointing contribution. Some authorities have thought along the lines of boarding out (e.g. Croydon) and of group homes (e.g. Colchester) with considerable success. None has reported the establishment of accommodation run on a self-supporting basis.

Local authority hostels development in Bristol has been good by national standards. Hostels have been referred to earlier for discharges from psychiatric hospitals, for subnormals, and for the elderly mentally infirm. Because of industrial development, the pressure for places in the community existed in Bristol before hostel accommodation was forthcoming. The agreement between ITO and the Department of Employment required that patients in sheltered groups in open industry should be discharged to the community as a term of their acceptance as sheltered employees. It was, therefore, imperative that some steps additional to the local authority's provision should be taken.

The Bristol Industrial Therapy Housing Association was formed in 1964 with the intention of providing living conditions of frugal comfort for persons rehabilitated economically through ITO.

The Association rents six council houses from the Bristol Corporation, three sets of semi-detached standard council houses separated from Glenside Hospital by a main road built on a strip of hospital land which the Housing Department bought from the Ministry of Health (now the Department of Health and Social Security). No subsidy attaches to these and a full economic rent is charged to the Association, plus standard rates (at present to £6.4.0d. per week). Five of these houses shelter discharged patients - five to each house. A manageress occupies the remaining house. Initially three houses were let to women and two to men but this proportion was changed to four for women and one for men when it was found to be very difficult to run group houses for men.

The Association also bought an hotel in Oakfield Road, Bristol - a mixed residential and private hotel area. This purchase was made possible by a loan of £10,000 on generous terms from the Transport and General Workers' Union. This sum, together with gifts in money and kind of about £2,000, enabled us to modernise this old hotel and to furnish it to take twenty residents. The first manageress of the Vale Hotel was a retired psychiatric nursing sister supported by a staff of two ex-patients and by a part-time cook.

In November 1970, the Association opened a new hotel - Belgrave House. This is a large Victorian house, previously a preliminary training school for nurses which, at the behest of the then Secretary of State (Mr. Richard Crossman), was let to us on a peppercorn rent by the Department of Health and Social Security. There are thirty-two residents in this hotel so that now the Bristol Industrial Therapy Housing Association is responsible for seventy-eight residents. The Association has just negotiated the purchase of the house next door to the Vale Hotel with a loan granted by the Housing Committee of the local authority. The cost of this loan is to be borne by the Social Services Committee of the local authority. When renovated, this house will provide accommodation for a further fifteen to twenty residents.

Up to now we have been able to offer full board and lodging at from £4.10.0d. to £5.0.0d. per week and have managed over four years, to show a small accumulated profit, certified in the accounts of the year 1970 as a balance in hand of £4,304 since the inception of the Association.

The Bristol Industrial Therapy Housing Association intends in the future to provide bed-sitting rooms, flats and houses so that a range of facilities may be available to each rehabilitee as nearly as possible appropriate to his requirements at any given time.
Summary

The most useful approach to rehabilitation in schizophrenia is to provide a series of attainable steps on the road to economic self-support and concurrently to offer a variety of possibilities accommodation-wise in the community so that the secondary handicaps of the illness may be gradually overcome.

Present facilities can be illustrated schematically thus:

| WORK |
|------------------|------------------|------------------|------------------|
| Hospital |
| Occupational Therapy Department |
| Hospital Maintenance Department |
| Industrial Therapy Department |
| Industrial Training Centre |
| Ministry of Employment and Productivity |
| Industrial Rehabilitation Unit |
| Government Training Centre |
| Sheltered Workshop |
| Industrial Therapy Organisation |
| Factories |
| Self-supporting work |
| Sheltered groups |
| Open |

Pre-Discharge Ward
Hospital

Local Authority Hostel

Bristol Industrial Therapy Housing Association, Rehabilitation houses

Bristol Industrial Therapy Housing Association, Rehabilitation hotels

Privately-run hostels, e.g. Church Army

Approved Lodgings

Own arrangements
REFERENCES


18. The Role of the Psychiatric Social Worker and After Care Services for the Mentally Restored

by

Mrs. Gudrun Hadell, Chief of Section, Rehabilitation Department, National Board of Health and Social Affairs, Stockholm

Florence Nightingale wrote a book 100 years ago on how a hospital should function. The first requirement was that the hospital should not injure the sick. Indeed, this is an important observation regarding mental health care. Much that is regarded as chronic schizophrenia is but behaviour resulting from isolation and passive care.

Such aspects influenced the tasks of the first PSW in Sweden (60 years ago). Her main function was to protect the patient in society and in medical care; to defend the patient's integrity as a person and to respect his interests according to the norms we now have in the declaration for human rights.

An example of what this indomitable lady - a teacher in needlework - succeeded in achieving will be of interest. Policemen were not permitted to be in uniform when transporting a patient to a mental hospital. There is after all some difference between criminals and the mentally ill.

This primary role as the patient's advocate was eliminated to a certain extent when medical social workers were employed in general hospitals.

Psychiatric Services in Sweden - Development, Present Situation and Plans

Sweden has a population of about 8 million people of whom 3 1/2 million are employed. Around 200,000 people between the ages of 16 and 65 are drawing early pensions. About 40 per cent of these cases are unable to work because of mental defects. Mental illness, including mental retardation is the dominant factor in the younger age groups, falling to 20 per cent in the older groups.

It is difficult to estimate the total number of handicapped persons in Sweden. The concept is defined so differently and uniform terminology or case-finding methods do not exist. The number of mentally handicapped (excluding mentally retarded) is usually estimated at about 3 to 4 per cent of the population, but how many of these need rehabilitation is difficult to say. One usually considers that the mentally handicapped comprise some 30 per cent of all handicapped persons of working age.

The psychiatric situation in Sweden, as in most places, has changed during the last decades due to a slowly growing awareness of the human aspects of the problems involved and a sudden revolution in pharmacy. The large isolated mental hospitals have changed character and are now used mainly for psychiatric long-term care, disturbed patients and so-called psychopaths or as one usually refers to them "patients in need of special care". Modern activating training, habit training, realistic occupational therapy, that is to say, meaningful tasks with pay as a stimulus, socio-therapy, etc., have given good rehabilitation results even among the large "carry over" of chronic schizophrenics. One example is the much appreciated trips abroad to Italy and other Mediterranean countries. The patients begin by saving as a group towards the trip and learning about the country and the language. These new "tourist groups" have, thanks to careful preparations and ground work, been well accepted, and these activities function as an incentive to continued outgoing activity and rehabilitation.
Indications for Admittance

Indications for compulsory entrance for psychiatric care have recently been greatly restricted. Patients admitted at their own request (some two-thirds of the cases) cannot be kept in confinement against their own will. A hospital physician is not authorised to certify a need for closed care for his own patient. The fear of being confined on false grounds has almost disappeared. Patients and their relatives co-operate more readily during rehabilitation when the hospitalisation and treatment are voluntary.

Number of Beds, Need for Care and Planning

Residential psychiatric care in Sweden comprises 30,000 beds, consisting of 27 psychiatric clinics and 30 mental hospitals. In 1964, 33,700 persons were discharged from mental hospitals and 16,700 from psychiatric clinics divided up in the following categories:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>7,200</td>
</tr>
<tr>
<td>Manic-depressive, including melancholia</td>
<td>7,100</td>
</tr>
<tr>
<td>Senile, pre-senile and arterio-sclerotic</td>
<td>2,600</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1,500</td>
</tr>
<tr>
<td>Psychosis (specific)</td>
<td>2,000</td>
</tr>
<tr>
<td>Paranoid psychosis and unspecified psychosis</td>
<td>17,300</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>3,800</td>
</tr>
<tr>
<td>Pathological personality</td>
<td>1,200</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>700</td>
</tr>
<tr>
<td>Mental defect</td>
<td>2,300</td>
</tr>
<tr>
<td>Other diagnoses</td>
<td>2,300</td>
</tr>
</tbody>
</table>

Although progress is slow we must strive for increased integration between psychiatric and somatic care. The expansion of psychiatric clinics in general hospitals is in progress. There is every reason to co-ordinate, as far as possible, general hospital rehabilitation resources as physical therapy and occupational therapy for all patient groups as long as each group is led by their own well-trained team.

Resources for open care and after care services are clearly inadequate. Let me therefore describe the latest suggestions for the organisation of psychiatric care and working methods.

The aim should be a programme of treatment with the individual patient disassociated as little as possible from his usual social group and environment. This means widely distributed, decentralised treatment facilities with outpatient departments of a new kind - medico-social centres with resources for home visits around the clock, beds for observation and night shelters. The medical care should be incorporated with social measures of all kinds, e.g. practical social domestic help, day centres, hostels, economic support in combination with social/psychological support and "at home" treatment, in the group where the problems occur.

The traditional form of psychiatric treatment influenced by crisis theories is being more and more transformed into social, psychic and physical services. Mental illness can sometimes be described as a symptom of a "living together problem" and not as an individual illness. The measures must concentrate on actual problems and not too much on investigation of the past history of the different members of the family. In future it will be impossible to make sharp distinctions between social, psychological, psychic and traditionally medical disturbances. Social workers will move out more and more into the field from the conventional welfare bureau. Such developments are dependent on the existence of a qualified team, which constantly keeps in touch with and supervises the field workers. The risk for the social worker to be too much involved in the family dynamics should not be underestimated.

Residential care could then be reduced to a department of intensive care and a department of general care in the general hospital, with resources for comprehensive treatment which as quickly as possible should be scaled down to what is described in Sweden as "care at the lowest efficient level of treatment".
The orientation towards rehabilitation must start at the beginning through a coordination of medical, social and vocational measures aimed at the patients' various problems as a whole.

The important factor is not the illness as such but how the patient functions. The treatment might be given within the rehabilitation institution itself or in the home but must all the time, in a realistic way, be adapted to life in society.

Rehabilitation - especially in so far as the mentally ill are concerned - is unfortunately not just a question of obtaining good relationships in the family, or finding suitable accommodation and employment. It is also concerned with maintaining stability, keeping a job and facing up to the conditions of day-to-day life. This underlines the importance of preventive care and of immediate help as soon as the patient comes into the "risk of relapse zone". The after care services should ensure that, in addition to the general resources previously mentioned, someone keeps in touch with the individual patient and ascertains what progress he is making. A check up at the place of employment, a home visit for no other reason than friendly interest may be of immense value. Both the patient and the people in his "milieu" need this. (Do not the leaders of sheltered workshops often have to perform the role of doctor, social worker and nurse?)

The problem associated with case-finding activities has recently been solved in Sweden through an amendment to the Social Assistant Act. To promote social rehabilitation the Act now provides that each local community through its Social Welfare Board has the primary responsibility for ensuring that persons living in the district shall receive such care as can be regarded as adequate in relation to their needs and general circumstances. The Board shall make itself familiar with the needs of the individual and endeavour to see that these are met by the community's own measures or through other authorities and bodies. Every person is entitled to this help and assistance from the local welfare board regardless of his financial situation.

The Role and Tasks of the Social Worker in the Rehabilitation Team

In Sweden we have the same academic training for both psychiatric and medical social workers. Through a recent increase in the number of schools of social work it will be possible to provide well-trained social workers for general social work in the local municipalities.

Regarding rehabilitation there is strong reason to underline the psychiatric and psychological aspects for all groups, not just for the mentally disturbed.

We all mingle together in the outside world; therefore, one should not - particularly in the field of vocational training (except under certain circumstances) - segregate the mentally handicapped clients more than is absolutely necessary. It is important to think in terms of functioning instead of diagnosis.

Only a few of our 12,000 places in sheltered workshops are reserved for the mentally ill. Of the total number of applicants (95,000) for resettlement in 1970, 40,000 had mental defects as the main handicap. And of the remainder, some two-thirds had mental disturbance as a contributing factor.

The responsibility for medical care, vocational rehabilitation and social welfare in Sweden is divided among different authorities, which causes difficulties in the practical work. Gaps between the various links in the "chain of rehabilitation" disturb the continuity so essential during the whole period of treatment. The economic resources for social follow-up care are provided by the Municipal Council; responsibility for sick-pay, etc., rests with the sick insurance offices. The PSW must therefore function in liaison with all various departments and bodies concerned with rehabilitation. One must also recognise that, in hospital care and in industrial rehabilitation units, social workers have played a minor role which undoubtedly has led to uncertainty in the question of professional status. It is not unusual to find that there exist just as many definitions of what a social worker shall do as there are members in the team.
In certain countries, among them Sweden, there has been some rethinking regarding the organisation of the PSW service. For example, one may ask what advantages and disadvantages would there be if all PSWs were allocated to the Municipal Council? As you see, such an arrangement would fit in with the trend towards decentralised, integrated care, mentioned above.

Investigation - Diagnosis - Treatment

The task of the rehabilitation team, once it has analysed all the questions of importance relating to the patient's readjustment, is to map out a rehabilitation programme and make a plan for continued care. Contrary to the medical diagnosis, the rehabilitation plan should take into account the patient's positive attributes and qualifications for a changed situation in life.

The role of the PSW is that of an expert on social support and help that society can contribute to the treatment of the patient to such a degree that he will be integrated as fully as possible in a normal social setting.

In order to ensure that the whole team has a better knowledge of and understanding for the social and emotional factors that influence and are influenced by the patient's illness or disturbance, a complete social history is required.

I wish to emphasise that a social history does not consist of a list of information about income, size of dwelling, number of children, type of occupation, etc. A psycho-social history shall above all give the whole team information as to how the patient and groups around him experience these facts. All too frequently, we mistakenly place our own values, for example, on the patient's housing and work situation. Monotonous work that we find soul-destroying may offer a satisfactory outlet to the mentally disturbed because it can lead to a feeling of fellowship on the job and partly relieves him from making his own decisions.

The social history should highlight the following aspects:

(a) Who is this patient and what is his situation?
   - the patient's personality;
   - the patient's relation to his family, to his employer, to his neighbours, companions, etc.;
   - what insight does he have into his problem and how has he previously tried to solve his difficulties;
   - what possibilities has the patient, with the support of the team, to contribute to a solution of his incapacity to work?

(b) What is the patient's external situation?
   - to what extent can the patient receive support from his environment; are there rehabilitation obstacles within the family or with other persons close to him - over-protectiveness, too great demands or likewise;
   - to what extent necessary, desirable or possible, can other family members, employers or fellow workers, social authorities, health insurance bureaux, etc., be involved in helping the patient?

(c) What services can society offer to assist the patient (and the team) to resolve his problems and social incapacity?

(d) What is the fundamental (basic) problem in the case, as the social worker sees it, against the background of her professional knowledge and experiences?
A social history is based on what the patient himself tells you and on information that the PSW can obtain through personal interviews, home visits, inquiries and contacts with persons concerned with the case. No statement should be obtained without the patient accepting it and understanding its meaning. The feeling of mutual trust between the PSW and the patient - the PSW's most important instrument in the social treatment - can be destroyed if the patient suspects that one is not frank and going behind his back. It is also important that the patient can rely on the fact that his confidence will not be misplaced. As with other medical personnel, the social worker must observe the oath of silence.

Referring to factors previously mentioned regarding the importance of treating the problems where they are discovered, the social worker's task is quite often directed towards other persons in the patient's milieu. It is therefore important that family members and other persons concerned can talk with the PSW. They may, for example:

- ventilate their problems and their concern for the patient;
- be given basic psychological information affecting human relations. If the PSW does not give this information herself, she must see that somebody else does;
- receive support and encouragement from the PSW in order that they can help the patient adequately.

It is advisable for the patient to meet the social worker on the first day of rehabilitation treatment. Worry about the family at home, financial problems, what people will say, etc., can often be a greater obstacle in rehabilitation than the illness itself.

The patient's mental balance should as a rule determine how often he should see the PSW. If the patient is going to be able to adjust to society and to employment he should also learn to respect predetermined visiting hours.

What might be termed the "social diagnosis" - the practical problems regarded in relation to the patient's personality and mental health - is a matter of importance to the team as a whole. The record should therefore include - not necessarily every little detail (lengthy records are rarely read) - but the essential information and conclusions.

Rehabilitation is often described as a problem-solving operation undertaken through case-conference discussions for the purpose of planning treatment. In this work the PSW should ensure that social aspects are taken into account by the other team members. For example, there may well be social contra-indications in otherwise highly recommendable measures. The vocational officer discusses job prospects with the employer; he knows the patient's skill and working capacity. But what about travel to and from working; taking meals in a cafeteria with unsympathetic strangers? Does the family agree to the patient's working in a factory? Many other examples can be given. On the other hand, the PSW must be aware of medical and psychological contra-indications in so far as social measures are concerned.

Patients often have many fears. Is he really receiving the right treatment? Are team members unanimous in their decisions? It is not uncommon to find that patients try to "play off" the different members of the team against each other, with a view to "controlling" their own treatment. The PSW, in such situations, often finds that all the other team members have some claim to knowledge of social problems. This is quite natural as life generally gives us all a certain insight into such problems. Nevertheless, it is dangerous to trespass into other professional fields. I have found it practical if, at least the doctor, the vocational officer and the PSW have their offices in close proximity to each other. Frequent, informal discussions just when a problem arises are necessary complements to the regular staff meetings. It is recommended that the vocational officer and the PSW together should watch the practical training of the patients. Vocational and social aspects are so interrelated that two opinions are needed to cover the situation as a whole.
With regard to sending reports to other institutions which take over treatment after the discharge of the patient, several questions must be asked. Do they understand your professional language? Can we invite them to a cup of coffee (or tea or whatever is the normal custom) to take part in the problem-solving process? (It is also easy to forget that the patient also belongs to the team; that one should not only talk about him, but to him.) Should the patient be present at the team conferences?

Most instructions for social workers state that they should give advice and help in personal, social and economic matters. It should be remembered, however, that the goal of our treatment is to give practical help combined with psycho-social-personal support in such a way that the patient will not be inhibited by the experiences of his own incapacity, but stimulated to mobilise his best resources, and/or make his own decisions. Social treatment should start even before a social history is taken. Without the therapeutic contact which gives the patient the feeling that we wish and are able to help and accept him just as he is, every investigation becomes superficial and incomplete even in so far as simple, uncomplicated problems are concerned.

This method—so often called "social case work"—can be performed through short contacts or during a longer period of time, individually or in groups of patients or their relatives.

A social worker must not only concentrate on the individual case, especially in rehabilitation of the mentally handicapped who always seem to be a greatly neglected group, but also function as "watch dog" to ensure that any necessary help is sought and obtained. In addition to help required with housing problems, transportation questions, technical aids, recreational activities (leisure time may indicate the weakest point in a whole rehabilitation programme) etc., many may need a complete reappraisal in so far as their financial obligations are concerned. The fear of debts and remaining payments of support can be responsible for the patients not wishing to recover. A prolonged financial support for sickness or advance pension, from the point of view of social economy, is often more expensive than writing off tax debts or other economical supportive measures. It is not always easy for a PSW to make authorities realise this.

Teamwork

Psychological factors affect our behaviour immediately we work together as a group. It may perhaps be some consolation for those who compare the social resources of their respective countries with Denmark, to point out that effective rehabilitation results depend more on harmonious working relationships than sophisticated buildings and modern equipment. Everyone who comes in contact with the patient is, to a greater or lesser degree, concerned with psychotherapy. We learn to understand how patients react to their problems. But we must also learn to understand how we ourselves respond to the patients' reactions and to the behaviour of the other members of the team. Only when we have gained respect for each other's roles can our co-operation be fruitful. All members of an effective rehabilitation team, from the chief medical officer and the administrator down to the janitor and charwoman, have to acknowledge a common responsibility and a continuing respect for each other's knowledge. How this can be achieved would provide material enough for an entirely new seminar.
19. The Role of the Clinical Psychologist in the Hospital, and in the Rehabilitation Centre

by

Allan A. Staehr,
Head of Clinical Psychological Sector,
State Psychiatric Department, Odense, Denmark.

The purpose of the work in the psychological sector is to take care of the clinical-psychological services to the hospitals for mentally sick and the rehabilitation centres at Funen, and furthermore, dependent on an extension of the clinical-psychological discipline, also to other medical organs within the Odense area, which may require this service.

The clinical-psychological service is dispersed over three areas: practical clinical-psychological work, education and research.

The psychological service is undertaken by a group of psychologists, who on an expert basis, try to comply with the demands made by the other professional disciplines.

In the practical clinical-psychological work, psychological functional analyses are made on the basis of the problems submitted. Furthermore, treatment of individuals or groups is undertaken.

Clinical-psychology is defined as the field within psychology to which are referred such psychological conditions which cause adjustment difficulties or interior conflicts in an individual; also patients with real psychopathological conditions. "It is, however, essential that clinical psychology deals with these conditions in the way they are understood in the light of the experiences gained within the field of normal psychology and as such, can be investigated, described, prevented or treated by means of psychological methods. Thus clinical-psychology has aims but not method in common with psychiatry whereas it has only to a certain degree the same aims but to a full extent the same methods, as normal psychology." (Østergaard 1964)

In practical clinical-psychological work we are as far as possible trying to make allowance for the above principles. In our department we undertake functional analyses as well as treatment on the basis of two main patterns taking into consideration the existing problems, i.e. one classical approach, inspired by psychodynamics and another more modern systemic approach inspired by Luria (1966) aiming at a systemic approach to the higher cortical function.

Generally recognised cognitive and projective tests are used in classical psychological functional analysis.

At a systemic functional analysis a test battery is used compiled by the Russian researcher, A.R. Luria. By means of some formulated test syndromes considering the regularity of behaviour, he tries to isolate possible malfunctions of the central nervous system. On this basis he tries to indicate where these malfunctions are located in the brain. This kind of functional analysis is used in patients with organic brain damages.

Treatment is given according to the following principles: a psychodynamic treatment in accordance with generally-known principles within the dynamic egopsychology and a systemic treatment aiming at re-establishment of systems destroyed as a consequence of organic brain damage.

The main principle of the systemic treatment is to permit undamaged parts of the brain to interact with or substitute the damaged parts. Treatment can be given on an individual as well as a group basis. Usually functional analyses are carried out in hospitals, but are made also on patients who have reached the rehabilitation institutions, and have "slipped through the net" without an adequate diagnosis.

Theoretically, treatment of individuals and of groups can take place in hospitals as well as in rehabilitation institutions. In practice we have started, on a small scale to treat individuals within the framework of the hospitals while
treatment of individuals as well as of groups is performed to a certain degree in the rehabilitation institutions. It must, however, be admitted that treatment is carried through in practice on a small scale, but plans have been made to expand the work existing, when the clinical-psychological sector has developed a sufficiently large capacity.

Education is carried out in training colleges and at university level and is aimed at giving non-psychological professions a knowledge of general psychological principles.

Finally research is undertaken concerning the relevance of the practical clinical-psychological work. As an example can be mentioned a project on local diagnosing of the brain damage.
20. Special Problems Encountered in Developing Countries in Rehabilitating the Mentally Handicapped

The Position in Uganda

by

P.S. Wabulya, Principal Rehabilitation Officer, Ministry of Culture and Community Development, Uganda

Background

Uganda is about the size of Great Britain and has a population of 9 million. About 50 per cent of the population consists of people below 18 years of age. Uganda like any other developing country in Africa is predominantly an agricultural country and only 10 per cent of the population live in urban areas; the rest of the population live in rural areas. In addition to agricultural activities there are copper and cement industries, tin, coffee and textile industries. About 10 per cent of the working population are engaged in wage-earning employment – the rest live on subsistence farming.

Like any other developing country, the physically and mentally handicapped in Uganda are by and large still considered as second-class citizens and people who cannot support themselves. This Africa-wide attitude towards the disabled received the Uganda Government's attention in 1965 when the Government, on the advice and assistance of the ILO, established a national vocational rehabilitation programme which not only assisted existing voluntary agencies in the field of rehabilitation but also established vocational rehabilitation centres, sheltered workshops and other institutions for the training and resettlement of the disabled including the mentally handicapped.

1. Today the Uganda National Rehabilitation Service consists of:
   - an industrial rehabilitation centre at Kireka near Kampala;
   - 5 rural vocational rehabilitation centres;
   - 2 resettlement homes (centres) for disabled beggars;
   - 5 sheltered workshops, one of them being an orthopaedic workshop;
   - a mobile rehabilitation unit for disabled mothers;
   - a marketing unit with a shop to deliver raw materials to home workshops and to collect and sell finished products from sheltered workshops, etc.;
   - a national disablement advisory council linked up with district disablement advisory committees to assist and advise the Minister and the rehabilitation staff in the training and resettlement of the disabled.

In addition to services provided under the national scheme there are services established and administered by voluntary agencies and these are:

- a school for blind children and an agricultural centre for the blind administered and financed by the Uganda Foundation for the Blind;
- a school for deaf children established in 1959 by the Uganda Society for the Deaf;
- a school for spastic children established in 1969 by the Uganda Spastic Society;
- a hostel and workshop established in 1970 by the Uganda Cheshire Homes Society;
- the Uganda Association of Mental Health.
2. Concept of Mental Illness in Uganda

In Uganda and possibly in other African countries mental illness must be considered in terms of culture. According to the culture of the people of Uganda some forms of mental illness are considered as deviated behaviour while others are thought of as part of the community's behaviour. Hence mental illness in Uganda is split into many forms depending on the symptoms. Western psychiatrists who have lived and worked in Uganda have, from the medical point of view divided mental illness into three groups: chronic patients, acute patients and those suffering from mental retardation. They maintain that mental illness is the result of the reduction of interpersonal skills, intelligence, etc. caused by social and economic factors as well as illness and accidents. Rehabilitation psychiatry in Uganda therefore aims at controlling the behaviour of patients and helping them to acquire social skills and to minimise their deviated behaviour rather than curing the disease.

3. Existing Services for the Mentally Handicapped

Due to lack of interest in the welfare of the mentally handicapped and partly to limited resources the services created for the mentally handicapped are not only few in number but also inadequate due to lack of trained personnel. The following are the services aimed at rehabilitating the mentally handicapped in Uganda:

- Butabika Hospital built in 1959 (to replace the old Mulago Hospital) to provide mainly medical treatment;
- mental clinics at Mulago (Kampala), Jinja Scoti in the Eastern Region and Fort Portal in the Western Region, none in the Northern Region. These clinics except Mulago are run by trained medical assistants but are visited regularly by consultants. The Mulago clinic is the biggest and has four full-time consultants from the medical school and it deals with 7,000 patients a year;
- Naguru and Sanyu Babies Homes which often admit and look after children with mental retardation;
- Industrial Rehabilitation Centre at Kireka and rural vocational rehabilitation centres as well as sheltered workshops under the national rehabilitation scheme accept mentally handicapped persons for vocational training and resettlement;
- the Uganda Association of Mental Health whose objective is to draw public attention to the problems, the incidence, methods of help, treatment, home nursing and care of mentally handicapped. The Association is at present constructing a home for mentally retarded children.

4. Butabika Hospital

(a) This is a government hospital situated on the shores of Lake Victoria about 8 miles from Kampala, the administrative capital. It has 967 beds with an admission and discharge rate of 3,000 patients per year. Being the only mental hospital in the country it mainly caters for chronic and acute patients of both sexes, including children. There are 18 wards, 1 for children, 5 for women and 12 for adult males. In addition to the 18 wards there are 2 occupational therapy workshops which were established 5 years ago by a Norwegian Volunteer with funds from Norway. While in the occupational therapy workshops patients learn handicrafts and furniture making under the guidance of a local occupational therapist trained in Great Britain, there is also a social work department with an establishment of 5 posts of psychiatric social workers. Four of these posts are filled by unqualified staff except 1 from Britain. Of the 3 untrained social workers one is now undergoing training in Britain.

(b) The main functions of the social work department are to assist the psychiatrists (consultants) in diagnosing the problems of the patients through a social history of the patient's case, work with the patients and
the patient's family, follow up of ex-patients, obtaining jobs for some of the patients discharged from the hospital and training social work students from Makerere.

Staff
The staff comprises:
1 medical superintendent;
5 full-time consultants of whom 4 come from Makerere University Medical School; 2 more consultants will be available, bringing the total number to 7;
1 senior hospital secretary;
1 deputy;
1 chief male nurse;
1 matron;
1 deputy male nurse;
1 deputy matron;
500 mental nurses of whom 2 come from overseas.

5. Training of Staff
Following a report of investigation in 1956 on the extent of the problem of mental illness a department of psychiatry was established within the Makerere University Medical School in 1966 and Uganda became the first country in East and Central Africa to establish a chain in psychiatry.

At the medical school the second-year students are introduced to psychiatry linking their physiological studies to the physiology of lighter nervous activity, personality theory, learning and intelligence in a theoretical and practical course. Staff from departments of sociology and preventive medicine are involved to teach methods of communication and interviewing techniques as well as family structure in East Africa. In the third year systematic psychiatry is taught in lectures over two terms and an introduction to some of the psychiatric problems of children is given to the students. In the fourth year the students are taught psychiatry proper with visits to the psychiatric ward at the teaching hospital. They also do revision in their fifth year.

Senior house officers participate in the general teaching facilities - case conferences and seminars - and are encouraged to start clinical investigations.

Lectures with discussions are given to medical assistants, police officers, health visitors and marriage counsellors. A post-graduate course leading to a diploma in psychiatry is to be established next year at Makerere University.

All mental nurses at Butabika Hospital and those working at mental health clinics are given a three-year residential course at Butabika Hospital. Those who complete their local training may be sent abroad mainly to Britain for further training and on return they are put in charge of wards.

6. Research
Dr. John Orley with support from the Nuffield Foundation has carried out an inquiry into the attitudes and beliefs of Baganda about mental illness and other illnesses especially as reflected in the fine shades of Baganda terminology (culture and mental illness). Other researchers have concentrated on the significance of hallucinations in certain groups and varying symptomatology of depressive illness. Studies of social change in relation to mental illness have been carried out in Ugandan and Rwandan immigrants; also group psychotherapy as
a means of delivering mental health care. At present there is a joint research project with a group of experts from the USA on the long-term effect of malnutrition in childhood and eventual mental development.

In conclusion one is impressed by the development of interest, the relevance of the work in progress to its local conditions and the collaboration with other university departments and outside agencies.

7. Immediate Future Plans

During the third five-year development plan the following services are to be established immediately:

(a) expansion and improvement of the occupational therapy workshops at Butabika Hospital;

(b) establishment of a rehabilitation village or community near Butabika Hospital. The village will take in some of those patients being discharged from hospital and each will be given a piece of land and agricultural tools and will be assisted to build his own house;

(c) a vocational rehabilitation centre under the administration of the National Vocational Rehabilitation Service is to be built near Butabika Hospital to give vocational training to mental patients in the field of agriculture, carpentry, handicrafts, etc;

(d) the existing rehabilitation centre to take in more mentally handicapped patients for vocational training;

(e) health visitors, family welfare officers and rehabilitation officers to be given training in the investigation of mental illness and to be used as auxiliary workers in the rehabilitation of the mentally handicapped.
Rehabilitation programmes in Mexico are developed through three main channels: the Government, the Social Security Institute and private institutions.

The Mexican Government is the main authority for rehabilitation programmes. The administration of the programme is divided between two agencies: the Ministry of Health and Welfare and the Ministry of Education.

In the Ministry of Health and Welfare there is a Directorate of Rehabilitation, which was established in 1953 and which is responsible for all rehabilitation programmes for all types of disabilities. This Directorate has six main departments: (1) medical; (2) social; (3) vocational rehabilitation; (4) biostatistics; (5) education and research; and (6) administration. The governmental rehabilitation centres operated by this division are normative and co-ordinate their activities with the local authorities in each state to develop rehabilitation programmes.

The Vocational Department plans and promotes the vocational rehabilitation programmes in the country. A new rehabilitation centre was opened recently for vocational evaluation, work adjustment and placement for all kinds of disabilities.

With the support of this Directorate a new private institution was established for the development of sheltered workshops. We started with the classic broom-and-brush factory for blind people and we are now planning workshops for all types of disabilities.

One of the centres of this Directorate is a rehabilitation centre for alcoholics with medical, psychological and social therapy programmes and services.

In 1960 the Directorate of Mental Health was established. The old hospital for mentally ill persons was closed and new facilities were built with modern installations, one for neurological patients, two hospitals for psychiatric patients, one for children and one for adults. Ten FHRM hospitals were established for chronic mental patients. Three were built near the capital city and the others in the vicinity of the main cities of the country.

In these hospitals there are very few occupational therapists and vocational rehabilitation personnel in charge of the rehabilitation programmes. Most programmes are conducted by craftsmen with medical supervision. There is not enough co-ordination for follow-up work with the patients when they are discharged from hospitals.

Out-patient services from the general hospitals and the public health centres are the responsibility of the psychiatric consultants and mental hygiene personnel.

The Ministry of Education has had responsibility for the programme for mentally retarded children and young people since 1940. This Ministry has a Directorate of Special Education with emphasis on mental retardation. There are special schools all over the capital and in the main cities of the country. There are two special institutions for young people: a farm and a vocational school. Recently a sheltered workshop for the mentally retarded was established.

There are special programmes for the socially handicapped under the Ministry of the Interior. There is a court for young delinquents and centres
where they can live and receive education and vocational training. There are growing problems but we are not going to discuss the subject in this Seminar.

The Social Security Institute was organised under a law which requires employers and the government to pay a certain sum related to the salary, thus enabling insured persons to obtain medical services, old-age and invalid pensions. The scheme covers 25 per cent of the population and has its own hospitals and out-patient clinics throughout the country.

The rehabilitation services provide physical rehabilitation, prosthetics, changes of occupation for medical reasons and co-ordination of cases with vocational training centres.

The Social Security Institute pays governmental and private psychiatric hospitals for in-patients who are treated in these hospitals. The out-patients are served in their own general hospitals and clinics.

The rehabilitation programmes in private institutions for the mentally ill are educational, medical and social. There are no vocational rehabilitation services in private institutions. These institutions are mainly: special schools for the mentally retarded, residential care facilities for very severe cases of mental retardation, hospitals for the mentally ill and the Alcoholics Anonymous associations.

Teachers, psychologists, psychiatrists, social workers and rehabilitation personnel are associated in scientific groups and participate in national or international associations in their special fields.
Rehabilitation Programmes for the Mentally Handicapped in Mexico

National Co-ordinating Committee for Health, Social Security and Welfare

Government

Ministry of Interior

Ministry of Education

Ministry of Health

Directorate of Special Education

Directorate of Rehabilitation

Directorate of Dental Health

Social security Institutions

Private Institutions

Hospitals, Clinics

Special schools
residential care
mentally ill
hospitals
alcoholics anon.

Physical rehabilitation, prosthetics and connecting services. Cost of services met by Ministry of Health

Three Hospitals

Neurological Mentally Ill Adult Mentally Ill Children

Ten Fach Hospitals for Chronic Mentally Ill

Outpatients' Clinics

National Rehabilitation Centres

Vocational Rehabilitation Centre

Sheltered Workshop

Local State Centres in collaboration with Local Government

Six Departments

Medical

Social

Vocational

Biostatistics

Education and Research Administration

National Rehabilitation Centres

Vocational Rehabilitation Centre

Sheltered Workshop

Local State Centres in collaboration with Local Government

Scientific Groups of Technical Personnel

Rehabilitation Association
22. General View of Research into Problems Affecting Vocational Rehabilitation of the Mentally Handicapped

by
Francis X. Lynch, Director,
Division of Developmental Disabilities
Rehabilitation Services Administration
Social and Rehabilitation Service
Department of Health, Education, and Welfare

Introduction

When viewed in historical perspective, research was a late component of comprehensive planning in the area of mental retardation.

It was not until the legislative amendments were made to the Vocational Rehabilitation Act in 1954 that there was an effort made to stimulate research.

Today, when we think of research on mental retardation and other handicapping conditions originating in childhood, we find ourselves dealing with cultural deprivation, various methods of assessing the individual's potential, communication, methods and media for educating and training the retarded, and vocational placement.

These are only a few facets of mental retardation research besides the more medical investigations into inborn errors of metabolism, pre- and post-natal infections, and birth injuries.

Now that we, in the United States, are dealing officially not only with mental retardation problems but have expanded our programmes to include those of developmental disabilities, our population served will be larger as well as will be the number and kinds of services needed.

And not the least of these will be research and the appropriate application of its findings.

Research in the United States is carried on at the national, state and local levels. It is carried on by official and voluntary agencies, by universities, in hospitals, in ghettos, in model cities.

Some research is carried on with the support of foundations and trusts, but much - much - of the research is possible because of the millions of dollars appropriated annually by the US Congress to carry on research in the national institutes of health, to support investigators throughout the country, and even investigators in other countries through our international currency programme.

I am from the Department of Health, Education, and Welfare which supports research programmes in several of its subagencies.

But, I shall pass over the work of most of these agencies briefly in order not to confuse you and to go on to the vocational rehabilitation aspects of mentally handicapping conditions in more detail.

Briefly then, within the covering agency, the Department of Health, Education, and Welfare:

- Research is conducted on education of the handicapped by our Office of Education.

- This current year about $11 million was spent by the national institutes of health on research and research training grants in mental retardation. These contributions directly or indirectly extend the mental retardation research efforts of other agencies within the Government.

- Another agency of DHEW (as the Department of Health, Education, and Welfare is popularly called) provides leadership and direction on programmes for the development of health care and maintenance. Here is where you will find studies - and services - on prevention of organically-based mental retardation. This subagency of DHEW, the Health Services and Mental Health Administration, provides leadership in immunisation programmes on measles and rubella.
And then we have the Social and Rehabilitation Services of the US Government -
the agency in which I am the Director of the Division of Developmental Disabilities.

Within the Social and Rehabilitation Services you will find most of the research on vocational rehabilitation and mental retardation being administered either singly or in combination.

The research and training activities of SRS were recently co-ordinated under one office to improve the administration of the grants programme and see that the research findings are utilised.

The research programme of SRS aims to discover new knowledge and develop new methods of assessing the handicapped individual's potentials, new techniques for working with the disabled, new methods of habilitation or rehabilitation, and the most effective methods of vocational placement and follow-up.

How Do We Operate?

With our goals in mind, how do we operate?

By a large project grant programme giving financial aid to investigators whose studies will further the solution of problems relating to disabilities — whether from mental retardation or otherwise. I will stay close to mental retardation and related disabilities or ones requiring care similar in nature.

International Activities

Besides the large national research programme in the United States, we are authorised to aid research investigators in foreign countries whose investigations might result in discoveries of value to the United States.

This is our foreign currency programme and is operated by the Division of International Activities, the focal point for the development of all SRS international activities.

These programme operations in social welfare, vocational rehabilitation of the physically handicapped and the mentally retarded are designed to supplement and complement domestic programmes and to strengthen relationships with other countries as well as to further US foreign policy goals.

A major segment of the international programme has been the development and support of co-operative research and demonstration projects in certain countries. This programme, financed with US-owned foreign currencies derived from the sale of agricultural commodities, was initiated by a precursor of SRS, the Vocational Rehabilitation Administration, in 1961.

A vital adjunct to these research activities is the interchange of experts programme. The Social and Rehabilitation Services have arranged for the interchange of scientists and experts engaged in research between the US and countries participating in this co-operative programme.

Under this special programme designed to supplement and complement the domestic research programmes we are able to avail ourselves of the unique talents and capabilities of foreign scientists who are dealing with problems similar to those confronting us in the United States.

In Israel, for example, a recently completed project demonstrated the effectiveness of group dynamics in developing and training teams of retarded youngsters for placement in the open labour market.

Since the beginning of the research and demonstration programme in 1961, eighteen projects in various aspects of mental retardation have been approved by the Division of International Activities. The range of research interest is very broad encompassing both medical and non-medical projects as well as clients of all ages.
Types of projects that are now in progress include the experimentation with new techniques for evaluating training, and placing mentally retarded persons; and investigations on the medical, psychological, social and cultural aspects of mental retardation.

During the past ten years, projects dealing with mental retardation were approved in India, Israel, Pakistan, Poland, Tunisia, and UAR.

These past achievements have helped to increase research competency in the foreign countries participating in the programme.

While continuing our search for new talent, we can now draw upon a corps of experienced investigators overseas who have proven their ability to conduct research of significance to the United States.

Many of these investigators have participated in, or benefited from, the two-way exchange of experts programme.

Under the interchange of experts programme, investigators on some of the mental retardation projects have been brought to the United States for consultation and observation. During May and June 1970, for example, two investigators on a research project concerned with rehabilitation of the mentally retarded in Warsaw, Poland, observed programmes and research in this field and consulted with specialists in the United States under this programme.

More recently, in June of 1971, thirty investigators from foreign countries came to an international research seminar in the United States to disseminate the findings of some of our mental retardation projects supported by the SRS Division of International Activities.

The purpose of the international seminar was to provide a forum for the exchange of information concerning vocational rehabilitation of the mentally retarded.

More specifically the participants explored those investigations pertaining to programmes, operations, and services of rehabilitation facilities.

In addition to the principal investigators in our overseas projects, researchers from countries in Central and South America, Western Europe, Africa, Asia, and Canada participated in the seminar.

In the three-week visit, the visitors had the opportunity to visit HEW and make site visits to a research and demonstration centre, to rehabilitation centres, and meet with and observe the work of voluntary agencies.

While in Texas, they attended the annual meeting of the American Association on Mental Deficiency.

During the course of their visits they met with or were accompanied by domestic researchers — thirty in all.

The Look Ahead

Congress recently appropriated $8 million for SRS research work overseas in the fiscal year 1972.

Under this international programme approximately sixty-five foreign experts in mental retardation and other specialities will be brought to the United States in 1972 for periods of up to three months to consult with US experts doing research or conducting programmes in the same fields.

Likewise, US experts going to other countries will serve as consultants and will assist investigators by aiding in the development of co-ordinated research procedures looking towards maximum comparability of data. They will also lecture and monitor projects.

The overseas project grants are made to governmental and private non-profit institutions not to individual scientists.
You might like to know what topics interest the overseas investigators.

In Israel, the social aspects of mongolism, diagnostic procedures in mongolism, and assessment of mentally retarded individuals.

In Cairo, vocational rehabilitation of the mentally retarded individual.

In India, an occupational training centre for mentally retarded persons, the training of mothers in day-care centres, and the education, treatment, and rehabilitation of the mentally retarded.

In Pakistan, the treatment and employment of mentally retarded individuals.

In Poland, rehabilitation of mentally retarded individuals in the invalids' co-operatives, and comprehensive day-centre services for the severely retarded.

And, in Tunisia, vocational training of mental retardates.

Notice the emphasis on vocational rehabilitation in all of these.

Domestic Programme

Now let us turn to the larger research programme of SRS - the domestic one.

Rehabilitation Research and Training Centres

Under this programme we have nineteen research and training centres in the United States with comprehensive programmes for the severely physically disabled, the mentally retarded, the deaf, and the vocationally handicapped.

Eight of these are distinct organisational and physical entities providing a continuing framework for psychological, social, vocational, and rehabilitation research and training.

And, at least on a demonstration basis, a comprehensive programme of evaluation, training, counselling and placement of the mentally retarded individual.

Three centres are for mental retardation research and training and the research conducted in these encompasses many aspects of the rehabilitation process, from onset to training and placement of the retarded individual. It is broadly directed to a wide range of psychosocial, vocational, or other fields of rehabilitation, and also to specific problems in the many aspects of rehabilitation of the retarded.

Further research is being conducted to seek out the cause of retardation, to assess the potential for education and rehabilitation, to develop training and remedial programmes suited to the needs of the retarded, and to ascertain the actual learning and socialisation difficulties encountered by the retarded. Also being emphasised is the development of adequate motivation for work in the retarded through family, school, and community resources.

The centres are directing attention to, and advancing understanding of behaviour modification techniques in a variety of settings, the learning and socialisation processes, psychosocial testing, work adjustment and vocational rehabilitation procedures. Such studies will hopefully bring about new knowledge not previously available, to be utilised in preparing the retarded for productive, independent living. This research will also be helpful in planning and developing remedial and rehabilitation programmes for the disadvantaged and culturally deprived in becoming more self-sufficient.

The rehabilitation research and training centres in FY 1972 will train new personnel to enter the fields of rehabilitation and also advance the training of experienced personnel so that the vital knowledge they gain can be used to implement new and better services for handicapped and disadvantaged persons. Research environments will be improved so that new knowledge and skills can be developed to solve existing problems. These centres already have considerable impact on the state vocational rehabilitation programmes and other state service agencies and this will be further strengthened.
Centre personnel will work closely with state agencies' staffs, co-ordinating training activities with them so that the greatest effort will be aimed toward the areas needed most by the states.

The training of medical and paramedical personnel and community volunteers in conjunction with the state agencies will have an important influence on the communities from which they come.

In addition, the centres will share a significant role in the provision of rehabilitation and employment services to the disadvantaged and poverty stricken in rural and urban settings. Each centre will provide rehabilitation research and training directed to the achievement of success in effectively serving the impoverished disadvantaged, and dependent, with emphasis upon the improvement of services for self-care.

We have one university mental retardation research and training centre in the process of completing a comparative study of the administrative structure of work-study programmes conducted throughout the United States jointly by state vocational rehabilitation and special education agencies.

This centre has also completed a study of the effectiveness of computer-assisted instructional methods of teaching certain basic skills necessary for independent money management. These skills include transfer of learning to simulation tasks in which the student was required to make purchases and count change in a simulated shopping situation.

Of prime significance is the longitudinal follow-up study of retarded young adults. This study should be particularly significant since one-fourth of those studied were Mexican-American. So the study, when completed, will include an analysis and comparison along ethnicity lines.

The University of Oregon Research and Training Centre is involved in research on:

1. socio-cultural ecology of upper level mental retardation;
2. an investigation of the post-high school vocational adjustment of educable retardates;
3. development of a model for evaluating the relationship between educable mentally retarded high school programmes and the socio-vocational success of terminated pupils.

Our third centre is located at the University of Wisconsin. At this research and training centre, the results obtained in the research and related activities of the Laboratory of Applied Behavior Analysis and Modification have provided an experimental basis for new rehabilitation practices with mentally retarded clients who present unusually difficult behaviour problems. The staff is enthusiastic about the implications of these findings and feel that continued pursuit of the behaviour-theory approach will result in a fully developed technology of rehabilitation practices for use with the mentally retarded client who previously had been dismissed from rehabilitation programmes as being dependent adults.

The Milwaukee high-risk population research programme conducted by the university's research and training centre contributed significant new survey data pertinent to the epidemiology of "cultural-familial" mental retardation. The new data extended previously reported survey data which indicated that the high prevalence of retardation found among disadvantaged population groups is accounted for, largely, by a relatively small proportion of the population involved.

Data from the family rehabilitation programme extend optimism (although still cautious) that this experimental approach may prove effective in preventing "cultural familial" mental retardation.

In the area of training, thirty-two short-term courses attended by 1,465 trainees were sponsored by the three mental retardation research and training centres. These included training for rehabilitation counsellors, physicians, special education personnel, nurses, parents, attendants, and others in specific rehabilitation techniques leading to employment of the retarded.
For 1972 specific research projects will focus on such high priority areas as improved work adjustment methods for motivating and training the dependent or potentially dependent for employment, new physical restoration techniques for increasing mobility potential of the severely handicapped, and factors affecting the etiology and acquisition of cultural deprivation and mental retardation in inner-city populations.

Training activities of the centres will prepare medical and other rehabilitation related professionals and supportive personnel to work with disabled welfare and other poverty stricken citizens, to recognize characteristics important in the planning and co-ordination of rehabilitation services. The use of both subprofessionals and volunteers will be increased during 1972.

Examples of Application of Research

A variety of community-based projects demonstrating involvement of community resources for training of retarded and for their transition to the wider community are the results of recent research efforts.

For example, a substantial number of work-study programmes for retarded adolescents has been sponsored by state divisions of vocational rehabilitation jointly with local school boards, parent organizations, private schools, and state departments of education. These projects were based on prototypes developed in the vocational rehabilitation research and demonstration programme.

VR has also conducted energetic programmes to place the retarded clients in a wide variety of civil service jobs.

A follow-up study of the first 2,000 mentally retarded workers placed with the federal government throughout the country to determine how effective the programme has been and how to improve and expand it to state governments as well has been completed.

Many retarded individuals leaving an institution do not have a home nor family to which to return. A demonstration programme designed for adult retardates who had no home but were considered good candidates for discharge into the community consisted of:

- pre-discharge evaluation;
- a social and vocational remedial education programme;
- half-way house activity concurrently with pre-industrial exploratory work experience;
- job placement;
- arrangements for independent living in the community; and
- long-term follow-up to assist the retarded person in his solution of emergent problems.

A noteworthy project in a state hospital accepted for service a random sample of all chronic older retarded in the hospital disregarding the retardates:

- age;
- length of institutionalisation;
- presence or absence of work history;
- previous education;
- or severity of accompanying disabilities.

It was found that almost one half of the older retarded, with provision for adequate evaluation and work adjustment services, could be trained vocationally, rehabilitated, and moved to full or partially-supporting employment outside the hospital.
A research project proved that certain kinds of management in state mental hospitals, behaviour of hospital personnel and different types of inter-relationships between ward attendants and the retarded persons have profound effects upon the retardate's abilities to learn and to respond to training programmes.

The most significant recent research and demonstration development for the retarded is a set of six projects carried out jointly by the National Urban League, Family Services Association of America and the National Association for Retarded Children. These six projects are demonstrations in model city neighbourhoods of new and more effective ways to reach culturally deprived and disadvantaged families with essential services for members of the families who may be retarded.

Role of our Research Programmes for the Mentally Retarded

Research findings are presented to Congressional Committees to justify requests for appropriations.

Research has proved that a much larger group – including the severely retarded – can be vocationally rehabilitated than was thought possible before.

It justifies changing the focus of manpower training programmes.

In the future we can expect a larger, not lesser, emphasis on research, out of which will come new patterns of and procedures for service to disadvantaged people.

We can look for unexpected solutions to problems of the severely disabled.

Also, more collaborative research with mutual benefits through general exchange of information.

Research of the past few years led to refinements of assessment techniques, to new methods and media for education and training, to more suitable job placement and more effective follow-up and guidance.

It has placed disabled handicapped persons on the job in the community, in situations formerly thought impossible for the mentally handicapped.

It has demonstrated that mentally retarded individuals can successfully hold down government jobs.

In the short span in which research has been an arm of the vocational rehabilitation movement, applied research has had dramatic results, much of it applicable in the international field.

With improved communications, increased resources to draw upon, more trained manpower, we have a duty to set our research goals extremely high at this conference so that today's dreams become tomorrow's reality.
23. Theoretical and Practical Problems Regarding Research on Social Adjustment of Mentally Handicapped Persons

by

P.H. Kühl, Research Director at the Danish National Institute of Social Research

In the most developed European countries a more human treatment and specified medical care and therapy of psychiatric patients and mentally retarded persons began in the last century. Since then, institutional care and medical treatment have improved, but only recently has serious work been done, aiming at social readjustment of former patients and handicapped persons.

New methods are developed and experiments in rehabilitation are made, and we believe that it is good for the clients, but we do not know exactly how they work. Systematic research on the effects of the efforts has hardly been done, but it seems as if social scientists are now examining this field. They are co-operating with the medical staff, social workers, vocational rehabilitation people and the social administration in general. At the same time they are establishing a separate group in the role of independent researchers, who will critically and objectively evaluate the working results of clinicians and practitioners.

A few years ago in this country the Danish National Institute of Social Research conducted a great research project on physically handicapped persons. One important result of this investigation was that personality factors and neurotic behaviour dispositions influence the rehabilitation process of physically handicapped persons in a very decisive way.

We are now planning a research project on the social adjustment of mentally handicapped persons, both former psychiatric patients and mentally retarded persons. I shall try to give you some impression of the theoretical considerations and the practical problems of research in this field.

Research Philosophy

The Institute partly perceives the task as an evaluation of the rehabilitation efforts which have been made by hospitals and institutions, and measured by description of the social situation of the clients after some years. The aim of therapy and social support is to make the sick or handicapped persons function socially as normally as possible. The success must be evaluated by comparing the social situation and adjustment of handicapped persons with the population in general. The well-functioning person will have a satisfactory relationship to work, including income and human relationships, to family, children and friends, to housing and living conditions and to recreational facilities, cultural values and social contacts. The individual patterns will vary, and the degree of satisfaction will depend on what people expect, their level of aspiration, but severe frustrations and obvious relative deprivation will reduce the physical and psychological well-being which is supposed to be the right of every human being.

You may distinguish between efficiency and well-being as sub-parts of social adjustment. Frequently the efficiency aspect is stressed, partly because it is easier to measure the number of working days and the amount of income, partly because the traditional western philosophy and life-style are characterised by a high estimation of efficiency, productivity and competition. It is generally accepted that the ultimate aim is human well-being and happiness, basic trust and friendliness among people, but it is sometimes expected to be an automatic consequence of material productivity. We know, however, that it is not necessarily so. Sometimes efficiency excludes well-being because people work too hard to enjoy the products. On the other hand it is obvious that the two concepts are not always competing and contradictory; it can be extremely rewarding to be efficient and creative, engaging the total personality in social co-operation and productivity. In the case of rehabilitation the two concepts may be united in the very process of training, making progress and establishing social co-operation and emotional contacts.
When a person is handicapped either physically or mentally he is characterised by a lack of something; he is deprived or underprivileged in some respects. Consequently, he will need some compensatory factors to re-establish a balance which can make him function despite his handicap. Sometimes the compensatory factor is internal in the person, e.g. if a man with a sensory handicap is highly intelligent; sometimes it is external, e.g. if a woman injured in a traffic accident has a rich family. In both cases they may adjust themselves socially by means of the compensatory factor. In the rehabilitation process it is often necessary to add one or more compensatory factors, e.g. additional education, improved housing conditions or transportation means. Very important factors of this kind are the personal relationships within the family and the working conditions. It is the task of the medical staff, the social welfare agency, the labour market and the primary groups to offer the handicapped person facilities and support which may compensate for the weak spots of his functional pattern.

In some cases environmental circumstances constitute further negative agents in the life of the handicapped person, e.g. bad housing conditions, an unloyal spouse or prejudices in the labour market.

Research Project

In the concrete research project we are now planning we aim to investigate the situation of about 1,000 mentally handicapped persons, partly psychiatric patients, partly mentally retarded persons, all of whom were institutionalised five years ago. We propose to register their mental disease or handicap when they were released; collect information from institutions and social agencies about the support they have received since then; and describe their actual situation through personal interviews with the clients and their families.

The principle of this procedure in brief is that we will select a number of persons who were objectively classified as mentally handicapped five years ago - irrespective of the reasons why they are handicapped. The next step is registration of positive and negative impulses from society as a whole including primary groups and family as well as social and therapeutic institutions. And the final test is the actual outcome, their social situation.

We have some hypotheses we want to test:

(1) Handicapped persons who are adequately stimulated have a better chance to function socially than persons who have less support or therapy.

(2) Mental handicaps are only compensated to a limited degree, so the consequence is generally a state of social deprivation.

(3) The more severe the mental handicap (diagnostically defined), the higher the degree of social problems.

(4) The risk of maladjustment among children of handicapped persons is higher than among children in the population in general, and this tendency will be aggravated unless support is given to the mentally handicapped parents.

(5) Mentally handicapped persons adjust better socially with adequate support from a primary group, provided that this group is neither over-protective nor too demanding.

(6) If the therapeutic institution has good contact with the primary group, this group will function as a therapeutic instrument in favour of the mentally handicapped persons.

(7) If the therapeutic institution is rejected by the primary group the situation of the handicapped person will deteriorate.

Selection of Samples

Selection of persons to be investigated can be undertaken in a variety of ways.
In the first place we try to identify persons who received institutional care and therapy five years previously, in order to ascertain what has happened since then and what their factual situation is.

A second method of selection may be done in cooperation with family doctors who can indicate which patients are psychiatric or mentally deviant. In this way we can get in touch with the feeble minded, psychotic cases and neurotic patients.

A third method will include interviewing of a large number among the general population, using the screening test which will give us information of persons with neurotic traits. This subgroup should be further interviewed about their actual social situation.

All three methods of selection will to some extent antagonise the different groups, who may resist our efforts.

In the first case we have already encountered much resistance from hospitals and clinics which are not very willing to tell even a scientific institution the names of "their" former patients. It seems as if the solution of the conflict will be that the therapeutic institutions will make a preparatory interview, asking the former patient if he/she is willing to be interviewed. The Social Research Institute will then collect information about the social situation, while medical and other information will be drawn from the institution papers by a psychiatric assistant.

In the second case I predict that there will be some resistance from medical doctors, because they take the attitude that no information about patients must be given to non-medical persons, not even to a research institution. The solution may be that the doctors who are co-operative will ask their patients if they are willing to receive an interviewer from the Research Institute. A possible consequence is that some types of patients will be more resistant than others and the sample will be oblique. This would be fatal if we wanted a representative sample, but if the research is aimed solely at analysing some cases of mentally handicapped persons and their social situation the procedure will be acceptable.

The third technique in many ways is the most sophisticated and satisfactory. If we want to know how mentally handicapped persons behave and adapt to our society the most rational procedure is to select from a representative sample of the total population those people who are characterised according to a definition and to a test which is able to identify them. A practical problem is the relatively high cost of interviewing a large sample of people who are not mentally handicapped just to identify the minority we will investigate more closely.

The research programmes I have mentioned have social-political perspectives and they do not include analyses of causations of mental handicaps, nor strict analyses of effects of therapy, not even real counting of the frequency of handicapped persons. As different projects have shown, the number of mentally handicapped persons depends to a very high degree on diagnostic formulations and definitions.

Finally I will mention briefly the implicit risk of tautological and circular conclusions. Mental handicaps and psychiatric diagnoses are defined to a high degree by social maladjustment, by behaviour patterns of a socially and normally unacceptable character. So it is of little use to find out that they really have social problems. To prevent that problem we try to establish a starting point in a situation where a person objectively has a behaviour problem which causes troubles to himself or other people; from that starting point we will explore how society reacts to the person with that behaviour pattern and whether primary groups, institutions and social agencies aggravate the troubles or are able to compensate for them and really help the client.

We do not expect it to be an easy task to do research in this field, and we do know that it is a difficult job to help the mentally handicapped subgroups. But both kinds of work are stimulating and fascinating, and we are going ahead with the task.
24. Training and Recruitment of Personnel
by
Børge Nielsen, Principal,
The Personnel Training School, Copenhagen

There can hardly be any doubt that legislation concerning the handicapped as well as treatment possibilities pass through various phases pari passu with the general development of the society; and if comparisons are made among a number of countries with related cultural patterns it is to be expected that the same stages will be repeated from country to country.

The Swedish psychiatrist Karl Grönwall suggests that the development of the care of the handicapped will pass through four phases which he describes in the following way:

1st Phase: Diagnosing - where number and size are ascertained, and where at the same time the need for treatment is formulated. It could perhaps be said that this is the period in which society defines the concept of handicapped or becomes aware of the problem.

This stage was initiated in Denmark about 100 years ago.

2nd Phase: Centralisation - is a natural continuation and this phase occurs at the time when people, having learned to understand the meaning of handicaps, start to investigate causations and thereby concentrate upon prevention. This period is governed by the specialists and is characterised effectively by the building of very comprehensive institutions - in some cases one category may need only one single institution.

3rd Phase: Differentiating - gradually, intensive investigations may result in the recognition that various age groups require different forms of treatment; contrary to former times where the same yardstick was applied to everybody.

At the same time different categories and degrees of handicaps are identified, which again influence the structure of institutions.

During this period the need arises for the involvement of various specialists from the medical, the paedagogical as well as the social field.

In Scandinavia this phase was initiated in the 1950s, but during the last few years there have been indications that the care of the handicapped is about to pass into a new phase, and that is:

4th Phase: Decentralisation and integration characterised by the fact that it should be possible to undertake care programmes according to the demand of each individual client irrespective of geographical residence and duration of treatment, and so flexible that the period of care as well as its intensity can be varied without any difficulty.

I have mentioned these four phases in my introduction because it is apparent that systems of treatment, as well as the need for personnel - quantitatively as well as qualitatively - are linked very closely with these developments. By studying the laws and regulations for the handicapped in a country one should be able to obtain some indication of the particular phase which has been reached. If, for example, we examine Danish legislation related to the mentally retarded over the years 1934-1959 then we find that the three objectives of the care of the mentally retarded are:

- to protect society;
- to protect the mentally retarded; and
- to relieve the family of the burden of caring for the disturbed and severely mentally retarded.
It was therefore quite natural during this period to build a number of comprehensive institutions and to place them in isolated parts of the country. There are in fact several buildings from that period which in the years ahead will come to be regarded as monuments and examples of centralisation.

If we next examine how development has influenced the recruitment and training of the majority of the specialist staff that make up the group caring for the handicapped, then we might find the vague outlines of a development pattern. On the whole, however, I must state that a conservative attitude prevailed. It is as if we could not escape from this period of the large institutions - Grünwald's Second Phase of centralisation.

In any well-organised society it is necessary to have a division of labour. Each individual member of that society will therefore have a role to play which will influence his life for a longer or shorter period; but during his working lifetime he will have the opportunity to participate in the development of society.

The view of what is normal and what is abnormal has changed essentially through the years, but in the Nordic countries certain fixed ideas on resettlement and treatment of psychically disabled persons have always prevailed. For several decades treatment in institutions has been preferred. Children's institutions were established mainly on a medical (and in some cases also educational) basis. In so far as institutions for adults were concerned, medical and legal aspects were stressed and this inevitably influenced the form of treatment.

The heads of these institutions were most frequently recruited from the medical profession, and in some cases they were influenced by strong religious beliefs. The personnel in the wards were recruited, not surprisingly, from the nursing profession.

The daily supervision and maintenance work was undertaken by auxiliaries - or care personnel. Usually they were untrained.

In Denmark, during the period 1920-1930, institutional staff were anxious to improve their knowledge and learn more about the specific problems facing them and their patients. Course activities were often started on a voluntary basis and gradually these developed into more substantial forms of training. But slowly and gradually the conservative viewpoint changed and it was realised that, in addition to the medical and paramedical personnel, other professional expertise was required.

The layout of the institutions was on traditional hospital lines - broad corridors, high ceilinged rooms, flagged floors and tiled walls. The rooms were specially arranged and one was never left in doubt as to the purpose for which these rooms were required. What could not be perceived from the rooms could be read in the rules and regulations, which indicated very clearly when and how social activities should take place.

In an instruction for a Swedish psychiatric hospital the first item one read was that the staff should take care that the patient did not escape. As a result, the staff developed an attitude which indicated that they were trying to live up to their role as custodians. The fear that patients might injure themselves - the restriction on all activities - the over-protective attitude which is still found in many institutions, are surely an expression of the same attitude.

In Denmark, new possibilities for treatment of the mentally handicapped were created by the Act of 1959. From that time, to a greater degree than ever before, attempts were made to involve various groups of co-workers actively in the treatment. This resulted in more all-round working assignments, especially for the care personnel, and at the same time greatly increased grants permitted in the establishing of many new and less comprehensive institutions.
Many institutions are still managed by medical officers but their role is more administrative and the daily round of the wards is the exception rather than the rule. In addition, the role of the nurses is gradually being taken over by care personnel in so far as control of the wards is concerned. Care activities are today considered to be a task of great responsibility, with the staff and management in a co-ordinated role. It can be said that care personnel not only take part in the treatment but also in the planning of it.

In many places the elaboration of independent training programmes has been initiated on a small scale. In addition, training is carried out within the institutions and also externally in day centres or in the homes of the clients.

In Denmark the training of care assistants can be traced back to the year 1919, and from its inception it was a three-year training programme. Until the Second World War, however, it was largely a question of in-service training and practical work.

In the year 1950 firmer guidelines were introduced, but it was still the individual institution which decided on the amount of theoretical training to be given, and this training was often given in the form of lectures outside working hours.

In 1961 the Personnel Training School was established in Copenhagen, and now all students from all institutions in Denmark receive their theoretical training there. Twenty-eight per cent of the training period is spent in the Training School and the rest is spent at practical work in the institutions in which the trainees are employed.

When taking into consideration that all members of society have the same right to care, one can assume that the goals which have been laid down in the report of 1970 of the Committee of Social Education concerning the training of care assistants for the elderly, weak and handicapped persons should also be valid for the training of care assistants who work with the most severely handicapped clientele who are the responsibility of the mentally handicapped and special care services.

In the above-mentioned report the following objectives are laid down:

The care assistant is recognised as the main contact for the patient and has over-all responsibility for his well-being in the environment of an institution or possibly in his own home.

The report also states that the objective of the training is to provide the requisite knowledge and skill for performing the duties involved in care of elderly, weak and handicapped persons in institutions or their own homes.

The task of the care assistant is to provide or arrange the social-paepagogical and practical support which may counteract, cure or relieve the consequences of a physical and/or psychical illness; also to ensure the greatest possible self-support and contribute to the best possible well-being of the patient.

The care assistant should be able to deal with all aspects of daily living and the patient's main requirements. He should also take into account all conditions related to the well-being of each individual client. The care assistant should be able to offer support and meet the patient's demands for psychical contact and physical care and treatment. In this respect he must have some insight into the work of practical auxiliary or professional staff (doctors, nurses, therapists, etc.). This will enable the care assistant to seek their help and co-operation when required.

As the central co-worker in the care activities for elderly and handicapped persons, the care assistant must have the necessary educational background to work unaided, to make observations and to report adequately on his findings. At the same time he must be able to participate in the elaboration and implementation of social-paedagogical and care training programmes as well as group and individual treatment courses.
As part of the general social rehabilitation and care activities, the care assistant should co-operate with public authorities, community care centres, relatives, inmates of the institution, etc.

The care assistant must be able to initiate and participate in special care activities, including vocational and social programmes, possibly in co-operation with special staff members (care counsellors).

The care assistant's duties must also cover activities of daily living, including personal hygiene, dressing and undressing, bedmaking, etc.; also general housework activities, including tidying of the apartment, cleaning, shopping, cooking and serving meals, repairing clothes, etc.

These duties may also be undertaken by other care personnel both in institutions and in the patients' homes (e.g. home helps and auxiliary care personnel). The care assistant must be conversant with these activities as auxiliaries are in short supply and may not be available when required.

The care assistant must furthermore be able to take part in the care and treatment of the client's disease or handicap. This includes limited care and treatment such as prevention and treatment of bed sores, changing of dressings and bandages, etc.; also special duties such as training in the use of prostheses and other orthopaedic devices, training patients to walk and feed themselves and start manual activities, etc. In addition, the care assistant must be able to co-operate with doctors, nurses and therapists at examinations and treatment.

The care assistant must also be able to share responsibilities in so far as disposal of equipment and material is concerned.

Curriculum of Training

The training lasts three years. Some 300 students are admitted twice a year which gives an annual total of 600 trainees.

Entrance Conditions

The trainee must have reached the age of 18 before training commences. Previous training is not required - but the minimum of previous knowledge is nine years' schooling.

Course of Training

The training starts with a two-week probationary course in one of the institutions for the mentally handicapped. A test given at the end of the probationary period determines whether the training can continue.

After passing the preliminary test the trainee takes the first part of the practical training in the institution. Following 3-4 months of such practical training the trainees take the first part of their theoretical training (this lasts five months) at the Personnel Training School in Copenhagen.

A test is given at the end of the theoretical course. The trainees passing this test continue with twelve months' practical training in their respective institutions; this is followed by a further five months' period of theoretical training and an examination at the Personnel Training School, with a final twelve months of practical training back at the institution.

Theoretical Training

During the total ten months' theoretical training period at the Personnel Training School, the trainees are taught the following subjects.
CURRICULUM

Psychological-Paedagogical Subjects
1. Student Guidance, Principles of Staff Meetings
2. Psychology
3. Child Development
4. Language Stimulation, Story Reading and Dramatisation
5. Exceptional Children (Mental Retardation)
6. Mental Health (including Sexual Hygiene)
7. Literature (Prose and Poetry)

Medical Subjects
8. Anatomy and Physiology
9. Drugs and Medication (Pathological Symptoms)
10. Psychiatry

Special Subjects
11. Social Service and Welfare (Law)
12. Civics
13. Rehabilitation and Vocational Guidance
14. Handicaps and Handicapped Persons

Practical Subjects
15. ADL-Training Programmes and Care Plans
16. Records, Data Forms and Observations
17. Book-keeping and Clerical Work
18. Occupational Therapy (Ergo-therapy)
19. Physical Training and Working Techniques
20. Leisure-Time Activities
21. Music, Singing and Rhythmics
22. Play and Games
23. Self-Defence (Elementary Judo)

The dominating group of subjects is to be found under the heading "Psychological-Paedagogical". A study of these subjects enables the trainees better to understand and help their mentally handicapped fellow countrymen take part in the daily life of the institutions and to offer counselling and support for those who can live outside institutions.
Furthermore, great importance is attached to providing the trainees with a broad elementary knowledge of anatomy and physiology so that, on the basis of an understanding of the normal condition, they can assist and supplement the work of the medical staff in the daily training and treatment.

This applies too to drugs and medication (pathological symptoms) and the teaching of psychiatry, which gives the trainee an insight into such mental conditions as psychoses, neuroses, epilepsy, autism, etc.

Under the heading of "special subjects" trainees become acquainted with social legislation and the structure of Danish relief programmes; the subject "Handicaps and the Handicapped Person" helps to widen the trainee's knowledge of the physical and psychological consequences of a handicap.

The group of practical subjects is aimed at the trainees' as well as the patients' well-being, covering such topics as physical training, working techniques, self-defence, etc. This ensures that the trainee will be able to motivate and occupy his clients, carry through various training programmes on an individual basis, and finally attend to various administrative functions involved in the work.

The Practical Part of the Training

During the periods of practical training at the institution, the trainee must work in a ward for children, an adults' ward and also a ward for the physically severely handicapped, for example, spastics. At least six months must be spent in two such wards. The trainee should moreover become acquainted with the activities of the institution workshop, kindergarten, day centre, etc. During the practical training period, clinical demonstrations and some theoretical teaching built up around the work of the institution and the work with the individual clients are also given.

Conditions of Appointment

The trainees are paid allowances during the whole period of training.

As from 1 April 1971 the allowances are as follows:

first year of training approximately 1,100 Kr. per month;
second year of training approximately 1,650 Kr. per month;
third year of training approximately 1,825 Kr. per month.

The initial salary on satisfactory completion of training is in the region of 2,800 Kr. per month.

For the well qualified auxiliary the possibilities for promotion are good.

Continued Education

Apart from various short-term courses within more specialised fields, an advanced course of seventeen months' duration has also been established with the aim of qualifying the care personnel for such independent duties as planning of treatment for individual patients, and instruction of personnel.

The condition for participation in the advanced course is that the basic training has been well performed and that at least 2 1/2 years of practical service has been carried through after this training.

The course comprises the following:

5 months' theory;
7 months' practice;
5 months' theory.

The practical training is divided into two parts, with one period being spent in an institution other than one connected with the mentally handicapped.
The students participating in this advanced course receive their wages in full throughout the period of training and also payment of out-of-pocket expenses arising from their participation.

In the past it was customary for care personnel to be instructed and trained by doctors and nurses. Today, however, to an ever-increasing degree, it is the care personnel themselves who, through continued education, are qualified to perform these fundamental tasks. Similarly, administrative duties are also being taken over by care personnel.

Thus we can see that the treatment of the mentally handicapped — and this is true for nearly all handicaps except those few cases which require a more intensive and specialised treatment — is no longer so dependent on hospital-like institutions as in the past.

If this development continues it is to be expected that, in the near future, we may attain a social-paedagogical and social-medical treatment pattern through which the client can receive care independent of place and time. Consequently, much thought will need to be given to the field of care of the handicapped, to independent planning of the necessary services where treatment of the client will alternate with instruction of parents and relatives.

To live up to these demands and thereby create better living conditions for the mentally handicapped it is necessary to intensify the demands for training of care personnel.

Previously, the development of new treatment methods was a painfully slow process. Recent experience shows beyond any doubt that greater investment in training and further education of specialised staff and also the parents of the handicapped have helped not only to speed up treatment but to ensure that effective results are obtained.
25A. Community Involvement and Responsibility in the Problems of the Mentally Handicapped

by

Father José I. Eguia, Vice-President, International League of Societies for the Mentally Handicapped

It is a privilege and pleasure for me to take part in the International Labour Office/Danish Inter-regional Seminar on Vocational Rehabilitation of the Mentally Handicapped, at which outstanding participants, principally rehabilitation and placement officers, social workers, psychologists, etc., from all over the world are gathered.

It is normal that developing countries, facing the many important problems related to their growth would find difficulty in programming and setting up the specialised services which are the subject of the present Seminar. Thus, when confronted with such a necessarily limited choice, such countries are particularly anxious to learn what kind of help can be given to this group of disabled, through local community programmes.

I apologise if, from the outset, I speak to you in personal terms. By so doing I hope that subsequent discussion will be facilitated. With this in view I shall draw your attention to certain aspects which I believe are essential if we are to reach practical and useful conclusions, which is the purpose of this gathering.

International Dialogue

I am pleased that Denmark is the host country, as no one doubts that it leads the world in caring for the mentally deficient. The information made available by the Danish experts will be the best guarantee of the success of their rich experiences, so valuable as guidelines for the other countries.

Much has been said of the importance of international dialogue for the promotion of better relationships between peoples. Needless to say, this is doubly so in reference to such a serious problem as mental deficiency, which so affects one of the main characteristics of man.

A wide range of possibilities is open to the mentally handicapped in the different technical and juridical aspects of international collaboration. The fact that they themselves are helpless to state their needs and rights has not impeded a strong current of feeling in their favour, which has greatly increased in the last few decades with legal, scientific and social repercussions. Outstanding mention must be made of the direct and universal help of the parents, grouping in societies and setting up everywhere of modern centres, in collaboration with specialists and authorities of the different countries. Experts and officials at these two levels can acquaint you with the implications. I should like to underline the benefits that will result from a wise collaboration with non-governmental voluntary groups, especially when there is an insufficiency of programmes or official schemes, and when normal resources do not cater for the basic necessities of each place.

The International League of Societies for the Mentally Handicapped, which I have the honour of representing here, is attempting to implement this aim at world level. The League was brought into being in World Mental Health Year 1960, by representatives of parent organisations, professional groups and by individuals anxious to advance the interests of the mentally handicapped without regard to nationality, race or creed.

Through the creation of a common bond of understanding between parents and others interested in the problems of the mentally handicapped, the League hopes to secure on their behalf, from all possible sources, the provision of efficient remedial, residential, educational, training, employment and welfare services.
The League seeks to realise its objects by:

(a) the interchange of experts and information, on the developing of services for mentally handicapped;

(b) the exchange of workers in the field of mental handicap between one country and another;

(c) the comparative study of legislation in member countries and beyond, concerning the mentally handicapped and the promotion and implementation of the same in their favour.

Unfortunately, through lack of funds, the League is unable to achieve its wide projects, and this, notwithstanding the amplification of its strength through the five international congresses which it has organised; (London, Brussels, Paris, Jerusalem, Montreal), the numerous symposia on specific themes; (sheltered work, legal aspects, education, guardianship, residential care, leisure) and a number of publications. In spite of the lack of financial aid this organisation extends to more than sixty countries, whose member societies benefit from a common spirit of representation and solidarity in favour of the mentally deficient. You will be glad to count on the strength and experience of these associations, which are real pressure groups with no party feelings nor ideological boundaries. It may be that at the outset their voices served only as a warning, a poorly articulated SOS, but later they have moved towards more direct action, challenging public opinion and governments, especially through the press, radio and TV. These media are within easy reach of society and may be used to create or quicken social consciousness of the problem.

The advantages of using the present solidarity of the groups concerned is obvious. Well directed it may be of great use to society, thus ensuring that familial anguish does not spread to affect the general welfare of the population.

Mental Health and Underdevelopment

It might be interesting to insist on the subject of this exchange, within the limits of each particular case. We cannot receive or export general situations such as those the Scandinavians have. We must take into consideration the socio-economic structure for each programme, especially in this matter where the person is much more dependent on his external circumstances. The mental handicap of a person - without special reference to his/her particular syndrome - reduces the normal capacity of living in a given environment. Thus, the mental deficiency and its treatment will develop in accordance with the system and possibilities that the community can offer. When we speak of community we refer to the group of individuals or neighbours living together and with common interests, but not excluding a wider radius of action extending to the rest of society.

It should not be forgotten within this sociological framework that a rapid social advance leaves behind the interests of mentally handicapped people. It is obvious that in countries with more basic problems such as malnutrition, bad sanitation or high child mortality, the question of mental retardation cannot be specifically studied and will remain just one more among so many other miseries. It is indispensable to have a minimum standard, that is, not to be classified as underdeveloped, before mental deficiency appears as a specific problem. So, we must consider this question within the line of evolution of other problems; starvation, illiteracy, lack of employment or other less universal but equally menacing problems: war that gives rise to huge outlay even in non-belligerent countries, racial strife, etc., as well as other physical or mental handicaps that cause social inadequacy.

Mental deficiency becomes specially serious when the mentally deficient himself is ostracised by society, deprived of adequate education and rejected by the community. The mentally retarded person also suffers educational and social disadvantages quite apart from his inherent deficiency.

The same happens when going from a familial and rural environment to an urban or industrial one. The mentally handicapped person does not feel isolated in the family and can even work in agriculture or in home industry. But as soon...
as he moves into an industrial economy or high production area he feels excluded: no one takes care of him, he does not belong and is left without work.

In the same way as landed-property civilisation and later that of industrial society created inequalities, so it has happened in technology, which divides human beings into the capable and incapable, the efficient and the inefficient, integrated or otherwise into the production system. The mentally handicapped as a misfit is a "subproduct of the technological era", more or less as a beggar is in society.

All of this underlines the fact that mental deficiency (as a community problem) cannot be separated from other areas of social concern. On this level it can only be "faced" by means of a deep socio-econornical restructuring. Otherwise any other solution will be only partial. Besides, this problem will become more acute if left until more urgent ones have been solved. One only has to look at more "developed" countries.

Developed countries have gone through different stages which may be summarised under three headings so far as caring for the mentally retarded is concerned. (The three steps are only aspects of the same problem.)

(a) From specialisation to normalisation. Countries with good schooling facilities have had to supplement this with special teaching. And after having "specialised" everything connected with the mentally handicapped they have come to realise that it was necessary to "normalise", reducing to its bare minimum all "specialisation", trying to make "normal" studies as wide and flexible as possible to include also the handicapped.

(b) From rehabilitation to prevention. First the aim was to help the mentally retarded as such: physical care, education, sheltered work. Then it was discovered that prevention is better, especially prophylactic and early treatment (in the first years of life).

(c) From charity to personal and other rights. Some rich countries that soon realised they had mentally deficient citizens who had no part in the social wealth solved the problem through charity, taking the wealth of some to provide for others less fortunate. But the theme of the Jerusalem Congress "From Charity to Rights" underlines that this situation is insufficient. Voluntary help was only the first step. From there we must advance to recognised rights and to social and administrative services.

From a certain point of view, the first steps that developed countries have followed - or had to follow - specialisation, late rehabilitation, charity, may be considered a mistake which could have been avoided if only they had been better informed. If ordinary schools were more flexible many special ones would be unnecessary. If medicine had been more social and preventive there would not have existed so many irremediable anomalies. If rights had been taken into consideration, charity would have been less essential.

Perhaps this first step was needed - perhaps not. The experience of some countries will serve others as a pointer to the correct approach.

In some ways developing countries are in an advantageous position to cater for their growth and the living together of their citizens, minimising as much as possible the excessive inequalities created by progress. I can assure you, ladies and gentlemen, I appreciate your delicate task of providing a professional and humanitarian solution, and you may rely on our enthusiastic collaboration.

Finally, may I express my admiration and respect for the ILO for its fifty years of wonderful protective and co-operative work across the globe. Its experts, so efficient in creating useful and satisfactory work both for the individual and for social groups will continue caring for mankind, the object and means of social progress. If the ILO has tried to find places and work in society for the physically handicapped, it is our hope that it will increasingly do so - as is indicated by this Seminar - for the mentally handicapped, who also have an inalienable right to participate fully in the adventure of life.
On behalf of my Society I would first of all like to thank the Board of
the Seminar for the opportunity given us to participate in this discussion.

During the period of your stay here in Denmark you have no doubt gained
the impression that Denmark is a rather wealthy country and that our social
standard could be compared with the best in the world. It would therefore also
be rather relevant to ask what our Society's attitude is to the group of people
we are representing, and furthermore what tasks remain to be solved. Un-
fortunately I must say that many problems still face us.

It is quite correct to say that the Danish people have a high standard
of living and that in the broadest sense social security has been provided for
the people; but having said that I must also stress - on behalf of the large
group of people we are representing - that a great deal remains to be done to
ensure equal opportunity for all disabled groups in our country.

This is where our Society comes into the picture, as it is our task to
point out to the authorities the needs and deficiencies within the mental
health organisation, compared with other sectors of the health system, and
through these initiatives to ensure that arrangements are made to improve the
conditions for the hospitalised as well as for those being discharged from the
hospitals.

Our Society does not and never will seek to influence treatment in the
hospitals. As you know we have a fine and competent body of specialists -
psychiatrists, psychologists, educators and other nursing personal. It is,
however, the task of the Society to try and ensure that the best and most
appropriate training possibilities are always available for the staff in our
institutions so that they are fully effective in their work. Furthermore, it
is also our Society's responsibility to underline the importance of reasonable
subsidies for research purposes, partly by granting such subsidies ourselves,
and partly by pointing out the need for such research to the authorities
concerned.

Our Society also has a role to play with regard to external facilities
for the mentally ill.

On discharge from a hospital, for example, after a long stay there, the
patient has to face harsh facts of everyday life which are quite unfamiliar
to him. In such cases a stay in a hostel for a period of 3-6 months as a
temporary arrangement can be of the greatest value in the often very painful
process of returning to normal life. Our Society has already shown the way
in this respect, for in 1968 we inaugurated the Hjørring hostel in Aarhus;
the experiences from this hostel are so valuable that practically all mental
hospitals here in Denmark now recognise the importance of such hostels. In
this respect I can mention that we have completed plans for a hostel in
connection with the mental hospital in Viborg. We are only waiting for the
necessary subsidies from the Government, as we, of course, have also been hit
by the financial restrictions prevailing here at the moment.

In addition a similar hostel is being projected in Sønderborg. In this
case we own the building site, and furthermore our Society has funds available
for this project to cover building costs.

Other and more permanent accommodation needs for these patients could
be mentioned, e.g. sheltered boarding houses and sheltered apartments.

Even if the majority of the patients from the mental hospitals are fortunate
enough to be discharged as totally recovered, and rarely come into contact
with the hospitals again, there is still a large group left who require help. In this case we are speaking of patients partly discharged to nursing care in nursing homes or in their own homes and also those who are able to help themselves, providing they regularly receive their drugs and other daily necessities.

Another of the Society's aims therefore is to establish sheltered boarding houses where all the normal daily requirements are available for the patient - against payment of course; also sheltered apartments where there is only limited control and supervision of the patient, e.g. with regard to distribution of drugs.

Many patients have probably been away from their original occupation for a long period, or perhaps they cannot for psychical reasons be readapted to their old jobs. In such cases, rehabilitation arrangements are important. All over the country there are, as you know, a number of rehabilitation clinics and workshops. By far the greatest part of these institutions are primarily adapted to work with clients with physical disabilities and only a very few are intended for those with psychical handicaps. Taking into consideration that many people with a physical handicap also become psychically handicapped we must consider the lack of such institutions for our clients as quite unreasonable. Therefore, our Society also has the task of pointing out these deficiencies and pressing for the establishment of more rehabilitation facilities for the psychically handicapped. As an example we have taken the initiative to have a rehabilitation scheme in Esbjerg established.

In connection with rehabilitation, it is also necessary to mention sheltered workshops. As you are no doubt aware it often appears - rather early during the treatment - that a patient will not be able to return to the normal labour market and that the person in question receives a disablement pension. Often such a person still has some productive capacity and wishes to utilise it. Rehabilitation centres can refer such persons to a sheltered workshop. Unfortunately, the Government's policy of subsidising such workshops means, in effect, that the workshop only receives a subsidy corresponding to what the sheltered worker has earned, but up to a maximum of 4,000 kr.; this means in fact that it will be very difficult for those with the lowest level of productivity to maintain their place even in a sheltered workshop. Therefore, it is also our task to underline the need for establishing such workshops where such persons can be employed and earn a little extra to supplement their pension.

The Society has taken the initiative to establish a sheltered workshop in Viborg, although this workshop is working in accordance with the normal rules for government subsidies.

From its inception our Society has, of course, accepted responsibility for the chronic mentally disabled, including those in nursing homes and those being taken care of in their own homes. For the first-mentioned group there are in the various nursing homes many therapeutic facilities, but for those living with their families there are no facilities at all. For those people who have not experienced the problems of the mentally disabled it is surely very difficult to visualise the burden, for example, of having a mentally disabled relative, requiring constant attention all day long. If the family could only send the disabled relative to a day centre which has fully qualified staff, say for a couple of times each week, this would greatly ease the family burden. Such day centres have not yet been established for the mentally handicapped, but we have them very much in mind for future development.

Last year our Society celebrated its tenth anniversary. The Society is organised in ten local district societies, each with its own board. These district societies form part of the national society, the board of which supervises the local branches and their work. Each of the district societies has developed close working connections with one of the mental hospitals. As you have probably heard, the organisation of mental hospitals in Denmark will be changed in the coming years, and management of mental health programmes will be effected by the county authorities. This means that we also face a reorganisation of our district societies by establishing a district society in each county. Such a reorganisation will be made this autumn.

Unfortunately we only have some 6,000 members and compared with the fact that approximately one person in eight of the Danish population needs psychiatric care once during their lifetime, this membership figure is very poor.
The responsibility for this rests upon ourselves, but this is not the entire explanation. Throughout the history of western Europe, insanity has always been looked upon with fear and disgust. Even up to the present day those suffering from mental illness are often regarded as being the recipients of "God's anger"; and even though psychiatry gains new ground every day the general public on the whole is more or less ignorant of the concept of insanity. Even with the authorities it is often difficult to get them to understand the complexities of the human problems involved.

The greatest task of the Society in the years ahead is, therefore, to spread information about the problems facing the mentally ill person and his family, in order to create a firmer base for the financial support we are demanding from the Government for radical improvement of their conditions. We must also encourage better relationships between the healthy part of the population and their fellow countrymen who are mentally ill.
250. Community Involvement and Responsibility in the Problems of the Mentally Handicapped

Paper Presented on Behalf of the Danish National Society for the Mentally Retarded

by

A. Christensen

I

Parents have a close association and mutual relationship with their children - even if the children are mentally deficient.

To this must be added their legal responsibility as guardians for their children - a guardianship which continues regardless of whether by reason of development or state of health the children have been committed to an internal institution under the National Service for the Mentally Retarded.

This requires as a matter of course that the parents, who are a powerful, effective and irrefutable factor in the work with public agencies, become involved with or responsible for the mentally handicapped or their problems.

II

For centuries the mentally retarded in this country have been exposed to serious inhuman discrimination.

Furthermore, the attitude on the part of society of ignoring and isolating those committed to institutions has resulted in a situation where the mentally retarded did not until 1959 participate in the prosperity and social benefits which otherwise to a great extent became available to the citizens of this country during the first part of this century.

Frequently those committed are even exposed to degrading inhuman conditions in old, worn-out and overcrowded institutions. Moreover, there are long waiting lists which need to be reduced.

III

It was therefore only natural and inevitable that the parents should take special initiatives in forming societies with a view to ensuring the rights and interests of the mentally retarded and the improvement of their over-all circumstances.

The Danish National Society for the Mentally Retarded was founded on 15 January 1952.

The aims of the Society include:

(a) improvement of conditions at the existing institutions and of all of the retarded persons living at home, as well as the establishment of all types of institutions which might serve these purposes, particularly nurseries, day homes, training and workplaces, occupational, holiday and relief institutions, as well as boarding houses, old people's homes, etc;

(b) representation of the mentally retarded and their relatives, including their relationship to social welfare for the mentally retarded;
(c) dissemination of knowledge of and efforts toward an understanding of the mentally retarded and the problems of their families;

(d) support of scientific research into mental retardation, its prevention and treatment;

(e) issue of a membership publication which at the same time would be an important factor in educational work and elimination of discrimination toward the mentally retarded and in improving their rights.

Immediately upon its founding the initiative was taken by the Society in applying to the Ministry of Social Affairs, to seek the adoption of humane conditions and improved living standards for the mentally retarded so that they - and particularly those committed to institutions - would attain living conditions which ordinary citizens consider as a matter of course, regardless of earnings or financial circumstances.

The application resulted in the Minister of Social Affairs establishing a committee on 30 April 1954 which issued a report in 1958 resulting in the "Act No. 192 of June 1959 Concerning the Care of the Mentally Retarded and Other Exceptionally Retarded Persons".

The objects of the Act may be accepted with complete satisfaction since conditions are being sought for the mentally retarded that enable them to obtain living conditions as near to normal as possible (taking into consideration their development and state of health) including the right and obligation of receiving instruction, in addition to a number of desirable services provided by the welfare agency, such as for example child-care guidance, treatment, etc.

Since the adoption of the Act the State has made every effort to live up to its ideals through substantially increased appropriations, but there is still a long road ahead - not least because of the State's repeated economic difficulties which have caused reductions of various welfare activities, postponement or cuts of facility construction, establishment of personnel ceilings, etc.

In recognition of the excellent work achieved by the modern welfare agency since the introduction of the 1959 Act on mental retardation, and because of the untiring and admirable efforts on the part of the personnel - frequently accomplished under very difficult conditions - the National Society has extended its activity for the benefit of the mentally retarded. And today they are no longer satisfied with criticism alone, but also, in close co-operation with the Danish National Service for the Mentally Retarded, they have made possible the buildings, boarding houses, nurseries, etc., far in advance of the building programme that the National Service itself would have been able to accomplish with the funds available through appropriations.

In this way, decent and homely accommodation has been obtained for the mentally retarded. Moreover, the overcrowded institutions have been correspondingly relieved by these new external establishments, the operation of which is handled entirely by the Danish National Service for the Mentally Retarded.

During the past nine years the National Society has established twenty institutions for this purpose, including boarding houses, relief homes, holiday camps, nurseries, workshops and continuation schools, with a total of 426 places. Under construction, projected or in the planning stage, it has an additional twenty establishments, including eleven boarding houses, five relief homes and four nurseries, with another 404 places.

Finally, the National Society has initiated a collective building programme which offers independent flats to the single mentally retarded and to mentally retarded persons who are fit for work. In addition boarding-house facilities in line with existing boarding houses for people of normal working capacity are also available.

The educational activities of the National Society - largely through the medium of the Society's own journal but with the unique assistance of the press, radio and television media, films, etc. - have resulted in a decided improvement in the public's opinion and understanding of the conditions and problems of the mentally retarded.
There has been a definite change in public attitude toward the mentally retarded. Recently in a Danish village a man wanted to discriminate against the mentally retarded by refusing to admit them to a local boarding house, and he was exposed to such violent public censure that he gave up his action.

In order to prevent and fight mental retardation the National Society has also supported scientific research. Recently through means made available to the Kennedy Institute it has supported the development of local research conducted by chief physicians Margaretha Mikkelesen, MD, and Erik Vamberg, MD.

The establishment of new and modern institutions and the possibility afforded to the Danish National Service for the Mentally Retarded to extend its activities are not in themselves sufficient to create desirable and ideal conditions for the mentally retarded.

In everyday life too, contact, understanding and intimate collaboration must be established between parents, the patients' relatives and welfare societies. With this in view the Danish National Service for the Mentally Retarded in Circular No. 22 of 22 February 1969 dealing with meeting activities, etc., issued certain guidelines for the establishment of collaboration between the departments of the individual institutions, the holding of discussions between members of the staff and patients' parents. The Circular also gives guidance on personnel matters, matters affecting clients and other problems. Also prescribed are meetings concerned with treatment, orientation, contacts and parent meetings - all with a view to establishing communication with and information about parents and other relatives as a necessary link in a modern practising welfare undertaking.

Meetings of clients are also included in the required meeting activity, and as to the mentally retarded who are competent, such meeting activities will have a great value and meaning.

In conjunction with the required meeting activities the management of the Danish National Service for the Mentally Retarded set up a working group to discuss further co-operation between the social welfare authorities and the parents, and this resulted in the report of July 1970. The main provisions of the report will contribute considerably towards creating the optimum possibilities for growth and development of mentally retarded children and adults, and harmonious conditions to enable the mentally retarded to achieve an existence befitting their possibilities, capabilities and needs.

Presently under preparation by the National Service is Circular No. 17-1971 which will not only authorise visits by parents but will also enable them to receive current information about their children, their relatives' condition, participation in meetings concerning treatment and, finally, in the event of conflicting situations, the possibility of establishing conditions that benefit the mentally retarded, their interests and problems.

To accomplish these aims, among others, consultations will be arranged for the individual units, with the participation of both the National Service staff and parents, and with the clients in cases where the latter may be considered capable of collaboration.

It will take some time before conditions are created for the mentally retarded that conform to human justice and dignity as envisioned in the Act of 1959 relating to mental retardation.

All possible efforts must be made to solve these problems. The welfare state of Denmark, in contributing to their solution, must not only be duty-bound, but must also be able to provide the financial resources available for the solution of the problems.
25D. Community Involvement and Responsibility in the Problems of the Mentally Handicapped

by

Else Hansen,
Representing Parent Groups for the Mentally Handicapped in Denmark

One can hardly imagine oneself as parents of a handicapped child, and yet one day we could have a child which is not like other children. A family with an autistic child is faced with an unexpected lifetime task of such magnitude and strain and it is difficult for them to appreciate at the outset the burdens and problems which confront them.

The child is apparently a healthy and normal infant, and neither the health visitor nor the examining doctor notice anything abnormal, but at about one year of age, the parents begin to suspect that all is not well. The child does not babble, does not look at the parents; nor does it show any sign of affection but only turns away to live in its own closed world. Now begins the endless wandering from one doctor to another where hope vacillates with fear. One doctor may report there is nothing wrong with the child; another advises that the condition is hopeless. From each new doctor comes a new diagnosis. Much of the contradictory advice may be given in good faith but is of no consolation to the parents.

In so far as mentally handicapped children are concerned, there is no other group about whom opinions are so divergent and for whom help to perplexed and disillusioned parents and the child itself is so difficult to obtain. Parents in their eagerness to help the child make so many consultations, wandering from specialist to specialist, initially with a reasonable expectation of hope, but confidence is slowly undermined by differing diagnoses. Yet one dare not refrain from following any advice given for fear that the child may be deprived of some benefit. Parents of autistic children are often considered aggressive and mistrusting. They were not necessarily so before the birth of the child but the constant struggle to help the child and the frustrations they encounter in doing so, leave their mark.

If at one time or another the diagnosis "psychosis" is added, the parents become aware that they have an insane child and the need for help is even more urgent. The task is so demanding and the child so domineering that the family's whole existence must change. Simultaneously while trying to create the correct milieu for the sick child, the other members of the family must also be cared for. Their needs are different, and so it becomes an inhuman task to plan family life in a way to suit all concerned. In many instances no help is offered the family, neither economical nor psychic, and they must use all their spare time and extra strength to manage the problem; in addition, feelings of parental guilt at having brought an autistic child into the world may be experienced.

If oneself is not involved in the problems of a handicapped child, one takes for granted that society takes care of him and offers the family the necessary support. Help is readily available for a physically handicapped child and is often taken for granted, but this can never be the case with a psychically handicapped child. Everywhere we are told that it is of the utmost importance that the child should receive treatment as early as possible, yet at the same time we must resign ourselves to the fact that help can only first be granted at the age of two to three years.

When the child reaches school age the problems increase. As other children of the same age start school, the autistic child's handicap and problems in relationship to his family and the outside world are highlighted. Parents notice that as time passes by the child acquires no learning and they fear for its future. No one seems able to offer a solution. Sometimes admission to children's psychiatric wards or mental hospital for observation and demonstration is advised. There is the problem of lack of specialised staff, coupled with the fact that incorrect diagnosis may result in admission to treatment centres or special classes where they do not belong. Such wrong placement adds greatly to the worries of the apprehensive parent.
Problems in relationship to the outside world, family and friends intensify. Knowledge about the child which parents have accumulated through the years is something which other people in the child’s environment do not possess. Parents despair of getting others to understand their odd and difficult child, and generally the result is that both family and friends slowly withdraw simply because they have no basic understanding of the problems involved. Because of their ignorance, they cannot find a way of giving some form of help or support.
Community Involvement and Responsibility in the Problems of the Mentally Handicapped

by

Svend Bache-Vognbjerg,
Secretary-General, Danish Federation of Trade Unions

My contribution to this panel discussion is to give you an idea of our experience in the LO (Danish Federation of Trade Unions) with regard to the vocational placement of the handicapped in general.

In using the expression "in general" I wish to make it clear that we on the part of the labour market organisations talk about "handicapped in general" from the point of view that handicapped persons must of course be given the same status in our general policy, whether their handicap is physical or mental. It is, in both cases, a question of labour market policy, but it is also, and above all, a social and humanitarian problem.

In 1960 the Danish Parliament passed the Rehabilitation Act, and it is worth noting that it was passed unanimously, because this means that there is a positive attitude in all parts of Danish society towards the rehabilitation of the handicapped and their placement in active employment after rehabilitation.

It has been of very great importance that the organisations of the labour market - the LO and the Employers' Confederation - are represented on all central committees, governing bodies, institutions and regional rehabilitation committees dealing with the conditions of the handicapped, because this makes it possible for them to follow the whole development with regard to the placing of handicapped persons.

It was previously a common attitude in the labour market that handicapped persons should be paid a pension or allowance, and that other workers had quite enough to contend with in solving their own problems. I feel that the workers' representatives in the enterprises - the shop-stewards - can do much to alter this attitude, and we in the LO will continue to make an active effort in this respect at the central level.

The attitude of the labour market organisations is in principle that if a handicapped person has received all possible medical treatment and has undergone rehabilitation, so that he will be able to do a specific job, then his vocational placement should only be a question of formalities. Employers, supervisors and shop-stewards should regard it as an honour to see to it that, in their particular place of work, the provisions of the Rehabilitation Act are being applied in the best possible way.

There are of course certain requirements which must be satisfied if the vocational placement of a handicapped person is to be successful. First of all the medical aspect of the matter must be settled. If it is a question of a person with a physical handicap the labour market parties need to be assured that rehabilitation has been completed, and that the person in question has recovered to the extent that he can take up employment in an enterprise. Experience shows that there are very seldom any serious problems in connection with the placing of physically handicapped persons. However, problems are likely to arise in cases where there is a mental as well as a physical handicap. In such cases much of the rehabilitation effort will be spoilt if a person is wrongly placed. It is only natural that an employer, who may have experienced several cases of handicapped persons placed at jobs which they cannot perform, will be doubtful as to whether he should continue to employ handicapped persons in his firm. In particular mentally handicapped persons may, if they are wrongly placed, cause considerable difficulties in so far as the smooth running of the enterprise is concerned.

Generally it is my experience that if a handicapped person is given the right type of work, i.e. if he is placed in a job which does not exceed his physical and mental capacity, then he will be an excellent worker, because then he will as a rule consider it an honour to live up to the general demands of the enterprise.
Thus, it is most important not to refer to the handicapped as reserve manpower. If a handicapped person has completed his rehabilitation, then he belongs no longer to the reserve, but becomes part of the team.

Another important aspect which must be stressed is that handicapped persons who have completed their rehabilitation should enter into employment on exactly the same terms as other workers, both with regard to wages and conditions of work and with regard to membership of trade unions. They must not be underpaid - I know that we have still in Denmark examples of underpayment of handicapped persons - but they should receive the wages stipulated in the collective agreements for the job in question. On the other hand the handicapped person himself should take up his place in the work team in a positive way; he should not expect pity from his fellow workers - and I dare say that this is not a normal characteristic of handicapped persons.

I should like to conclude these introductory remarks by saying that in my view it is extremely essential that the State and the local authorities, that is to say the whole of the public administration, should take the main responsibility for placing handicapped persons in the labour market. In Denmark at least, we feel that there is, in the public administration, a tendency to stick to certain old traditions, and I believe that a great effort should be made to ensure that the public administration is in the front rank in activities of placing the handicapped.

Over the years, consideration has been given to the introduction of a quota system by law, in such a way that the public administration would be under obligation to include a certain percentage of handicapped persons on their staff, both physically and mentally handicapped.

We in the labour market organisations find that this is not necessary. In Denmark we do not have the large number of war invalids which presents a great problem in some other countries and where it has simply been necessary to introduce a quota system.

In my view it would not be of any benefit to the handicapped to force them into employment in specific enterprises. I am of the opinion that it is much better to create a positive understanding in the working community for the problems of the handicapped; and here the labour market organisations have a great responsibility, for there will always be sceptics among our members who feel that, when there are unemployed workers in the trade in question, they themselves should be the first to get employment.

This is of course much easier under conditions of full employment. In the first years after the Rehabilitation Act was passed there was full employment in Denmark, and the vocational placement of handicapped persons did not give rise to problems. In recent years we have not had full employment, but it is gratifying to see that the handicapped have not suffered from this. The percentage of unemployment among the handicapped has not increased more in proportion to the percentage of unemployment of workers in general, and I conclude from this that, once handicapped persons have been adapted to their jobs, employers will not take the first opportunity to dismiss them.

We must of course take into consideration that there will always be a certain number of handicapped persons whom it will be difficult to place in open employment; we must also take into consideration that there is often a temptation to place handicapped persons in employment at too early a stage of their rehabilitation. Doctors and social advisers are sometimes doubtful as to whether a handicapped person has actually reached the stage where he will be able to cope with a job; it is as if they realise that he may have a break-down. With regard to such cases I would recommend the establishment of special workshops, where they could be placed, and which could serve as a kind of preparation for the open labour market - workshops where, for a short period after rehabilitation, the handicapped could adapt themselves to and become familiar with the tempo and atmosphere of a normal workshop. Such workshops should provide a sheltered environment, but only to the extent that the workshop - or whatever kind of work place it might be - would be almost equal to a normal workshop.

We have such a workshop in Copenhagen, and I happen to be a member of the board. We have found that the same employers apply to the workshop on several occasions to obtain workers for jobs which, in their experience, are done most competently by handicapped persons.
In conclusion may I say that we in the Danish trade union movement will continue to do our best to help the handicapped to obtain and to remain in employment.

I hope that this brief contribution to the discussion will call for your comments and provoke certain ideas.
26. ILO Technical Co-operation in the Field of Vocational Rehabilitation of the Disabled

by

Norman E. Cooper,
International Labour Office, Geneva

Introduction

The ILO's field of responsibility in rehabilitation of the disabled covers all vocational aspects of the process. In close cooperation with governments, other international agencies and voluntary organisations the ILO has provided the services of its experts in this field to some sixty developing countries over the past fifteen years.

The ILO's basic policy of vocational rehabilitation is to be found in an official international instrument - ILO Recommendation No. 99 concerning Vocational Rehabilitation of the Disabled. Although this Recommendation was adopted in 1955 the basic guidelines it embodies have stood the test of time, and are sufficiently broad and flexible to provide a firm basis for any governmental or voluntary organisation wishing to plan, organise and administer comprehensive or specific vocational rehabilitation programmes for disabled persons.

Basic Principles

It is impossible to lay down a "blue print" scheme of vocational rehabilitation which would be applicable to all developing countries. Significantly, ILO Recommendation No. 99 advocates that "vocational rehabilitation services should be adapted to the particular needs and circumstances of each country and should be developed progressively in the light of these needs and circumstances ...". Much of course depends on the level of social and economic development reached by a particular country; the incidence of disability in general and specific disability groups; the state of local knowledge and awareness of needs and possibilities; the pattern of industrial and rural development; the level of unemployment and underemployment; and last but not least the financial, administrative, technical and personnel resources available. These factors govern both the scope and objectives of a vocational rehabilitation programme and determine how it should be planned and organised.

With these important considerations in mind, it is imperative at the earliest stage of planning a vocational rehabilitation programme to define not only the meaning of "vocational rehabilitation" but also the term "disabled person". ILO Recommendation No. 99 provides clear and concise definitions of both terms as follows:

- Vocational rehabilitation means that part of the continuous and co-ordinated process of rehabilitation which involves the provision of those vocational services, e.g. vocational guidance, vocational training and selective placement designed to enable a disabled person to secure and retain suitable employment.

- A disabled person is an individual whose prospects of securing and retaining suitable employment are substantially reduced as a result of physical or mental impairment.

ILO Policy

Again, with the principles and guidelines of ILO Recommendation No. 99 very much in mind, it is the policy of the ILO to recommend that:

- each country decide for itself what its most pressing needs are and what form its initial vocational rehabilitation programme should take, i.e. whether to have a national or regional programme for all disabled or to concentrate on one or two major disability groups; whether vocational guidance, vocational training, special placement services, sheltered employment or a rehabilitation centre are first needed;
- each country's decision in this respect be based on a study of the available statistics of disability and the number, type and characteristics of available services;

- that even if the initial programme is restricted to certain disabled persons only, it be aimed at ultimately providing services for all disabled persons whatever the origin and nature of their disability, and whatever their age, provided they can be prepared for, and have reasonable prospects of securing and retaining suitable employment;

- the main objectives of any vocational rehabilitation should be: to demonstrate and improve the working qualities of the disabled; to emphasise their abilities and working capacities, not their disabilities; to promote working opportunities for them; to overcome employment discrimination against them - all these factors to be taken into account at the beginning of any programme;

- no matter what the scope of the programme, the greater attention and emphasis must always be placed on the final need for satisfactory placement in employment, i.e. resettlement;

- for each individual disabled person benefiting from it, vocational rehabilitation be considered as one comprehensive and continuous process from the moment of identification as disabled to the time of satisfactory resettlement in employment;

- that any programme of vocational rehabilitation should provide services of vocational assessment and guidance, vocational training and selective placement in open or sheltered employment; and

- that as far as practicable, these special services for the disabled be provided within the framework, and form an integral part of, existing vocational guidance, vocational training and placement services.

**Scope of ILO Technical Co-operation Activities in the Field of Vocational Rehabilitation**

The technical co-operation activities of the ILO in this field can be considered under seven separate headings:

1. **National Vocational Rehabilitation Service**
   
   ILO expert services provided under this heading are for the purpose of assisting in setting up a vocational rehabilitation programme at the national level to cover all categories of disabled persons. It involves a careful survey and study of the needs of the disabled and the resources available in terms of technical services, qualified personnel and financial backing and interdepartmental methods of co-operation and co-ordination. Detailed suggestions for the planning, organisation and administration of a national programme are provided later in this paper.

2. **Vocational Rehabilitation Services for Special Categories of the Disabled**
   
   Help given under this heading usually involves the establishment of vocational rehabilitation services for a particular category of disabled person such as the blind, deaf or mentally handicapped.

3. **Pilot Rehabilitation Centres**
   
   This type of project is particularly important to developing countries helping them as it does to create a pilot or demonstration centre which provides a complete range of services for the disabled. Such a centre is often the basis for a future national rehabilitation service and also provides opportunities for training professional staff. Typical activities of an expert include giving advice on the organisation, administration and establishment of the services involved, training of the staff concerned, and co-ordination of all the rehabilitation services in and outside the centre.
(iv) Vocational Guidance of the Disabled

The expert assigned to such a project must, of course, ensure that the emphasis in any such programme is on developing a service in which an individual appraisal of each disabled person is combined with realistic advice on employment market opportunities. The expert would also be responsible for advising on occupational classification, job analysis methods and the technique of matching the worker with the job. He would also be responsible for training of the necessary personnel.

(v) Vocational Training of the Disabled

The expert help provided by the ILO in this field may take several forms. In some cases the expert is called on to develop vocational training facilities for the disabled within the framework of a general vocational rehabilitation programme; in others, the vocational training service may be planned specially for one particular category or as part of the services in a comprehensive centre. In all cases, however, the main emphasis is laid on the selection of vocational training courses based on manpower requirements, available jobs and local skill levels.

(vi) Special Placement Service for the Disabled

ILO expert assistance is much in demand for organising and developing this type of service. Usually the special service is developed within the framework of an existing national employment service, and special placement sections are created in one or more local employment offices. Apart from giving technical advice on the detailed organisation of the placement service, the training of personnel, survey of the labour market, publicity campaign to convince employers and the general public that disabled workers are good workers, are important features of such an assignment.

(vii) Sheltered Employment

The ILO is often requested to provide the services of an expert to assist in the development of a sheltered workshop programme for those severely disabled persons who cannot be employed in the ordinary labour market. In many developing countries, the provision of sheltered employment facilities either in workshops or through home-bound schemes is often the only way of providing the disabled (even those with minor disabilities) with any work at all. This is particularly relevant when the unemployment and underemployment rate in the country concerned is very high.

Practical Application of Basic Principles and Policy

(a) General Considerations

Most developing countries are still predominantly agricultural and rely to a great extent on subsistence farming and rural pursuits. It has been estimated that 90 per cent or more of the people in many of these countries live in rural areas and depend on self-employment for their livelihood. Even though the trek to the cities is on an ever-increasing scale, the disabled are often left behind in the village to eke out a livelihood as best they can with older members of the family. It is essential therefore that national vocational rehabilitation programme planning should take into account the distinctive requirements of the rural disabled as well as the more readily identifiable urban disabled.

Whilst every effort should be made to ensure that the vocational rehabilitation programme should be genuinely national in size, scope and character, it is important to plan within the limits of national resources. It seems appropriate, therefore, to think in terms of creating national schemes that will cope eventually with the assumed number in working age groups becoming disabled annually.
Before detailed planning of a national scheme is undertaken a manpower survey (on a complete or sample basis) of all categories of disabled persons is essential. The survey should not be limited simply to a count of heads and the associated disability but if possible should provide in respect of each person, information on age, location, severity of condition, educational standard, previous training and employment. From the data obtained, basic planning requirements can be determined.

As already indicated, each country should itself determine the structure and scope of its vocational rehabilitation programme. The programme may be primarily sponsored by government in close co-operation with voluntary organisations (as in Uganda and Malaysia), a voluntary body (with active government support) may be given the task (as in Iran and Trinidad/Tobago), or the main efforts may be channelled through a national social security scheme (as in Colombia, Brazil and other Latin American countries). Whichever method is adopted, however, government involvement and financial support is imperative. Moreover, provision for vocational rehabilitation of the disabled should be included as an essential component of health, social welfare and manpower schemes in all national development plans. In effect, the economic value to the country of employing rather than passively supporting vast numbers of disabled persons needs to be recognised.

When contemplating the introduction of a national vocational rehabilitation programme, no one would question the wisdom of providing a firm legislative basis which would not only define the term "disabled" or "handicapped" person, but also provide support for long-term planning, organisation and administration of essential services. It is suggested, however, that in the initial stages of the rehabilitation programme no attempt should be made to introduce detailed and complicated legislative measures, including compulsory "quota" employment schemes for the disabled. Such schemes are expensive to operate and require highly trained administrative staff. It is far better to legislate for a national vocational rehabilitation scheme in general, broad terms with the proviso that the responsible ministry can introduce essential regulations, aimed at promoting employment opportunities for the disabled, at the appropriate stage of programme development.

(b) Planning

A fully co-ordinated and comprehensive vocational rehabilitation programme requires the co-operation of the labour, health, education, social welfare and community development ministries, social security departments, voluntary organisations interested in the disabled, employers' and workers' organisations. In the initial stage of planning some governments have found it advisable to convene an inter-ministerial rehabilitation committee to develop a planning framework for the programme and agree on joint policy and working procedures.

Community involvement at the earliest possible stage of planning is also essential and this can be realised through the formation of a national rehabilitation board or council on which all rehabilitation interests (governmental, non-governmental, employers' and workers' organisations) are represented. Such a national body, served by provincial and district subcommittees as appropriate, can play a leading role not only in identifying the size of the disablement problem but also the need for and type of services required. In addition, it can help educate the public, modify its attitudes and prejudices and explain policy in vocational training, employment and resettlement of the disabled. Through the national council, good public relations can be fostered, encouraging fund raising in support of projects for which government funds are not readily available.

The ministry or organisation responsible for planning the programme (through a specially created department or division of vocational rehabilitation) must take into account the need to create work opportunities for the disabled in both rural and urban areas, particularly when a high rate of unemployment exists in the country. This can be achieved by sponsoring sheltered workshops, cottage industries (utilising local materials), rural co-operatives, creating market outlets and selecting vocational training courses according to local demand.

A careful survey of services already available (particularly those developed by voluntary agencies) and including existing placement and vocational training
facilities for the general population, should be carried out at the earliest possible stage of planning, not only to avoid duplication of effort, but also to ensure their co-ordination with the national proposals.

Planning of the programme will be related to budgetary resources, available staff and buildings. In the first three years of operation of the programme, it is suggested that the minimum aim should be to plan for the establishing and full operation of some or all of the following services and pilot projects (with the final two years of a five-year plan being devoted to consolidation, extension and duplication of existing services):

(i) Identification and registration of the disabled on a continuing basis.

(ii) A ministerial department of vocational rehabilitation (headed by a director of rehabilitation or principal rehabilitation officer).

(iii) A national rehabilitation board or council.

(iv) An urban vocational assessment and work preparation centre for 100 disabled persons designed to offer short courses of physical re-conditioning and preparation for wage-earning employment. Associated vocational training courses could be considered both in the centre and in classes established elsewhere.

(v) An urban sheltered workshop (for 100 people and located in the vicinity of the assessment centre) providing employment for those who are too severely disabled to work in "open" industry.

(vi) A rural vocational rehabilitation centre (with associated sheltered workshop) for 100 disabled persons who, following a physical re-conditioning and assessment course, could be trained in suitable work methods in agriculture, small animal farming, home tailoring, shoe and leather work, rural crafts, literacy, hygiene and citizenship - the whole course averaging nine to ten months.

(vii) A rural co-operative designed to offer a livelihood to groups of workers (after training) in trades such as vegetable tanning, carpentry, bamboo work, market gardening, pig, poultry and rabbit keeping, etc.

(viii) A selective placement service for the disabled.

(ix) A mobile rehabilitation service for disabled women at rural level. (The mobile unit would concentrate on those women unable to leave their homes for courses in established centres, and teach methods of overcoming disablement in the home, including home management, child care, sewing, nutrition, hygiene, etc.)

(x) The provision of a "mobile" delivery and collection scheme possibly as a co-operative to organise the distribution of raw materials and the marketing of finished products.

Provision should also be made during the plan period for active support to be given to existing vocational rehabilitation services and for systematic training (through specialised courses and in-service methods) of the required staff.

Planners should also take the following factors into account:

- Before deciding on the introduction of specific training trades or production work for rehabilitation centres and sheltered workshops, a vigorous employment market investigation and feasibility study must be undertaken. This will ensure that rehabilitation and vocational training is organised and developed in relation to existing or anticipated job opportunities and that there is an assured market for goods produced in sheltered workshops.

- Planning should be on a geographical basis linked with centres of population.

- If possible, the costly "institutional" type of centre should be avoided and the aim should be for a relatively quick "through-put" of rehabilitees and trainees (i.e. short preparation and assessment courses and accelerated training).
Publicity for the vocational rehabilitation programme in the planning stage should be strictly controlled. To raise the hopes of thousands of disabled persons while facilities exist for only a few attracts criticism and creates despondency.

(c) Organisation

ILO Recommendation No. 99 offers the following guidelines on the organisational aspects of the programme:

- Vocational rehabilitation services should be organised and developed as a continuous and co-ordinated programme by the competent authority or authorities, and in so far as practicable use should be made of existing vocational guidance, vocational training and placement services.

- The competent authority or authorities should ensure that an adequate and suitably qualified staff is available to deal with the vocational rehabilitation, including follow-up of disabled persons.

- The development of vocational rehabilitation services should at least keep pace with the development of the general services for vocational guidance, vocational training and placement.

- Vocational rehabilitation services should be organised and developed so as to include opportunities for disabled persons to prepare for, secure and retain suitable employment on their own account in all fields of work.

In the practical organisation of any nationally planned scheme two factors are important:

- the national layout of vocational rehabilitation activities;

- the timetables of development.

Flexibility in the layout and timetable is extremely important if advantage is to be taken of local resources and foreign aid possibilities.

Factors that may influence the siting of centres are:

- availability of land and buildings (in many cases, existing rather than purpose-built buildings could be used);

- proximity to urban and/or rural employment opportunities (including suppliers of subcontract work);

- good road and/or rail communications;

- availability of water and power;

- availability of essential supporting services (educational, social and medical).

It is suggested that in organising and developing services for the disabled in the national programme, priority should be given in the first instance to establishing vocational assessment and work preparation centres for the disabled (as indicated in (b)(iv) and (vi) above). Such centres help to speed up the resettlement process - the short courses offer an opportunity to distinguish between the potentially skilled, semi-skilled and unskilled disabled for both "open" and sheltered employment. Such centres should be the focal point of the whole vocational rehabilitation programme, supplying suitably prepared and assessed disabled workers to industry, commerce and agriculture, to vocational training classes, sheltered workshops, co-operatives and home employment schemes. Equally important is the opportunity they present for training vocational rehabilitation staff on a team-work basis. Detailed guidance on the planning, organisation and administration of these centres is provided in the ILO publication "Vocational Assessment and Work Preparation Centres for the Disabled", reference D 15/1970. This handbook also indicates how vocational training courses can be organised for the disabled in association with assessment and work preparation courses.
In so far as a selective placement service for the disabled is concerned, this may be organised as part of an established government employment service or run in connection with a vocational rehabilitation centre or voluntary organisation. Comprehensive guidelines for the organisation of a selective placement service are to be found in the ILO document "Manual on Selective Placement of the Disabled" - D 34/1965.

Although in the Western world the view prevails that sheltered workshops should be reserved for the very severely disabled, and, as such, can never hope to be self-supporting or profitable, ILO experience has shown that this need not be the case in developing countries. Providing that necessary feasibility studies are first undertaken before selecting the product or products in which the sheltered workshop will specialise (this could be subcontract work for local manufacturers, production of articles such as umbrellas, radio batteries, etc., which are normally imported, cloth printing, bamboo work, decorative jewellery and wooden articles made from local material, etc.) there should be good prospects of developing a viable project. One such sheltered workshop in Ethiopia, employing 200 blind and sighted disabled persons, is in fact yielding annual profits in the region of $250,000 (Ethiopian) and is planning an ambitious expansion programme.

The employment creation role of sheltered workshops in developing countries with very high levels of unemployment is of the utmost importance, and in such conditions the development of a national network of such workshops should be given high priority.

(a) Administration

In line with the provisions of ILO Recommendation No. 99:

- Administrative responsibility for the general organisation and development of vocational rehabilitation services should be entrusted to one authority, or jointly to the authorities responsible for the different activities in the programme, with one of these authorities entrusted with primary responsibility for co-ordination.

- The competent authority or authorities should take all necessary and desirable measures to achieve co-operation and co-ordination between the public and private bodies engaged in vocational rehabilitation activities. Such measures should include as appropriate:

(a) determination of the responsibilities and obligations of public and private bodies;

(b) financial assistance to private bodies effectively participating in vocational rehabilitation activities; and

(c) technical advice to private bodies.

The Recommendation goes on to emphasise the important role of representative advisory committees at the national, regional and local level, and the need for the fostering and encouraging of research for the purpose of evaluating and improving vocational rehabilitation services for the disabled.

The importance of establishing a national rehabilitation board or council has been stressed elsewhere in this paper (paragraph (b) Planning). In most developed countries the board or council has a purely advisory role, but in some developing countries the view has been expressed that the board should play a much more active part in helping to administer and develop the national vocational rehabilitation programme. In this connection, it is sometimes argued that the ministry responsible for vocational rehabilitation does not have sufficient funds or the network of supporting services (e.g. employment exchanges, training centres, etc., particularly in the smaller towns and country areas), which are so essential to the full development of a national vocational rehabilitation programme. The direct involvement of the national rehabilitation board in operating the programme would of course require legislative backing; the board would presumably be concerned with the practical aspects of the programme (vocational rehabilitation and training, sheltered employment, community involvement, relations with voluntary organisations) but would be answerable to the designated ministry which would concern itself with policy.
The national rehabilitation board - whether it is formed on a voluntary or statutory basis - has undoubtedly a great contribution to make to the successful development of a national vocational rehabilitation.

In most countries, the financing of vocational rehabilitation programmes is shared by the government and voluntary organisations. Whilst the tendency in the past was to regard vocational rehabilitation solely from a humane and charitable point of view, the economic value of employing large numbers of persons who would otherwise be a charge on society, is gaining wider recognition. There is every reason to hope therefore that government planners will accord higher priority to allocation of funds for vocational rehabilitation programmes, thus permitting the development of services which in some cases have stagnated owing to lack of essential financial support. Such support is required not only for capital outlay but also for recurrent expenditure on salaries, allowances, raw materials, maintenance and running costs.

Rehabilitation Personnel

The non-availability of specialised personnel is a continuous problem in so far as the full development of vocational rehabilitation programmes in developing countries is concerned. It is considered that one of the main causes of staff shortages (and also the difficulties often encountered in retraining personnel) is the lack of an adequate salary scale.

Another difficulty often encountered in appointing the directing staff of vocational rehabilitation centres is in determining whether the posts should be filled by persons with an administrative or technical background. Much of course depends on the nature of the training and work undertaken in the centre concerned but, to avoid any misunderstanding, clear and detailed job descriptions must always be agreed and prepared in advance of recruitment. In the case of selecting a sheltered workshop manager, it is imperative that his management knowledge and his inherent capability for management be the main criteria for his selection.

Comprehensive staff training courses in vocational rehabilitation are essential, followed by refresher and specialised courses in particular aspects of the work. ILO country and regional experts can assist in arranging local and regional training courses which have the advantage that the training is conducted in the same conditions and environment that the staff concerned will encounter in their day-to-day work. Overseas fellowships and seminars offered through the United Nations and its specialised agencies and through bilateral channels are important avenues for specialised training.

The location of a vocational rehabilitation centre or workshop often has an important bearing on the availability of staff. For example, if a centre is located within easy reach of a hospital, any medical services or physiotherapists required by rehabilitees can often be obtained from the hospital on an ad hoc or part-time basis.

Finally, mention must be made of the excellent contribution that can be made by international volunteer workers to the rapid development of national vocational rehabilitation programmes in developing countries, particularly where local skilled staff are in short supply.

In Uganda, for example, the establishing of a comprehensive network of vocational rehabilitation facilities owed much to the skill and devotion of numerous volunteers from Canada, the United States of America, Scandinavia, the Federal Republic of Germany, Holland, Japan and the United Kingdom. Each volunteer had a particular skill to contribute to the programme and passed on his or her expertise to a local counterpart.

Provision of ILO Technical Assistance

Having described the various ways in which the ILO can assist developing countries with their vocational rehabilitation programmes, you will wish to know how such assistance is financed and how it may be obtained.

Technical assistance can be provided under one or other of the following programmes:
In the past, assistance under this heading has been provided under two sectors - a Special Fund sector (for large-scale projects which have an element of research or training) and a Technical Assistance sector (financed from funds especially voted by members of the UN for technical activities for use by the various agencies (including the ILO) providing technical assistance in conformity with the agreed request of governments). At the present time, a new method of planning and providing technical assistance through the UNDP system is being finalised. Inter alia, this will result in:

- the elimination of the distinction between the Special Fund and Technical Assistance components of the programme;
- the introduction of country programming exercises based on national development plans and/or priorities;
- the establishment of Indicative Planning Figures for each country;
- changes in the formulation, appraisal and approval of projects.

The Indicative Planning Figure (IPP) will be established for each country by the UN Governing Council on the recommendation of the UNDP Administrator. This figure does not represent a commitment but a reasonably firm indication for the purpose of country programming; it delimits the scope in dollar terms within which planning is to take place and projects may be prepared. IPPs have been allocated for the period 1 January 1972 to 31 December 1976 and each government will choose a three-, four- or five-year programme period to coincide with the planning cycle.

Detailed working procedures for country programming have still to be finalised, but in so far as requests for assistance in the field of rehabilitation are concerned one clear requirement already emerges, i.e. as the assistance to be provided through UNDP will be related to national development plans of the country concerned it is imperative that provision should be made in such plans for the development of rehabilitation services - otherwise requests for assistance will stand no chance of success.

(ii) The ILO's Programme of Technical Assistance

This is financed from the operational activities section of the regular budget of the ILO and is controlled by the ILO Director-General with the advice of a Programme Board.

(iii) Trust Funds

By this method governments may secure direct ILO technical assistance by providing funds themselves for financing the assistance required.

Assistance under one or other of these programmes can be provided in one of several ways - experts, fellowships, supply of equipment, seminars and training courses.

Before any such assistance can be provided, an official request from the government must be submitted. In the case of the United Nations Development Programme, this must be addressed to the United Nations Resident Representative in the country concerned, through the country programming procedure described above. In the case of the ILO regular programme or a trust fund the request should be made to the ILO through the appropriate area and regional offices.

The requesting government must also confirm its ability to bear local costs and to be able to continue with developing the project after ILO technical assistance has ended. For its part, the ILO must also confirm the technical feasibility of the proposed project, the approval of which is subject to the availability of necessary funds.
Annex

ILO Technical Co-operation Activities in
the Field of Vocational Rehabilitation
of the Disabled, 1970-71

A. Recent and Current Technical
Co-operation Projects

Argentina

Mr. Kurt Muller, ILO regional expert, paid a short visit to Argentina in
January 1971 to advise on the development of programmes for blind persons.
From 1 January 1972 the ILO will provide expert assistance on a long-term
basis to help establish a pilot rehabilitation centre and placement services
for the blind in Argentina.

Central America and Caribbean Area

In February 1971, Mr. Kurt Muller was reappointed to the regional vocational
rehabilitation expert post for this area after a break of eight months. During
the past year the expert visited Barbados, Costa Rica, Cuba, Dominican Republic,
Jamaica, Mexico, Panama, Trinidad and Tobago, and Venezuela. His main task
is to assist governments with the organisation and development of their vocational
rehabilitation programmes and help train specialist staff.

Colombia

Miss H.A. Schlesinger, ILO expert in vocational rehabilitation, is now in
the third year of her assignment helping to develop a national vocational
rehabilitation programme. During her mission a rehabilitation law has been
enacted and a vocational rehabilitation centre firmly established in Bogotá.

Dominican Republic

From 15-22 November 1970 Miss Hilary Schlesinger joined a team of experts
sponsored by the International Society for Rehabilitation of the Disabled who
advised the authorities on the development of comprehensive rehabilitation
services.

Ecuador

Mr. Kurt Muller, ILO regional expert, paid a short visit to Quito in
January 1971 to advise on the development of services for blind persons.

Hong Kong

Mr. P.H. McCluskey, ILO expert in vocational rehabilitation, completed a
two months' assignment on 28 February 1971, during which time he advised on the
co-ordination of rehabilitation services.

Iran

Mr. T. Aaen, ILO vocational rehabilitation expert, continues to advise
the Government and the National Iranian Society for Rehabilitation of the
Disabled on the development of national vocational rehabilitation services.
His mission, which started in September 1970, is expected to continue into
1972.

Kenya

Mr. E.G. Johnson, ILO expert in vocational rehabilitation of the disabled,
has been on assignment since September 1969 helping to develop a national
vocational rehabilitation programme for disabled persons in urban and rural
areas.
Malaysia

In April 1970 Mr. A.C. Sparshott, ILO vocational rehabilitation expert, completed an 18-month assignment during which time he assisted the Malaysian Ministry of Welfare Services with their plans for providing comprehensive rehabilitation services for the disabled.

Middle East Region

On 1 June 1970 Mr. A.C. Sparshott was appointed ILO regional vocational rehabilitation expert for the Middle East. Since his appointment he has assisted with the development of vocational rehabilitation programmes in the following countries:


Syrian Arab Republic

In January 1971 Dr. Helena Larek, ILO expert in vocational rehabilitation of the disabled, completed a 14-month assignment in Syria. During this time a pilot vocational rehabilitation centre in Damascus became operational.

Tanzania

On 9 March 1971 Mr. Sam Niwa, a Professional member of the ILO Vocational Rehabilitation Unit, Geneva, undertook a two-month survey mission in Tanzania aimed at paving the way for a long-term rehabilitation programme.

Thailand

ILO vocational rehabilitation expert Mr. E. Marland continues his long-term assignment helping the Government to develop a pilot vocational rehabilitation centre and other urban and rural rehabilitation programmes for the disabled. He also advised on the vocational aspects of a programme designed for rehabilitating drug addicts.

Venezuela

Miss Hilary Schlesinger carried out a short mission in Caracas from 2 to 9 November 1970 to advise on the organisation of training courses for occupational therapists.

Viet-Nam

In November 1970 Mr. J.G. Nicolet completed a long-term assignment in Saigon where he had helped to develop training and placement services for disabled persons attending the National Rehabilitation Institute. He returned to Viet-Nam in November 1971 to help develop vocational services for the disabled in rural areas.

Fellowships

Fellowship grants have recently been made to enable rehabilitation personnel from the following countries to undertake studies in Europe and/or the United States:

- Arab Republic of Egypt, Colombia, Rumania, Spain, Thailand, Viet-Nam.

Seminars

The Seminar on Vocational Rehabilitation of the Mentally Handicapped is the third vocational rehabilitation seminar to be organised jointly by the ILO and the Danish Government in the past four years.
Rehabilitation Programme

In Argentina, there are in existence several programmes for the mentally handicapped executed by different state departments. There is not just one coordinated programme using common resources, simply because the state administration has not yet studied the problem in its total aspects (general and specific). Moreover, the federal division of the nation into provinces and municipalities does not facilitate the development of a fully co-ordinated programme with similar aims and objectives. This difficulty in operating and administrating a rehabilitation programme is fully recognised by all concerned.

The National Institute of Mental Health is considered to be the principal organisation dealing with problems of the mentally handicapped. There is a Spanish tradition, with possibly French influence, which advocates that rehabilitation programmes should be medically oriented. It is for this reason that the majority of mentally handicapped cases have for many years been referred initially to the National Institute of Mental Health (NIMH).

With the emphasis on medical rehabilitation, recovery and cure are of paramount importance, but this approach can never be fully effective until rehabilitation is considered in its entirety, i.e. as a multidisciplinary task involving medical, social, educational and vocational aspects. In this connection, there is certainly a need for the NIMH to become more involved with other rehabilitation activities if the service it offers to its clients is to be fully effective.

Mentally Handicapped

This is considered medically and specifically as a psychiatric problem. In this context the other aspects - social, educational and vocational - are carried out by the different sectors of each hospital, institution or psychiatric service. But the links between the various services are by no means fully developed and in improving the situation, the role of the handicapped themselves in the rehabilitation process as well as the involvement of their families, and the influence of social, vocational and cultural considerations, should be appreciated and recognised.

In Argentina, the question of mental rehabilitation is also considered in the main, as a medical problem. Consequently there are many unco-ordinated programmes. Moreover, no distinction is made between the mentally retarded and the mentally disturbed. Initially the mentally retarded person with reduced capacity is first examined by and receives treatment in a psychiatric hospital or a special service for children with psychiatric problems. Then it is felt that the condition has improved, the patient is attached to a foster family.

In Argentina, there are approximately 17,000 psychiatric beds including private clinics and psychiatric services in the provinces. The patient who is admitted for treatment and rehabilitation is often employed on maintenance and general service work in the hospital and receives payment for this work which is called "peculio". There are some 5,000 and 2,000 patients in hospitals and colonies respectively. Also some 6,600 persons earning 300 pesos per day in sheltered workshops. Traditionally, the "peculio" is paid to those patients who wish to work, but such activity was not always considered in the light of therapy or reconditioning.
There are 15,000 patients who receive "peculio" payments in the various hospitals and colonies belonging to the NIMH. Eighty per cent are employed on maintenance work and 20 per cent on various production activities in the hospital workshops (carpentry, shoemaking, mechanics, etc.) and on gardening work.

These work activities undertaken by the patients are considered to be vitally important for their rehabilitation. They are also trained socially, e.g. to recognise the value of money and its use. The allowance paid to the mentally handicapped ("peculio") is also an important supporting factor in the attempt to train the mentally retarded in activities of daily living.

Medical Aspects

The NIMH maintains three hospitals and services for children and adults, including a residential institution offering facilities for different categories of mentally retarded persons.

Other Institutions

- private clinics and residential institutions;
- provincial hospitals for the mentally ill admit mentally retarded. They receive treatment and there are some rehabilitation activities;
- the Roman Catholic Church also organises a programme for profoundly mentally retarded children.

Educational Aspects

There are in the hospitals of NIMH some educational programmes but the problem is that the teachers and their programmes should be approved by the Ministry of Education and Culture. Then the teaching would be more adequately related to the needs of the mentally retarded. The Ministry of Education and Culture has an educational programme for instruction of mentally retarded children but without residential institutions. The child remains with his family which also receives some kind of therapy support from the psychopaedagogical team - psychologist, psychiatrist, psychopaedagogist, social worker and a specialised teacher. The children are instructed in a special school with the object of completing primary school, and there is very little emphasis on general habilitation.

There are a few schools for mentally retarded adults who are in the main in-patients in a psychiatric hospital or in the colony of "Montes de Oca".

There are specialised post-graduate teacher training courses, covering different aspects of the mentally handicapped; blindness, deafness, dumbness, mentally retarded, etc. Such courses consider rehabilitation as a process in its total aspects. The courses are organised by the Ministry of Education.

There are many private institutions for mental retardation that try to develop an intensive and effective programme but as state financial support is so limited these programmes are rather limited in scope. Private institutions tend to specialise in one particular aspect of disability such as poliomyelitis, mongolism, cerebral palsy, etc. and the co-ordination and communication between each institution and the Government is not so well developed. Consequently there is no over-all service of administration and organisation.

Some mentally retarded adults and children work in the sheltered workshops belonging to NIMH. These workshops organise a programme of rehabilitation and vocational training and employment in the different production units. The results of these recent experiences are very satisfactory.

The Mentally Ill

There are twelve psychiatric hospitals in the country apart from three hospitals which admit the mentally retarded as previously mentioned. The number
of mentally ill in the institutions of NIMH is approximately 13,000. No statistics are available for provincial or private residential and non-residential services. The NIMH has indicated a programme of rehabilitation using new techniques of social and institutional care. There are actually eight small hospitals which are organised as therapeutic communities. They show excellent results, practising the principles of considering the institution as an organisation, functioning and administrating as therapeutic in itself and co-ordinating the efforts of all specialised staff. This is a vast improvement on the traditional methods of custodial care and diagnosis. The basic principles of therapeutic communities are free communication and feed-back, between patients, personnel and staff. Case conference type discussions involving patient and staff help to prevent friction and conflicts and lead to a better understanding and appreciation of the many problems involved and may also give the patient a better insight into his condition. Work programmes are planned as flexible as possible, allowing for individual variations but not losing sight of the basic principles of rehabilitation. There are programmes of activities for the patients involving maintenance and production work both in the hospital, workshop or agriculture. The delegation of responsibility to individual staff members is considered to be very important as it fosters a better teacher/client relationship.

For the activities of the patient in therapeutic communities it is essential to consider carefully his background and also his occupational and vocational potential. The patient himself should have a say in selecting his activity but there should be a regular evaluation of his progress.

There are 15,000 patients who are paid a special allowance for their work or activities in maintenance of buildings and production in workshops or agriculture. It is estimated that this payment system contributes a great deal to the rehabilitation and resocialisation of the mentally ill and facilitates their entry or re-entry into society.

The traditionally huge psychiatric hospitals are also trying to apply these same principles of therapeutic communities in some of their activities.

It is very difficult to get society to accept the rehabilitated patient. This is due to the fact that there are many prejudices concerning mental illness, and the needs of employment for normal persons are very great. There are therefore great obstacles to the employment of recovered mentally ill persons.

There is a programme of social psychiatry in the north-east of the country covering four provinces and carried out inside the hospitals in the form of therapeutic communities, and outside as part of the community's social preventive programme in co-ordination with all the institutions of the zone. Their results are positive but there is much resistance by the traditional professionals.

Industrial Therapy Organisations

There are five sheltered workshops supported by NIMH that offer rehabilitation, occupational and vocational programmes to patients from hospitals and institutions. The total of patients in these institutions is 400 and everyone receives an allowance similar to a "peculio". This year, however, normal rates of pay will be paid. The work is regulated according to the capacities of the patients and there is a constant evaluation of the cases by the team (director (non-professional) psychiatrist, psychologist, occupational therapist, social worker, employers and administrative personnel).

The principal aim and purpose of the sheltered workshops is to give to the mentally handicapped an ability that will permit them to work satisfactorily outside the workshop and to lead a normal life.

The first workshop: 126 female patients, specialises in production of clothes (for men and women) with industrial sewing machines. There is also a weaving-shop and embroidery work.

The second sheltered workshop: elaboration of plastic elements with injection machines. Manufacture of surgical material and elements for hospitals and scientific laboratories. Production of knives, spoons and forks of stainless steel, etc.
The third workshop: 137 patients, majority male, work on the repair and manufacture of electrical elements, building maintenance and repairs, painting of furniture, steel and iron structures and elements for the hospital wards, typing, bookbinding and photocopies.

The fourth workshop: 35 patients (male) undertake bottling and packing for all mental hospitals of NIMH and some others.

The fifth workshop (included as a unit in workshop 3): manufactures, furniture of functional design for hospitals, tables, chairs, desks, nightlight tables.

The programmes in these workshops are industrially oriented.

The National Institute for Mental Health (NIMH)

The NIMH:
- supports the O.T. School at the University of Mar del Plata;
- provides short training courses for nurses, social workers, rehabilitation auxiliaries and administrative personnel for the mentally handicapped;
- provides general instructions for therapeutic staff;
- manages sheltered workshops, allowances, volunteers, hospital organisation, institutional structure, etc.;
- co-ordinates rehabilitation of the mentally handicapped with the National Bureau of Technical Education;
- provides occupational therapists to all the psychiatric hospitals;
- organises monthly meetings of directors and management of mental hospitals to discuss rehabilitation problems;
- plans the extension of sheltered workshops and agricultural production;
- runs the School of Occupational Therapy in Buenos Aires;
- arranges contacts with the provincial authorities to provide rehabilitation services;
- organises post-graduate courses for doctors and psychiatrists;
- with assistance of a WHO expert, is planning and organising a national programme of social psychiatry;
- co-operates with trade unions concerning rehabilitation and training of their mentally handicapped members.

Legislative Provisions
- Law of Mental Health;
- Law of Mental Retardation;
- Law of Alcoholism;
- Law of Sheltered Workshops;
- Law of Psychopharmacy;
Future Plans

- expansion of the therapeutic community facilities in mental hospitals and rehabilitation units in traditional psychiatric hospitals;
- foundation of three provincial hospitals;
- obtaining increased government support for more rehabilitation personnel;
- formation of rehabilitation units in the general hospitals for short-stay patients.

Problems

- insufficient beds and rehabilitation units for the mentally retarded;
- insufficient co-ordination and communication;
- lack of employment opportunity for the mentally handicapped;
- lack of appreciation by the general public of the problems of the mentally handicapped;
- need for establishing half-way houses, sheltered agricultural units, mental health centres, residential rehabilitation centres;
- need for the development of integrated rehabilitation programmes to cover mentally handicapped persons of all age groups.
2. Rehabilitation of the Mentally Handicapped in the Social Security System of Brazil

by

Dr. Odir Mendez Pereira

For this discussion we must divide Brazil's efforts in the rehabilitation of the mentally disabled into two different parts: the rehabilitation of disabled children and the rehabilitation of adults with mental disorders.

The first group is served in several private clinics and foundations offering treatment to mentally disabled children.

The National Social Security Programme (INSS), a government department, provides all the services for the welfare and the health of the people. The private clinics have contracts with the government department from whom they receive a per capita payment for the service they provide for the children.

At first the children are examined by a basic team of specialists including a doctor, social worker and a psychologist. Next these three technicians meet to decide whether a child is eligible for a rehabilitation programme. We have been serving children from four months of age to 16 years. They can receive treatment for a period of five years. These selected children are sent to the above-mentioned private school clinics or specialised foundations. The Government's organisation team supervises the treatment and makes repeated check-ups at regular intervals.

The specialised school clinics use the basic team bolstered by a doctor, social workers, physiotherapists, occupational therapists, psychologists, special teachers and phoniatrics. They use various approaches but principally the Bobath method.

We maintain the technical efforts of the clinic, side by side with the rehabilitation of the children. The staff observe the children in attendance at these schools and maintain contact with the child's family. There are three forms of attendance, full-board, part-time (maybe for half a day) and the whole day.

We cannot serve all the children who need rehabilitation services in our country.

In spite of good progress and many specialised school clinics, we have a large number of children waiting to be accepted. We have had to adopt a criterion when selecting the disabled children. We limit the service now to children who are handicapped for central neuro-pathological causes. The object of this assistance is to increase their residual capacities and to improve their family and social adjustment.

The INSS (Social Security) also gives material help to the rehabilitation programme: medicine, prostheses and orthotics, dental assistance and transportation.

We divide the children into three groups:

Group A - children who have only mental deficiency;
Group B - children who have personality disturbances;
Group C - children who are physically handicapped due to central nervous system injuries, but not necessarily associated with mental deficiency.

We decided on these three groups for family and humanitarian reasons. Family reasons because this category of handicapped children present a permanent problem for their parents. In most cases the parents would not be able to work nor would they have anyone to care for their children if we did not help them.

For humanitarian reasons we choose to serve severely disabled children for a rehabilitation programme.
We supervise these cases with great care. We care also for other types of handicapped children with other forms of assistance also aimed at improving the quality of the institutions. We support the clinics too, but in a general way, and not on a case by case basis. This form of payment is more economical and reaches all kinds of handicapped children. The extent of our support is determined by the standard and the numerical capacity of the institution.

We endeavour to stimulate the clinics to improve their technical standards. In this scheme there are some fifty school clinics throughout the country. We are pleased to note improving standards in a number of institutions and many new ones are being created.

We feel sure that this is the main role of social security in Brazil for assisting disabled children.

The number of disabled children in Brazil is 0.37 per cent of our population. We have 90 million inhabitants, so there are 333,000 children who need specialised care.

Despite all our efforts only some 9,000 children are being treated with our assistance in 117 institutions. The Brazilian Government is aware of the problem and is studying the organisation of a national foundation to bring together all the resources of the nation to assist disabled children.

For adults with mental diseases we are making our first attempts at rehabilitation.

We have nine vocational rehabilitation centres in our nine main cities. We have, of course, the common technical resources to rehabilitate males with physical defects or injuries and physical diseases; we train them in our own sheltered workshops and in community enterprises too. Among mental diseases we select the neurologically impaired and epileptics. They are our two main problems in the field of mental disorders.

We have 35,000 neurologically impaired and 9,000 epileptics who are unemployed and are receiving financial help from the social security organisation (INPS).

In general the main medical cause of unemployment is heart disease followed by rheumatic diseases including arthrosis; epilepsy also occurs in significant numbers.

Our rehabilitation centres have separate teams for mental cases, staffed by a psychiatrist, psychologist, social worker and vocational counsellor. This team receives the client and appraises his capacity and potential. If the client is considered capable of succeeding in the rehabilitation programme, he starts with psychotherapy, group therapy and diversional therapy. When good progress has been achieved the client is sent to a community programme for training under the control of our technical team. The doctor, social worker and vocational counsellor visit the client in his new job at regular intervals.

We have only recently started this work and we do not yet have sufficient experience with mental diseases but we hope to achieve very good results. We consider this Seminar to be very important indeed, because we know it will present us with the opportunity to learn a great deal.
I will comment briefly on our experience in the area of rehabilitation of the mentally handicapped. In our country there are no programmes for the complete rehabilitation of the mentally retarded; they are only receiving pre-vocational rehabilitation in special schools.

For many years psychiatrists have been very much interested in the question as it was very discouraging to see that only a small percentage of discharged patients were able to return to their jobs, but the lack of specially trained staff for such rehabilitation made it impossible.

In 1961 two ILO experts came to Chile to organise a vocational rehabilitation centre. Patients attending the centre were physically handicapped. Nevertheless psychiatrists thought the centre could offer an opportunity for the mentally ill and some of them were admitted. They could be trained in different techniques such as carpentry, technical drawing, tapestry, typewriting, etc.

It was very discouraging to see that while the physically handicapped had no problems in the learning process the results were quite different for the mentally ill.

It was found that the instructors at this centre were not trained to deal with a patient who presents defective symptoms such as lack of initiative, limited learning capacity, poor concentration, lack of capability to meet the demands in effort, energy and self-discipline, impaired social skills, etc.

In spite of all these problems a group of occupational therapists decided to demonstrate that the patient, under a special environment, after a period of training, could acquire an acceptable level of efficiency. A special effort had to be made to train the patient how to get along satisfactorily with his fellow workers; thus once a person has been accepted by and integrated in a group a successful result can be expected.

It was in this way that an experimental project was elaborated that could meet this objective. In 1968 a sheltered workshop was organised in the psychiatric hospital using the few resources in the section of occupational therapy. In the same hospital a centre was opened to sell the handmade products of the patients: toys, ceramics, basketry, etc. Industries were contacted for subcontract work; the jobs undertaken were painting of toys, dressing of dolls, label sticking, button carding.

At the same time a therapeutic social club was organised, where the patients could meet with each other socially, reinforcing in this way, the so much needed exercise of human relations.

This project has had quite good results, though it has given possibilities of work to a limited number of patients. It could be proved that the rehabilitation of the schizophrenic can be obtained through a sheltered workshop.

Actually, in 1971 we are more optimistic due to the fact that the government programme will give priority to the problem of health in all its aspects. In our field we have much to gain; we have been given the opportunity to work directly with the community, where action is being taken, with the idea of preventing mental illness through early treatment and family education in mental health units.

The government is also paying attention to the chronic patients. A rehabilitation centre is being organised in a province two hours distance from the capital, where 800 patients will be rehabilitated through agricultural work.
In the first place, Ethiopia feels proud to send you a friendly greeting wishing you all the best for the Seminar, hoping that it will be a very fruitful one for all who participate.

Since there is no particular nation without a certain problem, Ethiopia strongly believes that there is no better solution than co-operation and interpersonal relationships among different nations to resolve such problems together. This is our aim, hope and belief based upon co-operation, one nation with another, for the betterment of human society in every country.

The land area of Ethiopia is 450,000 square miles with a population of 25 million, but without institutions for the mentally handicapped except for very few adults in the umbrella factory. We once had an institution - the "Cheshire Home for Mentally Handicapped Children" but this has ceased to function for reasons unknown to us.

Therefore, I would like you to judge how difficult it is for the mothers of the mentally handicapped children - confined at home looking after their retarded children and with no time to cook for their husbands when they come home from work on the farm. Their home will be full of sorrow, unhappy and even severe quarrels may occur between husband and wife. It is a tragic situation - behind the handicap is the child, but behind the family is sorrow. I wish mothers of retarded children were present this moment to explain such difficulties more clearly.

This illness can afflict anybody's child whether it be a poor person or the president of a state, but its visitation is always unwelcomed. It is quite obvious that this problem is well known to both the WHO and the UN as their statistical data shows, and they know too how serious is this problem in some African countries today. Much could be done and achieved if developing countries asked for and received their help. Take my country as an example. Of course we do not wish to infer that WHO and the UN should take all the necessary measures alone - why should they? But, how much have they influenced these countries to start work in this field?

Why only WHO and the UN? The question should be addressed also to the well-developed countries. How much have they helped the developing countries? They take films, we see them; they have the statistical data of each country - we know it. Above all, they know the problems of each country well - but what have they done to resolve them?

They have some qualified personnel whereas some developing countries have none. They have big institutions where special training could be given if they would grant scholarships to the developing countries. I think it would not cost them much more than fellowship studies for engineers or medical students to whom they often offer scholarships for at least seven years.

It is said, whatever you want to be done to you so also do to others. I hope the mistakes of the past are not repeated. Therefore, I hope that the Seminar this year, 1971, will be the most fruitful one for all human society of all creeds. I sincerely hope it will.

I am still afraid as to what kind of hope and assurance to take with me home - because many handicapped children are there waiting for the result of the Seminar. This is my question. What would be your answer? Ethiopia asks you all.
5. Rehabilitation Programme for the Mentally Handicapped in India

by

Mrs. Leena Mazumdar

A major problem in rehabilitation has been the virtual absence of reliable data regarding the size of the handicapped population. This lack is particularly marked in the case of the mentally retarded because of the complexity of the problems involved in assessing mental retardation. Our instruments for assessment are inadequate. Moreover, it is well known that co-relation between test results in childhood and school performance and community adjustment are by no means satisfactory.

We have, therefore, in this country to depend on estimates derived largely from the projections made in the developed countries. Although some of the countries estimate that 2 to 3 per cent of all school-age children are retarded, it is usually believed that 1 per cent of them are grossly retarded. It is realised that estimates of retardation have to vary from country to country depending upon the sophistication of the culture in which children are expected to be brought up. Taking this factor into account we estimate that perhaps 1 per cent of our children in India are so retarded as to require specialised educational treatment and other vocational rehabilitation services. On this basis alone we arrive at a staggering estimate of 5-6 million retarded children.

As in many other countries efforts to help the retarded took the shape of residential institutions for their education and training. The first institution for the retarded was set up in Bombay in 1941. Earlier a psychomedical school for the retarded was set up in 1934 in the Central Nursing Home at Ranchi which is the health resort in the eastern part of the country. By now nearly seventy-one schools for retarded children have come into being in the country, as given in Appendix A.

The inadequacy of the existing services becomes apparent when one finds that only 0.01 per cent of our retarded children are receiving some form of education. The majority of our schools for retarded children cater for all types of retarded children ranging from those requiring custodial care to those on the border line. It is only in recent years that our schools have begun to appreciate the importance of having separate programmes for children with varying degrees of retardation. Most of the schools lay considerable stress on prevocational education. Some of them have also set up workshops where work adjustment training is provided.

Unfortunately, however, we have at present no well-organised programme for placement of retarded adults in suitable employment. This is due to a variety of reasons. The widespread prevalence of unemployment is a major cause. Another important reason is an inadequate awareness of the potential of the retarded by employers, legislators and others.

It is heartening, however, that community awareness of the need to help the handicapped has been steadily growing. This is partly reflected in the decision of the central Government to set up national centres for various categories of handicapped persons. These centres are to function as demonstration services which may be duplicated in other parts of the country. As a step in this direction the Government of India has set up a model school for mentally retarded children in New Delhi. This is a school intended for educable retarded children. Over one hundred children are on the rolls of the school. It provides free education and free board, lodging and clothes to children from low-income groups. In course of time it is proposed to set up other units such as a school for trainable children, a sheltered workshop, a centre for training teachers, and the like. The intention is to develop it as a national centre which may provide comprehensive services to a limited number of retarded children and adults and at the same time it should be a model to be duplicated in other parts of the country.

It may be some time before the national centre is fully developed. In the meantime a number of voluntary organisations have made commendable efforts in this area. Notable among them is the Federation for the Welfare of the Mentally Retarded which is endeavouring to co-ordinate existing services for the retarded
in the country. It is also trying to sponsor a trusteeship plan for the retarded. Such a plan will be of tremendous importance in a country such as ours where it has not yet been possible to enact legislation designed to provide social security and other protective measures to physically and mentally handicapped persons.

Thus India has already set the stage for the development of vocational rehabilitation services. It will of course be some time before various aspects of these services are fully developed. At present our focus is on education and prevocational training. On this basis we hope that in course of time other services will emerge.

The majority of our existing services are concentrated in urban areas. This is inevitable because of the stress on residential care and because of the cost of educating retarded children. But the great majority of our retarded children live in rural areas where social adjustment does not present identical problems. Considerable research is needed to discover new ways of training and employing mentally retarded persons in their own rural settings. This will greatly reduce the need for urban rehabilitation services which are expensive and tend to segregate the retarded from the community.

The modern concept of rehabilitation envisages the integration of the handicapped into their own community. This goal could be achieved in regard to the retarded only when we are able to develop training and employment services which meet the needs of retarded children and adults in rural communities. It will be an advantage if the Seminar could give some thought to the development of such services since the problem in most developing societies is likely to be similar.
### INSTITUTIONS FOR THE MENTALLY RETARDED

#### TABLE 1

<table>
<thead>
<tr>
<th>Name of States</th>
<th>No. of Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Andhra</td>
<td>5</td>
</tr>
<tr>
<td>2. Bihar</td>
<td>2</td>
</tr>
<tr>
<td>3. Delhi</td>
<td>8</td>
</tr>
<tr>
<td>4. Gujrat</td>
<td>6</td>
</tr>
<tr>
<td>5. Kerala</td>
<td>1</td>
</tr>
<tr>
<td>6. Madhya Pradesh</td>
<td>1</td>
</tr>
<tr>
<td>7. Madras</td>
<td>5</td>
</tr>
<tr>
<td>8. Maharashtra</td>
<td>22</td>
</tr>
<tr>
<td>9. Mysore</td>
<td>4</td>
</tr>
<tr>
<td>10. Punjab</td>
<td>7</td>
</tr>
<tr>
<td>11. U.P.</td>
<td>5</td>
</tr>
<tr>
<td>12. W.B.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>

#### TABLE 2

<table>
<thead>
<tr>
<th>Type</th>
<th>No. of Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>31</td>
</tr>
<tr>
<td>Government-aided</td>
<td>23</td>
</tr>
<tr>
<td>Government</td>
<td>9</td>
</tr>
<tr>
<td>Semi-government</td>
<td>4</td>
</tr>
<tr>
<td>Not known</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>
6. Rehabilitation Programme for the Mentally Handicapped in Indonesia

by

Mr. S. Mangoensandjojo

This paper illustrates only one example of various mental hospitals in Indonesia - the mental hospital "Sumberporong" Malang.

The mental hospital "Sumberporong" at Malang treats mentally handicapped adults and divides its activities under three headings as follows:

The Prevention Section

The aim of this section is to help the community to make use of the hospital as much as possible, by way of increasing the number of polyclinics for mentally handicapped persons in various places.

The Curative Section

This section deals with the medical activities and care of patients.

The Rehabilitation Section

This section deals with patients, who do not require further medical attention but only after care. It is concerned with:

1. vocational training;
2. preparation for normal daily life;
3. after care.

The vocational training is still given in the form of occupational therapy and is not a separate unit.

Some patients with good training potential who have completed their medical rehabilitation may be trained in specific jobs such as:

1. Carpentry
2. Sewing (girls and boys)
3. Cooking
4. Brick-making
5. Agriculture
6. Stock/cattle - breeder
7. Rice-milling

(All of these trades are found in the hospital itself.)

In addition, and within the framework of occupational therapy, and particularly on the mental side - remedial exercises, all kinds of sport, dancing and music are undertaken. There is also a small cinema-theatre and a swimming pool specially provided for the patients.

Still within the framework of occupational therapy, patients produce match-boxes for match factories in the neighbourhood of Malang.

It must be admitted that this method of vocational training and occupational therapy, carried out as it is in one room with patients and ex-patients, with the aim of stimulating activities of daily life (ADL) is not ideal. Nevertheless
some benefit is derived by the patients particularly those with aggressive temperaments who when fully occupied, respond favourably to work which entails the making of articles from raw materials.

It should be noted that all vocational training performed at Sumberporong is not provided with the open labour market in view, but only by way of handicraft and connected with the need of the hospital itself.

Another form of rehabilitation organised by the hospital for the "hospitalised" patients consists of various kinds of work in agriculture, in the rice-mill, cattle breeding, cookery and other jobs related to the needs of the hospital itself.

Furthermore the hospital is carrying out a pilot project concerned with the activities of daily life of the patients, who have completed their medical as well as vocational rehabilitation, but because of prejudice in the community cannot be sent back to their place of origin. The pilot project includes a special group of ex-patients who must attempt activities of daily living by themselves by housekeeping activities but still under supervision of the staff. The object is to promote in the members of this group a real feeling of independence in their daily life, such as ordinary people enjoy.

Indications are that this pilot project is very successful.

To stimulate this sense of daily life among the ex-patients, they are also paid a small sum of money by way of earnings on their products. It seems that this system is also successful as it creates incentive. This very incentive to produce more brings them nearer to the actual conditions of daily life of the people.

At present Sumberporong Hospital has 1,200 patients (with 1,500 patients as full capacity) and is managed by seven psychiatrists and one psychologist but there is a need for more social workers. In addition there are about 500 administrative and medical personnel.

The main problem in rehabilitating the mentally handicapped is their non-acceptance as normal members of the community by the general public purely on account of prejudice. In addition more financial support and government regulations are required.

In summing up the activities at the Sumberporong Mental Hospital in so far as rehabilitation of the mentally handicapped is concerned, this in the main can be said to be successful, although the greater part of the activities remain in the medical field and less within the orbit of vocational rehabilitation. This is due to the fact that all technical staff are medically oriented.

The situation can be remedied when there are sufficient funds available, so that in future this mental hospital can form the necessary link between the sick patients and normal social and economic life.

The total number of mentally handicapped persons registered at 26 mental hospitals throughout Indonesia at the end of 1970 was 4,087. A complete list under the various groups is available.
Taking into consideration that at least 1 per cent of the population at the present time may be considered as mentally handicapped, we must see what facilities exist for this group in the field of vocational rehabilitation.

With a single Act of Congress, in 1968 the National Iranian Society for Rehabilitation of the Disabled (NISR) was given over-all responsibility for the national rehabilitation programme, its budget being provided by the Plan Organisation. Up to the present time, due to its very young history the NISR has been limited in its ability to assist all disability groups, one of these groups being those classified as "mentally handicapped". However, it has tried to direct and assist such clients step by step in the completion of their rehabilitation to available organisations (governmental or non-governmental) offering services for this group.

Having in mind that the idea of a total rehabilitation programme is very recent in Iran, it must be realised that most of our energy is being concentrated in rehabilitation of the younger age groups especially insofar as the vocational rehabilitation of the mentally handicapped is concerned. Therefore I will limit myself, in presenting the vocational rehabilitation programme to those in the school age range, which would be approximately 6-18 years.

With its newly created Department for Special Education, the Ministry of Education, as part of its total special education programme, now has special classes (normal schools as well) for 1,000 mentally handicapped throughout the country and hopes to expand this programme within the next five years by creating also prevocational training schools in annexes within ordinary schools.

One of the institutes offering vocational rehabilitation for the mentally handicapped at present is the ORT Vocational Training Center. In the past year it has aided ninety mentally handicapped/slow learners (IQ ranging from 40-85) in training with the aid of a staff psychologist. For the boys the training consisted of welding and electrical installation and for the girls, sewing and hand and machine knitting. Placement for this group has been undertaken by the Institute.

The Exceptional Village in Shiraz which assists various disability groups has set up two special classes for the mentally handicapped as well as some vocational training and sheltered employment.

The National Organisation for the Protection of Children (NOPC) now offers limited vocational rehabilitation. However, it is hoped that with its EWIN Project now reaching its final stages, it will lay the foundations for a solid vocational rehabilitation programme for the mentally handicapped. This project will provide in an industrial atmosphere, work training and vocational training and accommodation for 120 mentally retarded orphans, selected from a group of 500 pupils of special schools. As this selected group will consist of the more mildly retarded who show some indication of social maturity, they may ultimately improve sufficiently as a result of prolonged vocational and social training (thus making up for deficiencies of late maturation) and approach or enter the normal range, and become integrated into normal society. As a next step and depending largely on the success of this project is the establishment of half-way houses and housing in a normal surrounding for those established in a normal economic situation thus enabling them to live on their own. Separately, in the same area, sheltered workshops are to be established for those whom it is not possible to place in open employment.

The project will consist of three workshop buildings including:
(a) welding and mechanical workshop (maximum thirty-five trainees);
(b) carpentry and wood carving workshop (maximum twenty-five trainees);
(c) light industry (maximum sixty trainees);
(d) general store (also for store-keeper training).

The laundry will serve both the institution and accept outside work, and will be part of the training scheme for a number of clients together with kitchen work and dormitory operations. The biscuit factory will cater for the enlarged production of the enriched biscuits now distributed to schools in some parts of the country. Besides adding to the industrial atmosphere of the institution, the factory will also provide employment for a limited number of clients.

It should also be stated that for permanent care of the more severely mentally retarded who socially are too immature for urban life, a number of farm estates are being planned where the clients will be engaged in different kinds of farming and simpler rural crafts.

The plans also provide for specially trained placement officers to cover the particular problems involved in placing the mentally handicapped in open industry.

As potential farmers, hard-core labourers and apprentices enter the classrooms, their mental potential and limitations are better assessed, observed and perhaps categorised; this will in fact show a rise in the statistics of those classified as mentally handicapped; at the same time the range of our previous classifications will no doubt be changed, then we shall have more border-line cases requiring different facilities. It is wise to consider this probable increase and plan our vocational rehabilitation programmes accordingly.
8. Rehabilitation Programme for the Mentally Handicapped in Iraq

by

Mrs. Angel E. Al-Jazrawi

We can hardly call it a rehabilitation programme when speaking of this group of handicapped, as so little has been accomplished in this field in Iraq; nevertheless some indication can be given of the work which has been done to make the mentally handicapped youngster fit for adult life.

Previous work and investigation has shown that the mentally handicapped can attain an average rate of speed in working but few are capable of work which demands accuracy and perception. Moreover, the mentally handicapped have difficulties in adapting themselves to adult life and occupation and are rarely motivated by results at some remote future date; hence some are absent minded, others are emotionally unstable, while some soon tire of monotonous work. They develop feelings of loneliness and inferiority which tends to cause difficulties in understanding new working instruction; also their spheres of interest are often childish in relation to their environment and surroundings. On the other hand they often maintain characteristics of frankness, kindness and sympathetic ways. These points are appreciated by their workmates.

We must fully realise the need and the necessity to train the mentally handicapped to co-operate with his fellow-workers, teaching him to adopt a cooperative and friendly attitude. By means of observation and psychotechnical tests we must find the weak and strong points in his mental condition and help him to find a suitable occupation. The main objective we must keep in mind at all times is not merely to give him something to live on but also something to live for.

The responsibility for education and vocational training of the mentally handicapped is shared by the Directorate General of Social Services, Ministry of Social Affairs and the Directorate of Local Administration, Ministry of Interior. The activities of the principal institutions engaged in this field of work are described as follows:

The Institute of Hope (El-Amal – Baghdad)

This institute established in 1954, and run by the Ministry of Interior, is a boarding school institute for mentally handicapped, deaf and dumb, boys and girls. In 1968 Al-Re Aya Institute emerged for the welfare of the mentally handicapped only. The Institute is staffed and operated by qualified teachers and the teaching of forty mentally handicapped is on very advanced lines. Vocational training includes leather work, stamp catalogues, toy-making, woodwork items, bookbinding. Difficulties are encountered in finding suitable employment for the trainees.

The Ramsi School – Baghdad

This school, opened in 1939 and run by the Association for the Socially Handicapped is a school for deaf and mentally retarded boys and girls; it is situated in northern Baghdad. It was transferred to new premises in 1955, and additional accommodation given by the Gulbenkian Foundation was opened in 1962; this enables 40-50 students to live in the school during their education and training. Practical vocational training courses are provided for the mentally handicapped of 14-16 years of age in the field of toy-making, leather work, gardening, paper-bag making; also packing overalls and aprons made by the tailoring workshop on the premises which is a vocational training workshop for the deaf.

Tel-Mohamad Sheltered Workshop

The Tel-Mohamad Rehabilitation Centre was converted in 1968 for use in the national rehabilitation programme as a sheltered workshop; its purpose is to
provide employment for the severely disabled who are unable to find work in normal industry and also those trainees from rehabilitation institutes and schools who are unable to secure a job. Thirty-five trainees whose disabilities include moderate mental retardation, alcoholism, neurosis, and some selected psychotic cases receive treatment at the nearby Al-Shamaiyia Hospital and vocational training at the workshop.

Various training activities include box-making and repair, pillow and cushion-making, wooden and cloth toy-making, garden furniture; there is also a government subcontract for paper-bag making, envelopes and bookbinding.

Al-Rashad Training Centre

The Al-Rashad Vocational Training Centre for the Disabled was founded in 1966. Its aim is to train and prepare for employment physically disabled persons and selected mentally ill cases for specific occupations by developing their vocational skill to the maximum potential; around fifty trainees are taking courses in bench fitting, machine operating, cabinet making and carpentry.

Al-Shammaiya Hospital for Mentally Ill

This large modern hospital with 1,500 beds was founded in 1961. Rehabilitation of the mentally handicapped receives little attention in this hospital but one hundred selected patients undergo indoor occupational rehabilitation such as painting and drawing, making small woodwork items, silver work, brush-making, sewing children's clothes, and gardening.

Al-Waziria Vocational Training Institute

This is a newly established institute in the national rehabilitation programme for the disabled. Inaugurated 7 April 1971 and built by the Gulbenkian Foundation, it is situated some 10 kilometres from the centre of Baghdad. Modern methods of vocational rehabilitation have been introduced which stress the need for proper selection of workers and jobs, matching the physical abilities of the disabled with physical requirements of jobs and finding employment suitable for their physical and mental capacities. Rehabilitation of forty mentally handicapped persons is undertaken in the institution through leather work, carpentry, painting, making small woodwork items and gardening.

Additional Note

The rehabilitation institutes render a social and welfare service in addition to the occupational training services. These institutes maintain communications with all interested persons and organisations and also provide a main daily meal for rehabilitees. The institutes also supply them with working clothes, machines and all raw materials free of charge. Thus the institutes render both a medical and care service free of charge during the period of training; moreover, there are playing fields and other sport and recreational facilities available in the institutes.
9. **Social Services in Jordan**  
(Care of the Handicapped and Disabled)  

by  
Mr. K. Faouri  

The Ministry of Social Affairs in Jordan provides many services.  

1. **The Mentally Retarded**  

   This is carried out as follows:  
   
   (a) There is a boarding school in Amman to care for the health, education and general training of children aged 6-12 years. Its aim is to help them to reach their full potential.  
   
   Places are too few, and admittance is given to those who, it is thought, will benefit the most in terms of achievement. Visits are made to the children's homes beforehand to try to evaluate them.  
   
   In an effort to offset this unsatisfactory situation, the children who must remain at home receive visits from social workers, to give the child's family advice on its care, home training, and also information about other sources of education that might be of benefit. In cases of hardship grants are available.  
   
   (b) For those children who leave school, and for those who have had to remain at home (but have proof of their ability to learn) the Ministry will give special training in suitable trades and occupations.  
   
   (c) There is in Jordan a "Swedish Society", which works with the Ministry in this field. Their experience and aid has been and still is very valuable in starting and developing this project. They look forward to seeing its expansion all over the country.  

2. **Youth and Juvenile Delinquents**  

   There are reform schools and remand homes where juvenile delinquents are detained for rehabilitation. Here they also have the opportunity to study and learn various trades. On release they are helped and guided by probation officers.  
   
   There are also youth clubs all over the country for all young people. Here, as well as passing their leisure time, they can, if they wish, learn a trade and advice and guidance is available.  

3. **The Deaf and Dumb and the Blind**  

   There is an institute for the deaf and dumb and one for the blind. These are residential schools where these children can receive an education and training to cope with their disabilities and learn a trade.  
   
   Although this service is widespread and well established, more is needed, and the Ministry is making efforts to expand and improve it.  

4. **The Physically Handicapped**  

   These people are offered the opportunity to learn a trade. Other rehabilitation needs are met by the Ministry of Health.  

5. **The Old**  

   There are old peoples' homes for the homeless, where all their needs are taken care of and every effort is made to make their last years pleasant. For those who have a home but are still in need, there are welfare services.
6. **Beggars**

There is a centre to cope with this special problem. They are taken there, given food and shelter, and also taught a trade so that they can leave and support themselves.

7. **Orphans**

There are a number of orphanages where these children are cared for and receive the same education as any other child in the Kingdom. When they leave school they can learn a trade of their choice or, if they wish, and have the ability, they can study further.

For all these people financial aid in the form of loans and grants is available, if this will help them to become self-supporting. All the efforts of the Ministry of Social Affairs are aimed at helping its less fortunate citizens to live full and productive lives wherever it is possible.

There are many small societies who work in these fields in Jordan. They work with and receive all possible support and co-operation from the Ministry. Their help, support, experience and advice is of great value and is much appreciated.

Despite the improvements and expansion made with their help the Ministry fully realises its services are not sufficient in certain areas, but finds it very difficult to correct this as quickly as it would like to. Lack of sufficient money is not the only problem, experienced and/or trained administrators and staff (especially in the newer techniques and approaches), equipment, machinery, are needed.
In the field of the mentally retarded Kenya is probably no better and no worse than the average African State. Voluntary work has been undertaken for some years in the field of education and Kenya has two schools with about 150 school places, one in Nairobi and one in Mombasa. The Nairobi City Council has two schools with classes for the educationally subnormal. Some district education authorities are adopting similar schemes. A teacher training college offers special courses (to qualified teachers) in the special skills and techniques required by teachers of the mentally retarded. In recent years a Kenya Society for Mentally Handicapped Children has been formed. It is not yet national in the scope of its activities but it is developing the responsibilities it has undertaken.

Perhaps the most promising aspect of Kenya's work for the mentally handicapped is the creation of a national vocational rehabilitation service under the care of government. An advisory body, the National Rehabilitation Advisory Council, is being formed which will offer guidance and informed opinion to the Minister. Since the creation of the service in the spring of 1970 eight centres of various kinds have been established. Six more are due to open before June 1972. Much requires to be done to ensure a satisfactory service, especially in the fields of staff training, job studies, employer training, vocational assessment and guidance. But we are moving forward and feel that in a couple of years we shall have a viable service to offer our handicapped. It has to be recognised that we have 750,000 handicapped people. It is estimated that about 7,000 to 8,000 suffer disablement annually. So we are not likely to help a whole generation of our handicapped people. But we are striving to create a service big enough to handle the annual problem. I think we shall succeed.

The new service has already opened a Pre-Vocational Unit for mentally handicapped teenagers where they may be taught the routines of work and in some cases moderate skills. There is a reasonable likelihood that there will be a flow of wage-earning employment for people completing the course. But job finding will be a hard task because of heavy unemployment and underemployment among the able-bodied. You will appreciate this if I tell you that half of Kenya's population is under 15 years old. Nevertheless I believe the scheme which I am introducing will be an employment charter for the disabled, whether working for themselves or for employers. We believe in a diversification of skills because Kenya really does offer good opportunities of comfortable living in the rural areas. In industry, which is now a rapidly growing sector, we believe in equality of opportunity — in getting jobs by merit. Employers will learn to see the value of this approach as they try out our clients, all of whom will have had good working qualities and attitudes instilled into them.

In addition to our Pre-Vocational Unit, we are now organising a sheltered workshop for the mentally handicapped specifically for those who could not succeed in industry but who could be satisfactorily resettled at a lower pace and under controlled conditions.

Perhaps the following extract from one of our circulars is the best description I could offer of our Pre-Vocational Unit:

"For the mentally handicapped the road to employment is likely to be substantially longer than for the physically handicapped and stress must be laid upon the procedures to be followed if successful resettlement is to be achieved. Fortunately, at Jacaranda School the Pre-Vocational Unit will be working with the children of enlightened parents; their early preparation will usually have been sound and there will be a useful background of education and discipline.

The Pre-Vocational Unit will need to check the standard reached by each child, build up the medical record, wean the child from school to working environment, encourage work by habit, inculcate the qualities of perseverance, industrial obedience, ability to work throughout the day, loyalty,
willingness, reliability, etc. By a number of assessment tests determine tool sense, manual dexterity, functional ability for heavy or other grades of work, ability to work with others, limits of accuracy, etc. Based upon the data thus provided, vocational guidance should be offered to the parents. The teenager should then have reproduced for him the sort of environment he is likely to meet at work. He should be trained until his work habits and responses are satisfactory and indicate his ability to obtain and retain employment. Placing action should follow at the standard rate of pay for the recommended employment.

Not all clients will make this grade and a sheltered workshop will be necessary for some. The cost of places in sheltered workshops is heavy and they should not be occupied by persons capable of normal employment, unless on a very temporary basis. There should be a half-yearly review of sheltered workshop employees to see whether sufficient improvement has been made to allow normal employment to be sought for them. It has to be recognised that some clients are not likely to succeed even in a sheltered workshop environment. Such cases should be identified as soon as possible and discussed objectively with the parents.

In order to create satisfactory working personalities the Pre-Vocational Unit must develop workshops based upon industrial routines. Classroom pace and privilege must give way to workshop attitudes and organisation.

The development of such a working environment, in which there will be ample opportunity for testing ability and creating workers acceptable to employers, will be based upon a variety of indoor and outdoor activities:

### Section of Work

1. **Horticulture**

   Growing vegetables, fruits, flowers, house and verandah plants, taking cuttings, potting up, composting, etc.

2. **Concrete Products**

   To make paving slabs, building blocks, edging slabs, to lay paths, to build blocks, e.g., low wall.

3. **Woodwork**

   To make concrete moulds, to make rustic seats, to make simple boxes, e.g. rabbit hutches, dog kennels.

4. **Small Animals**

   Poultry and rabbits; cleaning out, use of manure, gathering food, rearing the young, feeding, collecting eggs, drying skins.

5. **Metal Work**

   Cutting and bending of metal strip and tube, drilling, nut and bolt work, simple assembly, marking of parts, e.g. tubular chairs, stools, etc., using jigs, shaping of sheet metal into tins and trays, wire work, e.g. lamp-shade frames, pin figures. Soft metal (e.g. aluminium) crafts.

### Incidental Testing

1. **Ability to absorb instruction,**

   Ability to dig, to plant in straight rows, to space plants.

2. **Ability in manual effort,**

   Ability to mix quantities, to test mixtures, to pour into moulds, to tamp down and make blocks, slabs, etc.

3. **Accuracy tests,**

   Ability to cut with saw, plane, hammer and use other tools, accuracy tests, nailing, screwing, painting and varnishing; assembling.

4. **Handling of livestock,**

   Handling of livestock, e.g. care, gentleness, attitude, ability to work to set routines, ability to clean, to work to instructions, to work without supervision.

5. **Use of handsaw, hand and breast drill,**

   Use of handsaw, hand and breast drill, sizing of holes, counting, sizing and assembly of nuts and bolts, metal bending, shaping by filing, possibly soldering.
Problems

The following are some of the problems encountered while implementing the scheme.

1. Lack of adequate funds. Kenya is a developing country. It, therefore, has limited financial resources.

2. Lack of qualified staff, and lack of local training facilities.

3. Lack of research facilities. To establish a proper rehabilitation programme for the mentally retarded, there is need for constant research.
11. Rehabilitation of the Mentally Handicapped in Malawi

by

Mr. R.J. Mbekeani

1. Malawi is a narrow strip of land, lying in the heart of Africa, along the lake of a similar name. The land area is 36,325 square miles. The population above 4 million. Its boundaries were created by treaties which ignored tribal affiliations and, therefore, there has always been free and unrecorded movement across these frontiers between the homes of kinsmen.

2. The country is divided into three regions, consisting of 23 districts. There are 30 towns, including district centres. According to the last census (1966) it was revealed that 52 per cent of the population live in the Southern Region, 36 per cent in the Central Region, and only 12 per cent in the Northern Region.

3. The difference in the concentration of the population is due largely to the fact that the Southern Region is more developed economically. There are big estates of tea and tobacco, and some industry. The National Development Plan, however, at present is giving priority to equal distribution of development projects in the whole country.

Psychiatric Aspects

4. Against the background of 4 million people the country is served by one mental hospital at Zomba in the Southern Region, which has to deal with the entire range of psychiatric problems, from patients who need only observation to the chronic psychotic defective of long standing, and to the criminal confined to the mental hospital after being found "guilty but insane".

5. Professional experience and research in the field is limited in Malawi. Therefore, I will try to present a short analysis of the activities in 1967 when preliminary work was done by an interested Israeli psychiatrist.

6. In 1967 the mental hospital admitted 849 patients and discharged 817 (96 per cent). If one added to this figure the numbers treated in general and rural hospitals under the supervision of the staff from the mental hospital the total number of in-patients would be 1,213. In the study only 500 records were presented, because in the rest no sufficient information could be found. Of these 338 were male and 162 female.

367 patients were from the Southern Region (73.6 per cent)
100 from the Central Region (20 per cent)
33 from the Northern Region (6.4 per cent)

Of interest also is that:
261 patients (52 per cent) were from rural areas
239 patients (48 per cent) were from urban areas

Only 37 patients (7.4 per cent) were employed at the time of their admission. The same study revealed that 143 patients (28.6 per cent) received some sort of formal education.
The Distribution of Illness among the 500 Patients

<table>
<thead>
<tr>
<th>Illness</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychopathy</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>Schizophrenic disorders</td>
<td>292</td>
<td>58.4</td>
</tr>
<tr>
<td>Manic depressive and involutional disorders</td>
<td>20</td>
<td>4.0</td>
</tr>
<tr>
<td>Senile and pre-senile</td>
<td>5</td>
<td>1.0</td>
</tr>
<tr>
<td>Cerebral arteriosclerosis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other symptomatic psychosis</td>
<td>31</td>
<td>6.5</td>
</tr>
<tr>
<td>Anxiety and phobic reactions</td>
<td>10</td>
<td>2.0</td>
</tr>
<tr>
<td>Hysteria</td>
<td>2</td>
<td>.4</td>
</tr>
<tr>
<td>Depressive reaction</td>
<td>51</td>
<td>10.2</td>
</tr>
<tr>
<td>Other reactive and psychoneurotic states</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pathological personality</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alcoholism and addiction</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>Mental defect</td>
<td>6</td>
<td>1.2</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>23</td>
<td>4.6</td>
</tr>
<tr>
<td>Observation</td>
<td>58</td>
<td>11.4</td>
</tr>
</tbody>
</table>

7. A special mention of the epileptics: generally, the epileptics, whether they are psychotics or not, are sent to the mental hospital. During 1967, 40 patients (4.7 per cent) were admitted.

Vocational Rehabilitation Aspect

8. The rehabilitation process, if it is to succeed, should start early and if possible should start in the hospital. In keeping with this philosophy the mental hospital tries to include the majority of the convalescent patients in one of the occupational therapy programmes. The patients are engaged in agricultural and sisal work, with some carpentry; and this includes traditional carving, and a chicken farm. The hospital also tries to involve them in the maintenance work within the hospital, such as that found in the laundry and building. Some are encouraged in the distribution of food and the more educated help with clerical work.

9. I would like to mention that, inspired by Professor Lambo’s Aro experience, a village has been built within the hospital grounds. The huts are built by long-term patients who are unlikely to return to their villages. The experiment seems to have given good results and we intend to continue it, but since none of the 500 patients mentioned above is engaged in this experiment more thought is being put into total rehabilitation of all patients discharged from the hospital and in need of resettlement and vocational rehabilitation.

10. In Malawi, like all Africa, psychiatric problems are different from western countries because of the differing social structure and cultural background.

11. New thought on the rehabilitation of the mentally handicapped should also be considered in terms of our own situation. Every hospital has its own quota of cases and every year the number increases. This appears to be the heritage of social advancement. There is an increasing denial of social responsibility on the part of the indigenous people for their dependants and
there is also a tendency on the part of the authorities to send beggars, vagrants and other social nuisances to mental hospitals as a line of least resistance. This may lead to psychiatric hospitals having custodial functions.

12. At present in Malawi the National Government is engaged in establishing settlement schemes and the handicapped, particularly the blind, are being settled side by side with the sighted in a competitive farming pursuit. It is therefore hoped that in time to come the mentally handicapped together with other categories of the disabled will be made economically viable by participating in these development projects that are being developed throughout the country. With the establishment of a Council for the Handicapped, hospital farms, psycho-geriatric settlements and epileptic colonies as sheltered workshops could be tried in order to make the physically and mentally handicapped useful members of the nation.
12. Vocational Rehabilitation of the Mentally Handicapped in Malaysia

by

Mr. Lau Sun Leong

Introduction

For the purpose of this paper, mentally handicapped persons include those who are mentally ill and mentally retarded. In Malaysia, facilities for residential care, treatment and training of the mentally ill are provided by the Ministry of Health whilst the Ministry of Social Services is responsible for the care and rehabilitation of all types of handicapped persons including the mentally retarded. The primary aim of these services is to rehabilitate these persons compatible with their particular disability into useful productive citizens.

The Handicapped Persons' Services in the Ministry of Welfare include ascertainment of their disability through a system of registration, facilities for residential care and treatment, education and training, placement in open employment, sheltered workshops, sales organisations, provision of launching grants, artificial aids and appliances and, for the blind in particular, the scheme for compensatory allowance.

Various governmental and voluntary organisations in Malaysia are available to assist handicapped persons in their efforts to lead useful and independent lives. To receive help and guidance, a handicapped person must first register his name and give details to the Department of Social Welfare. After registration, consideration will be given to the most suitable form of assistance available. This may be a recommendation for further hospital treatment, such as physiotherapy, occupational therapy or fitting of artificial limbs. Reference may be necessary to the specialist associations for the deaf, blind, spastic or mentally retarded, for a course of educational or vocational rehabilitation which may benefit them.

Rehabilitation of the Mentally Ill

In West Malaysia, there are two large hospitals catering for mentally ill patients. The Tanjong Rambutan Mental Hospital in the north has a population of 5,000 patients, though when it was first built in 1909 the hospital was meant for 3,500 patients. The other hospital, the Tampoi Mental Hospital, was built in 1937 and was originally meant to house 1,200 patients but today there are 2,600 patients warded in this hospital. Besides these two mental hospitals, out-patient psychiatric units are set up in most of the general hospitals throughout the country.

Admission to the mental hospitals can either be on a voluntary or compulsory basis. In the case of the latter, it is necessary for each case to conform to the requirements provided in the Mental Disorder Ordinance. The whole treatment is mapped out and planned for every patient.

The rehabilitation programmes are classified into two categories, namely the close and open rehabilitation. The close rehabilitation is in the form of occupational therapy. Here the patients are stimulated to do work and are taught new trades. Open rehabilitation is in the form of vegetable and flower gardening, animal husbandry, working in laundry units and in the kitchen. Apart from this, there are other forms of diversional therapy such as art therapy, music therapy and games and sports.

The Ministry of Social Welfare has seconded one social welfare officer to each of these hospitals to assist in the rehabilitation programme. Among other duties, they are required to do placement work and to secure employment for discharged patients.
Rehabilitation of the Mentally Retarded

Services catering for mentally retarded children and young persons are available in two handicapped units in the Children's Home in Johore Bahru and the Old Persons' Home in Bedong. These two units provide institutional care. These children are on the whole so severely handicapped that 70 per cent of them can benefit only from custodial care. The rest are given physiotherapy and occupational therapy and social training in accordance with their ability to benefit from these services. Boys above the age of 14 years are housed in the Bedong Unit. Approval has been obtained for the construction of a new centre for the mentally defective and severely handicapped children in Johore Bahru. This centre, when completed, will house 300 children. Retarded children can be helped with the right approach and training. The aim of the training is to make such children socially acceptable at home and in the community as a whole and to develop to the full their innate ability and potential.

Voluntary Organisations

In the absence of a government agency, voluntary agencies have a very important role to play in the rehabilitation work. The following voluntary organisations are directly involved in the rehabilitation of mentally retarded children:

(1) The Selangor Association for Retarded Children

This association is run entirely on voluntary contributions from members and the public. The association's immediate development plans include the erection and establishment of a centre which will become the focal point in their work for study and for dissemination of information on mental retardation and education of retarded children. The association also runs three day centres for retarded children aged 6 to 12 years. These centres provide social training and primary education for the children.

(2) School for Mentally Retarded Children, Kampong Kepayang, Perak

This school was established by the Perak Branch of the Malaysian Child Welfare Council. It has both day and residential facilities and charges a minimum boarding fee of $M30/- per month per child for residents. The school has fifty mentally retarded children aged 6 to 14 years.

(3) Penang Association for Retarded Children, Penang

This association runs a day centre for retarded children aged 6 to 12 years. It has a maximum enrolment for fifty and the centre provides social training and primary education.

Problems Encountered in Vocational Rehabilitation
of the Mentally Handicapped

The ultimate object of a vocational rehabilitation service is the settlement of a handicapped person in a satisfactory gainful employment. This service cannot be effective unless a very wide range of employment opportunities is open to the handicapped person.

It is obvious that any scheme of vocational rehabilitation depends upon the structure of groups or individuals within the community. If the community accepts the idea that the handicapped are non-productive, to be sheltered or maintained as a public liability, they are unlikely to be willing to provide the facilities for their assimilation into the working community.

Malaysia, being a fairly young nation and a developing country, does not have a full employment society. This complicates the problem of vocational rehabilitation. It is because of this unemployment that the resettlement of the handicapped person in the community becomes much more difficult.
At present there is no law in Malaysia requiring a certain quota of work to be reserved for handicapped persons. In order to overcome this problem, the Ministry of Welfare Services started a Placement Service, in the hope that it will make a gradual and steady infiltration of handicapped workers among the able-bodied workers; this will help to demonstrate to the employers what the handicapped can do in selective work.

The lack of specialist staff in the rehabilitation work greatly hinders the progress of the service. Although the Ministry has provision for specialist staff such as physiotherapist, speech therapist, there are no suitably qualified persons to fill these posts. Thus to ensure that there is an adequate supply of specialist personnel and staff, the Ministry is endeavouring to provide more scholarships and training courses for persons dedicated to rehabilitation work.
13. Rehabilitation Programme for the Mentally Handicapped in Nigeria
by
Mr. B. Akinwale

For a variety of reasons, a comprehensive rehabilitation programme for the disabled generally in Nigeria has yet to be evolved. Prior to the attainment of national independence eleven years ago the nation was understandably pre-occupied with the provision of skilled and high-level manpower without which its immense national resources cannot be tapped for social and economic development. Like most developing countries, it had therefore accorded high priority to the able-bodied requirements of the population. Although an awareness of the existence of disablement in some sectors of the population was shown, and disablement was recognised as a social affliction, it attracted very low priority in the scheme of things. The connotation of disablement was indeed rather narrow, embracing just the blind, the deaf, the crippled and the homeless mentally ill.

In the circumstances, care of other categories of the disabled was regarded as a traditional family responsibility. With the prevailing pattern of mixed economy and social order, parents and other members of the extended family accepted the responsibility to care for the unfortunate disabled members of their family. The mentally retarded in particular were accorded the sympathy and care of their kith and kin. The general public, too, was activated by compassion and a sense of charity to assist the disabled. However, with the growing complexity of the modern economy it has become increasingly clear to all, more so to the Government, that the initiation of programmed rehabilitation services for the size of Nigeria with a population of about 60 million is a necessity. True to the saying that there is always a silver lining behind the cloud, the civil war which Nigeria went through has further stimulated progressive attitudes and thinking towards the issue of disablement. The issue has therefore assumed greater importance and priority. Participating in this Seminar is a United Nations expert on his way to Nigeria on the invitation of the country to advise on all facets of rehabilitation.

Notwithstanding the lack of reliable statistical data that will enable the number of the mentally handicapped to be determined, it is certain that the size of the problem has been further accentuated by the effect of the war. Both civilians and soldiers who suffered mental injuries in war-affected areas are known to be considerable.

Meanwhile missionaries and voluntary bodies have initiated in various parts of the country schemes for caring for, rather than rehabilitating, the mentally handicapped. It is to be noted in parenthesis that the medical treatment of the mentally ill is an exclusive affair of the Government in specially designed mental hospitals, notably the Aro Mental Hospital in Abeokuta otherwise known as the Ibadan Hospital. In appreciation of its obligation to the disabled, the Government gives assistance, both financial and expertise, to the missionaries and voluntary organisations that sponsor and run services for disabled persons including the mentally handicapped.

The services provided for the mentally handicapped in some parts of the country cater mainly for children in terms of providing shelter, food and limited education of a prevocational character. Such services seem to be an end in themselves and not as yet a means to an end. A real rehabilitation process aimed at catering for the whole person of the disabled with a view to his full integration into the life and work of society is yet to be accomplished.

Since independence, institutions like the Cheshire Home for Handicapped Children have been established in Lagos, Ibadan, Enugu and Kaduna. They take in and care for retardates and the physically handicapped generally. The training, which is strictly non-academic, is designed to make their young clientele more effective citizens.

Other voluntary organisations like the Good Samaritan School for Handicapped Children have sprung up within the last ten years in large centres of population such as Lagos and Ibadan. They cater for handicapped children, comprising those suffering from physical impairment and educationally subnormal pupils.
In short, they are open to pupils with multiple handicaps. Being non-government institutions they charge fees which are supplemented with token government grants and public donations. In this same category is the Child Treatment and Placement Home School in Apapa which caters for speech defectives, the physically handicapped and the emotionally handicapped as well.

In a small measure, the Government has begun to take practical steps to demonstrate the awareness of its responsibility for the care of the mentally retarded. To this end it has established a Child Care and Treatment Home School within the Institute of Education of Lagos University, as well as a child guidance clinic for guidance and counselling services in addition to rendering remedial teaching. The Educational Unit for the Handicapped established within the Royal Orthopaedic Hospital in Lagos lays stress on occupational therapy as a means of exploring innate potentialities.

There is no doubt that the future augurs well for the introduction and establishment of a comprehensive programmed rehabilitation service for the disabled generally. The long experience of developed nations and the experiments carried out the world over have brought out and highlighted the difficulties with which the nation must contend to have an effective service. Seminars of the type currently in session confer advantages of a late start.
14. Vocational Facilities Offered to the Mentally Retarded in the Republic of Panama

by

Mr. P. Alvarado

The Industrial Learning Center was created to cover the vocational needs of the young handicapped who belong to the different programmes developed by the schools of the Panamanian Institute of Special Habilitation. As a direct consequence of this fundamental premise, we have elaborated co-ordinated programmes according to the population that enrols at the Center and the programmes from which they come.

As conscientious teachers, we believe in the equality of all human beings, no matter what their physical or mental condition may be. Everybody has the right to develop all his abilities to the maximum of his capacity.

It is our obligation to carry on the exploration, discovery and development of all the potential that will help the mentally retarded to succeed in life.

At the moment we accept these postulates as an integral part of our professional work; we assume at the same time the obligation to establish the machinery to improve the same.

There are some basic principles which we practise in our daily curriculum:

(a) maximum development of the mental capacities of the individual;
(b) optimum realisation of physical health of each student;
(c) adequate development of the personality;
(d) acquisition of vocational abilities for economic independence according to the needs of the individual and the community in which he lives;
(e) development of social capacity for personal adjustment within the community;
(f) development of ethical and moral habits required to accomplish the duties and obligations of life;
(g) development of recreational activities for use in free time, as a complement to the formation of their personalities.

This is the description of the educational process used in the Republic of Panama by the Vocational Section for Mentally Retarded.

The students coming from the different school programmes of the institute begin with a complete evaluation using the following specialised staff:

1. general physician
2. neuropsychiatrist
3. social worker
4. otorrinolaringologist
5. phonoaudiologist
6. psychologist
7. vocational guidance counsellor.

At the moment each one of the professionals of the team renders his report to the Director of the Center who calls for a meeting in which the case is discussed.
The youngster enters the Center into the multiphasic workshop. Here we explore, discover and strengthen the vocational abilities of the individual.

The general programme of the multiphasic workshop covers the following areas: wood, metal, sewing, ceramics, drawing, painting, as well as other activities in which the adolescent shows interest and ability.

After a nine-month period in this programme, in which the instructor has followed a close monthly evaluation, the whole team meets again with all who have worked directly with the student in order to establish the placement within the vocational section.

Based on the study carried out by the team the student is placed in one of the following workshops:

- Metalshop
- Woodshop
- Agriculture
- Beauty shop
- Sewing
- Upholstery
- Home economics.

After a period of time no less than a year, taking as premise the instructor's report, the case is discussed by the team assessing in this way the achievement of the youngster. Subsequently, the individual is transferred to the production section. Within the production section, the individual adapts to the regimentation of a regular workshop, such as:

- (a) schedule (checking in and out, lunch break);
- (b) pricing of work (cost of materials, labour);
- (c) keeping delivery dates;
- (d) maintenance of and caring for working tools and the machinery of the workshop;
- (e) responsibility and independence in relation to personal security (body and equipment);
- (f) proper distribution of salary and free time;
- (g) reinforcement of the habits of:
  - work
  - health
  - civics
  - good relations with their fellow workers and their families.

Through the counsellors the youngsters who qualify are placed in the community as assistants in the areas in which they have been trained.

In this connection we have established a close relationship with the employers, specifying the strong and weak points of the individual. This is the result of the matching between the abilities developed in the child and the conditions required by the job.

When the capacity of the child to fulfill the demands of the job is assured, he is placed permanently. A follow-up study is carried on for at least a year. After this period of time the case is considered closed.
Problems encountered: only one, the competition with the unemployed population of our country.
The growth and well-being of any society depends upon the contribution of its members. It is assumed therefore that the members have been prepared for participation and productive roles. However, in any society there will always be a portion of the population who cannot come up to expectations and demands to fulfill this role - the handicapped. The mentally handicapped, composed of the mentally ill and the mentally retarded, present a problem which could have a crippling effect for a country if they are not given serious attention.

The undersigned uses children and youth as a frame of reference in this paper.

The United Nations Declaration of the Rights of the Child provides among other things that every child is entitled to special protection, opportunities and facilities by law and other means to develop his potential to the maximum. The Declaration further provides that the mentally, physically and socially handicapped are entitled to care, treatment and rehabilitation. Despite his handicap the child should be assisted to be as normal as possible in order to be self-reliant, productive and socially acceptable. To integrate him as a normal member of society he needs special attention and not over-protection; special services and not segregation.

The mentally handicapped need the care and assistance of their families with support from existing community resources particularly whenever their families are unable to provide the basic needs. However, the extent and quality of services and facilities for the mentally handicapped depend on the economic and social development of a country.

Statistics

The Philippines as a developing country has a population of 37 million, 55 per cent of whom are children and youth. It has one of the highest population growths with an annual rate of 3.5 per cent. The Philippines therefore faces the reality of a considerable number of its population with disabilities or handicaps which affects the over-all national development.

It is difficult to get reliable figures on the number of mentally handicapped in the Philippines because of lack of surveys and the extreme difficulty of reaching all the population in the more than 7,000 islands. Moreover, there are limited resources available throughout the country for making sound diagnosis in each case.

In an epidemiological survey of the province of Pampanga conducted five years ago the results indicated a prevalence rate of 36.44 per cent active mental cases per 1,000 population which includes the mentally retarded and the mentally ill.

For mentally retarded, it is estimated that 3 per cent of the youth population are mentally retarded. Of this mentally retarded group, 75 per cent are educable, 20 per cent trainable and 5 per cent severely handicapped. As to where these are spread out in the different regions of the country, there are no studies so far undertaken.

Agencies for the Mentally Ill

The National Mental Hospital provides care, treatment and rehabilitation to mentally ill patients. It is overcrowded and there is an urgent need to decentralize to the different parts of the country.
Hospitals of different universities within the population centres have psychiatric wards and/or out-patient clinics which offer diagnostic and evaluation services, training and rehabilitation with the latter to a limited extent.

The Philippine Mental Health Association is a voluntary agency which promotes mental health by undertaking preventive programmes and services.

**Agencies for the Mentally Retarded**

The Bureau of Public Schools, Department of Education, has now nineteen divisions in the different parts of the country offering special classes for the educable mentally retarded. For the school year 1969-70 it has an enrolment of 1,500 educable children.

There are four private day schools in the Greater Manila area which admit educable, trainable and severely retarded clientele from the upper income level. In Cebu province outside Manila there is a non-private day school for the educable and trainable mentally retarded youngsters.

The Department of Social Welfare through its Bureau of Child and Youth Welfare has a residential facility - the Elsie Gaches Village - which offers care, training and rehabilitation for youngsters from ages 4 to 21 years who are mentally retarded with or without physical handicaps. A sheltered workshop has been set up at the Elsie Gaches Village to serve both the Village wards and the mentally retarded children in the outlying communities. It provides shelter training and short-term sheltered employment.

Initiated by the Bureau of Child and Youth Welfare, day-care centres were set up in the community in collaboration with voluntary welfare agencies, church groups and local government. The rationale is to reach out to mentally retarded youngsters, minimise institutionalisation and to strengthen families in assuming their responsibilities for care. The Elsie Gaches Village, the sheltered workshop and the day-care centres serve as training facilities for the different disciplines involved in the rehabilitation of mentally retarded youngsters.

For diagnostic evaluation, existing community resources are used and purchase of services is utilised whenever indicated.

Vocational rehabilitation of the mentally handicapped is undertaken by the different agencies organised under private or public auspices. However, there is very little planning and co-ordination among the agencies. So far, there is no specific national policy for the mentally handicapped. An annual celebration is observed such as the Mental Health Week and National Retarded Week.

**Problems**

1. As a developing country there is a need for comprehensive and unified planning and co-ordination in the provision of services for the mentally handicapped.

2. Availability of resources for early detection and expert medical examination and evaluation of the mentally handicapped is indicated which require close collaboration among the different disciplines.

3. Facilities are concentrated in centres of population hence the need to provide facilities in the rural areas.

4. There is a dearth of qualified personnel to work on the vocational rehabilitation of the mentally handicapped, hence more emphasis on staff training and incentives for qualified workers to enter the field.

5. Research studies should be undertaken on the mentally handicapped such as surveys to determine the distribution of the mentally handicapped in urban and rural areas.

6. Development of treatment methods for the mentally handicapped adapted to Philippine culture need to be looked into by practitioners.
7. International co-operation should facilitate the sharing of knowledge and experience from experts of the different countries.

Bibliography

An Epidemiological Survey of Mental Disorder in a Philippine Community, study conducted by the staff of the Division of Mental Hygiene, Bureau of Disease Control, Department of Health, Manila, 1965.


International Rehabilitation Review, 3rd Quarter 1970.


President John F. Kennedy on Mental Illness and Mental Retardation, reprinted by Phil. Mental Health Association Inc., Quezon City, 1965.


United Nations Economic and Social Council

Community for Social Development


16. Services for the Mentally Disabled in the Syrian Arab Republic

by Mr. Khaled Tahhan

Care for the mentally disabled started quite early in the Syrian Arab Republic. The care was based on the reception of these disabled in institutions where treatment and care were offered and based on methods known and practised during these periods. This care was organised by government agencies, the main aim being to put the patient in an institution for treatment and exclusion from the people so as to prevent any harm being inflicted by the patients, especially the severe cases.

There were also some social voluntary organisations which had long ago taken the initiative to provide some forms of social care for the mentally disabled in some Mohafazats in Syria.

In 1929 a real and scientific work was begun for treating mentally disabled; the Ibn-Sina Hospital had been established near Damascus which began to receive patients from different Mohafazats; it progressed year after year until it is now a big hospital caring for about 600 patients.

Another hospital had been created in Aleppo, which is a big city situated in northern Syria, with 200 beds. This hospital provides similar services to those of Ibn-Sina Hospital in Damascus.

The Damascus and Aleppo hospitals receive the mentally disabled as well as those who suffer from different mental diseases, and diseases arising from alcohol or some general medicines. These hospitals provide services in many forms: medicine, treatment and employment.

There are in the Damascus hospital 125 employees, 3 of whom are doctors, 12 office staff and the rest are nurses and general workers. This hospital has two main sections: one for males and the other for females. The patients are classified according to the type of illness from which they suffer.

In the Aleppo hospital, there is one specialised doctor and a suitable number of office staff, nurses and workers. There are also two sections, one for males and the other for females.

The Ministry of Health has planned to promote these two hospitals in its five-year plan which aims at enlarging the Damascus hospital so that it can cope with 500 more beds, as well as enlarging the Aleppo hospital, also for 500 more beds, and to provide these hospitals with the necessary technical equipment.

But there is a great deficiency in doctors in the field of mental health; in this connection the following recommendations were raised in a report submitted to the Ministry of Health:

1. sending technical missions for specialising in mental health;
2. asking international agencies and friendly countries to send specialised doctors to Syria to promote the services offered in the present hospitals;
3. granting fellowships to doctors who are working in this field for observing or studying similar institutions in other countries to strengthen their experience;
4. preparation of technical nursing staff able to work in this kind of hospital;
5. providing technical-social staff to work with doctors, and indicating methods for treatment in order to lessen anxiety states which some patients suffer from and to care for work therapy.

In addition to the services offered by the Ministry of Health, the Ministry of Social Affairs and Labour encourages voluntary agencies to establish
residential institutions to receive the mentally handicapped and to provide them with social care and work training for their leisure time.

Four voluntary organisations in Damascus, Aleppo, Homs, Hama—which are the main cities in the Syrian Arab Republic—have established institutions for this purpose and offer services to more than 100 persons. The Ministry of Social Affairs and Labour provides financial help annually and supervises the technical aspects and offers guidance to those who are working in these institutions.

The Government has established a good residential institution for the mentally retarded in Aleppo (in north Syria); it has 140 inmates and has some workshops for vocational rehabilitation.

In 1969 the Syrian Government adopted a new Act No. 54 for the physically and mentally handicapped. Under the new Act, the Ministry of Social Affairs and Labour has created some modern institutions for the rehabilitation of physically handicapped persons. In our new plan we will try to establish some residential institutions for the mentally retarded. In addition the Ministry of Education has a plan to open special schools for mentally retarded children.

Finally may I say that we hope to make good progress with our programme. We urgently need so many trained staff and technical assistance.
17. Vocational Rehabilitation of the Mentally Handicapped in Tanzania

by

Dr. Paul Ladda

Like many developing countries, Tanzania has a very poor national economy. Medical services are inadequate in both the curative and preventive fields. Illiteracy and low per capita income make health education efforts appear not worth while. With this in mind there is practically nothing to discuss on the subject of rehabilitation of the mentally handicapped.

Psychiatric services started in Tanzania in the 1920s. Legal procedures affecting the mentally ill in East and Central African countries were drawn by the ruling nations about the time of establishing psychiatric services and are still in force today in spite of the departure of our rulers a decade ago.

In terms of the laws now in force, the mentally disturbed and the mentally retarded are subject to the same provisions and facilities as regards admission, treatment, discharge and rehabilitation. Due to lack of specialists (and interest) in the Mental Department, Tanzania has had only one mental hospital for over forty years. However, since the last five years or so there has been gradual expansion of psychiatric facilities so that they may be available at regional level. There are now three such smaller psychiatric units at regional hospitals and a fourth is due to open now. Voluntary agencies had two small institutions for chronic patients which have recently been taken over by the Government. In all there are about between 1,300 to 1,500 psychiatric beds for a population of 12.5 million.

Until about three years ago patients discharged from hospital had no form of rehabilitation other than to return home on their own and resume cultivation of the land around their villages. Since the inception of regional psychiatric units, however, the needs for organised rehabilitation have become more apparent.

About 95 per cent of our admissions to the units live in the rural interior. The psychiatric unit at Tabora, which has fallen under my direction since April 1970, has thirty beds. It has a catchment area of about 50,000 sq. miles and a population of about a million people. In my experience although Swahili is generally the common language, about half the inhabitants of the rural interior do not speak and understand the language well. Also, within this area communication is very difficult. Except for a small proportion of those who live in towns most of the inhabitants of Tanzania live on cultivated products. Although there are projects in villagisation and collective activities there can be no hope of getting enough jobs in industries and rehabilitation of the type talked about in developed countries is best forgotten in an undeveloped setting. Thus, our patients throughout the period of hospitalisation are prepared for their eventual return to this traditional vocation - cultivation.

To overcome congestion in hospitals, discharged patients normally spend two to four weeks at a village attached to the psychiatric unit. Our unit in Tabora has a maximum capacity of up to sixty patients, and of these about one-third are expected to remain at the same stage for the rest of their lifetime. The main activity at the village is cultivation. Thus, those who are returned home will have been reintroduced to their vocation by the time they go back to the villages.

Although the laws are still to be changed, relatives of patients are now encouraged to bring their mentally ill direct to hospital. This has proved useful for we are now able to see patients early in the course of their illness and the information extracted from relations aids early diagnosis and discharge from hospital.

Most patients find it difficult to return to hospital for follow-up sessions and more medication. It is therefore intended to set up treatment centres within the catchment area where a team of workers operating from the regional unit can arrange to meet their patients for treatment and any possible rehabilitation. And low per capita income make health education efforts appear not worth while. With this in mind there is practically nothing to discuss on the subject of rehabilitation of the mentally handicapped.

Psychiatric services started in Tanzania in the 1920s. Legal procedures affecting the mentally ill in East and Central African countries were drawn by the ruling nations about the time of establishing psychiatric services and are still in force today in spite of the departure of our rulers a decade ago.

In terms of the laws now in force, the mentally disturbed and the mentally retarded are subject to the same provisions and facilities as regards admission, treatment, discharge and rehabilitation. Due to lack of specialists (and interest) in the Mental Department, Tanzania has had only one mental hospital for over forty years. However, since the last five years or so there has been gradual expansion of psychiatric facilities so that they may be available at regional level. There are now three such smaller psychiatric units at regional hospitals and a fourth is due to open now. Voluntary agencies had two small institutions for chronic patients which have recently been taken over by the Government. In all there are about between 1,300 to 1,500 psychiatric beds for a population of 12.5 million.

Until about three years ago patients discharged from hospital had no form of rehabilitation other than to return home on their own and resume cultivation of the land around their villages. Since the inception of regional psychiatric units, however, the needs for organised rehabilitation have become more apparent.

About 95 per cent of our admissions to the units live in the rural interior. The psychiatric unit at Tabora, which has fallen under my direction since April 1970, has thirty beds. It has a catchment area of about 50,000 sq. miles and a population of about a million people. In my experience although Swahili is generally the common language, about half the inhabitants of the rural interior do not speak and understand the language well. Also, within this area communication is very difficult. Except for a small proportion of those who live in towns most of the inhabitants of Tanzania live on cultivated products. Although there are projects in villagisation and collective activities there can be no hope of getting enough jobs in industries and rehabilitation of the type talked about in developed countries is best forgotten in an undeveloped setting. Thus, our patients throughout the period of hospitalisation are prepared for their eventual return to this traditional vocation - cultivation.

To overcome congestion in hospitals, discharged patients normally spend two to four weeks at a village attached to the psychiatric unit. Our unit in Tabora has a maximum capacity of up to sixty patients, and of these about one-third are expected to remain at the same stage for the rest of their lifetime. The main activity at the village is cultivation. Thus, those who are returned home will have been reintroduced to their vocation by the time they go back to the villages.

Although the laws are still to be changed, relatives of patients are now encouraged to bring their mentally ill direct to hospital. This has proved useful for we are now able to see patients early in the course of their illness and the information extracted from relations aids early diagnosis and discharge from hospital.

Most patients find it difficult to return to hospital for follow-up sessions and more medication. It is therefore intended to set up treatment centres within the catchment area where a team of workers operating from the regional unit can arrange to meet their patients for treatment and any possible rehabilitation. And low per capita income make health education efforts appear not worth while. With this in mind there is practically nothing to discuss on the subject of rehabilitation of the mentally handicapped.
future, most admissions will have previously been recommended for admission by ourselves rather than the law.

Even with this programme, several problems have to be solved.

1. Shortage of manpower is experienced in all centres of psychiatric staff. This would impede any move to establish any scale of successful rehabilitation. For the same reasons doctors assigned to psychiatric duties often find that their services are in demand elsewhere in the regional hospital or the villages for what, apparently, is more pressing work.

2. Funds are always in short supply. Thus, nurses who have had in-service training to supplement qualified social workers often find they are unable to travel to the patients' homes and hand them to relatives.

3. Poor psychiatric orientation among medical personnel is a discouraging factor to those engaged in psychiatric work. Although medical students and student nurses who have trained within the country over the last four years have been fortunate enough to receive broad psychiatric orientation and experience, it will not be until they hold executive positions or until the old staff of medical personnel is greatly outnumbered by the new crop that we can expect psychiatric illnesses to be given the concern and priority due to them.

Since there exists no distinction between the mentally ill and the mentally retarded, the latter group, being as a rule harmless to the public and posterity, have been left out of the picture in our psychiatric and social services. It is now contemplated to start a small unit for this category of the mentally handicapped at the big mental hospital in the near future – if funds and manpower permit. Only then can we talk of rehabilitation of the mentally retarded in Tanzania.
18. Vocational Rehabilitation of the Mentally Handicapped in Thailand

by

Miss P. Khanphaboo

General Background

Thailand has a population of 35 million and an area of 514,000 square kilometres, situated in the Indo-Chinese Peninsula of South-East Asia. It extends from 5 to 21 north latitude while in longitude from 97 west to 106 east. Agriculture occupies 90 per cent of the population.

Mental Health Services

There is a major concern in the mental health problem in the country, which is quite extensive. Diagnosis, treatment and research in this field has been satisfactorily improved and developed. The Department of Medical Service of the Ministry of Public Health is responsible for the treatment and prevention of mental illness and mental subnormality. The first mental hospital in Thailand was established in 1912 and was reorganised and has developed into the well-known Somdet Chao Phaya Hospital of the present time. Since then, many hospitals and clinics have been built for the study and treatment of mental and neurological conditions. It was obviously considered that the existing facilities in mental institutions were insufficient to cope with the increasing number of mentally sick. During 1956-1961 all mental hospitals were able to expand their facilities by addition of new buildings and by increasing their staff. Mental health services in Thailand have undergone considerable change and development in recent years. Increasing attention is now being placed on community mental health services rather than institutional care.

Many child guidance clinics have been set up and operated since 1953, to deal with the emotional and behaviour problems among the younger generation. A hospital for emotionally disturbed children has been set up and has been in operation in recent years. All mental hospitals have out-patient clinics.

Apsychiatric unit was opened in 1965 at Nakhon Hatchama General Hospital and serves the north-eastern region of the country. The first mobile psychiatric unit, based at Suan Saranrom Mental Hospital, serves the southern region. Other mobile units have been established for the purpose of expanding services to the public throughout the rural parts of the country.

With the aim of helping the people suffering from neurological and nervous disorders, Prasart Neurological Hospital was established and began to operate in 1957. The number of in-patients and out-patients has increased rapidly. Prasart Neurological Hospital also acts as a study centre in the field of nervous disease as well as other organic nervous entities.

An institution of mental deficiency (the Pan-ya On Training School, a hospital for the mentally retarded) was established in 1960 and opened in 1961. This hospital is responsible for institutional care treatment, and training of mentally retarded children and youth between 7 and 18 years of age.

Education

The education of the mentally retarded in Thailand is administered in two groups. The Special Education of the Non-Vocational Education Division, Ministry of Education, is taking charge of those children with IQ 75-90, who are called slow learners. Now, ten special classes have been organised for slow learners in nine schools on an experimental basis.

The Pan-ya On Hospital and School for Mentally Retarded serves as a special school for the mentally retarded children with less than IQ 75 and a vocational training workshop. There is also a group of pre-school age children who are looked after in a day care centre and are trained in daily living activities.
Another group of adolescent boys of 14 to 18 years of age is trained, as a pilot study, in "half-way home" located in a separate building but still in the hospital compound.

Most of the children in the institution are responsive to training and education. For the educable ones, there is a more structured schedule. For the severely retarded, there is some teaching of skills and simple work.

Social Service and Vocational Training

The social organisation did not deal exclusively with mental rehabilitation or vocational training outside the normal mental hospital until 1964. With the approval of the Cabinet, the Department of Public Welfare of the Ministry of the Interior and the Department of Medical Services, Ministry of Public Health, were entrusted with the responsibility for the Mental Rehabilitation Programme. The Institution for Mental Rehabilitation was established accordingly in order to accommodate the former mental patients with a view to:

1. accommodating some patients who have recovered from their illness, but have been abandoned at the mental hospitals, in order to make rooms and beds available for the newcomers;

2. provide vocational training with regard to their preparation for a normal life after discharge.

The Co-ordination Committee for Mental Rehabilitation was set up by the Cabinet, assuming responsibility and authority as a consultant body.

The programme has been carried out by the Department of Public Welfare, and the Half-way Home was set up and opened in 1965; services provided are:

1. Remedial services - provided by the Department of Medical Services co-operating with the Mental Hospital Division. The patients are given medical care by the nurses of the home, and the psychiatrists who regularly visit the patients once a week.

2. Vocational training services - the Department of Public Welfare is responsible for providing institutional care including accommodation, social services, vocational training and employment services.

Training courses are also provided, i.e. welding, building, interior decorating, dressmaking, animal husbandry, gardening and planting.

At the first stage, the Home is able to accommodate 200 male patients discharged from mental hospitals ranging from 10 to 70 years of age. It is expected that the programme will be extended so that the Home will have capacity for 300 men, and extend services to 100 women in 1972. With regard to the programme approved by the Cabinet, it will admit 350 men and 150 women which will make a total capacity of 500 persons by 1973.

Welfare Institutions for the Destitutes and Disabled Persons

According to the Beggar Control Act B.E. 2484 (1941), begging is unlawful, and beggars are liable to be arrested and sent to the Institution for Destitute Persons. The Department of Public Welfare is responsible for the welfare institutions for the destitutes and for the physically handicapped. The Department runs one home for the infirm and four homes for the destitutes. The total number of inmates accommodated are 2,200 destitutes and 600 disabled. The purpose is to provide shelter, care and elementary occupational training to inmates found as vagrants or beggars. About 70 per cent of the inmates are found to have some mental and physical handicap. An effort has been made, after the training period, to place them in sheltered outside jobs.

Services given to them are:

1. Medical examination and treatment. Immediately after admission, every inmate has to undergo physical and mental examination, and be treated by
the doctor assigned to the Home. If the treatment requires any specialist treatment or hospitalisation, he/she will be referred to the hospital for proper attention.

(2) Social work activities and social adjustment. Social workers are assigned to pay close attention to every inmate in order to study the case and solve their personal problems as well as to determine the most effective ways to help them.

(3) Vocational training and sheltered workshop. Inmates are given vocational training as a preparatory measure to earning their normal livelihood after discharge. Courses given are: agriculture, piggery, and poultry, carpentry and woodwork including furniture making, weaving, matting, handicrafts, dressmaking and tailoring, welding and metalwork, labouring, chores and domestic work.

(4) Custodial care. Services given to inmates include everyday life necessities, recreational activities including occupational therapy and hobbies. Film shows as well as other forms of entertainment and religious preaching are also provided.

Conclusion

It can be seen that the rehabilitation programme for the mentally disabled in Thailand has made significant progress in the last decade. Work, behaviour, occupational, industrial, recreational and educational therapy have been successfully introduced.

Rehabilitation of the mentally handicapped in the transitional period is vitally important for most of the long-term institutionalised patients because of the severe cultural discontinuity existing between chronic ward and ordinary community life. The main problem encountered is the shortage of specialists and qualified personnel to cope with the work.

With regard to the service given to the mentally retarded, the programme of treatment which was recently started only aims at children and youngsters of school age. No social institutes deal with the rehabilitation of mentally retarded adults. The Home for the Destitute of the Department of Public Welfare accommodating the homeless destitute deals with the problem of mentally sick residents. It is estimated that more than 50 per cent are permanent residents who simply receive custodial care and protection. It is seen that occupation at homes and training institutions for mental defective adults should be established as well as a nursing home for long-term care of the severely retarded and homeless to extend welfare services and protection to them. The programme of reorganisation and development of the homes for the destitute for this purpose is now under preparation and it is expected to get underway in the near future.

With regard to the social aspect, few problems are encountered owing to the strict tie of family relationship. The disabled are being cared for as much as possible by their relatives and neighbours so that they live happily in their own homes. The only problem is to change the attitude of Thai citizens from "the disabled can do nothing" to "the disabled are able and can become productive workers".
19. Problems of Rehabilitation of the Mentally Handicapped in Turkey

by

Professor Fuat A. Gökse1, M.D.

Turkey is an eastern Mediterranean country of approximately 300,000 sq. miles. Economically, it takes its place among the newly-developing countries. The large majority of Turkey's 35 million population are farmers. Approximately 65 per cent of Turks live in communities of less than 10,000. In the newly-developing industrial centres rapid urbanisation is taking place. More than 60 per cent of the inhabitants of many cities are people who have moved from their villages to the city slum areas.

Educational and health institutions are concentrated, for the most part, in large centres. An effort has been made during the planned economy period of the past ten years to spread industrialisation and public services in a more balanced way. During this period the yearly increase of about 6 per cent in the material income has been diminished due to the 3.5 per cent rate of increase of population. Work in family planning is still new.

During the period of planned economy, medical and educational policies have been revised to give priority to regional and local development. The socialisation of medical services has been initiated, beginning with the least developed parts of the country. In rural areas small medical aid units (health stations) and health centres, to which the former units are attached, have been established. Parallel to this, maternal care centres and stations are showing widespread activity. The total number of hospital beds existing in public and private institutions is approximately 90,000. The large majority of these are either public-owned or belong to the national health security system. At present, 14 per cent of all Turkish doctors are practising in foreign countries. Sixty-two per cent of the 13,000 doctors in Turkey are specialists. Fourteen per cent of the working population in Turkey is able to benefit by national health insurance. National investments in health services amount to about $100,000,000.

Elementary education is nominally obligatory in Turkey and approximately 5 million out of 6 million elementary school-age children attend school. Work in the field of mental retardation in education is quite old in Turkey. There are no reliable statistics on the mentally retarded population in Turkey. A rough estimate indicates that 3 per cent of the population under 18 years of age is mentally retarded. At present, there is no differentiation between these and other sick physically handicapped persons in regard to the availability of health services.

Mentally retarded children and adults are taken to mental hospitals and neuro-psychiatric clinics. The present number of beds available for mental patients is about 5,500, most of which belong to three regional state hospitals. Included in this number are the psychiatric wards in university hospitals, each of which contain 60 to 150 beds. At the Istanbul State Mental Hospital, which is the largest regional hospital, 215 out of 3,000 resident patients are mentally retarded. Three to 6 per cent of the patients admitted to that institution are mentally retarded. These patients benefit from the rehabilitation and occupational therapy services of the hospital, as do many other patients there. These services were begun in 1960 and include construction, carpentry, sewing, music and folk-dancing. The hospital contains a children's unit of 300 beds which offers special care and readaptation. A public institution especially devoted to the treatment or rehabilitation of the mentally retarded does not exist in Turkey. Such private institutions as have been established have been short-lived due to financial considerations.

The five-year programme submitted to the State Planning Office by the Ministry of Health and Social Assistance envisages the following points:

Two institutions of 250 beds each in Ankara and Istanbul for the age group 0-14 years will be set up, as well as two more institutions of the same size in each city for those above 14 years of age. The land property for two of these four establishments has already been purchased. It is estimated that $5,000,000 will be needed to erect these four institutions which will provide for the care, treatment and rehabilitation of one thousand mentally handicapped persons.
The specifications for all institutions to be set up for the mentally retarded as well as for the personnel of such institutions have been determined in a draft prepared by a committee composed of representatives from the Ministry of Health and Social Assistance, the Ministry of Education and the universities. This regulation has been submitted to the Government for its approval.

Of the 16,987 needy children who are being sheltered and educated by the 125 institutions attached to the Ministry of Health and Social Assistance, the Ministry of Education and various social assistance and social service organisations, only a small proportion are mentally retarded and for these there is no special programme.

The large majority of those who benefit from rehabilitation centre treatment are physically handicapped. These centres do not, for example, provide special educational programmes for cerebral palsy victims.

Educational services for the mentally retarded are more available than health services in Turkey. In 1952 a Department of Special Education was formed within the Ministry of Education. The guidance centres which have been established progressively since 1954 deal especially with problems of failure in school work. At present, there are 264 special classes for mentally handicapped children in normal elementary schools; these classes are attached to 12 guidance centres. They provide special educational programmes for educable retarded children with a 50-75 I.Q. These children are trained and educated for social adaptation and participation in productive work. There is a total of 4,517 such students. A special class for mongoloids has been set up at the Ankara Guidance Centre.

Each year the guidance centres screen the primary schools in their areas for mentally retarded children and examine such children individually. Those having an I.Q. below 50 are returned to their parents who are given family guidance. Those with 50-75 I.Q. are sent to special classes which are increasing in number rapidly. The centres provide guidance to school administrations and teachers as well as the families for the "slow learners" who have a 75-90 I.Q. The centres have doctors, psychologists, trained psychometrists and social workers. They are also educational centres in the sense that they train counsellor-teachers and teachers of special classes.

The guidance centres also endeavour to find employment for the graduates of special classes. However, they are faced with great difficulties in this field. Beginning in 1972, the first apprentice school (practical vocational school) will open in Ankara with a total of 300 students. Graduates of special classes will be admitted to this school.

At present, there are no sheltered workshops or sheltered employment in regular establishments. A draft law pertaining to this subject has been prepared by the Government and submitted to Parliament.
Rehabilitation and Care of the Mentally Handicapped in Uruguay

by Mrs. A. Ainsa

1.1 The planning of vocational rehabilitation of the mentally handicapped in Uruguay must be divided as follows: the work situation of the mentally retarded and the work situation of the mentally ill. In the case of Uruguay it must be evaluated in relation to general rehabilitation, in which the major emphasis is given to mental retardation. In the Seminar of Evaluation of Institutional and Human Resources (SEPRI) held in Uruguay in December 1969, we learned that rehabilitation institutions offered services as follows: 55 per cent dedicated to mental retardation; 11 per cent to physically handicapped; 9 per cent to cardiac diseases; 8 per cent to blindness; 6 per cent to epilepsy; 6 per cent to psychiatric problems; 5 per cent to diabetes; 2 per cent to the deaf.

1.2 The co-ordination of all the services of rehabilitation depends on the National Committee of Rehabilitation, whose essential aims are:

(i) medical or recuperative procedures aimed at improving the general physical condition and psychological balance of the handicapped;

(ii) special instruction and education of the physically and mentally disabled, as well as guidance and vocational training;

(iii) procedures aimed at integrating the disabled person into his environment;

(iv) to evaluate the possibility of establishing a pilot education and training centre, to encourage and co-ordinate existing workshops and to make a study of the optimal conditions for the inclusion of the disabled person into the environment;

(v) to effect an improvement in the condition of the disabled, whether currently under care or not.

2. Occupational Habilitation of the Mentally Retarded

2.1 There are 32 schools for mental rehabilitation in Uruguay, 9 in the capital and the others spread over the country. Each of them possesses a pre-occupational habilitation workshop but only 3 of them have sheltered workshops in addition to this service.

2.2 Preoccupational Habilitation

At teenager level a preoccupational stage is started which is based on a dynamic process of information, orientation and training. The preoccupational information aims at familiarising the pupil with the working community, acquainting him with the conditions and requirements of each activity so that he understands occupational objectives and knows where and how to get a job. This is accomplished through audio-visual aids, visits to factories, workshops and stores. Teachers supply the necessary information about the jobs they might choose.

2.3 School for Mental Rehabilitation

In 1957 the first Habilitation Occupational Service was started whose specific aim is: to orient, train and place adolescents at work and supervise them until they are properly adapted to the work environment, either in the sheltered workshop or in the community.

2.3.1 This Occupational Habilitation Service operates with a permanent staff made up of "orienting" teachers, teachers of sewing, carpentry and home economics, Instructors of gardening, aviculture, horticulture, coffee shop and workshop auxiliaries supervisors.
2.3.2 The Occupational Habilitation Service has detailed information on the former education of each of the mentally retarded. Special attention is given to reading, writing and arithmetic levels, knowledge of skills and individual social and working characteristics.

2.3.3 The study of the client is completed with a medical-psychological, social and educational approach, including a knowledge of special techniques used in the working environment and in the investigation of the mentally retarded adolescents. One of such tests used in Uruguay is P.A.C. (Progress Assessment Chart) from Gunzburg in two ways:

Form 1 - for trainable mentally retarded.
Form 2 - for educable mentally retarded teenagers with an I.Q. between 55 and 80 which gives us a global information; also the progress made in four fundamental areas can be appreciated visually:

(a) personal independence;
(b) communication;
(c) occupation;
(d) social habits.

Skills and behaviours have been ordered in three levels of social efficiency and employment:

(a) work at home, centred on parents' protection of the teenagers;
(b) sheltered workshop;
(c) competitive work in the community.

2.3.4 The preoccupational training generally begins when the client is about 15 and continues simultaneously with the elementary education, up to the time when learning possibilities of the pupil have been academically completed. In a first stage every teenager attends the training centre, no matter what his I.Q. They attend the different classes: aviculture, workshop activities, coffee shop, home economics, horticulture, gardening, office boy, sewing workshop. In this way the "orienting" teachers have the opportunity to know the teenagers personally, their interests, their attitude towards work, social behaviour, etc. At the same time, the "orienting" teacher interviews the client, ascertains his personal ambitions. This teacher-client relationship is important and necessary for guidance and orientation.

2.3.5 Attendance at the preoccupational training centres gives a general indication as to how the client behaves at work and is useful to determine what kind of activities offer possibilities of success and satisfaction. Adolescents with good prospects of obtaining a job in the labour market continue their training at centres in the community.

2.4 Sheltered Workshops

The trainable semi-dependent mentally retarded, capable of taking a supervised job, enter the sheltered workshop, whose purpose is:

(a) to provide a job during the lifetime of the clients who are not able to join the open labour market;
(b) to provide real experience on work, for those mentally retarded who are in need of training for competitive work;
(c) to provide piece work.

2.4.1 There are two sheltered workshops functioning in the school for mental rehabilitation and one as a sheltered workshop only (ETRO).
2.4.2 ETRO (Escuela Taller de Recuperación Ocupacional)

This school provides pre-vocational training and allied services to mentally retarded of after-school age. Its capacity is up to 400 trainees who remain in the centre from a few months up to two or three years. Training is given in a variety of occupations and the staff includes a psychologist, medical doctor, social worker, phoniast, physical therapist, nurse, teachers and trade instructors. There is a great need for a qualified occupational therapist as well as expert advice on vocational guidance and selective placement.

2.5 Placement in the Community

The educable mentally retarded should be able to enter open employment. In this connection the teacher tries to provide comprehensive information and facilitate the integration of the mentally retarded in normal work, taking into account the socio-economic conditions in Uruguay. Nowadays, Uruguay is facing an unemployment problem and some workers are taking jobs that could be performed by the mentally retarded, thus creating serious difficulties for work integration.

2.5.1 When clients enter the labour market the supervision stage starts. The "orienting" teacher must assist the mentally retarded during the adjustment period to settle in the competitive work situation until the client becomes totally independent.

3. In relation to mental patients, Uruguay has two psychiatric hospitals, although there is very little provision made for vocational rehabilitation.

3.1 The physical facilities, a complex of old buildings, are totally inadequate for the large numbers of patients involved. Patients are now sleeping in corridors and on tables and there is no organised activity for them. A few individuals have been assigned to old workshops where they have worked for a number of years already and where there is no room for additional patients. It is doubtful if there is any effective supervision of the workshop programme and of the assignments of patients to it.

3.2 Efforts have been made to establish some community therapy and recreational activities but, so far, only a modest start has been made and the programme reaches only a small number of patients. There is a great shortage of all qualified personnel and even of untrained aids. The lack of any occupational therapy must be mentioned as a particularly great handicap to modernisation of wards and rehabilitation programmes.

3.3 The establishment of an occupational therapy department would be a great improvement but the workshop system also would require urgent reorganisation, modernisation and trained instructors to establish a meaningful therapeutic training programme.